Medication-Assisted Treatment (MAT) Providers Survey

Background:

As with other populations within the US, the opioid epidemic continues to pose a public health challenge for American Indian and Alaska Native communities.(CDC, Stanley, Stanley) Overdose deaths (OD) among AI/ANs follow similar trends to those of the general population of the United States, where the rate of opioid-overdose deaths (OD) has quadrupled since 1999. AI/AN OD mortality rates have risen to an average of 8 deaths per 100,000 (second only to Whites at 12/100,000 deaths). (CDC) although specific tribal data is scarce, ODs among AI/ANs vary substantially by state, reaching as high as 26 deaths per 100,000 in Minnesota. (Momper, Venner). This elevated mortality is likely linked to non-medical use of prescription drugs among AI/AN and, presumably, an increase in synthetic opioid use as well. (Momper, SAMSHA) Other factors involved include high rates of alcohol and substance use disorders in AI/ANs (CDC), historical cultural trauma, high rates of poverty and mental illness (Beals), and limited access to high-quality care. (Novins 1)

Currently three medications for the treatment of opioid use disorder (OUD) are available: methadone, buprenorphine/naloxone, and naltrexone. (SAMHSA 2018) When taken appropriately, medication-assisted treatment (MAT) is highly effective and produces superior abstinence, treatment retention, and treatment outcome measures compared relative to classic abstinence and psychosocial therapies. (Venner, Connery 2015, Mattick 2003) Buprenorphine/naloxone, a partial opioid agonist, is of particular appeal in the clinical setting given its low abuse potential. (SAMHSA)

Although there is currently a paucity of published data on outcomes from MAT in AI/ANs in the United States to date, some data exists to suggest the successful treatment outcomes seen in other populations with OUD may be applicable to AI/ANs. One randomized-control study showed that using naltrexone with sertraline in Alaskan Natives with alcohol use disorder was feasible in rural settings and effective for this population. (O'Malley) However, outcome data for use of MAT AI/ANs otherwise remains scarce.

Likewise, there do appear to be many barriers toward widespread MAT implementation in Indian Country. Of the 192 substance abuse treatment programs serving AI/ANs responding to a 2017 survey, only 28% reported implementing MAT. (Rieckmann) This is much lower than in programs treating the general population (>50%). (Abraham, NSSATS) The main predictor of MAT implementation in AI/AN facilities included whether or not MAT was consistent with the treatment approach and philosophy of the program. (Novins 2) Staff expertise and training in MAT was also highly predictive of MAT uptake by AI/AN facilities. (Novins 2) Again, a lack of qualitative data limits our current appreciation of the scope of the current barriers to MAT that exist in facilities servicing AI/AN populations.

Several studies have looked at provider-perceived barriers to MAT uptake in health care facilities outside of Indian Country. Common logistical and/or institutional barriers perceived by providers included: concerns about laboratory tests/induction logistics, lack of institutional support for MAT, resistance among practice partners to MAT uptake, limited counseling service availability, limited nursing and office support, limited addiction specialty support, and state restrictions on MAT.(Abright, Kissin, Hutchinson, Gordon) Common patient-specific barriers include: stigma of treating SUD patients, concern about attracting more SUD patients, concern about patients selling and/or abuse their MAT prescription, perceived need to be available to patient "around the clock" for SUD populations on MAT. Provider-specific barriers included concerns about attracting more SUD patients, lack of confidence in the provider's ability to manage addiction, and prior experience with methadone-maintenance prescribing. (Kernack) Provider characteristics associated with prescribing MAT included: working in a specialty other than psychiatry, solo practitioners, working in a specialty clinic, practice duration of greater than 5 years, and no prior experience with prescribing methadone maintenance therapy.

Institutional characteristics associated with MAT prescribing included: sufficient nursing demand, sufficient institutional support, Medicaid-insured clinics, and permissive home-induction policies. (All + Walley) Measures described by provider as likely to facilitate MAT prescription included: incorporating the presence of a "champion" to change the facility's culture regarding MAT, enhancing provider training in MAT, pilot testing MAT programs prior to widespread implementation and adequate time for MAT implementation, easing pharmacy requirements for prescribing MAT within a system, availability of local telemedicine access to specialists, sufficient nursing services, and prevention strategies for buprenorphine diversion.(all)

While it is likely that many of these same barriers present obstacles to MAT implementation in tribal clinics and IHS facilities, the extent and significance to which they do so is unclear. A better appreciation of these barriers may help to better optimize programming committed to tackling the opioid epidemic as it relates to AI/ANs.

Purpose of survey: The survey will assess current availability of medication-assisted treatment (MAT) within IHS facilities servicing AI/ANs and seeks to determine provider-perceived barriers that may be preventing a more widespread uptake and utilization of MAT within IHS.

Intended audience: All IHS Providers identified as having the potential to implement a MAT program will be considered eligible, and will be emailed the survey based on a randomized process.

Modality of survey administration: The survey will be administered via email containing a hyperlink using SurveyMonkey.® Respondents will be contacted 3 times by email to complete the survey. Responses will be anonymous by provider.

Proposed administration dates: April 2019

Copy of survey: A hard copy of the survey questions and available responses can be found at [Insert location if applicable].

Plan to disseminate survey to your target respondent group: The survey will be submitted by hard copy for review of content by leadership at the IHS Office of Clinical and Preventive Services (OCPS) in the first week of March 2019. After subsequent revisions (as necessary) the survey will be submitted to appropriate parties for review at IHS, including the Privacy Act Office. This will also include a Third Party Website Assessment to ensure the survey, its delivery vehicle, and responses are compliant with HIS and HHS mandated guidelines. After approval for dissemination, information regarding the survey and links to electronically accessing it will be emailed to a list serve of target respondents. An anticipated recruitment time of 3 weeks will be appropriated for data collection, with a subsequent reminder email to be sent out sent at the midpoint of this period to facilitate greater participation. After collection results will be generated and prepared for distribution to personnel within IHS and respondents over a two-week period.

Anticipated use of results: : Results of the survey will be distributed within OCPS and to IHS leadership for review. It is the objective of the survey that it be used to assess the current status of MAT within HIS and any policy and/or personnel limitations that may affect achieving goals of reducing OUDs in AI/AN populations over time.

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Survey Instrument:

1. What best describes your facility?
Urban facility
IHS (Federal) facility
Tribal (638) health center/clinic
Other

2. What state do you work in?
Text Box

3. What facility do you work in?
Text

4. Please let us know your licensure
Physician
Advanced Practice Nurse/NP
Physician Assistant
Pharmacist
Registered Nurse
Social Worker/Counselor
Other (please specify)

5. What best describes the clinical setting in which you primarily work?
Primary Care clinic
Hospital/Inpatient services
Emergency room/urgent care
Dental
Behavioral Health
Addiction and Substance Use Program
Opioid Treatment Program
Other (please specify)

6. Is opioid use disorder (OUD) is a significant health problem for the community you serve?
Not sure
Not a big issue—we don't see much of it
Somewhat of an issue—definitely present, but not too much
Significant issue—affecting a notable proportion of our patients
Other drugs are more of an issue in our community Please specify drug

7. Does your facility have an Interdisciplinary Pain Team?
No
Yes
Not sure

8. Does your facility offer non-pharmacological interventions for pain (e.g., acupuncture, massage, physical therapy, etc.)?
No

Yes (Select all that apply)
- Cognitive therapy
- Acupuncture/TENS
- Physical Therapy
- Massage therapy
- Traditional Medicine
- Other

Not sure

9. Is Medication Assisted Therapy (MAT) for opioid use disorder available for your patients? (if no or N/A, skip to question 11)
Not sure
Not available in our area
Yes, MAT is available in a nearby facility (within 30 minutes)
Yes, MAT is available in our facility

10.
Can you estimated how many patients in your facility are currently enrolled/referred in MAT Services? _number buckets____
Can you estimate the wait time (in weeks) to enroll/refer new patients? Number buckets_____
I am unable to estimate these numbers

11. What types of MAT-related services are utilized at your facility? (Select all that apply)
Not sure
Office-based MAT induction
ER-based MAT induction
Home-based MAT induction in certain candidates
Coordinated MAT care (RN, pharmacist, behavioral health, physician/APP are all involved)
Behavioral health (peer support, MSW, ADC, group meetings)
After-hours support for patients
Counseling
Needle exchanges
Pre-exposure prophylaxis for HIV (PrEP)
Naloxone
None

12. Which medications that are administered as part of MAT services at the site? (Check all that apply)
Methadone (e.g. Methadose® , Dolophine®)
Dual buprenorphine/naloxone products (e.g. Suboxone® , Zubsolv®)
Single buprenorphine products (e.g. Buprenex® , Sublocade®)
Naltrexone products (e.g. Vivitrol®)
Naloxone products (e.g. Narcan®)
Not sure

13. Do you personally have a DATA Waiver from the DEA for prescribing MAT?
Not applicable to my licensure
I'm not familiar with this term
No, I haven't had the training

I've started but not completed waiver training
I've completed training but am not certified to prescribe MAT
I'm certified but not currently dispensing
I'm certified and I am dispensing MAT

14. What role does medication assisted therapy (MAT) have in *<u>your</u>* practice?
I'm unfamiliar with MAT (Skip to "Are you interested in any of the following")
I'm not interested in MAT *(Skip to "What are your main concerns…?")*
I've considered implementing MAT but "see many pros and cons" (Skip to "what are your main concerns…")
I'm planning on implementing MAT, but I have not done so yet
I've implemented MAT, but it's not a permanent part of the program
MAT is a permanent part of my clinical program

15. MAT uses medication to maintain remission/prevent relapse in those with OUD. Would you be interested in the following?: (Not Interested→Very interested)
Educational information on the in's and out's of MAT.
CME/CE training for guidance on potentially prescribing MAT in your clinic
Greater access to addiction specialists for referring your patients with OIUD
(Skip to Other comments/end of survey question)

16. What are your main concerns with implementing MAT? (Select all that apply)
There isn't much need for MAT at my facility
Nursing shortages limit MAT potential
Behavioral Health/Counselor shortages limit MAT potential
I am not trained to start MAT coverage
There is a limited addiction specialist support at my facility
Competing priorities exist in our facility
Lab testing (Urine drug screens) and logistics are difficult
There are too many time constraints in clinic
I'd need to be available "around the clock" for patients on MAT
I don't want to attract more patients with OUD into my practice
I feel this replaces one form of addiction with another.
Other (Specify)
(Skip to Other comments/end of survey question)

17. How would you describe your experiences with MAT in your clinic to date? (Strongly disagree→Strongly agree)
Implementing a MAT program was easy.
MAT has improved recovery rates among my patients with OUD
Diversion/compliance is not a problem after my patients start MAT
I have access to addiction specialists when I need it.
COMMENTS

18. What would be most helpful toward starting/expanding MAT in your facility? (Likert scale Not helpful→ Most helpful)
Greater administrative/directorship support for MAT in clinic
Increasing nursing and staff training with MAT

Increasing lab capabilities (e.g., screening)
Increased counseling services
Having greater specialist / tele-specialist access
Developing a home induction protocol
Developing a call system to reduce after-hours burden on providers
Collaborative practice agreement with pharmacy
Improved lab testing policies and logistics
Syringe Services Program ("Needle Exchange")
Greater access to other recovery options
Other
(Skip to Other comments/end of survey question)

19. Other comments? What are your greatest needs/concerns for addressing opioid use disorder in your community at sufficient scale?
Comment

20. Can we contact you to hear more about your program, or offer technical support? If yes, please put contact info:
Free text

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