Collaborative Family Healthcare Association

A CASE STUDY

Building on Integrated Behavioral Health to Deliver Substance Use Disorder Treatment in Primary Care

Access Community Health Centers

Madison, Wisconsin



Access Community Health Centers (Access), a Federally Qualified Health Center based in Madison, Wisconsin, has become a statewide model for integrating substance use disorder treatment, including opioid, alcohol, and stimulant use disorders, within primary care. Founded to expand equitable access to care, Access now operates five clinics serving more than 32,000 patients annually, most of whom live below the federal poverty threshold and face barriers such as transportation, stigma, or being best served in a language other than English. Since 2010, Access has partnered with the University of Wisconsin–Madison Department of Family Medicine and Community Health to embed addiction treatment into its primary care model, transitioning from a co-located specialty service to a fully integrated, team-based approach.

Access Community Health Centers



Founded: 1982
Sites: 5
Patients: 32,000+
Population: 89% Below Poverty

In this model, primary care clinicians, behavioral health consultants, psychiatrists, nurse care managers, and care coordinators collaboratively manage substance use disorder and co-occurring mental health conditions through evidence-based care and expanded access. This philosophy—that primary care is the right setting for treating substance use—has strengthened clinical capacity, improved care quality, and advanced health equity, all of which contributed to Access being awarded a higher reimbursement rate under the Prospective Payment System in the state of Wisconsin.

Background

Access Community Health Centers (Access) was founded in 1982 as a volunteer-run clinic in Madison, Wisconsin, to meet the needs of community members who struggled to access affordable, high-quality care. These community-centered roots and holistic care philosophy positioned Access to become an early innovator in integrated behavioral health and, later, a leader in embedding substance use disorder (SUD) treatment directly within primary care. What started as a small, grassroots effort to serve uninsured and underinsured residents has grown into a regional Federally Qualified Health Center (FQHC) with five sites across Madison, Sun Prairie, and Dodgeville. Access serves a

varied patient population, with two-thirds being People of Color, nearly one-third best served in a language other than English (most commonly Spanish), and one-third under 19 years old. As the majority (89%) of patients live below the poverty threshold, services are provided on a sliding fee scale, with more than $6 million in discounted care delivered annually to ensure that cost is never a barrier to care. Its volunteer-driven origins continue to inform its mission: meeting people where they are and ensuring that all patients, regardless of background or circumstance, have access to equitable, whole-person care. [1]

Impetus

Access's integrated SUD treatment model emerged in response to growing community need and limited local options for accessible behavioral health care. Recognizing that lack of access to comprehensive behavioral health services was a major driver of poor health outcomes, Access began providing in-house integrated behavioral health services in 2006. Initially, the approach was to hire a single behavioral health clinician. Due to patients' positive response to integrated behavioral health services, Access expanded its behavioral health team and began identifying other behavioral health conditions, such as SUD, that could be treated in a primary care setting.

Integrated care combines medical and behavioral health services in a single setting to address the physical, emotional, and social factors that impact overall well-being. As a key element of whole-person care, this model is a leading approach in modern, high-quality health care and a core function of the advanced patient-centered medical home.

"Providers practicing integrated behavioral health care recognize that medical and behavioral health factors are important parts of a person's overall health. Medical and behavioral health clinicians work together as a team to address a patient's concerns. Care is delivered by these integrated teams in primary care unless patients request or require specialty services. The advantage is better coordination and communication, while working toward one set of overall health goals." (Agency for Healthcare Research and Quality)

Building Integrated Substance Use Care

In 2010 Access initiated a partnership with the University of Wisconsin (UW)–Madison Department of Family Medicine and Community Health, embedding an

addiction medicine physician, Dr. Randy Brown, within the Wingra Family Medical Center (WFMC) to build capacity and mentor family medicine residents through what came to be known as the Health Promotions Clinic. This early co-located model enabled providers from all three Access locations to refer patients for evaluation and treatment, serving as both a learning platform and a proof-of-concept. Access providers, including resident physicians who worked alongside Dr. Brown, reported increased competence and confidence in managing SUDs, including prescribing medications for non-opioid use disorders. The collaboration strengthened relationships between academic medicine and community health, laying the groundwork for a more sustainable, primary care-driven approach.

The Health Promotions clinic operated through January 2025 at WFMC, allowing Access to build internal capacity while still referring more complex cases. Dr. Walker Shapiro and the William T. Evjue Clinic are a prime example of how Access built its internal capacity. In 2016, Dr. Walker Shapiro, a resident physician graduating from WFMC was hired to work at the William T. Evjue Clinic. Given his interest and experience with managing SUD, he proposed incorporating his existing buprenorphine patients into his primary care workflow. This decision by Access to integrate SUD care into primary care at multiple sites was monumental in shifting to a primary-care-driven model for addressing SUDs. Over many years, Dr. Shapiro and the larger Access medical care team demonstrated that individuals with SUD could be seamlessly integrated into existing workflows, rather than the embedded-clinic model, in which only patients with SUD were seen. Additionally, Access leveraged the clinic's existing staff and robust integrated behavioral health team. As a result, he worked with Access's Chief Behavioral Health Officer, Elizabeth Zeidler Schreiter, PsyD, to expand this model and help other providers to do the same, including prescribing buprenorphine for opioid use disorder, naltrexone (oral and long-acting injectable) for alcohol use disorder, addressing stimulant use disorder, and individuals using multiple substances. Dr. Shapiro was assigned some protected administrative time as the SUD Provider Champion to initiate workflows, trial new treatments, and educate staff about the assessment and treatment of SUD. The combination of Dr. Shapiro’s education and advocacy, strong organizational commitment to treating the whole person, along with hiring other family medicine residents graduating from WFMC with experience managing SUD, helped to shift the culture at Access to one where providers feel responsible for initially managing SUD in their patients. By integrating these medical providers with its well-established behavioral health program, which includes licensed behavioral health consultants, a consulting psychiatrist, care coordinators, and nurse care managers, Access further strengthened its capacity to care for patients with SUD and co-occurring disorders in-house.

"What we have endeavored to do here is integrate [substance use disorder] right into everything else we do. We take care of diabetes, chronic kidney disease, lung disease, well children, aging, and opioid, alcohol, and cocaine use disorders. Those are all just routine parts of primary care." - Dr. Walker Shapiro

Partnerships beyond the clinic also played a key role in caring for individuals with SUD. Collaborations with Safe Communities, a local 501(c)(3) nonprofit coalition focused on overdose prevention and recovery support, connect patients to community-based peer recovery coaches and harm reduction services. Following the discontinuation of the Health Promotions Clinic at WFMC, Access has continued to utilize its long-standing relationships with UW-Madison's addiction medicine physicians by referring patients that require a higher level of care to the Compass Program.

Access identifies the following key decisions and actions for their impact:

- From the outset, Access adopted the philosophy that SUD, including polysubstance use, is a routine component of primary care and should be an offered service within the medical home. This perspective encouraged clinicians and staff to address these conditions directly rather than refer patients elsewhere.

- Instilling the strategic importance of this philosophy throughout each level of leadership, including the financial department, resulted in an organizational commitment to expanding capacity to address SUD, as seen by:
    - Having a Chief Behavioral Health Officer as part of the Senior Leadership team to help elevate the importance of strategic initiatives to address community needs regarding SUD and barriers to treatment.
    - Appointing Dr. Shapiro as a physician champion for treatment and providing protected administrative time to oversee, educate, and innovate models of care.
    - Recruitment of physicians who want to treat SUD, including polysubstance use disorder, in a primary care setting. Since 2022, nearly all medical providers at Access have been treating SUD.

    - Training and retaining a robust multi-disciplinary behavioral health team.
- Designating time monthly to facilitate collaboration between Dr. Shapiro, behavioral health teams, and nursing leadership to discuss and improve upon treatment initiatives. Examples of Access's growth in treating SUD that originated from these meetings include:
    - Workflows for requesting impromptu case reviews over lunch.
    - Development of the Nurse Behavioral Health Care Manager role to administer long-acting naltrexone.
    - Naloxone delegation protocol.
    - Expansion of the Behavioral Health Consultants and Psychiatric Consulting team already working within Access to assist in the management of co-occurring conditions in individuals being seen for SUD, including on the same day as a primary care appointment.

Access serves as the first point of engagement for SUD treatment in primary care and will refer patients to external facilities when they require a higher level of care that cannot be provided in-house. This includes situations where patients need residential treatment, intensive outpatient programs, or specialized behavioral addiction management services. Additionally, patients who are co-managed with methadone clinics may be referred out for their methadone management while Access handles their other medical and psychiatric needs. Facilitating such referrals is supported by the Nurse Behavioral Health Care Coordination team as well as connections to external partnerships such as Safe Communities.

Infrastructure of an Integrated Team

Access's team infrastructure is built on collaboration among top-licensed healthcare professionals, including primary care providers (PCPs), behavioral health team members, nurses, and other members of the broader care team. This collaboration is facilitated by the expectation that each care team member will use closed-loop communication to notify the entire team as a patient's recovery progresses or regresses. Ways in which Access facilitates this communication include scheduled and impromptu meetings, instant messaging, and the ability to forward documentation via its electronic medical record (Epic). Additionally, it leverages reports and shared internal registries to monitor patient touchpoints, including hospitalizations and emergency room visits. Data tracking includes the incidence of lost-to-care patients, the frequency of MyChart

messages, and overall engagement metrics, which help address complex care coordination.

Collaborative Care in Action:

Dr. Shapiro completes a new patient appointment with a patient with alcohol use disorder whose goal is to address cravings to decrease and hopefully discontinue alcohol use. Dr. Shapiro evaluates the environmental factors that contribute to stress and cravings. He also acknowledges the patient's mental health history, which includes major depressive disorder and post-traumatic stress disorder (PTSD).

Dr Shapiro suggests that, in addition to starting long-acting injectable naltrexone, the patient be referred to an integrated behavioral health consultant for targeted treatment and for further evaluation by a psychiatrist embedded within the patient's primary care office to assess whether changes to medication would be beneficial for his current level of depression.

Additionally, the patient is connected with a Nurse Behavioral Health Care Manager who not only ensures that the patient's naltrexone is accessible and administers it, but also calls the patient (in lieu of returning to clinic) in the coming days to check on the impact of the treatment plan on cravings and use, assess engagement with internal and external resources, and evaluate for side effects of the medication. The Nurse Behavioral Health Care Manager will then report back to Dr. Shapiro regarding the patient's progress and schedule a follow-up accordingly.

Throughout this process, all notes are sent back to Dr. Shapiro to keep him informed of the patient's progress and to inform him of adjustments to the treatment plan. The psychiatrist remains available to consult as needed via similar communication pathways.

Training and Capacity Building

Access is committed to training and capacity building to improve its staff's ability to provide dynamic, evidence-based treatments to the community. Access relies on the expertise of its providers to inform its training and capacity building. Examples of this include:

- The behavioral health team develops and leads routine training on bias and trauma-informed care every six months as part of the Employee Development Institute.
- Dr. Shapiro or members of the behavioral health team will provide addiction-specific training to staff at the time of hire and upon request to reduce stigma and improve support for these patients. This was expanded to include call center staff who are responsible for scheduling patient appointments.
- Quarterly provider meetings and peer reviews are organized to cover topics such as safe prescribing and adherence to guidelines, ensuring that quality improvement is continually addressed.

Access also utilizes outside resources to improve capacity and training, such as:

- Sending all Nurse Behavioral Health Care Managers to additional training on motivational interviewing at the time of hire to assist in addressing patients' motivation and engagement. Ongoing education and support of interviewing skills is also provided via the in-house team upon request.
- Providing training on how to educate patients on the use of fentanyl test strips and naloxone to prevent overdose. Madison and Dane County Public Health provided initial training to nursing staff. Thereafter, Access provides an internal train-the-trainer model to educate staff to deliver this training to patients.

Staffing and Services

Guided by the belief that SUD should be treated like any other health condition, Access expects all PCPs to address SUD in their practices. Instead of relying on specialists, Access supports its providers through integrated behavioral health and psychiatric teams, ensuring patients receive comprehensive, team-based care.

Access Community Health's medical providers are all board-certified family medicine physicians or primary care-trained advanced practice providers. Providers are assigned 1800 patients per 1.0 full-time equivalent (FTE). The number of patients with SUD among the 1800 patients varies.

Access employs 15 behavioral health providers (five PsyD, one PhD, five LCSW, three APSW, one Psychiatrist), four behavioral health fellows, and three behavioral health care coordinators.

- Behavioral Health Care Coordinator (3.0 FTE): gather resources and maintain updated information about community resources that may supplement services. These individuals offer care management, outreach, and support for patients.
- Behavioral Health Consultants (14.5 FTE): clinicians integrated into the medical teams who can interact with patients through warm hand-offs during their appointments with a medical provider to facilitate screening, deliver brief, evidence-based interventions, or schedule follow-up consultations with patients at later dates.
- Consulting Psychiatrist (0.75 FTE): provides expertise in the areas of psychopharmacology and complex psychopathology to the care of all patients through consultation activities, including chart reviews, case reviews, and one-time patient consultations. The role primarily supports the medical teams' prescribing, as the PCP retains all prescribing authority.
- Nurse Behavioral Health Care Managers (1.5 FTE): serve as extensions of the physician by coordinating care, monitoring patient progress, and ensuring treatment plans are followed effectively, which includes administering long-acting injectable naltrexone.

Finances and Sustainability

Access's innovation was also enabled by strong alignment between its Chief Behavioral Health Officer and Chief Financial Officer, resulting in enhanced Prospective Payment System (PPS) reimbursement for integrated SUD treatment. This sustainability mechanism reinforced the organization's commitment to whole-person care and ensured that integrated addiction treatment could be maintained long term. The program reflects not only a structural innovation but a cultural shift, one that views treatment for substance use, including stimulant use disorder, as a core component of comprehensive, equitable family medicine.

Access's leadership emphasized early on the critical role of integrating finance within the clinical team to ensure that both medical and financial decision-makers are informed of the organization's needs. This approach has led both parties to recognize SUD treatment in primary care as an essential component of patient care. Chief Financial Officer, Tenisha Grimmer, discussed how her regular presence in the clinic and meetings with both Dr. Shapiro (lead PCP overseeing addiction medicine initiatives) and the behavioral health providers enabled the finance team to present an accurate narrative and compelling

request to the state of Wisconsin to secure increased PPS reimbursement for services provided to Medicaid patients with SUD through a Change of Scope request in 2023.

The Prospective Payment System (PPS) is a reimbursement model used by Medicare and Medicaid to pay FQHCs a fixed, bundled rate per qualifying patient visit, rather than per individual service. This rate is designed to reflect the average cost of providing comprehensive care and is adjusted based on factors such as location and visit type (e.g., new patient or wellness visits). PPS ensures predictable funding for FQHCs, helping maintain financial stability while supporting care for underserved populations.

Medical providers (physicians or advanced practice providers) bill standard evaluation and management (E&M) codes for all visits, including initial evaluations. Consulting psychiatry uses psychiatric diagnostic interview codes in addition to standard E&M codes. Behavioral health providers (psychologists and licensed clinical social workers) use standard psychotherapy codes. Due to the high prevalence of co-occurring conditions and prescription medications prescribed for SUD, 99214 is the most commonly billed code by medical providers, while 90832 is the most frequently billed code by behavioral health providers. Both codes are for patients already established in the clinic and are time-based (99214 for 30-39 minutes; 90832 for 30 minutes), though medical E&M codes can also be billed based on the complexity of medical decision-making. Time spent by Nurse Behavioral Health Care Managers is captured under E&M code 99484, a behavioral health care management code used when the Care Manager is following the primary care provider’s treatment plan.

For uninsured and underinsured patients, Access uses a sliding-fee schedule for medical and behavioral health services, as well as for medications through its participation in the 340B Drug Pricing Program. Access's commitment to mental health care is demonstrated by its willingness to create a unique behavioral health sliding scale that allows patients to be seen by a behavioral health clinician, with or without a medical component to their visit. These sliding fee scales have proven indispensable in preventing interruptions in treatment and recovery for individuals with SUD who lose insurance while in care.

The 340B Drug Pricing Program, established by Congress in 1992 under the Public Health Service Act, is designed to help healthcare providers serving low-income and uninsured populations access outpatient medications at significantly reduced prices—often 20–50% below standard costs. These savings enable eligible organizations to stretch limited resources, expand services, and improve care for medically underserved communities. Participants, known as "covered entities," include FQHCs, disproportionate-share hospitals, rural referral centers, and other providers that care for patients regardless of their ability to pay. The program is administered and overseen by the Health Resources and Services Administration (HRSA).

Successes

Culture Shift: Fostering a culture in which PCPs lead the initial assessment, diagnosis, and treatment of SUDs, rather than referring out, has expanded providers' capabilities. Clinicians now confidently manage medications beyond oral buprenorphine, including long-acting injectables and naltrexone. They also address co-occurring conditions like mood and anxiety disorders and PTSD through a consultative psychiatry model. This approach has further enabled care for specialty populations, such as pregnant individuals with SUD.

Workforce Development: The Nurse Behavioral Health Care Manager role was established to alleviate care bottlenecks and meet patient timelines. Implementing this established approach [2] allows nurses to improve access to evidence-based SUD treatment while working at the top of their license. The role also boosts nurse satisfaction, often described as “a cup filler” because it fosters meaningful patient relationships.

The Behavioral Health Training program has been a key driver of having a steady stream of BHCs during periods of growth with the 10 of the 12 current Licensed Behavioral Health Consultant being trained as fellows and retained once licensed.

Operational Alignment: Clinic culture and operational structure work in tandem to provide routine primary care for mental health and SUD. A product of this alignment was the successful Change of Scope request, approved by the Wisconsin State Legislature, which led to increased PPS payment rates, thereby enhancing the financial sustainability of integrated roles such as behavioral health care coordination and Nurse Behavioral Health Care Managers. This achievement was driven by Access's integrated leadership model, where the Chief Behavioral Health Officer, Addiction Medicine Champion, and Chief Financial Officer collaborate in shared spaces.

Challenges

Stigma: Although Access's integrated behavioral health program had effectively managed the secondary health effects of substance use for multiple years, it had not worked to address SUD as a primary condition. This was, in part, due to concerns from clinic staff regarding the impact that treating SUD could have on the clinic's patient population—would patients be wary of coming to the clinic if persons with SUD were in the waiting room intoxicated, in withdrawal, or altered in any way? How would patients feel or react regarding routine screening for SUD? These concerns initially led the clinic to delay both routine medication prescribing and universal screening efforts. To address this efforts were made to provide education to staff regarding the impacts of SUD on health, wellness, and the community highlighting use disorders as a medical condition that Access had the skills, workforce, and expertise to treat. Further, efforts were made to facilitate both verbal and written messaging to destigmatize universal screening centered on the concept of "we ask all patients about substance use in an effort to provide support, treatment options, and partnership on a path to recovery."

Early challenges with a limited workforce: To develop a primary care-centric approach to treating SUD, including polysubstance use disorder, existing primary care providers and staff would need to buy in and learn about treatment options. While this took time, the clinical sites that demonstrated the fastest adoption were those that hired new providers who already endorsed this philosophy and had experience treating SUD. Many of the providers hired had completed the WFMC residency and received training at the Health Promotions clinic.

Recommendations

Sustain and Expand Integrated Care: Access expanded services to include SUD, reinforcing its commitment to primary care as the frontline for all chronic conditions, including behavioral health. Its mature integrated behavioral health program provided the staffing and workflows needed to incorporate SUD treatment seamlessly.

Leverage Success to Improve Funding: Access expanded SUD treatment by relying on existing teams and leadership rather than hiring new staff. Ongoing collaboration between internal leaders, such as the Chief Behavioral Health Officer and Chief Financial Officer, enabled the organization to build a financially sustainable model. This success led to higher PPS reimbursement rates, recognizing the value of integrated care delivered by existing teams.

Include Community as Part of the Team: Through regular engagement with external partners, such as the Safe Communities coalition, Access built strategic relationships to fill service gaps in peer recovery, withdrawal management, and residential treatment. These partnerships support the delivery of evidence-based SUD care within primary care settings, reinforcing the community's role in the integrated care model.

Invest in Workforce Training: Organizations with existing integrated behavioral health clinicians should consider expanding the impact of their behavioral health teams by utilizing clinicians to train staff on topics such as motivational interviewing, trauma-informed care, and harm reduction strategies. Additionally, expanding the behavioral health team by employing behavioral health trainees (e.g., interns, fellows) facilitates additional educational opportunities.

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Citations

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