

Background

The mission of the University of Vermont Center on Rural Addiction (UVM CORA) is to expand addiction treatment capacity in rural areas by providing consultation, resources, training, and evidence-based technical assistance to rural healthcare practitioners and community organizations. The aim of our Vermont baseline needs assessment was to identify substance use disorder treatment needs and barriers in rural areas with direct input from practitioners, community partners, and people impacted personally by opioid use.

Qualitative data collection for this needs assessment began in August 2021 and included interviews with people with lived experience with opioid use disorder (OUD) as well as with family members of people with lived experience with OUD. This report summarizes the data collected during interviews with people currently receiving medications for OUD (MOUD; e.g., buprenorphine, methadone). For a more comprehensive description of the experiences and perspectives of those interviewed for this project, refer to our companion *Qualitative Report: Opioid Use Disorder Treatment Experiences in Rural Vermont*.

Key Takeaways



Barriers to initiating and maintaining OUD treatment included timing, capacity, and location of treatment, as well as transportation, insurance coverage, and stigma.



Many interviewees were satisfied with their MOUD treatment providers and the care they were receiving and expressed hope that the progress made in quality of care for people with OUD would continue.



Living in rural areas exacerbated many barriers to OUD treatment, including the need for a vehicle, the time required for appointments and travel, and limited local services.



Interviewees emphasized several ways in which the healthcare system could better support them in their OUD treatment, including improved collaboration across providers or services, greater input and involvement in their treatment, increased contact time with providers, and better after-care planning when transitioning from residential to outpatient services.



Although clinic (OTP or “Hub”) settings were described as having the greatest capacity, interviewees attributed many barriers to these settings, including long travel times, lack of privacy, and inflexible policies.

Interviewees shared **BELIEFS** about OUD and treatment:

- The perceived importance of “readiness” to successful treatment initiation
- The belief that some people in treatment are “genuine” and abstain from all substance use, and that their treatment experience could be disrupted by those who access services in a harm reduction capacity
- The belief that relying on MOUD is a form of dependence incongruent with successful long-term recovery



Methodology

Recruitment and Eligibility

Recruitment occurred between August and December 2021, beginning with email outreach to contacts from UVM CORA's technical assistance activities, rural practitioner respondents to UVM CORA's Vermont baseline needs assessment survey, and a list of rural OUD treatment providers maintained by UVM CORA faculty. Partners in the recovery center network and at Syringe Services Program sites throughout rural Vermont assisted with recruitment. Interested individuals completed an online screening survey to determine eligibility. Eligibility criteria included living in a Vermont county designated as eligible for rural health grants by the Federal Office of Rural Health Policy in the Health Resources and Services Administration (HRSA), age 18 or older, and currently receiving MOUD; 43 people met these criteria. Of those, 16 individuals agreed to participate, completed interviews, and were included in this analysis.

Qualitative Interviews

We conducted semi-structured qualitative interviews using questions based on similar qualitative work done by University of Southern Maine's Substance Use Research and Evaluation Unit (USM SURE), UVM CORA's baseline needs assessment survey,¹ input from UVM CORA faculty, staff, and clinicians, and feedback from community partners. Questions focused on interviewees' current OUD treatment plan, challenges related to accessing and receiving MOUD, and potential gaps in OUD treatment or recovery services within the community. All interviews were conducted via the Zoom virtual platform by an experienced qualitative interviewer from USM SURE. The average interview length was 30 minutes. Interviews were transcribed verbatim using a professional HIPAA-compliant transcription service and analyzed using NVivo 20[®] software. Interviewees received a \$50 gift card for their time.

Data Analysis

Transcribed interviews were coded through an iterative process using a grounded theory approach (i.e., codes were drawn from the text and coding involved frequent comparative analysis of the data). We employed overarching analytic categories informed by survey data collected in the first phase of the Vermont baseline needs assessment (deductive codes) as well as additional themes (inductive codes) that emerged throughout the coding process. Transcripts were coded by a minimum of two members of the research team, which met weekly to discuss and refine the coding process. The final coding structure contained broader topics ("parent" codes, e.g., treatment experience) as well as "child" codes (e.g., within treatment experience: initiation, current experience, past experience). We queried the data and met regularly to review findings and ensure that data were captured consistently in the analysis. Interviewee quotations reflect original language with the

¹ University of Vermont Center on Rural Addiction (2021). *Vermont Baseline Needs Assessment: Rural Practitioners and Stakeholders*. Retrieved from: www.uvmcora.org/data-reports.

exceptions of removing pauses, repeated words or content that could be identifying. It is important to note that some of the quotes from patients include terminology that differs from that currently used in the field and may reinforce stereotypes. These verbatim quotes represent the views of interviewees with OUD and it is important to allow them the autonomy to define how they identify the services they receive and themselves. For example, interviewees often referred to MOUD as “MAT” (medication-assisted treatment), as evidenced in their quotations throughout this brief.

Respondent Characteristics

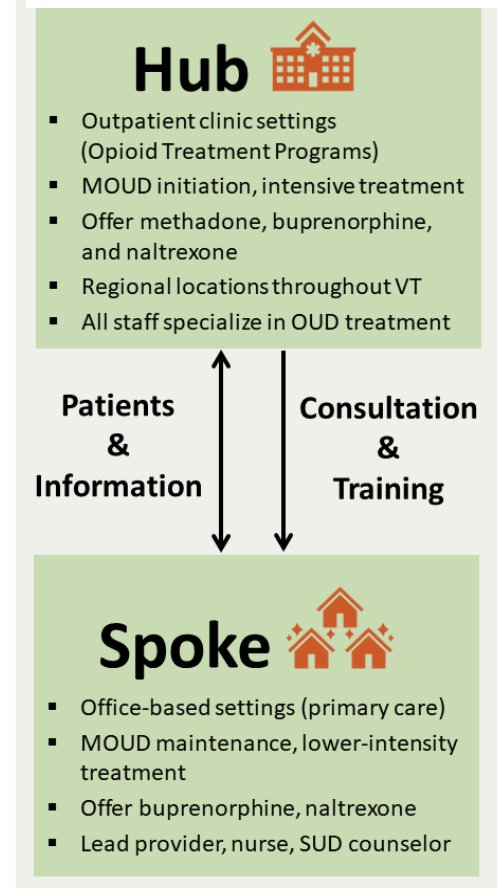
Most interviewees (n=16) identified as white (94%), non-Hispanic (100%), and female (69%). Interviewees had a mean age of 37 years (range 25-49 years) and reported living in seven of 13 rural Vermont counties. Figure 1 below provides an overview of interviewees engagement with treatment.

Figure 2



Vermont uses a Hub and Spoke² system of care to provide patients with MOUD treatment (Figure 2). Regional **Hubs** are Opioid Treatment Programs (OTPs), which provide MOUD initiation and intensive OUD treatment services in an outpatient clinic setting. Interviewees most often referred to these Hub sites as “clinic” settings, which is the language we primarily use in this brief. More widespread **Spokes** provide less intensive MOUD treatment in office-based (e.g., primary care) settings in the community, primarily for patients who are established in their MOUD treatment plan. Interviewees most often referred to these Spoke sites as “office” or “primary care” sites.

Figure 1



² Blueprint for Health: <https://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke>

Results

Overview

This brief provides a summary of key findings and themes related to the following areas of inquiry:

- Initiating Treatment
- Continuing Treatment
- Experience with MOUD
- Patient-Centered Care
- Long-Term Recovery Goals

Belief Themes



Emerging themes in the analysis included interviewee beliefs which were defined as value statements about substance use, treatment, and recovery. These **belief themes** are described in further detail throughout this brief and are indicated by the symbol above as well as **bold green** text.

Treatment Initiation


Interviewees reported varied reasons for beginning OUD treatment and noted the importance of an easy and accessible initiation process. They stressed the value of having quick and easy access to treatment services and supports when someone is ready to initiate treatment and discussed how barriers to accessing services at this critical time can dissuade individuals from initiating treatment altogether.

Interviewees reported a range of experiences from easy to difficult access to treatment. While many reported a relatively straightforward experience, not all did, which seemed to relate to the treatment setting (e.g., residential treatment was reported by some interviewees as harder to access than community-based outpatient services). Several interviewees shared more difficulties receiving treatment in the past relative to current day access and noted that the state has made headway on increasing MOUD access during the past several years.

*“I wanted to watch my kid grow up.
I wanted to raise him.”*

Facilitators to Treatment Initiation

Interviewees discussed several factors which can make it easier to initiate treatment for OUD. **Being “ready” or willing to commit to treatment was the most frequently discussed facilitator to initiate treatment, with many interviewees sharing the belief that being “ready” is the most likely indicator of successful treatment initiation.** Other facilitators discussed were personal motivating factors such as family, wanting to be there for a child, or to secure and maintain employment.



*“I heard a lot
about MAT and
the clinic through
other users.”*

Once someone is “ready” to seek treatment, interviewees mentioned that they needed to know about available treatment services in their area and be able to easily access those services. The ways people learned about available services varied, including hearing about treatment options from other individuals who use substances, medical providers and through a recovery center.

A few interviewees mentioned having gone to their primary care doctor for a non-ODU related health issue which resulted in a referral to treatment services. For some, legal issues provided a path to treatment initiation or continuation due to the availability of counseling services and having continuity of MOUD treatment from incarceration to a primary care doctor or clinic at discharge/release.

Ease of access to initial treatment services was very important to interviewees. Individual factors mentioned that facilitated access included: quick and easy access to MOUD and treatment services, having health insurance, having transportation (particularly a car), availability of a phone number to request treatment or counseling, childcare assistance, technology assistance, and peer and family support.

Barriers to Treatment Initiation

One of the most significant barriers to initiating treatment mentioned by interviewees involved the timing and capacity of treatment services. Interviewees described a lack of treatment options in rural areas, difficulty finding practitioners with availability, and long wait times, particularly for accessing residential treatment. Participants described concerns prior to beginning treatment of experiencing withdrawal due to an inability to quickly initiate MOUD and how this made it difficult to remain focused on entering treatment. Many attributed difficulties in accessing services to the limited number of prescribing providers and primary care practices accepting new patients.

“Somebody wants to go to [residential] treatment, but they have to wait 10 days... And then you're back at square one.”

“They're so overloaded with MAT patients... The trouble now is even finding a doctor that has room on his schedule.”

Interviewees described that given unpredictable capacity and availability of treatment options it could be difficult for those seeking care to understand where to start. Lack of information about treatment resources was mentioned as a barrier for those seeking treatment on their own as well as those trying to get referrals from an established provider who did not know what services were available.

Interviewees described how lack of transportation or access to a car is a barrier to initiating treatment in rural locations. While few interviewees mentioned personal challenges with stable transportation, many noted that it is a significant challenge among those who might be trying to initiate treatment.

Barriers on the path to treatment

- Long wait times or waitlists
- Lack of car or stable transportation
- Stigma among providers and community members
- Lack of providers and primary care practices
- Lack of childcare services
- Lack of health insurance or the inability to pay for treatment services

Interviewees described how stigma within communities affects access to care, such as experiencing judgment and the subsequent fear of being labelled when initiating services. They described how perceived stigma can cause individuals with OUD to be hesitant about disclosing substance use with providers or seeking appropriate care due to fear of judgment. Interviewees were also concerned that judgment from providers about their opioid use might lead to necessary care being withheld, such as receiving prescription opioids for pain management.

“I didn't want to out myself to any physician, because you're kind of shooting your foot if you do that, in a junkie's mind. Well, if I go to the ER or if I tell my doctor [about my OUD], then I'm going to be blacklisted.”

Other barriers to treatment initiation discussed by interviewees included: lack of childcare services; the complicated administrative process associated with entering treatment (application, paperwork, series of multiple interviews); the time requirements of clinic treatment settings that would prevent people from starting there; limited or no access to treatment facilities in the area; and lack of health insurance or inability to pay for services.

Treatment Continuation

Participants described how some factors made it easier or more difficult to stay engaged in treatment. Many of these factors are closely linked with high-quality, patient-centered care and facilitate treatment continuation. However, some factors are barriers that discourage ongoing treatment and recovery.

Facilitators to Treatment Maintenance

Providers and staff were key to facilitating continued treatment engagement. Overall, interviewees discussed how receiving patient-centered care facilitated treatment continuation through emotional and care coordination. Patient-centered care, for the purposes of this report, refers to collaborative, coordinated care where the patient receiving MOUD (and family, as appropriate) are part of the care team, working towards patient-centered goals. Many interviewees discussed elements that had a positive impact on their treatment experience, including patient involvement in medication decisions, caring and supportive treatment providers, and being treated in a respectful, nonjudgmental manner.

Participants reported that provider and staff support was key to maintaining treatment engagement.



Emotional support
(Dependability, guidance, empowerment)



Care Coordination
(Referrals, integrated care, social service resources)

“Every time I go in, she asks me, ‘Is this current dosing working for you, are you having cravings, do we need to adjust?’ So, yeah, I feel I can talk to her.”

“She’s very by the book. But if I have to say one thing, I need for her to put her damn foot down and say, you’re going to get in this office, or there’s going to be consequences. You know what I mean?”

Interviewees expressed that providers who made them feel comfortable and listened facilitated their continued engagement in treatment. They reported that they valued their provider organization as a resource for emotional support and advice, and many indicated they may not stay committed to their recovery without it. A few interviewees appreciated their provider’s strict treatment policies, viewing these as justified and necessary for their continued treatment engagement.

Providers were also noted as being effective at facilitating treatment continuation by providing participants with care coordination. This reportedly included providing timely access to appointments, ensuring appropriate communication with the pharmacy or other providers, and assisting patients with access to other resources (e.g., transportation, communication) to improve their quality of life. Participants also discussed receiving this support in the context of team-based care (e.g., interfacing with more than just the prescriber- perhaps a care navigator and/or support staff), indicating that the team-based treatment structure may be perceived as more accessible to patients.

Several persons shared that having positive, caring, and supportive treatment providers kept them motivated to remain in treatment, in some cases by simply helping them keep track of their appointments. Being comfortable both with the provider and the treatment setting were notable factors to feeling more at ease with treatment. Some described providers who they felt went out of their way to deliver additional resources or assistance. Others shared positive indicators of patient-centered care including being treated “with respect,” feeling comfortable within their treatment setting, and recovery setbacks that prompted a refocus on treatment goals or medication dosages rather than removal from the treatment program.

“They’ve all just been really caring and supportive and make it pretty easy to... Have my appointments and get my prescriptions. They stay on top of it, and it’s been good. ‘Cause I wouldn’t do it otherwise.”

“If you do have any kind of, you know—slip, fall, whatever you want to call it— and as long as you are honest with him—yes, he will be let down, but he needs you to not dwell on it and he needs you to get back in your program, brush yourself off, you know what I mean, don’t beat yourself up and keep using, just get to where you were before that and, you know—they care about you there.”

Barriers to Treatment Continuation

Participants also expressed concerns about some conditions that made it difficult to maintain engagement with treatment. Individuals in treatment reported that the absence of support for continuity of care, including referrals to and availability of different levels of care and communication protocols between providers, was a challenge to remaining engaged with treatment. Some participants reported that experiences such as leaving residential care without a referral and or not having clear and timely communication between providers were detrimental to their continuation of MOUD. Participants noted the importance for specialty providers to understand the role of primary care in MOUD as a step-down level of care for patients. Several participants shared that having MOUD prescribing taken over by primary care was easier and more accessible as they went through their treatment process.

“When somebody leaves a treatment facility, they're just basically on their own. They're not setting them up with any sort of after-care, except they might say, oh, here's a pamphlet.”

Reported stressors that can affect treatment continuation



Seeing family and friends outside of the treatment environment who use substances



Spending time with non-abstinent patients in treatment settings



Grief and loss in personal life that may require more intensive mental health treatment

The need for providers to facilitate accessible care across the spectrum of services was noted as critical in the context of triggers that individuals face throughout their recovery. For example, participants discussed how stressors can influence treatment needs, such as the need for additional counseling to address grief or loss, or when appropriate, receiving MOUD in a different setting to avoid triggers in the treatment environment.

Several interviewees discussed their surrounding environments and peers within their communities and treatment settings as factors that affected their treatment continuation. Some talked about removing themselves from the presence of people in active use, or choosing to spend their time with friends who did not use opioids, as key factors in continuing their treatment and recovery:

“We're all waiting for the bus [to treatment] together, so if one person is still using, hey, guess what? If you want to relapse, it makes it so easy... you don't even have to go looking.”

To that end, interviewees acknowledged the importance of treatment for people who are not abstinent, but many expressed that it can be difficult or triggering to be in treatment settings with people who were still actively using substances. They discussed their perception that treatment settings where people in active substance use receive services are particularly challenging environments due to the potential availability of non-prescribed opioids. Of those, some made the distinction between what they perceived as two separate groups: people who are actively working toward, or “genuine,” in their recovery, and people who receive MOUD while continuing to use illicit opioids.

Interviewees who received MOUD in a clinic setting reported that “take-homes” (getting doses weekly or monthly to take at home) were important, in part because they allowed individuals to avoid unnecessary daily triggers in the treatment environment.

Interviewees reported that stringent policies, particularly in clinic settings, could discourage people from staying in treatment. They described how penalties for program non-compliance, such as revoking take-home medication or withholding medication, sometimes increased the burden of participating in treatment or caused withdrawal symptoms. These penalties were especially discouraging in cases when an individual had requested support following a return to use. Scheduling involved with Vermont's treatment clinics was described by several participants as especially time consuming and inflexible, especially when daily appointments were required to receive MOUD, which can make treatment continuation more challenging and impact the likelihood of treatment success. This factor is made more significant for individuals balancing other scheduling considerations, such as long commutes to treatment, transportation access, or work schedules.

Many interviewees discussed logistical challenges that were barriers to continuing treatment and recovery services, including childcare, transportation, and hours of operation for treatment and recovery services. Regarding childcare, some participants reported struggling to find reliable and affordable options so they could attend doctor's appointments, recovery meetings, or other treatment and recovery-related activities. Securing childcare and transportation was particularly complicated for individuals who received their MOUD daily from clinics, and interviewees noted that this could prevent an individual from accessing services altogether. Some interviewees who lacked a personal vehicle discussed challenges related to using public transportation to attend appointments such as limited bus routes, long wait times, and the physical distance to service providers in their rural communities.

Some interviewees also expressed concern about their ability to continue treatment after transitioning from state-sponsored to employer insurance benefits. Despite the additional income from full-time employment, exceeding the income threshold for public benefits meant some individuals were concerned about their ability to afford treatment services not covered through insurance and lack of access to free rides to treatment.

"Now that I'm working full-time, all that goes away, and with that goes whatever [Medicaid coverage] I was getting... I know that's going to change, and honestly has caused a lot of stress and insecurity in being still actively recovering, because I'm scared to death that I'm not going to be able to afford my medicine. I'm not going to be able to afford that counseling that I get through the MAT team or seeing my physician."

Experience with Medications for Opioid Use Disorder (MOUD)

Perceived Benefits of MOUD

Interviewees described the positive experiences and perceived benefits of receiving MOUD, and how these affected their willingness to remain engaged with treatment. Experiences of initiating MOUD varied greatly, with a common theme of gratefulness for the relief from cravings that MOUD provided. Some of those who took methadone especially noted that they had positive experiences with treatment initiation because they did not have to be in opioid withdrawal prior to treatment initiation, as required by some buprenorphine providers, and did not experience negative physical side effects of withdrawal.

Those more established with their current treatment providers and medication tended to describe a more favorable current treatment experience than those who had been on their current MOUD or with their current provider for less time. Receiving MOUD through a primary care setting was viewed more favorably than receiving MOUD through a clinic setting where frequent appointments during specific time windows were required, resulting in more interaction with peers.

For people interviewed who were recently receiving treatment via daily visits to a treatment setting, the transition to fewer appointments with take-home medication greatly improved their treatment experience. One positive factor associated with “take-homes” was the ability to split one’s daily dose into doses in the morning and afternoon.

As discussed in more detail below in the Long-Term Recovery section, some participants who described wanting to discontinue or taper off MOUD as a long-term recovery goal also noted that use of MOUD was much better than having a reoccurrence or continuing to use opioids illicitly.



“Being on medication makes it possible to quit the second you decide to.”

Many reported that MOUD brought stability to their lives. In particular, some participants described that MOUD eliminated their cravings with minimal side effects.

Perceived Drawbacks of MOUD and Treatment Protocols

Interviewees discussed some drawbacks to MOUD, including logistical challenges to receiving the medication and issues with the medication itself. Interviewees reported that some providers were unnecessarily rigid in their prescribing, contributing to barriers to being comfortable on medication and secure in recovery. For example, some noted that there are doctors who may restrict or revoke a patient’s access to MOUD if they relapse or have a positive drug screen, making it challenging to restart or maintain their treatment. Treatment continuation was also tied to treatment provider policies, including requirements to be on time for appointments and to follow rules in residential settings (e.g., no cell-phone use).

Interviewees described that because they were on MOUD, experiencing cravings and unpleasant physical symptoms was especially frustrating. This frustration could be exacerbated by perceived punishment from provider organizations and unwillingness of providers to modify MOUD prescriptions to address breakthrough withdrawal symptoms.

“There’s everyday stressors that everybody has that are never going to go away, but [struggling with withdrawal and cravings] was one thing that shouldn’t be at the forefront of my daily struggles, because I’m on a medicine that’s supposed to help curb that.”

“I felt like I was still living the life of a drug addict every time I didn’t get my dose on time or missed a dose because they wouldn’t give it to me... When I’m in treatment and I haven’t used for years, I shouldn’t be lying in bed dope sick, sweating, with restless legs as if I just did heroin all weekend.”

Experiences with pharmacies could be inconvenient or disruptive to the treatment experience. Because of the status of MOUD as a controlled substance, there could be tension between the patient and their pharmacy if there were misunderstandings about the prescription or timeline for filling the medication. While an outlier, one individual who received their medication in the mail reported delays or potential gaps in the receipt of their medication. However, several individuals described positive experiences with accessing prescriptions at local pharmacies.

Some interviewees commented on unfavorable physical effects of medication. There were reports that sublingual forms of buprenorphine could burn or blister the mouth or taste bad. Some interviewees described that some forms of MOUD caused them to feel ill or nauseous. One interviewee reported not being in withdrawal from opioids before initiating buprenorphine treatment and described the resulting negative physical symptoms. Some participants described that methadone made them drowsy, which affected their routine. Experiencing any kind of withdrawal side effect, either attributed to normal dosing or a disruption in treatment, was reported as highly unpleasant and upsetting.

Interviewees perceived MOUD as another type of dependency and viewed this as negative. A few explicitly described MOUD as a “crutch” and likened it to past forms of dependency on illicit opioids. This belief was also reflected in some participants’ negative view of having to be on a high dose of MOUD to avoid cravings.

“If you’ve got to take something that makes you feel normal, then you’re not normal, but it’s better than the opposite of still being an addict and end up losing my life and destroying my son’s life at the same time.”

Suggestions to Improve Patient-Centered Care

Interviewees also shared suggestions for how providers and healthcare organizations might improve the experience of care for people with OUD. Several noted the positive impact of counseling and support or recovery groups and suggested that having childcare options during these meetings or expanded service hours into the evening might facilitate greater participation.

“I feel like if they were offering a group, I feel if they could have somebody that could watch the children... I think a lot more people could commit to that if they had somebody to watch their children.”

Improving patient-centered care was closely related to closing gaps in services and resources



Interviewees identified the need for further education to reduce stigma at the community and provider level as they viewed it as negatively affecting their treatment. For example, some interviewees expressed that being accused of drug-seeking behavior when they were open about their medical problems was hurtful and undermined trust in the provider relationship.

Interviewees shared that integration of care and enhanced care coordination were key factors to improving care for people with OUD. Highlighting this idea, one participant found it helpful to have their counselor available at the same location and time as the appointment with the primary care provider (PCP). Another suggested that this type of alignment of appointments would be helpful for many patients and would help reduce unnecessary travel time. A few participants stated that PCPs and other healthcare providers needed to do a better job communicating about treatment options, including residential care, and others noted that better communication was needed in general regarding resources available in the community.

“There have been plenty of times where I felt like there could be much better communication between different healthcare providers and different venues for seeking help... A better way of consolidation, basically, and having a more uniform... And consistent... Approach throughout the State to figuring out how to get help.”

Communication was noted as an important aspect of the care experience for persons with OUD. Participants suggested having more time with their PCP at each visit, more regular check-ins by the PCP or their staff, or office visits more often than once every other month. This was shared among interviewees who considered themselves further along in their recovery and who generally received fewer outpatient services.

“It would be nice if they reached out to me a little bit and check in how I was doing. Even if it was just a nurse calling like once a month and being like, how are you doing, is everything OK, are you feeling stable, do you need to see anybody, do you want to come in.”

In discussing suggestions or recommendations for resources to help persons with OUD, interviewees highlighted the significant gaps of transportation, childcare, housing, and the overall shortage of MOUD providers and rehabilitation facilities. In the context of these gaps, interviewees described how critical it was for existing services to come together to facilitate local, rapid access to treatment programs.

Suggestions for improved patient-centered care

-  Co-located services to reduce travel time
-  Education and outreach to reduce stigma
-  Improved communication of available services
-  Childcare options to support participation in meetings and counseling

Long-Term Recovery

Stability is seen as key to long-term recovery success.

Stable
Housing



Reliable
Transportation



Financial
Security



Interviewees shared their optimism, hopes, and dreams regarding their efforts in their journey to successful long-term recovery from OUD. Improved relationships with their children and families and a better self-image were frequently mentioned as benefits to successful recovery. Heightened self-esteem associated with recovery was related to social and personal goals, including helping others and being fulfilled.

“[Success is] to not really have to worry about money—literally, when you’re using, every dollar is going to that... So just a little bit of financial security, of job security, being able to go and do things.”



When asked what long-term recovery success looks like, most participants **believed that no longer receiving MOUD was a measure of success. That said, several noted that they did not feel external pressure to stop MOUD to be successful in long-term recovery; rather, it was a personal goal.** Those who believed successful long-term recovery meant eventually stopping MOUD agreed that support from providers and others in their lives is crucial.

Participants agreed that stable housing, transportation, and financial security are important to supporting long-term recovery for OUD, in addition to enjoying time with family, not worrying about cravings or withdrawal, assisting others in recovery, recovery from dependence on other substances, and successful management of chronic pain. They discussed that stability and lack of anxiety around transportation, living situation, and finances were closely tied to success in recovery.

“I want to be clean and sober, get around and do things with my youngest child and grandkids... And be in okay health doing it. That would be a success.”

Conclusions

The high rate of opioid misuse and subsequent development of OUD is an ongoing national and local public health crisis. Despite ongoing state and local efforts to improve access to treatment services, promote awareness of the opioid epidemic’ and foster safe opioid prescribing practices, Vermont’s rates of opioid related overdoses and deaths remain high. Feedback from Vermonters impacted by OUD indicates that strategies designed to address crucial access gaps in treatment infrastructure, provider training/education, and organizational capacity to deliver MOUD have resulted in improved access, timeliness, and quality of care. However, barriers to initiating and maintaining treatment for OUD remain. Feedback points to the continued need to address ongoing barriers to treatment access and engagement, many of which are exacerbated



given the rural nature of the state, including: enhancing treatment and recovery infrastructure, implementing strategies to reduce OUD related stigma, and expanding capacity to address social determinants of health.

Acknowledgements

We would like to thank the Vermonters who shared their thoughts and experiences with us for this project. The information gathered will inform CORA programs and resources and help us in our efforts to support rural communities.