MEDICAL PROTOCOL NEBRASKA DEPARTMENT OF CORRECTIONAL SERVICES		NUMBER: MP55	PAGE NUMBER: 1 of 9
POLICY 115.09	ACA 5-ACI-6A-42	SUBJECT: MAT Treatment Program	

PURPOSE

The purpose of this protocol is to establish standard criteria, procedures, and processes for incarcerated persons to receive medication assisted treatment (MAT) for opioid use disorder in the form of methadone, naltrexone, or buprenorphine or alcohol use disorder in the form of naltrexone the Nebraska Department of Corrections (NDCS).

GENERAL

This policy applies to all NDCS institutions. The program will be coordinated by the Clinical Director of Substance Use Programs and the Clinical Program Manager for Substance Use. They will also be responsible for monitoring and maintaining records for the DHHS and other state or federal agencies.

DEFINITIONS

Buprenorphine - A partial mu receptor opioid agonist used for the management of acute and chronic pain. Buprenorphine is also used for maintenance treatment of opioid use disorder. When used in treatment of individuals with OUD, buprenorphine increases treatment retention, reduces opioid craving, and blocks euphoric effects of other exogenous opioids. Due to the ceiling effect of buprenorphine, it is safer than methadone when agonist therapy is utilized. Any prescribing provider with a DEA registration can prescribe buprenorphine. Buprenorphine for OUD is available in the following formulations:

1. Long-acting injectable buprenorphine (Sublocade, Brixadi)
2. Sublingual tabs or films administered at doses up to 24 mg/day for most patients. These preparations may be the mono-product (e.g., buprenorphine, brand name Subutex) or the combined product (e.g., buprenorphine/naloxone) The latter formulation helps prevent misuse, i.e., injection of the product vs. sublingual administration.

Medication Assisted Treatment (MAT) - Refers to substance use disorder treatments that provide maintenance pharmacotherapy using an antagonist and/or agonist medication, which is ideally combined with other comprehensive treatment services, including medical and psychosocial services.

Medication for Opioid Use Disorder (MOUD) - Refers to opioid use disorder treatments that provide maintenance pharmacotherapy using an antagonist and/or agonist medication, which is ideally combined with other comprehensive treatment services, including medical and psychosocial services.

Methadone - A synthetic opioid agonist used for opioid maintenance therapy in opioid use disorder and for chronic pain management. Pain management uses may be prescribed by any physician while opioid use disorder applications are administered at certified methadone clinics or OTPs (Opioid Treatment Programs).

MAT Administrator - The MAT administrators for NDCS will be the Clinical Director for Substance Use and the Clinical Program Manager for Substance Use who assists with the selection, referral, treatment coordination and reporting on participants in the MAT program.

OUD/Opioid Use Disorder - Physical and psychological dependence on opioids, resulting in tolerance, cravings, preoccupation for obtaining opioids, and inability to address live responsibilities. See DSM-5-

TM criteria. Opioids are found in both legal/prescription and illegal drug formulations.

Naltrexone - An opioid antagonist, has demonstrated efficacy in reducing return to illicit opioid use, increasing treatment retention, reducing opioid craving, and blocking euphoric effects. Naltrexone is also effective in alcohol use disorders. Naltrexone is available in the following formulations:

1. Long-acting injectable naltrexone (Vivitrol)
2. Oral naltrexone administered at 50mg/day
    a. Appropriate for highly motivated and compliant patients.
    b. Very little diversion potential
    c. Not a controlled substance
    d. Naltrexone is currently the preferred agent for alcohol use disorder.

Opioid Treatment Program (OTP) - Accredited substance-use disorder treatment program, providing outpatient medication assisted treatment via medication (including methadone), counseling, and community-based services.

PROCEDURE

I. Program Intake procedures and possible continuation of MAT from the Community (All Patients)

A. All incarcerated persons shall be screened upon medical reception intake for Substance-Use Disorder and/or current MAT medication prescription history. This screening shall be completed using the Behavioral Health Intake Assessment (BHIA)and an approved substance use assessment tool (e.g., Texas Christian University Drug Screen V).

1. Incarcerated persons who have been prescribed MAT in the form of methadone buprenorphine, or naltrexone in the past 30 days, shall be referred to a Provider (Mental Health/ Medical) for consideration of continuing MAT.

a. MAT medications that arrive with the incarcerated person in the form of buprenorphine or naltrexone shall be profiled and will be valid for a period not to exceed the original expiration date of the prescription. A urine drug screen shall be performed to ensure prior compliance.

1) The medication must be properly labeled, and not more than sixty (60) days old.

2) The Medication shall be secured and dispensed by medical staff.

2. For individuals receiving or self-reporting a history of MAT in the community with no accompanying records, intake healthcare staff shall have the incarcerated person sign an Authorization of Release of Confidential Healthcare Information (Attachment D). The request of information is then sent to the individual provider (or pharmacy). Upon receipt, the records shall be scanned into the electronic healthcare record (EHR). Prescriptions may also be verified by the prescription monitoring drug program. To be eligible, the outside records must meet criterion in I.A.1.a above.

3. Incarcerated persons not eligible for buprenorphine or methadone will be referred to a provider. At this appointment, the patient will be assessed for MOUD. If appropriate, Naltrexone will be the drug of choice.
4. Incarcerated persons diagnosed with opioid use disorder or alcohol use disorder upon intake will be assessed by a MAT coordinator for level of treatment recommended to include intensive residential treatment, intensive outpatient treatment, or standard outpatient services. After completion of these programs peer services (e.g., NA/AA) are available for continued support.

B. Provider follow-up visits should occur monthly X 4 months, then no more than fewer than q 3 months.

C. Incarcerated persons without a prior diagnosis of SUD who have a positive urine drug screen for opioids or overdose (OD) shall be referred to the MAT coordinators/designees for program screening recommendations. Initial recommendations include assignment to one of the above programs. The incarcerated person will also be referred to the provider for MAT assessment.

D. MAT Non-Adherence

1. Creating an unsafe treatment environment
    a. Patients actively enrolled in the MAT program and exhibit threatening or aggressive behaviors will be referred to a Mental Health Provider. During the stabilization process the MH Provider will determine if MAT should be stopped. The MH and the medical provider should approve the continued need for the MAT program.
    b. Patients who are identified as diverting MAT medications will be referred to the MAT coordinator and provider. Patients found to be diverting MAT medications will be assessed for an alternative treatment program on a case-by-case basis. Rarely should the decision to stop MAT medications be made on the first or second incident.
2. Non-adherence with scheduled appointments
    a. Missed appointments will result in referral to the MAT coordinator/designee to identify a solution to avoid future occurrences.
    b. Consideration of modification of the patient's individualized treatment plan, up to and including an alternative treatment program may be considered.
3. Non-adherence with ordered medical drug screens
    a. A positive medical or security drug screen for substances other than prescribed medication will be evaluated by the provider and MAT coordinator on a case-by-case basis. Rarely should cessation occur with the first or second incident.
    b. Refusal or tampering with a medical drug screen will result in the inference that a specimen would be positive for substances other than the prescribed medications. This may lead to modification of the treatment plan up to and including an alternative treatment plan.
    c. A drug screen that is negative for the patient's MAT medication may lead to a dose decrease or change in medication in the patient's treatment plan.

4. Non-adherence with DOC medication administration protocols
    a. Patients attempting to divert MAT medications during direct observation medication administration will be referred to the provider and the MAT coordinator/designee to ensure patient is not being bullied, threatened and to determine the best course of action.
5. Alternative Treatment Plans (ATP)
    a. It is imperative that patients are considered for an ATP on a case-by-case basis. In most cases a third incident should result in consideration of an ATP.
    b. ATPs may include behavioral health interventions, dose changes, and/or medication change to naltrexone
    c. If buprenorphine or methadone is halted based upon one of the above factors every effort should be made to provide a humane and medically appropriate taper.
    d. Patients discharged from buprenorphine or methadone treatment who stabilize at a later period during their confinement may be referred back to the MAT coordinator for reconsideration.

II. Evaluation and Treatment for Pre-Release Harm Reduction Opioid Treatment Program (PHROTP)

A. Upon notification, the MAT Coordinator/designee shall conduct a face-to-face assessment for incarcerated persons who are eligible to participate in the Pre-Release Harm Reduction Opioid Treatment Program within 120 days of release. Eligibility will be determined based upon prior screening at intake, after positive urine drug screen or overdose, and/or self-referral. Preference will be given to those who have been screened and have participated in treatment programs. The substance use coordinator will perform the assessment provided to DHHS by SAMHSA and this should be scanned into the record. (See Attachment A)

B. Incarcerated persons must also meet the following criteria to participate in the MAT PHROTP:
    1. Voluntarily agree with informed consent and be willing to participate; (Attachment B must be completed)
    2. Have a clinical diagnosis of Moderate or Severe Opioid Use Disorder, according to the DSM-5-TM criteria as documented in the required EHR;
    3. Ideally participants should have actively participated in the appropriate institutional recovery treatment programs. Programming shall include:
        a. Intensive Outpatient Program (IOP)
        b. Outpatient Program (OP)
        c. Resident Substance Use Program
    4. Attend NA/AA/Fellowship/Self-Help support meetings and/or be engaged in approved pro-social and/or self-directed recovery activities.
    5. Must engage respectfully with staff to ensure a safe treatment environment.

C. Acceptance into the PHROTP shall immediately trigger referrals to a multidisciplinary

treatment team to include social work, behavioral health, re-entry, community services, utilization management team, probation, and the medical team 120 days prior to release date. Social work should be consulted as earliest as possible given the extensive connections they must make for the program to be successful. See workflow Attachment C.

D. Social work will collaborate with the MAT coordinators for discharge planning to an appropriate MAT practitioner and housing, if needed.

E. Other referrals may be considered on a case-by-case basis.

F. The provider will be responsible for determining the patient's treatment plan and documenting the plan of care in the patient's EHR.

1. PHROTP follow-up evaluations shall be conducted in person or via telemedicine for 30-day and 60-day follow-ups and medication discharges.

G. Drug testing shall be ordered by the medical provider prior to ordering PHROPT. The test results shall be recorded within the EHR and shall not be provided to security personnel.

H. Periodic laboratory/diagnostic testing is required for incarcerated persons receiving MAT medications and may occur at the following times:

1. Baseline liver function test/comprehensive metabolic profile (CMP) will occur to establish a baseline prior to therapy, one month after therapy initiation, then every six months. Medical Urine Drug Screenings (UDS) will be completed one week prior to therapy initiation and then randomly on all offenders receiving MAT medications.

2. Nursing staff or designated health care professionals will arrange with security staff to await a witnessed specimen collection. Patients will be provided water as needed to facilitate a specimen collection.

3. Prior to release, patients who are on MAT must have completed a Medical UDS within the last thirty-days prior to discharge or parole.

III. Medication Administration at NDCS Facilities

A. Administration of buprenorphine strips/tablets, naltrexone, and methadone shall be directly observed by the medical team and/or security. Patients receiving medications may be required to drink a small cup of water prior to administration

B. Monitoring patients until medication is dissolved is no longer required. This practice has not been demonstrated to significantly decrease diversion.

C. If an incarcerated person experiences an acute and/or adverse reaction to the medications, the incarcerated person or staff shall seek medical attention by IIR or emergency response.

D. Initiation of patients not currently withdrawing from opioids due to abstinence:

Conditions to avoid precipitated withdrawals are not required to initiate buprenorphine as described below for the Opioid Dependent Patients. A slower and lower induction should be used.

1. Day 1: Administer 2mg of SL buprenorphine/naloxone 2 hours later assess for

signs and symptoms of sedation or precipitated withdrawal.

2. Day 2: Administer additional 2mg SL buprenorphine and watch for signs of sedation or precipitated withdrawal. If sedation or withdrawal is not observed, then the stabilization dose is 4mg. If the patient becomes overly sedated on day 1, then the stabilization dose is 2mg.

E. Initiation for Opioid-Dependent Patients Day 1

1. Step 1 - Ensure conditions to reduce the risk of precipitated withdrawal have been met.

   a. If a patient has never experienced COWS score: 11, consider proceeding with *Initiation for Opioid-Abstinent Patients* instead. Begin patient at 2mg buprenorphine. Increase 2mg/day until 8mg is reached. Stop titration if oversedation occurs.

   b. If the patient has signs of opioid withdrawal or positive UDS in the past week, initiate buprenorphine after COWS score is >12. Administer 4mg of SL buprenorphine. Consider initiation with 2mg buprenorphine if the patient has been on fentanyl.

   c. Do not attempt conversion of methadone to buprenorphine until the methadone dose has been tapered to 30mg or less. Conversion should occur 24 hours later. Once the patient has been tapered to 30mg methadone, proceed as in 1.b. above.

2. Step 2 – For patients Ib and Ic: Evaluate patient 4 hours after administration of initial dose of 4 mg of oral sublingual buprenorphine/naloxone for patients with recent use of opioids.

   a. Relief of withdrawal symptoms should begin 30-45 minutes after the first dose. If symptoms have abated or resolved, administer a second dose of 2-4mg buprenorphine (depending upon improvement) 4 hours after the first dose and stop for the day.

   b. If symptoms of precipitated withdrawal occur (symptoms worsen), treat symptoms, and attempt initiation again in 24 hours.

F. Follow up MAT Day 2 (non-abstinent)

1. Step 1 - Administer the previous day's (day 1) total dose as one dose in the morning.
2. Step 2 Four hours after administering the dose of buprenorphine/naloxone, assess the patient for signs and symptoms of withdrawal using COWS.

   a. If withdrawal symptoms remain relieved and patient does not report cravings, skip additional doses. Consider 8mg as a maintenance dose. If oversedation occurs do not increase. If withdrawal symptoms persist after 4 hours of AM dose, administer an additional 2-4mg. The patient's total dose received on Day 2 is the starting dose for the patient's Maintenance Phase.

   b. Do **not** exceed a total daily dose of 16 mg of buprenorphine on day 2. Because of Buprenorphine's ½ life, multidose (BID or TID) administration is not recommended.

c. The maintenance dose may be increased to 24mg if the patient continues to complain or cravings or demonstrate withdrawal symptoms after day 2.

d. If no adverse reactions occur within 2-3 days, patient may be converted to the injectable Sublocade formation.

G If at any time, there is concern for patient impairment, an urgent dose adjustment may be necessary. The patient should be referred to the provider.

H. Sublocade should be administered 1-2 days prior to release or over two doses beginning one month prior to release followed by a second dose 1-2 days prior to release.

1. Sublocade should be initiated at 300mg SC
2. This dose should be repeated in one month.
3. At month 3, the maintenance dose should be 100mg – 300mg SC.

I. MAT Follow up should occur monthly for those in the PHROTP.

J. MAT Non-Adherence

1. Non-adherence with ordered medical drug screens or required labs.
2. Alternative treatment Plans (ATP)
   a. It is imperative that patients are considered for an ATP on a case-by-case basis. In most cases a third incident should result in consideration of an ATP to include a dose increase/decrease.
   b. ATPs may include behavioral health interventions and/or naltrexone
   c. If buprenorphine or methadone is halted based upon one of the above factors every effort should be made to provide a humane and medically appropriate taper including the use of comfort medications
   d. Patients discharged from buprenorphine or methadone who request re-evaluation at a later period during their confinement may be referred back to the MAT coordinator for reconsideration.
3. Discharge from PHROTP
   a. Discharge from PHROTP may occur due to the following circumstances:
      i. Medical ineligibility due to laboratory studies.
      ii. Participant declination or refusal to sign consent.
      iii. Patient self terminates from program.
   b. Participants found to be using illicit substances shall be referred to the MAT coordinators for intervention. Continued use of illicit substances may result in discharge from the program upon treatment team review.
   c. Participants with unexcused no-shows for provider follow-up may be discharged from the program upon treatment team review.
   d. The first and second unexcused absence shall result in a treatment team meeting and the participant shall be educated regarding program compliance

requirements.

i. A third unexcused absence may result in discharge from the program.

e. Upon community release from the Pre-release Harm Reduction Opioid Treatment Program.

i. Continuity of care will be monitored by the SUD team and the community release team, if appropriate.

ii. Participants shall provide the MAT coordinators with a post-release contacts.

4. Pregnant Patients
   a. There shall be no attempt to taper a pregnant person unless serious adverse effects occur.
   b. Pregnant Patients shall remain on the medication and dose they enter NDCS' custody.
5. Handling of MAT Medications
   a. MAT medications will only be administered by a qualified healthcare professional.
   b. The management of narcotics/controlled drugs will be managed in accordance with established scheduled medications.
   c. Medications used for MAT will not be dispensed directly to patients for self-administration. Medications that are classified as controlled substances will not be loaned from one patient to another by medical staff.
   d. Expired or discontinued narcotic medications will be returned to the NDCS Pharmacy for destruction in compliance with DEA regulations. Single doses will be disposed of via the "RX Destroyer" receptacle and documented as per DEA regulations.
6. Continuous Quality Improvement
   a. The fidelity of the program will be assessed by CQI studies

ATTACHMENTS:

Attachment A – SAMHSA Assessment

Attachment B – Behavioral Health Services Programming Accept / Decline Form DCS-A-mnh-035-pc (REV 02.2021)

Attachment C – Workflow for Post-Release Harm Reduction Program

Attachment D – Authorization for Release of Information DCS-A-adm-009-pc REV 08/2022

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