WAIVERED PRESCRIBER SUPPORT INITIATIVE

Training Needs Survey Summary Report

UCLA Integrated Substance Abuse Programs

UCLA

10/30/2019

Introduction

PURPOSE

As part of the effort to improve, expand and increase access to Medications for Addiction Treatment (MAT) services across the state, UCLA Integrated Substance Abuse Programs (UCLA) was contracted by California's Department of Health Care Services (DHCS) to provide training and technical assistance to California DATA 2000 waivered prescribers seeking further assistance and mentorship to increase prescriber/ provider skills in delivering MAT services. The UCLA team collaborated with clinical experts and MAT champions to deploy an online survey targeting California DATA 2000 waivered prescribers to identify why prescribers are NOT prescribing. Additional data were collected through qualitative interviews from a randomly selected subsample of the surveyed waivered prescribers who volunteer to be interviewed. The interviews provided a more in-depth understanding of the barriers and training needs indicated in the survey findings. Using this data, UCLA will provide the targeted mentorship, training, and technical assistance to address those barriers over the next year. Results from the online survey and qualitative interviews are described in this Summary Report. Access to more project information and direct services can be found at the project website: http://uclaisap.org/MATPrescriberSupport/

METHODS

Training Needs Survey

The UCLA team consulted with and received guidance from the CA Hub and Spoke evaluation team at UCLA to determine a robust sampling plan. Survey participants were randomly sampled from a statewide list of all DATA 2000 waivered prescribers in California (n=5,930), acquired in February 2019, with prescriber data updated through December 2018. A power analysis was conducted to determine the number of responses needed to obtain results that would be within ±5% of the true population mean 95% of the time. The analysis was based on dichotomous (checkbox) questions and the assumption that respondents would check the box 50% of the time. This analysis determined that a minimum sample size of 361 responses was required.

The questions for the survey were developed in consultation with the CA Hub and Spoke evaluation team who also develop interviews for prescribers within the H&S system. In addition, UCLA consulted with other stakeholders and experts including Rick Rawson, Mark McGovern, Candy Stockton, and Kelly Pfeiffer, as well as DHCS. See Survey Questions in Appendix A.

The survey was designed and administered using Qualtrics, an online survey platform. CA prescriber emails were processed through an email verifier service to reduce the number of invalid emails. An invitation to complete the online survey was then sent over email in three increments over an 8-week period (April 15 - June 7, 2019) to a total of 2,700 randomly selected potential respondents. An incentive of a $10 Amazon gift card was offered for time spent completing the survey, with a chance to win a 256 GB IPad (via random drawing).

Qualitative Interviews

From August 15 to September 15, 2019, 20 California DATA 2000 waivered prescribers were interviewed about a number of issues concerning the treatment of opioid use disorders (OUD) in their practices. Questions were driven from the issues that surfaced from the UCLA Training Needs Survey conducted between April 2019 and June 2019. Participants were a convenience sample of 20 prescribers randomly selected from a group of 68 prescribers who had completed the Training Needs Survey and agreed to do a follow up call interview. No compensation was provided for the interviews.

While the qualitative data were supportive to the survey results, the findings are incorporated into the Summary section. However, find the full report from the interviews including the interview guide in Appendix B.

SURVEY RESULTS

Survey responses were received from 768 individuals, denoting a 28.4% response rate. Following data cleaning and including data only from respondents reporting a valid patient caseload response, a sample of 467 responses were included for analysis to inform the training plan. The data from the other 301 respondents not included in this report will be included for future analyses; however a valid reported caseload was a critical data point to assess training needs. In an effort to assure the data for this report was representative, responses from the 467 and 301 respondents were compared and results were similar.

For this report, data were grouped by patient caseload (zero patients vs. any patients), defined as inactive prescribers (caseload = 0) and active prescribers (caseload > 0). Data were also grouped by reported waiver limit (i.e.: 30, 100, and 275 patient waiver limits). The percentages of prescribers by waiver limit in the survey sample were compared to the 2019 statewide prescriber list, which revealed a response bias toward those with higher waiver limits (see 'Caseload and Waiver Limits' below). This is not surprising as more experienced prescribers are typically more enthusiastic and therefore more likely to respond. Thus, the survey data was weighted to correct for this bias to improve statewide generalizability of the results. Descriptive analysis were conducted and described below.

Respondent Characteristics (N=467)

DEMOGRAPHICS

Across the sample, 46.9% of respondents identified as male, 43.9% identified as female, 0.4% as non-binary. 1.1% preferred not to answer, while some skipped the question. The majority of respondents listed their race/ethnicity as White or Caucasian (53.0%) followed by Asian (20.0%) and Black or African American (4.0%). Responses to these questions were not mutually exclusive.

Table 1: Demographics

Gender	
Male	46.9%
Female	43.9%
Non-binary	0.4%
Prefer not to answer	1.1%
Race/Ethnicity	
White or Caucasian	53.0%
Asian	20.0%
Hispanic or Latinx	5.6%
Black or African American	4.0%
Middle Eastern or Arab American	2.3%
American Indian or Alaska Native	0.7%
Pacific Islander	0.5%
Prefer not to say	9.3%
Prefer to self-describe	4.7%

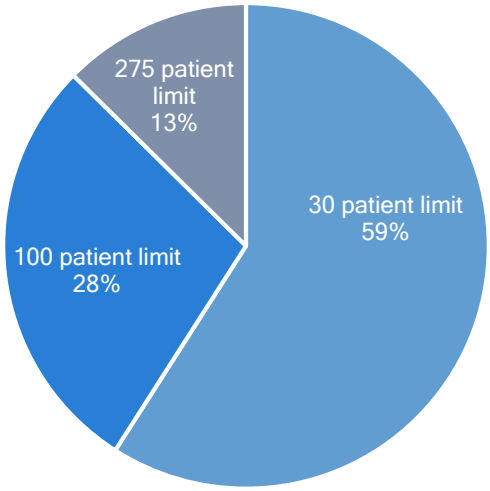
CASELOAD & WAIVER LIMITS

Survey respondents were asked to confirm their current SAMHSA-approved waiver limit, the number of years waivered, and the current number of patients on their buprenorphine caseload. Overall, the mean number of patients reported on caseloads was 18.4 (standard deviation=34.6). 33% of respondents reported zero patients on their caseload and are defined as inactive prescribers. The mean number of years waivered was 4.56 with the maximum length being 18.89 years.

Among active prescribers (patient caseloads >0), the mean number of patients reported on caseloads was 27.4 (standard deviation=39.3); the maximum reported caseload was 270 patients. Active prescribers were slightly more likely to have been waivered longer (M=4.8 years) than prescribers with zero patients (M=4.0 years). However, this difference was not significant.

Within this sample and of those who reported their waiver limit (n=381; 86 respondents skipped this question), the majority (59%) of respondents reported having a 30-patient waiver limit, while 28% reported a 100-patient waiver limit and 13% reported a 275-patient waiver limit. Statewide, 83.8% of providers have a 30-patient limit, 13.3% have a 100-patient limit, and 2.8% have a 275-patient limit. Therefore, data have been weighted, where indicated below, to reflect these statewide percentages.

Figure 1: Distribution of prescribers by waiver limit (unweighted)



Within each waiver limit group, **inactive prescribers** reporting zero patients were distributed as follows: just over one third (38.4%) of prescribers with a 30-patient limit were inactive; 15.7% of prescribers with 100-patient limit were inactive, and 10.4% of prescribers with a 275-patient limit were inactive.

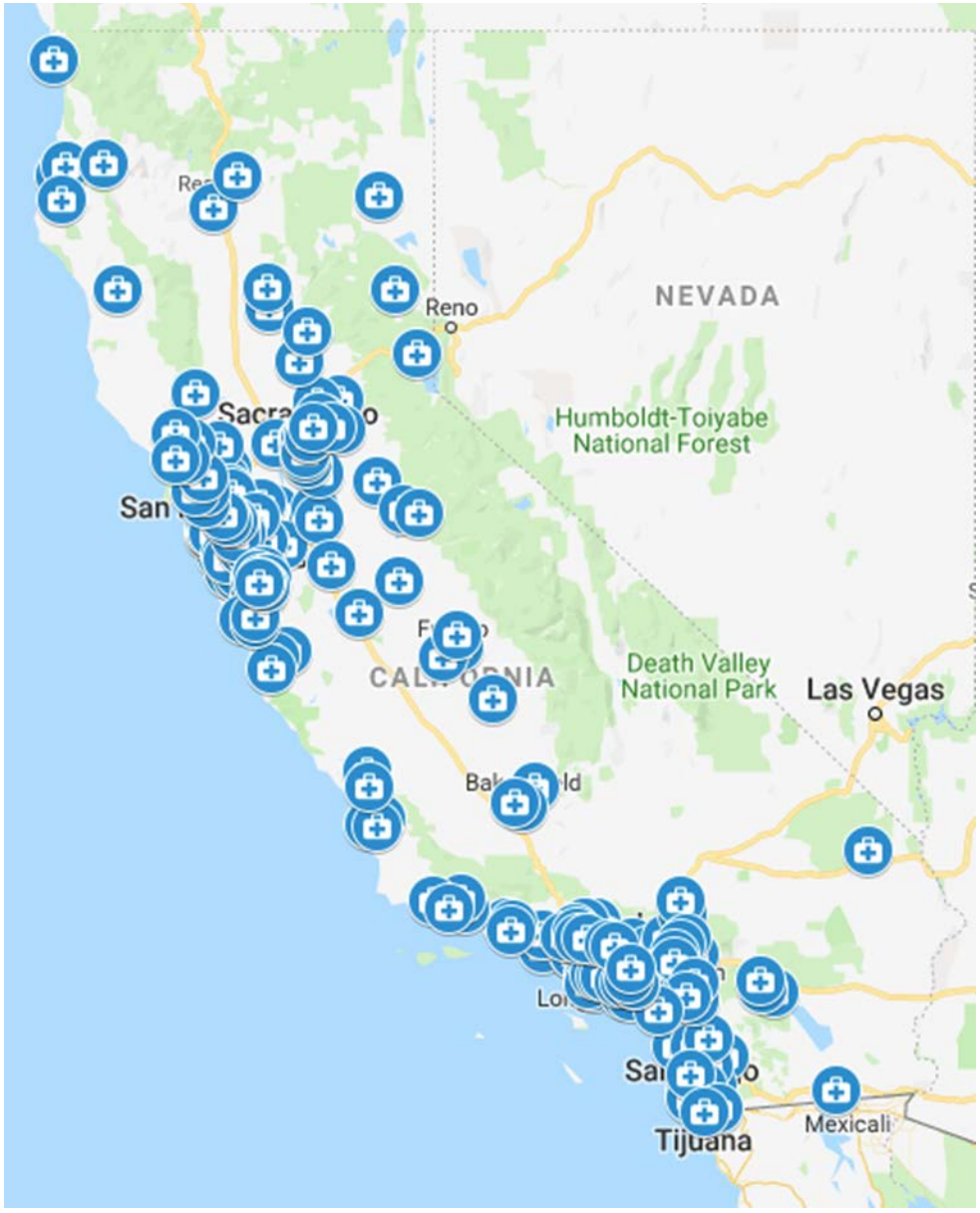
Among the **active prescribers** (caseloads > 0) within each waiver group, under-utilization of waivers was also measured by identifying a cut off utilizing a scatter plot method for each waiver limit group. Among the active prescribers with a 30-patient limit, 54.4% (n = 74) were under-utilizing their waiver (i.e., prescribing to ≤ 5 patients). The remaining 45.6% (n = 62) had >5 patients in their caseloads.

Among the **active prescribers** with a 100-patient limit, 56.8% (n = 50) were under-utilizing their waiver (i.e., prescribing to ≤ 30 patients).The remaining 43.1% (n = 38) had >30 patients in their caseloads.

WHERE DO THEY PRESCRIBE?

Figure 2 below shows the distribution of locations (by zip code) from which the sample of prescribers for this report most often prescribe buprenorphine. This sample reflects a wide distribution across the state, similar to the statewide prescriber list, supporting the generalizability of our results.

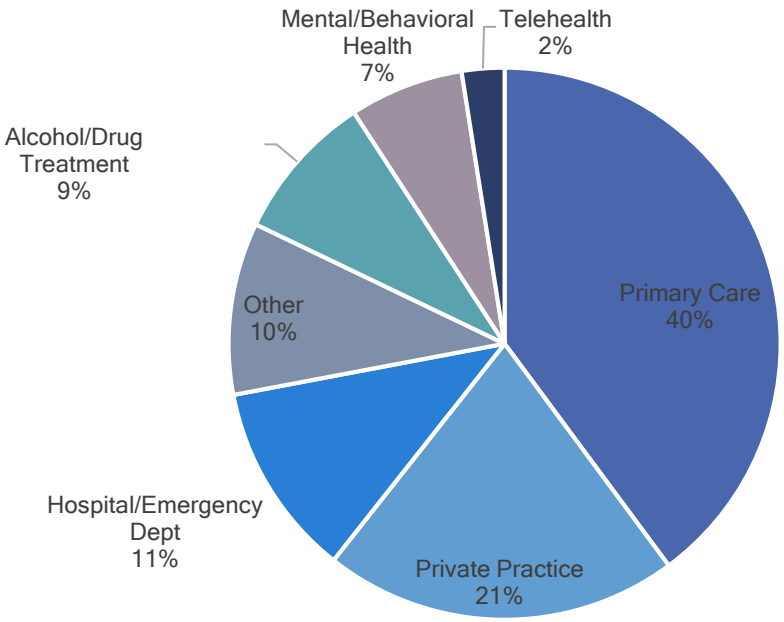
Figure 2: Distribution of prescribers by zip code (unweighted)



TREATMENT SETTINGS

The majority of respondents reported the primary setting for which they deliver MAT services was in primary care clinics (40%) and within private practice settings (21%). Additional settings represented in this sample included prescribers from alcohol and drug treatment programs, hospitals or emergency departments, mental/behavioral settings and telehealth programs.

Figure 3: Distribution of prescriber treatment settings (weighted)



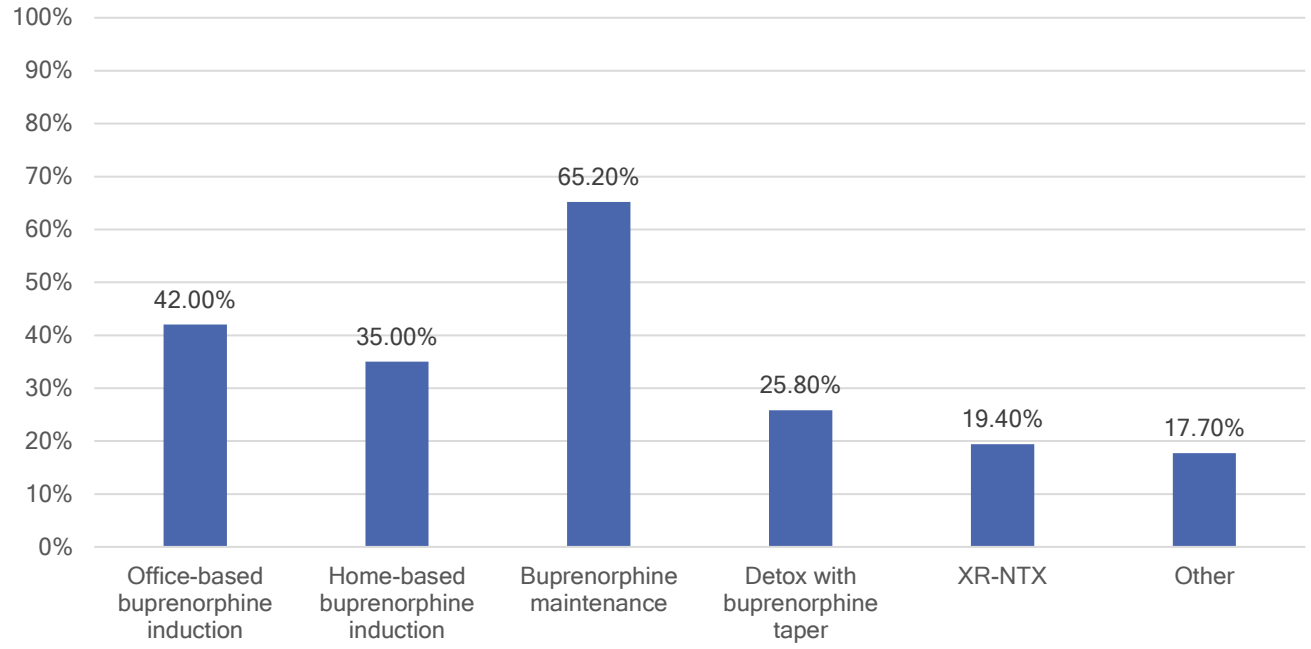
"Other" settings represented included:

- Correctional facility x 6
- Academic center x 3
- Veterans Affairs x 3
- Urgent care x 3
- Pain clinic x 2
- Skilled nursing facility x 2
- Palliative care clinic
- Healthcare for the homeless
- Syringe Access Center

SERVICES PROVIDED

Survey respondents were asked to select the types of services they provide to patients taking buprenorphine. Figure 4 displays the distribution represented in the weighted sample. Respondents were prompted to select multiple service types as necessary.

Figure 4. Distribution of services provided (weighted)



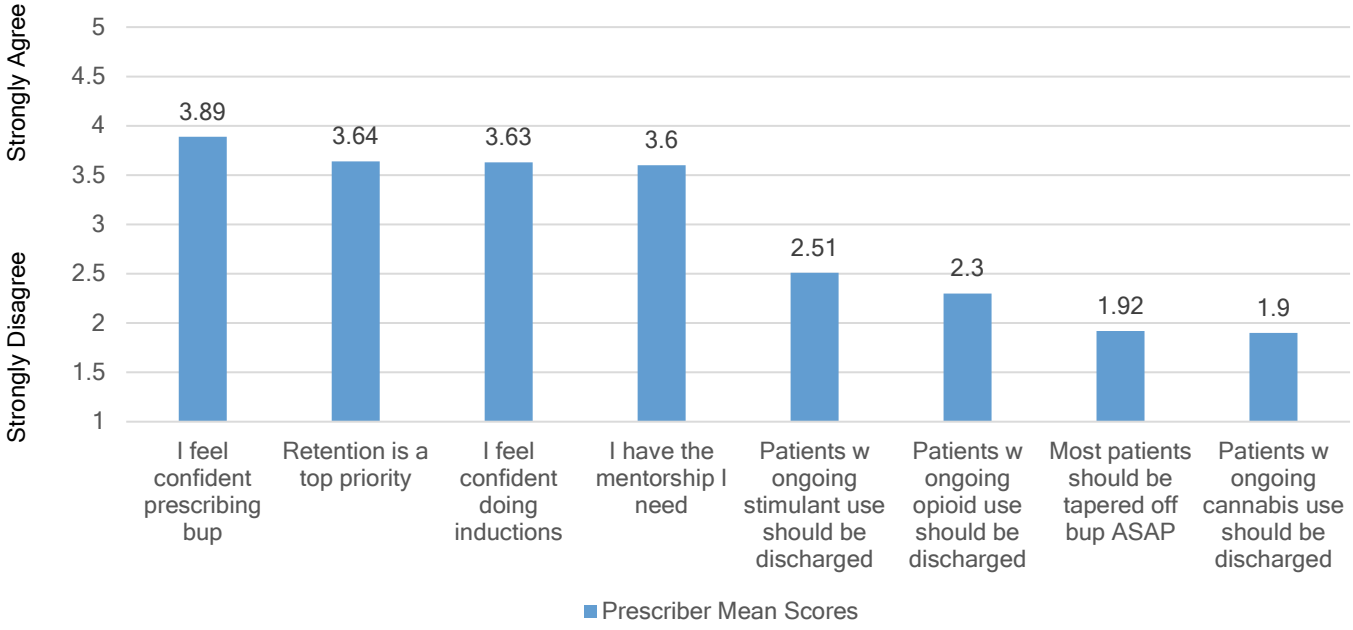
Among the sample, 57% of respondents provide any form of induction. Other services included:

- ED/hospital based induction x 17
- Street based Suboxone induction
- Sublocade x 7
- Counseling x 6
- Pain management/bup for chronic pain x 6
- Methadone x 3
- Buprenorphine implants x 2
- Transition from methadone x 2
- Dual diagnosis x 2
- Oral naltrexone
- Detox for pregnant patient

KNOWLEDGE & ATTITUDES

Prescribers ranked statements on their knowledge and attitudes about prescribing buprenorphine to patients using a 5-point Likert scale ranging from Strongly Disagree (1) to Strongly Agree (5). Overall, in the weighted sample, prescribers agreed most, but not strongly, with the statements "I feel confident prescribing buprenorphine" (M=3.89) and "Retaining OUD patients in treatment is one of my top priorities" (M=3.64). In contrast, prescribers disagreed most with the statements "patients with ongoing cannabis use should be discharged" (M=1.90) and "most patients should be tapered off buprenorphine as soon as possible" (M=1.92).

Figure 5. Knowledge and attitude mean ratings, overall (weighted)



<u>Inactive vs. active prescribers</u>

When comparing inactive and active prescribers in a weighted sample, **inactive prescribers** were significantly **less likely** to agree with the following statements than active prescribers:

- I feel confident prescribing buprenorphine (M = 3.33 vs. 4.18 for active prescribers)*
- I feel confident doing patient inductions on buprenorphine (M = 3.04 vs. 3.92)*
- I have the mentorship I need to effectively treat patients with opioid use disorders (M = 2.95 vs. 3.91)*

*p < .001

Active prescribers – low vs high utilization of their waiver

When comparing knowledge and attitudes of **active prescribers**, prescribers who were under-utilizing their 30-patient waivers (caseload ≤ 5 patients) were significantly **less likely** to feel confident prescribing buprenorphine (M = 3.8 vs. 4.3, p < .001) and doing patient inductions (M = 3.4 vs. 4.1, p < .001) than those who were prescribing to >5 patients. They were also less likely to feel they had the mentorship they needed to treat patients with OUD (M = 3.6 vs. 4.1, p = .002), and were less likely to agree that retaining patients in treatment was a top priority (M = 3.4 vs. 3.9, p = .001).

There were no significant differences in knowledge and attitudes between prescribers who were under-utilizing their 100 patient limit waivers (caseload ≤ 30 patients) and those who were prescribing to more than 30 patients.

Active prescribers – 30-patient vs 100-patient waiver limits

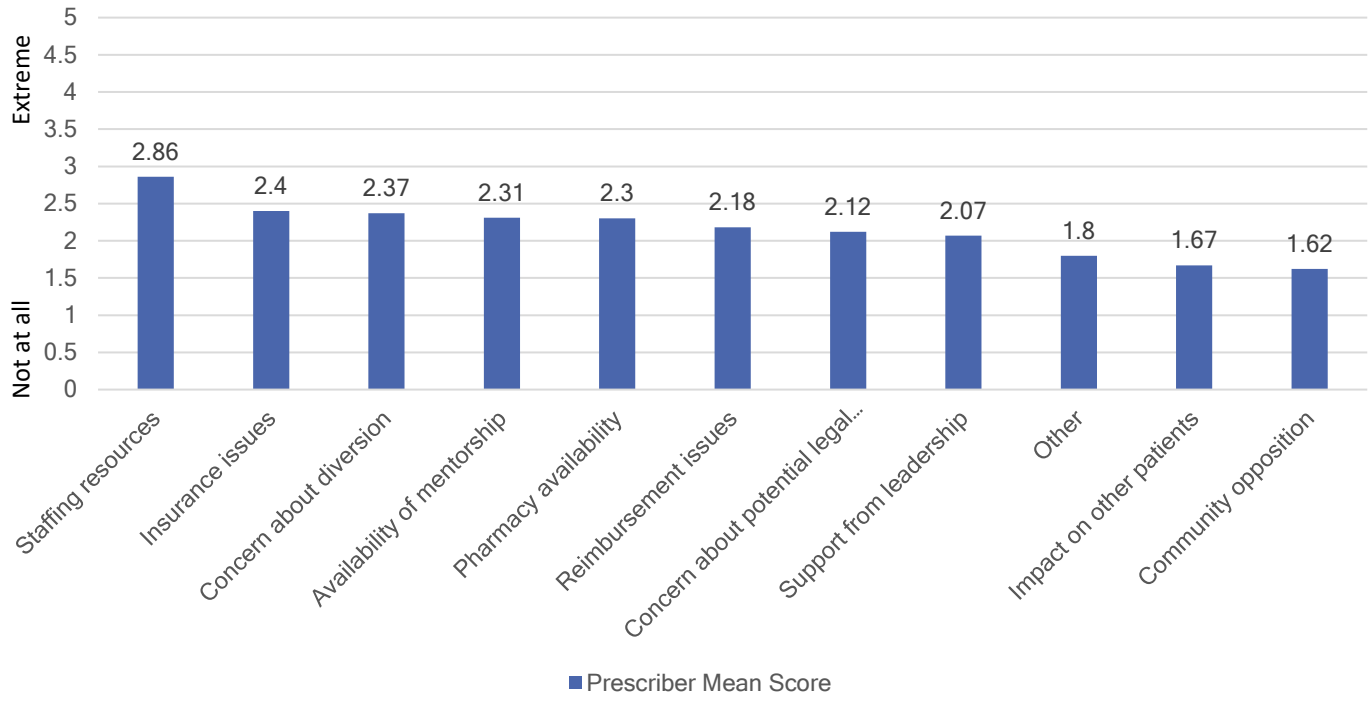
When comparing knowledge and attitudes between active prescribers with 30 vs. 100 patient limits, the prescribers with the 30-patient limit were significantly:

- More likely to find the availability of mentorship to be a barrier (p<.001)
- Less likely to feel they have the mentorship they need (p=.019)
- Less likely to feel confident prescribing buprenorphine (p<.001)
- Less likely to feel confident doing inductions (p<.001)
- More likely to feel patients demonstrating cannabis use should be discharged (p<.007)

BARRIERS

Prescribers ranked a list of barriers to prescribe buprenorphine to patients using a 5-point Likert scale ranging from "Not at all" (1) to "Extremely" (5). Overall, prescribers ranked top barriers to be: "staffing resources" (M=2.86) and "Dealing with insurance issues" (M=2.4). In contrast, prescribers ranked the lowest barriers to be: "Community opposition" (M=1.62) and "Concern about impact on my other patients" (M=1.67).

Figure 5. Barriers to prescribing – mean ratings, overall (weighted)



Qualitative comments describing "*other barriers*" and additional comments were grouped and listed below:

Stigma (community, law enforcement, other providers/staff):

- "12 Step Dogma"
- "County Jail doesn't do Suboxone, and homeless patients frequently get their suboxone confiscated by police for not having the original packaging"
- "Hard to overcome law enforcement's idea that it is substitution of one drug for another…"
- "Need more interested providers and non-judgmental staff"

- “Supportive staff and support from current organization”
- “Not enough SLE homes that accept Buprenorphine”

Patient resistance:

- “Patient resistance due to mythology or incorrect information”
- “Patient resistance to change from opiates is truly the greatest obstacle in my practice. When they consent and it works things go better.”
- “Patient awareness of availability of treatment and patient desire for treatment”
- “Pt unwillingness to engage in behavioral treatments concordant with MAT (to address core causes of OUD)”

Prescribing knowledge:

- “Variance in team or colleague prescription philosophy”
- “Early refills--how to handle”
- “Experience with induction”
- “Scheduling new patients quickly”

Co-occurring substance use:

- “Concomitant benzodiazepine use”
- “Controlled substance agreements; yay or nay?”
- “What to do if people are using other substances but not opioids when taking Suboxone, should they be discharaged or not?”
- “People addicted to both opioids and Methamphetamine”

Referral resources for long-term treatment, detox, MH services:

- “Availability of outpatient prescribers”
- “Access to follow up after initiation”
- “Finding a provider to continue with MAT”
- “Access to detox services is limited for patients with concurrent OUD and other use disorders when higher level of care indicated (before entry to residential programs)”
- “Inadequate resources for severe mental health diagnoses not appropriate for residential programs.

Pharmacies:

- “Adversarial pharmacists- this is huge!!! Immense amount of time obtaining PARs”
- “Pharmacies limited by population size to have only so much Bup allowed”
- “[Getting] Sublocade long acting injections is a hassle.”

Financial barriers for patients:

- "Cost of drug makes it inhibitory for some patients"
- "Suboxone film is now generic and my patients paying for it out of pocket saw the cost double."
- "The pharmaceutical cost [of] the buprenorphine is the largest barrier to treatment"

Reimbursement issues:

- "Conflicts with coverage, when they cannot afford the interdisciplinary team for cognitive behavioral, PTSD, adjunctive team support, acupuncture, massage, exercise etc. Just substituting suboxone won't treat their OUD, and I can't do the rest alone, I can't even get paid for the time it takes for induction and followup."

Insurance issues:

- "Insurance company prior authorization, limitation on the number of patients I am allowed."
- "Medicare and other insurance is a hassle to get Prior Auths. Partnership/Medicaid is great!"
- "Unable to prescribe for Medi-Cal patients due to my institution's restrictions"

Waiver limit policies:

- "Get rid of x-waiver requirement"
- "Removal of the 30 patient limit for new prescribers
- "Removal of extra barriers for PAs/NPs

Legal concerns/DEA:

- "DEA visits for prescribing Suboxone"
- "I would like DEA or state board to at least visit and critique our program at some point."
- "There is nothing that can be done in training to minimize the attitude of the DEA. The only problem that I see is that any prescription of Buprenorphine increases one's scrutiny to the DEA, and the DEA does not look at Buprenorphine prescribing as a good thing. Since they are the ones that have the power to take away a practice, it does not seem practical at all to start any substantial buprenorphine private practice."

Inactive vs. active prescribers

When comparing inactive to active prescribers, **inactive prescribers** were significantly **more likely** to find the following to be barriers than active prescribers:

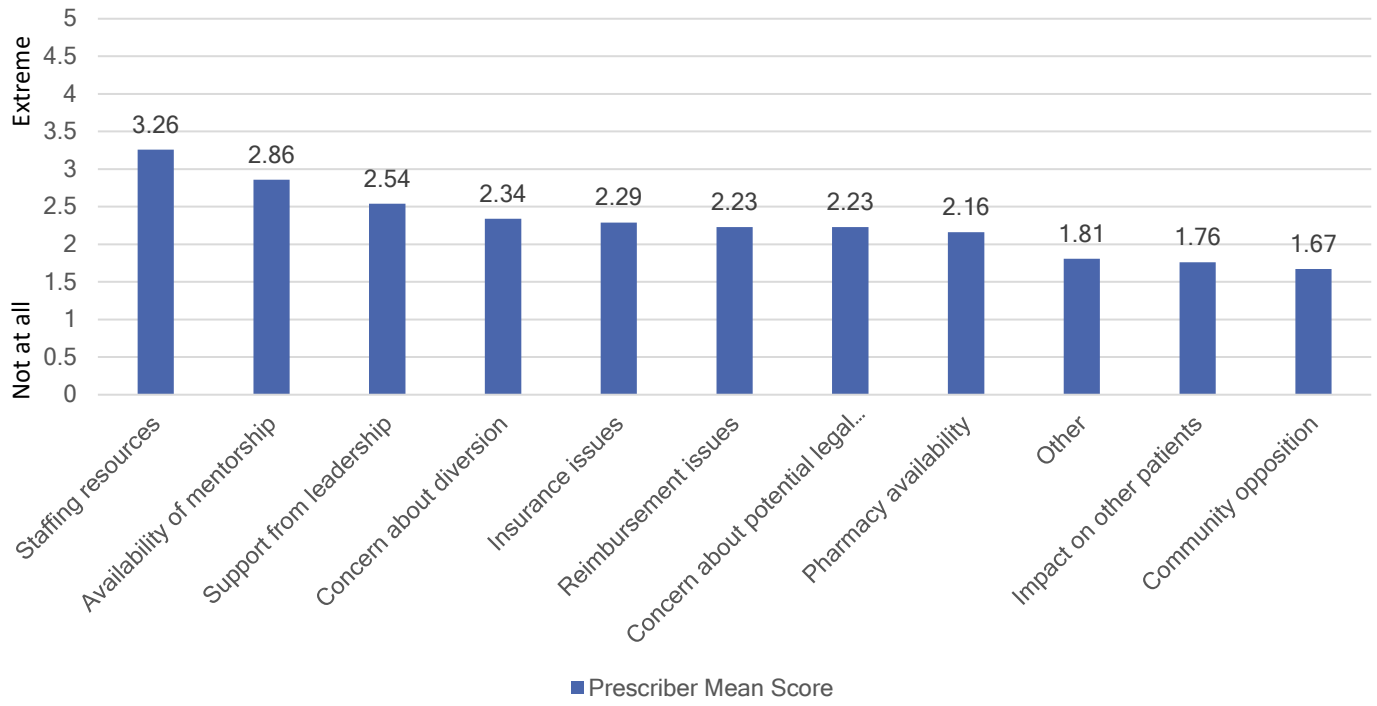
- Staffing resources (e.g., nurses and counselors to help with logistics) (M = 3.26 vs. 2.65 for active prescribers)*
- Availability of mentorship (M = 2.86 vs. 2.02)*
- Support from leadership within my organization (M = 2.54 vs. 1.83)*
- Pharmacy availability or pharmacies stocking buprenorphine (M = 2.16 vs. 2.38)**

*p < .001
**p < .05

Among active prescribers, although not significant, they were more likely to find the following to be barriers:

- Insurance issues

Figure 6. Barriers to prescribing – mean ratings, inactive prescribers (weighted)



Among inactive prescribers, the qualitative comments describing "*other barriers*" and additional comments included lack of experience with inductions, concern for DEA visits, minimal patient population seeking MAT, stigma from community, supportive staff and support from current organization.

Active prescribers – low vs high utilization of their waiver

When comparing reports of barriers among prescribers who were under-utilizing their 30-patient waivers, **under-utilizers were more likely** to find the following to be barriers to prescribing than their higher-prescribing counterparts:

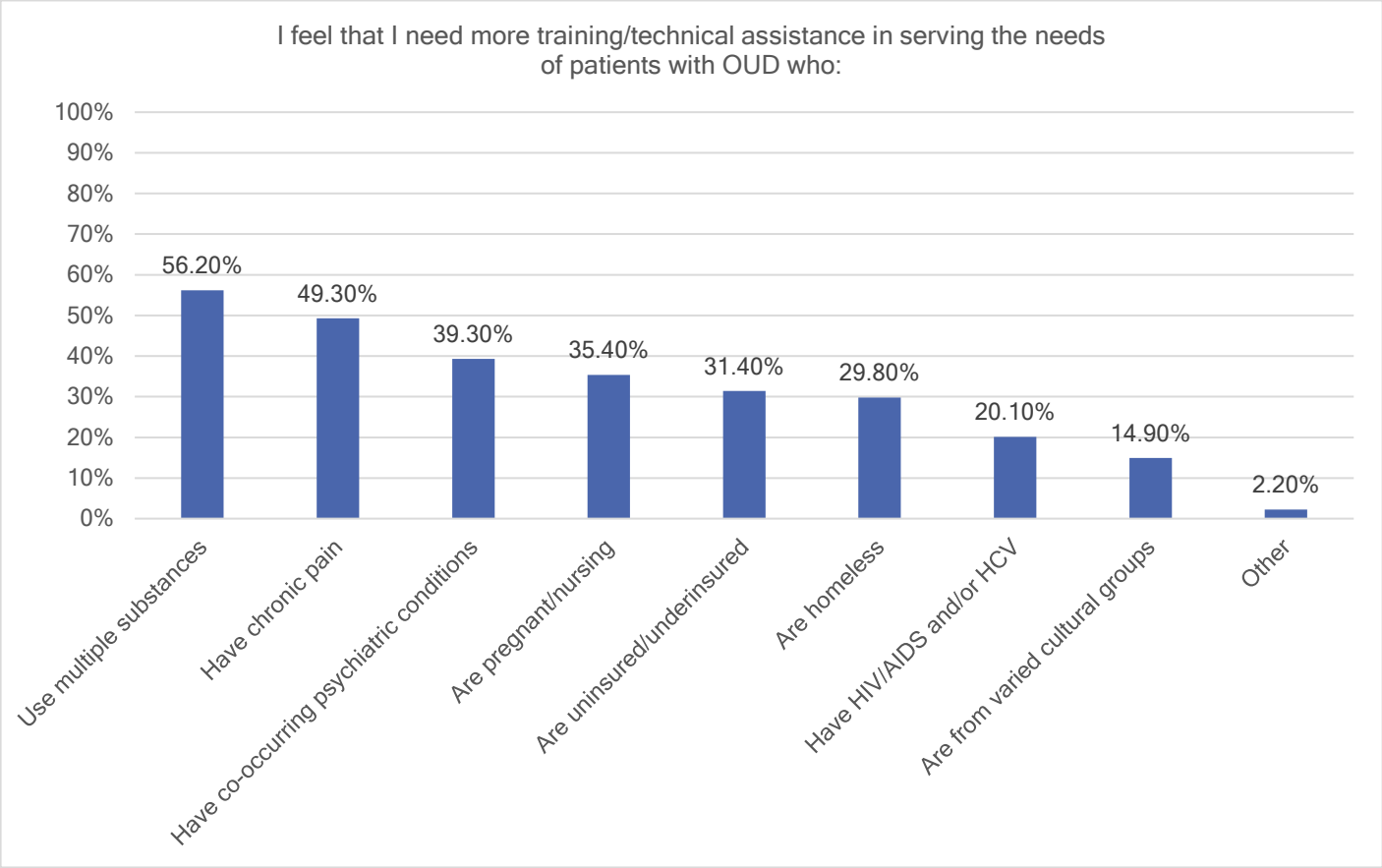
- staffing resources (M = 2.9 vs. 2.5, p = .01)
- dealing with insurance issues (M = 2.2 vs. 2.6, p = .01)

No significant differences were seen between prescriber reports of barriers among those under-utilizing their 100-patient waivers and those prescribing to more than 30 patients.

TRAINING & TECHNICAL ASSISTANCE (TA) NEEDS

Overall, respondents displayed a need for training and technical assistance to address the needs of a variety of patient populations. Of the selected list of options, the top areas of need were for patients who use multiple substances (56.2%) and have chronic pain (49.3%), followed by support for treating patients who have co-occurring psychiatric conditions (39.3%) and are pregnant/nursing (35.4%).

Figure 7. Areas of endorsement for more training



The most commonly reported training topics collected from an open-ended response option included: induction training, addiction training in general, training on Sublocade and/or implants, and long-term buprenorphine and tapering process.

Other types of TA most commonly reported from the open-ended response option included: mentorship (online, in person), where to find referral sources (psychiatric, counseling and outpatient), access to resources (hotline/warmline or online resource lists, including pocket reference guides).

Other training/TA topics mentioned included:

- Best practices trainings
- Identifying patients with opioid use disorder (OUD)
- Chronic relapse
- Cognitive behavioral therapy (CBT) & Motivational Interviewing (MI)
- Contingency management
- Prescribing buprenorphine for patients on methadone, other opioids
- Managing withdrawal
- Managing buprenorphine at time of surgery
- More information about risks and diversion
- Addressing stigma in the community/families
- Trainings for organizational leadership
- Training for nursing/support staff
- Training specific to Physician Assistants (PAs)
- VA-specific training
- Adolescent populations
- Understanding billing
- Regional trainings on insurance issues
- Maintaining records for DEA purposes

Limitations

Although, the survey sample was weighted to statistically correct for higher response rates among high waiver-limit prescribers, it is possible that additional uncorrected bias existed within waiver-limit groups. For example, within the 30-limit group, it is likely that more enthusiastic prescribers participated in the survey. This type of bias could not be statistically corrected. Additionally, given the high income level of this population, the financial incentives offered to participants may have been insufficient. The payment amounts were limited by SAMHSA guidelines in this study, but stronger incentives are recommended for future studies.

Summary and Conclusions

The UCLA team developed and deployed an online survey targeting California DATA 2000 waivered prescribers to identify why prescribers are NOT prescribing buprenorphine at all and/or to the full limits of their waiver. To further understand the barriers and training needs, UCLA also conducted qualitative interviews on a randomly selected subsample of those who completed the survey and volunteered to be interviewed.

The survey findings indicate that one-third (33%) of the waivered prescribers in this sample were inactive without any patients on their caseloads. There were more inactive prescribers with 30-patient waiver limit than 100-patient and 275-patient waiver limits (38.4% compared to 15.7% and 10.4%, respectively). In addition, of those that were actively prescribing, over half of the prescribers in both the 30-patient and 100-patient waiver limits were under-utilizing their waiver (54.4% and 56.8%, respectively). This data demonstrate that there is a lot of room for increased capacity among prescribers to treat more patients in California.

Inactive prescribers and prescribers underutilizing their waiver are significantly less confident to prescribe buprenorphine in general as well as to do buprenorphine inductions. They do not feel like they have the adequate mentorship needed which is a significant barrier to increase their prescribing activity. Additional education is needed to address knowledge and attitudes about managing co-occurring drug use and the importance of retaining patients in treatment and on MAT.

Staffing resources seems to be a consistent barrier to increase prescribing practices which will be further explored in qualitative interviews to assess specific type of support needed. However for those inactive and underutilizing their waiver, adequate mentorship and support from organizational leadership rose to the top as most common barriers.

The interviews with 20 California waivered practitioners documented a range of opinions and recommendations for strategies to promote and support use of buprenorphine for opioid use disorder in primary care settings. Among the most frequently mentioned activities are the development of a handbook or set of policies and procedures for use of buprenorphine in primary care; assistance with insurance issues; and providing more training to primary care docs about screening for opioid use disorder and promoting treatment.

Based on these findings, UCLA is developing a training and technical assistance plan to address these barriers and provide the support needed to increase prescriber skills to deliver MAT services. To start, UCLA has prioritized the following training topics to deliver as part of this project:

- Induction – covering clinical processes related to "quick buprenorphine starts" with the emphasis on minimizing fears of the practice in all settings, including home inductions.
- Overarching education about the need to treat opioid use as an emergency
- Addressing legal concerns from DEA and 42 CFR, Part 2 regulations
- Treating patients struggling with pain and opioid use disorder
- Treating pregnant patients with OUD
- Addiction 101 – addressing addiction as a chronic relapsing disease
- MAT Basics – review of medicines and how to talk about MAT
- More to be added

Each of these topics will be delivered as an online webinar that will be recorded and archived for self-paced viewing and ongoing access. Whether attendees participate live or self-paced, continuing medical education (CME) will be made available as much as possible. Length of trainings/information sessions will be kept as short and "bite-sized" as possible to accommodate the competing schedules of prescribers. We intend to build a resource catalogue to support the training topics and create other fact sheets addressing other areas that don't require a full training. The intent is to make accessible quick reference sheets for ongoing technical assistance. In addition to the online training support, prescribers have the option as well to submit requests for direct technical assistance. UCLA will respond to each request and connect the prescriber with an experienced buprenorphine prescriber (peer-to-peer) throughout California to access direct consultation. Services offered may include direct mentorship by phone or video, on-site or off-site TA (e.g., program/provider visits, prescriber shadowing), and in-person or virtual training activities related to treating patients with OUD.

APPENDIX A: TRAINING NEEDS SURVEY QUESTIONS

California Statewide Waivered Prescriber Survey

Please fill out this brief survey to the best of your ability. It should take you no longer than 5-7 minutes to complete. We are offering a $10 electronic gift card to anyone who completes the brief survey. In addition, you can be entered into a drawing to win an 256GB iPad Mini. Once you end the survey, you will be given the opportunity to provide your name and email so we know where to send the e-gift card. We will not use this information for any other purpose. Note: the electronic gift cards may take several weeks to arrive in your inbox.

We thank you in advance for helping us to facilitate increased access to treatment for people suffering from an opioid use disorder.

- UCLA Integrated Substance Abuse Programs SOR Waivered Prescriber Support Team

Note: entry into this drawing for the prize of the iPad Mini does not require completion of this survey. Email cfrable@mednet.ucla.edu if you would like to be entered without completing the survey. UCLA staff are not eligible for this drawing.

1) Position / Title

2) Professional license / certification title

3) Professional specialization (if applicable)

4) When did you obtain your waiver to prescribe buprenorphine (MM/YYYY) ?

5) How many patients are on your current buprenorphine caseload? (if you are unsure, please estimate in numbers)

6) What is your current SAMHSA-approved patient limit?

- ○ 30 patients
- ○ 100 patients
- ○ 275 patients
- ○ Don't know

You have indicated that your prescribing limit is 30 patients. Which of the statements below apply to your plans to increase your prescribing limit? (check all that apply)

- ☐ I am not currently prescribing buprenorphine.

- [ ] I am still in my first year of prescribing and am not eligible to increase my limit yet.
- [ ] There is not a big enough patient population at my program/clinic/practice for me to increase my patient limit.
- [ ] I don't want to prescribe to more patients. Please explain why.

  _____
- [ ] I did not know I could apply to increase my limit.
- [ ] I am prescribing at my maximum patient limit, and am in the process of increasing my prescribing limit.
- [ ] _____ Other (please describe):

You have indicated that your prescribing limit is 100 patients. Which of the statements below apply to your plans to increase your prescribing limit? (check all that apply)

- [ ] I am not currently prescribing buprenorphine.
- [ ] There is not a big enough patient population at my program/clinic/practice for me to increase my patient limit.
- [ ] I don't want to prescribe to more patients. Please explain why.

  _____
- [ ] I did not know I could apply to increase my limit.
- [ ] I am prescribing at my maximum patient limit, and am in the process of increasing my prescribing limit.
- [ ] _____ Other (please describe):

7) What is the zip code where you most often prescribe buprenorphine ?

8) Which category best describes the primary service setting where you most often prescribe buprenorphine? (Select one)

- ○ Hospital or Emergency Department
- ○ Alcohol/drug treatment program
- ○ Primary care clinic (e.g. FQHC, community health clinic, or county-operated clinic)
- ○ Private practice
- ○ Mental/behavioral health center
- ○ Telehealth program
- ○ Other (please specify)

9) I provide the following types of services to patients taking buprenorphine (check all that apply):

- ☐ Buprenorphine office-based induction

- [ ] Buprenorphine home induction
- [ ] Buprenorphine maintenance
- [ ] Detox with buprenorphine taper
- [ ] Extended-release naltrexone (for those completing detox)
- [ ] Other (please specify)
- [ ] None

10) Please indicate how you feel about the following statements.
If you don't know, select the "DK" option.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree	DK
A. I feel confident prescribing buprenorphine.	○	○	○	○	○	○
B. I feel confident doing patient inductions on buprenorphine.	○	○	○	○	○	○
C. I have the mentorship I need to effectively treat patients with opioid use disorders.	○	○	○	○	○	○

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree	DK
D. Patients demonstrating ongoing opioid use should be discharged from treatment.	○	○	○	○	○	○
E. Patients demonstrating ongoing cannabis/marijuana use should be discharged from treatment.	○	○	○	○	○	○
F. Patients demonstrating ongoing stimulant use should be discharged from treatment.	○	○	○	○	○	○
G. Most patients should be tapered off buprenorphine as soon as possible.	○	○	○	○	○	○
H. Retaining OUD patients in treatment is one of my top priorities.	○	○	○	○	○	○

11) Please elaborate on your responses to any of the statements above. (Optional)

12) To what extent do you find each of the following to be a barrier to prescribing burenorphine to patients?

	Not at all	Slight	Moderate	Considerable	Extreme
A. Staffing resources (e.g.: nurses and counselors to help with logistics)	○	○	○	○	○
B. Reimbursement Issues	○	○	○	○	○
C. Availability of mentorship	○	○	○	○	○
D. Concern about potential legal consequences	○	○	○	○	○
E. Pharmacy availability or pharmacies stocking buprenorphine	○	○	○	○	○
F. Support from leadership within my organization	○	○	○	○	○
G. Concern about impact on my other patients	○	○	○	○	○
H. Dealing with insurance issues	○	○	○	○	○
I. Concern about diversion (e.g.: patient selling buprenorphine)	○	○	○	○	○
J. Community Opposition	○	○	○	○	○
K. Other (please describe):	○	○	○	○	○

Training and TA Needs

13) I feel that I need more training or technical assistance in serving the needs of patients with opioid use disorders who: (check all that apply)

- [ ] Are uninsured/underinsured
- [ ] Are homeless
- [ ] Have chronic pain
- [ ] Are pregnant/nursing
- [ ] Have co-occurring psychiatric conditions
- [ ] Use multiple substances (e.g. benzodiazepines, stimulant, other CNS depressants)
- [ ] Have HIV/AIDS and/or HCV
- [ ] Are from varied cultural groups
- [ ] Other (please specify): _____
- [ ] None of the above

14) Are there any other types of training or technical assistance that would help you be comfortable in offering buprenorphine to more patients? (please describe)

15) What is the most convenient time for you to attend a webinar, mentoring call, or online training? (Check all that apply)

- [ ] 8am
- [ ] 12pm
- [ ] 4pm
- [ ] Other (please specify)

16) How likely are you to attend a training with the following formats and time commitments?

	Not at all	Possibly	Very Likely
Webinar - 1 hour	○	○	○
Webinar with case review - 2 hours	○	○	○
Face to face half day	○	○	○
Face to face full day	○	○	○

17) Would you be interested in providing peer support to other DATA 2000 waivered providers (e.g., be available by phone or email for questions, allow a physician to shadow you for a day, or otherwise help them increase their comfort level to prescribe)?

- ○ Yes
- ○ No

Please enter your name and best contact information.*

**By providing your name/contact info here, the UCLA project team will be able to view your survey responses.*

18) Would you be willing to have a brief follow up discussion to further inform the UCLA project team on the practice barriers of prescribing buprenorphine to OUD patients?

- ○ Yes
- ○ No, I'm not interested

Please enter your name and best contact information.*

**By providing your name/contact info here, the UCLA project team will be able to view your survey responses.*

Demographics

19) Gender (choose all that apply)

- [ ] Male
- [ ] Female
- [ ] Non-binary
- [ ] Prefer to self-describe:

20) Race/Ethnicity (choose all that apply)

- ○ American Indian or Alaska Native
- ○ Asian
- ○ Pacific Islander

- ○ Hispanic or Latinx
- ○ Black or African American
- ○ Middle Eastern or Arab American
- ○ White or Caucasian
- ○ [ ] Prefer to self-describe:
- ○ Pefer not to say

Waivered Prescriber Support Initiative:
Qualitative Interviews with California Prescribers

Summary of Activities and Results

Data Collection Activities: From August 15 to September 15, 2019, 20 California DATA 2000 waivered prescribers were interviewed about a number of issues concerning the treatment of opioid use disorders (OUD) in their practices. Questions were driven from the issues that surfaced from the UCLA Training Needs Survey conducted between April 2019 and June 2019. Participants were a convenience sample of 20 prescribers randomly selected from a group of 68 prescribers who had completed the UCLA written survey (Training Needs Survey) and agreed to do a follow up call interview. All interviews were conducted by UCLA project team, Richard Rawson or Christine Morgan. No compensation was provided for the interviews.

Interview Guide Questions:

1. Could the practice where you are working treat more patients with buprenorphine (bup) if you could make some changes in your organizations practices?

   If yes, what kind of changes? (e.g.: more prescribers, more support staff, more training, more reimbursement)

2. Are there some clinical issues regarding the use of bup to treat patients with OUD that would allow you to prescribe to more patients?

   If yes, what are these clinical issues (help with induction, treatment of non-opioid SUD, more staff support, more psychiatric illness specialists, etc.

3. If you could have all the staff support you needed to be able to deliver help to a larger number of patients what kind of staff support do you need?

4. Have you ever worked with a bup mentor or experienced a prescriber who helped you?

   If yes, describe how they helped you.
   If no would it be useful to you now? How so?

5. Do you consider your use of buprenorphine primarily as a method to "promote recovery" (rehabilitation) or to prevent overdose (harm reduction)?

6. How do you currently think about the optimal duration of bup treatment?

7. In what ways would you like to get additional support/training using bup?

8. If you were in charge of a statewide effort to expand the use of medication treatment for OUD, what would you do? How would you get more prescribers to take on more patients?

9. Other comments or thoughts on this topic or about your experience prescribing buprenorphine?

Results:

Participants: Seventeen waivered physicians and 3 Physician Assistants were interviewed. The waivered prescribers (or potential prescribers) worked in a variety of settings. Among the specific settings were: Kaiser Behavioral Health Unit; Addiction specialty clinics; Emergency Departments; Hospital-affiliated primary care practices; Urgent Care; Spine specialty clinic and FQHCs. Medical specialty/setting: 14 were working in primary care; 2 in addiction specialty care; 2 in pain clinics, 1 urgent care, and 1 in ED.

Buprenorphine prescribing: Participants included practioners who had never prescribed buprenorphine, those with small and moderate buprenorphine caseloads and practioners with large caseloads working near the top of their waivered capacity.

Prescriber caseloads: Eight prescribers had no current case load of patients; 6 had one or more, but fewer than 10 patients; 2 had 11-30 patients; 4 had over 30 patients.

Responses to Questions:

Q1: *Could the practice where you are working treat more patients with buprenorphine if you could make some changes in your organizations practices? ____If yes, what kind of changes? (e.g.: more prescribers, more support staff, more training, more reimbursement).*

Participants responded noting 5 theme areas cited by more than one participant. Theme areas for increasing buprenorphine patient census included:

- More logistical support….. More staff to help with patient scheduling, case management, referrals, getting insurance clearance, urine testing.

- More awareness of OUD and the availability of bup treatment among other practioners in the clinical setting.

- More insurance coverage for patients.

- More waivered practioners in the practice.

- Having written policies and procedures and/or a "handbook" for operating a buprenorphine practice within a primary care setting.

In addition to these themes cited by more than one practioner, it was also noted that it would be helpful to have a buprenorphine champion, more support from the organization and community education to promote recruitment and reduce community opposition.

One participant said the funding from the H&S project had allowed his organization to hire people to provide logistical support and that this had made a huge difference in his view of treating OUD in primary care:

> …..“The organization also deals with the insurance companies and pharmacies. I love what I do now. This is the first time it's clicked for me and I see the benefit of this medication. I had always been reluctant to treat these patients in my practice. It seemed like too many hassles, By the way, nobody wants to do this”

This physician now is a champion because he does not have to worry about the finances and he has all the resources he needs so he can just be the doctor.

Q2: *Are there some clinical issues regarding the use of bup to treat patients with OUD that would allow you to prescribe to more patients? if yes, what are these clinical issues(help with induction, treatment of non-opioid SUD, more training in counseling methods, more staff support, more psychiatric illness specialists, etc.,*

Participants had relatively few specific suggestions on clinical training. Three participants felt more training in CBT, DBT, MI and other behavioral tools could be useful, and three asked for training in how to address stimulant and benzo use. Other topics included, basic training in OUD and its treatment and methods to reduce stigma among staff.

However, the majority of training requests concerned better training of front office, administrative and billing staff. Logistical issues outweighed clinical issues as perceived training needs.

Q3: *If you could have all the staff support you needed to be able to deliver help to a larger number of patients what kind of staff support do you need?*

Participants noted 3 theme areas including:

- More administrative staff to assist with insurance approvals, billing, patient flow and patient scheduling.
- More behavioral counseling support staff for counseling and case management
- More professional mental health staffing including psychiatrist coverage, clinical social workers and general mental health support.

The last issue, psychiatric and mental health services was noted by 9 of the 20 participants. Many practioners felt that the prescribing of buprenorphine was extremely valuable to patients and for many, was sufficient to achieve good outcomes. However, there was a clearly a widely held view that many patients needed more sophisticated mental health care to address significant psychiatric illness among patients.

Q4: *Have you ever worked with a Bup mentor or experienced a prescriber who helped you? If yes, describe how they helped you. If no would it be useful to you now? How so?*

Eleven of the 12 participants who are now prescribing reported that they had worked with someone as a mentor and they felt it was a critical aspect to their use of buprenorphine. Four participants are now serving as mentors for new prescribers. Of the 8 participants who are not prescribing, none had the opportunity to work with a mentor. From the answers to this question, it does appear that having a mentor is virtually an essential part of developing a bup prescriber. As one participant said:

> "Bup champions are an important part of the puzzle. The idea of prescribing bup is a hurdle so doctors resist doing it, so mentorship is critically important"

Q5: *Do you consider your use of buprenorphine as primary as a method to "promote recovery" (rehabilitation) or to prevent overdose (harm reduction)?*

Participants all acknowledged the importance of both perspectives, but recognized that at the present time, 14 of 20 saw overdose prevention as their most critical priority. Several opinions included:

"Emphasis on recovery is optimal, but with certain patients with persistent OUD, overdose prevention is an excellent strategy."

"Ideally bup should be part of a comprehensive plan of care that includes all the elements-behavioral, medical and integrated. But realistically 80% of the time it's to get them Bup-to get them the fix-for harm reduction. The reality is they don't have access to all the supports that should be part of that care. "

Q6: *How do you currently think about the optimal duration of bup treatment?*

16 of 20 participants stated that the decision for duration of treatment on medications for opioid use disorder should be individualized, with no limit to treatment duration. 4 prescribers stated that there should be an attempt after 1-2 years to encourage patients to taper off medication. Several opinions included:

"Let's get you sober for 12-18 months w/ bup. This gives you time to get finances, relationships, living situation stable-then we can talk about a possible taper"

"Wherever they are; whatever they need. It could be for a lifetime "

"One year minimum, and as long as they will take the medication - no limit"

Q7: *In what ways would like to get additional support/training using bup?*

Eight of 20 participants reported that they felt organizations could use some kind of "handbook" or "protocols" describing how MAT treatment can be implemented within a primary care practice. There was good agreement that waiver training and mentoring activities have provided an excellent foundation on the basics of buprenorphine treatment. However, it is far less clear how the overall patient management and other, non-medication aspects of care should be managed. Other suggestions (4) focused on help with insurance issues, including a website for understanding key aspects of insurance treatment. An opinion:

"We really need an outline of policies and procedures for organizations- a packet for how to do all the aspects of bup treatment. Organizations are scared that we don't know how to efficiently deliver care."

Q8: *If you were in charge of a statewide effort to expand the use of medication treatment for OUD, what would you do? How would you get more prescribers to take on more patients?*

Participants comments emphasized 3 themes:

- Provide incentives to organizations and doctors for providing treatment in primary care settings (6)

- Provide more technical assistance on insurance eligibility and insurance approvals and insurance billings (6)

- Provide assistance in reducing intimidation by DEA regarding providing of buprenorphine (4)

In addition, there were suggestions: to increase community awareness of the benefits of treatment, specifically medications for opioid use disorders; more training among primary care practioners on the identification of OUD and promotion of treatment in primary care.

Q9: *Other comments or thoughts on this topic or about your experience prescribing buprenorphine?*

Among these open-ended suggestions were:

- "Getting through the initial hurdle is the hardest part"

- "When patients fall off MAT, they end up in the ER-need to have MOUD [medications for opioid use disorder] services there."

- "Patient cooperation isn't the problem. They understand the chronic nature and most are willing to be on medication. The challenge is once I spend all the time to do this - I get turned down by insurance."

- "Now that I am working with all the supports I need this is the first time that it has really clicked for me. I've done a 180 in my thinking about treating patients with OUD"

- "I find that patients with OUD will titrate the dose for you. They know how much they need and I've learned to trust them."

- "Current pain management doctors are not incentivized for treating OUD"

- "Cost of Bup is a problem - "I can prescribe it but there are those who can't pay for it. I believe there should be a public subsidy for this medication."

Conclusions:

The interviews with 20 California waivered practitioners documented a range of opinions and recommendations for strategies to promote and support use of buprenorphine for opioid use disorder in primary care settings. Among the most frequently mentioned activities are the development of a handbook or set of policies and procedures for use of buprenorphine in primary care; assistance with insurance issues; and providing more training to primary care docs about screening for opioid use disorder and promoting treatment.