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BRIEF REPORT

Prescribing Practices of Rural Physicians Waivered to Prescribe Buprenorphine

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Introduction: Opioid use disorder is a serious public health burden, especially throughout rural America. Although efforts have been made to increase the availability of buprenorphine (an office-based medication-assisted treatment), more than 60% of rural counties in the U.S. lack a physician with a Drug Enforcement Administration waiver to prescribe it.

Methods: This study surveyed all rural physicians with a Drug Enforcement Administration waiver in 2016 to prescribe buprenorphine for opioid use disorder in the U.S. and asked about physician's demographics, prescribing practices, and barriers to prescribing buprenorphine for treatment of opioid use disorder.

Results: Although 89.4% of physicians reported having prescribed buprenorphine for opioid use disorder, only 56.2% were currently accepting new patients for treatment. Physicians with a 30-patient waiver were treating, on average, 8.8 patients, but 53% were not treating any patients. Those with a 100-patient waiver were treating, on average, 56.9 patients. Significant practice variations were found throughout the U.S. by Census Division; more physicians in the Pacific Census Division accepted their own patients for treatment with buprenorphine whereas more physicians in the New England Census Divisions accepted patients of other clinicians in their practice. Although most physicians accepted private insurance, significantly fewer physicians in the East South Central and West South Central Census Divisions accepted Medicaid.

Conclusions: These findings suggest that without incorporating information about whether or not physicians are accepting new patients, how many patients are being treated, and which patients and reimbursements are accepted, estimating the supply of buprenorphine treatment services using the Drug Enforcement Administration waivered physicians list will overestimate treatment availability.

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INTRODUCTION

The U.S. is experiencing an opioid abuse epidemic that is a significant, ongoing public health emergency. More than 2 million individuals were estimated to be suffering from opioid use disorder (OUD) in 2015, and an estimated 828,000 were using heroin.[1] Buprenorphine is an effective treatment option for OUD,[2] but access to treatment continues to be a challenge for many people. Large, contiguous areas of many regions in the U.S. have extremely limited access to medication-assisted treatment (MAT). Despite

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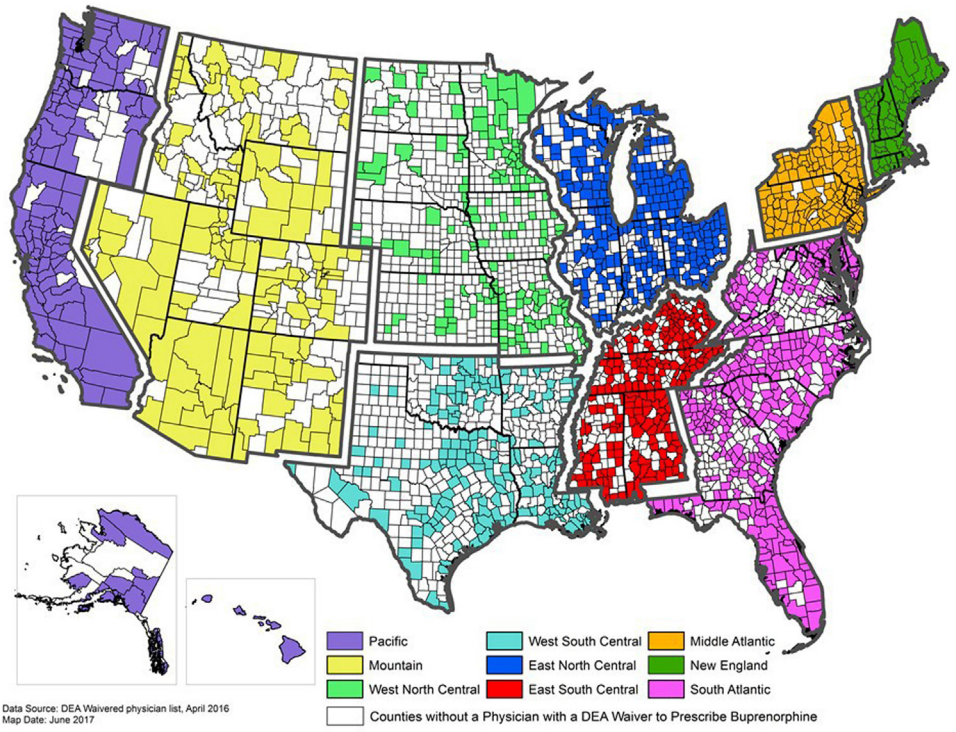

Figure 1. U.S. counties with at least one physician with a Drug Enforcement Administration waiver to prescribe buprenorphine for opioid use disorder, by U.S. Census Division.

substantial growth in the number of physicians with a Drug Enforcement Administration (DEA) waiver to prescribe buprenorphine for the treatment of OUD,[3] more than 60% of rural counties in the U.S. lack even one waivered provider, and prior research has shown availability of waivered providers varies substantially across Census Divisions (Figure 1, adapted from Andrilla et al., 2017).[4] Additionally, numerous studies show that many waivered physicians are not using their waiver to its full extent or at all, further diminishing access to treatment.[5–7] This study aims to quantify, describe, and compare the availability and prescribing practices of physicians with a waiver across the rural U.S. and further describe regional differences.

METHODS

Study Population

All rurally located physicians on the DEA list (April 2016) of waivered physicians were surveyed and categorized as rural if the Federal Information Processing Standard county code of the physician's addresses had an Urban Influence Code (UIC) of 3 through 12.[8] UIC codes classify counties based on both the counties' largest urban population core and the counties' adjacency to metropolitan areas. UICs >2 indicate that the largest urban core population in the county is <50,000 people. For example, a UIC code of 3 indicates a county with an urban core population up to 50,000 that is adjacent to a large metro area whereas a UIC code of 12 indicates the county is not adjacent to a metropolitan or micropolitan area and does not contain a town of at least 2,500 residents. Physicians who were determined to be practicing in an urban location were excluded from analyses.

Measures

The 15-item questionnaire asked physicians about their history and current practice of treating patients with OUD with buprenorphine, the number of patients currently being treated, the number and prescribing status of physician coworkers with a DEA waiver, and whether certain groups of patients (e.g., from another provider or clinic) and reimbursements (e.g., Medicaid, private insurance) were accepted for buprenorphine treatment. Physicians were asked to indicate from a list of barriers which ones they had experienced when incorporating buprenorphine into their practice for the treatment of OUD, provide details about practice characteristics and location, and answer basic demographic questions.

Paper questionnaires and web survey invitations were sent to all physicians at the address in the DEA file. The American Medical Association Physician Masterfile[9] and physicians' National Provider Identifier[10] numbers were used to correct addresses for nonresponding physicians and returned surveys. Research staff phoned all nonresponding physicians at the DEA, American Medical Association, National Provider Identifier, or Google Search result addresses until the physician's practice location was found. Participants received the paper survey at that address 2 more times 2 weeks apart, followed by an abbreviated version of the survey as a tear-off return postcard a month after follow-up