Medications for Opioid Use Disorder (MOUD): A Quality Improvement Assessment of Treatment Barriers at an Urban Psychiatric Hospital

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NURS 703B: DNP Project Planning

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Abstract

Opioid use disorder (OUD) remains a significant global and national public health crisis, with more than 16 million people affected worldwide and over 81,000 opioid-related deaths reported in the United States in 2022. Although buprenorphine and methadone are evidence-based, first-line treatments that reduce overdose mortality, access remains limited, with only 25% of individuals in need receiving medication-assisted treatment. Prescriber-mediated barriers, such as inadequate training, stigma, misconceptions about medication efficacy, and lack of confidence in prescribing, are among the most modifiable factors influencing treatment access. Evidence supports initiating medication for OUD (MOUD) in inpatient and emergency settings, which improves continuity of care and reduces mortality, yet many qualified prescribers report insufficient knowledge and institutional support. This quality improvement project aims to address these gaps by surveying prescribers at an urban psychiatric hospital to assess attitudes, barriers, and perceptions related to prescribing MOUD, specifically buprenorphine and methadone. Findings will inform targeted interventions to align clinical practice with evidence-based guidelines and improve care for patients with OUD.

Key words: Opioid use disorder (OUD), medications for opioid use disorder (MOUD), prescribing barriers

Introduction

Problem Description

Opioid use disorder (OUD) is characterized by patterns of maladaptive opioid use that result in clinically significant distress or impairment (Volkow & Blanco, 2021). It is estimated that in 2021, the prevalence of OUD was 16,164,876 million people worldwide and 2014.62 per 100,000 in the United States (Wang et al., 2025). The most recent national data for the United States estimates that 81,806 people died of "opioid-involved" overdose deaths in 2022 (Dowell et al., 2024). There has been an inequitable impact on communities of color; while opioid-related overdose deaths decreased among the general population between 2017 and 2022, rates of fatalities increased among Black and Hispanic populations (Faiz et al., 2022).

The three medications currently approved by the United States Food and Drug Administration (US FDA) for treatment of OUD are buprenorphine, methadone, and naltrexone (US Food and Drug Administration [US FDA], 2024). Buprenorphine and methadone are often referred to as the "gold-standard, first-line treatment" for OUD (Passman et al., 2022) and are recommended in clinical practice guidelines published by both the American Society of Addiction Medicine (2020) and Department of Veterans Affairs Department of Defense (2021). Medications like buprenorphine and methadone can significantly mitigate the risk for overdose deaths and overall mortality rates. However, data from 2022 shows that among the 9,367,000 adults in the US who needed treatment, only 25% received the recommended medication assisted treatment (Dowell et al., 2024). A range of barriers to treatment exist, including structural limitations, stigma, inadequate funding, and lack of integration between behavioral health and addiction services (Choi et al., 2023; Calcaterra et al., 2023).

Among the most modifiable barriers are those that are prescriber-mediated, such as insufficient training, discomfort with MOUD prescribing, misconceptions about MOUD efficacy and safety, stigma towards patients with OUD, and negative attitudes towards MOUD (Calcaterra et al., 2023; Shearer et al., 2024). Such attitudes towards MOUD are associated with poorer health outcomes for patients (Pasman et al., 2022). In a study of over 600 mental health prescribers, Pasman et al. (2022) found that perceptions of MOUD effectiveness, particularly regarding methadone, were significantly misaligned with the current evidence base.

Available Knowledge

Initiating MOUD in emergency and inpatient care settings is critical. Patients with OUD who have been hospitalized are at increased risk for fatal overdose (Englander et al., 2024; Weiner et al., 2024). The literature clearly supports this intervention, as MOUD initiation during inpatient hospitalization or emergency care is associated with increased follow-up with outpatient care and overall reduced mortality and morbidity (D'Onfrio et al., 2015; D'Onfrio et al., 2017; Herring et al., 2021). Addressing addiction in hospitalized patients is furthermore associated with overall increased adoption of MOUD across the healthcare system and improved prescriber and patient experiences (Englander et al., 2024). Despite a dramatic increase in opioid-related deaths in the past decade and demonstrated benefit of MOUD initiation (particularly in the inpatient setting), many prescribers who are qualified to manage such medications lack confidence in prescribing them.

Nurse practitioners have cited both inadequate addiction medicine education during training as well as limited access to methadone education as key barriers to prescribing MOUD (Banka-Cullen et al., 2023). Similarly, Titus-Glover et al. (2021) found that inpatient medical residents lacked knowledge of current MOUD guidelines and decision-making frameworks. Banka-Cullen et al. (2023) highlight a need for institutional and practice-level support to assist prescribers in managing OUD treatment effectively.

Unfortunately, education alone does not always result in practice change. While prescriber attitudes towards MOUD have improved over recent decades, negative attitudes and misconceptions persist (Pasman et al., 2022). These challenges are especially pronounced in psychiatric settings, where comorbid mental health conditions complicate treatment practices. Pasman et al. (2022) found that while MOUD education was associated with more positive perceptions of the effectiveness of naltrexone, it was not associated with improved attitudes towards methadone or buprenorphine. This suggests that prescribers may have medication-specific perceptions that are incongruent with current evidence-based practice.

Rationale

This project was guided by the Institute for Healthcare Improvement (IHI)'s Model for Improvement (MFI). A review of literature was completed and identified that prescriber attitudes towards MOUD treatment are varied and can impact patient care. A root cause analysis diagram (Appendix A) was completed and identified that there is no formal understanding of prescriber attitudes towards MOUD at an urban psychiatric hospital. This project seeks to address these factors by collecting data from prescribers at this facility to better understand the barriers to initiating MOUD in the emergency care and inpatient setting. This will be the first step in identifying modifiable factors impacting the prescribing of MOUD treatment specific to this hospital, which will inform the development of specific interventions in future Plan-Do-Study-Act cycles.

Specific Aims

The aim of this project was to gather and analyze survey response data and better understand prescriber attitudes towards MOUD prescribing at an urban psychiatric hospital by January 1st, 2026.

Methods

Context

The setting for this project was a 24-hour behavioral and mental health hospital located in a metropolitan city. The facility serves a diverse population of adults, children, and adolescents experiencing acute mental health crises. It hosts a psychiatric emergency center with substance use disorder services with 44 beds, three adult inpatient units with a total of 85 beds, and one child and adolescent unit with 22 beds. The interdisciplinary team at this facility comprises patient access specialists, licensed clinical social workers (LCSWs), psychiatric mental health nurse practitioners (PMHNPs), psychiatrists, registered nurses, behavioral health assistants (BHAs), and licensed behavioral health therapists. For the purposes of this paper, participants of the survey (psychiatrists and PMHNPs) will collectively be referred to as prescribers. The hospital is affiliated with a local university, contributing to ongoing research, professional training, and evidence-based practice implementation.

In the year prior to initiation of this project, a medical director at the facility designed and delivered a series of three lectures for prescribers, RNs, BHAs, LCSWs, and therapists on MOUD, specifically buprenorphine and methadone, prescribing. The primary objectives of these lectures were to increase foundational knowledge of FDA-approved medications for OUD, explain the pharmacology of methadone and buprenorphine, and outline the protocol for initiating buprenorphine in this setting. These sessions aimed to reduce stigma, enhance clinical confidence, and improve interdisciplinary collaboration around MOUD within this setting. This training was offered to all staff but not mandated, and participating staff were eligible to receive Continuing Education Units (CEUs) or Continuing Medical Education (CMEs). Data on prescriber comfortability with these topics was not collected prior to the lecture series.

Interventions

The intervention for this project was the delivery of a survey to prescribers at this facility that concluded on January 1st, 2026. Two PMHNP doctoral students designed an anonymous survey using the Qualtrics platform. This survey was distributed by email to advance practice nurses and psychiatrists working in a local psychiatric hospital. This survey (Appendix B) was the sole method of data collection and included Likert scale questions, binary questions, as well as one free-text response to provide a combination of quantitative and qualitative data. The survey was voluntary and designed to require a maximum of five minutes to complete, with the intention of mitigating survey fatigue and maximizing potential engagement. The survey was initially distributed to a small test sample of participants who provided feedback on clarity and flow before the survey was sent out to the larger group of participants. The results from this test sample were not included in the final project.

While there are several different medications used for OUD, comfort levels were assessed towards the two most commonly prescribed first-line, FDA approved medications for OUD: methadone and buprenorphine. Prescribers were asked about both sublingual and subcutaneous formulations of buprenorphine. Naltrexone was not assessed in this project for several reasons: Oral naltrexone has been shown to be no more effective than placebo, naltrexone in injectable form has been shown to be inferior to sublingual buprenorphine, and naltrexone in any form requires 7-10 days of opioid cessation prior to initiation, limiting its use in acute inpatient and emergency settings (Harris et al., 2026).

Study of Intervention

The primary outcome of the intervention was the survey response rate.

Measures

The primary outcome measure for this project was the information gathered on prescriber attitudes and comfortability towards MOUD prescribing at this facility. This outcome was chosen

because it reflects the project's aim of better understanding prescriber attitudes towards MOUD at this facility and identifying barriers to evidence-based prescribing for MOUD. Prescriber attitudes and comfortability are defined in the survey as a 1-5 Likert-scale range: 1. Very uncomfortable; 2. Somewhat uncomfortable; 3. Neither uncomfortable nor comfortable; 4. Somewhat comfortable; 5. Very comfortable (Appendix B).

The process measure for this project was the percentage of participants who submitted responses to the survey. We calculated our response rate using the total number of prescribing providers at this facility (100). The balancing measure for this project was post-survey feedback from participants about the time burden of the survey and any barriers to completing the survey.

Analysis

Data from the survey was collected using Qualtrics software. Three categories of prescribers were identified by setting (psychiatric emergency department/substance use disorder services, inpatient adult, and inpatient child and adolescent). Quantitative data from Likert-scale answers were analyzed using Excel and depicted using visual tools such as column bar graphs. Inductive coding was used to develop themes from the free-text responses, then the qualitative responses were coded using a six-code framework. Three responses were assigned more than one code, reflecting multiple themes within a single text response. Frequency counts represent the total number of codes assigned rather than number of unique responses.

Ethical Considerations

Prior to implementation, the project underwent formal review from the facility's Institutional Review Board (IRB) as well as Oregon Health & Science University's IRB. The project received exemption status from both IRBs, as data was collected in the context of a quality improvement project rather than

human subjects research (Appendix D). Informed consent was embedded into the introductory portion of the clinician survey, which outlined the voluntary nature of participation, anonymity of responses, and right to withdraw at any time without penalty. No identifiable information was collected, and data from the survey were stored on a password-protected platform only accessible to the doctoral student team. The intervention posed minimal risk to participants, as it was designed to improve clinical practice surrounding OUD treatment. No conflicts of interest were identified, and the doctoral student team affirms they have no financial or personal interests that could influence the study design, implementation, or interpretation of results.

Results

The survey was launched and distributed via email to medical directors of the psychiatric hospital on November 7, 2025, with a request that they send the link to their prescribing staff. An initial deadline for survey completion was set for November 21, 2025. There are a total of 100 full-time and part-time prescribers at this facility. 27 submissions were received by the initial deadline of November 21, 2025, resulting in an initial response rate of 27%. Based on the results of this process measure, a follow-up email was sent directly to all 100 prescribers on December 1, 2025. This email extended the survey deadline to December 5, 2025 with the goal of increasing the overall response rate. No changes were made to the survey after it was first distributed. The survey was officially closed on December 18, 2025, at which point the overall response rate was 37% (n=37). Three responses contained no data and were not included in any analyses, resulting in an actual response rate of 34% and an initial n = 34. Of the 34 respondents, two provided responses only to the department item and the free-text question. Consequently, these submissions were excluded from statistical analyses of the Likert-scale items, resulting in a sample size of n = 32 for those analyses. Response rate was also calculated by department

for the three inpatient departments at this hospital: psychiatric emergency services (PES/ESUD), adult inpatient services (Adult Inpatient), and child and adolescent inpatient services (CAP). The response rate for PES/ESUD was 22, representing 47.83% of the department. The response rate for the Adult Inpatient was 8, representing 25.81% of the department. The response rate for CAP was 2, representing 8.33% of the department.

Discussion

Summary

In order to address the specific aim of identifying prescriber attitudes towards MOUD prescribing, Likert scale scores from Questions 2 and 3 respectively (n=32, scale range 1-5) were averaged to calculate an overall level of comfort initiating or continuing MOUD at this facility. Prescribers from all departments reported an average comfort level of 3.39 (SD=1.22) in initiating MOUD and an average comfort level of 4.30 (SD=1.02) in continuing MOUD.

Likert-scale responses from Questions 2 and 3 were stratified by department, and mean scores were calculated to estimate the average level of comfort with initiating or continuing MOUD within each department. Overall, prescribers in the PES/ESUD had the highest comfort level in initiating MOUD with an average score of 3.61 (SD=1.32, n=22, scale range 1-5), compared to Adult Inpatient 2.96 (SD=0.86, n= 8) and CAP 2.67 (SD=0.94, n=2). Prescribers in CAP had the highest score of comfort continuing MOUD with an average Likert score of 4.50 (SD=0.71), compared to 4.35 (SD=1.14) and 4.13 (SD=0.75) in PES/ESUD and Adult Inpatient, respectively. The significance of these findings is limited by the variability in response rates between departments, and in particular, the low response rate from CAP (CAP n=2, which represents 3.64% of the department).

Prescribers appear most comfortable utilizing sublingual buprenorphine compared to methadone or subcutaneous buprenorphine, and least comfortable utilizing subcutaneous buprenorphine. The average Likert scale score for comfort initiating sublingual buprenorphine was 3.78

(SD=1.39, scale 1-5) compared to 3.28 (SD=1.44) and 3.09 (SD=1.23) for methadone and subcutaneous buprenorphine, respectively. The average Likert scale for comfort continuing sublingual buprenorphine was 4.50 (SD=1.02), compared to 4.34 (SD=1.12) for methadone and 4.06 (SD=1.22) for subcutaneous buprenorphine.

Training-related concerns accounted for 42% of free-text responses in which prescribers identified their greatest barrier to MOUD prescribing. 75% of prescribers indicated that more in-person training would improve their comfort level in prescribing MOUD. The next most frequently cited concern in the free-text responses was Patient Follow-up, representing over a quarter of the coded responses. A majority of respondents (71.88%) strongly agreed that a written resource on how to refer patients to outpatient MOUD treatment would be helpful (Likert mean score=4.40, SD=1.16, scale 1-5).

Interpretation

This data suggests an overall lack of comfort initiating MOUD compared with continuing MOUD. In addition, prescribers are least comfortable with utilizing subcutaneous buprenorphine. This is particularly significant because subcutaneous buprenorphine offers several advantages over sublingual buprenorphine and methadone. Methadone is only available at approved opioid treatment clinics (Oregon Health Authority, n.d.), and both methadone and sublingual suboxone require daily dosing. Research suggests patients experience higher satisfaction and more effective treatment with subcutaneous buprenorphine vs sublingual buprenorphine (Nunes et al., 2024; Lintzeris et al., 2021).

Quantitative and qualitative results suggest that many clinicians at this facility desire additional structural and practice-level support with MOUD prescribing. Because formal pre-training data was not collected prior to the MOUD educational series, we cannot determine the direct impact of this training on clinician attitudes. Nevertheless, this data suggests that a one-time training may not be sufficient to fully address clinician confidence and comfort with MOUD prescribing.

The literature on substance use disorder education suggests that many prescribers graduate from programs with very little training on substance use treatment. For example, in 2020 a study of Canadian nursing programs found that almost 50% of nursing students only received 1-5 hours of substance use education, and 20% received none at all (Gagnon et al., 2020). In 2020, the American Psychiatric Association noted that educational requirements for substance use treatment in medical school and residency are “disproportionate” to meet the need for substance use treatment (Williams et al., 2020). It is possible that many of the prescribers at this facility received insufficient education on OUD treatment prior to entering their respective fields. Additionally, prescribers may receive didactic training but lack experiential exposure to MOUD, contributing to ongoing discomfort with treatment of OUD as part of routine psychiatric practice. Ambiguity regarding which discipline and/or clinical setting is most appropriate for the treatment of opioid use disorder (OUD) may further undermine clinician confidence and present a barrier to the effective integration of MOUD prescribing within psychiatric practice.

Limitations

This survey was subject to participation bias, as responses were collected on an anonymous and voluntary basis. We received a disproportionate number of responses from prescribers who work within PES/ESUD (representing 68.75% of all respondents), thus the data may reflect responses from prescribers who are generally more engaged with and knowledgeable about opioid use disorder treatment. Prescribers with limited comfort or less familiarity with the topics referenced in the survey may be underrepresented. To account for this, we analyzed and reported data by department when possible. Finally, all responses were from prescribers at an urban psychiatric facility located in the United States, which may limit the generalizability of the findings to rural or resource-limited environments, where access to specialized training and practical prescriber support may differ considerably.

Conclusions

Our data suggests several opportunities for concrete interventions to improve MOUD prescribing at this facility. Responses indicate that tangible educational material with updated guidance for MOUD prescribing that prescribers can quickly reference in clinical practice would promote greater comfortability with initiating and continuing sublingual and subcutaneous buprenorphine and methadone. Future training initiatives should focus on enhancing clinician knowledge and comfort with prescribing subcutaneous buprenorphine specifically, as well as initiating MOUD more broadly. Additionally, the free text and binary question responses indicate a clear concern among prescribers regarding ability to connect patients with outpatient MOUD care. This data suggests that creating a resource to support clinicians in connecting patients with outpatient care would likely be immediately beneficial. Finally, results suggest an overall desire for greater support with MOUD prescribing, highlighting opportunities for supplementary, systems-level interventions such as consult access or addiction-medicine mentorship opportunities.

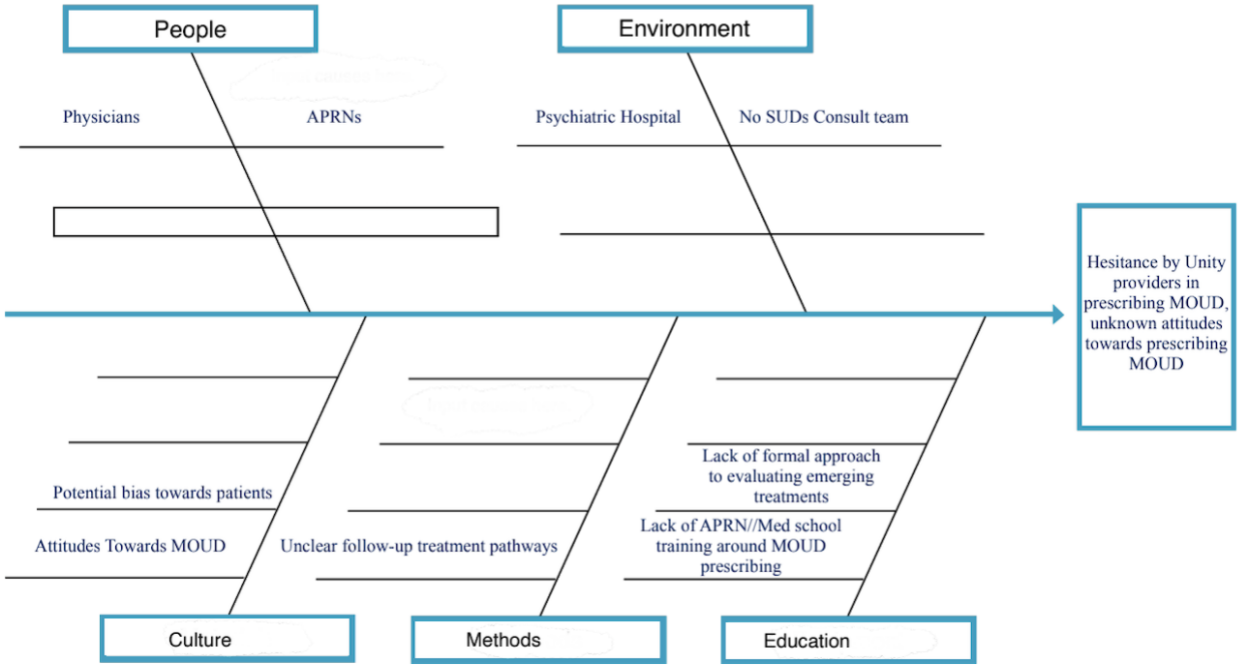
Appendices

Appendix A: Cause and Effect Diagram

Template: Cause and Effect Diagram

Team: Sabrina and Jason **Project:** Sabrina and Jason's DNP project

1) Input the effect you'd like to influence.
2) Input categories of causes for the effect (or keep the classic five).
3) Input causes within each category.



Appendix B: Survey

We are a team of Doctor of Nursing Practice (DNP) students conducting a study to better understand the current knowledge, attitudes, and perceived barriers clinicians face in prescribing medications for opioid use disorder (MOUD). The goal of this project is to identify key gaps and opportunities for improving clinical practice, education, and support systems. This survey is designed to take a maximum of **5** minutes of your time.

1) What setting do you primarily work in?

   Answers: [ ] PES [ ] Inpatient [ ] Child and Adolescent Inpatient

2) How comfortable do you feel **initiating**

(1. very uncomfortable; 2. somewhat uncomfortable; 3. neither uncomfortable nor comfortable; 4. somewhat comfortable; 5. very comfortable)

   a) Methadone -- 1-5 scale

   b) Sublingual Buprenorphine -- 1-5 scale

   c) Subcutaneous buprenorphine -- 1-5 scale

3) How comfortable do you feel **continuing**

(1. very uncomfortable; 2. somewhat uncomfortable; 3. neither uncomfortable nor comfortable; 4. somewhat comfortable; 5. very comfortable)

   a) Methadone -- 1-5 scale

   b) Sublingual Buprenorphine -- 1-5 scale

c) Buprenorphine subcutaneous - 1-5 scale

4) When initiating buprenorphine, I am comfortable managing the risk of precipitated withdrawal.

   Answers (1-7 scale): 1. Strongly Disagree; 2. Disagree; 3. Somewhat Disagree; 4. Neither agree nor disagree; 5. Somewhat Agree; 6. Agree; 7. Strongly agree

5) How comfortable do you feel providing harm-reduction based education/interventions?

   Answers: 1. Strongly Disagree; 2. Disagree; 3. Neither agree nor disagree; 4. Agree; 5. Strongly agree

6) Did you attend the MOUD Lunch and Learn Series? If yes, which sessions?

   Answer: (select all that apply) 1. No, I did not attend; 2. Yes, I attended June 11th, MOUD at Unity session; 3. Yes, I attended July 9th, Focus on Methadone session; 4. Yes, I attended August 13th, Focus on Buprenorphine session

7) Would more training increase your comfort level in prescribing these medications?

   Answers: [ ] Yes [ ] No [ ] Unsure

8) A written resource containing information on how to refer patients to outpatient suboxone and methadone services would be helpful to me when working with patients with opioid use disorder.

   Answers: 1. Strongly Disagree; 2. Disagree; 3. Neither agree nor disagree; 4. Agree; 5. Strongly agree

9) ESUD has been beneficial to Unity.

   Answers (1-7 scale): 1. Strongly Disagree; 2. Disagree; 3. Somewhat Disagree; 4. Neither agree nor disagree; 5. Somewhat Agree; 6. Agree; 7. Strongly agree

10) What is the GREATEST barrier that you face in prescribing MOUD in the emergency/inpatient setting?

    Answer: free response

Appendix C: Project Timeline

10/3/25 Deploy Test Survey

10/17/25 Deploy Survey, Post-QR codes, Begin outreach

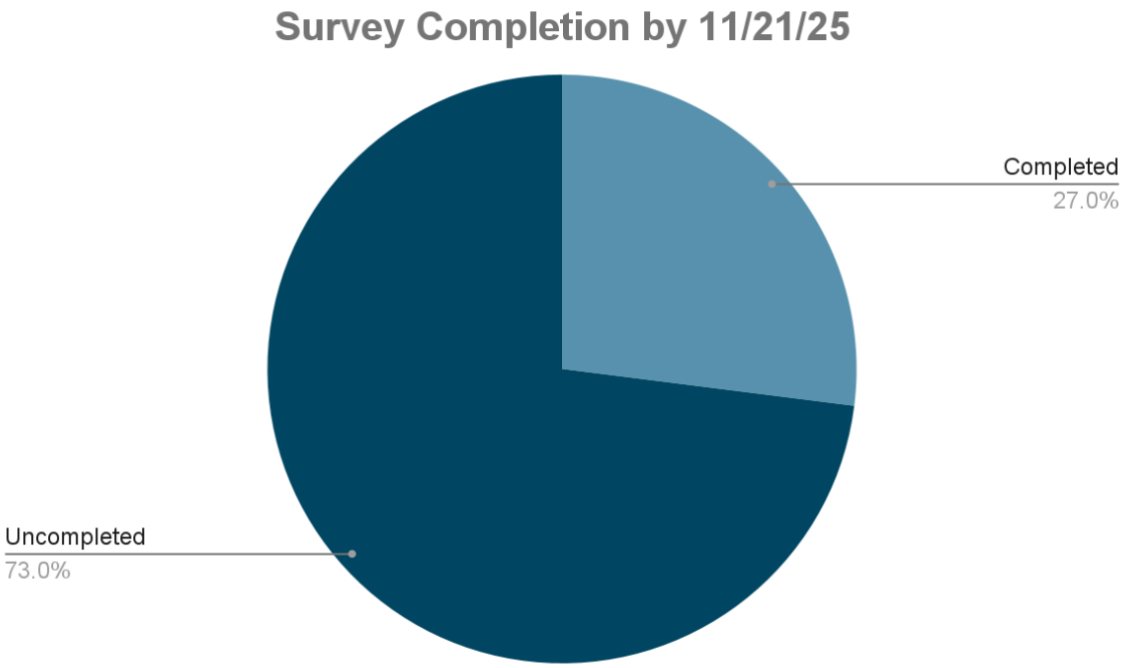
11/7/25 Assess Response Rate, Adjust outreach efforts as needed

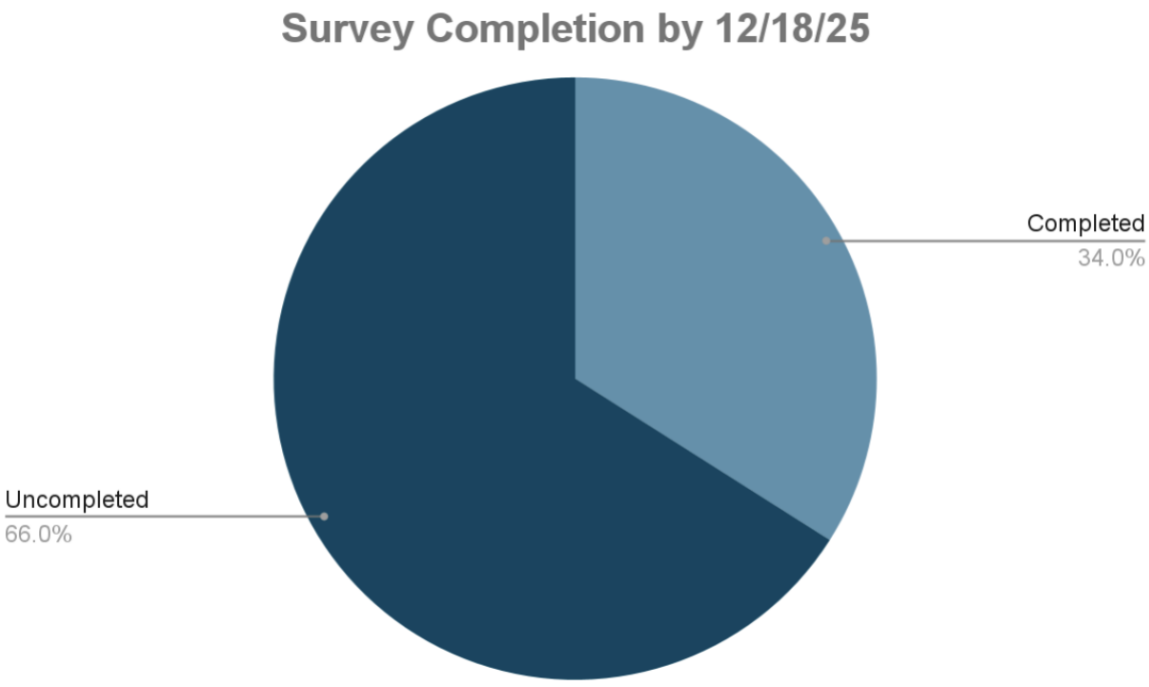
12/12/25 Assess Response Rate, Adjust outreach efforts as needed

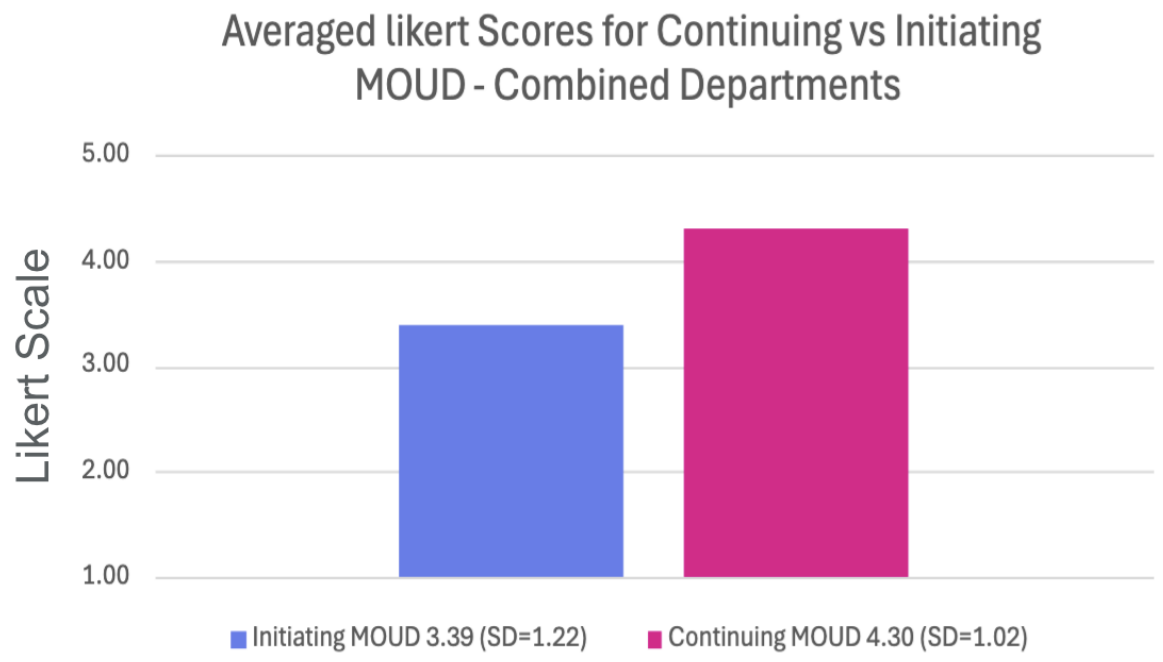
1/9/26 End Survey, Begin data analysis

1/30/26 Finalize results and discussion

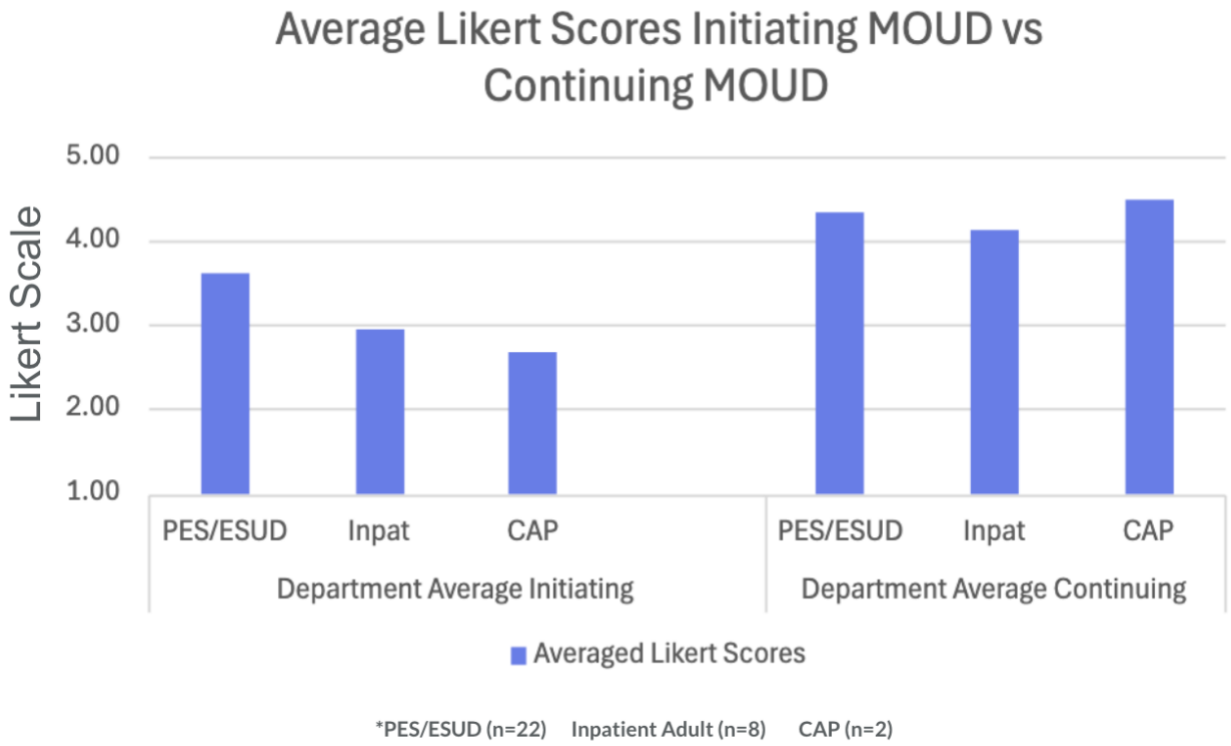
Appendix D: Results



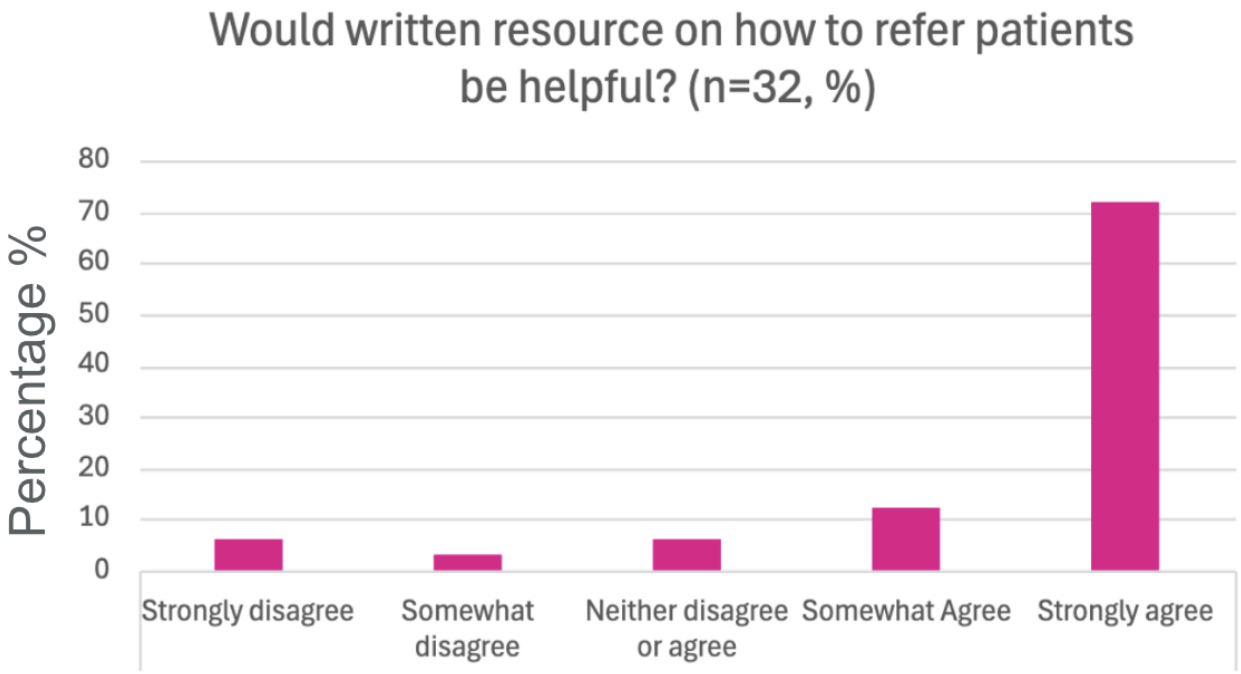

Survey Completion by 12/18/25
Completed
34.0%
Uncompleted
66.0%

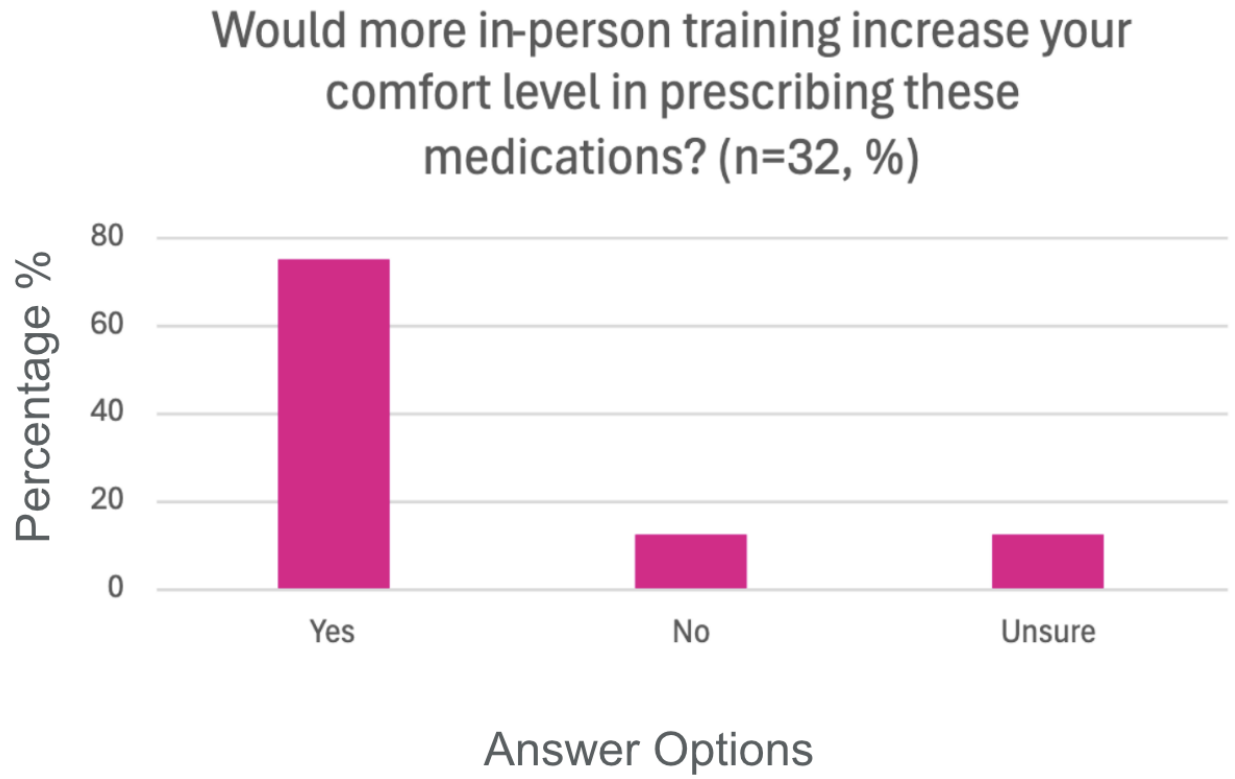


Likert scale: 1-5, least comfortable to most comfortable



*PES/ESUD (n=22) Inpatient Adult (n=8) CAP (n=2)


Would written resource on how to refer patients be helpful? (n=32, %)
Percentage %
80
70
60
50
40
30
20
10
0
Strongly disagree
Somewhat disagree
Neither disagree or agree
Somewhat Agree
Strongly agree
Answer Options


Would more in-person training increase your comfort level in prescribing these medications? (n=32, %)
Percentage %
80
60
40
20
0
Yes
No
Unsure
Answer Options

Appendix E: IRB Exemptions

LEGACY HEALTH | LEGACY RESEARCH INSTITUTE

Legacy Research Institute
1225 N.E. Second Ave.
Portland, OR 97232
503.413.2491 *phone*
503.413.4942 *fax*

LEGACY HEALTH INSTITUTIONAL REVIEW BOARD

NOTICE OF IRB ACTION

Protocol: *Medications for Opiate Use Disorder (MOUD): A Quality Improvement Assessment of Treatment Barriers at an Urban Psychiatric Hospital*	
Principal Investigator: Sabrina Khuon-Paige & Jason Nichols	Board Action: QI Determination/Acknowledged
Submission type/date: New QI 8/29/25	Date of Board Action: 9/8/25
Sponsor: none	Study Risk Level: Minimal Risk
Site(s): Unity	Jurisdiction: OHRP
IRB Tracking Number: 2291 Reviewing IRB: Exempt	Continuing Review: NA /QI Project /Exempt

SUBMITTED DOCUMENTS REVIEWED

- ✓ Legacy IRB Form:
  - Khuon-Paige Nichols Legacy Student Project
- ✓ Investigator's CV:
  - SKP Nursing Resume 10-4
  - NicholsJ Resume CPP CV
- ✓ Study Staff Training Information: CITI:
  - Khuon-Paige HSR Certificate
  - NicholsJ CITI Human Subjects Certificate

REVIEW

REVIEW TYPE	IRB ACTION
✓ Exemption Review ✓ QI Review ✓ Unity Nursing Lead Review	✓ Acknowledgement ✓ Exempt from IRB Review determination ✓ Not Human Subject Research Determination

ADDITIONAL FINDINGS AND REQUIREMENTS FOR THIS STUDY

✓ The IRB determined that the activity described consists of quality improvement only and does not meet the definition for human subjects research

IRB ACTION SIGNATURE

ACKNOWLEDGED BY LEGACY IRB – EXPEDITED REVIEW– DATE: 9/8/25

R Young

Rebecca Young – Research Regulatory Specialist

_____ _9/8/25_____

Rebecca Young, MA, CCRP **DATE**

Legacy IRB Research Regulatory Specialist

IRB CONTACT

If you have questions or concerns or wish to ask the IRB to reconsider its action, please contact Rebecca Young, Research Regulatory Specialist at, reyoung@lhs.org.

IRB INFORMATION

Legacy IRB: FWA00001280
REG: #1 (Good Sam): 00000677
REG: #2 (Emanuel): 00000678
LRI IRB (LRI): 00011999

END OF IRB ACTION DOCUMENT

OREGON HEALTH & SCIENCE UNIVERSITY

IRB MEMO

Research Integrity Office
3181 SW Sam Jackson Park Road - L106RI
Portland, OR 97239-3098
(503)494-7887 irb@ohsu.edu

NOT HUMAN RESEARCH

September 2, 2025

Dear Investigator:

On 9/2/2025, the IRB reviewed the following submission:

Title of Study:	Medications for Opiate Use Disorder (MOUD): A Quality Improvement Assessment of Treatment Barriers at an Urban Psychiatric Hospital
Investigator:	Lydia Anne Bartholow
IRB ID:	STUDY00029053
Funding:	None

The IRB determined that the proposed activity is not research involving human subjects. IRB review and approval is not required.

Certain changes to the research plan may affect this determination. Contact the IRB Office if your project changes and you have questions regarding the need for IRB oversight.

If this project involves the collection, use, or disclosure of Protected Health Information (PHI), you must comply with all applicable requirements under HIPAA. See the HIPAA and Research website and the Information Privacy and Security website for more information.

Sincerely,

The OHSU IRB Office

Appendix F: Site Letter of Support

Letter of Support from Clinical Agency

Date: *07/10/25*

Dear *Sabrina Khuon-Paige and Jason Nichols,*

This letter confirms that I, *Lydia Bartholow*, allow *Sabrina Khuon-Paige and Jason Nichols* (OHSU Doctor of Nursing Practice Students) access to complete their DNP Final Project at our clinical site. The project will take place from approximately *August 1st, 2025* to *March 31st, 2026.*

This letter summarizes the core elements of the project proposal, already reviewed by the DNP Project Preceptor and clinical liaison (if applicable):

- **Project Site(s)**: *Unity Center for Behavioral Health*
- **Project Plan:**
  - **Identified Clinical Problem:** *Literature suggests that provider knowledge and attitudes towards opiate use disorder treatment impacts treatment. There is a lack of a formal assessment of provider attitudes and knowledge surrounding medications to treat opiate use disorder at Unity.*
  - **Rationale:** *A survey to collect data and an in depth analysis of that data will allow the development of targeted interventions to address opiate use disorder prescribing at Unity.*
  - **Specific Aims**: *The specific aim is to deliver a survey to Unity providers and obtain 100% response rate by December 2025.*
  - **Methods/Interventions/Measures:** *We will design an anonymized survey and provide a hyperlink via email to Unity providers. In addition, we will post a flyer in provider work areas with a brief description and QR code link to the survey. We will analyze the data this coming winter.*
  - **Data Management:** *Data will be de-identified and collected using anonymized survey software.*
  - **Site(s) Support:** *We will need site support to provide access to provider email addresses, and occasional physical access to the site to post flyers describing the project.*

During the project implementation and evaluation, *Sabrina Khuon-Paige and Jason Nichols* will provide regular updates and communicate any necessary changes to the DNP Project Preceptor.

Our organization looks forward to working with these students to complete their DNP project. If we have any concerns related to this project, we will contact *Sabrina Khuon-Paige and Jason Nichols* and *Lydia Bartholow* (student's DNP Project Chairperson).

Regards,

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