Bridge Clinics

High Volume, Low-Barrier MAT Clinics Partnering with Emergency Departments

PROBLEM

Even with the dramatic increase in the initiation of medication for addiction treatment (MAT) in hospital emergency departments (EDs), there is still a gap in follow-up care. Many outpatient providers are not set up to provide immediate, low-barrier access to MAT; they may have limited appointment slots, waitlists, or intake requirements that delay or deter patient access.[1, 2]

BRIDGE CLINICS AS A SOLUTION

Bridge Clinics provide low-barrier MAT in an ambulatory setting through an innovative model that leverages the ED's mandate to provide 24/7, high-volume access to every person in their community. There are approximately a dozen Bridge Clinics in California, most of which were started by ED clinicians who observed a gap in outpatient treatment options and opened an outpatient MAT clinic within their own health systems. In general, these Bridge Clinics:

1. Provide low-threshold MAT for opioid, alcohol, and stimulant use disorders.
2. Provide same-day access for new patients, on-demand drop-in appointments, and telehealth as standard operating procedures.
3. Serve Medi-Cal and uninsured patients without pre-screening or limiting access based on insurance status.
4. Make harm reduction part of every visit with naloxone distribution and overdose prevention.
5. Develop substance use disorder (SUD) care pathways, clinical protocols, and staff training from the ground up with emergency and hospital-based care teams
6. Collaborate with hospital systems on quality improvement processes to maximize improvement of patient outcomes and health care utilization efficiency.
7. Integrate mental health screening and initiation of treatment with SUD care. This includes psychiatric medications and suicide prevention with linkage to long-term psychiatric care.

California Hospitals with Bridge Clinics

- Highland Hospital
- Marshall Medical Center
- San Francisco General
- Northern Inyo Hospital
- Adventist Howard Memorial
- Plumas District Hospital
- Barton Hospital
- Tahoe Forest Hospital
- Los Angeles County University of Southern California Urgent Care
- El Centro Regional Medical Center

A MODEL FOR SUCCESS

Care Integration

Clinics outside of the hospital system struggle to vertically integrate with the ED. Acute SUD care is sometimes complex, requiring constant communication to maximize quality of care. This type of dialogue is difficult to sustain across health systems due to confidentiality protections, asynchronous care plans, lack of personal relationships between providers, and the logistics of real-time collaboration. Bridge Clinics address this challenge by bringing follow-up outpatient treatment into the same health system so that there is continuity of providers, health records, treatment protocols, and geographic proximity.

High Patient Volume

Around California and the US, Bridge Clinic patients are "voting with their feet," demonstrating a preference for the accessibility and flexibility of services, the emphasis on harm reduction, the positive, non-judgmental, patient-provider relationships, and the integral role of peers and navigation staff.[3] While many clinic volumes have stagnated or fallen, Bridge Clinics have shown that they can attract impressive patient volumes. For example, there are 450 unique patients per month at the Highland Hospital Bridge Clinic in Oakland and 180 at the Marshall Medical Center Bridge Clinic in Placerville. Nearly all of these patients had no previous engagement in formal addiction treatment and had previously only accessed treatment in the ED, hospital, and jails.

High Follow-up Rates After the ED

As a result of the integrated Bridge Clinics at Highland Hospital and Marshall Medical Center, follow-up rates after starting MAT in the ED were 97% and 92% respectively. These rates were the highest documented in a retrospective chart review at 17 sites implementing the CA Bridge model for ED MAT.

Hub for Patient Engagement

Bridge Clinics have been shown to decrease ED utilization.[4] At Upstate Medical Center in New York State, ED patients with opioid use disorder (OUD) were observed to have a 42% drop in ED utilization after linkage with a similar Bridge Clinic model. Importantly, we have observed that in the expected relapsing-remitting pattern of SUD, many patients move the focus of their engagement attempts from the ED to the Bridge Clinic, improving both care quality and healthcare utilization efficiency.

Sustainable Win-Win Solution

ED care is expedited, reducing length of stay and improving staff morale, and the hospital system generates revenue from increased ambulatory clinic volume. County SUD systems benefit because Bridge Clinics are able to maintain engagement with patients who are not yet ready to enter traditional SUD treatment. After gaining some stability in Bridge Clinics, patients may be able to engage with more intensive programming. In Alameda county, a failing intensive outpatient treatment SUD program with only 12 patients increased their census eightfold to over 100 patients through partnership with Highland Hospital's Bridge Clinic.

VISION

California leads the nation in expanding access to MAT through hospital EDs, with almost 90% of EDs soon to be initiating patients on MAT. We believe there is tremendous potential to leverage this accomplishment to create more integrated systems of care that realistically respond to the complex reality of patients with SUD. Partnership between Bridge Clinics and affiliated hospitals would substantially increase the number of patients with SUD who are initiated and retained in treatment. CA Bridge encourages the state and counties to provide start-up funding for dedicated low-barrier MAT clinics to operate as Bridge Clinics in partnership with EDs.

ADDENDUM: CASE STUDY OF BRIDGE CLINIC IMPACT

Case Presentation

A 46-year-old man presents to the ED. He has been smoking methamphetamine and fentanyl for the last 8 months and living in and out of various forms of temporary housing. He has disorganized thoughts, some paranoia, but does not have a grave disability.

Scenario 1

ED with Navigator and Buprenorphine Program, but No Bridge Clinic

The ED provider lacks the confidence to treat fentanyl dependence with buprenorphine, is unsure what medication to use for methamphetamine use and does not typically address mental health issues.

- The navigator meets with the patient at the bedside and directs the provider to CA Bridge guidelines. The ED physician prescribes buprenorphine.
- The patient is provided the county mental health access line.
- The navigator links the patient to a follow up appointment in 6 days at a clinic 2 miles away.

Outcome

The patient goes to the designated pharmacy and they are out of Suboxone films; to fill that day, the prescription will need to be re-written for Suboxone tablets. The patient calls the navigator for help, but no physician is willing to prescribe for a patient they do not know. The navigator calls the ED and the clerk states that the patient will need to return to the ED in-person if they need a new prescription and there is a 3 hour expected wait time. The patient is frustrated and returns to use. The navigator calls the next day and their calls go to voicemail.

Scenario 2

ED Partners with Integrated Bridge Clinic

Before the patient is discharged from the ED, the navigator calls the Bridge Clinic in real-time and schedules the patient for a visit the next day. It is standard operating procedure for the clinic team to overbook and prioritize urgent appointments for hospital and ED patients. ED clinicians have been cross-trained with Bridge Clinic providers on care for people with SUD.

- Buprenorphine is prescribed for OUD by the ED clinician.
- Olanzapine is administered in the ED and prescribed for stimulant-related paranoia.
- In the Bridge Clinic, mirtazapine is prescribed for depression, insomnia and stimulant craving.
- The Bridge Clinic navigator calls the county access line with the patient and an appointment with a telepsych team is scheduled in 10 days.
- A plan to receive long-acting injectable buprenorphine in the clinic is made, it is prescribed in real time and administered at the visit the following day.
- The patient is enrolled in contingency management through the clinic.
- The patient and the ED clinicians feel supported in the care transition.

Outcome

The ED-based navigator calls the Bridge Clinic physician directly when the pharmacy barrier arises. The new e-prescription is sent immediately, and the patient is able to fill all his medications. The patient starts buprenorphine. At follow-up the next day, he meets with the Bridge physician and navigator and accepts a 30-day injection of long-acting buprenorphine. As part of his visit, he meets with the Bridge Clinic licensed clinical social worker, who begins psychoeducation and does lethal means counseling. The Bridge Clinic navigator congratulates him on a urine drug screen that is negative for stimulants, and he is given 3 spins on his contingency management application, resulting in a $25 gift card to Target.

- At 30 days, the patient is stable and engaged in care at the Bridge Clinic and has started antidepressants.
- The Bridge Clinic clinician closes the loop with the original ED team, informing them about how well things are going. They feel increased confidence and enthusiasm for the Bridge program and referrals steadily increase.

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