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State Opioid Response Grant: 2022 – 2023 Annual Report

Mobile Health Units Delivering Medication for Opioid Use Disorder

Year Five Evaluation Report

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Contents

HIGHLIGHTS

In year five of the State Opioid Response (SOR) grants, three clinics delivered medication for opioid use disorder to rural, frontier, and underserved areas of Colorado through pop-up clinics and mobile health units (MHU).

SUCCESSES

REACH - From October 1, 2022, through September 30, 2023, the clinical providers delivered medication for opioid use disorder to 484 individuals in 34 rural or underserved Colorado towns in all seven Sub-State Planning Areas. Clinics reported a cumulative total of 3,202 client visits.

EFFECTIVENESS - Clients reported high levels of satisfaction with access to treatment and level of care provided through the mobile health program and reported few barriers to participation. Clients indicated the treatment received had a positive impact on recovery and well-being. From October 1, 2022, through September 30, 2023, 67% of clients had two or more visits. In addition, 51% of clients remained in treatment for at least 45 days.

IMPLEMENTATION - Many teams utilized a pop-up clinic model to provide services in the community or were able to transition to a "brick and mortar" facility. They offered new services and demonstrated flexibility in meeting client needs.

ADOPTION - Clinical staff and leaders developed community partnerships to meet client and community needs, providing equitable whole person behavioral health services.

MAINTENANCE - Providers explored diverse funding sources and redesigned the program approach.

OPPORTUNITIES FOR PROGRAM IMPROVEMENT

1. Continue to support the clinics to be flexible and employ innovative methods to increase program reach and client engagement.
2. Continue to implement contingency plans (telemedicine, pop-up locations) and revise as needed to ensure client continuity of care.
3. Continue community outreach and relationship-building with partners in the communities they serve.
4. Support the coordination, collaboration, troubleshooting and shared learning among clinical teams.
5. Support the clinics in addressing staffing shortages.

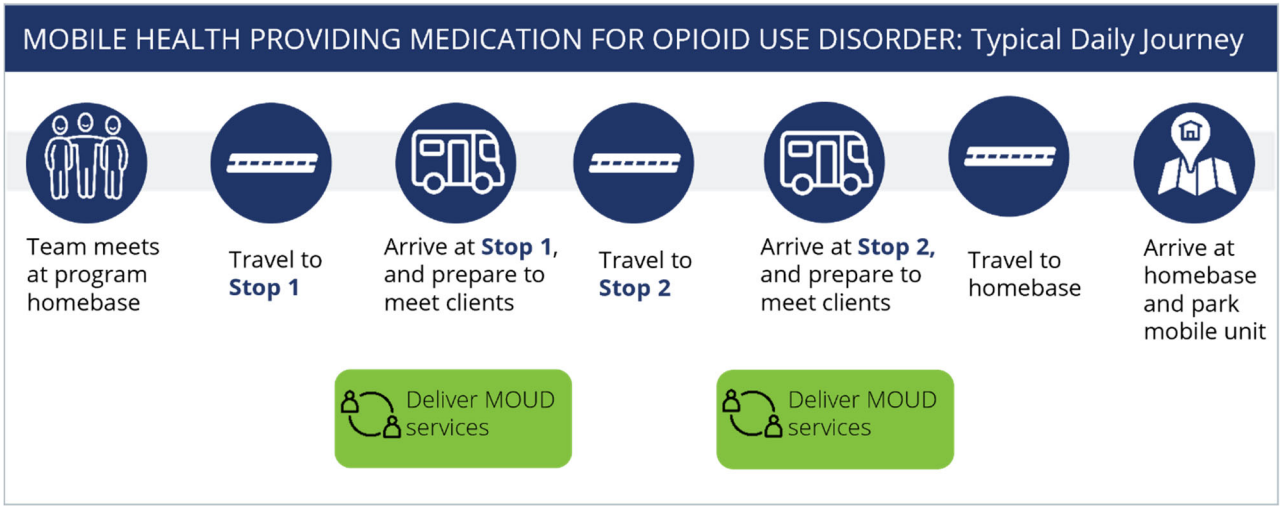
BACKGROUND

In 2019, a mobile health program was established to improve access to medication for opioid use disorder (MOUD) in rural, frontier, and underserved areas of Colorado as part of the state's response to the opioid crisis. The project funded the purchase and build-out of six MHUs to bring MOUD and other behavioral health services to communities where these services are unavailable.

PROGRAM CHARACTERISTICS

Three medical or behavioral health clinics implement the MHU program with staff traveling weekly to scheduled rural or underserved towns. The clinical staff delivers the same treatment model and clinical care implemented at the clinic's "brick and mortar" offices. The clinics have unique staffing roles, but all provide the same services and employ a buprenorphine waivered healthcare provider, who connects with clients through telemedicine, to treat opioid use disorder. Since the programs' inception, all the clinics strive to meet clients' diverse needs with extensive referrals to programs and services within the clinic or to resources in the local community.

Exhibit 1. Overview of the typical daily journey of the mobile MOUD program



MOBILE HEALTH UNITS

The MHUs are highly customized 35-foot recreational vehicles (RVs) that serve as mobile clinic offices. The units have a medical room, a counseling room, a waiting room, and a bathroom. The clinical staff drive the MHUs to designated locations in rural communities and provide services to scheduled or walk-in clients at a consistent time each week.

POP-UP CLINICS

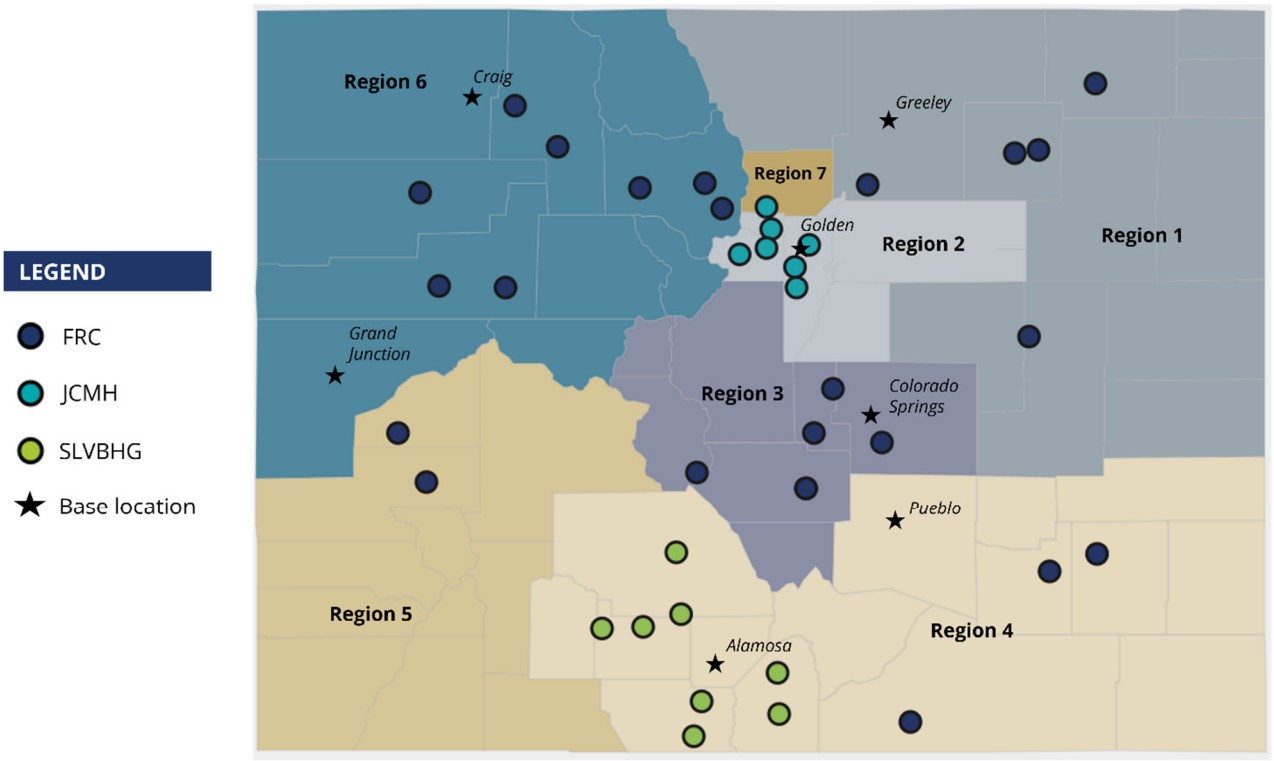
Pop-up clinics are borrowed or rented office space located in the community being served. Clinical staff travel to the pop-up location to meet with clients for a scheduled number of hours each week. The staff uses the pop-up clinics routinely in some communities, while in other communities they are used as a

back-up space when the MHU is off the road for repairs or when there is challenging weather that creates barriers for transportation.

PROGRAM SERVICE AREAS

The three clinics, San Luis Valley Behavioral Health Group (SLVBHG), Jefferson Center for Mental Health (JCMH), and Front Range Clinic (FRC), serve clients at locations in seven Sub-State Planning Areas (SSPA) in Colorado. Program staff originate from the home-base locations and travel to the areas shown in Exhibit 2.

Exhibit 2. Locations served by the three clinics within the SSPA regions



EVALUATION FOCUS

The evaluation is grounded in the RE-AIM Framework. In year five, the focus of the evaluation was to:

- Assess program reach across the state (Reach)
- Measure client satisfaction and outcomes (Effectiveness)
- Document the program challenges, facilitators, adaptations, and partnerships developed in the current year (Adoption and Implementation)
- Describe program sustainability (Maintenance)

The Evaluation Center conducted interviews with clinic leaders and program staff and surveyed and interviewed clients who received services on the MHUs. Evaluators developed and piloted a new client survey to collect more robust client satisfaction data. In addition, evaluators analyzed program monitoring data captured in the MHU Services Form, reviewed program documents and schedules, and observed monthly "all provider" conference calls. The evaluation methods and approach, including a description of the RE-AIM Framework, are detailed in the Appendix.

KEY FINDINGS

REACH

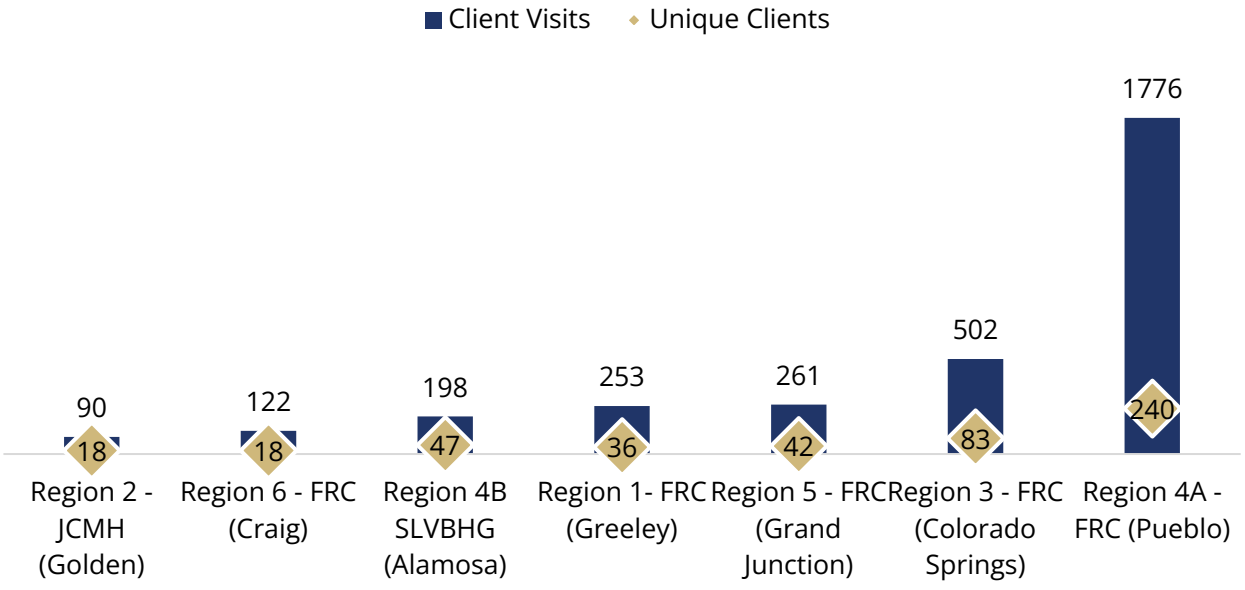
The program's geographic reach extended beyond the Front Range to the eastern plains, the San Luis Valley, the northwest region, the western slope, and the southwest region of Colorado.

DELIVERY OF SERVICES

Client Visits

From October 1, 2022, through September 30, 2023, the clinical providers delivered services to rural Colorado towns, serving 484 individuals.[1] Because clients could visit multiple times, the clinics reported a cumulative total of 3,202 client visits. The regions that reported the most client visits in the 12-month period were Region 4A (1,776 visits, 240 unique clients), Region 3 (502 visits, 83 unique clients) and Region 5 (261 visits, 42 unique clients), as shown in Exhibit 3. All three regions are served by FRC.

Exhibit 3. Number of client visits and unique clients served by region in year five



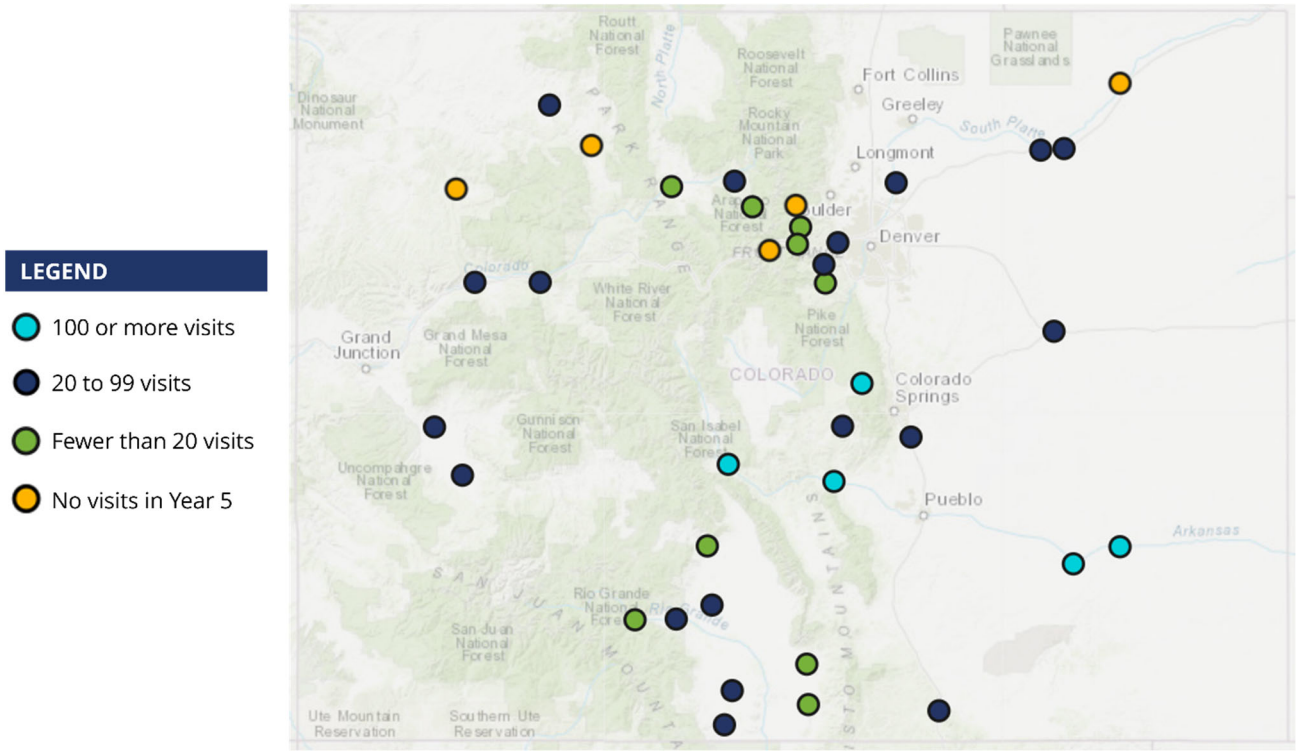
[1] Each client had at least one visit.

PROGRAM DELIVERY ACROSS THE STATE

Program Delivery to Colorado Towns

From October 1, 2022, through September 30, 2023, the clinics delivered MOUD to the prioritized regions for the program. In all, the clinics recorded client visits in 34 rural or underserved Colorado towns in all seven SSPA areas. The number of visits varied by location (shown in Exhibit 4 below). Most locations received 20 to 99 visits. Five locations did not receive any visits, and five locations received more than 100 visits. Throughout the year, the clinical teams gauged client volume and community engagement, adjusting their schedule to meet community needs. For example, JCMH added Georgetown and a second location in Black Hawk to the schedule. FRC continued to leverage the MHU program in building their long-term presence in new communities by establishing a permanent clinic independent from the mobile MOUD program.

Exhibit 4. Number of recorded client visits by service location, October 1, 2022, to September 30, 2023



EFFECTIVENESS

CLIENT SATISFACTION

Overall, clients reported high levels of satisfaction with access to treatment and level of care provided on the MHUs and at the pop-up clinics and reported very few barriers in participating in the program.[2] Clients indicated the treatment received had a positive impact.

Access and Proximity to Treatment

Most clients reported it was easy to access care because of the location of the mobile unit or pop-up clinic or the availability of telehealth. The majority (75%) of clients surveyed (*n*=16) agreed that the distance they traveled was acceptable, and 94% reported that it was easy to get an appointment. One survey respondent indicated that transportation to the MHU location or pop-up clinic was a barrier for them. None of the other clients surveyed or interviewed indicated any other barriers to accessing treatment.

Access to Medication and Referrals

The surveyed clients who were prescribed medicine (*n*=8) reported that they were satisfied with the ease of accessing medications from the pharmacy following their appointment and reported no barriers to accessing the medicine. Most of the clients surveyed (69%) indicated that the clinical staff referred them to other services including housing, job resources, and referrals to another medical provider or counseling.

Satisfaction with Care

All the clients surveyed and interviewed (*n*=17) indicated that their needs were met in their overall treatment experience. The surveyed clients (*n*=16) indicated that the treatment received helped them support their recovery journey or described that treatment has positively affected their life.

When asked what they would want others to know about the program, the client interviewee responded that they have told others, “It's in the neighborhood. It's a good resource, anonymous. It's a good team. That's how I refer people to the mobile unit.”

CLIENT OUTCOMES

Clients demonstrated a high rate of engagement with 67% of clients having two or more visits. Clinicians relayed stories that align with this engagement rate, noting that those who return to treatment show improvements in their mood, well-being, and stability.

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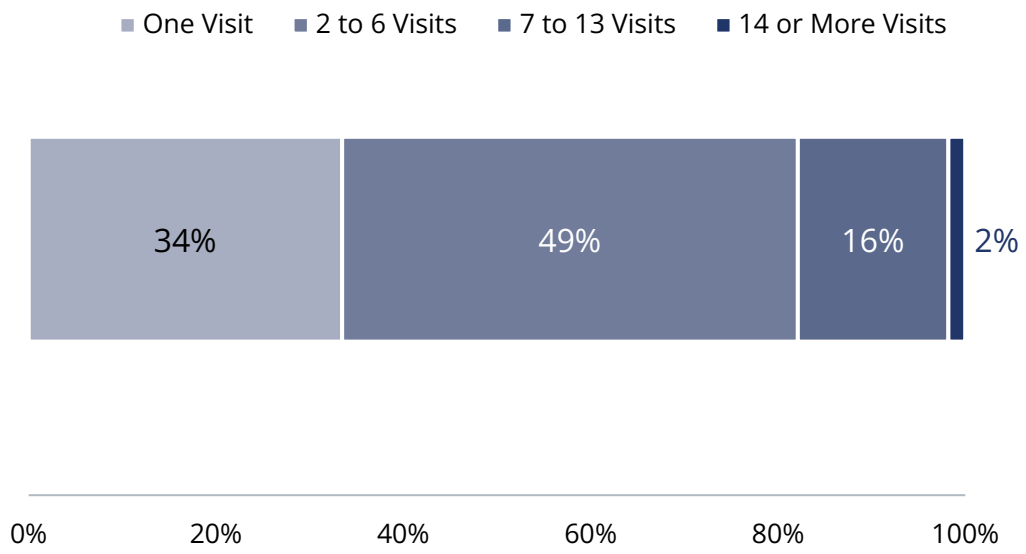
[2] Evaluators collected the experiences of clients in the program through in-depth phone interviews (*n*=1) or brief structured phone surveys (*n*=6) and a new client satisfaction survey administered after a client visit (*n*=10). The clients who participated represented SLVBHG and FRC. There were no completed interviews or surveys from JCMH clients.

Client Engagement and Retention

Of a limited sample of 224 unique clients[3] served from October 1, 2022, through September 30, 2023, 67% of clients had two or more visits (shown in Exhibit 9). In addition, 51% of clients remained in treatment for at least 45 days.[4]

Exhibit 9. Percent of clients and number of visits during October 1, 2022, to September 30, 2023



Client Success Stories

All interviewed clinical teams offered specific examples of client success. Each client's success story spotlighted changes that they saw in individuals who had utilized services. These changes included consistency in keeping appointments, increased independence, improved quality of life, and greater ability to maintain housing and employment. One clinician gave the following narrative about a client's success:

> "Her success truly has been her stability. … Her quality of life is so different than it was when it first began. She's willing to ask for help, she's willing to come back, she will take those steps."

Being able to access dependable services provides a more direct pathway to sobriety. Those struggling with opioid use disorder are given a more focused route to treatment that encourages interaction and stability. The presence of the MHU in the community demonstrates dependability that leads to community trust:

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[3] Evaluators conducted this analysis on a limited dataset therefore these findings are not representative of the program. Data represents only four regions.

[4] Evaluators calculated a 45-day retention rate by dividing the number of clients with visits spanning at least 45 days (*n*=101) by the number of clients who began treatment 45 days before the end of the fiscal year (*n*=200), yielding a 51% rate.

> "We saw two clients in particular that have returned, so they've been stable for at least two years. One of them is managing a sober living home now. They're doing well in their lives, and others in their circle that were in their cohort as well."

IMPLEMENTATION

CHALLENGES AND SOLUTIONS

The challenges described by the clinical staff were consistent with previous years. The clinical staff have addressed the MHU vehicle issues by implementing pop-up clinics and utilizing telemedicine to meet with clients.

MHU Vehicle Issues

In year five, the MHU teams continued to face mechanical and maintenance challenges with the RVs. Because of this challenge, many teams utilized a pop-up clinic model to provide services in the community or were able to transition to a brick-and-mortar facility:

> "We are primarily using the pop-up model. Right now, none of the mobile units are actually on the road."

A lack of constant use of the RVs can lead to a lack of visibility for services. One team member described how not being able to use the RVs decreases accessibility and negatively impacts the quality of care that can be given:

> "I think the biggest challenge is not being able to take those RVs out. There was a time when our patients were looking for those RVs and maybe we couldn't get ahold of them through their phone, and so they were just searching for the RV that's usually in that same spot. That was a bit of an obstacle that we ran into."

Staffing

Each of the providers reported difficulties in maintaining a large enough staff to fully account for the services they were providing. FRC identified the challenge of hiring and maintaining medical assistants (MAs) that can help to provide services to clients. When there is a shortage of MAs, care facilities have a difficult time maintaining both scheduled appointments and walk-in clients:

> "We look at the schedule to see if there's an injection. If there's no injection scheduled and we need an MA at a different location, we can send that MA there to give that injection. Right now, we'll have either an MA or an admin attend any of these clinics, and make sure the clinic is taken care of."

One provider mentioned that staffing was an issue all around and that the workload can feel overwhelming at times:

> "I do everything else. I get resources, I set appointments, I'm meeting a client this afternoon, I'm helping him pay for a phone, and I'm going to get some clothes for

> him. Then when I meet him, he'll have clothes. I do everything else. Sometimes I feel overwhelmed."

Location Needs and Accessibility

All providers mentioned that connecting with the community was a challenge in year five. This issue was partially attributed to a disconnect between the location of the MHU and the services requested:

> "It might seem like we have a lot of foot traffic through here, but none of them are looking for addiction services. That [location] might not be the perfect spot for us to be."

This issue was also attributed to a lack of knowledge about the services that can be provided to potential clients in the area. Lack of advertisement and knowledge about potential services greatly impacts the potential reach that the MHUs could have:

> "We're not having as much traffic in [this area] as we would like to see. I think there's a lack of knowledge about our services in that area."

PROGRAM DEVELOPMENTS

Changing Settings

A few of the clinics adjusted their service locations to access a greater range of clients. For example, FRC bases their service locations on the volume and population of a given area:

> "We are in some city libraries. We are in the health department. We are in other medical practices. In Woodland Park, we're in with the ambulatory system. They have an Urgent Care Mental Health Ambulance District up there. We're there."

For JCMH, team members also mentioned that locations changed based on the season due to high volumes of snow impacting clients' commute to receive services:

> "The location of the RV does change. In summer, for example, I believe, we go to a spot in Golden at a church, whereas, during the winter, we're more up in the mountains."

For FRC, locations were also adjusted if there was a high and consistent number of clients accessing a particular pop-up clinic or MHU location. If this was the case, the location of the pop-up clinic or MHU location shifted to a permanent, office-space location with a brick-and-mortar setting. This adjustment removed the location from grant funding:

> "By the time we are busy enough to rent our own office space and really have a Front Range Clinic in the community, it feels like it's time to move it [the service location] off of this project. [The services] would no longer require the grant funding."

New Services

SLVBHG has been able to expand their services to offer Hepatitis C and HIV testing on site:

> "We're able to offer Hep C testing, screening, and treatment on [the MHU] now. I think that's huge because just from conversations I've had, a lot of the time [the MHU staff] are the only healthcare providers some of these people will ever see."

FRC is working on providing Hepatitis C and HIV testing as well as providing PrEP (pre-exposure prophylaxis, a medicine that reduces likelihood of developing HIV from sex or injection drug use) to their population of clients. JCMH is making efforts to develop further education around services as well as broaden knowledge about MHUs and community resources:

> "A lot of good is done just in terms of education, Narcan education, MAT [Medication Assisted Treatment] education, and the health education that the staff do, which is probably the most beneficial element of this program."

SUCCESSES

Accommodating Clients' Needs

The clinics and team members had many successes during year five. Each clinic was able to address barriers that existed for potential clients seeking treatment and make accommodations to further ensure accessibility. At FRC, team members were able to remain flexible with clients to ensure that clients could receive the care they needed:

> "Our motto is high access, low barrier, so I think our ability to accommodate patients on a whim is commendable. Whether [clients] have something arise, their appointments have to be switched, or if they have emergencies, we're extremely flexible while trying to remain in the guidelines of their medications."

At JCMH, accommodating client needs meant connecting them to outside resources. Team members were able to redirect and refer clients to important resources that could ensure continued treatment. These resources were able to meet the needs of the clients:

> "[One of our successes is] our ability in the mobile MOUD team to connect people with whatever they need, be it a therapist or a psychiatrist, help with their child, or education, there are a lot of things. It's a pipeline, and that's one of the things that we're looking to emphasize."

For SLVBHG, team members made the effort to shift working hours to accommodate client schedules so that clients could be seen in greater numbers:

> "We're really good about working with [clients]. There was a client that wanted to be seen during their lunch hour, and that was at noon, but we usually leave at 11:30. What we were doing was leaving a little bit early and working through our lunch hour to accommodate the client."

Reducing Stigma

Clinical staff and team members made progress in reducing stigma related to substance use and treatment during year five. Clinical staff have reported welcoming new clients and encouraging those who return for services:

> "It could take a couple of tries, and that's the nature of this work. We invite them back in with no shame. We say, 'I'm glad you're here, I'm glad you're getting help, you're seeking us.' That's been great."

Specific efforts have been made to reduce stigma by normalizing the unit itself. According to one team member, normalizing the unit and familiarizing the community with its layout and location allows for questions about services to be answered:

> "We would give tours on the mobile unit so people could come on board and see what it was like. I just recently made a video that I put on our social media pages."

ADOPTION

PARTNERSHIPS

Each clinic was able to form and maintain important partnerships in year five that provided community engagement and outreach efforts. One team member described how having partnerships with other organizations that both share the same outreach values and have on-hand advertisements broadens the connectivity of available resources in a community:

> "We talk to those partners and know that they have printable brochures on their website, so we can put [them] in our clinic. We say, 'Hey, there's a great peer specialist. … Why don't we get in contact with them?' I think it all boils down to resources for patients, having the communication between [partners] and knowing who's available to help them."

The team members were able to explain in detail how partnerships benefited the daily care and treatment that they provide, as well as how the partnerships benefited the greater community. Some team members were able to use their personal experiences when talking to specific partner organizations to build community trust and showcase the long-term capabilities of receiving treatment:

> "[Our team member] communicated with a city council member or a county commissioner to [share] about his personal experience and ways that counties can address the opioid crisis. So the next meeting that the [council member or commissioner] has, they can go with that positive experience and speak to it."

Partnerships can also broaden the types of services that can be provided on site at the MHU. For example, SLVBHG was able to form a partnership that allowed them to provide HIV and Hepatitis C testing at a local event:

> "This year we were able to partner with a lot of different community entities like [the local sharps collection program]. They came on board our mobile unit and did HIV and Hep C testing at the festival, so it was free. We provided that free testing on the unit so that people would have some privacy."

More specific partnerships can provide advertisements that allow for a variety of different potential clients and populations to be accessed at once. SLVBHG formed a partnership with a local radio station so that they could advertise a local event, as well as get more information about their services out into the community:

> "We have a local radio station out here that we've been [partnering with] to promote our Hope and Recovery Festival. It was a huge turnout."

MAINTENANCE

PROGRAM SUSTAINABILITY

Access to funding is an important determinant of sustainability for the MHU program, but continued funding for this program is not guaranteed. A strategy used by one of the clinics to maintain the program is diversifying funding sources. A staff member explained:

> "We have 34 grants, currently. We're well-versed in exploring other funding options and have done quite a bit to diversify our funding. Not only diversify our funding but be able to add specific programming to the mobile unit sites."

This staff member noted that sustainability of the mobile MOUD program may also mean retiring the mobile units altogether and redesigning the program approach. One option is to transition fully to pop-up clinics which may help reduce stigma associated with seeking services in rural communities and would also mean fewer challenges associated with RV maintenance. This staff member explained:

> "We're going to have to retire the units. That's just a reality. Even if they had worked perfectly from day one, they were never going to live forever. I don't think using funding to rebuild those units is the right approach."

CONCLUSION

In this grant year, the clinics continued to outreach and serve communities and were able to provide critical care and MOUD to clients. The clinics offered services in locations that are convenient to clients in rural areas, maintained consistent schedules and appointments, provided easy access to medication, and made staff available to support clients in treatment. Clients reported satisfaction with their care and expressed few barriers to program participation and accessing prescribed medications. Program effectiveness was also shown by clients' retention in the program.

Despite considerable challenges, clinical staff and leaders have demonstrated flexibility and innovation to increase services and develop community partnerships to meet client and community needs, providing equitable whole person behavioral health services. The clinics addressed challenges to deliver

services, adapted their approaches to further community and client engagement and implemented contingency plans to ensure continuous, reliable care.

RECOMMENDATIONS

The following recommendations were made by clinical staff and clients during interviews in the past five grant years. Given the complexities and challenges involved with implementing and sustaining the program, it is acknowledged that the clinics may not have been able to respond to these recommendations previously. Therefore, the Colorado Behavioral Health Administration (BHA), the Managed Services Organizations (MSOs), and the clinics are encouraged to consider these recommendations for improving delivery of the mobile MOUD program. Program-level recommendations that align with three of Colorado's Six Pillars of a Strong Behavioral Health System[5] are presented.

Program Recommendations

Access

1. The BHA should continue to support the clinics to be flexible and employ innovative methods to increase program reach and client engagement. Strategies employed by the clinics included extending hours and modifying schedules to meet client demand and co-locating initiatives with local community health organizations. To maintain client engagement of current clients, the clinical teams provided consistent communication and follow-up with clients after appointments. Clients expressed appreciation for the follow-up communications as important to their recovery.
2. The clinics should continue to implement contingency plans and revise as needed to ensure client continuity of care. The clinics relied on telemedicine appointments and pop-up locations in each community for use when the MHUs are out of service or there is challenging weather that limits the use of the MHU. Clients expressed high levels of satisfaction with access to treatment and level of care provided on the MHUs and at the pop-up clinics and reported very few barriers in participating in the program.

Lived Expertise and Local Guidance

3. The clinics should continue community outreach and relationship-building with partners in the towns they serve. Outreach should include weekly or biweekly telephone calls and emails to community partners, and clinical teams should maintain a list of new and ongoing partnerships. Sustaining outreach and relationships in the community leads to increased awareness of the services offered, increased referrals to the program and opportunities for continued and renewed collaborations with community partners.

Workforce and Support

4. The BHA should continue to support the coordination, collaboration, troubleshooting and shared learning among clinical teams through regular "all provider" calls and one on one

[5] https://bha.colorado.gov/about-us

connections facilitated by the MSOs and the BHA. The collaboration among clinical teams and the MSOs proved to be helpful to address early mechanical issues affecting all the units. Maintaining communication and shared learning among the clinical teams will allow for strategic and timely solutions to issues as they arise.

5. The BHA should continue to support the clinics to address staffing shortages. The clinics employed several strategies such as cross-training staff in the necessary administrative duties, utilizing staff from other clinicals teams, hiring staff who provide services via telehealth, and revising job descriptions. Clients consistently reported high levels of satisfaction with the staff's client-centered approach to care, describing them as trustworthy, helpful, and empathetic.

Evaluation Recommendations

1. Evaluators will partner with clinics, MSOs, and the BHA team to conduct regular data quality checks on program level data (i.e., MHU Services Form and the GPRA Client Outcomes Tool) reported in the MHU Data Dashboards to ensure robust data.

2. Evaluators will collaborate with clinics to implement the new client satisfaction survey with all clinics. The new survey was only piloted with one clinic this year.

3. Evaluators will collaborate with clinics, MSOs, and the BHA team to analyze client or program level indicators, such as referrals to external resources, collected in the revised data collection tools.

4. Evaluators will work with clinics, MSOs, and the BHA team to identify the most relevant and appropriate measures of program geographic reach and align data collection efforts to include any additional variables of interest, such as locations of services delivered through other SOR funded programs.

APPENDIX: METHODS

OVERVIEW

The evaluation for the MHU MOUD program began with a literature review and development of a logic model and an evaluation plan.[6] The evaluation was guided by the RE-AIM Framework[7] which is used in the public health field to provide a comprehensive approach to planning, implementing, and evaluating the effectiveness of public health programs. The framework contains five elements (Reach, Effectiveness, Adoption, Implementation, and Maintenance) and asks several basic questions:

1. REACH: What are the characteristics of the intended program participants and how successful is the program at reaching this population?
2. EFFECTIVENESS: What is the primary outcome(s) of the program and how effective is the program at affecting those outcomes?
3. ADOPTION: What are the characteristics of the setting in which the program is being implemented and what effect does the setting have on program implementation?
4. IMPLEMENTATION: What adaptations have been made during implementation?
5. MAINTENANCE: How has the program been integrated into the organization and/or the local community?

The RE-AIM framework allows for contextual examination of programs including the environment in which they are run and the communities in which they serve. Additionally, the framework supports measuring program effectiveness and program adaptations over time. The RE-AIM framework provides a comprehensive roadmap for evaluating public health interventions.

In year five (October 1, 2022, through September 30, 2023) of the SOR grant, the evaluation focused on all five elements of RE-AIM. These were:

- Reach (improvements in access to care shown through locations of clients served)
- Effectiveness (client satisfaction, improvements in access to care, engagement in treatment)
- Adoption (community partnerships, clinic program integration)
- Implementation (successes and challenges to implementation, program developments)
- Maintenance (program sustainability)

Also, in year five of the SOR grant, the evaluators developed a short infographic style report highlighting key findings from year four, summarized clinic level data for each of the three clinics delivering MOUD

[6] State Opioid Response Grant Program Evaluation. September 2019. An updated evaluation plan was submitted to the Colorado Behavioral Health Administration Evaluation Manager in February 2023.
[7] Belza, B., Toobert, D., Glasgow, R. (2005). RE-AIM for Program Planning: Overview and Applications. Center for Health Aging and National Council on Aging.

services, updated evaluation instruments, piloted a new client satisfaction survey, and published a Data Dashboard that displays real-time data for ongoing monitoring by the BHA, MSOs and clinics.

DATA COLLECTION

Evaluators used a mixed methods approach by analyzing program monitoring data and collecting information from clinical staff and clients, through surveys and in-depth interviews.

INTERVIEWS AND SURVEYS

Evaluators conducted interviews with the clinic program coordinators and clinical staff (i.e., MHU teams, MOUD providers) once during year five (October 1, 2022, through September 30, 2023). Staff from Front Range Clinic, Jefferson Center for Mental Health, and San Luis Valley Behavioral Health Group participated in the interviews. A total of 13 individuals across the three provider clinics participated.

Evaluators captured feedback from clients through multiple ways (in-depth telephone interviews, brief telephone surveys and a new electronic survey administered by clinic staff after the client visit). Part way through the year, evaluators piloted a new client satisfaction survey at one clinic. In total, 17 individuals who received care on the mobile units or at pop-up clinics participated in these evaluation activities. The client participants represented only two of the three clinics. Client interviews and telephone surveys were conducted by The Evaluation Center Graduate Assistants (GPRA GAs) who are trained in trauma-informed interviewing and who complete the GPRA follow-up interviews. The table below provides a detailed summary of the qualitative instruments developed and administered.

INSTRUMENTS FOR QUALITATIVE INVESTIGATION OF PROGRAM IMPLEMENTATION

INSTRUMENT	PARTICIPANT	DESCRIPTION & ADMINISTRATION
MHU Clinic Staff Interview Protocol	Clinic MHU program leadership, MHU staff	The MHU clinic staff interview protocol was designed to capture program activities, goals and adaptations and reflections from clinical staff on implementation (such as supportive factors and challenges in the implementation process). The interviews were approximately 45-60 minutes. In year five, a total of 13 individuals (clinic leaders and program staff teams) from the three provider clinics participated.
Client Satisfaction Phone Survey	Volunteer clients contacted through GPRA process	This brief phone survey was conducted in conjunction with the routine 60-day GPRA check-in call. The brief phone survey contained closed-ended items to reduce the time commitment burden on the client. The number of eligible clients was limited by the number of clients who had a completed GPRA intake clients retained to treatment at 60 days, and those who were successfully reached by The Evaluation Center GPRA data collection graduate assistants. In year five, six clients participated.

Client Satisfaction Electronic Survey	Volunteer clients who were administered the survey by clinic staff	This survey was piloted with one clinic this year. Ten clients participated by completing the survey after a visit. It was developed collaboratively with input from clinical staff from the three clinics and the BHA Evaluation Manager. The survey expands on the information collected in the Client Satisfaction Phone Survey by including satisfaction with aspects of the client's most recent visit, experience with the staff, and whether they received referrals to other services or supports. In addition, the survey asked clients who have been in treatment for at least three months to rate how they perceive their health, well-being, and their recovery process.
Client In-depth Phone Interview Protocol	Volunteer clients recruited by clinics	The interview protocol was designed to capture client satisfaction, perceptions of access to services, and benefits and challenges to receiving services. In year five, staff from only one of the three clinics recruited clients. Ultimately one client participated. Participants received a gift card after completing the interview.

PROGRAM AND CLIENT DATA

Evaluators accessed multiple data sources to examine the reach and effectiveness of the program, including service delivery locations, and the number of visits and unique clients. The table below describes these data sources.

DATA SOURCE FOR PROGRAM AND CLIENT DATA		
DATA SOURCE	PARTICIPANT	DESCRIPTION & ADMINISTRATION
MHU Services Form	Clients	The MHU Services Form was developed by BHA evaluators with input from the clinical staff and The Evaluation Center team. Clinical staff enter information routinely to record client visits and services delivered to clients. Evaluators counted the visits per location and compiled visit dates by unique clients to calculate measures of client engagement (e.g., number of visits per client) and retention (e.g., clients retained to treatment for 45+ days). The MHU Services Form was updated this year to reflect the current towns being served, and to capture new information on resource referrals.
Client Outcome Measures	Clients	Administration of the GPRA Client Outcome Measures Tool is a requirement of the SOR grant and is administered to clients at various points during their recovery journey. Treatment site clinicians and staff administer the initial intake to SOR clients. Graduate Assistants at The

Tool (GPRA)		Evaluation Center contact clients by phone to complete the follow-up interview. During the intake and follow up interviews, clients self-report demographic information, substance use, utilization of services, and attitudes regarding quality of life and satisfaction. Year five data were limited therefore this data source was not used.
Client Contact Form	Clients	In conjunction with the GPRA survey administered at intake, treatment site staff also complete a client contact form. This form collects basic contact information in addition to data related to the clients' referral to treatment, mode of transportation to the intake appointment, and the amount of time it took for the client to travel to the appointment.
MHU Schedules	Program level information	The Colorado towns visited by the MHUs were mapped using the street addresses for each parking location to show program reach across the state. Evaluators accessed the schedules posted on the clinics' websites and contacted the clinics to confirm towns that may have been removed or added to the schedule.

DATA ANALYSIS PROCEDURES

Interviews were conducted by phone or video call, transcribed, and coded using MS Excel and NVivo 14 software. The analysis was based on a structured coding scheme organized by interview question. The evaluators used Qualtrics Survey Software, MS Excel, and IBM® SPSS Statistics software for quantitative data collection, management, and analysis. Lastly, evaluators used ESRI's ArcGIS software to create Colorado maps showing towns receiving MHU services.

MISSION

We strive to make evaluation a valued and widely accepted practice by increasing the use and understanding of evaluation. We collaborate with our clients to support evidence-informed programs, practices, and policies in schools, institutions of higher education, governmental agencies, and nonprofit organizations.

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