

DECREASING PROVIDER HESITANCY TO INITIATE SUBOXONE THERAPY
FOR THE UNHOUSED: A QUALITY IMPROVEMENT PROJECT

by

Deni Gardner

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A DNP Project Submitted to the Faculty of the

COLLEGE OF NURSING

In Partial Fulfillment of the Requirements

For the Degree of

DOCTOR OF NURSING PRACTICE

In the Graduate College

THE UNIVERSITY OF ARIZONA

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THE UNIVERSITY OF ARIZONA
GRADUATE COLLEGE

As members of the DNP Project Committee, we certify that we have read the DNP project prepared by Deni Gardner, titled Decreasing Provider Hesitancy to Initiate Suboxone Therapy for the Unhoused: A Quality Improvement Project, and recommend that it be accepted as fulfilling the DNP project requirement for the Degree of Doctor of Nursing Practice.

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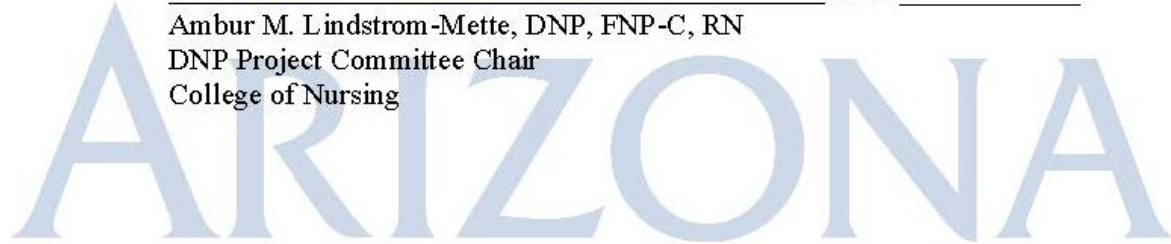
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Final approval and acceptance of this DNP project are contingent upon the candidate's submission of the final copies of the DNP project to the Graduate College.

I hereby certify that I have read this DNP project prepared under my direction and recommend that it be accepted as fulfilling the DNP project requirement.

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College of Nursing



LAND ACKNOWLEDGEMENT

We respectfully acknowledge the University of Arizona is on the land and territories of Indigenous peoples. Today, Arizona is home to 22 federally recognized tribes, with Tucson being home to the O'odham and the Yaqui. The University strives to build sustainable relationships with sovereign Native Nations and Indigenous communities through education offerings, partnerships, and community service.

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Abstract

Background: Opioid use disorder (OUD) remains a critical public health challenge in Arizona and across the United States (US), disproportionately affecting unhoused populations who face barriers to consistent and effective treatment. Despite the efficacy of medication-assisted treatment (MAT) with buprenorphine (Suboxone), provider hesitancy—driven by stigma, limited confidence, and concerns about treatment adherence—continues to impede access to care.

Purpose: The purpose of this quality improvement (QI) project was to decrease provider hesitancy to initiate Suboxone therapy for unhoused individuals through the delivery of a brief, targeted educational intervention and post-intervention survey.

Methods: A short educational video was developed by the Project Lead to address common provider concerns, reduce stigma, and highlight evidence-based benefits of MAT for unhoused patients. Providers were invited to view the video and complete a post-survey immediately, assessing changes in their knowledge, attitudes, and willingness to initiate Suboxone therapy—the Plan-Do-Study-Act (PDSA) framework guided project design and implementation.

Results: Survey responses indicated improvements in provider-reported knowledge and comfort levels regarding MAT initiation for unhoused populations. Respondents demonstrated increased willingness to consider prescribing Suboxone following the educational intervention. Although limited by a small sample size, single-site implementation, and reliance on self-reported data, the project's findings suggest that even brief, targeted education can have a positive influence on provider attitudes.

Conclusions: This project supports the value of focused educational interventions in addressing provider hesitancy to initiate Suboxone therapy. Implications for future practice include

expanding similar training across multiple sites, integrating content into continuing education programs, and conducting longitudinal assessments to evaluate the sustained changes in prescribing behaviors. By equipping providers with the confidence and knowledge to initiate MAT, healthcare systems can expand access to life-saving treatment and reduce disparities among unhoused individuals with OUD.

Background

In 2021, approximately 2.5 million people in the United States (US) aged 18 and older had a defined opioid use disorder (OUD), with only 22% receiving medications for the disorder and 36% receiving treatment of any kind for their opioid use (Volkow, & Dye, 2025). As the opioid epidemic has grown throughout the country, this project centers around the crisis in the state of Arizona. In 2024, the number of verified non-fatal opioid events in Arizona was 4,027, the number of confirmed opioid related deaths was reported at 1,585, and the number of emergency and inpatient visits involving suspected opioid overdose in the state was 7,820 (AZDHS, 2025). The combined cost of opioid use disorders and opioid-related fatalities in the US in 2017 was \$1,021 billion, with expenses encompassing emergency department visits, inpatient hospitalizations, substance use disorder treatment programs, lost productivity, criminal justice involvement, and Medicaid expenditures. The relative economic impact in Arizona specifically was reported at over \$21 million (CDC, 2025).

For persons without housing, the impact of this epidemic is more significant. Nationally, in 2014, more than one in ten (1:10) unhoused persons incurred opioid-related hospital visits, and this population had a significantly higher risk of overdose (Yamamoto et al., 2019). This could be due to various factors, including ease of access, social pressures, feelings of destitution, and a general mistrust of the medical community (Carter, Zevin, & Lum, 2019). While a lack of access to mental health services due to the absence of health insurance and other resources for the unhoused can be a contributing factor for abusing opiates, this can also play into the hesitancy many providers have for initiating MAT for these most vulnerable patients. The Federal Drug Administration (FDA) currently approves the use of three medications to treat opioid use

disorders, which include methadone, Suboxone, and naltrexone, and the evidence of efficacy of these medications when used for this purpose is supportive of their use (Oesterle et al., 2019). Additional hesitations reported by providers include confusion about prescribing regulations, stigmas surrounding opioid receptor agonist medications, misinformation relative to the safety and efficacy of MAT, and concern for lack of follow-up once the medication is prescribed and dispensed (Major et al., 2023).

Due to the global attention this crisis has garnered, many relevant clinical guidelines and agendas have been published. One is the International Standard for the Treatment of Drug Use Disorders (WHO, 2020). This document outlines the development of evidence-based treatment plans targeting medically underserved communities worldwide, which is directly related to this project's aim. Until the signing of the Consolidated Appropriations Act of 2023, providers were required to apply for a Drug Addiction Treatment Act (DATA) waiver, also known as an X-waiver, before prescribing buprenorphine or other opioid receptor agonist therapies. Section 1262 of this act (also known as the Omnibus bill) removes the federal requirement for practitioners to submit a Notice of Intent (have a waiver) to prescribe medications, like Suboxone, for the treatment of opioid use disorder and additionally removes the 30-patient limit per provider (LeFevre, et al., 2023). There may be a knowledge gap for providers who are unmotivated to prescribe these drugs due to the thought that this barrier, as well as the patient limit for buprenorphine, still exists. In the state of Arizona, the only regulated requirement for MAT with opioid dependence is registration with the DEA.

By educating providers on the safety, efficacy, and overall importance of opioid receptor agonist therapy, this project aimed to dispel the hesitancy primarily created by a lack of

knowledge on the subject. This has the potential to impact the unhoused community in Arizona positively, and, in turn, the state as a whole. The financial burden of opioid addiction and the ripple effect it creates in the community present a tremendous need for change. This objective can add significant value to the ease of prescriptive willingness on the part of those who provide clinical care for persons without housing in environments not explicitly designated as addiction treatment centers.

Literature Review Synthesis

Federally Qualified Health Centers (FQHCs) play a crucial role in enhancing access to Suboxone, particularly in rural and underserved areas. Brady et al. (2021) demonstrated that designating more FQHCs as office-based opioid treatment (OBOT) sites could significantly reduce drive times to care, particularly benefiting unhoused populations. These centers already serve as primary care hubs for vulnerable individuals, and their integration of Suboxone services could reduce stigma, normalize prescribing, and improve treatment accessibility. Yamamoto et al. (2019) further emphasized the disproportionate opioid-related harm experienced by the unhoused, calling for prioritization of this group in medication for opioid use disorder (MOUD) delivery. Volkow and Dye (2025) echoed this urgency, highlighting systemic stigma and regulatory barriers as key contributors to provider reluctance—obstacles that must be dismantled through provider education and evidence-based policy reform.

Low-barrier treatment models have shown promise in engaging individuals who are typically marginalized by traditional care systems. Carter, Zevin, and Lum (2019) reported positive outcomes from a San Francisco program that minimized bureaucratic hurdles for homeless individuals who inject heroin, leading to reductions in heroin use and sustained

engagement in care. In this setting, the street medicine team provided assessment, education, and MAT for the unhoused population in San Francisco. The study resulted in 23% of participants demonstrating at least one opioid-negative, buprenorphine-positive lab result after receiving these resources. Similarly, Fine et al. (2024) identified trust, individualized care, and nonjudgmental provider attitudes as key drivers of one-month treatment retention in unhoused patients. Magwood et al. (2020) reinforced the safety and effectiveness of buprenorphine in this population through a review of systematic reviews, advocating for flexible, co-located, and trauma-informed interventions tailored to the realities of homelessness.

Multiple studies have identified provider-facing barriers that hinder buprenorphine initiation for vulnerable populations. Cioe et al. (2020) found that lack of training, stigma, and institutional support discourage providers from initiating MOUD—concerns that are especially acute when treating people with complex needs, such as the unhoused. Major et al. (2023) expanded on this by revealing how pharmacists in rural areas are affected by stigma and regulatory ambiguity, contributing to inconsistent dispensing practices. These findings underscore the need for systemic interventions that foster provider confidence and clarify legal guidance to ensure consistent, compassionate care.

Finally, Masson et al. (2025) explored the experiences of providers delivering MOUD to the unhoused, citing emotional burnout, diversion concerns, and infrastructure deficits as persistent challenges. Despite recognizing the value of Suboxone, many clinicians felt unprepared to navigate the complexity of care for this population. Young et al. (2015) added that community-level stigma in rural areas also deters MOUD uptake, emphasizing the importance of shifting cultural narratives within both clinical and community contexts. Together, these studies

underscore the need for trauma-informed training, institutional backing, and flexible care models to reduce hesitancy and extend life-saving treatment to those most in need (Appendix A).

Implementation Model

This project utilized the Plan-Do-Study-Act (PDSA) model for quality improvement (QI). This model utilizes a straightforward tool to guide the project lead through the phases of targeted change, while also providing project evaluators with a user-friendly guide for navigating the project's process steps. The PDSA cycle is an effective tool to document the test of change. In the 'Plan' phase of the cycle, the project lead develops a plan to test the desired change. During the 'Do' phase, the test is carried out, while in the 'Study' phase, the test is observed and analyzed. Finally, the 'Act' phase provides the Project Lead with the opportunity to review the first three steps and make any necessary modifications, if a subsequent PDSA cycle is planned. In studies with only one cycle, the Act phase enables the evaluation of the project's efficacy and its likelihood of sustainability (Speroff & O'Connor, 2004).

For this project, the Plan phase involved identifying key stakeholders at the participating FQHC and assigning the project team, which comprised the project lead and sponsors. Additionally, the dissemination of information in this phase included promotional flyers emailed announcing an upcoming educational video promoting MAT, with a particular focus on the targeted patient population: unhoused citizens of Tucson. For the Do phase, the educational video and post-survey were emailed to participants and available for one week. The observations obtained during the Study phase of the model included assessing survey responses and aggregating/quantifying data from the survey. During the Act phase, the Project Lead highlighted the overall impact of the educational video and survey on provider knowledge, attitudes, and

willingness to initiate Suboxone for unhoused populations. Conclusions were drawn regarding what worked well in the previous phases and what barriers or gaps were identified. Information was disseminated to project sponsors and stakeholders (See Appendix B).

Purpose

Currently, there is evidence supporting provider hesitancy to prescribe MAT to the unhoused due to a perceived lack of follow-through and motivation in this patient population (Cioe et al., 2020). An opportunity exists to reduce this hesitancy by providing evidence-based education via asynchronous video to improve patient outcomes and reduce overall mortality related to opioid abuse and addiction. The purpose of this DNP project was to implement evidence-based teaching materials within a community health clinic to reduce provider hesitancy in initiating Suboxone therapy for unhoused adults in Tucson, Arizona.

Methods

Site

This project took place at a multispecialty FQHC in Tucson, Arizona, which provides healthcare services to a diverse range of demographics, with a particular focus on serving the medically underserved. The individuals included in this project consisted of 24 adult and family providers, with an emphasis on those able to prescribe Suboxone to adult patients. This clinic offers on-site services, including a pharmacy that dispenses Suboxone, as well as a variety of behavioral health therapies and an addiction treatment program. Any provider at this site can prescribe Suboxone to their adult patients, as there are no specific organizational policies in place that are not in line with current Arizona regulations.

Stakeholders

Key stakeholders included family medicine providers, adult medicine providers, and addiction treatment providers who aim to provide quality, safe care for all patients, encompassing risk reduction and ultimately decreased patient mortality. The site authorization letter was signed by the clinic's Chief Quality Officer (Appendix C). Indirect stakeholders included unhoused patients with an opioid use disorder.

Participants and Recruitment

The Project Lead encouraged all family and adult medicine providers at the specified clinic to participate in the project by watching an educational video and completing a seven-question survey following the video. Recruitment was made via an email sent internally by the project sponsor to announce the upcoming education, sent three days before the educational email (Appendix D), one to include the educational video (Appendix E) and QR code for Suboxone prescribing quick tips (Appendix F) and consent letter (Appendix G), and a final email reminding providers of the education and survey.

Intervention

The intervention in this study consisted of an educational video sent via internal email by the project sponsor to all clinic family medicine providers. A storyboard for the video was created before creating the video itself (Appendix H). The decision to use a video was made due to its ease of access and distribution. The video's length of less than two minutes also allowed more providers to complete the education. The video included easy-to-understand information regarding the benefits of Suboxone therapy for opioid addiction, as well as the potentially positive results of utilizing this therapy for the unhoused. Also addressed was the fact that

providers no longer need special authorization to prescribe MAT and that there are no longer limits on the number of patients a provider can prescribe suboxone therapy to at any given time. The email with the project video also included a link to a seven-question survey, which elicited feedback about the likelihood of prescribing Suboxone before and after watching the video, as well as general demographics of survey respondents.

Evaluation Measures

The success and impact of the project were evaluated via a post-education survey with seven questions aimed at determining provider knowledge about MAT as well as comfort with prescribing both before and after watching the educational video (Appendix I).

Analysis

Survey questions were compiled in Qualtrics, and the program was used to aggregate responses. Each question was analyzed relative to the number of respondents, which ranged from ten to thirteen. For the majority of questions, the response data were further analyzed by calculating the percentage of each response, along with the mean and standard deviation (Appendix J).

Ethical Considerations

This project was designed and implemented in alignment with all ethical guidelines. Participant involvement was voluntary, and answers to the post-educational survey were anonymous. Employment was not impacted based on project participation, and no remuneration was provided. All emails related to this project were sent securely via the internal email system. Surveys did not include any questions that may help identify the respondent. Links to the

educational video and the survey were provided via secure clinic email sent out by the on-site project sponsor, and the results were password-protected and accessible only to the Project Lead.

IRB Review and Approval

This project was submitted to the clinic's quality improvement department for preliminary approval before being submitted to the IRB. After a successful proposal defense, the project was submitted to the University of Arizona's IRB division, and approval was obtained before project implementation (Appendix K).

Results

Likelihood of Prescribing Suboxone

Before viewing the educational video, providers' reported likelihood of prescribing Suboxone to an unhoused patient with OUD varied widely. Of the 13 respondents, 40% indicated they were "somewhat unlikely" or "neither likely nor unlikely" to prescribe, while 50% fell into the "somewhat likely" or "extremely likely" categories. After the intervention, responses shifted positively: 70% reported being "somewhat likely" or "extremely likely" to prescribe, with an increase in the mean score from 3.0 pre-intervention to 3.9 post-intervention on a 5-point scale. This demonstrates an overall improvement in provider openness toward initiating Suboxone therapy after viewing the educational video.

Confidence in Low-Barrier Suboxone Strategies

Providers were asked to rate their confidence in understanding low-barrier Suboxone treatment strategies for unhoused individuals. Out of 13 responses, 56% reported being "somewhat confident" and 11% reported being "extremely confident," while 33% selected

“neither confident nor unconfident.” The mean confidence score was 3.1 on a 4-point scale, suggesting moderate confidence with room for continued growth in knowledge and skills.

Perceived Barriers to Prescribing

Participants identified their most significant perceived barriers to initiating Suboxone therapy. Among the 10 responses collected, the most reported barrier was limited training or clinical experience (40%), followed by system-level constraints such as time, resources, or protocols (20%). Concerns about diversion and lack of follow-up options were each cited by 10% of respondents, while 20% reported no significant barriers. These findings underscore the importance of provider education and institutional support in addressing hesitancy.

Intended Actions After Educational Video

When asked about planned actions following the video, respondents selected multiple options. The majority (60%) indicated they would seek further training on MOUD prescribing, while 40% reported they were likely to initiate Suboxone therapy in their clinical setting. Additionally, 30% planned to share the information with colleagues, and 20% selected “none at this time.” These results suggest that the educational intervention not only increased willingness but also encouraged ongoing professional development.

Provider Demographics

Of the 10 providers who reported demographic information, half (50%) were nurse practitioners (NPs), followed by 30% physicians (MDs), and 20% doctors of osteopathy (DOs). Regarding years of experience, the majority (60%) had between five and ten years of practice, while 20% had greater than 15 years, 10% had less than five years, and 10% reported 10–15 years of experience. These demographics provide context for interpreting the survey results,

suggesting that the intervention reached a group of mid-career providers with a diverse range of professional backgrounds.

Discussion

Alignment with DNP Essentials

This QI project aligned with multiple Doctor of Nursing Practice (DNP) Essentials as outlined by the American Association of Colleges of Nursing (AACN, 2006). *Essential I: Scientific Underpinnings for Practice* is demonstrated through the integration of evidence-based research on MAT and low-barrier Suboxone prescribing into an educational intervention. *Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking* was reflected in the project's application of the PDSA framework to address knowledge gaps among providers and reduce hesitancy within clinical systems. *Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice* was represented by the design, implementation, and evaluation of a scholarly intervention that measures provider responses and attitudes. *Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes* was supported through the inclusion of multiple provider types (NPs, MDs, DOs) in the intervention, highlighting the value of collaborative practice in expanding access to opioid use disorder treatment. Finally, *Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health* was addressed by targeting a highly vulnerable population—the unhoused—who experience disproportionate burdens of opioid-related morbidity and mortality (AACN, 2006).

Sustainability

Although this project was conducted as a single PDSA cycle, the intervention was intentionally designed to be low-cost, scalable, and easily integrated into provider education. The short educational video format enabled continued dissemination through onboarding modules, annual competency training sessions, or professional development workshops. Incorporating the video and survey into ongoing continuing medical education (CME) activities could further sustain impact by reinforcing provider knowledge and reducing stigma over time (Institute for Healthcare Improvement [IHI], 2023). Additionally, the ability to share the educational tool across clinical sites and provider networks, such as FQHCs, increases the potential for long-term adoption. Sustainability may also be strengthened through leadership support, integration of MAT prescribing guidelines into organizational policies, and periodic updates to the educational content to reflect emerging best practices in opioid use disorder care (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023).

Limitations

Data were collected through self-reported surveys, which may be influenced by social desirability bias and do not directly measure changes in prescribing behavior. The intervention assessed only immediate changes in knowledge and attitudes; long-term retention and actual prescribing practices were not evaluated. Additionally, the project was conducted as a single-cycle PDSA, limiting the ability to refine the intervention through iterative testing and improvement (IHI, 2023). Participant demographics revealed a predominance of mid-career providers, which may not fully represent the perspectives of early-career clinicians or those in diverse practice settings. These limitations highlight the need for future research and quality

improvement initiatives that incorporate longitudinal follow-up and objective outcome measures such as prescribing data.

Conclusion

Implications for Future Practice

This QI project demonstrated that a brief educational video coupled with a provider survey can serve as an effective intervention for addressing hesitancy in initiating Suboxone therapy for unhoused populations. By focusing on evidence-based information, stigma reduction, and practical prescribing guidance, the intervention promoted increased awareness and self-reported willingness among providers to consider medication-assisted treatment (MAT) in this vulnerable population. Even within the scope of a single PDSA cycle, the project demonstrated the potential of targeted educational strategies to influence provider knowledge and attitudes significantly.

While the short duration and reliance on self-reported survey data limit the generalizability of these findings, the outcomes underscore the importance of embedding stigma-reducing and confidence-building education into routine provider training. Future practice should consider expanding such educational interventions across multiple clinical sites, integrating them into continuing education modules, and pairing them with longitudinal follow-up to assess sustained behavior change. Additionally, organizational leaders may explore incorporating policy supports, clinical decision aids, and peer mentorship to further reduce barriers to initiating MAT.

Ultimately, this project contributes to the growing body of evidence that provider education is a critical step toward improving access to opioid use disorder treatment in

underserved populations. By equipping providers with the knowledge and confidence to prescribe Suboxone, health systems can advance equity, expand treatment capacity, and help close the care gap for unhoused individuals living with opioid use disorder.

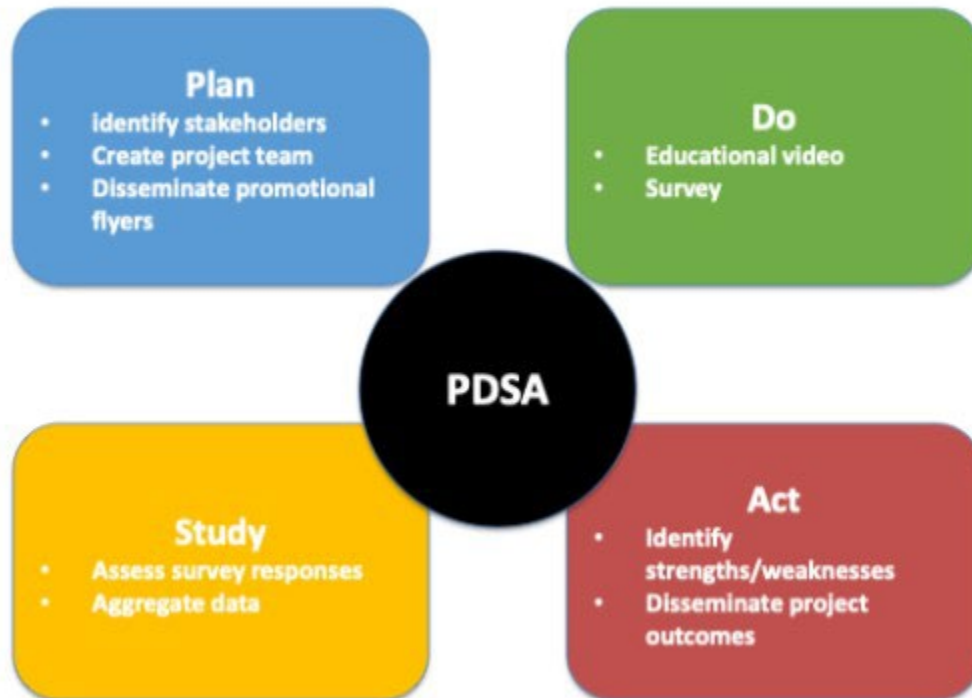
Appendix A
Evidence Table

Study Authors	Study Title	Study Type	Study Results	Relation to Project
Brady, B. R., Gildersleeve, R., Koch, B. D., Campos-Outcalt, D. E., & Derksen, D. J. (2021).	Federally Qualified Health Centers can expand rural access to buprenorphine for opioid use disorder in Arizona.	Observational / Programmatic Evaluation	FQHCs were effective at expanding rural Suboxone access by training providers and removing logistical barriers.	Demonstrates how system-level changes can support hesitant providers in offering Suboxone.
Carter, J., Zevin, B., & Lum, P. J. (2019).	Low barrier buprenorphine treatment for persons experiencing homelessness and injecting heroin in San Francisco.	Observational Study	Showed effectiveness of low-threshold buprenorphine models in homeless settings.	Strong support for making Suboxone easy to initiate in vulnerable populations.
Cioe, K., Biondi, B. E., Easley, R., Simard, A., Zheng, X., & Springer, S. A. (2020).	A systematic review of patients' and providers' perspectives of medications for treatment of opioid use disorder.	Systematic Review	Found significant misinformation among both patients and providers.	Highlights need for provider education to reduce hesitancy.
Fine, D. R., Critchley, N., Hart, K., Joyce, A., Sporn, N., Gaeta, J., Wright, J., Baggett, T. P., & Kruse, G. (2024).	"I'm on the Right Path": Exploring 1-Month Retention in a Homeless-Tailored Outpatient-Based Opioid Treatment Program.	Qualitative Study	Low-threshold care, personal motivation, and extended-release buprenorphine improved retention; barriers included environmental and logistic challenges.	Supports low-barrier, supportive clinic models to reduce provider hesitancy and improve Suboxone retention among unhoused individuals.
Magwood, O., Salvalaggio, G., Beder, M., Kendall, C., Kpade, V., Daghmach, W., Habonimana, G., Marshall, Z., Snyder, E., O'Shea, T., Lennox, R., Hsu, H., Tugwell, P. & Pottie, K. (2020).	The effectiveness of substance use interventions for homeless and vulnerably housed persons: A systematic review of systematic reviews.	Systematic Review of Systematic Reviews	MAT (including Suboxone) is effective in improving outcomes for homeless persons.	Strongly supports Suboxone initiation in the unhoused; decreases provider uncertainty.
Major, E. G., Wilson, C. G., Carpenter, D. M., Harless, J. C., Marley, G. T., & Ostrach, B. (2023).	Factors in rural community buprenorphine dispensing.	Qualitative / Mixed Methods	Rural pharmacies and providers face barriers due to stigma, regulation, and confidence gaps.	Addresses provider hesitancy and highlights the need for support and education.
Masson, C. L., Knight, K.R., Levine, E.A., Spillane, J.A., Liang, Y.C.A., Suen, L.W., Chen, M.M.,	Barriers to buprenorphine treatment among people experiencing homelessness: A	Qualitative Study	Identified lack of infrastructure and provider support as major barriers.	Shows that systemic fixes are essential to enable prescribing.

Study Authors	Study Title	Study Type	Study Results	Relation to Project
Zevin, B., Schwartz, R.P., Coffin, P.O., Sorensen, J.L. (2025).	qualitative study from the provider perspective.			
Volkow, N., & Dye, L. R. (2025).	Groundbreaking research from NIDA addressing the challenges of the opioid epidemic.	Review Article	Highlights progress in MAT (Medication-Assisted Treatment), including Suboxone, and access challenges.	Validates Suboxone as standard of care and underscores innovation to overcome access barriers.
Yamamoto, A., Needleman, J., Gelberg, L., Kominski, G., Shoptaw, S., & Tsugawa, Y. (2019).	Association between homelessness and opioid overdose and opioid-related hospital admissions/emergency department visits.	Retrospective Cohort Study	Homeless individuals are more likely to experience opioid-related ED visits and hospitalizations.	Highlights high-risk nature of homelessness; justifies early, proactive Suboxone initiation.
Young, L. B., Grant, K. M., & Tyler, K. A. (2015).	Community-level barriers to recovery for substance-dependent rural residents.	Qualitative Study	Cultural stigma, lack of providers, and limited services hinder treatment access.	Helps explain systemic hesitancy; supports the need to empower providers to act confidently.

Appendix B
PDSA Project Model

PDSA Project Model



Appendix C
Site Authorization Letter



June 16, 2025

Human Subjects Protection Program
The University of Arizona
845 N Park Ave., Suite 537A
Tucson, AZ 85719

Ms. Deni Gardner, University of Arizona Doctor of Nursing Practice student, has the support of El Rio Health to conduct a quality improvement (QI) project at El Rio for her project, *"Decreasing provider hesitancy to initiate suboxone therapy in the unhoused: A quality improvement project"* in collaboration with Marketa Jansky, FNP.

The purpose of this project is to implement evidence-based teaching material within a community health clinic with the goal of reducing provider hesitancy to initiate Buprenorphine/Naloxone (Suboxone) therapy for unhoused adults in Tucson, Arizona.

Ms. Gardner will provide a pre-intervention questionnaire, educational PowerPoint, and post-survey of health care providers at El Rio Health. Providers will be recruited via email invitation. The email will provide a description of the project, what they will be asked to do, and the time involved. Ms. Gardner's activities will be completed by November 14, 2025.

Ms. Gardner understands that El Rio Health requires a copy of the University of Arizona IRB determination letter prior to project commencement. Additionally, she will complete our Quality Improvement Project intake process prior to project commencement. Ms. Gardner will also be required to participate in our annual Research & Innovation Summit, hosted every Spring.

If there are any questions, please feel free to contact me.

Sincerely,

Rajiv M. Modak MD

Rajiv M. Modak, MD, FAAP
Chief Quality Officer
El Rio Health

Appendix D
Recruitment Email

Initial Recruitment Email

Good morning - I am sending this email on behalf of The University of Arizona's DNP Candidate, Deni Gardner. We value your participation in this Quality Improvement Project. An email will arrive soon with links to education and a survey. Please see the flyer below.

El Rio Approved
University of Arizona
Quality Improvement Project

Deni Gardner MSN RN DNP candidate

Watch a quick 2-minute video and answer a few multiple-choice questions. Your participation is greatly appreciated! THANK YOU!

**HELP IMPROVE
PATIENT OUTCOMES**

Participate in a
Quality Improvement Project

**Decreasing Provider Hesitancy
to Prescribe Suboxone
Therapy for the Unhoused**

Check your email for links to
education and survey coming soon!

Appendix E

Educational Video Link



SUBOXONE THERAPY FOR THE UNHOUSED

COMPASSION MEETS EVIDENCE-BASED CARE

Appendix F

Suboxone Quick Tips QR Code

SAMHSA Buprenorphine Quick Start Guide



<https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf>

Appendix G
Consent Letter

By completing this survey, you are agreeing to participate in a quality improvement project.

Thank you for watching “*Prescribe with Confidence: Suboxone for the Unhoused.*”

This brief post-video survey is designed to evaluate the impact of the educational material on provider knowledge, attitudes, and intentions regarding Suboxone prescribing for the unhoused population. Your participation is voluntary, and your responses are anonymous.

Appendix H
Video Storyboard

Storyboard: Prescribe with Confidence – Suboxone for the Unhoused

Slide #	Title	Content
1	Prescribe with Confidence:	Suboxone for the Unhoused [Visual: Blurred background of city street or encampment]
2	Hook & Introduction	Each day, someone dies of an opioid overdose—many of them unhoused. Most never receive life-saving treatment like Suboxone. Only 22% of people with OUD receive MOUD (SAMHSA, 2024) [Visual: City street, emergency response, tent encampment, subtle animation]
3	Identifying the Barrier	Why the hesitation? Providers cite concerns about: <ul style="list-style-type: none"> - Follow-up - Diversion - Limited resources [Visual: Busy clinic waiting room, provider on phone, text overlay with bulleted points]
4	Facts that Reassure	But the evidence is clear: <ul style="list-style-type: none"> - Buprenorphine is effective - Even in low-barrier settings Low-barrier treatment works [Visual: Patient receiving Suboxone, provider giving care, animated bar graph]
5	What You Can Do	You don't need a waiver. You don't need perfection. Start where you are: <ul style="list-style-type: none"> - Shelter - Mobile clinic - Any clinical encounter [Visual: Outreach van, clinician at intake desk, checklist animation]
6	Call to Action	Prescribing Suboxone is not risky— It's responsible. It's life-saving. Suboxone saves lives. You have the power to start the change. Thank you for watching. Please complete the attached short survey. [Visual: Clean CTA screen with logo, soft animation, survey link/QR code]

Appendix I

Evaluation Instrument: Post-Participation Survey Questions

Evaluation Instrument: Post-Participation Survey

1. Before watching this video, how likely were you to prescribe Suboxone to an unhoused patient with opioid use disorder (OUD)?

Scale:

- Not at all likely
 - Slightly likely
 - Moderately likely
 - Very likely
 - Extremely likely
-

2. After watching this video, how likely are you to prescribe Suboxone to an unhoused patient with opioid use disorder (OUD)?

Scale:

- Not at all likely
 - Slightly likely
 - Moderately likely
 - Very likely
 - Extremely likely
-

3. How confident do you feel in your understanding of low-barrier buprenorphine treatment strategies for unhoused individuals?

Scale:

- Not confident
 - Slightly confident
 - Moderately confident
 - Very confident
 - Extremely confident
-

4. What do you perceive as your biggest barrier to prescribing Suboxone to the unhoused?

(Select one)

- Concerns about diversion
 - Lack of follow-up options
 - Limited training or clinical experience
 - System-level constraints (time, resources, protocols)
 - I do not have any significant barriers
-

5. What action(s) are you most likely to take after this video? *(Select all that apply)*

- Initiate Suboxone in clinic or shelter settings
 - Share this information with colleagues
 - Seek further training on MOUD prescribing
 - None at this time
-

6. Type of Provider

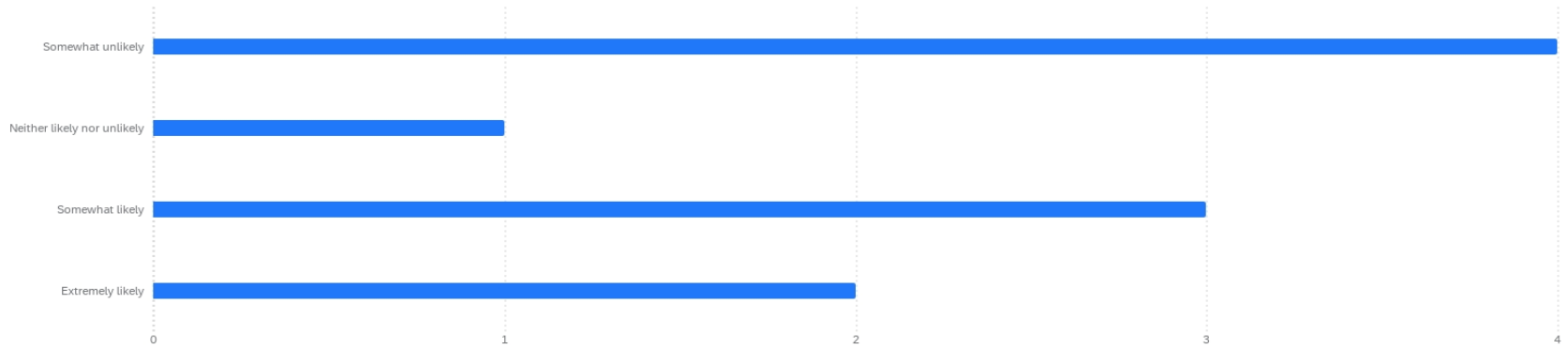
- MD
- DO
- NP
- PA

7. Years of Experience as a Provider

- Less than 5 years
- 5-10 years
- 10-15 years
- Greater than 15 years

Appendix J
Survey Data

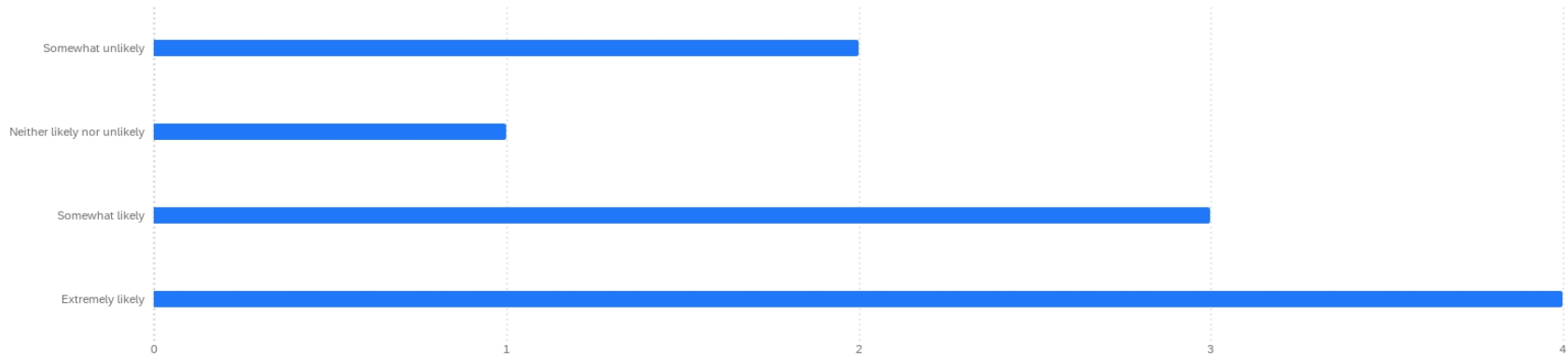
Before watching this video, how likely were you to prescribe Suboxone to an unoused patient with opioid use disorder (OUD)? 10 ⓘ



Before watching this video, how likely were you to prescribe Suboxone to an unoused patient with opioid use disorder (OUD)? 10 ⓘ

Q1 - Before watching this video, how likely were you to prescribe Suboxone to an unoused patient with opioid use disorder (OUD)?	Count	Count
Somewhat unlikely	40%	4
Neither likely nor unlikely	10%	1
Somewhat likely	30%	3
Extremely likely	20%	2

After watching this video, how likely are you to prescribe Suboxone to an unhoused patient with opioid use disorder (OUD)? 10 ⓘ



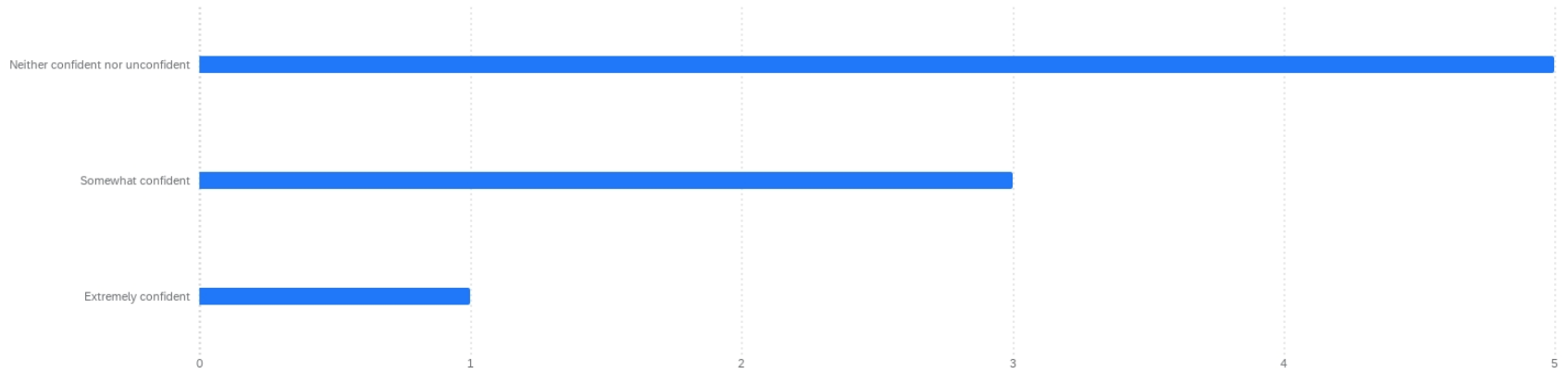
After watching this video, how likely are you to prescribe Suboxone to an unhoused patient with opioid use disorder (OUD)? 10 ⓘ

Q2 - After watching this video, how likely are you to prescribe Suboxone to an unhoused patient with opioid use disorder (OUD)?	Count	Count
Somewhat unlikely	20%	2
Neither likely nor unlikely	10%	1
Somewhat likely	30%	3
Extremely likely	40%	4

After watching this video, how likely are you to prescribe Suboxone to an unhoused patient with opioid use disorder (OUD)? 13 ⓘ

Average (Q2 - After watching this video, how likely are you to prescribe Suboxone to an unhoused patient with opioid use disorder (OUD)?)	3.90
Minimum (Q2 - After watching this video, how likely are you to prescribe Suboxone to an unhoused patient with opioid use disorder (OUD)?)	2.00
Maximum (Q2 - After watching this video, how likely are you to prescribe Suboxone to an unhoused patient with opioid use disorder (OUD)?)	5.00
Standard Deviation (Q2 - After watching this video, how likely are you to prescribe Suboxone to an unhoused patient with opioid use disorder (OUD)?)	1.14
Count	13

How confident do you feel in your understanding of low-barrier buprenorphine treatment strategies for unhoused individuals? 9 ⓘ



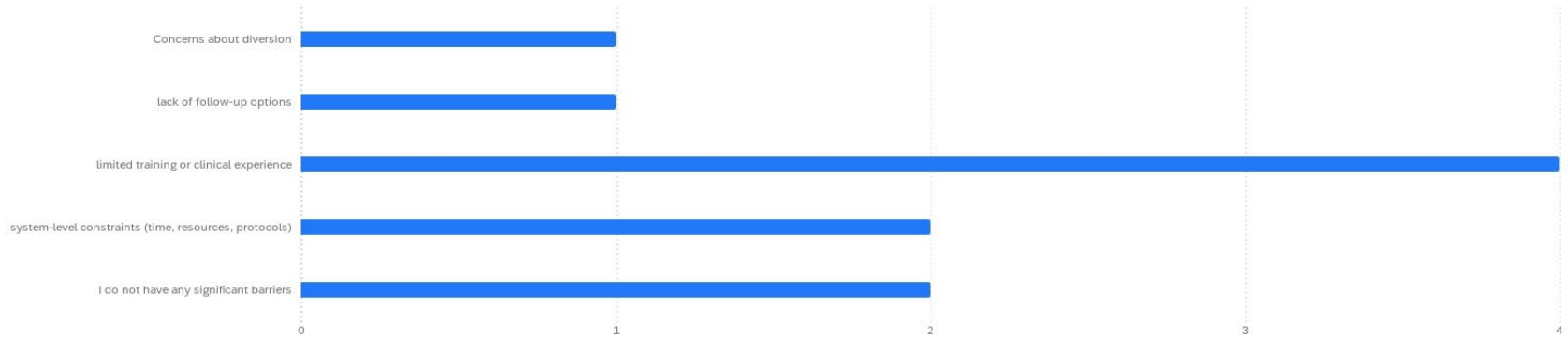
How confident do you feel in your understanding of low-barrier buprenorphine treatment strategies for unhoused individuals? 9 ⓘ

Q3 - How confident do you feel in your understanding of low-barrier buprenorphine treatment strategies for unhoused individuals?	Count	Count
Neither confident nor unconfident	56%	5
Somewhat confident	33%	3
Extremely confident	11%	1

How confident do you feel in your understanding of low-barrier buprenorphine treatment strategies for unhoused individuals? 13 ⓘ

Average (Q3 - How confident do you feel in your understanding of low-barrier buprenorphine treatment strategies for unhoused individuals?)	3.11
Minimum (Q3 - How confident do you feel in your understanding of low-barrier buprenorphine treatment strategies for unhoused individuals?)	1.00
Maximum (Q3 - How confident do you feel in your understanding of low-barrier buprenorphine treatment strategies for unhoused individuals?)	4.00
Standard Deviation (Q3 - How confident do you feel in your understanding of low-barrier buprenorphine treatment strategies for unhoused individuals?)	0.87
Count	13

What do you perceive as your biggest barrier to prescribing Suboxone to the unhoused? (Select one) 10 ⓘ



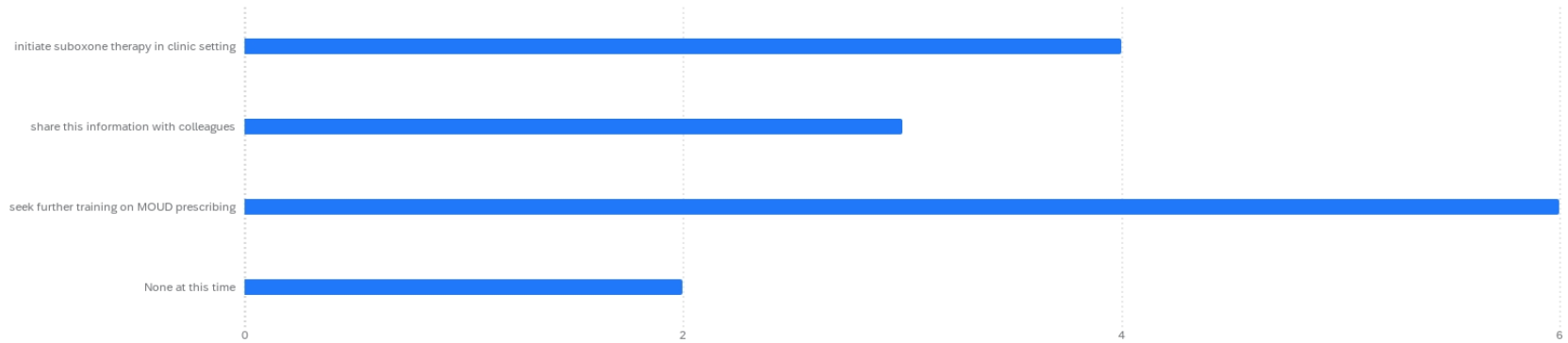
What do you perceive as your biggest barrier to prescribing Suboxone to the unhoused? (Select one) 13 ⓘ

Average (Q4 - What do you perceive as your biggest barrier to prescribing Suboxone to the unhoused? (Select one))	3.30
Minimum (Q4 - What do you perceive as your biggest barrier to prescribing Suboxone to the unhoused? (Select one))	1.00
Maximum (Q4 - What do you perceive as your biggest barrier to prescribing Suboxone to the unhoused? (Select one))	5.00
Standard Deviation (Q4 - What do you perceive as your biggest barrier to prescribing Suboxone to the unhoused? (Select one))	1.19
Count	13

What do you perceive as your biggest barrier to prescribing Suboxone to the unhoused? (Select one) 10 ⓘ

Q4 - What do you perceive as your biggest barrier to prescribing Suboxone to the unhoused? (Select one)	Count	Count
Concerns about diversion	10%	1
lack of follow-up options	10%	1
limited training or clinical experience	40%	4
system-level constraints (time, resources, protocols)	20%	2
I do not have any significant barriers	20%	2

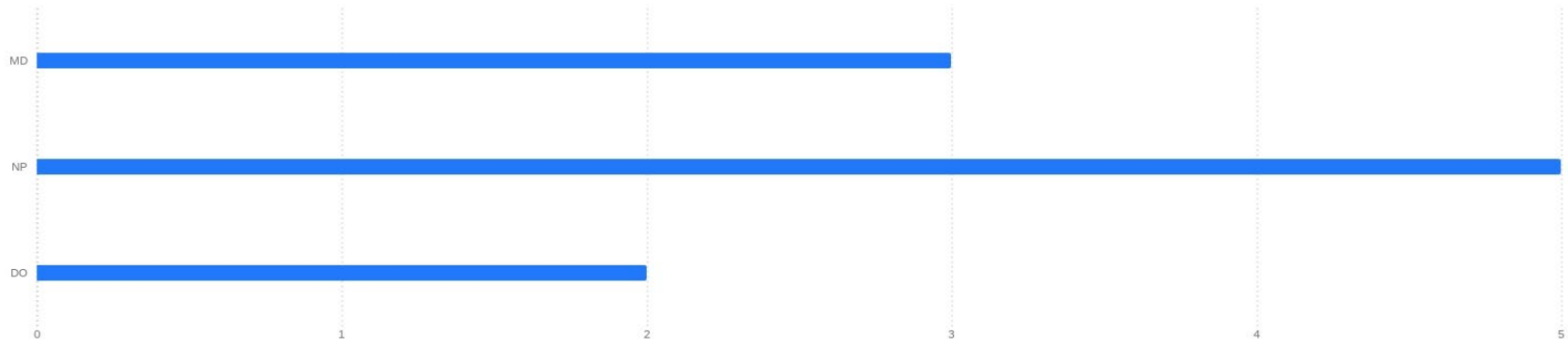
What action(s) are you most likely to take after this video? (Select all that apply) 10 ⓘ



What action(s) are you most likely to take after this video? (Select all that apply) 10 ⓘ

Q6 - What action(s) are you most likely to take after this video? (Select all that apply)	Count	Count
initiate suboxone therapy in clinic setting	40%	4
share this information with colleagues	30%	3
seek further training on MOUD prescribing	60%	6
None at this time	20%	2

What type of provider are you? 10 ⓘ



What type of provider are you? 10 ⓘ

Q6 - What type of provider are you?	Count	Count
MD	30%	3
NP	50%	5
DO	20%	2

What type of provider are you? 13 ⓘ

Average (Q6 - What type of provider are you?)	2.60
Minimum (Q6 - What type of provider are you?)	1.00
Maximum (Q6 - What type of provider are you?)	4.00
Standard Deviation (Q6 - What type of provider are you?)	1.11
Count	13

How many years of experience do you have as a provider? 10 ⓘ



How many years of experience do you have as a provider? 10 ⓘ

Q7 - How many years of experience do you have as a provider?	Count	Count
less than 5	10%	1
5-10	60%	6
10-15	10%	1
greater than 15	20%	2

How many years of experience do you have as a provider? 13 ⓘ

Average (Q7 - How many years of experience do you have as a provider?)	2.40
Minimum (Q7 - How many years of experience do you have as a provider?)	1.00
Maximum (Q7 - How many years of experience do you have as a provider?)	4.00
Standard Deviation (Q7 - How many years of experience do you have as a provider?)	0.92
Count	13

Appendix K

IRB Letter



University of Arizona IRB
 845 N Park Ave., Suite 537A
 Tucson, AZ 85719
 Fax: 520-621-9810
VPR-IRB@arizona.edu

NOT HUMAN RESEARCH

July 8, 2025

Deni Gardner

Dear Deni Gardner:

On 7/8/2025, the IRB reviewed the following submission:

Type of Review:	Initial Study
Title:	Decreasing Provider Hesitancy to Initiate Suboxone Therapy for the Unhoused: A Quality Improvement Project
Investigator:	Deni Gardner
IRB Submission ID:	STUDY00006629
Sponsor:	None
Prime Sponsor:	None
IND, IDE, or HDE:	None
Documents Reviewed:	<ul style="list-style-type: none"> • Advisor Attestation.docx, Category: Other; • IRB application.docx, Category: IRB Protocol; • Post video survey.docx, Category: Data Collection Tool; • Pre survey.docx, Category: Data Collection Tool; • quick start guide QR code.docx, Category: Participant Material; • recruitment email document.docx, Category: Participant Material; • Recruitment Flyer.docx, Category: Recruitment Materials; • Site Authorization Letter.pdf, Category: External Site Authorization; • Suboxone_Storyboard_Table_FullSlide.pptx, Category: Participant Material; • survey consent document.docx, Category: Consent Form;





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The IRB determined that the proposed activity is not research involving human subjects as defined by DHHS and FDA regulations.

IRB review and approval by this organization is not required. This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these activities are research involving humans in which the organization is engaged, please submit a new request to the IRB for a determination.

All Covered Individuals must disclose all sponsored and non-sponsored Research Projects to the Office for Responsible Outside Interests (OROI) prior to Conducting Research if the individual is an Investigator. Please visit the [OROI](#) website for more information.

We value your feedback and would appreciate you taking the time to complete our survey about your experience with the IRB staff:

https://uarizona.co1.qualtrics.com/jfe/form/SV_ehQ04WxNA06b42i.

If questions arise at any time during your study, please email the general IRB inbox at VPR-IRB@arizona.edu.



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