STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
P.O. Box 41100 • Olympia, Washington 98504-1110

December 23, 2020

Joanna Carns
Office of Corrections Ombuds
2700 Evergreen Parkway NW
Olympia, WA 98505

Dear Ms. Carns:

The Washington Department of Corrections appreciates the opportunity to respond to the OCO Report on the 'investigation into the February 2020 termination of an incarcerated person's suboxone treatment at Washington Corrections Center for Women' completed by the Office of Corrections Ombuds.

Recommendation	Response
If a patient is discontinued from the suboxone program by medical staff, a gradual taper should be implemented instead of an abrupt stop. All medications the patient is currently prescribed should be taken into consideration before suboxone is discontinued. OCO recommends a gradual taper of suboxone to be utilized when stopping the medication. The medical provider should review all available medical records and currently prescribed medications with the patient to ensure they receive appropriate care during withdrawal.	The "Protocol for Management of Medications for Opioid Use Disorder at Intake to Washington Department of Corrections" has been revised and approved on August 24, 2020 and gradual tapering is addressed on page three of the protocol.
If medication or medical treatment is halted due to perceived behavioral issues, those issues need to be documented through infractions, BOEs or medical chart notes, with associated notification and appeal opportunities for the incarcerated person. Further, grievance investigations into discontinuation of medication or medical treatment should rely on documented instances.	The "Protocol for the Induction of Medication for Opioid Use Disorder" (pages 8-9) has been revised and approved on August 24, 2020. Now, if a patient is suspected of a behavioral issue pertaining to a medication or medical treatment, the medication will not be decreased or discontinued prior to a meeting between healthcare practitioner and patient. It is NOT recommended to discontinue medication treatment for suspected behavioral issues, but rather adjust the current treatment plan. All providers are expected to document their patient encounters. Patients are encouraged to utilize objective evidence to engage in the resolution process regarding any disciplinary infractions.

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With regards to the two-month lapse in chemotherapy treatment, there was no evidence of harm to the patient that can be directly attributed to this lapse. That the providers were hesitant in restarting the chemotherapy medication without input from the oncologist is also reasonable and appropriate. However, a direct phone call to the oncologist's office to obtain recommendations for restarting treatment would have allowed the patient to resume care sooner rather than waiting for an in-office consultation. **OCO recommends that, when a new intake's prescription medications cannot be confirmed through a community pharmacy, DOC staff should attempt to obtain verification by contacting the prescribing community physician's office, to avoid any potential delays in care.**	Primary care clinicians have the option to attempt phone consultation with a community specialist and that option for prescription confirmation will be further promoted to the agency's clinicians.

The information provided by the OCO was useful to ensure the Department of Corrections is doing everything it can to ensure an incarcerated person's time in the agency's facilities is a fair and safe space for all incarcerated individuals.

We also appreciate your team's understanding of the unique processes across facilities and the addition of policies and procedures being put in place to address them. We are working towards proactivity and improving quality assurance processes throughout the department. Moving forward, Washington Department of Corrections will continue to collaborate with the Office of the Corrections Ombuds to implement additional policies, procedures, and security measures to continue to improve the facility operations.

Sincerely,

Steve Sinclair, Secretary
Washington Department of Corrections

Protocol for Management of Medications for Opioid Use Disorder at Intake to Washington Department of Corrections

Purpose

This protocol provides guidance and ensures consistent practice for the continuation or discontinuation of an active prescription for medication for opioid use disorder (OUD) for patients who are entering a Washington State prison facility. This protocol does not apply to pregnant females.

Introduction

Medications are an effective treatment for OUD. The primary goal of medication for OUD is to reduce mortality related to OUD by reducing risk of post-release overdose death, as well as reducing morbidity associated with intravenous drug use by overall reduction in illicit substance use. Ultimately, the goal of medications for OUD is to restore personal functionality and stability to the patient.

It is the intent of the Washington State Department of Corrections to support patients in their recovery from OUD by initiating medications prior to release and bridging them to a post-incarceration follow-up visit with a community prescriber. All patients releasing with medication for the treatment of OUD will also release with naloxone for reversal in the event of an overdose.

Three medications are currently FDA approved for the treatment of OUD: methadone, buprenorphine and naltrexone. As methadone can only be dispensed by a registered opioid treatment program, this guideline will address only the use of buprenorphine and naltrexone. For the purpose of this protocol, any reference to prescribing buprenorphine refers to a buprenorphine/naloxone combination.

Prior to prescribing buprenorphine for OUD, practitioners must first obtain a waiver from the US Substance Abuse and Mental Health Services Administration (SAMHSA) and an X DEA number from the US Drug Enforcement Agency. Buprenorphine for OUD cannot be prescribed without an X DEA number. The waiver can be obtained from SAMHSA by completing the requisite hours of training (8 hours for physicians, 24 hours for advanced practitioners). Training may be accessed by the following link: https://pcssnow.org/education-training/mat-training/. The application for the waiver is completed by accessing the following link: https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/apply-for-physician-waiver.

Naltrexone is an opioid antagonist and not a controlled substance. Therefore, there are no special requirements to prescribe naltrexone.

All DOC provider/nurses and practitioners are expected to be registered with the state of Washington's prescription monitoring program (PMP) per WAC 246-919-985, WAC 246-918-935, WAC 246-853-790, and WAC 246-840-4990.

Definitions of provider/nurse and practitioner used in this guideline are consistent with Washington DOC Health Plan definitions.

Patients Incoming on Buprenorphine

Patients entering DOC facilities on buprenorphine with **an unknown sentence length** will be continued on the medication until follow up with provider, which will be scheduled for one week later to clarify length of sentence.

Once an ERD/PRD has been determined at the follow up appointment, follow the appropriate protocol below.

Patients on Buprenorphine with a sentence greater than 6 months

Patients entering DOC facilities from jail, the community, work release, home monitoring, or other DOC re-entry program with a sentence greater than 6 months who have an active prescription for buprenorphine will be tapered in a controlled manner to reduce significant withdrawal symptoms:

1) Nurse confirms buprenorphine prescription, dose, current administration and indication from jail medical records, community pharmacy records or prescriber records.

2) Nurse or Practitioner will query the Washington State Prescription Monitoring Program (PMP) profile and either note results on a PER or print a copy for the chart and place in Consultation Section.

3) Perform a urine drug screen and alcohol saliva test.

    a. If Point-of-Care urine drug screen is negative for buprenorphine, confirm history of use and repeat urine drug screen. If urine drug screen remains negative for buprenorphine, consult a clinician with expertise in prescribing buprenorphine as needed.
    b. If the patient tests positive for alcohol or benzodiazepines, consider initiation of an appropriate withdrawal protocol and hold buprenorphine for 24 hours and until the patient does not appear clinically intoxicated. If a benzodiazepine taper is indicated due to chronic benzodiazepine use or for the treatment of alcohol withdrawal, it is appropriate to continue buprenorphine at half their regular dose until benzodiazepine taper is complete. Can return to full dose sooner if having significant signs of opioid withdrawal, and not overly sedated when given benzodiazepine doses. After resuming their regular dose, proceed with the usual taper of buprenorphine as per the instructions below in steps 4-7.
    c. If the patient tests positive for an illicit opioid, the prescriber will hold buprenorphine until the COWS score is 10 or higher. Alternatively, if the patient shows no signs of withdrawal within 72 hours of arrival, a buprenorphine taper may not be clinically indicated.
    d. Buprenorphine is not contraindicated in the setting of marijuana use.

e. Buprenorphine is not contraindicated in the setting of stimulant use, including methamphetamines. Timing of buprenorphine continuation should be based on the clinical presentation of the patient, and a clinician with expertise in prescribing buprenorphine should be consulted if there is uncertainty about the safety or timing of buprenorphine dosing.

4) If the patient is on greater than once per day dosing convert to a single daily dose prior to determining the dose for the first step of the taper. For instance, if the patient is on 8mg/2mg BID the dose will convert to 16mg/4mg once per day. If the converted dose is 24mg QD or greater, start taper from 24mg QD. (However, if the patient has a simultaneous prescription for a benzodiazepine that is being tapered, the maximum starting dose of buprenorphine is 16mg per day.)

a. *Example:*
If a patient at intake is on 16mg/4mg QAM and 16mg/4mg QPM convert dose to 24mg/6mg QD for 3 days then proceed to taper as described in step 5.

5) Reduce buprenorphine by 4mg every seven days until the patient reaches 2mg daily for seven days (if decreasing by 4mg every seven days results in a dose of 4mg then add another step of 2mg for seven days). In a final step, cut the 2mg strip in half in the med room **prior to going to pill line**. Administer a 1mg dose of buprenorphine for seven days, then discontinue.

a. *Example*:
If a patient enters a DOC facility on 16mg/4mg QD the taper should be 12mg/3mg QD for seven days, then 8mg/2mg QD for seven days, then 4mg/1mg QD for seven days, then 2mg/0.5mg QD for seven days, then 1mg/0.25mg QD for seven days, then discontinue.
b. Cutting strips of buprenorphine is a standard practice in the community that has been widely adopted and accepted as safe. Cut the strip in half as evenly as possible, but if it is slightly uneven, it will not be clinically significant.
c. Once a 2mg strip of buprenorphine is cut, it must be used during that med pass. The unused half must be wasted with a 2nd nurse **prior to going to pill line**.

6) If it has not occurred already, practitioner follow up with the patient will be at the intake physical exam or a provider visit within 14 days of entry. At that encounter evaluate for the presence of opioid withdrawal symptoms and manage as indicated per Outpatient Opioid Withdrawal Protocol (available on Sharepoint; Health Services; MOUD Documents). Enter opioid use disorder diagnosis code F11.20 (ICD10 Opiate Dependence, uncomplicated) in OMNI.

7) Director of Pharmacy or designee is to ensure that the number of patients being prescribed buprenorphine is checked weekly and the practitioner is notified if they are within 5 prescriptions of the DEA prescribing limit.

8) All patients with an active prescription for buprenorphine or methadone will be prescribed docusate sodium 200 mg QD unless there is existing contraindication

Patients Incoming on Methadone

Patients entering DOC facilities on methadone with an unknown sentence length will be tapered to buprenorphine as instructed below, then continued until follow up with provider, which will be scheduled for one week later to clarify length of sentence.

Once an ERD/PRD has been determined at the follow up appointment, follow the appropriate protocol below.

Patients on Methadone with a sentence greater than 6 months

Patients entering DOC facilities from jail, the community, work release, home monitoring, or other DOC re-entry program with a sentence greater than 6 months who have an active prescription for methadone, or are taking methadone as part of an opioid treatment program, will be tapered using buprenorphine to improve significant withdrawal symptoms. The Washington Department of Corrections is not a federally registered opioid treatment program and therefore cannot dispense methadone for opioid use disorder for more than three doses.

1) Nurse confirms methadone dose, current administration and indication from jail medical records, community Opioid Treatment Program (methadone clinic), community pharmacy records or prescriber records.

2) Nurse or practitioner will query the Washington State Prescription Monitoring Program (PMP) profile and either note results on a PER or print a copy for the chart and place in Consultation Section. (Note: methadone dispensed through an Opioid Treatment Program will not show up on a PMP)

3) Perform urine drug screen and saliva alcohol test.

    a. If urine drug screen is negative for methadone (MTD), confirm history of use and repeat urine drug screen. If urine drug screen remains negative for methadone (MTD), consult a clinician with expertise in prescribing methadone as needed.

    b. If the patient tests positive for alcohol or benzodiazepines, consider initiation of an appropriate withdrawal protocol. If a benzodiazepine taper is indicated due to chronic

benzodiazepine use or for the treatment of alcohol withdrawal, discuss with a clinician with expertise.

c. If the patient tests positive for an illicit opioid, discontinue methadone and transition to buprenorphine per usual, as detailed below in steps 4-10.

d. Methadone and buprenorphine are not contraindicated in the setting of marijuana use.

e. Methadone and buprenorphine are not contraindicated in the setting of stimulant use, including methamphetamines. Timing of buprenorphine or methadone continuation should be based on the clinical presentation of the patient, and a clinician with expertise in prescribing buprenorphine should be consulted if there is uncertainty about the safety or timing of buprenorphine or methadone dosing.

4) Once the patient is 24 hours from last methadone dose, admit the patient to the inpatient unit for monitoring and treatment per Infirmary opioid withdrawal protocol (available on Sharepoint; Health Services; MOUD Documents). When the patient is at least 48 hours from last methadone dose, AND has a COWS score of 10 or greater, proceed to step 5 to begin buprenorphine. Repeat assessments every 8 hours until COWS score is 10 or greater. If patient is less than 48 hours from last dose, but has a COWS score of 10 or greater, continue to treat symptomatically per the opioid withdrawal protocol, until patient is both 48 hours from last methadone dose **and** has a COWS score of 10 or greater.

5) On day one of buprenorphine, administer 2mg and repeat COWS score at 1 hour from first dose to assess for signs of precipitated withdrawal (see note under i. below). If no clear signs of precipitated withdrawal, repeat COWS score again at 2 hours from initial dose and continue to monitor COWS score every 2 hours for 8 hours after initial dose. If COWS score is greater than 8, administer 2mg of buprenorphine every 2 hours up to a total of 8mg in the first 8 hours. Continue monitoring every 2 hours, and if COWS score remains greater than 8 after 8 hours, give 4mg dose of buprenorphine. May repeat 4mg dose 2 hours later if COWS is still greater than 8. If after 14 hours COWS score is still greater than 8 administer 8mg of buprenorphine for a total of 24mg on day 1. Treat symptomatically as needed if withdrawal symptoms are still present per Infirmary opioid withdrawal protocol. Daily dose is established once withdrawal symptoms are relieved (not to exceed 24 mg buprenorphine in first 24 hours)

i. If COWS score increases by 4 or more points within a 1-hour time period, treat symptomatically per opioid withdrawal protocol, and contact a clinician with expertise immediately.

ii. Order set available for above transition from methadone to buprenorphine. Can be found on Sharepoint; Health Services; MOUD Documents.

6) Continue established daily dose for 5 days.

7) After 5 days, reduce buprenorphine by 4mg every seven days until the patient reaches 2mg daily for seven days (if decreasing by 4mg every seven days results in a dose of 4mg then add another step of 2mg for seven days). In a final step, cut the 2mg strip in half in the med room prior to going to pill line. Administer a 1mg dose of buprenorphine for seven days, then discontinue.

   a. *Example*: If a patient has a total daily dose of 16mg/4mg QD the taper should be 12mg/3mg QD for seven days, then 8mg/2mg QD for seven days, then 4mg/1mg QD for seven days, then 2mg/0.5mg QD for seven days, then 1mg/0.25mg QD for seven days, then discontinue.
   b. Cutting strips of buprenorphine is a standard practice in the community that has been widely adopted and accepted as safe. Cut the strip in half as evenly as possible, but if it is slightly uneven, it will not be clinically significant.
   c. Once a 2mg strip of buprenorphine is cut, it must be used during that med pass. The unused half must be wasted with a 2nd nurse prior to going to pill line.

8) If it has not occurred already, practitioner follow up with the patient will be at the intake physical exam or a provider visit within 14 days of entry. At that encounter evaluate for the presence of opioid withdrawal symptoms and manage as indicated per Outpatient Opioid Withdrawal Protocol. Enter opioid use disorder diagnosis code F11.20 (ICD10 Opiate Dependence, uncomplicated) in OMNI.

9) Director of Pharmacy or designee is to ensure that the number of patients being prescribed buprenorphine is checked weekly and the practitioner is notified if they are within 5 prescriptions of the DEA prescribing limit.

10) All patients with an active prescription for buprenorphine or methadone will be prescribed docusate sodium 200 mg QD unless there is existing contraindication

Patients on Buprenorphine with a sentence of 6 months or less

Patients entering DOC facilities from jail, the community, work release, home monitoring, or other DOC re-entry program with a sentence of 6 months or less who have an active prescription for buprenorphine for opioid use disorder will continue on maintenance therapy while incarcerated.

1) Nurse confirms buprenorphine prescription, dose, current administration and indication from jail medical records, community pharmacy records or prescriber records.
2) Nurse or Practitioner will query the Washington State Prescription Monitoring Program (PMP) profile and either note results on a PER or print a copy for the chart and place in Consultation Section.
3) Perform a urine drug screen and saliva alcohol test.

    a. If Point-of-Care urine drug screen is negative for buprenorphine, confirm history of use and repeat urine drug screen. If urine drug screen remains negative for buprenorphine, consult a clinician with expertise in prescribing buprenorphine as needed.

    b. If the patient tests positive for alcohol or benzodiazepines, consider initiation of an appropriate withdrawal protocol and hold buprenorphine for 24 hours and until the patient does not appear clinically intoxicated. If a benzodiazepine taper is indicated due to chronic benzodiazepine use or for the treatment of alcohol withdrawal, it is appropriate to continue buprenorphine at half their regular dose until benzodiazepine taper is complete. Can return to full dose sooner if having significant signs of opioid withdrawal, and not overly sedated when given benzodiazepine doses.

    c. If the patient tests positive for an illicit opioid along with buprenorphine, and is confirmed to have been taking buprenorphine with PMP or prescriber records, continue regular dose of buprenorphine without changes. The patient may need their dose of buprenorphine reassessed to determine if it is adequate.

    d. Buprenorphine is not contraindicated in the setting of marijuana use.

    e. Buprenorphine is not contraindicated in the setting of stimulant use, including methamphetamines. Timing of buprenorphine continuation should be based on the clinical presentation of the patient, and a clinician with expertise in prescribing buprenorphine should be consulted if there is uncertainty about the safety or timing of buprenorphine dosing.

4) If the patient is on greater than once per day dosing, convert to a single daily dose. Note maximum daily dose of buprenorphine per this protocol is 24mg.

    a. Example: If a patient at intake is on 16mg/4mg QAM and 16mg/4mg QPM convert dose to 24mg/6mg QD.

5) If it has not occurred already, practitioner follow-up with the patient will be at the intake physical examination or a practitioner visit within 14 days of entry.

   a. Enter opioid use disorder diagnosis code F11.20 (ICD Opiate Dependence Uncomplicated) in OMNI.

   b. Order 1 random urine drug screen per month for the purpose of monitoring for the presence of buprenorphine.
      i. If diversion is suspected, send urine for buprenorphine confirmation testing, and follow the details below in section addressing diversion

   c. Notify Re-entry Care Navigator of patient's entry into DOC facility and their community prescriber if they have one.

6) Re-entry Care Navigator:

   a. If establishing care with a new community prescriber or returning to a prior prescriber, obtain the ROI and schedule conference call with patient, lead MOUD nurse as available or Classification Counselor, and the community provider 3-14 days prior to release.

   b. Notify current primary care practitioner of pending release and request completion of DOC 13-574 and submission to the DOC Pharmacy approximately 30 days prior to release.

   c. Notify current primary care practitioner of time and date of community follow-up.

   d. Send discharge letter to community provider (DOC 13-533) 3-7 days prior to release.

   e. Notify community corrections officer (CCO) and DOC Nurse Desk (DOCNurseDesk@DOC1.WA.GOV) of buprenorphine/naloxone prescription if on community supervision.

   f. Will verify patient is on the list for overdose education and will receive naloxone kit prior to release

7) When the medication management nurse prints the CIPS Medication Summary Report for the practitioner in preparation for release, if buprenorphine is one of the active medications, they shall confirm the presence of the release supply of buprenorphine in the facility medication room. If the release supply of buprenorphine is absent, the nurse will ensure that the practitioner

orders the release supply by using DOC 13-574. Anything less than 7 day notice should be ordered using Moda

8) All patients with an active prescription for buprenorphine or methadone will be prescribed docusate sodium 200 mg QD unless there is existing contraindication

Patients on Methadone with a sentence of 6 months or less

The Washington Department of Corrections is not currently a federally registered opioid treatment program and therefore cannot dispense methadone for opioid use disorder for more than three doses.

1) Nurse confirms methadone dose, current administration and indication from jail medical records, community Opioid Treatment Program (methadone clinic), community pharmacy records or prescriber records.

2) Nurse or practitioner will query the Washington State Prescription Monitoring Program (PMP) profile and either note results on a PER or print a copy for the chart and place in Consultation Section. (Note: methadone dispensed through an Opioid Treatment Program will not show up on a PMP)

3) Perform a urine drug screen and saliva alcohol test.

   a. If urine drug screen is negative for methadone (MTD), confirm history of use and repeat urine drug screen. If urine drug screen remains negative for methadone (MTD), consult a clinician with expertise in prescribing methadone as needed.

   b. If the patient tests positive for alcohol or benzodiazepines, consider initiation of an appropriate withdrawal protocol. If a benzodiazepine taper is indicated due to chronic benzodiazepine use or for the treatment of alcohol withdrawal, discuss with a clinician with expertise.

   c. If the patient tests positive for an illicit opioid, continue transition to buprenorphine per usual, as detailed below in steps 4-12.

   d. Methadone and buprenorphine are not contraindicated in the setting of marijuana use.

   e. Methadone and buprenorphine are not contraindicated in the setting of stimulant use, including methamphetamines. Timing of buprenorphine or methadone continuation should be based on the clinical presentation of the patient, and a clinician with expertise

in prescribing buprenorphine should be consulted if there is uncertainty about the safety or timing of buprenorphine or methadone dosing.

4) Due to federal regulations and the long half-life of methadone, a clinically effective methadone taper is not currently possible. Therefore, methadone will be discontinued upon entry into DOC facilities unless dosing from an outside opioid treatment program can be arranged.

5) Once the patient is 24 hours from last methadone dose, admit the patient to the inpatient unit for monitoring and treatment per opioid withdrawal protocol. When the patient is at least 48 hours from last methadone dose, AND has a COWS score of 10 or greater, proceed to step 6 to begin buprenorphine. Repeat assessments every 8 hours until COWS score is 10 or greater. If patient is less than 48 hours from last dose, but has a COWS score of 10 or greater, continue to treat symptomatically per the opioid withdrawal protocol, until patient is both 48 hours from last methadone dose **and** has a COWS score of 10 or greater.

6) On day one of buprenorphine, administer 2mg and repeat COWS score at 1 hour from first dose to assess for signs of precipitated withdrawal (see note under i. below). If no clear signs of precipitated withdrawal, repeat COWS score again at 2 hours from initial dose and continue monitor COWS score every 2 hours for 8 hours after initial dose. If COWS score is greater than 8, administer 2mg of buprenorphine every 2 hours up to a total of 8mg in the first 8 hours. Continue monitoring every 2 hours, and if COWS score remains greater than 8 after 8 hours, give 4mg dose of buprenorphine. May repeat 4mg dose 2 hours later if COWS is still greater than 8. If after 14 hours COWS score is still greater than 8 administer 8mg of buprenorphine for a total of 24mg on day 1. Treat symptomatically as needed if withdrawal symptoms are still present per Infirmary Opioid Withdrawal Protocol. Daily dose is established once withdrawal symptoms are relieved (not to exceed 24 mg buprenorphine in first 24 hours)

   i. If COWS score increases by 4 or more points within a 1-hour time period, treat symptomatically per opioid withdrawal protocol, and contact a clinician with expertise immediately.

   ii. Order set available for above transition from methadone to buprenorphine. Can be found on Sharepoint; Health Services; MOUD Documents.

7) Continue established daily dose of buprenorphine.

8) At a minimum, perform 1 random urine drug screen per month for the purpose of monitoring for the presence of buprenorphine

a. If diversion is suspected, send urine for buprenorphine confirmation testing and follow details below in section addressing diversion

9) Notify Re-Entry Care Navigator of patient's entry into DOC facility.

10) Re-Entry Care Navigator:

a. Establish with the patient or the provider whether the patient wishes to continue buprenorphine upon release, or return to former Opioid Treatment Program and resume treatment with methadone.
   i. Obtain ROI
   ii. If returning to methadone treatment upon release, inform prior opioid treatment program of transition to buprenorphine and intention to transition back to methadone.
   iii. If establishing care with a new community prescriber or returning to a prior buprenorphine or methadone prescriber, schedule conference call with patient, lead MOUD nurse as available or Classification Counselor, and the community provider 3-14 days prior to release.

b. Notify current primary care practitioner of pending release and request completion of DOC 13-574 and submission to the DOC Pharmacy approximately 30 days prior to release.

c. Notify current primary care practitioner of time and date of community follow-up.

d. Send discharge letter to community provider (DOC 13-533) 3-7 days prior to release.

e. Notify community corrections officer (CCO) and DOC Nurse Desk (DOCNurseDesk@DOC1.WA.GOV) of buprenorphine/naloxone prescription if on community supervision

f. Will verify patient is on the list for overdose education and will receive naloxone kit prior to release

11) When the medication management nurse prints the CIPS Medication Summary Report for the practitioner in preparation for release, if buprenorphine is one of the active medications, they shall confirm the presence of the release supply of buprenorphine in the facility medication room. If the release supply of buprenorphine is absent, the nurse will ensure that the practitioner orders the release supply by using DOC 13-574. Anything less than 7 day notice should be ordered using Moda.

12) All patients with an active prescription for buprenorphine or methadone will be prescribed docusate sodium 200 mg QD unless there is existing contraindication

When diversion of medications is suspected

If patient is suspected of diverting a controlled substance that is being prescribed to them, immediate notification to healthcare practitioner (and prescriber) is warranted, and patient will then be scheduled to follow up with healthcare practitioner within 1-2 days, or alternatively can be called to clinic if appointment is not available. Medication will not be decreased or discontinued prior to meeting between healthcare practitioner and patient. Suspected diversion of medications will not be discussed with or in front of other patients, as, in general, details of patient care are not shared or discussed in the presence of any other person without appropriate permission from the patient, or if necessary for coordination of medical care.

Healthcare practitioner may order buprenorphine urine confirmatory testing (interpath code: 70086) to determine the presence of buprenorphine metabolites in urine. Healthcare practitioner will discuss suspected diversion with patient at follow up appointment, and determine next appropriate steps in treatment. It is NOT recommended to discontinue medication treatment as a punishment for diverting medications, but rather adjustment to current treatment plan to prevent further diversion of medication is recommended. Healthcare practitioner may consult addiction medicine specialist with any questions regarding specific situations and recommendations. (Addiction Specialist, Catherine Smith, DO, can be contacted via email at catherine.smith1@doc1.wa.gov or via phone at 253-509-5471)

If patient is found to have diverted medications, and objective evidence of diversion is present, this will be handled by custody officer(s), who may refer to Washington State DOC Policy 460.050 Disciplinary Sanctions, which details indicated sanctions for “giving, selling, or trading any prescribed medication, or possessing another offender’s medication”.

Approved:

Hayes, William E. (DOC) Digitally signed by Hayes, William E. (DOC) Date: 2020.08.18 09:55:41 -07'00'

8/18/2020

William E. Hayes
Director of Pharmacy

Date Signed

Sara Kariko

8/21/2020

Dr. Sara Kariko
Chief Medical Officer

Date Signed

Julie A Martin

8/24/2020

Julie Martin
Deputy Secretary

Date Signed

Protocol for the Induction of Medication for Opioid Use Disorder Prior to Release from a Prison Facility

Purpose

This protocol provides guidance and ensures consistent practice for the induction of medication for patients with opioid use disorder (OUD) who are preparing to release from a Washington State prison facility.

Introduction

Medications are an effective treatment for OUD. The primary goal of medication for OUD is to reduce mortality related to OUD by reducing risk of post-release overdose death, as well as reducing morbidity associated with intravenous drug use by overall reduction in illicit substance use. Ultimately, the goal of medications for OUD is to restore personal functionality and stability to the patient.

It is the intent of the Washington State Department of Corrections to support patients in their recovery from OUD by initiating medications prior to release and bridging them to a post-incarceration follow-up visit with a community prescriber. All patients releasing with medication for the treatment of OUD should also release with naloxone for reversal in the event of an overdose.

Three medications are currently FDA approved for the treatment of OUD: methadone, buprenorphine and naltrexone. As methadone can only be dispensed by a registered opioid treatment program, this guideline will address only the use of buprenorphine and naltrexone. For the purpose of this protocol, any reference to prescribing buprenorphine refers to a buprenorphine/naloxone combination.

Prior to prescribing buprenorphine for OUD, practitioners must first obtain a waiver from the US Substance Abuse and Mental Health Services Administration (SAMHSA) and an X DEA number from the US Drug Enforcement Agency. Buprenorphine for OUD cannot be prescribed without an X DEA number. The waiver can be obtained from SAMHSA by completing the requisite hours of training (8 hours for physicians, 24 hours for advanced practitioners). Training may be accessed by the following link: https://pcssnow.org/education-training/mat-training/. The application for the waiver is completed by accessing the following link: https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/apply-for-physician-waiver.

Naltrexone is an opioid antagonist and not a controlled substance. Therefore, there are no special requirements to prescribe naltrexone.

All DOC provider/nurses and practitioners are expected to be registered with the state of Washington's prescription monitoring program (PMP) per WAC 246-919-985, WAC 246-918-935, WAC 246-853-790, and WAC 246-840-4990.

Definitions of provider/nurse and practitioner used in this guideline are consistent with Washington DOC Health Plan definitions.

Candidates for MOUD Induction

Patients diagnosed with OUD who are preparing to release from prison to the community, including work release, who are not currently taking prescribed opioids.

Diagnosing Opioid Use Disorder

Patients must meet diagnostic criteria for OUD in order to be prescribed medication for this condition. The diagnosis of OUD can be made by a medical, mental health, or chemical dependency provider. This diagnosis should be made at time of intake exam for newly incarcerated individuals, but can be made at any time during incarceration. Formal psychiatric or SARU assessment may be indicated for some patients, at practitioner discretion. Practitioners may use the TCU5 diagnostic form to aid in the diagnosis of an individual with OUD if needed, which can be found on SharePoint; Health Services; MOUD documents.

Screening for opioid use disorder will be conducted at mental health orientation using Opioid Screening Questionnaire form 13-582ES. Patients identified with a positive screening exam will be referred for additional evaluation.

The diagnosis of OUD is defined as a problematic pattern of opioid use leading to clinically significant impairment or distress as manifested by at least two of the following DSM V criteria, occurring within a 12 month period (for incarcerated individuals, this can be the 12 month period prior to arrest or incarceration, regardless of actual length of incarceration):

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance as defined by either of the following
    a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of an opioid
    (Note that that criterion #10 is not considered to be met for those taking opioids solely under appropriate medical supervision for pain)
11. Withdrawal, as manifested by either of the following:
    a. Characteristic opioid withdrawal.

b. Opioids are taken to relieve/avoid withdrawal symptoms.

In addition to the standard patient evaluation, the baseline evaluation for OUD should include the following:

1. History of past substance use, including but not limited to:
   a. Substances used
   b. Age of first use
   c. Overdose history
   d. Prior treatment participation
2. Family History of substance use disorder, including OUD

Once a clinical diagnosis of OUD has been made, the medical or mental health practitioner will enter an ICD10 code of F11.20 (ICD-10 Opiate Dependence, Uncomplicated) into OMNI-HS.

If the patient has a history of opiate use but the diagnosis of OUD cannot be made with reasonable certainty, enter an interim ICD-10 code of F11.90 (Opiate use, unspecified, uncomplicated) until further assessment is conducted.

Identifying Individuals for Induction of Medications for OUD

Patients may be identified as candidates to be started on medication for opioid use disorder through multiple processes, outlined as follows:

1. A patient may send a kite to their primary care provider to let them know of their interest, and an appointment for discussion and diagnosis of OUD can be scheduled with primary care provider, followed by an appointment with MOUD lead nurse to provide education regarding medications for opioid use disorder and available treatments
2. A patient may be identified as a candidate by their primary care provider during their incarceration, and appointment with MOUD lead nurse can be scheduled to provide education regarding medications for opioid use disorder and available treatments
3. A patient may be diagnosed with opioid use disorder (F11.20), or opioid dependence (F11.90) at time of intake, or during period of incarceration, and will be referred for appointment with MOUD lead nurse for education regarding MOUD approximately 90-120 days prior to ERD
   a. List of patients with qualifying diagnoses in OMNI-HS, who are within four months of ERD will be generated by HQ, and sent to MOUD lead nurse, or other designee, on a weekly basis
   b. MOUD lead nurse, or other designee, will create an encounter in OMNI-HS and create an Internal Referral to the Patient Services Representative (PSR) to schedule an appointment with the MOUD lead nurse 90-120 days prior to ERD to provide education regarding medications for opioid use disorder and available treatments
4. Chemical dependency professional, nursing staff, or other health services or mental health services staff may identify a patient as a potential candidate for medications for opioid use disorder, and referral can be made for SARU evaluation and assessment, or referral can be made to primary care provider for evaluation and diagnosis of opioid use disorder
5. Medical practitioners may request SARU evaluation and assessment to confirm diagnosis of OUD if practitioner not comfortable, or unable, to make diagnosis; Referral can be made via email (DOCMatSudAssessments@DOC1.WA.GOV)
   a. SARU staff will:

   i. Schedule an appointment and complete an assessment.
   ii. Forward assessment to the facility MOUD lead nurse. The MOUD lead nurse will give the assessment documents to the patient's primary practitioner who will review and destroy as legally required (*these documents should not be placed into patient's medical records*)

6. When a patient that is identified to be a candidate for MOUD and is noted to have an S code of 3 or higher, the individual's name and DOC will be forwarded to the SARU clinical supervisor who will arrange consultation between primary care provider, primary MH Therapist, and, for individuals in RTU, include the Supervising Psychologist 4.
   a. The consultation will determine a recommendation regarding the initiation of MOUD based on current treatment of mental health disorder and stability of patient.
   b. If the clinicians involved determine further consultation is required or recommended, the case will be presented to the SARU Program Administrator, Addiction Specialist Physician and Director of Mental Health.

Prior to Induction of Medications for OUD

Patients must meet qualifications for an opioid use disorder prior to being started on medication for an opioid use disorder. As noted above, diagnosis can be made by medical, mental health, or chemical dependency provider.

1. Patients with current OUD diagnosis with an ERD of four months or less, will be scheduled with MOUD lead nurse, or designee, for education regarding medications for opioid use disorder and available treatment options
   a. Patients will be informed of their appointment for education session via kite, and may decline this education if desired
   b. If education is declined, MOUD lead nurse or RCN will create an individual or mass encounter in OMNI-HS to document patient decision
   c. After patient participates in education, they can proceed with the induction process starting at 90 days prior to ERD, or immediately if education is administered less than 60 days prior to ERD

2. MOUD lead nurse, or other designee, will perform the following:
   a. Provide education regarding medications for opioid use disorder, and discuss treatment options with patients, as well as assess interest approximately 90-120 days prior to ERD
   b. Have an appointment with the patient approximately 60-90 days before release to confirm continued interest in starting medications, discuss treatment plan with patient, and enter appropriate referrals for labs and provider appointments for MOUD induction
      i. Enter an encounter in OMNI-HS and create 2 Internal Referrals to the PSR: one for lab tests as specified below, and a second to schedule 60 day pre-release appointment with the practitioner
      ii. Place a medical hold on the patient specifying in comments that the hold is for induction of medication for OUD and include the practitioner and facility PSR mailbox (see appendix 1)

3. Laboratory studies ordered prior to induction by MOUD lead nurse/designee at 90 day pre-release appointment:
   a. To be completed within 7 days of 60 day appointment: CMP, CBC, urine drug screen (POC), urine HCG (as appropriate)

b. Consider if not done within 1 year of induction as appropriate: chronic Hep B/C panel (Interpath code 1884), HIV Ab/Ag (Interpath code 2845).

For patients who are eligible for work-release

Patients who are eligible for work release will not be inducted prior to work-release *eligibility* date, but may be inducted after finalization for transfer to work release facility.

1. HQs Classification Unit staff or designee will notify the MOUD lead nurse, or designee, when a patient with a qualifying diagnosis in OMNI-HS is finalized for transfer to work release facility

2. Patients who are eligible for work release, and subsequently are finalized for transfer, will have the following options to start induction onto medications for opioid use disorder:
   a. Continue induction as normal if there is appropriate time prior to transfer
   b. If time to transfer does not allow for normal induction protocol, options include the following:
      i. Undergo rapid induction, as directed by practitioner, who may consult addiction specialist for recommendations on timing, dosing and duration of medication (Addiction Specialist, Dr. Catherine Smith, may be contacted for consultation via email: Catherine.smith1@doc1.wa.gov or cell phone: (253) 509-5471)
      ii. Practitioner may provide patient with instructions for "home" induction, along with supply of release medications to be started by patient at time of transfer to work release facility, with follow up appointment with community provider within 2-3 days, to be arranged by RCN
         1. Practitioner may contact addiction specialist for instruction on "home" induction, as well as resources to provide to patient (contact information noted above)

Induction of Medications for OUD

1) Buprenorphine/naloxone:

a) Nurse performs point of care urine drug screen on day of induction.

b) Ensure urine drug screen is negative for opioids.

c) Order buprenorphine/naloxone according to the following dose escalation to start approximately 60 days prior to possible release date, or at appointment ASAP after patient is finalized for work release or graduated re-entry:
   i. Use Code 304.00 (ICD-9) for buprenorphine prescriptions in CIPS
   ii. Ensure your "X" DEA number is on the prescription
   iii. Buprenorphine/naloxone 2 mg/0.5 mg 1 film sublingual daily for 7 days (pill line only) THEN
   iv. Buprenorphine/naloxone 2 mg/0.5 mg 2 films sublingual daily for 7 days (pill line only) THEN
   v. Buprenorphine/naloxone 2 mg/0.5 mg 3 film sublingual daily for 7 days (pill line only) THEN
   vi. Buprenorphine/naloxone 8 mg/2 mg 1 films sublingual daily for 14 days (pill line only) THEN
   vii. Buprenorphine/naloxone 8 mg/2 mg 2 films sublingual daily until release (pill line only)

The dosing above is for facilities with a daily pill line only

Important notes about dosing:

1. Patient may request to stop up-titration of medication at any step if feeling stable at a certain dose
2. Patient may elect to skip 6 mg dosing and go straight from 4 mg to 8 mg daily if not having significant side effects during up-titration of medication
3. Doses of buprenorphine above 16mg can be prescribed at practitioner discretion. If higher doses are needed, then release meds should be modified accordingly
4. If release date is delayed, renew medication until patient is released.

d) Order docusate sodium 200 mg QD unless contraindication exists

e) MOUD lead nurse to notify Reentry Care Navigator [dochsreentrycarenavigators@doc1.wa.gov] and SARU [DOCMatSudAssessments@DOC1.WA.GOV] by email of prescription start date and medication type. The SARU email manager will then forward the message to the patient's CDP, if applicable.

f) The MOUD Lead nurse will create three Internal Referrals in OMNI HS to the PSR to schedule nurse assessments 1-2 days, 2 weeks and 4 weeks post-induction. Nurse assessments will include: vital signs, adverse reactions, and presence of side effects or cravings. If the patient reports side effects or cravings, the prescribing practitioner will be notified and the patient will be evaluated.

g) MOUD Lead nurse to order 2 random urine drug screens (POC) for every 4 weeks of treatment for the purpose of dose adjustment and confirmation of treatment compliance.

- If random post-induction urine drug screen is negative for buprenorphine or positive for another substance, discuss with patient and order an immediate follow-up urine drug screen prior to the patient leaving the clinic, and discuss case with practitioner.

h) Release meds: Buprenorphine/naloxone 8 mg/2 mg 2 film sublingual daily x 1 week. The practitioner will order release medications at the same time as the initial prescription for 7 days regardless of appointment time and date.

- If there is greater than 7 days until release or work release transfer, release medications will be ordered on the Medication for Opioid Use Disorder Release Orders Form 13-574. Facility medication management staff will send the form to central pharmacy for processing.

- If there is less than 7 days until release or work release transfer, release medications will be ordered via MODA and given to the patient at the time of release.

i) Director of Pharmacy or designee is to ensure that the number of patients being prescribed buprenorphine is checked weekly and the practitioner is notified if they are within 5 prescriptions of their DEA prescribing limit.

j) Individuals releasing through program will have transition plan created through Reentry Care Navigator. RCN planning duties will include the following:

a. Notify the Classification Counselor of the plan to start medications for OUD as necessary for release planning
b. Obtain the ROI and schedule conference call with patient, lead MOUD nurse as available, and the community provider 3-14 days prior to release
c. Notify practitioner once community follow-up has been made
d. Send discharge letter to community provider (DOC 13-533) 3-7 days prior to release
e. Notify Community Corrections Officer (CCO) and DOC Nurse Desk (DOCNurseDesk@DOC1.WA.GOV) of buprenorphine/naloxone prescription if on community supervision
f. Verify patient is on the list for overdose education and will receive naloxone kit prior to release
g. RCN will follow up with patient within one week of release, to verify the attendance at follow-up appointment, and continue follow up at 2 weeks, 1 month, 3 months, 6 months, and 12 months post-release.

2) Naltrexone:

a) Approximately 60 days prior to release, the MOUD Lead nurse will order:

a. Nurse visit approximately 21 days and 14 days prior to release for start of oral induction and injection
b. A point of care urine drug screen on day of induction of oral naltrexone
c. Order naltrexone starting the oral lead-in approximately 21 days prior to release and the injectable naltrexone administered 14 days prior to release
    i. Use Code 304.00 (ICD-9) for naltrexone prescriptions in CIPS
    ii. Use an oral lead of Naltrexone 50mg daily for 7 days THEN Naltrexone 380mg IM every 28 days. Oral naltrexone can be ordered for keep on person (KOP) or pill line (PLN) administration at the discretion of the practitioner.
d. Order LFTs 2 months after initiation of naltrexone, so that they will be drawn if patient is still in a facility. It is acceptable to allow transaminases to increase up to 4 times the upper limit of normal if benefits outweigh risks

b) On the day of oral induction, the nurse will:

a. Confirm with patient that they have not used opioids for at least 10 days
b. Perform a POC urine drug screen prior to giving first dose of oral naltrexone

c. Ensure urine drug screen is negative for opioids
d. If urine drug screen is positive for opioids (including buprenorphine), DO NOT start oral naltrexone, and discuss with practitioner (induction can be rescheduled to occur 7 days after last opioid use)

c) If on injectable naltrexone, release medications are not needed

d) MOUD lead nurse to notify Reentry Care Navigator [dochsreentrycarenavigators@doc1.wa.gov] and SARU [DOCMatSudAssessments@DOC1.WA.GOV] by email of prescription start date and medication type. SARU email manager will forward message to patient's CDP, if applicable

e) Nurse will perform a POC urine drug screen prior to administering the IM naltrexone dose
   a. Ensure urine drug screen is negative for opioids
   b. If urine drug screen is positive for opioids (including buprenorphine), DO NOT give injectable naltrexone, and discuss with practitioner

f) If either urine drug screen is positive for other substances aside from opioids, the patient will be referred to the practitioner for follow up discussion, but may proceed with starting medication (oral or injectable naltrexone) on that day, as long as UDS negative for opioids

g) Individuals releasing through program will have transition plan created through Reentry Care Navigator. RCN planning duties will include the following:
   a. Notify the Classification Counselor of the plan to start medications for OUD as necessary for release planning
   b. Obtain the ROI and schedule conference call with patient, lead MOUD nurse as available, and the community provider 3-14 days prior to release
   c. Notify practitioner once community follow-up has been made
   d. Send discharge letter to community provider (DOC 13-533) 3-7 days prior to release.
   e. Notify CCO and DOC Nurse Desk (DOCNurseDesk@DOC1.WA.GOV) of naltrexone prescription if on supervision, although it should be noted that naltrexone will not correlate with a positive finding on a urine drug screen.
   f. Verify patient is on list for overdose prevention education.
   g. Notify practitioner and PSR if patient has not released 28 days after the naltrexone injection so that a second injection can be scheduled.
   h. RCN will follow up with patient within one week of release, to verify the attendance at follow-up appointment, and continue follow up at 2 weeks, 1 month, 3 months, 6 months, and 12 months post-release.

When diversion of medications is suspected

If patient is suspected of diverting a controlled substance that is being prescribed to them, immediate notification to healthcare practitioner (and prescriber) is warranted, and patient will then be scheduled to follow up with

healthcare practitioner within 1-2 days, or alternatively can be called to clinic if appointment is not available. Medication will not be decreased or discontinued prior to meeting between healthcare practitioner and patient. Suspected diversion of medications will not be discussed with or in front of other patients, as, in general, details of patient care are not shared or discussed in the presence of any other person without appropriate permission from the patient, or if necessary for coordination of medical care.

Healthcare practitioner may order buprenorphine urine confirmatory testing (interpath code: 70086) to determine the presence of buprenorphine metabolites in urine. Healthcare practitioner will discuss suspected diversion with patient at follow up appointment, and determine next appropriate steps in treatment. It is NOT recommended to discontinue medication treatment as a punishment for diverting medications, but rather adjustment to current treatment plan to prevent further diversion of medication is recommended. Healthcare practitioner may consult addiction medicine specialist with any questions regarding specific situations and recommendations. (Addiction Specialist, Catherine Smith, DO, can be contacted via email at catherine.smith1@doc1.wa.gov or via phone at 253-509-5471)

If patient is found to have diverted medications, and objective evidence of diversion is present, this will be handled by custody officer(s), who may refer to Washington State DOC Policy 460.050 Disciplinary Sanctions, which details indicated sanctions for “giving, selling, or trading any prescribed medication, or possessing another offender’s medication”.

Approved:

_____ _____

Tami J. Kampbell
Health Services Opioid Grant Administrator

Date Signed

_____ _____

William E. Hayes
Director of Pharmacy

Date Signed

_____ _____

Dr. Sara Kariko
Chief Medical Officer

Date Signed

_____ _____

Mary Jo Currey
Assistant Secretary for Health Services

Date Signed

Appendix 1: PSR Mailbox List

Facility	Mailbox Address
Airway Heights Corrections Center (AHCC)	DOC**AHCC**PatientServices@DOC1.WA.GOV
Clallam Bay Corrections Center (CBCC)	DOC**CBCC**PatientServices@DOC1.WA.GOV
Cedar Creek Corrections Center (CCCC)	DOC**CCCC**PatientServices@DOC1.WA.GOV
Coyote Ridge Corrections Center (CRCC)	DOC**CRCC**PatientServices@DOC1.WA.GOV
Larch Corrections Center (LCC)	DOC**LCC**PatientServices@DOC1.WA.GOV
Monroe Corrections Center (MCC)	DOC**MCC**PatientServices@DOC1.WA.GOV
Mission Creek Corrections Center for Women (MCCCW)	DOC**MCCCW**PatientServices@DOC1.WA.GOV
Olympic Corrections Center (OCC)	DOC**OCC**PatientServices@DOC1.WA.GOV
Stafford Creek Correction Center (SCCC)	DOC**SCCC**PatientServices@DOC1.WA.GOV
Washington Corrections Center (WCC)	DOC**WCC**PatientServices@DOC1.WA.GOV
Washington Corrections Center for Women (WCCW)	DOC**WCCW**PatientServices@DOC1.WA.GOV
Washington State Penitentiary (WSP)	DOC**WSP**PatientServices@DOC1.WA.GOV