Collaborative Family Healthcare Association

A CASE STUDY

Using Generalists and Clinical Pathways to Make Substance Use Care Routine

Piedmont Health Services

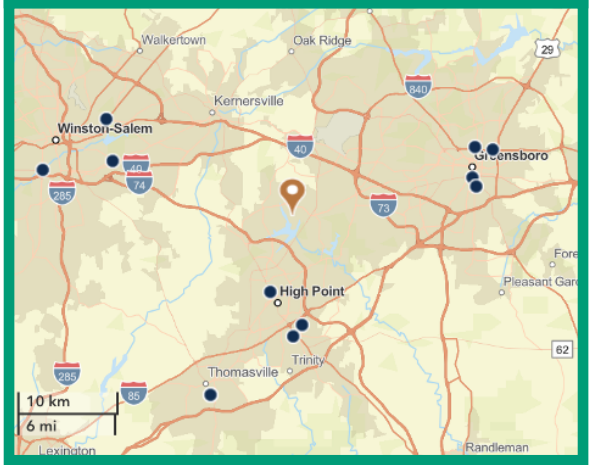
Chapel Hill, North Carolina



Executive Summary

Piedmont Health Services (PHS), a Federally Qualified Health Center based in Chapel Hill, North Carolina, aims to integrate substance use treatment into routine primary care. By using “clinical pathways” that outline the steps, roles, and tools for delivering consistent care, their generalist clinicians can more confidently screen, assess, and treat substance use disorders (SUD). Building on the success of its medications for opioid use disorder (MOUD) program launched in 2016, PHS replicated its structured pathway approach to opioid use disorder for the care of alcohol, nicotine, stimulant, and polysubstance use disorders. Embedded behavioral health consultants and rotating addiction counselors collaborate with primary care providers to deliver accessible, team-based care. They utilize a low-barrier model in which care is easily accessible, flexible, non-punitive, and welcoming to patients regardless of their insurance status, readiness for change, or prior use patterns. With 60% retention in MOUD treatment, reduced depression and anxiety among patients, and growing clinician confidence in managing SUD, PHS demonstrates how team-based, structured, low-barrier care can produce good outcomes in underserved populations. Their model also highlights how generalist medical and behavioral health clinicians can work together to normalize SUD care. Despite challenges with access to psychiatry, data systems, and funding constraints, PHS shows what is possible.

Piedmont Health Services



Founded: 1968
Sites: 16 + mobile
Patients: 58,000+
Area: 6 rural counties

Background

Serving the community for 55 years, Piedmont Health Services (PHS) was founded in 1970 as a Federally Qualified Health Center (FQHC) by healthcare professionals affiliated with the University of North Carolina at Chapel Hill. What began as a single rural clinic in Prospect Hill has grown into a regional network of 11 health centers across 14 counties. Today, PHS serves about 48,000 patients, many of whom live in small towns, rural areas, or suburbs. Nearly half (44%) are uninsured and are best served in a language other than English. To meet the diverse and often complex needs of its patient population, PHS provides a broad range of integrated services, including pediatric and adult

primary care, dental care at six locations, behavioral health services, nutrition counseling, and on-site pharmacies with free home delivery. The organization also operates two senior care centers and a targeted program for agricultural workers. To improve accessibility, PHS maintains mobile medical and dental units, as well as a school-based behavioral health center, reflecting its mission to "meet patients where they are," both geographically and clinically. This community-focused, comprehensive approach enables PHS to integrate substance use treatment into primary care, addressing a critical gap for their rural and underserved patients facing barriers to specialized substance use disorder (SUD) services.

Behavioral Health Services

Each PHS clinic is staffed with one or two behavioral health consultants (BHCs), supported by two addiction specialists who rotate among clinics and offer virtual assistance to patients and staff. The BHCs are licensed clinical social workers (LCSWs) or LCSW-Associates (LCSWAs), master's-level social workers practicing under supervision while working toward licensure. The addiction specialists possess dual credentials as LCSWs and licensed clinical addiction specialists (LCASs). In addition to providing counseling, they deliver care management to patients with SUDs. They also participate in program activities and help manage community partnerships and referrals.

In addition to seeing patients, BHCs serve on clinic leadership teams, which enhances communication and team coordination. They describe themselves as generalists who address behavioral factors that impact health, including SUDs. Although SUDs represent a small portion of their daily work—averaging about three visits per day across all clinics—30% of patients with a SUD engage with a BHC. Notably, nearly 40% of BHC visits occur on the same day as a primary care appointment, typically through a warm handoff. This accessibility is key to reaching patients with SUD, who often go without care.

While not all BHCs begin with confidence in treating SUDs, they undergo structured onboarding, including shadowing LCASs, training in medications for opioid use disorder (MOUD) and other SUD protocols, and access to ongoing LCAS support. These efforts have been crucial in boosting clinician readiness and confidence with SUD treatment, a key factor in encouraging greater BHC involvement with SUDs.

Impetus

The systematic approach to treating SUD at PHS started in 2016, just as opioid overdose deaths were soaring in North Carolina; the state experienced a 32% increase in 2017 compared to 2016. Recognizing the urgency, the medical and behavioral health primary care team members at PHS collaborated to develop a clinical pathway for MOUD. Initial funding from the Health Resources and Services Administration (HRSA) helped establish the pathway, and its ongoing success has naturally led to continued growth to this day.

Clinical Pathways

Clinical pathways, also known as "care pathways", have been central to PHS's efforts to make SUD care accessible and team-based. A clinical pathway provides clinicians with a standard structure for care, outlining evidence-based steps for effective treatment of a given condition. Pathways are commonly used in acute care settings but can also be a good tool for helping generalists in primary care (such as PCPs and BHCs) manage problems they are less familiar with (such as SUDs). They can also help ensure care is consistent across clinicians and sites. By outlining when and how to bring other team members into care, pathways also help enable the best use of team members. At PHS, pathways outline the steps for the care of various SUDs, including which screening tools and labs to use, key assessment questions to ask, which treatments to offer the patient, and the roles of different team members. Specific metrics, such as urine drug screening results, engagement with BHCs, and visit attendance, are tracked to help PHS teams monitor the pathway's impact.

In interviews with PHS clinicians, the success of the MOUD pathway was noted as a catalyst that opened the door to expanding treatment of other SUDs (particularly alcohol, stimulant, nicotine, and polysubstance use disorders). MOUD is an effective treatment that patients sought out and benefited from, and the pathway provided a structure that made care easier for clinicians to deliver. Dr. William Martin, a primary care provider (PCP) at the Moncure clinic within PHS

who introduced MOUD to the clinic, also observed that many PCPs who were initially wary of providing care for SUDs became proponents as they saw patients improve and MOUD care become smoothly integrated into the workflow. For many BHCs, engagement was facilitated simply by routine inclusion in care, as the MOUD pathway calls for. With the support of LCAS providers, BHCs' skills and confidence in working with SUDs gradually grew.

Building off the MOUD pathway success, PHS set about developing a similar pathway for nicotine use disorder, which is now a central strategy for increasing the reach of the behavioral health clinicians even further, and more recently for alcohol use disorder. Several years of planning also led two years ago to the launch of a contingency management (CM) program for patients who are receiving MOUD, to reinforce positive behaviors and reduce stimulant misuse in the case of polysubstance use. Approximately 40% of the 406 PHS patients with opioid use disorder (OUD) have a co-occurring stimulant use disorder.

MOUD Program

The MOUD pathway at PHS has had great success. In 2024, it served 406 patients, with more than 60% remaining engaged in treatment two years later. This retention rate exceeds even the one-year retention results of typical programs. In addition to high retention, patients report 33% and 11% reduction in depression and anxiety symptoms, respectively, after MOUD treatment. Clinicians credit their success to a non-stigmatizing, low-barrier approach that allows medication to be provided at the initial visit and a flexible follow-up strategy. They also offer naloxone, fentanyl, and xylazine test strips, which not only reduce the immediate risk of adverse health outcomes, but also signal their willingness to engage with patients in a non-judgmental manner. The accessible, generalist approach taken by BHCs also ensures that patients have additional behavioral health support when needed. Metrics used to track the impact of the MOUD pathway are maintained in a spreadsheet, mainly by the LCAS providers.

Contingency Management

Contingency management (CM) is the application of tangible, positive reinforcers to change behavior. In CM treatment for SUDs, desired behaviors such as abstinence or medication adherence are reinforced with monetary incentives during clinic visits. Currently, there are no FDA-approved medication treatments indicated specifically for stimulant use disorders (e.g., cocaine, methamphetamine), but CM is an evidence-based treatment backed by three decades of research. It is also an evidence-based adjunct to the medication treatment of other SUDs.

At PHS, CM use began in late 2023 with a grant from the North Carolina Health Care Association. PHS uses CM when indicated to bolster positive health behaviors in patients receiving MOUD (whether for opioids alone or for polysubstance use). Specifically, PHS utilizes CM to reinforce attendance at treatment and adherence to prescribed medication for other health conditions (e.g., diabetes) as well as to reward stimulant-negative urine specimens for patients whose treatment goals include cessation of stimulant use. Patients who have persistent transportation barriers are often offered CM to promote treatment engagement. PHS does not provide cash as a reinforcer. Instead, patients are given prizes such as journals, tote bags, toothbrush kits, sleep masks and earplugs, water bottles, stress balls, and Bluetooth listening devices (all with the PHS logo). The hope for PHS is that outcomes from the CM pathway, combined with the known effectiveness of CM, will position them well for continued grant funding of this initiative.

Philosophical Approach to Substance Use Care

During discussions with leadership and staff, two main themes surfaced as central to PHS's approach to treating SUD. First, the idea that care for SUDs should be a normal part of primary care; second, the importance of a flexible, non-judgmental approach for effective patient engagement. These beliefs may not be shared by every PHS staff member, but they are common among staff who regularly provide SUD care.

This first belief is evident in many ways throughout PHS, beginning with their approach to hiring clinicians. Dr. Adrian Mancheno, Chief Medical Officer,

explains that he has deliberately avoided hiring addiction medicine specialists into PCP roles because it could discourage other PCPs from treating SUDs and leave a patient panel that is hard to replace if the specialist departs. Instead, Dr. Mancheno opts to hire PCPs who are strong generalists and then build teams to support and expand their capabilities.

There is variation among PCPs (and other team members) in comfort and interest in treating SUDs. Staff estimate that around half of PHS providers ask patients seeking medication for a SUD to follow up with a different PCP who regularly provides it. However, even in these cases, say PHS team members, the initial PCP is typically willing to start medication for the patient. Most medications used to treat SUDs can be accessed at PHS (the exceptions being methadone for OUD and long-acting buprenorphine, which insurance usually does not cover).

The emphasis on primary care treatment for SUDs extends to behavioral health team members. During a meeting with BHCs, one noted, “We should all be able to do primary care and treat substance use as a primary care issue. It's a chronic disease, right? Like diabetes or hypertension."

In line with their PCP hiring practices, PHS has not hired SUD-specific counselors or peers for each team; instead, it has hired generalist behavioral clinicians. Although BHCs, like PCPs, vary in comfort and interest in working with SUDs, almost all reported moderate to high comfort in working with SUDs, and all reported regularly helping patients with SUDs.

This generalist view of the scope of care provided by PHS BHCs is uncommon among mental health professionals nationwide. PHS BHCs indicated their approach results partly from necessity, given the rarity with which their patients can or do access specialty SUD care. But it also results from perspective shifts; the BHCs view addiction as a chronic condition that they can support in primary care over time, and they prioritize broad health and functioning goals. Compared to a more specialized, narrow approach focused solely on substance use goals, their approach enables engagement with a wide range of concerns and patients. For example, if a patient with a SUD and diabetes can improve their diabetes management, that is considered progress even if the substance use does not change.

The second part of PHS’s philosophy, an emphasis on flexible, non-judgmental care practices, stems partly from the reality that patients present at varying levels of readiness for change. Some are brought to the clinic by concerned loved ones who hope the clinicians can prompt the patient to change; others are identified during universal substance use screening and may have little interest in change; and even motivated patients who seek out help still struggle with the

normal waxing and waning of motivation over time. For many such patients, say PHS staff, an abstinence-based approach would seem unattainable and risk deterring patients from care. Thus, staff instead try to make as much progress as possible in each moment. Referring to PCPs and the whole of PHS, one BHC noted, "I think we are in an environment where people are really stepping up, they're like being courageous to try to meet patients where they are."
Service Model

Integrated and Primary Care-Led Approach: Consistent with the belief that SUD care should be fundamental to primary care and given the paucity of specialty SUD care in many of the areas they serve, PHS clinics largely provide SUD care themselves. As one clinician put it, “Our default expectation is that we will be managing these patients ourselves.”

Identifying and Engaging Patients: Substance use concerns are identified in several ways: patients may seek help directly, issues may arise during visits for related medical or behavioral problems, or they may be detected through universal annual screenings conducted for all patients aged 12 and older. Approximately 17% of patients at PHS screen positive for problem substance use each year. A positive screen typically triggers a referral to a BHC (per the PHS pathway), though BHCs can be engaged at any point for any behavioral concern, including substance use. Screening uses a mix of evidence-based and locally developed tools:

> **Adolescents:** CRAFFT screening tool
> **Adults (drug use):** pre-screen with the NIDA Single-Question Screening Test; a positive response prompts the clinician in the electronic health record (EHR) to administer the more comprehensive Drug Abuse Screening Test–10 (DAST-10).
> **Adults (alcohol use):** Alcohol use disorder (AUD) pre-screening in adults is accomplished using two locally developed questions; one asks about binge drinking, and one about excessive weekly consumption. A positive response to either prompts for administration of the full Alcohol Use Disorders Identification Test (AUDIT).

Behavioral Health Integration: BHCs collaborate closely with PCPs through warm handoffs, often seeing patients immediately after a medical visit. To enhance accessibility, BHCs work in the same clinical space as PCPs and other team members, occasionally seeing patients in exam rooms, and have shorter visits (20-30 minutes) compared to traditional therapists in specialty care settings. When patients with SUDs are complex or not improving, BHCs may consult with an LCAS provider.

Care Coordination and Support Services: Member Care Coordinators connect patients to social services and community resources, support transitions of care, and help address barriers to engagement, such as transportation or housing instability. These team members generally have a Bachelor's degree in Social Work, Human Services, Public Health or a related field, or have relevant experience in a healthcare or human services field. There are no psychiatry services, peer specialists, or community health workers at PHS.

Collaborative Network: PHS clinics are part of a hub-and-spoke arrangement through North Carolina Substance Treatment and Recovery (NC Star). Focused initially on MOUD dissemination, three hubs offer didactics and stepped-up care to spoke clinics such as the PHS clinics. Staff at PHS noted that as their providers gained experience with SUD treatment, their need for outside assistance lessened considerably. In fact, other spoke clinics have begun treating PHS as a hub at times, seeking guidance on integrating SUD care into their routine offerings. Referrals to external specialty SUD programs may be triggered when patients are not improving, need additional support, or need psychiatry involvement. However, such referrals are now rare, reflecting PHS's growing internal capacity to provide comprehensive addiction treatment within the primary care setting.

Financing

Nearly half of PHS's patients are uninsured, making financial sustainability an ever-present challenge. Approximately 77% of PHS revenue is derived from patient service income, with an additional 20% from grants and contributions. Among insured patients, 33% are covered by Medicaid, 17% by private insurance, and 7% by Medicare. The remaining 43% who are uninsured are charged on a sliding fee scale, based on income. Like other FQHCs, PHS also receives Section 330 grant funding to help cover the cost of caring for uninsured patients.

Key grants at the time of writing this report, all from HRSA, include:

- $1.8 million to reduce maternal health inequities
- $1.1 million for behavioral health service expansion
- $400,000 to support early childhood development programs

The PCPs at PHS bill standard evaluation and management (E&M) codes for SUD visits, including initial assessment. The most billed codes are ICD-10 codes for the specific SUD, which range from F11 to F18, with severity levels of 0.10 or 0.20 added as needed to denote mild, moderate, or severe. The BHCs use psychotherapy codes for most visits, most commonly 90791 (for initial visits)

and 90832/34 (for 30- and 45-minute visits, respectively). Helpfully, there is no visit length requirement for the 90791 code, so BHCs' 30-minute visits can be billed under 90791.

The pharmacy at PHS also has access to 340B drug pricing, which helps uninsured and underinsured patients afford their care. Reimbursement rates for insured individuals, particularly those on Medicaid, help PHS cover services and administrative costs that do not directly generate revenue. With a high number of uninsured patients and others on Medicaid, PHS is closely monitoring the evolving landscape of federal grants and Medicaid funding.

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 HRSA.

Successes

Patient Engagement: A key feature of the PHS model is its ability to connect with patients. Nationwide, only 19% of individuals with SUDs received treatment in 2024. However, at PHS, 30% of patients who screen positive for problematic substance use see both a PCP and a BHC. Clinicians attribute this success to a low-barrier, non-judgmental approach, providing care in a familiar and trusted primary care setting, and well-organized systems of care that all team members are trained to use.

Patient Retention: The MOUD program achieves a patient retention rate of more than 60% after two years, which compares favorably to

community rates. For SUDs in general, patients complete 2.5 visits, on average, with any PHS clinician for an episode of care.

Organizational Culture Shift: PHS is fostering a culture shift, with anecdotal evidence suggesting that many, if not most, of its staff are embracing the notion that SUD care is part of routine primary care. All BHCs engage in SUD treatment, and patients can access care for polysubstance use or for opioid, nicotine, alcohol, or stimulant use at any clinic in the system from both PCPs and BHCs.

Building on Success: Learning from PHS's structured MOUD care pathway—which outlines screening, treatment initiation, and follow-up for patients with OUD—additional pathways have been developed for alcohol, nicotine, and stimulant use to further expand care options for patients. A novel CM program to reinforce positive behaviors among patients receiving MOUD and/or treatment for polysubstance use is a recent addition, something few FQHCs have attempted. Success with SUD treatment has not only provided a model for expanding care, but also inspired further innovation.

Challenges

Limited Psychiatric Support: While many PHS providers are comfortable prescribing a wide range of medications for mental health and SUDs, they occasionally feel the need for psychiatric assistance. However, a shortage of psychiatric prescribers across the region makes it difficult to arrange consultative partnerships or psychiatric management of patients.

Varied Pathway Success: The success of the original pathway, focused on MOUD, inspired the development of pathways for other substances; however, clinicians feel that subsequent pathways have not achieved the same level of success as MOUD. They think the nicotine pathway has reached more patients and driven more engagement of patients with BHCs than the alcohol and stimulant use pathways, but none have had the impact of the MOUD pathway yet.

Data Challenges: Several important issues relate to data. For example, staff want a registry that tracks patients; integrates with the EHR; and offers care reminders, report options, appointment tracking, and other features. The spreadsheet staff created to monitor patients receiving MOUD has limited capabilities and is not connected to the EHR.

Additionally, universal substance use screening data is collected on paper, which sometimes causes positive screens to be overlooked until the patient has left. Measurement-based care is also not yet routine at PHS, partly due to limitations in the current EHR.

Contingency Management Limitations: Staff believe the CM program has strong potential but limited reach. The LCAS providers mention challenges with team-wide engagement; for example, if a patient is seen only by a PCP, opportunities to reward targeted health behaviors are sometimes missed due to limited time and competing priorities. Additionally, behavioral health providers feel that the effectiveness of CM has been affected by funding constraints that reduce the variety and value of rewards offered, as well as by an internal policy prohibiting the use of cash reinforcers (i.e., gift cards), which research has shown to be the most effective.

Inconsistent Service Adoption: Variation exists across clinics in the extent to which SUD care is embraced. Some clinics hesitate to advertise SUD services due to community stigma, and some providers feel under-prepared for treating SUDs or still view SUD care as a specialty service rather than part of routine primary care.

Recommendations

In addition to the strategies described above that have helped treatment succeed at PHS, staff also shared several fundamental recommendations for systems considering expanding SUD care.

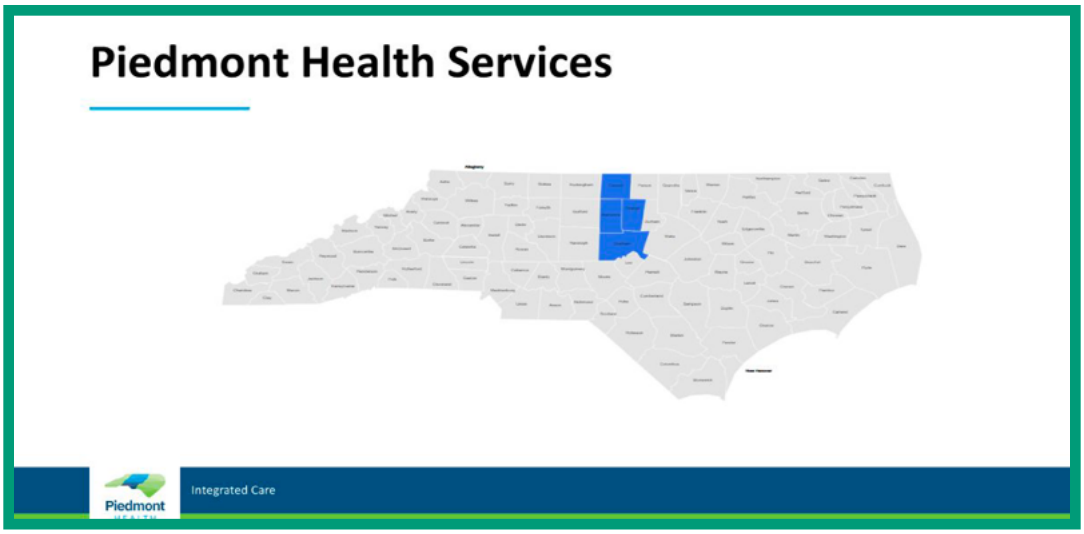
Don't Let Perfect Be the Enemy of the Good: Dr. Martin, a PCP champion of the SUD treatment effort at PHS, emphasizes that the most important step is "simply to get started." Implementation of SUD care will never be flawless; like any quality improvement effort, it requires iteration. However, the early benefits of expanded SUD care are often visible to both staff and patients, creating momentum that helps overcome initial barriers and sustain engagement.

Track Outcomes and Set Goals: As noted earlier, PHS tracks specific outcomes of interest for each pathway. For example, for the alcohol pathway, they track the number of patients referred from PCPs to BHCs and the number who complete one or more BHC visits. For MOUD, they track urine drug screen results and visit attendance. Consistent

outcome tracking enables teams to define priorities, assess their success, and identify opportunities for continuous improvement.

Know Your Community: PHS staff emphasize the importance of understanding the local population by listening to patients and staying informed about regional public health data and emerging trends. This awareness helps ensure that programs reflect community needs and are responsive to shifts in substance use patterns, access barriers, and social conditions.

Support Provider Passion and Innovation: A defining strength of PHS, as noted by several staff, is the leadership's willingness to support provider-led innovation. One PCP described joining PHS specifically because it was open to him pursuing his passion for SUD treatment. Encouraging clinicians to pursue initiatives that align with both community needs and their professional interests fosters a culture of shared ownership and long-term success. Particularly in rural areas, such as those served by PHS, where retaining providers can be challenging, it can also be a key factor in provider retention and satisfaction.



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