FEASIBILITY STUDY FOR
MOBILE OPIOID TREATMENT PROGRAM PLANNING AND SERVICE DELIVERY CONSIDERATIONS IN MONTANA

jg | RESEARCH & EVALUATION

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REPORT INFORMATION AND ACKNOWLEDGEMENTS

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INTRODUCTION

Significant investment from federal and state governments and broad expansion of access to treatment for opioid use disorders have yet to curtail increasing rates of overdose fatalities in the United States. One explanation is that those individuals who are highest risk for a fatality due to an overdose, are not able to access treatment programs. Access may be limited by geography, hesitance to visit a clinic, or a lack of awareness about treatment. With these three factors in mind, the following study used spatial analysis and qualitative research methods to inform a feasibility study for the establishment of mobile opioid treatment programs in Montana.

The provision of Medications for Opioid Use Disorder (MOUD) through a mobile unit is a relatively novel modality. Although pilot programs exist, widespread adoption of this modality was made more practical through the Drug Enforcement Agency (DEA) ruling on June 28, 2021 that eased restrictions on the transport of medications for treating Opioid Use Disorder (OUD).[1] After this ruling, it became simpler for mobile units to be able to deliver methadone or buprenorphine, with a recognition that each medication contained trade-offs and provided different types of opportunities for reaching different types of patients in a mobile setting. This report includes analyses that identify areas of Montana that could be well served by a mobile methadone unit and/or a mobile buprenorphine unit.

To our knowledge, this is the first study that links spatial analyses that identify need for services; qualitative interviews with stakeholders in communities to identify sources of support, resistance, or concern over a mobile unit; and an inventory of best practices and lessons learned from existing mobile unit providers and state agency staff. These results focus on Montana, and planning processes in other states may benefit from the findings of this study, methodological approach, and deliberate process for identifying routes best served by either mobile methadone or buprenorphine units. The need for these plans may be increased with the State Opioid Response III funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), which provides funding for the creation and implementation of mobile units.

1. https://www.dea.gov/press-releases/2021/06/28/dea-finalizes-measures-expand-medication-assisted-treatment

THIS STUDY HAS TWO PRIMARY GOALS:

1. Complete a feasibility assessment to inform planning and strategy for mobile van unit implementation in Montana.
2. Document current practices among existing mobile units to inform planning processes for the implementation of new units.

The feasibility assessment included a sequential analysis composed of spatial analysis and route selection and a series of interviews with key stakeholders in communities identified in the spatial analysis as areas of need. The documentation of current practices was accomplished through a series of interviews with experienced providers of mobile opioid treatment programs (OTP) in states and localities with existing mobile units. A methodological overview for each of the report sections is included in the Appendix.

KEY FINDINGS

- Suspected overdoses tend to be clustered in population centers in Montana that have existing opioid treatment services. There is evidence that additional services and innovative approaches may be needed in these areas to engage at-risk populations in treatment programs.

- Key stakeholders interviewed in Montana are generally supportive of additional services being provided to treat OUD in the form of a mobile unit and recognize this as a potentially innovative solution to under engagement in MOUD treatment.

- Experienced mobile OTP providers identified community education as the most important piece to successful implementation of mobile OTP services. Educational efforts should include details about mobile OTP as well as a direct discussion of stigma directed towards people who use drugs and towards addiction.

- Experts in implementing and running mobile units identified practical concerns related to funding, billing, and workflow that can be used to guide mobile OTP service implementation.

For more information or questions about this study or results, please contact brandn@jgresearch.org.

SPATIAL ANALYSIS INFORMING SITE AND ROUTE SELECTION

SPATIAL ANALYSIS

In undertaking a spatial analysis to understand need in Montana, the research team created a series of maps to identify areas of the state with the greatest potential need for additional OTP services, and to consider how these areas might best be served.

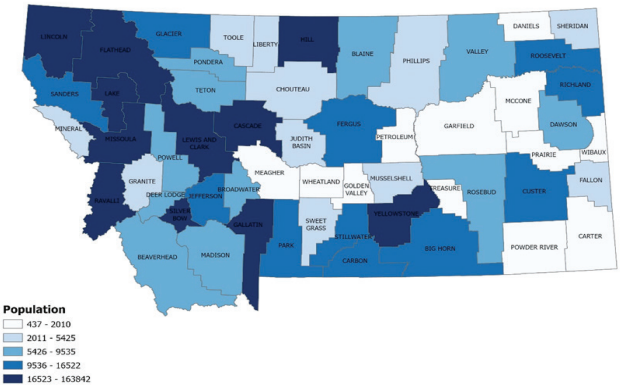
The analysis was completed in three parts:

1. Potential need (opioid prescription rates, overdoses, detention facility locations)
2. Current capacity (available treatment services)
3. Service opportunities (treatment providers, drive times, potential routes)

WHAT AREAS IN MONTANA HAVE THE GREATEST POTENTIAL NEED FOR OTP SERVICES?

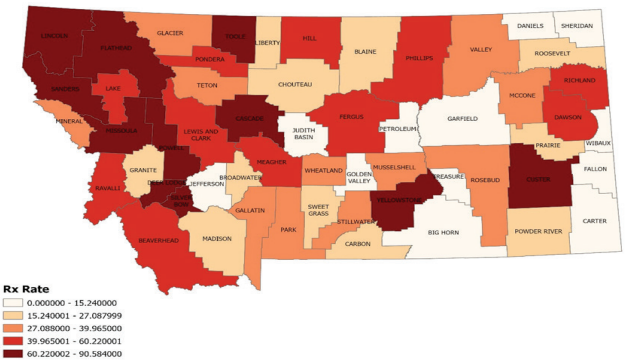
In Figure 1, population totals are mapped by county, identifying areas with the highest population across the state. It was important to understand population distribution as a first step in identifying potential areas of need. Data are from the State of Montana Census and Economic Information Center.

Figure 1. Total population by county, Montana 2020



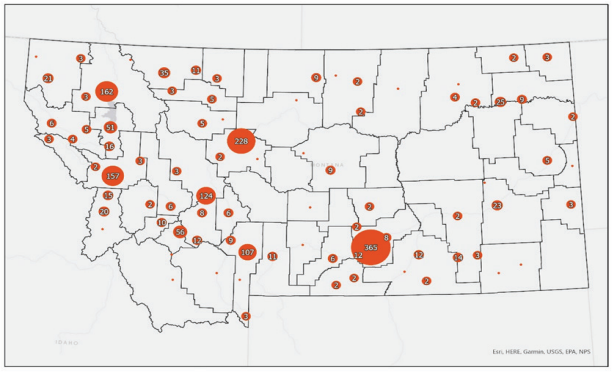
In Figures 2-4, opioid prescription rates and overdose locations are plotted across Montana. Opioid prescription rates from Figure 2 indicate a history of higher prescribing rates in northwest Montana and the more populated counties east of the Continental Divide.

Figure 2. Opioid prescription rates per 1000 by county, 2016-2020



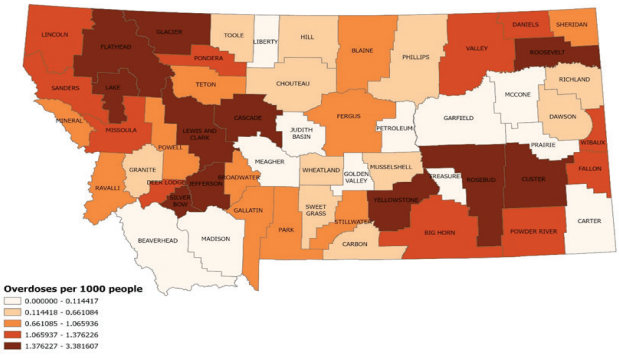
Clusters of opioid overdoses (Figure 3) follow a similar pattern as prescription rates, generally concentrating in areas with greater population.

Figure 3. Overdose clusters by county, 2018-2020



However, when mapped as an overdose rate per 1000, several smaller counties, primarily in eastern Montana, stand out as areas of potential need.

Figure 4. Overdoses per 1000 people by county, Montana 2018-2020



*Data from MT DPHHS, showing number of overdoses per 1000 people, from 2018-2020

After completing individual maps for the state by county, the research team grouped counties into quartiles to create Table 1, which identifies counties in terms of both high opioid prescription rates (potential addiction prevalence due to over prescribing) and high overdose rates (demonstrated addiction problem): Cascade, Custer, Deer Lodge, Flathead, Lake, Lewis and Clark, Lincoln, Missoula, Pondera, Sanders, Silver Bow, and Yellowstone. Big Horn, Daniels, Fallon, Glacier, Jefferson, Powder River, Roosevelt, Rosebud, Valley, and Wibaux counties also have high overdose rates, despite having lower opioid prescription rates. Prescription and overdose rate numbers in Table 1 reflect the quantile of the county from Figures 3 and 4, and the color is reflective of that assigned to each quantile in Figures 3 and 4.

Table 1. Opioid prescription rate from 2016-2020 per 1000 and overdose rate from 2018-2020 per 1000 by county

	Rx Rate 2016-2020	OD Rate/1000 People
Beaverhead	4	1
Big Horn	1	4
Blaine	2	3
Broadwater	2	3
Carbon	2	2
Carter	1	1
Cascade	5	5
Choteau	2	2
Custer	5	5
Daniels	1	4
Dawson	4	2
Deer Lodge	5	4
Fallon	1	4
Fergus	4	3
Flathead	5	5
Gallatin	3	3
Garfield	1	1
Glacier	3	5
Golden Valley	1	1
Granite	2	2
Hill	4	2
Jefferson	1	5
Judith Basin	1	1
Lake	4	5
Lewis and Clark	4	5
Liberty	2	1
Lincoln	5	4
Madison	2	1

	Rx Rate 2016-2020	OD Rate/1000 People
McCone	3	1
Meagher	4	1
Mineral	3	3
Missoula	5	4
Musselshell	3	2
Park	3	3
Petroleum	1	1
Philips	4	2
Pondera	4	4
Powder River	2	4
Powell	5	3
Prairie	2	1
Ravalli	5	3
Richland	5	2
Roosevelt	2	5
Rosebud	3	5
Sanders	5	4
Sheridan	1	3
Silver Bow	5	5
Stillwater	3	3
Sweet Grass	2	2
Teton	3	3
Toole	5	2
Treasure	1	1
Valley	3	4
Wheatland	3	2
Wibaux	1	4
Yellowstone	5	5

These data demonstrate a clear set of counties that have a higher likelihood of individuals who need treatment for OUD. In addition to these characteristics at the population level, the research team identified the locations of detention facilities, as access to treatment for OUD while incarcerated is very limited within the state of Montana due to low treatment capacity within detention facilities and few direct linkages with treatment providers within the communities where detention facilities are located. Detention facilities, as discussed in the third section of this report, have been identified in other states as locations that can be efficiently and effectively served by mobile units.

Figure 5. Secure detention facilities by incarcerated population size and methadone clinics, Montana 2021

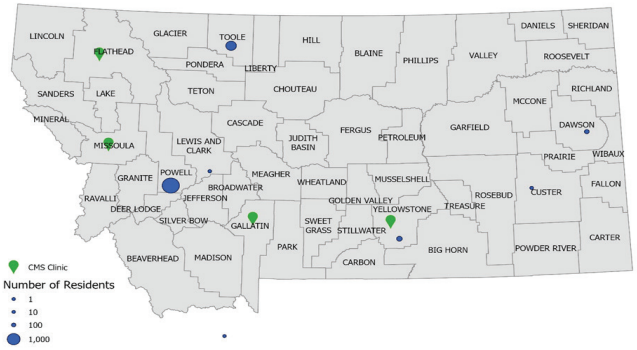
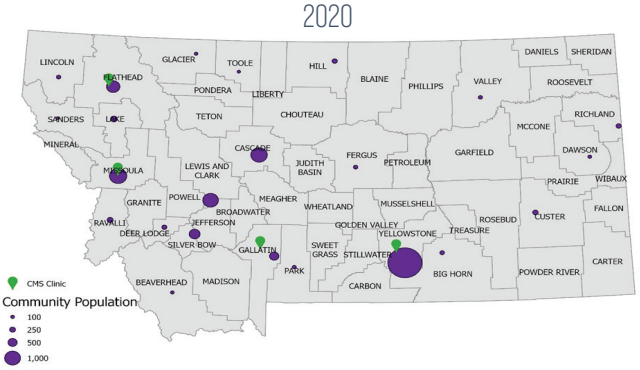


Figure 5 shows the locations of the six secure state-run facilities that house incarcerated people in Montana. These are in Dawson, Custer, Yellowstone, Powell, Lewis and Clark, and Toole Counties. The largest facility is the Montana State Prison located in Powell County.

The Department of Corrections also supervises over 10,000 offenders in the community based out of Probation and Parole Facilities throughout the state (Figure 6). The Billings Facility currently serves 2,000 offenders, and has the largest facility population in the state. In Figure 6, individuals on community supervision within the criminal justice system are identified, as this is another population at risk of overdose. In Montana, the size of the community where the parole offices are located is highly correlated with the county population. Future analysis could incorporate the local detention facilities (jails) as additional service delivery sites.

Figure 6. Population of individuals under community supervision, 2020

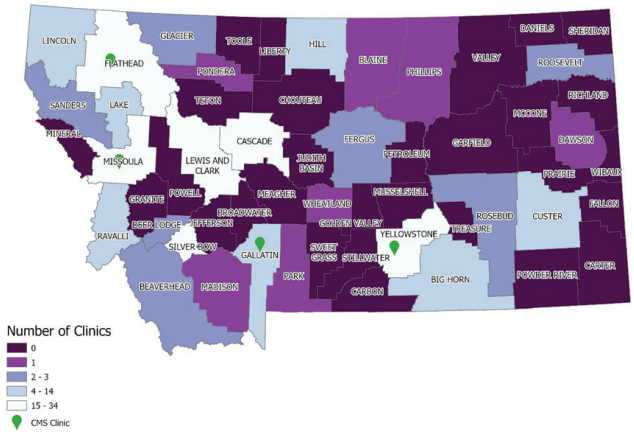


The spatial analysis demonstrated that at both the population level and with one at-risk population (those who are under criminal supervision), there are clear patterns that emerge for communities of focus for a mobile unit in Montana. However, this is a provisional conclusion, as part 1 of the spatial analysis did not yet include current treatment access and capacity within each county. Part 2 of this section provides those details.

WHERE IS THIS NEED FOR MOUD TREATMENT IN MONTANA POTENTIALLY BEING MET?

The primary mode for determining access to treatment is in the form of waivered providers and methadone clinics. In Montana, there is one organization with the ability to provide methadone treatment: Community Medical Solutions (CMS). Figure 7 provides an overview of treatment capacity for MOUD across Montana.

Figure 7. Methadone treatment locations and total number of clinics with a buprenorphine waivered provider, Montana 2021



Overall, many of the counties that stood out with the highest prescription rates and highest OD rates (Cascade, Custer, Flathead, Lewis and Clark, Missoula, Silver Bow, and Yellowstone), also have the most clinics (Figure 7). Methadone clinics (managed by CMS) are located in some of Montana's largest cities (Kalispell, Missoula, Billings) in the following three counties: Flathead, Missoula, and Yellowstone. Overall, it appears the spatial distribution of opioid misuse throughout the state is highly correlated with population, and there is a relationship with the location of treatment facilities.

It is interesting to note outlier counties where there is evidence of heavy opioid misuse, or potential opioid misuse, and very little access to treatment (Table 2).The majority of these counties are on the far eastern side of the state, which generally has little access to MOUD providers. Aside from Yellowstone County, no eastern Montana counties have more than 6 providers, with most having 0 or 1. Additionally, most providers within a county are typically clustered within the same town or city. Jefferson County has a high overdose rate, but has no providers, although it is adjacent to Gallatin, Lewis and Clark, and Silver Bow counties, all of which have a greater number of providers than other outlier counties, one of which has a CMS methadone clinic. Pondera County also scores highly in both prescription rates and overdoses, but has only 1 provider. While Pondera technically is adjacent to Flathead County, travel to Cascade County (Great Falls) for treatment is likely easier based on driving time. In Table 2, numbers and colors in the "Clinic Access Need" column reflect the quantile of the county from Figure 7.

Table 2. Risk and capacity comparison for determining areas of need

	Rx Rate 2016-2020	OD Rate/1000 People	Clinic Access Need (More Clinics = Lower Number)	CMS Clinic
Cascade	5	5	1	
Custer	5	5	3	
Daniels	1	4	5	
Deer Lodge	5	4	3	
Fallon	1	4	5	
Flathead	5	5	1	1
Glacier	3	5	3	
Jefferson	1	5	5	
Lake	4	5	2	
Lewis and Clark	4	5	1	
Lincoln	5	4	2	
Missoula	5	4	1	1
Pondera	4	4	4	
Powder River	2	4	5	
Roosevelt	2	5	3	
Rosebud	3	5	3	
Sanders	5	4	3	
Silver Bow	5	5	1	
Valley	3	4	5	
Wibaux	1	4	5	
Yellowstone	5	5	1	1

DETERMINING COUNTIES OF NEED

Based on mapping need and capacity, there are two main paths that can be explored for establishing mobile units in Montana.

1) Serve counties that have little or no access to MOUD providers but have relatively low populations in eastern Montana; alternatively, focus specifically on Pondera and Jefferson counties, which are closer to current treatment locations but are underserved.
2) Serve counties that do have access to MOUD providers, but are still seeing high rates of opioid overdoses.

Counties aligned with path two include Flathead, Missoula, and Yellowstone, all of which already have methadone and buprenorphine treatment locations. If incarceration facilities are an important target population for the OTP service, additional focus should be paid to counties with prisons.

PROPOSED ROUTES AND LOCATIONS FOR MOBILE UNITS IN MONTANA

The following discussion includes a series of maps to guide decision-making regarding the location and routing of mobile OTP services in Montana. It specifically focuses on Billings and Great Falls as potential locations of mobile clinics providing methadone, with a need for visiting the same location daily. The Butte-Helena-Great Falls corridor is better suited to a mobile clinic providing buprenorphine, with a weekly return time to each mobile unit stop.

CONTEXT

Some risk factors identified as good predictors of opioid abuse or overdose include:[2,3]

- Low educational attainment (high school or less)
- Low income (at or below poverty line)
- Unemployment
- Occupation (production/labor industries)
- Residential instability (vacant units, turnover, renters)
- Social isolation (living alone)
- Disability
- Lack of health insurance
- Public assistance
- Veterans
- Age
- Indigenous populations

A selection of these data was accessed from the American Community Survey at the census block level and then mapped for each of the identified communities of Billings and Great Falls.

Table 3. Social risk factors data accessed via American Community Survey

Demographic Variable	ACS Label	Calculation
Poverty	B29003: Citizen, voting-age population by poverty status	Income in the past 12 months below poverty level / Total
Education	B15003: Educational attainment for the population 25 years and over	No schooling completed through GED or alternative credential / Total
Living Alone	B11001: Household type (including living alone)	Householder living alone / Total

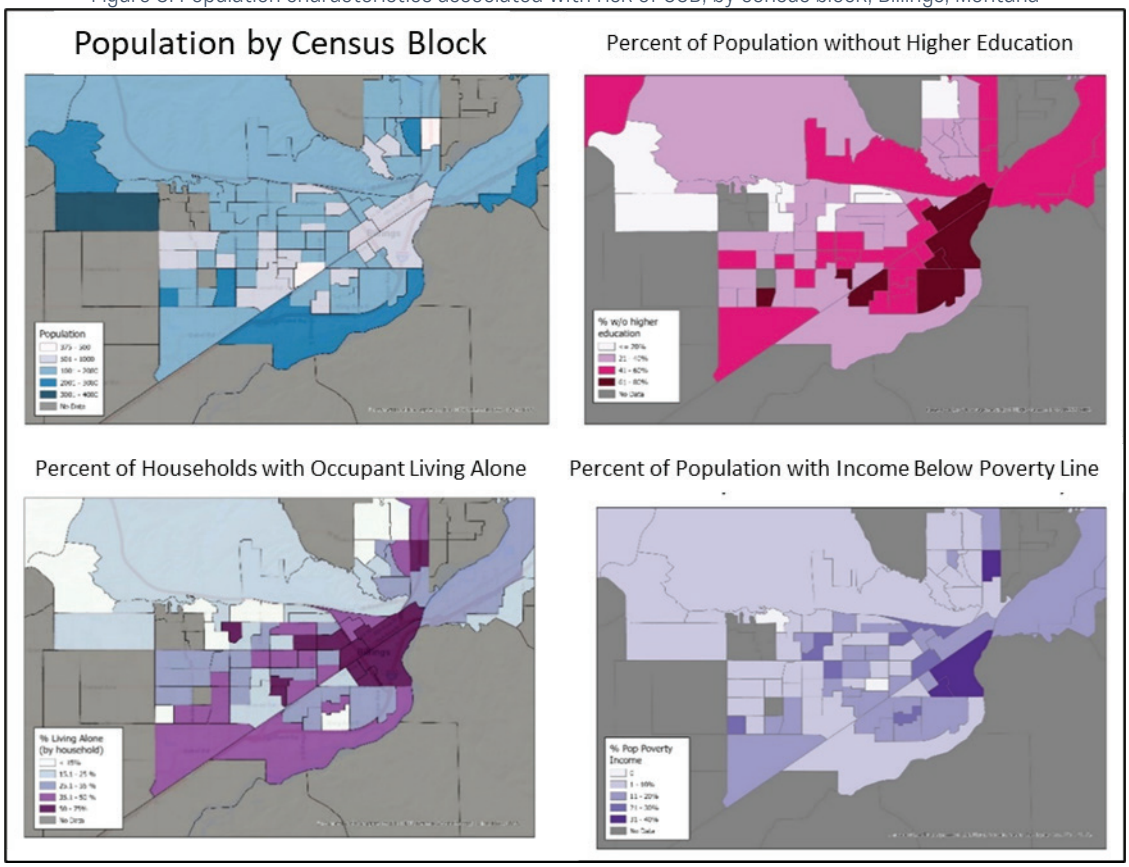
2. Rigg, K. K., Monnat, S. M., & Chavez, M. N. (2018). Opioid-related mortality in rural America: Geographic heterogeneity and intervention strategies. *The International Journal on Drug Policy, 57*, 119-129. https://doi.org/10.1016/j.drugpo.2018.04.011.
3. Monnat S. M. (2018). Factors Associated With County-Level Differences in U.S. Drug-Related Mortality Rates. *American Journal of Preventive Medicine, 54*(5), 611-619. https://doi.org/10.1016/j.amepre.2018.01.040.

BILLINGS

Billings is the largest population center in Yellowstone County, Montana. The following analysis utilized data from ACS on known risk factors for OUD and overdose from opioid use to identify the specific areas of the city that may be key areas of opportunity for a mobile unit.

IDENTIFYING HIGH RISK AREAS:

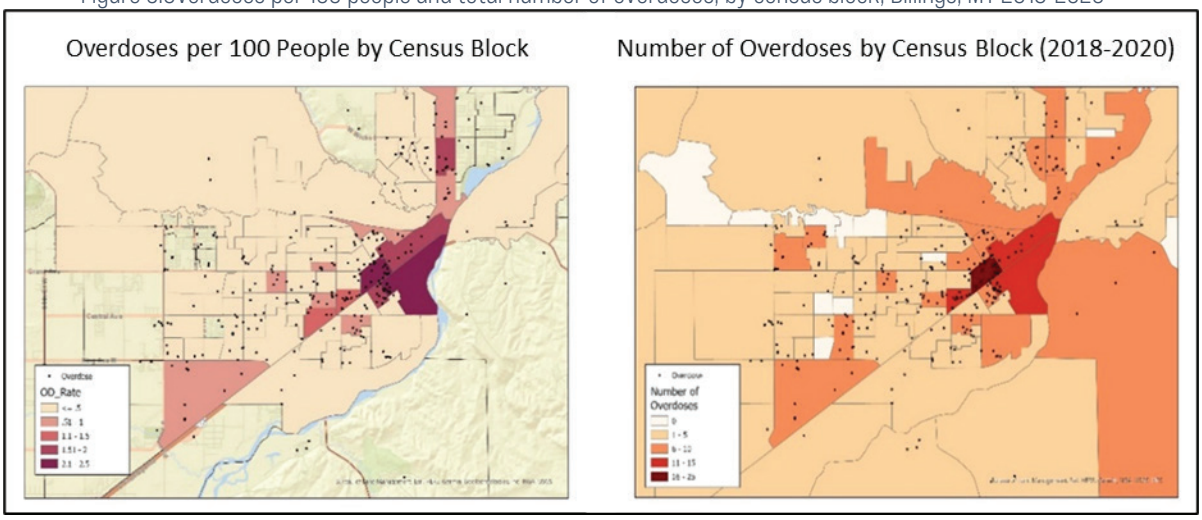
Figure 8. Population characteristics associated with risk of OUD, by census block, Billings, Montana



In Figure 8 above, a few key census blocks stand out, mostly clustered around the eastern side of Billings. Darker colors identify census blocks with greater percentage of each indicator.

Opioid overdoses between 2018 and 2020 were mapped in Figure 9 below by census block, both by total number of overdoses and the rate of overdoses per 100 people. Once again, the same census blocks in eastern Billings stand out, indicating that this is likely the key focus area for mobile OTP services.

Figure 9.Overdoses per 100 people and total number of overdoses, by census block, Billings, MT 2018-2020



DRIVE TIMES

Figure 10 provides an estimate of drive times from the methadone clinic based in Billings at 15-, 30-, and 60-minute ranges. Overlayed on the drive time ranges are suspected overdoses that occurred between 2018 and 2020. This map is also intended to support route planning, with a primary focus on methadone access and a secondary focus on buprenorphine access.

Figure 10. Suspected overdoses and multiple drive times of methadone clinic, Billings, Montana

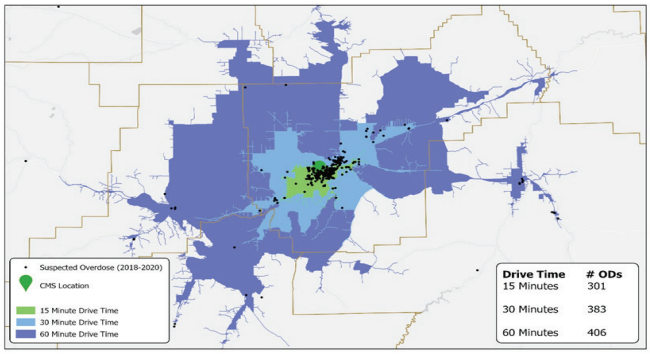
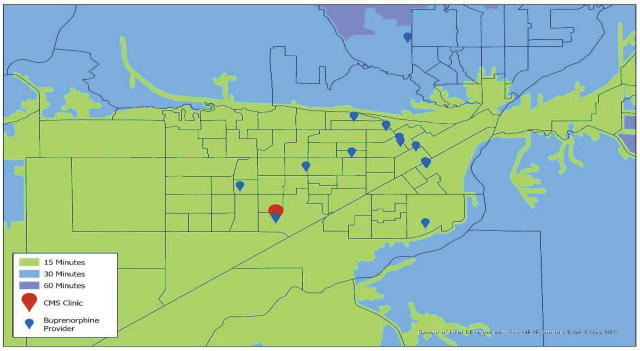


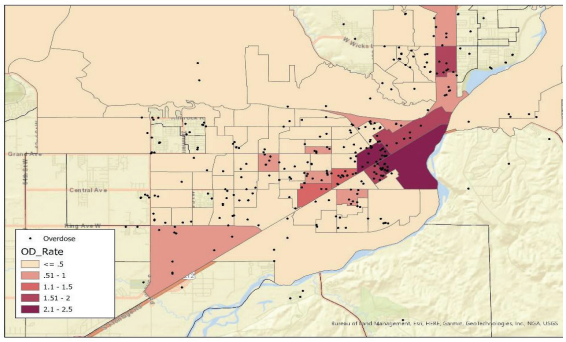
Figure 11. MOUD providers and drive time, Billings, Montana



An examination of drive times to the Billings Methadone Clinic (Figure 10) suggests the majority (301 of 418) suspected overdoses occur within a 15-minute drive from the clinic.

The methadone clinic is on the opposite side of town from the Census blocks that show the highest risk factors. However, there are several MAT waivered providers on the east side of town. Nearly all of the city of Billings is within 15 minutes of the methadone clinic or waivered buprenorphine provider (Figure 11). Aside from the cluster of high-risk census blocks in eastern Billings (red square), two additional census blocks stood out (arrows). Additional considerations for routing and parking for the Billings area are included in the Appendix to further support route planning and site selection.

Figure 12. Overdoses per 100 people by census block, Billings, Montana, 2018-2020

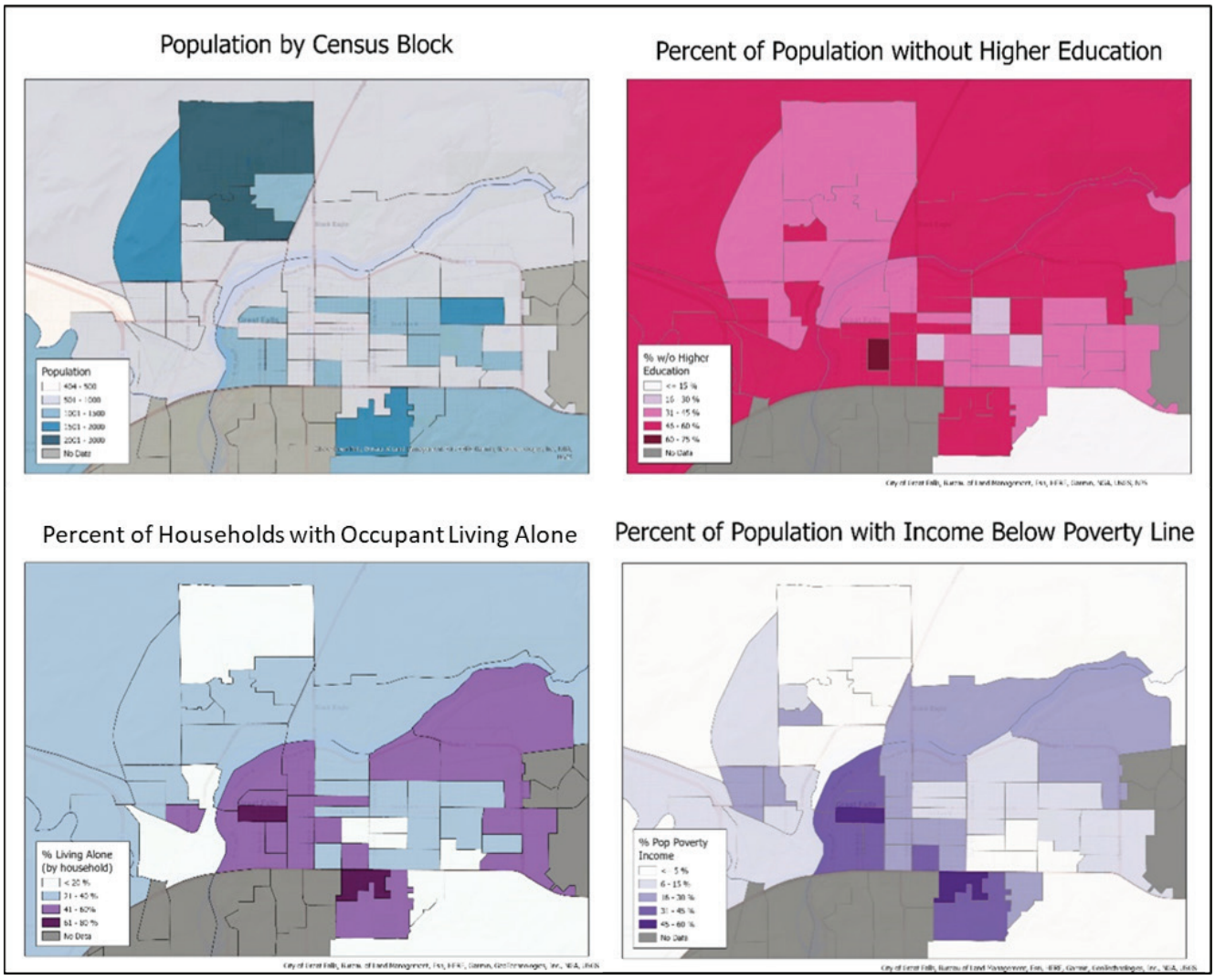


GREAT FALLS

Great Falls is the largest population center in Cascade County, Montana. The following analysis utilized data from ACS on known risk factors for OUD and overdose from opioid use to identify the specific areas of the city that may be key areas of opportunity for a mobile unit.

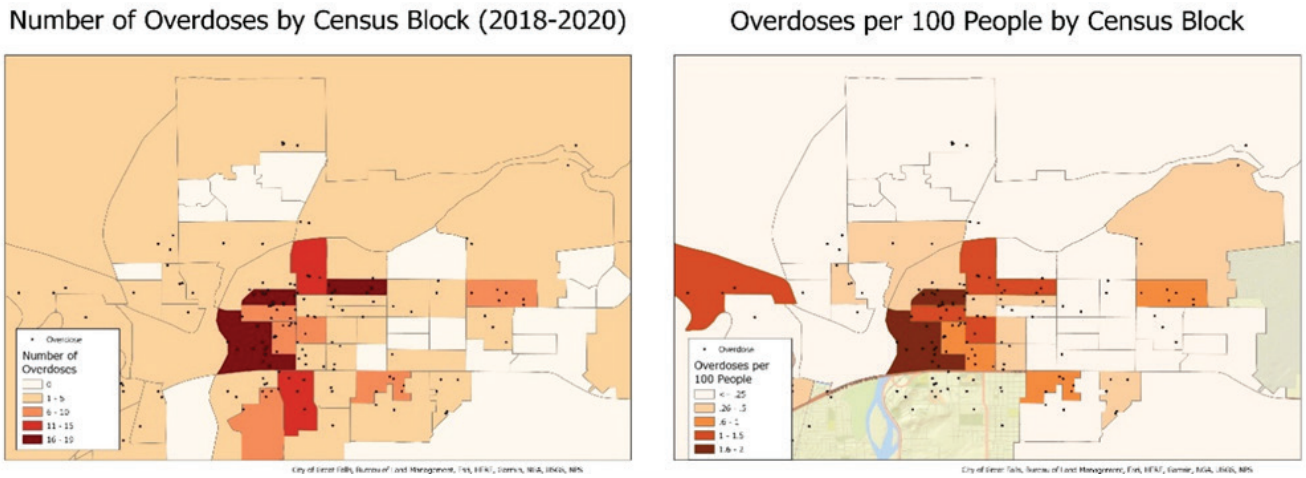
IDENTIFYING HIGH RISK AREAS:

Figure 13. Population risk factors, by census block, Great Falls, Montana



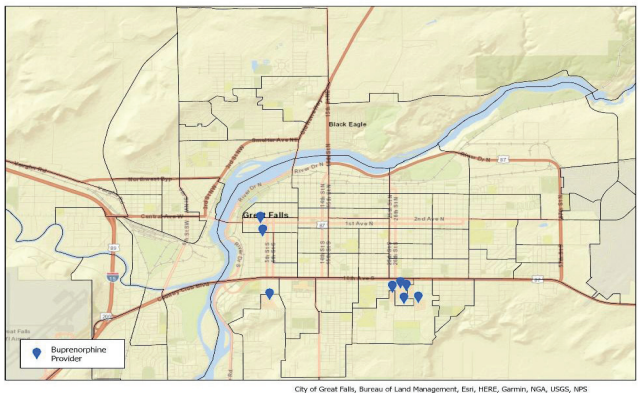
In Figure 13 above, there is not a clear pattern with respect to overlap between potential risk factors, although the western and southern parts of Great Falls appear at slightly elevated risk.

Figure 14. Overdoses per 100 people and total number of overdoses, by census block, in Great Falls, Montana



The overdose data (Figure 14) confirms that western Great Falls is an area of concern, including some census blocks in southwestern Great Falls that did not have census data available.

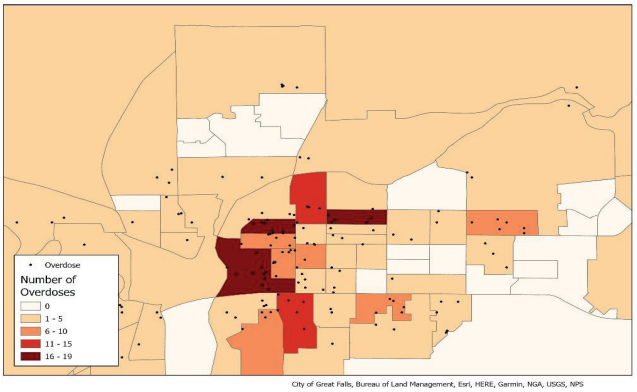
Figure 15. Current MOUD treatment providers in Great Falls, Montana, 2021



Currently, there is not a methadone clinic in Great Falls; however, there are waivered MOUD providers (Figure 15). Providers are clustered mostly in southern Great Falls (in one of the census blocks identified as high risk), and in western Great Falls.

AREAS OF CONCERN

Figure 16. Overdoses per 100 people by census block, Great Falls, Montana, 2018-2020

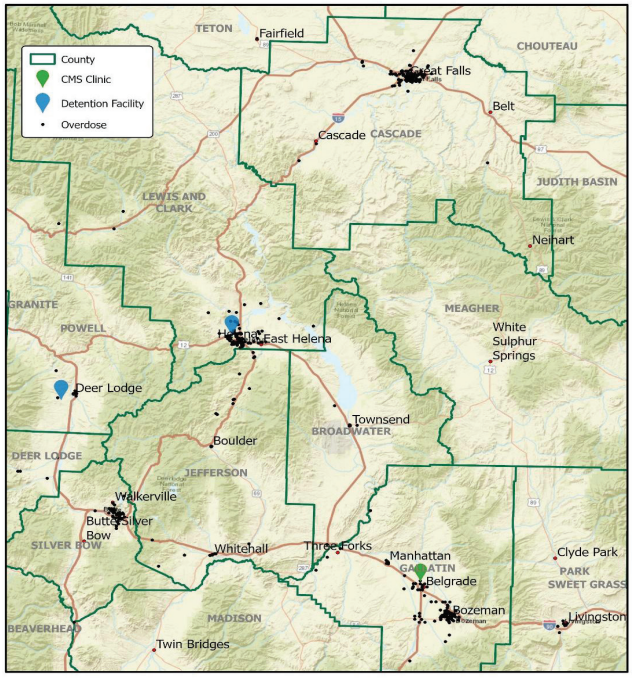


As was identified in the route planning spatial analysis for Billings, there appears to be one area that includes most of the high-risk census blocks in Great Falls (Figure 16, red square), and two additional census blocks that stood out (arrows). Additional considerations for routing and parking for the Great Falls area are included in the Appendix.

BUTTE-HELENA-GREAT FALLS CORRIDOR

In the first part of this analysis, counties with high rates of overdoses that may need additional treatment services were identified. Cities that stood out included Butte, Helena, and Great Falls. While these cities do have waivered MOUD providers, they do not have methadone clinics. Jefferson and Pondera Counties also stood out as counties with high overdose rates that lacked MOUD providers (Table 2). The following series of maps show route options for a mobile clinic providing buprenorphine. Buprenorphine is a more realistic option for providing mobile OTP across broad geographies, as a patient can receive a multi-day prescription, in contrast to methadone which requires daily administration from a clinic.

Figure 17. Suspected overdoses, MOUD treatment capacity, and detention facilities along western Montana corridor



Esri, HERE, Garmin, NGA, USGS, NPS

This broad geographic area could be serviced by a mobile unit following a route that originates in Belgrade (at a clinic) and passes through Butte, Helena, and Great Falls, with additional stops in Whitehall (OD cluster) and Deer Lodge (detention center).

Figure 18. Proposed travel route - Western Montana

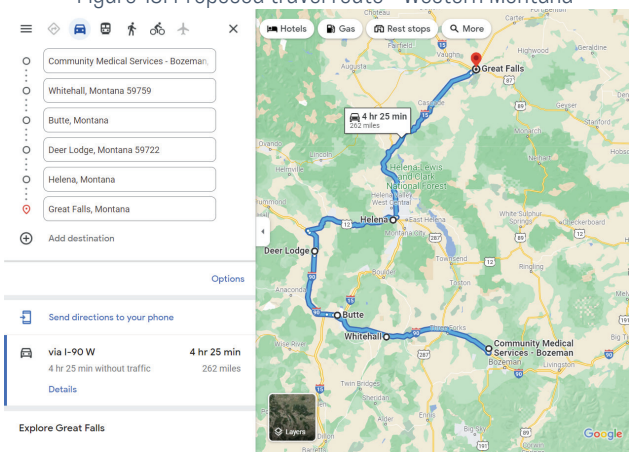


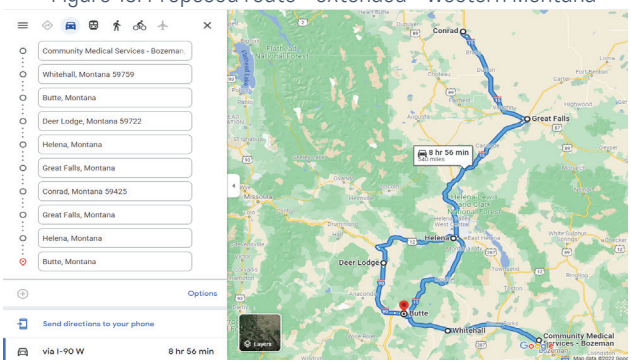
Table 4. Locations, drive times, and mileage between locations along proposed Western Montana route

Location	Driving Time from Previous Location	Miles from Previous Location
Belgrade/Bozeman CMS Clinic	--	--
Whitehall	50 minutes	52 miles
Butte	30 minutes	26 miles
Deer Lodge	35 minutes	37 miles
Helena	1 hour	55 miles
Great Falls	1.5 hours	91 miles

Standard practice for prescribing Suboxone informs the frequency of completing this route, as ideally patients should be seen at reasonable intervals (e.g., at least weekly during the first month of treatment) based upon the individual circumstances of the patient. Therefore, this route would be driven once per week.

If additional coverage is considered in Pondera and Jefferson counties, the route could be extended north to Conrad (in Pondera County), and pass through Boulder (along I-15) when headed back to Belgrade, skipping the detention facility in Deer Lodge.

Figure 19. Proposed route - extended - Western Montana



To make this route, or other similarly longer routes, work within a week-long time frame, some locations may need to be visited for only half a day.

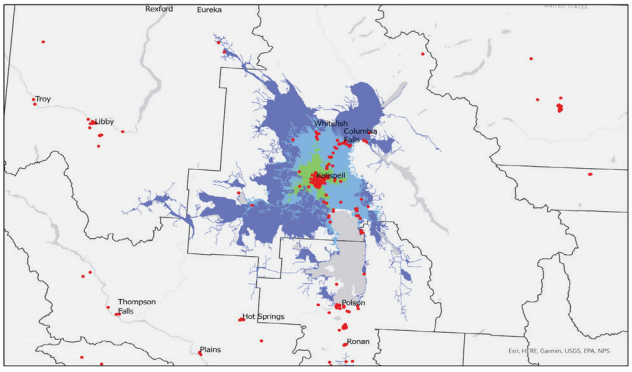
Table 5. Proposed schedule - extended route - Western Montana

Day	Itinerary	Drive Time
1	Bozeman (half day prep) to Whitehall (half day) to Butte (park overnight)	50 minutes
2	Butte (full day) – Deer Lodge (park overnight)	35 minutes
3	Deer Lodge (full day) – Helena (park overnight)	1 hour
4	Helena (full day) – Great Falls (park overnight)	1.5 hours
5	Great Falls (full day) – Conrad (park overnight)	1 hour
6	Conrad (half day) – Bozeman (pak overnight)	3.5 hours
7	Bozeman (day off/resupply)	--

Suspected opioid overdoses tend to be clustered around towns and correlated with population density, many falling inside the 15-minute drive time window of a clinic. However, there are also clusters of overdoses occurring outside of the one-hour drive time range to clinics in areas that may be accessible from the clinic locations using a mobile OTP service.

Using the community of Kalispell as an example, Figure 20 identifies towns across a broader geographic area where there have been historical clusters of overdoses.

Figure 20. Suspected overdose locations and drive time from Kalispell, 2018-2020



Ronan, Polson, and Libby stand out as potential locations where additional OTP services might be useful (Figure 19). Columbia Falls and Whitefish, while within an hour drive time, may also be good candidates for additional services.

Taking into consideration the locations mentioned above, it is possible to map out a few potential routes using Google Maps.

Figure 21. Proposed route - Northwest Montana

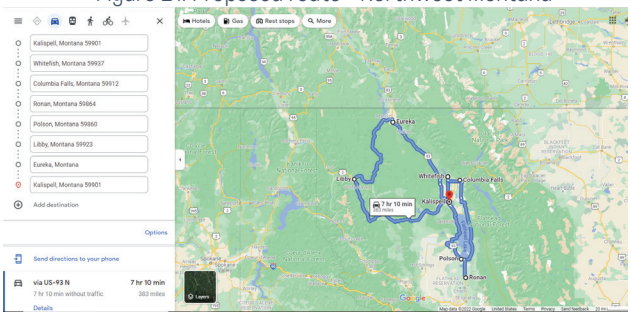


Figure 21 provides one potential route that can serve this region. Additional routes can easily be created that use the suspected overdose cluster communities as way points for a service that is primarily based in Kalispell. One option for this region of the state is a centralized mobile unit that has a series of routes, supporting the broadest geographic range for treatment access.

CONCLUSIONS

The next step in selecting the best possible route for a mobile OTP service is determining a prioritization schema for which populations should be served and determining how long a mobile unit needs to stay in any one location. Once a general route or mobile location is determined, specific parking locations can be explored.

Within any mobile route, it will be vital for the treatment provider to develop strong relationships with potential referral sources. Section 3 covers additional details about this need and strategies that have been implemented in states with existing mobile units.

MONTANA COMMUNITY INTERVIEWS

PURPOSE

As a companion to the spatial analysis described above, JG staff identified individuals in Billings and Great Falls with a connection to Opioid Treatment Program (OTP) services directly (i.e. treatment providers) or indirectly (i.e. law enforcement, social service providers) to assess interest, feasibility, and community concerns related to mobile OTP options.

INTERVIEWEES

A total of 7 individuals participated in interviews for this phase of the study.

- 5 from Great Falls
- 2 from Billings

AWARENESS OF MOUD AND CURRENT RESOURCES

Among those interviewed, varying levels of awareness of treatment options and availability were found. Some had little to no idea what resources were available outside of naloxone or drug court. When asked about familiarity with MOUD, a Great Falls provider responded, "Actually, I'm not sure what it is, to be honest." The same provider did mention that they were sure there were clinics in the community offering pharmaceutical treatments for OUD, but they would not know the details of those treatments. Others were aware of a myriad of service options and were able to name providers utilizing MOUD, locations of peer support services, other recovery options, and list the names of providers to reach out to for further interviews.

When asked about the availability of current resources to treat OUD, the most common response among interviewees was that there were too few services available and most would welcome additional options. One Great Falls provider suggested, "...I would say everyone's of course kind of doing the best they can, but I'd say there's not quite enough availability of resources to address the actual addiction. And certainly, more education would be helpful." There are also some concerns about MOUD, namely providers turning to only providing medication and moving away from therapeutic supports, including peer support and counseling. Apprehension regarding financial motivation influencing prescribing practices was expressed. This sentiment is highlighted by a Great Falls provider:

> Whereas, I think by and large, because it's so simple, there are a lot of providers (who) say, "Why am I going to take the time? It's so much administratively harder. Counselors are kind of a headache. Peers are a headache. And they're a huge liability concern. If what I want to do is maximize revenue, I'm going to do a simple MAT program, and I'm just going to give out drugs because it's simple, building simple. It's all simple."

During the discussion of additional resources to address OUD, a few interviewees bought up harm reduction as a strategy that had been considered in Great Falls previously. The primary harm reduction technique mentioned was a needle exchange, but at the time, this approach lacked support from the community and law enforcement. This lack of support was made clear by a Great Falls law enforcement representative who said, "...I know that, a few years ago, they started discussions about needle exchange programs and things like that. It's just the community, at that point, wasn't willing to go there, nor was our chief at that point. He was opposed to that."

During the interviews there were some responses that categorized MOUD as a harm reduction strategy, and the thought that prescribing someone another drug to use long-term was "just writing someone off with an addiction because they can't get better." There were other suggestions that more lenient drug enforcement or harm reduction principles could lead to issues

Montanans see in larger cities. Part of this vision is exemplified by what businesses and residents are reacting to as the result of a church in downtown Great Falls allowing people to camp out on their property with no requirements for abstaining from substance use. This public sentiment was characterized by this Great Falls provider: "... but we have a church where people are hanging out, and they're not required to stay clean or sober or anything."

MOBILE MOUD LOCATIONS

When discussing locations for a mobile OTP unit, nearly all interviewees mentioned Alluvion as a potential partner. Alluvion is the Federally Qualified Health Center (FQHC) in Great Falls and has experience serving high-acuity clients with substance use disorders. Alluvion would be a strong partner because of its proximity to downtown where the problem of opioid addiction is apparent. Partnerships with FQHCs was a positive strategy discussed in key informant interviews in the following section. A downtown location would also benefit from proximity to other recovery supports like meetings, counseling, and other peer support services. Stigma was not identified as a barrier because patients could visit an FQHC like Alluvion for a myriad of ailments. As stated by one Great Falls provider, "When I walk into Alluvion or City-County Health, I might be going to get a colon test for all you know. Or I might be going to pick up my Suboxone." A mobile unit associated with Alluvion may be easier to pair with additional supports like peer support and counselors as they already have the staff necessary to support mobile MOUD.

Generally, interview participants agreed with the results of our spatial analysis when asked about geographic locations for mobile OTP in their community, although they were able to provide more granular detail. A Great Falls provider suggested, "Your no brainer location is somewhere downtown. That's where not only, I think, you have the largest population of users but also the bus system is best down there." A Billings provider spoke to the presence of residential recovery housing in one of the areas highlighted by the spatial analysis, "Yeah. We've got two residential houses in that location," and confirmed this would be a good location.

The areas identified in the spatial analysis tended to also be areas where members of the community, as reported by interviewees, could "see" the problems associated with addiction. This vision was provided by the presence of homeless encampments or suspected drug use and criminal activity. Both law enforcement and EMS reinforced the appropriateness of the locations based on data they use, in the form of overdose mapping and naloxone use, when discussing potential locations. A Great Falls provider confirmed, "Yeah. Yeah. Well, I mean, if you run a map of where overdoses are occurring, it's all in a 10-block radius." Interviewees suggested that the use of only overdose data to identify potential locations was limiting, and that it was potentially equally important to select sites due to the presence of good partners.

A thought mentioned only once in interviews was the potential flexibility of a mobile OTP unit. During the discussion about locations, most participants focused on notable problem areas, but one Great Falls provider made a salient point, "You said that the Southwest side and the Northeast side, that could change on a dime. You'll have to be very mobile. Very mobile so if it changes, then you can relocate to a different location or back up and regroup." There was also little mention of other mobile OTP locations outside of town with the exception of taking it to far reaching rural areas of Cascade County that are under-resourced. Again, key informants, with the advantage of hindsight, did also mention flexibility in location and services provided as a key consideration.

When asked if partnering a mobile OTP unit with a detention facility would be beneficial, a Great Falls law enforcement representative responded,

> Oh, absolutely. I mean, that would be a great place to be. And I know the sheriff and the undersheriff actually worked for us here till they got elected up there. So the sheriff was one of my detectives that I think is pretty progressive thinking, when it comes to that. And I know that he's looking at trying to provide medical care, in the best way possible, up there at the jail. So I don't know for sure, but I think he would be open to that, because they work pretty closely with Alluvion, who's kind of the big dog in Great Falls, as far as different things.

This type of partnership between mobile OTP and detention facilities was mentioned as a positive strategy that resulted in reduction in recidivism and improved treatment outcomes by key informants in Section 3.

COMMUNITY EDUCATION

Community education including information about OTP, and specifically mobile OTP, was mentioned by several interviewees as an important part of the process for any organization planning to operate a mobile OTP unit. Several methods were suggested regarding different strategies to educate the community, from pairing with faith communities because of their presence in every neighborhood to having EMS, who spend a good amount of time on community education, update providers and residents about the options available for OTP. For example, a Great Falls provider said, "I'll give you an example. I'm a pastor and I meet with a group of pastors every week to pray for our city, and a church would be a good place to do that education training because it's neutral ground, or even a community center in that general vicinity, if we could find it."

Leading the discussion regarding mobile OTP in the community was important to some as this would allow the provider to describe what is planned versus having to explain and assuage rumors. A Billings provider describes the following strategy:,

> So if you're advertising or you're giving some publicity in the Gazette about a mobile MAT unit, and you describe what that is, how is this helping us? How is this actually benefiting the community? You control the message. If we put a branded vehicle out there, then they control the message. They think we're giving opiates out of the vehicle and we're allowing everybody to shoot up right there. Then they make the narrative whatever they want it to be.

Key informants discussed a situation where not branding a van led to issues in the community and reinforced the importance of being open, being honest, and educating the community about mobile OTP.

Distilling the feedback from interviewees about community education revealed key observations including: clearly describe the problem (OUD), explain how mobile OTP addresses the problem, state what mobile OTP is and is not, and describe how mobile OTP pairs with the larger system to address opioid addiction and subsequent problems associated with addiction.

COMMUNITY CONCERNS

Interviewees attributed much of the perceived community concern to a lack of awareness that could be addressed by the educational recommendations discussed in the previous section and by discussing issues circulating around social class and a perception of who suffers from addiction. A Great Falls provider captured community concerns, "... some people don't understand anything at all. Some will say you're giving them a crutch. You're just giving them another addictive medication. Some will think you're actually passing out heroin..." This comment reinforces the importance of education regarding what mobile OTP is and is not. Similarly, another Great Falls provider suggested that concerns may stem from a lack of understanding of the service being provided.

A member of law enforcement mentioned the community perceiving mobile OTP as a step in the direction they did not want their community to go:

> I think as far as your campaign and everything, it'd be, look, we're not turning Great Falls into a issue like you see in Portland or Seattle or wherever, where people are laying on the streets, you know, shooting up their dope and there's nobody to do anything about it. And you got camps on the street and that type of thing. I think that's really what people... And the lawlessness that goes on with that.

They continued with, "I think that's the vision you're going to have to overcome." This further highlights the importance of community education associated with implementing a mobile OTP unit.

Related to the worry of their city turning into something less desirable, several interviewees from Great Falls mentioned the absence of low barrier shelters for those experiencing a behavioral health crisis, however a church in downtown allows folks to camp out with no requirement to be abstaining from the use of substances. This commitment, according to interviewees, has caused issues with surrounding neighborhoods and businesses that do not appreciate this approach, and a local controversy has followed. One Great Falls provider suggested the same result manifesting from a mobile OTP unit, "So, I could see potentially a similar type of issue with a mobile unit. If you're, say, a business trying to attract in a certain type of clientele

and there's a mobile opiate treatment unit parked beside your business." A law enforcement official commenting on the church provided validation of neighbors' concerns, "They're allowing a lot of the transient, so-called transient population, congregate in their churchyard and whatever. And we're experiencing a lot of neighbor issues, a lot of crime, violent crime, and obviously drug use and alcohol use within that."

STIGMA

Stigma regarding OUD was queried when considering community education about mobile OTP and related to treatment-seeking behaviors. Both topics included an element of social class or perceived social class. When prompted about stigma, different opinions were mentioned based on the drug at the root of the addiction, specifically opioids compared to methamphetamine, changes related to society's understanding of addiction as a disease, and concerns with confidentiality related to preserving one's social status.

A Great Falls first responder, discussing education and community outreach, referred to locations like a soup kitchen and how that might be a good venue to educate about OTP or mobile OTP. However, there was no analogous suggestion about places where residents from higher social classes could receive education about OTP. It was not the intent of this individual to single out visitors to soup kitchens as the only class of individuals who become addicts, but they simply identified addiction how it is most often recognized, either at work as a first responder or downtown. To further establish the class element as it relates to stigma, the same individual suggested:

> But certainly at least my perception of the overdoses we go on, we're generally looking at lower income sector that is already in that downtown area. And presuming they in fact had a desire to get some help... It would actually be easier to get there if they don't have any transportation, it's going to be easier to get, to say a spot like Alluvion, than traveling to the Northeast section of town, which is kind of far away, not that there isn't issues in other parts of town and potentially in other socioeconomic stratai (sic). Which, if that were the case, let's say you were talking about someone, say a higher income, upper socioeconomic stratus that had developed an issue with opiates. Let's say they had, had a surgery, were prescribed pain meds, got addicted, and are now no longer have the prescriptions, but are getting them wherever they can. There probably would be a stigma for that person.

Similarly, another interviewee from Great Falls echoed the same divergent thoughts linked to class status or perceived class status. The individual stated,

> You know, I don't really think it matters. It's not like they... There may be some of that. Some people may be afraid of it, but I think overall, I think if they're truly looking to help themselves... I mean, they're so beyond that kind of thing that they're worried about, they may be just ripe to get better. You know what I mean? But not understanding the whole addiction process myself, but just, I don't see that as an issue.

Interviewees expressed the belief that residents who were middle class, or perceived themselves to be middle class, may not want to be seen going to a downtown mobile MOUD unit for treatment. A Great Falls provider explained this further, "But I just think we excuse middle class people for all sorts of things that we don't excuse other people for, right? And so it doesn't matter... And so they excuse that. But not me, I would never be homeless. Not me, I wouldn't be the drunk on the corner."

Finally, social status was mentioned when discussing different types of addictions. This Great Falls provider suggested,

> ...We have a social economic status attached to the two. And so I think the public perception is with opioids. They were originally prescribed. And so there was this legitimate reason, which means you had insurance, were taking care of yourself et al. Some horrible thing, like a car accident happened and you got hooked. For some reason, people are far more tolerant of that kind of addiction than the person with rotten teeth, on the street, snarfing up this cheap methamphetamine that's flooded our markets and addiction's addiction. So this is not my personal view. But I think as a society, we have different status attached to different types of addictions...

SECTION CONCLUSION

Mobile OTP in downtown locations, possibly affiliated with providers working in the community, are preferred. Interviewees supported the results of the spatial analysis regarding mobile unit location and some, stating their own data sources, suggested similar locations.

Generally, everyone interviewed was supportive of mobile OTP, suggesting a desire to have as many options available as possible to meet people where they were in the recovery process. There were some reservations to mobile OTP. These included the involvement of a specific organization in one community, the potential for providers to become motivated monetarily, and treatment patterns changing due to ease of prescribing MOUD when compared to counseling and other personalized treatment modalities.

Perceived community concerns mentioned in the interviews could likely be addressed through education campaigns and support from community leaders and community groups. It may also be important to address stigmatizing attitudes that persist towards drug addiction. One additional note, mobile units may also be important strategies for further distribution of naloxone as an overdose reversal intervention. Although this topic was not heavily discussed by interviewees, it was identified in subsequent conversations among the research team and reflects national best practices.

INTERVIEWS WITH EXPERIENCED MOBILE UNIT PROVIDERS

PURPOSE

The purpose of the key informant interviews with experienced mobile unit providers was to elicit: best practices, lessons learned and practical aspects of planning, and details regarding implementation process and routinely deploying mobile OTP services. This information could then be used to inform the development and implementation processes for state agency staff and provider organizations as they establish mobile units.

INTERVIEWEES

A total of 15 individuals participated in interviews for this study phase:

- 6 providers
- 9 state agency staff from three states

In addition to primary interview data, the research team gathered valuable details about mobile programs from other sources:

- 2 states offered information on planning via email
- 2 briefing papers from the Bureau of Justice Assistance, of the US Department of Justice, Office of Justice Programs were summarized. These briefs included overviews of programs in Maryland, New York City, Connecticut, and Colorado.

PROVIDER FEEDBACK

IMPETUS TO ESTABLISH SERVICES

Providers initiated mobile OTP services when looking for innovative strategies to address increases in overdose deaths, when there was an availability of funding, and when there were changes in state or federal policy. There were several instances in which these services were thought to be "not needed", but a subsequent event highlighted the need for services. In one case, an overdose death in the parking lot of a rural primary care provider spurred the start of mobile OTP. In another case, the warden of a county jail experienced an overdose death in the family. One interviewee suggested:

> You've got to find a champion to get this going. You need a champion.

COMMUNITY ENGAGEMENT

Providers with several years of experience providing mobile MOUD services all emphasized the need for community engagement and education. One provider strongly emphasized the importance of language and stressed that the words we use are very important and should reinforce the idea that mobile OTP is a part of treatment; for example those who are being treated are ***patients*** not ***addicts***. Providers noted they underestimated the level of effort and length of time needed to solidify viable delivery of mobile OTP. One provider emphasized the importance of community education by stating:

> Educate, educate, educate – you can't educate enough.

One strategy used by a rural provider was to survey local Chambers of Commerce to determine their level of interest in supporting the location to park the van and render services. All providers, whether offering methadone or buprenorphine, emphasized the importance of multiple presentations at town halls, health fairs, and other public gatherings to build support for mobile OTP.

Business allies proved to be as important as clinical allies for several providers. For example, some rural providers actively partner with grocery stores for parking. The mobile unit parks in the grocery store parking lot, and patients may use the bathrooms for urine screens as well as enter the store for shelter during cold or inclement weather. More details of other types of partnering or collaboration are covered in a subsequent section.

STIGMA/NIMBY

One interesting phenomenon identified during provider interviews was the stance that community leaders sometimes took in the early stages of the effort to secure support for a mobile OTP unit in that community. Several providers and state informants explained that even when utilization data indicating OUD was prevalent, the leaders replied "...it [mobile OTP] was not needed." Notice the words "not wanted" were not used. It was simply "not needed" in their view:

> One provider's board made an initial decision to not mark the van in a way to identify it with the services out of concern for creating stigma. This was found to be detrimental over time and changes were made to make the van more identifiable.

In another case, a county jail referred inmates to a brick-and-mortar facility miles away from the jail in spite of the physical presence of a mobile OTP unit in the parking lot of the municipal services complex where the jail was located. The reason given by the parole office to the provider was that the jail was concerned that the mobile OTP unit would not be available consistently over time. Whether this was stigma or legitimate concern is hard to ascertain in this case without interviewing jail staff.

One finding on stigma was the perception that mobile unit staff shared regarding how they had experienced bias against mobile OTP from SUD treatment providers. They felt they were viewed as less adequate or not respected. This was self-reported directly by one mobile OTP provider and indirectly referenced by another mobile OTP provider.

PLANNING AND IMPLEMENTATION

ROUTES/HOURS

There are two approaches to routes. One approach is that the van parks in the same spot every day returning to its storage area overnight to offload medications and clean and maintain the vehicle. Another approach is to travel to one or more dispensing parking sites one day a week, returning back to the storage area overnight. Providers noted the importance of hours, stating afternoons and evenings generate more foot traffic than mornings.

Dispensing site locations had as much to do with cooperation of a partner and community support as it did with indicator data such as overdose prevalence in a community. One state reported targeting areas where there were no doctors to prescribe buprenorphine. This same state targeted areas of high criminal activity and overdoses for Narcan distribution through the van.

Recent changes to allow "take home" doses, depending on federal criteria and local protocols, may potentially affect routes or foot traffic patterns. The criteria center on patient housing and financial stability.[4]

4. https://www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines/methadone-guidance

VEHICLE/INTERNET/SITE SELECTION

Providers shared best practices about how to operate a mobile unit, such as needing antifreeze in the bathrooms used by staff and patients on-board, and learning to not weld a generator onto a vehicle unit. One state reported that at the time they established their mobile unit, they had to get special permission from SAMHSA to purchase the van using federal dollars, as it was not at that time an allowable expense within their funding program—even though this represented a major start-up expense and potential barrier to the program. Recent guidance from SAMHSA appears to allow block grant dollars to purchase mobile units. In some locales, attempts were made early on to share buses/vans, but that was problematic from an operational and logistical perspective. One provider noted that units that dispense methadone need an extra heavy-duty frame (for effective bolting of a safe to the vehicle frame to ensure secure methadone storage) that must be specified during purchase, as these units are special order units.

> It was a 37-foot wonderful medical mobile unit. It was owned by the state, and it was through one of the state universities. The first thing, one of the challenges that we had, or lessons learned, is that this is a difficult thing to share. It needs to be very, very well, strategically planned, where a unit is going to go, and then, when the unit is going to go there. You need to build into your budget time, that people will get used to you even being there, so that if you are having billable services, you need to write off the first two months. There needs to be a very strategically done marketing plan, so that the people in the communities need to know that you're coming. That can be different for every community.

Poor internet service challenged many providers, most of whom served rural areas. Some reported having antennae or even piggy-backing on a partner's Wi-Fi which was not always viable. Internet access impacts the ability to complete patient medical charting. One workaround was to write notes in a Word document and then chart on return to the overnight parking area. One rural provider trained their driver in IT support and they also had an IT specialist "on call" for the van.

Partners should influence site selection. Interviewees mentioned referrals and uptake of services by new patients as a concern in site selection, and partners can drive both. Practical concerns such as access to public restrooms and shelter from inclement weather were influential in partner selection.

PATIENT EXPERIENCE

Providers reported creating patient "waiting rooms" through use of the van canopy, chairs, and even a TV with educational videos in the area adjacent to the van. Nearly all providers reported choosing partner parking lots based on the availability of indoor waiting areas with restrooms and/or perceived safety such as church, fire department, or police station parking areas. Interviewees also noted the importance of parking at existing social, human service, or county agencies, or primary care/FQHCs.

Not all providers reported active patient engagement outside of van visits. In one case, a provider tracked patients lost to care measures and developed an outreach protocol that starts the first day after a missed dose:

> ...we did some research into our stats, and we had a fairly high percentage of the new admissions leaving after a five-day AWOL, which is five missed doses. We have in place in our community clinics, as well as the mobile van, that we have an outreach even on the first day of missed doses, and definitely on the second day, so that we can engage the patients. Right now, we have in our [deleted] clinic, which is our largest clinic, some of our peer support specialists making those calls, as opposed to an RN or a clinician that the patients might not be able to quite have that engagement piece.

Of note, interviews with patients receiving services at a mobile OTP were not in the scope of this study. Thus the observations reported here are through the provider lens.

STAFFING

Staffing patterns varied primarily based on the medication dispensed. Multiple roles were commonly assigned due to the limited space available for passengers. Drivers often assisted with safety or site management and also provided peer support. Case management services were not always delivered by staff in the van; these were sometimes offered out of a brick-and-mortar facility, for instance:

> ...if you're talking about buprenorphine and Suboxone, the physical exam could be done via telehealth. If you're talking about methadone, even now the requirement ... at least in New Jersey, and I think it's federal. But definitely in New Jersey, is that the physical exam has to be done face-to-face. So that means you'd have to have either a medical ... a physician or an APN. And it's more cost effective to have an APN. But you'd have to have an APN on that mobile unit to do the physical exam, so you can do the induction. So from a staffing perspective, as they say, it ain't cheap. And a registered nurse, so you'd have to ... I mean you could have an APN who covers both. Because APNs are, do meet the criteria for a registered nurse as well. You could have just one. But you would definitely, and in [deleted], you'd have to have at least an APN to do that physical exam.

Telehealth services are available to access clinicians. One provider observed that the reliance on telehealth for clinical encounters was preferred more so by clinicians than patients; moreover, they perceived that it (telehealth) was to the detriment of the patient. The interviews revealed the importance of nursing in delivering mobile OTP. Physicians, PAs, and ANPs were less commonly assigned due to inability to bill out all hours.

> Initially, a couple days a week, we had a provider actually onsite on the unit. Fortunately, or unfortunately, they were able to do some other tasks while in-between patients, which was initially few and far between. It was not the best utilization of our prescribing staff at that point. We have advanced in our Telehealth use just prior to COVID and during COVID. I think that's a better route in regards to prescribing for suboxone, and we were only doing suboxone at that time, as we didn't have the go-ahead from DEA and CSAT to do the mobile dispensing of methadone. We now have that, so I think that what the plan would be (is) to have some hours of prescriber time on the van, so that we would be able to admit patients directly on that site, and have at that site in the community, as well as to be able to dose.

There are examples of mobile OTP where no medications are dispensed. One state shared that one provider deploys a van with a doctor and a recovery coach. People come to the well-marked ("loud" van) to be assessed and get a prescription. Pharmacies bring the medications to the van. The doctor educates the client about the induction process. Whenever possible, the team engages the client and encourages them to enter treatment, referring out to more traditional settings, as appropriate.

More than one provider noted challenges in staff shortages for both brick-and-mortar and mobile OTP service providers.

WORKFLOW/OTHER SERVICES

As one might expect, the workflow for a mobile OTP begins with the key step of intake, to place the patient in the right clinical setting based on their acuity. Some mobile OTP units had a protocol and staffing in place so that any person could receive services the same day. In this case, staffing had to match this service goal.

There was some variation in how providers addressed missed doses/discharge with need for reassessment and what type of clinician was needed to re-evaluate the patient who missed doses.

Some providers dropped observed urine screens and moved to unobserved urine screens, noting their studies revealed no significant diversion of medications. Data collected by local law enforcement revealed neither an increase in confiscated doses nor methadone related deaths.

Interviewees shared that dispensing only may take as little as 5 minutes. Uptake of new patients may be an important metric, with one provider reporting that 5 new patients per week was considered positive. There was a time when mobile OTP were not allowed to offer additional services. Now that those restrictions are lifted, providers are moving toward caring for the whole person.

> ...we were actually the first certified health home for OTP health homes in the country. We provide all kinds of wraparound services that are defined by CMS as health homes. And then, in addition, we also provide the medical services for the diagnoses that most typically present with our patients. We do STIs, reproductive health, and then we do other work, ops and referrals. And we're about to begin primary care. ...we have a 100% cure rate for Hep C.

Providers reported ties with other types of health providers for referrals and care. When discussing these arrangements, providers described the setup of the vehicle, staffing, and the services offered to highlight the scope of what is possible. One description of the setup resembles what would be expected when visiting a typical clinic:

> "...when they approach the vehicle, they're usually greeted by the peer recovery specialist, who then works with them to do the administrative intake (at) the front section of the vehicle. And once that is completed, then that person is then taken to... there's an exam room, counseling room in the back of the vehicle, and that's where the clinician will do the clinical intake and/or the counseling appointment for them.

When providers spoke about staffing the mobile unit, they described scenarios in which the resources inside matched the clinical capabilities of the staff. For example, "If our nurses are on the vehicle, that part of the vehicle is also outfitted to do anything that they would need... We have all the medical equipment that they would need just like our brick-and-mortar clinic has." Finally, providers shared how the mobile unit was able to partner with primary care clinicians, who were prescribing medication, to give patients therapeutic services, for instance: "The primary care provider manages that for those patients, and then we provide the therapeutic services. So we have a medication assisted treatment team meeting every week in which the primary providers participate with us to consult about shared clients."

REASON FOR DISCHARGE

"Danger to others or self" was cited as the primary reason for patient discharge. Some providers required reassessment after a threshold of missed doses was reached. Several providers reported that patient discharge is a treatment team decision. Several providers voiced the need to not discharge clients, even when considering their use of other substances:

> "It's so dangerous on the street right now, that we really struggle to keep people with us. And if someone is using other substances, cocaine, alcohol, whatever those other substances maybe, we work with them around that. That is not a reason for discharge, that's a reason for holding them closer.

SAFETY

Promotion of positive relationships with patients was fostered by the staff serving the safety role, usually the driver or case manager. Those patients who posed some degree of perceived risk were often served outside of the van. When mobile OTP served jail inmates, the van was parked in the transport area of the jail and jail guards escorted small groups (up to 5inmates) at a time. No provider expressed that a perception of danger kept them from delivering services.

COLLABORATION

JAIL/INMATE SERVICES

Providers with established jail services cited low rates of recidivism, and those cases were not perceived as directly related to maintenance of MAT. As Medicaid benefits tend to be terminated upon incarceration, state or county funding for providing jail services is essential.

One well-established mobile OTP program works in conjunction with the in-jail counseling and case management services. Two nurses sign-off for loading meds on and off the van for chain of custody control to curb potential diversion. This program has led to improved treatment and reduced recidivism:

> "Discharge planning and community re-entry supports from in-prison counselors led to 20% less recidivism in one state program.

The mobile OTP van goes to the jail all 5 days of the standard work week and parks in a secure inmate transport area. The inmates, escorted by guards, present in groups of 5. This has meant that providing care to the total number of inmates may take 3-plus hours, versus the 20 to 30 minutes in a non-forensic mobile OTP setting. "Take home doses" are shared and then dispensed over the weekend by the jail's on-site medical provider. Inmates are provided counseling and case management. Re-entry (or discharge) Planning often includes a recovery coach picking up the patient upon release and driving them to new MAT provider and transition housing, for instance:

> Our outcomes are great, 90% of the folks who leave the jail get linked to a community-based OTP program. We've actually expanded the program now where we're providing case management. Because we were only doing the counseling, now we're providing case management and peer recovery support services in the jail. They're actually following the person out of the jail. So they're continuing to provide those services after the person leaves the jail, and we've had great success with that.

One state described a scenario in which the mobile OTP model (with a van bringing meds to the jail seven days a week) might evolve into their goal of a full-fledged certified OTP established within the jail.

RECOVERY RESIDENCES AND RESIDENTIAL TREATMENT

Recovery Residences provide an important phase for many in recovery, and these facilities do not have clinical staff (or those with requisite scope of practice), positioning them as an important potential partner for mobile OTP services. One rural provider has prioritized services, especially for women, who live in recovery residences and residential facilities for those with co-occurring disorders. Critical opportunities to address co-occurring disorders and physical health concerns are present in these settings:

> ...we would like to expand what we're doing at the jail, to other treatment facilities that don't have the capacity to provide MAT, whether it's a residential program or an outpatient program. In [deleted], we have a lot of licensed halfway houses. And so they're not recovery houses, they're halfway houses. They're licensed under the same regulations that detox short-term, long-term residences are licensed. But they're not, they don't require medical staff. Most of them are not equipped to provide MAT, so we were looking at some of the halfway houses.

PARTNERING, COLLABORATION, AND OTHER CLINICAL AND SERVICE DELIVERY SYSTEM IMPLICATIONS

In some states, vans were operated by SUD treatment providers and some were operated by health providers such as FQHCs. Integrated health services such as prevention, screening, STI, Hep C, HIV/AIDs services, case management, and check-ups were offered by some providers, while other providers were in the process of planning to add these physical health services. Some providers had a second provider co-located with them on the van to offer services. For example, in one area, the local health department assigned a phlebotomist to the mobile OTP. A state reported they partnered with syringe service programs (SSPs) for treatment of shared clients. Other service providers, such as MAT-waivered clinicians in primary care settings, were highlighted as being important sources for referrals.

Pharmacies collaborated with mobile OTP in several ways, from delivering medication to the van's parking site to accepting ID cards created for homeless individuals through a partner social service agency. As one interviewee mentioned:

> Community partnerships. I think it's absolutely critical to have your community partners at the table with you ongoingly, open communication, reaching out. We have formal memorandums of understanding and agreement with our community partner, host sites, hearing them, what they need from us. We are expanding our community partner base for the mobile unit in the spring.

Another provider highlighted the need to allow time to develop relationships with community partners:

> I think the things that are most important are: know who your partners are and ensure that there is some kind of co-located service where you get to build from the trust that those individuals have in the community. Do not rush it, because what we found in our last iteration is we rushed it and we experienced some pain because of that. We learned from it, obviously, but I think that, had we slowed the process down and really focused on developing those relationships and establishing a contact other than just the Medicaid part of the contact, we would've been more successful in the implementation.

REIMBURSEMENT

In states with Medicaid behavioral health carve-outs, bundled rates were established for dosing only and for dosing with counseling. Several providers cited that the overhead costs for mobile OTP patients, especially those of greater acuity who require a different level/volume of services (e.g., intensive case management) were not adequately covered in their current rates.

DATA AND EVALUATION

This appears to be an area for potential focus and growth. Lead time to build-up patient volume, outdated EHRs, and even the cessation of evaluation due to the pandemic have hampered data collection efforts. There exists an opportunity to collaborate on common measures, methodology, and data specifications.

STATE/PAYER FEEDBACK

The primary lines of inquiry identified in the state and payer interviews included policy, regulations, technical assistance, and reimbursement.

POLICY, REGULATIONS, TA, REIMBURSEMENT

There were four main areas of concern expressed by state staff or providers during the interviews.

From an **accounting and grant fund expenditure perspective**, the long lead-time (potentially across multiple fiscal years) for ordering a van suited for mobile OTP, especially for delivery of methadone, can be challenging. The mobile OTP vans tend to be owned by the State. As result, an interviewee suggested:

> Even if not immediately planning to offer methadone, if buying a van, spec it so you can make that choice later in the future.

From a **reimbursement perspective** and consistent with Patient Centered Medical Home (PCMH) models, bundled rates for dosing, counseling, and **mobile modality/case management** are requested by providers. With respect to Medicaid budgets, states can and usually do cease Medicaid coverage for treatment services when a person is incarcerated. Some states are re-evaluating this because treatment decreases recidivism rates. There are also implications for providers that treat indigent persons, those who do not have Medicaid:

> ...we have about 80 folks in our medication assisted treatment program, weekly, and the majority of those individuals get their prescriptions done weekly. They're only given a week supply. And our federal funding is supporting many of them because most of those are indigent, but our case managers work to get them on Medicaid.... And I say that because one of the things that I've heard our prescriber talk about before she goes to more than a week's worth of dosing, she wants to make sure that they have reliable insurance, and whether it be Medicaid or other provisions, so that folks... We had someone transfer to our facility this past week, just to give you an example, they came to us with a $900 lab bill for urine screens and they were indigent. So those are things that we try and get ahead of, and make sure that we are not asking of a fragile population thing, adding other barriers, layers of barriers to them.

From a **licensing perspective,** mobile OTP units are governed by the rules applying to the "home" brick-and-mortar agency, even including "fire drills". There may exist opportunities to refine regulations at some future point. In some cases, state regulator staff and philosophy are entrenched in law enforcement or legal models, so education was needed during the process of setting up mobile OTP services. Delivery of services across state lines appears to be problematic and a potential area for larger policy discussions in cases where states with large rural areas bordering states with similarly situated rural areas may benefit from collaboration.

From a **system capacity/emergency preparedness perspective**, mobile OTP investments can give states and communities flexibility to serve at-risk populations. The onset of COVID and the sudden closing of brick-and -mortar clinics caused the mobile OTP units to assume new and valuable roles. In one case, a brick-and-mortar clinic closed with little notice, and the mobile unit was deployed to offer critical services until a new provider could be licensed to assume operations at the fixed site clinic, a process that took almost six months. In another scenario, the mobile OTP unit was repurposed during COVID to park outside of brick-and-mortar clinics and offer services to COVID-positive or symptomatic clients to mitigate the risk of exposure in the clinic. One program offered COVID vaccine shots and boosters via their mobile OTP. Providers and states also noted the role that mobile OTP staff had in distributing Narcan and training community members on its use. Mobile OTP units can benefit those at risk through mental health counseling, prevention services, a team approach to primary care (PCMH), referrals to specialty care, and care coordination. These additional services also potentially create additional revenue streams for providers.

SECTION CONCLUSION

The considerations identified in interviews with mobile unit staff, state agency staff, and payers for services are intended to highlight the barriers and solutions that other states and locations experienced. During the data analysis process, the research team concentrated on the identification of practical considerations that can aid decision-making and program implementation in Montana.

RECOMMENDATIONS

One important outcome of undertaking this research was establishing lines of communication with experienced clinicians and administrators. Firsthand experience is powerful, and the researchers and the State again thank all who graciously invested time and shared their perspectives.

ORGANIZATIONAL LEARNING

Outlining initial approaches to mobile OTP should be undertaken with the understanding that the OTP approach will evolve based on partner collaboration, uptake of services, staff availability, funding and regulatory changes, and development of best practices in treatment. This effort is best suited for providers who are quickly able to adapt and change strategic direction. One provider noted ideal staff have diverse skill sets and the ability to generate insights and service changes based on experiences during implementation. This suggests that interviews should be designed to elicit these attributes. Similarly, the provider organization will need to be responsive to staff feedback.

The work environment will resemble a two-week software coding sprint rather than a large, rigid bureaucratic system. Communicating across systems and stakeholders with different philosophies (law enforcement, treatment, funders, lay folk, clients) requires patience, skill, and time. Time is needed to plan, engage, educate, resolve conflicts, and demonstrate responsiveness and concern.

TIME

As the approach is modeled, it is important to allow time for a slower service uptake rate. Several months or even a year or more will be needed to establish foot traffic. It would be wise to establish a cushion of start-up time/bearable revenue losses, so that partnering and collaboration efforts can authentically evolve and not be pressured.

INITIAL PROJECTIONS FOR SERVICE DEMAND

The mapping included in this report is a preliminary account of projected service demand. Two different approaches were outlined, each with advantages and disadvantages. One potential option is to locate a mobile OTP unit in a population center (Billings or Great Falls) in need of additional resources to treat OUD. The other option is to identify a route that could be visited regularly (weekly) along corridors of established need.

MODALITY AND STAFFING

At the outset, it may be useful to establish several model options, as costs and flexibility vary across different configurations. If the decision to offer methadone (or other specific medication) is firmly established, that will affect the cost/benefit analysis. It may be helpful to consider more than one model depending on key factors.

PARTNERING AND COLLABORATION

The effort to identify partners has three key phases: establishing communication, building relationships, and aligning organizations. Not all possible partners become involved. Essential initial outreach should be planned with safety-net of providers of both health and human services, such as FQHCs and food pantries, health coalitions, jail wardens, drug courts, halfway houses/residential settings without clinicians, and payers (Medicaid, philanthropies that cover indigent costs). If there is an organization representing MAT-waivered clinicians, that would also be a stakeholder. Absent that, perhaps the state primary care association and AMA would be helpful in both communication with clinicians and communities and garnering feedback on "community readiness" to services. Use this process to find a champion, if you do not yet have one. Confounding or supporting forces may emerge as a deeper dive into "community readiness" is taken.

COMMUNITY READINESS

The traditions of nursing are very strong, including "start where the patient is", and this is true of the effort to establish mobile OTP in Montana. In the process of building partnerships, one should be able to learn where support and opposition exists and, more importantly, where there are opportunities to educate. The need to educate permeated all interviews, both among providers with experience providing mobile OTP and those interviewed in Montana. Hearkening to Prochaska's Stages of Change Model, community readiness is not unlike individual readiness for change. Providers in these interviews shared some examples of pivotal moments where they observed a change in the view of mobile MAT/MAT within a community, based on either family experience or the influence of a peer. Providers widely expressed the need for a champion.

SERVICE DELIVERY/FINANCING OF MOBILE OTP

The decision to integrate health and case management are both clinical and financial. Keeping patients engaged and using opportunities to prevent, educate, and intervene is a critical policy decision for both the State and providers. Providing additional billable revenue is possible with expanded services. A pilot to consider/reconsider bundled service rates with Medicaid could be considered. Medicaid PCMH demonstration projects across the country offer many lessons and economic analyses that could inform this discussion. The funding of services for delivery in detention facilities may need to be provided from grant funding or philanthropy if Medicaid does not provide coverage during times of incarceration in a given state. Regardless of funding source, initial outcome data indicates continuity of services following incarceration benefits one's social and economic wellbeing.

SYSTEM LEARNING

An informal community of practice may be useful to stimulate and sustain through the planning and implementation stages. Providers in other states have expressed an interest in hearing how others are approaching the work and appear willing to engage with and contribute to the field's growth.

APPENDICES

APPENDIX A: METHODS: SPATIAL ANALYSIS

MOBILE METHADONE CLINIC PRIORITIZATION: MAPPING METHODOLOGY

The spatial analysis for this project was approached in two stages: 1) identify priority counties with high levels of need and/or fewer resources; and 2) identify potential routes for a mobile methadone clinic at the local scale.

PART 1. IDENTIFY PRIORITY COUNTIES FOR ADDITIONAL SERVICES

At the county level, factors related to potential need were examined, including opioid prescription rates from 2016-2020, overdose data, and incarceration locations. The sources for these datasets are listed in the table below.

Table 6. Data sources for spatial analysis.

Title	Source	Methods
Opioid Prescription Rates 2016-2020	CDC (https://www.cdc.gov/drugoverdose/rxrate-maps/county2020.html and similar pages)	Data was scraped from the table on the CDC website using R, and then cleaned up (RX_rates_processing.R). Average Rx rate was calculated for 2010-2015, 2016-2020, and 2010-2020.
Overdoses 2018-2020	MT DPHHS	A data request was submitted to MT DPHHS (EMSTS Data Request Form) on 11/16/2021, and was filled by Hannah Yang (Hannah.Yang@mt.gov) on 01/11/2022 (JG_Research_dataset_011122).
Incarceration Locations	MT DOC (https://dataportal.mt.gov/t/COR/views/	Data was downloaded from the Daily Population Report Dashboard.

Maps were created to present all three datasets. Overdose rates were also normalized by population at the county level to show overdose rate per 1000 people.

Quantile normalization was used to classify prescription rate (2016-2020) and overdose rate in 5 quantiles and to classify each county on a scale of 1 to 5, with 1 being low prescription rate or low overdose rate, and 5 being high. Counties that fell into category 4 or 5 in both factors, were identified as high-need counties.

Data from existing treatment clinics were then used to identify where need is already being met. These data included the locations of CMS clinics, Ideal Options clinics, and other waivered buprenorphine providers. Number of clinics were counted in each county and again rated using quantile classification, where 1 is a higher number of clinics (more available access), and 5 is zero or minimal clinics. For counties that stood out in terms of high need (4 or 5 for prescription rate or overdose rate), the level of clinic access need was then examined. Counties that had both high need in terms of risk factors and low clinic access were noted as potential locations for additional services.

PART 2. IDENTIFYING POTENTIAL ROUTES TO MEET IDENTIFIED NEED

Given that CMS clinics may serve as a home base for a mobile methadone clinic, the areas surrounding the four existing CMS clinics in Bozeman/Belgrade, Billings, Kalispell, and Missoula, were examined for factors such as phone coverage and drive times.

Table 7. Data sources and methods for route identification.

Title	Source	Methods
Phone Coverage	https://fcc.maps.arcgis.com/apps/webappviewer/index.	Wireless Data coverage for Verizon, T Mobile, and ATT was merged into a single coverage layer
Drive Times	--	Drive time polygons were generated using the ArcGIS Online Drive Times Service with time intervals of 15, 30, and 60 minutes

APPENDIX B: METHODS: INTERVIEWS

METHODS: MONTANA COMMUNITY INTERVIEWS

The researchers relied on networking and internet searches to identify community members to interview. A draft interview guide was prepared, and recorded telephone or video calls started in April 2022. The recordings were transcribed verbatim and coded. The interviewer also took notes and made observations during the interviews. The research team developed the coding scheme based on lines of inquiry from interview questions. Through application of the broad coding scheme, themes were identified and are presented as results of the analysis. Qualitative analysis was completed using NVivo Qualitative Software (QSR International Pty Ltd., 2022).

The interview guide assessed awareness and need for mobile OTP in the community, locations, perceived concern of the community or interviewees, and stigma associated with mobile OTP. Results of the interviews are arranged around the following themes: awareness of OTP and current resources, desirable locations for mobile OTP, community education, community concerns, and stigma associated with OUD.

METHODS: INTERVIEWS WITH EXPERIENCED PROVIDERS

The researchers relied on networking, a review of scientific literature, internet searches, and snowball sampling techniques to identify state-level SOR and program leaders, payers, and providers who are engaged in supporting the delivery of mobile OTP/NTP services. All perspectives were useful, and state contacts were helpful in linking researchers to providers.

A draft interview guide was prepared, and video calls commenced in November. In some cases, state level administrators and providers were interviewed jointly. Provider interviews tended to include both an administrative or community liaison and a clinician (usually a nurse), to offer a fuller picture of their experience. The interviews were recorded and transcribed verbatim. The interviewer also took notes and made observations during the interviews.

The research team considered the possibility of "interview fatigue" as there are relatively few providers delivering mobile OTP services and several studies on MOUD. Care was taken to streamline questions and scheduled convenient online video calls. For this reason, the interview was set to be 30 minutes in length at the outset of this work. For the second round of calls, the appointment length was set at 45 minutes, as 30 minutes was not sufficient to cover the fullness of participant responses. In several cases, the interview lasted 45 to 60 minutes, which speaks to the willingness of providers to share their perspective and experience with others. Many also expressed interest in learning how other providers handle aspects of operation.

Appendix C: Additional Mobile Clinic and Routing Considerations

The following section contains additional information that organizations may want to consider prior to implementing mobile OTP services.

ROUTING: BILLINGS

In determining a route for a mobile methadone clinic, it's important to consider parking options. A survey of personnel involved in mobile methadone clinic efforts around the country mentioned the following locations for parking:

- Safeway (or other grocery stores)
- Fire and police stations
- Churches
- Jail
- Formal clinic
- Community mental health center
- Community center
- County park
- Low-income housing
- Pharmacy

The city of Billings has an online web map hosted through ArcGIS Online that shows some of these features here: https://billings.maps.arcgis.com/apps/webappviewer/index.html?id=fda8d0c2bb094e27b942987295f358ec

Figure 23. Hospitals and fire stations in East Billings, Montana.

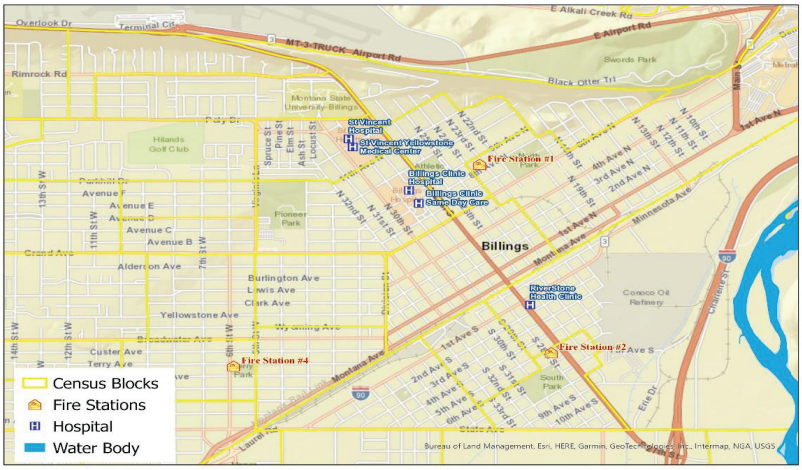


Figure 24. Grocery stores and pharmacies in east Billings, Montana.

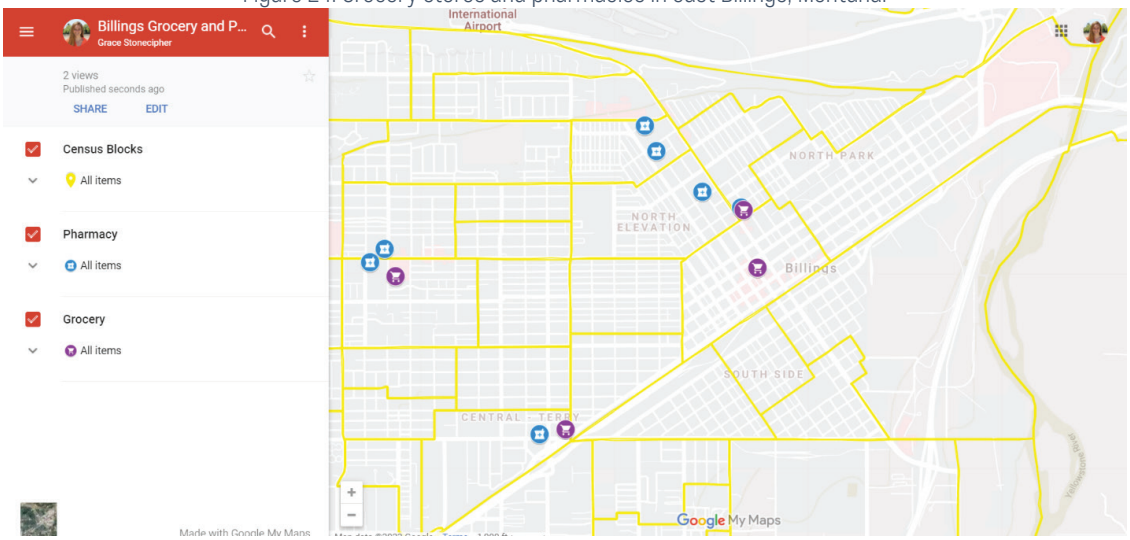


Figure 25. Grocery stores and pharmacies in all of Billings, Montana.

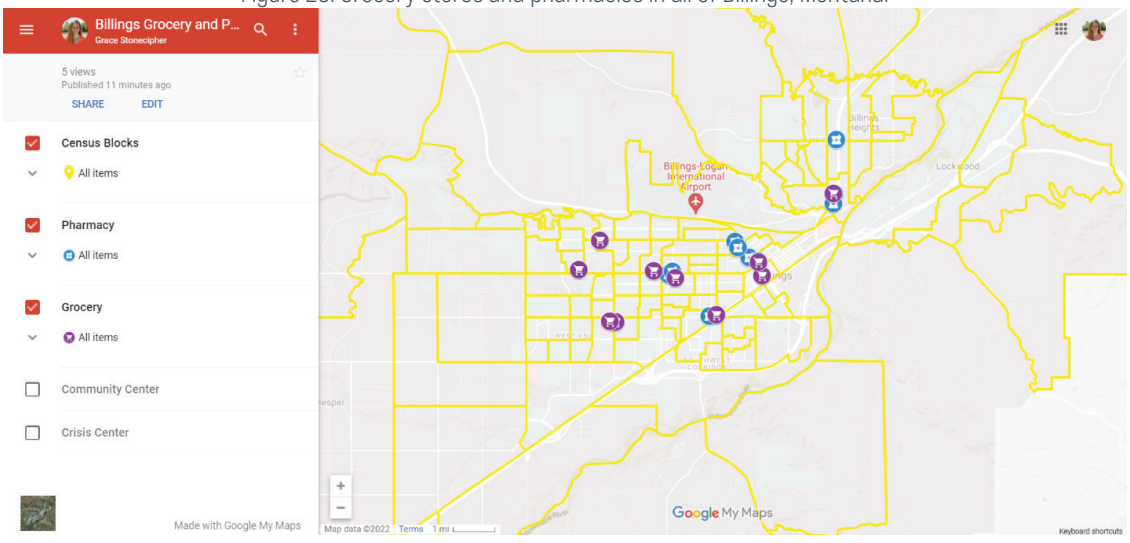


Figure 26. Community centers and crisis centers in east Billings, Montana.

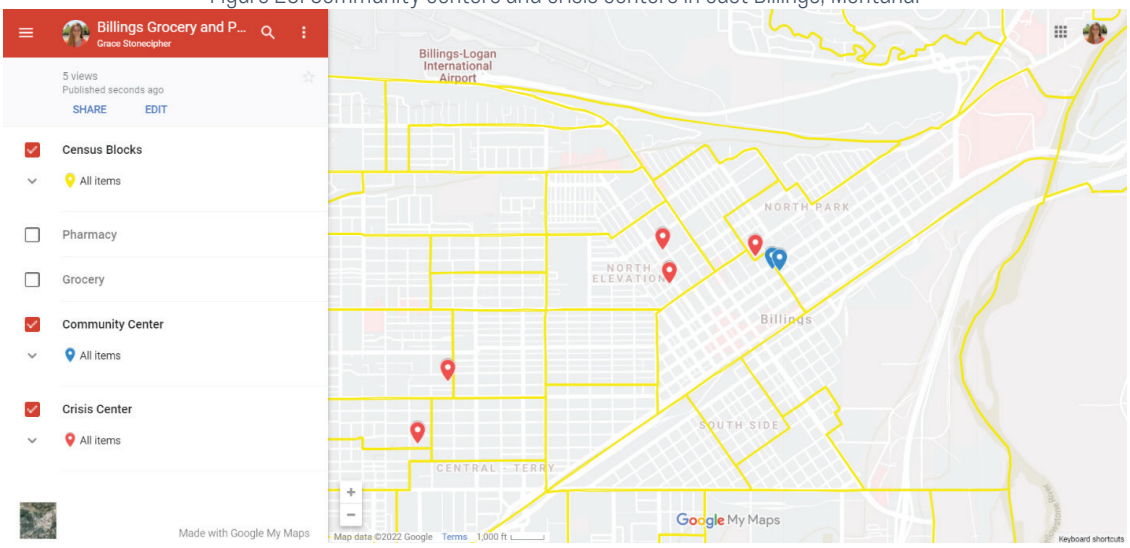


Figure 27. Community centers and crisis centers in all of Billings, Montana.

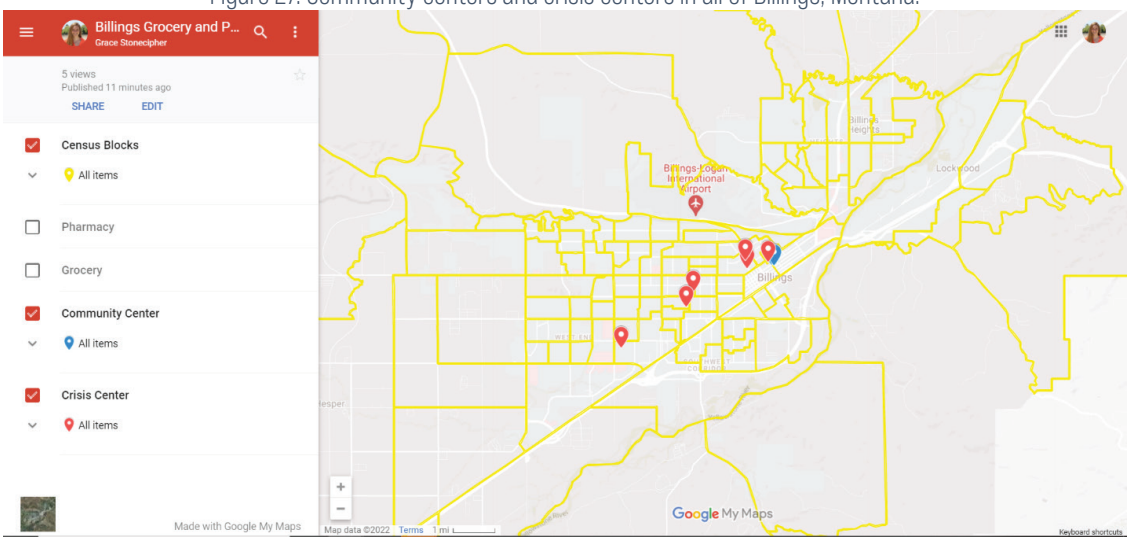
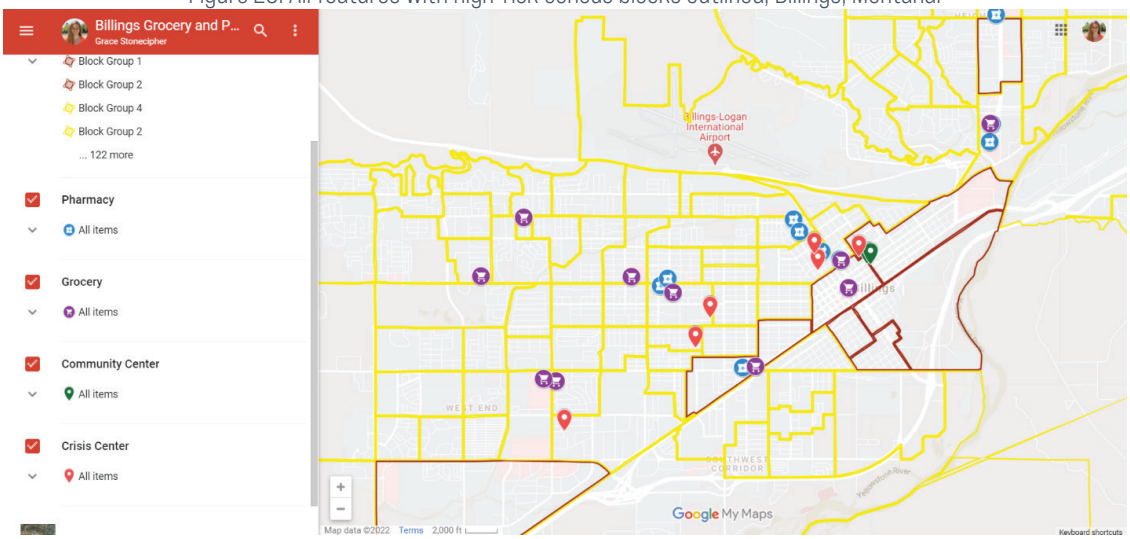
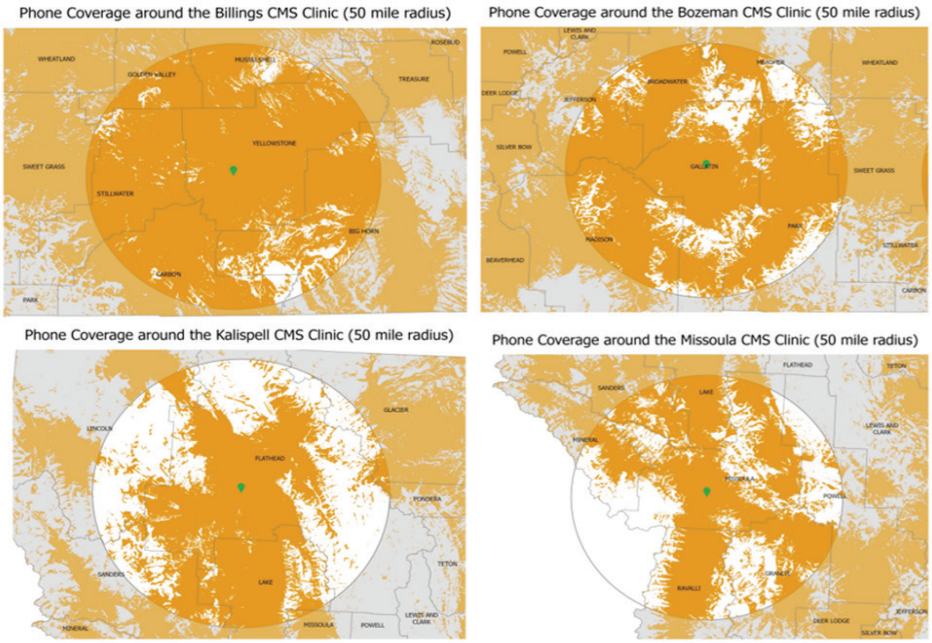


Figure 28. All features with high-risk census blocks outlined, Billings, Montana.



Phone data service (access to the internet through a mobile device) may be an important factor in terms of connecting those who need it to a mobile OTP service.

Figure 29. Phone coverage in a 50-mile radius around CMS Clinic, Billings, Montana.



INITIAL THOUGHTS:

Significant existing infrastructure (groceries, pharmacies, hospitals, community centers, etc.) is located northwest of the highest risk zones in eastern Billings. Fire Station #2 (shown above) could be an interesting option for hitting some of the neighborhoods further south. Additional options for parking may need to be explored, if there is desire to go to the census blocks in the southwest and northeast corners of town.

ROUTING: GREAT FALLS

As with Billings, in determining a route for a mobile methadone clinic, it's important to consider parking options. A survey of personnel involved in mobile methadone clinic efforts around the country mentioned the following locations for parking:

- Safeway (or other grocery stores)
- Fire and police stations
- Churches
- Jail
- Formal clinic
- Community mental health center
- Community center
- County park
- Low-income housing
- Pharmacy

Figure 30. Hospitals and fire stations in Great Falls, Montana.

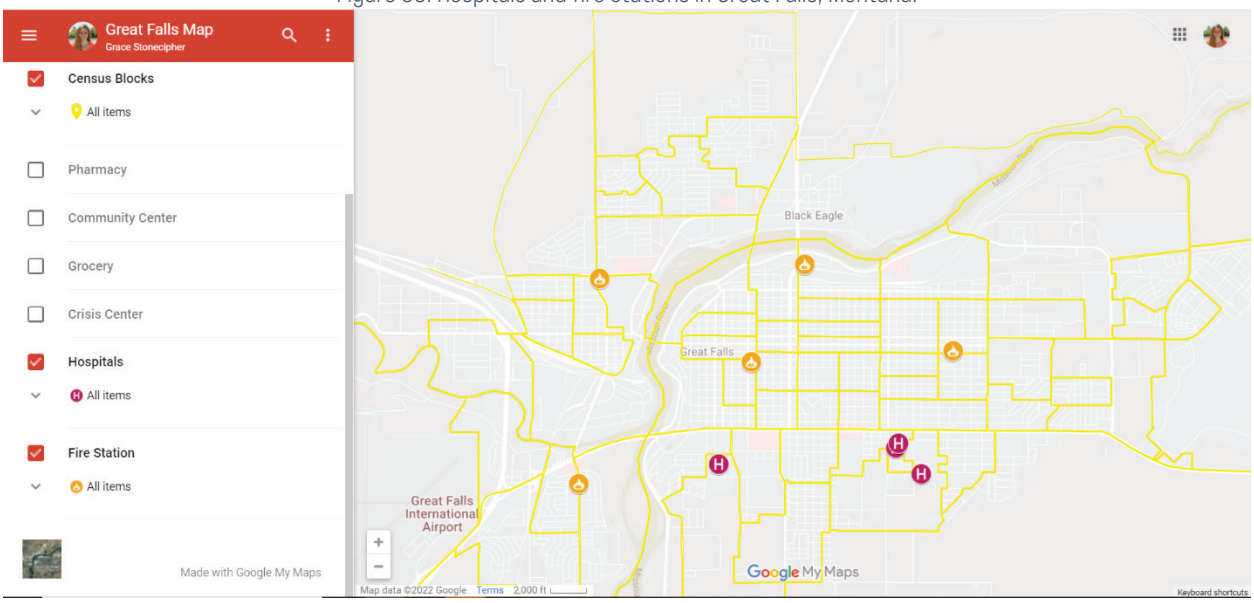


Figure 31. Grocery stores and pharmacies in Great Falls, Montana.

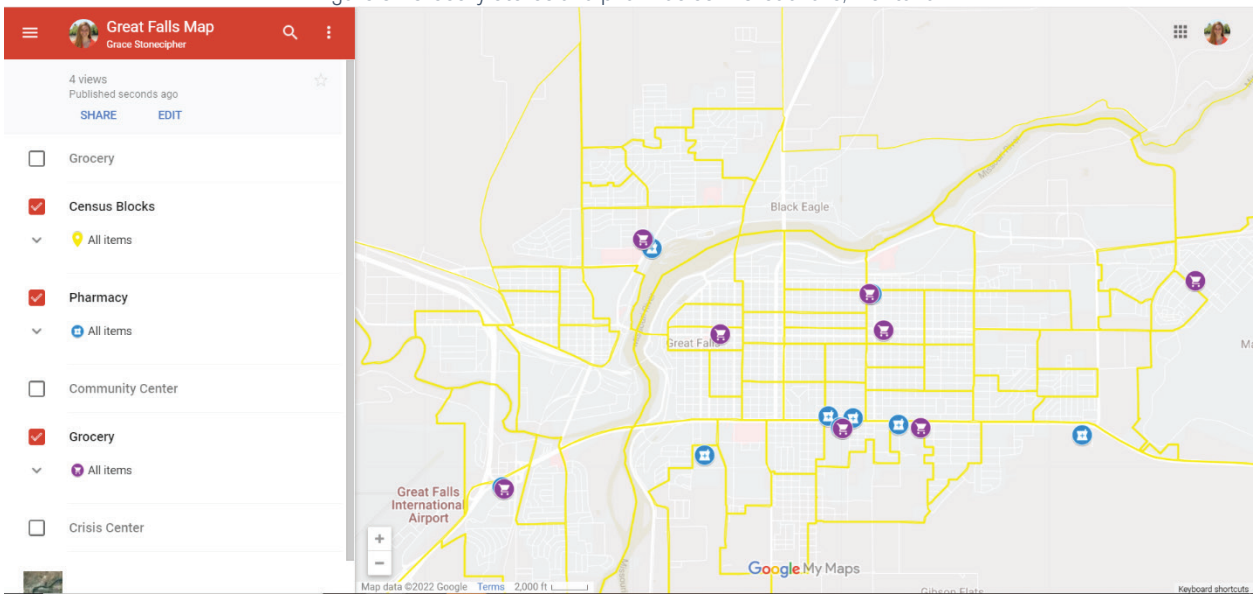


Figure 32. Community centers and crisis centers in Great Falls, Montana.

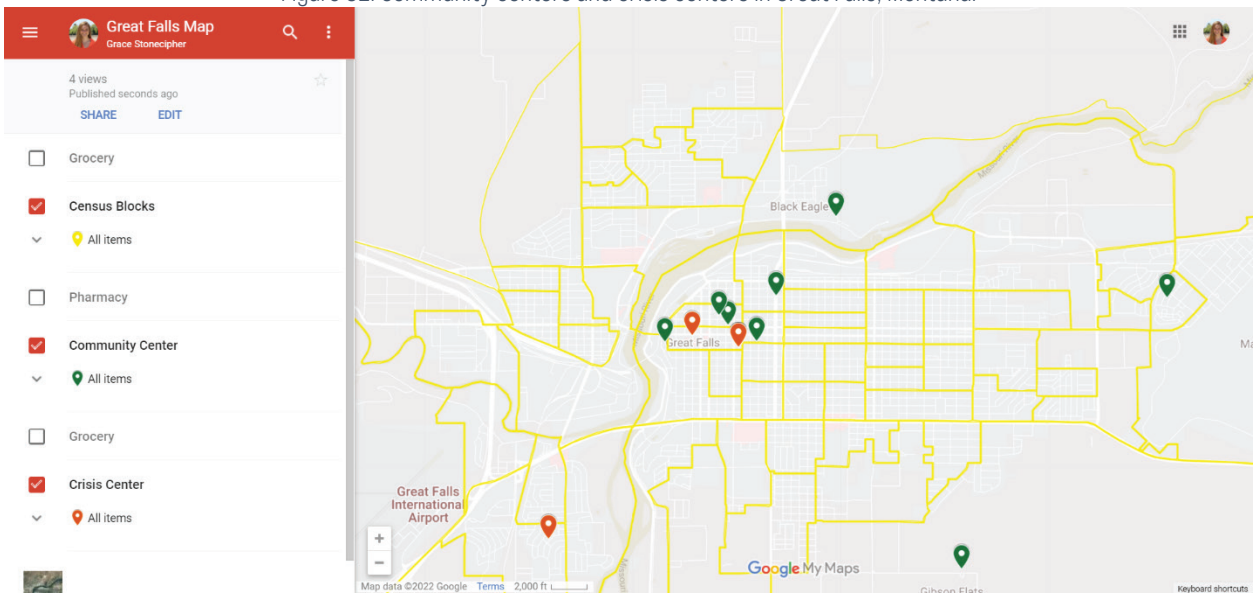
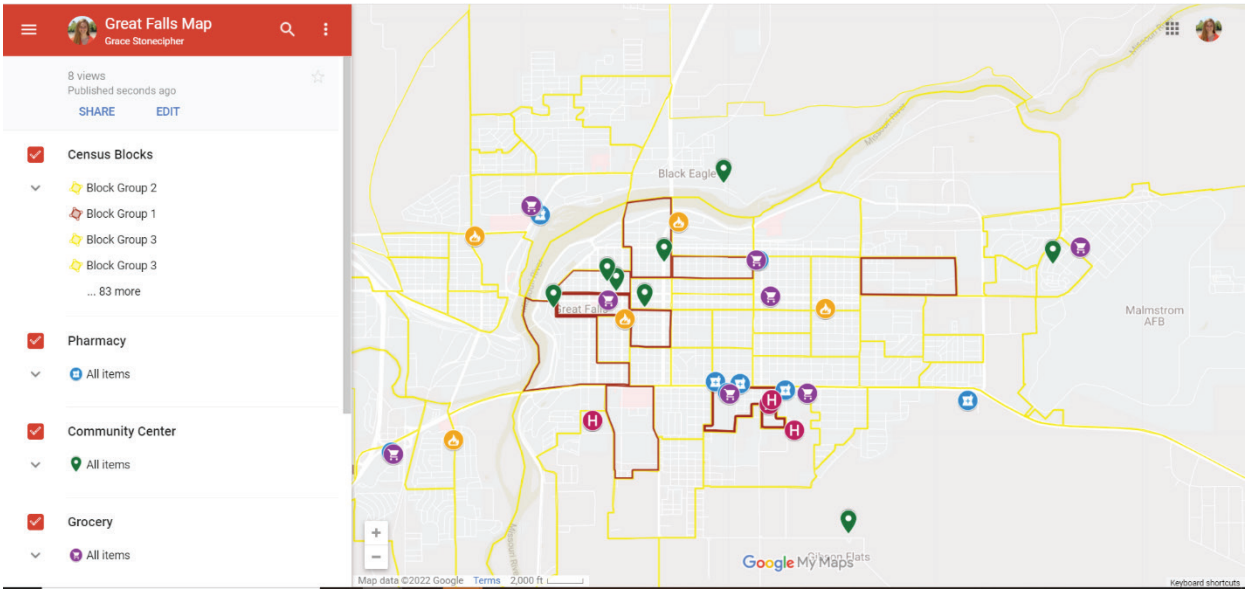


Figure 33. All features with high-risk census blocks outlined, Great Falls, Montana.



INITIAL THOUGHTS:

Existing infrastructure (groceries, pharmacies, hospitals, community centers, etc.) is spread throughout Great Falls, with a high concentration of medically oriented infrastructure (hospitals, pharmacies, MAT clinics) in southern Great Falls, and a high concentration of community centers in western Great Falls. However, the two high-risk census blocks in the southwest corner of town, and the one in the northeast may be good locations to focus initial attention.

APPENDIX D: DETAILED TABLES ON IMPLEMENTATION CONSIDERATIONS FOR MOBILE OUD TREATMENT

Site #	Meds on Van	Take Home Dosing	Route vs. Station	Rural/ Urban/ Mixed	Parking Location Partners	Service Types	Prison (Y/N)	Halfway or Recovery Houses (Y/N)	Typical Staffing
1	S, V Scripts as no meds are on van	n/a	Route	Rural	Safeway grocery stores – their bathrooms are used for UA/U; waiting room in inclement weather; engaged local Chambers of Commerce in site selection	I, PE, Ax, UA/U, CM, HR, HH-like approach ~~~~ Refer out counseling and LHD for STI, Hep C, HIV/AIDS; wound care referred to PC or urgent care	N	Y, very important; lack of capacity for co-occurring disorders in this level of care, particularly for women	Peer specialist and RN Counselor
2	M, B	Y, as per CSAT Guidance Q4 CY 2021	Route	Mixed	Fire and police stations and church parking lots	Certified as HH; I, PE, Ax, Hep C, Adding Primary Care Counseling		N	Driver/security; nurse mgr or nurse; peer recovery support; no prescriber is onboard but would like that
3	V, S, Na, and psycho-tropic	Y, weekly	Route	Rural	Formal MOUs with parking sites	I, Ax, Psych RN with SUD credentials has MAT waiver and she is the prescriber; MAT waiver docs are at primary care centers; van delivers therapeutic services	Y	N	Prevention services supervisor who is also IT; peer recovery specialist; licensed clinician (LCSW with credential in addiction)

Site #	Meds on Van	Take Home Dosing	Route vs. Station	Rural/ Urban/ Mixed	Parking Location Partners	Service Types	Prison (Y/N)	Halfway or Recovery Houses (Y/N)	Typical Staffing
4	M, B, N	n/a	Station (at Jail 5 days a week)	Urban	Jail	I, PE, Ax and Induction (if appropriate) at first contact; Counseling occurs in the jail, they do UA/O; PE must be face-to-face	Y	N, but thinking of adding as these sites do not have medical staff	Driver/Safety Aid (also prison staff) Recovery Coach; RN nurse for dispensing and charting; APM for physical exam
5	M, B, S	Y, stable is up to 30 day supply, unstable is up to 2 week supply	Station at this time	Urban	Adjacent to brick-and-mortar clinic	I, Ax HIV, STI, HR UA/U Would like to add IH/HH in the future	N	N	RN or LPN; support staff in dispensing area; case manager who manages the milieu; security person
6	B, S, V	The SUD service provider contracted to operate the MCU does not distribute medications directly off of the MCU. The physician prescribes medications to clients; dosage varies based on Ax and state guidelines.	Route	Mixed	Community mental health (CMH), county parks, low-income housing, recovery community organization (RCO), community centers	I, Ax, UA/O, UA/U, C, HR, CM, PC	N But parked in city owned parking area adjacent to the jail. Probation refers all inmates to a brick-and-mortar provider, and this is challenging.	N	The fiduciary (PIHP) contracts with a local SUD service provider to operate the MCU. Current staffing includes: MCU case manager/therapist, recovery coach/driver, physician as needed (usually via telehealth). Consider assigning/ training back-up drivers to ensure minimal service interruption. Consider which staff will be responsible for emptying grey/black water tanks daily.
7	B	Several- day supply	Route	Mixed	Local Pharmacy brings meds to the van	I, Ax, PE, Induction,	Y	Y	

KEY	
Dispensing Type	Methadone = M; Buprenorphine = B; Suboxone = S; Naltrexone = N; Naloxone = Na; Vivitrol = V; SUD Counseling Only = SUD/C
Type of Area Served	Rural = R; Suburban = S; Urban = U; Mix = M
Service Types	Intake = I; Physical Exam = PE; Psychosocial Assessment = Ax; Urine Assessment/Observed = UA/O; Urine Assessment/Unobserved = UA/U; Blood draw = B; Counseling = C; Harm Reduction = HR; Sexually Transmitted Infection = STI; Hep C = Hep C; Primary Care = PC; Case Management = CM; Peer Counseling/Recovery Coach = PC; Integrated Health = IH* HH = Health Home/PCMH *General term to connote physical and mental health services as similar to health home. Only Provider #X appears to be officially recognized as a health home. It is aspirational or in active planning for Providers X, Y, Z and W.
Provider Number	1 = Western state 2 = Eastern state 3 = Eastern state 4 = Eastern state 5 = Western state 6 = Central state 7 = Eastern state

Notable Van Aspects
Winnebago; Consider the terrain; Unit is broken down 40% of the time; document in word doc offline – chart on return to base
None noted.
Unit has a canopy, for outdoors waiting area, with chairs and TV for educational videos; locked refrigerator safe; medical equipment. At first it was not well-marked as per direction of agency board, but that was not helpful. Evolved to clearer marking.
School bus owned by state—constant repairs but cheaper than new unit
The PIHP owns the MCU and leases it to the operating provider for $1 each year. PIHP worked with a vendor in Colorado to build a custom vehicle from a used F550 chassis. The 24-ft long MCU has two exam rooms, a bathroom, a waiting room, wall-mounted monitors for telehealth and viewing educational videos/material, A/C and heat, LED lighting, and a wheelchair lift. A commercial driver's license is not required to operate this size/class of vehicle. When the temperature is below freezing for more than 24 hours, the vehicle must be winterized, which prevents clients and staff from using the bathroom in the winter. To overcome this barrier, the staff either flush with antifreeze or escort patients inside partner agencies to use the bathroom. Finding a temperature-controlled storage unit large enough to store the MCU is challenging. Mixed response to van markings. Do not weld generator onto van, difficult to service.
Brightly colored, "loud, hard not to miss, wanted to normalize being there." The State created a "Live Loud" media campaign

Service Partners
MOUs with PCPs; counseling can be by telehealth. Promote to law enforcement; probation officers; legal; coffee shops; teen centers
Refer out wound care
Community Board; Sheriff's Office; Promoted through "Town Halls"
Jail Other providers and meetings
Local Department of Health; well-established agency service sites in targeted neighborhoods that provide counseling and PEs
Department of health and human services, community mental health, community centers, county courts, jails, FQHCs, recovery community organizations (RCOs)
Departments of Public Health, Health, Consumer Protection, DFS