Mobilizing Primary Care Against the Opioid Crisis in the Post X-Waiver Era

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In January 2023, congress passed the Consolidated Appropriations Act, which among other provisions removed the federal requirement for an X-waiver to prescribe buprenorphine. The X-waiver, introduced into law in 2000, required clinicians to undergo special training and apply for an amendment to their DEA licenses to prescribe buprenorphine for the treatment of opioid use disorder (OUD). As overdose deaths hit record numbers amid the COVID-19 pandemic and potent synthetic opioids such as fentanyl have become ubiquitous, many addiction experts called on congress to eliminate the X-waiver, framing it as an unnecessary barrier to engaging more clinicians in treating OUD. The removal of the X-waiver requirement is a monumental policy step forward in expanding access to OUD treatment nationally, but achieving its full impact will depend on the much more difficult task of culture change within medicine itself.

No area of medicine holds greater potential to expand access to high-quality OUD treatment than primary care. Several aspects of primary care, including its geographic reach, expertise in chronic disease management, team-based models of care, telehealth infrastructure, and focus on whole-person health, make it the ideal vehicle for OUD care delivery. Evidence suggests that OUD treatment within primary care is comparable in quality to specialty addiction programs, and patients may prefer primary care-based treatment.[1, 2] Yet despite the relative safety, simplicity, and tremendous efficacy of prescribing buprenorphine, fewer than 10% of primary care clinicians (PCPs) offer this life-saving treatment amid one of the greatest public health crises of our time. Identifying and addressing the reasons for this discrepancy must be an urgent task for health systems, clinics, and individual PCPs to ensure that the removal of the X-waiver will translate into meaningful improvements in buprenorphine treatment infrastructure.

While the X-waiver requirement likely deterred some PCPs from adopting buprenorphine treatment into practice, qualitative research has identified concerns like a perceived lack of institutional support and inconsistent access to specialty consultation as greater impediments.[3] Furthermore, stigma negatively affects perceptions of people with OUD and buprenorphine treatment (i.e., "replacing one addiction with another") among many healthcare professionals. Stigma not only serves as a barrier to greater adoption of buprenorphine prescribing in primary care settings, but also deters people with OUD from seeking treatment. These factors may explain why measures such as removing the mandatory training requirement to obtain an X-waiver in 2021 had little impact on clinician uptake of buprenorphine prescribing or overdose deaths.[4] If PCPs are to become engaged in treating OUD, strong leadership at the health system level must provide the mentorship and resources necessary to make it a feasible and meaningful experience. Moreover, shifts in health policy and payment models must incentivize health systems to promote uptake of integrative OUD treatment (i.e., medication plus behavioral health support) within primary care.

Convenient access to training and expert consultation is a crucial step in increasing uptake of buprenorphine prescribing among PCPs. While buprenorphine is not an overly complex medication, most clinicians have received little or no education on how to prescribe it during training. Several resources and tiered mentorship models can greatly expand the reach of OUD treatment expertise (see Table 1), but exhorting PCPs to independently explore these tools is impractical. Health systems must play a larger role in developing clinician supports and local leadership to foster change. For example, health systems could hold OUD trainings for primary care leadership (e.g., medical directors, residency program directors, and academic division leaders) to develop core skills and perspective necessary to prioritize local initiatives aimed at facilitating OUD treatment uptake among PCPs. They can also promote system-wide quality improvement goals related to screening and treatment benchmarks for OUD

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Table 1 Select OUD Educational Resources for Clinicians

Resource	Website	Content/time commitment	Key features	Free
Providers Clinical Support System	https://pcssnow.org/medications-for-opioid-use-disorder/buprenorphine/	• Several one-hour training modules on various topics related to OUD care • 8-h comprehensive online training on buprenorphine prescribing • Contains trainings on stigma reduction	• Federally funded website featuring training by national addiction experts • Created by a coalition of 23 leading national healthcare organizations led by the American Academy of Addiction Psychiatry	☑
MORE Training	https://drericgarland.com/training-in-more/	• 13-h training on Mindfulness-Oriented Recovery Enhancement that can be completed by Zoom or in person	• Supported by high-quality evidence including randomized controlled trials • Manualized modality that can be delivered by a range of clinical disciplines	
Project ECHO	https://ruralhealth.und.edu/projects/project-echo/topics/oud-management	• Several one-hour training modules on various topics related to OUD care • Contains trainings on stigma reduction • Focus on rural OUD care delivery	• Evidence-based initiative that provides clinical education and mentorship in a wide variety of fields, including managing opioid use disorder	☑
UCSF Warm Line	https://nccc.ucsf.edu/clinician-consultation/substance-use-management/	• Individualized consultation to assist with specific questions related to OUD treatment	• Interdisciplinary team provides direct advice to individuals about specific clinical cases • Operates Monday–Friday 0900–2000 ET	☑
Addiction-focused Podcasts	• https://thecurbsiders.com/addiction • https://www.theaddictionfiles.com/ • https://www.crackdownpod.com/ • More	• Variety of educational tools and perspectives on substance use	• Encompass a variety of perspectives and educational topics relevant to substance use disorders and people who use drugs	☑

care. Furthermore, health systems and payors can move away from fee-for-service models of primary care, which often fail to adequately cover important facets of OUD treatment such as harm reduction counseling, care management, and behavioral health that help patients and support PCPs in providing comprehensive care. Finally, at the state and national levels, policies that ensure robust insurance coverage of medications for OUD without cumbersome prior authorization requirements can facilitate more seamless integration of OUD treatment into existing primary care infrastructure.

Another role that health systems must play in promoting access to primary care-based OUD treatment is to expand the range of venues in which patients may access this service. Some individuals with OUD face substantial economic and logistical barriers to engaging with a traditional primary care infrastructure, which is built around assumptions that patients can keep specific appointment times, travel to clinics, have access to a computer and/or telephone, and have active health insurance coverage. Developing diverse avenues for treatment such as telehealth, mobile clinics, and clinics co-located with other services such as shelters or syringe services programs can ensure more equitable access to both primary care services and OUD treatment.

Improved behavioral health support may also embolden PCPs to adopt buprenorphine treatment. While evidence suggests that providing medications for OUD can provide substantial benefit even in the absence of behavioral therapy, providing patients with a range of therapeutic modalities to address other recovery-related outcomes (e.g., psychiatric symptoms, quality of life) is clearly optimal. Moreover, for clinics and health systems that have integrated behavioral health support, innovative psychosocial treatments may provide a significant advance over extant therapies. For instance, Mindfulness-Oriented Recovery Enhancement (MORE), a structured intervention designed to target the psychological and neurobiological mechanisms undergirding OUD and its comorbidities (e.g., chronic pain, emotional distress), has demonstrated robust efficacy within primary care, reducing the occurrence of opioid misuse by 45%.[5] Because MORE is a manualized therapy, it can be delivered by a range of health professionals including physicians, nurses, and behavioral health specialists with no prior addiction expertise required. Contingency management is another evidence-based behavioral intervention for OUD and stimulant misuse that can be administered by a range of healthcare professionals without extensive training.[6] Investing in these programs at the health system and clinic level

can increase support for PCPs, improve patient care, and engage a broader range of clinical disciplines within primary care in OUD treatment.

While bolstering supports for PCPs is necessary to facilitate greater uptake of buprenorphine prescribing, overcoming stigma remains an essential and formidable barrier to achieving meaningful gains in primary care OUD treatment. A sustained and concerted effort at national and local levels, especially among health system and clinic leadership, is required to surmount the effects of stigma. Several techniques for reducing stigma in clinical settings have shown promise, including mentorship from individuals representing stigmatized groups and skill-building workshops.[7] Online educational tools aimed at stigma reduction developed by national expert groups should be incentivized for clinics receiving state or federal funding. Additionally, the repeal of the X-waiver was accompanied by a new educational requirement attached to DEA license renewal. Stigma training, behavioral health information, and buprenorphine education should be integrated into this required professional development.

The end of the X-waiver marks a historic advancement in OUD care, opening the door for a new wave of clinicians to join the fight against the opioid crisis. However, realizing its full impact will require overcoming significant systemic and ideologic barriers. Primary care is uniquely positioned to deliver person-centered, high-quality, integrative OUD treatment, but repealing the X-waiver must be paired with local leadership support, policies that facilitate OUD treatment, integrated behavioral health interventions to improve outcomes, and culture change within medicine to fully realize its potential.

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Declarations

Conflict of Interest *None*

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