AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 245
(A-22)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Expanding Access to Methadone Treatment for Opioid Use Disorder in the Midst of the Opioid Crisis

Referred to: Reference Committee B

Whereas, The United States is in the midst of an opioid crisis in which, between 1999 and 2020, more than a half million (564,522) people died of an opioid-related overdose;¹ and

Whereas, The three medications approved by the Food and Drug Administration for the treatment of opioid use disorder (OUD) are methadone, buprenorphine and naltrexone and;² ³ ⁴

Whereas, Methadone has been used since the early 1960s for long-term treatment of OUD;⁴ and ⁵ ⁶ ⁷ ⁸

Whereas, Methadone has been shown to be effective in the treatment of OUD ¹³ ¹⁴ ¹⁵ including reducing opioid use¹⁵-¹⁷ ¹⁶ ¹⁷ and overdose mortality;⁵ ¹⁵-¹⁷ and

Whereas, Interim methadone, allowing prescribing clinicians in licensed opioid treatment programs (OTPs) to induce waitlist patients onto methadone without counseling, has been shown to be safe, and has been shown to reduce opioid use, HIV risk behavior, reduce illegal income, and days incarcerated compared to waiting list participants; 18 19 20 and

Whereas, Medical maintenance, allowing office-based prescribing clinicians to manage stable patients referred from opioid treatment programs has been shown to be safe and effective at reducing treatment dropout, overdoses, mortality, HIV transmission, emergency department and hospital utilization, and cost of care;5,14 21 22 23 and

Whereas, Office-based methadone treatment for opioid use disorder in collaboration with community pharmacists that can dispense and supervise methadone dosing has been shown to be safe and improve retention in treatment for patients while reducing costs and increasing treatment capacity, especially in rural areas where access to specialty clinics may be limited;5 24 25 and

Whereas, Prescribing methadone to treat OUD in emergency departments (EDs), hospitals, and other controlled environments (e.g., jails and prisons) has been shown to be safe and improve outcomes; and

Whereas, Methadone prescribing for OUD treatment in EDs has been associated with reduced risk of fatal overdose and decreased all-cause mortality, increased patient use of ambulatory care, reduced use of ED and inpatient care, and indicated no net increase in expenditures; 26 27 and

Whereas, Methadone prescribing for OUD treatment from hospitals has been associated with improved retention in treatment, reduced readmission rates among patients with OUD and serious infections requiring hospitalization; 28 29 30 and

24 Gauthier G, Elbi JK, Marsh DC. Improved treatment-retention for patients receiving methadone dosing within the clinic providing physician and other health services (onsite) versus dosing at community (offsite) pharmacies. Drug Alcohol Depend. 2018/10/01 2018;191:1-5.
Whereas, Methadone prescribing for OUD treatment in jails and prison has been associated with increased medication initiation on release, improved continuity and coordination of care, and less injection drug use six months after release;17 31 32 33 34 and

Whereas, Many patients with OUD prefer methadone over buprenorphine and/or naltrexone;6 35 and

Whereas, Current Federal and State regulations are highly restrictive of the use of methadone for the treatment of OUD;16,18,21 38 39 40 41 42 43 and

Whereas, Many parts of the United States, particularly rural areas, have been described as "Methadone Deserts", because of poor access to this lifesaving treatment; 44 45 and

Whereas, Methadone cannot be prescribed by licensed physicians or advanced practitioners for treatment of OUD except in a clinic that meets all of the current regulations;3,16,21,39-41,43 and

Whereas, In many Western developed countries, including Canada since 1996, physicians can prescribe methadone in an office setting for the treatment of OUD;3,21,35,40, 46 47 48 and

Whereas, The American Society of Addiction Medicine (ASAM) has recommended reducing a) regulatory barriers to greater access to methadone and b) regulatory challenges to optimizing quality of care using methadone;49 and

44 Robert Bohler MD, Constance Horgan. *Addressing the Opioid Crisis in Small and Rural Communities in Western Massachusetts*. Massachusetts Health Policy Forum 2019.
Whereas, The National Academy of Science, Engineering, and Medicine, on March 3-4, 2022, held a Workshop on Methadone Treatment for Opioid Use Disorder: Examining Federal Regulations and Laws.\(^50\) Several presentations discussed how federal regulations that limit the use of methadone to treat OUD could be modified or removed; and

Whereas, Despite a near-doubling of take-home methadone doses during the COVID-19 exemption period, the increase in take-home doses was not associated with negative treatment outcomes in methadone-adherent clients;\(^51\) and

Whereas, Increased access to providing methadone for OUD treatment in the United States would substantially increase the availability of evidence-based OUD treatment\(^52 \) and decrease opioid overdose deaths and other medical and social problems associated with OUD in the United States; \(^4 \) \(^5 \) \(^6 \) \(^7 \) \(^8 \) \(^9 \) \(^10 \) \(^11 \) \(^12 \) \(^13 \) \(^14 \) \(^15 \) \(^16 \) \(^17 \) \(^18 \) \(^19 \) \(^20 \) \(^21 \) \(^22 \) \(^23 \) \(^24 \) \(^25 \) \(^26 \) \(^27 \) \(^28 \) \(^29 \) \(^30 \) \(^31 \) \(^32 \) \(^33 \) \(^34 \) \(^35 \) \(^36 \) \(^37 \) \(^38 \) \(^39 \) \(^40 \) \(^41 \) \(^42 \) \(^43 \) \(^44 \) \(^45 \) \(^46 \) \(^47 \) \(^48 \) \(^49 \) \(^50 \) \(^51 \) \(^52 \) \(^53 \) \(^54 \) \(^55 \)

RESOLVED, That our American Medical Association recognize that current federal and state regulations are overly restrictive and limit the clinically indicated use of methadone to treat opioid use disorder (OUD) (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for reform of Federal and State regulations to promote ready access to methadone treatment for OUD in diverse medical settings and for implementation of effective and equitable models of increasing access to methadone, including:

(a) Remove regulations restricting methadone treatment of OUD to specially certified clinics (Opioid Treatment Programs); (b) Remove regulations that make it difficult for patients to start and continue methadone treatment of OUD, such as limitations on take home dispensing and prohibition of telemedicine visits for the physician history and physical examination; (c) Allow physicians to prescribe methadone for OUD; (d) Allow pharmacists to dispense methadone for treatment of OUD; (e) Allow the initiation of methadone for treatment of OUD in emergency departments, hospitals, detoxification programs, skilled nursing facilities, home care settings, and other controlled environments; (f) Authorize medical clinicians in jails, prisons and other carceral settings to initiate and continue all FDA-approved medications for OUD without the burden of additional licensing and regulation; and (g) Ensure equitable access to methadone treatment for groups historically and currently excluded from full access to healthcare, including black, Latinx, and American Indian and Alaskan Native peoples. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/18/22

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\(^52\) Reif S, Brolin MF, Stewart MT, Fuchs TJ, Speaker E, Mazel SB. The Washington State Hub and Spoke Model to increase access to medication treatment for opioid use disorders. J Subst Abuse Treat.

