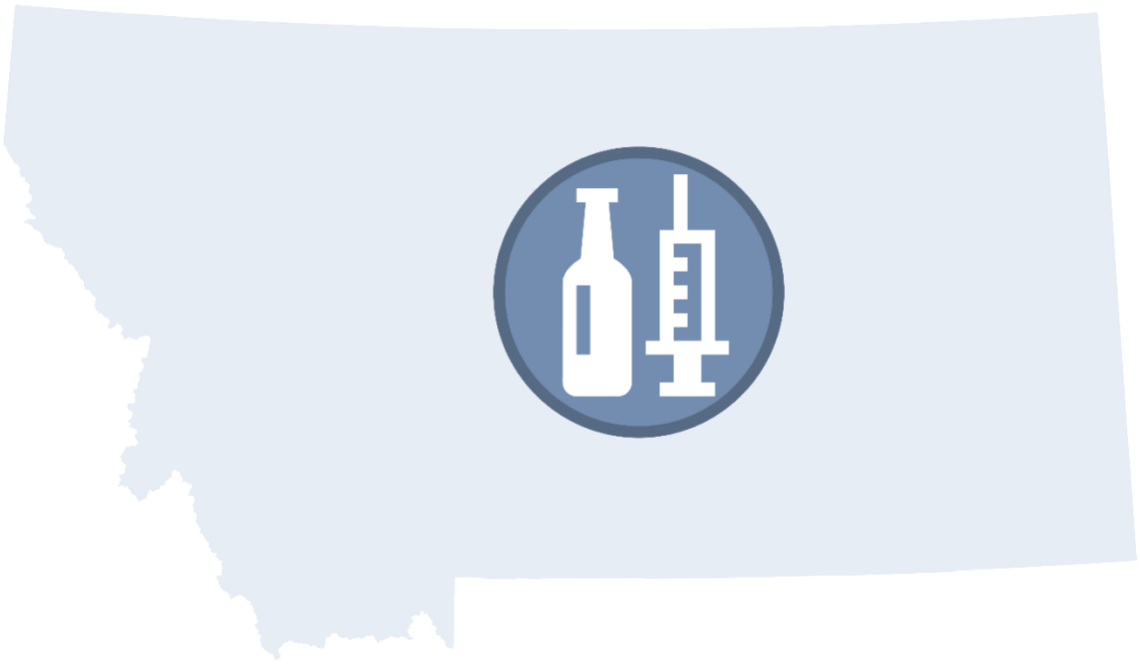
Montana Addictive and Mental Disorders Division

State Targeted Response (STR) to the Opioid Crisis Grant Final Evaluation



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Dr. Brandn Green led all primary data gathering and analysis in collaboration with Dr. Matthew Filteau. Dr. Kristal Jones provided additional support.

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EXECUTIVE SUMMARY

State Targeted Response (STR) funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) was utilized by the Addictive and Mental Disorders Divisions (AMDD) of the Montana Department of Public Health and Human Services (DPHHS) to decrease adverse outcomes from opioid use and link individuals with opioid use disorders (OUD) to treatment programs. The grant program activities were intended to further two primary goals:

1. ***Support OUD prevention programs and services in Montana***
2. ***Develop comprehensive, evidence-based services for OUD treatment in Montana***

STR funded activities are occurring within a complex and broad array of interventions to support prevention programs and expand access to services for OUD in Montana. Therefore, this evaluation design concentrated on the outcomes specific to all grant activities as well as the implementation process for medication-assisted treatment (MAT).

The grant program was successful at supporting prevention programs and services, as well as contributing to the development of comprehensive, evidence-based services for OUD treatment in Montana. Highlights of the grant activities include:

- ***Distribution of 1473 units of Narcan across 35 of the 56 Montana counties***
- ***Expansion of MAT waivered providers from 22 to 131 during the grant period***
- ***Receipt of MAT at STR grant funded sites by 535 unique patients***
- ***Clients report high degrees of satisfaction with their MAT program***

The report is organized around three primary sections which provide full overviews of the prevention and treatment outcomes, MAT implementation processes, and patient perspectives of those served by STR funds. Site specific profiles as well as the evaluation methodology are included as appendices.

Section 1. Background on MAT and STR

The State Targeted Response to the Opioid Crisis Grant (STR) funding was awarded to the Addictive and Mental Disorders Division (AMDD) of the State of Montana Department of Public Health and Human Services (DPHHS) by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), and Center for Substance Abuse Prevention (CSAP). The grant program aimed to support states in addressing the opioid crisis by "increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose-related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD)" (SAMHSA, 2017). Grant activities began in fall 2017.

Montana Context

Relative to the nation, Montana has been fortunate to have a low age-adjusted rate of opioid-involved deaths, with 3.6 deaths per 100,000 persons as compared to the national average of 14.6 deaths per 100,000 persons in 2017 (NIDA, 2019). The 2017 rate for Montana is slightly below the long-term age-adjusted rate for Montana, which is closer to 5.8 per 100,000 persons (DPHHSb, 2018). Usage of opioids, however, is consistent with national proportions as 0.34% of the total U.S. and 0.33% of Montanans are estimated to have used heroin in the past year. The estimated number of Montanans with a pain reliever use disorder is 0.72%, as compared to the national estimates of 0.63% (NSDUH, 2017). In population numbers, these estimates suggest that approximately 6,300 Montanans over the age of 12 have a pain reliever use disorder and approximately 3,000 Montanans reported using heroin in the past year (NSDUH, 2017). Access to prevention and treatment programming for these individuals is hindered by the geography, weather, and limited substance abuse treatment and mental health services availability across much of the state (DPHHSa, 2018).

Within this context, the STR grant program goals were intended to efficiently and effectively utilize the funding to ensure that the rate of opioid-involved deaths remained low and to expand access to treatment for those with an OUD. The STR grant program in Montana adopted

the Hub and Spoke model, which was developed in Vermont as an organizational approach to medication-assisted treatment (MAT) that maximizes scare medical capacity in rural areas (Brooklyn and Sigmon, 2017). The Hub and Spoke model creates formal relationships between Hub providers, who initiate MAT and stabilize patients on buprenorphine, and Spoke providers, who can take over ongoing MAT care and integrate other types of care for patients over time.

STR Grant Program Overview

As stated in the program overview by AMDD and provided to the researchers, the goals for the STR program were organized around the two categories of prevention and treatment. These goals and objectives are summarized in Table 1. These goals and objectives are the primary focus of the evaluation presented in this report.

Table 1. STR grant program goals

Goal	Objectives
Prevention	
1. Support OUD prevention programs and services in Montana	1.1 Increase the number of emergency medical services (EMS) and law enforcement staff trained in the use of naloxone/Narcan
	1.2. Increase the number of EMS and law enforcement providers carrying naloxone/Narcan for emergency purposes
	1.3 Publish a comprehensive OUD needs assessment for Montana by January 2018
	1.4 Publish a strategic plan for OUD prevention and treatment in Montana, with the input from statewide stakeholders by January 2018
	1.5 Increase access to disposal bags among those receiving an opioid prescription
Treatment	
2. Develop comprehensive, evidence-based services for OUD treatment in Montana	2.1 Increase the number of Montana providers trained on the use of MAT
	2.2 Increase the number of providers in Montana implementing MAT at Hub and Spoke treatment sites funded under this grant
	2.3 Increase the number of individuals receiving MAT for OUD at the Hub and Spoke treatment sites funded under the grant
	2.4 Increase the number of individuals in Montana trained to provide Peer Support and Recovery Services
	2.5 Increase the number of individuals receiving OUD Peer Support and Recovery Services at the Hub and Spoke treatment sites funded under the grant

Report Structure

The STR evaluation was designed to document the progress AMDD did or did not make on the outcomes associated with the prevention and treatment goals outlined in in Table 1. The data associated with the tracking of these outcomes is the focus of Section 2 of this report, which concentrates on quantitative, short-term outcomes of the STR funding, and information is presented in both charts and maps to show differences over time, across types, and across geography.

Section 3 of this report is an analysis of implementation processes among sites that expanded MAT programs for individuals OUD. Sites in Montana reported varied experiences with MAT prior to the STR funding support, with six sites being new MAT providers due to STR funding. The implementation of MAT was examined using qualitative data collection and analysis methods and focused on the phases of implementation within each site.

Section 4 of this report is an analysis of patient experiences and perspectives on MAT as well as excerpts from provider interviews about their biggest successes. Section 5 of the report summarizes the key findings across the outcome and process evaluations and provides recommendations as the state moves into the next phase of addressing opioid related harms in Montana through the application of State Opioid Response (SOR) funding. The report also includes appendices with full methodological information, additional detail on a subset of MAT clients, and individual profiles of each of the MAT sites.

Section 2. Evaluation of Prevention and Treatment Outcomes

Introduction

Within the goals of the STR funding overviewed above, there are key treatment and prevention goals with outcomes that can be measured quantitatively over time and space. The purpose of this section is to present data on several of these outcomes and to summarize the key findings or insights that these data can offer about the impacts of STR funds and opportunities for further investment with the forthcoming round of SOR grant funds.

Outcome Evaluation Methodology

The quantitative data presented in this section were gathered from several sources, all of which are participating parties in the STR program and are thus required to report to AMDD the outcomes of their work. All data were summarized and visualized in Microsoft Excel and ArcGIS Pro software. When possible, comparisons to past values were provided to characterize change over the course of the STR funding period. A full overview of the outcome evaluation methodology is included in Appendix A.

Outcomes of Prevention Objectives

Increasing the capacity of professionals to use naloxone

- **Objective 1.1 Increase the number of EMS and law enforcement staff trained in the use of naloxone/Narcan**

The STR program used a train-the-trainer model to increase the capacity of professionals in the state to obtain and utilize Narcan. Best Practices Medicine (BPM) in Bozeman was contracted to provide training for the 'master trainers,' and these trainers in turn trained individuals in their own communities. Figure 1 shows the locations of master trainer trainings held over the course of the funding period.

Figure 1. Locations of Narcan master trainer trainings

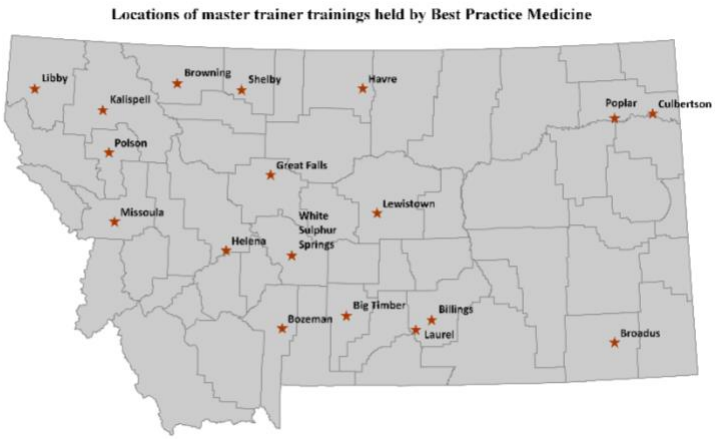
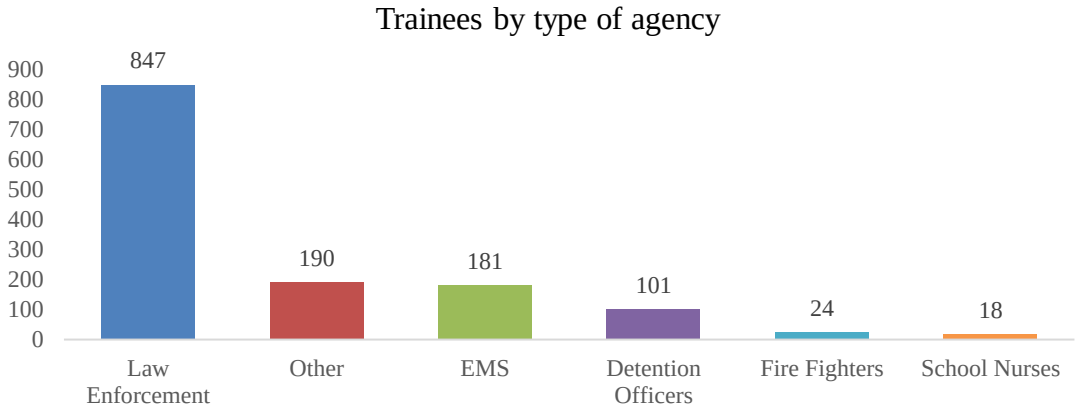


Figure 2. General trainees in use of naloxone by organization type



Over the course of the STR project period, BPM trained a total of 745 master trainers, who in turn trained 1,361 professionals in the use of Narcan. These 'general trainees' (those trained by master trainers) were overwhelmingly members of law enforcement, emergency services

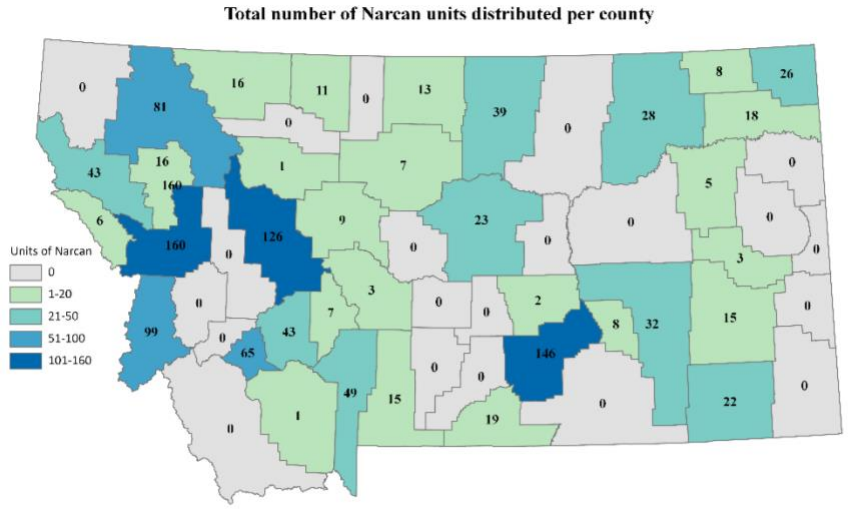
providers, or detention officers. Figure 2 shows the breakdown of trainees by the type of agency for which they work, and highlights that that prevention objective (1.1) of ***increasing the number of EMS and law enforcement staff trained in the use of naloxone/Narcan*** was achieved, as over 1,000 staff were trained in the proper use of this opioid-overdose death prevention intervention throughout the funding period. An additional 125 other public safety professionals, including detention officers and fire fighters, were also trained, as were close to 200 additional types of professionals.

Expanding access to naloxone

- **Objective 1.2 Increase the number of EMS and law enforcement provider carrying naloxone/Narcan for emergency purposes**

Over the course of the STR funding period, a total of 1,473 units of Narcan were distributed to a number of organizations and professionals. Figure 3 shows a map of the total number of Narcan units distributed by county.

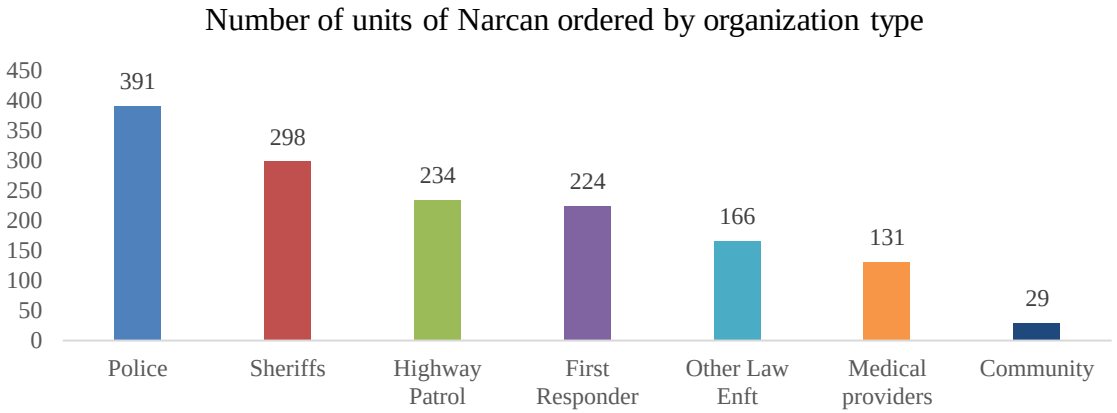
Figure 3. Map of total units of Narcan distributed by county



- Three counties received more than 100 units
- Three counties received between 51-100 units
- Nine counties received between 21-50 units
- Twenty counties received between 1-20 units
- Twenty-one counties received 0 units of Narcan

Figure 4 shows the total distribution of Narcan units by organizational type. Not all organizations could be attributed to a specific county (for example, the Montana Highway Patrol received 234 units to be used by their staff across the state) and so the numbers on the map in Figure 4 reflect only the 1,165 units that could be geographically attributed.

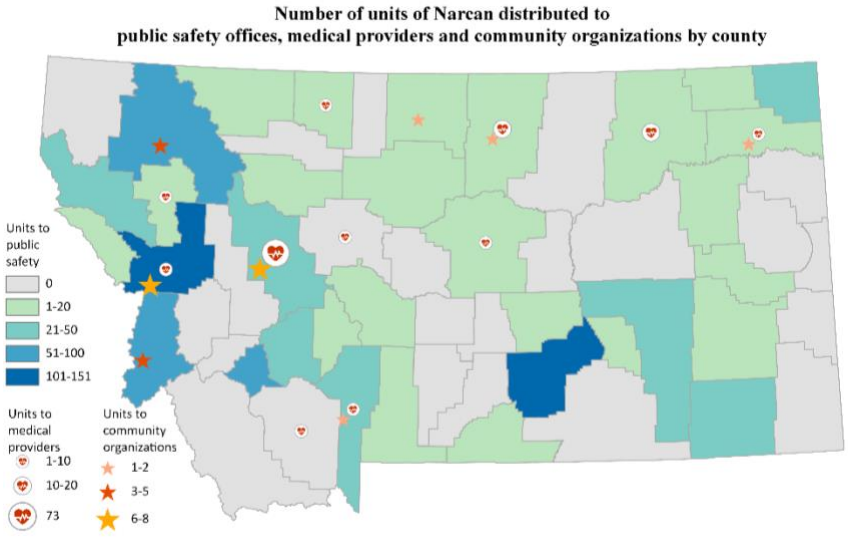
Figure 4. Number of Narcan units distributed by organizational type



Figures 3 and 4 demonstrate that the prevention objective (1.2) of ***increasing the number of EMS and law enforcement staff carrying naloxone/Narcan for emergency purposes*** was clearly achieved, as the vast majority of Narcan units distributed were to public safety organizations. Units were also well-distributed across the state, with over half of counties receiving at least one unit of Narcan. Missoula, Lewis and Clark, and Yellowstone counties each received over 100 units.

Figure 5 shows a map of the total units distributed by organizational type by county, with all public safety agencies (police, sheriff, highway patrol, first responders, and other law enforcement) combined into a single category.

Figure 5. Map of number of Narcan units distributed by county and organizational type



In all but one county, public safety organizations received the most units of Narcan. In Lewis and Clark County, medical providers received more units than public safety organizations, mostly because of the STR Hub site that was present in the county. In two counties in northeastern Montana, medical providers and public safety organizations received roughly the same number of units. In no county did community organizations (including schools and non-profit organizations) receive more than a few units of Narcan over the funding period. Again, Figure 4 highlights that it was law enforcement and emergency services that enabled the wide distribution of Narcan across the state.

Engage in strategic planning for OUD prevention and treatment

- **Objective 1.3 Publish a comprehensive OUD needs assessment for Montana by January 2018**
- **Objective 1.4 Publish a strategic plan for OUD prevention and treatment in Montana, with the input from statewide stakeholders by January 2018**

In coordination with key offices at DPHHS, AMDD staff completed the STR grant funding needs assessment to summarize the key epidemiological data associated with the burden of opioid use in the state. Utilizing data from the Prescription Drug Monitoring Program (PDMP), Office of Vital Statistics, Youth Risk Behavior Survey (YRBS), Behavioral Risk Factor Surveillance Survey (BRFSS), Hospital Discharge Data System, Montana Department of Corrections, Medicaid, National Survey on Drug Use and Health (NSDUH), and program level inventories of program activities, AMDD provided a comprehensive assessment of the opioid care needs and service infrastructure as of July 31, 2017. Results of the needs assessment informed the strategic plan for STR, completed in January of 2018.

The strategic plan focused on increasing the number of providers and recovery support services. These efforts were to be supported by financial interventions associated with STR funding and public and private funds (e.g., Medicaid, state and local funds, private insurance). Key populations were identified and plans were presented to engage special populations through collaboration with state agencies and entities involved in Criminal Justice, Child Welfare, Drug Courts, and Probation/Parole.

Key gaps and areas of high need identified in the needs assessment and highlighted in the strategic plan included

- Focus on prevention activities
- Increasing utilization of the PDMP and data collection efforts
- Enhancing overdose education and training associated with administration of naloxone
- Expanding awareness of opioid overdose prevention

Expanding access to opioid disposal bags

- **Objective 1.5 Increase access to disposal bags among those receiving an opioid prescription**

In the first year of the grant period, STR funds were used to purchase and distribute 100,000 Deterra bags across every county in the state. In year 1, disposal bags were delivered to prevention specialists who then distributed the bags to key stakeholders in their communities. Disposal bag distribution was targeted at organizations that serve older Montanans, including Adult Protective Services, Area Agencies on Aging, and senior centers. This targeting was based upon analysis completed by DPHHS staff, demonstrating that those between 60–69 were the most likely Montanans to visit the emergency room for overdose (Troeger, 2019). During the second year of the grant period, the state purchased and distributed 39,200 bags, and Verde Industries, the firm with which the state contracted for the purchase of Deterra bags, donated an additional 22,800 bags to the state. These donated bags were used to target additional specific populations. These numbers demonstrate that another key prevention goal (1.5) for the STR project, to ***increase access to prescription drug disposal bags for individuals who have prescription medications***, was met during the project period. In addition, the success of the outreach and educational materials that accompanied the disposal bags as well as an investment by the state in drop boxes for 54 counties means that going forward the promotion and use of drop boxes will be the primary prescription opioid abuse prevention strategy in the state.

Outcomes of Treatment Objectives

Increasing the number of providers trained on the use of MAT

- **Objective 2.1 Increase the number of Montana providers trained on the use of MAT**

A more general goal of the STR program was to increase the capacity for MAT delivery in the state. Figures 6 and 7 show clear progress on the treatment objective (2.1) of ***increasing the number of Montana providers trained to use MAT***. In 2017, before the start of the funding period, there were 22 waivered providers in the state, all of whom were medical doctors. As of March 2019, there are 131 waived providers. In addition, over a third of these are mid-level providers (nurse practitioners or physicians' assistants), who tend to practice in satellite health clinics and rural areas. All of the data presented in Figures 6 and 7 represent only those waived providers whose contact information is publicly available in the Buprenorphine Practitioner Locator maintained by SAMSHA.

Figure 6. Waived providers in Montana before (2017) and upon completion (2019) of STR grant period

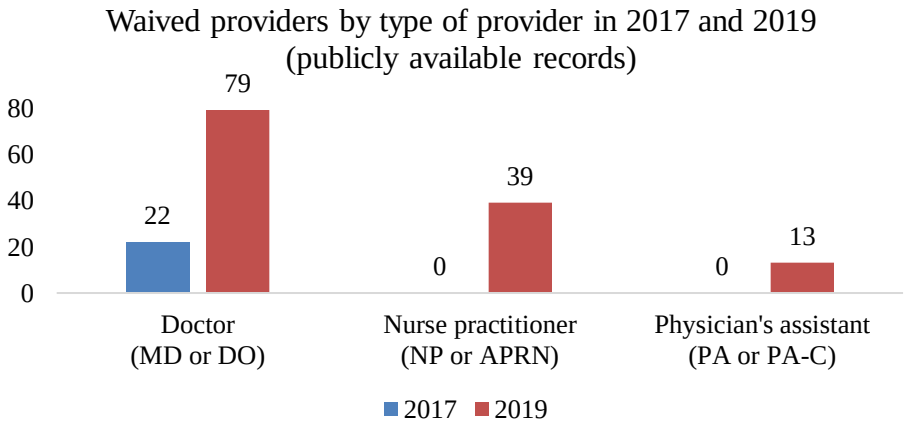
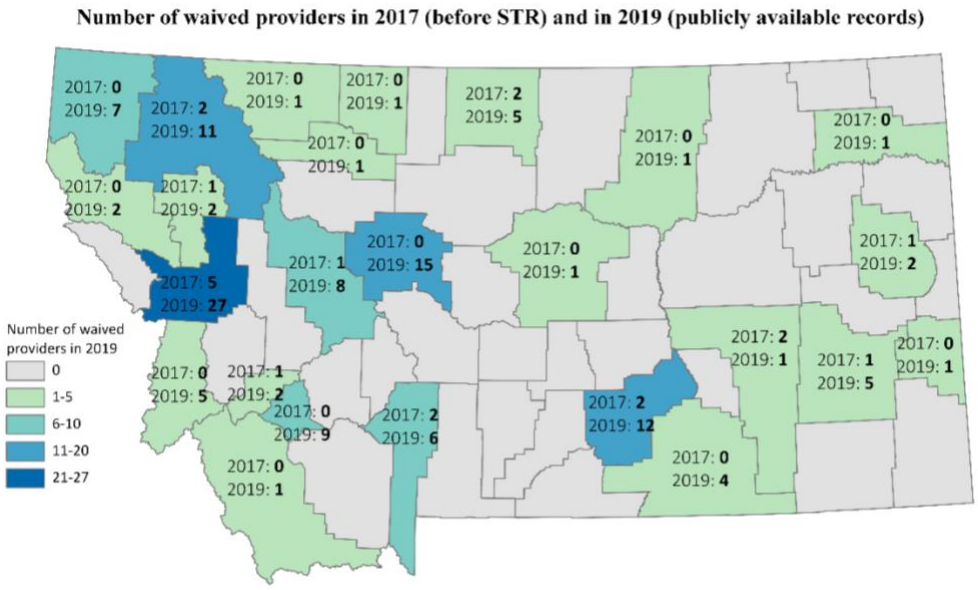


Figure 7 depicts the geographic distribution of waived providers in 2017 and 2019 and highlights that not only has the goal of increasing the number of waived providers been achieved but there is also a more even distribution of these providers across the state. There are 50 providers across 14 counties who have become waived during the funding period in counties that previously had no waived provider.

Figure 7. Number of waived providers by county in 2017 and 2019

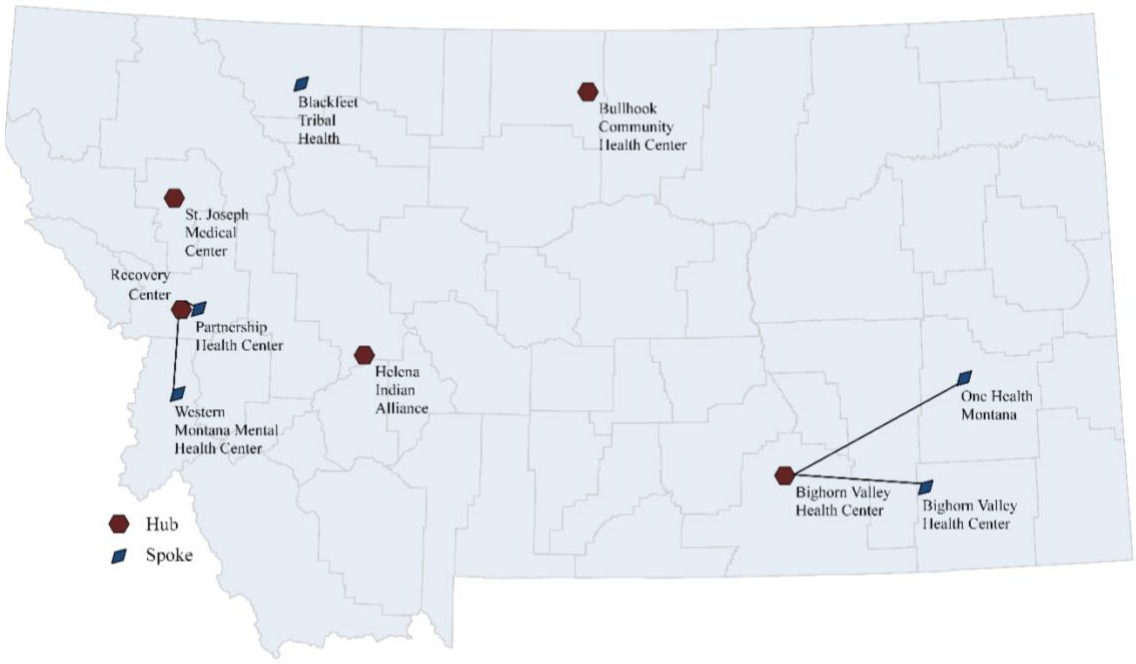


Increasing the number of providers implementing MAT

- **Objective 2.2 Increase the number of providers in Montana implementing MAT at Hub and Spoke treatment sites**

According to the baseline data gathered for the needs assessment undertaken prior to the start of the STR grant period, there were four Opioid Treatment Programs (OTP) operating in the state of Montana, and approximately 30 locations with Office-Based Opioid Treatment (OBOT)-certified providers. An informal scan was conducted for the needs assessment report completed by AMDD, many of these certified providers were not currently providing MAT treatment at the time of initiation of the STR grant, and none of the OTP or OBOT programs were operating with the Hub and Spoke model. The treatment objective (2.2), to ***increase the number of providers implementing MAT at Hub and Spoke treatment sites***, was clearly met, as six Hub sites and five Spoke sites were established during the grant period. Nine of eleven sites served patients during the grant period, while two were established but not yet serving patients with STR funding. Figure 8 shows the locations of the Hub and Spoke sites that were established during the STR grant funding period.

Figure 8. Location of STR Hub and Spoke sites providing MAT treatment



Increasing the number of individuals receiving MAT

- **Objective 2.3 Increase the number of individuals receiving MAT for OUD at the Hub and Spoke treatment sites**

As of April 22, 2019, MAT sites that have received STR funding had provided treatment to a total of 535 unique patients, as compared a total of 105 patients as of March 27, 2018, the first date of reporting for STR sites. A five-fold increase in MAT patients over the grant period suggests that the treatment objective (2.3) of ***increasing the number of individuals receiving MAT for OUD*** was achieved.

Increasing the number of individuals trained to provide peer support services

- **Objective 2.4 Increase the number of individuals in Montana trained to provide Peer Support and Recovery Services**

Table 2 demonstrates clear progress on the treatment objective (2.4) to ***increase the number of individuals trained to provide peer support and recovery services***. A total of 198 peer

support specialists (PSSs) were reached with in-person training, and five of them have passed the State of Montana Board of Behavioral Health certification exam to become certified PSSs.

Table 2. Participation in peer support specialist trainings by training type

PSS training type	Number of total participants	Number of locations offered
In-person PSS certification training	198	8
Additional (post-certification) in-person training	45	5
Supervisor/organization training	63	4
New skills webinars (for certified PSSs only)	11	NA
Capacity building webinars	235	NA

All training was provided by the Montana Peer Network and PSSs who passed also had the option to take additional in-person or online training. Participation numbers for these trainings are listed in Table 2 as well, as are numbers for the trainings that are also offered for supervisors or leaders of organizations that include PSSs.

Increasing the number of individuals receiving OUD peer support services

- **Objective 2.5 Increase the number of individuals who received OUD Peer Support and Recovery Services at the Hub and Spoke treatment sites**

The treatment objective (2.5) focused on ***increasing the number of individuals who received OUD peer support and recovery services.*** Over the period of 5/1/2017-4/30/2019, 531 individual persons received recovery support services. At the start of the STR funding period, there were no persons with OUD at STR sites who were receiving peer support and recovery support services.

Outcome Evaluation Conclusion

By all numerical measures made available for this report, the objectives associated with the STR grant goals and activities have been achieved. As shown in Table 3, across the 10 objectives, AMDD achieved the objective of increasing the number of or access to the given prevention or treatment intervention.

Table 3. Outcome evaluation status by program goal and objective

Goal	Objectives	Status
Prevention		
1. Support OUD prevention programs and services in Montana	1.1 Increase the number of emergency medical services (EMS) and law enforcement staff trained in the use of naloxone/Narcan	**Achieved**
	1.2. Increase the number of EMS and law enforcement providers carrying naloxone/Narcan for emergency purposes	**Achieved**
	1.3 Publish a comprehensive OUD needs assessment for Montana by January 2018	**Achieved**
	1.4 Publish a strategic plan for OUD prevention and treatment in Montana, with the input from statewide stakeholders by January 2018	**Achieved**
	1.5 Increase access to disposal bags among those receiving an opioid prescription	**Achieved**
Treatment		
2. Develop comprehensive, evidence-based services for OUD treatment in Montana	2.1 Increase the number of Montana providers trained on the use of MAT	**Achieved**
	2.2 Increase the number of providers in Montana implementing MAT at Hub and Spoke treatment sites funded under this grant	**Achieved**
	2.3 Increase the number of individuals receiving MAT for OUD at the Hub and Spoke treatment sites funded under the grant	**Achieved**
	2.4 Increase the number of individuals in Montana trained to provide Peer Support and Recovery Services	**Achieved**
	2.5 Increase the number of individuals who received OUD Peer Support and Recovery Services at the Hub and Spoke treatment sites funded under the grant	**Achieved**

SECTION 3. EVALUATION OF THE MAT IMPLEMENTATION PROCESS

INTRODUCTION

Numerical outcome measures associated with tracking increases or decreases of program activities have a limited capacity to portray the experiences associated with the actual processes associated with implementing a program or intervention (Isett et al., 2007). This reality is compounded with a statewide program such as STR in Montana, where there is potentially much variation among sites implementing MAT for OUD. To ensure that the story as well as the outcomes of the STR grant activities were documented, the evaluation design included a process evaluation of the implementation of MAT at provider sites who received STR funding.

The goal of the process evaluation was to depict the similarities and differences in implementation experiences of STR MAT provider site grantees. This goal supported both an expanded understanding of the STR grant funding impact as well as providing insights and Montana specific best practices that could be applied to the activities taken by AMDD in response to the SOR grants.

The process evaluation design relied upon qualitative data and analysis. At the time of this report, two of the originally intended 11 sites have not yet started providing MAT and have been granted a no-cost extension. No information about these sites is included in this report. Eight of the nine other sites express a range of experiences with each stage of the MAT implementation process. Table 4 provides a list of the sites that were included in the process evaluation as well as the positions of staff with whom the research team completed interviews. In addition to staff, patients at each site were also interviewed. In total, across all sites, the interview team completed interviews with 65 staff and 25 patients. A full methodology for the process evaluation is included in Appendix A.

Table 4. Process evaluation locations and interviewee roles

Health center name	Respondent site	Provider interviewee roles
St. Joseph's Medical Center	Polson	Program Director, Program Manager, MSN, Care Coordinator, LCPC, Peer support specialist, Prescribing Provider, Prescribing Provider, LCPC, COO
Recovery Center	Missoula	Care Manager, Grants Manager, RN, Program Manager, Support Staff resistant to MAT, LAC, Prescribing Provider, APRN, Peer support specialist
Western Montana Mental Health Center*	Hamilton	APRN, CEO, Care Manager, RN, LAC
Blackfeet Tribal Health*+	Browning	Director, Care Coordinator, Needle Exchange Director, RN
Community Medical Services+	No Location	Regional Director, Program Manager
Helena Indian Alliance	Helena	Clinical supervisor, Receptionist, MAT Coordinator, LAC, Peer support specialist, CEO, LAC, LAC, APRN
Bullhook Community Health Center	Havre	CEO, COO, Behavioral health manager, MAT program coordinator, Care manager, APRN, RN, MAT Director, RN, Peer support specialist, LCPC, Prescribing Provider, MA
The Montana Peer Network	No Location	CEO
Bighorn Valley Health Center	Hardin	CEO, Behavioral Health Director, MAT Program Coordinator, Prescribing Provider, Care Coordinator, LAC, RN, Grant Manager, Peer support specialist
One Health Montana*	Miles City	Prescribing provider, RN, Care Coordinator, Program manager, RN
Bighorn Valley Health Center*	Ashland	Care Coordinator

* Denotes a Spoke site

+ Provided no services during the evaluation period; services will begin in 2019 during the STR no-cost extension

Note: Partnership Health in Missoula was not included in this study due to scheduling challenges

The National Implementation Research Network (NIRN)–developed implementation framework was selected as a tool for structuring data collection and analysis. The framework is comprised of four basic phases of program implementation: 1) exploration, 2) installation, 3) initial implementation, and 4) full implementation (NIRN, 2017). These phases informed the creation of the interview guide that was utilized with providers at each site.

The process evaluation reporting is primarily focused on general observations within each of the implementation phases that were true across most or all locations. In addition to exploring the general challenges and accomplishments of STR funding as identified by patients and staff at each MAT facility, we also include a set of seven site-specific profiles in the Appendix C. These

profiles use the NIRN implementation framework to structure analysis of the site-specific data. One site (Ashland) included in the study process is not included in this report, as it has only one staff member and is currently serving two patients. An interview was completed with the Ashland staff member, and the research team decided to not include it in a site-specific profile.

Exploration Phase

Overview

The exploration phase was relatively short and brief for the majority of sites. Sites reported that they were either identified by the state or chose to pursue the opportunity because of an executive who was aware of both the need among their patient population and the funding opportunity. Sites vary in their prior experience with being a MAT provider, with two sites (Recovery Center Missoula [RCM] and Helena Indian Alliance [HIA]), having been MAT for OUD providers using Data 2000 waivered providers prior to STR funding. Bullhook reported the use of MAT for OUD, but that their providers prior to STR did not use prescriptions that required the Data 2000 waiver. Additional details about site processes for all sites are included in the site summaries in the Appendix to this report.

Uncertainty about the program

The primary challenge sites reported for the exploration phase was uncertainty about how much of a burden providing the program would place on their organization. This is demonstrated by a Polson provider interviewee, *"I think it was kind of an interesting process on how the grant was rolled out. And that we didn't know what the objectives were completely before we signed up for it. So those developed after we were approved for the grant. So, we've adapted to that. I think I still would've signed up, but I don't think we had a model in mind when we said yes."*

Setting limits

Sites managed the uncertainty associated with the initial phase of the program by creating caps to the number of patients that they would serve with the program. A few sites used a staged approach by starting with 15 patients and then slowly expanding patient load to 30. The limits were explained as being a way to ensure quality care, protect providers from burnout, and manage how the anticipated patient demand would burden the overall functioning of the clinic.

INSTALLATION PHASE

Overview

Montana's unique geographic size, rural composition, and behavioral health system presented challenges for expanding MAT access within the state. STR funding allowed sites to expand staff, receive training, and grapple with the administrative challenges associated with providing a new service. The primary challenges in the installation phase were related to 1) attempts to recruit sites for the Hub and Spoke model and 2) recruiting and retaining the staff necessary for implementing the program. The primary accomplishments in the installation phase were related to 1) the ease of acquiring a Data 2000 waiver and the role of state-based trainings in supporting this for new providers and 2) the comparative ease of installation at sites with a background in integrated behavioral health (IBH).

Hub and Spoke recruitment

All sites, including sites with functioning Hub locations, reported a very significant challenge in recruitment of Spoke locations. Each Hub – St. Joseph's, Recovery Center, Bullhook, Big Horn, and HIA – outlined a range of the challenges they faced as they diligently attempted to recruit Spokes both during the initial phase of the grant and throughout the grant cycle.

Sites seeking to implement the Hub and Spoke model reported resistance or non-engagement from potential Spokes. Leadership at the Polson location reported that they lacked the

basic information required to support a Spoke site as they would try to evaluate the financial solvency of providing MAT.

> *The challenge is getting the Spokes, and I think we would've been able to provide, we would've set somebody up if they had been willing to. Things that took time for us, as I said, it's cost...And when you net it out, we did a pro forma based on what the expenses are, what's being covered by grant, and then moving forward what will not be covered by the grant going forward…and we pencil out to the point where we are, for a clinic, doing well. That means break even or a small margin for us…I think it's a huge win [knowing the financial balance]. Because I didn't have that information to go to Plains…I didn't have that information to go to a Plains or to Deer Lodge or to St Luke and say, "Hey, I've got something that is going to solve some of your problems, clear up some of the headache [of trying to make the financial decision].*

There was some discussion from interviewees about the limitations of the Hub and Spoke trainings and the content that could have been of assistance with potential recruitment and eventual implementation and support of a Spoke.

> *That was one of the things that would've made STR much easier. The training was focused on the provider, on the waiver. The process of program administrations as simple as how do you bill?...What to put in your MAT contracts? We've had to revise our patient MAT contract repeatedly. Things like what to include in your diversion prevention plan? We've kind of created that as we went, but more trainings focused on the logistics would've been helpful.*

Hub staff reported that their attempts to engage in outreach to potential Spokes, when those Spokes were not offices of a shared health system, were met with initial interest. This initial interest would create opportunities for the Hub staff to complete a presentation and to engage in preliminary conversations with Spoke executives. Spoke sites would inevitably decline the offer, for a disparate set of reasons, which included; 1) not having enough medical providers interested in the service, 2) fear of having too much patient demand, or 3) an interest in receiving the grant funding directly. Among Spoke sites that did become established, they shared how the presence of expertise from the Hub staff during initial implementation was invaluable and essential to their success. Hamilton staff shared how their frequency in contact with their Hub mentor, Dr. Nauts, declined overtime as a demonstration of their growing expertise and confidence with the program.

Support from the Hub shifted from weekly to now being used mainly for advice on specialty cases, *"we were talking with Dan every week and now it's every other week. And sometimes it's once a month…And really, Dan's wonderful, I've been so fortunate to be able to call Dan when I have questions, not just about Suboxone but about psychiatry."*

At this stage, Hub and Spoke sites explained that they are better equipped to recruit Spokes but continue to be challenged by the geographic size and dearth of professional expertise in Montana that hampers using Hub and Spoke as a treatment model. The geographic isolation and remote location for some sites within Montana strained the Hub and Spoke structure. Staff at one Hub site reflected upon the challenge of providing services across a vast landscape: *"We've got probably between seven and ten thousand miles and very limited services within that. We have Hardin clinic but they have two providers. IHS [Indian Health Services] has very limited services and then it's Billings or it's Sheridan."*

Recruiting and supporting staff

Montana suffers from a lack of behavioral health providers. This statewide challenge was also felt in the STR sites, that even with the additional grant funding they struggled to find specific types of expertise relevant to a team-based MAT program.

Many sites report staffing issues, particularly recruiting and retaining trained staff such as licensed addition counselors (LACs) and PSSs. In Browning, a housing shortage limits the lodging options for prospective staff, while in other places, it is hiring qualified staff to keep up with demand that has been challenging. For example, staff in Missoula report a need for additional help due to team members serving in multiple roles and struggling to keep up with increasing workloads.

The successful recruitment and retention of MAT patients create an unmet demand for services and a straining of current resources to treat currently enrolled patients. A provider at a Spoke stated there are staffing needs that go unmet.

But to me, I would like funding increased that we could hire a designated care coordinator for this program. It would just make so much sense. And I don't need a peer person, I need a care coordinator. And honestly, I'm afraid what's gonna happen is we're gonna get this poor soul in [peer supporter], and they're gonna get tasked with care coordination responsibilities…I would be willing to grow the program. I would be willing to pursue patients and grow the program a lot more aggressively if we had that resource.

In a MAT clinic housed within a hospital setting, one clinician discusses how turnover impacts care, and the ways STR funding has helped to partially address this challenge.

We really struggle with staffing here. There's a lot of turnover. So that's been beneficial: the money from the grant has been most beneficial for that. Because we really do struggle here to get support from the administration to hire people. To hire more social workers or counselors.

MAT programs housed within larger healthcare establishments such as hospitals and integrated healthcare facilities often reported struggles with funding essential staff positions.

Staff members described MAT programs as not only labor intensive but requiring an emotional investment *"not for the faint of heart."* One significant challenge is among staff who are filling dual roles; in particular, care coordinators who are also nurses.

[Interviewer]: So, in addition to nursing, you do most of the care coordination?

[RN/Care Coordinator]: All of it, yeah, and plus I do other duties within the center, the whole community, I do the group home. I have multiple tasks, so it's just hard to get everything done.

This staffing challenge led nearly every site to create a self-imposed cap on the total number of patients they would accept under STR. These totals varied around a general median number of 30 per site.

Ease of acquiring a Data 2000 waiver

In alignment with treatment objectives 2.1 and 2.2 (to increase the number of waived providers and provision of MAT), multiple staff at STR funded sites were able to obtain a Data 2000 waiver for the first time and began implementing MAT. During the installation phase, staff who were to become waivered providers needed to received training and apply for approval from

SAMHSA. This process was rather seamless for the majority of interviewees for whom this was relevant, with one stating how even though the training was quite simple, it was still within the context of broader uncertainty about how the program would look once it was actually implemented.

> *I feel like the training was very thorough, but I feel like it was challenging because we didn't have a program, so we really didn't know what we were doing, to be quite honest. The things that we needed to have in place really weren't in place. We knew what we wanted it to look like, but we didn't really have all the pieces in play and we weren't really sure what the end product was gonna' look like, so that part was challenging. The nice thing is right now, it's a huge focus for everyone, so there's resources everywhere. If you have a question, you can find somebody to ask. So that part is nice.*

The accessibility of current training materials and resources reflect a potential difference for SOR grantees without prior MAT experience, in that there is a broader knowledge base about MAT implementation in Montana and across the country. Many of the Montana STR grantees did not have that benefit and received effective training within the context of broad program implementation uncertainty.

Integrated behavioral health background

Sites that had prior experience with delivering IBH in a clinic setting had a simpler time installing MAT for OUD. Much of this was attributed to the team-based and outcomes focused tenants of IBH, as both correspond well to MAT for OUD program. This is not to say that IBH sites had no installation processes to adjust, they reported that the structure of their program enables them to more easily address these unknowns and create new protocols and procedures to ease program implementation.

Sites with prior experience with MAT or IBH modes of delivery reported that MAT did not produce new procedural challenges but fit within their existing operating procedures and models of care. Most often, these site interviewees reflected on how they needed to work with longer term staff to update their thinking about addiction and to align it with a harm reduction model of care in MAT. This tension is presented through quotes from two separate providers at

one location, one of whom is relatively new to the field and the other who has been an LAC for over 30 years.

> *Some people think that it's like cheating. Or using a substance to get off a substance. And I'm relatively new – I started counseling in October of 2017. And then you've got…{Name} He was our behavioral health director and he's so old school. That they're just like…Don't really like it as much. But I say, what's recovery? Are you healthy? Are you happy? Are you engaging with your friends and family? Recreational activities that you enjoy? Do you have a job, career, family? And that's what's important. It's not about how you do it.*

> *I've been doing this since 1970 so I've seen an awful lot of changes in our field…My thinking is always evolving as well. I think that…there's nothing – that it's an all or nothing issue. I don't think there's any grey area at all…I'm not saying that there aren't people who are on the fence or borderline with their addiction, but mostly who we see here are full blown…No, that's not my intention. My intention is stay on the medication as long as you need to, but work toward a time where you're free, where you don't have to depend on it. If that's possible.*

Initial Implementation

Overview

All sites made modifications to their initial MAT procedures and processes after they began to provide services. These modifications took place for 1) Hub sites as they learned how to more effectively support Spokes, 2) for individual providers as they learned of the emotional burden of being an MAT provider, and 3) for sites as they learned how to balance abstinence-based models with harm reduction.

Supporting Spokes

The billable hours at Spokes did not reflect the actual work demands placed on some staff. Some Spokes report challenging mechanisms for funding within the broader system of care.

> *We are a Spoke to the Hub of Recovery Center. And so, money gets filtered through there. If we could be independent…we could definitely structure a way to maybe capture the reimbursement sources that might be out there. And two years is forever, you know? In the money world.*

The Hub and Spoke model is not viewed by all sites as being only a source of challenges, as it has contributed to continuity of patient care when staffing turnover would have otherwise left patients without the appropriate clinical personnel.

> *[Interviewee]: We've lost a provider at Ashland, so we don't have a full-time provider. We have one of our Hardin providers doing some in-person but more, we've moved to telehealth for the Ashland site. Miles City is a fully functional team. Everything basically is in place and in-house there, but we may add another provider and we'll have a fourth one coming online, also for Hardin. We'll have four across the three sites.*
>
> *[Interviewer]: And is that a sufficient number for your patient load?*
>
> *[Interviewee]: Mmm hmm. Well, we never have enough providers.*

Overall, interview participants reached the conclusion that the Hub and Spoke model is simpler and easier to implement at health systems with multiple locations, rather than across health system organizations. A health system with multiple locations can instruct locations how to provide the service versus asking; additionally, billing is simplified, and there are no concerns about competition for grant dollars.

Rather than a Hub and Spoke model across multiple health systems, one suggestion made by interviewees was for academic detailing and support for smaller locations as they explore becoming an MAT provider or begin the implementation process to be provided by the state to support new sites for the SOR funding cycle.

> *I think you could go to not having Hubs and Spokes. Like I don't feel like you need to ... if Polson can do it, if we can be a Hub in Polson, I think you could be a Hub in Glasgow Montana…I don't know why they couldn't. They've got the same issue up there that we do…but you could keep an LAC busy in all these different areas, and you can at least have your physicians take the minimum Suboxone training.*

This was echoed by a Spoke site as well.

> *Yeah, I was going to say, honestly, being able to have your own team with all the players would be the most ideal situation so even us, being able to have a LAC here …for any Spoke site, it would be better if they could have all the players. Then they could just use the Hub site as a resource if they really needed it.*

Different experiences by the background of providers

Sites varied in their experience with the team-based care delivery model inherent in MAT. At locations with a history of IBH, interviewees reported that MAT was nothing new, simply the addition of a new medication to a care delivery process. In locations with less of a history of team-based approaches or less integration of behavioral health with physical health, the process challenges associated with this patient population and care delivery model were frequently noted.

For providers who come from a primary care background, they report that it's a new challenge to work with the MAT population.

> *They're emotionally very difficult patients too because you see, they come to you very vulnerable and wanting to make this change and you have to see them messed up or not be able to succeed in the ways they want to succeed and it's just, coming from doing primary care to this program, the patient population is just very different.*

This emotional burden and the newness of it among individuals who have less history with behavioral health care extends to their experience of being a symbol within their community of MAT.

> *I feel like it's so emotionally weighing at least for me, because I'm looking at, you're not only fixing this person but you're potentially breaking the cycle and you're making their kids have a better life and not have to deal with the drug addiction and any trauma that they could have experienced having drug addicted parents. Just looking at the big picture of what our program is trying to do for our community and then it gets very frustrating when you have setbacks and maybe, even though you're not, feel like you're making as much of a difference as you wanted to by doing it. I don't know. I feel like a lot is weighing on the shoulders of our program and we're under the microscope and scrutinized by any other, every other discipline that has any involvement with drugs and drug addiction.*

Many patients like and speak to the effectiveness of integrated health care facilities for bettering their overall health and well-being and providing them with a more confidential healthcare experience while entering, waiting in, and exiting these facilities. However, managing the local demand for general healthcare and MAT treatment proves challenging for these programs. Staff describe how additional SOR funding would benefit their programs and, hopefully, lead to the hiring of necessary staff.

Balancing abstinence with harm reduction

Diversion of Suboxone and management of patients who have a difficult time passing urinalysis (UA) screenings are two key challenges that providers are trying to balance, and that they are balancing in different ways across STR sites. Diversion of Suboxone occurs when individuals who are enrolled in an MAT program for OUD take their prescribed medication and sell it or share their prescribed medication with family, friends or acquaintances who do not have a prescription for Suboxone. One collection of providers view diversion as a non-issue, noting that *"It's inadvertent harm reduction, okay, because they use it one, I can't get my heroin, so this will keep me out of withdrawal. Two, I can't get into treatment, but this is what I know I need. You don't get high from this stuff."* Other providers see diversion as another form of drug abuse. This view does little to change or shift the prescribing practices among STR sites, as all providers reported a high degree of concern and oversight of their Suboxone prescribing practices with random strip counts and careful patient monitoring and engagement. It does shape how staff discussed the impact of MAT providers who may have different standards of oversight.

Differences in the view of UA screenings also reflected variation across the spectrum from abstinence as an expectation of patients to one of harm reduction. Speaking of the types of patients who enroll at their site a provider stated:

> *It takes, for example, if you put somebody on buprenorphine, it generally takes about six months before your patient population achieves 50% negative urines. It takes about a year to where you're getting to a point of about 85% negative urines. Then you would say, "What do we do now?" Well, you can taper, but generally again, the relapse rate is in that 80 to 90% range.*

This provider is in contrast to others who reported using a numerical threshold for when failed UAs would lead to dismissal from the treatment program.

The impact that this variation has on sites is that it informs how the sites approach their potential pool of patients. Sites that viewed the program goals as being closer to abstinence reported selecting patients who were more stable and less complicated at the time of presentation to the site. Screening of patients varied across locations, with some accepting high-risk patients

and others prioritizing low-risk patients, defined by the presence of co-occurring disorders and severity of the addiction. This variation should not be viewed negatively, as sites varied greatly in their staff training with addiction and experiences as substance use treatment providers. It is important to note, however, that this variation in patient selection will likely shape differences in patient outcomes across sites.

Adjusting practices

In communities throughout Montana, staff commented on the need for MAT programs and associated wraparound services.

> *[Staff Member]: We ramped up to 30 over time and have stayed right around 30.*
>
> *[Interviewer]: And that is because? Why 30?*
>
> *[Staff Member]: That just seemed to be where the need of the community is at. I mean, I'm always accepting new referrals for this. But it seems like, you know, for the past several months it's been lose a few, gain a few.*

Some staff at programs believed they were able to meet the demand from the local community, while others stated that they would grow if they had the staff resources. One provider stated, *"I would be willing to grow the program, I would be willing to pursue patients and grow the program a lot more aggressively if we had the resources."* In order to bolster retention and create a transparent treatment process, a few programs have attempted to involve patient family members. This enables the family to learn about the treatment process and provide support outside the clinic. For example, staff state:

> *But one of the things that is really important is that, and what we're trying to do here is get family involved from the beginning, because family is really important especially when it comes to you're going through treatment, and as you're getting close to that transition date to transfer them to a lower level of care from a 3.5, is to look at who can you turn to in your family who's going to give you that support. And then, we get a lot of family members. A lot of people sending their friends and family our way.*

Involving the family is a tricky issue as some patients do not want their families to know about their treatment and hide their disorder from them. This is one area where MAT programs

and their adherence to HIPPA has helped to bolster trust among prospective and current patients and legitimize the program as a safe place to seek treatment.

> *I had a particular experience a couple months ago about this whole HIPPA stuff because this patient's mother would go down to IHS and just freely ask the staff what is this my son is being seen for? And the staff members would tell her everything. There was no privacy. So at first, he was really guarded with me, telling me about his whole background because of that I'm frustrated. I assured him, I said unless you give us a written permission saying that we can disclose, nobody can find out what you're being seen here for. So I think it's refreshing for patients that come from [IHS] to here to understand what their rights are, what information can and can't be disclosed is really refreshing.*

One of the additional accomplishments noted in a few MAT programs is a capacity to have success treating co-occurring disorders.

> *So, I treat a very specialized population here: the co-occurring mental health and substance use disorders. It's very impactful to see the stabilization of a co-occurring mental health disorder alongside the substance use disorder. Especially I will say with personality disordered females.*

One thing that enables staff to treat patients with co-occurring disorders, and cater to the many facets of these disorders, is the diverse nature of MAT program staff. Peer support specialist and care management staff provide the MAT team representation from community residents who identify with the population they are serving culturally.

> *A strength of our team and the MAT program is our cultural diversity. Since we're close to the rez we've got wonderful native professionals here that have lived on the rez, are functional professionals as well as other non-natives that have also had that cross-cultural experience. I think that's been a, I don't think that's been valued at the level and strength that I think our team has.*

Full Implementation

Overview

Full implementation in the NIRN framework is reached when "50% or more of the intended practitioners, staff or team members are using the innovation with fidelity and good outcomes" (NIRN, 2017). Across all sites, this level of implementation has been achieved. With full implementation comes continues challenges and accomplishments. This section presents the

continued challenges or areas of practice that sites reported as being keys to successful full implementation.

Standardizing program protocols

The role out of STR funding created a need for funded sites to quickly adopt a set of standardized practices and approaches. During the year of implementation, at least four sites have created (and shared with us) procedure manuals and practice guidelines to ensure consistent care across patients. The systematic nature of these documents, and the pride with which staff shared these documents, suggests the establishment of more expertise in the state associated with MAT across different provider settings.

> *So, at the conference, the last conference, we talked about all the stuff that had been developed for the program and how, essentially, we have an intensive outpatient treatment program of a family practice at a hospital. And he said, "That's not common"…But, it initially was just a written protocol, and it started the protocol and then moved on to intake questions. I added, as like an appendices type thing, with the protocol with appendices. And then, a colleague said that you should consider putting it in more of a toolkit, and then that way people could be able to navigate it a little bit better.*

> *And so, [Staff Member's Name] did a lot of work on making the contracts, and the toolkit, and the protocol. And it just…we just change it all the time. Something comes up and it's like, "Oh, that would be a really good thing to add." We would add it. A couple months ago, surgery came up, so we developed some surgery guidelines.*

> *Something that we can give to other providers in the building and say, "This is how we run. These are our ideas. These are our recommendations." Sort of, we're just all on the same page.*

The structure of each program also provides an opportunity for AMDD to pull together best practices guidelines or overview of the strategies being utilized within the state. This would support site leaders as they could have the authority of the state behind the recommendations they are making to fellow providers and administrators within their sites.

> *Moving forward, as Montana gets best practices, that makes my job easier because it's not just me saying "This is the best way to do it" and then I have an MD say that someone else taught me how to do it differently. That's been a big struggle, and*

as the state figures out that we're gonna' roll out the best practices and train at the same idea, that would be helpful on my part when talking with providers about the program.

Professionalization of peer support specialists

At least three sites reported the use of the peer support specialist position and funding from STR to create an informal staff recruitment pipeline. Noting that it is difficult to find good staff in rural locations across all the staff positions, especially in behavioral health, multiple sites have started to view the peer support role as a strategy for training new staff. Hardin has created a program with the local tribal college and is the best example of this approach to the peer support role. In doing so, especially in very rural places, professionalization of the peer support specialist via additional education, training, and professional experiences can expand their capacity to differentiate their past from their present, while continuing to support others with their stories of recovery. In addition, professionalization of the peer support specialist can be a workforce training method that has the potential to expand the talent pool of staff for the medical center.

[Interviewee]: As far as what the actual duties of the peer support person were, it's just kind of morphed into our care manager and we've given that person those skills, those trainings to be more part of the team, I think.

[Interviewer]: Sure. Yeah, it just seems like the staff recruitment would be the rub for the really small places, right?

[Interviewee]: I think so.

The peer support specialist is a good idea and very difficult to implement in a rural setting. Because you can have people who remember the disasters you've caused when you weren't in recovery. We're a border community. On reservations, everybody really is related to everybody else. People remember what you did in middle school and carry that over so.

Having peer support who worked, is in recovery and yet for them, to have credibility to be accepted by the community is a qualitatively different thing in Missoula. What we wanted was someone with a skill set but also…basically, a pipeline for people to be able to grow because recruiting is extremely difficult. We needed someone who could come in at the very professional level, have a track where if you wanted to do just that. If you want to do more, we've got the training and the opportunity for you to do that. You could progress theoretically from a peer

support specialist to an LCSW [licensed clinical social worker] at some point, and along the way pass through the LCSW curriculum and that was behind the, okay what's going to happen.

In heightening the sophistication of the peer support specialist role expectations, this site as well as the two others that are taking this approach, have made the peer support specialist an integral part of their care team. In other sites, the peer support specialist functions as more of a sponsor and friend who can help with logistics and provide encouragement to the patient outside of the care setting. Variation in the role of the peer support specialist is one important cross-site finding.

Sustainability

In general, programs reported a general view that the program would be sustainable after funding from SAMHSA via STR and SOR conclude. Sustainability of the program is entirely dependent though on the continuation of Medicaid expansion in the state. When asked about the program sustainability, staff reported that sustainability was likely, *"As long as we have Medicaid expansion, I think that it's certainly capable."*

There are two areas of the program sustainability that are not fully sustained via Medicaid or reimbursable funding sources, namely, PSSs and the care coordinator position. *"Then you've got a peer mentor. It's hard to put in a peer mentor when the grant's going to go away. Because I don't know the billing structure for that, how to make that sustainable."* As noted in the Spoke section, there was some complexity with the reimbursement rates from Spokes with Hubs.

Areas of continued need

Even when a program has been fully implemented, there continued to be areas of need and opportunities for improving the quality of the program or expanding the capacity of the service delivery area of population. There is some variation across sites in the level of staff stability. A few care teams reported a level of stability and little concern about staff turnover and burnout while others reported quite a bit of concern about staff turnover and burnout. These sources of

variation are presented within each site profile. The final area of continued need that was identified across all sites was the need for advanced support for MAT providers. All sites reported that they feel under supported by the state for continuing education that could help them make decisions about complex patients.

Process Evaluation Conclusion

STR has funded a significant expansion of MAT for OUD in Montana. Sites with little to no history of providing behavioral health care now utilize these new resources to offer MAT. Preliminary results show that increased behavioral health knowledge among new providers is helping to improve outcomes and increase access to care. We see these outcomes in both the patient reports and in the conceptual sophistication with which participants discussed addiction and the practice of caring for this population. All sites reported a desire for increased support when thinking through how to make decisions for patients with unique circumstances and for patients who are not in compliance with the program's protocols. Finally, interviewees reflected upon some of the challenges inherent in balancing a care delivery program where abstinence is not the goal, and simple definitions of success are hard to find. Continued support from the state in helping sites know how to best think about program goals for both their site and participants, as well as support in knowing how and when to dismiss a patient from treatment, form some of the biggest needs remaining among STR grantees.

> *If your outcome is abstinence, good luck with that. We need to have some metrics but what can you measure, because abstinence as your outcome doesn't leave you much… We had to use different metaphors, like caffeine. We can function in life but caffeine kind of keeps us going, MAT is the same and we really had figure out who has that perspective and who doesn't…That's the call, it's not getting off of opioids…It's more of a step system and that's where the integrated piece comes from. We're able to tackle a lot of things at once and be able to be functional and then once we do well, we can tackle the meth. We can tackle the next level of things. Because you have that team, you can really structure it. It's less overwhelming. You can really track what you're succeeding and what you're not succeeding and then kind of strategically tackle those things and make sure that they're functioning in life.*

SECTION 4. CLIENT PERSPECTIVES

Patient interviews focused on their experiences in the STR funded MAT programs throughout the state. Overall, patients spoke glowingly of their providers and about the positive effect STR funded MAT programs played in stabilizing them in their recovery. They also identified a number of logistical challenges associated with the program structure and the barriers they face as Montana residents.

CONFUSION AND FEAR

Customizing each patient's treatment plan is a challenge for MAT programs. Patients often reported inconsistencies in their understanding of goals and trajectories of treatment. Now, it should be noted that these inconsistencies may be due to a clinician's insight into each patient's addiction. Nevertheless, many patients consistently mentioned their confusion with the duration of their treatment plan and Suboxone's effects on the body.

> *[Interviewer]: What's the end goal? When are you done with the program?*
>
> *[New Patient 1]: I don't know. I'm kind of afraid to find out. I'm hoping it will go on a year. I think maybe they give you a good six months before they start putting you on a timeline, I don't know. Eventually, I'm sure I'm going to have to start going down on my strips but I don't even want to think about it right now.*
>
> *[New Patient 2]: I don't have an end date yet and I'm not concerned about that yet, because I'm still new in it and it could be a lifetime maintenance thing for me, and if that's the case, that's the case. [Interviewer: And, so, you know that: it could be a lifetime] Absolutely. It was told to me right up front. [Staff member's name] also told me right up front about the side effects of the medication.*

Some patients worry about getting cut off from their medication.

> *[Patient]: Oh, putting a time limit on the patients, of how long they can be in the program…Since it is a prescription from a doctor, I'm always so worried there's going to be a timeframe on how long each patient can be in this program…I guess I'm worried they're going to say that by this date you can't be on this program anymore. And I think that would put a lot of pressure on me to be 100% by that date, otherwise, it's all on me again."*
>
> *[Interviewer]: What could the program do a bit better?*
>
> *[New Patient]: Maybe just education of the medication itself, on Suboxone.*

[Interviewer]: How so?

[New Patient]: Just knowing how it works in the body. Because I've had to…I'm still looking it up and learning about it on my own, myself. I'm one of those people: I like to know the whole picture. I like to not just "take this because it works."

Some patients were unclear about the duration of their treatment plans and whether they would be able to wean off of Suboxone: *"I'm not sure I'll ever get off of Suboxone."* Other patients were adamant about not looking long-range and were focused on their immediate goals: "*I'm just trying to get stable right now, man. I don't wanna' know what's down the road. Stable is all."*

Access: Contact & Delayed Enrollment

Patients often reported difficulty reaching staff through bureaucratic channels and even understanding the best processes for contacting someone at their treatment center.

[Patient]: It would be nice to be able to reach people. Like on the phone, it's quite difficult sometimes. At the recovery center, it's nearly impossible to get a callback.

[Interviewer]: Why do you think that is?]

[Patient]: I have no idea because I have seen somebody at the desk all the time."

[Interviewer]: if I gave you a magic wand, what would you change about the program?]

[Patient]: Being able to call [Dr. Name] directly. Ha ha ha! [Interviewer: Meaning what?] Well, because, instead of talking to [Dr. Name] directly, we have to go through the front desk and then it comes to [Staff Member's Name] and then when [Staff Member's Name] has a chance to go talk to [Dr. Name]. But we can't just call and leave a message for [Dr. Name].

[Interviewer]: What would that do for you?

[Patient]: Well, when I was pregnant, I had a hard time getting ahold of [Dr. Name] and it had been a few hours and I needed to switch over to the buprenorphine 'cause it was important that I did it as soon as possible, and I had to wait a couple hours until I was even able to get ahold of [Dr. Name]. There's so many dead ends.

[Interviewer]: So when did you come in here and what did that look like?

[Patient]: Okay, so here's something of note: it took about 2 ½ to 3 weeks to get in here. So had I been injecting heroin or something, I could have been dead. [Interviewer: So when was that?] I was trying to get in before Christmas and I finally got in early January. And once I just got through the door, they were real great. But that's the thing, if I were using more dangerous opioids, I could have died long before I got through the door and got help. [Interviewer: So you walk in the door in December and they said…] They were packed out, the nurse told me they were so booked out that it would be a week, and a week rolled around and I contacted and they said it would be another week, and it was like oh my goodness.

I was going through withdrawals pretty hard…The guy tells me that I'm not going to be able to take the Suboxone until I get done with the orientation—I can't think of what it's called—I had to do a two-hour-long meeting at the beginning with the doctor and counselors until I could get the prescription in my hands, so I had to wait another four days. Meanwhile, I'm telling him and my probation officer there's gotta' be something you can do to fix all this because I'm about to say 'fuck all this and go get some pills because I'm feeling like shit.' And somehow or another, I made it through those four days before I got the prescription.

Some sites deploy their peer support specialist to bridge the gap between when patients make first contact and the day of their enrollment. Other patients have trouble accessing services due to their personal histories. For example, those in the criminal justice system fear jail time or suffering other consequences for seeking treatment. One such patient states:

I was getting random UAs while on probation, but it had been 9 months since the last one so I was able to use. And if I had started one of these programs without telling [my probation officer] I would have gotten called in for a UA and they would have found out anyway and I would have gotten in big trouble. [Interviewer: So walk me through that again…] I was teasing this idea of starting one of these programs for a couple months before I actually did, but I was scared to tell my probation officer because he thought I was on the straight and narrow. I had never been on probation before and was afraid if I told him I'd been using, he'd arrest me and throw me in jail and not let me out until I snitched on the people I got the drugs from. One day it was a surreal moment and I went over there to his office, and he said, "How can I help you?" and I flat out told him I needed some help, I've been using and I'm really suffering here. And he said "Well, how can I help?" Then he recommended me over to the Recovery Center.

The challenge of patients accessing care to ensure continuity while being involved with the criminal justice system was also noted by providers, including one site that changed the contract they have new patients sign to allow for continued services while a patient was in jail.

Group Therapy and Support

Most patients praise group therapy sessions as an integral part of their therapy. A few negative patterns also emerged. First, some patients described how those required to be there may not view group as positively or take it as seriously as those voluntarily there. Second, a pattern of redundancy emerged. Some patients expressed a desire for alternating activities and events rather than using the whole block of time to just sit and talk.

> *[Interviewer]: So tell me about group.*
>
> *[Patient]: I wish we had some other things going on, like homework assignments, instead of the same topics. When we go in there we do our thoughts and feelings, and talk about a topic, and if we have cravings or use. And it gets kind of lame. We do the same routine every week.*

At other sites, patients desired peer groups in order to create more structure and hold one another accountable for their recovery and treatment.

> *[Patient]:I think there should be a peer group, maybe coed, or maybe two groups. I think there's always going to be a black market, in a group, in a setting, getting to trust, getting to understand each other, they're going to keep that person from abusing those drugs, or they're going to help them, or they're going to be there for them so they don't sell 'em. If you're in a group setting and you start knowing them, and we've been in group for four or five months and I see you at so and so's house and I know they sell Suboxone. It's going to be a little more difficult for you and you're probably not even going to do it if you get confronted on it if it's from a peer, someone in your group.*
>
> *[Interviewer]: Would you participate in the group you're describing?*
>
> *[Patient]: I'd facilitate it.*

Other patients were curious as to why their family members were unable to attend the same groups as them.

> *My mom used to be a really bad alcoholic, but we can't go in the same group as our family members. And I think that would be a nice thing—she wanted to learn more about the Suboxone and be in the group to learn more about her own addiction—but I guess that's because of people's stories. If they wanted to attend treatment, they'd need to be in a different group. It would be nice, or beneficial if your family member could join you in the class.*

In addition to caring staff, patients described the emotional connections and relationship bonds made in group therapy and with PSSs as integral components to their recovery.

> *In order for you to get the full effect, I think group therapy should be required. I don't think anybody can get the full benefit without the therapy being part of the treatment. It's kind of like getting your leg out of a cast and skipping the physical therapy. It's kind of like treating an injury like that just with pain medication; where that other component is so important.*

Sites that have active group therapy sessions can struggle to keep the programs fresh and engaging. Even with this limitation, patients acknowledge their benefit to the treatment process. In addition to the group, interviewees consistently noted the importance of the peer support specialist in ensuring cohesion of the program. These staff members serve as liaisons between the clinical staff and internal and external resources. For example, one patient states:

> *[Patient]: It's not like they're just doing the bare minimum. [Name of peer support specialist] has gone above and beyond to help me in ways.*
>
> *[Interviewer]: Give me an example.*
>
> *[Patient]: He has literally set up my schedule for me for CPS [Child Protection Services] so they would quit harassing me about my care. He has gone out of his way to look up programs through my tribe, which is actually [out-of-state] to see what I'm eligible for and ways that the Indian Alliance here can work with my tribe to get me help. Anytime I come in here with a problem through the day, he will stop what he is doing and focus on that problem and print off some paperwork from a resource he has that will help me. He has given me his cell phone number so if I'm having a bad day or something happens, I can call him or text him for advice. He realizes those stressors are actually the things that could make me relapse. And he helps me realize I'm capable of working through these problems and solving them.*

PSSs play a number of vital roles: bridging the gap between when patients contact the clinic for help and when they actually receive treatment, being an ally, transporting patients to appointments, helping patients secure housing, helping patients contact CPS and the courts and engage in community work.

Care, Love & Community

Many patients described how the treatment programs in which they are currently enrolled saved their lives and the staff was a major reason they decided to stick with the program. The

following question brought out descriptions of gratitude and deep emotional reactions to the staff and the care patients receive:

> *[Interviewer]: What should they never stop doing here?*
>
> *[Patient]: I would say what they're doing is being warm, and being on time with everything, making a person feel like their worth something; making it so easy on a person to go through this treatment.*
>
> *[Interviewer]: It's easy?*
>
> *[Patient]: It's easy now. Like I say, I was terrified. They make you feel like you're part of the human race and worthy of their attention. They make you feel so good. They've been awesome from day one.*
>
> *[Interviewer]: So, what does that mean? Give me an example of "awesome from day one."*
>
> *[Patient]: The way they treated me. The way they helped me—if somebody saves your life, they're pretty awesome. Every single one of them…I haven't used since. And, you know, I thought I was going to my death bed. I don't know what to say: I wouldn't be alive without 'em.*

Patients often needed to be probed several times and encouraged to think deeply about how the program could be changed for the better because most were entirely grateful for the care they received. Even after being prodded by the interviewer ["*Interviewer: So, just reflecting on that, how do we make the program better?"*], many patients responded in a manner similar to one patient who stated, *"I don't really have an answer for that. I mean, I feel like they're my family here—I can call them up whenever I want and I guess that could happen for everyone."* Other patients stated:

> *I hold [staff member's name] and [staff member's name] in such high regard. I find them both very intelligent and I actually care about what they have to say, and I've also gotten the feeling that they do care about me: that this isn't just a job for them. And so that's really helped me want to come.*

Other patients were adamant that staff should never give up on patients, never stop caring, and expressed their sincere appreciation for the attention and care they received. Interviewers witnessed patients getting emotionally choked-up when describing their gratitude. Patients also

explained their appreciation that the staff allowed them to make mistakes, including relapsing, all while displaying and unwavering confidence in their ability to recover. One patient stated:

> *[Interviewer}: So, just reflecting on that, how do we make the program better?"*
>
> *[Patient]: Allowing room for mistakes. Not condemning somebody for a mishap…*
>
> *[Interviewer]: And they do that now?*
>
> *[Patient]: Yeah, they allow room for mistakes, messing up. They allow you to learn from your mistakes instead of condemning you right away if you mess up one time and kick you off the program if you relapse.*

The above patient echoes the sentiments of many patients who describe an environment that patients feel comfortable voicing problems, cravings, relapses, and asking questions. The staff has created more than clinics. In many cases, these clinics foster community. One patient states, *"Sometimes I just come down here to see who's around. See what's going on."*

Improved Access to Healthcare

The population utilizing the services offered by MAT clinics is an underserved one within the general healthcare system. Sites that do both behavioral and general healthcare reach this population and provide services many patients describe omitting from their lives prior to participation in the MAT program.

> *[Interviewer: What are some of the primary benefits you have received since starting here?*
>
> *[Patient]: Basic healthcare that I probably didn't know I needed. A lot of counseling, the counseling has been great for me. Had I not gotten on Suboxone I wouldn't have had my hypertension taken care or, my anxiety…I really like that there's a counselor here, and whether you need help with dental care, anything like that, they know a lot of resources.*
>
> *[Interviewer]: What resources do they steer you towards?*
>
> *[Patient]: I've gotten help with dental care; I've gotten help finding a job; housing, I was having housing issues and they were helping me with that; food stamps, Medicaid.*

[Interviewer]: Can you tell me an example of one of these and how they helped you?

[Patient]: Yeah, when I came here, I didn't realize Medicaid was a program I could get into and thought I made too much money. So when I was coming in I was paying for the initial visit and then having to pay for the Suboxone. In the beginning that wasn't that big a deal, but Suboxone when you pay out-of-pocket is $312 for a week's worth. After a few weeks, I was thinking about dropping out of the program. And that's when they went through the income guidelines with me and let me know where the office was and how to reach them.

Patients applaud having their treatment covered by both Medicaid and private insurers. Not worrying about how they will be able to afford treatment has likely improved retention, while other treatment facilities and programs cost more money and are described as less effective. An overwhelming number of patients mentioned seeking care at other facilities, but Ideal Options was by far the one facility most patients were relieved they could now avoid by participating in the MAT program at an STR grantee site.

[Patient]: I started at Ideal Options in Billings. It wasn't a doctor's office like this, it seemed like it was just a place to make money.

[Interviewer]: What do you mean by that?

[Patient]: People in and out the door. They didn't take blood pressure or ask you how you were doing. It was just urine samples and here's your prescription. And it was so uncoordinated, and the cost of that program was ridiculous. I was only able to go twice and had to drive 100 miles to get there. And my bill was so much I couldn't afford it. [Interviewer: How much was it?] I think it was like almost $600 per visit. For me personally, because I have private insurance—they were billing me $600 dollars.

[Interviewer]: And how much is it here?

[Patient]: Well, here it's health treatment—I see a doctor—and my insurance is covering it…There are two kinds of Suboxone: there's a strip and a capsule. Ideal Options will only deal with strips, and my insurance company wouldn't cover it. They'd only cover a percentage of it so my payment was like $140 every two weeks, and I had a $40 co-pay, so it was $180 every two weeks to continue my program, which I did for almost a year. When I came here, my insurance covers everything but the $10 co-pay on my meds. That's it. The program is more feasible for me. Every aspect of this program has been a plus for me. [Interviewer: Unpack that for me, what does that mean to you?] It means a lot. The stressors of having to drive, the stressor of having to pay, all those stressors can cause a relapse at any time for

me. Taking out all those stressors and centralizing it here for me took a lot of pressure off.

Patients also spoke about how the MAT program was tailored to their individual needs. The flexibility was attributed to each patient's best treatment plan, but also a lack of need to bill the patient for services. One patient states, *"It's an option here. If you're doing good, you can move up to monthly, instead of one week, two weeks. And I think that's just 'cause of money. [Ideal Options is] billing you every two weeks when they didn't need to, in order to take advantage."*

Successful Clients

Across all sites, staff shared stories of patients who successfully turned their lives around because of the services they received in the MAT program. Each site profile includes two or three success stories. In this section, we present a selection of success stories to highlight the ways in which access to MAT for OUD is making a difference in the lives of Montanans. Staff report helping patients through a number of life challenges and shared successes. These successes were always couched in the reality that recovery is a process and temptations continually exist. One staff member states, *"If you feel like somethings going to happen, call us and we've had those that have called and said, 'Hey, I was feeling really tempted this weekend, my old dealer got out of jail.'"*

The success viewed by staff is energizing amidst a challenging program. A few of those stories are presented here:

We have a really good success story. It's a couple that came to us. She had premature twins because she was using and they took all the kids away. They had like six, six kids. [CPS] took all the kids away. They [the parents] came to us, to our program. They've been in here a year and a half now. Year and a half. They both have jobs. They got the kids back. They have their own house. They have a vehicle, whereas when they came to us, they had nothing.

We've seen a number of our patients getting jobs. So like coming to us with really nothing and one of our really difficult ones got a job, one that had no confidence and was just really nervous and was like I could get a job but it'd have to be at night and now he's like got a day job. Just I think that is a positive thing, having them see themselves the way we see them.

We have a young lady I've worked with for almost a year, heroin and methamphetamine and incredible cannabis use, and has done really well with MAT,

really has been impaired by her cannabis use. She's stayed abstinent, amazingly, with regarding meth. We actually even had her in inpatient to try to get her through the worst of her cannabis withdrawal. She got through that and did really well, started feeling really well, but resumed her use shortly thereafter. Struggled along. I said, "Look, I'm not kicking you out of here." They were really struggling with her in the psychosocial groups. Finally, we backed off and just said, "Okay, this is what we expect of you. You've got to make your provider visits and you're going to do at least case management with your counselor once a month," and she absolutely never misses. Well, about two visits ago, she came in and said, "Look, this is the deal. I really want to reestablish a relationship with my children. They're in Texas and I need to clean it up. I need to get off of it," and she pretty much self-tapered [inaudible 00:36:52]. She's got to that place of doing work.

Just from an observation level, I have watched patients go from being extremely ill and extremely dysregulated and extremely sad to people who sit in the waiting room…and I'm thinking of one patient in particular…and every time I walk by I get the daze, "Okay, I'm on month seven" or whatever that is. And it's just, they've received their lives back to a certain extent and we've had patients who say no thanks. I've tried this, this is not working, I'm just gonna' go do what I do. And that's fine. But the success stories are so successful that it really is life changing.

Yeah, it's very rewarding because we do an initial when somebody's interested in MAT program and then MAT nurses screen them and they're potentially a good fit, we do their initial…We do a meeting with all of them. Talk to them, with all of us. And we kind of do a round table thing with them. Seeing them, I feel like that's usually their lowest, when they're breaking down and they're just talking about all of the crap that's happened to them and then seeing them, succeed and get a job. Get their kids back, be happy. Breaking those connections.

SECTION 5. CONCLUSIONS

By all measures, the STR funding has supported expanded access to prevention and treatment interventions in Montana.

PREVENTION OUTCOMES

During the grant cycle, STR funds have generated the distribution or expansion of:

- 1473 units of Narcan across 35 of the 56 Montana counties
- 1816 individuals were trained in the delivery of Narcan. 1153 being public safety professionals.
- 161,000 Deterra bags
- MAT waivered providers increased from 22 to 131 during the grant period. And there is at least one waivered provider listed on the SAMHSA treatment locator in 24 counties.
- 535 unique patients received MAT at STR grant funded sites during the grant program
- 5 new Montana board certified PSSs were trained with STR funding

The primary goals and objectives were framed around the result of increasing these interventions, and these goals and objectives have been achieved. Subsequent evaluation efforts for these interventions may want to consider the addition of more performance metrics to enable a more complete assessment of their effectiveness at decreasing OUDs and overdoses deaths from opioids in Montana.

IMPLEMENTATION PROCESS

Across all MAT provider sites, full implementation of the MAT program has been achieved. Interviews with providers and patients identified a range of successes and continued areas of need for specific sites and for the state as they broadly support new MAT provider sites. In summary, the process study of STR sites identified a number of general patterns by implementation phase:

Exploration/Installation

- Preparation time for sites was very brief. Those with no prior MAT experience reported feeling blind going into the grant program.
- All sites were able to access expertise in state or across their professional networks to support installation of the program.

Implementation

- All sites reported settling into a patient load that fit their staffing capacity.
- Most sites developed standardized procedures to ensure fidelity to their MAT care model.
- Many sites shifted into a nurse/care coordinator hybrid model for reasons associated with both financial and program structures.
- Once patients become stabilized, they begin to use additional health care services.
- All STR sites have achieved full implementation of their programs
- Sites report that the program is sustainable with Medicaid expansion.
- Warmth, responsiveness, and openness to patients from staff was a key element of the programs.

Areas of continued challenges

- Recruiting peer support staff can be more difficult in areas with smaller populations.
- All sites reported a desire to have more support for complex patients and cases that were unusual or peculiar in some fashion.
- Many interviewees reported that this type of service delivery can be uniquely emotionally taxing, due to the frequency of interaction with and characteristics of patients.
- There is a tension reported by patients and staff between abstinence-based views of recovery and MAT.
- Hub and Spoke program model was largely unsuccessful for a variety of reasons.

The primary goals of STR funding were to 1) Support OUD prevention programs and services in Montana and 2) to Develop comprehensive, evidence-based services for OUD treatment in Montana. Even within a relatively short timeframe between the grant implementation and evaluation period, each goal appears to have been achieved. Noting this short timeframe and the specific scope of this evaluation, subsequent evaluations may want to consider additional data sources to track how grant activities may be associated with opioid overdose prevention within the Montana population. The second goal was broadly achieved, as treatment program access has been expanded. Subsequent evaluations may want to focus on the effectiveness of treatment programs and identify keys to what makes MAT treatment for OUD work for Montanans.

Appendix A. Methodology

Outcome Evaluation Methodology

Government Performance and Results Act (GPRA) data was collected by two Hub sites via paper intake and follow-up surveys and was entered into the SAMHSA GPRA data system by the evaluation project team. A de-identified dataset of GPRA measures was retained by the evaluation team and is used in the outcomes section. Data on the distribution of Narcan units was reported by the prescribing pharmacy (Ridgeway) to AMDD. Data on trainings for the use of Narcan was reported by Best Practice Medicine, the organization contracted to provide the master trainer trainings across the state. Master trainers were then expected to record and provide data on the general trainees who attended their training sessions, but these data were variable in quality and not easily monitored. Data on training of PSSs was provided by the Montana Peer Network, who provides the trainings. Data on the units billed and months billed for peer support services were provided by each STR site. Data on waivered providers was obtained from the SAMHSA Buprenorphine Practitioner Locator. Data on disposal bags was tracked by AMDD staff.

Process Evaluation Methodology

The primary mode of data collection for the process evaluation were interviews. Interviews with staff were completed as either one-on-one or in small groups. Each site was provided with a set of requested interviewees by the research team. This list included:

1. STR Care Coordinator
2. STR Program Manager
3. Behavioral Health providers (one or two)—Including Social workers and therapists
4. Prescribing providers (one or two)—Including MD, DO, APRN, Pharmacologist
5. Executive leadership at your site
6. PSSs who work with your site
7. Any medical staff who have been resistant to MAT
8. A few current and former patients (e.g. former, meaning patients who left the program)

There was slight variation in the final interviewees within each site due to availability and differences in MAT team staff structure. All sites included interviews with at least one patient. We were unable to speak with any former patients who had left a program. The care coordinator or program director at each location was the point of contact and the individual who finalized the agenda and recruited all interviewees at each site. Table 4 in the main body of the evaluation report provides details on who participated in provider interviews at each site.

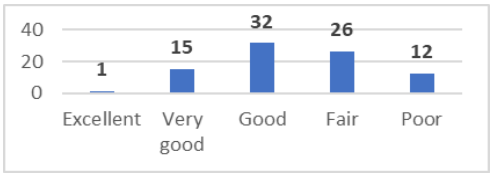
Each interview took approximately one hour. A semi-structured interview guide was used to collect both open and close-ended survey questions. Separate interview guides were created for the patient and provider interviews by the research team and reviewed by AMDD staff. All data analysis used qualitative coding based upon an inductive coding scheme created by the research team to correspond with the NIRN implementation framework. Additional deductive codes were identified by the research team during the process of reviewing the transcripts. All interviews and small groups were audio recorded, transcribed, and coded by two members of the research team. This process is intended to ensure a higher degree of coding reliability. All qualitative data analysis was completed in NVivo.

In addition to the qualitative data collected at each site, we asked the primary prescriber and the behavioral health care director (or comparable staff) to complete a MAT program composition survey. This brief-survey contained open-ended and yes/no questions about 17 elements of a MAT program. The survey was informed by the *ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioids* (ASAM, 2015) and the *SAMHSA Treatment Improvement Protocol 63: Medications for Opioid Use Disorder* (SAMHSA, 2018). Results from this survey were used to produce the site profile tables featured in each site profile.

APPENDIX B. GPRA CLIENT AND CARE CHARACTERISTICS

The data presented in this section provides a descriptive summary of patients based on GPRA intake interviews at two Hub sites only. This is due in part to the fact that the most complete information about patients is collected at intake. In addition, sites were still conducting follow-up and discharge interviews, but intake had ceased as of the writing of this final report. The results presented here represent information on 89 unique patients – 78 new treatment patients and 11 patients in recovery. Table 5 presents a summary of the characteristics of all patients for whom GPRA intake forms were completed during the STR grant across the two sites that were required to collect this information.

Table 5. Characteristics of GPRA patients

Gender		**Age**						**Ethnicity**		
Male	*Female*	*18-24*	*25-34*	*35-44*	*45-54*	*55-64*	*65+*	*White*	*American Indian*	*Hispanic*
53%	**47%**	**11%**	**48%**	**23%**	**11%**	**4%**	**3%**	**72%**	**27%**	**1%**
Employed		**Education**						**Training**		
Yes	*No*	*Less than 12th*		*HS diploma*	*Some college/ vo-tech*	*Bachelor or higher*		*Enrolled full-time*	*Enrolled part-time*	*Not enrolled*
41%	**59%**	**21%**		**38%**	**34%**	**7%**		**6%**	**3%**	**91%**
Children		**Housing**						**Housed location**			
Yes	*No*	*Housed*		*Shelter*		*Institution*		*Own/rent*	*Someone else*	*Residential treatment*	*Other*
73%	**27%**	**94%**		**4%**		**2%**		**64%**	**29%**	**5%**	**1%**
Co-occurring screening		**Screening outcome**						**Rate overall health**			
Yes	*No*	*Positive*		*Negative*							
95%	**5%**	**81%**		**19%**							

N = 89

On average GPRA patients are young – almost half (48%) are 25–34 – and there was more representation among American Indian than the general Montana population (27% of GPRA patients in this sample are American Indian compared to 6% of the general population[1]). This overrepresentation of American Indian patients is due to the location and patient population of Big Horn Valley, and the reporting from only two of the STR sites. The vast majority (94%) are housed, with almost two-thirds (64%) living in their own rented or owned home. Most (74%) have children, and almost half (41%) are currently employed full- or part-time. Taken together, the characteristics of GPRA patients suggest that they are fairly stable in many respects (housing, overall health) and yet face challenges associated with youth, lack of education, and co-occurring health issues.

[1] US Census 2010 estimate.

Figure 9 expands on this summary finding and provides insight into the support systems and coping strategies among GPRA patients. Because patients are asked these questions at intake, Figure 9 provides a snapshot of the supports (or lack thereof) that many prospective MAT patients face at the time of initiation of treatment.

Figure 9. Support systems and coping strategies of GPRA patients (n=86)

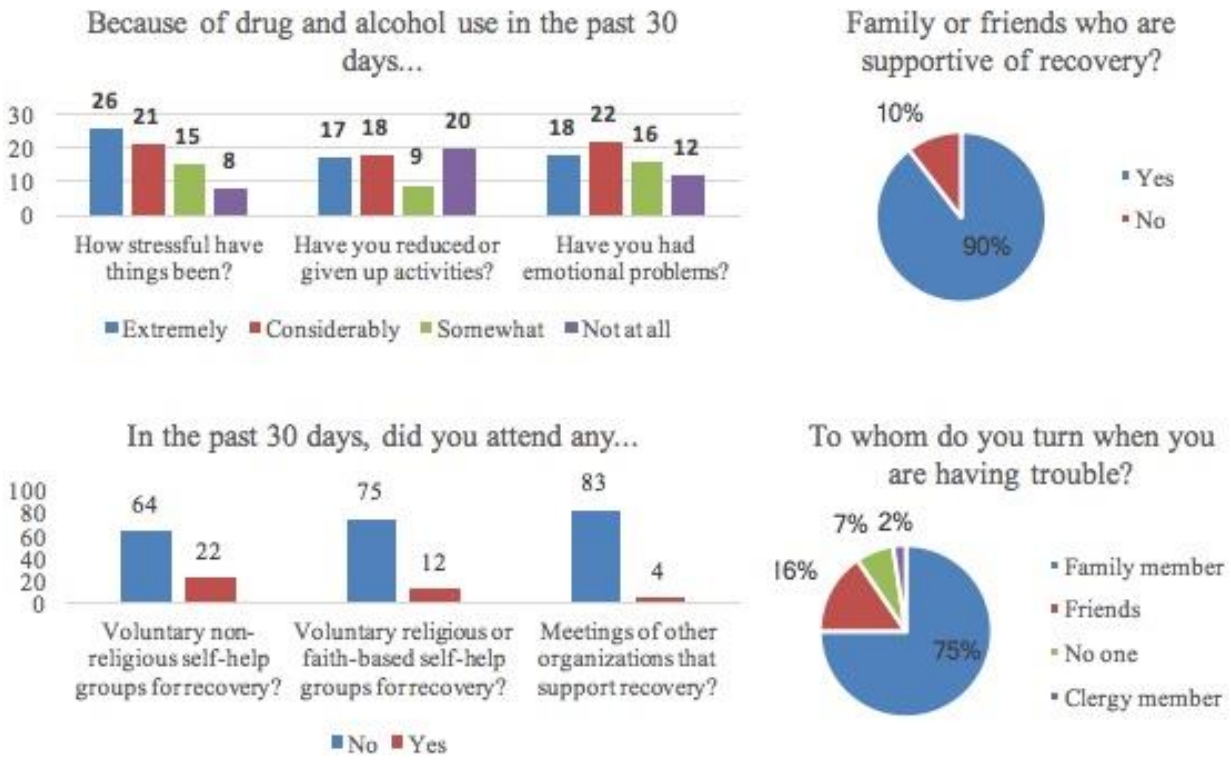


Table 6 presents the services associated with MAT and are included in the GPRA measures that were reported as being planned for more than 50% of GPRA patients. All services that were planned for more than 90% of patients were directly related to MAT and addressing substance use disorders. The rest of the services offered to most patients and listed in Table 6 focus either on other medical-related care, or on support services for individuals in recovery, and provide evidence that at least GPRA sites have reached the goal of **increasing access to comprehensive, evidence-based services for OUD**.

Table 6. Types of services provided to at least 50% of GPRA patients and proportion of patients for whom each service was planned

Type of service	Number of patients who received	Percent of patients who received
Treatment planning	87	98
Pharmacological interventions	86	97
Alcohol and drug testing	86	97
Screening	85	96
Substance abuse education	85	96
Outpatient care	83	93
Recovery support	82	92
Medical care	67	75
HIV/AIDS medical support and testing	64	72
Individual counseling	62	70
Relapse prevention	60	67
Continuing care	58	65
Assessment	56	63
Peer coaching	53	60
Case management	52	58
Group counseling	50	56
Aftercare	50	56
Co-occurring treatment	47	53
Self-help and support groups	46	52
Information and referral	46	52

APPENDIX C. PROFILES OF INDIVIDUAL MAT TREATMENT SITES

PROFILE: ST. JOSEPH MEDICAL CENTER – POLSON

Type of medical organization: Rural hospital	**Setting:** Regional town, rural service area	**Hub or Spoke:** Hub
Integrated Behavioral Health: No	**History with MAT:** Partial – Waivered providers, not member of MAT team	
MAT delivery elements		
Initial point of contact for patient	RN Coordinator	
MAT medication(s)	Subutex, Sublocade, Buprenorphine, Zubsolv	
Frequency of dosage	Levels of care standards	
Induction availability	Monday-Friday (Wednesday for new patients)	
Goal from patient contact to treatment initiation	One week	
Use of peer support: Y	**Allow walk-ins:** N	**Patients receive counseling and medication:** Y
Ancillary support elements		
Data tracking tool or system: Excel		**Engagement with law enforcement:** Y
Transportation: Y		**Training of front office staff about MAT:** Y
Warm hand off with emergency room: N		**Training of nursing staff about MAT:** Y

REASON FOR PARTICIPATING IN STR

I got a phone call in an airport, going off to something called Providence Leadership Formation to talk about our mission. So it made me maybe feel a little bit more guilty to say no to something like this…Someone called from your community, recommended your hospital for this grant. We think you'd be perfect for this grant. And I heard the amount of money on this grant and I got to be honest with you, I didn't really want to do it. Just the work that's involved. And personally, my fear of starting a program that may not be sustainable, and only having like a week to evaluate that. Because it was like the end. We needed another hospital to do this. It felt irresponsible in some ways for me. Like you really don't want to, especially something like this, take over people's lives, create a program and then say, "I can't afford to continue this." We talked about our strategic plan and our number two mission is to improve behavioral health and mental abuse and substance addiction. So that's how we came to say we'd do this.

EXPLORATION

St. Joseph's hospital in Polson was recruited by the state AMDD office to be a grant participant. Upon the request, hospital leadership scrambled to reach out to professional colleagues and experts in MAT to assess their readiness, especially as it related to staffing. One major concern was the creation of an important program for their patients that would not be sustainable after the grant period ended. Interviewees shared a view that they were not quite able to fully know what they were committing to as STR grantees, but that they felt it was within their organizational mission and goals. *"I think it was kind of an interesting process on how the grant was rolled out. And that we didn't know what the objectives were completely before we signed up for it. So those developed after we were approved for the grant. So, we've adapted to that. I think I still would've signed up, but I don't think we had a model in mind when we said yes."*

INSTALLATION

Recruitment of core program staff in the roles of prescribing provider and care coordinator were top priorities for the Polson leadership and MAT team. More than other Hub sites, Polson reported a need to get up to speed quickly with the program components. They did so by reaching out to the experts at the Recovery Center – Missoula, using some STR funding to facilitate the engagement with Dan and Tammera Nauts.

> *And so, we went there and kind of witnessed their programs [at recovery center Missoula]. And had lots of phone calls with both Dr. Nauts and Tammera. We were able to just bounce things back and forth. Like, "Hey, we have this issue. What do you guys think?" And so, they were really important to us getting started…So realistically, it's almost like we started as a Spoke for them, but it developed.*

Polson interviewees shared that their lack of experience proved challenging in the beginning, but their program grew and evolved as they added waivered providers, recruited staff, and grew more knowledgeable through experience. They also fostered community engagement and outreach, which resulted in broad support for their program from both the hospital system and community.

> *Shockingly, this tiny little community has been really supportive of us. And, the people that were on board with that needle exchange program, in the beginning, weren't necessarily on board with our Suboxone program. And so, it really took bridging those two, and getting everybody in the same room, to understand the why, and why we do what we do. And so, with that, we have the chief of police, the judges, county commissioners, Tribal police. I mean, we just have…Everybody just knows about us now. And we didn't advertise at all, we didn't hang anything up except for a few little pull tabs.*

The success of their program was largely dependent upon the willingness of key staff members to self-sacrifice and push to achieve program implementation. *"I think that it is accurate, and I think that it's like that because the team just doesn't give up. So, we had a family medicine doc that said, 'I'm not doing that because I'm not gonna' be a drug dealer.' And, now he refers patients."* This challenge was a concern for the application of their model to other locations, with the recognition that personalities are hard to identify during the staff recruitment process. *"Yeah we really are lucky. And that's the part I don't know that you can duplicate, particularly…like I said. Somebody who's mid-level to take on the work."*

Polson was to act as a Hub site. After repeated attempts to recruit four separate sites, they were ultimately unsuccessful at establishing a Spoke. This challenge was described by interviewees as being the result of, *"It seems like the initial meeting of trying to develop the Spoke, that was really hard because I know we reached to a lot of different places at least try and say to them, 'Can we at least come and talk to you guys about it?…I think there still is a pretty big stigma, and people don't want to treat—They don't want consistently just treating addicts."*

Initial Implementation

Updated processes

During initial implementation, key MAT delivery team staff began to notice variation in core practices between prescribing providers. In an effort to improve fidelity to a care model, they created a guide for MAT provision and articulated their internal processes. *"But, it initially was just a written protocol, and it started the protocol and then moved on to intake questions. I added, as like an appendices type thing, with the protocol with appendices. And then, a colleague said that you should consider putting it in more of a toolkit, and then that way people could be able to navigate it a little bit better."* One major change they made over time was to categorize patients on a continuum of care ranging from 1-4.

> *We kind of have a level system, so our new patients are a level one. So that means they see us weekly, at least a minimum of four weeks. And with that, they see a counselor, and they do drug screens and random drug screens. And the level two is kind of moving them out farther, so every other week. And then, level three is monthly. And then, level four which is every three months. And then, we kind of just go out and check on them, see how they're doing.*

Tracking of data associated with the patients has been the primary responsibility of the care manager, who reports, *"It's color-coded. Not many people are allowed to touch it…I'm a little possessive,"* exercising a level of control over the Excel sheet utilized by the team. As a central component to the team, the care coordinator at this location has increased her role and responsibility within the program over time and in comparison, to other sites.

Linkage of patients with counseling and peer support services continues to evolve at the Polson site. As a primarily medical site, interviewees shared that the sequencing of screenings and the processes of incorporating counseling and peer support services into a treatment program are not yet solidified, *"So one of the frustrations, for me, has just been that since it's not required, there's not a lot of consistency."*

Staffing

As with many locations, Polson has had both some turnover with specific positions and stability in others. There has been turnover or the inability to find qualified staff for the LAC and a peer support specialist throughout much of the initial implementation of the program. Staff involved in many other elements of the team have been very stable, with multiple interviewees sharing that they have been involved in the program since the beginning. Staff who have been present for the length of the program, and patients who were interviewed, reported the value for care that came from the continuity stable staffing has offered to patients and providers.

Continued challenges

During the initial implementation phase, Polson interviewees reported a general challenge of learning how to ensure consistency in care for all patients. Their solution to this problem of creating a guide for care was well supported across interviewees. The need to integrate psychosocial elements of the MAT program model was noted across interviewees, with a general

concern that the lack of a requirement among program participants to attend counseling sessions may limit the long-term effectiveness of the program.

Full Implementation

The MAT program funded by STR has been fully implemented within the Polson site. They reported being a hospital that has become increasingly engaged with behavioral health care models, and that this program opportunity has helped them to expand their expertise and comfort with linking physical and mental health care. *"I don't think there are very many facilities, well, first, that have a clinic attached to a hospital in the same building, so we know each other really well. But also, a group of people that really cares about the community. They're not just here to get their student loans paid off."*

There remain continued concerns about the lack of Spoke sites, with some ambiguity in the view of whether the Hub/Spoke delivery model was relevant in Montana. If anything, the site views itself as a model for how to provide MAT within a hospital in a largely rural service area.

Successes

Participants at each site were asked to share stories about successes they have had during the MAT program.

> *I think supporting moms with kids is…That's a big part of what we do. And I think that we would be happy to go anywhere to present anything that we've created. I feel like, we feel like we're really successful.*
>
> *I think where we see our successes is when kids get put back into their homes. Yeah, or the individual success is not necessarily the only kind of the success, but we've had a couple patients who are off Medicaid because now they're working.*

Sustainability

The program reports being financially sustainable without additional grant funding. *"We created a model that is sustainable that will continue on either way. This is a program we're committed to."* Site leaders shared that they both have not utilized much of the STR funding and have been able to provide the service without losing money. The one exception to the general sustainability of the program is the peer support specialist role, *"Then you've got a PDR peer mentor. It's hard to put in a peer mentor when the grant's going to go away. Because I don't know the billing structure for that, how to make that sustainable."*

PROFILE: RECOVERY CENTER – MISSOULA

Type of medical organization: Treatment center	**Setting:** Urban	**Hub or Spoke:** Hub
Integrated Behavioral Health: No	**History with MAT:** Yes	
MAT delivery elements		
Initial point of contact for patient	RN case manager	
MAT medication(s)	Suboxone, Sublocade	
Frequency of dosage	Weekly	
Induction availability	Monday-Thursday	
Goal from patient contact to treatment initiation		
Use of peer support: Y	**Allow walk-ins:** Y	**Patients receive counseling and medication:** Y
Ancillary support elements		
Data tracking tool or system: GPRA		**Engagement with law enforcement:** N
Transportation: Sometimes		**Training of front office staff about MAT:** Y
Warm hand off with emergency room: N		**Training of nursing staff about MAT:** Y

REASON FOR PARTICIPATING IN STR

We had an administrator who was really active in getting this grant for us. She knew that we needed to serve more people.

EXPLORATION

As one of two state-certified, substance abuse treatment providers among the STR grant organizations, Recovery Center Missoula (RCM) had little need for exploration of this grant opportunity. They had the expertise and experience with MAT in Dr. Dan Nauts and a former executive director, both of whom were proactively engaged with the pursuit of the funding opportunity. One element of exploration was about the patient characteristics they considered including in the MAT program. The initial wave of patients for the MAT program came from RCM: "*When we first started this in 2017, we were getting the majority of our referrals from Recovery Center Missoula."* The cohort that started the program was rather stable, as they had been integrated into cognitive behavioral therapy or dialectical behavioral therapy.

As a Hub site, RCM also had to undergo an exploration phase associated with identification of Spokes. They developed two Spokes, Partnership for Health in Missoula and Western Montana Mental Health Center (Western) in Hamilton. Due to scheduling constraints, we were unable to connect with staff at Partnership Health for this evaluation. During the exploration phase at Western, RCM key staff member Dr. Nauts and the former executive director engaged in outreach, structured the recruitment, and provided initial support for the installation of the MAT program.

INSTALLATION

RCM was able to recruit multiple Spoke sites, ending up with a Spoke in Hamilton and a Spoke with Partnership Health in Missoula. The installation process for each Spoke varied, due to different organizational relationships and affiliations between Partnership Health and RCM and for Hamilton and RCM.

The initial staff team to support the installation of the program had largely moved on to other positions within RCM or outside of the organization but the time of our site visit. This limited our understanding of the initial installation phase at the site. In speaking with current staff, they spoke of a process that was largely dependent upon the existing expertise and staff in the facility.

One challenge of initial installation that remained present in the interviews was the integration of MAT patients with the psychosocial therapeutic programs being offered at RCM. As a treatment center, RCM has staff with expertise as therapists and counselors, as well as an initial patient load that was directly connected with Turning Point, the addiction services facility connected to RCM.

Initial Implementation

The MAT program consists of four elements at RCM: *"One part med management, one part therapy, one part peer support, and random urinalysis drug screens."* Balancing these four components, and the processes to integrate the patient experience across these four elements, was the primary goal of the initial implementation phase of the program. The care manager managed the peer supporters, both for RCM and for the MAT program. Medication management was managed by the nurse, therapy by a licensed counselor, and random urinalysis as a combination of management from both the care manager and nurse. Medication management was the responsibility of the team psychiatrist. Over time, RCM increased their Data 2000 waivered provider capacity adding a waivered psychiatric nurse to the team.

Updated processes

Processes for the MAT program at RCM shifted during the initial implementation phase due to changes in staff, shifting needs of the patient population, and a shift toward a less abstinence-based model of care. Around month six, the care manager position transitioned from a staff member without a nursing background to a care manager with a nursing degree. This shift in the program created an opportunity for updated processes and procedures. With a nurse in this role, the intake processing, urinalysis screenings, and data collection could be managed by a single person. As the program has evolved, it has become a nurse coordinator model. This adaptation has placed some additional strain on staff in this role, who report a need for assistance:

> *I do the…whatever paperwork they take from me, they put the chart together, they deal with what has to be done. They write the billing out for it. They do the phone calls to these dumb drug companies. A lot of that stuff, they're calling my patients saying, "Hey you did not show up for urine today. Hey, you did not show up for your one-on-one today. Hey, you're doing an awesome job, urine came back clean, that's a great improvement. Good job." They are making these contacts with the people that are on my program. So, I think that there needs to be another me.*

The initial structure of the MAT program included a group therapy component. Staff reported that initially group therapy *"was seven hours a week,"* but that of "*we just didn't have enough people enrolled and we had…some weeks I had two people showing up…some weeks I had one…the most we ever got up to was five. So, the numbers were not supporting us keeping that group."*

As new staff has come on board at RCM, there have not been standardized procedure manuals created or provided that could ensure new staff easily transition into team, *"There's not a lot of standardized things. I was given the actual contract, which I had to be honest I kind of had limited time to really read. I was given a box there, this…Here's the SAMHSA booklets. And I had a couple days with [staff name]."*

When asked about the most significant adjustment or shift that has occurred during the process of implementing the program, one staff reported, "*I think the biggest shift is creating a harm reduction path, basically…I always wasn't...I was a hard ass in the beginning just as much as anybody."* There is a recognition that MAT patients with OUD may be a different type of substance use disorder patient, one that will not achieve traditional models of abstinence, although this does not mean that they cannot achieve stability or success. One key consideration as noted by interviews at RCM is that the process to stabilization takes time, and the MAT treatment program needed to learn how to support patients. *"If you put somebody on buprenorphine, then generally it takes about six months before your patient population achieves 50% negative urines. It takes about a year to where you're getting to a point of about 85% negative urines."*

Staffing

Staffing transitions have been an element of the MAT program at RCM. In a desire to ensure adequate care for patients, RCM, like many other sites, capped their patient load at around 30. This level of care does reflect a view from staff of both demand and capacity: "*We ramped up to 30 over time and have stayed right around 30. [Interviewer: And that is because? Why 30?] That just seemed to be where the need of the community is at"* and their current staffing capacity to provide care *"this growth spurt that we've just gone through has been awesome, but I'm feeling bad and feeling kind of an anxiety because I don't feel like I have enough to offer them. I don't have enough services out there to offer them all."*

Continued challenges

As a treatment center, RCM encompasses multiple treatment settings, including inpatient/outpatient and group home settings. Within this collective of staff, all of whom have expertise with addiction, there are multiple opinions and perspectives about MAT as a treatment modality. The view that abstinence is the goal of addiction treatment is present in staff across RCM and may impact MAT patients as they attempt to integrate into other areas of their suite of treatment options.

There is a degree of autonomy among MAT staff at RCM that differed from the IBH team models found at other locations. A simple indicator of the different program models is reflected by the physical structure of the RCM staff, all of whom had separate offices that were spread across multiple buildings. Although they reported the same level of structured team-meetings as other sites, they also shared a view of being less connected and less able to share the intellectual and procedural work of the MAT program.

> *I can tell you something right now, I'm not just saying this; there is nobody who can just jump in and do what I'm doing. Nobody here and nobody at RCM. People don't want to do it either. I will articulate that as well. I think the compensation*

aspect too. I want to feel like my work is needed and valued. I can feel supported by my colleagues and co-workers at RCM absolutely but…it could be higher.

Another element of being a treatment facility is that availability of therapists and access to psychosocial treatment supports such as group therapy is in tension with access to these services and service providers for others enrolled at RCM.

Full Implementation

Successes

Participants at each site were asked to share stories about successes they have had during the MAT program.

Well, I guess it's people like [patient's name]. When I talked to him today. And there's two real recent ones, [patient's name] was another one of them. You met with her today. And another gal, very similar situation, where they just, my overall message that I'm getting from them is, "This saved my life. You know what, this has saved my life." And how much difference it's made.

We have two men that have recently come on, that nothing has worked for them. They haven't been able to work with providers. One of them was a referral from Partnership…The first time he was on our waiting room over there in Recovery Center, the staff woman there wants to kick him out because he was talking to himself and he was irritable and angry. And he's just transformed, as he's got on Suboxone and his nerves aren't fried all the time.

We have a young lady I've worked with for almost a year, heroin and methamphetamine and incredible cannabis use, and has done really well with MAT, really has been impaired by her cannabis use. She's stayed abstinent, amazingly, with regarding meth. We actually even had her in inpatient to try to get her through the worst of her cannabis withdrawal. She got through that and did really well, started feeling really well, but resumed her use shortly thereafter. Struggled along. I said, "Look, I'm not kicking you out of here." They were really struggling with her in the psychosocial groups. Finally, we backed off and just said, "Okay, this is what we expect of you. You've got to make your provider visits and you're going to do at least case management with your counselor once a month," and she absolutely never misses. Well, about two visits ago, she came in and said, "Look, this is the deal. I really want to reestablish a relationship with my children. They're in Texas and I need to clean it up. I need to get off of it," and she pretty much self-tapered…She's got to that place of doing work.

Sustainability

The program is intended to transition to the SOR grant, with the majority of the grant funding going to support staff positions. When asked about the program sustainability, staff reported that sustainability was likely *"As long as we have Medicaid expansion, I think that it's certainly capable."*

Areas of continued need

Morale among staff involved with the MAT program was low during our visit, and several staff echoed this sentiment shared by a staff interviewee, "*This is a difficult place right now. I'll just be straight with you…There's that part of it, shifting locations of service."* This uncertainty appears to be a by-product of broader organizational shifts and changes that were outside of the scope of this evaluation. Within the confines of this investigation, there was a recognition that an ongoing challenge at RCM of linkage of the MAT team with the broader RCM administrative and organizational structure.

One concern was that the addition of new patients without new or expanding staff support for therapeutic services would limit the effectiveness of the program for newer enrollees,

> *The biggest challenge totally is feeling like I bring on all these new patients that I don't have the services to offer them that I want to be able to offer them. You know what, I really think that our IMAT program needs to have pretty close to intensive outpatient type component to it. I'm not saying that every individual that becomes part of our program needs that. But I'm saying there are people, that I want to be able to offer that. And we don't have anything close to that.*

The overall patient totals at RCM were viewed as being lower than many staff had anticipated, *"there has to be so many patients and patients struggling, but where are they? Where are they receiving services? Where are they not receiving services? Why aren't they here? I would think I should have 12 or 15 people in my group. I should be doing 30 direct hours a week but it's not happening."* There was not a specific theory offered by staff that explained the lower than anticipated total, but staff did offer, *"I'm sure we're eating some of it from Ideal Options and maybe Community Medical because it's less structured and less comprehensive."* One potential explanation, based upon statements made at other sites, is the stigma associated with a treatment center, in contrast to the anonymity offered at an FQHC or primary care doctor providing MAT.

PROFILE: WESTERN MONTANA COMMUNITY MENTAL HEALTH CENTER – HAMILTON

Type of medical organization:	**Setting:**	**Hub or Spoke:**
Treatment Center	Regional town, rural service area	Spoke
Integrated Behavioral Health: No	**History with MAT:** No	
MAT delivery elements		
Initial point of contact for patient	RN Coordinator	
MAT medication(s)	Suboxone, Vivitrol, Buprenorphine	
Frequency of dosage	Biweekly then monthly	
Induction availability	Tuesdays	
Goal from patient contact to treatment initiation	No response	
Use of peer support: N	**Allow walk-ins:** N	**Patients receive counseling and medication:** Y
Ancillary support elements		
Data tracking tool or system: GPRA		**Engagement with law enforcement:** Y
Transportation: Sometimes		**Training of front office staff about MAT:** Y
Warm hand off with emergency room: N		**Training of nursing staff about MAT:** Y

REASON FOR PARTICIPATING IN STR

> *So, this was like a word of mouth thing. And I think that we entered into this not knowing what we were entering into*.

EXPLORATION

The Hamilton location was recruited by RCM. Hamilton is a complicated location for MAT provision, and members of the site were aware of this, due to the history of a well-known, over-prescribing doctor. "*Well, we had a huge case in this county with Chris Christianson. And he, yes, it's quite famous actually. So, I think the physician network kinda' did a, 'Oh, crap' and they had to readjust their point of focus."* This need in the community, and the willingness of a provider at the Hamilton site to become waivered, created the opportunity for their participation in the STR grant program.

Noting the gap between their capacity and the need in their community, site leadership was very cautious about how they were going to roll out the program, and all members of the team echoed the value in taking this approach to start.

> *When she started, we really had to go into this slowly, because we couldn't be inundated at once...I mean, we want to help as many people as possible. But we're all a little [hesitant] to advertising we now have a Suboxone program because, you know, sometimes when you're successful you can't get too successful too quick because it loses the quality of the care.*

INSTALLATION

With the creation of the Hub/Spoke relationship, Hamilton began to expand its staff capacity for service. No new staff was hired to provide MAT at Hamilton, rather, existing staff had this program added to their individual responsibilities. One expectation expressed by interviewees was the belief that the program would *"be very structured."* In contrast, upon experiencing the initial implementation of the program, staff began to see the value in a softer and flexible approach, *"So we didn't hard line it, 'you got to do this or you're gonna flunk the program.' So we went about it a very flexible way. And that works. It's about how can we help you [patient] be successful in your recovery?"* The need for flexibility was also reflected in the need for flexible and constantly changing practitioner schedules, as patients would want to initiate treatment or transfer their care from another MAT provider.

Support from RCM primarily came through Dr. Nauts, for whom the key prescribing provider at Hamilton spoke highly and noted the importance of his advice as they set up the program.

INITIAL IMPLEMENTATION

Updated processes

The primary development at the Hamilton site was their growth as an independent provider of MAT services to patients. They reported both the initial value of being a Spoke and the ongoing observation that their skill set and expertise has expanded, thereby allowing them to operate as a very independent Spoke. Support from the Hub is mainly in specialty cases, *"We were talking with Dan every week and now it's every other week. And sometimes it's once a month…And really, Dan's wonderful, I've been so fortunate to be able to call Dan when I have questions, not just about Suboxone but about psychiatry."*

One key to the MAT program is the ability of the prescribing provider to have 30-minute appointments, a policy of the agency. *"And one of the things that I'm very fortunate for in this agency, is that they allow me to do 30-minute appointments. So, I am able to do, to the best of my ability, some supportive psychotherapy."* This allows for one small piece of psychosocial care to occur during the prescribing meetings, thereby ensuring that patients receive this element of the care model.

Staffing

The staffing in Hamilton has been stable, with the expansion of a second waivered provider in the process during the site visit. This site has not been able to utilize a peer support specialist, due to a lack of suitable candidates. The main challenge they identified in finding a peer support specialist was being able to find someone who was stable in their own recovery to be able to fill the position.

Continued challenges

Noting that their treatment program is nested within a treatment group, staff reported a need to push against the normative expectations of abstinence-based recovery models. This initial push back from staff associated with the treatment center was managed proactively and it shifted and impacted the access to group therapy among MAT patients. *"There's been pushback from some of our internal LACs who are in recovery. There is one particular person who is in recovery himself*

and who believes that recovery is recovery and you're not in recovery unless you are total abstinence."

Proactive management of the stigma in the community was also taken on by staff at Hamilton, in conjunction with other treatment providers in the area, in the form of a community forum about opioids and treatment for OUD, *"So you know, we had an opioid summit last July in Hamilton. It was a huge gymnasium and it was full. We thought we'd get 20 people, it was full. It was awesome."*

A prescribing provider spoke passionately about the naive overextension of authority that she has in general, and most pointedly from a parole officer.

> *Okay. Alright. This is a story from last week. I have a new Suboxone patient who is kind of a lifelong criminal and is on federal probation, okay? This dude has been prescribed pain medications forever and a day. Long, long, long, long time. Well, he came to me said "What I've really been doing with these things, is I get them and then I use them all in five days. And then I wait for my next refill, and I have whole new supply…And I'm like ding dang, that sounds like a Suboxone patient, right?...So, I put him on Suboxone, doing great, had a great week, doing great. I get a call from his federal probation officer expressing some really dissenting opinions about this decision. And I gave him hell. I said, "Gee, he's been getting this medication for years. Did you ever call the physician who's been giving him this and ask the physician if it's being monitored appropriately?" It wasn't. He had never had a urine drug screen, he had no questions asked ever. But then I get…but then my decision-making process gets questioned. Yeah. And boy, I tell you what, slam pissed me off.*

FULL IMPLEMENTATION

Successes

Participants at each site were asked to share stories about successes they have had during the MAT program.

> *I think the people that originally started with us are still present and are still patients and are still seeking services. Whether it be one time a month or once every other month. But they are still there and they're pretty loyal as far as where they wanna' be. And they are so open as to what it is that they feel that they need. They are the directors of their life so, you know, we take that into consideration.*
>
> *There are patients who she's graduated from seeing individually because she's like "Hey, you're stable, you're doing great. You don't have to come talk to me anymore, unless you want to!" You know? And so, she sends them out.*
>
> *Just from an observation level, I have watched patients go from being extremely ill and extremely dysregulated and extremely sad to people who sit in the waiting room...and I'm thinking of one patient in particular...and every time I walk by I get the days, "Okay, I'm on month seven" or whatever that is. And it's just, they've*

received their lives back to a certain extent and we've had patients who say no thanks. I've tried this, this is not working, I'm just gonna' go do what I do. And that's fine. But the success stories are so successful that it really is life changing.

Sustainability

As a Spoke, this site mentioned the desire to have a higher reimbursement rate for the grant program to cover the costs of care coordination, *"Well, I'd say we function pretty independently. We do, but we're still a Spoke. We'd like to have that pot of money instead of…how we're reimbursed is [staff member] time reimbursed 5% from the Hub. And she spends a lot more than 5% of her time on IMAT."* The lack of funding for a full-time care coordinator is now limiting the capacity of the program to grow to meet the capacity of the waivered prescribing provider, "*If I had the money, yeah. I would be willing to grow the program. I would be willing to pursue patients and grow the program a lot more aggressively if we had that resource. I'm not able to bill right now."*

Beyond financial sustainability, the emotional challenge of this population can burn out providers. Noting the balance of success and challenges, a staff member said,

It would be a lot easier to not do this…I treat a very specialized population here and the co-occurring mental health and substance use disorders. It's very impactful to see the stabilization of a co-occurring mental health disorder alongside the substance use disorder. Especially I will say with personality disordered females.

Areas of continued need

The main need is that of a full-time care coordinator and a peer support specialist. Participants at this site did not express an equal level of interest in these two positions, noting that the care coordinator who is currently in the role would expand her level of effort and decrease some of her other work obligations. There was also concern that a peer support specialist would be recruited into responsibilities that extended to the care coordinator position, which could increase the likelihood of losing the peer support specialist, *"And I don't need a peer person, I need a care coordinator. And honestly, I'm afraid what's gonna happen is we're gonna get this poor soul in [as a peer support specialist] and they're gonna get tasked with care coordination responsibilities. And they're gonna be like screw you guys, I'm not interested in this."*

PROFILE: HELENA INDIAN ALLIANCE (HIA) – HELENA

Type of medical organization: FQHC Look Alike	**Setting:** Urban	**Hub or Spoke:** Hub
Integrated Behavioral Health: Yes	**History with MAT:** Yes	
MAT delivery elements		
Initial point of contact for patient	Receptionist	
MAT medication(s)	Suboxone, Subutex, Sublocade, Vivitrol, Buprenorphine	
Frequency of dosage	8 weeks at once or twice per week	
Induction availability	Monday-Friday	
Goal from patient contact to treatment initiation	24 hours	
Use of peer support: Y	**Allow walk-ins:** Y	**Patients receive counseling and medication:** Y
Ancillary support elements		
Data tracking tool or system: Excel		**Engagement with law enforcement:** Y
Transportation: Y		**Training of front office staff about MAT:** Y
Warm hand off with emergency room: Y		**Training of nursing staff about MAT:** Y

REASON FOR PARTICIPATING IN STR

> *We've actually been providing MAT for OUD for about six years. We're required to use grants with contracting positions...Then the opportunity was there to have this funding so, and this was before my time, they decided they were going to apply for the state for the STR…That's how we started. Just jumping on a way to get the program funded but we were providing the services prior to that.*

EXPLORATION

HIA pursued the STR funding opportunity to support their existing MAT program for OUD. They were slated to be a Hub site for Browning and potentially Billings. At the time, MAT services at HIA were under the direction of a medical provider who left the center over conflicts associated with the implementation process of the STR grant funded OUD program. The challenges of implementation, along with the different perspectives on being a Spoke site, meant that neither planned Spoke site became linked to HIA as a Hub. Conflicts that arose during the contracting process led to a delayed implementation and a need for HIA leadership to rework the goals of the original grant application and scope.

HIA is currently the only urban Indian health center provider of MAT in the country, as one staff interviewee informed us that they had recently been asked to do a national webinar with the National Council of Urban Indian Health. *"And we're the only one of the, you know, urban centers that are providing the services nationally…We're talking like some big centers like Seattle...Denver, San Diego, Sacramento, But we have lots to share…we've been really successful in what we have."*

The challenges associated with the STR exploration and initial installation appear to have been addressed, with changes in staffing at both the granting agency and with the site.

Installation

As a site with a pre-existing MAT delivery model, HIA reported that the main action they took with STR funds at the beginning of the program *"was to hire a full-time care coordinator."* Transitions among the potential patient base also occurred, as a collection of patients remained with the former medical provider who left the center. As with other sites, HIA elected to have a cap of patients around 30 (35 to be exact). The new provider who was hired and received a Data 2000 waiver to be the prescriber on the MAT team was hired not for MAT, however:

> *Her main objective was primary care, family care. I said I want to put a cap on you because if we let this program, it will take you, take all your time away from what you are here to do. We're not...we provide a service, which is a MAT clinic, but we're not a MAT clinic. We work in, we're primary care services that offers MAT, it's not going to be the other way around. So, I said well, this program probably could run away with you if we let it.*

Hub and Spoke

The challenges associated with the first six months of installation impacted the capacity of HIA to support Spoke sites. The challenges with the state compounded the difficult task of recruiting and supporting potential Spoke sites. After multiple efforts, presentations, and conversations with multiple sites, HIA was unable to secure a Spoke during STR. One interviewee mentioned that this is an *"East Coast model"* and may have not been well suited to the geography and communities of Montana.

Initial Implementation

Updated processes

After the delay, STR implementation started in earnest at HIA. Having a pre-existing MAT program meant that they had pre-existing protocols for care. They lacked clear systems for the care coordinator, a gap that was readily addressed by staff. During the initial implementation phase, staff reported that they were able to become *"more organized [by implementation of a data tracking system]. We can look at one thing that includes their UEs, that includes their prescriptions, their appointments with counselor, provider. This has everything in there. And then the data stuff that I prepare and send to the state, monthly. So I can pull that right off there, too, because it has their ethnicity, their gender, their race. So, it's a nice tool."*

The one other item that staff reported updating from the existing MAT protocols was a fuller integration of the peer support specialist into the care delivery model. STR allowed for the site to bill for peer support services, which interviewees reported as being *"a big deal."* As the peer support specialist grew in the position, he reported growing in the position and learning how to strike the balance between providing social support to patients and not being viewed as a counselor or as a friend, but someone with both lived experiences and professional expertise that could offer support.

> *So initially, that was a really difficult balance for me to achieve. I struggled to find that with my peers because my peers would be like, "My counselor," and I'd have to say, "Well no I'm not your counselor, I'm your peer support specialist." I'm not*

a counselor, that's not what I am. I'm just here to help you cope. I'm here to support you through whatever decisions and choices you're making. If you're struggling with choices or decisions, you can call me or text me and I can be there to provide support through that. I have the ability to assist them in advocating for themselves or I can advocate for them or refer them to outside sources. So I guess to balance it, it's kind of a fine art, really. It's not an easy balance to establish. In that initial visit, I have specific referrals that we sign, and I think that that really helps to establish those boundaries. These are the boundaries. I am in a professional role, and these are the reasons why.

Continued challenges

As with RCM, HIA is a substance treatment center, with a staff who share a range of perspectives on the goal of treatment being abstinence, stability, or a harm reduction model. During interviews at HIA, we learned of a very recent MAT patient about whom staff had a disagreement. The disagreement centered around the appropriateness of prescribing Adderall to an MAT patient who with a history of polysubstance use of meth and opioids prior to her enrollment in the MAT program. Although the disagreement was not over buprenorphine, staff discussed this case across all interviews as being illustrative of a tension between those who view medication as a key element to support individual stabilizing, and those who view medication as at risk to exacerbating pre-existing addictions, and that it should, therefore, be avoided and limited in use.

As with all sites that included an integrated approach to MAT, and engagement with a mental health provider, (e.g. LAC, therapist, or psychologist), there are a collection of patients who resist the involvement in the mental health elements of the treatment program.

Well, I think people just want a magic fix. They just want that magic wand and they don't wanna do the work. And sometimes I feel like when you're first getting sober, you don't have energy. Like who wants to do all this weekly and do all this stuff and maybe just wanna get right back to work or right back to this. And what I say is, you don't put first things first, you will lose all of that. Everything. Your kids. Your home. Your job. And so really trying to put sobriety first I think is just hard for people.

Full Implementation

Successes

Participants at each site were asked to share stories about successes they have had during the MAT program.

Yeah, so a lot of successes that I've seen probably one of the biggest successes that stands out to me is with the youth. So, we have several younger men that participate in our program or have participated that have been wildly successful...From changing their daily life, their routine, being part of what they call the game. Changing their lifestyle from selling drugs to being employed. Changing their life socially. So it goes from cruising around all day trying to sell drugs with your buddies to going to work, going to an AA meeting, and going to the gym. And so, there's two specific cases that I can think about that were really severe IV heroin

users, and so to see that change...And that's been more long-term. That's been five months or greater than both of them have continued with their sobriety, longer lengths of sobriety they've had since they were 15 years old. And now they're 22, 25.

I think also reducing stigma has probably been one of our biggest successes also. Kind of like training, but it's more of an educational presentation that we've provided to a number of different state agencies, law enforcement, our agency itself. And I think that that's really helped to reduce stigma in a lot of ways.

Sustainability

Funding at HIA is primarily utilized to support personnel. The ability to bill for peer support was identified as being a key positive outcome for the program. In general, staff described that the program was financially solvent before STR and would continue to be so after STR.

Areas of continued need

There is more demand for MAT services at HIA than current capacity allows.

And right now, the hard thing is, and then I hate to do it, is we are full. Because she can only take 30 patients, 30 MAT people. So, we do have to turn away a lot of people. We try and give them options of here's where you can go. It's hard. It's hard. So, when they come in, usually they're coming in. They're like, "Hey. I'm interested. I want to get on the...And I usually just have to say, "I'm really sorry right now our program is full."

The ongoing challenge of balancing the demand, with the broader commitments of HIA, and of the staff capacity limitations is present at HIA and not unique to HIA among STR sites.

PROFILE: BULLHOOK COMMUNITY HEALTH CENTER – HAVRE

Type of medical organization: FQHC	**Setting:** Regional town, rural service area	**Hub or Spoke:** Hub
Integrated Behavioral Health: Yes	**History with MAT:** Yes	
MAT delivery elements		
Initial point of contact for patient	Case manager, Provider, Peer support specialist	
MAT medication(s)	Suboxone, Vivitrol	
Frequency of dosage	Weekly->biweekly->monthly Suboxone, Monthly Vivitrol	
Induction availability	Monday-Thursday	
Goal from patient contact to treatment initiation	Client specific	
Use of peer support: Y	**Allow walk-ins:** Y	**Patients receive counseling and medication:** Y
Ancillary support elements		
Data tracking tool or system: Excel		**Engagement with law enforcement:** Y
Transportation: N		**Training of front office staff about MAT:** Y
Warm hand off with emergency room: N		**Training of nursing staff about MAT:** Y

REASON FOR PARTICIPATING IN STR

> *So, I came and I talked to [former executive] and one of the things that she was pretty excited about was the Suboxone program. She had just gotten this grant and she really needed a provider who would be willing to do the training and then prescribe Suboxone in order to meet the criteria for the grant. She had hired a nurse right before I came who was so excited about the program, so I said, "fine, I'll do it." So, I just did the training and here we are.*

EXPLORATION

Havre has been providing MAT for OUD in the form of Naltrexone as part of an expanded suite of behavioral health treatment options for SUD prior to the STR grant funding. A behavioral health provider was offering MAT, but not buprenorphine, and did not, therefore, require a Data 2000 waiver. Their efforts suggested that they had the expertise and capacity to add buprenorphine through the STR funding and by expanding their base of Data 2000 waivered providers. The executive team at the site reviewed their patient population and demand, while also taking into consideration the physical space needs and the staffing capacity of their office

They pursued the funding under a previous CEO who in turn recruited staff, who in turn needed to be trained and get the Data 2000 waiver. Recognizing that the capacity to provide training was nascent in the state at the time, this provider has a historical perspective on the differences in transitioning from a training to implementing a program.

> *I feel like the training was very thorough but I feel like it was challenging because we didn't have a program so we really didn't know what we were doing, to be quite honest. The things that we needed to have in place really weren't in place. We knew what we wanted it to look like, but we didn't really have all the pieces in play and we weren't really sure what the end product was gonna look like, so that part was*

challenging. The nice thing is right now, it's a huge focus for everyone, so there's resources everywhere. If you have a question, you can find somebody to ask. So that part is nice.

INSTALLATION

The care delivery model at Bullhook is unique among STR sites, in that there is a MAT provider without a Data 2000 waiver, a Data 2000 waivered provider with the professional background as a mental health provider, and a Data 2000 waivered provider with the background of a physical health provider. Each interviewee discussed how the process for initiating the MAT program differed by the workflows and patterns of care built into the different parts of the building where they are each located. Each prescriber was interviewed with the registered nurse (RN) or medical assistant (MA) that supports their work, also suggesting a care delivery model that functions in dyads, more than as a full team model. The presence of a behavioral health director to oversee the implementation process, to encourage standardization of care across patients, and to manage the expansion of their behavioral health program stabilized the installation of the treatment modality.

As with other Hub sites, there were repeated and unsuccessful attempts to establish Spoke sites. As a facility located near the Rocky Boy Reservation, Bullhook sought to partner with the tribal health agency to provide MAT. This attempt was unsuccessful as the leadership at Rocky Boy opted to pursue their own, independent MAT program. This result was consistent with observations made by other Hub sites, as potential Spokes began to realize that they lacked a pool of providers. *"To be honest I don't know. Most of them I think felt they didn't have a provider that was engaged. Yeah, not that the need wasn't there."*

Havre, as an FQHC, is organizationally similar to Big Horn. This organizational similarity and prior relationships made it natural and simple for them to get support and use existing materials from Big Horn as they initially developed the program. *"And I think that our basic support for that came mostly from Hardin so we were lucky. We used Hardin as our resource, and now I feel like I've been able to give other people, "okay this works well, be careful of this.'"*

Bullhook providers and leadership took the process of MAT implementation cautiously, developing a plan during the installation phase of limiting the total number of patients to 10 per prescribing provider and focusing on patients with fewer co-occurring disorders, *"We had decided when we first were starting this process that neither one of us was going to take more than 10 patients for a little while. 'Cuz we had no idea what we were doing. We didn't know what was involved."* Even with a slower process, providers report a steep learning curve for taking on the unique characteristics of MAT patients,

> *I had those moments in the beginning, like "oh crap, what are we doing?" And you get your first patients and I can tell you right now, my first three weeks of doing it…on the first week, every single patient that came back was dirty and I'm like "what is happening?" Okay, what am I doing wrong? So, it was a struggle and then you just realize as you get to know your patients, and you get to understand their*

personalities and reasons behind their use, then it's a lot easier not to take it personally.

INITIAL IMPLEMENTATION

Updated processes

After program implementation, staff recognized a need to adapt their patient data tracking system and processes to better care for MAT patients. They reported working diligently on improving the workflow.

> *I think we re-did that standard operating procedure. I don't know how many times. I mean but it took quite a while to make sure that we had everything covered and the way the providers wanted it and the way it would work here. And looking at what's happening in the rest of the country and trying to mesh all of that together was quite the process, but I think at this point we have it pretty well together now People feel pretty comfortable.*

This commitment to updating and expanding the effectiveness of the MAT model is still ongoing, with a report of a recent adaptation of how they integrated the peer support specialist at intake to increase exposure of each patient to their peer support specialist.

During the initial implementation phase, the leadership at Bullhook transitioned and implemented a new, center-wide, policy about absenteeism among patients. This procedure impacted MAT patients.

> *And the no show policy got super intense, very rigid…Entire clinic, yep. So, we really stepped up. And we gave them [patients], like, obviously a chance, two chances, maybe we were a little more lax because I felt like you couldn't put them on a dependence crossing med and then just rip them off. But at the same time, they're adults, they have jobs, they're responsible enough to make it or call to their appointments…It was a short-lived thing, and we really don't have that issue with any of them anymore. Like you said, it's more, I expect them to come more often than I do my others.*

Staffing

Havre experienced turnover in their core MAT staff during the initial implementation phase. An NP central to the initial development of the program took another position at another facility, the care manager transitioned to become an LAC, and they had multiple PSSs start and stop. These staffing changes are varied enough in the reason for the change that they do not suggest anything of concern, rather, a recognition that the MAT program faces the same challenges being faced by the facility, *"At the time they weren't able to find a person and it was a matter of, okay, now we have all these pieces in place and we're doing this and we have to do this, so how can we make this work the best way possible?...we have a challenge getting support staff here. I don't know why, we just do."*

These staff challenges did result in slightly different roles from the care coordinator, with a transition being reported from a care coordinator who had nursing training, to a care coordinator without this type of training. The difference impacted how the care coordinator functioned within the team,

> *When we started, it's like I said, we had a nurse who was in the role. So, the overall vision of this whole program was "okay we have this nurse. This nurse is going to be able to do the inductions, reach out to the patient, to start with, to make sure they're going in the right direction, they're getting the things they need. We would do the induction to but the care manager would be the one who would be there to sit with the patient and administer the strips. Now, because we don't have a health care provider in that role, it's become more of a responsibility of the provider. Which isn't necessarily a bad thing, but sometimes inductions can take hours if you have something that doesn't go very well or the patient's not doing as well as you like, they can be here for hours and it's just not feasible.*

Continued challenges

The rural geography and regional patterns of healthcare access among the patients being served by the Havre location continued to present challenges throughout the MAT program implementation period. The main challenge they noted was that the lack of a continuum of care for substance use disorders limited the potential effectiveness of a Hub and Spoke model, in contrast to the general availability of treatment options along the continuum of care in Vermont.

> *But in terms of the Vermont model. You know I think some feedback I would give to people is if you look at our geography and look at their geography, there is just not way to even compare. I mean I know they think it's rural but compared to us, no not, just not. And they have all these drop-in centers and they have so many more resources than we do you know a sober living houses and I mean we just don't have anything. It's just completely different it's just not the same at all.*

One particular example of the impact the rural geography has on MAT patients is the challenge of attending group therapy in the midst of a treatment regimen that requires quite a bit of time in the office.

FULL IMPLEMENTATION

Successes

Participants at each site were asked to share stories about successes they have had during the MAT program.

> *And nothing that they tell us is going to shock us. I think a lot of times, other patients don't come in and they don't share everything about what's going on because they feel like either they'll be judged or we'll be shocked by whatever they say, whereas these patients, they already know that we're seeing them at their worst, in their mind. You know that this is my problem, and this is what's going on. And I tell you,*

things that I wouldn't tell anybody else. This is what I was doing and this is why I used.

Sustainability

As with other sites, the financial model for MAT delivery is strong and suggests that the services are largely sustainable within the funding reimbursements offered to FQHCs via an expanded Medicaid program. Providers also spoke of being impressed, shocked even, by the ease of reimbursement for services.

[Provider]: You can fight for days, weeks with insurance companies to get payment for certain diabetic medications or even testing strips, but most of the time, I submit to Suboxone, and it comes back with no issues. It's like "okay here you go." And they pay for the urine. We haven't had any real issues or anything.

[Interviewer]: And it's been easier comparatively to other care?

[Provider]: Yes, it has been so from that standpoint.

Areas of continued need

MAT programs are structured with a balance of authority and leeway for patients. Across the evaluation, and across the providers we interviewed in Havre, there is variation in what constitutes the ideal balance of these two among prescribing providers. At Havre, this variation was mentioned across multiple interviews, by both those who had a view of there being too much authority and those who had a view of there being too little authority. *"I guess the other thing I'd say is that we probably need to do a better job of implementing quarterly strip counts, quarterly random urine, something like that, just more supervision in the program."*

Staff mentioned an interest in continuing to be exposed to the most current research and best practices in MAT delivery via a method for mentorship and the sharing of experiences among MAT providers in the state.

PROFILE: BIG HORN VALLEY HEALTH CENTER (BVHC) – HARDIN

Type of medical organization: FQHC	**Setting:** Rural and frontier	**Hub or Spoke:** Hub for Miles City and Ashland
Integrated Behavioral Health: Yes		**History with MAT:** No
MAT delivery elements		
Initial point of contact for patient	Behavioral health care manager	
MAT medication(s)	Vivitrol, Buprenorphine	
Frequency of dosage	Client specific	
Induction availability	Mondays and Wednesdays	
Goal from patient contact to treatment initiation	24 hours	
Use of peer support: Y	**Allow walk-ins:** Y	**Patients receive counseling and medication:** Y
Ancillary support elements		
Data tracking tool or system: Excel		**Engagement with law enforcement:** N
Transportation: N		**Training of front office staff about MAT:** Y
Warm hand off with emergency room: N		**Training of nursing staff about MAT:** Y

REASON FOR PARTICIPATING IN STR

> *We had been asked by the state, would we be interested in doing MAT…I have always been sort of discouraged about how substance abuse impacts people's lives and how it seems to either cause or result in poverty, result from poverty and this endless cycle of not being able to break out and it interferes with health care. It interferes with everybody's lives, the whole life. Just finding out that there's a tool that we could use for one small segment, that is very powerful. Just really got me motivated to get the waiver and start treating people.*

EXPLORATION

BVHC had a history of providing IBH and viewed the addition of MAT through the STR funding as a logical expansion of their existing practices. *"We already have embarked upon integrated behavioral health before joining MAT, so we felt that we had a good ground in how to do that. I think because of that we have been able to move forward in ways that other sites haven't."* Executive leaders expressed how beneficial it was to have been well connected with technical assistance providers and colleagues from other states who could offer protocols, guidance, and draft protocols and workflows for MAT. *"Up until recently, our colleague was associated with one of the largest FQHC's in New York State. They had been doing MAT for quite some time and so we kind of picked her brains and not start from scratch in terms of policies and procedures. She was very gracious and then that led us to think that, okay we can do that."* These pre-existing relationships provided a foundation for decision making and increased the capacity of BVHC to develop an initial strategy for MAT implementation that allowed leadership and staff to feel comfortable and confident.

Comfort and confidence in their MAT program model extended to the approach taken by BVHC as a Hub site. The structure of the BVHC Hub and Spoke model is based upon consolidation of community health centers via the expansion of BVHC. During the time of the grant, BVHC

incorporated One Health in Miles City and, in turn, expanded MAT service via this Hub. Exploration of MAT for the Miles City site was relatively absent, although it is assumed that the BVHC leadership reviewed the possible patient load and staff capacity prior to initiation of MAT at this Spoke site.

There was a low-level of resistance from providers or internal constituencies as reported by BVHC interviewees in Hardin. There was some initial resistance from community members and colleagues from emergency rooms, hospitals, and law enforcement. *"Yeah, it was kind of bouncing marbles off a hardened surface. Yeah, not too super receptive about it? They just think it's just another form of drug. They don't see it as a way to help, they just see it as another avenue."* Leadership at BVHC took an active approach to engaging this concern with the result of public and internal trainings and education. *"We'll probably have to talk first of all about how we had to retrain our trainings. Everybody, especially our LACs, our doctors, we really had to understand and use metaphors in that training of…We used it like caffeine, right? So, we can still function in our life but caffeine kind of gets us going."*

Being a primary care provider offering integrated health also helps to limit the possibility of patients experiencing stigma, *"Being a primary care integrated health, that's huge because if they see someone they know in that waiting room, they don't know if they're here because they have an infected toenail or if they're here for the meth program."*

Installation

As an established IBH providing FQHC, Hardin was not looking to recruit additional MAT staff except for peer supporters and a care manager. They reported that the installation process was eased by the relationships they have with a rural MAT provider from New York State who offered the initial protocols, workflows, and patient contracts.

> *We got a template for our policies and procedures from the New York State FQHC. That's what we started with and it didn't take us long to figure out that some of the stuff that was in there was just not workable for us or it didn't address areas that we needed to be addressed. It was a starting point, but it really doesn't look anything like it does now. We've gone through so many changes.*

As a site with existing behavioral health expertise among the administrators, staff training for BVHC-Hardin staff was directed by the expertise within the organization. The administrative support at BVHC is important to note and provides a secure base within which MAT providers can innovate and improve service delivery without fear of losing their capacity to provide the program.

BVHC-Hardin developed a set of performance measures and indicators unique to MAT patients, noting that the outcomes that can be easily tracked among this patient population can be tricky, and yet essential to a true IBH model of care. "*We actually have some data. Not as much as we'd like, but part of the foundation for us that's really critical is that the concepts of integrative and being to treat to target outcomes. We had the metrics and if people weren't achieving change, that we'd do something different."*

INITIAL IMPLEMENTATION

Updated processes

Hardin interviewees reported the need to adjust components that were specific to MAT, not components related to an IBH model of care delivery.

> *We've had to adapt and make changes to our policies and procedures frequently. We'll find some new diversion technique that people have come up with so then we have to figure out a way and maybe it's doing strip counts and every visit or increased UAs. We've had to revise and adapt a lot.*

This commitment to policies and procedures has also influenced their interaction with Spoke sites, noting that *"Hub and Spoke is sometimes difficult too with trying to manage, making sure that everybody is following policies and procedures."*

MAT patients who suffer from chronic pain were not being well served by the program at the time of initial implementation.

> *So, one of the aha moments for us was well, many of our folks started with a legitimate pain, injury, somethings all torn up, all busted up, everything out here. So, going back to the drawing board then was what could we ever do about getting people more skills to deal with chronic pain because part of this journey for them is still that same, we never did anything about that. So, we modified the group.*

Modification of the group setting to be a location for those with chronic pain, more than those with an addiction, enabled the group setting to shift the language of discussion from addiction, a deficit view, to that of healthy living, a positive view.

Staffing

Staffing among the BVHC MAT team has been stable. Their only challenge was to find a peer support specialist. During their initial implementation phase, site leaders realized that it was essential to the success of the position for it to be professionalized, and for there to be a pathway for professional development for their peer supporters. They reported creating a recruitment program with the tribal college through the creation of a class that was useful for students pursuing their LAC certification.

By their own identification, BVHC staff view the behavioral health care manager as the essential element to an effective MAT program, *"We think the secret sauce is the behavioral health care manager."*

The balance of staff time for BVHC as an FQHC was noted as well. The need to proactively manage provider schedules to ensure that MAT does not singularly dominate their availability was noted. *"We are a primary care center and so, you always gotta go back and forth. If you're a primary care provider with a waiver, okay great but your whole practice is not and never will be MAT. Keeping that balance has been difficult."*

Continued challenges

BVHC-Hardin reported few internal challenges at this time. Staff unanimously view this as being a by-product of an IBH care delivery model that requires ongoing team engagement, problem identification, and problem solving. *"I think the communication of the whole team gives them a better shot at success than it does if it's just the doctor, behavioral health over here and counselor over there. It makes a huge impact waiting to have all that right here."* Staff noted that without clear goals, metrics, and fidelity review processes, the quality of the program delivery would suffer.

This is not to say there are not challenges, as they also reported the general difficulty of providing MAT care in a frontier environment with many low-income patients who are in need of extra levels of care and face the challenge of transportation.

> *So having the peer support do that when there isn't anything to get them to is another part of that. Also, you aren't going to go to Ashland, which is 90 miles that way to pick somebody up and get them to an AA meeting in Lame Deer. That's probably…the distance is then that you can't get there from here kinds of things really are the major differences for our part of the world.*

One bureaucratic barrier identified by site staff is the different reporting requirements for IBH models of care the grant requirements. The interviewee suggests that the standardized reporting forms (most likely GPRA) are not well suited to the IBH philosophy on treatment integration.

> *I think my ideal would be for everything, for our grants and you know reporting is all still traditional style so it's really hard for me to record things on a traditional aspect just because I've started here working on the integrated model so there's not a lot of flexibility with that. I would like to see something more of our integrated approach instead of always being traditional because it's really hard to report things because they want things to be separate. Whereas our model we incorporate all that at once.*

FULL IMPLEMENTATION

Successes

Participants at each site were asked to share stories about successes they have had during the MAT program.

> *We've had a woman work her first full year and get a promotion. Job reliability and this never happened to her before. She said she submitted income taxes and she's getting a return and she was so excited about all of these grown-up things that people do that she had never actually accomplished before. It's an important part of what we do is training people to keep those appointments. It's not just inconvenient for us. It's just part of the- It's part of the actual integrated model.*

Another one, we had a patient that came in around when I first started which was November. He came in just in a wheelchair and he was really hardened to the pain medications and had some traces of methamphetamines in this system. He was just really in poor shape. After a couple months seeing Ben, working with Dr. Gentry he eventually got back to where he could stand upright and walk around on two feet again…Before he had to have his electric scooter. He didn't even have the ability to propel himself. So now he can ride on his motorcycle. He can physically do all this stuff that he needs to do.

We have a really good success story. It's a couple that came to us. She had premature twins because she was using and they took all the kids away. They had like six, six kids. Took all the kids away. They came to us, to our program. They've been in here a year and a half now. Year and a half. They both have jobs. They got the kids back. They have their own house. They have a vehicle whereas when they came to us they had nothing.

Sustainability

The STR grant is not keeping the MAT program at BVHC-Hardin financially solvent, as the program is financially solvent without the STR funding. STR grant funding is being utilized to provide the essential role of peer support and to supplement some time for the program care manager.

Areas of continued need

Staff at BVHC reported a need for continued, expert-level trainings for MAT providers. Noting that they have the advantage of having administrators who are the MAT trainers for Montana Primary Care Association-sponsored IT Matters, staff also shared a desire to have additional support as it relates to very complicated patients.

You guys as this site are kind of above those already. You guys are the experts and that's kind of—there isn't anything above that for you guys at Harden…So the other sites, the other Spoke sites, they get that information and they have to but you guys are the experts and so there isn't another level for you guys yet in training wise in Montana. Cause you're the experts.

More broadly, the concern about transportation was again mentioned, *"I think transportation and really figuring that and putting our heads on there if we could get a public transportation of some sort for medical care in general. If I had a magic wand, if the state could do a public transportation, just, in general, I think our lives would be easier."*

The final area of continued need mentioned by site staff was improved integration with Ideal Options, as a way to improve upon the continuity of care for patients who transition back and forth between the two sites.

Ideal Options to get there or really getting continuity of care would be nice, which isn't general at all but getting in their discharge plans or we're getting a lot of or kind of the people that fall into our program are rejects from ideal options and it

would be nice to have one big system to say okay, they're in Ideal Options, either they're still in there, they're out of there, this was their treatment plan and then if we were gonna send them.

PROFILE: ONE HEALTH COMMUNITY MEDICAL CENTER – MILES CITY

Type of medical organization: FQHC-BVHC satellite office	**Setting:** Regional town, rural service area	**Hub or Spoke:** Spoke
Integrated Behavioral Health: Yes	**History with MAT:** No	
MAT delivery elements		
Initial point of contact for patient	Receptionist	
MAT medication(s)	Suboxone, Subutex, Vivitrol	
Frequency of dosage	Client specific	
Induction availability	Monday-Friday	
Goal contacted to treatment hours	No response	
Use of peer support: Y	**Allow walk-ins:** Y	**Patients receive counseling and medication:** Y
Ancillary support elements		
Data tracking tool or system: Excel		**Engagement with law enforcement:** Y
Transportation: Sometimes		**Training of front office staff about MAT:** Y
Warm hand off with emergency room: Y		**Training of nursing staff about MAT:** Y

REASON FOR PARTICIPATING IN STR

> *Well, I think the program started with the previous nurse practitioner because we joined with BVHC and that was something they were starting up over there.*

EXPLORATION

Once the One Health community medical center was acquired by BVHC, and after the initial transition in leadership and organizational policies was completed, MAT was implemented within the site. One Health had a nurse who was a major driver of the implementation of the program and the initial support. Staff reports a patient load that is "*Mostly, I think our oldest patient is 43? 44? We have mostly men, well we have like five to six girls that I can think of. Mostly men. We have a couple of couples. Most, who have a job. It was kind of half and half between who had jobs and who didn't."*

INSTALLATION

As a Spoke site, MAT installation at Miles City was largely directed and driven by the leadership in Hardin. Hardin staff provided initial materials and protocols, directed Miles City staff to trainings, and determined the preliminary schedule for patients who were under the care of a prescribing provider at the Hub site. There was an installation phase and then after a staff change to a key team member, a re-installation of a new process with the Hub.

> *[Interviewee]: Before, [former provider] was here and we were pretty independent at that point in time and then we went for about six months probably, five months, not having an actual provider here that was waivered and so we did everything through TeleHealth. So, weekly huddles, behavioral health staff meetings and then doing our patient load throughout the week with [provider names]. And they're there for any kind of resources that we need, any kind of extra "Hey, we have this*

situation going on, what do you guys think about it?" They're kind of a support network for us also.

[Interviewer]: And that tends to be for really complicated cases basically?

[Interviewee]: Yeah, well we do use their LAC because we don't have one here.

INITIAL IMPLEMENTATION

Updated processes

During the initial implementation phase, Miles City expanded their provider capacity with the receipt of the Data 2000 waiver by a medical provider at One Health. This development greatly improved their care coordination and cohesion as a care team. It also meant that they were able to make small modifications to the processes and protocols inherited from Hardin to better reflect their care context. *"It completely changed the entire process and layout of the MAT program and how we would go through a day, because it was pretty much just me and [mental health provider] here. And then it just opened up to having a whole functioning team.*"

As noted in multiple sites, providers expressed how the creation of standardized procedures associated with the dismissal of the program due to non-compliance among patients can decrease the emotional toll of working with MAT patients. In Miles City, staff reported developing a new procedure for when a failed UA would produce a dismissal from the program.

So, we've started, I do good with visual things and just to kind of take the emotions out of it, we've started doing, a little chart that shows, and not that all the decisions should be based on their urines but, if there's no Suboxone in your urine more times than there is Suboxone in your urine, and you have morphine and meth and everything else that you could find in your urine every time, it's telling me that you are not ready to be in this program.

Ensuring consistent quality of care as a Spoke site was noted as being of high importance to staff. They have been tweaking and adjusting the frequency and style of interaction with the Hub. One additional change brought about during the transition to becoming associated with BVHC was a physical move, which in turn produced positive outcomes for patient experiences.

I feel like this location has by far been our best and most welcoming as far as what our clinic looks like. Because when the program first started, we were at another facility that was really difficult to access and it wasn't welcoming, it wasn't new. Now people come in and there's this, maybe even a sense of pride, like oh, I come here, there's a pharmacy here, it's a nice clinic.

Staffing

Interviewees reported variation in the level stabilization in their staffing and capacity to provide care during the implementation phase. This had one ancillary impact, an orientation away from reaching out to the hospital and other organizations within the community to raise awareness about the MAT program. *"And I made those contacts at the hospital and nothing's really come about*

and there's been a lot of changes in our program and stuff and I've kind of held off just a little it for that reason because we haven't really gotten everybody on board and kind of in the groove and all of us working together." The staff has stabilized, as they added a care manager, integrated multiple nurses in the MAT program due to a core member being on maternity leave. As with a few other locations, they continue to operate without a peer support specialist, *"I think that is coming down the line. It just hasn't come together…I don't think we've had anybody that's been long enough that we think they would be able to offer it."*

Continued challenges

There was some concern about Suboxone diversion among the Miles City staff. Staff made the observation that diversion can increase resistance to their provision of MAT, as it may exacerbate community concerns about One Health functioning as a pill mill.

The emotional weight of working with this patient population, and the frequency of face to face interaction among those who start the program, continues to be a challenge for providers at Miles City.

> *[Interviewer]: If you're a behavioral health specialist or you're a counselor you get a lot of specialized training, basically how to create emotional distance between yourself and presumably that's part of nurse training and part of primary care.*
>
> *[Interviewee]: That's why I make all of these guys sit in my blue chairs and during the week…It feels like it's an important part of what it means to have an effective program, basically the well-being of the provider.*

This challenge is not unique to these providers, as it was echoed across all sites.

Another challenge is the burden on the scheduling process of the clinic, as they offer MAT as needed for patients and attempt to adjust schedules as needed. Noting that all of their providers are engaged in multiple forms of medical care throughout the day, they expressed a general tension about wanting to focus on MAT on specific days of the week and noting the need for flexibility to best serve this patient pool.

> *And so then, before you know it, we're doing this on Tuesdays and Thursdays and then you've got patients on Wednesday and Fridays and it's every single day. And then it consumes your entire day because it's not just that appointment. It's the crisis before and the crisis after. We always say, "their crisis is not our crisis" so let's stop and step back.*

FULL IMPLEMENTATION

Successes

Participants at each site were asked to share stories about successes they have had during the MAT program.

We're constantly strategizing with each other and our patients how to help them succeed. Everything from transportation on how to get them here, non-compliance, how to get them to pay for their medication, how to pay for their dental, what are they doing for, it's not just the addiction side of it. It's How to address the underlying issues. Well for example if you have a patient that 100 percent wants to succeed but then he has non-supportive family at home and then they kick him out, he's homeless. He doesn't have a car and he can't make appointments. It's just a snowball. Making sure he has the support they need outside of us too.

We've seen a number of our patients getting jobs. So, like coming to us with really nothing and one of our really difficult ones got a job, one that had no confidence and was just really nervous and was like I could get a job but it'd have to be at night and now he's like got a day job. Just I think that is a positive thing, having them see themselves the way we see them. Yeah, watching them build themselves back up. Yeah, it's very rewarding because we do an initial, when somebody's interested in MAT program and then MAT nurses screen them and they're potentially a good fit, we do their initial…We do a meeting with all of them. Talk to them, with all of us. And we kind of do a round table thing with them. Seeing them, I feel like that's usually they're lowest, when they're breaking down and they're just talking about all of the crap that's happened to them and then seeing them, succeed and get a job. Get their kids back, be happy. Breaking those connections.

Sustainability

As a Spoke site, and without the inclusion of a site executive, there was very little discussion of program sustainability.

Areas of continued need

One of the ongoing needs is higher order education and training. At this stage in their program development, Miles City interviewees reported a high degree of confidence in their competency and team-based expertise. They also noted that it is an ongoing desire to stay as current as possible with the research and best practices in the provision of MAT, as well as noting a desire for higher order trainings, specifically tied to complex patients. "*We want input on other programs, bigger programs, how they're running. I mean we use Hardin as much as we can. I just would like a bigger perspective and how bigger programs, programs that have been functioning for longer and have all the same players that we have, work."*

Stigma management and engagement with community members was noted as a continued need as staff has experienced general resistance from professionals in Miles City.

And people just kinda are like, whatever, they're just peddling fake methadone or whatever. That's kind of the stigma and this whole, they're overdosing on Suboxone now, it's like well that's not the case. If that's your concern, here's what we need to do. Getting lab work, this and that. There's resistance to that because providers, doctors don't want to hear how to be told how to do their jobs.

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