

New Hampshire Baseline Needs Assessment

Practitioners and Community Stakeholders



Center on
Rural Addiction
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Policy and Practice



University of
New Hampshire

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Executive Summary

The mission of the University of Vermont Center on Rural Addiction (UVM CORA) is to expand addiction treatment capacity in rural counties by providing consultation, resources, training, and evidence-based technical assistance to healthcare practitioners and other staff. With our baseline needs assessment, we aim to identify current and future addiction treatment needs and barriers in New Hampshire with direct input from practitioners, policymakers, and other stakeholders. The online survey was conducted from October 2020 to March 2021. This report includes responses from practitioners and community stakeholders working in all counties in New Hampshire, highlighting rural counties designated by the Health Resources & Services Administration (HRSA). Throughout the report, we compare practitioner responses by rural and non-rural work location, as well as by role type (i.e., counselors compared to clinicians), and buprenorphine waiver status of practitioners who can prescribe medication (i.e., waived practitioners compared to non-waived practitioners). We present the latter two comparisons both statewide and among rural practitioners only.

Our respondents included 152 practitioners and 101 community stakeholders working in New Hampshire. Among practitioners, defined as working in a field where they may provide direct care to persons with opioid use disorder (OUD), nearly half of respondents worked in counseling roles (e.g., counselors, case managers, social workers; 47%). The remainder of practitioners worked in clinical roles (53%), including nurse practitioners (18%), primary care practitioners (i.e., MD, DO) (13%), and nurses (12%). Among community stakeholders, defined as working in a field where they interact with or provide services to persons with OUD through work in the community, respondents worked in a wide variety of settings including family resource centers/family support (19%), recovery centers/recovery community organizations (13%), public health (13%), and community mental health (7%).

Survey topics included concerns about substance use, comfort treating patients with substance use disorder (SUD), training and support needs, provider and patient barriers to treatment, beliefs about SUD and treatment, impacts of COVID-19, and the UVM CORA resources which may be of interest and assistance to practitioners.

When asked about their concerns regarding substance use among their patients, practitioners' greatest concerns were related to fentanyl, methamphetamine, and opioids in combination with alcohol, stimulants, and sedatives. When asked about their concerns regarding substance use in their community, community stakeholders were most concerned about fentanyl, heroin, methamphetamine, and opioids in combination with alcohol, stimulants, and sedatives.

Practitioners overwhelmingly endorsed lack of time, transportation, and other supports as a top barrier to their patients receiving treatment for opioid use disorder (OUD). Community stakeholders

similarly selected lack of time, transportation, and childcare access as a key challenge to patients receiving treatment for OUD. Stakeholders also reported stigma, insufficient treatment capacity, and lack of care coordination as top patient barriers.

Practitioners in New Hampshire reported a moderate level of comfort in treating patients with OUD and treating special populations (i.e., families, adolescents, and pregnant patients) for SUDs. Frequently requested UVM CORA resources included support and training for treating vulnerable populations and training for addressing conditions co-occurring with SUDs.

When asked about their beliefs, two thirds of practitioners (65%) agreed or strongly agreed with the statement, “Medications (like methadone and buprenorphine) are the most effective way to treat people with opioid use disorder,” with seven percent disagreeing or strongly disagreeing. A significantly greater proportion of practitioners in clinical roles (81%) agreed with the statement compared to those in counseling roles (48%).

Given that our New Hampshire baseline needs assessment was conducted concurrently with the COVID-19 pandemic, we also included several questions on the impact of the pandemic on substance use and treatment availability. Substantial proportions of practitioners and community stakeholders believed that substance use (practitioners: 77%; community stakeholders: 79%) and opioid use (practitioners: 67%; community stakeholders: 57%) had increased in their communities since the start of the COVID-19 pandemic. In contrast, very few practitioners (6%) and community stakeholders (5%) believed that access to medications for OUD (MOUD) had increased.

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

Abbreviations Used Throughout This Report

UVM CORA: University of Vermont Center on Rural Addiction

OUD: Opioid use disorder

SUD: Substance use disorder

MOUD: Medications for opioid use disorder

HRSA: Health Resources and Services Administration

RCO: Recovery Community Organization

Responses and Inclusion Criteria

Practitioners and community stakeholders working across New Hampshire, from HRSA-designated rural counties as well as non-rural counties¹ (Figure 1), responded to our baseline needs assessment survey. The online survey was conducted from October 2020 to March 2021. We began by sending a contact survey link to practitioners and community stakeholders via email listservs, mailers, and social media. Contacts whom we validated as being practitioners or community stakeholders working in New Hampshire were invited to complete the corresponding full survey (i.e., practitioner survey or community stakeholder survey). Our partners at the University of New Hampshire Institute for Health Policy and Practice's New Hampshire Citizens Health Initiative conducted additional outreach with these invitees, including regular email outreach, to maximize the response rate. After exclusions (further described in the sections below), we received valid survey responses from 152 practitioners and 101 community stakeholders.

This report includes responses from practitioners and community stakeholders working in all counties in New Hampshire. Throughout the report, we compare practitioner responses by work location (i.e., rural compared to non-rural), as well as by role type (i.e., practitioners in counseling roles compared to practitioners in clinical roles), and buprenorphine waiver status of practitioners who can prescribe medication (i.e., waived practitioners compared to non-waivered practitioners).

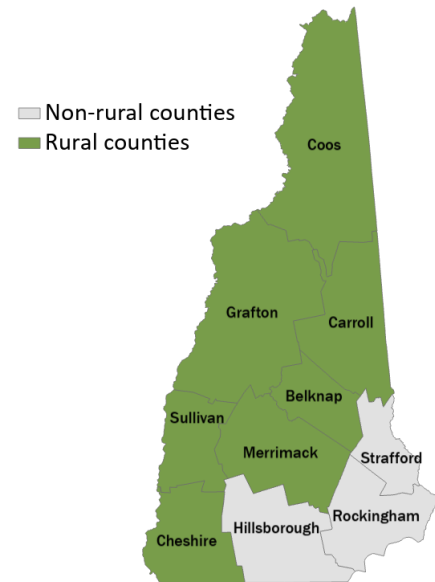


Figure 1. Map of HRSA-designated rural counties (green) and non-rural counties (grey) in New Hampshire.

Practitioners

Of the 246 practitioners who responded to the contact survey and were invited to complete the baseline needs assessment survey, 159 went on to complete the practitioner survey, and 152 responded to substantive survey questions (i.e., any questions other than role, work setting, and work location). Our final cohort of practitioners includes these 152 respondents (response rate=62%).

¹For the purposes of this report, partially rural counties (those with some rural census tracts and some non-rural census tracts; see Section II of the document linked below) are considered non-rural.

<https://data.hrsa.gov/Content/Documents/tools/rural-health/forhpeligibleareas.pdf>

Community Stakeholders

Of the 148 community stakeholders who responded to the contact survey and were invited to complete the baseline needs assessment survey, 104 went on to complete the community stakeholder survey, and 101 responded to substantive survey questions (i.e., any questions outside of work setting and work location). Our final cohort of community stakeholders includes these 101 respondents (response rate=68%).

Rural County Location

Practitioners

Practitioner responses (n=152) included representation from all 10 New Hampshire counties (Table 1). Of these respondents, 81 (53%) reported working in at least one rural county, whereas 70 (46%) reported working only in non-rural counties. One practitioner reported working in multiple New Hampshire counties but did not provide sufficient information to determine whether they worked in rural counties or not. The most-represented rural county was Grafton (20% of all responses), whereas the most-represented non-rural county was Hillsborough (30% of all responses).

Table 1. Practitioner responses by New Hampshire county.

NH county in which practitioner works	Total	
	Freq.	Percent
<i>Rural Counties</i>		
Grafton	30	19.7
Multiple counties (rural)*	17	11.2
Carroll	7	4.6
Coos	7	4.6
Merrimack	7	4.6
Cheshire	5	3.3
Belknap	4	2.6
Sullivan	4	2.6
<i>Non-Rural Counties</i>		
Hillsborough	45	29.6
Strafford	13	8.6
Rockingham	11	7.2
Multiple counties (non-rural)**	1	0.7
Multiple counties (unknown)***	1	0.7
Total	152	100

*Practitioners working in at least one rural New Hampshire county.

**Practitioners who reported only working in non-rural New Hampshire counties.

***One practitioner did not provide sufficient information to determine whether they worked in rural New Hampshire counties or not, however they did respond that they worked in New Hampshire, in multiple counties.

Community Stakeholders

Community stakeholder responses (n=101) also included representation from all 10 New Hampshire counties (Table 2). Of these, 74 (73%) respondents reported working in rural counties, whereas 27 (27%) reported working only in non-rural counties. Respondents were well-distributed across all counties. The most represented rural county was Grafton (13% of all responses), whereas the most represented non-rural county was Hillsborough (13% of all responses).

Table 2. Community stakeholder responses by New Hampshire county.

NH county in which community stakeholder works	Total	
	Freq.	Percent
<i>Rural Counties</i>		
Grafton	13	12.9
Multiple counties (rural)*	12	11.9
Coos	11	10.9
Carroll	10	9.9
Cheshire	9	8.9
Merrimack	8	7.9
Sullivan	7	6.9
Belknap	4	4.0
<i>Non-Rural Counties</i>		
Hillsborough	13	12.9
Strafford	10	9.9
Rockingham	4	4.0
Total	101	100

*Community stakeholders working in at least one rural New Hampshire county.

Work Setting and Role

Practitioners

Table 3 shows the distribution of work settings among practitioner respondents (n=152) working in rural (n=81) and non-rural (n=70) counties. Practitioners reported working in a wide variety of settings including Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) (15%), community hospitals (15%), and community mental health centers (13%). In addition, many practitioner respondents reported working in SUD treatment settings, including addiction specialty treatment providers (9%) and opioid treatment programs (7%).

Table 3. Rural and non-rural practitioner work settings.

	Rural		Non-rural		Total	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Federally Qualified Health Center or Rural Health Clinic	14	17.3	9	12.9	23	15.1
Community hospital	6	7.4	16	22.9	23	15.1
Community mental health center	8	9.9	12	17.1	20	13.2
Addiction specialty treatment provider	7	8.6	7	10.0	14	9.2
Hospital-owned practice	6	7.4	8	11.4	14	9.2
Private practice	6	7.4	5	7.1	11	7.2
Other	7	8.6	4	5.7	11	7.2
Academic medical center	10	12.4	0	0	10	6.6
Opioid treatment program	5	6.2	5	7.1	10	6.6
Corrections	4	4.9	2	2.9	6	3.9
Family Resource Center	3	3.7	0	0	3	2.0
Peer recovery	2	2.5	0	0	2	1.3
Hospital (non-academic, non-community)	1	1.2	1	1.4	2	1.3
Behavioral health clinic	1	1.2	0	0	1	0.7
Urgent care	0	0	1	1.4	1	0.7
Recovery Community Organization	1	1.2	0	0	1	0.7
Total	81	100	70	100	152	100

Table 4 shows the professional roles of New Hampshire practitioner respondents (n=152) working in rural (n=81), non-rural (n=70), and unknown (n=1) counties. Among practitioner respondents, there were 71 counselors, case managers, psychologists, and recovery coaches (42 rural, 29 non-rural; hereinafter referred to as “counselors”), and 81 clinicians and pharmacists (39 rural, 41 non-rural, 1 unknown; hereinafter referred to as “clinicians”). There were 55 clinicians (nurse practitioners, primary care physicians, specialist physicians, advance practice nurses, and physician assistants) that we grouped together for some analyses because they were able to prescribe medications (28 rural, 27 non-rural; hereinafter referred to as “prescribing clinicians”). The remaining 26 clinicians (11 rural, 14 non-rural, 1 unknown) were not able to prescribe medications (nurses, nursing or medical assistants, and pharmacists).

Table 4. Rural and non-rural practitioner roles.

	Rural		Non-rural		Total	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
<i>Prescribing Clinicians</i>						
Nurse Practitioner	13	16.1	14	20.0	27	17.8
Primary Care Physician	9	11.1	10	14.3	19	12.5
Specialist Physician	4	4.9	1	1.4	5	3.3
Advanced Practice Nurse	2	2.5	0	0	2	1.3
Physician Assistant	0	0	1	1.4	1	0.7
Multiple	0	0	1	1.4	1	0.7
<i>Non-Prescribing Clinicians</i>						
Nurse	6	7.4	11	15.7	18	11.8
Other	2	2.5	2	2.9	4	2.6
Nursing or Medical Assistant	2	2.5	1	1.4	3	2.0
Pharmacist	1	1.2	0	0	1	0.7
<i>Counselors</i>						
Counselor	11	13.6	14	20.0	25	16.6
Alcohol and Drug Counselor	10	12.4	9	12.9	19	12.6
Recovery Coach	10	12.4	3	4.3	13	8.6
Case Manager	8	9.9	2	2.9	10	6.6
Other	2	2.5	1	1.4	3	2.0
Psychologist	1	1.2	0	0	1	0.7
Total	81	100	70	100	152*	100

*One practitioner did not provide sufficient information to determine whether they worked in rural New Hampshire counties or not.

Among the prescribing clinicians that provided their specialty (n=47 of 55 total prescribing clinicians), 40% reported specializing in family medicine/general practice. Table 5 shows the distribution of specialties among rural (n=24) and non-rural (n=23) prescribing clinicians.

Table 5. Rural and non-rural practitioner specialties.

	Rural		Non-rural		Total	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Family medicine/general practice	6	25.0	13	56.5	19	40.4
Addiction medicine	5	20.8	2	8.7	7	14.9
Psychiatry	4	17.4	2	8.3	6	12.8
Multiple/other	4	16.7	0	0	4	8.5
Internal medicine	2	8.3	2	8.7	4	8.5
Pediatrics	2	8.3	1	4.4	3	6.4
Emergency/urgent care	1	4.2	1	4.3	2	4.3
Total	24	100	23	100	47	100

Community Stakeholders

Table 6 shows the distribution of work settings among rural (n=74) and non-rural (n=27) community stakeholders who responded to the question (total n=101). Community stakeholder work settings included fire and/or emergency medical services (19%), child welfare (13%), health care/hospital (13%) and community mental health (11%). In addition, there were several community stakeholder respondents working in addiction specialty provider settings (7%), recovery community organizations (RCOs) and recovery centers (6%), and family resource centers or family support settings (4%).

Table 6. Community stakeholder work settings

	Rural		Non-rural		Total	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Family Resource Center/family support	18	24.3	1	3.7	19	18.8
Public health	10	13.5	3	11.1	13	12.9
Recovery Community Organization/recovery center	8	10.8	5	18.5	13	12.9
Other	7	9.5	4	14.8	11	10.9
Health care/hospital	7	9.5	1	3.7	8	7.9
Library	4	5.4	4	14.8	8	7.9
Community mental health	5	6.8	2	7.4	7	6.9
Fire and/or emergency medical	3	4.1	3	11.1	6	5.9
Addiction specialty provider	5	6.8	1	3.7	6	5.9
Education & school health	2	2.7	2	7.4	4	4.0
Community coalition	3	4.1	1	3.7	4	4.0
Child welfare	2	2.7	0	0	2	2.0
Total	74	100	27	100	101	100

Practitioner Waiver and Ability to Treat OUD

Among prescribing clinicians that reported their waiver status (n=47 of 55 total prescribing clinicians), 60% reported having a waiver to prescribe buprenorphine² at the time of the survey (Table 7).

Table 7. Buprenorphine waiver status of rural and non-rural prescribing clinicians (i.e., MD, DO, NP, PA).

	Rural		Non-rural		Total	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Waivered	15	62.5	13	56.5	28	59.6
Not waived	9	37.5	10	43.5	19	40.4
Total	24	100	23	100	47	100

Among prescribing clinicians who responded to the question (n=45), 23 reported currently treating patients with OUD using U.S. Food and Drug Administration-approved MOUD (e.g., methadone, buprenorphine, naltrexone) (Table 8). Of these 23 practitioners, 22 (94%) were waived to prescribe buprenorphine, and 91% reported primarily prescribing buprenorphine (Table 9).

Table 8. Rural and non-rural practitioners currently treating patients with opioid use disorder (OUD) using U.S. Food & Drug Administration-approved medications for OUD (MOUD).

	Rural		Non-rural		Total	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Treating OUD with medications	13	56.5	10	45.5	23	51.1
Not treating OUD with medications	10	43.5	12	54.6	22	48.9
Total	23	100	22	100	45	100

Table 9. Primary medication prescribed by practitioners currently treating patients with opioid use disorder (OUD) using U.S. Food & Drug Administration-approved medications for OUD (MOUD).

	Rural		Non-rural		Total	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Buprenorphine	11	84.6	10	100	21	91.3
Methadone	1	7.7	0	0	1	4.4
Naltrexone	1	7.7	0	0	1	4.4
Total	13	100	10	100	23	100

²The 2021 change to federal practice guidelines allowing practitioners to obtain a waiver to treat up to 30 patients with buprenorphine without a training requirement was not in effect at the time of the survey.

Practitioner Difficulty Retaining Patients

Practitioners currently treating patients with OUD using MOUD who responded to the question (n=22) reported a moderate level of difficulty (scale 0–10; mean score=5.1) retaining patients on their recommended MOUD treatment regimen, with one-third (32%) reporting a difficulty level of 7 or higher (Figure 2).

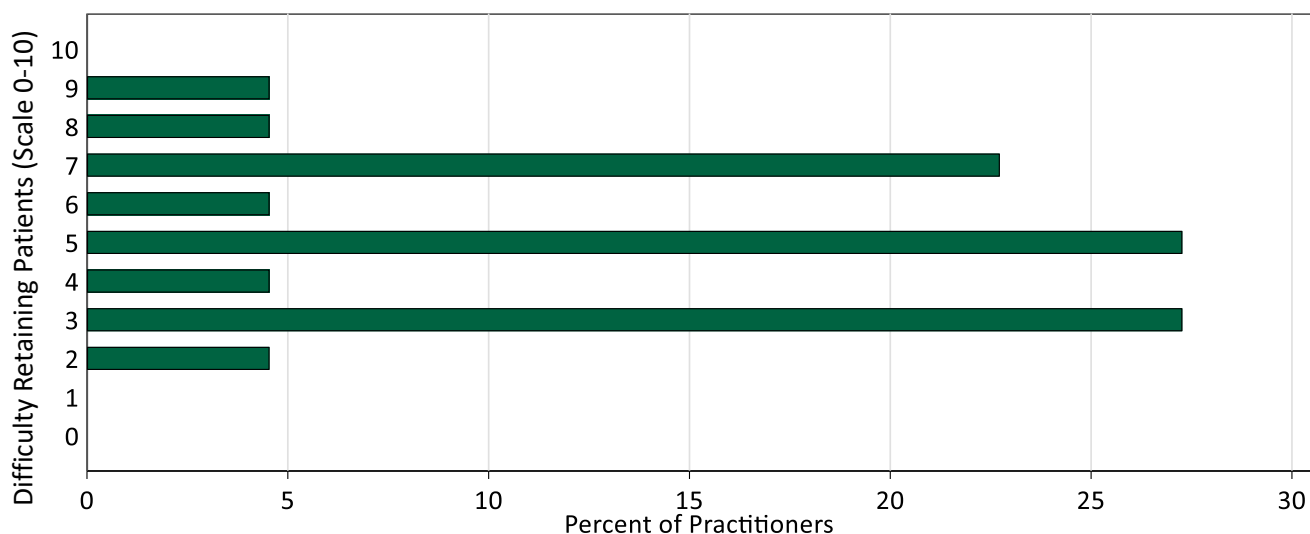


Figure 2. Distribution of reported difficulty retaining patients in their medication for opioid use disorder (MOUD) treatment regimens among practitioners currently treating patients using MOUD (n=22).

Figure 3 shows box and whisker plots³ of the distribution of difficulty levels reported by rural (n=12) and non-rural (n=10) prescribing clinicians currently treating patients with MOUD regarding retaining patients in their MOUD treatment regimens. Using an independent samples t-test, there was no significant difference using a cutoff of $p < 0.05$ between the mean difficulty level reported by rural and non-rural practitioners. Most prescribing clinicians (82%) reported that their patients stay in treatment for six months or longer. Using a chi-square test of independence, there was no significant difference between the proportion of rural and non-rural practitioners that reported that their patients stay in treatment for six months or longer (data not shown).

³For further description of data distribution in boxplots, please consult:

<https://www.open.edu/openlearn/ocw/mod/oucontent/view.php?printable=1&id=4089>

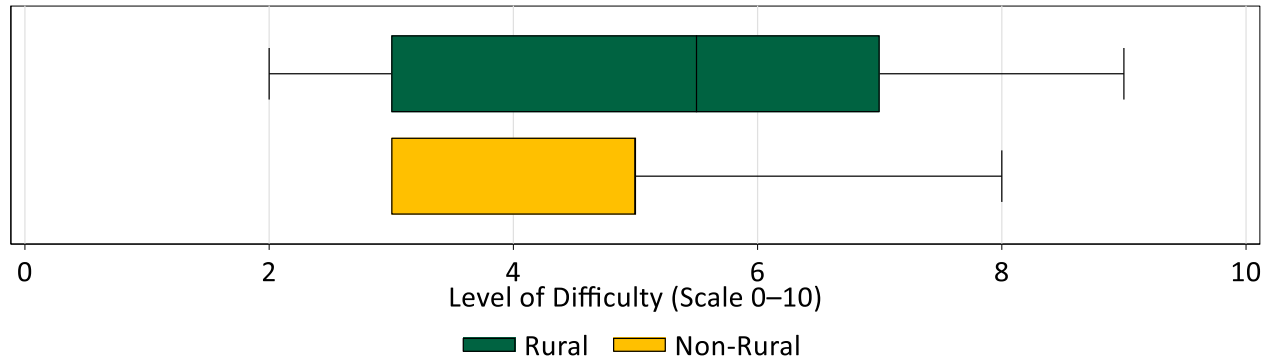


Figure 3. Box and whisker plot showing quartiles of the distribution of difficulty levels in retaining patients on MOUD treatment regimens, as reported by rural (n=12) and non-rural (n=10) practitioners currently treating patients using MOUD. Middle lines of the colored boxes represent median values and left and right lines represent 25th and 75th percentile values, respectively. The leftmost and rightmost lines represent the lower and upper adjacent values of the distribution. In this figure, the 25th percentile value (3) among non-rural practitioners is the same as the minimum value. Similarly, the median value (5) is the same as the 75th percentile value. There are no outlier values.

Practitioner Concern about Treatment Adherence

Figure 4 shows the distribution of practitioners’ levels of concern regarding patient non-adherence to the recommended MOUD treatment regimen, among practitioners currently treating patients using MOUD (n=23). The average level of concern was moderate (mean score=4.5), with fewer than one-third (30%) reporting a level of concern of 7 or higher.

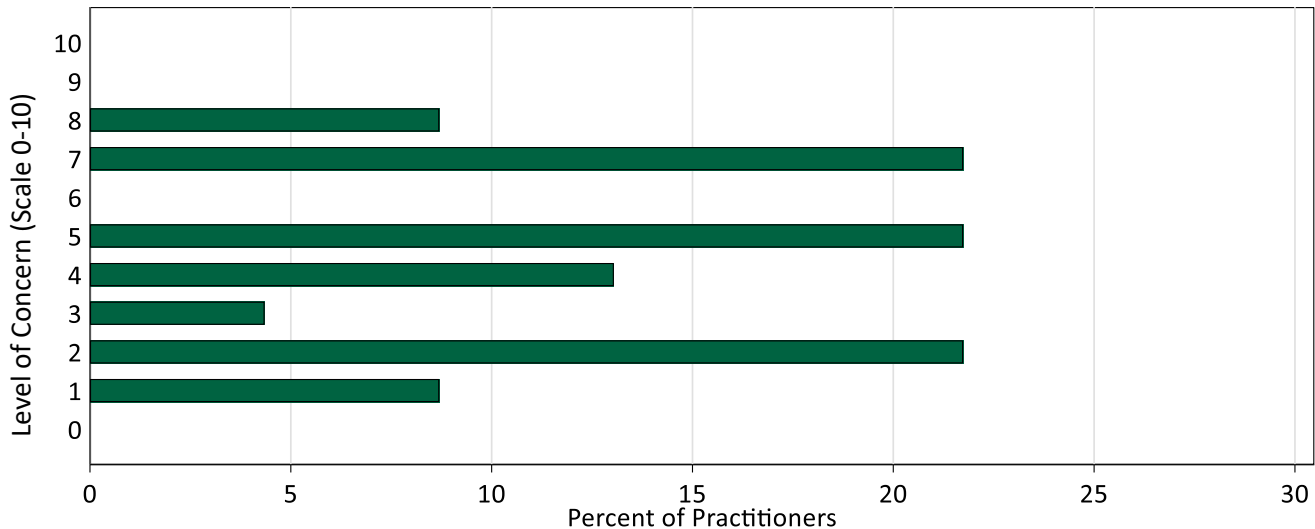


Figure 4. Distribution of concern regarding patient non-adherence to the recommended medication for opioid use disorder (MOUD) treatment regimen, among practitioners currently treating patients with MOUD (n=23).

Figure 5 shows box and whisker plots of the distribution of concern that rural (n=13) and non-rural (n=10) prescribing clinicians currently treating patients with MOUD reported regarding patient non-adherence to the recommended MOUD treatment regimen. Using an independent samples t-test, there was no significant difference between the mean concern level of rural (mean score=4.8) and non-rural (mean score=4.2) practitioners regarding patient non-adherence to the recommended MOUD treatment regimen.

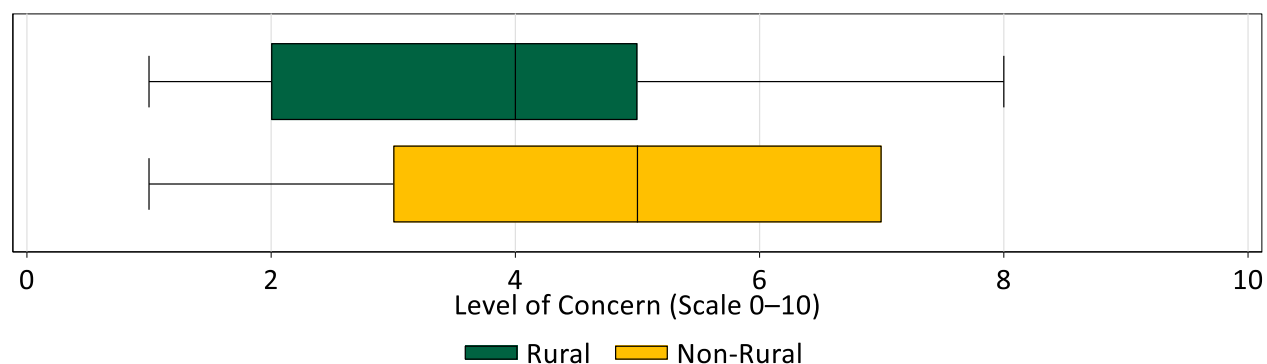


Figure 5. Box and whisker plot showing quartiles of the distribution of concern regarding patient non-adherence to the recommended medication for opioid use disorder (MOUD) treatment regimen, among rural (n=13) and non-rural (n=10) practitioners currently treating patients with MOUD. Middle lines of the colored boxes represent median values and left and right lines represent 25th and 75th percentile values, respectively. The leftmost and rightmost lines represent the lower and upper adjacent values of the distribution. In this figure, among non-rural practitioners the 75th percentile value (7) is the same as the maximum value. There are no outlier values.

Number of Patients: Total and OUD Treatment

Table 10 shows the number of patients cared for each week by practitioners for all reasons. Among practitioners who responded to the question (n=151), five practitioners reported seeing zero patients per week; these individuals reported working in nursing, case management, and other roles, with four reporting working in management positions. Additionally, seven practitioners reported seeing 100 or more patients per week, two of whom reported seeing over 400. Among these seven were two nurses, two nurse practitioners, a case manager, a primary care physician, and a psychologist.

Table 10. Number of unique patients cared for each week by practitioners (for all reasons), grouped by rural location, buprenorphine waiver status, and role group.

	N	Mean	Median	Min	Max
All practitioners	151	35.3	25	0	460
Rural practitioners*	80	31.3	20	0	100
Non-rural practitioners*	70	40.0	25	0	460
Waivered prescribing clinicians	23	40.4	40	10	100
Non-waivered prescribing clinicians	22	45.5	45	1	200
Clinicians	81	44.5	35	0	460
Counselors	70	24.6	20	0	100

*One practitioner did not provide sufficient information to determine whether they worked in rural New Hampshire counties or not.

Table 11 shows the number of patients that practitioners with buprenorphine waivers who responded to the question (n=22) reported treating with MOUD at any one time. Seven (36%) respondents reported treating five or fewer patients, while six (23%) reported treating 50 or more patients, including two who reported treating 100 or more patients.

Table 11. Number of patients treated by practitioners (n=22) using medications for opioid use disorder (MOUD) at any one time, by work location.

	N	Mean	Median	Min	Max
All practitioners currently treating patients with MOUD	22	54.0	22	0	600
Rural	12	65.7	10	0	600
Non-rural	10	40.1	32	3	100

Concern about Substances

Practitioners

Practitioners were asked to report their level of concern (scale 0–10) regarding the use of different substances and substance combinations (Table 12). Throughout this section, we use independent samples t-tests with a conservative cutoff of $p < 0.01$ to account for multiple comparisons to determine statistical significance.

Practitioners were most concerned about fentanyl (mean score=7.9), methamphetamine (mean score=7.5) and the combinations of opioids with stimulants (mean score=7.7), alcohol (mean score=7.5) and sedatives (e.g., benzodiazepines; mean score=7.4).

Table 12. Practitioners’ mean level of concern (scale 0–10) regarding use of various substances among their patients.

	N*	Mean		N	Mean
Fentanyl	149	7.9	Tobacco	146	6.3
Opioids + stimulants	146	7.7	Cocaine	149	6.2
Opioids + alcohol	149	7.5	Benzodiazepines	149	6.2
Methamphetamine	147	7.5	Rx stimulants	150	5.5
Heroin	150	7.4	Marijuana	146	5.4
Opioids + sedatives	148	7.4	Other street drugs	146	4.8
Alcohol	151	7.3	Over-the-counter or prescription drug misuse	142	4.8
Rx opioids	150	6.4			

*Sample sizes differ between substances because not all practitioners provided a level of concern for every substance.

Figure 6 shows the mean level of concern regarding the use of different substances among waived and non-waived practitioners. There were no significant differences in mean concern levels reported by waived and non-waived practitioners regarding their patients’ use of these substances, among all practitioners (Figure 6) and rural practitioners only (data not shown).

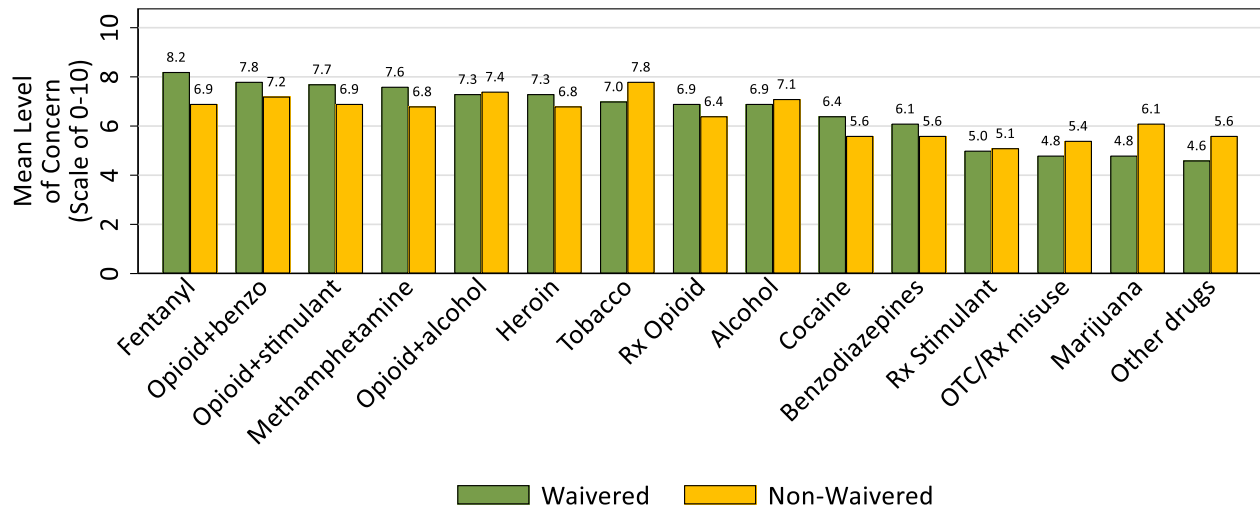


Figure 6. Mean level of concern among waived (sample size range: n=27–28) and non-waived (sample size range: n=17–19) practitioners regarding their patients’ use of substances, ordered by waived practitioner concern. OTC: over-the-counter; Rx: prescription.

Figure 7 shows the mean level of concern regarding the use of different substances among rural (sample size range: n=77–80) and non-rural (sample size range: n=64–70) practitioners. There were no significant differences between rural and non-rural practitioners' mean concern levels regarding their patients' use of these substances.

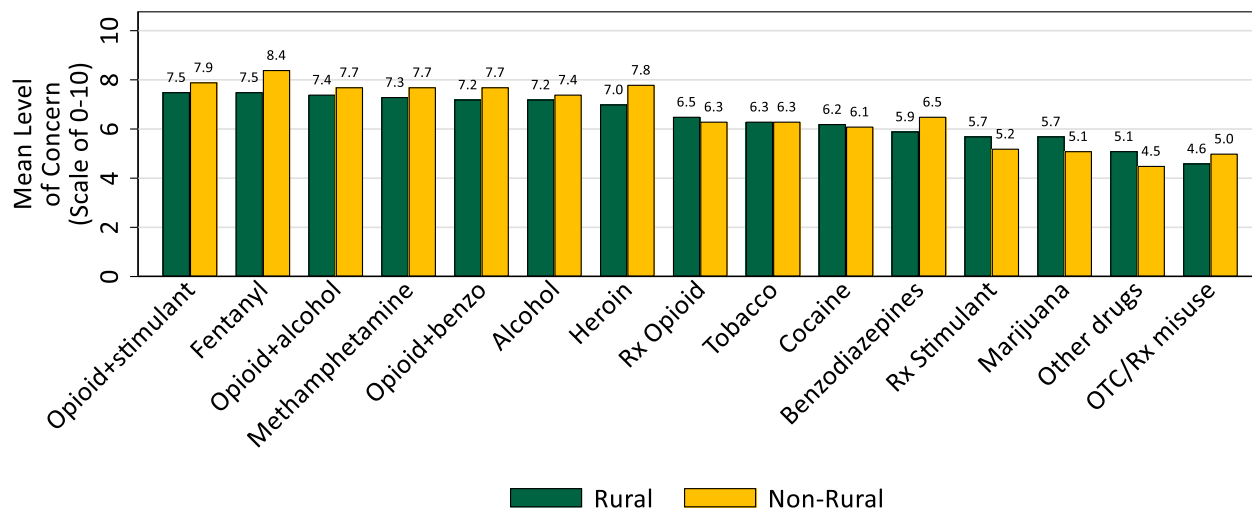


Figure 7. Mean level of concern among rural (sample size range n=77–80) and non-rural (sample size range n=64–70) practitioners regarding their patients' use of substances, ordered by rural practitioner concern.

Figure 8 shows the mean level of concern regarding the use of different substances among clinicians (sample size range: n=76–80) and counselors (sample size range: n=66–71). Clinicians reported significantly greater concern about their patients' tobacco use (mean score=7.1) compared to counselors (mean score=5.4; $p=0.001$). There were no significant differences between these groups for other substances. When limiting the analysis to rural practitioners only, there were no significant differences between clinicians' and counselors' mean levels of concern regarding their patients' use of these substances (data not shown).

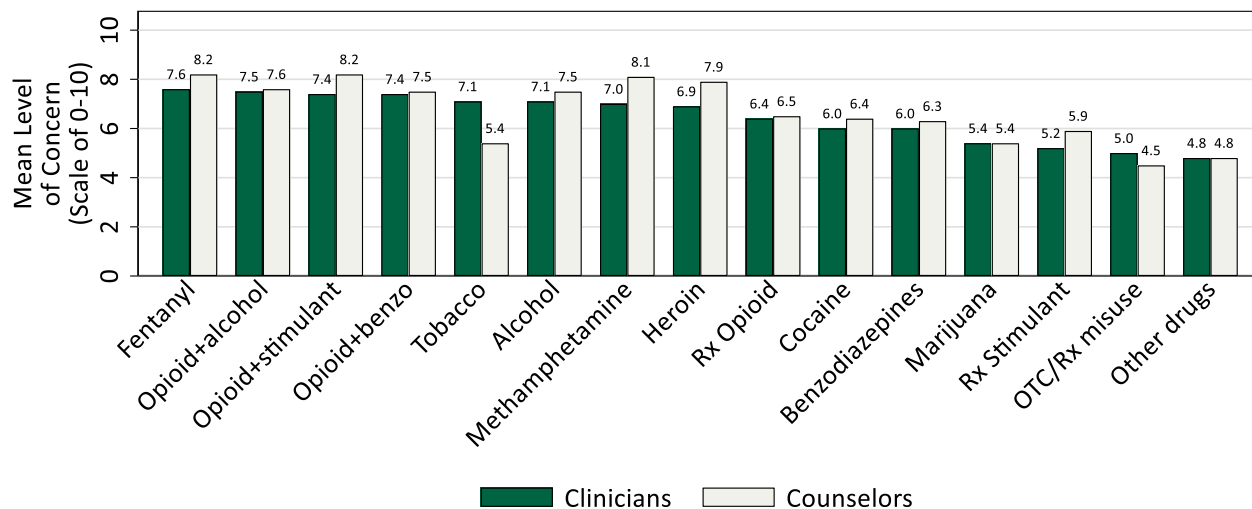


Figure 8. Mean level of concern among clinicians (sample size range: n=76–80) and counselors (sample size range n=66–71); see Table 4 for more information on these role groups) regarding their patients' use of substances, ordered by level of concern among clinicians. OTC: over-the-counter; Rx: prescription.

Community Stakeholders

Table 13 shows community stakeholders' reported levels of concern (scale 0–10) regarding the use of substances and substance combinations in the communities in which they work. Community stakeholders were most concerned about fentanyl (mean score=8.3), methamphetamine (mean score=8.0), heroin (mean score=7.9), and the combinations of opioids with alcohol (mean score=7.9) and stimulants (mean score=7.9).

Table 13. Community stakeholders' mean level of concern (scale 0–10) about use of substances in the communities in which they work.

	N*	Mean		N*	Mean
Fentanyl	100	8.3	Rx stimulants	100	6.8
Methamphetamine	100	8	Cocaine	99	6.6
Opioids + stimulants	100	7.9	Tobacco	100	6.5
Heroin	100	7.9	Benzodiazepines	100	6.2
Opioids + alcohol	99	7.9	Other street drugs	101	5.8
Alcohol	101	7.8	Over-the-counter or prescription drug misuse	99	5.6
Rx opioids	100	7.8	Marijuana	98	5.5
Opioids + sedatives	99	7.4			

*Sample sizes differ because not all stakeholders provided a level of concern for every substance.

Figure 9 shows the mean level of concern among practitioners (sample size range: n=142–151) and community stakeholders (sample size range: n=98–101) regarding substance use among the patients and communities with whom they work. Using independent samples t-tests with a conservative cutoff of $p < 0.01$ (to account for multiple comparisons), community stakeholders (mean score=6.8) had a 1.3-point greater average concern level regarding the use of prescription stimulants than practitioners (mean score 5.5; $p < 0.0005$). Community stakeholders (mean score=7.8) had a 1.4-point greater concern level about the use of prescription opioids than practitioners (mean score=6.4; $p < 0.0005$).

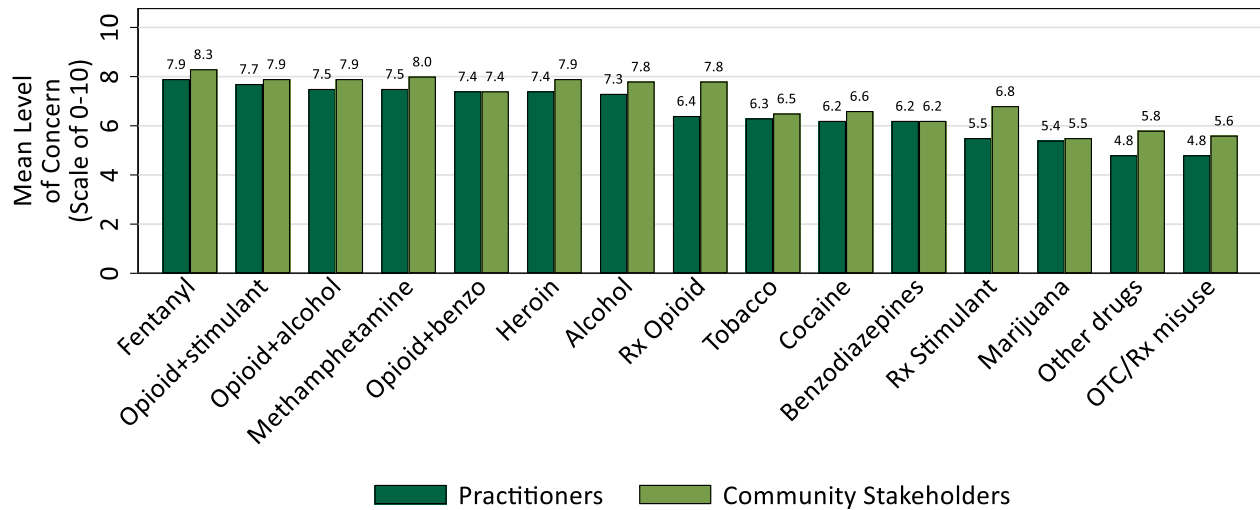


Figure 9. Mean level of concern among practitioners (sample size range: n=142–151) and community stakeholders (sample size range: n=98–101) regarding substance use among the patients and communities with whom they work. OTC: over-the-counter; Rx: prescription.

Figure 10 shows the mean level of concern among rural (sample size range: n=72–74) and non-rural (sample size range: n=26–27) community stakeholders regarding substance use in the communities in which they work. Using independent samples t-tests with a conservative cutoff of $p < 0.01$ (to account for multiple comparisons), there were no significant differences in concern levels between rural and non-rural community stakeholders (p -values > 0.05).

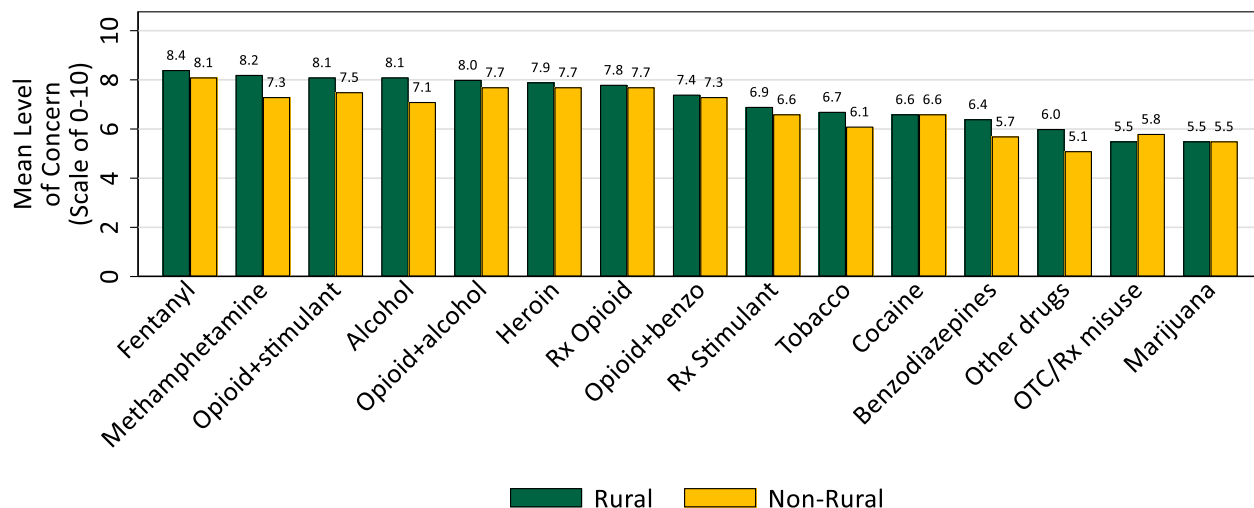


Figure 10. Mean level of concern among rural (sample size range n=72–74) and non-rural (sample size range n=26–27) community stakeholders regarding substance use in the communities in which they work. OTC: over-the counter; Rx: prescription.

Practitioner Comfort Treating SUD

Practitioners were asked to report their level of comfort in treating patients with OUD and in treating SUD in special populations. Throughout this section we use independent samples t-tests with a cutoff of $p < 0.05$ to determine statistical significance. Figure 11 shows the distribution of practitioners' level of comfort in treating patients with OUD (scale 0–10). Practitioner respondents reported an average comfort level of 7.6, with 31% rating their comfort level as 10 out of 10 and 70% reporting their comfort level as 7 or higher.

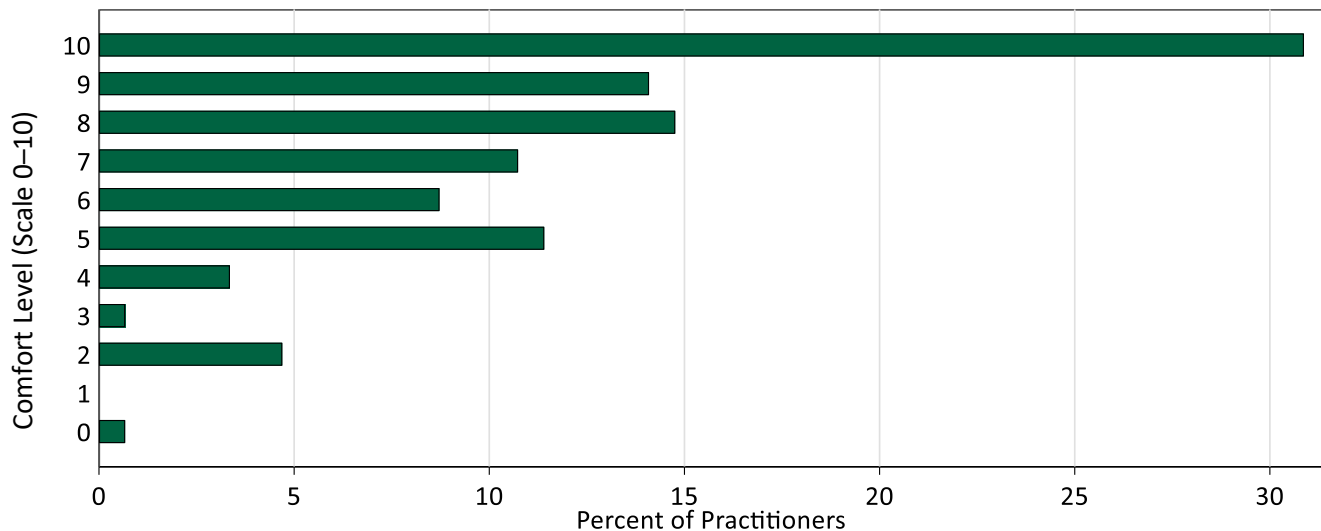


Figure 11. Distribution of practitioner responses to the question, “How comfortable are you addressing/treating opioid use disorder in your patients?” (Scale 0-10).

The following three boxplots present the distribution of practitioner comfort in treating OUD, stratified by practitioner waiver status (Figure 12), rurality (Figure 13), and role type (Figure 14).

Waivered practitioners ($n=28$) reported significantly greater comfort in treating patients with OUD (mean score=8.2) compared to non-waivered practitioners ($n=19$; mean score=5.5; $p < 0.0005$) (Figure 12). This difference persisted when limiting the analysis to rural waivered ($n=15$; mean score=8.3) and rural non-waivered ($n=9$; mean score=6.0; $p=0.016$) practitioners.

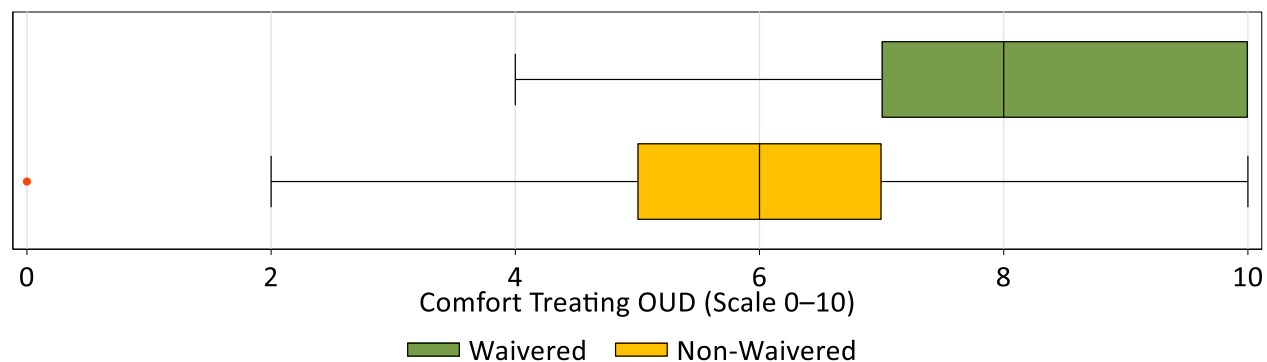


Figure 12. Box and whisker plot showing comfort treating opioid use disorder (OUD) among waived (n=28) and non-waived (n=19) practitioners. Middle lines of the colored boxes represent median values and left and right lines represent 25th and 75th percentile values, respectively. The leftmost and rightmost lines represent the lower and upper adjacent values of the distribution, and dots outside the lines represent outlier values. In this figure, the maximum value among waived practitioners (10) is the same as the 75th percentile value.

There was no significant difference in the mean comfort level of rural (n=79; mean score=7.6) and non-rural (n=69; mean score=7.7) practitioners in treating patients with OUD (Figure 13).

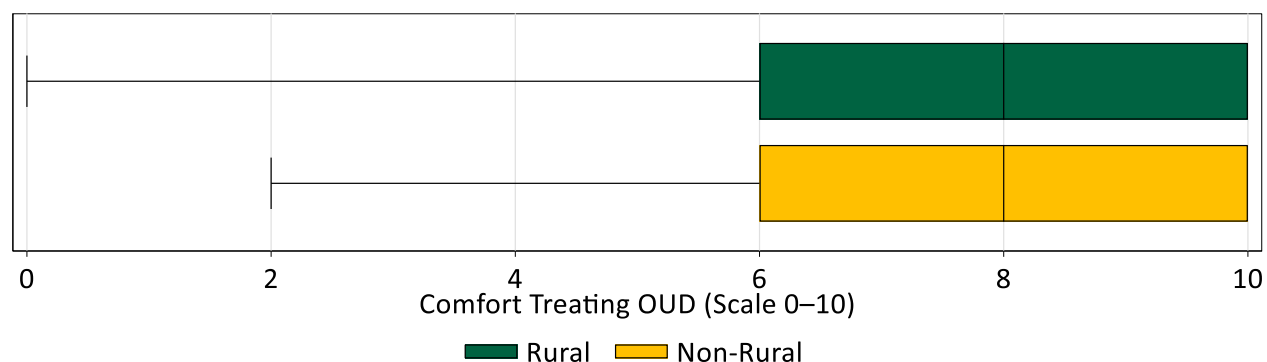


Figure 13. Box and whisker plot showing comfort treating opioid use disorder (OUD) among rural (n=79) and non-rural (n=69) practitioners. Middle lines of the colored boxes represent median values and left and right lines represent 25th and 75th percentile values, respectively. The leftmost and rightmost lines represent the lower and upper adjacent values of the distribution. In this figure, the maximum value among rural and non-rural practitioners (10) is the same as the 75th percentile values. There are no outliers.

Counselors (mean score=8.3) reported significantly greater comfort treating OUD than clinicians (mean score 7.0; $p=0.001$) (Figure 14). This difference persisted, but was not significant, when limiting the sample to rural counselors (n=41; mean score=8.1) and clinicians (n=38; mean score=7.1).

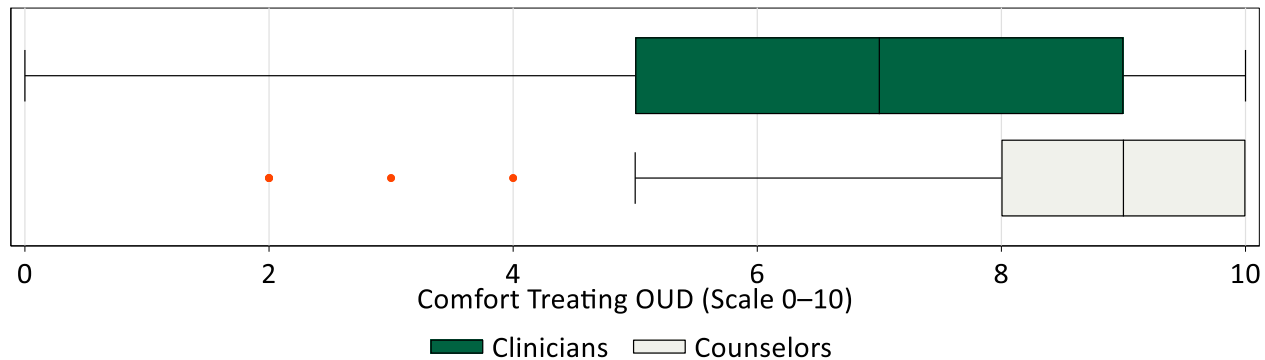


Figure 14. Box and whisker plot showing comfort level in treating opioid use disorder (OUD) among clinicians (n=79) and counselors (n=70). Middle lines of the colored boxes represent median values and left and right lines represent 25th and 75th percentile values, respectively. The leftmost and rightmost lines represent the lower and upper adjacent values of the distribution, and dots outside the lines represent outlier values. In this figure, the maximum value among counselors (10) is the same as the 75th percentile.

Figure 15 shows practitioner respondents’ mean comfort levels in treating SUD among special populations. Practitioners reported the most comfort in treating older adults (mean score=6.4), and the least comfort in treating adolescents (mean score=3.9).

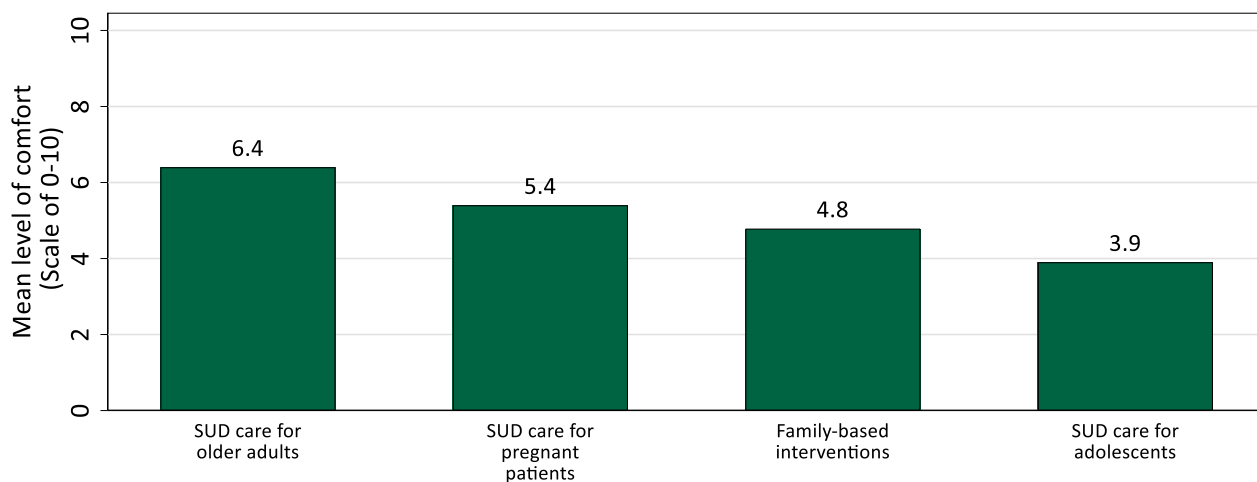


Figure 15. Mean comfort level in providing substance use disorder (SUD) services to special populations among all practitioner respondents (sample size range: n=144–147).

Figure 16 shows mean practitioner comfort level in providing SUD services to special populations among prescribing clinicians with buprenorphine waivers (sample size range n=26–28) and without buprenorphine waivers (sample size range n=18–19).

In treating older adults, waived practitioners had over a three-point greater mean comfort level than non-waivered practitioners ($p < 0.0005$). This difference persisted when limiting the analysis to rural practitioners only (waivered n=15, non-waivered n=9; $p = 0.005$) (Figure 16).

In providing SUD care to pregnant patients, buprenorphine-waivered practitioners reported a two-point greater mean comfort level than non-waivered practitioners (Figure 16; $p = 0.031$). This difference was not significant when limiting the analysis to rural practitioners only (waivered n=14, non-waivered n=9; data not shown)

There were no significant differences in mean comfort level between waived and non-waivered practitioners in providing family-based SUD interventions and support for families of individuals with SUDs or in providing SUD care or counseling for adolescents or minors (Figure 16). When limiting the sample to rural practitioners only, there were also no significant differences in mean comfort levels for these two special populations based on practitioner waiver status (data not shown).

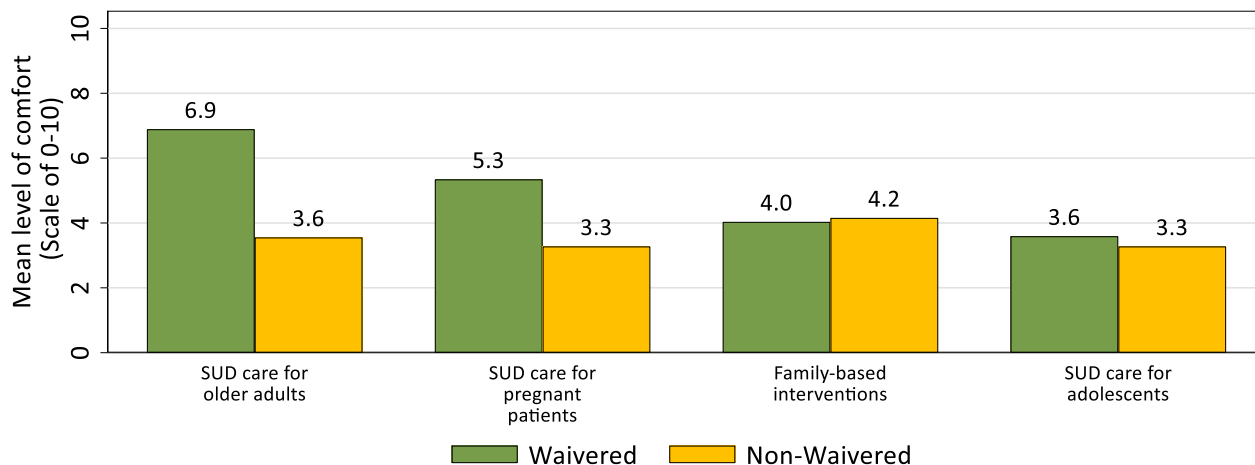


Figure 16. Mean comfort level in providing substance use disorder (SUD) services to special populations among waived (sample size range n=26–28) and non-waivered (sample size range n=18–19) practitioners.

Figure 17 shows mean comfort level in providing SUD services to special populations among rural (sample size range n=78–80) and non-rural (sample size range n=64–69) practitioners. There were no significant differences between rural and non-rural practitioners' comfort in treating any of these special populations.

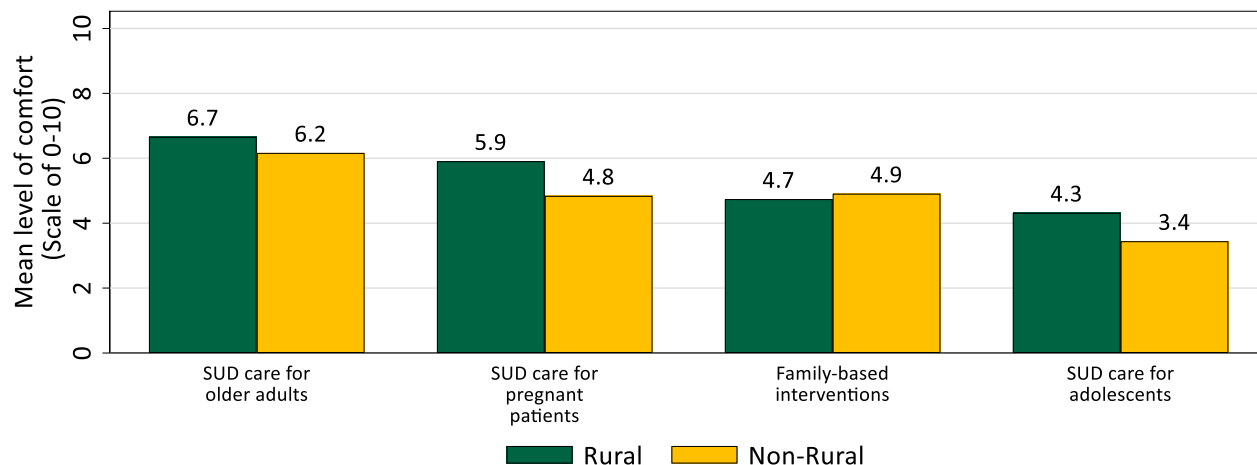


Figure 17. Mean comfort level in providing substance use disorder services to special populations among rural (sample size range n=78–80) and non-rural (sample size range n=64–69) practitioners.

Figure 18 shows mean comfort level in providing SUD services to special populations among clinicians (sample size range n=75–79) and counselors (sample size range n=67–69). In treating older adults, counselors had a one-point higher mean comfort level than clinicians ($p=0.03$). Among rural practitioners only, there was no significant difference. There were no significant differences in mean comfort level between counselors and clinicians in providing SUD care to pregnant patients, providing family-based SUD interventions and support for families of individuals with SUDs, or providing SUD care or counseling for adolescents or minors (Figure 18). When limiting the sample to rural practitioners only, there were also no significant differences in mean comfort level in providing substance use disorder services to these special populations based on practitioner role group (data not shown).

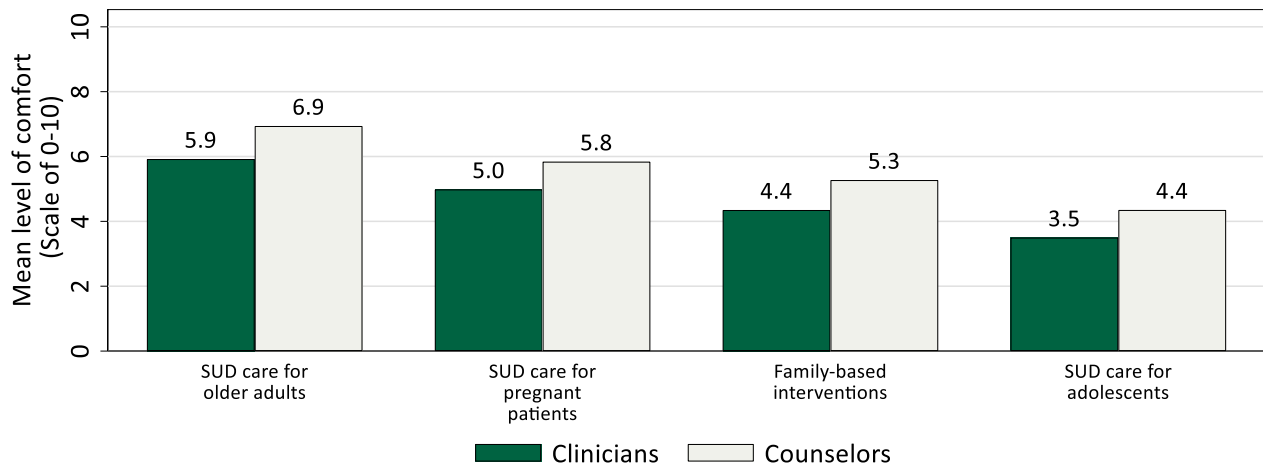


Figure 18. Mean comfort level in providing substance use disorder services to special populations among clinicians (sample size range n=75–79) and counselors (sample size range n=67–69). (See Table 4 for more information on these role groups).

Training and Supports

Prescribing clinicians were asked, “**To what degree do you feel you have the training, experience, and supports you need to induct patients on opioid treatment medication? (Scale 0–10)**” The average self-rated training, experience, and support level was 6.2; 55% of respondents reported scores of 7 or higher. Table 14 shows practitioner training, experience, and support to induct patients on MOUD by rurality and buprenorphine waiver status. Figure 19 shows the distribution of training, experience, and support levels among all respondents. Throughout this section we use independent samples t-tests with a cutoff of $p < 0.05$ to determine statistical significance.

Table 14. Practitioner perception of having adequate training, experience, and support to induct patients on medications for opioid use disorder by rural location and buprenorphine waiver status (scale 0–10).

	N	Mean
All Practitioners	38	6.2
Rural	20	6.2
Non-rural	18	6.3
Waivered	28	7.3
Not waived	10	3.3

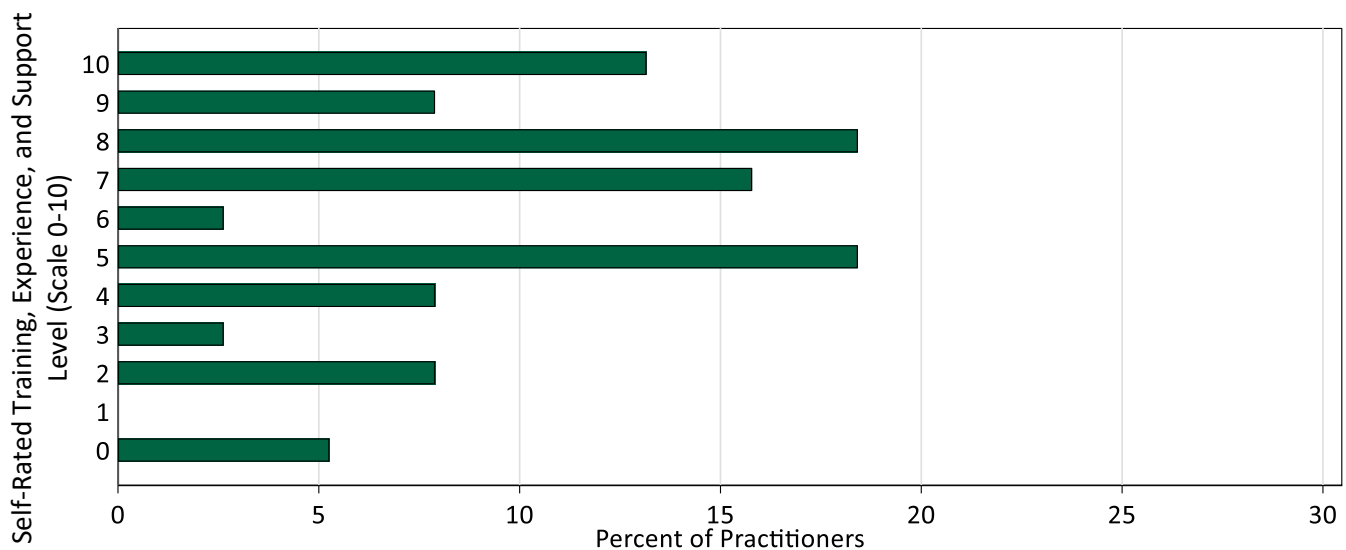


Figure 19. Prescribing clinicians’ (n=38) perceptions of having adequate training, experience, and supports to induct patients on medications for opioid use disorder (MOUD).

Figure 20 shows the distribution of self-rated training, experience, and support level among rural (n=20) and non-rural (n=18) prescribing clinicians. There was no significant difference in mean self-rated training, experience, and support level between rural (mean score=6.2) and non-rural (mean score=6.3) practitioners.

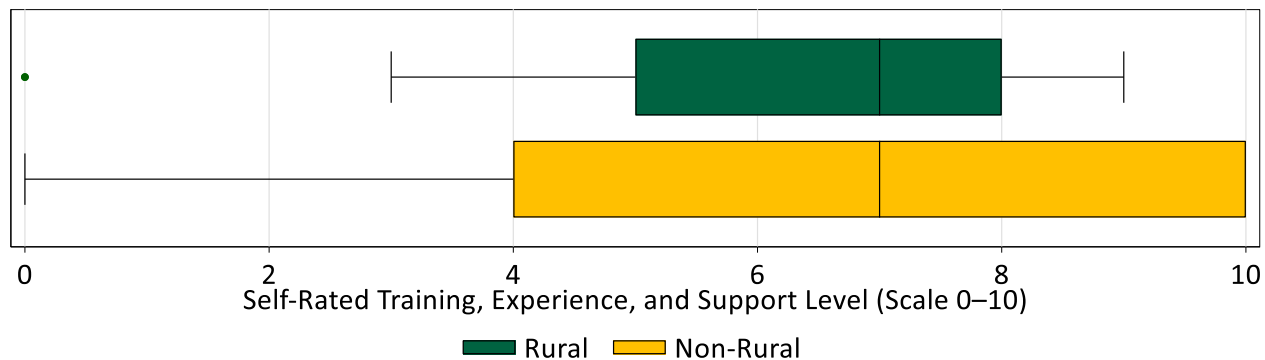


Figure 20. Box and whisker plot showing the distribution of self-rated training, experience, and support to induct patients on medications for opioid use disorder (MOUD), among rural (n=20) and non-rural (n=18) practitioners. Middle lines of the colored boxes represent median values, left and right lines represent 25th and 75th percentile values respectively. The leftmost and rightmost lines represent the lower and upper adjacent values of the distribution, and dots outside the lines represent outlier values.

Figure 21 shows the distribution of self-rated training, experience, and support levels among waived (n=28) and non-waived (n=10) prescribing clinicians. Waivered practitioners reported a four-point higher training, experience, and support level (mean=7.3) than non-waived practitioners (mean=3.3; $p<0.0005$).⁴ This difference persisted among rural practitioners only, although the magnitude of the difference was smaller (waivered n=15, mean=6.8; non-waived n=5, mean=4.4; $p=0.047$).

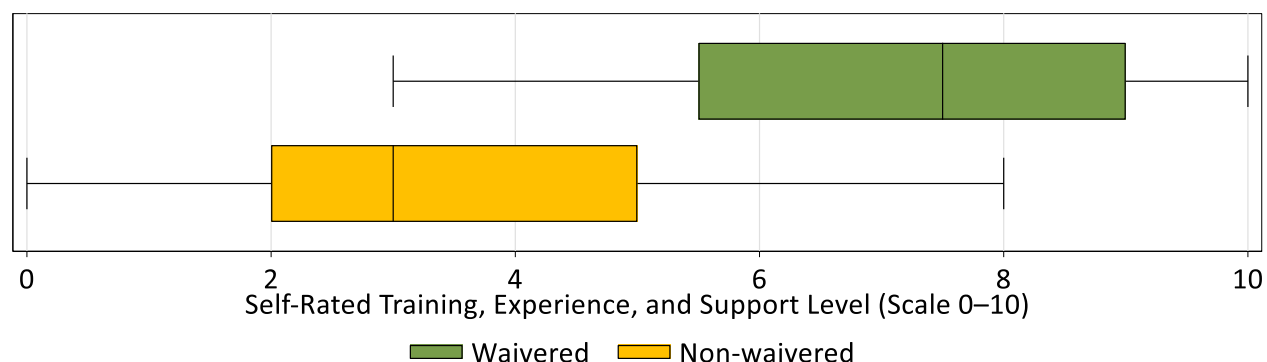


Figure 21. Box and whisker plot showing the distribution of self-rated training, experience, and support to induct patients on medications for opioid use disorder (MOUD), among waived (n=28) and non-waived (n=10) practitioners. Middle lines of the colored boxes represent median values, left and right lines represent 25th and 75th percentile values respectively. The leftmost and rightmost lines represent the lower and upper adjacent values of the distribution. There are no outlier values.

Treatment Barriers

Practitioners

Practitioners were asked about barriers to treating and retaining patients with OUD, as well as patient-related barriers to OUD treatment. Throughout this section, we use chi-square tests of independence to examine the relationship between practitioner characteristics and reported barriers to treating patients with OUD. For all statistical tests in this section, we use a conservative cutoff of $p<0.01$ to account for multiple comparisons.

⁴This difference is notable given the 2021 change to federal practice guidelines, which allows practitioners to obtain a waiver to prescribe buprenorphine without completing training. Although removing the training requirement eliminates a barrier, many non-waived practitioners report that they do not have the training, experience, and support needed to induct patients onto medication for OUD.

Figure 22 shows practitioner-identified top barriers to their practices treating patients with OUD and retaining patients in OUD treatment.

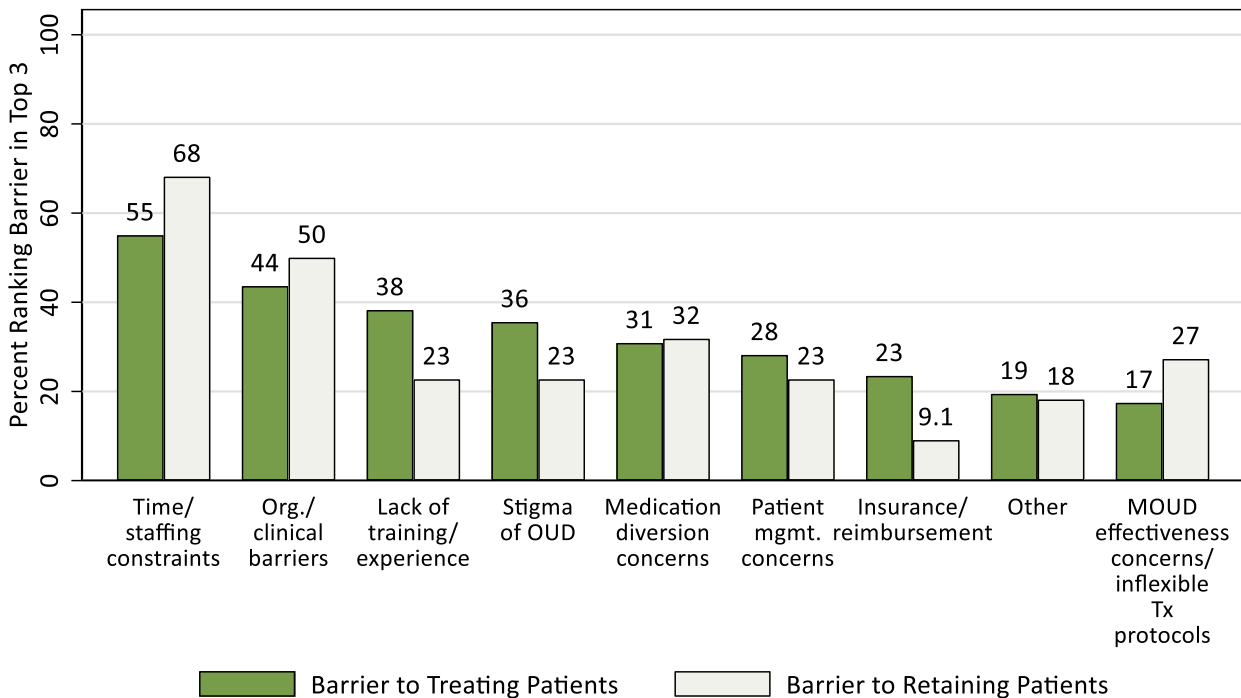


Figure 22. Practitioner-identified top barriers to their practices treating patients with opioid use disorder (OUD) (n=149) and retaining patients in OUD treatment (n=22; only practitioners that reported currently treating patients using FDA-approved medications for OUD were asked about barriers to retaining patients).

Note: “MOUD effectiveness concerns” was asked as a barrier to treating patients, “Inflexible treatment protocols” was asked as a barrier to retaining patients.

Over half of New Hampshire practitioners who responded to the question (n=149) identified constraints on time or staffing as a top barrier to treating patients. Among practitioners currently treating patients with MOUD (n=22), 68% identified constraints on time or staffing as a top barrier to retaining patients. Around half of practitioners identified organizational and clinical barriers as top barriers to treating patients with OUD and retaining them in treatment.

Notably, approximately one in five practitioners identified “other” top barriers to treating (19%) and retaining patients (18%) in treatment for OUD. These other barriers included lack of available housing, lack of available counseling or social work support for patients (especially un- and under-insured patients), and lack of affordable treatment options.

Figure 23 shows the top barriers to treating patients with OUD identified by waived (n=28) and non-waived (n=19) prescribing practitioners. A significantly higher proportion of non-waived practitioners (74%) identified training as a top barrier compared to waived practitioners (29%;

$p=0.002$). Additionally, a significantly higher proportion of waived practitioners (36%) indicated insurance or reimbursement issues as a top barrier to treating patients, compared to none (0%) of the non-waived practitioners ($p=0.003$). Among rural practitioners only (waived $n=15$, non-waived $n=9$), this association persisted, but was not statistically significant (data not shown; $p=0.015$). There were no significant associations between practitioner waiver status and any other reported barriers among all practitioners.

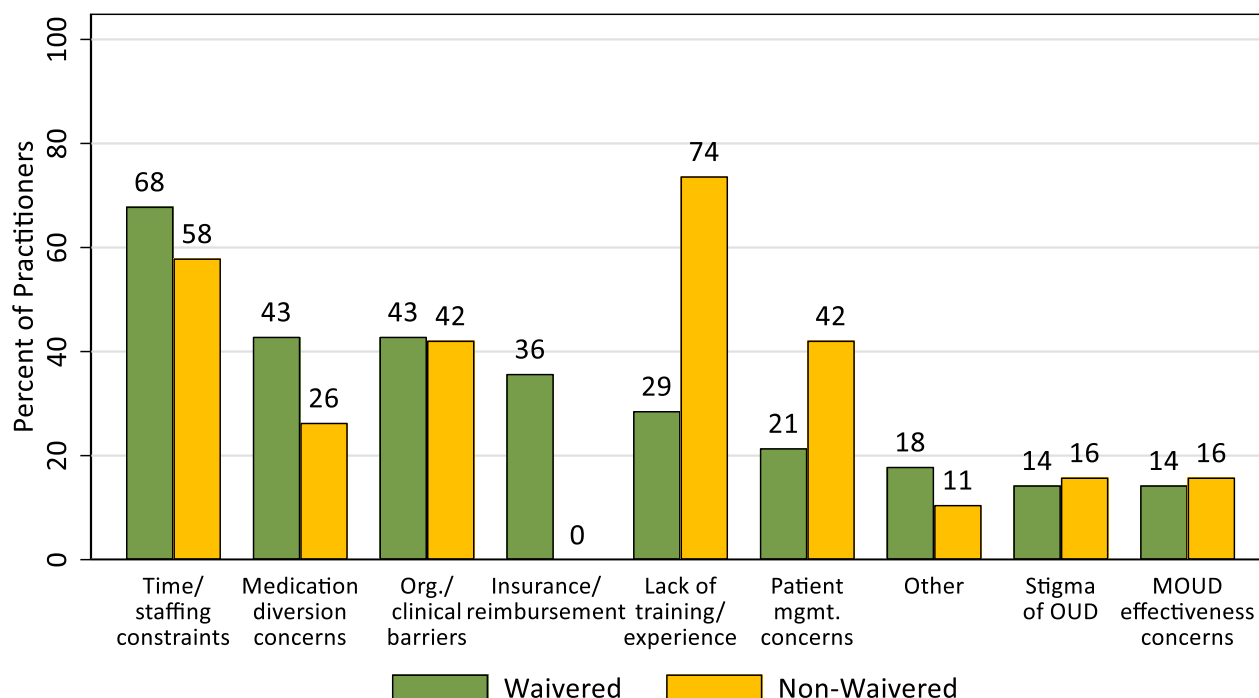


Figure 23. Waived ($n=28$) and non-waived ($n=19$) practitioner-identified top barriers to their practices treating patients with opioid use disorder (OUD).

Among rural practitioners only (waived $n=15$, non-waived $n=9$), a significantly higher proportion of rural buprenorphine-waived practitioners (93%) identified time and staffing constraints as a barrier compared to non-waived practitioners (44%, $p=0.007$). A significantly smaller proportion of rural waived practitioners (7%) identified concerns about managing OUD patients as a barrier than that of rural non-waived practitioners (56%, $p=0.007$). Other than the association regarding insurance and reimbursement referenced in the paragraph above, there were no significant associations between practitioner waiver status and reported barriers among rural practitioners.

Figure 24 shows the top barriers to treating patients with OUD identified by rural (n=79) and non-rural (n=69) practitioners. There were no significant associations between practitioner rurality and reported barriers.

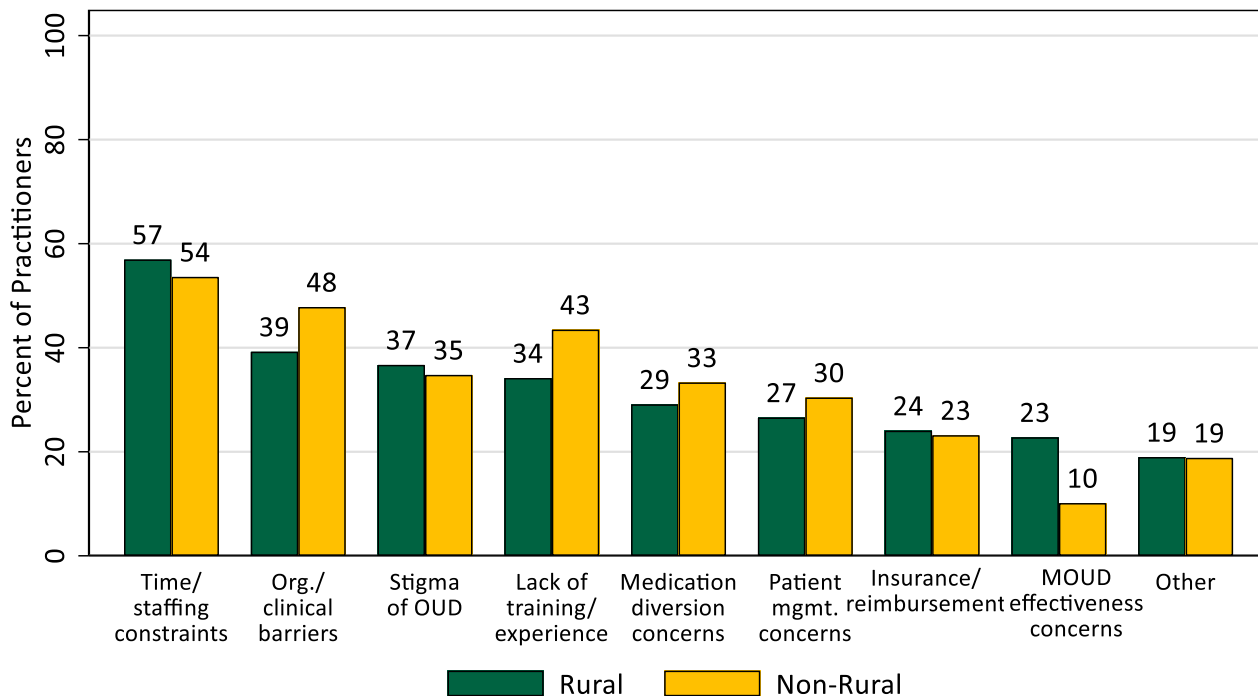


Figure 24. Rural (n=79) and non-rural (n=69) practitioner-identified top barriers to their practices treating OUD among their patients.

Figure 25 shows the top barriers to treating patients with OUD identified by clinicians (n=79) and counselors (n=70). A greater proportion of counselors (49%) identified stigma of OUD as a top barrier compared to clinicians (24%; p=0.002). There were no other significant associations between practitioner role group and reported barriers to treating patients with OUD.

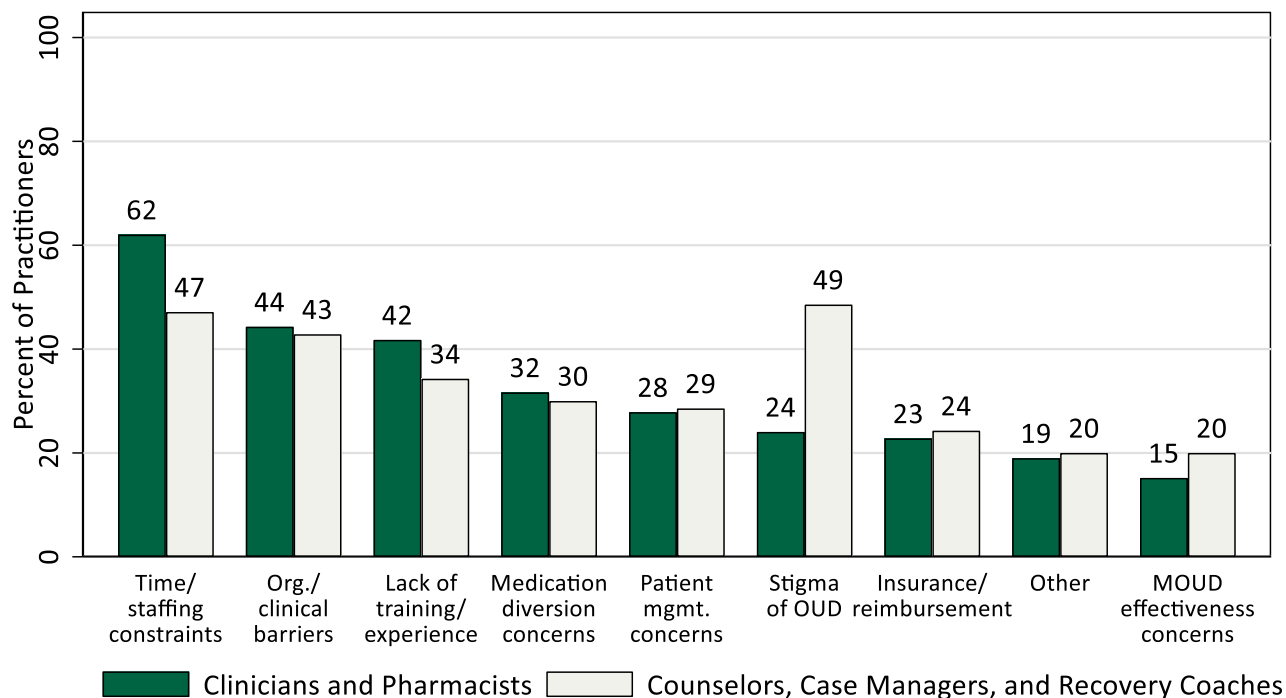


Figure 25. Clinician- (n=79) and counselor- (n=70) identified top barriers to their practices treating OUD among their patients.

Among rural practitioners only (counselors n=41, clinicians n=38), the association between practitioner role group and identification of stigma as a top barrier to OUD treatment remained: a greater proportion of rural counselors (51%) identified stigma of OUD as a top barrier compared to rural clinicians (21%, p=0.005). There were no other significant associations between practitioner role group and reported barriers to treating patients with OUD among rural practitioners.

Figure 26 shows the proportion of practitioners that identified various top barriers to patients receiving (n=150) and remaining in (n=147) OUD treatment. Lack of time, transportation, and other supports was identified by most practitioners as a top barrier to patients receiving (79%) and remaining in (84%) OUD treatment. Among those identifying a lack of time, transportation, and other supports as their primary concern for patients receiving treatment (n=45), 40 (89%) noted transportation or other access issues, 34 (76%) identified lack of social support, 20 (44%) noted lack of time due to childcare, and 4 (9%) noted a lack of language support or interpretive services. Other frequently endorsed top barriers included stigma of OUD (receiving treatment: 59%, remaining in treatment: 46%), insurance or reimbursement issues (receiving treatment: 39%, remaining in treatment: 42%), concerns about treatment and co-occurring health issues (receiving treatment: 40%, remaining in treatment: 38%), and family or parenting demands (receiving treatment: 33%, remaining in treatment: 41%).

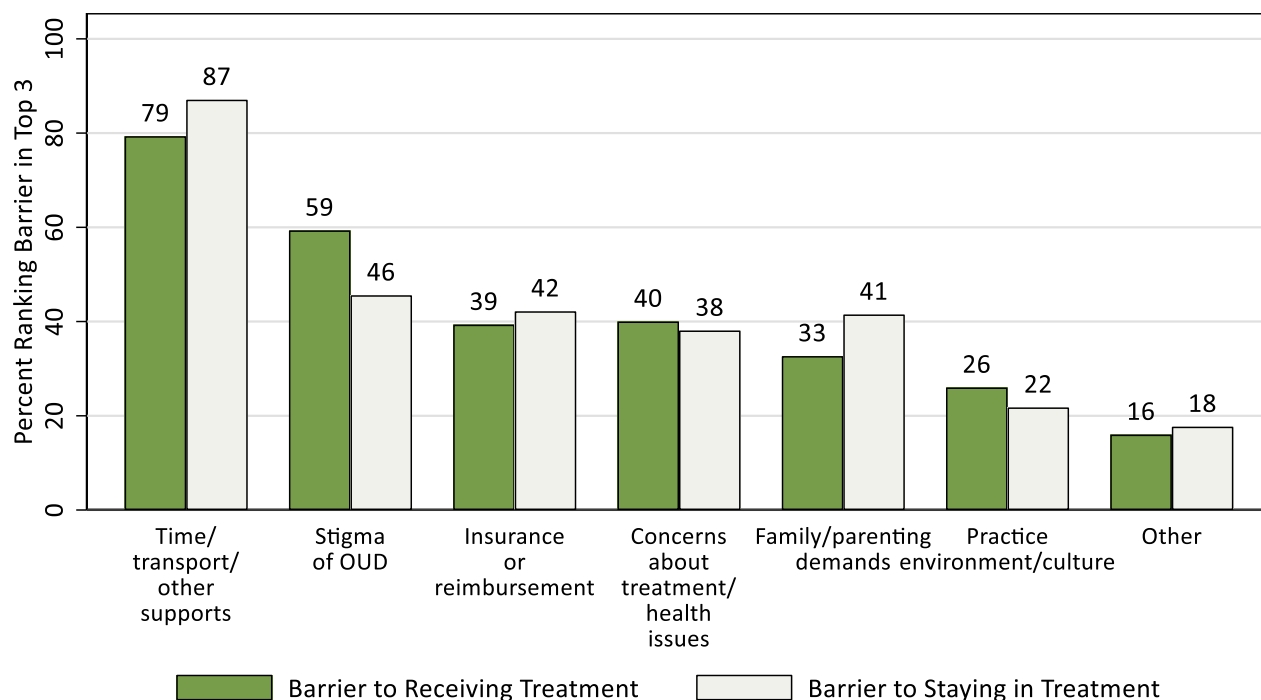


Figure 26. Practitioner-identified top barriers to patients receiving (n=150) and remaining in (n=147) opioid use disorder (OUD) treatment.

Figure 27 shows patient-related barriers to OUD treatment as identified by waived (n=28) and non-waived (n=19) prescribing clinicians. There were no significant associations between practitioner waiver status and reported patient-related barriers to OUD treatment. Similarly, among rural practitioners only (waived n=15, non-waived n=9), there were no significant associations between practitioner waiver status and reported patient-related barriers to OUD treatment.

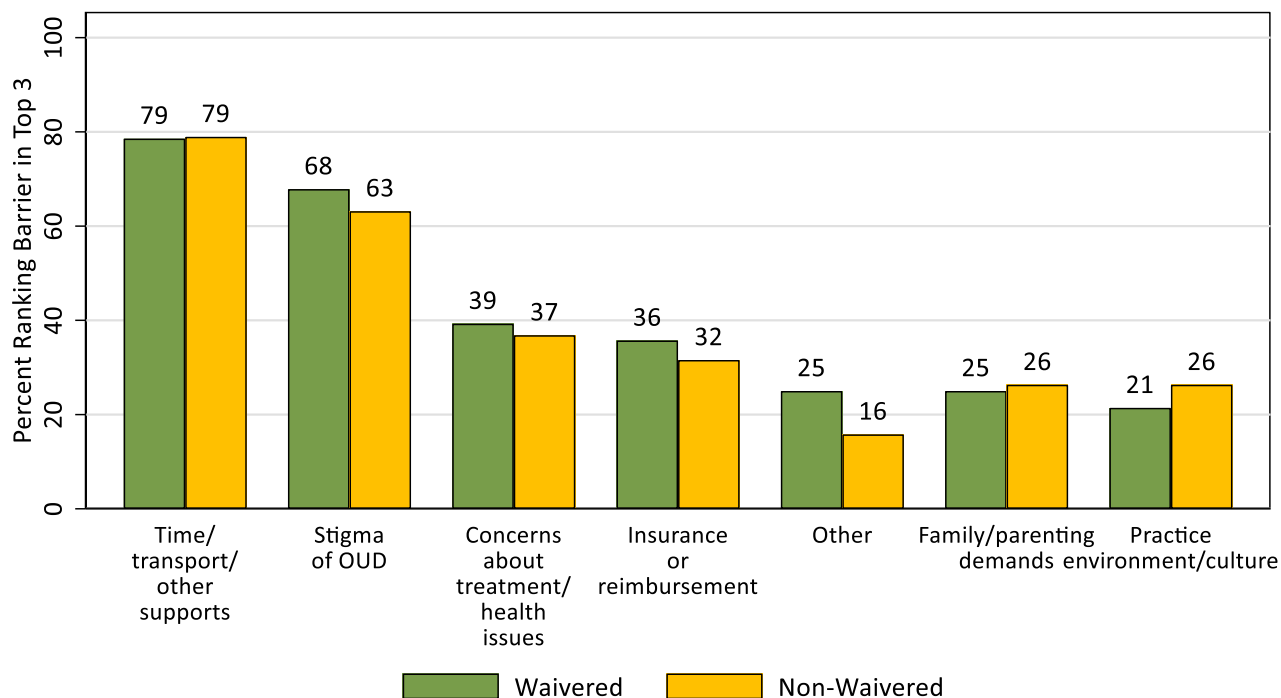


Figure 27. Patient-related barriers to receiving opioid use disorder (OUD) treatment identified by waived (n=28) and non-waived (n=19) practitioners.

Figure 28 shows the proportion of rural (n=80) and non-rural (n=69) practitioners that identified various barriers among their top barriers to patients to receiving OUD treatment. A greater proportion (43%) of rural practitioners identified parenting and family concerns as a top barrier to patients receiving OUD treatment compared to non-rural practitioners (22%; $p=0.007$). There were no other significant associations between the rurality of practitioner rurality and reported patient-related barriers to treatment.

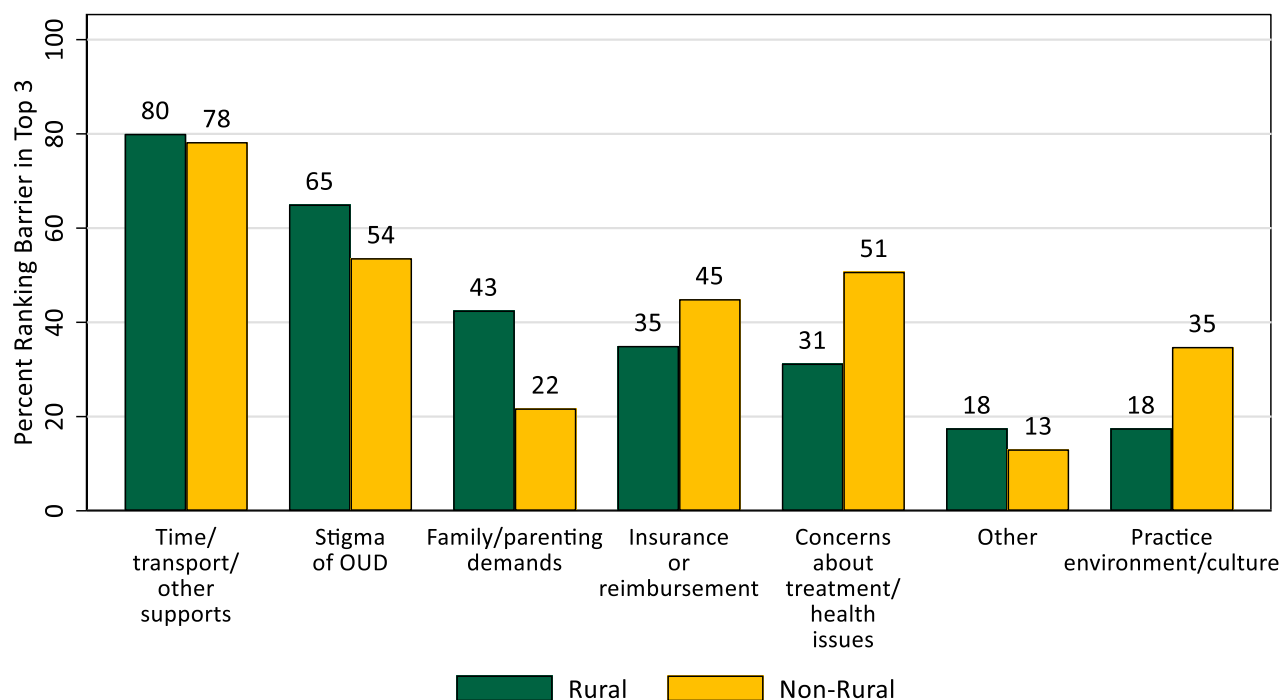


Figure 28. Patient-related barriers to receiving opioid use disorder (OUD) treatment identified by rural (n=80) and non-rural (n=69) practitioners.

Figure 29 shows the proportion of clinicians (n=79) and counselors (n=71) that identified barriers as among their top-three barriers to patients to receiving OUD treatment. There were no significant associations between the role type of practitioners and patient-related barriers to treatment that they reported. Similarly, among rural practitioners only (clinicians n=38; counselors n=42), there were no significant associations between the role type of practitioners and patient-related barriers to treatment that they reported.

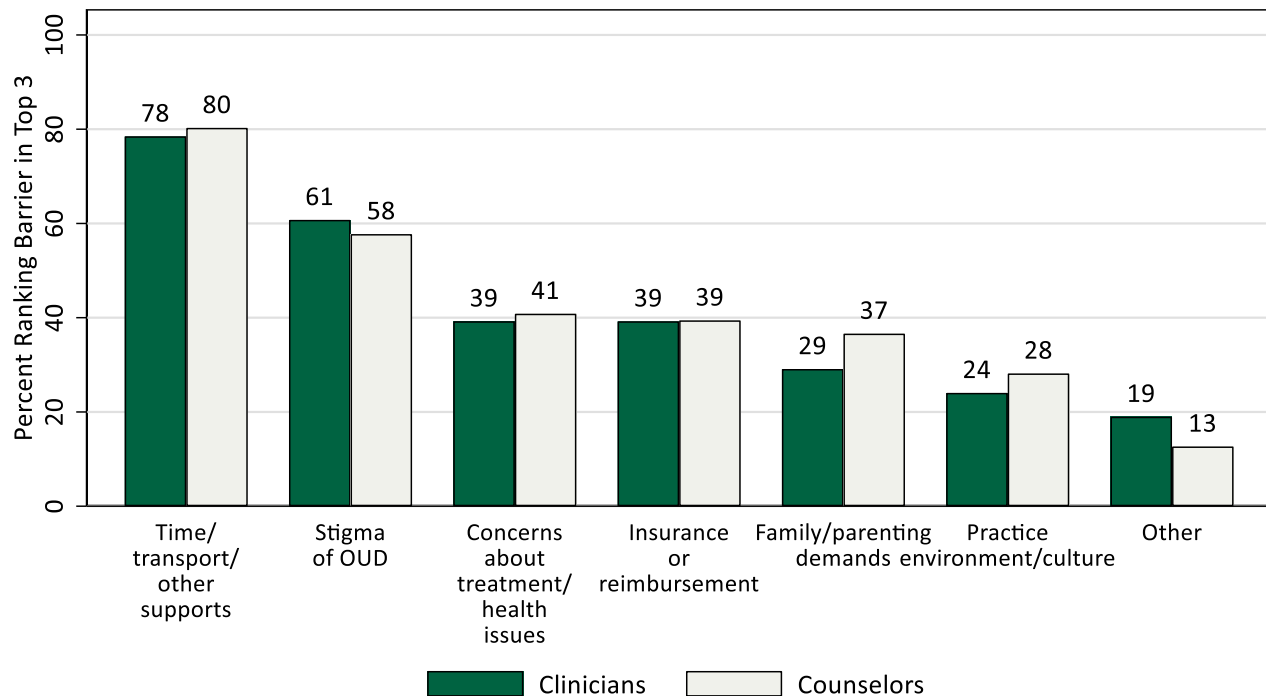


Figure 29. Patient-related barriers to receiving opioid use disorder (OUD) treatment identified by practitioners in clinician & pharmacist (n=79) and counseling, case manager, and recovery coach (n=70) roles.

Community Stakeholders

Community stakeholders were asked to identify the greatest challenges to treating OUD in the communities in which they work. Throughout this section, we use chi-square tests of independence to examine the relationship between stakeholder characteristics and reported challenges to treating OUD. For all statistical tests in this section, we use a conservative cutoff of $p < 0.01$ to account for multiple comparisons.

Table 15 shows the proportion of community stakeholders who responded to the question (n=99) that identified various challenges among the top three challenges to treating OUD in their communities. Over half (56%) of community stakeholders identified patient access barriers (e.g., transportation, time, and childcare) as a top challenge. This is consistent with practitioner respondents who similarly were most likely to identify time, transport, and other supports, as a top barrier to patients receiving treatment. Other key challenges reported by community stakeholders included lack of capacity to treat patients in their communities (42%), and stigma of OUD (40%) (Table 15).

A greater proportion of non-rural community stakeholders (11%) identified medication diversion concerns as a challenge compared to rural community stakeholders (0%; $p=0.004$); however, it is important to note the small overall number of community stakeholders that identified this concern ($n=3$, 3%). There were no other significant differences in challenges identified by rural ($n=72$) and non-rural ($n=27$) community stakeholders.

Table 15. Community stakeholder- ($n=99$) identified challenges to treating patients with opioid use disorder (OUD) in their communities.

Challenge to treating OUD	Rural ($n=72$)		Non-Rural ($n=27$)		Total ($n=99$)	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Barriers to accessing treatment for patients (e.g., transportation, time, childcare)	42	58.3	13	48.2	55	55.6
Not enough capacity to treat patients	29	40.3	13	48.2	42	42.4
Stigma of opioid use disorder	31	43.1	9	33.3	40	40.4
Not enough care coordination for individuals with complex needs (linkages to social supports / community resources)	27	37.5	11	40.7	38	38.4
Insurance barriers (e.g., lack of coverage, prior authorization requirements, fail first requirements)	27	37.5	8	29.6	35	35.4
Difficulty getting individuals to adhere to the requirements of their treatment	19	26.4	8	29.6	27	27.3
Providers need more supports for treating OUD (training, resources, assistance with waiver process)	10	13.9	7	25.9	17	17.2
Misconceptions of medications used to treat OUD (e.g., buprenorphine, methadone)	12	16.7	3	11.1	15	15.2
Difficulty retaining individuals in treatment once they are enrolled (low retention)	7	9.7	4	14.8	11	11.1
Lack of adequate language support or interpretive services	7	9.5	0	0	7	6.9
Concerns about diversion of treatment medications (methadone, buprenorphine)	0	0	3	11.1	3	3.0
Other challenges	1	1.4	1	3.7	2	2.0
Pharmacy restrictions	1	1.4	1	3.7	2	2.0
Not enough administrative support for providers (billing, reimbursement, scheduling)	1	1.4	0	0	1	1.0
Administrative/organizational buy-in or support	0	0	0	0	0	0

Beliefs

Practitioner (sample size range n=124–146) and community stakeholder (sample size range n=94–96) respondents reported the degree to which they agreed with statements about SUD and SUD treatment. Samples sizes vary because not all respondents answered each question. For all results presented in this section, we combined responses of “somewhat agree” and “strongly agree” (also referred to as “agree/strongly agree” in the text and figure legends below) and “somewhat disagree” and “strongly disagree” (also referred to as “disagree/strongly disagree” in the text and figure legends below). Throughout this section we use chi-square tests of independence with a statistical significance threshold of $p < 0.05$ to compare the proportion of respondents indicating that they agree/strongly agree, versus those who responded that they disagree/strongly disagree combined with those who selected “neither agree nor disagree.”

There was no significant difference between the proportion of practitioners (45%) and community stakeholders (35%) that agreed or strongly agreed with the statement, **“People in the community where I work have adequate access to an effective form of substance use treatment when they need it”** (Figure 30).



Figure 30. Distribution of agreement among practitioners (n=143) and community stakeholders (n=96) with the statement, “People in the community where I work have adequate access to an effective form of substance use treatment when they need it.”

There were no significant differences in the proportion of practitioners that agreed or strongly agreed with the statement, **“People in the community where I work have adequate access to an effective form of substance use treatment when they need it,”** based on practitioner waiver status, rurality or role type (Figure 31). Among rural practitioners only, there were also no significant differences in the proportion of practitioners that agreed or strongly agreed with the statement based on waiver status or role type (data not shown). There was also no significant difference in the proportion of rural (36%) and non-rural (35%) community stakeholders that agreed or strongly agreed that people in the community where they work have adequate access to an effective form of substance use treatment when they need it (Figure 32).

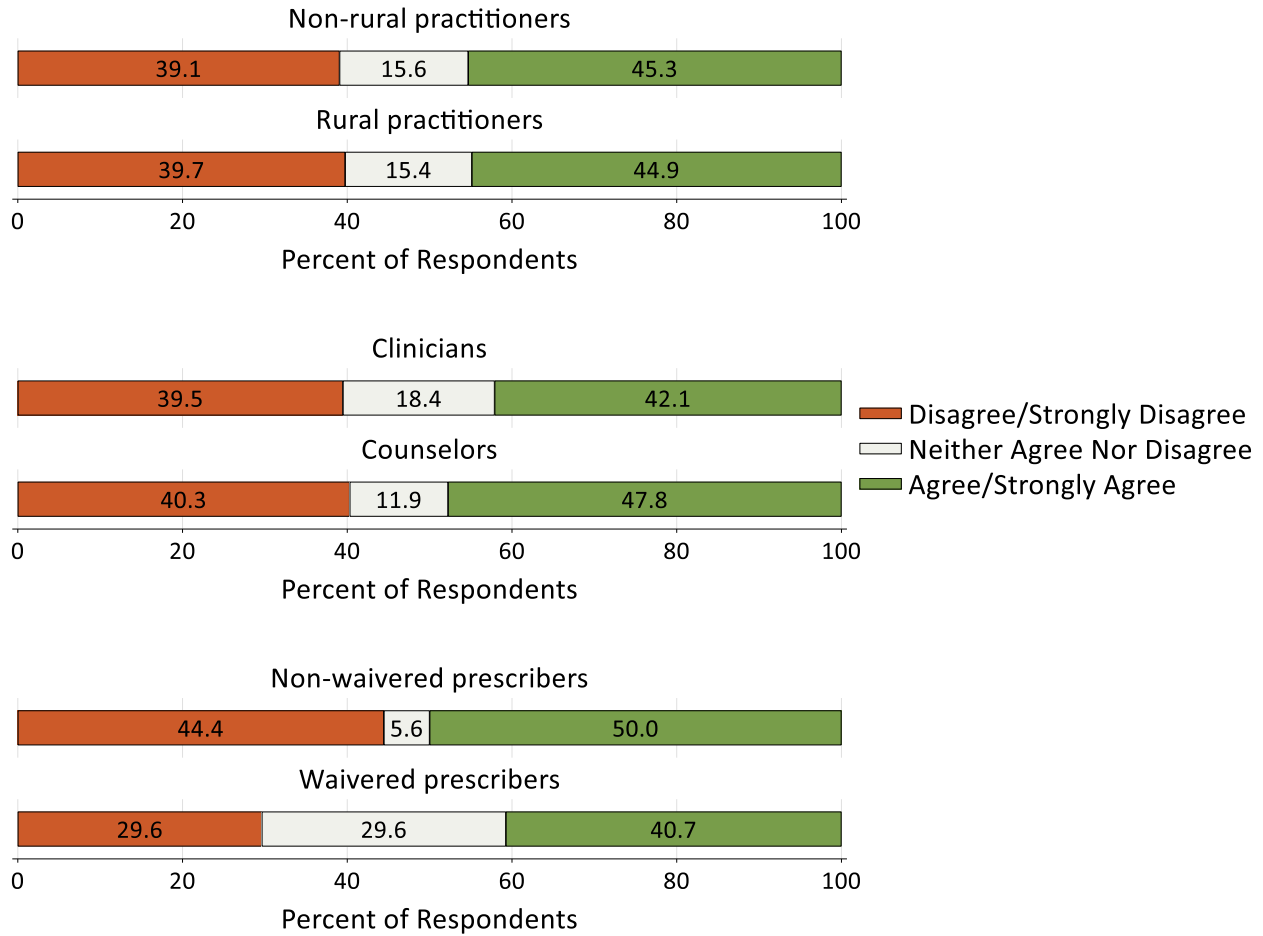


Figure 31. Distribution of agreement among practitioners by clinicians (n=76) vs. counselors (n=68); waived (n=27) vs. non-waived (n=18) prescribing clinicians; and rural (n=78) vs. non-rural (n=64) practitioners with the statement, **“People in the community where I work have adequate access to an effective form of substance use treatment when they need it.”**

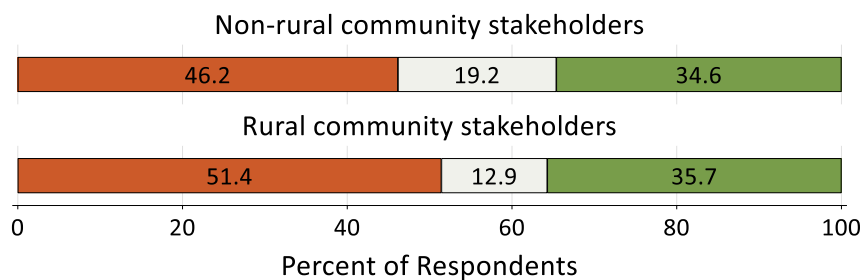


Figure 32. Distribution of agreement among rural (n=70) and non-rural community stakeholders (n=26) with the statement, **“People in the community where I work have adequate access to an effective form of substance use treatment when they need it.”**

Figure 33, Figure 34, and Figure 35 show the distribution of agreement among practitioners and community stakeholders with the statement, **“If a person came to me and confided that they were suffering from opioid addiction, I feel confident that I would know where to refer them for treatment.”**

There was no significant difference between the proportion of practitioners (83%) and community stakeholders (75%) that agreed or strongly agreed with the statement, **“If a person came to me and confided that they were suffering from opioid addiction, I feel confident that I would know where to refer them for treatment”** (Figure 33).

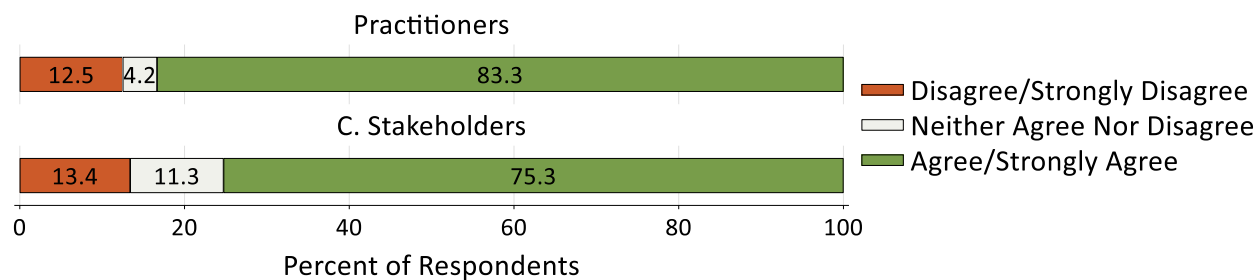


Figure 33. Distribution of agreement among practitioners (n=144) and community stakeholders (n=97) with the statement, **“If a person came to me and confided that they were suffering from opioid addiction, I feel confident that I would know where to refer them for treatment.”**

The proportion of counselors (91%) that agreed or strongly agreed with the statement, **“If a person came to me and confided that they were suffering from opioid addiction, I feel confident that I would know where to refer them for treatment,”** was significantly higher than that of clinicians (76%; $p=0.017$) (Figure 34). There were no significant differences in practitioner agreement by waiver status or rurality (Figure 34). Among rural practitioners only, there were no significant differences in agreement with the statement by waiver status or role type (data not shown).

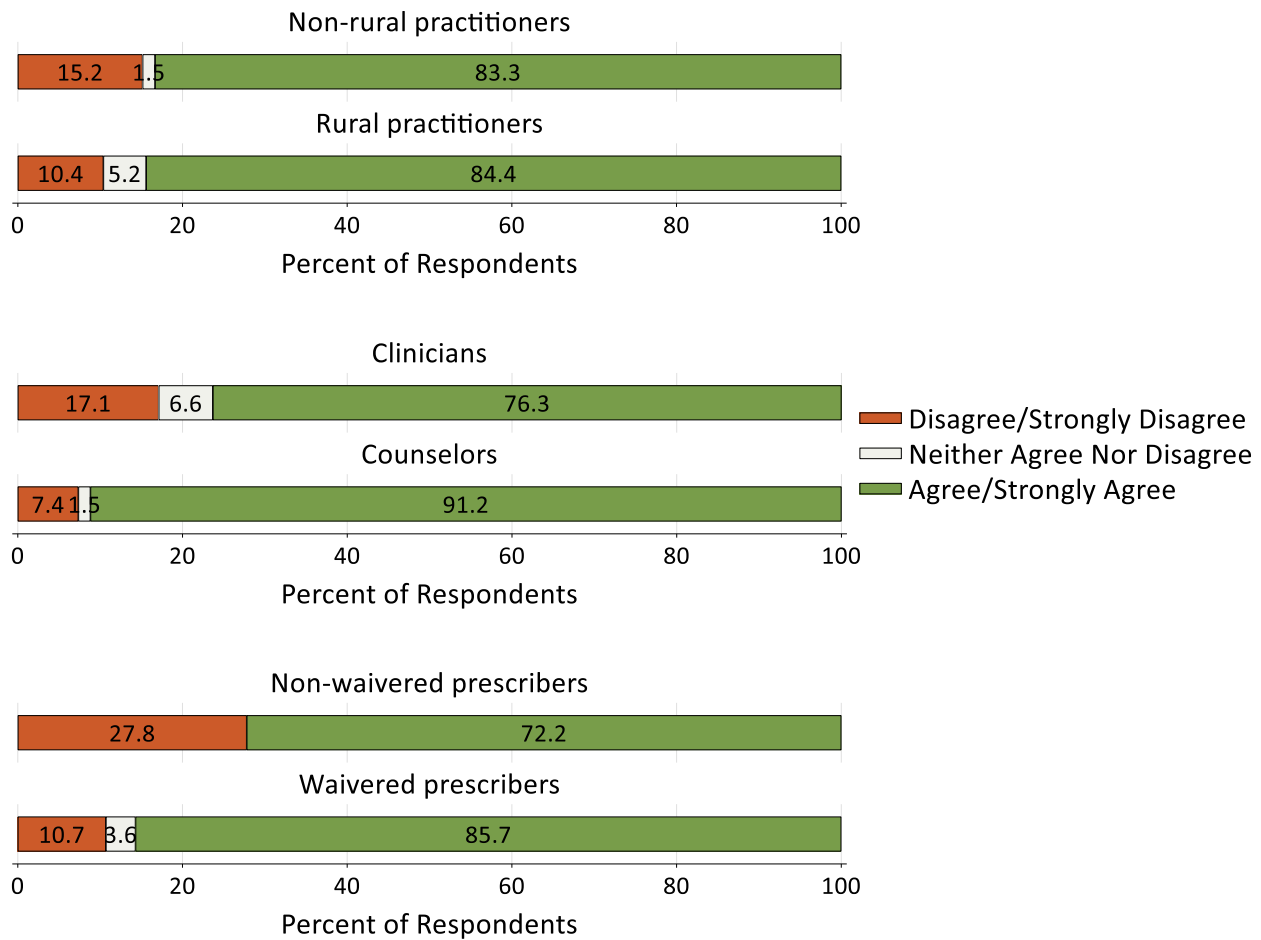


Figure 34. Distribution of practitioner agreement with the statement, **“If a person came to me and confided that they were suffering from opioid addiction, I feel confident that I would know where to refer them for treatment,”** stratified by role type (clinicians $n=76$ vs. counselors $n=68$); waiver status (waivered $n=28$ vs. non-waivered $n=18$); and rurality (rural $n=77$ vs. non-rural $n=66$)

There was no significant difference in the proportion of rural and non-rural community stakeholders that agreed or strongly agreed with the statement, **“If a person came to me and confided that they were suffering from opioid addiction, I feel confident that I would know where to refer them for treatment,”** (Figure 35).

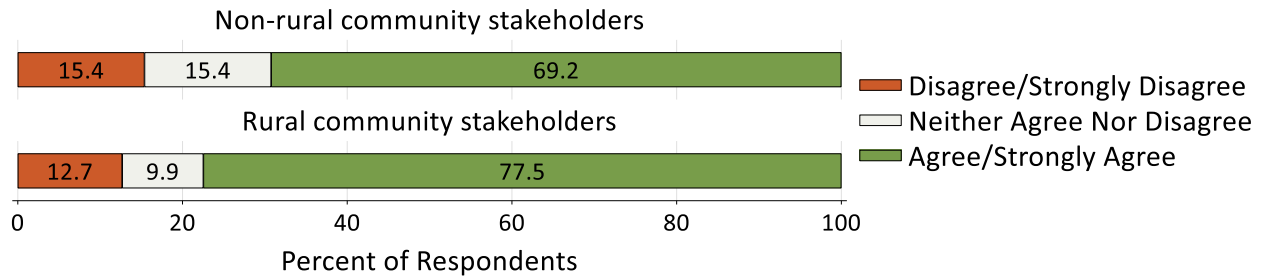


Figure 35. Distribution of agreement among rural and non-rural community stakeholders (n=96) with the statement, **“If a person came to me and confided that they were suffering from opioid addiction, I feel confident that I would know where to refer them for treatment.”**

Figure 36, Figure 37, and Figure 38 show the distribution of responses among practitioners (n=144) and community stakeholders (n=97) with the statement, **“If a person came to me and confided that they were suffering from opioid use disorder, I feel confident that they would have access to services from the place where I referred them for treatment.”** There was no significant difference between the proportion of practitioners (58%) and community stakeholders (49%) that agreed or strongly agreed with the statement (Figure 36).



Figure 36. Distribution of agreement among practitioners (n=144) and community stakeholders (n=97) with the statement, **“If a person came to me and confided that they were suffering from opioid use disorder, I feel confident that they would have access to services from the place where I referred them for treatment.”**

The proportion of waived practitioners (75%) that agreed or strongly agreed with the statement, **“If a person came to me and confided that they were suffering from opioid use disorder, I feel confident that they would have access to services from the place where I referred them for treatment,”** was significantly higher than the proportion of non-waived practitioners (44%; $p=0.036$) (Figure 37). There were no significant differences in the proportion of practitioners that agreed or strongly agreed with the statement based on practitioner role type and rurality. Among rural practitioners only, there were no statistically significant differences between practitioner agreement by waiver status or role type (data not shown).

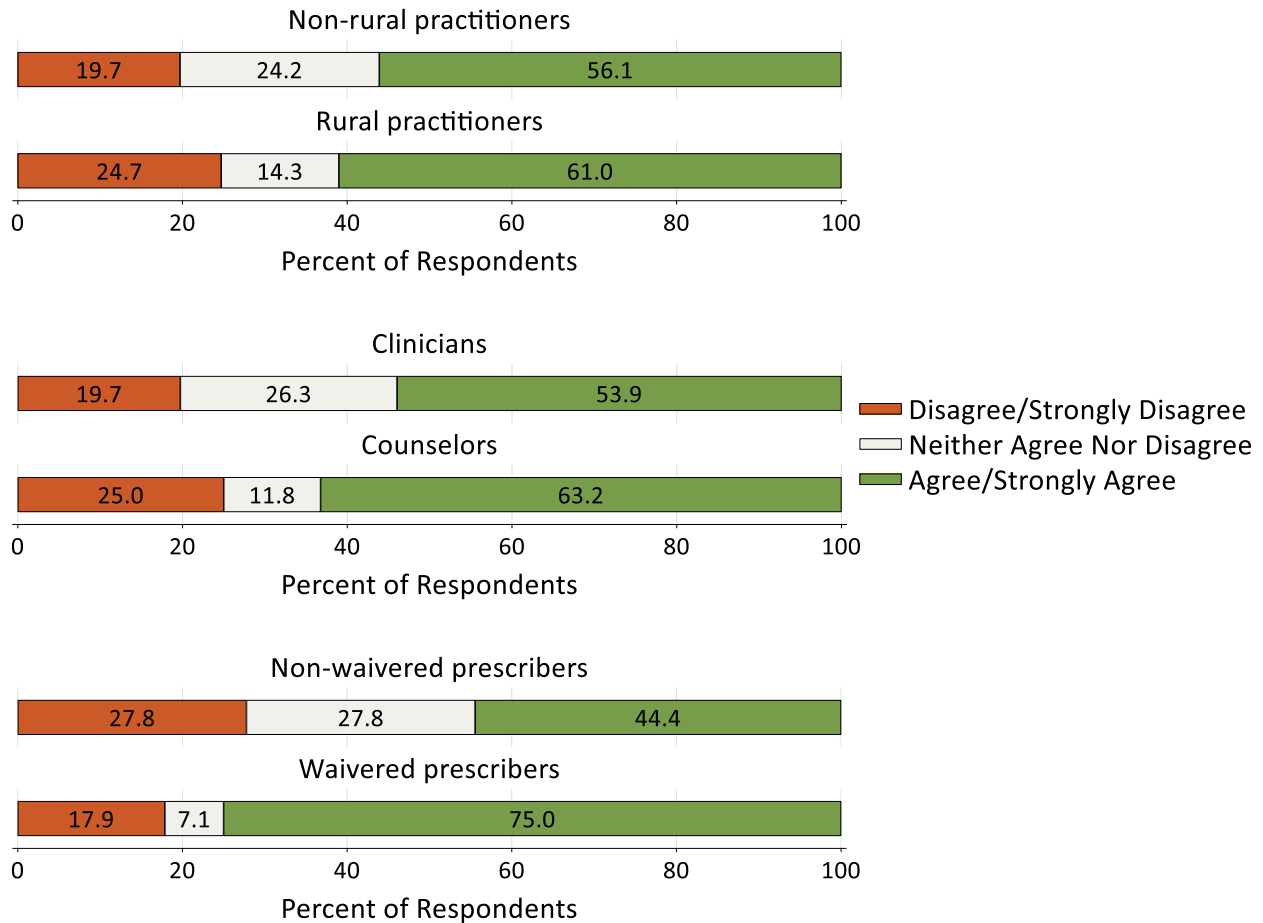


Figure 37. Distribution of agreement among practitioners with the statement, **“If a person came to me and confided that they were suffering from opioid use disorder, I feel confident that they would have access to services from the place where I referred them for treatment,”** stratified by role type (clinicians $n=76$ vs. counselors $n=68$); waiver status (waived $n=27$ vs. non-waived $n=18$); and rurality (rural $n=78$ vs. non-rural $n=64$)

There was no significant difference in the proportion of rural and non-rural community stakeholders that agreed or strongly agreed with the statement, **“If a person came to me and confided that they were suffering from opioid use disorder, I feel confident that they would have access to services from the place where I referred them for treatment.”** (Figure 38).

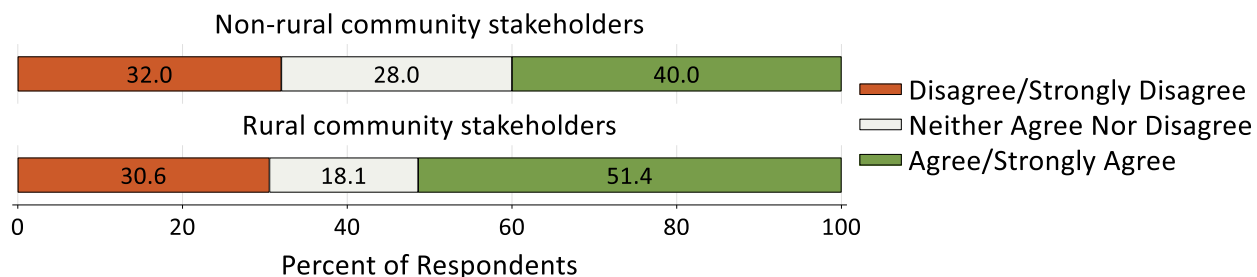


Figure 38. Distribution of agreement among rural (n=70) and non-rural (n=26) community stakeholders with the statement, **“If a person came to me and confided that they were suffering from opioid use disorder, I feel confident that they would have access to services from the place where I referred them for treatment.”**

Figure 39, Figure 40, and Figure 41 show the distribution of responses among practitioners (n=145) and community stakeholders (n=98) with the statement, **“If a person came to me and confided that they were suffering from opioid use disorder, I feel confident that they would receive high quality services from the place where I referred them for treatment.”** There was no significant difference in the proportion of practitioners (63%) and community stakeholders (55%) that agreed or strongly agreed with the statement (Figure 39).



Figure 39. Distribution of agreement among practitioners (n=145) and community stakeholders (n=98) with the statement, **“If a person came to me and confided that they were suffering from opioid use disorder, I feel confident that they would receive high quality services from the place where I referred them for treatment.”**

Among practitioners, there were no significant differences in the proportion that agreed or strongly agreed with the statement, **“If a person came to me and confided that they were suffering from opioid use disorder, I feel confident that they would receive high quality services from the place where I referred them for treatment,”** by waiver status, rurality, or role type (Figure 40). Among rural practitioners only, there were no significant differences in the proportion of practitioners that agreed or strongly agreed with the statement based on waiver status or role type (data not shown).

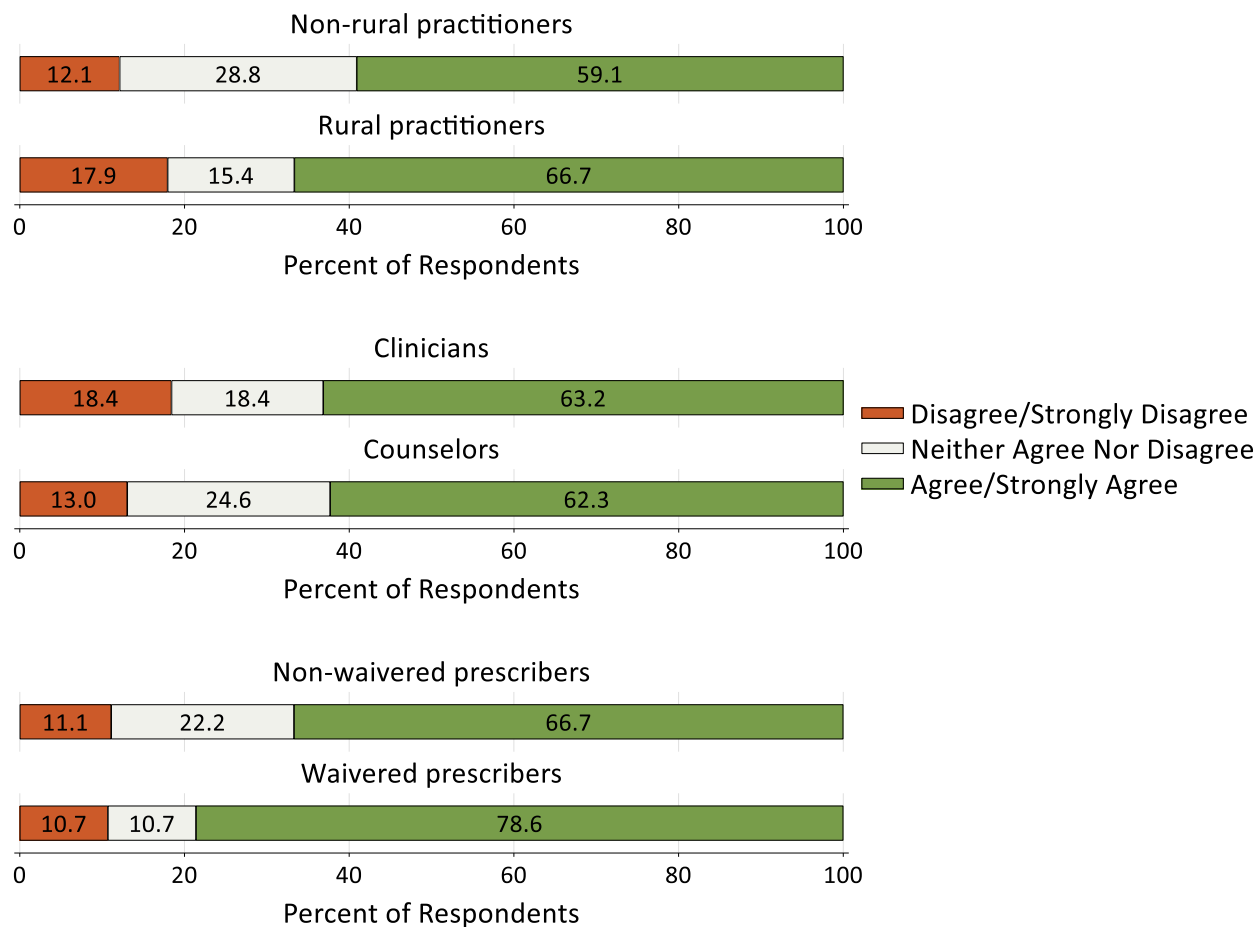


Figure 40. Distribution of agreement among practitioners with the statement, **“If a person came to me and confided that they were suffering from opioid use disorder, I feel confident that they would receive high quality services from the place where I referred them for treatment,”** stratified by role type (clinicians n=76 vs. counselors n=69), waiver status (waivered n=28 vs. non-waivered n=18), and rurality (rural n=78 vs. non-rural n=66).

There was no significant difference between the proportion of rural (57%) and non-rural (50%) community stakeholders that agreed or strongly agreed with the statement, **“If a person came to me and confided that they were suffering from opioid use disorder, I feel confident that they would receive high quality services from the place where I referred them for treatment”** (Figure 41).

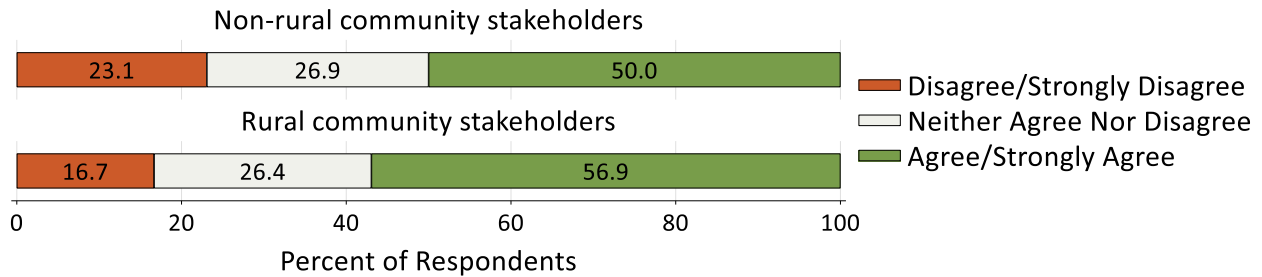


Figure 41. Distribution of agreement among rural (n=72) and non-rural (n=26) community stakeholders with the statement, **“If a person came to me and confided that they were suffering from opioid use disorder, I feel confident that they would receive high quality services from the place where I referred them for treatment.”**

Figure 42, Figure 43, and Figure 44 show the distribution of responses among practitioners and community stakeholders with the statement, **“If a person came to me and confided that they were suffering from opioid addiction, I feel confident that they would receive timely access to services from the place where I referred them for treatment.”** There was no significant difference in the proportion of practitioners (43%) and community stakeholders (34%) that agreed or strongly agreed with the statement (Figure 42).

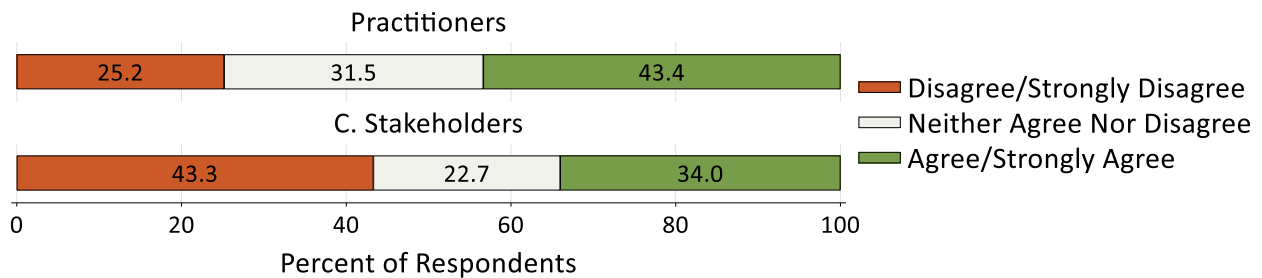


Figure 42. Distribution of agreement among practitioners (n=143) and community stakeholders (n=97) with the statement, **“If a person came to me and confided that they were suffering from opioid addiction, I feel confident that they would receive timely access to services from the place where I referred them for treatment.”**

The proportion of rural practitioners (52%) that agreed or strongly agreed with the statement, **“If a person came to me and confided that they were suffering from opioid addiction, I feel confident that they would receive timely access to services from the place where I referred them for treatment,”** was significantly higher than the proportion of non-rural practitioners (34%; $p=0.030$) (Figure 43). The proportion of clinicians (51%) that agreed or strongly agreed with this statement was significantly higher than the proportion of counselors (34%; $p=0.041$) (Figure 43). Nearly two-thirds of waived practitioners (64%) agreed or strongly agreed with the statement compared to 39% of non-waived practitioners, but this difference was not significant (Figure 43). Among rural practitioners only, the proportion of clinicians ($n=37$; 64%) that agreed or strongly agreed with the statement was significantly higher than that of counselors ($n=40$; 40%; $p=0.029$). Among rural practitioners, there was no significant difference in agreement by waiver status (data not shown).

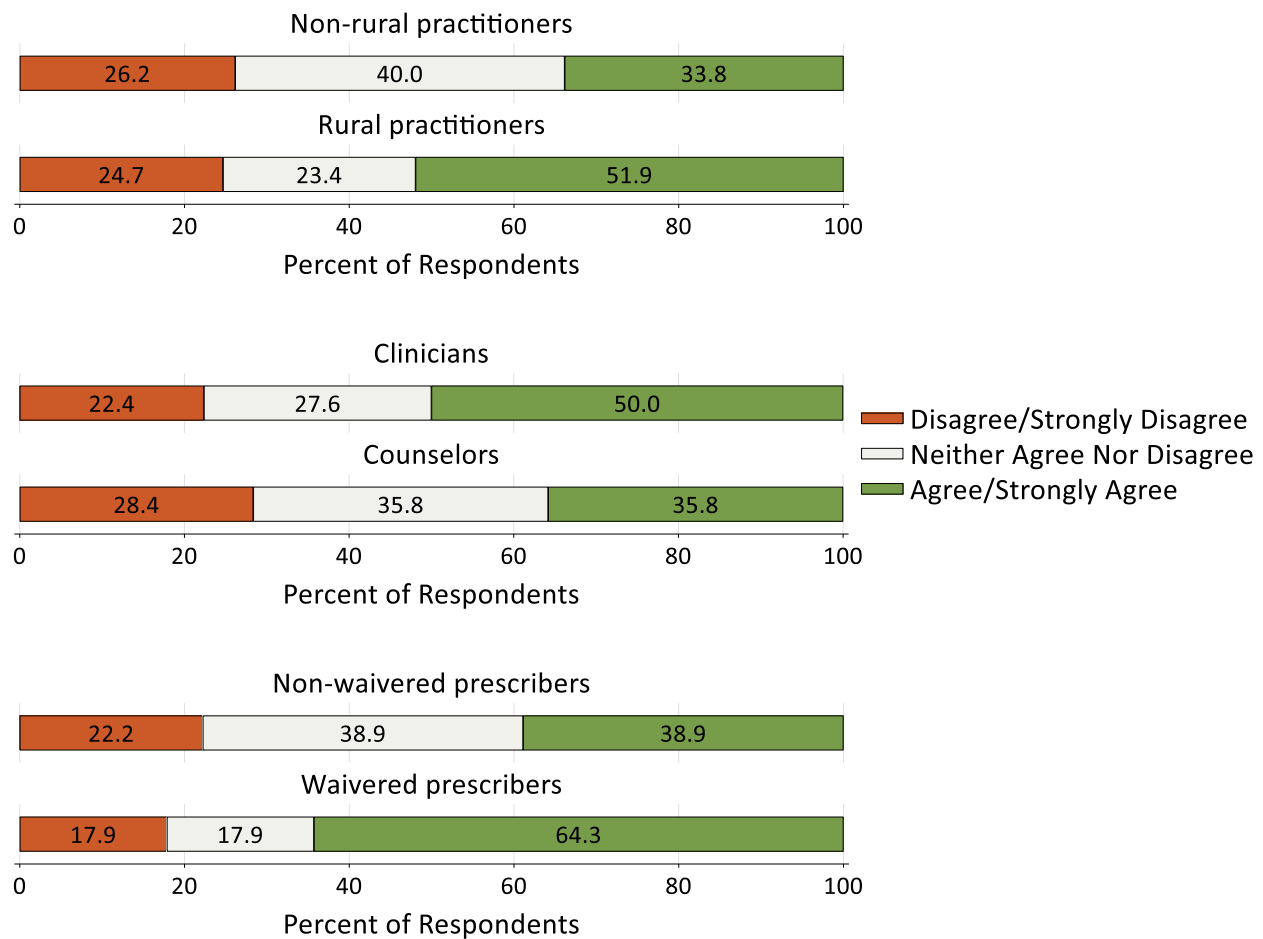


Figure 43. Practitioner agreement with the statement, **“If a person came to me and confided that they were suffering from opioid addiction, I feel confident that they would receive timely access to services from the place where I referred them for treatment,”** stratified by role type (clinicians $n=76$ vs. counselors $n=67$), waiver status (waivered $n=28$ vs. non-waivered $n=18$), and rurality (rural $n=77$ vs. non-rural $n=65$).

There was no significant difference in the proportion of rural and non-rural community stakeholders that agreed or strongly agreed with the statement, **“If a person came to me and confided that they were suffering from opioid addiction, I feel confident that they would receive timely access to services from the place where I referred them for treatment”** (Figure 44).

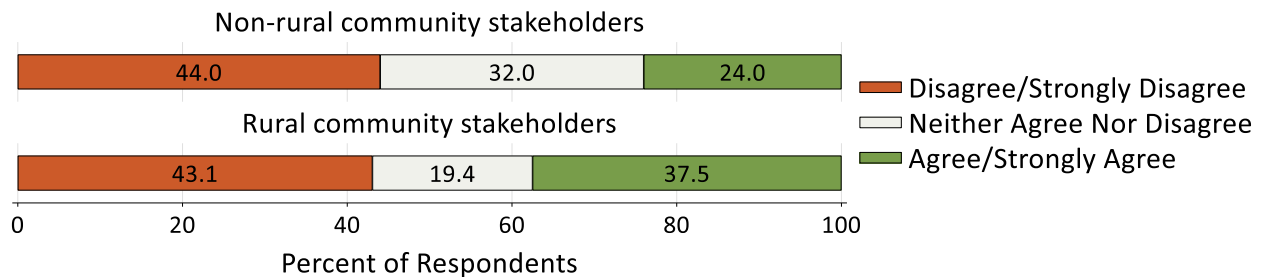


Figure 44. Distribution of agreement among rural (n=72) and non-rural (n=25) community stakeholders (n=96) with the statement **“If a person came to me and confided that they were suffering from opioid addiction, I feel confident that they would receive timely access to services from the place where I referred them for treatment.”**

Figure 45, Figure 46, and Figure 47 show the distribution of agreement among practitioners and community stakeholders with the statement, **“Medications (like methadone and buprenorphine) are the most effective way to treat people with opioid use disorder.”** The proportion of practitioners (65%) that agreed or strongly agreed with the statement was significantly higher than the proportion of community stakeholders (35%; $p < 0.0005$) (Figure 45). Only 7% of practitioners disagreed or strongly disagreed with this statement.

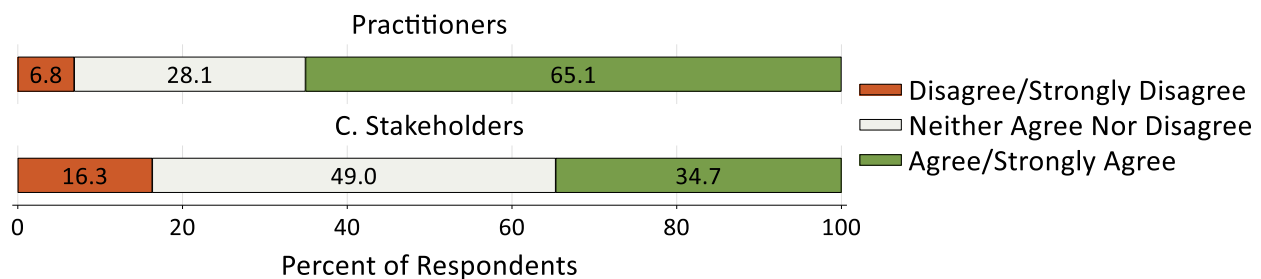


Figure 45. Distribution of agreement among practitioners (n=146) and community stakeholders (n=98) with the statement, **“Medications (like methadone and buprenorphine) are the most effective way to treat people with opioid use disorder.”**

The proportion of clinicians (81%) that agreed or strongly agreed with the statement, **“Medications (like methadone and buprenorphine) are the most effective way to treat people with opioid use disorder,”** was significantly higher than that of counselors (48%; $p < 0.0005$) (Figure 46). There were no significant differences in practitioner agreement by rurality or waiver status.

Among rural practitioners only, the proportion of clinicians (n=37; 81%) that agreed or strongly agreed with this statement was significantly higher than the proportion of counselors (n=41; 39%; $p < 0.0005$). Among rural practitioners only, there was no difference in agreement by waiver status (data not shown).

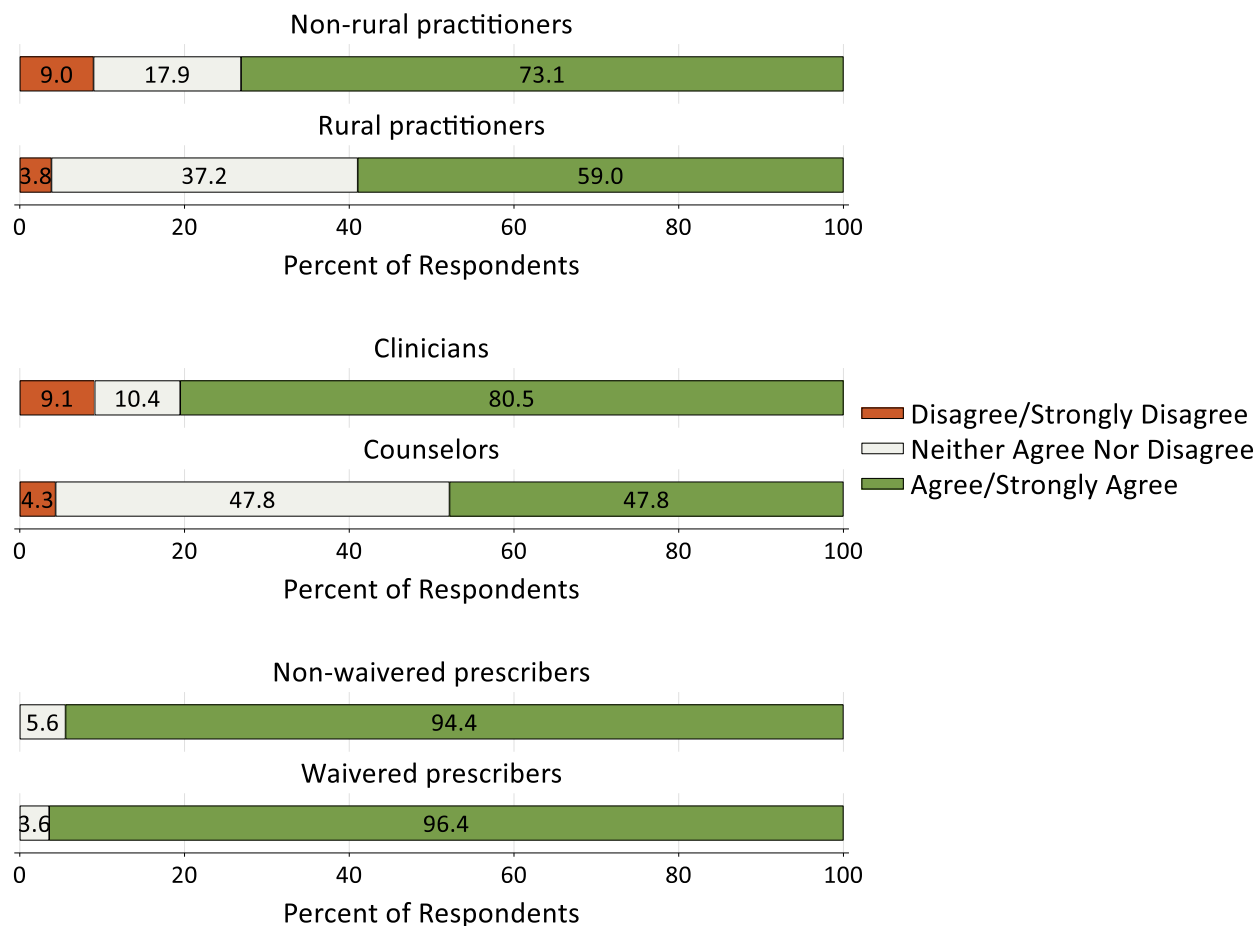


Figure 46. Distribution of practitioner agreement with the statement, “Medications (like methadone and buprenorphine) are the most effective way to treat people with opioid use disorder,” stratified by role type (clinicians n=77 vs. counselors n=69), waiver status (waivered n=28 vs. non-waivered n=18), and rurality (rural n=78 vs. non-rural n=67).

There was no significant difference in the proportion of rural and non-rural community stakeholders that agreed or strongly agreed with the statement, **“Medications (like methadone and buprenorphine) are the most effective way to treat people with opioid use disorder.”** (Figure 47).

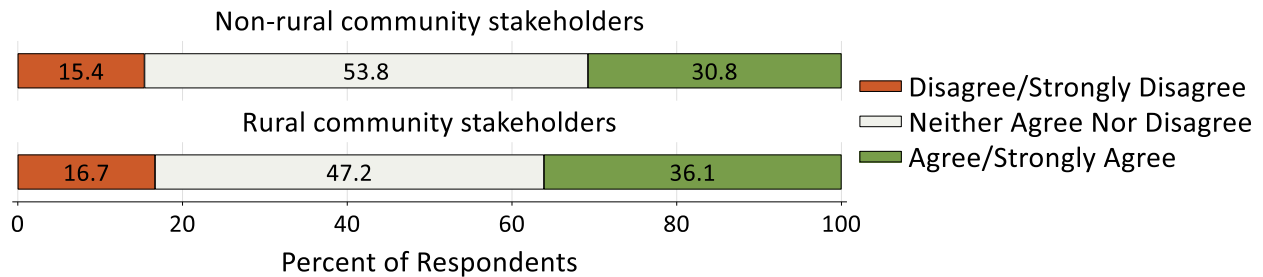


Figure 47. Distribution of agreement among rural (n=72) and non-rural (n=26) community stakeholders with the statement, **“Medications (like methadone and buprenorphine) are the most effective way to treat people with opioid use disorder.”**

Figure 48, Figure 49, and Figure 50 show the distribution of agreement among practitioners and community stakeholders with the statement, **“Treatment involving detoxification/abstinence should be tried before medications (like methadone and buprenorphine).”**

There was no significant difference between the proportion of practitioners (17%) and community stakeholders (27%) that agreed or strongly agreed with the statement, **“Treatment involving detoxification/abstinence should be tried before medications (like methadone and buprenorphine)”** (Figure 48). Notably, 56% of practitioners disagreed with this statement.

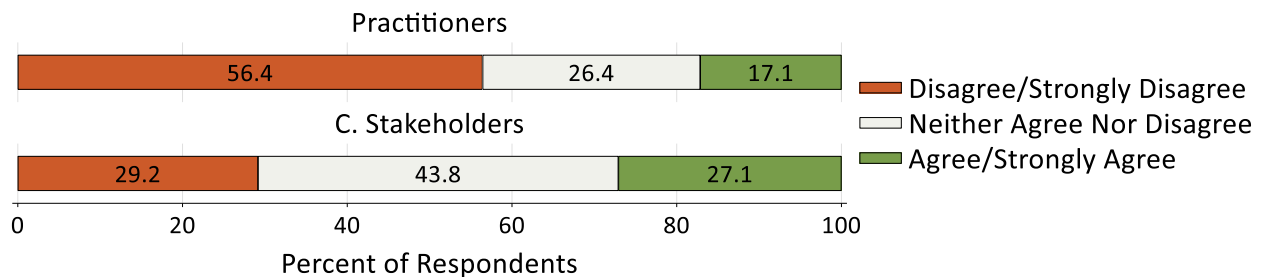


Figure 48. Distribution of agreement among practitioners (n=140) and community stakeholders (n=96) with the statement, **“Treatment involving detoxification/abstinence should be tried before medications (like methadone and buprenorphine).”**

The proportion of non-waivered practitioners (17%) that agreed or strongly agreed with the statement, **“Treatment involving detoxification/abstinence should be tried before medications (like methadone and buprenorphine)”** was significantly higher than that of waived practitioners (0%), none of whom agreed with the statement (p=0.038) (Figure 49). There were no significant differences in the practitioner agreement with the statement by rurality or role type. Among rural practitioners only, the proportion of counselors that agreed or strongly agreed with the statement (n=40; 30%) was significantly higher than that of clinicians (n=35; 9%; p=0.021).

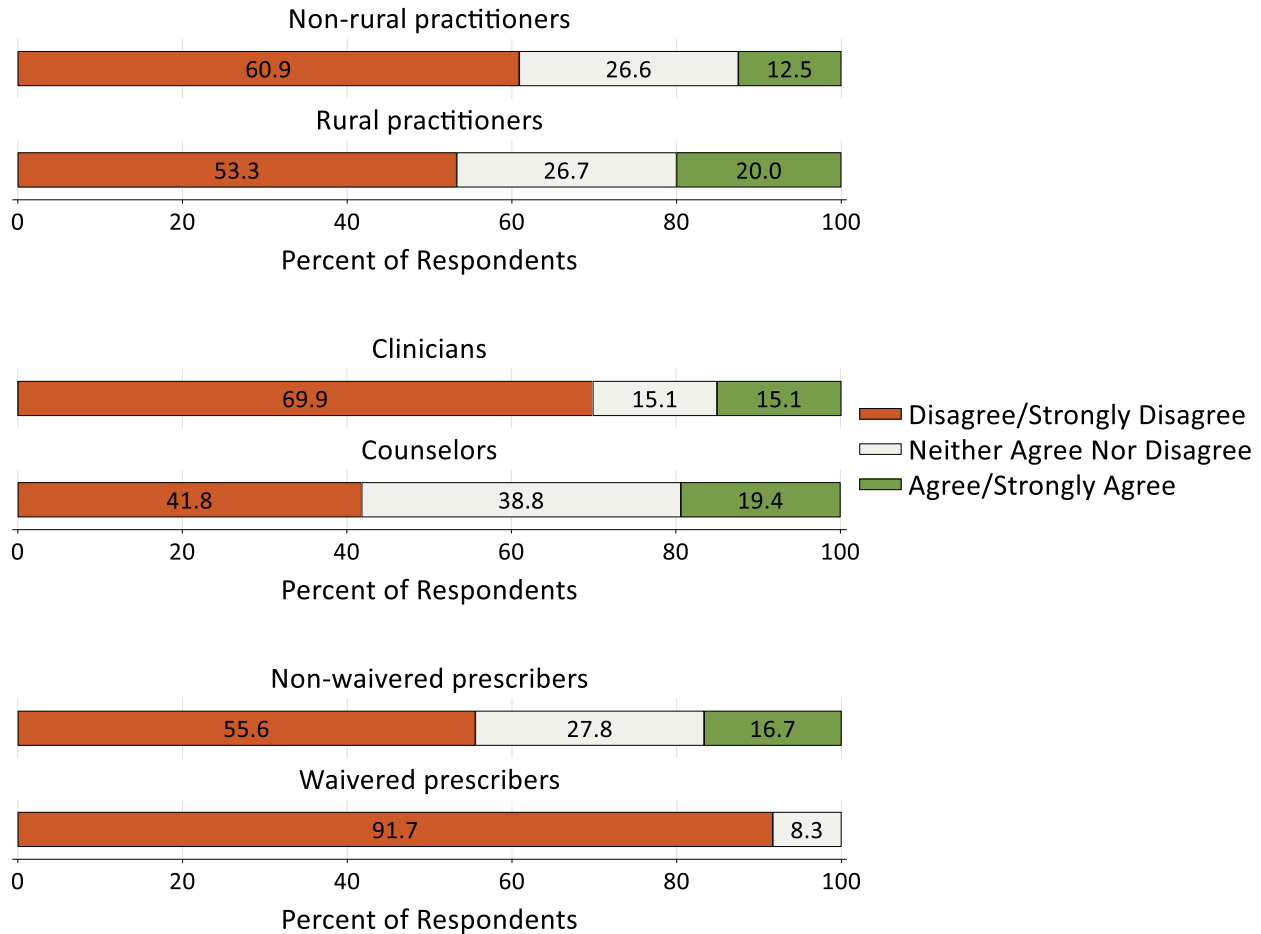


Figure 49. Distribution of practitioner agreement with the statement, **“Treatment involving detoxification/abstinence should be tried before medications (like methadone and buprenorphine),”** stratified by role type (clinicians n=73 vs. counselors n=67), waiver status (waivered n=24 vs. non-waivered n=18), and rurality (rural n=75 vs. non-rural n=64).

There was no significant difference in the proportion of rural (25%) and non-rural (32%) community stakeholders that agreed or strongly agreed with the statement, **“Treatment involving detoxification/abstinence should be tried before medications (like methadone and buprenorphine)”** (Figure 50).

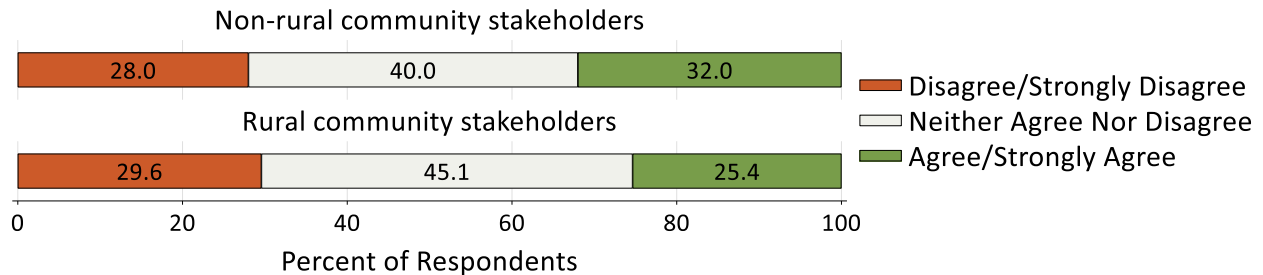


Figure 50. Distribution of agreement among rural (n=71) and non-rural (n=25) community stakeholders with the statement, **“Treatment involving detoxification/abstinence should be tried before medications (like methadone and buprenorphine).”**

Figure 51, Figure 52, and Figure 53 show the distribution of agreement among practitioners and community stakeholders with the statement, **“Medications given to treat people with opioid use disorder (specifically methadone and buprenorphine) replace addiction to one kind of drug with another.”**

There was no significant difference between the proportion of practitioners (18%) and community stakeholders (27%) that agreed or strongly agreed with the statement, **“Medications given to treat people with opioid use disorder (specifically methadone and buprenorphine) replace addiction to one kind of drug with another”** (Figure 51).



Figure 51. Distribution of agreement among practitioners (n=126) and community stakeholders (n=94) to the statement, **“Medications given to treat people with opioid use disorder (specifically methadone and buprenorphine) replace addiction to one kind of drug with another.”**

There was no significant difference in practitioner agreement with the statement, **“Medications given to treat people with opioid use disorder (specifically methadone and buprenorphine) replace addiction to one kind of drug with another,”** by waiver status, rurality, or role type (Figure 52). Among rural practitioners only, there was no significant difference in practitioner agreement with the statement by waiver status or role type (data not shown).

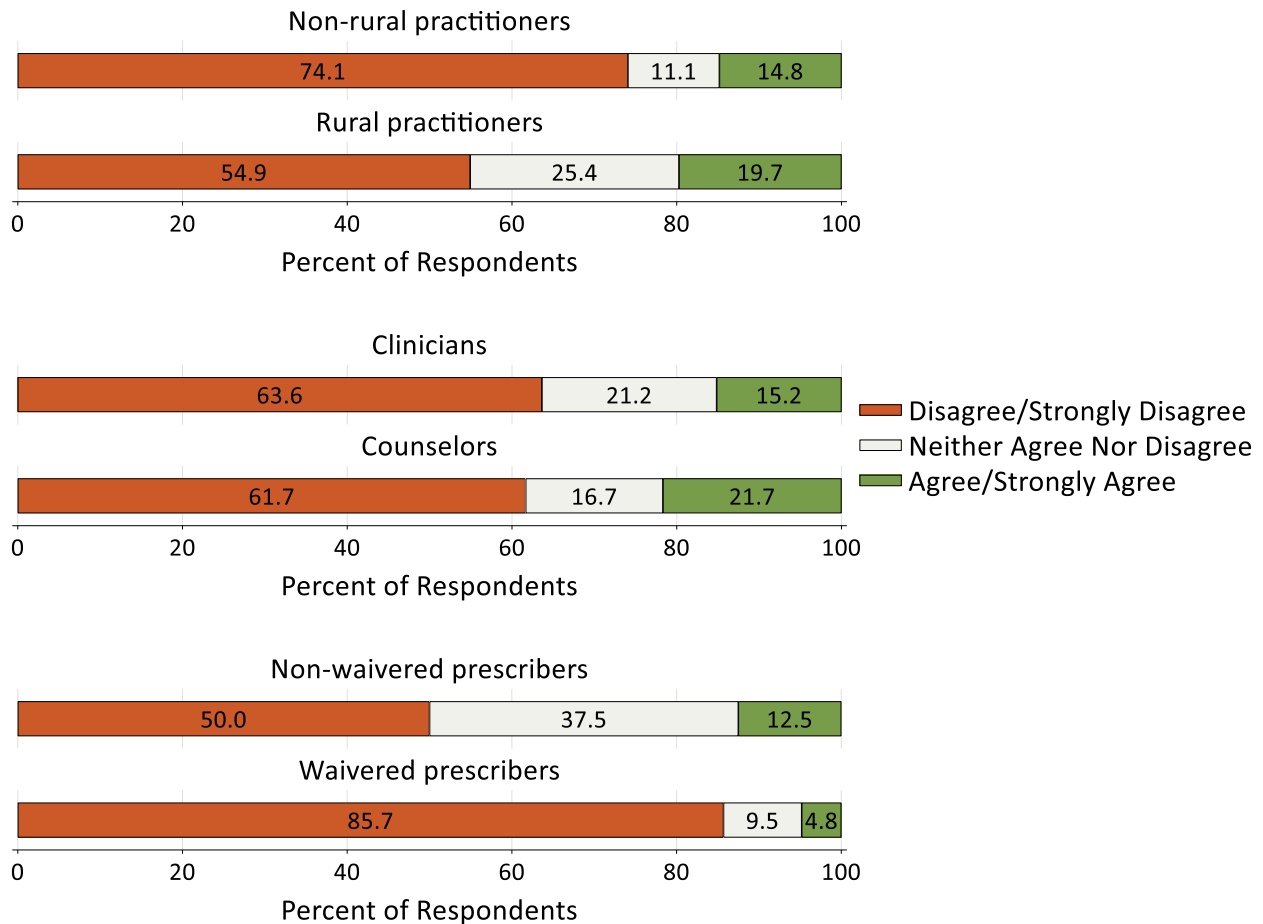


Figure 52. Practitioner agreement with the statement, **“Medications given to treat people with opioid use disorder (specifically methadone and buprenorphine) replace addiction to one kind of drug with another,”** by role type (clinicians n=66 vs. counselors n=60), waiver status (waivered n=21 vs. non-waivered n=16), and rurality (rural n=71 vs. non-rural n=54).

There was no significant difference by rurality in community stakeholder agreement with the statement, **“Medications given to treat people with opioid use disorder (specifically methadone and buprenorphine) replace addiction to one kind of drug with another.”** (Figure 53).

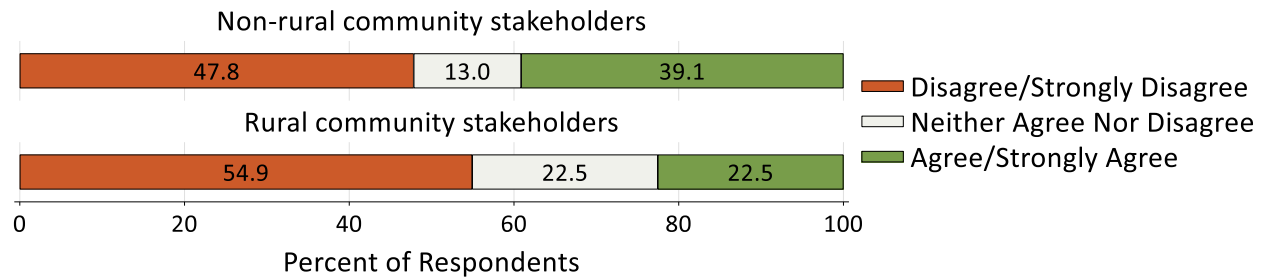


Figure 53. Distribution of agreement among rural (n=71) and non-rural (n=23) community stakeholders with the statement, **“Medications given to treat people with opioid use disorder (specifically methadone and buprenorphine) replace addiction to one kind of drug with another.”**

Figure 54 shows the distribution of agreement among all practitioners (n=136) with the statement **“I would prefer to prescribe extended release Vivitrol/Naltrexone instead of extended release buprenorphine.”** Notably, 54% of practitioners neither agreed nor disagreed with the statement, whereas 24% agreed. Practitioners who agreed listed reasons for their agreement, which included less chance of medication diversion, medications being harder to abuse, and availability of the medication. Reasons for Vivitrol preference included it not being an opiate derivative medication, and perceptions that it is a healthier medication choice.

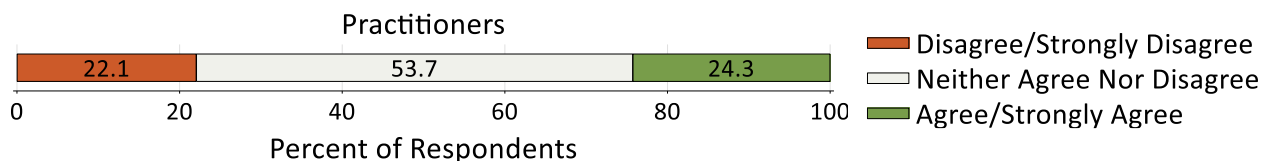


Figure 54. Distribution of agreement among practitioners (n=136) with the statement, **“I would prefer to prescribe extended release Vivitrol/Naltrexone instead of extended release Buprenorphine.”**

A significantly higher proportion of non-waivered practitioners agreed with the statement, **“I would prefer to prescribe extended release Vivitrol/Naltrexone instead of extended release buprenorphine,”** than waived practitioners ($p=0.044$) (Figure 55). There was no statistically significant difference in practitioner agreement by rurality (Figure 55). Among rural practitioners only, there was no statistically significant difference in practitioner agreement by waiver status (data not shown).

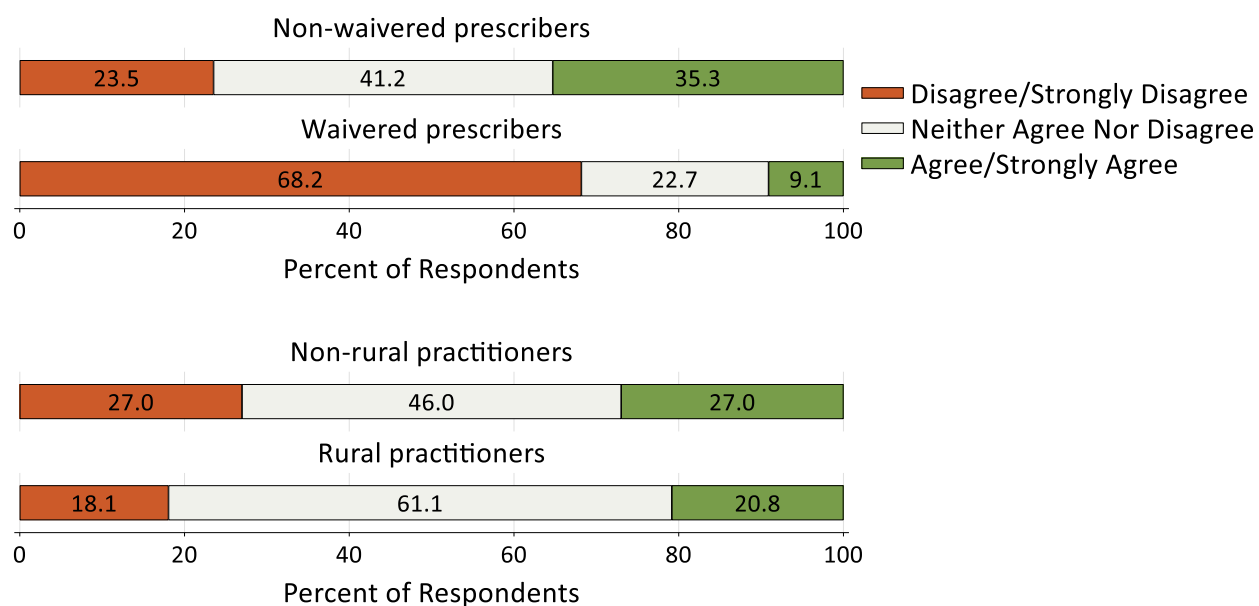


Figure 55. Distribution of agreement among practitioners the statement, **“I would prefer to prescribe extended release Vivitrol/Naltrexone instead of extended release Buprenorphine,”** by waiver status (waivered $n=22$ vs. non-waivered $n=17$), and rurality (rural $n=72$ vs. non-rural $n=63$).

COVID-19 Impact

Our survey included questions about the COVID-19 pandemic and its impact on health, substance use, and treatment access. Throughout this section we use chi-square tests of independence with a significance threshold of $p<0.05$ to assess differences between groups.

New Hampshire practitioners ($n=142$) and community stakeholders ($n=96$) were asked about their concern about the health of people in their practice/community in regard to the COVID-19 pandemic (scale 0–10). Table 16 shows the distribution of these levels of concern among practitioners and community stakeholders who responded to the question. Levels of concern among practitioners (mean score=7.6) and community stakeholders (mean score=7.7) were generally high. There was no significant difference between rural and non-rural practitioners in their concern about the health of patients in their practice regard to the COVID-19 pandemic. Similarly, there was no significant difference in between rural and non-rural community stakeholders in their concern about the health of people in their community regarding the COVID-19 pandemic.

Non-waivered practitioners' mean concern level (8.8) was significantly higher than waived practitioners' mean concern level (7.4; $p=0.048$). This association did not persist when limiting the analysis to rural practitioners only (data not shown). There was no significant difference in mean concern level by role type (clinicians vs. counselors) among all practitioners (Table 16) or among rural practitioners only (data not shown).

Table 16. Practitioner and community stakeholder mean level of concern (scale 0–10) about the health of people in their practice/community regarding the COVID-19 pandemic.

	N	Mean
<i>All practitioners</i>	142	7.6
Rural practitioners	77	7.6
Non-rural practitioners	64	7.5
Waivered practitioners	28	7.4
Non-waivered practitioners	16	8.8
Counselors, case managers, and recovery coaches	67	7.3
Clinicians and pharmacists	75	7.8
<i>All community stakeholders</i>	96	7.7
Rural community stakeholders	70	7.6
Non-rural community stakeholders	26	7.9

Table 17 shows practitioner ($n=130$) and community stakeholder ($n=88$) perceptions of substance use changes during the COVID-19 pandemic. The overwhelming majority of practitioners (87%) and community stakeholders (88%) reported that substance use had increased since the start of the COVID-19 pandemic. These proportions were similar across rural and non-rural respondents among both practitioners and community stakeholders (data not shown).

Table 17. Distribution of practitioner and community stakeholder responses to the question, “How has substance use changed since the COVID-19 pandemic began?”

	Practitioners		Community Stakeholders		Total	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Substance use increased	113	86.9	77	87.5	190	87.2
Substance use stayed same	15	11.5	10	11.4	25	11.5
Substance use decreased	2	1.5	1	1.1	3	1.4
Total*	130	100	88	100	218	100

*Excludes responses of “I don’t know” (practitioner freq.=10, community stakeholder freq.=7) and “Other” (practitioner freq.=6, community stakeholder freq.=3).

Table 18 shows practitioner (n=125) and community stakeholder (n=77) perceptions of opioid use during the COVID-19 pandemic. Most practitioners (79%) and community stakeholders (71%) reported that opioid use had increased. These proportions were similar across rural and non-rural respondents (data not shown).

Table 18. Distribution of practitioner and community stakeholder responses to the question, “How has opioid use changed since the COVID-19 pandemic began?”

	Practitioners		Community Stakeholders		Total	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Opioid use increased	99	79.2	55	71.4	154	76.2
Opioid use stayed same	21	16.8	20	26.0	41	20.3
Opioid use decreased	5	4.0	2	2.6	7	3.5
Total*	125	100	77	100	202	100

*Excludes responses of “I don’t know” (practitioner freq. = 17, community stakeholder freq. = 15) and “Other” (practitioner freq. = 4, community stakeholder freq.= 4)

Table 19. Distribution of practitioner and community stakeholder responses to the question, “How has access to opioid treatment changed since the COVID-19 pandemic began?”

Table 19 shows practitioner (n=122) and community stakeholder (n=87) perceptions of changes in access to MOUD treatment during the COVID-19 pandemic. The majority of practitioners (62%) and community stakeholders (61%) reported that access to MOUD had decreased since the COVID-19 pandemic began. These proportions were similar across rural and non-rural respondents (data not shown).

Table 19. Distribution of practitioner and community stakeholder responses to the question, “How has access to opioid treatment changed since the COVID-19 pandemic began?”

	Practitioners		Community Stakeholders		Total	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Access to MOUD decreased	75	61.5	53	60.9	128	61.2
Access to MOUD stayed same	38	31.2	28	32.2	66	31.6
Access to MOUD increased	9	7.4	6	6.9	15	7.2
Total*	122	100	87	100	209	100

*Excludes responses of “I don’t know” (practitioner freq.=14, community stakeholder freq.=10) and “Other” (practitioner freq.=10, community stakeholder freq.=1).

Figure 56 shows the proportion of practitioners (n=144) that reported taking various measures to ensure continued treatment for SUD during the COVID-19 pandemic. Most practitioners (83%) reported using telehealth for individual appointments, while fewer engaged in other measures, including telehealth for group sessions (32%), changing prescribing patterns (26%), and conducting appointments outside (21%).

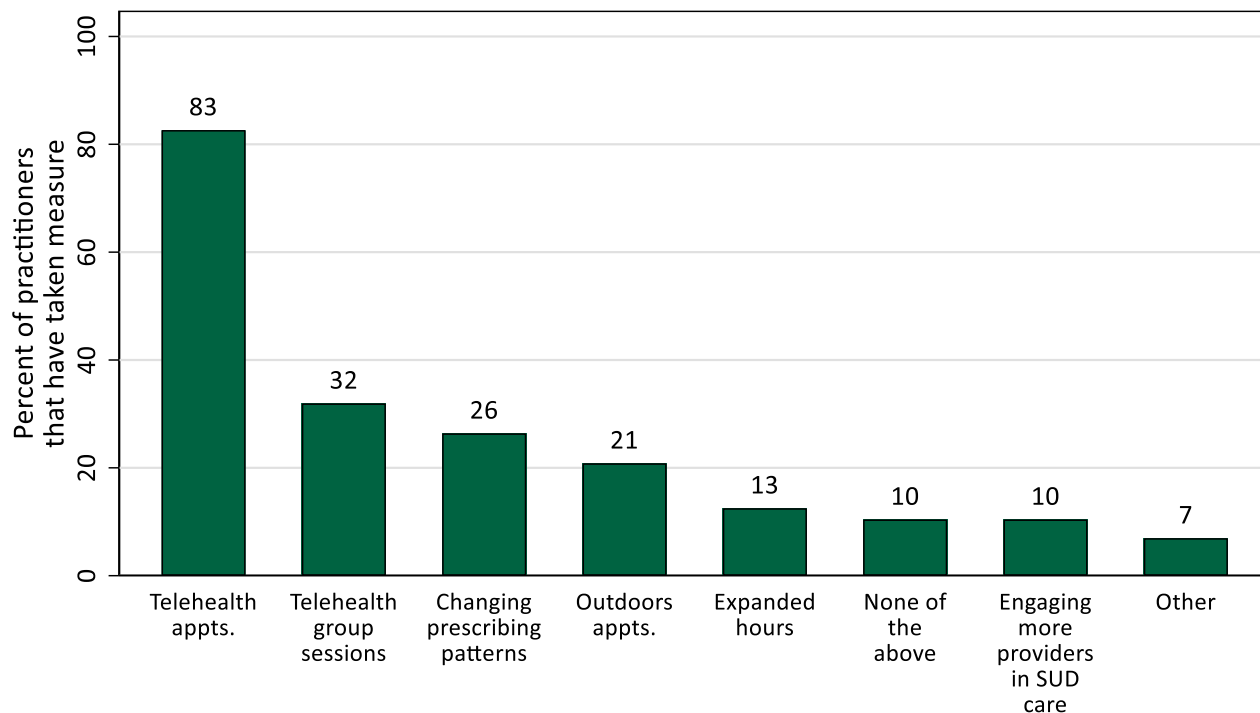


Figure 56. Measures taken by practitioners (n=144) to ensure continued substance use disorder (SUD) treatment for patients during the COVID-19 pandemic.

Figure 57 shows the proportion of rural (n=76) and non-rural (n=67) practitioners that reported taking various measures to ensure continued treatment for SUD during the COVID-19 pandemic. A greater proportion of rural practitioners than non-rural practitioners reported conducting appointments outdoors (rural=28%, non-rural=13%; p=0.037) and utilizing telehealth for group sessions (rural=45%, non-rural=18%; p=0.001). There were no other statistically significant differences between rural and non-rural practitioners.

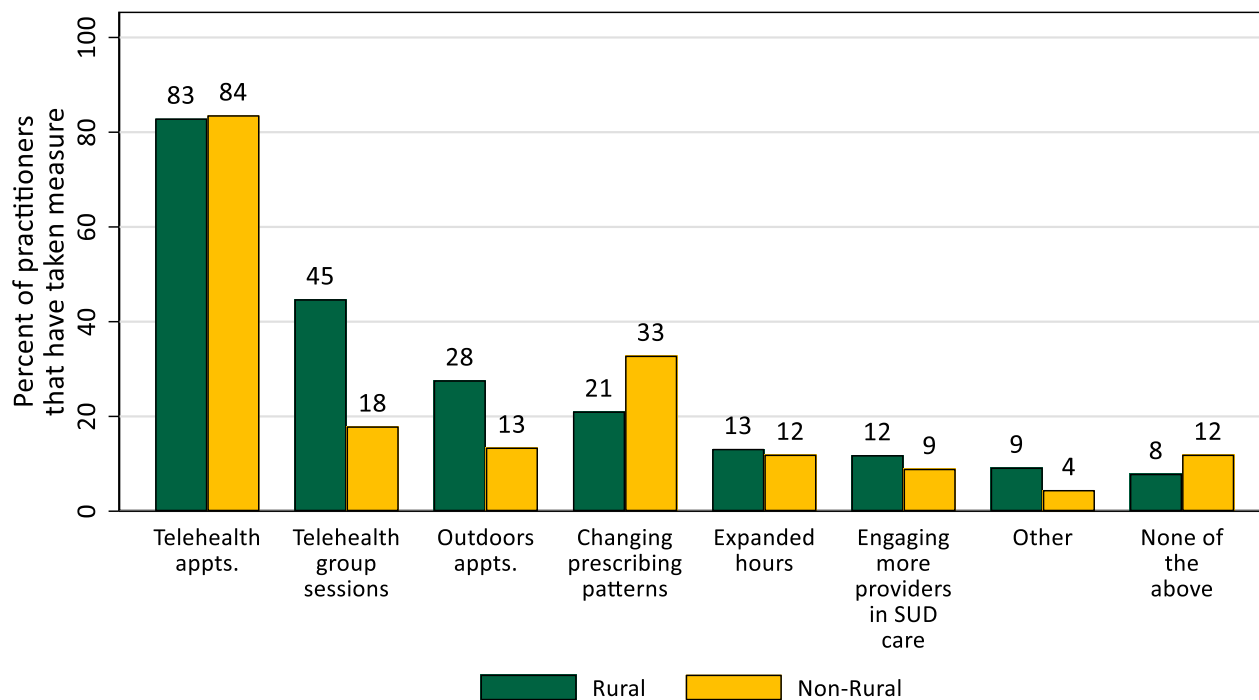


Figure 57. Measures taken by rural (n=76) and non-rural practitioners (n=67) to ensure continued substance use disorder (SUD) treatment for patients during the COVID-19 pandemic.

Figure 58 shows the distribution of practitioner responses to the question, “**What has your experience been with changes in substance use disorder treatment services during the coronavirus pandemic (COVID-19)? What has been working or not working for you?**” Practitioners generally reported that getting paid or reimbursed for telehealth services was working for them (91%). In contrast, there were several treatment services that practitioners reported were not working. Nearly two thirds (63%) of practitioners reported that random pill counts were not working, and nearly half of practitioners (44%) reported issues with patients having sufficient cellphone data or minutes to attend telehealth appointments. There were no statistically significant differences in processes identified as working or not working across rural and non-rural practitioners (data not shown).

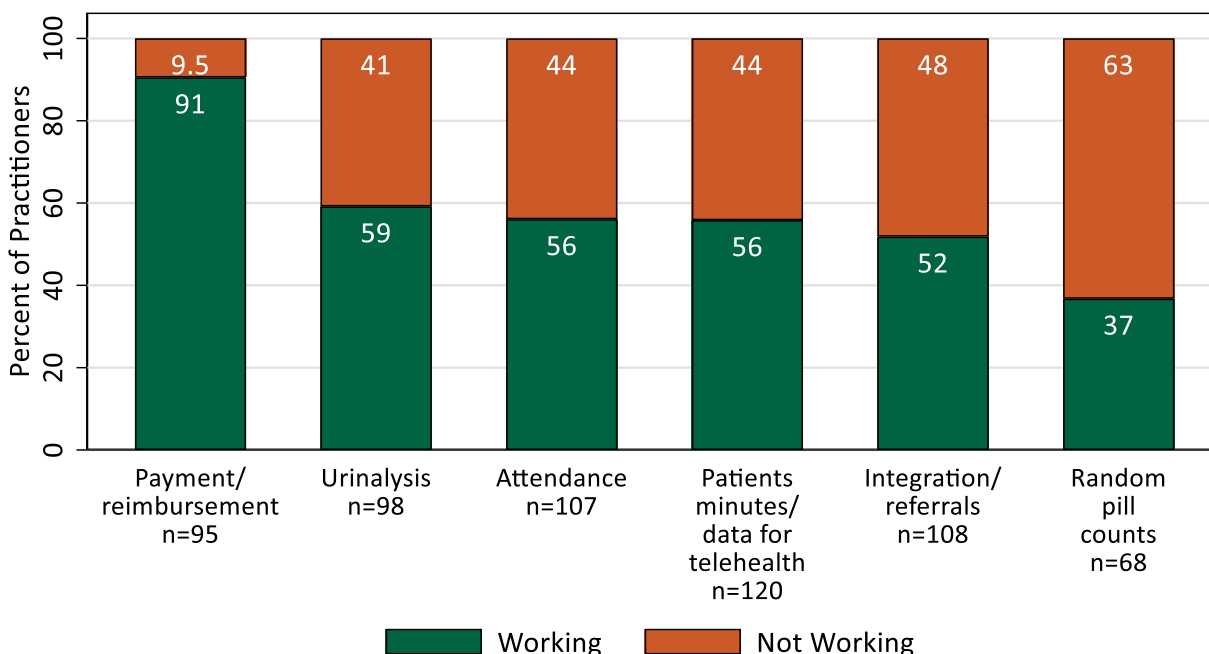


Figure 58. Distribution of practitioner responses (sample size range: n=68–120) to the question, “**What has your experience been with changes in substance use disorder treatment services during the coronavirus pandemic (COVID-19)? What has been working or not working for you?**”

Practitioner UVM CORA Resource Requests

Our survey included questions about which UVM CORA resources would be most helpful to practitioners. Throughout this section we use chi-square tests of independence with a significance threshold of $p < 0.05$ to assess differences between groups.

Practitioners were asked, **“Which of the following resources available through the UVM Center on Rural Addiction would you like to learn more about for your own clinical practice?”** Figure 59 shows the proportion of practitioners ($n=147$) that selected various UVM CORA trainings or resources as “high priority,” and Table 20 provides in-depth descriptions of these resources. The resources most commonly ranked as “high priority” by practitioners were vulnerable population management (82%), manualized trainings for co-occurring conditions (75%), and consultation and support from community “champion” providers (e.g., mentoring, coaching, consultations around complex patients, medication management; 71%) (Figure 59). There was no significant difference between the proportion of rural ($n=81$) and non-rural ($n=70$) practitioners interested in any UVM CORA resource (data not shown).

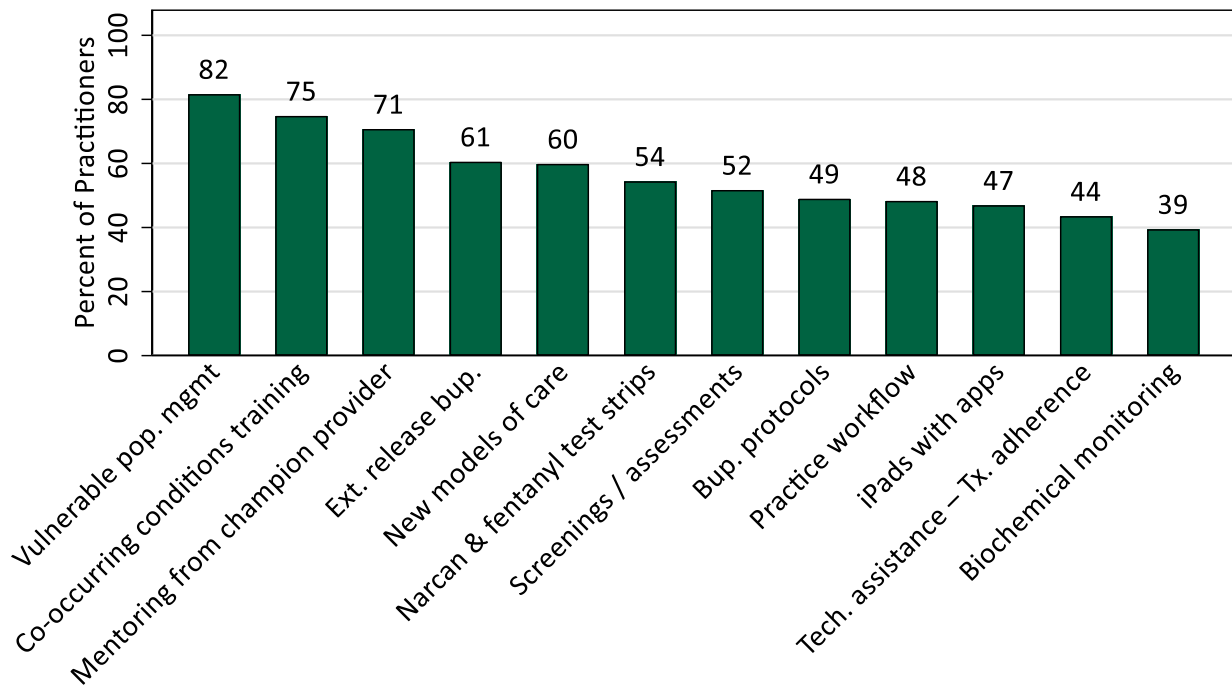


Figure 59. Percent of practitioners ($n=147$) indicating "high priority" interest in UVM CORA resources.

Table 20. University of Vermont Center on Rural Addiction (UVM CORA) Resources.

Resource	Description
A. Vulnerable population management*	Support with managing and coordinating care for vulnerable populations (e.g., pregnant patients with SUDs, families, patients with co-occurring conditions)
B. Manualized trainings for co-occurring conditions*	Training in manualized treatments for addressing co-occurring conditions (i.e., smoking cessation, stimulant use, PTSD)
C. Mentoring from champion providers*	Consultation & support from community "champion" providers (e.g., mentoring, coaching, consultations around complex patients, medication management)
D. Extended release buprenorphine medication and training*	Providing medication & training on extended-release buprenorphine (e.g., monthly depot formulation) for potential use with patients
E. Buprenorphine protocols	Protocols for buprenorphine induction, stabilization, maintenance, taper, etc.
F. Technical assistance on treatment adherence	Technology-assisted hardware & software to support opioid use treatment adherence in patients (e.g., portable computerized medication dispensers, IVR system for making automated telephone calls to patients for clinical monitoring, random call backs, etc.)
G. New models of care*	Consultations on new models of care for opioid use disorder treatment (e.g., hub-and-spoke model, buprenorphine initiation in ED)
H. Screenings/assessments for treatment needs*	Screening/assessments to help identify patients' substance use treatment needs
I. Fentanyl testing strips and intranasal naloxone*	Providing fentanyl testing strips; intranasal naloxone (Narcan®) & materials on its use
J. Biochemical monitoring assistance	Help with biochemical monitoring of recent drug use (e.g., urine toxicology support, hand-held alcohol breath monitors, hand-held smoking monitors)
K. iPads with apps	iPads pre-loaded with automated apps on opioid overdose, HIV, Hepatitis C prevention that can be used by patients while waiting
L. Practice workflow consultation	Consultation or practice workflow or practical implementation opioid treatment

*Rated as high priority by at least 50% of practitioners who responded to the question (n=147).

Figure 60 shows practitioner respondents' preferences regarding how they would like to receive UVM CORA resources, trainings, and support to serve more patients with SUDs. The most preferred methods among practitioners were webinars/online trainings (81%) and provider-to-provider consultations (68%). There were no significant differences in rural (n=77) and non-rural (n=68) practitioners' preferences regarding methods for receiving UVM CORA resources, trainings, and support to serve more patients with SUDs.

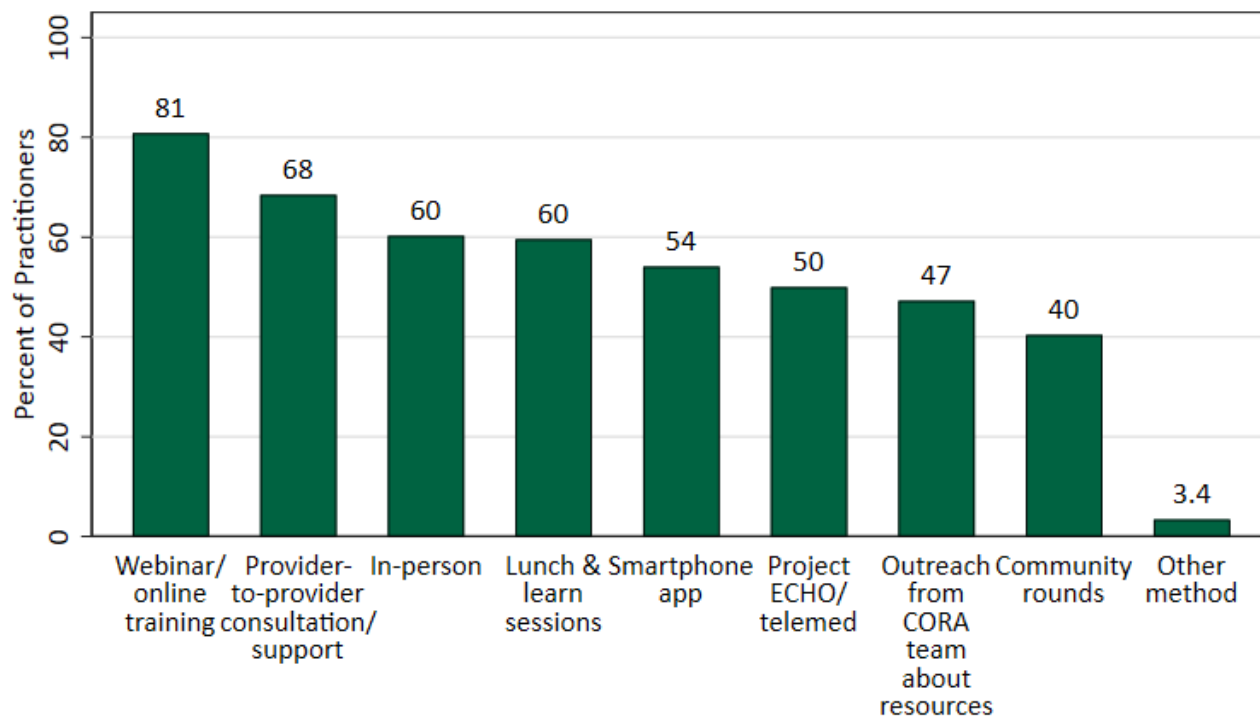


Figure 60. Practitioners' (n=146) preferred methods for receiving University of Vermont Center on Rural Addiction (UVM CORA) resources and trainings.

Figure 61 shows practitioner responses to the question, **“What resources or services would help you to become waived to prescribe buprenorphine?”** which was asked only of prescribing practitioners who did not have a buprenorphine waiver at the time of the survey. Although there have been changes in federal policy around training requirements for obtaining a buprenorphine waiver since the time of survey administration,⁵ the answers to this question remain relevant for understanding practitioner barriers to treating patients with OUD.

Among these non-waivered practitioner respondents (n=16), two-thirds listed financial support or incentives (63%), and waiver training on-location at their practices (63%) as resources and services that would help them obtain a buprenorphine waiver (Figure 61). Although the sample sizes for each group were small (rural n=8; non-rural n=8), a significantly higher proportion of non-rural practitioners (63%) selected provider-to-provider consultation or support than rural practitioners (13%; p=0.039). Additionally, a significantly higher proportion of rural practitioners (75%) selected ongoing training via webinars than non-rural practitioners (25%; p=0.046). There were no other significant differences in UVM CORA resources selected by practitioner rurality (data not shown).

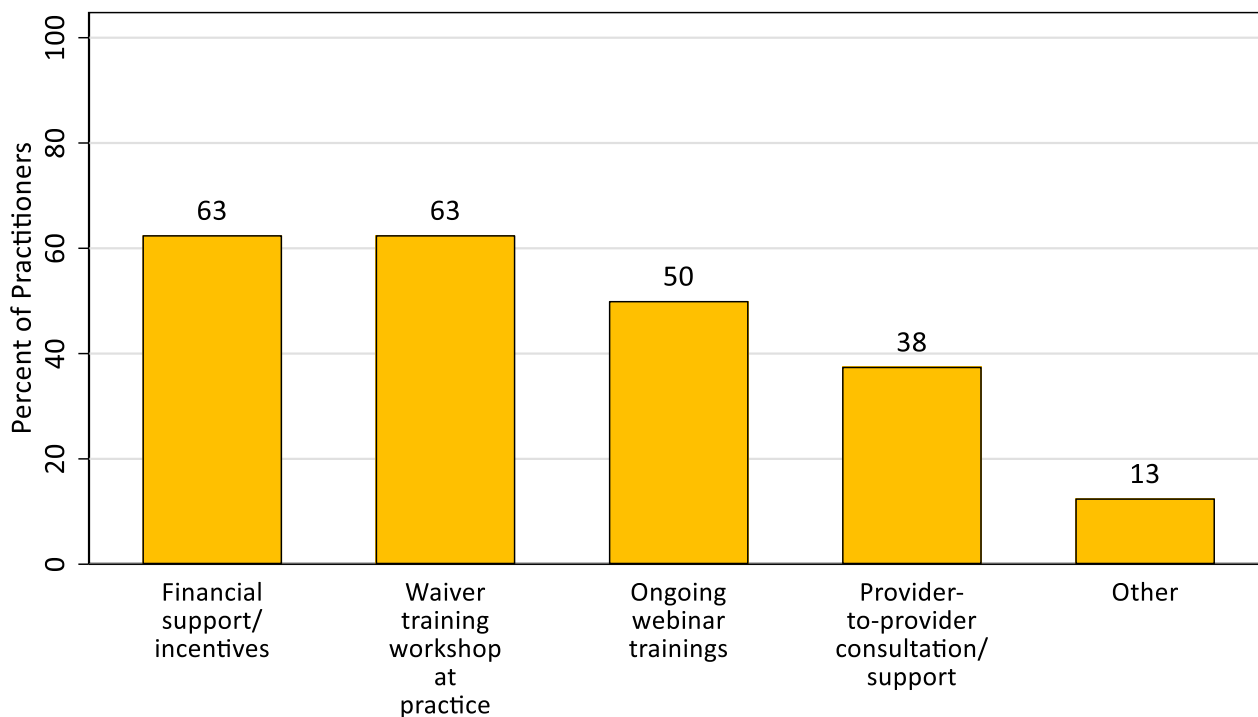


Figure 61. Selection of UVM CORA resources in response to the question, **“What resources or services would help you to become waived to prescribe buprenorphine?”** among prescribing practitioners without buprenorphine waivers (n=16).

⁵ For more information about current buprenorphine waiver policies, please visit:

<https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner>

Practitioner Ability to Provide Data for Evaluation Efforts

Figure 62 shows the different types of data that practitioners reported being willing and able to share as part of UVM CORA evaluation efforts. Nearly three-quarters (73%) of practitioners reported that it would be feasible to share the number of patients treated for OUD. Almost two-thirds (64%) reported that it would be feasible to share the number of providers at their practice who have prescribed MOUD. Only one-quarter of practitioners reported that it would be feasible to collect and share the number of patients offered new or improved SUD interventions.

A significantly higher proportion of non-rural practitioners (n=48; 52%) reported that it was feasible to collect and share their number and types of SUD treatments, resources, and referrals compared to rural practitioners n=52; 33%; p=0.050). There were no other significant differences between rural and non-rural practitioners in the evaluation metrics they identified as being willing and able to share (data not shown).

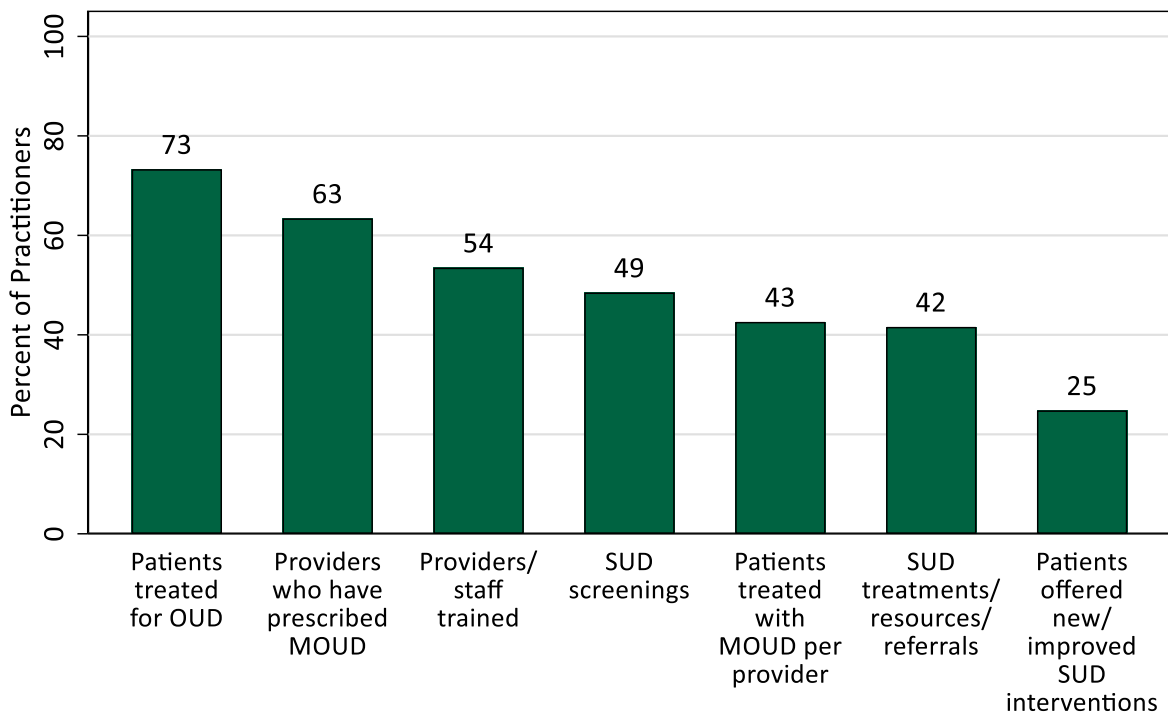


Figure 62. Percent of practitioners (n=101) reporting evaluation measures as feasible to collect & share with the UVM Center on Rural Addiction (UVM CORA). Abbreviations: OUD—opioid use disorder; SUD—substance use disorder; MOUD—medications for opioid use disorder.

One of the services that UVM CORA offers is assistance with surveillance and evaluation efforts for practitioners. Table 21 shows the distribution of practitioner responses (n=106) to the question, **“What support would you most need to be able to collect and share these data with UVM CORA?”** The most-identified support was assistance with data collection systems (41%). There were no significant differences between rural (n=58) and non-rural (n=47) practitioners in the supports that they identified.

Table 21. Practitioner supports (single choice) needed to collect and share data with the University of Vermont Center on Rural Addiction (UVM CORA).

	Freq.	Percent
Data collection system	42	40.0
Other	29	27.6
Financial support	18	17.1
Data entry	11	10.5
Help chart audit	5	4.8
Total	105	100

Most Important Improvement Needed

Practitioners and community stakeholders had varied responses to the question, “**What would you recommend as the SINGLE most important improvement to increase access to opioid use disorder treatment?**”

- “Increasing the number of providers in the region that offer appropriate levels of care for individuals with opioid use disorders.” – *Non-rural community stakeholder*
- “More treatment providers. We have a good Doorway program but not enough places to refer to.” – *Non-rural community stakeholder*
- “To be timely in response. The window that someone chooses to make this life change can be small, and if organizations allow too much time between patient contact and response, that time may pass.” – *Rural community stakeholder*
- “Having more providers available. When patients are ready for help, they need to have that help in a more timely manner.” – *Non-rural practitioner*
- “Availability of treatment sites in less populated areas.” – *Rural practitioner*

Share and Learn

Below are highlighted responses to the question, “**Is there anything else you would like to share with us?**”

- “An individual's treatment plan should depend on the needs of that individual—the state of NH needs better processes in place to ensure appropriate levels of care are available for individuals once they've received a clinical assessment. Additionally, programs such as drug court (and others) need to move away from ‘one approach fits all’ and allow individuals to utilize the appropriate level of care for them (i.e., not sending everyone through 28-day programs).” – *Non-rural community stakeholder*
- “Most important improvements are in policy and legislation—buprenorphine should be free of cost and access not restricted by X-waiver requirements.” – *Rural practitioner*
- “Telehealth needs to stay—it's increased options for our remote patients without transportation.” – *Rural community stakeholder*

Acknowledgements

We would like to thank the many New Hampshire Practitioners and Community Stakeholders that participated in UVM CORA's Baseline Needs Assessment. Their responses to our questions and their comments will help us as we continue to develop and improve our ability to support rural communities.

We would also like to thank our colleagues within UVM CORA and at the University of New Hampshire Institute for Health Policy and Practice (IHPP) and the New Hampshire Citizens Health Initiative (NHCHI). UVM CORA faculty and staff, our partners at NHCHI, and members of the UVM CORA Clinician Advisory Group in New Hampshire, Maine, and Vermont provided helpful suggestions and guidance as we were developing the questions for this Baseline Needs Assessment and as we prepared this report. We look forward to continued collaboration.

Questions

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

Suggested Reference

University of Vermont Center on Rural Addiction (2022). *New Hampshire Baseline Needs Assessment: Practitioners and Stakeholders*. Retrieved from: www.uvmcora.org.



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