Beyond the Waiver: Multilevel Interventions Needed to Expand Buprenorphine Treatment

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From May 2020 to April 2021, over 100,000 people died from an overdose, more than any prior 12-month period. Most overdose deaths involve opioids, predominantly fentanyl analogs. Opioid agonist medications for opioid use disorder (OUD), methadone and buprenorphine, reduce mortality and overdose and improve person-centered outcomes. There are an estimated 2.7 million people with OUD living in the US, and expanding access to buprenorphine is a key component of our national strategy to reduce overdose deaths; however, few people with OUD receive any medication for OUD.

Many factors contribute to the low provision of buprenorphine treatment for OUD. A leading factor is the limited availability of buprenorphine prescribers. In 2018, more than 40% of counties in the US did not have any clinicians permitted to prescribe buprenorphine, and more than half of the counties with the greatest treatment need had inadequate treatment capacity. Treatment has expanded during the last decade, but it has been unevenly distributed, and buprenorphine access remains highly restricted, particularly in rural areas and in minoritized racial and ethnic communities.

To prescribe buprenorphine for OUD, Drug Enforcement Administration (DEA)-licensed physicians, advanced practice nurses (APNs), and physician assistants (PAs) need to apply for an X-waiver from the Substance Abuse and Mental Health Services Administration. Historically, there has been a training requirement to obtain a waiver: 8 hours for physicians and 24 hours for APNs and PAs. As of December 2021, less than 10% of DEA-licensed clinicians were waivered. In April 2021, the Biden-Harris administration removed the training requirement to receive a waiver to treat up to 30 patients to expand the number of waivered clinicians, reduce buprenorphine prescribing barriers, and expand buprenorphine access. In this issue of JAMA Network Open, research by Spetz et al and Lanham et al provides important insights into factors influencing buprenorphine prescribing capacity and provision.

Beyond Training

Using DEA registrant data, Spetz et al compared quarterly changes in the number of waivered clinicians from 2018 to 2021. They found that while total treatment capacity has risen, the rate of growth in the number of waivered clinicians declined during the pandemic and continued to decline despite the relaxation of the waiver training requirement. These findings suggest that removal of the training requirement alone is not sufficient to expand the clinician workforce able to prescribe buprenorphine, much less actively prescribing buprenorphine.

Most waivered clinicians do not regularly prescribe buprenorphine. The research of Lanham et al builds on prior work seeking to understand why many waivered clinicians do not prescribe buprenorphine. They surveyed clinicians attending a waiver training to identify barriers and facilitators to obtaining their waiver and, subsequently, prescribing buprenorphine. Less than half of the survey respondents obtained their waiver, and about one-third of those who received their waiver reported prescribing buprenorphine. Primary barriers to obtaining a waiver after completion of the training included the complexity of the waiver process and the lack of professional support and a referral network. Facilitators included the receipt of prescribing support and changes to the waiver...
training and registration process. Both studies\textsuperscript{8,11} underscore the need for a multilevel approach—at the clinician, health system, medical education, and federal policy levels—to successfully expand the buprenorphine treatment workforce and treatment access.

**Motivating Individual Change**

Individual-level clinician change is challenging, particularly across specialties, geographic regions, and practice settings. To successfully change clinician behaviors, the desired behavior change—obtaining a waiver and prescribing buprenorphine for the treatment of OUD—should be made as easy as possible. Closing the gap between clinician intention and action requires removing logistical barriers, changing practice norms, reducing stigma, creating easy-to-follow clinical pathways, expanding trainee education, and providing support for practicing clinicians. Local practice norms can reinforce and amplify clinicians’ underlying motivations. A lack of consistent and positive reinforcement for treating OUD can undercut clinician motivation to obtain a waiver and to prescribe buprenorphine once they have a waiver. Public or organizational waiver-promotion campaigns, specialty society recommendations, individual incentives, and organizational or administrative support and expectations for obtaining a waiver can support new norms, reduce stigma, and increase clinician motivation.\textsuperscript{13}

To increase motivation to become a buprenorphine prescriber, clinicians also need to understand the salience of prescribing buprenorphine, the difference it can make in patients’ lives, and the improved outcomes associated with buprenorphine treatment. It is also crucial to address clinician stigma about people who use drugs, people with substance use disorders (SUDs), and evidence-based OUD treatment.\textsuperscript{14} Many clinicians may not have had the opportunity to observe patients successfully engage in treatment and recovery. Exposing clinicians to positive outcomes from OUD treatment amplifying success stories of patients receiving medication for OUD can address stigma, humanize people with SUDs, and support clinician motivation to obtain their waiver and become a prescriber.

**Organizational Change**

Organizational culture and norms have a central role in whether clinicians choose to prescribe buprenorphine. Development of organizational treatment guidelines, administrative support to obtain a waiver, and professional networks that support newly waivered clinicians to prescribe buprenorphine are paramount to facilitate buprenorphine prescribing. Organizations can help shift their practice culture by prioritizing OUD treatment, highlighting departments or clinicians successfully prescribing buprenorphine, emphasizing patient recovery stories, and funding OUD treatment and quality improvement initiatives.

Once clinicians have their waivers, it is important that health organizations support them. Respondents to the survey in Lanham et al\textsuperscript{11} indicated that the waiver training alone does not sufficiently prepare clinicians to start prescribing buprenorphine. Having robust institutional treatment algorithms and referral pathways combined with professional mentorship and supervision can support buprenorphine prescribing. There have been a wide variety of implementation efforts that have effectively supported waivered clinicians becoming buprenorphine prescribers. For example, California Bridge,\textsuperscript{15} which features a low-threshold buprenorphine treatment approach with a network of supportive clinician mentors and patient navigation from the hospital to outpatient addiction treatment, provides 1 model for how organizations can do this effectively in academic, community, rural, and urban clinical settings. Other clinician support models include learning collaboratives,\textsuperscript{16} consultations and clinician support provisions by local champions, clinician support lines like the University of California San Francisco National Clinician Consultation Center,\textsuperscript{17} and Project ECHO tele-education initiatives.\textsuperscript{18}
Medical Education, Health Care Delivery, and Health Policy Changes

There are multiple state, regional, and national efforts by professional societies, payers, and government agencies to improve health system capacity and capability to provide evidence-based treatment for OUD. Removal of the waiver requirement, as proposed by the Mainstreaming Addiction Treatment Act, would remove important logistical hurdles to clinicians being able to prescribe buprenorphine and help reduce stigma associated with OUD treatment. Additional changes to federal regulations to permit new treatment models, such as telehealth, will further improve treatment access.

To effectively prepare clinicians to care for patients with OUD, it is essential to incorporate training into the general medical student, APN, PA, and residency education. Current clinical training prepares clinicians to successfully perform many complex and difficult tasks, and learning patient-centered, evidence-based treatment for SUDs should be normative practice. There will, of course, still be a need for specialty addiction care, but given the high prevalence of SUDs, there is a basic foundation of knowledge, which all clinicians, particularly generalists, should be able to master.

Additional training and resources are also needed to enable clinicians to understand and address patients’ complex social needs, which are key drivers of substance use, treatment engagement, and patient outcomes. Clinicians are generally trained to identify and treat discrete diagnoses; however, the people we take care of and the challenges they face, are not discrete. Furthermore, clinicians have limited time and resources to sufficiently address patients’ health-related needs during a brief clinical encounter. Use of a multidisciplinary care team, comprising people with lived experience and those who specialize in services navigation and individualized support for people with SUDs (eg, peer recovery specialists, community health workers, and social workers) can improve treatment initiation and engagement, even in busy clinical environments. However, these initiatives need sustainable funding and organizational support for successful and equitable implementation and dissemination.

Finally, payers have a powerful role in supporting practice change and improving patient outcomes. For example, Medicaid expansion has helped improve treatment access and reduce overdose death in expansion states, but 12 states have still not expanded Medicaid, and underinsurance and insurance gaps remain nationwide. Removal of prior authorization for buprenorphine, enforcement of parity requirements for insurance coverage for addiction treatment, and use of quality metrics or incentives would strongly influence organizational and individual clinician behavior change and promote the delivery of high quality, evidence-based patient care.

Conclusions

The federal government can and should continue to remove logistical barriers to prescribing buprenorphine in concert with interventions and policy changes at the individual, organizational, health system, and societal levels. However, it is important to note that these interventions will likely not reach optimal effectiveness without addressing the socioeconomic factors and drug policies that enforce treatment barriers, exacerbate drug-related harms, criminalize people who use drugs, and perpetuate stigma toward people with SUDs. Thus, a comprehensive, multilevel approach is essential to expand treatment workforce capacity to effectively care for people with SUDs, improve patient outcomes, and reduce overdose deaths.

ARTICLE INFORMATION

Published: May 12, 2022. doi:10.1001/jamanetworkopen.2022.12425

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Conflict of Interest Disclosures: Dr Martin reported being a White House Fellow from 2021 to 2022. No other disclosures were reported.

Funding/Support: Dr Samuels is partially supported by grant P20GM125507 from the National Institute of General Medical Sciences of the National Institutes of Health and the Substance Abuse and Mental Health Administration New England Addiction Technology Transfer Center.

Role of the Funder/Sponsor: The funders had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Disclaimer: The content is solely the responsibility of the authors and does not necessarily represent the official views of the Biden-Harris administration National Institutes of Health or the Substance Abuse and Mental Health Administration.

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