

# Improving Practitioner Readiness to Prescribe Buprenorphine:

Implications for Access to  
Medications for Opioid Use  
Disorder in Kane County, IL



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## Abstract

Opioid use disorder (OUD) continues to pose a serious public health challenge in the United States and in Kane County, contributing to preventable illness and death. Buprenorphine is an FDA-approved, safe, and effective medication for OUD that is associated with a significant reduction in mortality. Despite the repeal of the federal X-waiver in 2022, many clinicians remain hesitant to prescribe buprenorphine due to limited training, lack of ongoing support, and persistent stigma toward individuals with OUD.

The Kane County Health Department conducted a pilot study to evaluate a targeted educational and peer support intervention aimed at increasing clinician knowledge, confidence, and willingness to prescribe buprenorphine. The intervention included a two-hour physician-led training, follow-up peer support sessions, and financial incentives for participation. Changes in knowledge, attitudes, and self-reported prescribing practices were assessed using pre- and post-intervention surveys.

Participating clinicians demonstrated increased understanding of buprenorphine pharmacology and clinical use, improved confidence in prescribing and counseling patients, and reduced perceived barriers related to safety concerns and diversion. These findings suggest that pairing education with structured peer support can help address key barriers to buprenorphine prescribing and improve readiness among clinicians to provide evidence-based OUD treatment.

This initiative offers practical insights for local health departments and healthcare systems seeking to expand access to medications for opioid use disorder. By investing in clinician support and reducing stigma within healthcare settings, communities can strengthen systems of care, improve treatment access, and reduce opioid-related harm.

## Introduction

The opioid crisis remains a significant public health emergency in the United States, with opioid use disorder (OUD) driving high rates of overdose, hospitalization, and mortality. In the U.S., there was a 30% increase in drug-related overdose deaths during the COVID-19 pandemic compared to pre-pandemic rates.<sup>1</sup> These overdose deaths were primarily driven by opioids and highlight the importance of access to treatment as opioid-related mortality was exacerbated during the pandemic.<sup>2</sup>

Kane County was not exempt from the effects of the opioid crisis. Between 2018 and 2023, there were 2,224 opioid-related overdose visits at Kane County Emergency Departments.<sup>3</sup> During that same period, 417 Kane County residents died from an opioid overdose.<sup>4</sup> In 2023, there were 93 drug-related deaths in the county, and 76% involved opioids.<sup>5</sup>

Patients receiving medication-assisted treatment for OUD cut their risk of death from all causes in half.<sup>6</sup> Additionally, a large Medicare study found that people who received buprenorphine after surviving an opioid overdose had a 62% reduced risk of opioid-involved overdose death compared with those who did not receive buprenorphine.<sup>7</sup>

Despite the proven effectiveness of buprenorphine for OUD, only a minority of individuals with OUD receive this treatment. In the United States in 2022, among adults who needed treatment for OUD, only about 25% received medications for opioid use disorder (MOUD) including buprenorphine, methadone, and naltrexone, highlighting substantial gaps in access to evidence-based pharmacotherapy for OUD.<sup>8</sup>

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<sup>1</sup> <https://archive.cdc.gov/#/details?url=https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html>

<sup>2</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9617630/>

<sup>3</sup> NSPP-ESSENCE

<sup>4</sup> IDPH Vital Records - Deaths

<sup>5</sup> Kane County Coroner's Report, 2023

<sup>6</sup> Watts BV. et al., "Association of Medication Treatment for Opioid Use Disorder with Suicide and All-Cause Mortality", *American Journal of Psychiatry* (2022)

<sup>7</sup> Samples H, Nowels M, Williams AR, Olfson M, Crystal S. Buprenorphine after nonfatal opioid overdose: Reduced mortality risk in Medicare disability beneficiaries. *Am J Prev Med.* 2023;65(1):19-29. doi:10.1016/j.amepre.2023.01.037

<sup>8</sup> Centers for Disease Control and Prevention (CDC). *Treatment for Opioid Use Disorder: Population Estimates — United States, 2022.* MMWR Morb Mortal Wkly Rep. 2024;73(25):569-574.

Access to buprenorphine remains limited, largely due to barriers within the healthcare system. Although a federal X-waiver requirement was repealed in 2022 to expand prescribing access, many clinicians continue to report hesitancy in initiating treatment. Physicians frequently encounter barriers to providing buprenorphine for OUD including stigma toward individuals with OUD, limited familiarity with medications for OUD, and concerns about regulatory and practice requirements. Commonly cited challenges include concerns about medication diversion (buprenorphine getting into the hands of those who were not prescribed), lack of ongoing clinical and professional support after training, and limited referral networks for comprehensive care.

Addressing these barriers is critical, as practitioner knowledge, confidence, and attitudes directly influence prescribing practices and patient access to life-saving care. To address this challenge, the Kane County Health Department implemented an initiative aimed at increasing access to medication assisted recovery via buprenorphine treatment – the compassionate and evidence-based gold standard for individuals suffering from OUD – by providing practitioner training, support and incentives and assisting patient connection to recovery services, and naloxone.

The objectives of the initiative were to:

- Assess the effectiveness of the intervention in improving knowledge and attitudes in participating practitioners.
- Examine how these changes influenced self-reported prescribing behavior.
- Increase the number of practitioners prescribing buprenorphine in Kane County.
- Provide ongoing support and referral resources to participating clinicians.
- Develop a set of actionable recommendations to guide community efforts in expanding access to medication for opioid use disorder.

## Program Design

Taking place from April through September 2025, the initiative had four components including (1) practitioner training, peer support, and financial incentives, (2) encouragement of the use of a patient referral network, (3) community outreach and awareness, and (4) assessment of prescribing behavior change.

The initiative offered an educational workshop to physicians, physician assistants and nurse practitioners practicing in Kane County who are eligible and interested in prescribing buprenorphine. KCHD then coordinated two peer support sessions at two and five months following the initial training led by the physician trainers at which participants shared their experiences and questions that may have arisen since the training. This allowed participants new to the practice of addiction medicine involving buprenorphine and experienced clinicians with a track record of prescribing buprenorphine to learn from one another, establish a good local standard of practice, receive ongoing support, guidance, and clinical consultation to their peers, and build confidence and competence in prescribing buprenorphine.

To increase the number of Kane County practitioners trained to prescribe buprenorphine, a stipend of \$400 was paid in exchange for:

- Completing a 10-minute pre-test that assessed knowledge and attitudes toward prescribing buprenorphine to those with opioid use disorder and current prescribing behavior.

- Attend the April 18, 2025 training session.
- Attend at least one 1-hour virtual peer support meeting that took place in July and September, 2025.
- Complete two 10-minute post-tests that assess knowledge and attitudes toward prescribing buprenorphine to those with opioid use disorder and post-intervention prescribing behavior.

Participation in all of the four activities (pre-test, training, peer support meeting, post-test) was required to receive the full incentive.

Participants were encouraged to use existing KCHD information and referral services and MAR NOW (a 24/7 telephone access line for Illinois residents seeking treatment for opioid use disorder that connects them to a tele-health provider who can prescribe medications that treat OUD) to connect individuals with OUD to local physicians who prescribe buprenorphine and treatment services in an effort to streamline the process of accessing treatment and ensure a continuation of care following the initial prescription experience.

The initiative also included a public awareness campaign (as part of a larger Behavioral Health Communications Campaign) to educate the community about the effectiveness of buprenorphine treatment for OUD, reduce stigma associated with medication-assisted recovery, promote MAR NOW, and inform the public on where to access free naloxone. This campaign utilized various channels such as the KCHD website, social media, local events, and partnerships with community organizations.

Evaluation immediately, and at 3 and 6 months following the training was conducted to assess the impact and effectiveness of the initiative. Key performance indicators will include the number of practitioners trained in buprenorphine prescribing, the number of patients receiving buprenorphine treatment, treatment retention rates, and opioid-related overdose rates. Feedback from participants, patients, and stakeholders will also be solicited to inform ongoing program improvements.

## Intervention Details

Twenty-nine Kane County practitioners participated in a comprehensive buprenorphine training intervention designed to increase clinical confidence and capacity to treat OUD in outpatient settings. The intervention began with a live, virtual training titled “Prescribing Buprenorphine for the Treatment of Opioid Use Disorder,” held on April 18, 2025 led by Diana Bottari DO, FAAP, ADM, ABOIM, and Stephen Holtsford, MD, two local physician experts in the field of medication-assisted recovery. Topics included:

- Evidence-based support for buprenorphine as a life-saving medication for OUD
- Buprenorphine 101, including induction, dosing, and maintenance
- Considerations for treating women with opioid use disorder
- Harm reduction principles and strategies
- Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines
- Mitigating diversion risks
- Patient confidentiality
- Individual and organizational barriers to prescribing buprenorphine
- Local and regional opioid use disorder wrap-around services and referral pathways

- Case-based discussions to support real-world clinical decision-making

To reinforce learning and address common implementation barriers, the intervention incorporated two structured follow-up sessions held at two- and five-months post-training. These sessions allowed participants to discuss clinical challenges, share best practices, and receive ongoing peer support. The follow-up sessions were designed to promote sustained adoption of buprenorphine prescribing, reduce professional isolation, and support long-term integration of evidence-based OUD treatment into clinical practice.



## Data Collection and Interpretation

Participants were asked to complete a pre-test and two post-tests to evaluate changes in knowledge, attitudes and barriers in relation to buprenorphine prescribing. The first post-test followed the virtual training on April 18, 2025. The two post-tests followed the peer support session in June and September of 2025. Full assessment details are provided in the Detailed Data Tables section at the end of this report.

## Demographics

- All 29 participants completed the pre-test, 97% (n=28) completed first post-test, and 69% (n=20) completed the final post-test.
- Over half (n=16, 55%) of the participants were female and 45% (n=13) were male.
- By age group, most participants were 35-44 years (n=17, 59%), followed by 25-34 years (n=7, 24%), 55-64 years (n=3, 10%), and 45-54 years (n=2, 7%).
- Most participants were White (66%), followed by Asian (21%), Black or African American (7%), Hispanic or Latino (3%), and Middle Eastern or North African (3%).
- Over half of the participants were Physicians (52%), followed by Nurse Practitioners (34%), and Physician Assistants (14%).
- By specialty, most participants were specialized in Emergency Medicine (52%), followed by Primary Care (17%), Psychiatry (14%), Orthopedic Surgery (10%), and Addiction Medicine (7%).

- By years of practice, most participants have practiced medicine between 5-10 years (41%), followed by those in practice for less than 5 years (35%), 10-20 years (14%), and over 20 years (10%).
- Nearly all (97%) participants' medical training background was from the United States, while 3% of participants received international medical training.
- All participants practice in Kane County. Over 4 in 5 participants were in an urban area (n=25, 86%), while the remaining participants practice in a rural setting (n=4, 14%).

### Buprenorphine Prescribing Data

- When participants were asked "What percentage of your patients have substance use disorder (SUD) or opioid use disorder (OUD)?", only 6% of participants selected that 25% or more of their patients have SUD or OUD, while the majority indicated that between 10% and 25% of their patients have SUD or OUD.
- Around 3 in 5 (n=17, 59%) participants reported that they have prescribed buprenorphine before. The remaining 2 in 5 (n=12, 41%) participants reported that they had not prescribed buprenorphine before.
- Of the 59% of participants who have prescribed buprenorphine in the past, past prescribers responded that their frequency of prescribing buprenorphine was very rarely (n=7, 41%), followed by occasionally (n=6, 35%), rarely (n=3, 18%), and frequently (n=1, 6%).
- Participants who have previously prescribed buprenorphine were asked about the number of buprenorphine prescriptions written in the last month, and more than 1 in 4 (n=8, 28%) stated that they had prescribed no buprenorphine prescriptions in the last month, 21% stated less than 5, and 10% indicated between 5 and 10. Only one respondent reported prescribing more than 10 buprenorphine prescriptions in the last month.
- Of the total 29 participants, 48% (n=14) indicated that they have previously completed X-waiver or any other type of buprenorphine training prior to the training program, while 52% (n=15) indicated that they have not.

### Knowledge and Attitude Change

Participants were asked to respond to a confidence assessment, attitude assessment, and barriers by using a range of Likert scales. Each participant's response was assigned a numerical value. The group average for each measure was computed and compared across pre-test, post-test 1, and post-test 2 to see the absolute value change (delta) and percent change.

- Not at all confident (1) to Very confident (5)
- Strongly disagree (1) to Strongly agree (5)
- Not a barrier (1) to Significant barrier (5)
- Not at all familiar (1) to Extremely familiar (5)

Participants' average familiarity with SUD guidelines increased from 2.4 (pre-test) to 3.3 (post-test 2), representing a 37.5% increase from baseline to following the completion of the training and at least one peer session.

Participants showed an overall increase for all measures of the confidence assessment from the pre-test to the final post-test. Participants' average confidence in administering or prescribing buprenorphine

increased from 2.8 (pre-test) to 4.0 (final post-test), indicating a 42.9% increase. Similarly, participants' confidence in linking patients to outpatient addiction treatment increased by 33.3%, from 3.3 to 4.4 between the pre-test and final post-test. Participants also noted an average increase in confidence when asked about counseling patients about medication for opioid use disorder (OUD), demonstrating an 29.0% increase from the pre-test (3.1) to the final post-test (4.0). Additionally, participants noted an increase in their pre-test and final post-test confidence assessment when asked about providing brief substance use counseling (3.3 to 4.1, 0.8-point or 24.2% increase) and identifying patients at risk for opioid overdose (3.7 to 4.3, 0.6-point or 16.2% increase).

The participants were asked nine questions on the pre-test, post-test 1, and post-test 2 to assess their knowledge on buprenorphine prescribing practices. The average score of the knowledge assessment on the pre-test was 78.9%, the first post-test was 81.7%, and the final post-test was 83.3%. The knowledge assessment average knowledge assessment score increased by 4.6% overall from the pre-test to the final post-test.

For the attitude assessment, participants were asked a series of questions regarding their attitude towards buprenorphine prescribing on a scale of strongly disagree to strongly agree. They were asked to provide a ranked response to the following statements:

1. I believe that prescribing buprenorphine is an effective way to treat OUD.
2. I am concerned about regulatory or legal consequences related to prescribing buprenorphine.
3. I believe there is a stigma associated with being a buprenorphine-prescribing clinician.
4. I think buprenorphine should be part of the standard treatment plan for OUD.
5. I feel that the benefits of prescribing buprenorphine outweigh the potential risks.

Participants had higher average scores when asked if they believed that prescribing buprenorphine is an effective way to treat OUD, with an average score of 4.2 on the pre-test to 4.4 after the training program and final post-test, indicating a 4.6% average increase. Participants' average attitude surrounding stigma associated with being a buprenorphine-prescribing clinician increased from 2.7 (pre-test) to 3.1 (final post-test), representing a 13.8% increase. Conversely, participants had an average score of 3.0 from the pre-test when asked if they were concerned about regulatory or legal consequences related to prescribing buprenorphine. Following the training program and final post-test, there was a 0.3 decrease in average attitude score, representing an 11.0% decrease. Lastly, participants had higher average scores when asked to rank their attitude on having buprenorphine as a part of the standard OUD treatment plan (4.0 to 4.4, 0.4-point or 9.1% increase) and that the benefits of prescribing buprenorphine outweigh the potential risks (4.1 to 4.4, 0.3-point or 8.1% increase).

### **Barriers to Prescribing Buprenorphine for Opioid Withdrawal and OUD Treatment**

The barriers showing the greatest drop in average barrier scores from the pre-test to the final post-test were lack of knowledge about buprenorphine (3.3 to 2.4, 0.9-point or 27.5% decrease), comfort with counseling patients about buprenorphine (3.0 to 2.4, 0.6-point or 20.0% decrease), concerns about medication safety or adverse effects (2.7 to 2.2, 0.5-point or 18.5% decrease), and diversion and misuse of buprenorphine (2.7 to 2.4, 0.3-point or 11.1% decrease).

Participants' average likeliness to start prescribing buprenorphine following the training increased from 3.9 to 4.2 (a 0.3-point or 7.7% increase).

When respondents were asked what additional resources or training would increase their confidence in prescribing buprenorphine, multiple respondents noted that dosing protocols and guidelines would be beneficial. Respondents also shared that any additional training courses with opioid use disorder (OUD) experts would be useful in the continuance and support for buprenorphine prescribing. Additionally, respondents noted in the first and final post-tests that hosting department-wide trainings could increase confidence in buprenorphine prescribing so that prescribing is not clinician-dependent, but rather organization-dependent.

A common barrier that most respondents noted was lack of familiarity, comfort, or confidence when it comes to hesitancy in prescribing buprenorphine. One respondent stated, "My clinic is uncomfortable because they have never done any kind of MAT before." Another respondent noted, "I still face several barriers when prescribing buprenorphine. Time constraints during clinic visits make it challenging to thoroughly assess patients, provide counseling, and arrange follow-up care. Limited availability of outpatient addiction treatment and support services can complicate continuity of care. I also have concerns about diversion or misuse, and sometimes patients are hesitant or prefer other treatment options. Occasionally, minor resistance from staff or pharmacy protocols adds to the challenges."

### Public Health Recommendations to Increase Access to Buprenorphine in Kane County

Findings from this initiative highlight that increasing access to buprenorphine requires coordinated action at the clinical, organizational, and community levels. While participant knowledge and confidence improved through training and peer support, persistent structural and systemic barriers indicate a need for broader public health strategies to sustain and expand access.

- 1. Expand ongoing clinical support and mentorship models.**

The positive impact of peer support sessions underscores the importance of reducing professional isolation among prescribers. Health agencies should institutionalize recurring peer consultation opportunities such as learning collaboratives, case consultation hours, or mentorship networks to support clinicians as they integrate buprenorphine into routine practice. Ongoing access to addiction-trained peers can help address emerging clinical challenges, reinforce best practices, and maintain confidence beyond initial training.

- 2. Normalize buprenorphine prescribing across healthcare organizations.**

Several participants noted that prescribing hesitancy is often organizational rather than individual. Public health efforts should focus on engaging healthcare leadership to promote department- or system-wide adoption of medication for opioid use disorder (MOUD). This includes developing standardized protocols, standing orders, clinical workflows, and pharmacy coordination to ensure that buprenorphine prescribing is supported consistently and not dependent on a single clinician.

- 3. Strengthen referral networks and care coordination.**

Limited access to outpatient addiction treatment and wrap-around services remains a significant barrier to sustained prescribing. Public health agencies can play a convening role by strengthening referral pathways between emergency departments, primary care, behavioral

health providers, and community-based organizations. Continued promotion of centralized access points, such as MAR NOW and health department referral services, can streamline patient entry into care and improve continuity following initiation of buprenorphine.

4. **Address stigma through community and workforce education.**

Although attitudes toward buprenorphine improved, stigma related to OUD and MOUD persists at both the provider and community levels. Public health campaigns should continue to emphasize buprenorphine as an evidence-based, life-saving treatment and position OUD as a chronic medical condition. Messaging that targets healthcare staff, pharmacists, and the broader community can help normalize treatment, reduce resistance, and support patient engagement.

5. **Invest in practical, skills-based training.**

Participant feedback indicates that clinicians value concrete tools such as dosing protocols, clinical guidelines and real-world case examples. Future training efforts should prioritize practical application over didactic content alone and include refreshers or advanced training focused on complex cases, diversion mitigation, and workflow integration.

6. **Incentivize participation and sustain engagement.**

Financial incentives were effective in encouraging participation in training and evaluation activities. Public health agencies should consider continued use of incentives like stipends, continuing education credits, or recognition programs to support clinician engagement, particularly in high-need or underserved communities.

7. **Leverage Kane County's Integrated Referral and Intake System (IRIS) and the newly formed Kane County Buprenorphine Providers Directory to connect individuals with OUD to wrap-around services.**

Effective buprenorphine treatment often depends on patients' ability to access supportive services that address housing instability, transportation, food insecurity, behavioral health needs, and other social determinants of health. Public health efforts should more intentionally integrate Kane County's Integrated Referral and Intake System (IRIS) and Information and Referral Specialists into OUD care pathways. By equipping clinical staff with clear referral workflows and the ability to use IRIS for warm-handoffs, patients initiating or maintaining buprenorphine treatment can be more rapidly connected to ongoing care. Utilizing IRIS as a centralized access point can reduce provider burden, improve care continuity, and increase treatment retention by addressing non-medical barriers that commonly interfere with recovery.

A web-based directory of Kane County buprenorphine prescribers was created as a result of this project to assist the public in locating providers who are trained and willing to prescribe buprenorphine for the treatment of opioid use disorder and is available at:

<https://www.kanehealth.com/opioid-awareness/Pages/buprenorphinedirectory.aspx>

## Conclusion

This initiative demonstrates that targeted education combined with structured peer support can meaningfully improve knowledge, confidence, and attitudes toward prescribing buprenorphine for opioid use disorder (OUD). Participants showed measurable gains in familiarity with clinical guidelines, confidence in prescribing and counseling, and belief in buprenorphine as a standard and effective treatment for OUD. Importantly, key perceived barriers including lack of knowledge, concerns about safety, and diversion decreased following the intervention.

At the same time, the findings indicate that education alone is not sufficient to ensure widespread and sustained buprenorphine prescribing. Organizational culture, limited referral options, time constraints, and system-level support influence practitioner engagement in substance use disorder treatment. Participant feedback highlights the importance of moving beyond one-time trainings and embedding medication-assisted treatment into routine clinical practice.

This evaluation has several limitations. The sample size was small and participation was voluntary, which may limit generalizability. Participants self-selected into the training and likely already had an interest in prescribing buprenorphine, which may explain the modest increase in reported likelihood to begin prescribing following the intervention. In addition, prescribing behavior was self-reported and may not fully reflect actual clinical practice. Despite these limitations, the findings provide useful insights into strategies for increasing buprenorphine access in community settings.

For local health departments and health agencies, these results suggest that education is most effective when paired with peer support, organizational buy-in, and strong referral systems. By addressing both attitudinal and structural barriers, health agencies can play a central role in expanding access to life-saving treatment, strengthening local systems of care, and ultimately reducing opioid-related morbidity and mortality. Continued investment in practitioner training, mentorship, and system integration will be essential to continued progress and ensuring that individuals with opioid use disorder can access evidence-based care in Kane County.

## Appendix A: Detailed Data Tables

**Table 1. Buprenorphine Training Program Registrant Descriptive Statistics (n=29)**

<b>Measure</b>	<b>n</b>	<b>%</b>
<b>Respondents</b>		
Registration	29	100%
Pre-Test	29	100%
Post-Test #1	28	97%
Post Test #2	20	69%
<b>Demographics</b>		
<u>Gender</u>		
Female	16	55%
Male	13	45%
<u>Age Group</u>		
25-34 years	7	24%
35-44 years	17	59%
45-54 years	2	7%
55-64 years	3	10%
<u>Race and Ethnicity</u>		
Asian	6	21%
Black or African American	2	7%
Hispanic or Latino	1	3%
Middle Eastern or North African	1	3%
White	19	66%
<b>Medical Training and Practice</b>		
<u>Title</u>		
Physician	15	52%
Nurse Practitioner	10	34%
Physician Assistant	4	14%
<u>Specialty</u>		
Emergency Medicine	15	52%
Primary Care	5	17%
Psychiatry	4	14%
Other (Orthopedic Survey)	3	10%
Addiction Medicine	2	7%
<u>Years in Practice</u>		
Less than 5 years	10	34%
5-10 years	12	41%
10-20 years	4	14%
Over 20 years	3	10%
<u>Medical Training Background</u>		
U.S.	28	97%
International	1	3%
<u>Geographic Location of Practice</u>		
Urban	25	86%
Rural	4	14%

**Table 2. Registrant Buprenorphine Prescribing Practices**

<b>Measure</b>	<b>n</b>	<b>%</b>
<b>Percentage of Patients with Substance Use Disorder</b>		
Less than 10%	10	34%
Between 10% and 25%	17	59%
Between 25% and 50%	1	3%
More than 50%	1	3%
<b>History of Prescribing Buprenorphine (n=29)</b>		
Yes	17	59%
No	12	41%
<b>Frequency of Prescribing Buprenorphine (n=17)</b>		
Very Rarely	7	24%
Rarely	3	10%
Occasionally	6	21%
Frequently	1	3%
<b>Number of Buprenorphine Scripts in Last Month (n=17)</b>		
None	8	28%
Less than 5	6	21%
Between 5 and 10	2	7%
More than 10	1	3%

**Table 3. Changes in Buprenorphine Attitudes, Knowledge, and Barriers**

<b>Measure</b>	<b>Pre-Test (n=29)</b>	<b>Post-Test #1 (n=28)</b>	<b>Post-Test #2 (n=20)</b>
<b>Familiarity with SUD guidelines</b>	2.4	3.0	3.3
<b>Confidence Assessment</b>			
Provide brief substance use counseling	3.3	4.2	4.1
Identify patients at risk for opioid overdose	3.7	4.5	4.3
Counsel patients about medication for OUD	3.1	4.3	4.0
Administer/prescribe buprenorphine	2.8	4.1	4.0
Link patients to outpatient addiction treatment	3.3	4.3	4.4
<b>Attitude Assessment</b>			
I believe that prescribing buprenorphine is an effective way to treat OUD.	4.2	4.5	4.4
I am concerned about regulatory or legal consequences related to prescribing buprenorphine.	3.0	2.9	2.7
I believe there is a stigma associated with being a buprenorphine-prescribing physician.	2.7	2.6	3.1
I think buprenorphine should be part of the standard treatment plan for OUD.	4.0	4.3	4.4
I feel that the benefits of prescribing buprenorphine outweigh the potential risks.	4.1	4.4	4.4
<b>Barriers to ordering buprenorphine for opioid withdrawal and/or treatment of OUD</b>			
Time constraints	2.7	2.6	2.7
Concerns about medication safety or adverse effects	2.7	2.2	2.2
Lack of knowledge about prescribing buprenorphine	3.3	2.4	2.4
Comfort with counseling patients about buprenorphine	3.0	2.3	2.4
Concern about diversion or misuse of buprenorphine	2.7	2.1	2.4
<b>How likely are you to start prescribing buprenorphine after this training?</b>	-	3.9	4.2



## Appendix B: Resources for Healthcare Professionals and Patients

### [Addiction Technology Transfer Center \(ATTC\) Network](#)

Provides regional and national workforce development training focused on implementing and integrating medications for opioid use disorder (MOUD) into clinical practice.

### [American Society of Addiction Medicine \(ASAM\)](#)

Offers CME-accredited, evidence-based courses on treating opioid use disorder, including comprehensive training on buprenorphine prescribing.

### [Behavioral Health 360](#)

The Kane County Health Department's Behavioral Health 360 website provides mental health and substance use self-help resources including assessments, articles, videos, podcasts and links to local agencies.

### [CA Bridge Emergency Department Buprenorphine Quick Start Guide](#)

A clinical guidance packet created by the CA Bridge Program, part of the California Department of Health Care Services and the Public Health Institute offering evidence-based treatment protocols to support healthcare providers on how to start and manage medications for addiction treatment, particularly buprenorphine and methadone for opioid use disorder.

### [Illinois Department of Human Services Drug Overdose Prevention Program \(DOPP\)](#)

Works to reduce opioid overdose deaths by expanding community-based Overdose Education and Naloxone Distribution (OEND) services. Through the Access Narcan program, eligible organizations can order free naloxone to distribute in their communities, ensuring more people are equipped with the knowledge and tools needed to prevent overdose deaths and save lives across Illinois.

### [Illinois Helpline and MAR Toolkits for Professionals](#)

Statewide, 24/7 resource that connects individuals and clinicians with substance use treatment, recovery support, and harm-reduction services, including referrals and immediate care coordination for opioid use disorder (OUD) treatment. The MAR (Medication Assisted Recovery) toolkits are clinician-focused resources that offer practical guidance, protocols, training materials, and clinical tools to help healthcare providers implement and manage medications for opioid use disorder. These toolkits include streamlined workflows, patient education resources, and links to deeper learning modules to support professional practice.

### [Integrated Referral and Intake System \(IRIS\)](#)

The Kane County Health Department's IRIS is a web-based platform that allows more than 250 Kane County health service providers to connect clients with the programs and services they need.

### [Kane County Buprenorphine Prescribers Directory](#)

Prescribers are encouraged to submit their information for inclusion, and community members can use the directory to find providers experienced in buprenorphine prescribing.

### [KCHD Information and Referral Services](#)

The Kane County Health Department's information and referral services connects residents with resources for mental health, substance use, food, financial assistance, and more. Services include personalized screening, care coordination, advocacy, and ongoing follow-up.

### [KCHD Substance Use Prevention and Naloxone Distribution Program](#)

The Kane County Health Department's program reduces overdose deaths through prevention education, community outreach, and expanded access to naloxone. It partners with local organizations and healthcare providers to distribute free naloxone, provide overdose response training, and connect residents to treatment and recovery resources.

### [The Naloxone Project](#)

A clinician-led nonprofit dedicated to expanding access to naloxone and reducing overdose deaths. The organization works to reduce stigma and build sustainable naloxone distribution systems by partnering with providers, policymakers, and community organizations to ensure people at risk receive naloxone and overdose prevention support.

### [SAMHSA: Medications for Opioid Use Disorder](#)

Reviews three Food and Drug Administration-approved medications for opioid use disorder treatment - methadone, naltrexone, and buprenorphine - and the other strategies and services needed to support people in recovery. The primary federal resource hub offers clinical guidelines, toolkits (including TIP 63), and training materials for buprenorphine prescribing and MOUD implementation.

### [Opioid Response Network](#)

Provides free, evidence-based education, training, and technical assistance to help communities, healthcare providers, public agencies, and organizations address opioid, stimulant, and other substance use disorders across prevention, treatment, and recovery. Delivers free, tailored training and technical assistance to healthcare providers, health departments, and community organizations to expand access to MOUD.

### [Overdoseinfo.org](#)

The Kane County Health Department's overdose prevention website for clinicians, healthcare agencies, policy makers and community members with information about opioids, addiction, medication assisted treatment, professional resources, local support agencies and more.

### [Patient's Guide to Starting Buprenorphine at Home](#)

Developed by the American Society of Addiction Medicine, this guide outlines what medication-assisted treatment is, describes the induction phase when buprenorphine is started, explains preparation steps, how to know when to safely begin your first dose (including stopping other opioids and recognizing withdrawal), and what to expect during home induction.

### [Providers Clinical Support System \(PCSS\)](#)

A national mentoring and training network offering expert guidance and one-on-one support for clinicians prescribing buprenorphine.



## Appendix C: Buprenorphine for Opioid Use Disorder Provider Fact Sheet

### Clinical Overview

Buprenorphine is an evidence-based, FDA-approved medication for the treatment of opioid use disorder (OUD). It is a Schedule III partial opioid agonist that can be prescribed in office-based settings and is associated with reduced overdose mortality, improved retention in care and improved patient outcomes.

### Mechanism of Action

Buprenorphine acts as a partial agonist at the mu-opioid receptor, reducing cravings and withdrawal symptoms while producing a ceiling effect on respiratory depression. This pharmacologic profile contributes to a strong safety margin compared with full opioid agonists.

### Clinical Benefits

- Reduces all-cause and overdose mortality
- Improves retention in treatment
- Supports outpatient initiation and maintenance
- Appropriate for long-term maintenance therapy

### Formulations

- Sublingual tablets and films (often combined with naloxone)
- Extended-release injectable formulations (weekly or monthly)
- Transdermal patches and buccal films (pain indications)

### Safety Considerations

Common side effects include constipation, nausea, headache, and sedation. Risk of respiratory depression is low when used as prescribed but increases when combined with alcohol or benzodiazepines. Counseling on safe storage is critical to prevent pediatric exposure.

### How to Get Started Prescribing Buprenorphine

1. Confirm eligibility: Any DEA-registered clinician with Schedule III authority may prescribe buprenorphine for OUD.
2. Complete recommended training: While X-Waivers are no longer required, clinical training improves confidence and outcomes.
3. Screen and diagnose OUD using DSM-5 criteria.
4. Initiate treatment: Begin during mild-to-moderate withdrawal or use low-dose initiation protocols when appropriate.
5. Monitor and support: Schedule follow-ups, adjust dosing, and provide or refer to counseling and recovery supports.
6. Coordinate care: Establish referral pathways for behavioral health, peer support, and higher levels of care.



## Appendix D: Buprenorphine Myths vs. Facts

**MYTH:** *Buprenorphine simply replaces one addiction with another.*

**FACT:** Buprenorphine is a partial opioid agonist that stabilizes brain chemistry, reduces cravings and withdrawal, and supports engagement in meaningful daily functioning. Research consistently shows that medications for opioid use disorder (MOUD), including buprenorphine, are associated with large reductions in opioid-related overdose deaths and other harms, countering the idea that it is simply “another addiction.”<sup>9</sup>

**MYTH:** *Diversion risk outweighs benefits.*

**FACT:** The risk of misuse and diversion of buprenorphine is relatively low, particularly when compared to the benefits of treatment. Analyses of prescription data found low rates of atypical prescribing patterns and misuse, supporting broader access to buprenorphine while maintaining appropriate safeguards.<sup>10</sup> Moreover, when diversion occurs, it is frequently used by individuals attempting to self-treat withdrawal, which suggests unmet treatment needs rather than recreational misuse.<sup>11</sup>

**MYTH:** *Patients should taper off buprenorphine as soon as possible.*

**FACT:** Buprenorphine treatment is effective as a long-term maintenance therapy and is recommended for many individuals. Evidence and clinical guidance recognize that ongoing maintenance can improve retention in care and reduce risk of relapse and overdose, whereas premature tapering may undermine gains in stability.<sup>12</sup>

**MYTH:** *Counseling must occur before starting medication.*

**FACT:** Current clinical guidance emphasizes that buprenorphine should not be delayed while waiting for counseling availability; initiating medication therapy promptly is a priority, and counseling can be delivered concurrently or when feasible. This approach helps reduce barriers to medication initiation, which may otherwise deter patients from engaging in treatment.<sup>13</sup>

**MYTH:** *Medication isn't necessary; abstinence alone is sufficient treatment for opioid use disorder.*

**FACT:** Medication-based treatments like buprenorphine are the most effective approach for opioid use disorder for many patients. Abstinence-only programs result in higher relapse rates and do not reduce mortality as effectively as evidence-based MOUD.<sup>14</sup>

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<sup>9</sup> Wakeman SE, Barnett ML. *Medication for opioid use disorder after nonfatal opioid overdose and association with mortality: A cohort study.* JAMA. 2018;320(24):2613–2621. doi:10.1001/jama.2018.18460

<sup>10</sup> Office of Inspector General, U.S. Department of Health and Human Services. *The risk of misuse and diversion of buprenorphine for opioid use disorder appears to be low in Medicare Part D.* OIG Report OEI-05-23-00040. 2023. <https://oig.hhs.gov/reports/all/2023/the-risk-of-misuse-and-diversion-of-buprenorphine-for-opioid-use-disorder-appears-to-be-low-in-medicare-part-d>

<sup>11</sup> Lavonas EJ, Paone D, Gladden RM, et al. *Use of diverted buprenorphine: A systematic review.* Drug Alcohol Depend. 2023;250:109679. doi:10.1016/j.drugalcdep.2023.109679

<sup>12</sup> U.S. Food and Drug Administration. *FDA urges caution about withholding opioid addiction medications.* FDA Drug Safety Communication. 2017. <https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-urges-caution-about-withholding-opioid-addiction-medications>

<sup>13</sup> U.S. Food and Drug Administration. *Medication-assisted treatment for opioid use disorder: Current clinical guidance.* FDA Guidance Document. 2022. <https://www.fda.gov/media/168027/download>

<sup>14</sup> Fiellin DA. *The best way to combat opioid addiction is with medication.* Yale Medicine. 2025 (discussion of evidence that abstinence-only approaches have higher relapse rates and medication treatment is most effective).