Mobile Outpatient Treatment Program

Introduction

Medication assisted treatment (MAT) is a proven recovery solution for people experiencing opioid use disorder (Maglione et al, 2018). Integration, expansion, and accessibility of recovery and harm reduction services is lacking due to minimal funding and provider capacity for addiction treatment (Rural Project Summary, 2021). Transportation can also be a significant barrier for marginalized, disabled, and individuals in rural settings in obtaining comprehensive opioid treatment (Greenfield et al., 1996). The project has three goals: to increase access to MAT and substance use disorder counseling, to increase patient retention, and to connect individuals to ongoing recovery resources by partnering with mission-aligned organizations. This paper details research findings surrounding estimated costs of the implementation and operationalization of a mobile opioid treatment program (OTP), identifying opportunities for collaboration with other harm-reduction focused organizations in the Portland metro and Oregon north coastal areas, and providing the framework for mobile OTP implementation.

Background

Under federal law, only healthcare providers are permitted to dispense methadone for opioid use disorders. Many patients travel long distances to access a licensed MAT provider. Despite The Substance Abuse and Mental Health Services Administration's (SAMHSA) implementation of the MAT Waiver Training to increase the types and number of providers prescribing buprenorphine, the number of MAT providers is still scarce. The Drug Enforcement Agency (DEA) revised the rules to allow registered OTPs to establish and operate mobile methadone units without obtaining separate DEA registrations for each vehicle. By allowing mobile methadone units to operate without individual registrations, OTPs will be able to add mobile resources without the arduous paperwork or prohibitive wait times. This reduction in administrative burden should make expansion of mobile methadone delivery possible (El-Sabawi et al., 2021).

Financial Analysis and Build Out

Mobile health units are successfully deployed throughout the country to provide targeted medical services to communities in need. These units range from being as small as a passenger van, to being upwards of 50 feet in length. Larger vehicles can hold up to 4 individual exam rooms with equipment for numerous services. Medical healthcare units have lower overall customer approval ratings than new mobile unit providers, as used vehicles require additional maintenance. Used small vehicles can cost from $100,000 to $250,000, large vehicles cost from $250,000 to $450,000. The capstone team recommends pursuing funding through grants/contracts, philanthropy partnerships, and hybrid models with larger healthcare systems.

Market Analysis

Despite the prevalence of harm reduction services, there are no mobile OTPs servicing the Portland metro and Oregon north coastal areas. Tillamook County Public Health hosts syringe exchanges in Tillamook, Cloverdale, and Wheeler (K. Crombie, personal communication, 2022). The Clatsop County Department of Public Health has been working to establish additional harm reduction services and opiate treatment. Current harm reduction sites are in Seaside, Warrenton, and Astoria. The geography of the region must also be considered.

With several hundred miles of coastline, unfinished and often small highways, access to areas throughout the coast can be difficult. Partnering with existing wrap around services provided by the county public health department, county behavioral health departments, and community resources will allow for the easiest entry into this patient market. Behavioral health and public health departments voiced enthusiasm regarding collaboration with CODA on a mobile OTP.

In the Portland metro area, there are seven brick-and-mortar OTPs with two mobile OTPs in the process of state approval. Unfortunately, there are still not enough OTPs to meet patient demands. Partnering with local houseless support projects and housing sites would allow CODA to reach large reservoirs of patients in need. Additionally, these community services would be able to assist CODA by providing security protection and established protocols. This includes stationing mobile OTPs next to churches and fire departments.

Overall, our findings support the need for mobile OTPs in the two geographical regions that CODA is pursuing. County leadership and coordinated care organizations (CCOs) voiced support and interest in partnering with CODA on this endeavor.

Strategic Analysis

Mobile OTPs provide a range of services, targeting the full recovery spectrum of addiction. For example, a mobile OTP could support current patients as well as do intake for new patients. The expansion of services to include a mobile OTP is also a market development strategy that allows CODA to enter new geographical markets while providing their presently recognized and reputable OTP services. Due to the requirements and regulations surrounding the implementation of a mobile OTP, CODA would need to enter this market through internal development strategies, rather than acquisition or cooperative strategies. The application process for implementing mobile OTP services within an established OTP can take months to a year to reach approval (J. McIlveen, personal communication, 2022). Instead of an RV, one competitive application leverages Ford F-150s with trailers in tow.

Recommendations

The capstone team recommends pursuing a mobile OTP build with ADI Mobile Health, who have built mobile clinics for over 30 years, provide grant funding support through their office, and adapt to changing regulatory requirements. Staffing infrastructure and sustainability are also key considerations. A licensed practical nurse, security personnel/driver, peer support specialist, and licensed independent provider are suggested mobile OTP staffing. The partnering brick-and-mortar should be able to accommodate 90% of the referrals and intakes. Cross-training, sign-on bonuses, and a capacity analysis will bolster and sustain brick-and-mortar staffing for new patient influx.

Next Steps

This project serves as the beginning stage for CODA to further analyze the presented findings and recommendations. Given that mobile OTP services are recent innovations, there is little historical data and further financial analysis is warranted. It is recommended CODA perform a more detailed sensitivity analysis to identify the variables most impactful to success. If a mobile OTP is feasible, the capstone team recommends applying with the Oregon State Opioid Treatment Authority as soon as possible due to a potentially long application process. Our final recommendation is for CODA to partner with other mission-oriented organizations to establish an Oregon Mobile OTP Learning Collaborative. Learning collaboratives provide regular discussions of shared challenges, barriers, and lessons learned. With CODA already

leading and convening statewide OTP meetings, they are well-positioned to host a learning collaborative. Partnering with the NW Mobile Healthcare association, as well as other future mobile OTPs in the region to participate in and form learning collaboratives is recommended. As CODA and other organizations navigate the mobile OTP climate, they will benefit from information sharing. Limited funding with high demand emphasizes the need to eliminate the false narrative of competition. Clinics must collaborate or continue to struggle in underfunded siloes.

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