

Building Bridges: Increasing Access to Care and Continuation of Medication for Opioid Use Disorder Through Community Partnerships

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The opioid epidemic continues to pose a formidable challenge to public health, necessitating innovative approaches to enhance access to care and support continuity of treatment for individuals with opioid use disorder (OUD). Opioid overdose-related deaths in Detroit have increased over four-fold from 1999 to 2019, yet the rate of medication for opioid use disorder (MOUD) prescriptions in Detroit has been half the rate compared to Michigan as a whole. Limited access to care remains a major factor in continued opioid use, which is driven in part by an individual's insurance coverage. As the largest payer of substance use disorder services in the United States, Medicaid plays a central role in efforts to address the opioid epidemic. Over half of the Detroit population is either enrolled in Medicaid or uninsured. Henry Ford Hospital (HFH) continues to treat hospitalized patients with OUD. Post-discharge follow-up appointments for continuation of MOUD have been shown to increase rates of prolonged abstinence, reduce rates of readmission, and decrease mortality rates. Despite HFH's significant community impact, there have been limitations on which insurance carriers are accepted at our institution when patients try to establish outpatient primary care or specialty addiction medicine services for MOUD. This insurance-driven barrier has consequently limited our ability to provide best practices in supporting patients with OUD. To address this disparity, we aimed to investigate the impact of leveraging our partnership with Community Health and Social Services (CHASS) Clinic, a local Federally Qualified Health Center network, as an opportunity for underinsured and non-insured patients with OUD to have increased access to post-discharge follow-up appointments with qualified providers for continuation of MOUD.

In collaboration with the HFH Addiction Medicine Consult team, HFH Primary Care Physicians, and CHASS MOUD providers, we designed a multifaceted intervention to improve the continuum of care for patients with OUD. We established a post-discharge referral pathway between HFH and CHASS, enhancing communication channels to facilitate care coordination. If a patient was admitted to HFH with a diagnosis of OUD and received an Addiction Medicine consult, the primary team was advised to arrange a post-discharge follow-up appointment for MOUD. The location of the appointment was determined by the patient's insurance. Patients already established with HFH, or with commercial insurance, were scheduled with HFH providers for MOUD. Patients with Medicaid or no insurance were scheduled with CHASS MOUD providers. In the six months prior to implementation, only 3 of 60 (5%) of patients with a diagnosis of OUD that received an Addiction Medicine consult were scheduled to have a post-discharge follow-up for MOUD. In three months after implementation, 8 of 32 (25%) patients received post-discharge follow-up for MOUD.

By utilizing the partnership between HFH and CHASS, our intervention was associated with a five-fold higher rate of follow-up appointments for continuation of MOUD. These findings underscore the effectiveness of community partnerships in addressing barriers to care and enhancing treatment for individuals with OUD.