

INTEGRATING MEDICATIONS FOR OPIOID USE DISORDER AT FQHCs

VIP Community Services: An Opioid Treatment Program in the Bronx, New York

By Meryl Schulman and Ashley Jasko, Center for Health Care Strategies

Opioid treatment programs (OTPs) administer and dispense U.S. Food and Drug Administration (FDA)-approved medications for opioid use disorder (MOUD), including methadone, buprenorphine, and naltrexone. [To provide services for opioid use disorder](#) (OUD) patients, OTPs must successfully complete a certification and accreditation process, be licensed by the state(s) in which they operate, and register with the Drug Enforcement Administration (DEA). OTPs are [the only entities](#) that can dispense methadone, a full opioid agonist, for the purposes of treating someone with OUD. As some patients prefer and/or respond better to methadone than to other forms of MOUD, OTPs are a critical partner to federally qualified health centers (FQHCs) looking to expand access to this effective form of MOUD.

This case study explores implementation of an MOUD program at an organization in the Bronx, New York with a long history as an OTP that also operates an FQHC and a certified community behavioral health clinic (CCBHC). The Center for Health Care Strategies developed the case study drawing from a series of interviews with OTP and FQHC staff.

Background

VIP Community Services (VIP) was founded in 1974 by community members and Father Robert Banome in the Bronx, New York. Together, they sought to address the neighborhood's most pressing problems, including poverty, unemployment, and drug use, through job training and placement. Initially it served as a vocational program intended to address the Bronx's social problems. As drug use in the Bronx became more problematic, they responded by establishing an innovative outpatient drug treatment program that offers support, mutual respect and treatment for substance use disorder (SUD).

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.

Since then, VIP has grown to serve approximately 10,000 children and adults annually through an array of integrated health and social programs, including residential care, outpatient counseling, shelter care, medical services, supportive and affordable housing, and employment services. The program provides residential programs throughout New York City, encompassing more than 260 units of supportive housing, eight buildings with affordable housing, shelter programs, and sanctuary hotels, and two residential SUD programs including an 80-bed co-ed residential program.

To deliver non-residential services, VIP operates a robust OTP to offer methadone to patients with OUD; provides medical and behavioral health services through its FQHC, which offers buprenorphine for OUD; and provides intensive behavioral health services [through a CCBHC](#). The road to building these entities was incremental.

Many of the people who receive care and services from VIP have low incomes, identify as Black and/or Hispanic, and speak Spanish as their primary language. They live in the Bronx and surrounding communities; some reside in public housing, and many are unstably housed or are experiencing homelessness. Most people served by VIP live in New York City's under-resourced communities.

The OTP first opened in 1982, offering methadone treatment to community members with OUD. The drug use epidemic of the 1980s led VIP leadership to open an outpatient treatment center, leading to the discovery that many patients were also using heroin. VIP followed the advice of state officials and launched an OTP. Decades later, when the FDA approved buprenorphine for treatment of OUD, the program expanded to offer it.

In 2015, VIP added an FQHC to better meet the primary care needs of its patients. In 2019, co-located primary care providers at VIP's FQHC began offering patients buprenorphine and extended-release injectable naltrexone to better treat people who were not already enrolled in the OTP. Some of these patients seek MOUD from their primary care provider to circumvent the stigma associated with SUD in general, and with seeking care in an OTP. Consistent with providing comprehensive care in FQHCs, new and established VIP patients are screened for SUD including alcohol use and dependency using standardized tools including [SBIRT](#) (Screening, Brief Intervention and Referral to Treatment) and the [AUDIT C](#) (Alcohol Use Disorders Identification Test). Patients are treated based on their preference including any of the MOUD options offered by VIP. Patients who are not successful with a particular treatment (for example, buprenorphine for OUD) can remain at VIP and try other options, such as methadone.

In 2017, responding to the intense case management and behavioral health services that many of their OUD patients needed, VIP grew its mental health and addiction treatment programming by becoming a CCBHC. [New York State was part of the original CCBHC demonstration](#) awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare & Medicaid Services. This allowed the organization to better support patients with behavioral health conditions beyond what an FQHC can provide. They were able to hire and receive reimbursement for services provided by peers and offer crisis care and high-touch case management services to ensure that patients are following treatment regimens and connecting with other needed social service providers.

While VIP offers all forms of MOUD, most patients with OUD receive methadone. Staff estimate that approximately 75-80 percent of patients on MOUD receive methadone at the OTP. The OTP also remains the main point of entry for MOUD patients into VIP's other programming, such as the FQHC for primary care or the CCBHC for behavioral health, among others. Approximately 78 percent of patients receive care across the OTP, FQHC, and CCBHC.

How We Built This

Infrastructure

VIP offers all forms of MOUD, specifically methadone, buprenorphine, and extended-release injectable naltrexone. Methadone is solely dispensed at the OTP. Naltrexone is offered at the FQHC and CCBHC. Buprenorphine products are offered at the FQHC, OTP, and CCBHC.

Most of VIP's care is provided in their main, six-story building. The first floor is where the OTP stores and dispenses medications. The OTP has nine windows to dispense patients' medications. On any given day, five to nine windows are open for use. The second floor houses the FQHC and the fourth floor houses the CCBHC. The remaining floors are where OTP and outpatient clinical staff work with patients, and also house the vocational program and the Access Center, a 24/7 drop-in center for people seeking SUD services.

New patients entering through the Access Center sign a consent form during the intake process specifying shared access to patient information. Patients also sign a similar consent if they enter through the FQHC. VIP uses eClinicalWorks as its electronic health record (EHR), and patient medical records are accessible to staff across the organization. The medical director for the OTP noted that the shared EHR provides information about care a patient is receiving at the FQHC and other programs. Integrating information in this way facilitates streamlined care coordination and reduces burdensome paperwork to share information. Furthermore, the shared health record tracks whether a patient has followed through with a referral. Staff at the OTP noted that if a patient misses an appointment at the FQHC, they can address contributing factors and get them connected to care.

Training and Capacity Building

VIP ensures its staff have the knowledge and understanding of how best to work with people with OUD and alcohol use disorder. VIP trains every staff member in overdose prevention with ongoing required follow-up training every two years as a condition for employment. There are Approved Opioid Trainers who ensure that all staff in their departments are trained upon hire and then every two years. Each department has naloxone kits located throughout all the facilities. At the OTP, staff also receive training on person-centered care, how to improve client engagement, effective individual and group counseling, crisis prevention and de-escalation, how to work with people with alcohol or substance use who are unable to sustain abstinence, withdrawal management, and relapse prevention. The FQHC offers ongoing support for its providers who prescribe MOUD, including informal peer-to-peer conversations, mentorship, and supervised patient visits with experienced prescribers for providers who are new to MOUD. In addition, when the FQHC first started offering MOUD, VIP paid for and supported staff in receiving their federal [X-waiver](#) to prescribe buprenorphine. Overall, staff in the OTP, CCBHC, and FQHC note that open lines of communication between staff members help facilitate learning and problem solving across the three programs. In addition, all staff, including front desk staff, receive education and training on MOUD — including the impact it can have on patients — and trauma-informed care. This allows staff to communicate in a more informed way about the value of MOUD for their patients and deliver services that are trauma informed.

Staffing and Services

For patients receiving MOUD at the OTP and the CCBHC, the care team includes:

- **Eight MOUD prescribers**, including a medical director for the OTP (VIP's chief medical officer), one medical director for the CCBHC, two psychiatric nurse practitioners, a physician, and two physician assistants. 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.
- **Twenty nursing staff** (totaling approximately 10 FTEs), including the director of nursing, the assistant nurse manager, registered nurses (RNs), and licensed practical nurses (LPNs). The director of nursing oversees RNs and LPNs, and RNs and LPNs are responsible for executing medication orders and dispensing methadone to patients.
- **Twenty-six counselors**, including [credentialed alcoholism and substance abuse counselors](#) (CASAC) and trainees. Counselors focus on supporting both the physical and social aspects of OUD with OTP patients through clinical care and SUD counseling. As ordered by providers, they conduct diagnostic assessments, evaluations, interventions and referrals, and lead individual and group counseling. OTPs are required to offer counseling services as part of their licensure.

- **Eight peer navigators**, who have lived experience of SUD and work directly with a subset of patients to address their social needs and support them in general in their recovery. More specifically, the peer navigators may help patients access housing, navigate Supplemental Security Income, and engage in conversations with their counselor. They may also act as a liaison between medical providers and patients, support them in advocating for themselves, and demonstrate leadership and conflict resolution skills. Not all patients at the OTP work with a peer navigator, but the OTP is looking to grow this aspect of its program.
- **Three medical secretaries**, who are responsible for enrolling people in the OTP program, scheduling intake appointments, and handling admissions.
- **Ten licensed clinicians**, who are licensed mental health clinicians and licensed social workers, responsible for mental health screenings, crisis interventions, counseling services, and referrals.
- **Two case managers**, who are responsible for addressing patients' social needs and assisting with referral management.

For patients receiving MOUD at the FQHC, the care team includes:

- **Four MOUD prescribers**, including a physician, three nurse practitioners (NPs), and a physician assistant. Similar to the MOUD prescribers at the OTP, these providers are responsible for completing intake assessments with patients, reviewing medical histories, and working with the patient to identify an appropriate medication and dosage, which is monitored over time. Psychiatric NPs staffed at the CCBHC act as back-up prescribers to FQHC MOUD prescribers.
- **One certified SUD counselor**, who provides mental health counseling services to patients on buprenorphine who do not have intensive behavioral health needs. According to VIP, more than half of patients on buprenorphine receive counseling. Those with co-occurring mental illness and polysubstance use are referred to the CCBHC for mental health services.
- **One mental health clinician**, who is responsible for mental health screenings, crisis interventions, counseling services, and referrals.
- **Four outreach workers**, who are responsible for in-reach and outreach activities to ensure patients follow up for appointments, both at VIP and external referrals. They also provide education to patients in the community to ensure they are aware of available resources and how to use them as needed.

The FQHC also employs three psychiatric NPs who provide behavioral health care to patients.

Triage: How Patients Enter the Program

Receiving Methadone at the OTP

Patients receiving methadone maintenance do so at the OTP. When a patient first enters the program, they move through an intake process conducted by a physician and a physician's assistant. Staff create a treatment plan for the patient and orders are placed to start methadone. Various labs are conducted, and referrals are made to the FQHC for primary care when there is an identified medical need (e.g., patient tests positive for HIV or HCV, does not have a PCP). Patients are offered a core set of CCBHC services for behavioral health care (e.g., outpatient mental health groups and individual counseling, peer services, crisis services, psychiatric rehabilitation), as needed. The FQHC has same-day appointments available, so a counselor can easily conduct a warm handoff to the primary care team.

When a patient arrives at the OTP for methadone dispensing, they line up inside the clinic. The patient then goes to a medication window where they are observed by a nurse as they take their methadone. After receiving their methadone, patients can move through the building to access other services. Patients who meet criteria (negative urine drug screens, regular attendance, absence of behavior problems at the clinic) are provided multiple doses of methadone for take-home administration. In some cases, patients receive up to a two-week supply, while a few patients receive a four-week supply [per federal regulations](#). There is a reinstatement process in place for patients who miss methadone doses where the patient comes into clinic and sees the provider to get a dosage based on the number of doses they missed.

Patients receiving methadone maintenance at the OTP who want to switch to buprenorphine can receive it at the CCBHC or the FQHC. These patients can also be referred to a credentialed alcoholism and substance abuse counselor to receive buprenorphine counseling. If an OTP patient wants to switch to buprenorphine, the medical director will ensure that the patient is ready (must have gone 48 hours without methadone or an illicit substance). The patient can then begin a starter dose of buprenorphine. Once the initial dosage is determined, the OTP conducts a warm handoff to the FQHC or CCBHC where the patient is provided the medication, and the patient is released from the OTP's care. These patients do not follow the assessment process for new patients that seek MOUD in the FQHC (see below).

Receiving Buprenorphine at the FQHC

Most MOUD patients at the FQHC come via the OTP. Patients receiving primary care services in the FQHC choose to have all their health care services coordinated by VIP to promote continuity of care. Interviewees noted that it also reduces stigma, decreases barriers, and promotes access.

When a patient looking to get started on MOUD arrives for their first appointment, an in-depth assessment is conducted, which includes a patient history, family information, psychosocial assessment, [Patient Health Questionnaire \(PHQ\)-9](#), SUD screening using SBIRT and AUDIT C for alcohol, physical exam, and lab work. Patients also complete the [Protocol for Responding to and Assessing Patients' Assets, Risks, and Experience](#) (PRAPARE) tool, which assesses a variety of health-related social needs. The intake assessment helps the care team determine the level of care needed, and providers (physician, PA, or NP) speak with patients about next steps, which might include a warm handoff to a CCBHC clinician, Pre-Exposure Prophylaxis specialist if needed for HIV prevention, or the OTP if methadone is the preferred form of MOUD. Case management is provided by staff at the FQHC.

If the patient and provider identify buprenorphine as the best MOUD option, they receive that through the FQHC. Prescribers follow evidence-based guidelines for buprenorphine induction. Providers use the [Clinical Opiate Withdrawal Scale](#) to assess a patient's signs and symptoms of withdrawal. Most patients receive home inductions for buprenorphine. Maintenance is individualized and based on where a patient is in their recovery. Some patients come in monthly for maintenance appointments, while others are scheduled at two-to-three-month intervals. If an FQHC patient receiving buprenorphine wants to switch to methadone, the FQHC refers the patient to the OTP. The FQHC works with the medical secretaries who handle OTP admissions, schedules an intake appointment, and enrolls the patient into the OTP program. On average, patients are seen for intake within 1-3 days and start medications within 2-5 days.

Financing

Methadone dispensing is financed through [Ambulatory Patient Groups](#) (APG) and bundled rate billing via revenue billed to Medicaid and private insurance. Historically, billing occurred for every dose with a reduced amount billed for each additional visit through the week. The bundled rate supports comprehensive services and covers the evaluation for and dispensing of methadone, nursing, and support staff, and MOUD counseling.

Counseling that is not directly related to MOUD (e.g., for issues such as tobacco and alcohol use, hepatitis and sexually transmitted infections, and overall mental health) occurs through the CCBHC and is billed at the CCBHC Prospective Payment System (PPS) rate. In general, all services directly related to methadone dispensing (e.g., medication management, SUD risk reduction counseling, methadone education, overdose prevention training and education) are carved out of the CCBHC and billed using either the bundled or APG rate. The medical director of the OTP serves as the chief medical officer of VIP. His time is allocated to various programs, including an allocation to the CCBHC. In addition to his administrative responsibilities, the medical director provides direct care at the CCBHC. In New York State, OTPs do not receive contract dollars, also known as net deficit funding; all revenue is generated by methadone dispensing and clinical services.

Due to its status as an FQHC, the clinic is paid through a PPS. Buprenorphine visits for all patients are billed as medical encounters. Patients must see a provider to start buprenorphine, which results in a PPS reimbursement for the service. Other related services that occur on the same day as the provider/medical visit are nonbillable. In New York State, FQHCs are only allowed one billable encounter per patient per day for a medical visit. Case management, SUD counseling, or peer visits are not billable services for the FQHC. The cost to provide these services are calculated in VIP's PPS rate, however, staff noted that the PPS rate does not cover the total cost of care provided.

Successes

VIP staff noted several successes to their program model, including co-location of the OTP, FQHC, and CCBHC. The structure is advantageous as patients can receive an array of services in one place, often on the same day. They also shared that co-location creates an environment where FQHC patients know they can ask about SUD treatment, particularly methadone given that patients “see” how the OTP functions. This can also lead to greater conversation about the various treatment options available to patients with OUD. Staff also described how co-location can help with internalized stigma since the presence of the OTP signals to patients that they can ask for treatment. The stability of patients in MOUD care is high with 44 percent of OTP patients in care for more than five years. Of these, 22 percent have been in care 5-10 years, more than 11 percent in care 10-20 years, and more than eight percent in care 20-30 years. Since 2019 when the FQHC started treating patients for MOUD with

buprenorphine, over 90 percent of the patients treated with buprenorphine remain on the medication and continue to receive primary care at VIP today.

Challenges

Staff noted an array of challenges inherent to operating their MOUD programs. Sustaining the workforce to care for people with MOUD has been a challenge for VIP. Staff see this challenge in the limited number of providers that are trained and willing to treat people with SUD and with recruitment of counselors and support staff. VIP continues to see a significant amount of stigma — both in staff and the community served — associated with SUD. As such, VIP seeks to reduce stigma by creating a trauma-informed environment for staff and patients. The organization spends a substantial amount of resources on implicit bias and trauma-informed trainings and demystifying myths about SUD. The organization ensures its policies and procedures are trauma-informed, avoid biases, and incorporate feedback from patient experiences. While there are enormous benefits to co-location, staff did mention that select patients, particularly those with children and who are not receiving MOUD, expressed concern about taking their children to the FQHC for care given the SUD services the health center provides.

FQHC staff also talked about challenges related to accessing MOUD. For example, they described challenges related to discrepancies from insurance companies regarding which forms of medications they will cover, and that obtaining prior authorizations for MOUD is sometimes challenging. A significant challenge is full reimbursement for MOUD services. The complexity of the patients served requires multiple care coordination of different disciplines. However, in the FQHC only a single visit is reimbursed. This leaves the health center with unreimbursed costs for that comprehensive visit. Health center staff noted that it takes a considerable amount of outreach to sustain patients in MOUD care. As such, outreach workers, peer navigators, and community health workers are critical to the success of these programs, and health center staff noted that it is important that they receive reimbursement for the services provided by these staff.

Recommendations

Staff at VIP offered several recommendations for other health centers and programs looking to offer MOUD:

- **Identify the right staff candidates to ensure a compassionate workforce.** Hire staff, ideally at all levels, who are empathetic, compassionate, and genuine in wanting to work with patients with OUD. Programs can use the interview process to help identify the right candidates, by making sure that they understand what working with the MOUD patient population entails and assessing their past experiences working with this population. An open conversation with potential hires can help identify candidates who would be a good fit for the program.
- **Support staff in enhancing their understanding of OUD.** Staff noted the importance of training and capacity building to ensure that care team members understand OUD and MOUD, and how best to support people in their recovery. In addition, staff underscored that many people, even those in helping professions, stigmatize people who use drugs. Educating team members on an ongoing basis about the root cause of addiction can help combat stigma.
- **Avoid duplication of services to ensure more coordinated care.** As an organization with multiple programs that serve MOUD patients, it is important to avoid duplication of services (e.g., paperwork, repeat toxicology screens, multiple “annual” physicals). Coordination and communication across programs and care teams helps improve the quality and continuity of care. VIP has a dedicated HER that providers and counselors can access to avoid duplication of services.
- **Acknowledge that having an OTP allows for many opportunities to “reach” patients.** Patients often come in daily for methadone during the first week after induction. This allows frequent opportunities to build trust, relationships, and engage patients in care — whether that be to additional behavioral health supports, primary care, and/or connections to social services.



Your patients are going to see through you and they’re going to see if you really care about them because you’re asking the extra questions. How are you feeling? How are you really doing?

– Anna Otero, Director of Health Services,
VIP Community Services



Being addicted to opioids does not change that you are a human being and a person. You have the right to seek help just like everybody else with any other medical problem.

– Christopher Chambers, CASAC Counselor,
VIP Community Services

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