Collaborative Family Healthcare Association

A CASE STUDY

Innovating to Address Substance Use Disorders

Delaware Valley Community Health

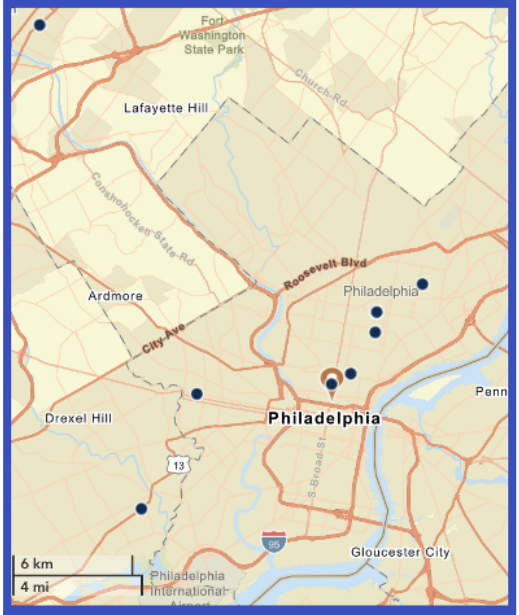
Philadelphia, Pennsylvania



Executive Summary

Delaware Valley Community Health (DVCH), a Federally Qualified Health Center (FQHC) serving Philadelphia since 1969, has established itself as a leading model for integrating primary care and substance use treatment in urban, underserved settings. In 2016, DVCH partnered with The Behavioral Wellness Center at Girard to open Fairmount Primary Care Center at Girard Medical Center (GMC) in response to the local opioid overdose crisis. Initially focused on opioid use disorder, GMC has adapted to increasing rates of polysubstance use, expanding services for patients using opioids alongside alcohol or stimulants. Its patient-centered philosophy, grounded in life-saving strategies and an emphasis on engagement rather than patient abstinence, has improved retention and satisfaction while reducing barriers to care. Supported by the 340B Drug Pricing Program, Health Resources and Services Administration (HRSA) grants, and Pennsylvania Center of Excellence designation, GMC has achieved a 53% increase in unique patients and a 438% rise in visits since opening. For context, national Uniform Data System (UDS) data show that the number of patients served by HRSA-funded health centers increased from 30.2 million in 2021 to 30.5 million in 2022, an annual growth rate of about 1% [1]. Although FQHC patient volumes continued to grow nationally after 2022 [2], UDS data indicate that overall FQHC growth during this period remained modest relative to GMC's expansion, placing its growth trajectory above typical National Health Center Program trends. The clinic's collaborative partnerships and flexible, integrated model demonstrate how health centers can lead community-level innovation in treating complex substance use disorders.

Delaware Valley Community Health



Founded: 1972
Sites: 10
Patients: 45,000+
MAT: 1,000+ active

Background

Delaware Valley Community Health, Inc. (DVCH), a Federally Qualified Health Center (FQHC), has served as a cornerstone of community-based care in Philadelphia since

1969, when it was founded as a satellite of Hahnemann Medical College's Department of Family Medicine. As an FQHC, the center provides comprehensive, affordable primary care, behavioral health, and dental services to uninsured and underinsured residents through a sliding-fee scale. Over time, it has grown into a network of ten health centers serving diverse, medically underserved communities across the region. Since 2006, DVCH has advanced an innovative model of embedding primary care within behavioral health organizations to expand access for patients with complex medical and psychosocial needs. One of DVCH's earliest and most successful partnerships emerged with The Behavioral Wellness Center (BWC), formerly Girard Medical Center, which provides inpatient and outpatient behavioral health and substance use treatment. In 2016, DVCH and BWC launched the Fairmount Primary Care Center at Girard Medical Center (GMC) in response to Philadelphia's escalating opioid overdose crisis. Initially designed to provide medical evaluations for individuals entering residential treatment, the clinic quickly evolved to meet the broader medical and behavioral needs of patients with substance use disorder (SUD). Over time, GMC's integrated, patient-centered approach earned the designation as a Pennsylvania Center of Excellence (COE) for Opioid Use Disorder. This regional model requires the integration of primary care, addiction treatment, and behavioral health services in a single, coordinated setting. The COE designation has expanded GMC's ability to treat SUD by requiring GMC to increase its care management staff and hire recovery specialists as well as by enabling DVCH to receive Medicaid reimbursement for these and other integrated SUD services.

Impetus

The establishment of GMC in 2016 was a direct response to Philadelphia's growing overdose epidemic. In 2015, 80% of fatal overdoses [3] in the city involved opioids, with North Philadelphia disproportionately affected. Under the leadership of Dr. Scott McNeal, DVCH responded to a citywide call for FQHCs to play a greater role in expanding access to SUD treatment. Recognizing both the urgent need and its own organizational strengths in integrated primary care, DVCH partnered with BWC to co-locate a primary care clinic on its campus.

This collaboration initially focused on conducting medical evaluations for individuals who had been diverted from incarceration into BWC's residential treatment programs and otherwise had limited access to primary care. The clinic quickly became a critical point of connection, providing ongoing medical management and facilitating a seamless

transition from inpatient stabilization to community-based outpatient care. As local demand for outpatient services grew, so did GMC's scope, staff, and infrastructure.

DVCH also recognized that the social and legal barriers faced by many patients, such as unstable housing, food insecurity, and lack of identification, directly impacted health outcomes. To address these barriers, DVCH partnered with Philadelphia Legal Assistance (PLA) to establish a Medical-Legal Community Partnership (MLCP) program on-site. This collaboration engaged an attorney at the clinic one day per week to address "health-harming" legal issues, allowing patients to focus more effectively on recovery and ongoing care.

As the clinic began identifying high rates of Hepatitis C and other infectious diseases among its patient population, DVCH expanded services again, partnering with the Health Federation of Philadelphia's C Change program to increase access to Hepatitis C treatment. Through this partnership, GMC overcame medication access challenges that had limited treatment options elsewhere in the city, dramatically improving rates of diagnosis and cure. Together, these partnerships created a foundation for GMC's model of integrated, whole-person care.

From Partnership to Program: Building GMC

Having secured a partnership with BWC to provide primary care on its campus, DVCH opened the Fairmount Primary Care Center at Girard Medical Center (GMC) in December 2016. The clinic initially occupied 1,600 square feet and was led by physician champion Dr. Daniel DeJoseph, whose experience with buprenorphine and openness to treating SUD made him a natural fit. Initially, Dr. DeJoseph split his time between GMC and another DVCH site. Early demand focused on opioid use disorder (OUD) treatment. Still, as referrals from BWC increased, GMC quickly began serving patients with alcohol and stimulant use disorders, as well as co-occurring conditions such as Hepatitis C, HIV, and chronic mental health needs. This growing complexity prompted the clinic to specialize its services further. Examples of this include starting to use medications beyond buprenorphine to treat alcohol and stimulant use disorders and hiring a physician assistant with specialized training in Hepatitis C and HIV management to address the increasing number of cases of each identified in BWC patients. To facilitate the expansion of medication utilization, DVCH's pharmacy team obtained 340B Drug Pricing Program status. This designation allowed DVCH to purchase Hepatitis C and HIV medications at reduced cost and later expand access to long-acting injectable medications for OUD. This ability to adapt service, in direct response to patient needs, helped GMC become one of the fastest-growing DVCH clinics. At opening,

approximately 90% of its patients were BWC clients; by 2024, that number had decreased to 60%, reflecting GMC's successful expansion into the broader community while maintaining a unique continuum of integrated medical and behavioral health services.

The 340B Drug Pricing Program, established by Congress in 1992 through the Veterans Health Care Act (P.L. 102-585), 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).

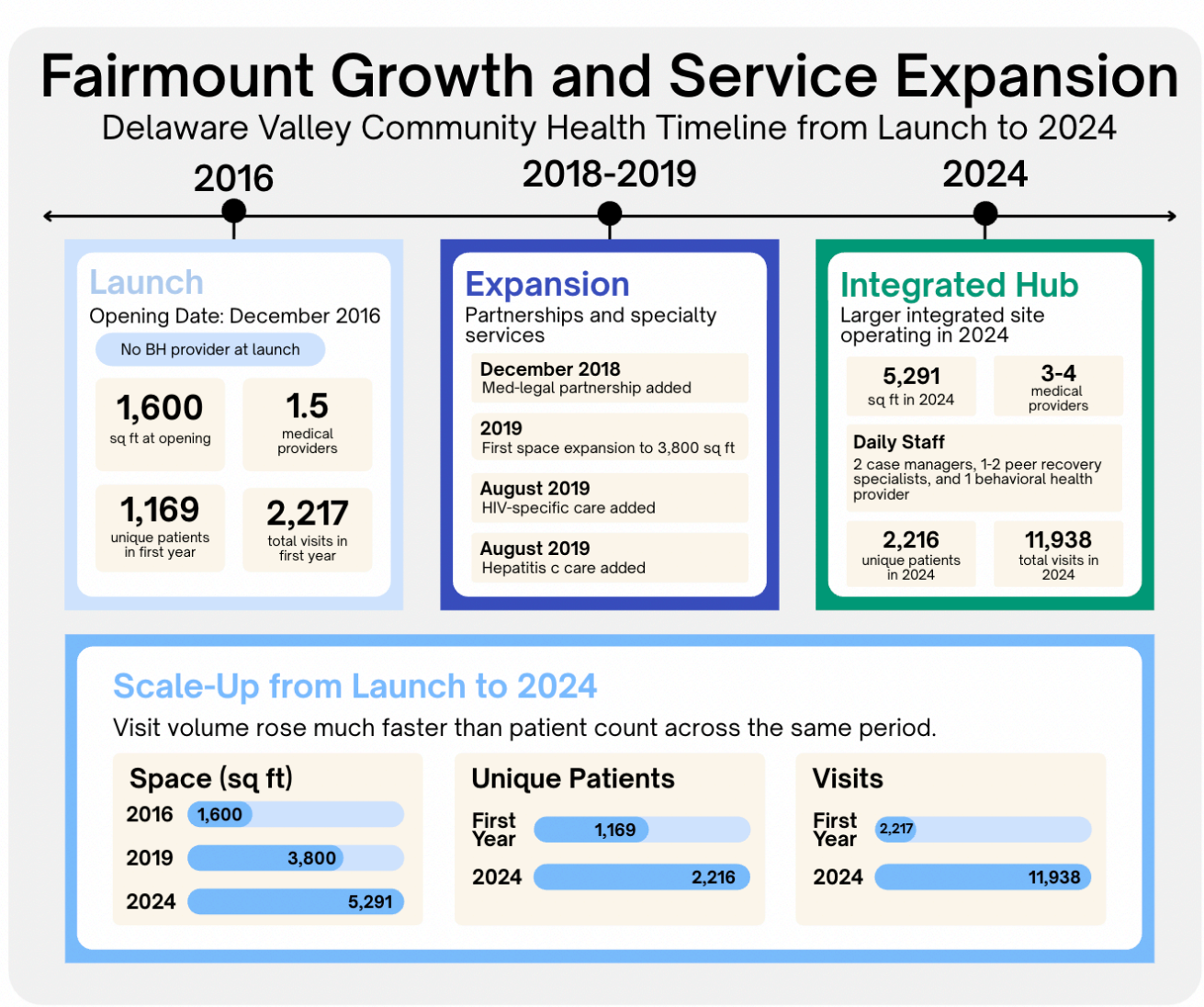
In addition to addressing the medical needs of patients at BWC, the creation of GMC was seen as a strategic opportunity for DVCH to not only meet the community's growing need for SUD care, but also develop an internal hub and spoke model to expand SUD care to its other ten sites.

The internal strategy was two-fold:

1) Develop a hub and spoke model within DVCH, in which GMC would act as the specialized "hub" to provide initial assessment and treatment planning for SUD, including medication initiation, and other DVCH sites would act as the "spokes" to offer ongoing support and treatment. This model was designed to enhance treatment capacity and enable patients to transition between levels of care based on their stability.
2) Have providers rotate at GMC to learn and become comfortable with addiction medicine to staff the hub and spoke model.

By June 2025, DVCH was operating GMC as the hub for SUD treatment to which other DVCH clinics could refer. The experience yielded several key lessons about developing and sustaining a specialized SUD hub within a health center:

- **Primary care engagement requires an intentional strategy**. While many individuals seek care at GMC, in instances when substance use is the patient's primary concern, providers have noted that the complexities of their substance use care can take precedence. This makes it essential to adopt a deliberate approach to introduce and integrate primary care services from the beginning.
- **High-frequency, small-panel care is necessary.** Because of the intensity of SUD treatment, particularly for opioid, stimulant, and alcohol use disorders, patients require more frequent visits for stabilizat ion and monitoring than in standard primary care. As a result, GMC maintains a smaller active patient panel compared with other DVCH clinics.
- **Care must accommodate varying treatment goals and co-morbidities.** Not all patients aim for abstinence, and many present with complex co-occurring conditions such as HIV, Hepatitis C, or mental health disorders. Ongoing, flexible scheduling and multidisciplinary support are critical to sustaining engagement.
- **Relationships drive retention.** Patients often form strong, trusting relationships with GMC's integrated care team, leading many to continue receiving care at the clinic even after achieving stability rather than transitioning back to a general primary care site. Word of mouth has allowed GMC to expand services to family and friends of patients being seen for substance use treatment, as well as individuals needing primary care services who are already receiving medication for opioid use disorder through Behavioral Wellness Center's methadone program.



Timeline

View full-sized image here

This reflects a 53% growth in unique users and a 438% increase in total visits over seven years. Visit growth has significantly outpaced user growth, underscoring increased care intensity and broader service integration, particularly with the introduction of behavioral health services.

Philosophical Approach to Polysubstance Use

Given DVCH's focus on patient-oriented access, leadership prioritized SUD at GMC to achieve the secondary goal of engaging patients in primary care. By meeting patients where they were at the time of their GMC entry, the clinic has consistently achieved satisfaction scores of 93% or higher since its inception in 2016. With that level of trust and satisfaction, the clinic has been able to help patients see that often their need for primary care services matches and exceeds their needs for substance use treatment over time, particularly as SUD stabilizes through treatment.

> ***"For the patients that we serve, whether it be for substance use disorder, or chronic mental illness, or intellectual disabilities, their time is usually more consumed trying to access services for these conditions, because they're usually longer visits and there's more things involved... but now it's going to be very, very difficult to access primary care. So, this is the co-located model that DVCH has successfully developed with other partners and one that we could provide at Girard."***
>
> ***- Dr. Scott McNeal, Retired President and CEO Emeritus of DVCH***

Providers and staff at GMC all espouse the philosophy that SUD is a chronic medical condition, and a patient-centered approach that does not require abstinence or a specific visit frequency is requisite to engage in care patients who have variable levels of motivation. Dr. DeJoseph detailed the clinic's evolution to embracing this philosophy, noting that initially GMC attempted to have a set expectation surrounding frequency of visits and quickly realized that while well-intentioned, it did not fit well with the goal for patient-centered care and patient-oriented access, particularly in advanced stages of SUD that included the use of multiple substances. "My goal is to keep them coming back, so if that means that I am not going to see them weekly because they aren't motivated for that, but they will come in two or three weeks, they are coming, and we can work on what they want. They have to be coming for me to help."

As such, DVCH elected to individualize visit frequency based on the patient's specific medical needs and care goals. This has proved particularly important in the

management of polysubstance use disorder, in which patients want to discontinue use of one, but not all, substances. Dr. DeJoseph highlighted an example of how, under the clinic's initial rules, an individual on buprenorphine without further use of opioids would be seen once a month, but because of ongoing cocaine use, would be required to be seen weekly. In this case, the individual is using cocaine weekly, but not daily, and sees this as progress. Under the old rules, seeing this individual weekly would have resulted in missed visits, increased resource utilization to reach out to the patient, and ultimately, little change or engagement from the patient. By embracing a patient-centered approach and allowing appointment intervals to be dynamic rather than static, the patient has been engaged, there have been no increased rates of overdose or hospitalization, and resources such as appointments and case management are more available.

This approach to SUD care, particularly for those using more than one substance, has developed into a central precept of GMC's philosophy for treatment by not requiring abstinence or predetermined frequency of visits. This view has a positive impact on patient outcomes and has increased staff investment in the clinic.

"I would say we're different because we don't just collect the patient's urine and provide them their medication, but we also physically get into the patient's problems, right? Where is this stemming from? [Are] there triggers? And if so, how can we help the patient with not falling back into their addiction? We try to be a little bit more lenient with our patients. We understand that they're going through something, obviously. So, each scenario, you know, varies based on the patient."

- Medical Assistant

"I'm not mad at you, because I understand. I've been there, and you're not ready to stop. I can't be mad at you because you're not ready to stop getting out of it.' So still being there for them, even in use, meeting them where they are, having that nonjudgmental kind of statement to them helps carry that empathy so they know that you really are there for them and you're not judging them."

- Peer Recovery Coach

GMC employs a non-abstinence, patient-directed care philosophy, including training staff in naloxone administration, strategies to reduce exposure to infections associated with substance use, and discussions on reducing higher-risk forms of use. In the same vein, GMC offers an opt-out model with many SUD treatments, including medications (buprenorphine and naltrexone-based therapies to treat opiate and alcohol use, gabapentin for alcohol use disorder, and topiramate for stimulant use disorder). Opt-out services also include therapists who help with individual assessments and brief interventions, case management, and peer recovery specialists. GMC continues to offer services to individuals when they are ready. This requires a team-based approach in which timely communication is key.

Evolution of Communication Infrastructure

Central to the philosophy of patient-centered access through co-located care is ensuring that critical clinical information, such as treatment plans, care coordination, and follow-up needs, is accessible to all members of the care team. GMC's experience managing disruptions to continuity-of-care standards in substance use treatment led to the development of an infrastructure and culture that prioritize full-circle communication. Key strategies include:

- Shared access to the electronic medical record (NextGen): All team members, including external partners such as attorneys from the Medical-Legal Community Partnership, can view and document patient updates.
- Secure real-time messaging: Staff utilize internal messaging to coordinate evolving needs, particularly when patients are on-site.
- Condition-specific registries: Case managers maintain up-to-date registries for HIV, Hepatitis C, and SUD to track medication administration, lab requirements, and appointment schedules.
- Patient locator forms: Initially created for Hepatitis C patients to ensure medication delivery, these forms record addresses, contacts, and communication preferences, and are now used broadly to support re-engagement when patients are challenging to reach.

Training and Capacity Building

GMC developed a specialized training track for medical providers who will work at this site. This training includes an online course focused on SUD and other specialty services offered by clinicians at GMC. Once the course is completed, the provider is

scheduled for specific in-clinic days during which they will see patients alongside Dr. DeJoseph. The duration of precepting and oversight is based on experience treating conditions that commonly co-occur with SUD and familiarity with the electronic medical record. Thereafter, providers take turns delivering didactic sessions on areas of interest, such as Hepatitis C or HIV care, to ensure that staff are adequately cross-trained and informed about the various specialty treatments offered at GMC. This education is scheduled during weekly meetings to discuss patients at higher risk. Education is provided on an as-needed basis, such as when evidence for treatment protocols changes. In 2024, DVCH recommenced hosting family medicine residents. In July 2026, they will have a full contingent of residents, with four in each of the three years of a three-year residency. The goal is for GMC to be a site where residents can regularly rotate once the residency is fully staffed. Residency training in SUD treatment will then serve two purposes: 1) expanding cross-training opportunities for DVCH faculty who oversee residents to expand their knowledge and skills with caring for SUD in other DVCH clinics, and 2) increasing the number of residents graduating with this knowledge and skill base who may stay in the area and benefit Philadelphia.

Staffing and Services

GMC is physically designed to facilitate team-based, co-located care. Medical providers, behavioral health consultants, peer recovery coaches, and the medical-legal representative share a team room to facilitate real-time communication and case discussions. Case managers work in a shared space to coordinate care across multiple registries, ensuring continuity for patients with complex needs. Team-based roles are as follows:

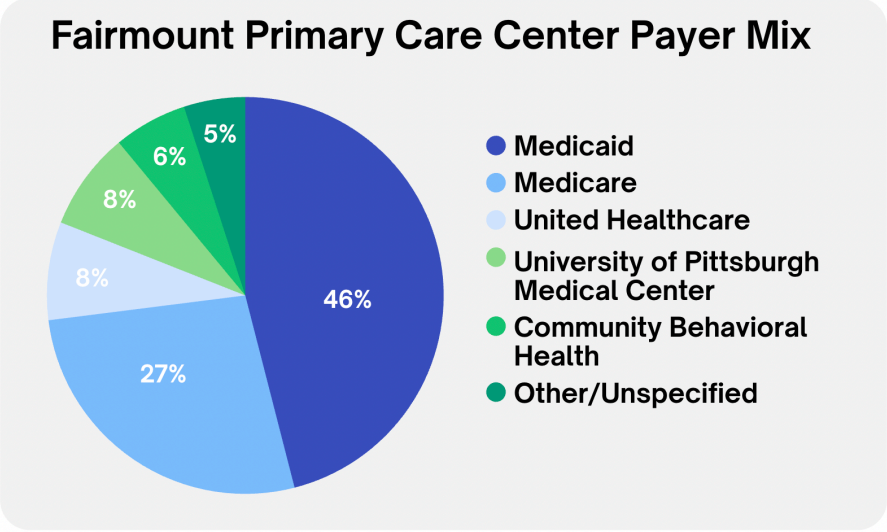
- **Medical Providers** (3.0 full-time equivalent (FTE) average per half-day): Two physicians and two advanced practice providers deliver integrated medical and addiction care. One is board-certified in addiction medicine, and all are cross-trained in managing HIV and Hepatitis C as well as administering long-acting injectable medications. Additional providers rotate through the clinic to expand training and coverage.
- **Medical Assistants** (2.0-3.0): collect and process urine drug screens, support patient flow, and, under protocol, administer long-acting injectable naltrexone.
- **Behavioral Health Consultant** (0.6–1.0 FTE): Two licensed providers (LCSW, LMFT) share this role, offering brief interventions and biopsychosocial assessments that inform diagnoses and individualized treatment plans.
- **Case Managers** (3.0 FTE): assist patients in navigating both internal and external care systems. One focuses on SUD and medications for OUD, one

manages Hepatitis C cases, and one supports patients with HIV. Licensed staff also administer injections as needed—expansion enabled by the COE designation.

- **Peer Recovery Specialists** (2.0 FTE): Individuals with lived recovery experience provide on-site peer support, fostering trust and improving engagement and treatment adherence—made possible through the COE designation.
- **Pharmacists** (0.1-0.2 FTE): oversee medication procurement and delivery processes, including protocols for long-acting injectables. A DVCH pharmacist is on-site weekly to address medication concerns and provide staff education and training.
- **Medical-Legal Representative**: An attorney is available one day per week, through a partnership with Philadelphia Legal Assistance, to assist patients in resolving legal and social issues that affect their health.

Financing and Sustainability

GMC's operations are sustained through a blend of standard billing practices, enhanced reimbursements, discounted medication programs, and targeted grants. Medical and behavioral health providers bill standard Evaluation and Management (E&M) codes for all visits. Given the clinic's high prevalence of co-occurring conditions and medication management, CPT 99214 is the most frequently billed code by medical providers, while 90832 is the most common for behavioral health consultations. Care management utilizes CPT code G5011. These codes are billed based on time and complexity of care. GMC's payer mix includes 46% Medicaid, 27% Medicare, 8% United Healthcare, 8% University of Pittsburgh Medical Center, and 6% Community Behavioral Health.



DVCH credits two programs as central to GMC's sustainability:

- 340B Drug Pricing Program, which reduces medication costs for long-acting injectables and specialty treatments for HIV and Hepatitis C.
- Pennsylvania Center of Excellence designation, which provides expanded Medicaid reimbursement for SUD services like peer recovery and care management that would otherwise not be reimbursed, and aligns with the organization's goals to integrate primary care, behavioral health, and peer support.

Pennsylvania Centers of Excellence for Opioid Use Disorder

The Pennsylvania Centers of Excellence (COEs) for Opioid Use Disorder are state-funded initiatives designed to improve care coordination and access to evidence-based treatment for individuals struggling with OUD. Administered by the Department of Human Services, COEs leverage Medicaid dollars to support increasing access to care across multiple domains, including physical and mental health services, as well as care management to address social needs and peer resources to assist in on- and off-site navigation of recovery. These centers also work to enroll uninsured individuals in Medicaid or connect them to county-level resources, ensuring continuity of care. By emphasizing whole-person care and partnerships with community organizations, COEs aim to reduce overdose rates and strengthen Pennsylvania's response to

In addition, federal and state grants expand and strengthen services, including:

- The HRSA American Rescue Plan Grant (ARP), which initially funded the Medical-Legal Community Partnership program, is now fully supported by DVCH.
- Additional HRSA grant received for HIV/PrEP, expanded behavioral health, and opioid treatment model. (Pre-exposure prophylaxis (PrEP) is a medicine that reduces the chances of contracting HIV).
- Foundation Grant from IBX Foundation for the care coordination model.
- Additional Pennsylvania state grants have been used to expand vaccine access.

Successes

Medical-Legal Community Partnership: Recognized by the National Center for Medical-Legal Partnership [4], DVCH's collaboration with Philadelphia Legal Assistance removes social and legal barriers to health, addressing issues such as housing, identification, and food insecurity. The program achieves an estimated $11 return for every $1 invested, a remarkable outcome in Philadelphia, the nation's poorest large city [5].

Financial Sustainability: Through operational efficiency, robust data reporting, and a Center of Excellence designation, DVCH has achieved stable reimbursement for SUD services. Coupled with 340B Drug Pricing Program savings, these strategies provide the financial flexibility needed to sustain a specialized treatment hub.

Case Management Coordination: Weekly multidisciplinary meetings focus on high-risk patients, enabling timely adjustments to care plans. This structured collaboration enhances communication, fosters accountability, and facilitates rapid responses to emerging patient needs.

Challenges

Stigma and Community Perception: DVCH leadership acknowledges an ongoing need to challenge stigma regarding SUD (both internally among staff and within the community). DVCH aims to mitigate bias by having medical providers train their peers and by encouraging providers to manage conditions internally rather than referring patients to external services. Such an approach has been helpful as demand for services increases in Philadelphia following a recent mayoral executive order [6] that authorizes police to divert individuals arrested for certain low-level drug offenses to same-day medical and behavioral health services rather than jail.

Financial Constraints: Potential cuts to Medicaid and rising uninsured rates pose risks to long-term sustainability, as reimbursement rates for uninsured patients are significantly lower than those for Medicaid beneficiaries under

Section 330 of the Public Health Service Act. The uncertain future of Medicaid coverage threatens not only reimbursement stability but also, by extension, access to essential services for both parties.

Space Limitations: High patient volume and growing service demand have outpaced the clinic's physical capacity, limiting expansion of integrated behavioral health and SUD programs.

Balancing Services: There is a challenge in balancing the need for SUD treatment with other primary care services. Providers note that it is common for primary care to be bypassed to address a patient's substance use.

Recommendations

GMC's experience offers a replicable model for health centers seeking to expand SUD treatment through integrated, patient-centered care.

Develop clinical champions: Success depends on providers with a strong interest and training in SUD care who can model best practices and mentor peers.

Build strong community partnerships: Collaborate with behavioral health organizations, legal aid programs, and social service agencies to address co-occurring needs and strengthen referral networks.

Ensure access to specialty behavioral health care: Incorporate co-located behavioral health clinicians to expand access to brief interventions while maintaining partnerships for intensive outpatient and residential treatment, particularly for stimulant use disorder, to facilitate access to longer-term treatment.

Remain flexible and responsive: GMC's growth was driven by adaptability—expanding services as needs evolved, leveraging partnerships, and aligning leadership support with emerging opportunities.

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