Experts and policymakers acknowledge that substance use disorder (SUD) is a chronic disease that can and should be treated in a primary care setting, where integrated services can treat the whole health of each patient and address co-occurring health conditions. Regular primary care for people with SUD has been shown to decrease hospitalizations by up to 30 percent. Patients with SUD incur two to three times the total medical expenses of patients without these disorders. Health centers have now been called to help address the complex and spiraling problem of addiction. Still, there remain a host of challenges ahead.

Despite significant federal investment for the treatment of opioid addiction, the upfront costs of creating the workforce and capacity to ensure success are daunting. As nonprofits, health centers typically operate on slim financial margins. Each individual SUD patient may require a multitude of interventions and support services over a lengthy period, or more frequent patient visits.

The national opioid epidemic, which has impacted millions of lives, has undoubtedly fueled a rise in the demand for behavioral health services at health centers. Visits for mental health and substance use disorders have grown by 83 percent since 2010.
encounters. Such scenarios can divert staff and financial resources from the rest of the patient population. Compounding the financial hardship is the uncertainty around Medicaid reimbursement. Some services may not be reimbursed depending on the state where the health center is located, or the service being provided – such as pain management, group therapy, substance use counseling or telehealth.

**Reimbursement Challenges**

Adequate reimbursement is always difficult for health centers. Each state’s Medicaid policy may vary, especially when it comes to reimbursing for services related to SUD. Moreover, reimbursement typically requires a face-to-face encounter, so services such as telehealth, which 57 percent of health centers are using to address a variety of health conditions, may not qualify for reimbursement. If a health center utilizes a recovery coach to coordinate services for a patient by telephone or through text, the same principle applies. In many states, group therapy may not be covered by Medicaid, but some health centers have found innovative ways to keep that option in their SUD treatment tool box.

“Reimbursement is a huge challenge,” says Jane Powers, Director of Behavioral Health at Fenway Health in Boston, MA. “The way current reimbursement models work we still find it difficult to do more of the innovative work that we’d like to be doing.”

In some cases, a service that Medicaid does not cover may, ironically, save the health care system money. Roderick Seamster, MD, from Watts HealthCare Corporation in Los Angeles, CA, describes how he was prescribing physical therapy for patients suffering from pain, even though in many cases the service was not reimbursed by Medicaid. “I went through and analyzed our patient data and found the hospital admissions among these physical therapy referral patients were significantly reduced.” Bottom line: the health center was losing money on an intervention that appeared to be working.

**Workforce**

Treating SUD also requires a new framework in primary care with new staffing models, such as peer recovery specialists, case managers and care coordinators. Health centers have expanded their enabling services staff to over 20,000 professionals — a nearly threefold increase since 2000 to help boost patient engagement and maintain treatment regimens. The demand for behavioral health services continues to grow as visits have outpaced other health center services. Yet, finding and retaining staff to meet the challenge of treating SUD remains an uphill battle. Encouragingly, 33 percent (452) of health centers have at least one physician that is MAT-certified (Medication Assisted Treatment). But more are needed. There is a limited supply of providers who treat SUD and intense competition among private providers to recruit them. That leaves a limited supply to help the medically underserved. According to the Substance Abuse and Mental Health Services Administration, 23.5 million people are estimated to need SUD treatment, yet only 2.6 million receive it. Residents living in rural pockets of the U.S., where opioids have had a devastating effect on communities, especially experience difficulty accessing care.

Although staffing shortfalls are nothing new to health centers (95 percent of which have at least one
Clinical staff vacancy), attracting workforce is likely to be an even bigger challenge given that health centers face another funding cliff. With mandatory funding for the federal Health Center Program set to expire in less than two years, health center leaders are already focused on the potential impact on recruitment.

**Confidentiality Laws**

Confidentiality laws have also added another layer of complexity for health centers treating patients with SUD disorders. Since the 1970s, the federal government has required that the medical records of patients who receive SUD treatment are given extra protections to ensure confidentiality. These federal rules — commonly known as 42 CFR Part 2 — are more extensive than the standard protections required under the Health Insurance Portability and Accountability Act (HIPAA). The regulations determine under what limited circumstances information about a patient’s treatment may be disclosed with and without the patient’s consent. Who and what are covered can be confusing and cumbersome, especially for health centers that are integrating behavioral health with primary care.

There is no one-size-fits-all protocol for compliance. Even more complex is health center sites within a single health center organization can differ in their approach.

“To help address those problems, recent revisions made some simplifications to the consent process,” writes NACHC Senior Policy Adviser Colleen Meiman in a recent NACHC blog post. “For example, patients can now consent to sharing their records with all providers within a specified group, as opposed to having to name each provider individually. In addition, some states and providers are adopting innovative approaches to support care coordination while maintaining appropriate confidentiality.”

While these changes are helpful, there is still room for improvement toward systemic change that promotes coordination among providers, makes services easier to access for SUD patients and encourages successful treatment models.

“We need a new framework,” writes Ron Yee, MD, NACHC’s Chief Medical Officer, in an op-ed recently published in *Modern Healthcare*. “From a patient’s perspective, it means being able to move seamlessly across a continuum of care from prevention, to management, to maintaining sobriety. The HIV/AIDS epidemic of the 1980s taught us that the health care system can be transformed to effectively address a crisis... Beyond resources, leaders, policymakers and the public health community must commit to a strategy that not only widens the options for affordable services, but creates pathways for patients with substance use disorders.”

Creating change to boost care coordination for SUD patients across systems of care will require a cultural shift on all fronts. Health centers must continue gathering data to build the case for evidence-based medicine in SUD treatment. Policymakers and leaders must also look beyond MAT and invest in alternative therapies and efforts to address the root causes of addiction. Building successful treatment models in primary care for the SUD patient population demands, above all else, vision, collaboration and the unraveling of past assumptions about what it takes to address a national addiction crisis. ✪