THE USE OF BUPRENORPHINE IN OFFICE-BASED PRACTICE

SUMMARY OF FINDINGS

PHASE THREE PHYSICIAN INTERVIEWS

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In the Fall of 2006 and again in the Spring and Summer of 2008, MedChi conducted telephone interviews with Maryland physicians regarding their experience using buprenorphine for the treatment of opioid dependence in office-based practice. In 2006 we interviewed 17 physicians about their practice with specific attention to issues related to reimbursement for these services. In 2008 we conducted the second group of interviews to gather information about changes in practice that may have occurred due to external influences or because of personal decisions on practice management. In the second phase, we reached 13 of the physicians interviewed in 2006 and interviewed an additional three (3) physicians to gain more diversity of geography and specialty. Finally, in the Spring of 2010 we conducted a third set of interviews, reaching 13 of the group of 20 we had spoken to over the first two phases. The purpose of these final interviews was to further explore changes identified in 2008, any new developments since then, and to learn these experts' opinions regarding the current status of this practice after several years of experience with it.

Description Of Respondents

Physicians identified themselves and their practices according to the following categories: (please note, totals may be over 13 because some interviewees gave multiple designations)

Specialty:

Psychiatry= 2 ; Addictions Psychiatry = 2

Family Practice= 2; Family Practice & Addiction Medicine = 1

Internal Medicine= 2; Internal Medicine & Addictions = 2

General Practice = 1

Addiction Medicine= 1

Physiatry (Physical Medicine & Rehabilitation) & Pain Management= 1

Location:

Urban (Baltimore) = 7

Suburban (Harford, Baltimore, Carroll and Howard Counties) = 5

Small to mid-size city (Easton, Hagerstown or Salisbury) = 1

Practice Type:

Academic medicine = 4

Private practice = 5

Opiate Treatment Provider (OTP) = 4

Outpatient Substance Abuse Treatment Program (publicly funded) = 1

Specialty Clinic (Psychiatry) = 1

Primary Care Center = 2

The range of experience of the respondent physicians was broad and deep. All but one, who directs a Methadone treatment program in an academic medical center, had several years experience in the use of buprenorphine in outpatient treatment settings. These settings represent a broad range of practice, including private practice offices, privately owned addictions treatment centers, primary care or specialty clinics, and publicly funded addictions treatment programs, both Methadone and drug-free models. Some had additional experience in inpatient settings.

Discussion of Findings

Following the 2006 interviews, MedChi prepared a report that summarized research on legal and regulatory guidelines that govern treatment with buprenorphine, the interview findings, and made recommendations for specific actions that should be taken to improve access to buprenorphine treatment. The 2008 follow up interviews were designed to determine what effect advocacy efforts to implement recommended actions might have had, and to determine whether certain events had had an effect on physicians' practices. Those events were: 1) a ruling by the DEA in December 2006 that raised the upper limit of patients allowed to be treated with buprenorphine in office based practice at any one time from 30 to 100; 2) the implementation of the Baltimore Buprenorphine Initiative in Spring 2007; and 3) a series of articles on buprenorphine maintenance in the Baltimore *Sun* beginning in January, 2007.

Interview Design

The purpose of Phase 3 interviews was to explore further certain findings of Phase 2 interviews and to examine implications of maturing practice as well as continuing changes in the external environment. The Phase 3 interview guide was designed first to inquire about any new changes in or affecting practice since 2008, then to explore continuing factors discussed during previous interviews. These factors include approach and philosophy of addictions management, 3rd party payer issues, experience with diversion of buprenorphine, and a summary of the current status of this practice from the respondent's perspective. Finally, the interview guide asked a general question about information that the physician wished to discuss that had not been covered, in order to allow the respondent an opportunity to share his/her thoughts, knowledge, or experience on aspects of the practice that are of importance to her/him.

According to these noted areas of focus, the following discussion will address each of these issues using interview data* to illustrate.

Practice Changes/Developments

In general respondents did not note dramatic changes in their practices in the past two years, but used the introductory question inquiring about changes to discuss certain factors that may have become more prominent in their practice with increasing experience, or to anticipate certain factors the interview guide asked about in subsequent questions. These factors or themes that reoccurred throughout are:

- Availability or sufficiency of providers
- Increased attention to diversion
- Tapered reduction and discontinuation of buprenorphine
- Co-morbidities responsive to buprenorphine
- DEA inspections
- Use of buprenorphine for chronic pain and interaction with addiction
- Matching patient to treatment setting
- Disincentives
- Comprehensive disease management model

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* Please note: interviews were not tape recorded, so physician statements are an approximate accounting from interviewer's notes. For that reason, they are indicated in italics rather than with quotation marks.

In addition to these themes that emerged very early and recurred throughout the interview, several others emerged subsequently. These include the complicated nature of medication-assisted addictions treatment, concerns about use in primary care, and concern over the lack of similar regulations to control the abuse of Oxycontin.

Availability or sufficiency of providers

There was disagreement among those providers who mentioned capacity in their practices. Two providers in Baltimore city noted that they have greater capacity than demand:

- *People are not busting down our door to get on Suboxone. That's due to several things: perhaps location (inner city); and it's not an easy fix with us, we put them through a rigorous course to get a 28 day prescription and we don't give refills. . . . The demand is still there, but there are so many people prescribing Suboxone now. We're holding stable at about 60 maintenance patients now; we don't take many new ones on, but we don't lose many either.*

- *Yes, but to the same limited number of people, only 60-70 people among 20 doctors in the whole practice. There is a need out there (40,000 addicts in Baltimore) but not a demand. They're not coming to community health centers and asking for Bup.*

On the other hand, two other providers, outside of Baltimore mentioned lack of provider capacity:

- *. . . my 65th birthday, I used that as a date to end my practice. I tried to find someone to take over the practice, but there was no interest in the community. Some doctors took the course when Med Chi came down here to give the course for certification, but they were not interested in taking on my practice. So I found myself in the situation of no one to transfer the patients to. . . . We tried to find places to transfer people, some may go to Baltimore or Delaware, or those who are doing pain management.*

- *. . . it's been fairly steady with people seeking treatment. I sometimes wonder if there are enough providers. People who come to me seem to have a sense of urgency. I get my referrals in two ways, either by satisfied patients recommending me, or from the Provider Locator on the web. These people seem to call down the list until they find someone who will take them. I get very few referrals from other physicians. I refer those I can't take, because of my busy practice to a colleague in my group practice who also uses Suboxone.*

Increased attention to diversion

One respondent noted that the biggest change in his practice in the last two years is more attention to diversion. During the 2008 interviews, several respondents identified that the *Sun* series on buprenorphine use in office-based practice called attention to the potential of diversion for illegal purposes. Two years later, all of the providers interviewed identified that it occurs and that they see people in their practices who have already tried buprenorphine before coming to the practice. For example:

- *The people I see for induction have bought on the streets to help withdrawal, but it's only for that or to bridge over until they can get a prescription for Bup. I would call this "therapeutic diversion."*

This respondent's term "therapeutic diversion" frames it positively, rather than a worrisome threat. Others agree:

- *I don't worry about diversion myself, but it shows that the person is not doing well if they are buying it on the street, and the public worries about it.*

- *It's an issue. Almost all of my patients have tried Bup on the streets before they see me. And I've caught patients diverting. I don't know how to get a grasp on it, but I see it as a necessary evil.*

- *I think it's out there; I'm not sure it's a bad thing. Some people who can't get to a doctor's office, for whatever reason, then they come to me when getting it themselves becomes a big pain getting it, or it's too expensive, or whatever; or they become ready to go to a doctor. They are not using it to get high, but to ease their withdrawals.*

- *Diversion occurs and can't be stopped. But the benefits of the treatment far outweighs the risk of diversion. People use it for self-detoxification, but that's usually and inadequate dose and length of treatment. I still give them a try under my management, even if they've already self-medicated to prevent withdrawal.*

Several respondents offered explanations for why they think diversion has increased:

- *The higher the dosage (over 16 mg) the more likely it will be diverted.*

- *I have seen people coming for Bup who have already started themselves; think that reflects a larger supply.*

- *I can only presume that has increased over the last 7-3 years, but you ought to think of it as related to the number of prescriptions that are now being written.*

- *In my experience there is more diversion; I don't know if that's because we're better at catching it.*

This respondent who notes that perhaps providers are now more effective at catching diversion alludes to the many measures providers now take to prevent diversion. All respondents stated measures they use in their practice ranging from urine tests (some

witnessed) to verify the presence of buprenorphine in the urine and/or the absence of other substances, to pill counts, call backs to the pharmacy, carbons of prescriptions, and so forth. One respondent does training for MedChi on such "Security Tips."

Tapered reduction and discontinuation of buprenorphine

One respondent introduced the discussion of tapering dosage with a goal of ultimate discontinuation, when responding to the initial question concerning changes in practice:

- *One thing that has become more prominent is tapered reduction and discontinuation. There are many people on Bup who been coming to me for several years and have turned their lives around and decided to change their lifestyles. Once they have a new, stable life they decide they don't want to take it their whole life, so they taper down a to minimal (< 1mg) dose but many are not able to go off entirely. What characterizes these individuals is that they have a co-morbidity, another condition that Bup is helpful for. But I could not prescribe Bup for irritable bowel syndrome, or chronic stress, or depression. I'm not allowed to use it off label, like you can with other drugs. The federal government says you can only prescribe it for opiate addiction. But with other drugs you're allowed to use them off label for other conditions. The patient looks at the medication as something necessary to balance out the co-occurring condition, so they can't go off completely. The two conditions are so interwoven in their minds and with practitioners.*

Others referred to it when discussing the concept of buprenorphine allowing the treatment of addiction using a chronic disease management approach:

- *I have had several patients taper off. I ask people how long they want to stay. Some want to stay on, and others don't. In the family medicine clinic I had a patient who tapered off after failed call backs. I'd say a small # of patients, maybe 15-20%, taper off in that clinic.*

- *I was trying to do a tapering program, but Suboxone is so much more potent than internal opioids that patients and doctors think they're tapering but they're not able to get completely off. There might be better ways to taper the drug. I have tried several ways (tried to put in solution), but you can't cut the drug. It was developed for another indication, not for dependency tapering. That might be the reason you can't get them down, because you're not really weaning them off. This seems rich for research, but I haven't seen any on this.*

- *A few transferred from Methadone and switched to Bup, then tapered. They had already been tapering down on Methadone and they could tolerate the Bup taper better than Methadone. A couple had a really tough time getting <1 mg, but then ultimately came off completely.*

- *Yes, but there's always a cycling of treatment, relapse, drop out, return, taper down. Such variability in practice patterns. . . . I do taper, but it is highly*

unpredictable and variable who will be able to come off completely. There are no predictors of who these might be. In fact we just had this discussion at a conference of the American Psychiatric Association recently. There were lots of experts discussing the issue of those who taper down to a very small dose, but then cannot come off.

Comprehensive disease management model

Physicians discussed tapering and discontinuation of buprenorphine when queried about whether their approach to addictions management can be characterized as chronic disease management. All respondents agreed that they consider addiction a chronic disease and, as such, approach its management from that perspective. Several then spoke to the issue of whether the long term use of buprenorphine as a maintenance medication is desirable:

- *With this chronic disease, I don't worry about what meds people take. Opiate use over time is safer than other drugs people take, including alcohol. So I don't have a problem with people who want to stay on long term.*

- *I see addiction as a chronic disease. Medication is one tool or approach to treatment, but does not define the treatment. It is a tool used in many settings. I don't like just one tool or modality, but use many based on patient characteristics.*

- *As compared to what? That's a way of asking about detox as opposed to maintenance. Yes it's a chronic disease, but is it something a primary care provider can manage on her own? It's better than nothing, but I prefer it in conjunction with IOP (Intensive Outpatient Treatment). . . . You want a cardiologist in on someone with heart disease; I want an addictions specialist in on addictions treatment. You can't just dump it on the primary care provider.*

- *It became much clearer to me that Suboxone becomes a maintenance medication. It eliminates the negative symptoms of withdrawal, but it doesn't take care of the heart and soul. . . . It's the mentality that the medication will work instead of internal capabilities for change. It's dangerous to think of it as a primary care medication; it is more of a psychological medication. . . . I see people getting on it when their goal is to get off, but it's not realistic unless they are able to put up with the discomfort of hard work to make life changes. . . . If you can couple the drug with relationship therapy where they can learn what to do with the anxiety, then you'll get a positive outcome. . . . This type of relationship is not what you get with the medical model, with just giving or using Suboxone. In addition to the medical model, you need the psychological model. If you set up relationships with people you have a more effective model.*

These last three respondents speak to another recurring theme throughout this discussion, that is the use of this medication in conjunction with some other form of treatment involving counseling and the psychological work necessary for major life change. In fact one respondent explained and renamed the approach:

- *Being more of an addictions psychiatrist I'm much more attuned to the disease model, relapse model. It is psychotherapy with Suboxone as an additional tool, not just the medication alone. The manufacturer of Suboxone said from the beginning that it should go along with counseling, that the provider should refer and work with a psychosocial intervention. It is* ***comprehensive disease management****. Yes, this describes it, and most important for me is that people are addressing and treating their psychiatric problems.*

Matching patient to treatment setting

This focus on the use of a *comprehensive*, rather than *chronic*, disease management model was reflected in the comment above expressing concern about whether a primary care provider can handle the disease of addiction "*on her own."* Other primary care providers echoed her concern:

- *I'd be reluctant to use it in primary care. I'd want to network with psychiatrists, addictions counselors who know where the patient is in the disease process, so we know what can be helpful for them. I think I'd recommend to a new person not to get involved unless you can integrate into full treatment.*

- *I work at 2 induction centers and in a primary care practice; I have been appreciating more how important it is to match the person to the correct treatment setting. I refer to a treatment center first, then they may get referred back to a primary care setting. . . . There are other primary care clinics that have integrated addictions treatment and primary care (Chase Brexton and Total Health Care). A significant number of patients do well with case management and don't need an IOP.*

- *I think that over time it will disappear from primary care practice. Until Addictions Medicine comes about in a big and proper way, and show that this is a good approach. PCP's can't manage addicts in big numbers, and will give it up. When I went through my residency, I was comfortable prescribing insulin for diabetes. Then it became so onerous to manage brittle diabetics in primary care-testing, food logs, hiring a dietician, etc. , that I gave it up. With difficult patients, people will give it up, because the patients are too difficult. They will never be handled in primary care practice.*

- *I'm trying to figure out setting; what is the appropriate first place to put someone on buprenorphine? You may not have the resources or desire to use it in a solo practice setting. You have to go into it with realistic expectations. My sense is that at first it seemed so easy. The medication itself is easy. But it's everything else that makes it so complicated. So maybe we overshot at first, trying to get people to try it.*

The director of an addictions treatment center spoke to some of those other factors that "*make it so complicated*" and how those factors relate to capacity within the treatment setting:

- *Also, consider what the services are that are available within the treatment context. In primary care, patients who don't need more comprehensive services, such as the psychosocial—housing, financial, etc. —will do better. The more needy patients with social issues and co-morbid conditions need more comprehensive services. If a drug treatment program is using Bup, then it gives them another tool. It's more the range of services of the facilities that determines success.*

The physician who recognized that "*at first it seemed so easy*" but now sees "*everything else that makes it so complicated*" agrees that the interaction of treatment context and setting are critical:

- *The model the Baltimore Buprenorphine Initiative has (induction and stabilization with other psychosocial services for 90 days) is useful in a place like Baltimore where psychosocial aspects of addiction are so prominent. If you can provide that structure, it makes it possible to then pass patients on to physicians. Outside Baltimore you don't have the volume of patients to make it seem worth it to try. As an individual physician in less urban areas you see the poverty because it's there, but it doesn't rise up to the same level of intensity.*

Co-morbidities responsive to buprenorphine

When discussing buprenorphine as a tool in chronic disease management, some respondents noted that buprenorphine is also effective for other conditions, especially chronic pain. They recognize another complex interaction between opiate dependency and the treatment of pain:

- *Most of my patients are on long term because of underlying pain in addition to the dependency. As long as they are stable, it keeps them at bay. It is a chronic condition. There is literature that says that buprenorphine is for pain, but the FDA doesn't approve that. The brochure says it's only for opioid dependency. It can be a deal breaker for those who don't want to consider that they have dependency.*

- *I'm concerned that some are continuing for conditions other than opioid dependence, for example, anxiety, pain, somatic stress-linked condition deactivation. Somebody should do a clinical trial on Bup with irritable bowel syndrome.*

- *Those with chronic pain; it is good for pain control. People who take very small doses for that. People who go from NSAID's to mega doses of opioids—that's how they got to me. These are the most constructive. These are people who are worn out by pain. They need to learn that pain is not the enemy, but learn how to live with it and how to live your life in it.*

- *I think that's why Bup has been so much adopted in W. VA, where prescription opiates are prescribed for pain from work injuries, etc. in poorly controlled and*

problematic pain management. To me that's where the reframing should focus. Part of the problem is when you talk about chronic pain management, it becomes clinically more complicated. We need to figure out how to better deal with this. I don't know that anyone has looked at how to manage pain and substance abuse in a practical way. More attention is being paid, but the research hasn't reached the level to say it's practical.

DEA Inspections

The relationship between pain control and opioid dependency came up again when respondents discussed inspections the DEA is currently conducting of office-based practices that use buprenorphine for the treatment of opioid dependence. For example:

- *Why isn't the DEA inspecting the pain clinics where they are sending out Oxycontin in great numbers?*

- *But the question is, what is the DEA doing to prevent diversion of Oxycontin, Percocet and even benzos? These are much more dangerous. One reassuring thing about Bup is that people don't get high on it.*

- *Certainly the DEA thing is scaring people away. They are focusing so much more on Bup than on Oxycontin, for example.*

In regard to other concerns about actual DEA visits, most physicians are aware of this possibility but did not express major concerns. There was recognition that for those who keep medication on site, such visits would be more demanding:

- *I'd be OK if they came, since I don't dispense, so it would not be an audit. They just look at patient logs and make sure you have a copy of prescriptions in the patient record.*

- *I am aware of it, but I am not concerned because we are so compliant they wouldn't believe it. I want them to come and see how compliant I am. But it won't prevent diversion. No. I do keep medication on site. I have a safe where I keep the meds and we log what goes in and what goes out.*

- *Yes, I am aware of this, but no, I have not yet been audited. I am a member of a group of mentor physicians who help others with less experience. This is a very big issue with them. The DEA is nasty with its audits. I don't ordinarily keep the medication on site, but I had one patient getting it from Reckitt so I did have to keep it for him and that was a mess, all I was required to do. So I don't want to be involved with keeping it.*

- *I've had 2 inspections. The DEA presumes you're guilty until proven innocent. I guess I'm OK because they haven't stopped me. I had full audits in December, 2009 and March 2010. I do keep the drugs on site, but I'm probably going to stop that because it makes the record keeping, etc. more onerous. It would be less trouble without that.*

Disincentives

These last two physicians allude to certain issues in the use of buprenorphine in office-based practice that can be characterized as disincentives or discouragers of physicians to use this practice. Other disincentives that respondents spoke about are related to the practical aspects of running a practice. For example:

- *I also realize how much extra legwork I have to do in a primary care setting, such as urine testing, reliable call backs, pill counts, missed work slips, etc. I'm doing it all myself in the family medical clinic. I think I said it in a previous interview, if there were a way to hire an assistant or a case manager who could coordinate these things, and do authorization. It takes extra time from me in the primary care setting. This is a disincentive in the primary care setting, so I limit the number I see for buprenorphine there.*

- *Yes, but it's becoming more difficult to maintain because the pharmacy plans are making it more difficult. Even though I don't participate in health insurance plans, I still have to get preauthorization for the medication. They always find a way to complicate things with paperwork, urine tests, etc.*

- *I worked out a business model that worked in a small community. You need to have something else to support your practice; you can't do Suboxone addictions treatment alone. So unless you can get patients off of Suboxone, you can't run a practice on Suboxone alone. The business model has a negative emphasis on failure (when people leave the practice slots are freed for new patients). You also need a very low overhead (less than 5%). You can't support a secretary, etc. on that overhead. It was a good business, but a supplementary business.*

  You need to be on call, make a commitment to be available. If I were to do it again, I would have family involved to report once a month. I got involved with people who said they'd do this, but I got no feedback, no follow up. These are busy people who don't have time for that. I wasn't able with intentionality to set up a system that could monitor this. But I also couldn't get it reimbursed. Because anxiety is such a problem, people wouldn't do it, and I couldn't set up the monitoring system. You'd have to have a way to fund this system. But there's not enough sophistication on how such a practice works.

- *The 3rd party payer thing is making it more difficult than needs to be; that scares people away (scares me sometime). But in general I'm doing it as a big part of my practice; I'm up to 50+ people in my practice.*

- *I will continue to use it. I will keep this practice, but streamline it so I don't have as many onerous requirements, like paperwork. That is, I'll be stopping inductions in the office, so I don't have to keep the meds on site.*

- *I don't understand why they don't take the 100 patient limit away for docs who are board certified in Addictions Medicine. It makes no sense. I could write prescriptions for 10,000 Oxycontin patients, but only for 100 buprenorphine*

patients. That's why I'm so expensive. We have 250 patients with 3 doctors. I spend time not seeing patients because of the limits. If one of the 3 of us goes to 101, we have to hire another physician. I could lower my prices if they'd let me see more than 100. It makes no sense to limit such an effective treatment.

Current Status of the Practice

As we discussed changes or developments in the practice of buprenorphine use in office-based practice, physicians reflected on resulting benefits to patients and society, the necessity for collaboration with others, factors that support or inhibit success and recommendations for continued work in support of practice enhancement.

Benefits

One of the reasons for the initial interviews in 2006 was to explore consequences of buprenorphine treatment that could make a case for characterizing it as an approach to the management of addiction as a chronic disease. With several more additional years of practice experience, respondents note benefits such as:

- *Yes, I do chronic disease management. . . . These are all benefits I see. There are many measures of effectiveness such as better health, returning to work, family involvement, lower rates of HIV infection—these are all better with medically assisted treatment (Bup & Methadone) than abstinence. I don't know how to measure these things, but you can measure arrests before and after initiation of treatment, and the insurance companies have the health information to show effectiveness.*

- *It's a miracle drug that gives people their lives back. They can work, support their families, go on trips, take care of their kids, they don't go to prison, etc. When successful, this treatment benefits not only the patients through these things, but their families and society. It has a huge ripple effect.*

- *In general, it lowers the high cost of health care utilization, with people able to give better attention to their overall health (for example dental or other preventive health care). We incorporated communicable disease testing (Hepatitis B and A) into our treatment program. We vaccinated a huge number of patients, and picked up unknown Hep C. It got people to pay attention to their overall health. From a psychosocial perspective, you see family reunification, increased employment, decreased arrests and incarcerations, etc.*

Collaboration

Respondents discussed both receiving referrals from other providers and referring for other forms of treatment themselves. In the 2008 interviews we were interested in the effects the introduction of the Baltimore Buprenorphine Initiative might have had on physician practices. At that time there was some discussion about transition from a structured treatment program where induction and stabilization was conducted having potential risks for patient continuation or stability upon transfer to an office-based

practice. In response to this year's follow up question about accepting referrals who have had induction elsewhere, all respondents found this process to go well and found no difference in the long term management of these patients from those they had induced themselves.

- *As of January we have been accepting referrals from the BBI because of PAC. Also, in the context of primary care I have always accepted referrals from others who have done induction. I don't think these patients are different to manage than those who come to me for induction and maintenance. Both groups seem similar to me.*

- *I accept insurance, so if a doctor who induced them accepts cash only, they may transfer to me after induction. So I have a few that way. These are different from my ordinary patients because they do not have a pain indication, but became addicted on the streets. But most of my patients have a pain indication. I also have arrangements with Dr. Hayes and Dr. Scotto where they do the induction then send me the patient when stable. These are for patients who need a quicker assessment of their withdrawal. They may need too high a dose, so I send them because they'll need induction with IV Subutex, which doesn't lend itself to my office practice.*

- *I take everybody, don't turn anybody away. Some patients have started with someone else and come to me for a variety of reasons, usually because they are unhappy with something in the other practice. Or, more likely they relapsed, then come to me for a second try. In general, many who come from other doctors have been misinformed, or misunderstood, so they tell me bizarre things about what the other physician required. . . . These patients are different from others in primary care, and with physicians who don't have experience with addicts they sometimes get angry with their behavior and then make irresponsible demands on these patients.*

- *We got a fair number who had initially been to fee-for-service providers, but couldn't afford them any more. There was no difference between them and the patients we induced; they blended in. The difference would be in going from a substance abuse treatment program to an office-based physician; that transition would be harder. When coming from a physician to us, they had to adjust to the counseling as well, but they adapted to that. The larger degree was how much counseling was emphasized.*

Respondents again discussed the issue of the use of counseling in response to a follow up question inquiring whether they are now referring to other forms of treatment more or less than when we last spoke in 2008. Many indicated they may be referring slightly more, that they appreciate a second perspective, and echoed an effort to encourage counseling along with buprenorphine treatment.

- *A little bit more, but I have homeless people doing well on Bup.*

- *I think I'm referring more now to some type of counseling. I don't know that very many go, but I am referring.*

- *When the problem is a true abuse (snorting or injecting) and /or the patient has significant psychological problems, or is taking too high a dose, I refer. I often get a second opinion, then decide.*

- *A little more. There are certain people who can't stay with the program, so I will refer them to inpatient units. I also refer for consults to Dr. Hayes and Dr. Scotto when I need a second perspective.*

- *In general I encourage people to be engaged in some kind of counseling. I see it as really positive. I've always encouraged this. I feel it's very important to be in some form of support.*

Factors supporting or inhibiting success

Related to referral to other forms of treatment for certain patients is the question of whether physicians can determine which patients are most likely to be successful using buprenorphine. Some respondents did not think they can identify those most likely to succeed, while others indicated certain factors that can identify those most likely to respond to buprenorphine treatment.

- *People with polysubstance abuse are as likely to be successful with Bup, so I don't see/can't predict who might be successful with Bup versus other forms of treatment.*

- *People who respond well to Suboxone are more likely not to have been involved in the heroin street trade. To really show the effectiveness of this method you need to take out the street trade group. Those who got on to Oxycontin for pain management are the people who do best on Suboxone. Of course they are more likely to have stable families, be working, etc.*

- *The better motivated people will do better with Bup because it is easier to walk off of Bup, whereas with Methadone if you stop, you go into withdrawal.*

- *I believe there is a difference in the characteristics of these patients based on how they were first initiated to addiction, that is iatrogenic or self-induced on the streets. . . . If you're asking who is the ideal patient, it's an iatrogenic dependency, some drug dependency but no active abuse (not snorting Oxycontin, for example). They have some external consequences from someone like a family member or employer that causes them to rethink their situation. They want to keep their marriage, job. etc., so they decide, "I need to do something different. Doctor, help me." Legal consequences are not so powerful. Then there's a shift in the locus of control. They must have the will power to stop the Oxycontin for 2 days until they start the Suboxone. Just the fact that there is an induction, they must go off their pain meds and go through withdrawal, shifts that locus of*

control. Once a patient understands this and commits to it, they are more likely to succeed. A patient on Methadone maintenance does not do this.

- *From a strictly medical standpoint, if someone has a tolerance/needs too high a dose, then that's a medical failure and they need Methadone or a more intensive form of treatment, they can't be handled in an outpatient practice. Or for those whose lives are so out of control—they don't have the finances, transportation, family support. Often I can't stabilize them because they live in an environment where they can't be stable because everyone else is using, their lives are a mess. But the same is true with other chronic diseases. If a diabetic comes in and is destitute, if the economic and social conditions are the same, the diabetic is no easier to control. They can't eat right, have structure in their life, understand the disease process and how their behavior affects it, etc. If someone can fix the social, I can treat the disease.*

- *Some who are more severely addicted, or some who, for whatever reason, do better on Methadone. Some self-select out and go back to Methadone programs themselves, not on my referral. But then they still come back to me for primary care.*

- *The other thing we recognized was people who didn't do well in an office-based practice without the structure of an Outpatient Treatment Program. For those few patients we set up an agreement with a Methadone provider to administer Suboxone daily through their program, but those patients came to us for counseling and urine checks. After a month we'd evaluate; if the patient was doing well, they could come back to us for office-based treatment. . . . No matter how much structure we provided, if the home environment doesn't support recovery, it doesn't work.*

Summary and Recommendations

Finally we asked physicians to summarize their perspective on the current status of this practice both in their own practice and in general. Their responses were positive and hopeful for the future. They echoed some of the themes stressed throughout such as the need for comprehensive disease management, the benefits to patients and society, concern over abuse of prescription drugs, the threat of diversion, and so forth.

- *Looking at the area, in Baltimore, you can look at things like the homicide rate, arrest statistics, work and health status of addicts. I contend that medically assisted treatment has had an effect on those. Baltimore should be commended for Methadone and buprenorphine treatment improving things for addicts.*

- *There are still "bad Bup doctors" out there. Training won't help them. Part of it is a philosophy that, "they passed this law so I can write a prescription," or "medicalizing treatment", and by doing that it takes away the stigma. However, this is a behavioral disorder, so we need to treat the behavior with whatever modalities are appropriate.*

- *I think nationally that most of the docs willing to do it are in urban areas. This doesn't address a huge abuse of prescription drugs. This is a huge smoking gun of patients who get their narcotics from their doctors. Those are the docs who need to recognize addiction. Med Chi needs to train those doctors to recognize and be aware of it.*

- *It is very solidly integrated into addictions treatment and accepted by abstinence model programs, who see that it's not exactly like Methadone. You can see the intoxication effect with Methadone, but you just don't see that with Suboxone. So it is different from Methadone for agonist therapy. It is also well accepted in the community because it is not noticeable the way a Methadone treatment center is (long lines, every day, etc). So I'm very encouraged; I see it as having a place in addictions treatment. I see an acceptance by Psychiatric residents to get their DEA number and get experience in this. There is a lot more interest in it, especially in the city. Same thing in Family Medicine; they just got a 5 year grant to do this training statewide.*

- *I think it has been a great service to the addicted population of the city; it is a great alternative to Methadone and inpatient treatment. It is good for people who wouldn't go to a treatment program. It's an advantage that they don't have to go and be stigmatized in a strange place. But it doesn't fit everybody. It is not a panacea, and it doesn't solve the problem of addiction, but it is a great help. I will continue to use it.*

- *Overall it's been a really effective and useful medication for a lot of people. I'm glad it's available. But it does have its risks as far as diversion. If we had a better way of monitoring, I'd feel more comfortable writing prescriptions. It would be nice to have more resources available.*

Some respondents also made recommendations to MedChi for future work in this area. These recommendations were in two areas, education and research. Aware of the role MedChi has played educating providers to equip them in this practice, two providers made recommendations for future educational programs:

- *I've found out that some of my patients are coming to me for Suboxone and going to another doctor for Oxycodone. I have a patient who had surgery, after which she received Oxycodone, and she was using the Suboxone to bail her out, tide her over until she got more Oxycodone. It was poor understanding on the part of the surgeon that she shouldn't be taking both. Even doctors who don't prescribe Buprenorphine, they need education to understand it. Med Chi should be doing training for the other (non-prescribing) doctors as well.*

- *. . . address a huge abuse of prescription drugs. . . . patients who get their narcotics from their doctors. Those are the docs who need to recognize addiction. Med Chi needs to train those doctors to recognize and be aware of it. I have a friend (in an ex-urban practice), who I was in residency with, who got certified and now has 30 Bup patients. She wants her partners to get certified. Those are*

the doctors who need training. I'm going to go meet with them to talk about this treatment and encourage them to get trained. Med Chi should not stop in-person training. It is very much needed.

This recommendation is from the city physician who noted the huge need in Baltimore yet she does not see a matching demand for buprenorphine treatment in her community health center practice. Yet she strongly supports the extension of education to practitioners in suburban or rural areas who see patients with iatrogenic dependencies.

Research is another area several providers mentioned as an area for future work. One provider suggested that the question of why drug tapering does not automatically result in discontinuation would be worth exploring:

There might be better ways to taper the drug. I have tried several ways (tried to put in solution), but you can't cut the drug. It was developed for another indication, not for dependency tapering. That might be the reason you can't get them down, because you're not really weaning them off. This seems rich for research, but I haven't seen any on this. If I were an academic, I'd do that. This is something that is evolutionary.

Another is interested in the relationship between pain management and addiction:

Part of the problem is when you talk about chronic pain management, it becomes clinically more complicated. We need to figure out how to better deal with this. I don't know that anyone has looked at how to manage pain and substance abuse in a practical way. More attention is being paid, but the research hasn't reached the level to say it's practical.

Or other co-morbid conditions:

Somebody should do a clinical trial on Bup with irritable bowel syndrome.

A fourth suggestion:

I see that you can't get outcome data. I'd be interested in that. If you hear about researchers at NIH who are thinking about these things, I'd be interested and have the energy to talk to researchers about this.

This offer comes from the physician who has just closed his practice on his 65th birthday, yet he prefaced the above statement by saying, "*I'm still in the process. I don't think this will be my last word on this topic.*" Hopefully none of the expert physicians who have participated in this process of sharing their experience and practice wisdom with MedChi during the past four years have spoken their last words on this topic. They have been extremely thoughtful, honest and articulate about the topic and generous with their time. Many seemed eager to engage in discussion on this issue to learn from the experience of the other interview participants and to hear reinforcement regarding shared challenges or dilemmas. Some expressed a wish for forums in which to continue such

discussion. One specifically noted, "*I'd like to see how this is going to impact policy in the recommendations of your report, and how it will impact my practice in the future.*"

Thus as the Maryland state medical society seeks to fulfill its role of advocacy and education for the physicians of Maryland, there are clear areas in which MedChi can continue its work on the issue of buprenorphine in office-based practice. These include:

1. Continued education for physicians seeking certification to prescribe buprenorphine and additional education on the relation of addiction and pain management for those who prescribe opioids for pain control.

2. Continued advocacy on behalf of physicians in relation to third party payment policies and government regulations.

3. Participation on coalitions or task forces dedicated to addictions treatment improvement, such as NCADD-Maryland.

4. Support and encouragement of applied as well as basic research in areas directly related to physician practice using buprenorphine.

5. A forum for physician exchange/dialogue on this topic. Perhaps the Buprenorphine Advisory Board can be convened to develop a mechanism to reach out to and communicate with prescribing physicians throughout the state.

After several years of education, research and advocacy on this issue, MedChi should take the approach of our retiring interview participant to continue this process. This should not be MedChi's last word on this topic.