Buprenorphine-Waivered Providers Survey: Summary

Key Points

- The majority of responses (90%) indicated that they were waivered for less than 5 years.
- Ninety percent of responses reported prescribing to less than 30 clients at the time of the survey.
- More than half (58%) of responses indicated serving less than 10 clients at the time they completed the survey. Three indicated prescribing to over 100 clients; and those providers' client bases were exclusively rural.
- Despite a large amount of enthusiasm by the waivered responses, respondents described a lack of ability to prescribe due to organizational barriers, especially within the Emergency Department (ED).

Introduction

Medication-assisted treatment (MAT) is the use of medications in combination with counseling and behavioral therapies to treat substance use disorders (SUD). Research shows that MAT can successfully treat Opioid Use Disorder (OUD), help sustain recovery, and prevent or reduce opioid overdose. MAT has been shown to "improve patient survival, increase retention in treatment, decrease illicit opiate use and other criminal activity among people with substance use disorders, increase patient's ability to gain and maintain employment, and improve birth outcome among women who have substance use disorders and are pregnant".[1] The public health benefits of increasing access to MAT are vast.

Buprenorphine is one of the three medications approved by the Food and Drug Administration (FDA) to treat Opioid Use Disorder (OUD) and is the first opioid agonist/partial agonist medication to treat OUD that can be prescribed or dispensed in settings other than opioid treatment programs (OTP) and therefore not be accompanied by counseling (although counseling is strongly recommended), which has increased opportunities for access to this important medication. However, historically, in order to prescribe buprenorphine outside of OTPs, eligible providers (physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives) were required to obtain a waiver by completing specialized training to administer, dispense, and prescribe buprenorphine and notify Substance Abuse and Mental Health Services Administration (SAMHSA) of their intent. Providers that have completed the waiver process are referred to as waivered providers.

In order to inform efforts to increase access to MAT for Iowa residents, the Iowa Department of Public Health (IDPH) and the Iowa Maternal Quality Care Collaborative (IMQCC) Mental Health and Substance Use Disorder Sub-Committee sought the perceptions and experiences of waivered providers using a survey. Only waivered providers are legally allowed to prescribe buprenorphine to clients with OUD. The survey link was emailed to all 389 Iowa-based waivered prescribers on April 19, 2021 via a controlled distribution list from SAMHSA. There were 9 bounce backs from the distribution list and the last response was recorded on May 6, 2021. The survey closed with a total of 118 recorded responses, resulting in a 31% response rate. Providers were asked about their perceptions and experiences of the following categories and their responses are summarized below:

- Professional practice setting and clientele;
- Experience with waiver and SAMHSA Buprenorphine Practitioner Locator;
- Provision of buprenorphine to pregnant patients;
- Why respondents chose to obtain the waiver; and
- Perceptions and/or experiences of being waivered.

[1] SAMHSA, https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions

Professional Practice Setting and Clientele

Nearly two-thirds of waivered providers who responded to the survey (62%) identified their healthcare role as a physician (MD/DO) and one third (33%) of the total responses identified their role as a nurse practitioner (ARNP). Physician assistants, certified nurse-midwives, certified registered nurse anesthetists and clinical nurse specialists combined accounted for just slightly over 5% of healthcare roles indicated by respondents (see Table 1.). In regards to professional role, the survey was largely proportionately representative of waivered providers in Iowa.

Currently in Iowa, physicians (MD/DO) comprise 62% of waivered providers, nurse practitioners comprise 33%, physician assistants account for 4%, certified nurse-midwifes, certified registered nurse anesthetists and clinical nurse specialists combined account for 1%. Compared to those who completed the survey, physicians and nurse practitioners were exactly proportionately representative (62% of survey and population as well as 33% of survey and population, respectively) while physician assistants were slightly under-represented (4% of population but 2% of the survey) while certified nurse midwives, certified registered nurse anesthetists and clinical nurse specialists were slightly over-represented (1% of the population 4% of the survey).

Table 1. Healthcare Role of Respondents (n=118)

Healthcare Role	% of Responses	Count
Physician, MD/DO	62%	73
Advanced Registered Nurse Practitioner, ARNP	33%	39
Physician Assistant, PA	2%	2
Certified Nurse-Midwife, CNM	2%	2
Certified Registered Nurse Anesthetist, CRNA	1%	1
Clinical Nurse Specialist, CNS	1%	1
Total	100%	118

When asked, *"What is your practice setting?"* responses identified practicing in a wide variety of settings, with a little less than one third (36 of 118) citing more than one practice setting. As Figure 1. demonstrates, Primary care and Hospital-based were the two most commonly identified practice settings (identified by 30% and 29% of responses respectively), followed by Federally Qualified Health Centers (FQHCs) (17%) and Academic Medical Centers (16%).

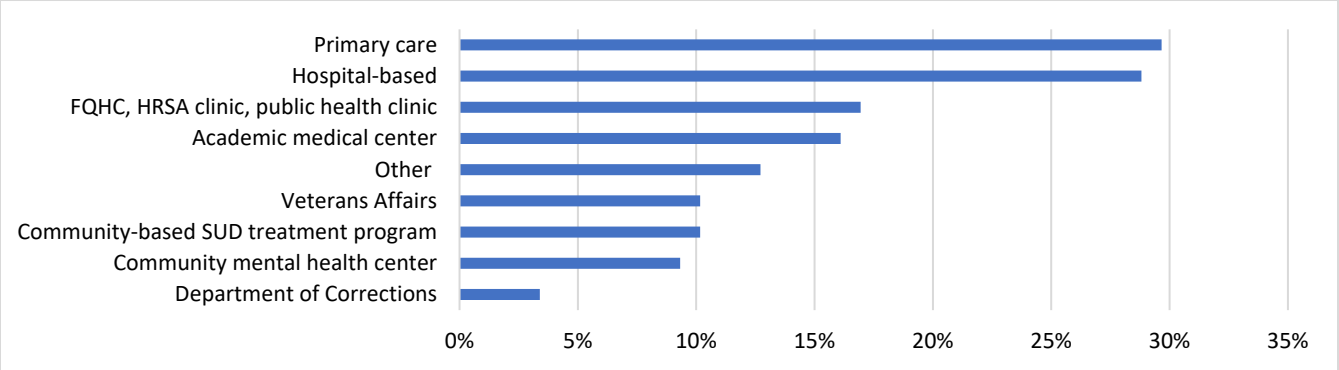

Figure 1. Practice settings of participants by percentage of responses (n=162 responses, with more than one answer possible for a total of 118 answers to this question)

When asked, *"What is your primary field of practice?"*, more than one third of waivered respondents (35%) indicated Primary Care as their primary field of practice, a little over one quarter of responses (28%) identified Psychiatry/Mental Health, and Emergency Medicine (13%). Thus most of the responses to this survey were waivered physicians practicing in primary care and hospital-based settings in the fields of primary care and psychiatry/mental health.

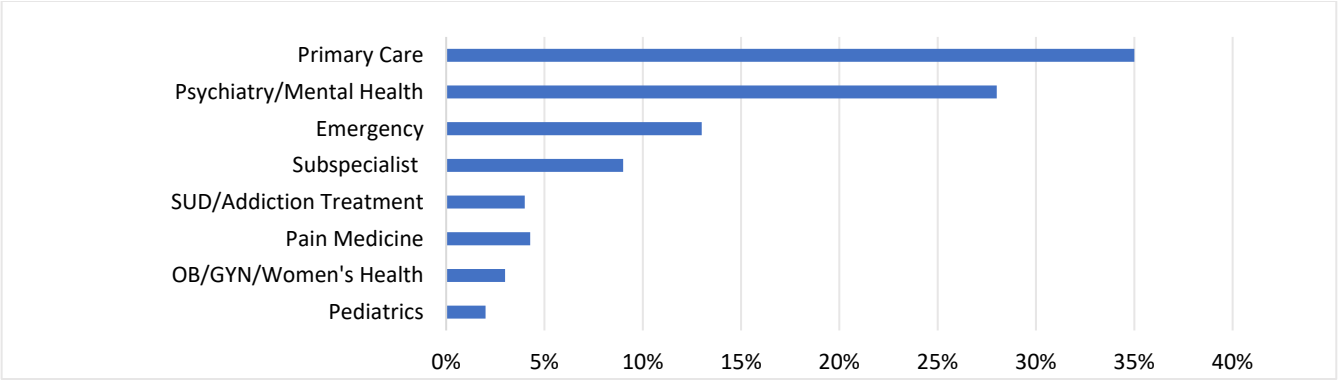

Figure 2. Primary field of practice by percentage of responses (n=117)

Experience with Waiver & SAMHSA Buprenorphine Practitioner Locator

When asked, *"How long have you been waivered to prescribe, administer, or dispense buprenorphine to a patient with Opioid Use Disorder?"* the vast majority of responses (more than 90%) indicated that they had been waivered for 5 years or less. Only 9.5% of responses indicated being waivered for 6 years or more (see Figure 3.).

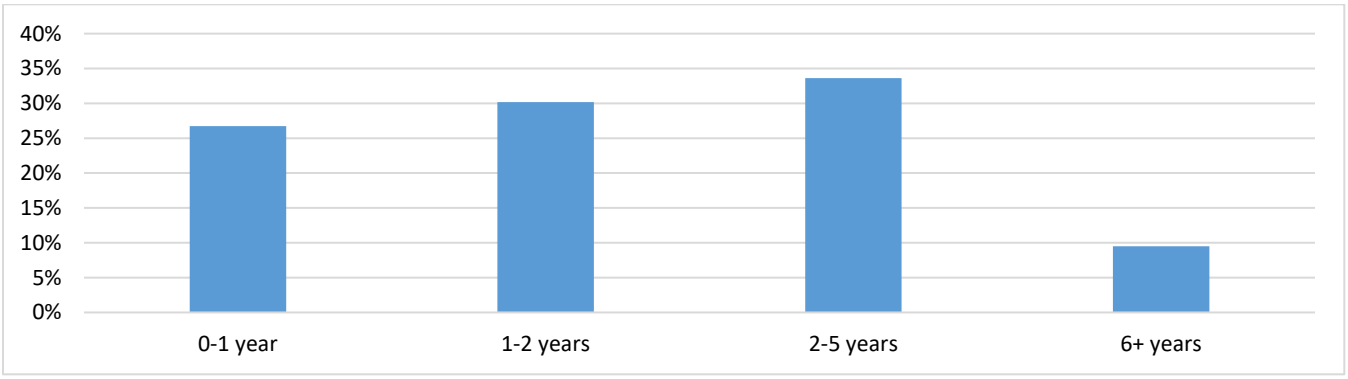

Figure 3. Years waivered by percentage of responses (n=116)

When asked, *"Have you ever prescribed, administered or dispensed buprenorphine to a patient for opioid use disorder?"* more than one quarter (27%) of those who had gone through the process to obtain the waiver and responded to the survey had never prescribed, administered, or dispensed buprenorphine for OUD (see Figure 4.). There were two main reasons indicated by responses that had not prescribed, administered or dispensed buprenorphine. The first and most commonly cited reason was a lack of appropriate infrastructure within their clinics and/or employer support and the second was a change in their patient population that did not require buprenorphine for OUD.

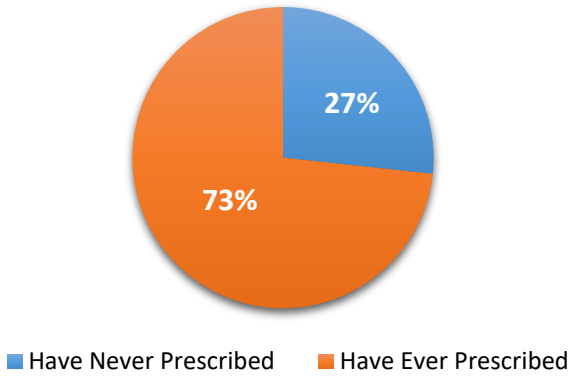

Figure 4. Percentage of responses ever prescribing, administering, or dispensing buprenorphine for OUD

When asked, *"Approximately how many patients are you currently treating with buprenorphine for patients with opioid use disorder?"* more than half (58%) of respondents currently prescribing buprenorphine to patients were prescribing to less than 10 clients at the time they completed the survey. Only 18% were prescribing to 10-20 clients, 14% to 21-30 clients, and 10% were prescribing to more than 30 clients. Three of the 7 responses prescribing to more than 30 clients indicated that they were prescribing to around 100 clients and that their clients were exclusively rural. Comparatively, 89% of responses to the question, *"What is the maximum number of patients you can prescribe, administer, or dispense buprenorphine to?"* indicated a panel limit size of 30 or more.

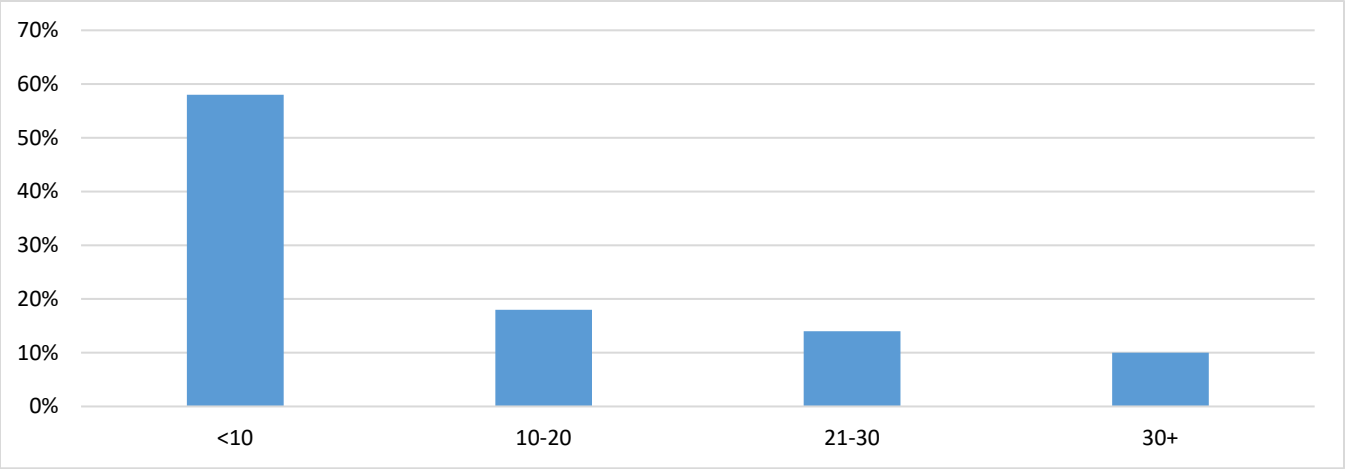

Figure 5. Number of OUD clients at time of survey by percentage of responses (n=71)

When asked, *"Have you chosen to opt out of having your information on the SAMHSA Buprenorphine Practitioner Locator?"* almost two thirds of responses (65%) chose to *opt in* to the SAMHSA treatment locator. For respondents that chose to *opt out* of the SAMHSA locator, the main reason cited for this decision was limited treatment capacity. Other reasons included: not wanting to publicize MAT services or working in spaces in which it would be difficult for patients to request their services such as telework, the ER, or the government.

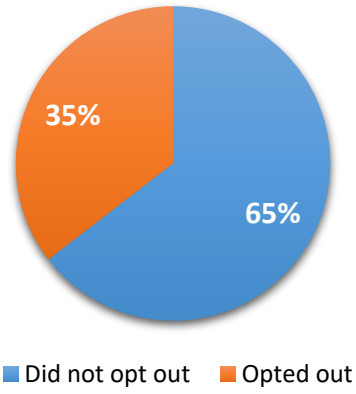

Figure 8. Percentage of responses that opted out of SAMHSA locator (n=108)

Provision of buprenorphine to pregnant patients

When asked, "*What care do you provide to people who are pregnant*?" only 17 out of 113 responses (15%) indicated that they provided prenatal care. More than half of the responses (62%) indicated that although they did not provide prenatal care, they did provide care to pregnant patients. Thus more than three fourths of the responses (77%) provided care of some kind to pregnant patients. However, a little less than a quarter of responses (23%) indicated that they did not provide care to pregnant patients (see Figure 6).

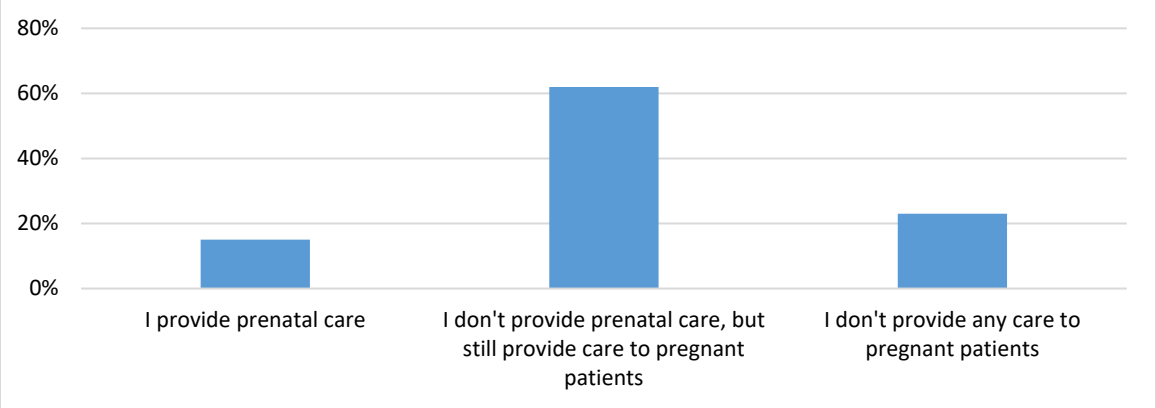

Figure 6. Percentage of responses providing care to pregnant patients (n=113)

As Figure 7. illustrates, when asked *"Have you prescribed buprenorphine to a pregnant patient with opioid use disorder in the past 12 months?"* more than three fourths of waivered responses (86%) indicated that they had not prescribed buprenorphine to pregnant patients in the past year and only 14% indicated that they had.

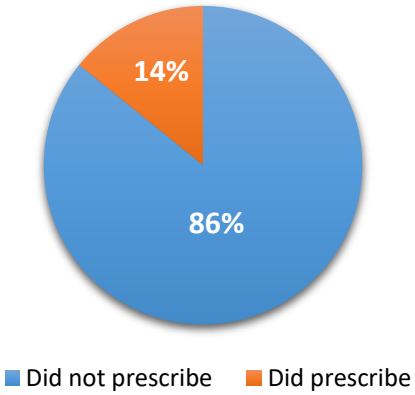

Figure 7. Percentage of responses that prescribed buprenorphine to pregnant patients in the last 12 months. (n=113)

Why respondents chose to obtain the waiver

When asked, *"Why did you decide to get waivered to prescribe, administer or dispense buprenorphine?"* The most common theme respondents identified as to why they decided to obtain the waiver was, "*To provide a standard of care to people with OUD*" and that MAT is simply *"good patient care"*. As one respondent put it, "*I believe that a patient with [opioid] dependence deserves to live."*

Others described specific positive experiences with patients. One respondent talked about an "*experience with a client that was suicidal after taken off pain meds and got better when had access to MAT services.*" Another respondent talked about their experience with a pregnant patient:

> *"Because I had an OB patient who struggled with heroin use in pregnancy and couldn't get help despite trying. Her first baby died. Her second she lost custody of (I cared for her during second pregnancy), then I became waivered, treated her during her third pregnancy and she got SOBER and delivered a healthy baby."*

Most respondents described feeling a responsibility to fill a gap in access to care within their community. For example, more than half of the responses to this question stated that they "*saw [a] local need*", a local "*community need*" or "*Limited providers in the area*" and that they felt it was their responsibility "*To help with the opioid addiction problem in my community."*

While many respondents described a general need in the community, some respondents described specific gaps in care, especially within the ED. As this provider described:

> *"We see many patients in the ED who request assistance with addiction treatment. In the past and in various areas in Iowa it can be very difficult to find providers who treat addiction. Basically, I saw a need and an opportunity to start therapy for those presenting to the ED."*

Other respondents also described seeing an "*increasing number of patients in the ED requesting treatment and the added availability of a MAT clinic at our hospital*" and the need "*To help with initiation of treatment in the ER and offer pain/treatment alternatives to patients*" as well as feeling the need "*To help [with] acute withdrawal in the ED*".

While some respondents indicated their reason for obtaining the waiver was due to the waiver being "*needed for employment*" or a "*Requirement upon hire*", the majority focused on the greater good of addressing the opioid issue affecting our country. As one respondent stated, "*There is an opioid epidemic in the United States. I signed up to help fight this epidemic*."

Perceptions and/or experiences of being waivered

When asked to *"Please describe the benefits you have experienced as a buprenorphine waivered provider"* many respondents described satisfaction in meeting the gaps they sought to meet when getting waivered. For example, *"I have the ability to help a patient in need, 24/7/365 and bridge them to an appropriate long-term treatment provider"* and *"treat[ing] opioid withdrawal in the ED while giving them a bridging Rx to f/u with a local provider for continuing care".*

Some described the personal practice improvements, such as having *"additional tools to treat pain",* being "*more comfortable caring for patients with opioid use disorder"*.

However, most of the responses centered on the professional and personal satisfaction in seeing patients change their lives around and recover. As this respondent describes:

> *"I am thrilled to journey with a patient in such darkness and suffering to a place of healing and hope. My patients' specifically have benefited in the following areas: from steady employment; advancement of training (education/ college); revitalized & new healthy relationships; reduced/ eliminated hospitalizations; and successful payment of dues/ fines with a sense of normalcy and comfort."*

When asked to *"Please describe the challenges you have experienced as a buprenorphine waivered provider."* An often-indicated, and significant challenge with being waivered was the role of stigma. Responses included, "*Stigma from other parts of the health care system*" and "*Stigma from pharmacists when my patients try and fill their prescriptions*" and "*overall negative stigma that goes along with addiction.*" Surprisingly, "*Stigma from other providers towards my patients who are on buprenorphine*" and the overall "*Lack of support from colleagues"* was also described as a huge barrier for the providers that responded to the survey.

Another challenge identified by respondents was "*Finding follow up providers as I am an emergency physician and they won't be coming back to see me*". These care integration challenges were identified by many respondents, as this person describes, "*Sometimes people need more help in addition to buprenorphine and it's hard to get into treatment programs, especially ones that will work with someone taking buprenorphine.*"

The other most commonly identified barrier was that "*access to mat and any form of mental health care is awful in rural Iowa. People travel long distances for [buprenorphine], but can't get other care and services locally*".

Some providers described no benefits of being waivered. It's important to note that many of these respondents had not prescribed buprenorphine or struggled with *"The red tape of actually using it."* Other responses indicated, "*I would love to treat OUD, but my clinic is not able to meet the rigid requirements and therefore we go unused"* or "*challenges with policies, protocols, and procedures*" and "*Prior-authorizations from insurance companies*".

Future Focus Areas Recommended by IDPH

Waiver Requirement Changes

The current opioid epidemic in the U.S. has been well-documented. The "gold standard" of treatment for OUD is Medication Assisted Treatment (MAT). At the time of the survey, a waiver was necessary for eligible providers to prescribe buprenorphine outside of OTPs. Since the survey closed, SAMHSA now allows eligible providers to prescribe buprenorphine without a waiver to less than 30 clients. As this survey demonstrates, most of the waivered providers that completed the survey (90%) were prescribing to less than 30 clients at the time of the survey. As a result, the change in waiver requirements may help to reduce barriers to access for clients with OUD in obtaining MAT, such as in rural areas where the waivered survey respondents described prescribing to over 100 clients. Future efforts could document the effects of this policy change, especially in rural contexts.

Process Issues

It was identified from the survey that over a quarter of those waivered and able to prescribe buprenorphine (27%) in this survey had never prescribed it to OUD patients. Respondents repeatedly described an inability to treat OUD in their practice settings due to *"rigid requirements"* and the *"red tape"* of the policies, protocols and procedures for this particular medication, especially within their clinics and/or hospital systems.

A solution to this issue may lie with medical systems in which waivered providers practice establishing collaborative relationships with established substance use disorder treatment providers and greater knowledge translation on the benefits of buprenorphine in medical settings to hospital systems. As recommended by SAMHSA, substance use disorder treatment (counseling) should accompany the delivery of MAT. If a collaborative relationship is pursued, MAT providers could assist SUD treatment providers by offering them referrals for clinical treatment services. In turn, the SUD treatment providers can offer much of the case management that is seen as a barrier, or *"red tape"* by the MAT providers.

Prior Authorization

Prior-authorization from insurance companies was also cited as a barrier to prescribing buprenorphine to OUD clients. Policies, protocols and procedures within organizations and insurance systems regarding prescribing buprenorphine should be assessed to remove barriers to treatment.

A potential solution to this issue may be to catalogue third-party payor policies regarding prior-authorization requirements. Several third-party payors have recently modified these processes, identifying specific versions of MAT medications that are now available without the need for prior-authorization. Specifically, in 2019 legislation was passed in Iowa that made at least one version of each of the FDA approved forms of MAT available for Medicaid patients without need for a prior authorization. In the event that it is determined that MAT is not a covered service, the recent expansion of Iowa's State Opioid Response grant to include direct reimbursement to MAT prescribers, as well as coverage of medication costs, could be an opportunity to support efforts.

Reduce Stigma

Reducing systemic and organizational stigma among providers is an important step to improve outcomes for those with OUD and access to the "gold standard" of treatment in Iowa. This survey suggests that even though providers were able to prescribe buprenorphine, they described obstacles of being unable to get the prescription filled by the pharmacist, not having support among their peers, and their clients experiencing stigma from other providers.

Recently, the Iowa Department of Public Health launched a new media campaign, focused on various forms of stigma. A specific effort of this campaign is focusing on stigma in health care settings, using health care providers as advocates for change. The campaign, entitled *It Starts With Us*, is intended to help change the narrative around how individuals with substance use disorder are seen by professionals.

Treatment Access

Many of the respondents cited emergency medicine as their primary field of practice (third most common among responses) and that they obtained the waiver after perceiving a need for OUD treatment in the ED. However, they also described barriers in linking their clients to follow-up care. This survey suggests that furthering integration of care between the ED and the community may help clients in accessing buprenorphine.

As mentioned previously, established relationships between those prescribing MAT and substance use disorder treatment providers can be a win-win situation. This collaboration could be expanded to include hospital emergency departments.

In addition, as indicated in Figure 6. of this summary, a large percentage (77%) of respondents do care for people who are pregnant. Effectively treating and supporting pregnant people with opioid use disorders and their families requires a comprehensive approach to medical care. To assist in service delivery to this population, healthcare providers who care for people who are pregnant could benefit from additional training to improve their competency, knowledge, skills, and expertise to understand the implications of opioid use during pregnancy and the interventions and needs in the prenatal through the postpartum time frames.

Your Life Iowa is a comprehensive website developed by IDPH that provides a wealth of information on issues such as substance use/misuse, problem gambling, mental health and suicide prevention. Part of this website is a treatment locator that can assist anyone in Iowa to find treatment services, based on the individual's specific needs, in addition to 24-hour assistance by trained staff. A tailored effort to educate the medical community regarding this resource could be helpful in bridging the gap.

As the well-documented benefits of MAT become accepted by the medical (and treatment) communities, the settings for introducing this form of treatment are also growing. With the continued increase in deaths involving opioids, there is an equally concerning number of individuals being treated for non-fatal opioid overdoses in ED's and by EMS personnel. Increasing the induction of buprenorphine in the ED is an evidence-based strategy that could save lives in Iowa. This opportunity offers individuals an immediate alternative to not only the ongoing risk of potential overdose, but also reduces the barrier or fear of withdrawal symptoms and helps directly introduce them to a path to treatment (counseling in combination with buprenorphine) rather than risking the lack of follow-through that often comes with a referral at discharge. To address the lack of familiarity with this approach by ED providers, the development of a technical assistance network could be a valuable resource.

As indicated, IDPH sees opportunities in the information identified by survey responses and supports the above approaches to increasing access to MAT in order to improve the quality of life, and support recovery, for Iowans.