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Recovery as a Continuum: Family First Health's Primary Care-Based Substance Use Treatment Program

Introduction

Dr. Debra Bell had finished seeing her patients at Family First Health (FFH) for the afternoon and returned to her desk to prepare for her presentation. In a just a few short weeks, her team would host a summit to educate the York County, Pennsylvania community about addiction and challenge how others viewed substance use treatment. Passionate about providing substance use treatment to her primary care patients, the double boarded family and addiction medicine physician began musing about the ways in which she could make the science of addiction not only understandable, but relatable to the audience. Although it would be a new audience, it was a familiar task as she had taken the lead in the development of a primary care-based substance use treatment program at FFH and in educating other providers. Reflecting on the program and the team that had been built, Bell knew the summit was an opportunity to increase the program's visibility and expand their reach. She opened up PowerPoint to begin her work not only as the champion for her health center, but also for her community.

The Opioid Crisis

The opioid epidemic was characterized by the misuse of and addiction to opioids, including prescription pain relievers, heroin, and synthetic opioids such as fentanyl. The public health crisis resulted in a staggering increase in opioid-related deaths in the United States, with trends indicating a four-fold increase in overdose deaths between 1999- 2008. In 2017, more than 47,000 Americans died due to opioid overdose and an estimated 1.7 million individuals met criteria for an opioid use disorder (OUD). Most inpatient treatment centers in the US were based on the Minnesota Model, which embraced an abstinence-based approach to treating OUD and other substance use disorders (SUD). Although this approach was effective for some, other forms of treatment were critically needed. To further address the crisis, medication-assisted treatment (MAT) and related programs were developed. Often considered the "gold standard" of addiction treatment, MAT-based interventions included pharmacological support with medications such as buprenorphine or naltrexone as well as counseling or other support services.

Although the epidemic was pervasive throughout the country, it was particularly prevalent in the state of Pennsylvania. Overdose deaths in the state increased by 16.9% between 2016 and 2017 alone (see **Exhibit 1** for age-adjusted overdose death rates in Pennsylvania). In Pennsylvania, York county experienced 130 overdose deaths in 2015. The south-central county, home to 40,000 residents, had experienced an

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economic downturn, which resulted in a surge of addiction and SUDs among the population. Furthermore, one in four residents had depression and one in three residents had anxiety. York county also experienced one of the highest rates of suicide and child abuse in the state. The compounding experiences with trauma and addiction were endemic in the community, and there was a high demand for substance use treatment.

The Experimental Phase

Established in 1970, FFH was a Federally Qualified Health Center (FQHC) that provided medical, dental, and social services to patients in Pennsylvania's York, Adams, and Lancaster counties at six locations (see **Exhibit 2** for a map of FFH locations). In light of the pervasiveness of the opioid crisis in their community, FFH leadership examined how the organization may have contributed to the prescribing patterns that fueled the epidemic (see **Exhibit 3** for FFH organizational chart). Dr. Bell and Dr. Asceline Go, FFH's VP of Medical Services, led a complete reevaluation of opioid prescribing at FFH, beginning with close monitoring of FFH medical providers' prescribing patterns and intervening through education and mentoring for those with aberrant prescribing habits. At the time, FFH had a policy in place that stipulated that opioids could only be prescribed to new patients after their first six months in the practice. Although the opioid crisis was a problem with which the community was already familiar, its scope had shifted. "As a provider, the pill-seeking just felt like more of a nuisance. For a time it was merely a nuisance, but now we are faced with a difficult reality, a reality where young adults are dying. There was one weekend when I lost three patients. It evolved from a nuisance to an industry," Dr. Go explained.

Jenny Englerth, CEO of FFH, did not think that understanding FFH's contributions to the epidemic was enough; the organization needed to be a part of the solution. A Health Resources and Services Administration grant presented an opportunity to ease the health center into a new service line: delivering treatment for substance use. Englerth approached Dr. Bell and asked if she would champion this new effort. It was fitting that Dr. Bell, a family physician, would take the lead since Englerth believed that this type of treatment belonged in primary care. As Englerth noted, "We really had to define what we could do. Was there a role for medical providers? As we started understanding some of the more recent treatment options that were effective, or could be effective, that started shaping our role. At our core, we are a primary medical provider. We can't bypass that role for something else." A portion of Dr. Bell's time was dedicated to the SUD population and the leadership team hired Erin Cosgrove-Findley, a licensed professional counselor, to partner with Dr. Bell in pioneering these efforts.

When thinking about how to design the treatment program, Dr. Bell, Cosgrove-Findley, and FFH leadership grappled with concerns shared by practices around the country: the potential for high demand for services and a high volume of patients overwhelming a practice, adding substance use treatment detracting from the organization's core mission, and the possibility that families may choose to seek care elsewhere if SUD patients shared the same waiting room. While Dr. Bell and Cosgrove-Findley initially envisioned that FFH would serve purely as a MAT prescriber, their experimental work in clinics revealed that this approach would not be sufficient.



The dynamic duo championed the program in its infancy. As their PCP, Dr. Bell was prescribing to patients, and Cosgrove-Finley served in several roles including project manager, case manager, and social worker. In the process of prescribing to patients, Dr. Bell found that she often spent substantial time talking with patients and working to understand the scope and underlying cause of their substance use. Rather than looking at addiction as the end-all be-all, Dr. Bell wanted to ensure that the program evolved to consider addiction as one factor in a patient's physical and psychological well-being. While patients raved about the deep level of engagement from Dr. Bell and the support received from Cosgrove-Finley, the duo knew that this program could not be sustained by the two of them alone. With limited personnel, patient appointments were increasing in length, hindering the speed of patient flow. They were eager to continue the work and see it expand, but recognized that they needed a team in order to do so and to meet the growing demand for substance use support.

In 2016, FFH received a Center of Excellence (COE) grant for treatment of opioid use-disorders from the state government. The COE Program was initiated by Pennsylvania Governor Tom Wolf in 2015 when he allocated \$15 million of behavioral health funding to jump-start programs at 20 organizations treating opioid addiction and bringing together treatment and primary care. Twenty-five more organizations were selected the following year, including FFH. One COE funding stipulation was that FFH treat 300 patients in the 2017 calendar year in a program that included MAT. The guidelines and requirements of the COE funding necessitated a larger team and Dr. Bell and Cosgrove-Finley eagerly began the process of expanding their program.

Reframing Recovery as a Continuum

Before ramping up the program, Dr. Bell and Cosgrove-Finley needed to make philosophical decisions that would guide the approach of the program and serve as its underlying foundation. From the exploratory phase, one thing was clear: they viewed addiction as a chronic, relapsing, remitting disease. Englerth reflected on this notion:

One of the questions that we got early on was when were we going to discharge people, when would they be done? And was that going to be 30 days, 60 days, or 90 days? The questions were really around this very defined, traditional model in some way, and this assumption that we're going to lay this traditional model into primary care. My response would be, if we really absorb substance use disorder as a chronic illness, then I could compare it to diabetes, and I would never say, 'Well, we got a diabetic, a new diabetic, through her first 90 days, so we're good, we're checking her off our list. Let us know when you have a problem.' So, there is a great opportunity to start to frame recovery as a lifelong process, where professionals really can be available to people throughout that process. They are in recovery for the remainder of their lives. So, why would we not build that into our model? That was my first indication that we were talking about something very different.

The team viewed recovery as a continuum whereby treatment was a long-term activity requiring different degrees of intensity depending on the acuity of the symptoms. In thinking about the structure



and philosophy of their model, Dr. Bell and Cosgrove-Findley learned about Boston Medical Center's Office-Based Addiction Treatment (OBAT) model, also known as the Massachusetts Model. The duo learned more about the OBAT model by participating in Boston Medical Center's Extension for Community Healthcare Outcomes (ECHO®), a series of online information sessions, trainings, and case-based discussions. The OBAT model also focused on primary care, but heavily relied on empowering nurse managers that worked alongside prescribing physicians.

Although inspired by the model, Dr. Bell and Cosgrove-Findley sought to expand their care team and to surround the patient with medical, psychological, and social support systems. This biopsychosocial approach focused on the many spheres of a patient's recovery and the ways in which many factors coalesced to fuel one's battle with substance use (see **Exhibit 4a** for the biopsychosocial model). "We recognized that there is more to it than just treating the drug problem. We realized that there was also even more to it in that it's about people rebuilding their lives," Dr. Bell affirmed. A core tenet of primary care is a whole-person approach and Dr. Bell believed that it was critical that their approach to substance use mirrored this core principle of primary care delivery.

Forming a Team

Shortly after receiving the COE funding, Anika Jackson was hired to serve as the director of the program and was charged with overseeing its growth. There was an immediate need to hire a team, so Jackson partnered with Cosgrove-Findley to accomplish the task. Given the urgent need to hire staff, Jackson and Cosgrove-Findley did not have the opportunity to develop a formal hiring strategy. However, they aimed to ensure that there was alignment between the hired individuals and the model's philosophical underpinnings and approach to care. "We did not just do blanket interviews where we asked about peoples' experience with MAT," Jackson continued, "but we instead asked, 'What is your philosophy about recovery? What is your philosophy about MAT?'" Cosgrove-Findley added, "We were very cognizant of some of those questions around culture and philosophy, because I am a big believer that you can teach skill, but you cannot really teach your core beliefs. So, if you're coming in, and you are the polar opposite from what we're trying to build, it's just not going to work, especially as a new program." Initially Jackson and Cosgrove-Findley hired two case managers and two certified recovery support specialists (RSS), and later were able to add a third case manager and RSS as the team diversified their funding.

In the experimental phase, Dr. Bell and Cosgrove-Findley had only seen patients at FFH's Hanover location two days a week. In February 2017, the team started seeing patients on a limited basis at the George Street location in York. Given that each provider's panel size was limited to 100 SUD patients, Dr. Bell and Cosgrove-Findley knew that they needed recruit more primary care physicians to the team. In July 2017 another FFH physician, Dr. Junia Tiruchelvam, started seeing patients in the substance use program followed by Dr. Marie Kellett at the Columbia location in September 2017. By the end of the ramp up phase, the care team for each patient was comprised of a provider, a case manager, an RSS, a MAT licensed practical nurse (LPN), and a licensed clinical social worker (LCSW). Each of these team



members played a specific role on the team and in the care of the program's patients (see **Exhibit 5** for list team member roles and responsibilities).

Providers

The primary care physicians on the team oversaw the medical and behavioral health needs of patients, which included the prescribing of MAT. Providers in the program prescribed both buprenorphine products (Suboxone® and Subutex®) and naltrexone products (Vivitrol® and ReVia®) for qualifying patients.

Case Manager

Case managers were responsible for helping patients navigate any barriers to their care and recovery and for connecting patients with resources to support behavioral health needs (i.e. counseling or psychiatry). The case managers also linked patients with outside agencies or supports that could assist with issues pertaining to the social determinants of health, such as housing, food security, and transportation. In addition to their role in resource navigation, case managers scheduled patient appointments and tracked data associated with those visits.

Recovery Support Specialist

The RSS, an individual with lived experience with their own substance use and recovery, conducted several patient check-ins, by phone call, text, or in-person, in between clinic appointments. During these interactions they served as a form of coach for the patient and discussed topics including accountability, challenges to recovery, and coping mechanisms.

MAT LPN

The LPN on the team was responsible for overseeing the prior authorization process for the MAT-related medications. Additionally, they ensured quality measure compliance, supported providers in the ordering and administration of MAT such as Vivitrol®, and managed patient triage and subspecialty referral coordination.

Licensed Clinical Social Worker

LCSWs assisted in connecting patients to outside providers, coordinated patient mental health services, and provided initial, brief interventions following the behavioral activation model. Through behavioral activation they helped patients to understand how behaviors influence emotions and taught patients skills for coping with depression and anxiety.

Operationalizing a Team-Based Approach

By December 2017 the two-woman operation had expanded into a 12-person team caring for 255 total patients, 206 of which were in the COE, over the course of 1,411 medical appointments (see **Exhibit 6** for patient demographic data). Dr. Bell and the team were surprised to find that around 70% of the patients in the program were first-time FFH patients and that they had heard about the program through word of mouth or referrals from other programs. Although this was the initial way in which patients entered the program, Dr. Bell wanted to develop a strategy for identifying existing FFH patients that were in need of substance use treatment and the accompanying services. Historically, PCPs at the practice asked patients



about drug and alcohol use as part of the social history. However, Dr. Bell and the team found that this approach was inadequate and that validated screening tools were needed to effectively screen for addiction among the patient population.

The team worked to implement a screening tool and began screening every patient age 12 and older for substance use through the Screening, Brief Intervention, and Referral Treatment (SBIRT), an evidenced-based practice used to identify substance use and dependence, at every FFH appointment. Unlike other practices that may administer screening tools orally during appointments, the FFH screening tool was on a piece of paper that patients filled out and self-reported while in the waiting room. CarrieAnn Frolio, VP of Integration and Business Development, observed that “by putting it on a piece of paper that somebody fills out themselves... allows almost for a level of privacy as they’re filling it out, as opposed to answering face-to-face questions.” Jackson elaborated, “You start to have people not just checking boxes, but they’re writing stuff in the columns. All kinds of stuff. So you may be getting even more information that way, which you don’t think about. You’re thinking, ‘Oh, it’s just a piece of paper. Check the boxes and move on.’ But they will comment and can use their own words, and they can clarify, and actually, getting that clarification is really helpful.” Through screening all patients at FFH the team was able to identify patients in need of substance use treatment that otherwise would have gone unnoticed. Dr. Kellett saw this with one of her patients, “I did not know that this person, who had uncontrolled diabetes and I’ve been seeing for 10 years, was drinking every single day, until this screening happened.”

Touchpoints & Patient Engagement

The team structure was critical to acting on the biopsychosocial model, which aimed to address patients’ biological, psychological, and social needs (see **Exhibit 4b** for team structure and overlap with the biopsychosocial model). Once patients engaged in the program, whether connected by word of mouth or by screening, a team-based approach with consistent touchpoints was used to stabilize the patient and support their recovery. Depending on whether the patient was given buprenorphine or naltrexone, there was a general patient engagement process which consisted of a staged timeline with set touchpoints and phases (see **Exhibit 7** for a breakdown of the patient engagement processes). For example, a new patient on buprenorphine started in Phase 1 which lasted for at least 3 weeks and required weekly appointments. When moved to Phase 2, the patient instead attended bi-weekly appointments and remained in the phase for at least two appointments. In Phase 3, the patient attended monthly appointments and could remain in the phase for as long as their recovery necessitated. This engagement process was bidirectional, meaning that patients were able to both progress to new phases and return to previous phases for more intensive support when needed or during relapse. Overall, it was expected that team members frequently interacted with patients and set touchpoint goals based on the patient’s stage in recovery.

On direct patient care days, team collaboration was especially important. During this time the SUD team took over a small portion of the clinic and shared the team space for the duration of the day. The proximity enabled ongoing and fluid communication between team members. When patients came to the clinic for their appointment they first met with the MAT LPN. After meeting with the patient the MAT LPN would then debrief with the team and the case manager then met with the patient. After leaving the



room the case manager returned to the team and again they debriefed any relevant updates and discussed items that the provider should cover when meeting with the patient. It was then the provider's turn to meet with the patient to address medical needs and check-in on MAT progress and management. The MAT LPN, case manager, and provider could then have a final debrief in order to ensure that all members were up-to-date and follow-up care was agreed upon (see **Exhibit 8** for a summary schematic of the appointment structure). Given the interactions with a number of care team members, patient appointments typically lasted 50-60 minutes.

Prior to the medical appointment, patients might also have engaged with a LCSW in a 20 minute visit. Kathleen McCadam, Director of Behavioral Health Integration, explained why this touchpoint was also an important component of the team-based approach:

We're started scheduling 20-minute behavioral health appointments prior to the medical appointment because we're finding that the substance use population tends not to come in on their own. They may be in outpatient treatment, they may be getting support where they are living, and they might not necessarily see the value of coming in and talking about insomnia, but if we can pair that with a medical visit, then we know that Dr. Bell doesn't have to talk about the insomnia. She can instead focus her attention to the medical issues at hand.

A RSS did not join the patient in the room or schedule a time to meet with the patient; however, on DPC days they made themselves available and sat in the clinic should the patient wish to check-in while at the practice. As Dr. Bell had come to find, the RSS was a particularly critical member of the team and essential to its cohesion.

Building Trust & Credibility: The Role of the Recovery Support Specialists

The recovery support specialists were in a unique position on the team in that they served as a bridge between the patients and the other care team members. As Mark McCullough, an RSS, explained, the relationship between an RSS and a patient is markedly different:

I think that dynamic of the relationship when it comes to the recovery support specialist is different, automatically. I share my walk, whatever it is, even personal experiences in therapy because for me, that's what it took for me to get into and maintain my recovery. For me, my perspective is if I'm withholding any of that stuff, it might be a piece that they need for their own puzzle to put [it] together. I knew that walking in to this that I needed to be comfortable sharing myself on all levels, and I do that. Of course, I will keep boundaries. There are some instances where patients will start to feel like you're more a friend and you kind of have to reel that back in. It's a balancing act. I go through it all the time. I need to also share those experiences with my coworkers and my supervisor as well to keep myself in a good place.

The FFH team had countless stories about patients who reached out to their RSS when a family member passed, or when they texted pictures of the new car they were able to buy as a result of being in recovery



and doing well at their job. Patients often trusted their RSS and this trusting relationship often extended to the broader care team.

Dr. Bell affirmed that the RSS added to the credibility of the team and that the team also learned from the RSS about the challenges and nuances of addiction as well as the recovery process:

The biggest thing that we've tried to emphasize, and that we've learned to emphasize, is that we've got to take a team-based approach, and it's got to be us working together to kind of navigate that. It includes really using the recovery support specialist, who's been in their shoes. My RSS folks are able to say, "Yeah. I remember when I was there." I really listen to them. I'll try to understand different patient situations from the RSS perspective. They add credibility to what I say. They add those pieces that I could never do. They taught me what the lingo is, changed my vocabulary.

Weekly Rounds

Every Friday all members of the substance use team convened for weekly rounds. During this team gathering the team reviewed and discussed all patient appointments for the upcoming week, giving additional attention to critical patients. Before diving into patient updates, they kicked off the meeting by celebrating the good things that had happened in the week. Although reviewing some upcoming appointments and patient updates brought up some intense and emotionally draining situations, there was laughter, encouragement, and moments that lightened the mood. This team-based approach not only enabled patient-centered care couched in a biopsychosocial approach, but fostered a unifying, supportive culture within the team.

Team Culture

Although much of her initial efforts centered on making sure that patients had excellent care, Cosgrove-Findley's focus shifted to ensuring that the staff worked well together. When building the team, one challenge that Cosgrove-Findley and Jackson encountered was getting the team comfortable with disagreeing. "I see the ability to disagree as a great thing because if you are willing to argue your point for the sake of a patient, you have the compassion necessary to do a good job. I have always enjoyed those conversations. It took a good while for us to build trust within the team. To be able to say ok you're arguing your point and I actually trust that even though it is different than mine," Jackson noted.

Cosgrove-Findley and Jackson not only wanted their team to be able to disagree, but to feel comfortable being vulnerable. Cosgrove-Findley explained:

We've worked really hard to build a supportive culture because it is such emotional work and we want the team to be okay with being vulnerable. We talk about offering grace to team members. If somebody comes in and they are not on their A game and we know that this is not typical for them, say something to them. Maybe something happened with a patient or maybe even in their personal life. We want to make sure we are aware because we are doing this type of work. The team is paying attention to each other.



The collaborative and supportive nature of the culture was especially valued among the providers. Dr. Elizabeth Horst joined FFH in 2018 and had a panel in the substance use program and a standard primary care panel. In reflecting on her substance use direct patient care days relative to her more standard clinic days she stated, “I love my substance use clinic days. I actually have a team and friends.” Not only did the team approach ensure that the many facets of patient needs were met, but also fostered a culture of collaboration and solidarity that was especially valued when the work was challenging and complex.

A Culture Clash

Although many members of the FFH substance use team reported that they valued the culture within their team, they noted that the larger practice culture at FFH was different. The substance use program had formed a microculture within their team that differed from the broader culture of the organization. “Being a new line of service is challenging from a culture standpoint,” Cosgrove-Findley observed. The substance use team had a shared philosophy around recovery and substance use disorders; however, the same perspective was not always shared among other colleagues at the FQHC.

McCullough recalled hearing past comments from colleagues such as, ‘Why do they get special treatment?’, ‘Did you see that substance use patient earlier’, or ‘We’re wasting appointments on them.’ Although these comments were frustrating and difficult for the substance use team to hear, they understand that one of the ways in which they can resolve these cultural tensions is through educating and advocating. Annie Beegle, one of the case managers, offered an example of the ‘educate and advocate’ approach in action:

Well, within the organization, I think from registration on down, just make sure that they're educated. When you get a call from somebody who is sick and cancelling their appointment, don't automatically think "substance use issue." Our patients have medical issues also. Don't think they're withdrawing. We've had that happen, and we've had to address it and say, "It's not withdrawal. They're sick." Have them see a doctor or direct them to a nurse. They get sick, too. It's no different. I've had so many conversations about that. People need to be educated, even the people who greet patients the minute they walk through the door.

Cosgrove-Findley was aware of the difficulties that surface when dealing with a microculture within a differing macroculture. She explained, “When the team is feeling the pressures of some of the negative stuff on the outside, it really takes a toll on them, and we oftentimes have to come together to talk about it, and there’s been a number of times that I ask them to push through, to make our culture contagious.”

Maturation of the Model

Since its initial year of COE funding in 2017, the program had evolved. With the program being in its third year in 2019, the team had seen patients retained and engaged in the program for months and even years (see **Exhibit 9** for patient retention and engagement data). It had also been long enough for the team to see patients progress through the program and achieve stable recovery. These stable patients could transition back to a regular primary care panel, but still have access to the substance use team should they



experience a relapse or challenges to their recovery (see **Exhibit 10** for data on patient transitions in and out of the substance use program).

Reflecting on how far they had come, case managers noted that there had been an increased use of behavioral health services and LCSWs over time. Engagement with LCSWs was important since they were able to lead behavioral activation therapy, providing patients with skills to cope with substance use, anxiety, and depression. This added support enabled the care team to further focus their time, especially during direct patient care days, on how well the patient was maintained on their MAT, the state of their health, and how their social circumstances had declined, improved, or stabilized. Beegle noted, “It’s been good to really utilize the LCSWs’ skills and bring them deeper into what we’re doing. It takes a lot of weight off us when we can rely on them to do the behavioral health piece that we sometimes found ourselves doing despite having less training to do so. It’s a lot more effective to have them in-house and around during patient appointments.” Dr. Horst also valued the increased behavioral health use. As she asserted, “Behavioral health is how people recover, MAT just gives space for that recovery.”

Codification of Processes & Knowledge

While the early years of the program were characterized by substantial experimentation, Cosgrove-Findley and Jackson recognized the importance of codifying their processes and procedures. Jackson explained:

We reached a point where we knew we needed to begin putting something down. We’ve tried these different ways of doing things and done a ton of work. Getting that stuff down on paper to say, ‘This is what we’re committed to’ was an important next step. Sometimes we aren’t always sure, but we know we need to just make decisions and write the processes and procedures down. Because otherwise, you can’t really measure anything if you’re constantly changing.

The impact of their codification efforts trickled down throughout the program. McCullough affirmed that the change improved his confidence in his role. “I feel like I’m in a really good place. I know exactly what is expected of me and how to get my work done,” he continued, “and in the beginning it was difficult to understand the expectations because they would change and that’s what happens in a new program, and that’s ok. Now I’m at a place where I’m really comfortable doing the day-to-day work.”

Defining and Measuring Success

Throughout the experimental phase and the program’s initial years, the SUD team grappled with the challenge of defining and measuring success. The team believed that the way in which the COE and other programs defined success fell short and did not truly capture the progress of the population over time. Englerth expanded on the difficulty of the required state-level metrics:

The success metric at a state level is reduced deaths due to overdose, which is tough to meet. I get that’s a powerful metric, and it speaks well politically, and we all want less people to die. That’s easy to get our arms around. But, we’ve had weekends where you have heroin that’s had particularly high rates of stuff that people don’t anticipate being in there, and we have four



deaths over one weekend in this community, and other communities have the same thing. That is a tough success metric, and I know that's what, politically, folks want to overlay a lot, but as a provider who wants to see this in a framework of primary care, that's just not the way we see the world. Philosophically, we can all agree, but I think that's where we get really short-term thinking. You're going to get that one weekend, and that wasn't in anybody's control.

Through years of experience running the program, the team decided to define and measure success in a way that more closely mirrored the program's approach to SUD as a chronic condition. Dr. Bell affirmed that they "want to look at those things that we can really influence, which is engagement and reduced use over time." The team defined success at the individual patient level as the progression through the phases of treatment and retention in the program, and at a population level as reduced substance use over time. Although defining success required much debate, Cosgrove-Findley was confident in their approach:

If we want to reduce stigma and normalize the treatment for substance use disorder, we need to be seeing it through the same lens as other chronic diseases. I think it is dangerous to see this as, 'We have a crisis in our community, so we're gonna jump in and do a little bit of something.' I think, one, you're always going to feel like you fall short because you really have to look at this over time. And, two, you're going to spend a whole lot of resources, so if you don't jump in with both feet, you're going to be dissatisfied with your success.

Finding Sustainability in a Shifting Landscape

In thinking about sustainability, the team constantly evaluated the ways in which they should prepare for an impending change in funding. The COE funding enabled FFH to build out a team and afforded them with protected time to learn, experiment, and refine the program. However, the slowing of the COE funding and program resulted in a shift from the lump sum funds to volume-based funding. Along with volume-based funding, the SUD team also grappled with challenges related to reimbursement. Notably, practices could be reimbursed for patient interaction with an RSS in behavioral health, but not within primary care. Dr. Bell elaborated on the issue:

Doing this work allows a lot of regulatory and policy issues to surface since there are funding inequities between behavioral health and physical health. Sometimes, there's ways that we can leverage the physical health payers to cover things that behavioral health couldn't dream of. Then there are times, particularly in the substance use space, where because behavioral health has been the traditional system, they've had some reimbursement methodologies that have been longstanding and are difficult to change."

In addition to the challenges accompanying volume and reimbursement, Englerth observed that other state and federal grants did not appear to be long-term sustainable solutions to their funding conundrum. "At the government level we are seeing an emergency response and not one that considers how we can make this systematic, ongoing care. So as providers, we're stuck in the middle of trying to translate that because we know that this is ongoing work. Many of the payment systems, public payment systems in particular, are developing emergency response type payment mechanisms," Englerth asserted. The FFH



team saw this approach to funding as problematic since they viewed their program as a long-term venture that would not be satisfied or adequately supported by quick, short-term funding.

The Push for Integration and Scale

For several years the SUD program had been siloed, but given the increased volume of patients and demand for services, Dr. Bell and the team knew that this would not be sustainable for much longer. It had become apparent that the team must begin thinking about integrating and scaling substance use treatment at the organization. As Jackson observed:

We are now pushing up against capacity, for the substance use blocks that we have with the providers we have. We recognize the other demands that we have as an organization and that we are not the only line of service. However, every provider is seeing someone who could benefit from some level of service related to substance use. So, how do we integrate and scale it? How do we do that responsibly, while also maintaining the general primary care?

One of the hallmarks of FFH's substance use program was its high number of touch-points and emphasis on patient engagement. However, Cosgrove-Findley observed the challenge of balancing the impending growth and scale of the program with its human-intensive design, explaining that the demand of the program would eventually become greater than what the team could manage, "...so we have to really think about how we do this in a way that allows us to give our best and to keep the patient our core focus. Because that's why we're here. But, at this stage if we just keep adding slots, it's just going to be like a wild animal." In order for integration and scale to occur at FFH, Dr. Bell knew that she would be faced with an additional task: getting all of the FFH providers onboard at some level.

Demonstrating Value

A critical part of sustaining the SUD program would entail demonstrating the value of the program within the FQHC and the value of integrating substance use treatment in primary care as a whole. In order to invest in meaningful and usable data that could substantiate anecdotal claims, Jackson recruited data analyst Nathan Webb to the team. One of Webb's initial findings was that the no show rate among patients in the substance use program was 14%, whereas as the overall patient no show rate for FFH was 17%. These preliminary data analyses indicated that the program may confer value to the overall practice given that the no show rates were lower, on average, among the substance use patient population. As Jackson noted, "Providers are held accountable to utilization and productivity. So, we have to be able to demonstrate to them that their time block for substance use is not having a negative impact on them overall. So, that's when we started pulling this stuff out to say, actually, in this block of time you may be doing better."

Although Webb's work had shown promise, Englerth recognized that figuring out how to measure value in primary care was a challenge overall. "There is a piece, particularly in primary care, that's messy and unmeasurable, and in large part, it's because of the history and the current state of the patient never comes to you in a clean package. Not matter how simple," she explained.



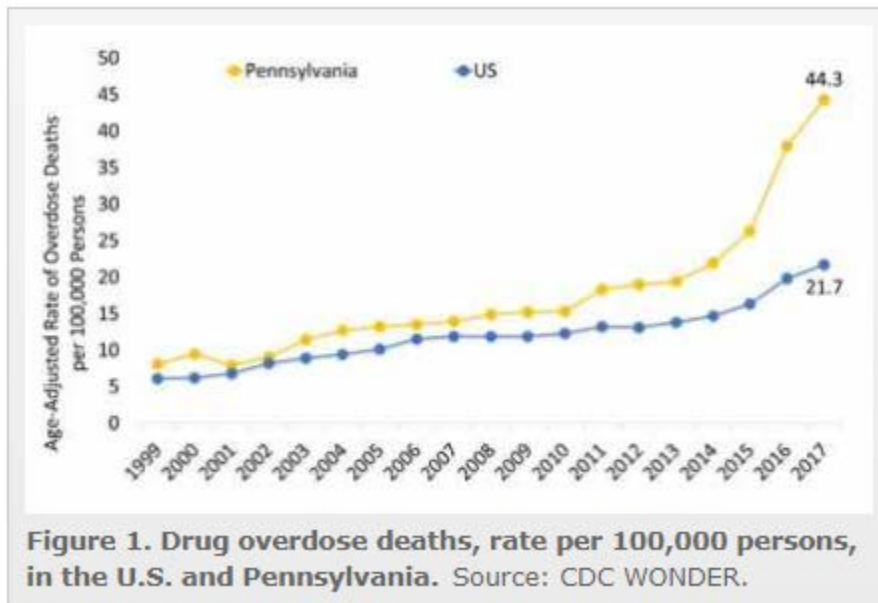
Conclusion

Dr. Bell had been steadfastly devoted to her patient population and determined to combat the stigma surrounding addiction and the treatment of substance use in primary care. Although others were more hesitant to engage, Dr. Bell had been the leader and provider champion the organization needed. “The champion role is making it easy for everybody else just to get on board, and if that champion is not there, then it’s going to be pushing a rock up a hill. Because to do this at scale, people have to be able to see this as a lighter lift compared to the time that Dr. Bell put in to create and build the program,” Englerth reflected. With the summit fast approaching, Dr. Bell continued to ruminate on the contents of her speech, and she already knew that there was a core message she sought to communicate: no matter where people were in their substance use, everyone had a part to play. Although the task of integrating a substance use program in primary care was accompanied by much trial and error, provider and community education, and funding and sustainability questions, for Dr. Bell the reason for doing the work was fairly simple: “Why wouldn’t we?”



EXHIBITS

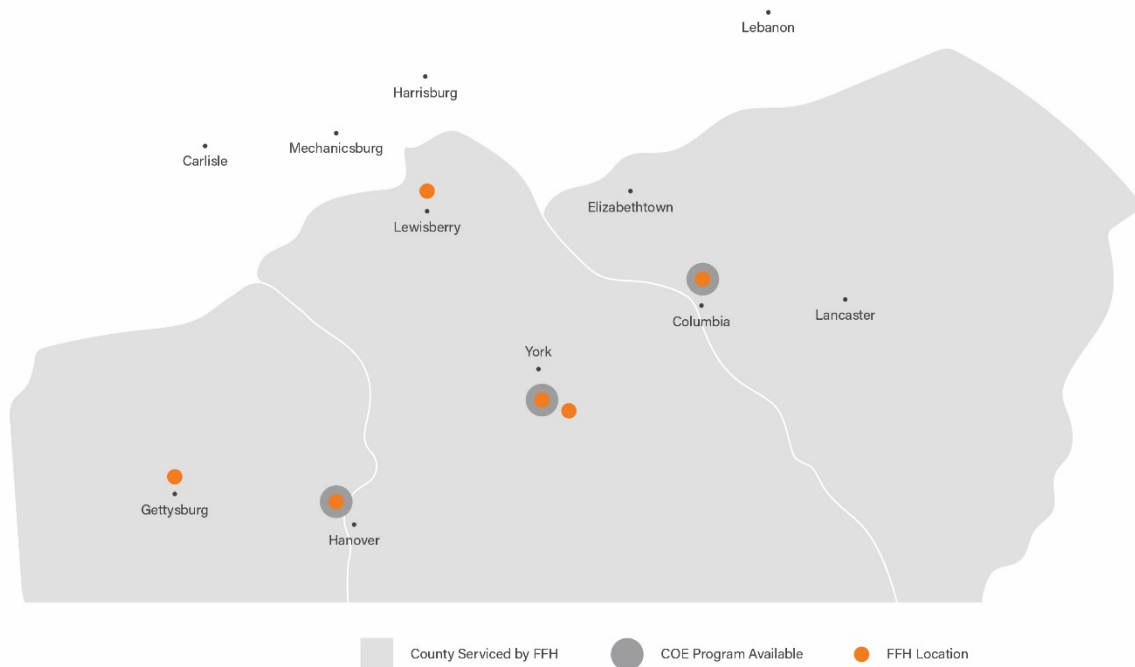
Exhibit 1: Age-adjusted overdose death rate in the United States and Pennsylvania



Source: Pennsylvania Opioid Summary: Overdose Deaths (2019). Retrieved from <https://www.drugabuse.gov/opioid-summaries-by-state/pennsylvania-opioid-summary>



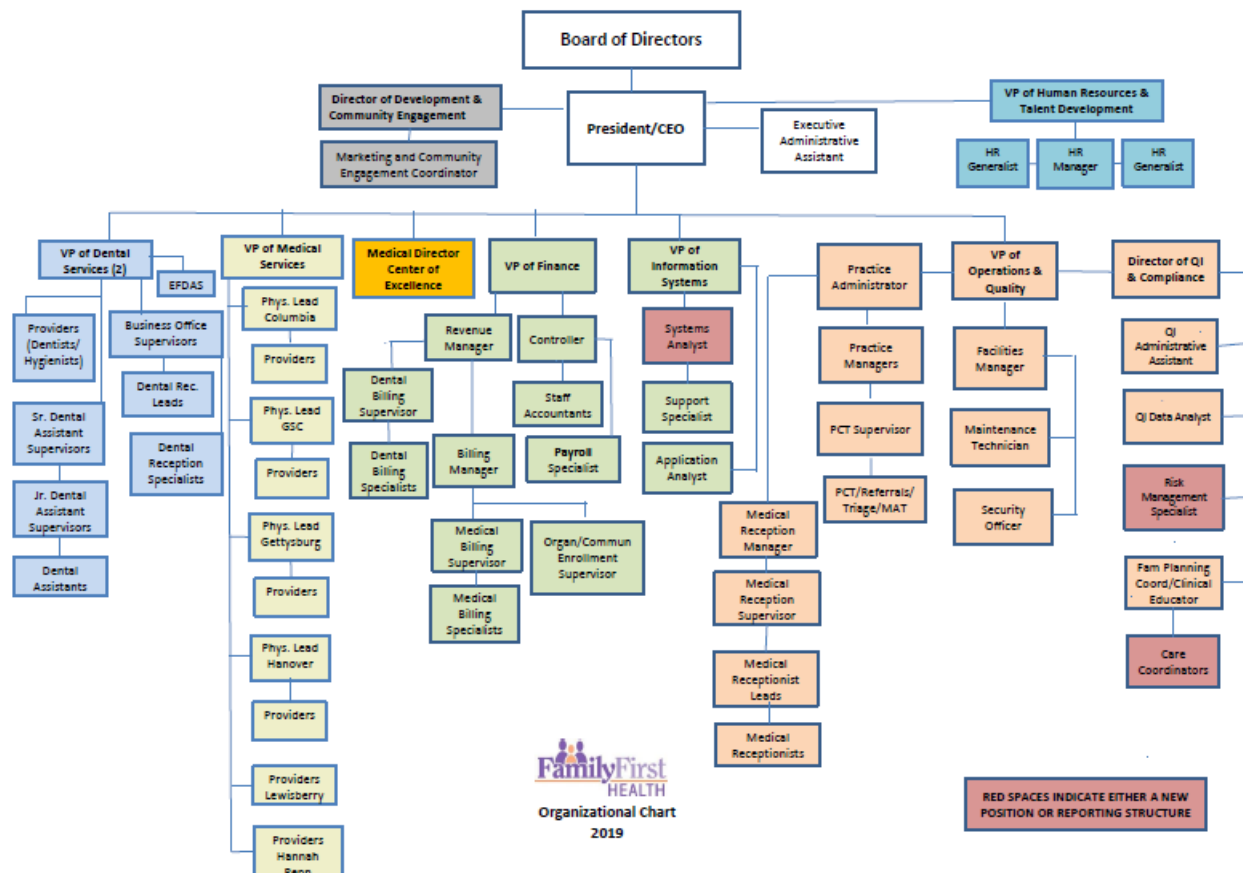
Exhibit 2: Map of FFH locations



Source: Family First Health



Exhibit 3: FFH organizational chart

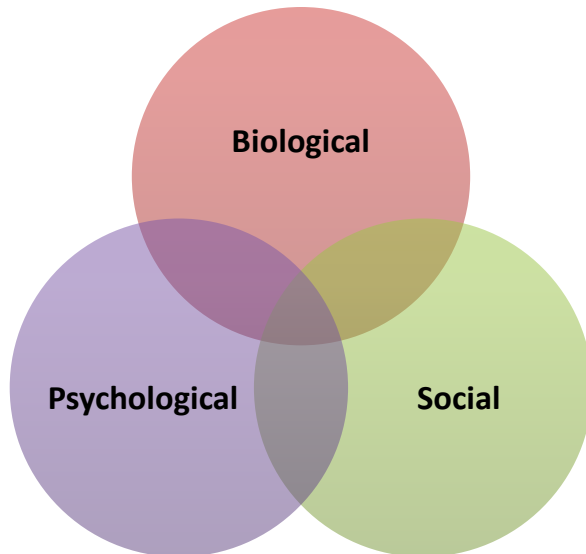


Source: Family First Health

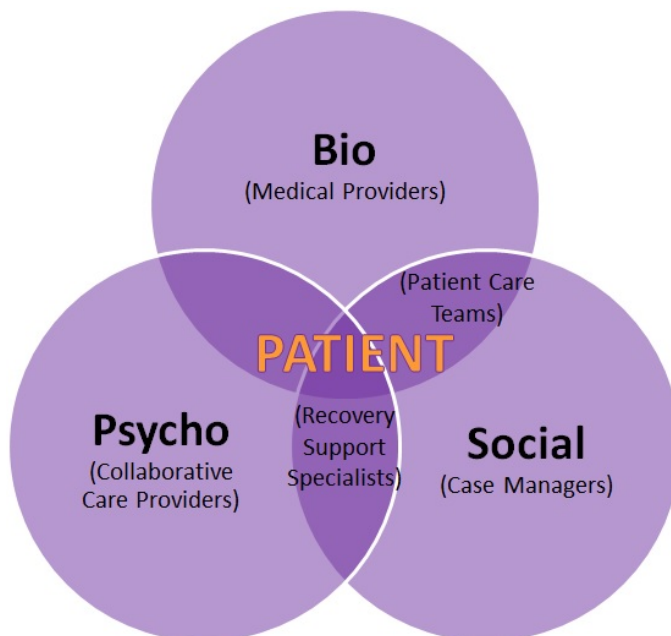


Exhibit 4: FFH's use of and approach to the biopsychosocial model

A. The biopsychosocial model



B. FFH team structure and overlap with the biopsychosocial model



Source: Family First Health



Exhibit 5: List team member roles and responsibilities

Role	Responsibilities
Program Manager	• Create community partnerships with Director • Train and manage case managers and recovery support specialists • Coordinate with quality improvement department (dashboard) • Check charts/audit • Coordinate SBIRT (screenings, etc.) rollout across all sites • First contact for new patients • Ensure patient voice is heard • Sit on committees (with Director) • Schedule, oversee and participate in huddles • Supervise program staff in delivery of care • Write policy, processes, etc. (with Dr. and Director)
Drug and Alcohol Case Manager	• Complete patient intakes • Facilitate patient appointment scheduling with provider • Ongoing follow-up with agencies/organizations to which patient is referred to ensure patient compliance and effective alignment of resources for patient • Primary and on-going, regular contact with patients (easily accessible) • Assist with connecting ED patients to treatment • Refer patients to outside agencies (housing, food, transportation, etc.) • Verify referrals have occurred • Complete patient consents/release of information • Assist patient with navigating insurance issues, with MAT LPN • Track patient data related to visits, etc. • Determine appropriate follow-up with patients • Patient retention/engagement in program • Assist with ED patient connection for treatment • Ensure compliance with CLAS (Culturally and Linguistically Appropriate Services) standards • Assess patient needs and barriers • Participate in team huddle
Recovery Support Specialist	• Accountability to “walk the path” • Create recovery plan with patient • Assist with identifying recovery services (AA, SMART recovery, etc.) with each patient • Spend time with patient talking about recovery (challenges, etc.) • “Coach” to patient • Assist patient in developing coping skills • Participate in team huddle



LCSW	• Navigate patient barriers to mental health services • Cultivate external social work connections • COE team liaison to FFH's behavioral health team • Lead development of patient treatment plans • Provide initial brief intervention services • Provide patients with mental health referrals and referrals to more intensive treatment • Lead development, coordination and execution of patient support groups • Assist patients in developing coping skills • Participate in team huddle
Provider	• Facilitate patient primary care visits (assess patient clinical needs, etc.) • Prescribe and oversee medication management for patients • Refer patient to necessary outside clinical supports (specialists, etc.) • Advocate for patient appropriate management in psychiatry and emergency department • Participate in team huddle • Ongoing SUD training/education for all providers • New provider recruitment and training for SUD treatment • Resource for providers in medication management • Cultivate practice-specific connections for specialists
MAT LPN	• Navigate and process prior authorizations • Ensure quality measures and compliance • Train PCT members • Train clinical staff in process in Vivitrol® injections • Support providers/team in care of patients (order and administer Vivitrol®, check PDMP, room patients, etc.) • Train and assist staff in SBIRT process • Patient triage and referrals • Work with case managers to navigate and resolve patient insurance issues • Participate in team huddle



Director	• Participate in learning collaborative (provided by State) • Supervision of COE staff • Ensure program meets State expectations • Cultivate and ensure program sustainability • Facilitate integration with other services/ departments (quality improvement, behavioral health, caring together, etc.) • Lead program communication (internal and external) • Facilitate development and deployment of appropriate program and FFH staff training • Lead program/process review and refinement • Facilitate connections with other COEs • Ensure program integrity • Ensure timely and accurate state reporting • Create community partnerships with program manager • Daily oversight of program • Participate in appropriate community organizations to represent the COE (York Opioid Collaborative, etc.) • Ensure tools/technology are optimized for program implementation and tracking • Data analyst/ administrative assistant • Create and manage tracking/data collection mechanisms • State and federal grant reporting • Coordinate meetings, as needed • Ensure completion of patient surveys
Data Analyst	• Assist in developing written processes • Research revenue stream options • Develop patient experience process • Work with Director to ensure tools/technology are optimized for program implementation and tracking • VP of Integration and Business Development • Development of marketing collaboration • Assess feasibility of FFH becoming a licensed drug and alcohol facility (through DDAP) to facilitate level of care assessments • General program development and oversight • Ongoing assessment of program/renovations
Other (CEO, CFO, Practice Managers, Practice Administrator)	• SBIRT implementation across all sites

Source: Family First Health



Exhibit 6: Patient demographic data

	FFH Patients Percentages	SUD Patients Percentages
Age		
0 - 9	17%	0%
10 - 19	18%	0%
20 - 29	13%	25%
30 - 39	15%	43%
40 - 49	13%	19%
50 - 59	12%	10%
60 - 69	8%	3%
70 - 79	3%	0%
80 - 89	1%	0%
90 - 99	0%	0%
Gender		
Female	56%	45%
Male	44%	55%
Race		
American Indian or Alaska Native	0%	1%
Asian	1%	0%
Black or African American	16%	6%
Native Hawaiian or Other Pacific Islander	1%	0%
Other Race	25%	11%
White	54%	80%
Patient declined or refused	3%	1%
Ethnicity		
Hispanic or Latino/Spanish	38%	12%
Not Hispanic or Latino	60%	86%
Patient declined or refused	2%	2%

Source: Family First Health



Exhibit 7: Breakdown of the patient engagement processes and practice guidelines

A. Patient engagement process – buprenorphine (Suboxone®, Subutex®, etc.)

	Time in Phase	Medical Appointment	Prescription	Urine Drug Screen (UDS)*	Behavioral Health (BH)	Case Manager (CM) Engagement	Recovery Support Specialist (RSS) Engagement	Clinical Rounds Discussion
Phase 1 (all buprenorphine patients begin at phase 1) At least first 3 weeks	At least three weeks	Weekly	Written for no more than one week at a time	Must show only prescribed medication (and/or quants trending down) to move to phase 2	Work w/ LCSW to identify BH needs during second appointment	- At least one follow-up with CM or RSS, outside of medical appointment - Weekly calls - First follow-up must be within three days of the first medical appointment		Yes
Phase 2 At least 4 weeks	At least two appointments	Bi-Weekly	Written for no more than two weeks at a time	Random UDS and med counts** If substances outside of prescribed Bup or THC, move back to Phase 1	LCSW identifies BH/DA needed- Provides recommendation to team	- At least two follow up calls on off weeks of appt, follow up in medical appts and as needed - Biweekly calls - Recovery Plan required		Use Rounds spreadsheet for updates as needed.
Phase 3		Every 4 weeks monthly	Written for no more than four weeks at a time	Random UDS and med counts** If substances outside of prescribed Bup or THC, move back to Phase 1	Continuing to follow LCSW recommendation (internal and external BH)	- Weekly follow-up with CM or RSS, outside of medical appointment - Weekly calls - Recovery plan follow-up, adjusted as needed – RP updated every 6 months		Use Rounds spreadsheet for updates as needed.



Re-engagement***	Back to Phase 1 and moves through phases again, as appropriate	Weekly	Follow above phases	Must show only prescribed medication (and/or quants trending down)	Schedule with LCSW for updated intake and assessment	- Weekly follow-up with CM or RSS, outside of medical appointment - Weekly calls - Discuss change in treatment, expectations of program, etc. - Sign paperwork again if it has been longer than 3 months and treatment plan has changed	Yes
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Exceptions: Any exceptions to this process should be discussed between the Medical Provider, CM, and RSS. The Medical Provider should communicate any exceptions related to patient medical care and/or prescription with the CM. The Program Manager should be included in exception discussions, as needed. All exceptions must be documented thoroughly in the patients chart inside an encounter or in a patient case, as appropriate.

* UDS results with THC are discussed

** See “random UDS and Med Count” process

B. Patient engagement process – naltrexone (ReVia®, Vivitrol®, etc.)

	Time in Phase	Medical Appointment	Urine Drug Screen (UDS)*	Behavioral Health (BH)	Case Manager (CM) Engagement	Recovery Support Specialist (RSS) Engagement	Clinical Rounds Discussion
Phase 1 (all naltrexone patients begin at phase 1)	At least one appointment	Weekly	Must show only prescribed medication (and/or quants trending down) after first visit* Reference clinical guidelines on other substances	Work w/ LCSW to identify BH needs – provide recommendations to the team	- At least one follow-up with CM or RSS, outside of medical appointment - First follow-up must be within three days of the first medical appointment - Begin Recovery Plan creation, if possible	Yes	
Phase 2	After 1 st appt	Every four weeks (monthly)	Must show only prescribed medication Reference clinical guidelines on other substances	Continuing to follow LCSW recommendation (internal and external BH)	- At least one follow-up call outside of appt, follow up in medical app and as needed - Monthly calls - Recovery Plan completed, follow-up, adjusted as needed – RP updated every 6 months	Use Rounds spreadsheet for updates as needed.	



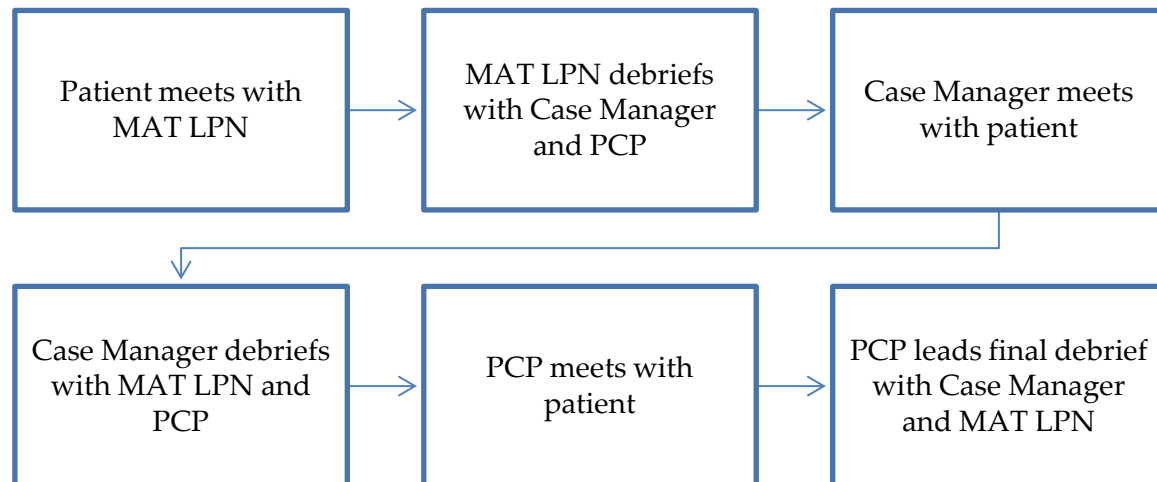
Re-engagement***	Varies based on patient progress	Every four weeks (monthly)	• Focus on stabilizing MAT dosing • Essential labs only • Essential chronic medical and psychiatric needs	Schedule with LCSW for updated intake and assessment	• At least two follow-up calls on off weeks of appt, follow-up in medical apps and as needed • Discuss change in treatment, expectations of program, etc. • Sign paperwork again if it has been longer than 3 months and treatment plan has changed	Yes
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* UDS results with THC are discussed

Source: Family First Health



Exhibit 8: Schematic of patient/care team flow on direct patient care days



Source: Case Writer



Exhibit 9: Patient retention and engagement data

Patient Retention Rates	
30 Days	15%
60 Days	10%
90 Days	7%
180 Days	3%
360+ Days	15%
Average Number of Days Engagement	246

Source: Family First Health



Exhibit 10: FFH patient transitions in and out of the substance use program.

% of SUS Patients that Started in Primary Care and moved to SUS Program	40%
% of Graduated SUS Patients that were retained as Primary Care Patients	36%

Source: Family First Health