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RESEARCH

Pharmacists' readiness to provide naloxone in community pharmacies in West Virginia

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ABSTRACT

Objectives: The objective of this study is to assess West Virginia pharmacists' stocking and dispensing practices of opioid-related medications and to identify the educational needs relating to providing naloxone in community pharmacies.
Design: A cross-sectional, anonymous, 49-item survey was created and validated to assess the educational needs of West Virginia community pharmacists.
Setting: West Virginia.
Participants: The data collection instrument was administered to 266 pharmacists currently licensed in West Virginia at 6 continuing pharmacy education events throughout the state from March 1 to June 15, 2016.
Outcome measures: Pharmacists' educational needs were determined using the Extended Parallel Process Model, which has 4 main constructs: perceived severity, perceived susceptibility, response efficacy, and self-efficacy. Pharmacists' stocking and dispensing of opioids and related medications were also assessed.
Results: Pharmacists completed 157 surveys. They were mostly male (56.1%), full-time employees (67.5%), worked mostly in community pharmacies (69.4%), and had a mean age of 50.19 years (SD = 13.62). The newly adapted opioid perceived efficacy and perceived severity of opioid adverse events scales were tested for reliability and validity. Only 20.4% of the community pharmacists surveyed felt comfortable selling naloxone without a prescription. As for the other opioid-related medications, only 53.3% stocked buprenorphine and 74.8% stocked buprenorphine/naloxone.
Conclusions: As the most accessible health care providers, community pharmacists are acutely aware of how the opioid epidemic affects their communities. Some pharmacists in West Virginia are hesitant to stock and dispense opioids and opioid-dependence medications. Although this may decrease the flow of potentially abused drugs into the community, it may also restrict access to necessary therapy for patients with opioid use disorder. Furthermore, pharmacists in West Virginia are not yet comfortable stocking and dispensing naloxone. Tailored educational materials can help in controlling the pharmacists' fear and reinforce the benefits of over-the-counter naloxone use.

Opioid misuse and abuse is a health crisis in the United States, with 1.9 million Americans abusing prescription opioids in 2014.[1-4] The picture becomes more grim for those living in Appalachia, a cultural region stretching from southern New York to northern Mississippi.[5] Appalachia includes all of West Virginia and parts of 12 other states. In 2015, West Virginia had the most deaths caused by drug overdoses, with 35.5 deaths per 100,000 inhabitants—twice the national average.[4] Because of its reliance on community pharmacies to provide access to health care professionals and its current high levels of opioid abuse and associated high death rate, West Virginia was chosen as the state to evaluate the capacity of community pharmacies to provide the potentially life-saving drug, naloxone.[4,6]

Community pharmacists are the most widely available health care professionals,[7] and they have a key role in community-

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Key Points

Background:

- Opioid prescribing, misuse, and abuse has increased significantly over the past 2 decades to become a health crisis in the United States.
- West Virginia leads the nation with 35.5 deaths per 100,000 inhabitants because of prescription drug overdose—twice the national average.
- Community pharmacists can have great individual responsibility and control over what medications are stocked and dispensed in their pharmacies.

Findings:

- Few community pharmacists felt comfortable selling naloxone without a physician's prescription.
- Using the Extended Parallel Process Model, tailored educational materials need to focus on controlling the pharmacists' fear and reinforcing the benefits of increased naloxone availability through community pharmacies.

based harm reduction strategies to prevent unintentional injuries and to reduce the number of deaths related to opioid overdose.[8-11] Community pharmacies throughout the country have taken on naloxone distribution as part of the public health mission to prevent opioid overdose–related deaths.[8] To maximize pharmacists' efforts in this regard, states have expanded pharmacists' legal abilities to furnish naloxone.[8,12-15]

Community pharmacists are the gatekeepers to prescription opioids and medications used to treat opioid use disorder. Providing naloxone within the community pharmacy is a voluntary act; therefore, pharmacists' stocking and dispensing practices must be evaluated to determine the real-world availability of these medications.[16,17] Previous literature suggested that pharmacists' stocking and dispensing behaviors can be influenced by their perceptions of opioid abuse in their communities.[17] Wright et al.[17] measured the level of concern about prescription drug abuse in the community among health care providers in Indiana. More than 80% of the licensed pharmacists who responded dispensed fewer controlled substances, usually out of concern for community opioid abuse.[17]

Community pharmacists have been shown to worry about community opioid abuse. To help mitigate these concerns, provider education must be made available to help pharmacists do their jobs more effectively.[18] Education has been identified as a key component in curbing opioid abuse in the United States.[3,18,19] Educational materials need to be formulated with a validated framework to affect change in certain outcomes. One such framework, the Extended Parallel Process Model (EPPM), has been used extensively to create public communication campaigns by appealing to the individual's desire to control either danger or fear.[20,21] EPPM has 4 key constructs that need to be measured to categorize individuals into 4 groups with unique educational goals: (1) perceived severity, (2) perceived susceptibility, (3) response efficacy, and (4) self-efficacy.[20-22] Perceived severity and perceived susceptibility are considered threat variables, and response efficacy and self-efficacy are efficacy variables. By measuring these constructs, 1 of 4 unique educational strategies can be identified that best match with the pharmacists (Table 1). Evaluating the perceptions and actions of the community pharmacists providing naloxone in community pharmacies has been identified as an important next step by clinicians and promulgated by the American Pharmacists Association.[13]

With this in mind, the current study was guided by the leading research question surrounding pharmacist behavior and practices: what is the community pharmacists' readiness regarding stocking and dispensing of opioid-related medications in West Virginia? Based on the EPPM, it was expected that the methods for conferring education to West Virginia pharmacists will need to be individualized to certain groups falling into the aforementioned categories in Table 1. With the recent passage of a law allowing pharmacists to act as first responders and naloxone providers, effective educational materials are needed quickly.[23]

Objectives

The objective of this study is to identify the educational needs relating to over-the-counter naloxone and to assess West Virginia pharmacists' stocking and dispensing practices of opioid-related medications.

Methods

A cross-sectional, anonymous, 49-item survey was created to assess the educational needs of community pharmacists in West Virginia (see full survey in the Appendix). Content validity and comprehension of the survey was assessed by 4 pharmacists and revised based on their feedback. The survey items were separated into 4 sections. The first section collected pharmacists' demographics and practice characteristics. Demographics included age and sex. Practice characteristics included licensure status, licensure state, primary employment county, hours worked per week, position, year of first licensure, and type of pharmacy of primary employment. The categories for licensure decade, types of pharmacy employment, and position were incorporated from the 2014 National Pharmacist Workforce Survey.[24]

The second section contained 26 items, including an approximation of opioid-related medication processing and a group of items that used a 5-point Likert scale ranging from 1 (representing “strongly disagree”) to 5 (representing “strongly agree”). Those items included an opioid perceived efficacy scale (6 items), buprenorphine and buprenorphine/naloxone efficacy (3 items), opioid adverse event scale (6 items), naloxone self-efficacy (1 item), response efficacy (1 item), and other opioid-related medication perceptions (6 items). The 2 opioid scales were adapted from the Clinicians' Attitudes and Beliefs about Opioids Survey (CAOS) perceived effectiveness and impediments and concerns subscales[25] for use with pharmacists. Despite the perceived effectiveness of opioids and the impediment and concerns items being valid content areas for pharmacists, the CAOS instrument was originally developed for physicians.[25] To ensure the appropriateness of these items for pharmacists, validity and reliability testing were performed in the pharmacist sample. The mean scale scores, scale statistics, and the individual items are listed in Table 2.

Table 1
Individualized educational strategies based on constructs measured as part of the Extended Parallel Process Model

	High Efficacy: High belief in the effectiveness of the intervention and their ability to provide the intervention (response efficacy and self-efficacy)	**Low Efficacy**: Low belief in the effectiveness of the intervention and their ability to provide the intervention
High Risk: High belief that the threat is harmful (Perceived severity and Perceived susceptibility)	Pharmacists believe that community naloxone use is highly effective and the risk in their community is high. Education needs to provide a call to action and an infrastructure to deliver the intervention.	Pharmacists believe that their communities are at risk, but do not believe that they are capable providing naloxone or in the effectiveness of its use. Education needs to focus on their ability to act and the role they can play.
Low Risk: Low belief that the threat is harmful	Pharmacists believe in the effectiveness of the intervention, but are not convinced the risk of opioid death in their community warrants their involvement. Education needs to focus on the risk of opioid misuse and abuse in their communities.	Pharmacists believe that their communities are not at risk and they are unable to provide the intervention. Education will need to focus on both their ability to act and the risks in their community.

The Extended Parallel Process Model audience and strategies were modified from the Health Communication Capacity Collaborative's Research Primer.[22]

Section 3 contained 13 items and was to be completed only by community pharmacists. This section focused on stocking practices (2 items), new prescriptions processed (1 item), dispensing practices (8 items), and estimated community opioid-related medication misuse and abuse (2 items). The final section contained an open-ended question allowing all pharmacists to expand on their thoughts about opioid use and prescribing in their county.

Participants were recruited to complete an anonymous paper version of the survey while attending 1 of 6 live continuing pharmacy education (CPE) events throughout West Virginia from March 1 through June 15, 2016. Eligible participants were pharmacists currently licensed in West Virginia. Participants left completed surveys in a collection box in the back of the room to maintain anonymity. The project was approved by the West Virginia University Institutional Review Board.

Data analyses

Data were entered manually into an Excel spreadsheet by 2 of the researchers. To reduce the possibility of an incorrectly entered value, limits were placed on each cell. Data were validated to identify gaps or inaccuracies in the information by looking for outliers. Principal Component Analyses and Cronbach's α statistics were assessed for the 2 newly adapted scales (opioid perceived efficacy scale and perceived severity of opioid adverse event scale). Principal component analysis is a data reduction technique that selects a subset of variables based on correlation or covariance (validity). Cronbach's α is a measure of internal consistency of the scale (reliability). The threshold values of Principal Component Analysis and Cronbach's α were set at 0.4 and 0.7, respectively. The minimum sample size of 50 respondents for scale development was determined using the ratio of 10 respondents per item.[26,27]

Descriptive (e.g., frequencies, means, and standard deviations) and inferential statistics were used to describe the data from this cross-sectional research survey. A χ^2 analysis was used to examine the differences in demographics between all respondents and the community pharmacist subgroup. This comparison was used to validate the 2 new scales for all pharmacists. All statistical analyses assumed a significance level of $\alpha = 0.05$. The study data were analyzed using SPSS Statistics version 24.

Results

At the 6 live CPE events, 266 individual pharmacists were in attendance, resulting in 160 returned surveys (60.2% response rate). Three surveys were incomplete, resulting in a 59.0% (n = 157) usable response rate. The respondents were mostly male (56.1%), full-time employees (67.5%); they worked mostly in community pharmacies (69.4%), and had a mean age of 50.19

Table 2
Scale development for community pharmacists

Variable	Mean[a]	SD	Component 1	Cronbach's α[b]
Opioid perceived efficacy scale items (n = 106)				0.742
Opioids are the most effective treatments available for persistent pain.	3.01	0.96	0.71	
In general, opioids are effective for nociceptive pain.	3.33	0.93	0.70	
In general, opioids are effective for mixed pain.	3.27	0.88	0.80	
In general, opioids are effective for neuropathic pain.	2.35	0.87	0.60	
Opioids are effective in controlling chronic non-cancer pain.	3.34	0.93	0.69	
Scale mean score	15.30	3.21	—	—
Perceived severity of opioid adverse event scale items (n = 105)				0.787
Physical dependence is an impediment to taking opioids for long periods of time.	3.72	0.87	0.74	
Tolerance is an impediment to taking opioids for long periods of time.	3.75	0.84	0.67	
Addiction is an impediment to taking opioids for long periods of time.	3.89	0.84	0.69	
Cognitive functioning side effects are an impediment to taking opioids for long periods of time.	3.66	0.86	0.77	
Taking opioids for long periods of time will decrease their efficacy.	3.80	0.90	0.59	
Long-term opioids are an impediment to physical functioning.	3.50	1.02	0.72	
Scale mean score	22.32	3.72	—	—

[a] Mean scores were estimated using the 5-point Likert scale which ranged from 1 (representing "strongly disagree") to 5 (representing "strongly agree").
[b] Cronbach's α is an estimate of how closely a set of survey items are as a group. This value can also be used to assess the reliability of a psychometric test or scale in a survey.

Table 3
Demographics for all pharmacists and community pharmacist subgroup

Demographic	All pharmacists (n = 157)	Community pharmacists only (n = 109)
Mean age, years (SD)	50.19 (13.62)	48.8 (12.98)
Missing	2 (1.3%)	2 (1.8%)
Employment status, n (%)		
Full-time	106 (67.5)	79 (72.5)
Part-time	45 (28.7)	27 (24.8)
Missing	6 (3.8)	3 (2.8)
Employment position, n (%)		
Owner or part-owner	19 (12.1)	17 (15.6)
Management (includes pharmacist-in-charge)	40 (25.5)	30 (27.5)
Staff	93 (59.2)	60 (55.0)
Missing	5 (3.2)	2 (1.8)
Licensed decade, n (%)		
1970 and before	12 (7.6)	8 (7.3)
1971 to 1980	32 (20.4)	16 (14.7)
1981 to 1990	35 (22.3)	27 (24.8)
1991 to 2000	38 (24.2)	29 (26.6)
2001 to 2010	24 (15.3)	19 (17.4)
2011 or later	16 (10.2)	10 (9.2)
Gender, n (%)		
Female	69 (43.9)	48 (44.0)
Male	88 (56.1)	61 (56.0)

years (SD = 13.62). West Virginia was the primary state of licensure for 80.3% of the respondents. The community pharmacist subgroup used for this study's analysis is compared with all respondents in Table 3. There were no significant differences in demographics between all respondents and the community pharmacist subgroup. Pharmacists in other practice settings (e.g., hospital, long-term care, home health, retired, or other) were not used in the analysis because the objective was to provide educational materials for community pharmacists.

The opioid perceived efficacy and perceived severity of opioid adverse events scale items with mean, standard deviation, component score, and overall Cronbach's α (for each scale) are presented in Table 2. Dimensionality and reliability of the scales were acceptable since both scales loaded onto one component and had Cronbach's α scores greater than 0.7. Overall, the opioid adverse event scale, which represents the perceived severity construct, had a mean of 22.3 (SD = 3.72).

Next, the other 3 constructs in the EPPM, in addition to items related to naloxone preparedness and perceptions of the opioid problem in the community, were assessed. Only 20.4% of the community pharmacists were comfortable selling naloxone without a prescription (self-efficacy), but 72.5% disagreed with the statement that naloxone is not effective (response efficacy). For perceived susceptibility, the pharmacists estimated that 22.9% (SD = 20.7%) of individuals filling prescriptions for opioid medications were misusing or abusing opioids. Most pharmacists (84.4%) also agreed or strongly agreed that opioids were overprescribed in their counties; they were helping to curb opioid diversion (71.5%), but 42.6% agreed that they were also harming some patients by denying care. After reverse coding the item, 71.3% agreed that letting patients purchase naloxone without a prescription will increase opioid overdosing. These items are summarized in Table 4.

All pharmacists participating in the study stocked opioids in their pharmacies; however, only 53.3% stocked buprenorphine and 74.8% stocked buprenorphine/naloxone. The vast majority of pharmacists reported stocking the same or higher quantities of all 3 medication types this year compared with the previous year (89.8% for opioids, 83.1% for buprenorphine, and 88.9% for buprenorphine/naloxone). The comparative stocking was considered only if the pharmacist marked that their pharmacy stocked the medication of interest. Nearly all (89.6%) of the community pharmacists declined to fill an opioid prescription at least 1-2 times per week, but that was only the case 58.1% and 60.8% of the time for buprenorphine and buprenorphine/naloxone, respectively. The 2 geographic factors assessed (out-of-state and out-of–local area prescribing) were significantly associated with whether the pharmacist would fill the prescriptions for opioids. The results for each item are provided in Table 5.

Table 4
Community pharmacists' naloxone preparedness, perceptions, and estimated community misuse and abuse (n = 109)

Variable	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Naloxone outcomes					
Self-efficacy: I am comfortable selling naloxone over the counter in my pharmacy. (n = 108)	17 (15.7%)	37 (34.3%)	32 (29.6%)	20 (18.5%)	2 (1.9%)
Response efficacy: Using naloxone for opioid overdose is not effective.	23 (21.1%)	56 (51.4%)	24 (22.0%)	6 (5.5%)	0 (0.0%)
Prepared: I do not feel I am adequately trained in the use of naloxone over the counter.	2 (1.8%)	9 (8.3%)	14 (12.8%)	50 (45.9%)	34 (31.2%)
Worsen problem: Letting patients purchase naloxone over the counter will increase opioid overdosing. (n = 108)	7 (6.5%)	24 (22.2%)	36 (33.3%)	30 (27.8%)	11 (10.2%)
Perceptions					
Opioids are being overprescribed by practitioners in my county.	1 (0.9%)	4 (3.7%)	12 (11.0%)	48 (44.0%)	44 (40.4%)
Pharmacists are curbing opioid diversion and abuse by declining to fill some prescriptions for opioids.	0 (0.0%)	12 (11.0%)	19 (17.4%)	65 (59.6%)	13 (11.9%)
Pharmacists are harming some patients who have legitimate pain issues by declining to fill some prescriptions for opioids. (n = 108)	3 (2.8%)	32 (29.6%)	27 (25.0%)	43 (39.8%)	3 (2.8%)
Misuse, mean (SD)					
For every 100 patients in your pharmacy who fill prescriptions for opioid analgesics excluding buprenorphine/naloxone and buprenorphine, how many patients do you estimate misuse or abuse prescription opioids? (n = 103)					22.9 (20.7)
For every 100 patients in your pharmacy who fill prescriptions for buprenorphine/naloxone and buprenorphine, how many patients do you estimate misuse or abuse them? (n = 82, excluding those who did not stock)					23.6 (26.8)

Table 5
Stocking and dispensing outcomes by community pharmacists (n = 109)

Do you order and stock the following products for your primary employment site?			
	Yes	**No**	
Opioid analgesics (n = 107)	107 (100%)	0 (0.0%)	
Buprenorphine (n = 107)	57 (53.3%)	50 (46.7%)	
Buprenorphine/naloxone (n = 107)	80 (74.8%)	27 (25.2%)	
Have you ever declined to fill a prescription for a patient for the following products?			
	Rarely, if ever	**≥1-2 times per week**	
Opioid analgesics (n = 106)	11 (10.4%)	95 (89.6%)	
Buprenorphine (n = 93)	39 (41.9%)	54 (58.1%)	
Buprenorphine/naloxone (n = 97)	38 (39.2%)	59 (60.8%)	
How likely are you to fill a prescription for the following products written by an out-of-state practitioner?			
	Not at all likely	**Somewhat likely or higher**	
Opioid analgesics (n = 108)	40 (37.0%)	68 (63.0%)	
Buprenorphine (n = 102)	75 (73.5%)	27 (26.5%	
Buprenorphine/naloxone (n = 103)	66 (64.1%)	37 (35.9%)	
How likely are you to fill a prescription for the following products for a patient who does not live within your pharmacy's local area (eg, patient lives outside a 20-mile radius of your pharmacy)?			
	Not at all likely	**Somewhat likely or higher**	
Opioid analgesics (n = 107)	60 (56.1%)	47 (43.9%)	
Buprenorphine (n = 102)	84 (82.4%)	18 (17.6%)	
Buprenorphine/naloxone (n = 103)	77 (74.8%)	26 (25.2%)	
In the past year, has your pharmacy stocked more, less, or about the same quantity of the following products compared to the previous year?			
	More	**Less**	**About the same**
Opioid analgesics (n = 108)	38 (35.2%)	11 (10.2%)	59 (54.6%)
Buprenorphine (n = 59, excluding those who did not stock)	24 (40.7%)	10 (16.9%)	25 (42.4%)
Buprenorphine/naloxone (n = 81, excluding those who did not stock)	46 (56.8%)	9 (11.1%)	26 (32.1%)

Discussion

Only one-fifth of the pharmacists surveyed are comfortable selling naloxone without a prescription in their pharmacy, and three-quarters of the respondents do not believe they are adequately trained in the use of naloxone. There is clearly an educational need regarding naloxone use in West Virginia pharmacists. By allowing well-trained pharmacists to dispense naloxone without a prescription, many of the patients' barriers to accessing naloxone in the community[8] can be removed. However, the access to naloxone will only increase if the pharmacists choose to be trained[15] and to stock the naloxone products.

All community pharmacists indicated that their pharmacies stocked opioid medications; however, the availability of medications for opioid use disorder (buprenorphine and buprenorphine/naloxone) is less than opioids themselves. Pharmacists are trusted health care providers, trained in the safe and effective uses of medications. This trust and relative autonomy in stocking and dispensing decisions emphasizes the importance of community pharmacists in combating community public health crises such as opioid abuse. This research provides insight into the practices and attitudes that drive those practices for West Virginia pharmacists. It is not readily apparent why pharmacists would not be comfortable providing naloxone without a prescription. However, the huge range of estimated opioid misuse or abuse and the high percentage of pharmacists who believe that letting patients purchase naloxone without a prescription will increase overdosing do not help to alleviate this stress. These results indicate that research into their tailored educational needs is required to optimize naloxone's availability and use in the state.

The community pharmacists surveyed had an above-average perceived severity and perceived efficacy scores, as measured with the newly adapted and validated scales. Both of these constructs make up the threat variables of the EPPM and represent the perceived threat relating to opioid abuse in the pharmacists' communities. Self-efficacy and response efficacy make up the efficacy variables in the EPPM. Both of these items had low scores, indicating that the community pharmacists participating believe that their ability to practice effective naloxone distribution in the community is low.

Community pharmacists also had high threat and low efficacy levels according to the EPPM. As shown in Table 1, pharmacists believe that their communities are at risk (high-threat constructs), but do not believe that they are currently capable of providing naloxone or in the effectiveness of its use in the community (low-efficacy constructs). These needs are in stark contrast to the currently mandated[23] educational materials provided by the West Virginia Office of Emergency Medical Services. The training materials were created for first responders; they are not pharmacist-specific, and they emphasize emergency use of naloxone rather than the provision of it in the community for future use.[28] With this model, educational needs should focus on controlling pharmacists' fear as a means to increase pharmacists' ability to act and to emphasize the role they can play to help patients in West Virginia.

With the exponential growth in opioid prescribing and high death rate caused by opioid overdoses in West Virginia, community pharmacists are in a unique position to bring about change as the epidemic continues to be battled. One important aspect of care that community pharmacists can influence is access to medications used to treat opioid use disorder, specifically buprenorphine, buprenorphine/naloxone, and naloxone. All 3 of these medications have proven efficacy in the treatment of opioid use disorder.[29-31] If access to these

medications is not provided, there are disparities in the availability of effective treatments for opioid use disorder. The risk of opioid-related injury and death is shared by many stakeholders, including patients, prescribers, and pharmacists.[8]

Limitations

There were potential limitations to this study. First, survey results of pharmacists from one state might not be generalizable to pharmacists in other states. However, these results are being used to develop educational materials tailored to the needs of pharmacists in West Virginia based on the EPPM. Second, the validity of the results may be affected by the usual limitations of self-report questionnaires; therefore, it might not fully reflect the respondents' beliefs, attitudes, or actual practices. Another potential limitation is that a convenience sample of pharmacists was used for this survey. The demographics of the nonresponders at the CPE events could not be compared with those who did complete the survey. Future research that uses a sampling frame could assess this nonresponse bias.

Conclusion

The risk for opioid-related injury and death has increased steadily and markedly over the past decade because of a confluence of factors. As the most accessible health care providers, community pharmacists are acutely aware of how this epidemic affects their communities. Some pharmacists in West Virginia are hesitant to stock and dispense opioids and opioid-dependence medications. Although this might decrease the flow of potentially abused drugs into the community, it can also restrict access to necessary therapy for patients with opioid use disorder.

Furthermore, pharmacists in West Virginia are not yet comfortable stocking and dispensing naloxone. Tailored educational materials can be helpful to control the fear and reinforce the benefits of over-the-counter naloxone use. Ongoing research will allow the results to be weighted demographically to improve generalizability so that statewide education can be implemented quickly and effectively.

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Appendix

Pharmacist Stocking and Dispensing Practices Survey

Instructions: Taking part in this study includes doing a brief 10-15−minute survey. This survey is anonymous. Your personal information will not be stored and will not be used to identify your responses or shared with anyone. Your participation is voluntary. You may refuse to answer any questions or stop the survey at any time without penalty.

If you have any questions or if you are distressed by this survey, you may ask me or call Dr. [redacted] at [redacted], the principal investigator of the study for additional information.

Section 1: Demographics and feelings on opioids and related disorders

1. Are you a licensed pharmacist?

   ▫ Yes ▫ No ***(If no, please STOP survey)***

2. Please list the STATES in which you are licensed: (Example: FL, MD)_____

3. In what COUNTY and STATE is your primary employment (where you have worked the most hours the past 12 months)? (Example: Kanawha, West Virginia) _____

4. Estimate the number of hours you work per week at your primary employment site (Choose: 0-40)_____

5. What position best describes your employment?

   ▫ Owner or Part-owner ▫ Management (Includes Pharmacist-in-charge) ▫ Staff

6. In what year were you first licensed?

   ▫ 1970 or before
   ▫ 1971 to 1980
   ▫ 1981 to 1990
   ▫ 1991 to 2000
   ▫ 2001 to 2010
   ▫ 2011 or later

7. What is your age in years? _____

8. Gender

   ▫ Female ▫ Male ▫ Other

9. What type of pharmacy best describes where you are primarily employed as a licensed pharmacist?

   ▫ Community, Retail Chain
   ▫ Community, Independent
   ▫ Community, Supermarket
   ▫ Hospital
   ▫ Long-term care/Home Health
   ▫ Retired
   ▫ Other patient care (*please specify*, _____)
   ▫ Other non-patient care (*please specify*, _____)

Please use this list of pharmaceutical agents for reference to answer questions 10-49.

Opioid analgesics		Opioid partial agonist/antagonists	
Generic name	Brand name(s)	Generic name	Brand name(s)
codeine	Tylenol #2, 3, 4	buprenorphine	Subutex
hydromorphone	Dilaudid	buprenorphine/naloxone	Suboxone, Zubsolv
morphine	Morphine IR, MS Contin, Kadian, Avinza	naloxone	Narcan
oxycodone	Tylox, Percocet, Percodan, Oxycontin		
hydrocodone	Lortab, Vicodin, Vicoden ES, Vicoprofen, Norco		
fentanyl	Duragesic patches		
methadone	—		

10. For every 100 prescriptions filled (or orders processed for hospital pharmacists), approximately how many are for the following products? **(Please answer 0-100 for each)**

a. Opioid analgesics
b. Buprenorphine (*Subutex*)
c. Buprenorphine/naloxone (*Suboxone*)

11. Are you aware of West Virginia House Bill 4035 which would permit pharmacists to sell naloxone over the counter without a prescription?

▫ Yes ▫ No

Please indicate how much you agree or disagree with the following statements by checking the appropriate box.

Variable	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1. Opioids are the most effective treatments available for persistent pain.	▫	▫	▫	▫	▫
2. In general, opioids are effective for nociceptive pain.	▫	▫	▫	▫	▫
3. In general, opioids are effective for mixed pain.	▫	▫	▫	▫	▫
4. In general, opioids are effective for neuropathic pain.	▫	▫	▫	▫	▫
5. Taking opioids for long periods of time is necessary for many of my chronic non-cancer pain patients.	▫	▫	▫	▫	▫
6. Opioids are effective in controlling chronic non-cancer pain.	▫	▫	▫	▫	▫
7. In general, buprenorphine and buprenorphine/naloxone are effective for treating opioid dependence.	▫	▫	▫	▫	▫
8. Buprenorphine and buprenorphine/naloxone are the most effective treatment choice available for opioid dependence.	▫	▫	▫	▫	▫
9. Taking buprenorphine and buprenorphine/naloxone for long periods of time is necessary for many of my opioid-dependent patients.	▫	▫	▫	▫	▫
10. Physical dependence is an impediment to taking opioids for long periods of time.	▫	▫	▫	▫	▫
11. Tolerance is an impediment to taking opioids for long periods of time.	▫	▫	▫	▫	▫
12. Addiction is an impediment to taking opioids for long periods of time.	▫	▫	▫	▫	▫
13. Long-term use of opioids is overprescribed for patients with chronic non-cancer pain.	▫	▫	▫	▫	▫
14. Cognitive functioning side effects are an impediment to taking opioids for long periods of time.	▫	▫	▫	▫	▫
15. Taking opioids for long periods of time will decrease their efficacy.	▫	▫	▫	▫	▫
16. Long-term opioids are an impediment to physical functioning.	▫	▫	▫	▫	▫
17. Some clinicians in my county prescribe opioids to their patients with chronic non-cancer pain for long periods of time too frequently.	▫	▫	▫	▫	▫
18. I do not believe that I am adequately trained in the use of naloxone over the counter.	▫	▫	▫	▫	▫
19. Using naloxone for opioid overdose isn't effective.	▫	▫	▫	▫	▫
20. Letting patients purchase naloxone over the counter will increase opioid overdosing.	▫	▫	▫	▫	▫
21. I am comfortable selling naloxone over the counter in my pharmacy.	▫	▫	▫	▫	▫
22. Opioids are being overprescribed by practitioners in my county.	▫	▫	▫	▫	▫
23. Pharmacists are curbing opioid diversion and/or abuse by declining to fill some prescriptions for opioids.	▫	▫	▫	▫	▫
24. Pharmacists are harming some patients who have legitimate pain issues by declining to fill some prescriptions for opioids.	▫	▫	▫	▫	▫

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If you are a COMMUNITY PHARMACIST (if you selected community pharmacist above in #9) PLEASE CONTINUE with questions 36-49.

Otherwise, please GO TO THE LAST PAGE to answer the final question (#49).

Section 2: The following questions will ask about practices related to STOCKING and ORDERING opioids and related medications. Please check the most appropriate answer.

36. Do you order and stock the following products for your primary employment site?

a. Opioid analgesics	▫ Yes, I do	▫ No, but someone else does	▫ No, we do not order opioids
b. Buprenorphine (*Subutex*)	▫ Yes, I do	▫ No, but someone else does	▫ No, we do not order buprenorphine
c. Buprenorphine/naloxone (*Suboxone*)	▫ Yes, I do	▫ No, but someone else does	▫ No, we do not order buprenorphine/naloxone

37. In the past year, has your pharmacy stocked more, less, or about the same quantity of the following products compared to the previous year?

a. Opioid analgesics	▫ Significantly more	▫ More	▫ About the same	▫ Less	▫ Significantly less	▫ I do not stock these products
b. Buprenorphine (*Subutex*)	▫ Significantly more	▫ More	▫ About the same	▫ Less	▫ Significantly less	▫ I do not stock these products
c. Buprenorphine/naloxone (*Suboxone*)	▫ Significantly more	▫ More	▫ About the same	▫ Less	▫ Significantly less	▫ I do not stock these products

38. How many patients per week present a new prescription for the following products?

a. Opioid analgesics
b. Buprenorphine (*Subutex*)
c. Buprenorphine/naloxone (*Suboxone*)

39. Have you ever declined to fill a prescription for a patient for the following products?

a. Opioid analgesics	▫ Yes	▫ No
b. Buprenorphine (*Subutex*)	▫ Yes	▫ No
c. Buprenorphine/naloxone (*Suboxone*)	▫ Yes	▫ No

40. How frequently would you estimate that you decline to fill an opioid for a new patient?

a. Opioid analgesics	▫ Rarely, if ever	▫ 1-2 times per week	▫ 3-5 times per week	▫ More than 5 times per week
b. Buprenorphine (*Subutex*)	▫ Rarely, if ever	▫ 1-2 times per week	▫ 3-5 times per week	▫ More than 5 times per week
c. Buprenorphine/naloxone (*Suboxone*)	▫ Rarely, if ever	▫ 1-2 times per week	▫ 3-5 times per week	▫ More than 5 times per week

41. How likely are you to fill a prescription for the following products written by an out-of-state practitioner?

a. Opioid analgesics	▫ Not at all likely	▫ Somewhat likely	▫ Likely	▫ Extremely likely
b. Buprenorphine (*Subutex*)	▫ Not at all likely	▫ Somewhat likely	▫ Likely	▫ Extremely likely
c. Buprenorphine/naloxone (*Suboxone*)	▫ Not at all likely	▫ Somewhat likely	▫ Likely	▫ Extremely likely

42. How likely are you to fill a prescription for the following products for a patient who does not live within your pharmacy's local area (eg, patient lives outside a 20-mile radius of your pharmacy)?

a. Opioid analgesics	▫ Not at all likely	▫ Somewhat likely	▫ Likely	▫ Extremely likely
b. Buprenorphine (*Subutex*)	▫ Not at all likely	▫ Somewhat likely	▫ Likely	▫ Extremely likely
c. Buprenorphine/naloxone (*Suboxone*)	▫ Not at all likely	▫ Somewhat likely	▫ Likely	▫ Extremely likely

43. For every 100 patients in your pharmacy who FILL PRESCRIPTIONS for opioid analgesics excluding buprenorphine/naloxone and buprenorphine, how many patients do you estimate misuse or abuse prescription opioids? **(Please answer 0-100)** _____
44. For every 100 patients in your pharmacy who FILL PRESCRIPTIONS for buprenorphine/naloxone and buprenorphine, how many patients do you estimate misuse or abuse them? **(Please answer 0-100)** _____
45. In the last week, how frequently have you declined to fill a prescription for an opioid out of concern that the prescription was fraudulent? Please check one of the following.

▫ Rarely, if ever	▫ 1-2 times per week	▫ 3-5 times per week	▫ More than 5 times per week

46. In the last week, how frequently have you declined to fill a prescription for an opioid out of concern that the prescription was not written for a legitimate medical purpose? Please check one of the following.

▫ Rarely, if ever	▫ 1-2 times per week	▫ 3-5 times per week	▫ More than 5 times per week

47. In the last week, how frequently have you declined to fill a prescription for buprenorphine/naloxone and buprenorphine out of concern that the prescription was fraudulent? Please check one of the following.

▫ Rarely, if ever	▫ 1-2 times per week	▫ 3-5 times per week	▫ More than 5 times per week

48. In the last week, how frequently have you declined to fill a prescription for buprenorphine/naloxone and buprenorphine out of concern that the prescription was not written for a legitimate medical purpose? Please check one of the following.

▫ Rarely, if ever	▫ 1-2 times per week	▫ 3-5 times per week	▫ More than 5 times per week

49. Please give us your thoughts on opioid use and prescribing in your county. Thank you for your time.

_____

_____

_____

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