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Inquiries about and initiation of buprenorphine treatment in an inner-city clinic

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In the U.S., opioid dependence continues to increase (1). To address this increasing need for treatment of opioid dependence, buprenorphine can now be prescribed in primary care settings. Despite this, buprenorphine treatment in primary care is limited, and treatment of opioid dependence remains inadequate (2–3). Although there are many reasons why administrators and physicians are reluctant to offer buprenorphine treatment (2,4), two particular reasons may include concern about becoming overwhelmed with opioid-dependent patients and attracting patients from outside of the neighborhood that a health center serves. Few studies describe buprenorphine treatment experiences in primary care, and none describe patterns of new inquiries and treatment initiation over time. We document inquiries about and initiation of buprenorphine treatment in an inner-city health center.

Methods

In 2006, we developed a buprenorphine treatment program in a community health center in the Bronx, NY. Six general internists collaborated with a clinical pharmacist to provide treatment with buprenorphine/naloxone within general primary care. When patients inquired about treatment, a provider typically spoke with them in-person or by phone within 48 hours. Appointments to evaluate patients for clinical eligibility (based on national guidelines) were made within seven days. We conducted outreach to inform physicians, patients, community-based organizations, and the surrounding community about our program. Physicians were also listed on two websites that posted contact information of buprenorphine providers.

We collected information on age, gender, race/ethnicity, zip code, and referral source from everyone who inquired about buprenorphine treatment, and then extracted medical record information about whether they initiated buprenorphine treatment. The study was deemed exempt by the Montefiore Medical Center institutional review board.

Results

From 2006–2008, 324 people inquired about and 180 (55.6%) initiated buprenorphine treatment. Of those who inquired, the mean age was 43.8 years (SD=9.8 years), 74.9% were male, 66.5% were Hispanic, 21.0% were non-Hispanic black, and 80.4% resided in a zip code

within three miles of the health center. Common sources of referrals included: community-based organizations (32.4%); the health center or affiliated medical center (20.9%); the internet, newspapers, flyers, or telephone hotlines (20.9%); family or friends (13.4%); drug treatment or detoxification programs (8.2%); and unaffiliated health care facilities (4.2%). The proportion of those who inquired about and initiated treatment did not change over time (trend test: $p=0.46$).

Discussion

After developing a buprenorphine treatment program in an inner-city health center and conducting outreach to inform patients, physicians, and the community about our program, inquiries about treatment gradually increased over time. Neither the physicians nor health center were overwhelmed with patients seeking buprenorphine treatment. The majority of individuals who inquired about and initiated buprenorphine treatment did not travel from far distances to receive treatment. Thus, in providing buprenorphine treatment, the community health center continued to serve the need of the surrounding neighborhood. Our results may help allay physicians' and health center administrators' concerns about the potential of becoming overwhelmed with patients or attracting patients from far distances if they offer buprenorphine treatment. These findings can help physicians and administrators plan for buprenorphine treatment programs.

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References

1. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Office of Applied Studies. Results from the 2005 National Survey on Drug Use and Health: Detailed Tables. Available at <http://oas.samhsa.gov/NSDUH/2k5nsduh/tabs/2k5TabsCover.pdf>
2. Cunningham CO, Kunins HV, Roose RJ, Elam RT, Sohler NL. Barriers to obtaining waivers to prescribe buprenorphine for opioid addiction treatment among HIV physicians. *J Gen Intern Med* 2007;22(9):1325–1329. [PubMed: 17619934]
3. Fiellin DA. The first three years of buprenorphine in the United States: Experience to date and future directions. *J Addict Med* 2007;1:62–67.
4. Turner BJ, Laine C, Lin YT, Lynch K. Barriers and facilitators to primary care or human immunodeficiency virus clinics providing methadone or buprenorphine for the management of opioid dependence. *Arch Intern Med* 2005;165(15):1769–1776. [PubMed: 16087826]