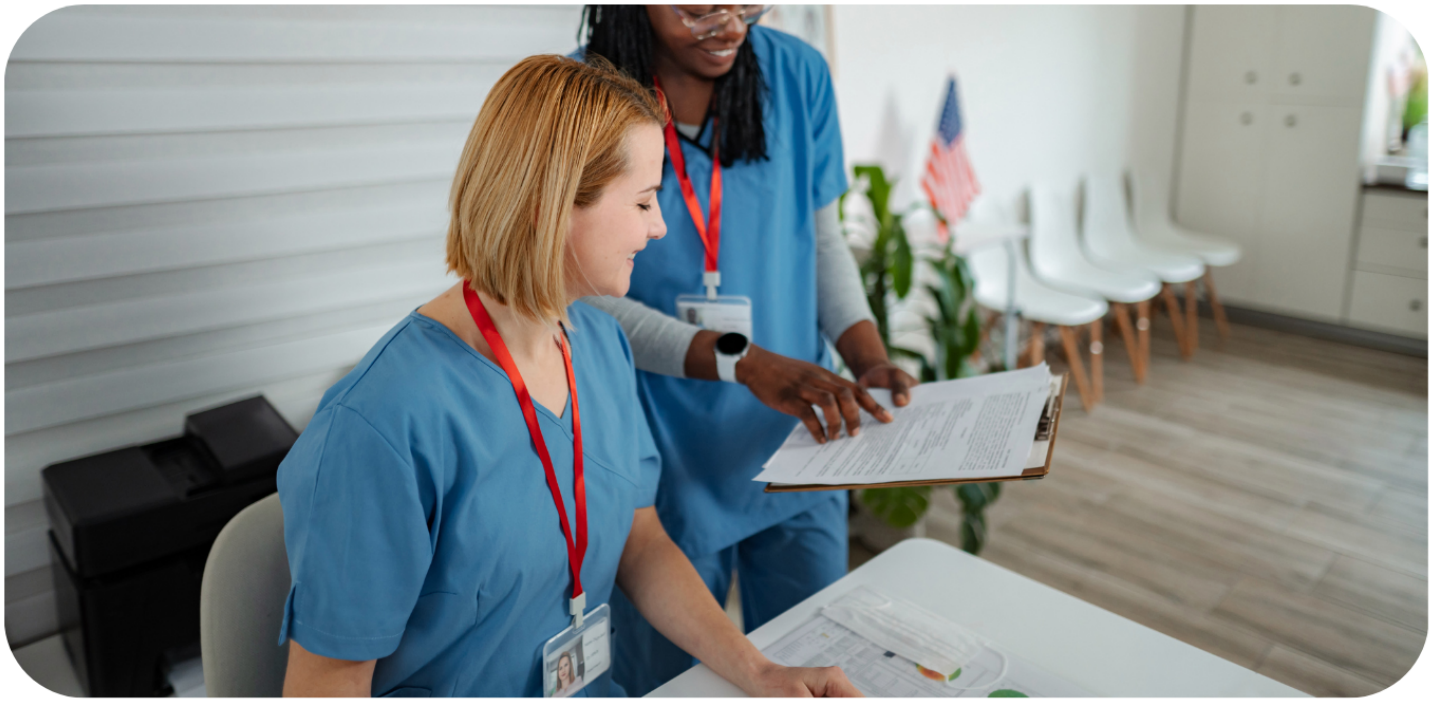
Collaborative Family Healthcare Association

A CASE STUDY

Primary Care Addiction Medicine: Empowering Community Solutions Through Evidence-Based Integration

Waco Family Medicine

Waco, Texas



Executive Summary

Waco Family Medicine (WFM), a Federally Qualified Health Center in central Texas, has become a national example of how primary care can lead in addressing substance use disorders, including opioid, alcohol, and stimulant use disorders, through innovation, integration, and community-based training. Founded in 1969 to address critical gaps in primary care access, WFM now operates 13 clinics, serving over 70,000+ patients annually, with the majority (over 70%) having incomes below the federal poverty threshold. In response to regional shortages of behavioral health and addiction specialists, WFM developed two initiatives: The Waco Guide and Primary Care Addiction Medicine (PCAM). The Waco Guide offers evidence-based, expert-vetted decision tools for prescribing medications to treat mental health and substance use disorders and managing these conditions in primary care. PCAM integrates addiction medicine consultation and treatment within routine primary care workflows. Together, these initiatives transformed WFM's culture, empowering family medicine clinicians to confidently treat substance use, expand behavioral health integration, and reduce barriers to care.

Waco Family Medicine

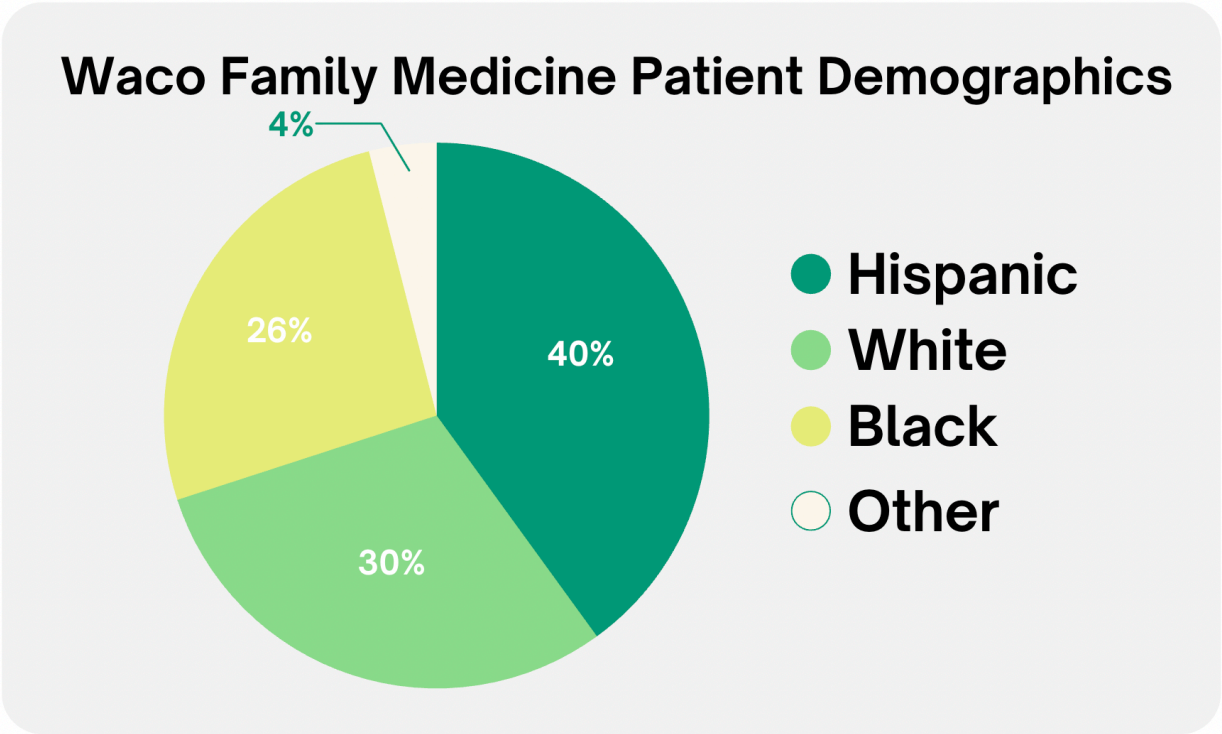


Founded: 1969
Sites: 13
Patients: 70,000+
Role: FQHC and GME

Background

Waco Family Medicine (WFM) was established in 1969 by local physicians and civic leaders in McLennan County, Texas, anchored by the city of Waco, to address severe physician shortages and healthcare inequities in the region. The Waco–McLennan County Family Practice Residency Program, launched in 1970, was the first in Texas with the mission to train family physicians. Designated as a Federally Qualified Health Center (FQHC) in 1999, WFM expanded its integrated medical, dental, and behavioral health services with federal support, a designation that provides stable funding and broader access for underserved patients. WFM began its more formal integration efforts approximately 10 years ago and now operates 15 clinics, serving nearly one-fifth of the county's population. The sustained focus on training has directly addressed provider

shortages; more than half [1] of the area's family medicine physicians are graduates of the WFM residency program. This history of innovative workforce development and mission-driven care [2] laid a foundation for ongoing innovations, positioning the organization as a national model for system-level transformation.



Impetus

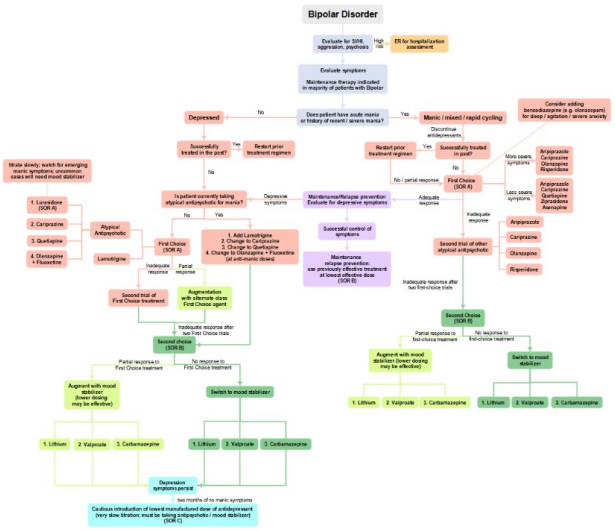
WFM has long held that proactive, resourceful, and self-reliant approaches can overcome regional healthcare limitations. This philosophy first guided its founding amid physician shortages and, decades later, as behavioral health and addiction needs grew beyond the community's capacity. By 2010, limited access to counseling and almost no local options for substance use treatment left many patients without care. WFM responded by hiring its first behavioral health clinician and, by 2016, launching the Integrated Behavioral Health Program, which embedded Licensed Clinical Social Workers (LCSWs) in primary care teams. As demand for therapy services increased, WFM developed a behavioral health training program and established an independent therapy office to provide longer-term care. Persistent shortages of psychiatric and addiction specialists resulted in the development of new resources—The Waco Guide and Primary Care Addiction Medicine (PCAM)—enabling primary care

> **"...our detection rates went up [because providers were more aware of behavioral health diagnoses], so now we said, well, biggest pain point is psychopharmacology and we need to have some guidance for our prescribers in this area. That's where the Waco Guide came from. That was the actual driving force for the Waco Guide."**
> **-Dr. Lance Kelley**

clinicians to manage behavioral health and substance use disorders (SUDs) within the clinic.

The Waco Guide

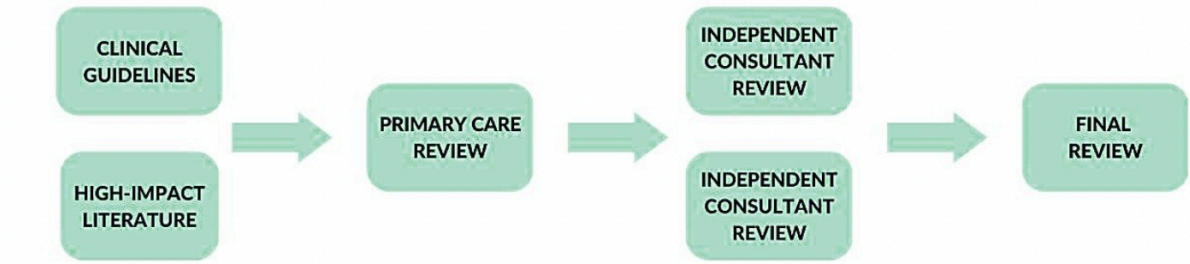
Before 2019, behavioral health and medical clinicians at WFM collaborated to identify evidence-based pharmacotherapies that could help primary care providers manage bipolar depression and other complex behavioral health conditions. Their efforts resulted in a one-page, paper-based decision-support tool (see below for the updated version)—the first iteration of The Waco Guide. The Waco Guide to Psychopharmacology in Primary Care was created to support primary care clinicians managing mental health disorders and SUDs, particularly in rural and underserved communities, where primary care often functions as the de facto mental health system. High provider interest led to the development of additional tools for other high-need conditions, such as depressive disorders or generalized anxiety disorder, resulting in the printing of a compilation of clinical decision tools (the second iteration of The Waco Guide) to be used across the organization to support consistent, comprehensive, evidence-based practice. Since its launch, The Waco Guide has been accessed by over 60,000 users nationwide in its first eight years alone [3], demonstrating



View Full Size Image Here

strong demand for practical, evidence-based psychopharmacology resources in primary care.
As a premier primary care training site, WFM hosts medical students and residents from other institutions. When these trainees began to request permission to use and distribute The Waco Guide to peers when they returned to their home institutions because of its impact on their confidence in addressing mental health conditions, WFM recognized the broader potential. WFM partnered with ZimDot, a developer of user-friendly medical apps, and, with support from the Episcopal Health Foundation (EHF), launched the first digital version of The Waco Guide in 2021. EHF, a Houston-based philanthropy established by the Episcopal Diocese of Texas, funds initiatives to improve health equity across 81 counties through community-based care, policy innovation, and systems change.

To ensure clinical rigor, WFM partnered with Massachusetts General Hospital Visiting (MGH Visiting), part of the Division of Professional and Public Education in the Department of Psychiatry, to provide expert faculty review, literature validation, and ongoing consultation, integrating Strength of Recommendation Taxonomy (SORT) designations to ensure that each recommendation met the highest standards of evidence. SORT ratings (A, B, or C), indicate to clinicians the strength and consistency of the underlying evidence, helping them quickly determine whether a treatment is strongly supported, supported by limited or inconsistent evidence, or mainly based on consensus; information that directly informs real-time decision-making in primary care settings.



Waco Guide to Psychopharmacology in Primary Care® - an evidence-based, expert-vetted, free resource, created to support primary care clinicians managing mental health and substance use disorders, especially in rural and underserved communities. For SUDs, the tools provide structured algorithms that highlight first-line medication options (e.g., naltrexone for alcohol use disorder or buprenorphine for opioid use disorder), second-line strategies when initial

treatment is ineffective or contraindicated, and adjunctive approaches, including off-label options, behavioral interventions, and risk-mitigation strategies, to aid primary care clinicians in decision-making.

Primary Care Addiction Medicine (PCAM)

The Primary Care Addiction Medicine (PCAM) program at WFM, like many of the organization's innovations, emerged in direct response to unmet community needs for accessible addiction treatment. In 2018, WFM received an Expanding Access to Quality Substance Use Disorder and Mental Health Services (SUD-MH) grant from the Health Resources and Services Administration (HRSA) to strengthen SUD care within primary care. At that time, WFM had limited infrastructure for screening or treatment, patients with SUDs were frequently referred out for specialty care, and prescribers faced barriers such as the federal Drug Enforcement Administration (DEA) buprenorphine waiver requirement before its elimination in 2023. With the repeal of the "X-waiver," any DEA-registered clinician can now prescribe buprenorphine for opioid use disorder (OUD) without additional training or patient-cap limits, significantly reducing administrative barriers and expanding access to treatment.

The HRSA grant supported Dr. Zachary Sartor, a family medicine physician and residency faculty member, who became the program's clinical champion. Partnering with Dr. Lance Kelley, Chief Behavioral Health Officer, he launched a small pilot clinic that evolved into what is now PCAM. The clinic's early goals were two-fold: (1) to provide initial evaluations and prescribe buprenorphine for patients with OUD receiving care within WFM clinics, and (2) to train and mentor resident and attending physicians to build confidence in managing SUDs within WFM clinics.

Initially operating only half a day per week, the clinic expanded as referrals increased. As cases of opioid use in combination with alcohol or stimulants, or alcohol and stimulants as primary substances used, became more common, Dr. Sartor pursued additional training through continuing medical education and the American Society of Addiction Medicine (ASAM), broadening PCAM's focus beyond OUD to the full spectrum of SUDs. This evolution included attention to stimulant use disorder, where behavioral interventions remain the primary treatment, but off-label medications are prescribed as appropriate.

> **"There is this idea that if you have a little bit of a backstop, you're more likely to wind up and throw the ball pretty hard… [through PCAM] we have that backstop so that [providers] can wind up and throw the fastball… if we could give people just a little bit of structure and guidance… then they could really run and excel with treating patients with behavioral health disorders and substance use across the spectrum." - Dr. Zachary Sartor**

By 2025, PCAM had completed 1,460 patient encounters, averaging 9–12 per half-day, and expanded operations to three half-days per week, supported by an additional faculty physician, an advanced practice provider, and behavioral health clinicians. The model remained flexible, integrating behavioral health staff as needed to address co-occurring mental health conditions or provide referrals for therapy.

A hallmark of PCAM's success has been its team-based adaptability. Medical assistants (MAs) became central to the model, taking on hybrid roles in patient coordination, HIV and Hepatitis C screening, patient education, and ongoing follow-up. Their consistent presence provided both operational efficiency and relational continuity, ensuring that patients remained connected to care and treatment adherence improved. This resourceful, interdisciplinary structure enabled PCAM to expand access to evidence-based addiction treatment within primary care while maintaining high quality and continuity amid rapid growth.

Building on this success, WFM developed the PCAM Implementation Guide, a structured, evidence-informed framework designed to support the replication of the model by other primary care systems. The guide outlines best practices, workflow adaptations, and clinical tools for integrating behavioral health and addiction treatment within primary care settings. Continued development was supported by the Bloomberg American Health Initiative at the Johns Hopkins Bloomberg School of Public Health, which invests in national efforts to strengthen public health responses to addiction, adolescent well-being, and other pressing health challenges. Consistent with its mission, WFM does not charge for access to The Waco Guide or the PCAM Implementation Guide. Instead, the organization collaborates with private funders to support ongoing development and clinical review, ensuring that both resources remain current, evidence-based, and freely available. This open-access approach reflects WFM's enduring commitment to empowering primary care clinicians to meet the rising demand for behavioral health and addiction treatment.

Primary Care Addiction Medicine Implementation Guide – aims to improve addiction care in primary care settings through a multimodal service-delivery model. This model addresses barriers to effective implementation by consolidating resources into a hub-and-spoke model that leverages extant resources.

PCAM Workflow:

Pre-appointment:

1. Receipt of referral from other WFM primary care providers, which MA screens for appropriateness.
2. Patient contacted by MA to obtain additional information as necessary and to schedule the patient in the first available visit. Patients are often seen within two weeks of referral.

Appointment:

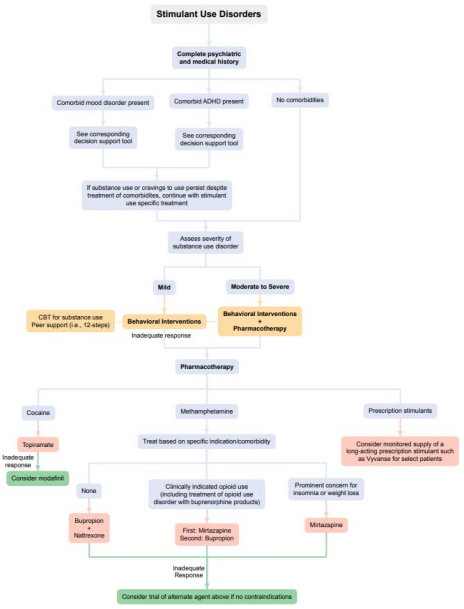
1. Medical provider and MA complete a pre-clinic huddle to discuss the day's patients.
2. Patients check in at the front desk, just like for any other primary care visit.
3. MA escorts the patient to the designated PCAM area of the clinic (typically two to three exam rooms and one provider room), records vital signs, and collects an initial history, summarizing key information for the provider.
4. MA notifies medical provider if lab work, including HIV or Hepatitis C screen, is needed.
5. Medical provider sees the patient and assesses patient's progress toward treatment goals or helps to develop treatment goals consistent with the patient's values.
    a. If a family medicine resident is rotating with the faculty physician, the resident will see the patient first after reviewing the case with the faculty physician. After seeing the patient, the resident (if present) will discuss the case with the faculty physician.
6. Brief interventions by medical provider, and if appropriate, behavioral health clinician.
7. Treatment plan and proposed interventions reviewed with patient utilizing motivational interviewing, including individualized strategies for polysubstance use when present. Prescriptions are refilled, and laboratory tests are ordered as needed.
8. Long-acting injectable medications (Naltrexone, Buprenorphine) are administered in the clinic as needed.
9. MA reviews physician recommendations, including medication instructions, with the patient and schedules the patient's next

appointment. Patient does not utilize the primary care front desk for check-out.
10. If the patient needs lab work or other services, they will leave PCAM and receive them elsewhere within the clinic.

Post-appointment:
1. MA will field patient calls throughout the week and, as needed, discuss them with medical providers.
2. MA maintains a list of upcoming appointments and long-acting injectables in the electronic medical record, cross-checks it, and contacts patients.

Integrating PCAM Workflow and The Waco Guide in Practice

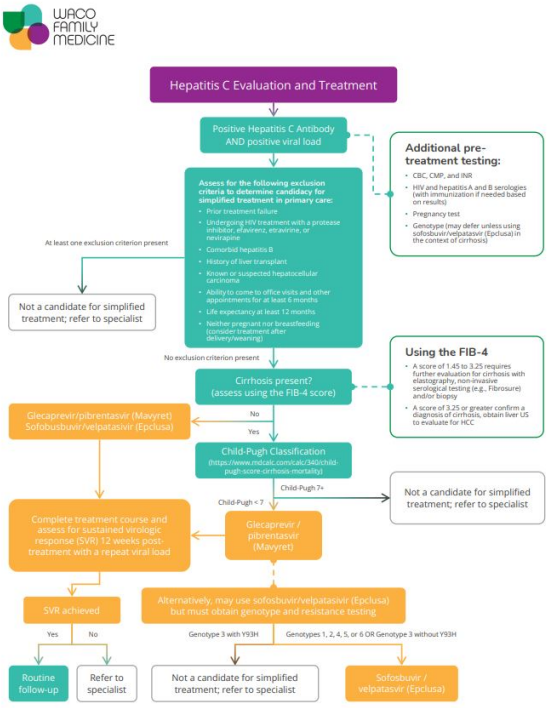
A 46-year-old male is referred to PCAM by his primary care provider from an external Waco Family Medicine provider for stimulant use. He is being referred following an emergency room visit for chest pain, in which the workup was negative for cardiac disease. He was found to be positive for Hepatitis C with an active infection as part of lab work completed before the visit. At his initial evaluation, he is seen by a resident physician, who is overseen by a physician experienced in the treatment of stimulant use disorder and Hepatitis C. The resident physician uses motivational interviewing to identify and leverage the patient's intrinsic motivation and is coached by his supervising physician on co-occurring mental health issues. As a result, the patient is found to have a history consistent with posttraumatic stress disorder (PTSD), which is impacting his stimulant use. Reviewing The Waco Guide, the physician assists the resident in developing a treatment plan for stimulant use disorder that includes both pharmacotherapy and behavioral health interventions. Additionally, confirmation of prior Hepatitis C infection, without exclusion criteria, allows them to discuss treatment options for this condition. At the same time, the patient is connected with an integrated behavioral health clinician who discusses brief written exposure therapy as a means to address his PTSD and the impact this has on his cravings for methamphetamine. The MA arranges follow-up appointments for individual therapy with the behavioral health and PCAM clinicians before the patient leaves the exam room.



Waco Stimulant Use Disorder Disorder Treatment

Retrieved 10/4/25

Click Here to View Full Image



Waco Hep C Evaluation and Treatment

Retrieved 10/4/25

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Urine Drug Tests

PCAM has adopted the approach of offering urine drug testing to patients when clinically indicated, but not requiring it for all patients or at every visit. Additionally, completion of a urine drug test is never necessary to receive treatment. Clinicians adopted this stance for several reasons, including the cost of sending out tests, inefficiencies in immunoassay testing that lead to false positives/negatives, and the inability to test for common substances such as buprenorphine. One way in which urine drug tests are beneficial is in offering to test when an individual is using multiple substances to identify whether more dangerous substances are present but unknown to the patient.

"We need to be able to come alongside the patient to address other use, and a urine test rarely will change my clinical decision based on the other information I have received."

Training

Waco Family Medicine has made significant and purposeful strides in building PCAM capacity by embedding addiction medicine training into its residency and faculty development programs. Training for clinicians has been highly experiential, with clinicians learning through direct patient care, continuing medical education, and mentorship from more experienced colleagues. As a result of this training model, primary care faculty physicians have qualified to sit for the Addiction Medicine board certification exam through the American Board of Preventive Medicine's Practice Pathway, which concluded in 2025. The product of this experiential learning style, when combined with WFM's commitment to an evidence-based treatment model and a culture that integrates specialty services into primary care, has been seamlessly adopted by WFM's residency education program. The residency is primarily funded through standard Graduate Medical Education (GME) sources, including Medicare payments to hospitals shared with the clinic, clinical revenue from the FQHC, funds from the Texas Higher Education Coordinating Board, and HRSA grant funding, among others. This creates a stable foundation for maintaining this integrated training model. The breadth of trainees receiving instruction on addiction medicine through WFM's residency program includes family medicine residents, medical students, and behavioral health trainees. The PCAM Implementation Guide comprises a sample GME curriculum, educational goals,

and supporting resources. PCAM is a mandatory rotation in WFM's curriculum, with most clinic time allocated in the first year. Additionally, family medicine resident physicians have the opportunity to spend more time in the clinic during the final two years of residency if a specific interest arises.

Beyond training future professionals, PCAM provides immediate capacity building within its community by serving as a consultation clinic that educates WFM providers who refer patients for care from any of its 15 clinics. The PCAM consultation clinic serves as both a referral hub and a training ground, allowing clinicians to co-manage cases and gain confidence in treating SUDs through feedback from PCAM providers. Additional collaborative benefits arise when these same PCAM providers are actively engaged in other medical settings, such as other WFM clinical sites or the two regional hospitals, and are broadly interfacing with members of the medical community. These clinical and personal relationships led to WFM meeting requests for additional formalized training within the region by hosting a local summit, where best practices, including those from PCAM, can be further disseminated. WFM's peer-to-peer and collaborative approach to training and capacity building has enabled PCAM to become a sustainable and scalable model.

Staffing

PCAM operates through a small, highly dedicated team of clinicians who collaborate across disciplines and within the broader health system. Its growth has been driven by providers eager to learn, innovate, and build expertise to improve patient outcomes. Its sustainable success has been supported by primary care providers resuming care of patients referred to PCAM who have achieved stability through PCAM's treatment plan.

Medical Providers (0.3 full-time equivalent (FTE) total): Two faculty physicians and one advanced practice provider each staff the clinic for a half day weekly. They coordinate patient continuity, supervise residents, and facilitate brief teaching sessions, while maintaining other clinical responsibilities across WFM.

Medical Assistant (1.0 FTE): Serve as the central coordinator and consistent point of contact for PCAM patients. The MA manages referrals, scheduling, chart reviews, and screenings; facilitates warm handoffs; and provides patient education and follow-up.

Behavioral Health Clinician (LCSW; variable FTE): Embedded within primary care teams to support screening, intervention, and treatment. They collaborate with residents and faculty, provide therapy, and

develop clinical pathways. Because all PCAM patients receive care within the WFM system, any available behavioral health clinician can be engaged for direct support as needed.

WFM's financial sustainability, especially for PCAM, relies on maximizing existing resources and adapting to local funding realities. The organization initially leveraged its Expanding Access to Quality Substance Use Disorder and Mental Health Services (SUD-MH) grant (2018-2020) to establish the clinic, followed by EHF funding (2020-2021) to optimize clinic workflows and offset the time invested in faculty uptraining. Since 2024, the clinic has been sustained through fee-for-service billing by medical and behavioral health clinicians, as well as through 340B status to ensure affordable access to medications for SUD through its on-site pharmacy. Time-based billing codes are most frequently used by medical providers (99213-99215, ranging from 20 to 40 minutes) and behavioral health clinicians (90832, 30 minutes). Despite challenges such as staff retention and limited external referral options, WFM maintains its programs by integrating behavioral health services, utilizing flexible staffing models, and prioritizing connections to primary care to facilitate treatment engagement. This pragmatic approach, combined with ongoing quality improvement and innovative evidence-based support tools, helps WFM sustain and grow its behavioral health and addiction medicine services even in a resource-constrained environment.

The 340B Drug Pricing Program, established by Congress in 1992 through the Veterans Health Care Act and coded as Section 340B of 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

Creation of an Integrated Clinic: WFM successfully developed the PCAM clinic within its existing primary care infrastructure, staffed entirely by current clinicians. This integration produced multiple benefits:

- Providers gained expertise, leading to board certification in Addiction Medicine.
- Embedding addiction care in primary care improved care coordination across medical, behavioral health, and specialty services.
- As PCAM operates within primary care, it avoids additional confidentiality restrictions under 42 CFR Part 2.

42 CFR Part 2 A federal regulation that protects the confidentiality of SUD treatment records by restricting disclosures without written patient consent, thereby creating protections beyond those in standard Health Insurance Portability and Accountability Act (HIPAA) privacy rules. Because Part 2 applies specifically to standalone SUD treatment programs, clinics that are not classified as such (like addiction care embedded within general primary care) are not subject to these stricter consent requirements, allowing clinicians to share relevant SUD information under routine HIPAA rules and support more seamless care coordination.

Cultural Transformation in Primary Care: Before PCAM, SUD treatment was not widely regarded as part of primary care. The program has since shifted clinical culture, with WFM and community providers now routinely identifying and treating SUDs within primary care settings. This mindset is reinforced through residency training, empowering future physicians to sustain this integrated model.

"I'll do it if it is a part of the community's need. I can advocate for it if it is a need. It can be integrated into normal clinic flow, especially if I have the support of a social worker."
- WFM Family Medicine Resident

Advancing Evidence-Based Practice: WFM's commitment to evidence-based innovation has led to the development of The Waco Guide and the PCAM Implementation Guide, both of which provide accessible, clinician-friendly tools that support model replication and promote high-quality, data-informed care.

Challenges

State Policy and Funding Barriers: State-level policies continue to restrict innovation in behavioral health and SUD treatment. Between 2024 and 2025, Medicaid disenrollment led to a 9% decrease in the number of enrolled WFM patients. Evidence-based interventions such as peer recovery coaching remain unreimbursed in Texas, and Contingency Management, the most effective intervention for stimulant use disorder, is not supported under current state policy, limiting the adoption of proven treatment models.

Limited Access to Specialty Services: Texas ranks 50th out of 51 states [4] for access to mental health care, reflecting widespread shortages of affordable services. WFM developed PCAM primarily in response to the lack of regional options for SUD treatment. While PCAM provides medications and integrated therapy, access to intensive outpatient or residential programs remains limited, particularly for Medicaid-insured patients.

Workforce Retention: Despite successful training of behavioral health clinicians, WFM faces challenges in retaining staff. Highly skilled clinicians are frequently recruited by external organizations, creating ongoing staffing fluctuations and program instability.

Recommendations

Leverage Existing Resources and Funding: WFM successfully utilized multiple grants to establish and operationalize PCAM. Other FQHCs can expedite implementation by referencing the PCAM Implementation Guide, which consolidates lessons learned, workflows, and templates to facilitate model replication without duplicating prior grant-funded efforts.

Start Small and Adjust Capacity Gradually: When introducing addiction medicine services, WFM recommends beginning with a limited number

of dedicated appointment slots rather than blocking a full clinic session. Early overestimation of demand led to underutilization; gradual scaling ensures efficiency and sustainability.

Empower Primary Care Providers to Lead in SUD Care: WFM emphasizes that SUD treatment belongs within the scope of primary care. Providers should start with manageable steps, such as initiating buprenorphine for OUD, and build confidence through experience.

"Start with low-hanging fruit like providing buprenorphine for opioid use disorder… when polysubstance use is identified, and it will be, because polysubstance use is the rule, not the exception - do something. The only wrong thing to do is not to do anything."
- Dr. Zachary Sartor

Acknowledgments

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