

# Don't "Waive" Goodbye to Education for Opioid Use Disorder

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## Introduction

As the United States continues grappling with the COVID-19 pandemic, a long-standing and worsening public health crisis escalates. In 2020, more than 93,000 people in the U.S. died of drug-related overdoses largely due to the synthetic opioid fentanyl—the most ever recorded [1].

COVID-19 has further fueled the American overdose epidemic. In addition, isolation and physical distancing decreased access to services for people with opioid use disorder (OUD), including medication and psychosocial treatment and harm reduction services, intensifying treatment deserts across the nation [2]. In this context, opioid overdoses and the sequelae related to drug use, such as infective endocarditis and skin and soft tissue infections, increased.

To reduce the growing morbidity and mortality related to OUD, the U.S. health system must expand and sustain OUD diagnosis and treatment by training an interprofessional health care workforce. The Biden administration recently removed the educational requirements for obtaining the X-waiver, allowing clinicians to treat OUD in outpatient settings with buprenorphine. This change provides an opportunity for targeted and meaningful workforce development across the health professions.

## Limitations to Prescribing Buprenorphine for OUD

There are three medications for OUD approved by the Food and Drug Administration (FDA): extended-release naltrexone (XR-NTX), methadone, and buprenorphine. Despite FDA approval, these medications have significant barriers to access. XR-NTX, an opioid antagonist,

is a noncontrolled substance but remains prohibitively expensive and difficult to initiate for people with OUD as it necessitates an opioid-free period. Thus, it is not a first choice for many patients. Methadone is dispensed in highly regulated opioid treatment programs (OTPs), which require daily clinic visits, with a small recent exception for mobile units to administer medication in more remote locations [3]. In this paper, the authors focus on buprenorphine, which can be prescribed for OUD in outpatient settings by physicians, physician assistants (PA), and advanced practice nurses (APN) with an X-waiver.

The Drug Addiction Treatment Act of 2000 provided the framework for physicians to prescribe buprenorphine for OUD; specifically, after completing a federally mandated 8-hour training, physicians could apply for a waiver to treat OUD using FDA-approved drugs (currently only buprenorphine) outside the setting of licensed OTPs. Subsequent legislation in 2016 and 2018 provided a similar construct for PAs and APNs but required a 24-hour training.

In April 2021, the Biden administration removed the 8- to 24-hour training requirement for physicians, PAs, and APNs, permitting them to prescribe buprenorphine for OUD treatment for up to 30 patients concurrently after completing a notification of intent to prescribe through the Substance Abuse and Mental Health Services Administration.

As interprofessional practitioners, educators, and researchers who care and advocate for people with OUD in our communities, the authors celebrate regulatory changes that allow for increased buprenorphine access. Here, the authors discuss the previous limitations of mandatory X-waiver training requirements and provide considerations focused on education to ensure

our health care workforce is appropriately prepared to diagnose and treat patients with OUD and respond to this national crisis.

### Importance of Training and Education

Most practicing health care professionals were not educated about OUD diagnosis or treatment during their formal training and are uncomfortable caring for patients with OUD and initiating buprenorphine [1]. Many of those who received training to prescribe buprenorphine did so through educational programs offered by professional associations. The prior mandated X-waiver trainings were broadly delivered across all audiences without consideration for individual experience or specialty. For example, a primary care specialist with 15 years of experience was provided identical X-waiver training to that of a first-year medical student, and a practitioner working in hospital medicine was provided the same training as a women's health provider. Before the Biden administration's recent change to remove the mandated training to receive the X-waiver, the content and duration of the curricula were strictly defined, and customization at the institutional level was discouraged.

Although removing the mandated 8- to 24-hour training eliminates one barrier to obtaining the X-waiver, much work remains to educate health care professionals about OUD diagnosis and treatment with buprenorphine. Furthermore, the health care system must also incorporate education about inequities in addiction. This education includes applying a racial and ethnic justice framework into buprenorphine treatment, given long-standing racial and ethnic disparities in access and outcomes. Creating educational opportunities related to these topics early in training would empower the health care workforce and advance OUD treatment.

The original 8- to 24-hour X-waiver training durations appear to have been chosen arbitrarily. To the knowledge of the authors, there is no research suggesting the appropriate length of training. Studies indicate that 8 hours may be insufficient for many physicians to become comfortable addressing OUD, and 24 hours is too burdensome for advanced practice providers [4,5].

The federally mandated training also advanced the false notion that prescribing buprenorphine for OUD treatment is complicated or unusually dangerous—a sharp contrast to the fact that no federally mandated training exists for prescribing full-agonist opioids such as oxycodone, which has in part driven, not alleviated, the opioid overdose epidemic.

OUD is a chronic and treatable biopsychosocial condition that health care professions should address. However, too much of OUD treatment continues to exist in silos. The lack of OUD education across health professions, coupled with the previously required X-waiver training, was exclusionary. More health care professionals might participate in buprenorphine prescribing if they received professional training. Another group that could be empowered to broaden buprenorphine prescribing are the so-called “dabblers” [6]—well-rounded clinicians outside of defined addiction specialties who prescribe buprenorphine only occasionally but do not actively promote or advertise their ability to treat OUD with pharmacotherapy.

The authors acknowledge that many people who completed X-waiver trainings never wrote a single buprenorphine prescription [7]. While many reasons for this exist, one is that providing only didactic content to clinicians is inadequate to instill confidence or promote practice change [8]. Buprenorphine-prescribing barriers occur at institutional, health system, payer, state, and national levels, pointing to needed broad education for the public, policymakers, and health systems leaders. Despite increased numbers of waived clinicians over the years, buprenorphine prescribing is not occurring at rates to sufficiently expand access to OUD treatment. Less than 20 percent of those with OUD receive pharmacotherapy [9]. Some communities are more impacted by the lack of buprenorphine prescribing than others. In 2017, fifty-six percent of rural counties had no DEA-waivered clinicians, and in counties with a waived clinician, nearly half appeared unable to add new patients [10]. Numerous studies confirm that Black and Latinx persons receive markedly lower rates of buprenorphine treatment compared to white persons [11].

### Priorities for Expanding Buprenorphine for OUD Treatment

The authors applaud the recent reduction of federal mandates that impede access to OUD treatment. Concurrently, the authors recognize that the absence of any education, given the lack of OUD teaching during formal health care training, is swinging the pendulum too far. The recent federal changes to the X-waiver education requirements present an opportunity to more meaningfully educate the existing and rising health care workforce to provide OUD treatment. Therefore, the authors call for the creation and dissemination of holistic education and training opportunities for OUD treatment, based on the following principles:

**1) Create standard competencies to educate the rising and practicing health care workforce.**

- a. It is imperative to have a coordinated and deliberate approach to planning, developing, and disseminating standard competencies and learning objectives across health professions training and for the practicing interprofessional workforce. This work can build on previously written competencies [12,13,14]. The absence of visible competency-based OUD education in the current regulatory environment presents a risk for ill-informed prescribing beliefs, habits, and patterns that may harm patients.
- b. Health professions schools, health care systems (e.g., clinics and hospitals), professional organizations, and licensing bodies must be accountable for providing this education to a broad range of health care professionals.
- c. Differences between the existing workforce and the rising workforce necessitate different approaches. Current student and trainee approaches may be more complete than those for the practicing workforce with more experience.

**2) Ensure all practicing professionals have the skills to assess, diagnose, and treat individuals with OUD.**

- a. All health care professionals, regardless of discipline or specialty, should have basic foundational knowledge of OUD that empowers them to:
  - i. Diagnose OUD based on the Diagnostic and Statistical Manual, Fifth Edition (DSM-5).
  - ii. Understand the role of pharmacotherapy for OUD treatment, including differentiating between buprenorphine, methadone, and XR-NTX and their relationship to cross-discipline patient-focused care plans.
  - iii. Apply principles of harm reduction, including safer use practices such as syringe service programs and overdose prevention training (i.e., "don't use alone" messaging, fentanyl test strips, and naloxone).
  - iv. Appreciate challenges and opportunities for patients to receive evidence-based OUD care through systems-practice and health equity lenses. This includes education to dismantle stigma and promote equitable access to evidence-based care.
  - v. Counsel patients to recognize and mitigate potentially unhealthy opioid use.

- vi. Refer patients with OUD who need a higher level of care to specialists.

**3) Develop discipline-specific competencies.**

- a. Form workgroups to establish and implement discipline-specific competencies, in addition to the core knowledge above. This priority is based on recognition that clinical practice and care settings are vastly different and include primary care, women's health, hospital medicine, emergency medicine, psychiatric and behavioral health care, and correctional medicine, among many others.

**4) Build OUD competencies into state licensing.**

- a. State licensing boards can require competency-based education in OUD treatment as a condition for licensure. While many states now require focused training on appropriate prescribing of opioids for pain, the lack of OUD treatment and recovery education promotes an imbalanced approach to this crisis.

**5) Blend didactic and practice-based OUD teaching.**

- a. Educational goals can be achieved through a blend of didactic and practice-based training. The development of OUD treatment competencies is amenable to the "see one, do one, teach one" approach of clinical education. Clinicians and trainees can observe buprenorphine initiation, perform an initiation with mentorship, and then go forth and share with others. As in other areas of clinical training and practice change, the authors suggest incorporating asynchronous content, synchronous lecture or discussions, and perhaps most importantly, guided mentorship. Ongoing quality improvement including curricular outcomes studies will inform and refine pedagogical methods.

**6) Ensure the interprofessional workforce can participate in these efforts**

- a. The rising and practicing health care workforce is needed in order to respond to the U.S. overdose epidemic. Educating and empowering the full multidisciplinary workforce, including physicians, PAs, APNs, pharmacists, nurses, and social workers in OUD treatment is critical.
- b. The X-waiver expansion did not include pharmacists as authorized providers, which has compounded logistic and behavioral dispensing challenges: limited or no buprenorphine stock-

ing, pharmacist stigma, and lack of trust in prescribers. Expanding practice opportunities will help increase OUD education of these accessible yet underutilized health professionals.

## Conclusion

This commentary focuses exclusively on the need for an intentional and principles-based interprofessional approach to educating the existing and rising health care workforce about OUD treatment. However, additional barriers limit the ability of health care professionals to care for people with OUD. Such barriers include limits on the number of patients who can be treated at one time with buprenorphine; the existence of the X-waiver itself; an antiquated system for prescribing and distributing methadone; restrictions on clinician scope of practice both generally as well as specifically when it comes to treating OUD; and significant variability in state laws, regulations, and insurance coverage of medications for OUD treatment, especially in Medicaid programs.

In addition, while this commentary focuses on OUD treatment needs with buprenorphine, the authors recognize that OUD is one of many substance use disorders, which often coexist and are associated with significant morbidity and mortality. In fact, untreated and often unrecognized substance use disorders are driving recent reductions in U.S. life expectancy, prior to and compounded by COVID-19. Therefore, key entities that comprise the health care system will ultimately need to provide, promote, evaluate, and improve broad competency-based substance use education to empower the full health care workforce to treat these problems. The opioid overdose epidemic is a glaring opportunity to start doing so, and one that we can no longer afford to address with small and incremental changes.

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