Northern New York

Needs Assessment
Rural Practitioners Report

Center on Rural Addiction
UNIVERSITY OF VERMONT

Prepared by the UVM Center on Rural Addiction
Surveillance & Evaluation Core

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Executive Summary

The University of Vermont Center on Rural Addiction (UVM CORA) aims to expand substance use disorder (SUD) treatment capacity in rural communities by providing consultation, resources, and evidence-based technical assistance to healthcare practitioners and community partners. With our Northern New York (NNY) needs assessment, we aimed to identify SUD treatment needs and barriers in the region with direct input from rural practitioners.

In June 2023, UVM CORA invited 928 NNY practitioners to participate in an online needs assessment survey. We received 202 responses (response rate: 22%), including 162 rural practitioners who reported directly serving patients in rural areas of UVM CORA's NNY service area. Among these 162 respondents, 41 reported working in counseling roles (e.g., counselor) and 121 reported working in clinical roles (e.g., physician, nurse practitioner). Of the practitioners in clinical roles, 106 (88%) were able to prescribe medications (e.g., MD, NP), with 43 (41%) reporting currently prescribing medications for opioid use disorder (MOUD). Throughout this report, we provide comparisons between those currently prescribing MOUD vs. those not currently prescribing MOUD.

Among all practitioners, the greatest concerns about use of individual substances among their patients related to tobacco or e-cigarettes, fentanyl, and alcohol, and the greatest concerns about substance combinations related to opioids plus alcohol, opioids plus benzodiazepines, and opioids plus stimulants. Practitioners reported moderate comfort treating patients with opioid use disorder (OUD) and stimulant use disorder. Among special populations with SUDs, practitioners reported the greatest comfort treating older adults and the least comfort treating adolescents. Three quarters of practitioners reported knowing where to refer patients for OUD treatment (76%), while two thirds reported knowing where to refer patients for stimulant use disorder treatment (63%).

A greater proportion of prescribing clinicians not currently treating patients using MOUD, compared to those currently treating patients using MOUD, reported lack of training or experience and patient management concerns as top *practitioner barriers* to treating patients with OUD. A greater proportion of practitioners currently treating patients using MOUD, compared to those not currently treating patients with MOUD, endorsed medication diversion, stigma of OUD, and insurance or reimbursement as top *practitioner barriers* to treating patients with OUD. Among all practitioners, access barriers such as lack of time, transportation, housing, or other supports and lack of local treatment options were most frequently endorsed as top *patient barriers* to receiving OUD treatment.

Half of practitioners agreed that people in the community where they work have adequate access to an effective form of SUD treatment (49%), and nearly three quarters of practitioners reported that their practice or organization's leadership supports treating patients using MOUD (73%).

Most practitioners agreed that OUD is a chronic medical condition (76%) and two thirds agreed that MOUD are the most effective way to treat OUD (66%). Half of practitioners disagreed that MOUD replaces addiction to one substance with another (48%).

Among prescribing clinicians only, a greater proportion of those currently treating patients using MOUD than those not currently treating patients using MOUD agreed that MOUD are the most effective way to treat OUD (91% vs. 54%), that treating OUD is an important part of their clinical practice (88% vs. 32%), that OUD is a chronic medical condition (91% vs. 64%), and that most people with OUD who receive MOUD treatment will recover and return to productive lives (79% vs. 47%).

Overall, practitioner respondents reported experiencing positive emotions (i.e., low stigma) toward people with OUD (mean=55; scale 10–70[1]). Practitioners reported using both preferred (i.e., non-stigmatizing) and non-preferred (i.e., potentially stigmatizing) SUD terms[2] in clinical settings, with many non-preferred terms used by fewer than one third of practitioners.

Finally, when asked which resources they would like to learn more about, the resources most frequently endorsed by practitioners as high priority were recovery housing information and resources, support treating patients with polysubstance use, and support managing and coordinating care for vulnerable populations with SUDs .

Visit **uvmcora.org** to find information about our needs assessments in Vermont, New Hampshire, and Maine, as well as resources and technical assistance on substance use treatment.

Acronyms

HRSA: Health Resources and Services Administration
MOUD: Medication for Opioid Use Disorder
NNY: Northern New York
OUD: Opioid Use Disorder
SUD: Substance Use Disorder
UVM CORA: The University of Vermont Center on Rural Addiction

[1] Brown SA. Standardized measures for substance use stigma. *Drug Alcohol Depend*. 2011; 116 (1-3): 137-141. Affect Scale for substance use disorder; scale: 10 (negative emotions/high stigma) -70 (positive emotions/ low stigma).

[2] For more information about preferred and non-preferred terms, please see the National Institute on Drug Abuse's Words Matter.

Background

UVM CORA seeks to expand SUD treatment capacity in rural communities by providing consultation, resources, and evidence-based technical assistance to healthcare providers and community partners. With our Northern New York needs assessment, we aimed to identify SUD treatment needs and barriers in the region with direct input from practitioners.

Areas addressed in the survey:

- Substance use concerns
- Comfort treating SUDs
- Barriers to SUD treatment
- Beliefs about SUDs and treatment
- Stigma toward people with SUDs
- Stigmatizing and non-stigmatizing language used in clinical practice
- High priority resources

Methods

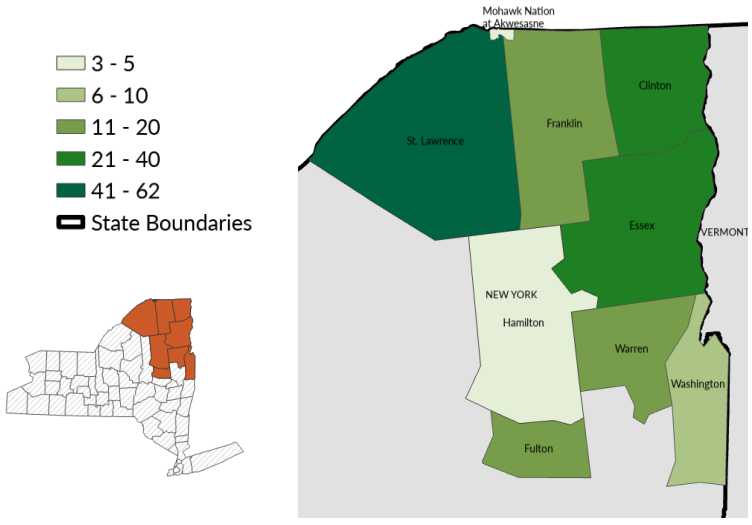
UVM CORA conducted an online needs assessment survey (June 1-30, 2023) of practitioners in our NNY service area, which includes the counties of Clinton, Essex, Franklin, Fulton, Hamilton, and St. Lawrence (designated as fully rural by HRSA), the rural areas of Warren and Washington counties (designated as partially rural by HRSA), and the Akwesasne Mohawk Nation, which lies within the geographic borders of two fully rural counties.

We collected practitioner contact information through internet searches, word-of-mouth referrals, and invited contacts in UVM CORA's network to provide practitioner contact information via an online survey. The needs assessment survey was distributed via email to 928 contacts, followed by weekly reminders.

We received 202 survey responses (response rate: 22%), 162 of which were from practitioners who reported currently working in our NNY service area in a role directly serving patients. These 162 rural NNY practitioners are the focus of this report.

We received responses from each of the counties and territories in our NNY service area, with some practitioners reporting working in more than one county (**Figure 1**).

Figure 1. Rural Practitioner Respondents



Practitioner Respondents

Demographics & Professional Roles

Practitioner respondents were primarily white (83%), non-Hispanic (93%), and female (65%), with a mean age of 47 (**Table 1**). Respondents included 121 practitioners in clinical roles (e.g., physician (MD/DO), nurse practitioner (NP)) and 41 practitioners in counseling roles (e.g., counselor, case manager; **Table 2**). Of the practitioners in clinical roles, 106 reported working in roles able to prescribe medications (e.g., MD, NP), 43 of whom reported currently treating patients using MOUD.

Table 1. Practitioner Demographics

	Clinicians	Counselors	All
Practitioner respondents – n (%)	**121 (75%)**	**41(25%)**	**162 (100%)**
Age – mean (range)	46 (25-73)	48 (21-73)	47 (21-73)
Female – n (%)	76(63%)	29(71%)	105 (65%)
White – n (%)	96 (79%)	39 (95%)	135 (83%)
Non-Hispanic – n (%)	112 (93%)	39 (95%)	151 (93%)
Prescribing Clinicians† – n (%)	106 (88%)	N/A	106 (65%)
Prescribing clinicians currently treating patients using medications for opioid use disorder (MOUD) – n (%)	43 (36%)*	N/A	43 (27%)

† See **Table 2.** for clinical roles able to prescribe medications (i.e., prescribing clinicians).
* 4 prescribing clinicians did not respond to the question "Are you currently treating patients for opioid use disorder using [MOUD]?"

Table 2. Professional Roles

Clinical Roles	121 (75%)	Counseling Roles	41 (25%)
Nurse Practitioner†	38 (23%)	Social Worker	11 (7%)
Primary Care Physician†	28 (17%)	Alcohol and Drug Counselor	7 (4%)
Specialist Physician†	19 (12%)	Recovery Coach/Peer Support	7 (4%)
Physician Assistant†	17 (10%)	Mental Health Counselor	6 (4%)
Emergency Medical Technician (EMT)	7 (4%)	Case Manager	4 (2%)
Certified Nurse Midwife†	4 (2%)	Psychologist	4 (2%)
Paramedic	4 (2%)	Other Counseling Role	2 (2%)
Nurse	3 (2%)		
Firefighter	1 (<1%)		

† Clinical roles able to prescribe medications (i.e., prescribing clinicians).

Practitioner Respondents
Work Settings & MOUD Treatment

Most practitioners (87%) worked in clinical settings, including 23% in Federally Qualified Health Centers, 19% in primary care practices, and 18% in hospital settings. (**Table 3**).

The median number of patients served by practitioners per week for all reasons was 50 among clinicians and 25 among counselors. Among clinicians who reported currently treating patients using MOUD, the median number of MOUD patients treated at a given time was 20 (*data not shown*).

Practitioners currently treating patients using MOUD reported moderate difficulty retaining patients in MOUD treatment (mean=4; scale 0–10) and moderate concern about patients not taking their MOUD as prescribed (mean=5; *data not shown*). Most practitioners reported that their patients generally receive MOUD for six months or longer (85%; *data not shown*).

Buprenorphine was the most frequently prescribed MOUD (95%) followed by naltrexone (60%) (**Table 4**).

Table 3. Work Settings

	n (%)
Clinical Settings	**141 (87%)**
Federally Qualified Health Center	37 (23%)
Primary Care Practice	30 (19%)
Hospital	29 (18%)
Mental or Behavioral Health Organization	25 (15%)
SUD Treatment Provider	10 (6%)
Opioid Treatment Program	3 (2%)
Rural Health Clinic	3 (2%)
Other Clinical Setting	4 (2%)
Community Settings	**21 (13%)**
Emergency Medical Services	13 (8%)
Recovery Community Organization	4 (2%)
School System or Higher Education	2 (1%)
Correctional Setting	1 (<1%)
Local or State Health Department	1 (<1%)
Total - N (%)	**162 (100%)**

Table 4. MOUD Prescribed

	n* (%)
Buprenorphine	41 (95%)
Naltrexone	26 (60%)
Methadone	6 (14%)

* n=43 prescribing clinicians currently treating patients with medication for opioid use disorder (MOUD; see **Table 1).**

Note: MOUD are not mutually exclusive.

Comfort Treating SUDs

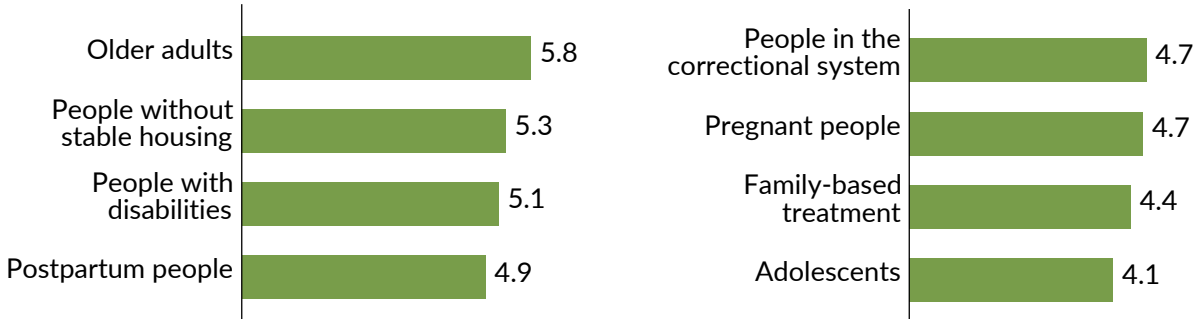
Overall, practitioners reported moderate comfort treating patients with OUD (mean=6.8; scale 0-10; **Figure 2**). Practitioners also reported moderate comfort treating patients with stimulant use disorder (mean=5.7; **Figure 2**).

Prescribing clinicians currently treating patients using MOUD reported having greater levels of training, experience, and support to induct patients on to MOUD (mean=6.7) than prescribing clinicians not currently treating patients using MOUD (mean=2.8; *data not shown*).

When asked about special populations with SUDs, practitioners reported the most comfort treating older adults (mean=5.8) and the least comfort treating adolescents (mean=4.1; **Figure 3**).

Figure 2. Mean Comfort Level Treating Opioid Use Disorder and Stimulant Use Disorder (Scale 0–10)

Figure 3. Mean Comfort Level (Scale 0–10) Providing Substance Use Disorder Services to Special Populations

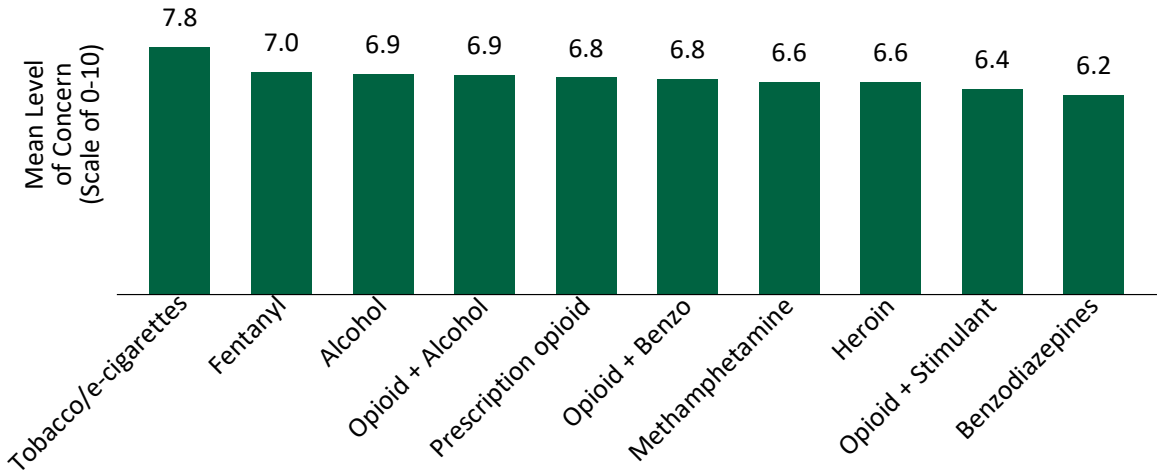


Substances of Concern

Among individual substances, practitioners reported the greatest concern about their patients' use of tobacco or e-cigarettes (mean of 7.8; scale 0–10), fentanyl (mean of 7.0), and alcohol (mean of 6.9; **Figure 4**). The substance combinations of greatest concern were opioids plus alcohol (mean of 6.9), opioids plus benzodiazepines (mean of 6.8), and opioids plus stimulants (mean of 6.4; **Figure 4**).

Some practitioners also expressed concerns about substances and substance combinations in their open-ended survey responses (see example quotes below).

Figure 4. Substances and Substance Combinations of High Concern



"[I'm concerned about] people who are mixing multiple substances in marijuana for consumption."

"[I'm concerned about] mixing of uppers and downers, multiple substances."

"[I'm concerned about] prescription drugs being pressed and laced with fentanyl."

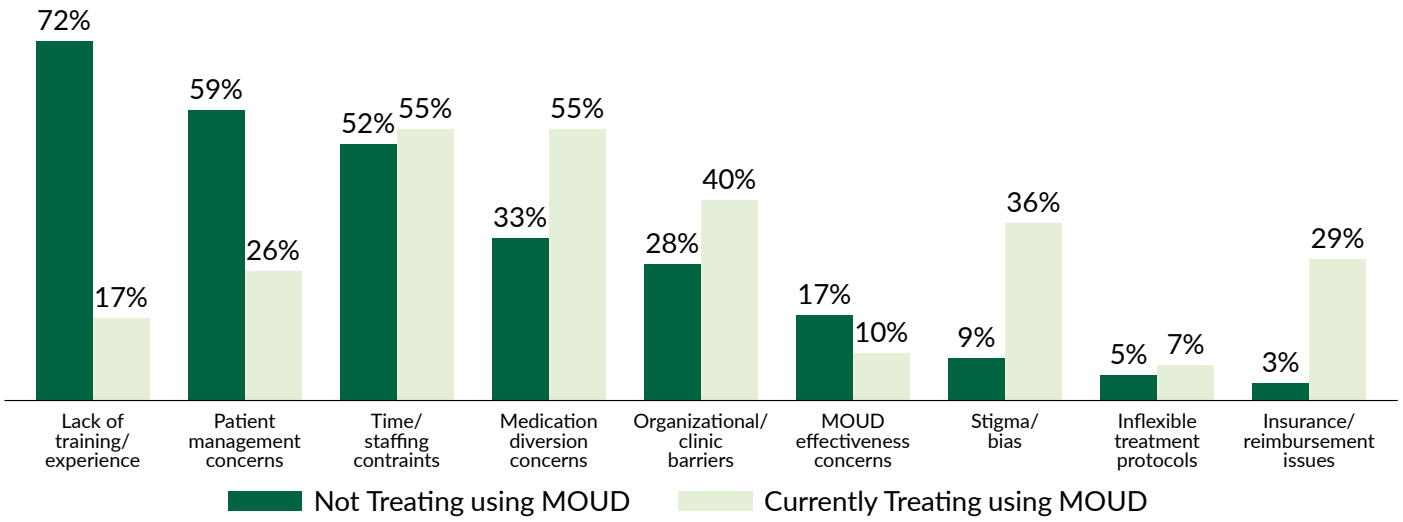
"Everything is being cut with multiple things in our area."

Prescribing Clinician Barriers

Treating Patients With Opioid Use Disorder

Among prescribing clinicians, a greater proportion of those not currently treating patients using MOUD than those currently treating patients using MOUD ranked lack of training or experience (72% vs. 17%; p<.01) and patient management concerns (59% vs 26%; p<.01) among their top three barriers to treating patients with OUD (**Figure 5**). Conversely, a greater proportion of those currently treating patients using MOUD than those not currently treating patients using MOUD reported stigma or bias (36% vs 9%; p<.01), and insurance or reimbursement issues (29% vs. 3%; p<.01) as important barriers to treating patients with OUD. Some practitioners described barriers to treating patients with OUD in their open-ended survey responses (see example quotes below).

Figure 5. Practitioner Barriers to Treating Patients with Opioid Use Disorder



"[The] biggest barrier right now is my practice environment. It is not supportive of this."

"[We need] staffing to assist with outreaching to other providers and helping maintain communication."

"Time to complete training [is a barrier]."

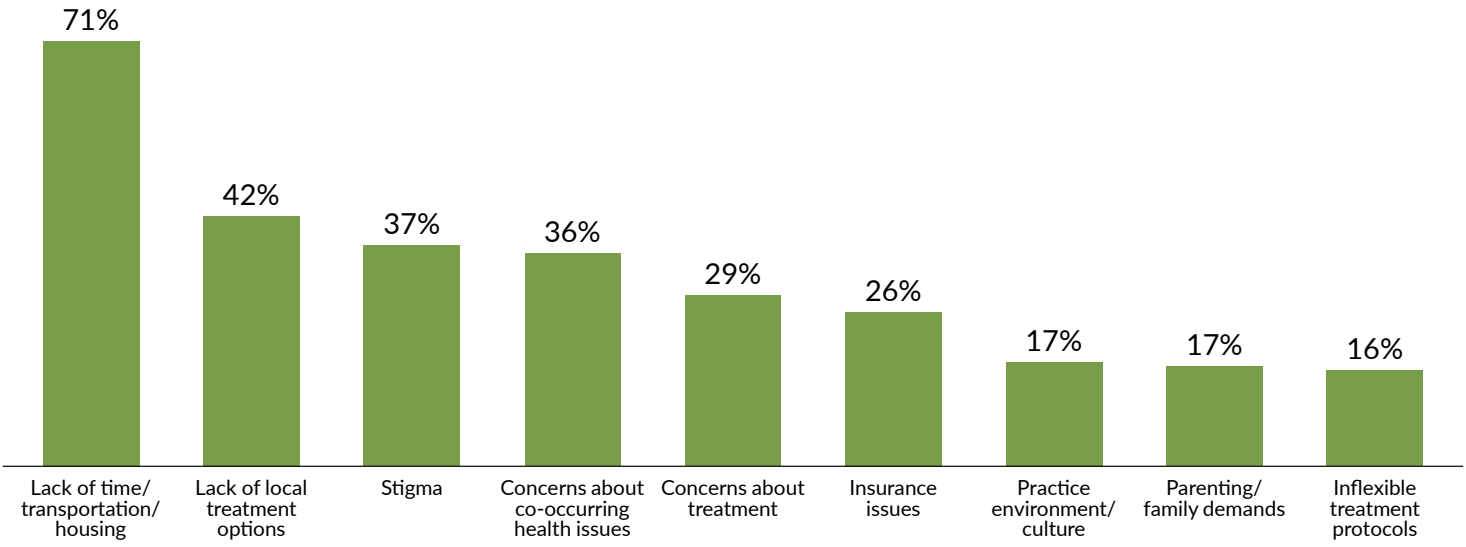
"[We need] adequate mental health and social work support; adequate access to community resources."

Patient Barriers

Receiving OUD Treatment

Practitioners ranked access barriers (lack of time, transportation, housing, or other supports) and lack of local treatment options as the top barriers to patients receiving OUD treatment (**Figure 6**).

Figure 6. Practitioner-Identified Barriers to Patients Receiving Opioid Use Disorder Treatment



Unique Barriers for Rural Patients

"Little to no public transportation, limited medical transportation scheduling options, limited access to internet/technology."

"One appointment becomes an all-day adventure due to transportation scheduling."

"Lack of treatment centers in the county."

"Lack of mental health support [and] being immersed in the culture that surrounded their opioid use."

Practitioner Beliefs

Access to Substance Use Disorder Treatment

Half of practitioners *agreed* (agreed or strongly agreed) that people in the community where they work have adequate access to an effective form of SUD treatment when they need it (49%; **Figure 7**). Most practitioners reported knowing where to refer people for OUD treatment (76%) and approximately half *agreed* that patients would be able to access services (59%), would receive timely access to services (46%), and would receive high quality services (51%) at the location to which they were referred.

Figure 7. Practitioner Beliefs About Access to Substance Use Disorder Treatment

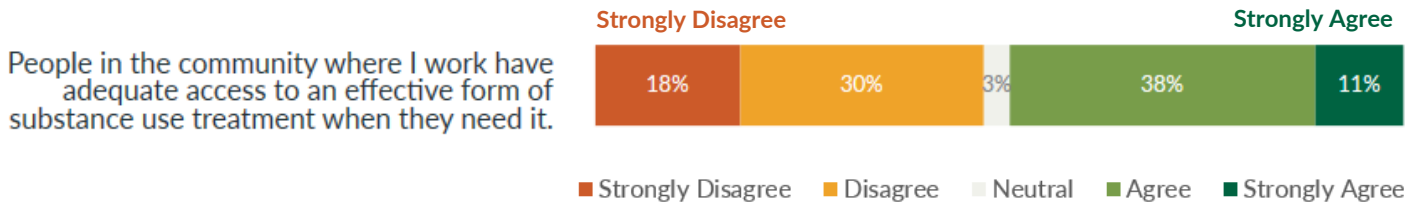
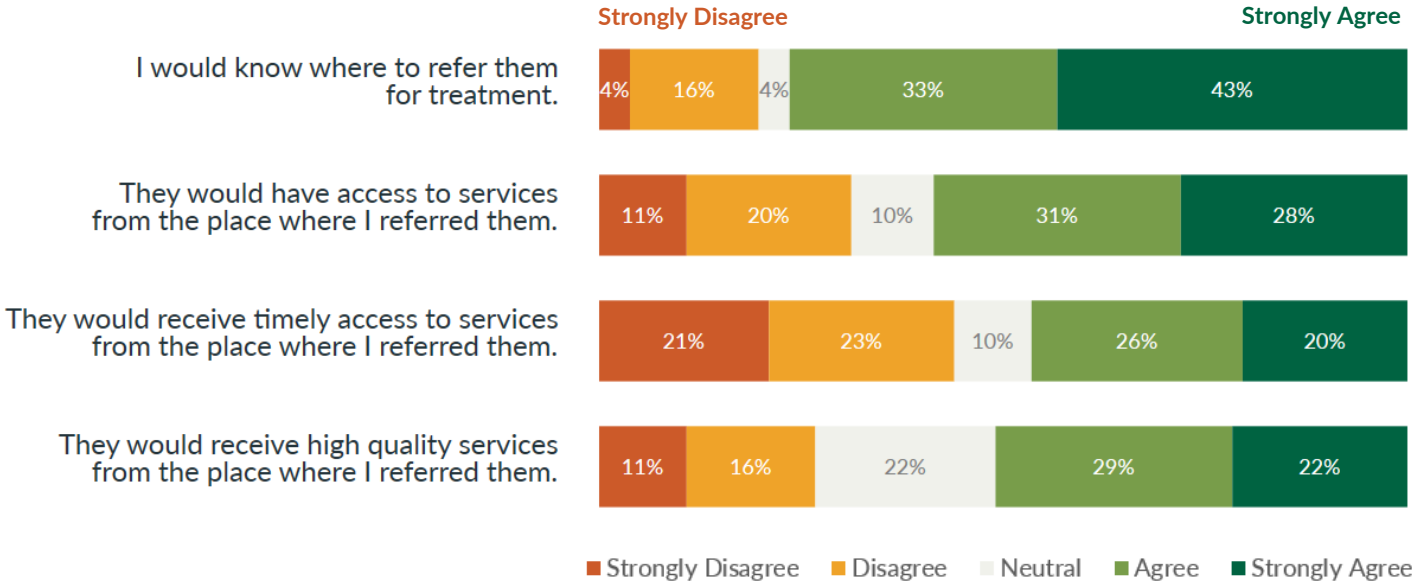


Figure 8. Practitioner Beliefs About Access to Opioid Use Disorder Treatment

If a person came to me and confided that they were experiencing opioid use disorder, I feel confident that:



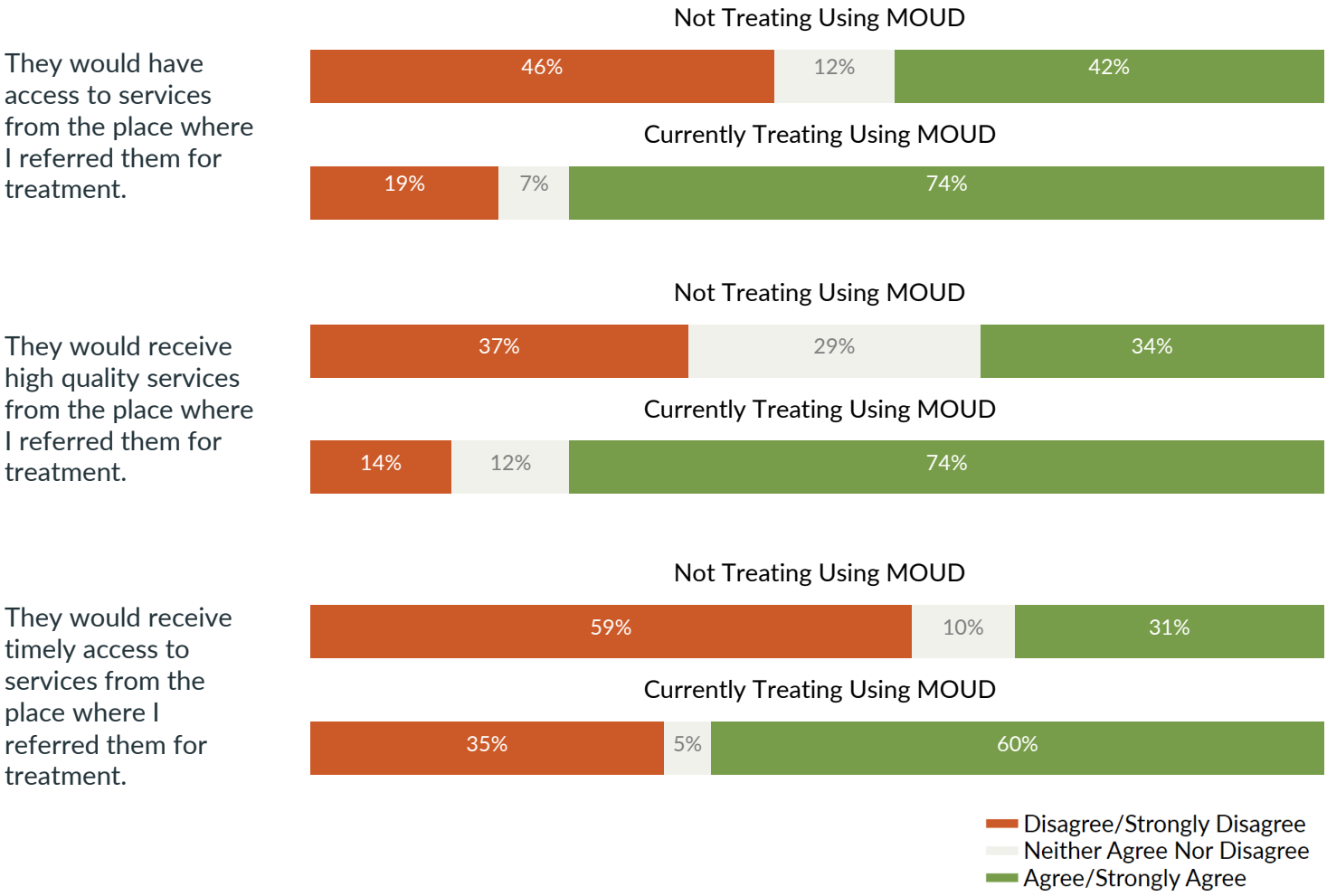
Prescribing Clinician Beliefs

Access to Opioid Use Disorder Treatment

A greater proportion of prescribing clinicians currently treating patients using MOUD than those not currently treating patients using MOUD felt confident that a person experiencing OUD would have access to services from the place to which they were referred (74% vs. 42%; p<0.01; **Figure 9**), that they would receive high quality services from the place to which they were referred (74% vs. 34%; p<0.01; **Figure 9**), and that they would receive timely services from the place to which they were referred (60% vs. 31%; p<0.01; **Figure 9**).

Figure 9. Prescribing Clinician Beliefs About Access to OUD Treatment

If a person came to me and confided that they were experiencing opioid use disorder, I feel confident that:

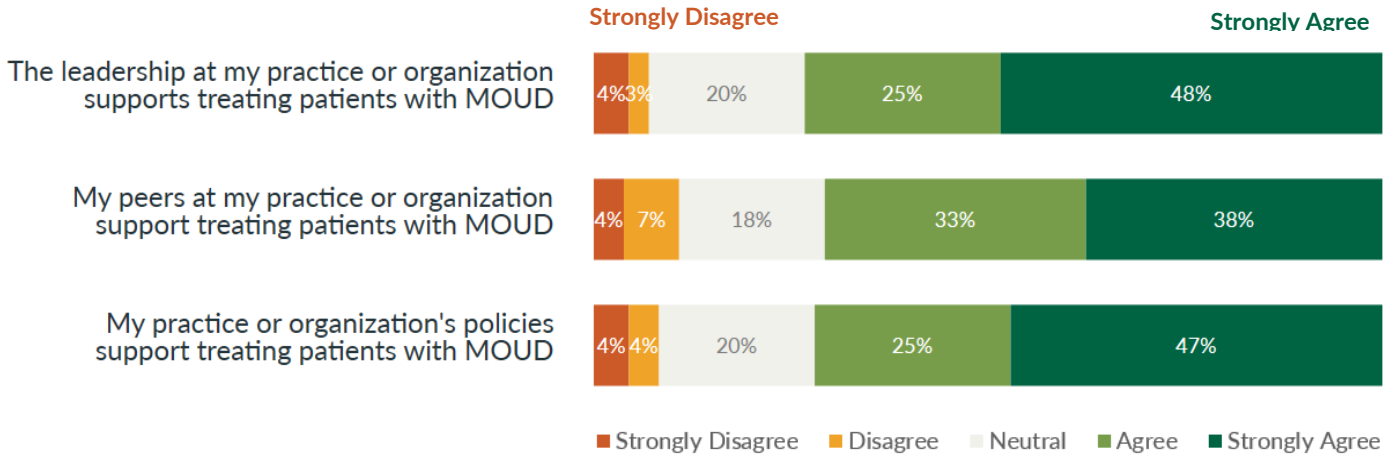


Practitioner Beliefs

Institutional Support for MOUD Treatment

Practitioners generally reported support from their institutions and peers for treatment of patients using MOUD, with most practitioners *agreeing* that the leadership at their practice or organization supports treating patients using MOUD (73%), that their peers at their practice or organization support treating patients using MOUD (71%), and that their practice or organization's policies support treating patients using MOUD (72%; **Figure 10**). However, a handful of practitioners *disagreed* with these statements, and some expressed a need for additional institutional or peer support in their open-ended survey responses (see example quote below).

Figure 10. Institutional Support for Treatment of Patients Using Medications for Opioid Use Disorder



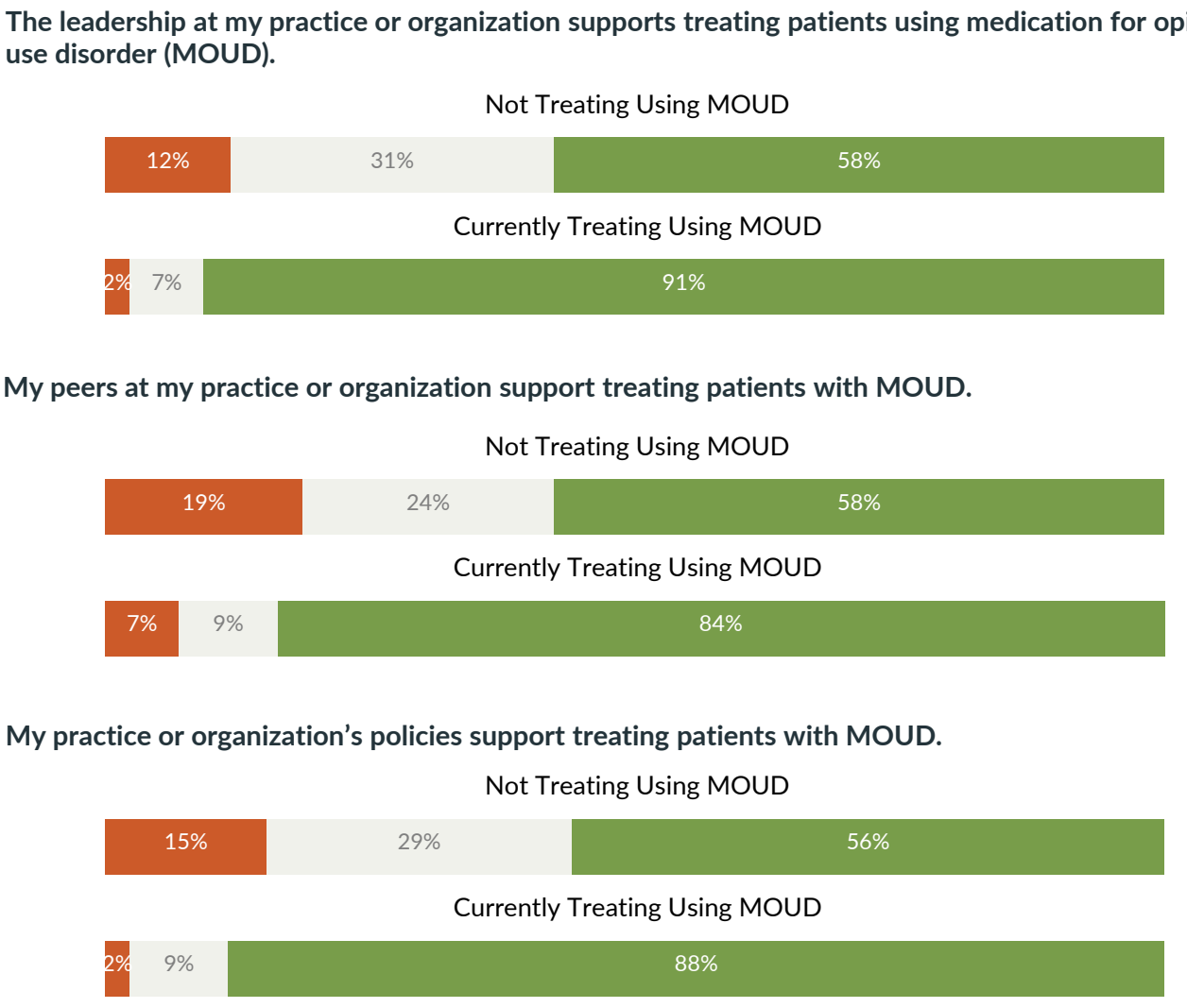
> ***"[Barriers to providing OUD treatment include] negative stigmas and colleagues not recognizing opioid use disorder as a medical problem and treating the patient appropriately."***

Prescribing Clinician Beliefs

Institutional Support for MOUD Treatment

Among prescribing clinicians, a greater proportion of those currently treating patients using MOUD than those not currently treating patients using MOUD *agreed* that their practice or organization's leadership supports treating patients using MOUD (91% vs. 58%; p<0.01; **Figure 11**), that their peers at their practice or organization support treating patients using MOUD (84% vs. 58%; p<0.01; **Figure 11**), and that their practice or organization's policies support treating patients using MOUD (88% vs. 56%; p<0.01; **Figure 11**).

Figure 11. Prescribing Clinician Beliefs About Institutional Support for Treatment Using Medication for Opioid Use Disorder



Practitioner Beliefs

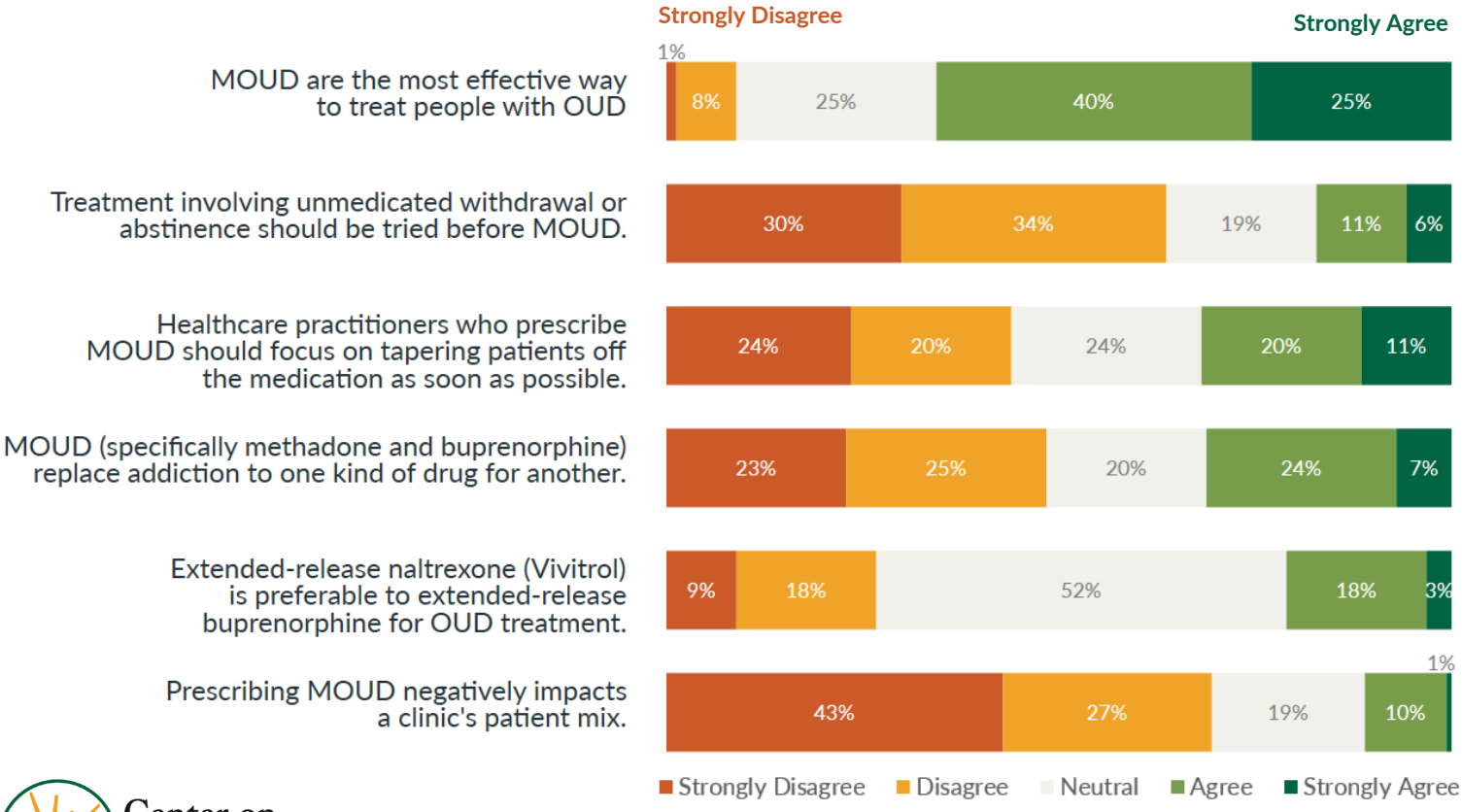
Medications for Opioid Use Disorder

Most practitioners *agreed* that MOUD are the most effective way to treat people with OUD (65%) and *disagreed* that treatment involving unmedicated withdrawal or abstinence should be tried before MOUD (64%; **Figure 12**). Nearly half of practitioners (44%) *disagreed* that prescribers of MOUD should focus on tapering patients off MOUD as soon as possible. Half of practitioners (52%) *neither agreed nor disagreed* that extended-release naltrexone is preferable to extended-release buprenorphine for OUD treatment.

While nearly half of practitioners *disagreed* that MOUD replace addiction to one kind of drug with another (48%), one in three *agreed* with this statement (31%). And, while most *disagreed* that prescribing MOUD negatively impacts a clinic's patient mix (70%), some practitioners *agreed* (11%). Some practitioners shared concerns about other practitioners' beliefs about MOUD in their open-ended survey responses (see example quote at right).

> ***"Bias against [patients] with OUD and especially those in MAT—especially methadone—[is a challenge]. Courts are especially bad."***

Figure 12. Practitioner Beliefs About Medications for Opioid Use Disorder



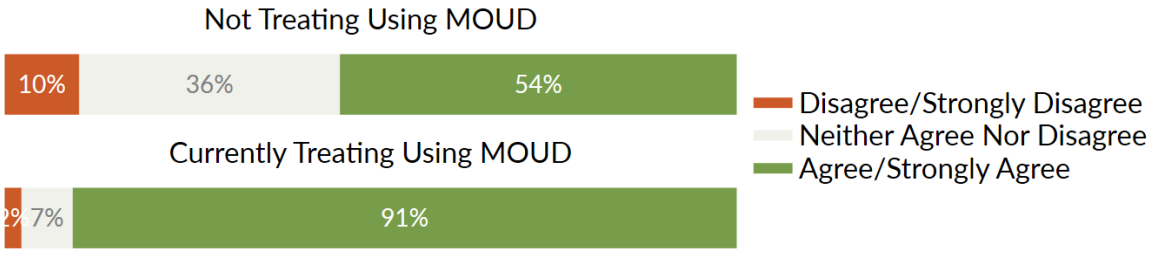
Prescribing Clinician Beliefs

Medication for Opioid Use Disorder

Among prescribing clinicians, a greater proportion of those currently treating patients using MOUD than those not currently treating patients using MOUD *agreed* that MOUD are the most effective way to treat people with OUD (91% vs. 54%; p<.01; **Figure 13**).

Figure 13. Prescribing Clinician Beliefs About the Effectiveness of Medication for Opioid Use Disorder

MOUD are the most effective way to treat people with OUD.



Practitioner Beliefs

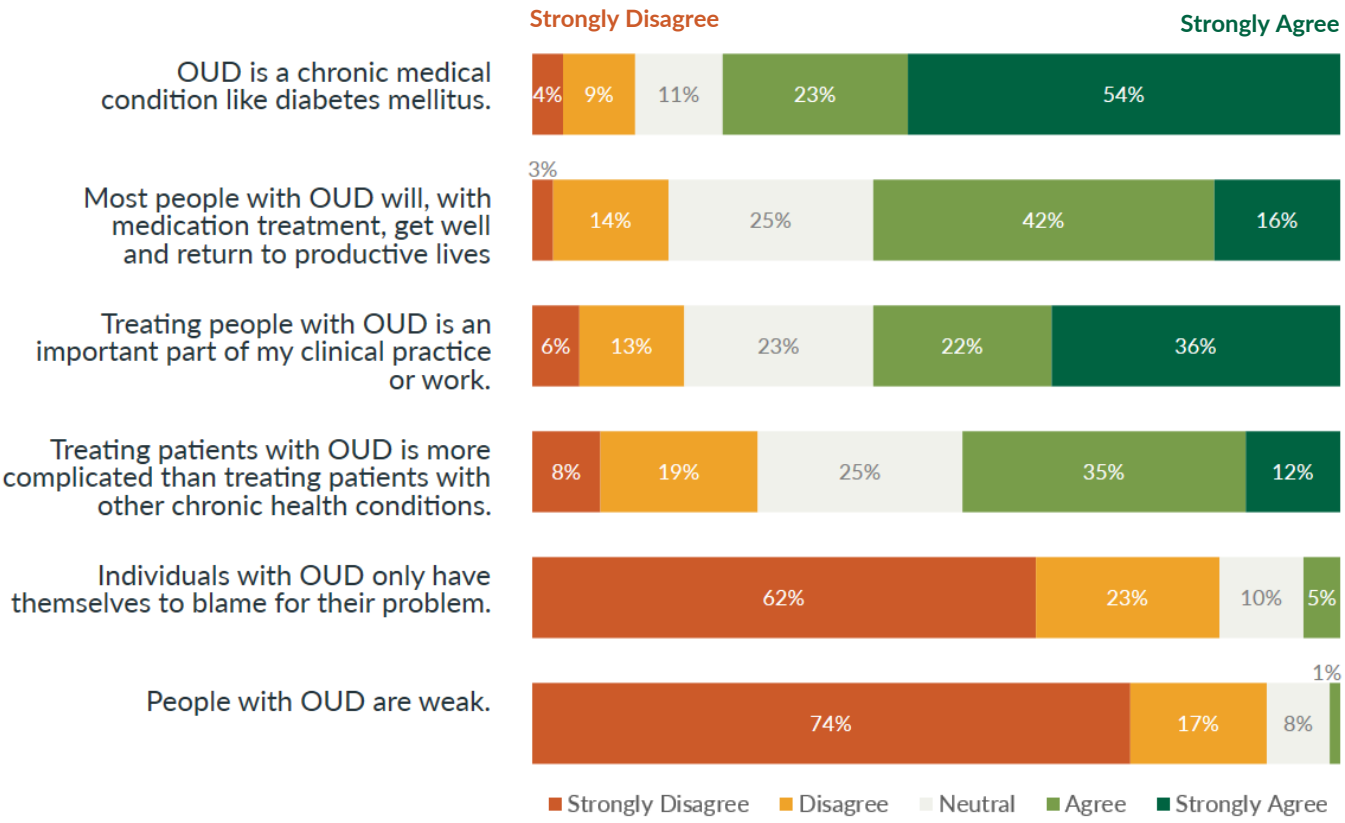
Opioid Use Disorder

Most practitioners *agreed* that OUD is a chronic medical condition (76%; **Figure 14**), while more than half *agreed* that most people who receive MOUD treatment will get well and return to productive lives (58%) and that treating people with OUD is an important part of their clinical practice or work (58%).

Practitioners reported a range of beliefs regarding whether treating patients with OUD is more complicated than treating patients with other chronic health conditions, with 47% *agreeing*, 25% *neither agreeing or disagreeing*, and 28% *disagreeing* (**Figure 14**).

Practitioners largely *disagreed* with the stigmatizing statements that individuals with OUD only have themselves to blame for their problem (85%) or are weak (91%), although a handful of respondents *agreed* with these statements (5% and 1%, respectively) (**Figure 14**).

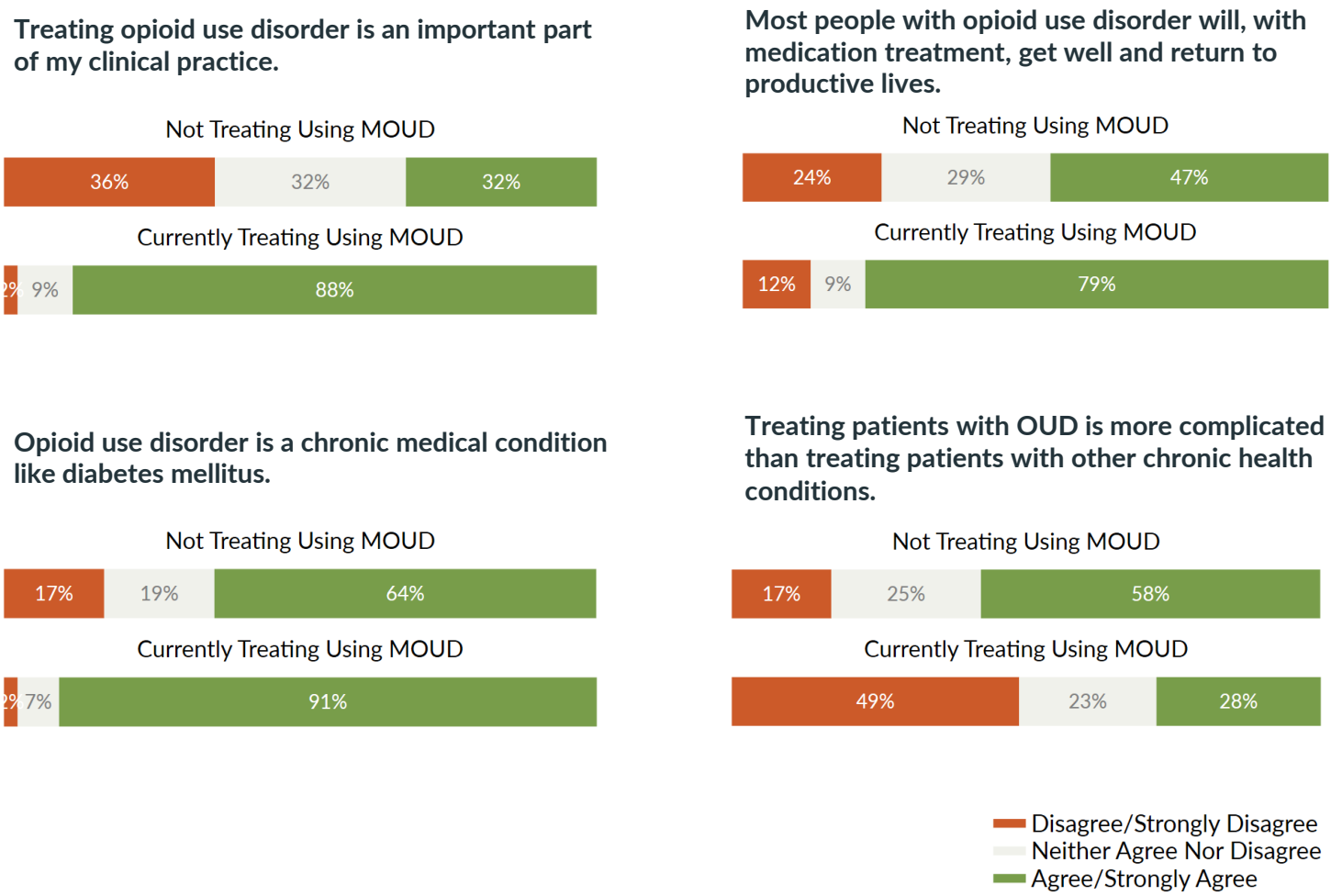
Figure 14. Practitioner Beliefs About Opioid Use Disorder



Prescribing Clinician Beliefs
Opioid Use Disorder

Among prescribing clinicians, a greater proportion of those currently treating patients using MOUD than those not currently treating patients using MOUD *agreed* that treating OUD is an important part of their clinical practice (88% vs. 32%; p<0.01; **Figure 15**), that OUD is a chronic medical condition (91% vs. 64%; p<0.01), and that most people with OUD will recover with medication treatment (79% vs. 47%; p<0.01). Additionally, more clinicians currently treating patients using MOUD than those not currently treating patients using MOUD *disagreed* that treating patients with OUD is more complicated than treating patients with other chronic health conditions (49% vs. 17%; p<0.01).

Figure 15. Prescribing Clinician Beliefs About Opioid Use Disorder



Practitioner Beliefs

Stimulant Use Disorder

Almost two-thirds of practitioners reported knowing where to refer patients for stimulant use disorder treatment (63%; **Figure 16**).

Just over half of practitioners *agreed* that most people with stimulant use disorder will, with treatment, get well and return to productive lives (55%; **Figure 17**).

Practitioners largely *disagreed* with the stigmatizing statements that individuals with stimulant use disorder only have themselves to blame for their problem (83%) or are weak (88%), although a handful of respondents *agreed* with these statements (5% and 1%, respectively) (**Figure 17**).

Figure 16. Practitioner Beliefs About Access to Stimulant Use Disorder Treatment

"If a person came to me and confided that they were experiencing stimulant use disorder, I feel confident that:"

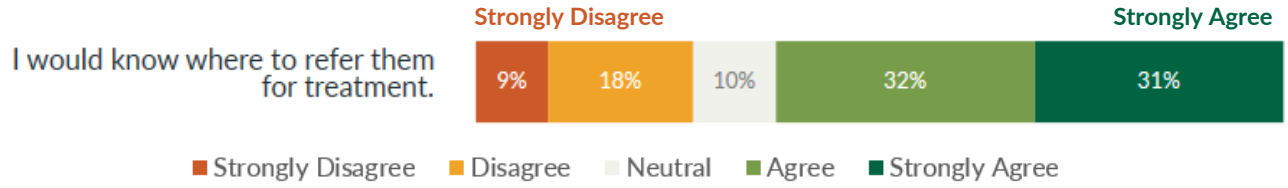
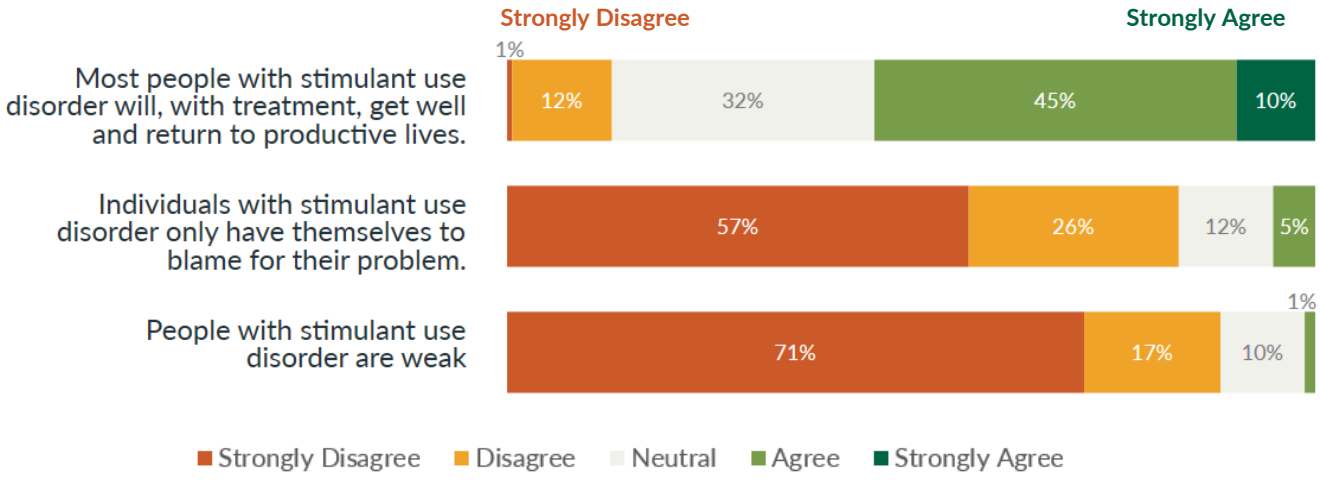


Figure 17. Practitioner Beliefs About Stimulant Use Disorder

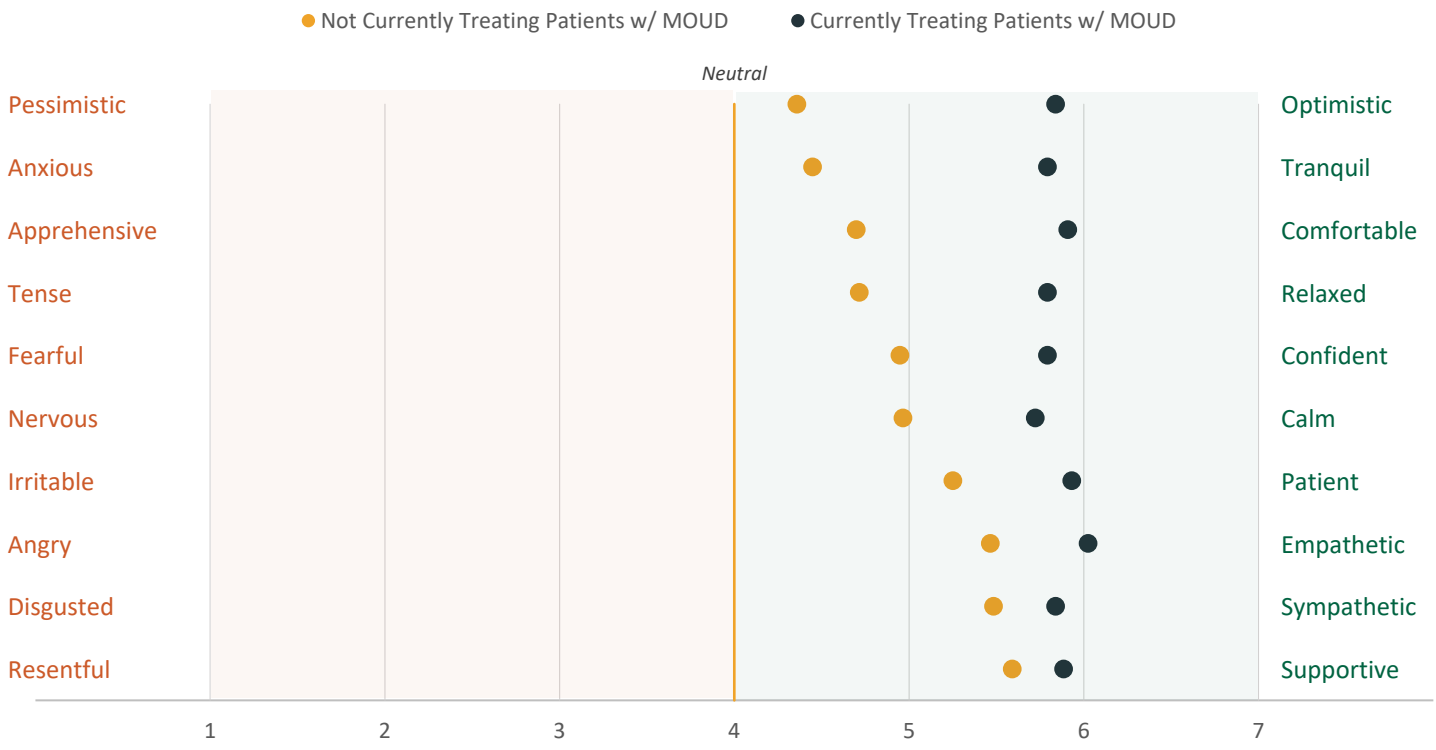


Practitioner Affect

Opioid Use Disorder

Overall, practitioner respondents reported experiencing positive emotions (i.e., low stigma) toward people with OUD (mean=55; scale 10–70; *data not shown*) as measured using a validated affect scale for SUDs[1], in which respondents rated 10 opposing emotion pairs on a 1–7 scale. Responses to each pair were summed for an overall score of 10–70 with 10 representing negative emotions (i.e., high stigma) and 70 representing positive emotions (i.e., low stigma). Comparing prescribing clinicians who were currently treating patients using MOUD with prescribing clinicians who were not, prescribing clinicians treating patients using MOUD had overall more positive emotions toward people with OUD (mean=59 vs mean=50; p<0.01). **Figure 18** shows ratings by prescribing clinicians for each affect pair broken down by MOUD prescriber status.

Figure 18. Prescribing Clinician Affect Ratings When Interacting With A Person With Opioid Use Disorder, by MOUD Prescriber Status



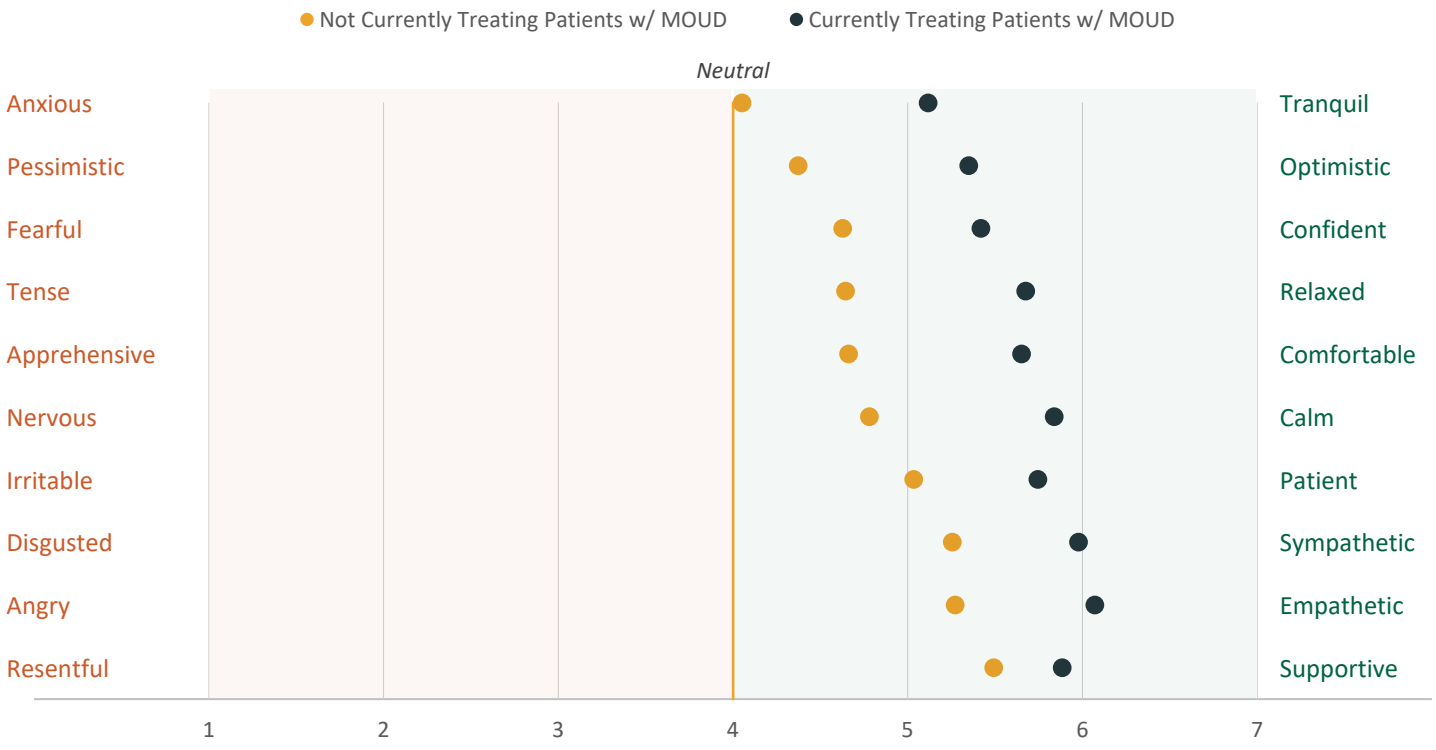
[1] Brown SA. Standardized measures for substance use stigma. *Drug Alcohol Depend.* 2011;116(1-3):137-141.

Practitioner Affect

Stimulant Use Disorder

Overall, practitioner respondents reported experiencing positive emotions (i.e., low stigma) toward people with stimulant use disorder (mean=53; scale 10–70) as measured using a validated affect scale for SUDs[1], in which respondents rated 10 opposing emotion pairs on a 1–7 scale. Responses to each pair were summed for an overall score of 10–70 with 10 representing negative emotions (i.e., high stigma) and 70 representing positive emotions (i.e., low stigma). Comparing prescribing clinicians who were currently treating patients using MOUD with prescribing clinicians who were not, prescribing clinicians treating patients using MOUD had overall more positive emotions toward people with stimulant use disorder (mean=57 vs mean=48; p<0.01**). Figure 19** shows ratings by prescribing clinicians for each affect pair broken down by MOUD prescriber status.

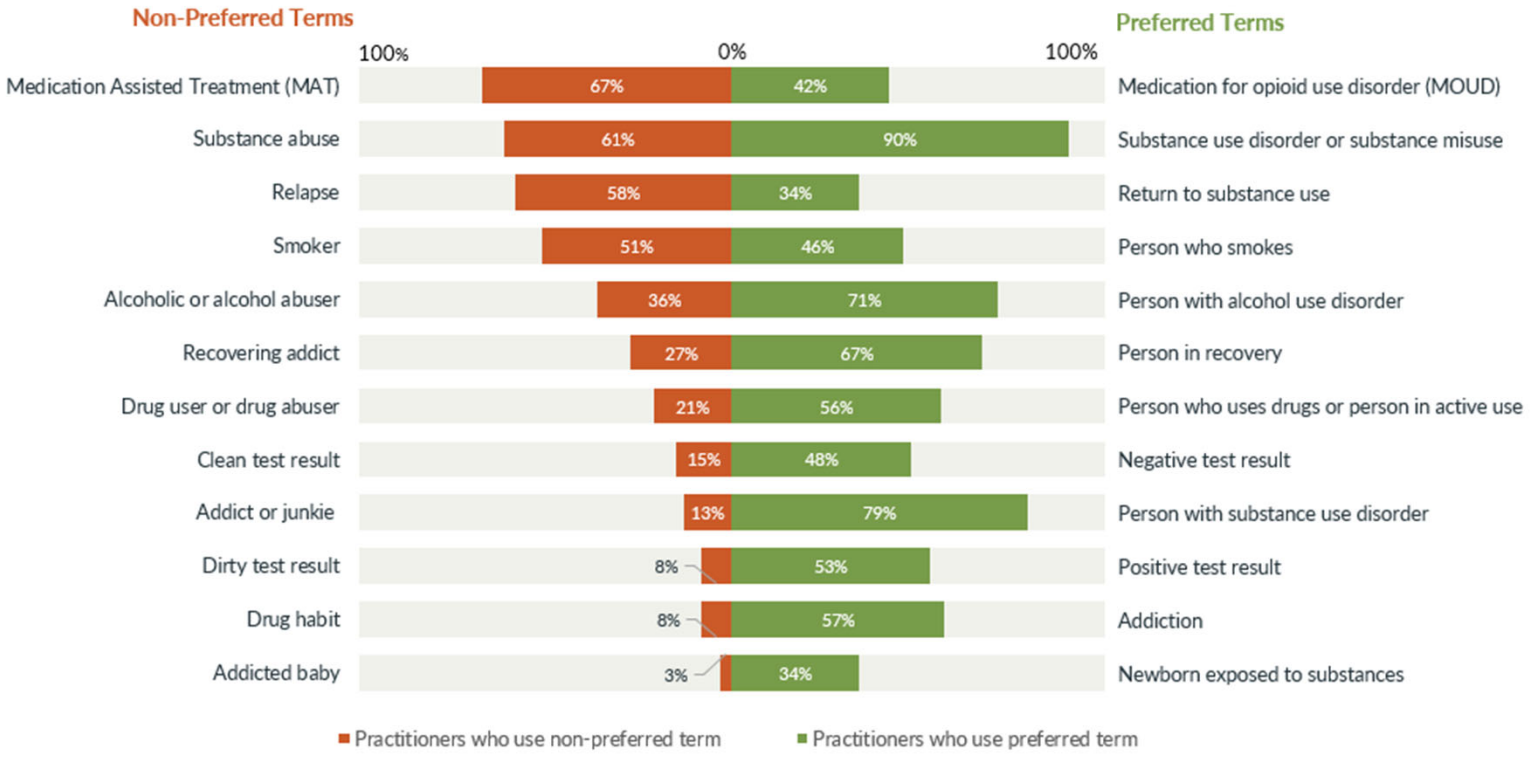
Figure 19. Prescribing Clinician Affect Ratings When Interacting With A Person With Stimulant Use Disorder, by MOUD Prescriber Status



Preferred & Non-Preferred Language

Respondents reported using both preferred (i.e., non-stigmatizing) and non-preferred (i.e., potentially stigmatizing) SUD terms in clinical settings (**Figure 20**). The most used non-preferred term was "medication-assisted treatment (MAT)" (67%). While many people continue to use the term "MAT," in recent years the National Institute on Drug Abuse (NIDA) and others have recommended replacing it with "MOUD."[2] Other frequently used non-preferred terms included substance abuse (61%), and relapse (58%). Most non-preferred terms were used by fewer than a third of respondents.

Figure 20. Proportion of Respondents Who Report Using Preferred and Non-Preferred Terms in Clinical Settings



[2] For more information about preferred and non-preferred terms, please see the National Institute on Drug Abuse (NIDA)'s Words Matter.

High Priority Resources

The resources most endorsed as “high priority” by practitioners were recovery housing information and resources (82%), support treating patients who use multiple substances (82%), and support managing and coordinating care for vulnerable populations with SUDs **(**e.g., pregnant patients with SUDs, families, patients with co-occurring conditions; 81%; **Table 5).**

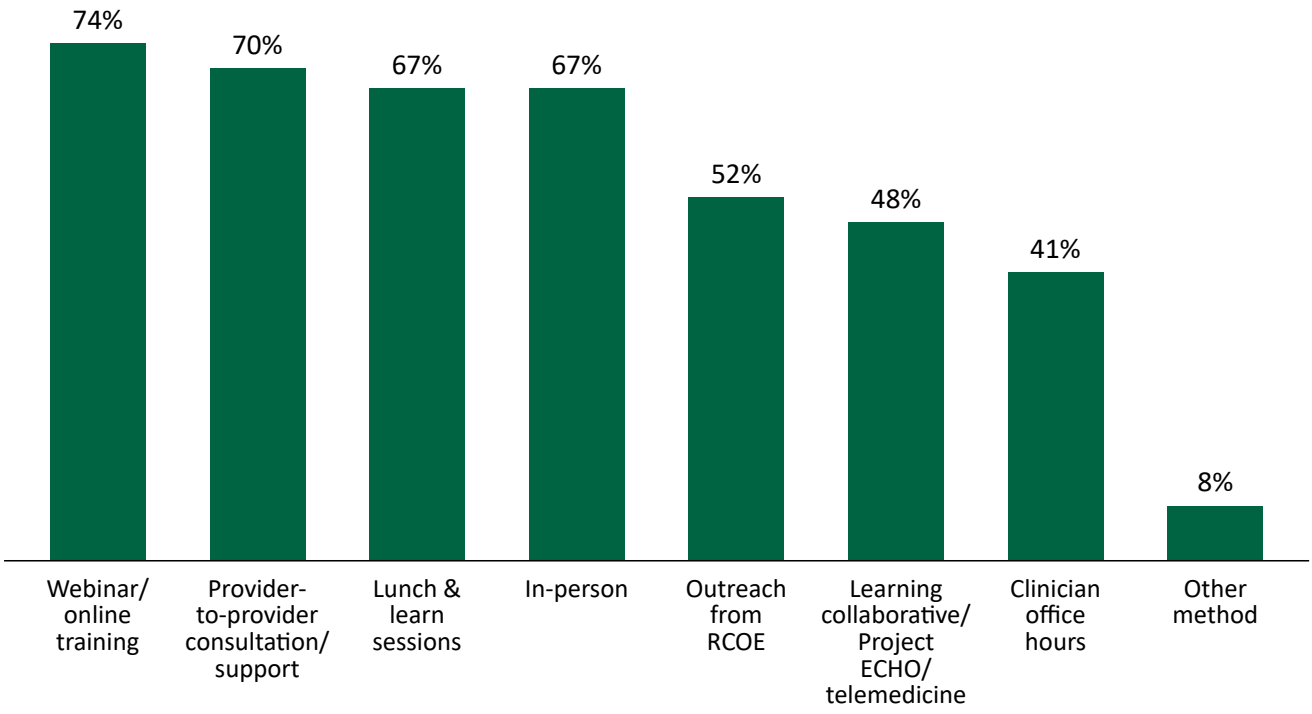
Table 5. Resources Rated as High Priority by Practitioner Respondents

Resource	High Priority
Recovery housing information and resources	82%
Support treating patients who use multiple substances (polysubstance use)	82%
Support managing and coordinating care for vulnerable populations with SUDs	81%
Recovery coaching information and resources	73%
Training in manualized treatments for co-occurring conditions	73%
Harm reduction supplies and materials on their use	72%
Consultations on new models of care for OUD treatment	64%
Training on stigma and bias related to opioid use disorder and treatment	63%
Consultation & support from "champion" providers	63%
Patient substance use disorder screening or assessment tools	61%
Protocols for buprenorphine induction, maintenance, taper	60%
Training on extended-release buprenorphine (i.e., monthly depot formulation)	58%
Technology to support patient adherence to opioid use disorder treatment	56%
Protocols for extended-release naltrexone induction and maintenance	53%
Consultation on practice workflow or practical implementation of opioid treatment	51%
Training and workflow support for front office staff and back-office revenue cycle	50%
Biochemical monitoring of recent substance use	50%

Methods for Receiving Resources

Figure 21 shows practitioners' preferences regarding how they would like to receive training, resources, or support to care for people with SUD. Practitioners were asked to rate each mode as "preferred" or "non-preferred." The most preferred methods among practitioners were webinar or online trainings (74%) and provider-to-provider support or consultation (70%; **Figure 21**).

Figure 21. Preferred Methods for Receiving Resources and Training Among Practitioners



Recommendations

Most Important Improvement to Increase OUD Treatment Access

"More treatment and housing options for people with opioid use disorder."

"Outreach to individuals to let them know that services are available, and we can assist with barriers that prevent them accessing treatment."

"Awareness of resources to ALL organizations that treat patients or have some connection to substance use/abuse."

"Direct access at any point of care, ED, urgent care, primary care."

"A clear referral process and list of substance use disorder treatment providers/clinics so that I can refer patients for ongoing treatment after an ED visit."

"Education and psychiatry support."

"Getting more primary care providers to treat this just like they treat other medical issues."

"Increased funding for safe, reliable transportation."

"Evidence based treatment modalities with support for maintaining patient's livelihood while in treatment."

"Access to care, especially for co-occurring counseling/mental health supports."

"Psychological support. We can provide the medications, but I feel success is hindered due to lack of access to mental health support."

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Questions

Please visit **uvmcora.org** for more information or contact us at **cora@uvm.edu** with any questions.

Suggested Reference

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