Collaborative Family Healthcare Association

A CASE STUDY

Integrating Substance Use Treatment Through Robust Teams

HealthPoint

Seattle, Washington



Executive Summary

HealthPoint, a Federally Qualified Health Center in King County, Washington, leverages strong teamwork to integrate substance use disorder (SUD) treatment into primary care. Rather than offering specialty SUD treatment, HealthPoint applies its long-established interdisciplinary primary care team model to treat a broad range of SUDs, including polysubstance use. The organization's innovative Whole Care clinic adds to its offerings as a clinic specifically designed to provide low-barrier, person-centered care for patients with complex medical, behavioral, and social needs, most of whom have opioid or polysubstance use disorder.

With robust teams supported in part by a unique training pipeline, a focus on the Quintuple Aim, a commitment to innovation, and strong financial standing, HealthPoint has steadily expanded its capacity to meet the SUD treatment needs of its communities.

HealthPoint

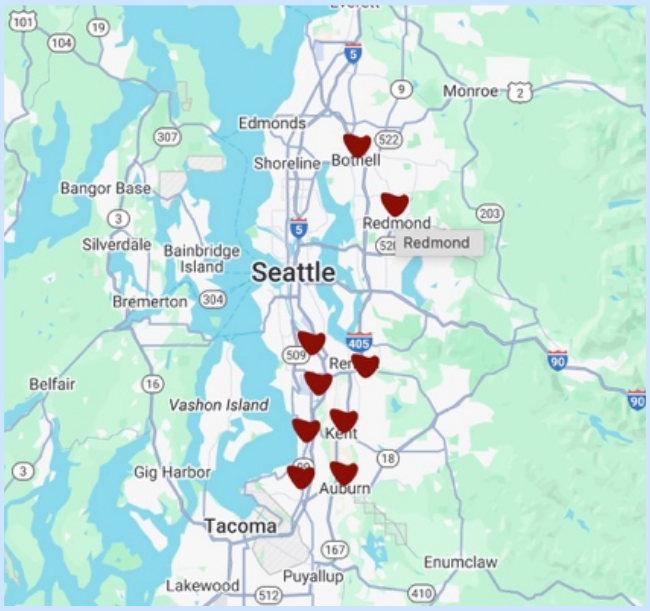


Founded: 1971
Sites: 13
Patients: 66,000+
Area: King & Pierce

Background

The Federally Qualified Health Center (FQHC) now known as HealthPoint was founded in 1971 as Community Health Centers of King County. Its clinics are located solely in King County, Washington's most populous county, home to Seattle and several suburbs. HealthPoint operates in the suburban areas north and south of Seattle, complementing the city's numerous other FQHCs. HealthPoint emerged during the economic downturn of the 1970s, when high unemployment and regional industrial layoffs left many residents underserved. What began as a single small clinic in Kent has grown into a network of 20 clinics across the county. Reflecting the diversity of the areas it serves, HealthPoint's patients speak more than 80 languages as their first language.

In 2025, HealthPoint recorded roughly 200,000 medical visits for more than 100,000 unique patients. Their portfolio of clinics comprises 19 primary care clinics (six of which are school-based) and one urgent care clinic. Dental and pharmacy services are co-located with nine of the medical clinics (represented on the map shown here). One clinic hosts a family medicine residency, and a care team focused on the refugee population travels among sites. Behavioral health is integrated into the team at each primary care clinic, with services varying by site.



Clinic Locations
https://www.healthpointchc.org/find-clinics

Infrastructure

HealthPoint does not operate a specialty substance use disorder (SUD) treatment program; instead, SUD care is integrated into its primary care model. While a few board-certified addiction medicine specialists and two substance use dependence professionals (SUDPs, a bachelor's-level credential specific to Washington state) are present throughout the organization, SUD treatment is offered only as part of primary care. All clinicians can treat SUDs, and only the SUDPs were specifically hired to provide SUD treatment. Much of HealthPoint's SUD treatment focuses on delivering medication for opioid use disorder (MOUD) and on polysubstance use that includes opioids. However, they also routinely treat other SUDs such as nicotine, alcohol, and stimulant use disorders.

In total, HealthPoint has 86 full-time equivalent primary care provider (PCP) positions (currently filled by 116 providers) and 43 behavioral health providers. They also employ 54 dentists and 12 complementary and alternative medicine providers (acupuncturists, dietitians, and naturopathic physicians, who provide a broad spectrum of primary care and combine natural therapies with conventional care). Of the 43 behavioral health providers, 35 are behavioral health consultants (BHC), two are psychiatric nurse practitioners, four are master's-level mental health therapists who provide specialty mental health care, and two are SUDPs.

Behavioral Health Consultant Service

Of the 43 behavioral health providers employed by HealthPoint, 35 function as behavioral health consultants (BHC; their role is described later in this case study). Twenty-four of these are staff BHCs, and 11 are trainees (eight psychology predoctoral interns, three psychology postdoctoral fellows).

The BHC services at HealthPoint make a significant contribution to the system's SUD treatment efforts and are notable for several reasons. First, the service was started over two decades ago, in 2002, making it one of the country's early adopters of integrated behavioral health. Additionally, the size (35 BHCs) is large, nearly half the size of the PCP full-time equivalent staff. The provider composition is also noteworthy, as all BHCs are doctoral-level psychologists (PhD or PsyD). Yet, despite its size and the higher salaries typically paid to doctoral-level providers, the service operates at a financial profit. Retention is strong, with many staff BHCs having served five or more years at HealthPoint.

Melissa Baker, PhD, a 17-year HealthPoint clinician who leads the behavioral health service, credits the service's success to a strong training pipeline. Fellows and interns are encouraged to apply for positions before completing training to ensure a steady supply of well-matched hires. HealthPoint also maintains a consistent PCP-to-BHC ratio across clinics, expanding behavioral health capacity as the organization grows.

Although HealthPoint does not provide specialty-level SUD care, it operates the Whole Care clinic at its Auburn location, which features a separate floor dedicated to patients with complex medical, behavioral, and social needs. Approximately 70–80% of Whole Care patients have a SUD, most involving polysubstance use (usually opioids with methamphetamine and/or nicotine),

along with high rates of housing instability and co-occurring health conditions. The Whole Care clinic functions independently of the main Auburn clinic.

The "Whole Care" Clinic

In late 2022, HealthPoint initiated a pilot program to provide care for patients with complex needs at its Auburn clinic. Using grant funding for a "health engagement hub" from the Washington State Health Care Authority, HealthPoint established its "Whole Care" clinic. The clinic is designed to address the needs of those with multiple challenges, such as unmanaged chronic diseases, mental health disorders, SUDs, lack of housing, and other social needs.

The Health Care Authority's stated goal with the grant was to build "an all-in-one location wherein those who use drugs may access a range of social and medical services, including harm reduction services." The Washington State Legislature had appropriated $4 million from opioid abatement settlement funds for the state fiscal year 2024-2025 to implement two pilot sites in the state, one urban and one rural. HealthPoint was selected as the urban site.

As described by HealthPoint's Chief Health Officer, Evan Oakes, MD, MPH, Whole Care provides an "intensive team experience" and regular community outreach to engage patients with complex needs.

The Whole Care team includes two half-time PCPs, an SUDP, a nurse, a patient care navigator, a BHC, a half-time psychiatric nurse practitioner, a peer support specialist, and a medical assistant (MA). Patients are scheduled for 30-minute visits with the PCP (one per hour) and for one-hour visits with the BHC and SUDP, though counseling or other team services are not required. The BHC and SUDP note that visits commonly require less than an hour; the extra time allows flexibility if patients meet with other team members or if the BHC or SUDP visit is interrupted to see another patient. Flexible scheduling also helps the team accommodate walk-ins and address multiple health concerns in a single clinic visit. Walk-ins are accepted at any time during the workday.

Treatment of opioid use disorder (OUD) is the focus of most of the team's SUD care, and a low-barrier approach is used to ease access to care (e.g., walk-ins are accepted, insurance and identification are not required, patients are seen regardless of substance use status). However, given the near-universal polysubstance use among the clinic patient population using opioids, other SUDs are also commonly treated. Exam rooms in the clinic have also been modified to be more conducive to conversation; for example, the exam table has been replaced with a recliner.

Community outreach is also a central strategy of the clinic. Members of the team (most commonly the nurse, but also others at times) regularly collaborate with homeless outreach teams from other organizations or visit shelters. While out, nurses regularly use video calls with PCPs to help patients with medical concerns (e.g., obtaining wound care advice) and to distribute supplies to reduce health risks for patients who use methamphetamine (e.g., mouthwash, fidget tools, electrolyte drinks). Staff most frequently work with Don's Place, an emergency housing program with a special focus on Veterans and older adults, serving up to 90 people experiencing chronic homelessness.

Engaging patients where they are, both literally and figuratively, has built trust and fostered a positive reputation, which in turn has helped increase the Whole Care clinic's success. Community partners regularly refer patients to the clinic after an encounter with a team member. Nathan Kittle, MD, a founding Whole Care PCP and HealthPoint's Director of Addiction Medicine, notes that, in the beginning, "I wasn't very busy. But now I often see more patients in a day than I would in a regular primary care clinic." Last year, Whole Care saw 300-500 patients per month, averaging 37 new patients per month.

When patients seen in Whole Care are already connected elsewhere with a PCP, they can opt to switch to Whole Care for all their primary care needs, or to continue with their established PCP. Quite often, patients have on file a PCP or a specialty mental health provider, but are not engaged with that provider. When needed, the Healthy Planet platform within the Epic Electronic Health Record (EHR) system enables the team to send specific information to a patient's providers in other healthcare systems that do not use Epic. Additionally, using the Care Everywhere platform, the team can view care provided by other systems that utilize the same Epic EHR. The Whole Care team aims to be a stabilizing resource, in whatever form that may take.

The Care Process

While the Whole Care clinic is especially well-suited for treating SUDs, every HealthPoint clinic can and does regularly treat SUDs, with a similarly low-barrier approach. Most clinics accommodate walk-ins whenever possible and also block one afternoon per week specifically for walk-in appointments for new or existing patients receiving MOUD. During these walk-in visits, patients can receive a same-day prescription for buprenorphine and oral naltrexone and/or be planned for extended-release injections. On weekends, this service is offered in HealthPoint's urgent care clinic. Because polysubstance use is nearly

universal among the population receiving MOUD at HealthPoint, care for other SUDs is commonly incorporated into these visits.

Enabled by every clinic having at least one BHC, teamwork is key to making this walk-in process work. Patients typically see the BHC before the PCP, during which the BHC gathers the necessary history to inform the PCP's prescribing decisions. The BHC also conveys basic treatment options to the patient during this time and assists in developing a treatment plan. The BHC may also help patients set a self-management goal. The BHC and PCP huddle to discuss the patient, enabling the PCP, in many cases, to spend just a few minutes with the patient to manage the prescription plan.

This teamwork allows for handling most walk-ins, as BHCs have more flexibility than PCPs (i.e., some BHC appointment slots each day are reserved to accommodate walk-ins and also to facilitate warm handoffs, in which a PCP introduces the patient directly to the BHC during a PCP visit). HealthPoint has recently begun using its nurses and BHCs in this way and hopes to continue improving and expanding this approach, potentially for other conditions such as diabetes and other chronic health conditions.

In addition, non-opioid SUDs are regularly treated during routine office visits by both PCPs and BHCs. The most common SUD diagnoses among HealthPoint patients are two “generic SUD” diagnoses (meaning the clinician did not identify the specific SUD being treated) and alcohol use disorder (AUD). Their fourth most common SUD diagnosis is OUD. Overall, about 25% of patients have a SUD noted on their EHR problem list.

When patients do present with non-opioid SUDs, many, if not most, PCPs and BHCs feel able to provide care. A core principle of the BHC role at HealthPoint is to practice as generalists, meaning they can engage with any health concern affected by behavior or emotions, including SUDs. On the PCP side, medications for AUD and nicotine use disorder are regularly prescribed.

Philosophical Approach to Treating SUDs

For their general population, HealthPoint organizes its care around three broad categories of patients: those who are healthy (e.g., preventive and acute care without other medical conditions), those with moderately complex needs (e.g., patients with generally stable chronic diseases or moderately complex social factors), and those with complex needs (e.g., patients with uncontrolled chronic conditions, SUDs, and social factors that influence their health). HealthPoint's goal is for every clinic to have the resources needed to support patients in each of the three groups. The Whole Care clinic is a pilot designed to better meet the needs of patients in the third group, and they are evaluating whether and how to expand it to other locations.

HealthPoint also believes in interdisciplinary teamwork. They consider teamwork especially important in SUD treatment, so both patients and PCPs receive optimal support. They also value having staff who specialize in addiction medicine. These specialists are not expected to assume care for SUDs from other HealthPoint clinicians; instead, they serve as organizational champions for SUD treatment and help design SUD care structures and train HealthPoint clinicians.

Training

The goal of improving care for SUDs, says Dr. Oakes, has required a system-wide education effort to overcome stigma and operational hurdles. For example, the rollout of buprenorphine treatment, which has occupied the most attention, was led by a PCP champion who developed a comprehensive curriculum and training for all staff, from the front office to clinicians. The Whole Care team has also provided organization-wide training every other year since 2018, covering topics including patient-centered and whole-person care, regional overdose statistics, and related issues. The addiction medicine providers also hold monthly meetings, during which they invite providers to ask questions. There is no systematic training for new providers who were not present during the early training push; instead, they learn mainly on the job. Anecdotally, Dr. Kittle has noticed that an increasing number of new providers entering HealthPoint have already had exposure to the basics of SUD care.

Financing

Prior to the COVID-19 pandemic, Washington State piloted a value-based care model called Alternative Payment Model 4 (APM4). This model enabled participating organizations to focus on value over visits. HealthPoint used the opportunity to expand its care teams, but shortly after the pandemic, Washington reverted all FQHCs back to APM3, a visit-dependent Medicaid managed care payment model. APM3 does not reimburse for certain services that HealthPoint was hoping to add, such as peer services. Thus, the continued expansion of teams and offerings has hinged on sound fiscal management and leveraging other revenue streams.

For one, HealthPoint attempts to maximize value-based components into its managed care contracts with Medicaid payers (something any independent healthcare organization can negotiate). HealthPoint also regularly capitalizes on events that allow it to request a higher visit rate under the FQHC Prospective Payment System (PPS). The PPS helps FQHCs cover the full cost of caring for their population by paying for each visit rather than each service, and the visit rate may increase with various triggering events (e.g., a new service line or new access point). The PPS is helpful because not all services and team member visits are directly reimbursable. For example, the Whole Care clinic provides care navigation services, nurse visits, and SUDP visits that are not typically billable. HealthPoint has consistently scored below the Washington state average for total cost of care, underscoring the value it provides to patients and the community.

Regarding HealthPoint's billable visits for SUD treatment, most are completed by PCPs and BHCs. The BHCs use primarily the Psychiatric Diagnostic Evaluation (for the initial assessment), 30-minute Psychotherapy, and Health Behavior Assessment and Intervention codes. The PCPs bill standard evaluation and management (E&M) and ICD-10 codes for SUD visits, including initial assessment.

In addition to these reimbursement models, HealthPoint (like many FQHCs) relies on grant funding from a variety of sources, including federal, state, and local

agencies and private foundations. Most notable for SUD treatment at HealthPoint is the grant from the Washington State Health Care Authority that (along with reimbursable visits) has helped stand up the Whole Care clinic.

Successes

Culture Shift: Though still a work in progress, addiction medicine providers have noticed a clear shift in how care is conceptualized and practiced at HealthPoint for patients with SUDs. A decade or so ago, says Dr. Kittle, the care was often "paternalistic," with the clinician prioritizing the treatment of the SUD and focusing narrowly on it, without always considering patient preferences and life context. Rules and rigid practices that formed barriers to care were standard. Today, these providers see a markedly different approach, one that is person-centered and focuses on helping patients regardless of whether they are currently interested in quitting substances. Dr. Kittle states, "our clinicians today think more broadly about the person and don't just focus on the substance. Maybe they don't want medication today, but they want to get their vaccines or a pap smear. It's really just about approaching people as humans."

Making SUD Care Routine: Another positive change observed by HealthPoint's addiction medicine providers is a greater willingness among their fellow PCPs and teams to take on SUD care. As Dr. Baker noted, "In the past, our model would be to rely on our specialty partnerships to make sure this patient gets the higher level of care they need. But then realizing that's just not happening the way we had hoped and realizing we can actually do this really well here." Both this change and the culture shift noted above stem less, she says, from top-down leadership messaging or organized attempts to promote these changes. Rather, they are essentially the result of "a thousand small conversations over time", continually encouraging team members to view SUD care as a routine part of primary care.

Team-Based Care: HealthPoint has long emphasized integrating disciplines across its clinics, and those efforts have paid off. The integration of dental services with primary care, for example, regularly leads to new patients for SUD care in Whole Care and other clinics. Patients who initiate care for dental concerns related to SUD use often end up walking into primary care for SUD treatment immediately after seeing a dentist (the dental service also accommodates walk-ins). HealthPoint PCPs say their ability to work patients into their schedule would not be possible without the help of the BHCs, and Whole Care was developed entirely around the goal of offering patients a broad array of team members. The growth and longevity of the behavioral health service are a testament to the belief in team-based care and its ability to deliver results.

Challenges

Universal Screening: HealthPoint does not currently conduct universal screening for SUDs. Partly this is due to a recent EHR switch (they previously screened), and partly from having patients who speak many languages. With over 80 first languages spoken by patients, finding screeners for universal screening is challenging. However, HealthPoint also became concerned that screening was leading to too many referrals to specialty care (which typically did not result in the desired specialty care). This was particularly evident during implementation of the prevention strategy known as Screening, Brief Intervention, and Referral to Treatment (SBIRT). SBIRT entails universal screening, followed by brief goal-setting or motivational interventions for patients engaging in risky substance use, or referral to specialty care for patients with SUDs. SBIRT messaging on referrals led practices to run counter to HealthPoint's efforts to integrate SUD care into primary care and created a barrier to care, given the low referral success rate. Despite these challenges, HealthPoint believes that screening can be valuable when implemented correctly and continues to explore screening options that could serve all of their patients.

Whole Care Expansion: HealthPoint has found great value in the Whole Care clinic. They are convinced it can help them manage patients with complex needs, and they would like to expand it to other locations. However, finding new hires who are dedicated to this approach and population, as Auburn's staff are, can be difficult. Most training programs, they have found, do not prepare clinicians to work as Whole Care clinicians do or to treat patients with such complex needs. Current reimbursement models are also not a good fit for their Whole Care model, given that much of what Whole Care does (such as community outreach, nursing and SUDP visits, and care navigation) is not billable.

Recommendations

Balance the Quintuple Aim Components: Introduced in 2022, the Quintuple Aim is a framework for improving healthcare that balances five key areas: improved population health, enhanced patient experience, lower healthcare costs, improved provider well-being, and advancing health equity. Dr. Oakes, Chief Health Officer, refers to the Quintuple Aim as a guide for designing, implementing, and assessing new and existing patient- and quality-of-care initiatives. Offering SUD treatment in primary care through a team-based approach, as in both the Whole Care clinic and HealthPoint's other clinics, aligns squarely with the framework. Treating the whole person can improve health outcomes; being flexible with walk-ins enhances the patient experience; tending to mental health and substance use issues can lower overall healthcare costs; a team approach takes pressure off the PCP, leading to better provider well-being; and health equity is advanced by reducing the stigma surrounding SUD care.

Create a Training Pipeline: Finding clinicians who feel confident working with SUDs can be challenging, in both the behavioral health and medical fields. To maximize the likelihood of finding clinicians who can address the broad range of concerns patients bring to their clinics, HealthPoint has expanded its training opportunities. It now trains over 200 "learners" each year, from various disciplines. Many of these learners go on to find

work at HealthPoint after completing their training. The BHC at Whole Care, for example, was trained at HealthPoint and developed a passion for working with the population served during his training. Some learners come from local universities, which may not be feasible for FQHCs without a nearby university; however, others, such as family medicine residents and psychology residents, come from around the country.

Adopt Value-Based Payment Models: HealthPoint's experience under Washington's APM4 model was that value-based payments can expand team capacity to help them meet quality goals. They believe a similar payment model that reimburses the full spectrum of primary care services would help them address the complexities of SUD care. For example, reimbursement for peer support, outreach, non-physician clinicians, and care coordination (in addition to core primary care) would help expand and improve their SUD care. Similarly, they believe that payment based on meeting outcome goals in areas such as treatment retention, engagement in care, and reductions in unnecessary emergency department use would better support them than payment based on visit volume.

Acknowledgments

The Collaborative Family Healthcare Association (CFHA)–The Integrated Care Association extends its sincere appreciation to the following individuals at HealthPoint for their invaluable contributions to this case study: Melissa Baker, PhD, Comprehensive Behavioral Health Director; Evan Oakes, MD, MPH, Chief Health Officer; Nathan Kittle, MD, Director of Addiction Medicine; and William Martin, MD, Primary Care Provider. The authors would also like to thank Leslie Paulson, MPH, MSW, Consultant; Marcelo H. Fernández-Viña, JD, MPH, Officer, Substance Use Prevention and Treatment; and Alexandra Duncan, PhD, MPH, Project Director, Substance Use Prevention and Treatment, of The Pew Charitable Trusts for their guidance, expertise, and support in the development of this case study.