

INTEGRATING MEDICATIONS FOR OPIOID USE DISORDER AT FQHCs

Greater Portland Health: Treating Patients at a Health Care for the Homeless Program in Maine

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Select federally qualified health centers (FQHCs) [receive funding](#) under Section 330(h) of the Public Health Service Act to serve people experiencing homelessness. Under Section 330(h), Health Care for the Homeless (HCH) programs must [provide or arrange for substance use treatment services](#), and they typically offer case management, outreach, and support services more often than other health centers. Across the country, FQHCs with HCH funding provide a disproportionately larger share of medications for opioid use disorder (MOUD) when compared to health centers that do not receive HCH funding. Health centers [that received HCH funding](#) treat three percent of all health center patients, but they staff 36 percent of buprenorphine providers and serve 43 percent of patients receiving medications for addiction treatment (MAT).

This case study explores implementation of MOUD through an FQHC serving as an HCH program in Portland, Maine. The Center for Health Care Strategies developed the case study drawing from a series of interviews with FQHC staff.

Background

Portland Community Health Center, referred to as [Greater Portland Health](#), is an FQHC founded in 2009 to increase access to primary care services and reduce unnecessary utilization of the city's emergency departments. Since then, it has grown to serve over 12,600 people at 16 locations throughout the Greater Portland area, including in Portland, South Portland, and Westbrook. Across multiple sites, the FQHC provides comprehensive, team-based care to children and adults including medical, behavioral health, dental, substance use treatment, chronic and infectious disease management, and psychiatric services. Greater Portland Health is a certified level three [Patient-Centered Medical Home](#), reflecting its commitment to

Integrating Medications for Opioid Use Disorder at FQHCs

This case study is part of a series, developed by the Center for Health Care Strategies with funding from The Pew Charitable Trusts and support from Bloomberg Philanthropies, to help federally qualified health centers integrate medications for opioid use disorder treatment into clinical practice. See also a [companion report](#) that outlines opportunities at the community health center, state, and federal levels to support the adoption of these medications.

continuous quality improvement and a patient-centered approach to care. The health center is also a [Medicaid Opioid Health Home \(OHH\)](#), which enables it to provide medical and behavioral health care as well as peer support to uninsured patients. The OHH covers the full cost of MOUD for uninsured patients. In partnership with their community, Greater Portland Health operates seven school-based health centers in three school districts and three public housing sites in collaboration with [Portland Housing Authority](#), enabling residents to receive primary care services and MOUD in their housing sites.

In 2014, Greater Portland Health received an HCH grant to support additional services and better coordinated care for the increasing number of patients experiencing homelessness. The HCH grant enables Greater Portland Health's Bayside clinic to operate as a stand-alone HCH program, since approximately 40 percent of the center's total patient population experiences homelessness at any one time. The Bayside Clinic partners with [Preble Street](#), a homeless services organization, to help with housing and case management for those with substance use disorder (SUD). As part of this partnership, the Bayside Clinic offers primary care and MOUD at Preble Street's [Housing First](#) sites. The health center added two additional locations to support its homeless community members in 2023. It is now located in the City of Portland's Homeless Service Center and at 934 Congress Street, a site that also offers recuperative care services along with medical, substance use, mental health, and case management services.

The comprehensive MOUD program at Greater Portland Health includes Greater Pathways and the Medication Assisted Recovery Program (MARP), which are both integrated into primary care alongside other behavioral health services and wrap-around supports.

Greater Pathways started in response to the opioid crisis. Patients with opioid use disorder (OUD) are referred through primary care or the center's substance use program manager to meet with a licensed clinician (LCSW, LCPC) to devise a treatment plan. MOUD and recovery support is provided through the Greater Pathways program at three sites and was made possible by an [Access Increases in Mental Health and Substance Abuse Services grant](#) through the Health Resources & Services Administration (HRSA) in 2017.

Greater Pathways staff recognized that many patients with SUD would benefit from more intensive services to enable successful treatment engagement and prevent overdose. Concerns were raised around safe medication storage as unhoused patients were worried about their medications getting stolen. This led to the creation of MARP, a daily dosing program housed at the Bayside Clinic that offers intensive outpatient treatment including MOUD, behavioral health support, peer support, and intensive case management to people who are unhoused and not able to access residential treatment. MARP services are not financially sustainable based on program revenue alone due to the intensity of services, requiring multiple staff to support patients. This program was initially supported by a state grant. When the grant ended, a Homeless Opioid User Service Engagement grant through the state-supported MARP supported the program until June 2023. Since then, Greater Portland Health applied for Substance Abuse and Mental Health Services Administration (SAMHSA)

grants in hopes of filling the gap in funding. In the meantime, MARP is being supported through the health center's 330 grant, its OHH funding, SAMHSA grant, and program revenue.

Greater Portland Health triages and assigns new patients with OUD to the BrickHill Clinic, the Park Clinic, and the Bayside Clinic (the HCH program), based on their acuity level. The BrickHill Clinic is for patients who are on MOUD maintenance and are seen every four to six weeks and the Park Clinic is for patients who are seen every one to four weeks. Patients at these two clinics are enrolled in Greater Pathways. The Bayside Clinic is for patients who need the most support in their MOUD treatment, where they may be enrolled in Greater Pathways or MARP depending on their needs. Patients can easily move between locations as their needs change throughout treatment since the clinics are geographically close to each other.

How We Built This

Infrastructure

The Bayside location was originally selected to be the HCH program due to its proximity to the affected patient population — the city's adult shelter and the local day center. This allowed staff from the clinic to walk to these neighboring facilities if they needed to get in contact with a patient. Today, people experiencing homelessness are more dispersed throughout the city, possibly because the day center closed during the COVID-19 pandemic and the shelter moved to a new location. As a result of this evolving landscape, Greater Portland continues to refine its outreach model to meet the needs of the people it serves. Health center staff keep a release of information on hand, which allows them to make referrals and find resources for patients while they are at the center. Staff must act quickly, as it can be challenging to find patients with the population being so dispersed.

All Greater Portland staff use [NextGen Healthcare](#) for their electronic health record, so regardless of which clinic a patient receives care, the care team can access their records. In addition, when a patient transitions from receiving care at one clinic to another, the care team will leave a message for the receiving care team, so they are apprised of the patient's background and trajectory. Patients can also access their health records via the patient portal. Greater Portland has patients sign a release of information that covers all organizations that they collaborate with (e.g., local Opioid Treatment Programs, community-based organizations that provide case management), so that patient information can be exchanged with these partners while following federal privacy rules (42 CFR part 2). The health center's case managers, program director, and community health workers (CHWs) discuss cases at least once a week and the case managers communicate with the medical team regularly for care coordination purposes.

Patients who are part of Greater Pathways pick up their medications at the pharmacy of their choice. Patients engaged in the daily dosing program and who need assistance with medication storage receive their MOUD (typically buprenorphine) at the Bayside Clinic, alongside any other medications they are taking. These medications are stored onsite, and the clinic also has a close working relationship with a pharmacy located in its building. This arrangement is particularly helpful since many Bayside Clinic patients are unhoused and do not have a safe place to store their medications. All three clinics have [extended-release injectable buprenorphine](#) onsite to use when indicated.

Training and Capacity Building

Greater Portland Health looked to other organizations for support and shared learning when building their MOUD program. In the early stages, the center received support from the [Maine Primary Care Association](#), which established an opioid workforce taskforce to assist its health centers in identifying funding streams for development of their MOUD programs. The HCH program participates in a learning collaborative run by [MaineHealth](#), the local hospital system, which focuses on treating patients with SUD, including OUD.

Staff at each clinic offering MOUD, including the HCH program, complete a new hire orientation that focuses on harm reduction, which includes training on naloxone administration and how to respond to an overdose. Staff also receive training on SUD more generally, including information on trends related to the drug supply in the area. Within the HCH program, trainings are conducted during monthly team meetings that dive deeper into additional harm reduction topics. Ad hoc trainings on priority issues are also held with staff as the program embraces a “learn as you work” mentality. Many HCH staff have also completed valuable trainings on office-based addiction treatment through [Boston Medical Center’s Grayken Center for Addiction](#). Interviewees noted that providers in the HCH program seek to expose new team members to the array of services the health center offers so they know how best to support patients.

Both formal and informal case conferencing occurs regularly among HCH staff. Formal case conferencing is held for patients covered by grants that include support for case management services. There are also two meetings per month where the care team discusses patients with SUD. The first is organization-wide and focuses on patients receiving MOUD across different Greater Portland Health sites. The second is specific to the HCH program and often focuses on patients who use multiple substances given the complex needs of such patients. The MARP and Homeless Outreach and Mobile Engagement teams discuss patients through a collaborative team that includes the primary care provider (PCP), social worker, nurse, Preble Street case manager, and the program director. During these case conferences, the care team addresses problems and ensures they are supporting the patient in working toward their long-term goals. Although these inter-agency conferences occur infrequently, they are essential in facilitating a positive trajectory for patients.

Staffing and Services

At the HCH program, a robust team supports MOUD patients given the complexity of their medical and social needs. These team members support patients in both Greater Pathways and the MARP program. This care team includes:

- **Six MOUD prescribers**, including the medical director, a physician, and three primary care nurse practitioners and one psychiatric nurse practitioner. Prescribers are responsible for completing intake assessments with patients, reviewing medical histories, and identifying an appropriate dosage of methadone. These providers may also make referrals to the FQHC for a same-day appointment, as needed.
- **MAT nurse**, who sees MAT patients at the Bayside Clinic as well as at another Greater Portland clinic and a local shelter. The nurse checks in with patients, sends appointment reminders, administers MOUD injections, manages prior authorizations, administers urine drug screens, and offers harm reduction consultations. More broadly, the nurse plays an important role in continuity of care for patients, which becomes especially important for those who see different providers across visits.
- **Primary care nurse**, who sees patients during primary care appointments.
- **MOUD program supervisor**, who manages administrative aspects of the program including grants and contract reporting requirements as well as patient-focused workflows, practice management systems, and procedures and protocols. The program supervisor also completes intake and assessments for new patients, supports discharge planning and documentation, supervises the SUD CHW, conducts overdose response training, distributes naloxone, and collaborates with community organizations.
- **Licensed clinicians including LCSWs and LCPCs (1.5 FTE)**, who help patients develop healthy coping skills to better manage life stressors and disruptive emotions. This is integral to patients' self-defined path of recovery. The HCH program is currently seeking to add more clinicians to the team.
- **Case managers**, some of whom are employed by Greater Portland Health directly while the remaining are employed by local partnering organizations.
- **CHW**, who helps people engage in the MOUD programming and conducts outreach in the community.
- **Medical assistants**, who package and dispense medications, submit prior authorizations, and observe dosing of medications.
- **Peer support coordinator**, who has lived experience related to SUD and acts as a liaison between the patient and the medical team. Staff in this role complete a [state-based certification program](#).

Greater Portland Health uses a team-based approach to care. Behavioral health services are also integrated, with social workers and psychiatric nurse practitioners co-located at each clinic. Patients have the option of accessing these services, but additional behavioral health services are not required for participation in MOUD programming.

Extending Care into the Community through Street Outreach

Greater Portland Health has a partnership with [Milestone Recovery](#), a community-based organization that offers SUD treatment, transitional housing, street outreach, detoxification programs, and other services to people experiencing homelessness and who have SUD in the Portland area. Greater Portland Health embeds staff in Milestone's Homeless Outreach and Mobile Engagement Team, which provides street outreach services to engage people experiencing homelessness in medical and behavioral health care. Greater Portland Health primary care providers spend one day per week as part of the street outreach care team, providing low-threshold buprenorphine to encourage engagement in ongoing treatment.

Milestone originally paid Greater Portland for provider street outreach with block grant funding from the City of Portland. That funding recently ended. However, the team still spends one afternoon a week on the Milestone mobile van and two mornings each week providing care in the local encampment. Greater Portland is currently having a mobile van built to support more mobile outreach next year.

Financing

MOUD at Greater Portland Health is financed through a combination of insurance reimbursement, state/federal grant funding, and private grants. The payer mix at Greater Portland Health consists of 41 percent [MaineCare](#) (Medicaid), 14 percent private insurance, eight percent Medicare, and 37 percent uninsured.

In addition to Greater Portland Health's [330E HRSA funding](#) that all FQHCs receive, the HCH program at Bayside Clinic also receives [330H HRSA funding](#). 330E and 330H funding fall under one grant and do not impact each other. When Greater Portland receives their notice of award from the federal government, it breaks down how much is health center funding and how much is HCH funding. The 330 grants represent a small portion of Greater Portland Health's overall funding. Remaining expenses are covered by maximizing revenue from insurance reimbursement and securing additional federal, state, and private grants.

Funding the Greater Pathways Program

Greater Pathways is currently financed primarily through billable visits (medical, behavioral health, and dental) and 330 funding. A [Medication-Assisted Treatment – Prescription Drug and Opioid Addiction \(MAT-PDOA\)](#) program grant through SAMHSA also helps to support Greater Pathways. This federal funding supports patients who graduated from the HCH daily dosing program but are not yet at a very stable place in their recovery where they can spread out their visits to once a month or every few weeks. The MAT-PDOA grant enables these patients to receive case management services at the three locations providing MOUD, including the HCH program. In addition to case management, the MAT-PDOA grant provides for additional nurse time and peer supports.

Funding the Daily Dosing Program

MARP, the daily dosing program within the center's HCH program, was initially funded through Maine's Department of Health and Human Services' Office of Behavioral Health. Due to the intensive nature of daily dosing, Greater Portland worked with the Office of Behavioral Health to create a grant to cover non-billable services, such as peer supports. When that initial grant ended, Greater Portland secured a Homeless Opioid User Service Engagement grant through [MaineHousing](#) and the state's [Office of Behavioral Health \(OBH\)](#). The MaineHousing component of the grant enabled HCH staff to help patients find housing and the OBH component covered case managers and other staff who provide non-billable services. This funding ended in June 2023. Greater Portland has applied for additional SAMHSA grants and continues to look for grants to fill the gap.

Spotlight on the Prospective Payment System

The Prospective Payment System (PPS) covers billable visits, which includes medical and behavioral services provided by medical providers, psychiatric nurse practitioners, and social workers.

The Maine Primary Care Association recently advocated for the PPS rate to be reassessed and updated. Interviewees noted that the increased PPS rate has been particularly helpful for Greater Portland Health post-pandemic. The center lost many visits and patients during the pandemic and then saw a great increase in patient visits post-pandemic. Interviewees noted that the acuity level of post-pandemic visits has been higher since many patients were not attending to their medical needs during the public health emergency. In addition, many staff resigned during the pandemic. Greater Portland Health lost a lot of their historical knowledge as a result and while hiring to replace team members, the organization has also hired 70 additional team members during the pandemic to meet the increased needs of community members.

Triage: How Patients Enter the Program

At Greater Portland Health, a CHW, case manager, or program manager assesses patients for SUD at all locations as part of the intake process using the [CAGE-AID Substance Abuse Screening Tool](#). Patients often present asking for treatment, and Greater Portland Health receives referrals from the local correctional facility, Cumberland County Jail, for SUD treatment. As many as 90 percent of people in the jail are on buprenorphine.

Upon intake, the provider conducts a [level of care assessment](#). The tool determines what health center a patient will receive care at based on their level of acuity, as well as their risk for overdose. Greater Portland Health provides care to unhoused patients at all their locations, but Bayside Clinic is committed to caring for this population specifically through its HCH program.

Receiving MOUD at Greater Portland Health

The Greater Pathways program primarily offers buprenorphine to its patients including all forms of administration. Naltrexone is also available but is rarely used. Staff encourage patients to use injectable buprenorphine, due to challenges with compliance. It is easier to comply with monthly injections than daily pills. Injectable buprenorphine is also commonly used for patients who are very stable in their recovery and do not want to take medication every day or who may be averse to the taste of oral buprenorphine products. For patients who ask specifically for methadone, Greater Pathways has a referral relationship with a local Opioid Treatment Program (OTP). The Portland community has local programming that can help facilitate access to the OTP via transportation support and community liaisons that accompany patients to appointments. This is particularly useful for people who are unhoused and in need of extra support.

When a patient arrives for their first appointment, they meet with the MOUD Supervisor to complete intake assessments (e.g., level of care and forms required by grants, such as the Government Performance and Results Act). Then they meet with the PCP, who determines their medication dosage and frequency.

Induction: Every induction is different depending on the quantity and type of use and where the patient resides (e.g., in a shelter, on the streets). Most providers give patients the medications and allow them to self-manage their induction, including prescribing “comfort medications” to manage symptoms during withdrawal. Providers often use Boston Medical Center’s [Grayken Center for Addiction Bup Initiative Mobile App](#) as a tool for navigating inductions. For select patients, providers will micro-dose or macro-dose buprenorphine to initiate them on the medication or support them through medically tailored detox.

Maintenance: When patients arrive to the clinic, they take a urine drug screen. The PCP will follow up with the patient if there are any unexpected test results. The medical assistant then dispenses buprenorphine and observes the patient as they take the medication. If a patient is receiving an injection, it is administered by a nurse. Appointment frequency depends on where the patient is in their recovery, as well as their life circumstances.

Successes and Challenges

Successes

Staff interviewed agreed that Greater Portland Health's team-based approach is a major contributor to the programs' success. Providers, licensed clinicians, CHWs, case managers, and peer support specialists all work together to meet patient needs. This is especially important given the complex needs of patients receiving MOUD and experiencing homelessness. Providing primary care affords staff the opportunity to establish therapeutic relationships with patients, who may then feel more comfortable to begin MOUD or treatment of other conditions. For example, integration enabled one Greater Portland provider to successfully treat chronic Hepatitis C in five of her patients receiving MOUD. Staff have also built strong relationships with community partners such as Preble Street, who provide services to people experiencing homelessness. This enables Greater Portland's patients to receive a wider range of services than the health center can provide directly.

Staff support patients through all phases of treatment, including identifying non-medical contributing factors to drug use and solving problems together, which increases treatment success. For example, Greater Portland staff learned that one patient who has a history of trauma was having a difficult time maintaining her sobriety during the weekend when she was feeling bored. Staff encouraged her interest in art, and they also connected her with a trauma support group. The patient spent her weekends creating a painted rock garden, engaged in treatment, and is in the process of moving from a group home to her own apartment.

Challenges

Greater Portland Health staff identified several challenges that arise in their HCH program, including prior authorization for select medications and dosages. Prior authorization poses an administrative burden for staff and can also create delays in treatment for patients seeking care. For example, staff acknowledged that sometimes prior authorization requests are denied for patients seeking to start injectable buprenorphine if they are doing well on oral buprenorphine. [Prior authorization](#) is also required by MaineCare (Medicaid) for doses of buprenorphine that exceed 16 mg for more than 30 days.

Another challenge reported by staff is effectively meeting the complex health and social needs of people experiencing homelessness and who may have disengaged from health care for an extended time. This can make providing care more complicated for the HCH team and can impact a patient's ability to engage in care. For example, staff noted that there are often many last-minute walk-in appointments. This is compounded by workforce shortages and difficulty hiring, which are widespread throughout the health care system. Staff also noted the challenges related to stigma about MOUD and SUD including shame from patients and perceived stigma from the community and from staff. To help reduce stigma, Greater Portland Health trains staff on the importance of person-centered language across the prevention,

treatment, and recovery continuum. For example, it is important to say, “person with a substance use disorder” rather than “drug user.”

Connecting people to stable housing is also a challenge. Staff shared that not only is there a shortage of affordable housing in the Portland area, but many people they work with have a history of eviction or failed housing. This may lead clinic staff and case managers to look for housing outside of the Portland area, creating a long commute to the health center for patients. The care team relies on case management from their partner organization, Preble Street, to support patients in accessing housing, and they also leverage case conferencing to work with case managers to identify the type of housing that may be the best fit for a patient.

Patient Story: Illustrating the Value of MOUD

A provider shared a 62-year-old patient’s journey receiving MOUD and other services at Greater Portland Health. When he first came to Greater Portland, he was living in an emergency hotel as there was no space in the city shelter. He was on his own, with no family and friends in the area after moving to Maine, because it was his wife’s dream to retire in the state, and they were not able to do that before she passed away. Staff initially engaged with the patient to address his various primary care needs including type 2 diabetes, high blood pressure, and osteoarthritis. A few months later, he shared that he had relapsed on opioids. While he didn’t engage in MOUD treatment right away, he re-engaged in services at Greater Portland Health’s HCH program once he returned to Maine. The patient learned that he had contracted Hepatitis C when he relapsed, for which he received treatment. After that, he became motivated to start MOUD, and his induction went smoothly. Staff initially started him on oral buprenorphine with daily clinic visits, and he eventually switched over to injectable buprenorphine, with clinic visits every week to two weeks. He is now stable on MOUD. The patient also moved from a tent into senior housing, with support from a grant program through Greater Portland Health. In addition to MOUD and primary care, the patient receives psychiatric care at Greater Portland Health and plans to start counseling soon to process his post-traumatic stress disorder. The provider reflected on the strong relationships created between staff and patients, stating “we’re family.”

Recommendations

Staff at Greater Portland Health shared the following recommendations for similar programs seeking to start offering MOUD for people experiencing homelessness:

- **Take an interdisciplinary, team-based**

approach to care. It is helpful to have a care team with an array of perspectives, experiences, and expertise to support patients and contribute to their care. Every staff member contributes to the care of patients, and everyone from the front desk staff to the primary care provider are focused on building a relationship with patients. Adopting a team-based approach also enables staff to support one another, which is important because the work is difficult but gratifying.

- **Be flexible and creative when providing MOUD to people experiencing homelessness.**

Meeting patients where they are is especially important for unhoused patients. Embracing a low-barrier, nonjudgmental approach helps to engage people in treatment, provides some stability to better navigate other aspects of their lives, and lifts the shame that people often feel related to their substance use. This may look like having walk-in availability and understanding that it can be difficult for patients to arrive at a scheduled appointment time. Helping with early medication refills may also be needed. Expect that the day often will not go as planned and recognize that patients are doing the best they can, given their circumstances.

- **Leverage different funding streams to support whole-person health.**

Health centers need to leverage grant opportunities to be able to provide the wrap-around supports that are inherent to providing whole-person care. At Greater Portland Health, HRSA funding is just a portion of their total budget. Other revenue streams, including grant funding, are critical to providing HCH patients with the care they need. The center has an entire team dedicated to seeking private, state, and federal grant opportunities to ensure their financial sustainability.

- **Hire staff who understand the needs of patients and support staff through training and education.**

Greater Portland Health wants to hire people who understand the complex needs of people experiencing homelessness. Working with this population is not for all providers, and that is okay. It is important to provide training and support to set staff up for success.



If someone comes in and has opioid use disorder, and there is any sort of capacity and they are expressing interest in buprenorphine, we start it. And we will do that even before the official Level of Care [assessment]... As we are looking at the urine toxes, we talk about what else is in the urine, but we do not hold being on buprenorphine that you can't be on anything else.

– Kevin Sullivan, MD, Medical Director, Healthcare for the Homeless, on low-barrier programs.

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