Considerations for Health Centers in the Treatment of Substance Use Disorders, Spotlight on the States: Arizona

November 2016

Introduction

According to a report published in 2016 by the Centers for Disease Control and Prevention (CDC), 78 Americans die every day from opioid overdoses. In 2014, the deadliest year due to drug overdose on record, six out of every ten drug overdose deaths involved opioids. Further noted by the report is that, as the number of prescription opioids sold in the U.S. almost quadrupled between 2000 and 2014, the number of deaths due to opioid overdose also quadrupled. Coupled with a surge in heroin overdoses, prescription opioid pain relievers are a primary factor in the increasing rate of deaths due to drug overdose.

The staggering number of deaths due to opioid overdose has prompted a number of studies and findings related to the underlying causes and financial effects of this epidemic. The statistics related to the receipt of treatment and costs of care are of particular relevance to this brief. According to the March 2015 report, Substance Use Disorders and the Role of the States by The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, approximately 21.6 million Americans had substance use disorders in 2013, of whom only 18 percent received needed treatment. Referencing the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Results From the 2013 National Survey, the report notes that unemployed adults were 60 percent more likely to be classified as having a substance use disorder; and, of the one-third who recognized a need for treatment but did not receive it, most cited lack of insurance coverage and unaffordability as the reasons for not receiving care. In its evaluation of costs, the report noted that, in 2009, $24 billion was spent on treatment for substance use disorders, with 69 percent of the spending underwritten by Medicaid, Medicare, federal grants, and state and local governments. The difference was made up by private sources.

---

2 Ibid. There were a record 28,647 deaths in 2014 involved opioids.
3 Ibid.
4 Ibid. In 2009, state and local governments spent $9.4 billion, including Medicaid expenditures, to combat substance abuse through various methods.
Health centers currently serve over 25 million patients from all walks and backgrounds in over 1,400 organizations with over 9,800 sites. Health centers, particularly those that receive grants under Section 330 of the Public Health Service Act (PHS) (hereinafter, Health Center Program grantees or grantees), provide affordable, high quality, comprehensive primary care to these individuals, regardless of their insurance status or ability to pay for services. As a matter of fact, the majority of health center patients live below the Federal Poverty Level, and 1 in 6 patients of grantees are Medicaid beneficiaries. Whereas health centers provide both primary care and additional health services to the medically underserved, it should come as no surprise they also serve as a first line of defense in battling the country’s opioid abuse crisis. Health centers have the ability to identify problems, make necessary referrals for treatment and monitor patients to reduce the problem of overprescribing.

In 2014, Health Center Program grantees, specifically, reported that they provided behavioral health services to more than 1.3 million patients, of whom 567,000 individuals received substance abuse treatment services in more than 2.2 million visits. In 2015, they provided substance abuse treatment services to over 667,000 individuals through over 2.5 million visits. In only one year, grantees provided substance abuse treatment services to approximately 18% more individuals and almost 13% more visits. Not unexpectedly, health centers, including grantees, have shared the burdens of the increases (supra) cited by the CDC and SAMHSA.

However, relief was imminent. In March 2016, 271 health centers, including three in Arizona, received some additional assistance when they were awarded a total of $94 million in federal funding from HRSA to help improve and expand the delivery of substance abuse services in an integrated primary care/behavioral health model with a specific focus on Medication-Assisted Treatment (MAT) of opioid use disorders in underserved populations. HRSA’s investment is expected to help health centers hire approximately 800 providers to treat nearly 124,000 new patients. Additionally, the HHS Secretary recently exercised her rulemaking authority to expand access to MAT. Effective August 8, 2016, eligible practitioners will now be able to treat up to 275 patients with certain Schedule III, IV and V maintenance and detoxification medications. (Previously, the limit was 100 patients. See, Medication Assisted Treatment for Opioid Use Disorders. 81 Fed. Reg. 81, 44711-39. (July 8, 2016.) Notwithstanding the foregoing, there

---

5 In this document, unless otherwise noted, the term “health center” is used to refer to Health Center Program grantees (federally-funded health centers), and FQHC Look-Alike organizations, which meet the Health Center Program requirements but do not receive Health Center Program grants.

6 NACHC, 2016. Includes patients of federally-funded health centers, non-federally funded health centers, and expected patient growth for 2016.


9 See footnote 8.


11 Ibid.
remain myriad issues to be addressed for health centers to be able to treat substance use disorders with maximum effectiveness.

**Important Considerations for Addressing the Issue of Substance Use Disorders**

As health centers position themselves to be “at the forefront of the fight against opioid abuse in underserved communities”, several key factors - operational and cultural - must be considered in order to properly address substance use disorders.

**Staffing and Capacity**

In 2013, SAMHSA examined growing concerns related to high turnover rates, shortages, an aging workforce, stigma and inadequate compensation in the workforce. The current opioid crisis further compounds these concerns as staffing demands increase, leading to competition among health care organizations for the limited supply of providers who treat substance use disorders. According to SAMHSA, only one in ten people needing treatment is receiving it. Some treatment facilities serve only targeted populations, such as women or the elderly, and many facilities are not geographically accessible to rural or frontier areas.

**Data Privacy**

Concern often arises regarding the release of medical information about individuals with substance use disorders. One of the challenges that providers face, especially with individuals having substance use disorders or for patients with serious mental illness (SMI) who may also have substance use disorders, are the restrictions imposed by HIPAA, 42 CFR Part 2. Providers and payers are seeking administrative clarity to assure improved coordination for patients receiving addiction treatment. The layer of privacy protection at present is perceived to be a barrier to the sharing of information. In early 2016, however, the federal government sought public comment on proposed rule changes aiming to modernize the Confidentiality of Alcohol and Drug Abuse Patient Records regulations at 42 CFR Part 2. In April 2016, the National Association of Community Health Centers (NACHC) submitted comments which focused on protecting patient confidentiality and clarifying the law’s requirements with respect to applicability for health center providers.

**Reimbursement**

Given the high cost of providing effective substance use treatment, fair and adequate reimbursement for substance disorder treatment services is of paramount importance to

---

12 Ibid, see statement by Jim Macrae, Acting Administrator, HRSA.
providers. The expansion of Medicaid in 31 states and the District of Columbia, has provided a reimbursement source for the treatment of substance use disorders for some. The early impacts, as seen in Arizona, are addressed herein. However, to date, the federal mandate of mental health parity16, which includes substance use disorder benefits in health plans, has not been fully realized due to misunderstanding and misapplication of the law.

**Stigma**

In addition to operational and financial barriers to accessibility, social barriers often encumber individuals in need of treatment.17 This includes the stigma associated with the misuse of drugs or alcohol. As a result, the need for services may be underestimated in terms of policies and programs to effectively address the problem.

**Arizona’s Substance Abuse Crisis**

According to the Arizona Criminal Justice Commission’s 2015 data, there were enough pain pills dispensed in Arizona last year to medicate every adult in Arizona around the clock for two weeks straight.18 This data points to nationwide concern with the four-fold increase in the quantity of prescription pain relievers sold in the past fifteen years. The misuse of prescription drugs and other substances impacts the overall health system as well as the criminal justice and child welfare systems. A glimpse at the following Arizona data19 demonstrates the broad scope of issues involved:

- The number of infants born to substance using mothers increased 205 percent between 2008 and 2013, with about three out of every 1,000 babies affected, and often resulting in removal of children to the Department of Child Safety.20
- According to the Arizona Department of Health Services (ADHS), the average cost for hospitalization due to a drug overdose was over $33,000. The statewide tab was $213 million, with 41 percent of those costs charged to the Arizona Health Care Cost Containment System (AHCCCS serves as the state’s Medicaid agency).21
- Overdoses not requiring hospitalization cost just over $69 million, with AHCCCS underwriting 40 percent of that cost.22

---

21 See footnote 18.
22 See footnote 18.
Total funding for substance use treatment services in Arizona in Fiscal Year (FY) 2015 was $162.9 M, including both Medicaid and various federal grant programs. This represented a 26.9 percent increase over the prior year.

As people dependent on prescription opioid drugs to alleviate chronic pain find that they are no longer able to easily obtain refills or new prescriptions, they resort to prescription drugs circulating on the streets. But, as the cost of drugs purchased on the streets becomes prohibitively expensive, many switch to cheaper and more readily available illicit drugs such as heroin. The CDC reports that 45 percent of those using heroin are also addicted to prescription opioid painkillers. This weighs heavily on other state resources, such as the criminal justice system when individuals are arrested and/or jailed for illegal use or possession related offenses. In Arizona, the number of arrests for driving under the influence of drugs increased over 99 percent since the year 2000, and narcotic drug possession arrest rates increased 15 percent from 2010 to 2012.

The Statewide Response

Arizona is in the midst of completing a large-scale public health system shift designed to better serve people and protect public health. The separate functions of the Arizona Medicaid and Behavioral Health Services divisions and the resulting complex eligibility categories have presented challenges to managing the integration of care. In 2015, the legislature approved the move of the ADHS/DBHS to AHCCCS which contracts with managed care organizations that, in turn, contract with health providers statewide for the full continuum of health services.

Until recently, behavioral health services were excluded from those contracts for primary care and children not involved in the child welfare system. The move by the state is designed to improve and promote administrative simplification as well as to combine oversight and contract functions. State contracts, using federal and state funds, have been awarded for the integration of behavioral health and acute care systems to improve patient outcomes. ADHS/DBHS has historically contracted with Regional Behavioral Health Authorities (RBHAs, analogous to managed care organizations, which may be for-profit or nonprofit agencies that provide services in geographically assigned areas of the state usually defined by county boundaries) and with four tribal agencies, for the delivery of behavioral health services for Medicaid and state-only eligible individuals with a serious mental illness (SMI) who are not Medicaid-eligible or individuals served by federal block grants for mental health or substance use grant funds). RBHAs then contract with community-based agencies for the actual delivery of behavioral health and substance use treatment services.

As each of the RBHAs operate as an integrated provider for SMI populations, adjustments have been made in the contracting and working relationships among providers for both primary and

behavioral health services. In some instances, there is co-location of behavioral health and primary care at the same facility under the operation of the single provider. There have also been behavioral health providers who will deliver services in the office or suite of a primary care provider, including health centers. For other primary care providers who have physical plant limitations or who have not developed a strategic plan, the use of electronic records and tele-health sessions are improving coordination of care for the SMI population. Arizona has undergone revisions in the licensure standards in the past two years to foster such efforts to integrate.

As a principal payer, AHCCCS has undertaken steps to:

1) improve E-prescribing and CSPMP performance;
2) develop criteria for prescribing opioids for non-cancer patients; and
3) examine “lock in” criteria for AHCCCS members exhibiting high-risk of controlled substance seeking behavior with patients then assigned to a single prescriber and pharmacy to reduce problems.

The AHCCCS health plans are also working to develop a Neonatal Abstinence Syndrome (NAS) pilot program, and to facilitate connections with the state’s Health Information Exchange system to foster improved data sharing.

Collaborating to Share Data and to Protect Privacy

While Arizona providers move to virtual integration, there are challenges with sharing data, as noted earlier, around individuals with a substance use disorder because of the privacy requirements of the HIPAA, 42 C.F.R., Part 2. The Arizona Health-e Connection, a non-profit, public-private partnership that drives the adoption of health information technology (HIT) and advances the secure and private sharing of electronic health information exchange (HIE), is working with providers statewide and with AHCCCS to find potential strategies for data sharing.

Prescription Drug Monitoring

In 2007, the Controlled Substances Prescription Monitoring Program’s (CSPMP) central database was established to detect diversion, abuse, and misuse of prescription medications classified as controlled substances under the Arizona Uniform Controlled Substances Act. All prescribers in Arizona are required to register, but, statewide, only 36.3 percent were signed up as of September 2015. Among health centers, most are enrolled and their providers are encouraged to utilize the system if they prescribe controlled substances.

Addressing Workforce Capacity

Arizona faces a shortage of medical, dental and mental health professionals across the state.27 These shortages impact the abilities of the medical community and health centers to respond to the crisis of opioid addiction and overdoses. As noted in the section below on state legislative responses, efforts are underway to establish a state student loan repayment assistance program

---

26 Ibid.
which would provide a resource to address these shortages. Other state resources include $16.5 million in state funds to support crisis services. State funds are used to support crisis teams, crisis phone services and other resources designed to reduce the incidence of adverse outcomes in overdose situations.

Services for Special Populations – Formerly Incarcerated Individuals

AHCCCS recognizes that many individuals returning to the community from prison or jail have behavioral health or substance use problems. The agency has entered into agreements with many county jails and with the Arizona Department of Corrections to enroll inmates into the AHCCCS program and to interface with the RBHA system so that necessary follow-up services and supports can be provided. Efforts also are underway using state funds to provide transitional services as inmates return to the community.

Administrative Efforts by the Governor

On an administrative level, the Governor’s Office of Youth, Faith and Families is supporting the efforts of the Arizona Substance Abuse Task Force, a 28-member coalition of leading substance abuse experts, providers and community members. The Task Force was asked by Governor Doug Ducey to address the growing epidemic of drug abuse and addiction in Arizona communities by finding the best treatments and reducing barriers to care. It will be making recommendations to the Governor by October 2016. The Task Force will examine 1) access to treatment; 2) evidence-based practices; 3) neonatal abstinence syndrome; and 4) best practices in medication assisted treatment.

The Arizona Council of Human Service Providers, is an Arizona trade association representing ninety behavioral health, substance abuse, child welfare and juvenile justice service agencies. In a cooperative effort with SAMHSA, AHCCCS, National Council of Behavioral Health and the Governor’s Office of Youth, Faith and Families, it is participating in a learning collaborative to educate providers and support cooperation to address the opioid crisis. To that end, the Arizona Council will survey its members, promote evidence-based practices for opioid treatment, as well as provide training on medication-assisted treatment and training to work with specific patient populations. The Arizona Council also will present at conferences and training events and distribute materials from the National Council of Behavioral Health.

State Legislative Responses

Effective January 1, 2017, Senate Bill 1283, will require a medical practitioner who intends to prescribe more than five days of an opioid analgesic or benzodiazepine controlled substance to obtain a patient utilization report for the preceding twelve months from the CSPMP’s database tracking system. Prescribers will be allowed up to six months to come into compliance. Exemptions to the requirement include: if the patient is receiving hospice care or palliative care for a serious or chronic illness; if the patient is receiving care for cancer, a cancer-related illness or condition; dialysis treatment; or if a medical practitioner will administer the controlled substance. The law enhances a program that has been in place since 2007.

---

House Bill 2355 allows a doctor, nurse practitioner or other health professional with prescribing authority to prescribe or dispense naloxone hydrochloride, or any other opioid antagonist that is approved by the U.S. Food & Drug Administration (FDA), to a person who is at risk of experiencing an opioid-related overdose, or to a family member or community organization (including schools) that may assist that person. A pharmacist is authorized to dispense, without a prescription, naloxone hydrochloride or any other opioid antagonist that is approved by the FDA. The law takes effect in August 2016.

SB 1194, passed in the 2015 legislative session, expanded the number of medical providers eligible to participate in the state loan repayment program, thus beginning to address the insufficient number of providers serving rural and underserved communities.

The Distinct Role of Health Centers in the State of Arizona

With Arizona’s public health care system in flux, the roles and responsibilities of health centers are evolving. The state currently has twenty-one health centers program grantees and two organizations designated as Health Center Program Look-Alikes. In 2014, these health centers and Look-Alikes served over 565,000 patients at 149 locations statewide. Arizona’s health centers are a vital source of primary care, providing prevention, treatment, and disease management services in family-centered, patient-governed ‘medical homes’, using the most advanced care practices.

In 2014, over 1.6 million patient visits were delivered by Arizona health centers, with some 7 percent of patient encounters for behavioral health services. Almost 46 percent of the health care costs were underwritten by AHCCCS. Depression and anxiety are the most frequent reasons for patient visits with the behavioral health staff. The behavioral health staff work as a team with medical staff serving patients who have difficulties managing chronic diseases such as diabetes and hypertension.

92.99 of 929.7 FTEs at Arizona Health Centers are Mental Health Specialists (UDS)

---

Since 2014, Arizona has added an additional FQHC and an additional Look-Alike, while one Look-Alike has been converted to full FQHC status. A list of AHCCCS Federally Qualified Health Centers (health centers) and Rural Health Clinics at [https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/FQHC-RHC.html](https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/FQHC-RHC.html).

See footnote 5.

Ibid.

Ibid.
In 2014, three Arizona health centers were utilizing Screening, Brief Intervention, and Referral to Treatment (SBIRT), according to data provided in the 2014 Uniform Data System (UDS) reports. According to the Substance Abuse and Mental Health Services Administration, the SBIRT model was incited by an Institute of Medicine recommendation calling for community-based screening for health risk behaviors, including substance use. More information on SBIRT is available at http://www.integration.samhsa.gov/clinical-practice/SBIRT.

SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. Recently, Horizon Health and Wellness, Inc. was awarded a substance abuse service expansion grant from the U.S. Department of Health and Human Services Health (HHS) through the Health Resources and Services Administration (HRSA). In addition, other health centers have begun to utilize SBIRT as part of their screening protocol, utilizing reimbursements from AHCCCS or other payers.

Recognizing that pain management is central in the treatment of chronic pain, health centers are developing a variety of responses to meet patient needs. To avoid over-prescribing opioids, health centers are examining alternatives to balance the needs of their patients, such as massage therapy, acupuncture, and herbal medicine, etc. At the April 22, 2016 Behavioral Health Peer Group meeting sponsored by the Arizona Alliance of Community Health Centers strategies were discussed along with delineation of outcome measures to determine the efficacy of alternatives.

A few of Arizona’s health centers provide referrals to pain management clinics for patients with chronic pain and provide only indicated medications as a bridge to the appointment. A challenge that can result from this model is that many patients find it difficult to obtain appointments in a timely manner. Another approach that health centers use is Project ECHO® at the University of New Mexico to provide specialist teams virtual clinics on chronic pain and headache management. The heart of the ECHO® model is its hub-and-spoke knowledge-sharing networks, led by expert teams who use multi-point videoconferencing to conduct virtual clinics with community providers. Guidelines are being discussed and developed to assist primary care providers when prescribing opioids for pain.

Health centers also use telehealth to increase access to behavioral health care. However, health centers must consider the reimbursement issues in order to sustain services. AHCCCS does allow for reimbursement for tele-psychiatry when the provider and patient have a “real time” interaction and necessary documentation is provided. A survey of Arizona’s health centers in 2014 indicated that telehealth was being used for internal consultations at three health centers, with six other health centers using telehealth. Further development of telehealth as a resource for connecting with specialty providers is still needed.

As healthcare systems across the country move towards integration, each of Arizona’s health centers is charting its own course to respond to system changes as well as to the needs of the communities they serve, as defined by their local boards of directors (51 percent of whom are

34 According to the Substance Abuse and Mental Health Services Administration, the SBIRT model was incited by an Institute of Medicine recommendation calling for community-based screening for health risk behaviors, including substance use. More information on SBIRT is available at http://www.integration.samhsa.gov/clinical-practice/SBIRT.


37 At this time, none of Arizona’s health centers report having the ability to respond to an on-site overdose of opioids. If a patient arrives in distress, the procedure is to contact the local 911 operator.
While this exploration is underway, many of the health centers provide or are expanding behavioral health services designed to promote improved self-management of chronic diseases and, when necessary, are making referrals to specialized care for the management of substance use disorders, serious mental illness and other behavioral health issues. For some health centers, referrals to local specialized behavioral health agencies are in accordance with a contract between the agencies, while for other health centers, referrals are made to any specialized provider that has capacity to accept the referral, or are made based upon a patient’s wishes. Health centers in Arizona that follow the non-contract approach include Mountain Park, El Rio, Adelante and Sun Life.

Horizon Health, Valle del Sol and Terros were initially behavioral health providers who have recently become either FQHC-designated health centers or Health Center Program Look-Alikes. The addition of the FQHC-designation for these health centers has complemented their delivery of behavioral health care. All three have co-located behavioral health with their primary care. The arrangement of delivery of primary care services varies based upon the physical plant arrangement that, for example, has Valle del Sol’s primary care services delivered in a suite at their site, while behavioral health is delivered in other suites within the same building. Native Health, another of Arizona’s health centers, began initially as a behavioral health provider serving urban American Indian populations, and in 2010 acquired FQHC-designation. The health center follows an integrated approach to services and holds a contract with the local RBHA.

MHC Healthcare in Marana, Arizona also provides an integrated model of behavioral health and primary care at their main campus and at some of their additional community sites. At the co-located integrated sites, MHC serves as an intake center for their local RBHA. Other MHC sites provide only primary care services, with those sites licensed as outpatient centers.

At this time, at least four of the MHC sites have obtained certification as Integrated Clinics from the AHCCCS administration. Under this program, clinics that provide primary health services from a specified list are eligible for a 10-percent enhancement above the usual fee-for-service payment. How this approach intersects with current reimbursement requirements has not been fully resolved. Often, health centers struggle with the increased documentation and reporting requirements imposed by the RBHA, which differ from the basic medical charts used for primary care patients.

As mentioned above, the RBHAs statewide have moved forward with contracting for the delivery of integrated physical and behavioral health for the SMI population. Contracts have been put in place with the health centers for the delivery of primary care, but not always for behavioral health services. The RBHAs have relied instead, especially for the SMI population which often has high needs, on the local behavioral health providers. This barrier is diminishing as health centers expand their expertise in the delivery of integrated behavioral health not only for SMIs, but also for others with behavioral health needs.

Arizona’s move to value-based purchasing is aligned with the Arizona Alliance for Community Health Centers’ approach to primary care. The Alliance aims to be an active partner with AHCCCS on the development of such an approach for health centers. Considerable work is ongoing among the health centers, behavioral health providers, health plans, tribal governments, and AHCCCS, since there is a proposal to submit an 1115 waiver that includes Delivery System Reform Incentive
Program (DSRIP) with a key component being behavioral health services. The focus of the DSRIP proposal under development involves three populations: 1) Physical Health/Behavioral Health Integration for adults and children; 2) Justice System Transitions; and 3) American Indian Health Program Care Coordination. Value-based purchasing as well as the discussions about DSRIP will be critical items for further consideration by each health center as it plans its course forward.

The Arizona health centers are evolving as each program adapts based upon the direction of their respective Boards and the demands of their local communities. One particularly strong effort, led by the Alliance and easily adaptable elsewhere, fosters not only the involvement of upper management, but includes the involvement of specialty health providers through “peer group meetings”. Through the sharing of information, resources, best-practices, and lessons-learned, this collegial approach encourages change and flexibility as essential components of staying current with the ever-changing healthcare environment.

**Conclusion: Early Observations for All Health Centers**

What has been described above is a mere snapshot of Arizona’s systemic response to equip its health care system with the mechanisms needed to address the prescription opioid overdose epidemic in its state. However, health centers around the United States face many of the same or similar challenges that have been experienced by Arizona’s health centers. Significant changes have taken place due to the expansion of Medicaid, the addition of newly insured individuals through the Marketplace, and growing concerns of private insurers about costs. The resulting pressures are forcing administrative, financing and programmatic adjustments.

As health centers tackle the opioid overdose epidemic and work to treat and prevent substance use disorders, they are expected to move towards integration of physical and behavioral health care services. Such progression will require systemic changes in workforce, referral and reimbursement mechanisms, and practice parameters to ensure that patients’ needs are being met. Health centers around the country can, at the very least, look to Arizona for examples of: implementing evidence-based interventions such as SBIRT; creating contract and reimbursement mechanisms to support integration; changing administrative and legislative policies to support data sharing while protecting patients’ privacy; promoting telehealth to expand and enhance access to care; incentivizing the recruitment and retention of new providers through programs such as loan repayment assistance; recognizing the role of the criminal justice system; and fostering improved outcomes through value-based purchasing.

Although Arizona’s successes and challenges are still being learned, early indications show that a health center’s ability to tackle the prescription opioid overdose epidemic and treat substance use disorders will not occur in a vacuum. Success for health centers providing treatment or referral for substance use disorders, will largely depend on a thorough assessment of the health care system in the state. An entire shift may not be necessary, but multi-stakeholder supports must be in place to facilitate care integration at health centers, and to increase treatment options and accessibility for patients.
Considerations for Health Centers in the Treatment of Substance Use Disorders: Spotlight on Arizona

Prepared By:
Eddie Sissons, C.P.M.

For more information about this publication, please contact:
Dawn McKinney
Director, State Affairs
dmckinney@nachc.org | 202.296.3800

This publication was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant U30CS16089, “Technical Assistance to Community and Migrant Health Centers and Homeless.” (Total grant award is $6,375,000.00. Zero percent of this project was financed with nongovernmental resources.) This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.