

STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH




Deidre S. Gifford, MD, MPH  
Acting Commissioner

Ned Lamont  
Governor  
Susan Bysiewicz  
Lt. Governor

HEALTHCARE QUALITY AND SAFETY BRANCH

BLAST FAX 2020-74A

TO: Hospitals, Hospital Addiction Medicine

FROM: Commissioner Deidre S. Gifford, MD, MPH 

CC: Deputy Commissioner Heather Aaron, MPH, LNHA  
Adelita Orefice, MPM, JD, CHC, Senior Advisor to the Commissioner  
Barbara Cass, RN., Branch Chief, Healthcare Quality and Safety Branch  
Donna Ortelle, Section Chief, Facility Licensing and Investigations Section

DATE: October 21, 2020

SUBJECT: Guidance to Hospitals for Inpatient Medication Use for Opioid Withdrawal Management and Opioid Use Disorder Treatment

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The Department established a Medication Assisted Treatment (MAT) workgroup to discuss identified challenges in the treatment for individuals with a substance use disorder. Please see the attached document that has been developed to facilitate treatment for individuals in a hospital inpatient setting who have elected medication assisted treatment.

Amendment reflects:

On pages 1 and 3 of the attached guidance, the word "disorder" was omitted in the context of opioid use disorder.



Phone: (860) 509-7400 • Fax: (860) 509-7543  
Telecommunications Relay Service 7-1-1  
410 Capitol Avenue, P.O. Box 340308  
Hartford, Connecticut 06134-0308  
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Healthcare Quality and Safety Branch

### Guidance to Hospitals for Inpatient Medication Use for Opioid Withdrawal Management and Opioid Use Disorder Treatment (rev. 8/25/20)

1. In accordance with Federal Regulations and the Regulations of the Connecticut State Agencies, hospitals are permitted to initiate methadone or buprenorphine (herein referring to buprenorphine/naloxone and extended release buprenorphine formulations) for the treatment of opioid withdrawal and opioid use disorders. These medications can be continued, and the doses adjusted throughout hospitalization. Special licensure or registration (e.g. DATA 2000 "X" waiver) is not required for any of these medications to be started in the hospital.
2. Hospitals and methadone clinics, specifically, are encouraged to establish a relationship prior to initiating methadone inductions. It is suggested that a memorandum of understanding (MOU) is developed that details the collaborative process for both parties. A process for meeting regularly to review the MOU including the referral process and make recommendations for improvements is also suggested.
3. Methadone can be given to hospitalized patients for both treatment of opioid withdrawal and opioid use disorder. For opioid use disorder treatment, hospital providers should be aware of the eligibility criteria for ongoing methadone treatment including the patient having a one-year history of opioid use disorder (with some exceptions: injection drug use, HIV, and pregnancy). All patients who are treated with methadone for opioid use disorder should be educated about the efficacy, effects and side effects as well as the need to go to a methadone maintenance clinic daily for the first 90 days of treatment. Alternatives including buprenorphine and naltrexone should also be discussed.
  - a. Methadone for the treatment of opioid withdrawal can be utilized without this one-year requirement but should be tapered prior to hospital discharge.
  - b. Hospital staff should work with their addiction specialists or local methadone maintenance clinics for questions about methadone eligibility including prior methadone clinic involvement.
  - c. Patients discharged to skilled nursing facilities may be given an exemption from the 90-day rule for daily methadone clinic attendance.
4. For seamless transition of methadone, hospitals need to work in collaboration with a licensed and federally accredited methadone maintenance clinic for continuation of the medication after hospital discharge. A list of methadone clinics can be found at: <https://dpt2.samhsa.gov/treatment/>.



Phone: (860) 509-7406  
Telecommunications Relay Service 7-1-1  
410 Capitol Avenue, P.O. Box 340308  
Hartford, Connecticut 06134-0308  
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- a. Hospital transitions staff, with the patient's written permission, should provide the methadone clinic with documentation of substance use history, opioid use history, the CT Prescription Drug Monitoring Program (also known as Prescription Monitoring Program) results (<https://portal.ct.gov/DCP/Prescription-Monitoring-Program/Prescription-Monitoring-Program>), and if performed, recent urine drug testing results, ECG, HIV/HCV and syphilis screening. Any other relevant clinical information from the hospital admission, including date, time and dosage of last methadone administration, must be clearly communicated to the methadone clinic.
  - b. If the methadone clinic has a waiver from the Department of Public Health, the physical examination performed on hospital admission, if less than 30 days old, may satisfy the clinic's requirement for a physical exam.
  - c. Patient discharge planning shall be done collaboratively between the hospital and methadone clinic. The hospital and the clinic should agree upon the date and location of intake at the methadone clinic; this is typically Monday through Friday.
  - d. The hospital is not permitted to provide a written/electronic prescription for methadone for the treatment of opioid use disorder nor are they permitted to provide any supply of methadone upon discharge from the hospital.
5. Buprenorphine can also be used for both the treatment of opioid withdrawal and opioid use disorder treatment. Patients should have documented opioid withdrawal or opioid use disorder. Medical providers are not required to have a DATA 2000 "X" waiver to initiate this medication in the hospital setting.
  6. Extended release injectable naltrexone can be used for the treatment of opioid use disorder in the hospital setting without restriction. Oral naltrexone is not advised for the treatment of opioid use disorder. It is important to note that naltrexone does not treat opioid withdrawal and should not be used for that purpose.
  7. In the absence of addiction medicine, addiction psychiatry, or other experienced hospital medical providers in the treatment of opioid withdrawal and opioid use disorder, the hospital is encouraged to work with medical staff from their local methadone clinics or outpatient providers of buprenorphine to assist with the provision of methadone, buprenorphine, and naltrexone use.
  8. Referral for ongoing opioid use disorder treatment and seamless medication continuation is the standard of care and an important component for successful opioid use disorder treatment. It is strongly recommended that each hospital establish a collaborative relationship with their local methadone or outpatient providers of buprenorphine to facilitate a seamless transition within 24 hours from hospital to ongoing outpatient treatment.
  9. For ongoing buprenorphine treatment, hospitals should work in collaboration with hospital affiliated or a DATA 2000 "X" waived prescriber to provide a prescription at discharge and ongoing continuation of care. Addiction medicine specialists, addiction psychiatrists, or other hospital medical providers who are DATA 2000 "X" waived can also provide a bridge prescription from hospital discharge to outpatient follow up. A list of DATA 2000 "X" waived prescribers can be found at: <https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator>

10. All patients with opioid use disorder should receive a prescription for intranasal naloxone at discharge along with opioid overdose prevention education. Other harm reduction information may also be needed.
11. Hospitals are encouraged to identify hospital-based experts in the treatment of opioid use disorder and substance use disorder such as addiction medicine physicians or addiction psychiatrists to assist with complex hospital-based addiction related cases and facilitate treatment.
12. Any questions related to regulatory issues may be directed to [Barbara.cass@ct.gov](mailto:Barbara.cass@ct.gov) at the Department of Public Health or [lauren.siembab@ct.gov](mailto:lauren.siembab@ct.gov) at the Department of Mental Health and Addiction Services.
13. Specific federal regulations on this topic are below. There are no superseding CT state regulations on this topic and DPH and DMHAS strongly encourage increased access for all patients to medication treatment for opioid use disorder.
  - a. [https://www.deadiversion.usdoj.gov/21cfr/cfr/1306/1306\\_07.htm](https://www.deadiversion.usdoj.gov/21cfr/cfr/1306/1306_07.htm)
  - b. <https://www.samhsa.gov/medication-assisted-treatment/legislation-regulations-guidelines/special>

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**See below for an example of pertinent information that may be helpful for methadone or buprenorphine transitions from the hospital to a clinic:**

**ADDICTION MEDICINE CONSULT REFERRAL NOTE/METHADONE OR BUPRENORPHINE REFERRAL**

**PCP: @PCP@**

**@NAME@ is a @AGE@ @SEX@ with PMH of \*\*\* who was admitted to the hospital for \*\*\***

**Methadone Dose in the Hospital:**

**Date last given:**

**Criteria for Methadone Maintenance Treatment:**

- ✓ Opioid Use Disorder (OUD) > 12 months:
- ✓ History of injection drug use:
- ✓ Age > 18:
- ✓ Previous use of methadone: YES/NO
  - If so, where and when:
- ✓ Previous use of buprenorphine:
- ✓ Last use of heroin/fentanyl:
- ✓ Last use of illicit prescription opioid:

**SUBSTANCE USE DISORDER and MEDICAL DIAGNOSES:**

**PMH:**

**INPATIENT MEDS:**

✓ Drug Allergies:

**SOCIAL HX:**

**DATA:**

**URINE DRUG TEST RESULTS:**

**FOR METHADONE MAINTENANCE REFERRAL: RPR Result, LFT result, HIV result, HCV result, PPD result, ECG result:**