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The Role of Peer Support Workers in Emergency Departments to Engage Individuals Surviving Opioid Overdoses – Qualitative Assessment

Overview

Drug overdose and opioid-related deaths continue to increase in the U.S. The Centers for Disease Control and Prevention (CDC) reports that from 1999 to 2015, the amount of prescription opioids dispensed in the U.S. nearly quadrupled, and the number of drug overdose deaths has never been higher with the majority of these deaths (more than 60% in 2016) involving opioids.[i] The current opioid epidemic has awakened communities and stakeholders of all types of the need to create novel approaches for addressing substance use, and strengthen current interventions.

Despite the need for prevention, treatment, and recovery services conveyed above, nearly 80% of individuals with an opioid use disorder do not receive treatment of any type,[ii] and only 41.2% of addiction treatment providers offer some type of FDA-approved medication to treat opioid use disorder (OUD).[iii] Access to prevention and recovery services is often even more difficult to come by, although the exact percent of individuals who have access to prevention and/or recovery services is difficult to ascertain.

Emergency departments (EDs) present one opportunity to increase the provision of addiction-related services, particularly for individuals who have received overdose reversal treatment (i.e., naloxone). Hospitals and EDs have the ability to intervene with an individual who has just been revived from an opioid overdose, and immediately connect them with pertinent services and support, including treatment such as medication-assisted treatment (MAT). However, many EDs do not have the workforce, expertise, or experience necessary to engage with the overdose survivor. Consequently, many individuals are released from care or leave against medical advice. This missed opportunity often results in a "revolving door" in which the same individual repeatedly returns to the ED in need of additional overdose reversal treatment. In many cases, an individual returns to use, eventually overdoses, and often dies.

To fill this gap, several programs have begun to employ peer support workers* in emergency department settings to engage individuals surviving opioid overdoses. A growing body of evidence suggests that peer support workers can efficiently connect individuals suffering from opioid use disorder with proper treatment interventions, often to greater effect than primary care or clinical behavioral health staff.[iv] Despite the growing evidence, little research or analysis has been conducted that codifies the best-practices for a peer support worker in an ED setting.

**For this issue brief, we will use the term to peer support worker to refer to a provider with lived experiences that support the recovery and wellbeing of an individual. Other terms for this workforce include: peer recovery coach, peer recovery specialist, and peer support specialist, amongst others.*

Evidence for Peer Interventions in ED Setting

Peer support services have a good backing of research to indicate its effectiveness in improving a myriad of health and wellbeing outcomes.[v] [vi] A systematic review evaluating the use of peer support workers reported significant decreases in substance use and improved recovery capital (e.g., housing stability, self-care, independence, and health management) for patients who used peer support services.[vii] Research also points to an increased likelihood of abstinence among those exposed to peer support workers.[viii] Further, studies examining effects of recovery coaching on recidivism rates in ex-offenders living with OUD show that those who work closely with a peer support worker are less likely to become repeat offenders compared to those who do not receive such services.[ix] [x]

A key differentiating factor in the peer support worker role from other mental health positions is that in addition to traditional knowledge and competencies in providing support, the peer support worker operates out of their own lived experience and experiential knowledge.[xi] Peer support workers operate in the context of recovery, frequently utilizing language based upon common experience rather than clinical terminology, and person-centered relationships to foster strength based recovery.[xii] These advantages that peer support workers bring to their work have been shown to have a range of favorable results for fostering patient relationships. [xiii] [xiv] [xv] Information provided by peers may be viewed as more credible than that provided by mental health professionals. [xvi] Additionally, when peers are part of hospital-based care, the results indicate shortened lengths of stays, decreased frequency of admissions, and a subsequent reduction in overall treatment costs for patients presenting with behavioral health issues.[xvii] Other studies also suggest that the use of peer support can help reduce the overall need and use for mental health services over time.[xviii] [xix] [xx]

Despite the extensive evidence to support the efficacy of peer support services to improve patient outcomes, only moderate research exists that specifically identifies the effectiveness of peer support workers within emergency department settings, and almost no research has been done to indicate the most effective way to integrate and operationalize peer support workers within an emergency department setting. However, the need for novel recovery engagement strategies in the wake of the current opioid crisis has pushed many hospital systems into creating and embedding peer support programs of their own within their ED.

Qualitative Assessment

This issue brief intends to highlight current and promising practices used to create peer support programs and integrate peer support workers into ED settings. To understand the current practices and efforts underway to involve peer support workers in emergency department settings, the National Council has conducted a qualitative assessment involving an environmental scan and semi-structured interviews with pertinent stakeholders. The emphasis of this work is to understand the placement, role, and promising practices of peer support workers in ED settings, specifically workers that assist individuals who have been revived from an opioid overdose.

Structure of Analysis

Information gathered as part of the Environemtnal scan was collected primarily utilizing online searches with a collection of key words such as: peer support workers, emergency department, emergency room, opioid overdose, recovery, and medication assisted treatment. Information was primarily gathered from grey literature sources. Along with information gathered as part of the Environemtnal scan, individual and group interviews were conducted to ascertain information on program examples, promising practices, and common themes across programs. The following individuals were interviewed as part of this analysis:

- Patrick Stropes, Certified Peer Recovery Mentor; GrowthWorks Inc. (Michigan)
- Kristen Aja, Project Director & Sarah Munro, Executive Director; Vermont Recovery Network (Vermont)
- Dr. Terry Horton, Chief, Division of Addiction Medicine, Medical Director, Project Engage; Christiana Care Health Services (Delaware)
- Michael Santillo, Executive Director; John Brooks Recovery Center (New Jersey)
- Dr. Craig Allen, Chief of Psychiatry/Medical Director, Midstate Medical Center (Connecticut)
- Eric McIntyre, Lead Recovery Specialist, RWJ Barnabas Institute for Prevention (New Jersey)
- Todd Whitmore, Associate Professor, Co-Director, Department of Theology, University of Notre Dame (Indiana)
- Kimberly Miller, Mental Health America Indiana; Rebekah Gorrell, Mental Health America Indiana; Melissa Reyes, Eskenazi Health; Dennis Watson, Indiana University; Amy Brinkley, Indiana Family and Social Services Administration
- Deb Dettor, Director, Anchor Recovery; George O'Toole, ED Manager, Anchor Recovery (Rhode Island)
- Tony Sanchez, Director, Office of Recovery Transformation, GA Department of Behavioral Health; Neil Campbell, Executive Director, GA Council on Substance Abuse; Owen Dougherty, Deputy Executive Director, GA Council on Substance Abuse
- Jennifer Chadukiewicz, Recovery Coach Program Manager, CT Community for Addiction Recovery (CCAR)

Prominent Interview Themes

Based on environmental scan research and interviews, the following themes have been identified as a sampling of promising practices:

Theme #1: Relationship Between Hospital and Recovery Community Organization

The relationship between the hospital and the Recovery Community Organization (RCO) that employs the peer support worker is an integral part to the success of the program. While not every program includes this relationship (for example, some hospitals may choose to employ the peer support workers directly), for those that do establishing a relationship between the hospital and RCO is typically the first development that occurs. The relationship success of this program partnership is typically predicated on two areas: pre-existing relationships and contractual relationships.

Pre-existing relationship refers to the informal ways that the RCO and hospital are connected. It is ideal for at least one individual at the RCO, whether within the Executive Leadership Team or Board, to have a relationship with an individual within the hospital's leadership team. This informal relationship is often a conduit for establishing the peer support program and can strengthen buy-in from other pertinent stakeholders at the RCO as well as hospital. Several organizations that were interviewed as part of this brief highlighted this relationship as an instrumental component for the creation of their program.

A formal relationship often comes after significant buy-in from leadership at both the RCO and. This formal relationship typically takes the form of a memorandum of understanding (MOU) or contract and outlines the details of the peer support program. Some details that may be included in an MOU or contract – stakeholder responsible for employing and paying the peers, training or clearance requirements for peers to work in hospital or health system, scope of work and expectations of peer providers, etc.

Case example: Opioid Overdose Recovery Program (OORP), New Jersey

The purpose of the OORP is to respond to individuals reversed from opioid overdoses and treated at hospital emergency departments because of the reversal. The OORP utilizes specially trained peers to engage individuals reversed from an opioid overdose to provide non-clinical assistance, recovery supports, and appropriate referrals for assessment and substance use disorder treatment. OORP workers are employed part-time. OORP services are currently provided in 11 counties, with plans to expand funding for OORP services will be expanded to all 21 counties in New Jersey.

Each OORP in New Jersey is either led by a hospital, or an RCO that has an MOU with a hospital. Establishing an MOU between an RCO and a hospital can be difficult, particularly if a pre-existing relationship between these two organizations does not exist. Bureaucratic and legal barriers may inhibit the relationship, as can differences in stakeholder practices. For example, one hospital in New Jersey that was interested in hosting an OORP sought out an RCO to collaborate with. The hospital required that all staff that work within its setting pass a criminal background check – however, the RCO did not have this as a requirement for employment as a peer within their organization. Support from administrators and organization leaders allowed the hospital and RCO to come to an agreement around hiring practices, as outlined in their MOU.

Theme #2: ED Staff Understand the Value and Scope of Peer Support Services

Staff within the ED setting and, in some cases throughout the entire hospital, should understand the role, scope, and value of the peer support worker. This can be an important component for encouraging teamwork, empowering ED staff to properly leverage the impact of peers to improve patient outcomes, and to combat potential bias and discrimination that ED staff may hold towards individuals with addiction.

Interviews with RCOs and hospitals revealed that ED staff training was a major component of early implementation of the peer support program and was seen as a primary factor for overall program success and sustainability. Formal trainings and resources for ED staff can disseminate pertinent details about peer support workers and should serve to empower both the peer worker as well as the ED staff. In-person trainings, research, articles, workflow structures, and group discussions can help ED staff understand the exact role and scope of peer workers, as well as the value that peers bring to patient care. This educational component can be particularly important to ensure that peer support workers are not asked to perform any duties that are outside of their scope or role (sometimes referred to as "cooptation") and are utilized to the fullest potential of their profession. Trainings and resources should be provided often and on a continual basis, particularly in the early stages of program development, to ensure that all staff across all ED shifts are given access to this information.

Many programs discussed the need for ED staff to acknowledge that "recovery does happen". ED staff may have their own experiences with addiction, in either their personal life and/or most likely in their professional life. Due to the relapsing nature of addiction, ED staff may have encountered, even provided opioid overdose-reversing medication to, the same individual several times. As such, ED staff may become jaded to the possibilities of positive outcomes for individuals with an addiction, and stigma and bias may present themselves within ED settings. RCOs, hospitals, EDs and peers themselves should support ED staff in addressing any preconceived notions, stigma, or biases that may be present within the ED setting and amongst staff.

Case example: Georgia Council on Substance Abuse and Northeast Georgia Medical Center

In partnership with Northeast Georgia Medical Center (NGMC) and Georgia's Department of Behavioral Health and Developmental Disabilities (DBHDD), Georgia Council on Substance Abuse (GCSA) provides peer support to individuals having experienced an opioid overdose or any substance use disorder related incident in NGMC's three campus emergency departments in Gainesville, Braselton, and Winder. Since its inception this program, entitled CARES in the Emergency Department (CARES stands for Certified Addiction Recovery Empowerment Specialists), has also spread to Neonatal Intensive Care Units (NICUs) in NGMC's hospitals located in Gainesville and Braselton.

After establishing formal relationships with both the state and NGMC, the Georgia Council on Substance Abuse focused on gaining ED staff buy-in, particularly amongst the nursing staff. GCSA hosted four listening sessions specifically with nursing staff at the Northeast Georgia Medical Center, where staff were presented with the program concept and asked to weigh-in on its design. In particular, nursing staff were asked about what they would like support on when addressing addiction and overdose within the ED, as well as what characteristics they thought a peer worker should have to find success in this specific ED setting. The Georgia Council on Substance Abuse also engaged with the medical center's manager for behavioral health intake, who allowed GCSA staff to sit-in on nursing meetings. GCSA estimates that they have a very strong relationship with around 75-80% of the entire medical center's nurse managers, who utilize the peer support services for their patients often.

One way to encourage staff buy-in and promote the value-add of peer workers is to include peer support workers as part of daily/shift huddles. This may help other ED staff understand that peer workers are indeed "part of the team" and allow staff to engage with peer workers more regularly on both a personal and professional level. Additionally, peer support workers should be encouraged to report-out positive patient outcomes following discharges from the hospital, to help ED staff reconceptualize the possible outcomes for patients with a substance use disorder (SUD) and see the impactful role that peer support workers can have.

Theme #3: Peer Support Worker Hiring Processes and Employment Requirements

Employment requirements and hiring processes for peer support workers may differ greatly due to a number of factors, such as state or county regulations, hospital rules and codes, and unique community factors, amongst others. However, interviews with RCOs and hospitals revealed several hiring and employment decisions should at least be considered.

Employment requirements for peer support workers will almost certainly include specific training and certification requirements. State or local regulations may dictate which trainings/certifications are required (e.g., many states have their own certification) – in general, most trainings/certifications will include topics such as ethics training, medical disease of addiction, motivational interviewing, pathways to recovery, etc. Organizations looking to employ peer support workers should ensure that they are abiding by any state or local requirements for employment, particularly if peer support services are reimbursable by payers.

Another consideration for employment requirements is the criminal history of applicants. Individuals in recovery may have had previous interactions with criminal justice systems – for some, these interactions may have helped shape their recovery process. As such, applicants with criminal backgrounds may be seen as assets for any peer support program, as this lived-experience may prove useful in assisting others in initiating or maintaining their recovery. When possible, organizations interested in employing or hosting peer workers should consider the impact that criminal background disqualification employment rules have on individuals gaining employment as a peer support worker. Creative hiring structures, such as contracting with peer support workers for their services, may assist organizations that have strict rules in this regard.

Case example: Project POINT, Indiana

Project POINT, a partnership between Indianapolis Emergency Medical Services, Eskenazi Hospital's emergency department, and Midtown Mental Health, provides peer recovery services to individuals who have experienced an opioid overdose. Project POINT has developed a hiring process for their peer support workers that focuses on finding the most appropriate individuals for the job.

The process begins with a phone screening interview to ensure that each applicant meets employment criteria. This is followed-up by several in-person interviews, which are led by different staff members at Project POINT. Incorporated in this hiring process is an opportunity for applicants to shadow a peer support worker to ensure that applicants are aware of the work conditions and style. This is a particularly important component of Project POINT's hiring process, as the ED setting and the work being done by peer support workers at Eskenazi can be chaotic, triggering, and in some cases, traumatic.

Another important facet to Project POINT's hiring process is to ensure that each peer recovery coach has their own wellness plan in place. While applicants/new hires are not required to disclose the specifics of their wellness plan, Project POINT emphasizes the importance of self-care and recovery maintenance for their staff and offer additional supports in this regard as needed.

Length of recovery is another topic that is often considered during the hiring process. Interviews with RCOs and hospitals revealed some variation between what is required of peer support workers for employment, with some organizations mandating a minimum of 4 years of self-defined recovery, while others only mandated several months. Most often cited was a requirement of 2 years of self-defined recovery. Any decision-making around "recovery requirements" for employment should include feedback from current peer support workers and the recovery community. Other prominent hiring processes and employment requirements that were discussed during the interviews include: including ED staff during the interview process, shadowing/on-the-job training prior to official start date, and screening applicants to ensure "right fit" in the ED setting.

Theme #4: Emergency Department Workflows and Processes

Integrating peers into workflows and procedures may look very different depending upon the size, scope, demographics, and other factors of the emergency department and surrounding community. Other factors, such as the peer worker employment type (e.g., full-time, per diem, on-call, etc.) and contractual requirements of a peer worker program (e.g., data-reporting requirements) can also dictate the manner in which peers are integrated into workflows and procedures.

One workflow component discussed in many of the interviews with RCOs and hospitals is the precipitating event that initiates the involvement of a peer worker. Most prominently, this event is an opioid overdose reversal using a naloxone product. However, there are other events that can initiate peer involvement, such as self-disclosure of substance use and positive blood screening for substances. In some instances, particularly for peer support programs within hospital inpatient units, the presenting physical issue may in itself be the triggering event, as outlined in the case example below.

There are two other workflow variables that were discussed in many of the interviews as occurring before patient contact is made by a peer support worker: patient agreement and stabilization. As a patient-centered intervention, peer recovery support should not begin unless the patient explicitly agrees to meet with a peer support worker. In a similar fashion, peer recovery support should not begin until the patient has been physically stabilized. The simple fact that an individual has been brought into the ED means that they are in some form of crisis, and a minimum of level of stabilization should be met before a peer support worker can safely and effectively engage with the patient. This may be particularly true for individuals who have just been revived from an overdose as such individuals may be confused, embarrassed, frustrated, or feeling unwell.

One workflow point stressed across many of the interviews is around the end goal and final workflow step of peer support within the ED. As discussed in the previous section, peer support workers and their colleagues within the ED should be aware and knowledge about the role, scope, and overall goal of peer support. As such, the end-result of a peer interaction with a patient may take a variety of forms. Some patients may choose to enter detox or treatment (medication or otherwise), while others may agree to continue engagement with the peer or the RCO. It is important that peers, ED staff, the RCO and the hospital understand that the goal of peer support services in the ED is not *solely* to support patients into entering treatment. Much of peer services are rooted in the stages of change,[xxi] and as such, are dictated by the patient's readiness to begin (or not begin) a recovery pathway. The primary goal of any peer interaction should be to establish a relationship with the patient, so that if and what that individual is ready to begin their pathway to recovery (whatever route that may take), there is support and guidance readily available.

Case example: Project Engage, Christiana Care Health System, Delaware

Project Engage is an early intervention and referral to substance use disorder treatment program designed to help hospital patients who may be struggling with alcohol or drug use. Project Engage integrates peers in recovery, who are called Engagement Specialists, into the clinical setting in the hospital to meet with patients at their bedside about their alcohol and/or drug use. The Engagement Specialists learn about the patient's goals and coordinate treatment options that support the patient's needs. The Engagement Specialists use motivational interviewing to empower each patient in the decision-making process, assisting them to take that critical first step to seek help for their substance use. Project Engage began in 2008 at Wilmington Hospital, and has since expanded to Christiana Hospital in 2011 and to the Emergency Departments at Christiana and Wilmington hospitals in 2013.

Project Engage at Christiana Hospital has distinct workflow components for engaging individuals in recovery support services depending on whether they are in the emergency room or inpatient setting:

Project Engage Pathway in the Emergency Room
This workflow is very dynamic, as ED staff may not have as strong of a relationship with the patient compared to the inpatient setting (due to time constraints, nature of admission, etc.) In this setting, Engagement Specialists are a part of the ED staff, and can help identify individuals that may be misusing. The Engagement Specialists are highly visible within the ED to facilitate their engagement and identification of individuals misusing substances. Engagement Specialists can assist the team in any way within their scope of practice, and in addition to waiting for case referrals can utilize the hospital's electronic health record (EHR) to assist in identifying individuals who may be misusing substances.

Project Engage Pathway in the Inpatient Unit
Individuals brought into the inpatient unit may be screened for an SUD based on their presenting physical issue (e.g., endocarditis or liver issues) – the hospital does not use universal SUD screening in this setting. When an individual who may be misusing substances or has an SUD is identified, an order is placed into their chart for an Engagement Specialist to meet with that individual. It is often a nurse who will place this initial order, as they typically see the patient first and spend the most time with the patient. Nursing staff are trained in Motivational Interviewing to in

Opioid Withdrawal and Pharmacologic Treatment Pathway
Patients that are identified as possibly having an opioid use disorder may be screened using the Opioid Withdrawal Risk Assessment (OWRA) and Clinical Opioid Withdrawal Scale (COWS). If clinically appropriate, patients can initiate treatment with Suboxone within the emergency room or inpatient setting. Engagement Specialists may assist patients in making an informed decision about the use of MAT in their treatment and recovery. For patients that initiate MAT within Christiana Hospital, or are interested in engaging in Medication-Assisted Recovery (MAR) following discharge, Engagement Specialists are well equipped to connect patients with community partners.

Theme # 5: Medication Assisted Treatment (MAT) and Recovery (MAR)

Medications used to treat opioid use disorder and support recovery are key elements in assisting many individuals in overcoming their addiction. Emergency departments may be a particularly suitable place for individuals with OUD to access these medications, as individuals who have just been revived from an opioid overdose may be more amenable to the use of medications to treat their illness (i.e., in the appropriate stage of change, as referred to above). Additionally, a hospital setting presents a suitable environment in which to initiate patients onto medications to treat OUD (a process that requires medical screening and oversight).

Peer support workers in ED settings should feel comfortable discussing the use of medications to treat addiction and support recovery. This is true regardless of whether the peer support worker used (or continues to use) medications to support their own recovery. Under the mantra that there are "multiple pathways to recovery", peer support workers should offer medications as one possible support for recovery, while also discussing other common supports of recovery (e.g., group supports/meetings, social supports, etc.) Additionally, all approved medications to treat OUD should be discussed as an option with the patient – regardless of whether the medication is provided by the hospital or by another provider.

While it is ideal for hospitals to be able to offer MAT/ MAR on-site, and within a reasonable time limit, some organizations interviewed mentioned that they did not offer MAT/MAR on-site or were not able to do so in a reasonable time limit. Thus, regardless of whether a hospital offers MAT/MAR on-site, hospital staff, including peer support workers, should have strong relationships with community providers that do offer MAT/MAR. The nature of these relationships, and the ensuing referrals made to these providers, is critical – for instance, referrals should not be made to community providers that cannot see patients in a timely manner. If an MAT/MAR provider is not available to meet the patient in the near future, the peer support worker should discuss a plan with the patient of how they will access the services when they are available, and what supports are needed in the interim.

Case example: Hartford HealthCare, Connecticut

Hartford HealthCare employs peer support workers in several of their hospital emergency departments. These peer support workers, employed by the Connecticut Community for Addiction Recovery (CCAR), will meet with a patient within two hours of them agreeing to peer support services.

For patients that are interested in beginning MAT/MAR, and are medically cleared to do so, many providers within Hartford HealthCare EDs are eligible to provide one or two of the approved medications (buprenorphine, which requires federal certification to prescribe, and naltrexone, which can be prescribed by any provider authorized to prescribe medications). Initiating patients onto MAT/MAR within the ED setting aligns with recent research that ED-initiated treatment for OUD results in increased engagement in treatment services after discharge. [xxii] [xxiii]

For patients that initiate MAT/MAR within the ED, and/or those that are interested in beginning treatment outside of the ED, the peer support workers play an important role in facilitating the continuation of treatment within the community. Peer support workers may be responsible for calling the patient to remind them of their appointment for treatment in the community, and in some cases, are able to drive the individual to their treatment appointments. This warm support is in-line with contractual obligations for the peer support workers – for patients that meet with a recovery coach while in the ED, the recovery coach is asked to connect with the individual at least 10 times over the first 2 weeks following discharge (when possible).

Commented [JA1]: AAAP might not want us to use "MAR", but I've been seeing it a little more and I do think it helps reduce bias that individuals on medication are not in recovery. I can take this out, but it could be nice to try to push out documents that start to blend these terms a little more? Unless I am mistaken and they are distinct terms with distinct meanings

Commented [JA2]: Could also talk about funding and data collection. Data collection was talked about a couple of times. The biggest take-away is that success of peer support workers should not only be measured by the number of individuals connected to MAT or treatment in general. That sentiment is somewhat discussed in other sections, but I can draft another section if we think it important

Funding probably does not need to be discussed here, as funding will be very different for communities. Many communities are using STR funds, and in some rare cases peers are Medicaid reimbursable.

I'm open to adding sections about one or both of the above – but since we are already over 7 pages, I figured I'd leave them out for now

Discussion for Replication and Expansion

The themes discussed above represent only some of the promising practices that RCOs and hospitals are utilizing to deploy peer support workers in ED settings. Other factors, such as funding and sustainability of peer support programs in EDs, will be highly contextualized to the unique community and organizations.

Commented [JA3]: Still need to work on this section

Special Thanks

A special thanks to all of the individuals and organizations that provided their time and insight as part of this issue brief.

For more information about the organizations interviewed in this issue brief:

Anchor Recovery Community Center

Connecticut Community for Addiction Recovery (CCAR)

Georgia Council on Substance Abuse

Growth Works

Hartford HealthCare

Opioid Overdose Recovery Program (OORP), New Jersey

Opioid Overdose Recovery Program (OORP), RWJ Barnabus

Project Point, Indiana – Link 1, Link 2, Link 3

Project Engage, Christiana Care Health System

Vermont Recovery Network

Endnotes

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