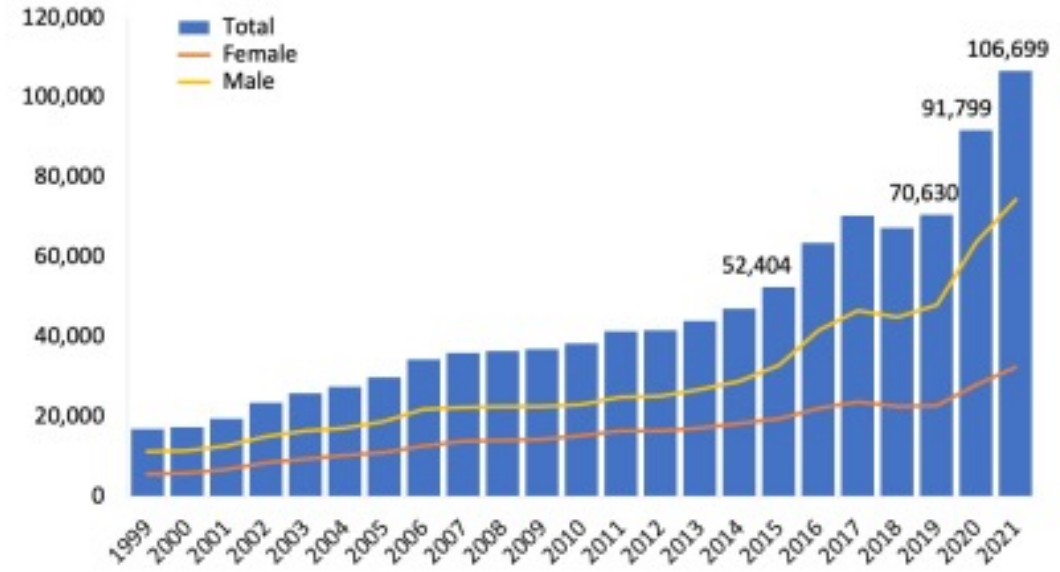
Mass General Brigham

Substance Use Disorder Bridge Clinics

Sarah Wakeman, MD
Senior Medical Director for Substance Use Disorder, Mass General Brigham
Associate Professor of Medicine, Harvard Medical School

A public health crisis due to inadequate care & failed policy

Figure 1. National Drug-Involved Overdose Deaths*, Number Among All Ages, by Gender, 1999-2021

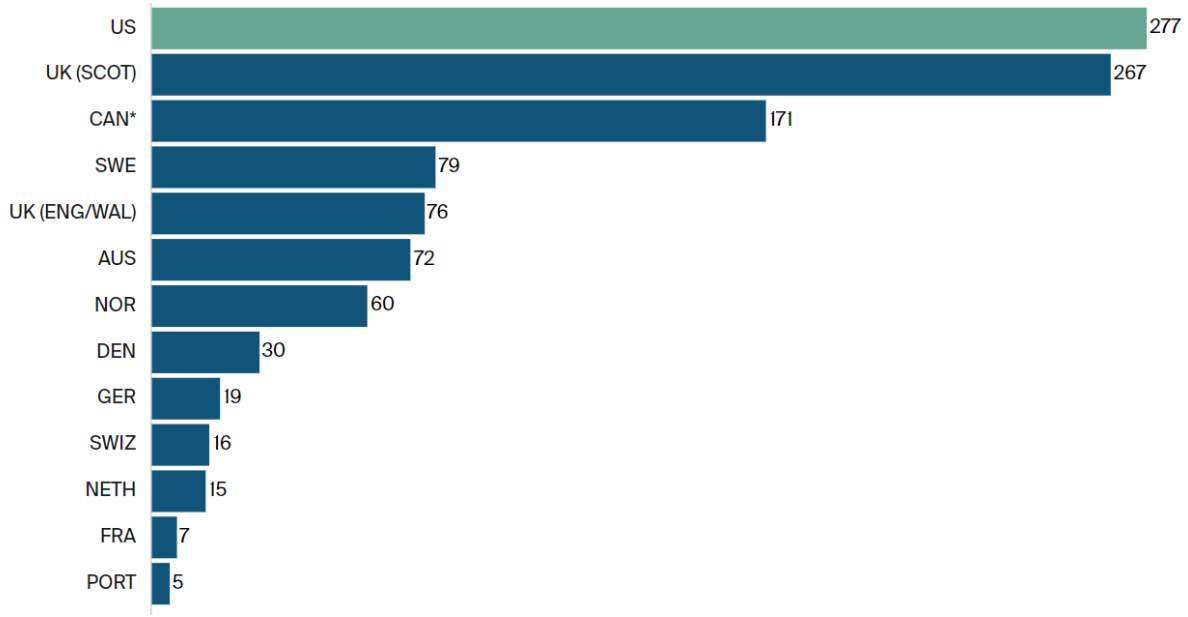


*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision.
Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2021 on CDC WONDER Online Database, released 1/2023.

US leads the globe in overdose deaths

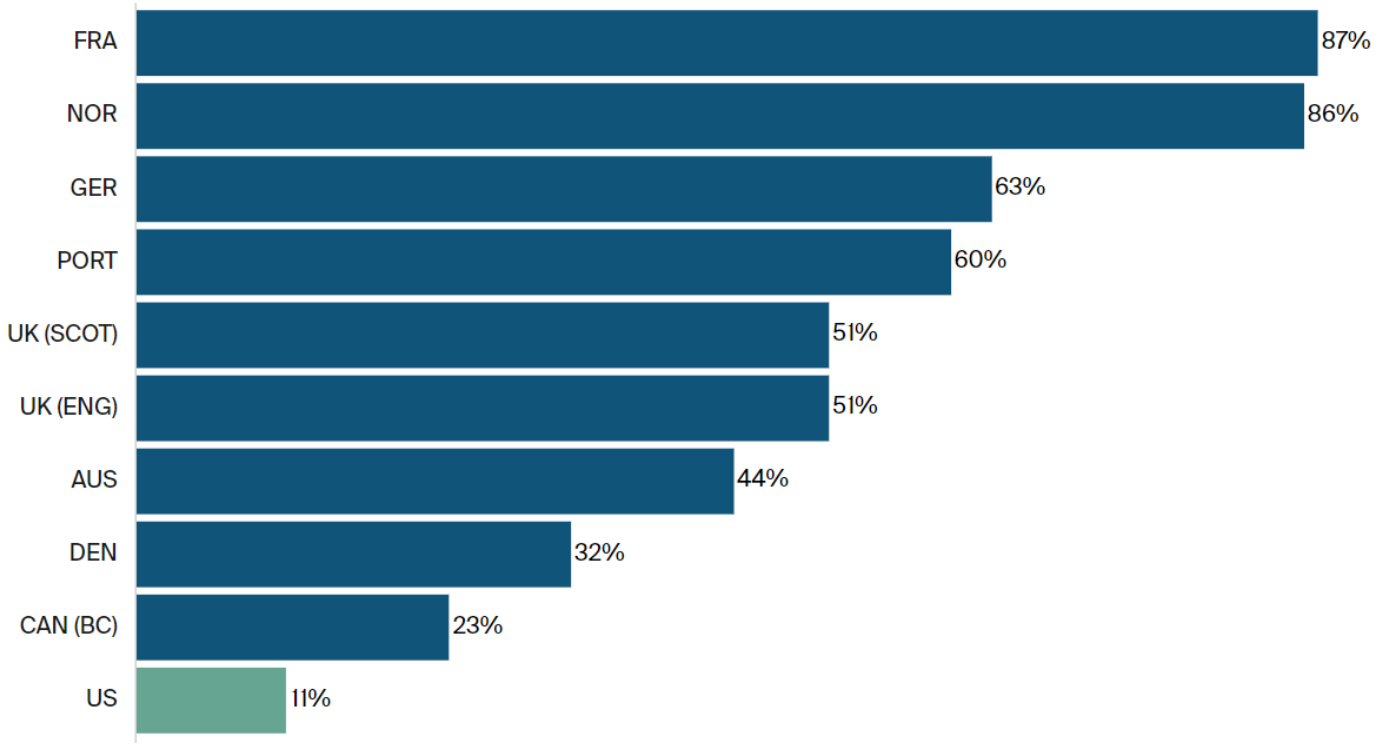
Overdose/drug-related deaths are highest in the United States, followed closely by Scotland.

Overdose or drug-related death rate per 1 million population (unadjusted), 2020 or latest year available



Immense Opioid Use Disorder Treatment gaps

Percentage of people with high-risk opioid use or opioid use disorder (OUD) who received opioid-substitution treatment

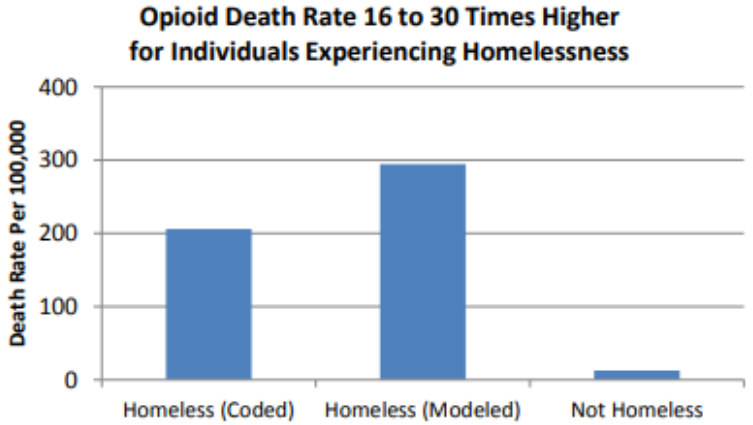


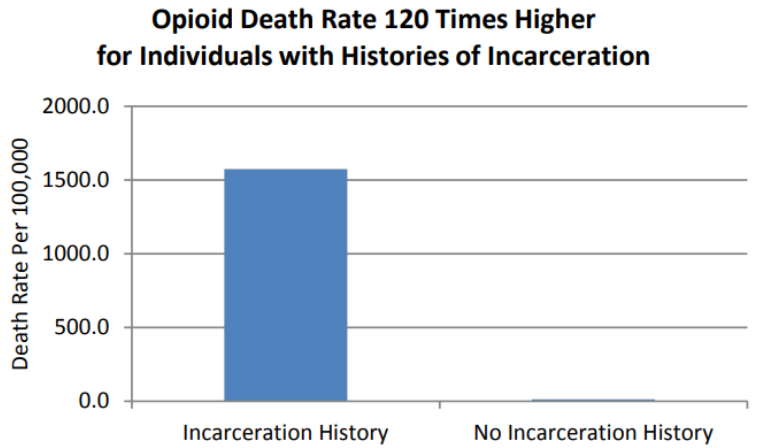
Overdose *does* discriminate

Those at greatest risk of death often most marginalized

People experiencing incarceration & homelessness have markedly higher rates of overdose death

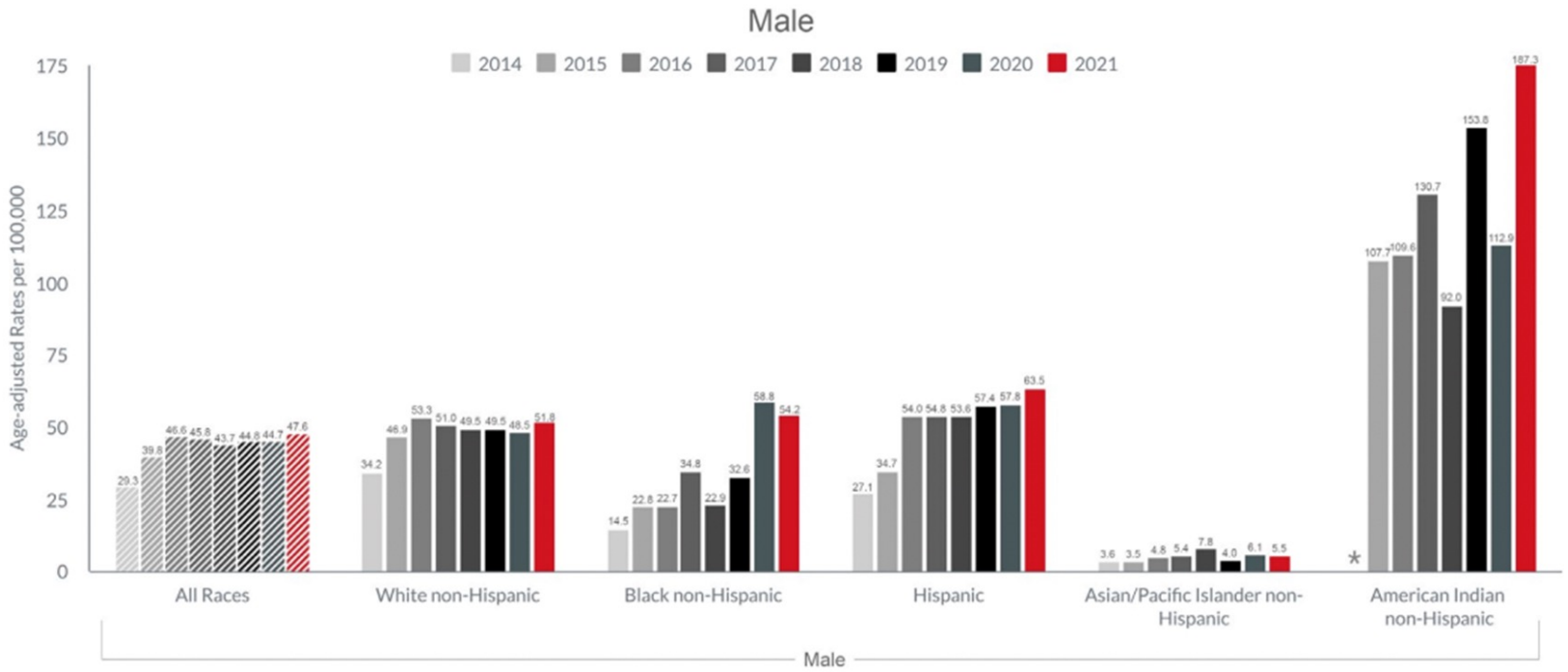
Treatment models not designed with these populations in mind

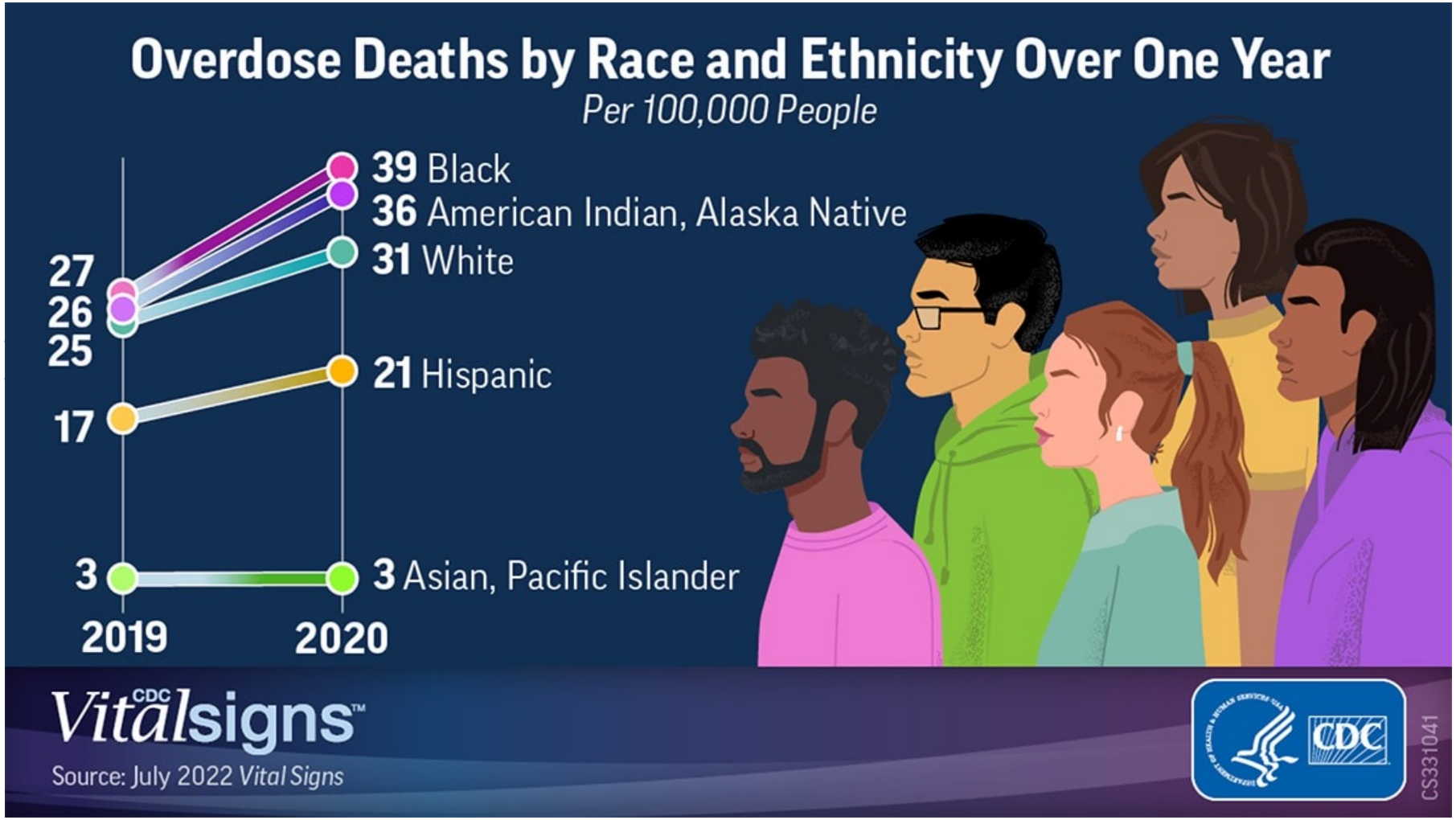




MA DPH. https://www.mass.gov/files/documents/2017/08/31/legislative-report-chapter-55-aug-2017.pdf

Opioid-related overdose death rates in MA highest for Black, Latino, and American Indian men





https://www.cdc.gov/vitalsigns/overdose-death-disparities/index.html

Effective treatment exists, similar to other chronic condition management

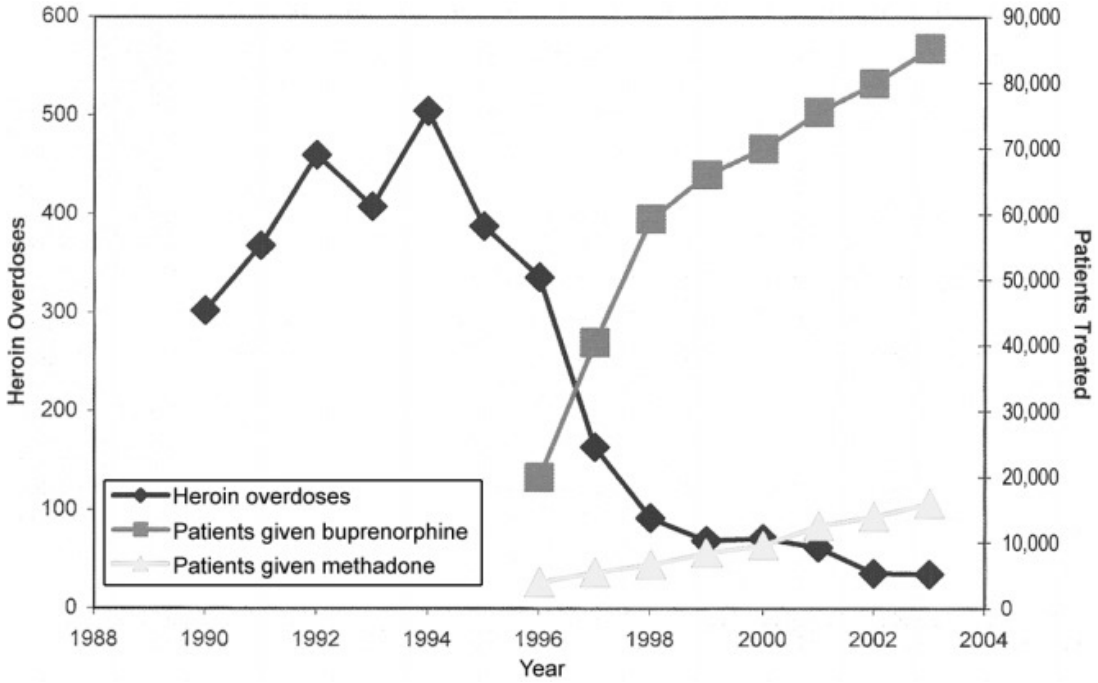
Medication

Psychosocial interventions

Recovery supports

Harm reduction

Access to opioid agonist therapy saves lives



France expanded access to buprenorphine

No required physician training, no patient limits, no toxicology or counseling requirements

~90,000 pts treated w/ buprenorphine, 10,000 w/ methadone

5-fold reduction in heroin overdose deaths, 6-fold reduction in active IDU, HIV prevalence among PWID decreased from 40% to 20%

Carrieri MP, Amass L, Lucas GM, Vlahov D, Wodak A, Woody GE. *Clin Infect Dis*. 2006;43 Suppl 4:S197–S215. doi:10.1086/508184

Methadone and buprenorphine reduce mortality

All cause **mortality rates (per 1000 person years):**

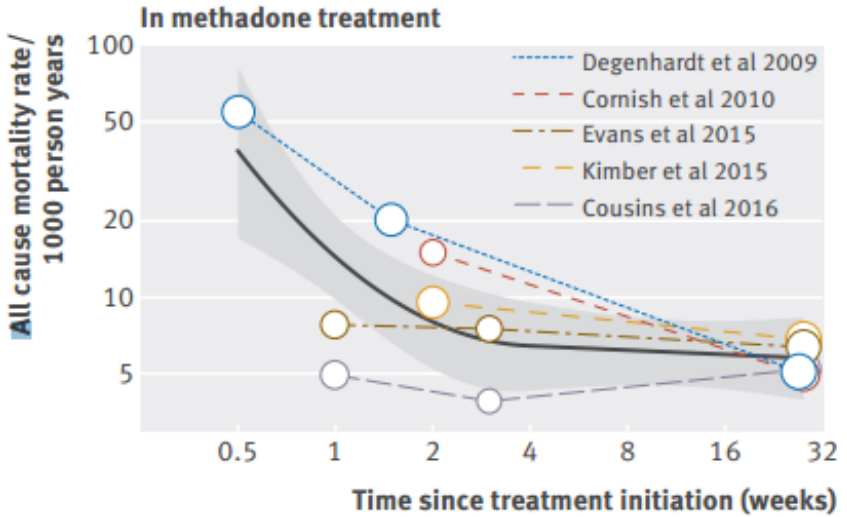
- In methadone treatment: 11.3
- Out of methadone treatment: 36.1

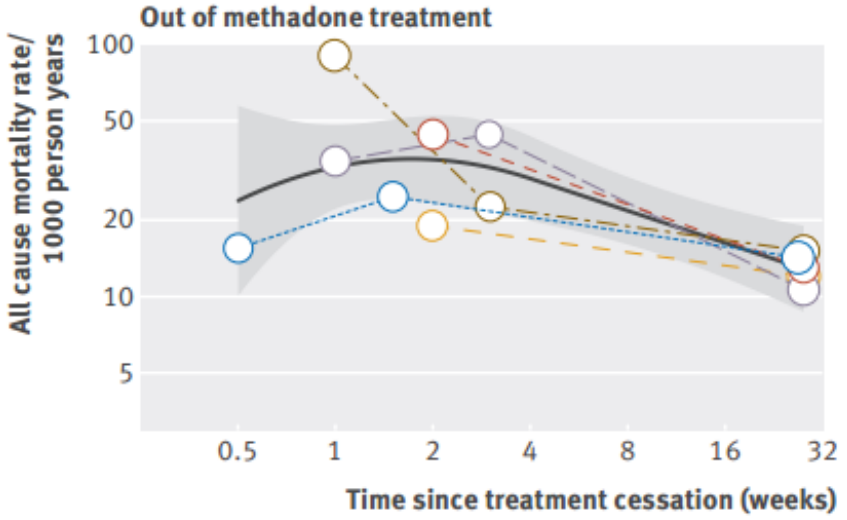
- In buprenorphine treatment: 4.3
- Out of buprenorphine treatment: 9.5

Overdose **mortality rates:**

- In methadone treatment: 2.6
- Out of methadone treatment: 12.7

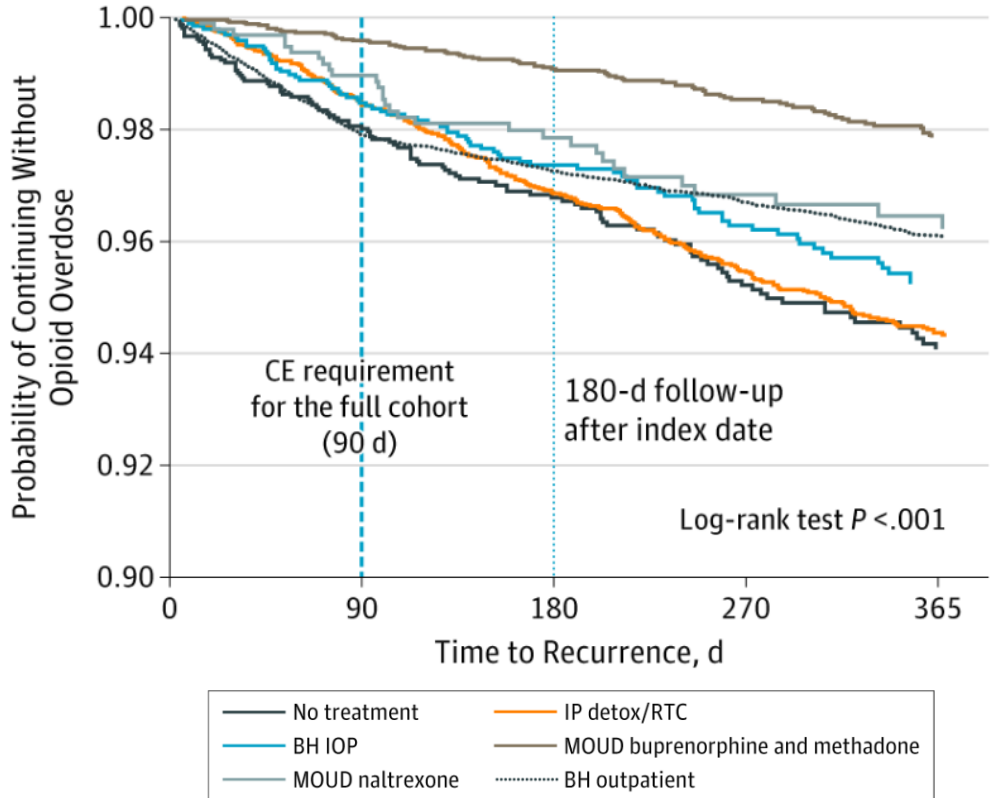
- In buprenorphine treatment: 1.4
- Out of buprenorphine treatment: 4.6





Sordo L, Barrio G, Bravo MJ, et al. *BMJ*. 2017;357:j1550. Published 2017 Apr 26.

Methadone/buprenorphine associated w/ reduced OD



Wakeman SE, Larochelle MR, Ameli O, et al. *JAMA Netw Open.* 2020;3(2):e1920622.

Using hospitalization as a reachable moment

J Gen Intern Med. Aug 2010; 25(8): 803–808; JAMA Intern Med 2014 Aug;174(8):1369-76.)

Initiating methadone in hospital:

- 82% present for follow-up addiction care

Initiating buprenorphine vs detox:

- Bupe: 72.2% enter into treatment after discharge
- Detox : 11.9% enter treatment after discharge

Treatment initiation and linkage in the ED

Table 2. Baseline and 30-Day Secondary Outcome Measures Among Opioid-Dependent Patients Treated in the Emergency Depart

	Referral	Brief Intervention	Buprenorphine	*P* Value[b]
Days of Self-reported Illicit Opioid Use in the Past 7 Days, Mean (95% CI)				
Baseline	5.4 (5.1-5.7)	5.6 (5.3-5.9)	5.4 (5.1-5.7)	<.001, Tr
30 d	2.3 (1.7-3.0)	2.4 (1.8-3.0)	0.9 (0.5-1.3)	<.001, Ti .02, Int
Outpatient Addiction Treatment in the Past 30 Days, Mean (95% CI)[c]				
No. of outpatient visits				
Baseline	0.38 (0.0-1.0)	1.16 (0.6-1.7)	0.20 (0.0-0.8)	.07, Trea
30 d	4.99 (3.1-6.8)	5.67 (4.0-7.4)	3.71 (2.1-5.3)	<.001, Ti .63, Inter
ED-Based Addiction Treatment in the Past 30 Days, No./Total (%)				
Any addiction-related ED visit				
Baseline	8/104 (7.7)	6/111 (5.4)	5/114 (4.4)	.57
30 d	15/69 (21.7)	12/82 (14.6)	18/93 (19.4)	.51
Inpatient Addiction Treatment in the Past 30 Days, No./Total (%)[d]				
Any inpatient addiction treatment				
Baseline	10/104 (9.6)	7/111 (6.3)	7/114 (6.1)	.55
30 d	31/84 (36.9)	32/91 (35.2)	11/100 (11.0)	<.001

Abbreviation: ED, emergency department.

[a] All patients were screened and referred to a community-based treatment service. Patients in the brief intervention group received a 10- to 15-min manual-driven, audiotaped Brief Negotiation Interview and facilitated referral to treatment services. Patients in the buprenorphine group received a Brief Negotiation Interview and ED-initiated treatment with buprenorphine if they exhibited moderate to severe opioid withdrawal until a scheduled appointment within 72 hours in the hospital's primary care center could be arranged.

[b] χ^2 Test with 2 degrees of freedom used to test for differe ED treatment. Mixed-model procedures used to test for self-reported illicit opioid use and outpatient addiction tr patients in the sample were included. Treatment × time effect.

[c] Includes both office-based and addiction treatment cent

[d] Includes residential and hospital-based treatment.

D'Onofrio et al. JAMA 2015 Apr 28;313(16):1636-44

- 78% vs 37% engaged in buprenorphine treatment
- Fewer days of self-reported opioid use

SBIRT to STIR: screen, treatment initiation, refer

Identify patients through screening or acute presentation

Make a diagnosis

Initiate treatment without delay

Retain patients in treatment

Essential components of care are just like those for other medical conditions

- Why aren't all providers doing this?
- Barriers often cited (time, resources, multi-morbidity) exist for other conditions too
- We don't talk enough about joy & satisfaction of this work!

Identify
Discuss the diagnosis and treatments
Treat
Refer (for specialized care and for services)

Slide adapted from Dr. Rich Saitz, NASEM Presentation

High threshold vs low threshold care

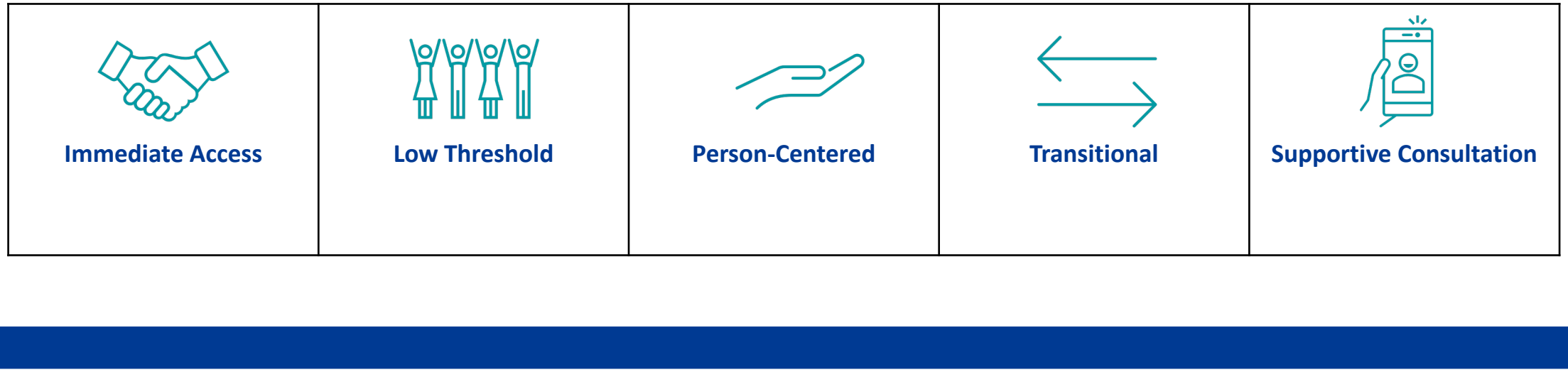
People with substance use disorder face numerous barriers to engage in services

Low-threshold care aims to reduce barriers ('thresholds') through less stringent eligibility criteria to broaden potential reach

Thresholds:

- Registration threshold (accessing care and staff)
- Competence threshold (ability to communicate needs)
- Efficiency threshold ("What about those who need 1000 cups of coffee before they start to speak about their needs?")
- TRUST

Bridge clinics offer low-threshold, rapid access to SUD treatment and bridge the many gaps and transitions in the system



History and model of bridge clinics at MGB

- Launched in 2016, initially to Bridge hospital and ED treatment initiation with community
- Multidisciplinary team: MD/APP, therapist, peer recovery coach, nurse, resource specialist
- Walk-in or scheduled appointments
- No requirements, minimal barriers
- Range of patient needs and severity
- Average duration of bridge clinic engagement ~2-3 months, some need less, some much more

What is the patient experience in a Bridge clinic? Collaboration with the patient is the centerpiece of care.

Identification of patient with SUD, for example in ED, and initiation of treatment

Connection to ongoing low threshold treatment

Multidisciplinary teams focuses on engagement and stabilization

Linkage to SUD treatment in primary or community care

The Importance of Philosophy & Approach

"They [staff] treat you like you're a person, and trying to make your life better, and encourage that. And I [patient] think that's an awesome thing instead of not believing that you can even do it."

"…no one's [staff] going to judge you or give you a hard time. You'll [patients] find that everyone is really understanding. It's hard for me [patient] to open up, honestly…I keep everything to myself…but it's easy here…it's just nice to be able to talk about things."

"…it's nice to be able to just walk in somewhere [immediately post incarceration], and they [staff] are understanding, and accepting, and willing to help still."

"…and coming here [clinic], there was something redeeming about it. I [patient] felt safe. I felt warm. In fact, I felt nurtured, I think would be the best word."

The MGH Substance Use Disorder Initiative

Spreading the message

- https://youtu.be/oHdjRosXkI0


Mass General Brigham