

BRIDGING OPIOID TREATMENT & FQHC CARE: A COMMUNITY-INTEGRATED HCV, HIV, & PRIMARY CARE ACCESS INITIATIVE

Community Health Systems' (CHS) "Bridging Opioid Treatment and FQHC Care: A Community-Integrated HCV, HIV, and Primary Care Access Initiative" created a low-barrier pathway between opioid treatment programs and CHS for patients at elevated risk for hepatitis C virus (HCV), human immunodeficiency virus (HIV), hepatitis B (HBV), STIs, behavioral health needs, and unmet primary care needs. The initiative helps patients move more quickly from screening to evaluation, treatment, and ongoing care by addressing common barriers such as transportation, stigma, fragmented systems, and competing recovery-related needs.

The team redesigned access through direct referrals, patient navigation, telehealth visits, protected clinical access, and standardized workflows. This approach began with hepatitis C care and expanded into a broader whole-person model that connects patients to infectious disease care, primary care, behavioral health, and other CHS services.

CHS is tracking early process and outcome measures to evaluate the access pathway. Current progress includes:

Partner Engagement & Pathway Reach

- Opioid treatment program sites engaged: 3
- Patients referred or scheduled through this pathway: 60

Hepatitis C Linkage & Treatment

- HCV RNA-positive patients linked to CHS care: 8
- Patients started on HCV treatment: 6
- Treatment initiation among linked HCV RNA-positive patients: 75%
- Patients completing HCV treatment to date: 1
- Patients achieving sustained virologic response/cure to date: 1

Appointment Follow-Through & Connection to Broader Care

- No-show rate for pathway-related appointments: 4.7%
- Patients also linked to primary care, HIV care, HBV care, behavioral health, or other CHS services: 20
- Percentage of referred or scheduled patients linked to additional CHS services: 33%

Early Impact

These results are especially meaningful for patients receiving opioid treatment services, who often face barriers that make traditional referral pathways unreliable. Engaging 60 patients, starting hepatitis C treatment for 75% of linked HCV RNA-positive patients, maintaining a 4.7% no-show rate, and connecting one-third of referred or scheduled patients to additional CHS services demonstrates early but important impact.

Next Steps

The model shows promise beyond hepatitis C treatment by supporting primary care engagement and whole-person care. As the pathway matures, CHS will continue tracking hepatitis C treatment completion, sustained virologic response 12 weeks after finishing treatment/cure, time from referral to first visit, time from positive HCV RNA result to treatment start, and additional primary care and behavioral health linkages. This initiative is positioned as a scalable regional model for connecting high-risk, medically underserved patients receiving opioid treatment services with FQHC-based treatment and longitudinal care.

Community Access and Viral Hepatitis Care Team

- Michael F. Potnek, DNP, AAHIVS, AGPCNP-BC – Medical Director / HIV Specialist / Clinical Lead
- Sonia Chanthalangsy, Patient Navigator – Referral and Care Navigation Lead
- Brooklyn Trumpy – Chief Compliance & Information Officer / Quality and Systems Support
- Carrie Beck – Clinical Systems Coordinator
- Rachel Pearson – Revenue Cycle Advisor
- Angela Reingold – Director of Access
- Andrea Baez – Administrative Assistant to the CEO
- Medical Operations Team
- Medical Assistants and Nursing Team Members
- Community Partners, including Comprehensive Treatment Center and CMS Opioid Treatment Program Teams
- Annie Fridh, PsyD, CEO – Executive sponsorship



Community
Health Systems
Staff