

# Challenges and Opportunities for Integrating Substance Use Disorder Treatment into Community Health Centers

## ISSUE BRIEF

### AUTHORS

### OVERVIEW

Fatal overdoses surged during the acute phase of the COVID-19 public health emergency and continue to rise. Stressors, loss of social support, and disruptions in treatment and recovery services exacerbated longstanding gaps in access to high-quality substance use disorder (SUD) treatment, particularly for communities of color. Community health centers (CHCs) focus on medically underserved populations and have long delivered comprehensive and culturally-informed care. They are well-poised to improve outcomes for patients with complex needs, address equity gaps, and support improved access to high-quality SUD treatment by further expanding integrated, team-based primary care models. Although CHCs have made great strides in expanding access to Medications for Opioid Use Disorder (MOUD) and other evidence-based SUD services, CHC leaders continue to report significant logistical, workforce, reimbursement, policy, and stigma-related challenges that have inhibited the adoption and sustainability of SUD services within CHC settings.

### Key Recommendations

To support and sustain integration of SUD treatment in CHC settings, federal and state efforts are needed to encourage additional payment and delivery reforms, remove existing policy barriers to MOUD access, and provide guidance and resources to support integrated care models. Specifically:

- Federal and state leaders can address the financial barriers associated with integrating SUD treatment in CHCs through payment and delivery reforms and models that provide incentives for whole-person approaches.
- States and the federal government can support further adoption and scaling of high-quality SUD care by removing existing barriers to evidence-based MOUD, leveraging new sources of opioid funding, supporting telehealth in CHC settings, and clarifying existing guidance and resources.

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Fatal overdoses surged during the early stages of the COVID-19 pandemic and continue to rise, with more than [104,000](#) drug-related overdose deaths reported between March 2021 and March 2022. Although longstanding gaps and disparities in access to high-quality SUD treatment and recovery services precede the COVID-19 pandemic, stressors, loss of social support, and disruptions in treatment and recovery services have accelerated challenges for individuals with SUD.

- Recent [research](#) illustrates how overdoses have had unequal impacts, with disproportionate overdose increases for Black and Native American populations and for people in areas with significant income inequality.
- The current fragmented SUD treatment system often fails to reach those most in need of services, with nearly [half of all rural counties](#) (more than 1,000 counties) lacking any Drug Addiction Treatment Act (DATA)-waivered (or “X-waivered”) providers authorized to provide MOUD,<sup>2</sup> considered the “[gold standard](#)” for treatment in an office-based setting. In these counties, this deficiency means that treatment likely would be available only in inpatient settings and federally certified opioid treatment programs.
- In 2020, only [6.5 percent](#) of individuals 12 or older who had a SUD received any sort of treatment, and access to high-quality services, including MOUD, remained fragmented and inequitably distributed across race and ethnicity, income, insurance status, and geography.
- National surveys of SUD treatment facilities (which includes but is broader than opioid treatment programs) suggest that only [36.1 percent](#) of SUD treatment programs offered at least one form of FDA-approved MOUD.

With their focus on medically-underserved populations, CHCs (including Federally Qualified Health Centers [FQHCs], Rural Health Centers, and FQHC look-alikes) are well-poised to address current access gaps in SUD treatment, particularly for historically-marginalized communities that have lacked access to high-quality treatment and recovery services. CHCs’ experience in delivering comprehensive, culturally-informed services make them equipped to implement the type of integrated, team-based SUD treatment models within primary care settings that have been shown to improve outcomes for patient populations with complex physical, behavioral, and social needs (see [Appendix A](#)). Although many CHCs have moved toward further integration of physical and behavioral health, wider adoption of effective models has been hindered due to implementation and sustainability challenges, including regulatory barriers, logistical and workflow challenges, data infrastructure, behavioral health workforce, social service network capacity, and sustainable financing.

The Duke-Margolis Center for Health Policy interviewed CHC leadership and clinicians, national experts in addiction and primary care, provider associations, and state policymakers to better understand how to support CHCs in further expanding the implementation of integrated SUD treatment models. This brief summarizes the lessons learned from those interviews and background research, including barriers to expanding integrated SUD services into CHC settings; examples where CHCs have implemented broader SUD programs; and recommendations for federal and state policies to support integrated care models, remove existing policy barriers to access, and encourage additional payment and delivery reforms to support the sustainability of integrated models.

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## Momentum for Expansion of SUD Services in Community Health Centers

CHCs are a critical access point for individuals and communities that lack access to specialty treatment providers to receive screening, referral, evidence-based treatment, linkages to social supports, and other essential services needed to reduce overdose risks and support individuals with SUD into recovery. The provision of primary care in CHCs can play a critical role in providing a low-barrier pathway to SUD treatment as well as treat

[comorbid physical health conditions](#), such as HIV, AIDS, viral hepatitis, and cardiovascular disease associated with substance use. CHCs also play an important role in the prevention of SUD through integrated pain management programs [situated within CHCs](#), which help patients manage pain and reduce use of pain medication through alternative pain management services.

<sup>2</sup> FDA-approved Medications for Opioid Use Disorder, including methadone, buprenorphine, and naltrexone, are also commonly referred to as “Medication-Assisted Treatment” (MAT).

Even prior to the COVID-19 pandemic, CHCs responded to increased treatment need and federal attention to the opioid epidemic by adding resources, workforce, and capacity to provide MOUD and other SUD services. National data from health center grantees from the Uniform Data System (UDS) indicate that staffing for Substance Use Services [doubled](#) between 2016 and 2020, while the number of patients receiving treatment services increased [108 percent](#) over the same period. According to [Kaiser Family Foundation's](#) 2019 survey of community health centers, the number of centers providing MOUD services increased substantially, from 48 percent in 2018 to 64 percent in 2019. The rates of CHCs delivering MOUD were [significantly higher](#) in states that expanded Medicaid, given the significant resources that Medicaid provides for CHCs.

To support expansion of MOUD in CHC settings, the Health Resources and Services Administration (HRSA) has [awarded](#) over \$646 million in funding to health

centers since 2018 for efforts such as establishing integrated primary care models, hiring substance use service providers, adding or enhancing MOUD services, coordinating services, and providing training and educational resources. HRSA also has invested over \$400 million in rural health centers and other organizations serving rural communities through its [Rural Communities Opioid Response Program](#), which supports rural health centers with planning and sustaining SUD services that focus on medication-assisted treatment (MAT) expansion, Neonatal Abstinence Syndrome, and misuse of psychostimulants. Many CHCs also have benefitted from a variety of other state and federal funding streams (see [Appendix B](#)) to support activities related to treatment expansion, overdose prevention, and other goals. In the future, CHCs may also receive funding from [recent legal settlements](#) with opioid manufacturers, distributors, and retailers to support SUD integration.

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## Addressing Racial and Ethnic Treatment Disparities

While drug-related overdoses have risen among nearly all demographic groups, driven by shifting drug use patterns toward heroin and illicit fentanyl, drug-related overdoses have [risen](#) most rapidly for non-Hispanic Black populations. While these trends precede COVID-19, pandemic-related disruptions in treatment have been layered on top of a legacy of [disparities](#) in treatment access, utilization, and [outcomes](#) for Black Americans resulting from stigma, structural racism, and other systemic barriers within the health care system.

Numerous [studies](#) have elucidated the role of racism, income, geography, and insurance status in affecting an individual's access to the full range of MOUD and substance use treatment services, with stigma within the health care system, fear of law enforcement involvement, and a lack of culturally responsive care also constituting key [barriers](#) to equitable treatment access. Even as overdoses have continued to rise among Black Americans, a 2019 [study](#) found that non-Hispanic, white patients were 35 times more likely to receive buprenorphine in an office setting compared to Black patients. Additional studies have [found](#) that buprenorphine treatment rates are highest in areas with the highest income and lowest percentage of Black and Hispanic residents, while methadone treatment

rates are greater in low-income areas with a high percentage of Hispanic residents. The result has often been a ["two tiered treatment system,"](#) with privately insured non-Hispanic, white patients receiving buprenorphine in office settings, while publicly-insured individuals of color are often diverted to opioid treatment programs with onerous daily dosing requirements.

These findings underscore the need for the expansion of role of CHCs in reducing SUD treatment disparities for communities of color. CHCs can offer the full range of effective treatment for OUD, increasing their ability to serve patients currently receiving methadone maintenance therapy who are [disproportionately likely](#) to be a member of a historically marginalized population. With their focus on underserved areas and populations that have been historically marginalized, CHCs are well-positioned to address established treatment gaps in buprenorphine access for communities of color and individuals that are publicly insured or uninsured.

To further improve equity in SUD treatment, CHCs can invest in anti-stigma training and initiatives, work actively to recruit a culturally-responsive workforce, and engage with both community-based organizations and individuals with lived experience to inform culturally-responsive and trauma-informed interventions and services.

## Key Takeaways:

1. CHCs have responded to increased treatment needs and federal attention to the opioid epidemic by adding resources, workforce, and capacity to provide MOUD and other SUD services, doubling staffing and the number of patients utilizing SUD services between 2016 and 2020.
2. HRSA has invested significant financial resources through grants and cooperative agreements in support of to support CHCs and rural health centers in establishing integrated primary care models, hiring substance use service providers, adding or enhancing MOUD or other new services, coordinating services, and providing training and educational resources.
3. CHCs are well-positioned to play an important role in addressing historical gaps in access to high-quality, effective treatment for OUD, particularly for communities of color.

## Challenges for Integrating SUD Treatment Services into Community Health Center Settings

CHC leadership, clinicians, state officials, and national experts interviewed for this report identified multiple challenges that CHCs face in establishing SUD treatment services or incorporating SUD care into existing operations. Interviewed CHC leaders often reported being challenged by competing demands, complex patient needs, limited resources within the safety net, and limited experience in implementing integrated SUD care models. Beyond general capacity challenges, stakeholders raised a number of other specific barriers as challenges for integrating SUD services into CHC settings.<sup>3</sup> These challenges vary by CHC, given variation in CHC size, capacity, resources, available services, and patient populations served. While interviewed CHC leaders had developed strategies for confronting these challenges (see [Appendix C](#) for case examples), federal and state policymakers also can support these efforts by providing resources and support for SUD treatment integration, while working to identify and remove barriers to patient access and care. The major challenges raised by interviewed stakeholders included:

- ***Stigma Against Substance Use and Individuals with Substance Use Disorders***

A primary challenge raised by stakeholders, both within CHCs and more broadly across health care settings, is the continued stigmatization of substance use and individuals with SUDs. A number of treatment providers and experts described a reluctance among leadership to devote limited safety net resources to SUD treatment as well as resistance from providers based on a belief in “abstinence only” approaches, unfamiliarity or discomfort with MOUD or management of patients with SUD, concerns about diversion of buprenorphine, or concerns about the ability to meet the unique needs of SUD patients within primary care clinical settings. The stigma-driven propensity to see the drug-using population as “others” also can drive potential pushback against “mixing” SUD and primary care populations, a dynamic which may be especially pronounced if the CHC is considering becoming a formally-recognized [Opioid Treatment Program](#). Providers highlighted the importance of clinician champions, educational efforts, and [Project ECHO](#)-modeled initiatives that can connect primary care providers (PCPs) to experts and technical assistance for integrating services into primary care settings.

<sup>3</sup> For more information on challenges for primary care integration, see the National Academy for State Health Policy's [State Strategies to Support Substance Use Disorder Treatment in the Primary Care Safety Net](#) and the Technical Assistance Collaborative's [Integrating Substance Use Disorder Treatment and Mainstream Medical Care: Four Ground-Level Experiences](#).

## SPOTLIGHT: CHC Strategies for Addressing Stigma and Provider Buy-In

Although [Fenway Health](#) in Boston, Massachusetts has had a long history of serving historically-marginalized populations and delivering behavioral health services, efforts were needed still to encourage providers to deliver office-based opioid treatment. Providers at Fenway Health are encouraged through an opt-in approach to complete X-waiver training. To help make it easier for providers to opt-in to the required eight-hour training, Fenway Health began carving out dedicated hours for providers to complete their trainings by leveraging grant funds from the state's Bureau of Substance Addiction Services (BSAS) to cover loss of revenue for missed office hours. Fenway also helped tackle provider stigma toward MOUD by using both provider and patient advocates as champions and aligning the treatment of SUD to their mission of serving the most vulnerable populations using MAT and other harm reduction strategies. To support providers, a resident expert in behavioral health and MOUD helps to educate and train other providers and serves as a primary support person for any questions or concerns that PCPs may have. Fenway Health also has worked with patients with lived experience to identify how to utilize culturally-appropriate, trauma-informed, and destigmatizing approaches and language when treating patients.

*For more information on Fenway Health's approach for addressing practice implementation challenges, see [Appendix C](#).*

### • **Data and Interoperability Challenges**

Stakeholders interviewed noted an overall lack of interoperability in electronic health records (EHRs) between primary care, behavioral health, and specialty care providers. For example, CHCs may lack the resources to invest in well-known EHR systems, like Cerner or Epic, that are compatible with larger health systems and specialty facilities. This issue can lead to delays in timely access to vital patient data, including medications for managing physical and behavioral health conditions. Additionally, while treatment records created by PCPs prescribing buprenorphine are exempt from updated [42 CFR Part 2](#) regulations intended to protect the confidentiality of SUD treatment records, providers may face actual or perceived challenges with bi-directional data exchange with specialty treatment providers or compliance with privacy regulations.

### • **Meeting the Unique Needs of SUD Patients in CHC Settings**

Numerous providers operating in CHC settings referenced challenges in adapting primary care workflows and models to meet the unique needs of individuals with SUDs who may have less predictable schedules than a general primary care population or who may be distrustful of health systems based on previous experiences of stigma and discrimination. Providers emphasized the role of telehealth, care coordinators, partnering with community-based organizations and other trusted providers, and peer recovery support in being able to flexibly deliver services. Additionally, providers highlighted the need to listen carefully to the experiences and preferences of individuals with lived experience in developing “[low threshold](#)” approaches for MOUD access, including same-day treatment availability, flexibility in service delivery, and providing treatment in convenient and comfortable settings. Furthermore, adopting a “[harm reduction](#)” philosophy that centers on risk reduction and personal dignity for people who use drugs was highlighted as a key priority for effectively delivering services to individuals with SUD.

## SPOTLIGHT: CHC Strategies for Building Community Partnerships

To improve integration of their behavioral health services, [Alameda County Health Care for the Homeless \(ACHCH\)](#) created a multi-disciplinary [Street Health Team](#) that includes a psychiatrist, registered nurse care manager, and outreach workers, who operate out of a small mobile unit to gain trust with and connect people who are homeless or are at risk of homelessness to providers in the field and in clinics. Street Health teams are able to provide on-demand MOUD and connect individuals on the streets and in homeless encampments to clinics for MOUD, detox/sobering, and recovery services. Outreach workers adopt a harm reduction approach to address health literacy challenges by simplifying instructions given to patients, including what withdrawal symptoms to expect and how to combat them. To support continuity and coordination of services for patients (while recognizing the limited bandwidth of clinic providers), ACHCH also provides life/health coaches who follow-up with patients to ensure medication adherence and treatment retention.

*For more information on ACHCH's approach for addressing practice implementation challenges, see [Appendix C](#).*

### • **Workforce Capacity and Access to Trained Specialists**

Integrated SUD models rely on a team of clinicians, nurses, behavioral health specialists, case managers, and other paraprofessionals, such as peer-recovery support coaches. Throughout the pandemic, health care providers across the country have been challenged by [significant workforce shortages](#), particularly for nursing staff. Acute staffing challenges facing CHCs are compounded by a long-standing shortage of behavioral and mental health providers in [many regions](#) across the country. This shortage is particularly apparent in rural areas, which lack access to higher levels of mental and behavioral health care specialists, such as psychiatrists. To help lower barriers for PCPs who may wish to offer MOUD in office-based settings, the Biden Administration issued new practice guidelines that waives the eight-hour training requirements under the [DATA 2000 Act](#) for providers that intend to treat 30 or fewer patients. However, many providers continue to [cite](#) training requirements as a hindrance to buprenorphine prescribing and access.

### • **Lack of Access to Social Supports and Care Coordination Resources to Meet Patient Needs**

Individuals with SUDs may have complex social needs and experience barriers, including involvement in the criminal justice system, unstable housing or employment, and lack of transportation, all of which can impact an individual's path to recovery. For example, one interviewee noted that it is difficult to see how individuals with SUD can stop drug use while living with the instability of homelessness. Securing [stable housing](#) for SUD patients can help start and sustain their treatment journey and decrease ED visits and hospitalizations. While CHCs have significant experience in addressing patients' social needs, they are challenged with a lack of resources for counselors, care managers, and other services.

## SPOTLIGHT: CHC Strategies for Building Community Partnerships

[Agape Health Services](#), located in North Carolina, has worked to build strong partnerships with hospitals, other health care organizations, state and local government agencies, public health departments, and community organizations to help meet the unique social and health care needs of their patients. For example, Agape is part of the leadership team for Beaufort County 360 (BC360), a community group focused on addressing issues that can impact quality of life. As part of their efforts, BC360 created a Behavioral Health Taskforce to help address behavioral health issues in the county by identifying behavioral health system changes, including an assessment of needs and assets in the county and increasing awareness of community behavioral health resources. Partnering with and being part of community groups, like BC360, helped Agape address some of the social barriers their patients face, like housing and transportation.

### • **Regulatory and Licensing Issues**

Numerous stakeholders pointed to regulatory requirements at the federal and state level that may make integration of physical and behavioral health services difficult. These barriers include regulatory requirements for federal [Opioid Treatment Program](#) certification, prohibition of same-day billing for physical and behavioral health services in some states, clinical requirements that MOUD must be accompanied by counseling services, limitations on provider types that can be reimbursed under Medicaid, and multiple layers of licensing or requirements that may apply to physical and behavioral health care services regulated by separate agencies. While many regulations are intended to reduce drug diversion and ensure patient safety, the federal government and states are reassessing the impact of regulations on patient care in light of flexibilities enacted during the pandemic.

### • **Reimbursement and Financing**

CHCs are required to serve uninsured and underinsured individuals, providing comprehensive health services regardless of insurance status or ability to pay. While funding from Section 330 grant dollars and reimbursement under the Prospective Payment System (PPS) can help offset costs of care for uninsured patients and non-billable enabling services required for comprehensive care, several CHC stakeholders highlighted resource limitations in supporting care for high-need individuals or to provide non-billable enabling services. Many CHC leaders emphasized the importance of supplemental Section 330 funding to expand SUD services, along with a variety of other state and federal funding sources that can support start-up and continuation of SUD services for CHCs. However, CHC leaders cautioned that grants are often time-limited and require effort to apply, such that additional strategies are needed to support the long-term program sustainability. Funding from recent [legal settlements](#) with opioid manufacturers, distributors, and retailers, which will be disbursed over the next two decades, may provide an opportunity to support new and existing SUD integration efforts in CHCs.

Alternative payment methodologies (APMs), which are operational in over 20 states and can include approaches like per-member-per-month payments or bundled payments linked to quality indicators, also can provide additional flexibility and potential sustainability in the delivery of high-quality care. However, experts cautioned that health centers' experience and capacity for adopting complex payment structures may be variable across settings, and that CHCs face statutory barriers and practical concerns in adopting more advanced APMs involving shared downside risk.

## Key Takeaways:

1. Integrating SUD care models in the CHC setting is often challenged by competing demands, limited resources (although new funding sources are becoming available), and limited experience in implementing such models.
2. Implementing integrated SUD models in CHCs is further challenged by stigma, data infrastructure, workforce capacity, adapting models to meet the unique needs of individuals with SUD, access to social supports and care management resources, regulatory and licensing issues, and reimbursement.

## Recommendations: Future Directions and Policy Priorities for Expanding Integrated SUD Models

While CHCs have made significant strides in implementing and scaling integrated care models, the following recommendations for federal and state leaders can help promote further adoption and scaling of high-quality SUD care in CHC settings and focus on strengthening federal guidance and resources, removing existing barriers to evidence-based MOUD, and supporting payment and delivery reforms that provide incentives for whole person approaches.

- ***Encourage Payment and Delivery Reforms that Can Support Sustainable, High-Quality Care***

The federal government and states can implement additional SUD-focused alternative payment models (APMs), such as bundled payments, pay-for-reporting, or quality incentives, that offer CHCs greater flexibility in how its providers deliver care and provide incentives for greater integration across physical, behavioral, and social services not typically covered by Medicaid. Multiple existing payment reforms could be adapted or expanded to support CHC efforts, including those from the Center for Medicare & Medicaid Innovation (CMMI) or through Medicaid section 1115 waivers or state plan amendments. It is important to note that nuanced technical issues exist in implementing CHC-focused APMs in Medicaid, such as the Medicaid Prospective Payment System (PPS) for Federally Qualified Health Centers. Examples of existing SUD-focused payment and delivery models that could be scaled include:

- CMMI's [Value in Opioid Use Disorder Treatment \(Value in Treatment\) Medicare Demonstration Program](#), which provides a potential APM approach that could be expanded by the Centers for Medicare & Medicaid Services (CMS) or adapted within state Medicaid programs. This program includes a per beneficiary per month care management fee, which can be leveraged for substance use disorder services that are not otherwise eligible for payment, as well as performance-based incentives in order to encourage evidence-based MAT. Performance is measured by criteria set by CMS, including patient engagement and retention in treatment.
- [Virginia Medicaid's Addiction and Recovery Treatment Services \(ARTS\) Program](#), which utilizes a "Gold Card" approach for recognized Office-Based Opioid Treatment (OBOT) providers who have on-site credentialed counselors or other addiction treatment professionals and meet other criteria related to provision of MAT. These providers are eligible to bill a [\\$243 per-member per-month care coordination code](#) and bill higher rates for individual and group opioid counseling, among other benefits. [Outcomes from the first year](#) of the ARTS program show an increase in the number of members with SUD receiving treatment and a decrease in emergency department (ED) visits related to OUD.



- **Medicaid Health Homes:** Another Medicaid model that supports integrated care for individuals with SUD is the Health Home model, authorized by the ACA's optional Medicaid State Plan benefit. Michigan's [Opioid Health Home \(OHH\) pilot program](#) provides comprehensive care management and coordination services to Medicaid beneficiaries with OUD using a monthly case rate and a [payment for quality performance](#), including increases in initiation and engagement in treatment, increased follow-up after SUD-related ED visits, and decreases in opioid-related hospitalizations. Outcomes from the program's first year shared by the [Michigan Department of Health and Human Services](#) show increased 7-day follow up appointments after hospitalization, decreased readmissions, and increased initiation and engagement in alcohol or other drug dependence treatment.

• **Remove Policy and Regulatory Barriers to MOUD Access**

States and the federal government should examine and take steps to remove appropriate policy and regulatory barriers to MOUD, including studying and moving to make permanent flexibilities that removed barriers to patient care during the COVID pandemic. In response to concerns that disruptions to in-person care would threaten access to MOUD, the federal government [took action](#) to relax previous regulatory rules that could pose barriers to access. These changes granted licensed MOUD providers flexibility to: 1) provide take-home doses of methadone for up to 28 days, while relaxing refill limits on Drug Enforcement Administration (DEA) controlled substances, and 2) initiate buprenorphine for those whom they have not conducted an in-person medical evaluation and refill prescription for treatment via telehealth, including telephone-only services.

Recent CMS policies, notably the CMS 2023 Physician Fee Schedule proposed rule, also could improve resources for community health centers. The [proposed rule](#) would allow opioid treatment programs to bill for initiation of buprenorphine treatment via two-way audio-video communications technology for Medicare patients, signaling a commitment at the federal level to a more flexible approach to SUD treatment that may eventually benefit other regulatory environments.

With new DEA and Substance Abuse and Mental Health Services Administration (SAMHSA) guidance, CMS also is proposing services furnished via opioid treatment program mobile units that can be paid under a bundled payment and/or add-on billing codes. This new regulatory flexibility, if finalized, can improve access to opioid use disorder treatments, particularly in remote or underserved areas.

Many states took additional action to relax state prescribing, prior authorization, drug screening, or counseling requirements that exceeded federal guidelines. While the impact of these flexibilities on access and outcomes for patients will continue to be evaluated, initial [reports](#) indicate that providing patients with the flexibility of take-home prescriptions of methadone have resulted in easier access and fewer challenges for opioid treatment programs. The methadone take-home flexibilities have been [extended](#) for a year after the end of the federal public health emergency, which provides an opportunity for states and the federal government to examine the impact of regulatory restrictions and take steps to eliminate policies that prevent individuals from accessing medications.

• **Leverage Federal Opioid Funding to Bolster CHC Capacity and Support Health care Transformation Efforts**

Broadening access and uptake of evidence-based care and promoting integrated care for individuals with co-occurring physical and behavioral health disorders are all key priorities of the Biden Administration's [Overdose Prevention Strategy](#) and the [2022 Drug Control Strategy](#).

States received a significant influx of federal funding for state substance use treatment systems during the COVID-19 pandemic. This funding includes an additional \$1.5 billion in Substance Abuse Prevention and Treatment Block Grant (SABG) support through the [American Rescue Plan Act of 2021 \(ARPA\)](#), as well as \$1.85 billion in SABG funding from the [FY 2022 Omnibus Appropriations Bill](#). States have until the end of 2024 to decide how to spend ARPA funding and until the end of 2026 to use the funding. With CHCs as a critical access point for MOUD, state behavioral health agencies can work closely with state primary

care associations and CHCs to support infrastructure upgrades, start-up costs, training, and other costs for expanding SUD treatment services. State behavioral health agencies also can work closely with state Medicaid programs as they consider implementation of APMs that can support integrated care, including the potential for leveraging flexible funding for critical support and recovery services, such as peer recovery coaches, housing, or other social support services. Finally, CHCs can also consider how funds distributed to states, counties, and municipalities through [recent opioid settlements](#) can be leveraged to support SUD integration, though there is some variability nationwide in how these funds will be [administered](#) and spent.

- **Support Adoption of Telehealth in CHC Settings**

Telehealth has played an [enhanced role](#) in the delivery and continuity of care in health centers throughout the pandemic and has provided greater access to care for beneficiaries who require more frequent visits, like those receiving [treatment for SUD](#). Telehealth helps reduce [no show rates](#) and [increases volume](#) for providers. It also can help address geographic, transportation, and language barriers for patients. Telehealth also could be an effective tool, particularly in the SUD space, to more easily connect patients with their care teams, case manager, and social services needed to improve recovery outcomes. While recent regulatory flexibilities have strengthened provider ability to initiate and prescribe buprenorphine via telehealth, CHCs will need continued resources and support for integrating telehealth into existing models of care.

During the pandemic, HRSA [awarded](#) emergency funding to CHCs to enable health centers to expand telehealth services, but the future of telehealth beyond the pandemic is uncertain. A concerted effort by policymakers to sustain and build on these effective telehealth reforms past the public health emergency, including the need for [adequate broadband access](#), determining which reimbursement model to use to allow for long-term sustainability, and continuing flexibility on originating site and geographic restrictions, can help CHCs recruit additional workforce and expand their impact to patients that may lack access to in-person services.

- **Provide Additional Federal Guidance and Incentives for SUD Integration**

CHCs have significant flexibility on how they integrate SUD services into existing health center settings. For example, awardees receiving HRSA [Integrated Behavioral Health Services funding](#) are required to add at least one-half, full-time equivalent SUD or mental health service personnel and demonstrate an increase in patients receiving SUD or mental health services. While federal guidance often provides a “floor” for minimum services, several interviewed providers noted additional opportunities exist to provide guidance on best practices and quality incentives for further integration and expansion of services.

Quality incentives require SUD-specific quality measures, and multiple such measures currently exist. Examples of measures that are in use, and often National Quality Forum (NQF) endorsed, are highlighted in [Table 1](#).

TABLE 1

## Example SUD Quality Measures

Measure	Example Programs Using Measure	NQF Number
Continuity of care after medically-managed withdrawal from alcohol and/or drugs	Medicaid Innovation Accelerator Program (IAP)	NQF 3312
Use of pharmacotherapy for opioid use disorder (OUD)	Medicaid IAP Medicaid Health Homes CMMI Value in Treatment Medicaid Adult Core Set	NQF 3400
Prescription or administration of pharmacotherapy to treat OUD		NQF 3589
Initial opioid prescribing for long duration		NQF 3558
Continuity of care after inpatient or residential treatment for SUD	Medicaid IAP	NQF 3453
Initiation and engagement of alcohol and other drug abuse or dependence treatment	Medicaid Health Homes CMMI Value in Treatment Medicaid Adult Core Set Merit-Based Incentive Payment System Program (MIPS)	NQF 0004
Continuity of pharmacotherapy for OUD	CMMI Value in Treatment MIPS	NQF 3175
Concurrent use of opioids and benzodiazepines		NQF 3389
Use of opioids at high dosage in persons without cancer		NQF 2940
Emergency Department use due to opioid overdose	CMMI Value in Treatment	
Follow up after an ED visit for alcohol and other drug abuse or dependence	Medicaid Health Homes Adult Core Set	NQF 3488
Annual monitoring for persons on long-term opioid therapy		NQF 3541

### Key Takeaways:

1. CHCs have made significant strides in implementing and scaling integrated care models, but additional action at the state and federal level is needed to address structural, payment, and policy barriers that continue to pose challenges for sustainably delivering these services.
2. Federal and state leaders can address the financial barriers associated with integrating SUD treatment in CHCs by following the lead of existing models that encourage payment and delivery reforms and provide incentives for whole person approaches.
3. States and the federal government can support further adoption and scaling of high-quality SUD care by removing existing barriers to evidence-based MOUD, leveraging opioid funding, supporting telehealth in CHC settings, and strengthening federal guidance and resources.

## Conclusion

Community health centers have played a critical role prior to and during the pandemic for linking individuals with high-quality SUD treatment and recovery services, and will continue to be a primary source of physical and behavioral health care for the uninsured and underinsured into the future. CHCs have made great strides in expanding access to MOUD and other evidence-based SUD treatment services, including the expansion of integrated, team-based care models that can improve outcomes and reduce costs for patient populations with complex physical, behavioral, and social needs.

As both the overdose crisis and the COVID-19 pandemic continue to evolve, CHCs are uniquely equipped to work with community partners to reduce racial and ethnic disparities in access to SUD treatment, while addressing social determinants of health through the implementation of “whole person” models that address each individual’s unique physical, behavioral, and social needs. While we have accumulated significant experience and lessons learned from health centers’ experiences in implementing SUD services to date, additional investment, guidance, and policies are needed to improve CHC capacity to adopt more advanced payment and delivery models, and to address remaining data, workforce, and payment challenges.

## What is an Integrated System of Care for Substance Use Disorders?

Primary care providers (PCPs) can provide a range of preventive, medical, and behavioral health services, often serving as an [entryway](#) into the behavioral health system. Although there is no “one size fits all” model for integration of SUD into primary care services, “integrated care” often refers to a [spectrum of approaches](#) that seek to align delivery, financing, training, and other aspects of care to support a “whole person” approach that addresses physical, behavioral, and social needs. The Agency for Healthcare Research and Quality (AHRQ) has developed a framework for [Integration of Behavioral Health and Primary Care](#), which provides health systems with tools for measuring progress across key domains for integrated care, including care team expertise, clinical workflow, patient identification, patient and family engagement, treatment monitoring, leadership alignment, operational liability, business model sustainability, data collection and use, and desired outcomes. Integrated care models, such as the [Collaborative Care Model](#), have been shown to be effective in both treating [behavioral health conditions](#), like depression and anxiety, and reduce health disparities across [racial and ethnic groups](#). Approaches to integration of SUD services into the primary care setting can include [components](#) such as provider training, implementation of [Screening, Brief Intervention and Referral to Treatment \(SBIRT\)](#), co-location of treatment and primary care, integrated or team-based models, or development of health homes focused on the needs of individuals with SUD.

The [Massachusetts Collaborative Care Model](#) provides an example of an integrated system of care for SUD treatment. Under this model, a nurse care manager provides clinical support to DEA-waivered providers and is the initial contact for patients, overseeing screening, medication induction, and ongoing monitoring and follow-up visits in collaboration with other care team members. The model started with grants that supported one full-time equivalent nurse care manager in each clinic with a caseload of 100 patients; financing has transitioned to be based on number of people served. The model has expanded to over 30 health centers, with participating patients [demonstrating](#) lower overall health care expenditures and significantly reduced rates of relapse, hospitalizations, and ED visits.

For PCPs offering MOUD through Office-Based Addiction Treatment (OBAT) or Office-Based Opioid Treatment (OBOT), [team-based](#) approaches often include addiction or behavioral health specialists that can consult and support the prescribing physician, along with [case managers](#) or care coordinators (often nurses, psychologist or licensed social workers) that can serve as a single point of contact for the patient, track patient progress over time, and coordinate across health and social services.

## Federal Funding Streams that can Support SUD Treatment Delivery in CHC Settings

CHC revenue is composed of a variety of sources, including Medicaid, Medicare, and commercial reimbursements, Section 330 grant funding, as well as a variety of other federal, state, and private grants. With the federal government allocating significant resources to address the opioid epidemic, CHCs have drawn from variety of discretionary funding streams to support prevention, treatment and recovery activities. Medicaid accounts for roughly [44 percent](#) of health center revenue, with CHCs required to serve a large number of uninsured patients and provide enabling services, such as case management, referrals, and other social supports that can support “whole person” models of care. While CHCs are eligible to receive some of these grants directly, many are administered through state SSAs, which allocate resources based on state strategies and needs. In these cases, CHCs would need to work with state behavioral health leadership, state opioid coordinators, or other entities overseeing allocation of funding to local, community, and private sector entities.

### Federal Funding Streams Available to Community Health Centers to Address the Opioid Epidemic

HRSA GRANTS	Eligibility	Description	FY 2020 Funding	FY 2021 Funding	FY 2022 Funding
<a href="#">Rural Communities Opioid Response Program</a>	All domestic public or private entities, including faith-based and community-based organizations, tribes, and tribal organizations in the U.S. and its territories and outlying islands.	Multi-year initiative addressing barriers to treatment for SUD/ODU. Provides five grant programs in HRSA-designated rural areas: <ul style="list-style-type: none"> <li>• Planning</li> <li>• Implementation</li> <li>• Medication-Assisted Treatment Expansion</li> <li>• Neonatal Abstinence Syndrome</li> <li>• Psychostimulant Support</li> </ul>	<a href="#">\$91 M</a>	<a href="#">\$109.6 M</a>	<a href="#">\$135 M</a>
<a href="#">Integrated Behavioral Health Services Program</a>	Organizations currently receiving H80 funding. Recipients must: <ul style="list-style-type: none"> <li>• Add at least 0.5 SUD and/or mental health service personnel FTE to support expanded services,</li> <li>• Increase new and/or existing patients receiving SUD and/or mental health services</li> </ul>	Increase access to high quality, integrated mental health and SUD/ODU services.	<a href="#">\$200 M to 1,208 health centers in FY2019 that must be used by FY2020</a>	N/A	N/A
<a href="#">National Health Service Corps Loan Repayment Program</a>	Licensed primary care, dental, or mental health providers practicing in a Health Professional Shortage Area for at least two years.	Loan repayment assistance for licensed health professionals.	FY 2018 - first received funding to repay SUD professionals.	FY 2021 - received \$800 M from American Rescue Plan to increase future repayments.	<a href="#">\$121.6 M</a>

## Federal Funding Streams Available to Community Health Centers to Address the Opioid Epidemic

SAMHSA GRANTS	Eligibility	Description	FY 2020 Funding	FY 2021 Funding	FY 2022 Funding
<a href="#">Certified Community Behavioral Health Clinic Expansion Grants</a>	CCBHCs or clinics that can meet certification criteria within 4 months of award. Must provide access to 24/7 crisis intervention services.	Increase access to and improve the quality of community mental health and SUD treatment services by expanding CCBHCs.	<a href="#">\$200 M to 100 recipients for 2 years.</a>	<a href="#">\$250 M to 125 recipients for 2 years.</a>	<a href="#">\$315 M</a>
<a href="#">Substance Abuse Prevention and Treatment Block Grant</a>	U.S. states, territories, and tribal entities that designate executive entity for administering; apply annually; and, distribute locally.	Plan, implement, and evaluate activities that prevent and treat substance abuse. Focuses on: <ul style="list-style-type: none"> <li>• Pregnant women and women with dependent children;</li> <li>• Intravenous drug users;</li> <li>• Tuberculosis services;</li> <li>• Early intervention services for HIV/AIDS; and,</li> <li>• Primary prevention services.</li> </ul>	<a href="#">\$1.858 B.</a> Grantees must spend at least 20% of allotment on primary prevention strategies.	<a href="#">Total Available: \$5,008 B</a> <ul style="list-style-type: none"> <li>• <a href="#">\$1.858 B via 2021 Appropriations Act</a></li> <li>• <a href="#">\$1.65 B in COVID-19 supplemental funding</a></li> <li>• <a href="#">\$1.5 B in supplemental funding via American Rescue Plan</a></li> </ul>	<a href="#">\$1.9 B</a> <ul style="list-style-type: none"> <li>• Remaining COVID-19 supplemental funding available until 2023</li> <li>• Remaining American Rescue Plan supplemental funding available until 2025</li> </ul>
<a href="#">Harm Reduction Grant Program</a>	U.S. states, territories, and tribal governments; community non-profits; primary care and behavioral health organizations.	Support community-based overdose prevention programs, syringe services programs, and other harm reduction services. Increase access to opioid overdose reversal medication; build connections to community-based counseling and health education services; and, mitigate infectious disease spread.	N/A	N/A	<a href="#">Anticipated \$29.25 M over 3 years with 25 annual awards of up to \$400,000</a>
<a href="#">Emergency Grants to Address Mental and SUD During COVID-19</a>	U.S. states, territories, and tribal governments.	Provide crisis intervention services, mental health and SUD treatment, and related recovery supports for children and adults impacted by COVID-19. Address the needs of individuals with SMI, SUD, COD, and lower severity.	<a href="#">\$110 M to 60 grantees up to \$2 M per state and \$500,000 per territory or tribe.</a>	N/A	N/A
<a href="#">State Opioid Response Grants</a>	Single State Agencies (SSAs) and territories.	Increase access to medications for OUD, reduce unmet treatment need, and reduce opioid overdose deaths using prevention, treatment and recovery services. Also addresses stimulant use disorders.	<a href="#">\$1.42 B for 57 grantees over two years, with 15% set aside for 10 states with highest drug-related mortality rates.</a>	Continuation of funding subject to meeting program targets.	<a href="#">\$1.5 B</a>

In order to demonstrate how CHCs have developed unique approaches for overcoming challenges and meeting the needs of unique patient populations, we conducted in-depth interviews with three CHCs that have worked through internal challenges and developed strategies to expand access to “whole person” care. The following examples demonstrate the importance of assessing and addressing internal processes that hinder integration, the need to adopt “[low threshold](#)” approaches for patient access to MOUD, and the importance of partnerships with law enforcement, harm reduction providers, and community organizations to deliver services to individuals in places that are trusted and safe.

## Case Example 1: Fenway Health Lowers the Barriers to Care

### *Service Delivery Model*

With five main clinics in the Boston area, many of [Fenway Health's](#) behavioral health clinicians are integrated within the primary care team. This level of integration gives primary care patients access and linkage to a wide range of services, including but not limited to psychotherapy, psychiatry, and group therapy, as well as recovery coaching, recovery groups, and acupuncture through the Addiction Recovery and Wellness Program (ARWP). Fenway reached over 30,500 patients in 2021, and is certified as a [National Committee for Quality Assurance \(NCQA\)](#)-Certified Level 3 Patient-Centered Medical Home (PCMH) with NCQA's [Distinction in Behavioral Health Integration](#). Integral to their success in expanding services within the community have been efforts to increase provider buy-in among their PCPs and staff, as well as identifying opportunities to lower barriers to care for individuals who may need services.

### *Challenge: Confronting Stigma and Increasing Provider Buy-In*

Although Fenway has had a long history of serving historically-marginalized populations and delivering behavioral health services, efforts were still needed to encourage the number of providers able and willing to provide office-based opioid treatment. Providers at Fenway Health are encouraged, through an opt-in approach, to complete X-waiver training. To help make it easier for providers to opt-in to the required eight-hour training, Fenway Health began carving out dedicated hours for providers to complete their trainings by leveraging grant funds from the state's Bureau of Substance Addiction Services (BSAS) to cover loss of revenue for missed office hours. Fenway also helped tackle provider stigma toward MOUD by using both provider and patient advocates as champions, aligning the treatment of SUD to their mission of serving the most vulnerable populations using MAT and other harm reduction strategies. To support providers, a resident expert in behavioral health and MOUD helps to educate and train them and serves as a primary support person for any questions or concerns that PCPs may have. Fenway Health has also worked with patients with lived experience to identify how to utilize culturally-appropriate, trauma-informed, and destigmatizing approaches and language when treating patients.

### *Challenge: Identifying and Removing Barriers to Treatment*

To ensure that they were reaching patients needing services within the community, Fenway also carefully assessed potential practical or internal process barriers that may create unintentional burdens for patients and make them less likely to seek care. As an example, Fenway found that the behavioral health division (including ARWP) did not have a way for patients entering into MAT to automatically become eligible for behavioral health support services. Therefore, if patients wanted to enroll in behavioral health services outside of the MAT program, they had to complete separate MAT and behavioral health intakes, which providers felt were burdensome and emotionally difficult for patients. To address this barrier, Fenway Health leveraged a grant from the RCHN Community Health Foundation to pilot a “dual intake” process that could lower both administrative burden and demands on individuals seeking care. In the six-month pilot (which was shortened by the COVID-19 pandemic), a small group of patients completed a simplified MAT and behavioral health intake during the initial MAT appointment with a behavioral health clinician. Patients also were provided a tour and information on services offered by the behavioral health division, with immediate connections and scheduling of service appointments. An initial evaluation found that participating patients had a higher uptake of behavioral health support services compared to the group of patients who did not receive the dual intake.



## Case Example 2: Agape Health Services Improves Access to Social Support Services through Community Partnerships

**Service Delivery Model:** [Agape Health Services](#), located in Williamston, Washington, and Plymouth, North Carolina, is a NCQA-Certified PCMH, as well as a [certified community behavioral health clinic \(CCBHC\)](#), with two-year CCBHC expansion grant funding from SAMHSA beginning in May 2020. The CCBHC designation allows patients to come into the center easily from either the behavioral health side or medical side (including the dental department). Their behavioral health clinicians are integrated within the primary care team and provide a wide range of services, including but not limited to MOUD, individual/group/family counseling, strategies for relapse prevention, life skills training, and psychiatric services.

### **Challenge: Strengthening Linkages to Social Supports**

Agape Health Services has worked to build strong partnerships with hospitals, other health care organizations, state and local government agencies, public health departments, and community organizations to help meet the unique social and health care needs of their patients. For example, Agape is part of the leadership team for Beaufort County 360 (BC360), a community group focused on addressing issues that “adversely affect the quality of life in the county.” Their vision is to build “a user-friendly collaborative network to improve the quality of life for citizens of Beaufort County.” As part of their efforts, BC360 created a Behavioral Health Taskforce to help address behavioral health issues in the county through identifying behavioral health system changes, including an assessment of needs and assets in the county, and increasing awareness of community behavioral health resources. Partnering with and being part of community groups, like BC360, help Agape address some of the social barriers their patients face, like housing and transportation.

### **Challenge: Building partnerships to meet the needs of justice-involved populations**

Agape partners with local law enforcement through the North Carolina Harm Reduction Coalition (NCHRC) to provide a Law Enforcement Assisted Diversion (LEAD) program for persons with law enforcement involvement. The program offers discretionary authority to police officers to divert individuals who commit low-level law violations and who have unmet behavioral health needs to a community-based, harm-reduction intervention in lieu of the “normal criminal justice system cycle.” The program allows police officers to refer individuals to a trauma-informed, intensive case-management program, like the case-management and behavioral health services offered at Agape, to receive support services, including drug treatment and transitional or permanent housing.

## Case Example 3: Alameda County Health Care for the Homeless’ Street Health Team Prioritizes Community Outreach

**Service Delivery Model:** [Alameda County Health Care for the Homeless \(ACHCH\)](#), housed in the Alameda County Office of Homeless Care and Coordination and located in Oakland, California, provides direct care services and improves access to care for people experiencing homelessness. In partnership with county and community health clinics and organizations, ACHCH provides patient-centered, clinic-based, shelter-based, and street-based (e.g. “Street Health”) homeless health care services, including primary, behavioral health, dental, and optical care, as well as case management. Their behavioral health clinicians are integrated within the primary care team and provide a wide range of services, including but not limited to psychiatric services, counseling, MOUD, and recovery services.

### **Challenge: Designing care models to meet the needs of unhoused populations**

To improve integration of their behavioral health services, ACHCH leveraged HRSA funding to create a multi-disciplinary [Street Health Team](#) that includes a psychiatrist, registered nurse care manager, and outreach workers, who operate out of a small mobile unit to gain trust with and connect individuals who are homeless and those who are at risk of

homelessness to providers in the field and in clinics. Additional state funding through [Proposition 63 – Mental Health Services Act \(MHSA\)](#) increases capacity in behavioral health services on the team. In 2004, California voters approved the MHSA in 2004, which instituted a one percent tax on personal income in excess of \$1 million per year to support a broad array of infrastructure, technology, training, and serves across the public behavioral health system. Using these funding streams, the Street Health teams are able to provide on-demand MOUD, connecting individuals on the streets and in homeless encampments to clinics for MOUD, detox/sobering, and recovery services. Outreach workers adopt a harm reduction approach to address health literacy challenges by simplifying instructions given to patients, With this support and engagement, patients are able to understand withdrawal symptoms to expect and how to combat them and retain them in treatment. To support continuity and coordination of services for patients, ACHCH also provides life/health coaches who follow-up with patients to ensure medication adherence and treatment retention, helping to minimize pressure on clinic providers.

### ***Challenge: Lowering barriers to care***

The COVID-19 pandemic has hindered some of the Street Health team outreach, but ACHCH has found innovative ways to continue serving the community as much as possible. These efforts include partnering with a local pharmacy to bubble pack micro-dosed films of buprenorphine, as well as bubble pack supportive withdrawal medications (e.g., anti-diarrheal, anti-anxiety, anticonvulsants, and anti-nausea pills), to allow for take-home induction for some lower access threshold patients. By lowering the access threshold (and with the help of life/health coaches and case management), the intent is to assist more patients as they follow through with their treatment protocols.

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