

Commentary on Jones & McCance-Katze (2018): Buprenorphine and the glass half full—why can't we prescribe more of it, and will nurse practitioners and physician assistants fulfill a chronic unmet need?

To achieve a meaningful increase in the number of individuals receiving buprenorphine treatment, resources must be directed toward models of care that directly support and employ new buprenorphine providers, including nurse practitioners and physician assistants. Waiver training among general practitioners does not appear to sufficiently close the treatment gap. Worsening overdose rates dictate more direct action.

The large national survey reported by Jones & McCance-Katze of 2017 US buprenorphine waiver recipients is a timely and important reminder of how far we have yet to go in responding to the worsening opioid epidemic [1]. Approximately 75% of newly waived providers go on to write any buprenorphine prescriptions during their first year. Inadequate institutional and collegial support, limited time and administrative hassles, such as prescription prior authorizations, remain prominent barriers. The survey also found perceived low demand for treatment, which is surprising in light of the 1 million Americans with untreated opioid use disorders (OUD) [2]. An unmeasured influence on participants' responses that may contribute to explaining perceived low demand was probably state-level variation in Medicaid coverage for buprenorphine, which is essential to population-wide access [3].

Some good news was that the approximately 3000 new prescribers were treating, on average, 10 patients. This adds up to a substantial number of patients receiving treatment (~30 000 patients/month), but it is not nearly enough to close the national OUD treatment gap. More disappointing was that much of the reported under-prescribing was occurring in general care settings, including federally qualified health centers, where we might expect more robust adoption.

Clearly, much more is needed in terms of organizational and cultural reforms and flat-out marketing to transform the average regional health system into a center for buprenorphine treatment. Blanket waiver training of medical staff may be worthwhile for educational purposes, but this alone will not expand treatment. Training must be accompanied by hiring of both waived prescribers and the clinical staff needed to support them in providing treatment to large numbers of patients with OUD. Collaborative care approaches, such as the Massachusetts Nurse Care

Manager model [4], greatly increase the number of patients treated with buprenorphine by primary care providers, but are difficult to fund. Greater federal, state and regional efforts to expand treatment capacity in general care settings by testing scalable and effective practice models, as in the impending NIH Helping to End Addiction Long-term (HEAL) initiative [5], are sorely needed.

Another reform might be to staff each regional health system or rural county health department with providers dedicated to prescribing as much buprenorphine as possible. A 'Champion Model', consisting of one or more busy, specialized, OUD prescriber(s) [6], appeared in this survey to be among the most likely ways to immediately expand buprenorphine treatment. Nurse practitioners and physician assistants appear ready to step into this role, as they reported prescribing at modestly higher rates overall and were more likely to be near the 30- and 100-patient limits, in comparison to physicians. These data points are encouraging, and recent 2018 Federal Opioid legislation, which expands waived prescribing to a larger roster of allied health professionals, is welcome [7].

While there is reason to be hopeful about treatment expansion, the finding that low patient demand was among the most common barriers to prescribing should give us pause. Even in the face of a deadly opioid epidemic, a minority of Americans with OUD seek and enroll in effective treatment [8]. Stigma is certainly a barrier, along with practical obstacles. Buprenorphine needs to be available in the settings where individuals with OUD want to receive it, and treatment must be affordable, welcoming, accessible and of sufficient quality to keep them in care. As with other effective medications for prevalent and highly morbid conditions, buprenorphine should be offered in any health-care setting, but currently is not. We also need to be thinking about new delivery approaches, such as low-threshold access [9] or increased use of telemedicine [10], that make it more realistic for people with OUD to access care where and when they need it.

Waiver-training already busy and time-starved providers, and then hoping for substantial levels of prescribing, has taken us only so far. It is time for both innovation and realism, and adequate resources dedicated to these practices, these patients, their families and all our communities. If the goal is more buprenorphine prescribing, let us find out what patients want, make use of models that work, pay for it, and make sure that it happens.

Declaration of interests

None.

Keywords Buprenorphine, nurse practitioner, opioid use disorders, pharmacotherapy, physician assistant, primary care, X-waiver.

JOSHUA D. LEE  & JENNIFER MCNEELY

Department of Population Health, Department of Medicine/Division of
General Internal Medicine and Clinical Innovation, NYU Langone
Health, New York, NY, USA
E-mail: joshua.lee@nyulangone.org

Submitted 8 November 2018; final version accepted 20 December 2018

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