

Specialty Program Buprenorphine Induction: A Viable Means of Improving Diffusion into Office-Based Settings?

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Background

Although physician uptake has gradually increased, there is room for improvement:

- **November 2006: Of 12,000 MDs trained, 9,500 (80%) requested and received a waiver to prescribe (Fiellin, J Addict Med, 2007)**
- **Nearly 1/3 were not prescribing the medication (Waivered Physician Survey, Stanton, 2005)**
- **Lack of experience and concern about induction are important barriers among new trainees (Gunderson, 2006)**
- **Could specialty program induction effectively improve diffusion into office-based settings?**

Patient Characteristics (n=97)

Age (years)	41
Gender (Male)	72%
Race: White	67%
Black	2%
Hispanic	8%
Other/Unknown	33%
Opioid Use on Admission to Program:	
Rx opioid medication	60%
Heroin	24%
Buprenorphine maintenance	9%
Methadone maintenance	6%
Chronic Pain	30%

Referral Sources

Physician referral	26%
Internet/Google	19%
Patient referral	17%
Other Treatment Programs	5%
Newspaper/Media	5%
Columbia Employees	1%
Unknown	25%

Buprenorphine Program Treatment Retention

Time in Treatment (mean)	1.7 years
Patients leaving Program during the past four months (n)	33 patients
Completed Treatment	48%
Lost to follow up	24%
Found more convenient location	9%
Inpatient Rx	6%
Other	9%

Clinical and Logistical Considerations of Specialty Program vs. Office-based Induction and Stabilization

- Effectiveness of linked model of care
- Length of time before transfer
- How to define stabilization prior to transfer
- Patient selection
- Co-morbidity (medical, psychiatric, other substance use)
- Economic costs
- Patient satisfaction
- Diffusion into physician office-based practices

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