UCHealth Memorial Hospital

Hospital Context	UCHealth Memorial Hospital Central is a Level 1 Trauma Center in Colorado Springs, Colorado. The 413-bed facility is part of the three state UCHealth system that serves Colorado, Wyoming, and Nebraska.
Program Model	The Memorial Hospital grant funding pays for multiple RSS stipends. RSSs are "on-call" during several shifts for the ED and employed by Springs Recovery Center.
Funding	$125,000 for two years

Memorial hospital is a 501(c)(3) nonprofit organization established in 1904. It has four community hospitals (Central, North, Grandview, and Pikes Peak Regional hospitals) and over 80 outpatient locations in El Paso County, Colorado. The site of the ED-RSS program (Memorial Hospital Central) is located in the urban center of Colorado Springs, has the busiest ED in Colorado, and is the seventh busiest in the country. The Memorial Hospital ED has over 150 employees and served more than 60,000 patients in fiscal year 2018 – 587 of whom were identified with a primary SUD diagnosis.

Memorial Hospital Central's ED medical social workers, in partnership with nursing staff and the Behavioral Health unit, manage care coordination. Additionally, community partners, such as domestic violence and sexual assault advocates, hospice organizations, and members of the local CARES (Community Assistance, Referral and Education Services) Program, contribute to care coordination. Memorial Hospital did not use RSS services in the ED prior to the pilot program.

Prior Efforts and Resources to Address Substance Use Disorder at Memorial Hospital

Prior to RSS program implementation, Memorial hospital had a limited social worker/counselor infrastructure in place for supporting ED patients with an SUD. Additionally, Memorial Hospital did not have a workflow for ED patients with an SUD and referrals to community resources were limited. Whether or not a patient was connected to outpatient services or other SUD treatment resources upon discharge was largely dependent on if the physician or counselor/social worker who treated them had knowledge about addiction counseling or resources in the community. One Physician said, *"In terms of the existing capacity, it was physician- or provider-dependent. It was counselor or social worker-dependent on whether or not [the provider] had a significant background in addiction counseling or not. There was no patient flow defined. There was no pathway defined for these patients as they're coming in with addiction issues."*

Memorial hospital has collaborative relationships with a variety of SUD community treatment providers such as Aspen Pointe, Crossroads, Peak View Behavioral Health, Footprints to Recovery, Achieve Whole Recovery, Recovery Village, and the Phoenix. However, interviewees mentioned that prior to the RSS program, many hospital staff did not know of these resources or did not regularly refer patients to them.

Many patients with SUD were simply discharged with a packet of information on community detox facilities. The hospital staff did not have the same working relationship or referral capabilities as the RSSs. Hospital staff have become more aware and knowledgeable of the community resources available to patients with SUD since implementing the RSS program.

Although buy-in and implementation of Medical Assisted Treatment (MAT) at Memorial has been slow due to a lack of general support and skepticism, hospital leadership and champions of MAT in the ED are pushing to implement a MAT program in the ED by March 2020. One physician described Memorial Hospital as slower to adopt SUD programs compared to hospitals in the Denver metro area: *"The issue is that Memorial is about a year-and-a-half to two years slower in adopting [SUD programs]."*

In March of 2018, Memorial Hospital began its inpatient Hope Unit through Addiction Medicine. The Hope Unit is for patients experiencing substance withdrawal and requiring acute medical treatment due to withdrawal or other medical concerns unrelated to SUD. Providers working in the Hope Unit have specific training in addiction medicine and strong relationships with community agencies providing MAT, SUD inpatient facilities, and Intensive SUD Outpatient Programs.

Hospital and Springs Recovery Connection (SRC) leadership already had a strong working relationship through the Colorado Springs Opioid Coalition. Because of this relationship and collaboration, SRC provided an RSS on a voluntary basis to work in the Hope Unit. Memorial Hospital, and the Hope Unit found the volunteer RSS beneficial. Memorial did not have a financial arrangement with SRC and was unable to provide monetary compensation to the RSS or SRC. As a result, the program ended. Its success, however, fostered the implementation of the RSS program.

"In terms of the existing capacity, it was physician- or provider-dependent. It was counselor or social worker-dependent on whether or not [the provider] had a significant background in addiction counseling or not. There was no patient flow defined. There was no pathway defined for these patients as they're coming in with addiction issues."

-Physician

Supports for Implementation

Memorial Hospital and Springs Recovery Connection leadership already had a strong, collaborative relationship due to the Hope unit RSS program and their collaborative work in the Colorado Springs Opioid Coalition. This fostered a smooth and streamlined implementation of the ED-RSS program. Leadership from SRC researched ED-RSS programs implemented in other hospitals and chose the on-call model. Hospital staff and leadership, SRC leadership, and peer supervisors met biweekly to discuss implementation and ensure all partners received necessary support. Hospital leadership said, *"Through that first three months and even prior to the launch, I was meeting, in the beginning, twice a week and then once a week after the launch, in person, with e-mails and phone calls back and forth working out the protocol and the algorithms to the workflow process."*

After the RSS program was implemented, hospital and SRC leadership held informal daily phone calls to discuss necessary changes to the program, which were implemented in real time. They also met once a week to review data, review program processes, and discuss problems. All program partners had the opportunity to provide feedback to make the necessary changes. SRC supervisors held bimonthly meetings with the RSSs to check-in and plan for updates or changes. The two RSS Supervisors served as the on-call RSS once a month to observe program implementation and gather feedback from ED staff.

Both the leadership for Memorial Hospital and SRC were highly invested and knowledgeable of the program, but hospital staff had gaps in understanding. Several interviewees mentioned that a more formal training or meet-n-greet session with all ED staff and the RSSs would have further streamlined program implementation. One of the RSS supervisors said, *"We have a recovery message training that we do, and it introduces the idea of peer recovery support, and of what recovery community organizations are about, this is what we're doing, and we're not coming in to try and change anything about the way you're doing. We're here to help.'... But I think it was lack of education of knowing what we were doing there. Although I think people tried, I don't know if we did a great job of doing that, so that would be a piece for future reference that I think we could do better."*

Program Buy-In

Program buy-in is imperative to successfully implement and maintain a program - especially in a busy ED setting. At the outset, hospital and SRC leadership had support and buy-in from hospital staff involved in planning and coordination. One Mental Health Evaluator said, *"I ran a part of it in the beginning when they started it. I threw a lot of support at it, because I believe very much in any kind of peer-to-peer programming."*

Still, six interviewees mentioned that some hospital and ED staff were initially hesitant or unsure of the program stemming from a lack of understanding and education of SUD in general, and of exactly what the RSS role would be. One of the RSSs stated,*"There's been a little bit of pushback I think just because there's a lack of understanding of what we're doing and what our role is, but I think there is some education that could have taken place or should take place to really educate the staff better on what our role is and why we're there."*

More rigorous ED staff trainings about the program may have mitigated this issue. Interviewees expressed that as time went on and ED staff could see the benefits of the RSS program and learn from the RSSs, there was full buy-in for the program among all staff. One RSS supervisor said, "*When the staff get a chance to interact with our recovery coaches for the amount of time that they're there and ask the questions that they really don't understand, then they're like, oh, okay. It gives us an opportunity to change the culture in the ED [around SUD].""*

7 interviewees reported full buy-in and support for the program from the start

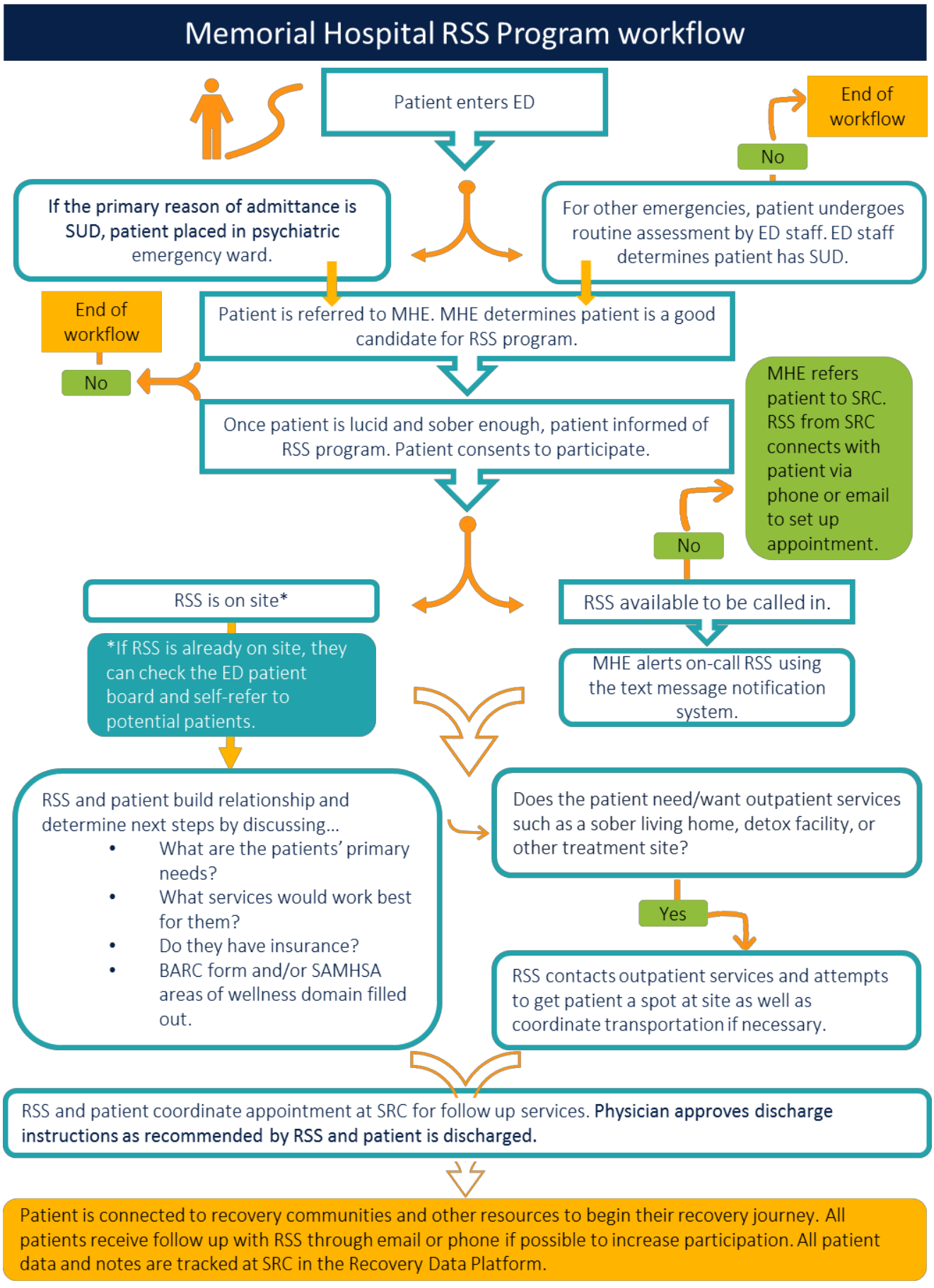
6 interviewees reported some initial push-back or hesitation about program in the beginning, but now all staff are in full support of the program.

Program Workflow

Hospital and SRC leadership updated and fine-tuned the workflow as the program progressed to best support patient care and clinicians' workload. During the initial rollout of the program when RSSs were only available three to four days a week, ED staff and leadership assessed which days generally received the highest volume of SUD patients so RSSs could maximize their time. At the time interviews were completed, there was an on-call RSS scheduled six days a week.

Each day there is an AM (8 a.m.-4 p.m.) and PM (4 p.m.-12 a.m.) shift for the on-call RSS. When a Mental Health Evaluator finds a good candidate for the program, they use a text message alert system to notify the on-call RSS, who must then report to the hospital within 30 minutes. Once at the hospital, the RSS stays for three hours and connects to any patient present who seems likely to benefit from an RSS intervention. Some RSSs may refer two to three or more patients in one shift. The RSS on the PM shift has begun to self-report by 9pm if an MHE has not notified them to come in. This ensures they will not be called in at 11:30 p.m. and have to stay until 3 a.m.

Once at the hospital, if an RSS is not connecting with a patient, they can work in the MHE offices. MHEs and hospital staff contact the RSS on-site when they have an appropriate patient for the program. Additionally, some RSSs have begun to review the ED board and self-refer patients who may be good candidates. One Hospital staff noted: *"The RSS comes in, looks at the board, looks at why they're here, identify people, and then can refer themselves, which has helped significantly with that process."*


Memorial Hospital RSS Program workflow
Patient enters ED
If the primary reason of admittance is SUD, patient placed in psychiatric emergency ward.
For other emergencies, patient undergoes routine assessment by ED staff. ED staff determines patient has SUD.
No
End of workflow
Patient is referred to MHE. MHE determines patient is a good candidate for RSS program.
No
End of workflow
Once patient is lucid and sober enough, patient informed of RSS program. Patient consents to participate.
No
MHE refers patient to SRC. RSS from SRC connects with patient via phone or email to set up appointment.
RSS is on site*
*If RSS is already on site, they can check the ED patient board and self-refer to potential patients.
RSS available to be called in.
MHE alerts on-call RSS using the text message notification system.
RSS and patient build relationship and determine next steps by discussing...
What are the patients' primary needs?
What services would work best for them?
Do they have insurance?
BARC form and/or SAMHSA areas of wellness domain filled out.
Does the patient need/want outpatient services such as a sober living home, detox facility, or other treatment site?
Yes
RSS contacts outpatient services and attempts to get patient a spot at site as well as coordinate transportation if necessary.
RSS and patient coordinate appointment at SRC for follow up services. Physician approves discharge instructions as recommended by RSS and patient is discharged.
Patient is connected to recovery communities and other resources to begin their recovery journey. All patients receive follow up with RSS through email or phone if possible to increase participation. All patient data and notes are tracked at SRC in the Recovery Data Platform.

Initial Successes and Benefits

Partners from the RSS program at Memorial Hospital shared the initial benefits and successes they had seen since program implementation. Interviewees shared a wide array of benefits, with the primary benefit being improved care coordination and patient success. One behavioral health staff member said, *"I can say personally, people that [I interact with] from the ED that have already connected with RSS have had nothing but positive things to say about it. They are excited, they feel supported, and they feel like they have a partner in their sobriety. They like the fact that that person has also been through what they've been through …I think it's been very motivating for our patients."*

One RSS shared a story about seeing increased hope amongst patients they were seeing. The RSS stated, ***"We're able to communicate with the patient on a different level, because they're not hearing the same things that they've heard before. They're hearing their own language. You should see their eyes when you tell them you're in recovery. We're able to give them hope that it is possible, when it's most critical."***

Monthly reports submitted by Memorial Hospital detail the reach of the RSS Program. Data below was collected from June 2019 to January 2020. Memorial Hospital will submit additional data throughout the grant cycle further understand the number of patients who have benefited from the program.

216 Patients received an RSS intervention at Memorial Hospital between June 2019 and January 2020.

79 Patients followed through with recovery and support referrals.

36 Patients followed through with treatment referrals.

"We're able to communicate with the patient on a different level, because they're not hearing the same things that they've heard before. They're hearing their own language. You should see their eyes when you tell them you're in recovery. We're able to give them hope that it is possible, when it's most critical."

-Recovery Support Specialist

Additionally, several program representatives shared stories of seeing reduced use of ED Services by patients. One Recovery Support Specialist shared, ***"It helps to keep people from falling into the cracks. The recidivism factor is really big at this hospital. I believe that that's the thing I think it's helping the most with, is trying to not get people to come back two to three times a week."***

Another clinician shared, *"I think it's decreasing the total pertinent load of subsequent emergent problems from patient addictions; hopefully, we're seeing less overdoses; hopefully, we're seeing less deaths because patients are getting intervention before they hit that point."*

While more data is needed to verify trends in lower use of ED services due to the RSS program, initial data from Memorial Hospital suggests that patients connected to an RSS have lower ED use. From the start of the program in June 2019 through January 2020, the Memorial Hospital ED reported 194 patients used the ED repeatedly in the past 12 months. During the same time period, Memorial only re-admitted six patients to the ED after having an RSS intervention session.

Hospital staff and clinicians personally benefited by gaining a wider understanding of what living with an SUD can be like beyond what they learned in their clinical education. They also learned of the many paths and resources to recovery available to patients. One clinician shared, "*One of the biggest successes is – the peers have been fantastic about educating us…The two [peers] that I worked with at night were so fantastic about educating us not just about addiction, but actually really educating us around some homelessness issues and around drugs of choice. They would tell us their* experiences *which was so fantastic for us. We learned so much from that, I think it was absolutely great."*

The RSSs were a valuable resource in establishing patient relationships that allowed for continued patient follow up and support. The relationships that RSSs establish with patients allows for easier patient follow up. In a typical ED setting, follow up with patients after discharge is rare and challenging. One staff member shared,*"…It's easy for hospital systems that are so large to discharge and then not be able to continuously follow up with all of our patients… Having an RSS there, we know those patients and we know that they're consistently getting follow up with an RSS. As long as the patient's willing to engage, RSS is there for them, and they keep the patients engaged."*

The RSS program was also beneficial to the RSSs. Several RSSs shared that using their oftentimes stigmatized, lived experience in a positive way was rewarding. Connecting with patients and supporting them in recovery was fulfilling. One RSS shared, *"I find it rewarding. I enjoy what I'm doing. It keeps me in self-check. Being in recovery myself, I enjoy being there for others and sharing my experience with them. The results have been good for me. People are staying sober, staying in contact with us through the office. They're taking on different paths. That' the part of it I enjoy the most."*

Challenges to Implementation

At the time of the evaluation interviews, representatives from the Recovery Support Specialist Program at Memorial Hospital shared several challenges encountered in getting the RSS program started and running smoothly.

The primary challenge Memorial Hospital's ED faced in implementing the RSS program was establishing a new process in the ED workflow. Program representatives reported that it took time and reminders to make sure that all ED staff and clinicians remembered this service was available and readily knew how to use it, especially when ED shifts became busy or hectic. One ED staff member shared, *"I think the biggest challenges honestly came on our end, which was just making sure that our staff didn't get so busy that they neglected to actually make the referrals. Because it's easy, when you have 10 mental health evaluations to complete, to forget to send that piece of paper or to make that phone call sometimes. That's been something that we've had to just make sure that our manager has sent out continuous reminders to our staff."*

Others felt that while this was a challenge, the learning curve to implement a brand new program would be inherent in almost any hospital setting. ED staff were confident they had overcome the challenge through continuous attention and dedication to making the program work. Leadership for the RSS program at Memorial spent a great deal of effort to continuously refine and adapt the program to the ED workflow.

A few individuals reported some initial hesitation or pushback from ED staff at the start of the program. Despite clear communication and planning with program leadership, details about the program did not filter down to all ED staff. A few ED staff were not aware of the RSSs and the purpose of their work. Working alongside non-clinical staff was a culture shift for some ED staff. Many program representatives shared that this initial challenge could have likely been prevented with an in-person educational session to learn about the program and introduce any hired RSSs. One mental health evaluator shared, *"Even if it's just a meet and greet type of situation, I think is important...I think when people see tattooed people or people that aren't in suits, they make judgments. If they can meet people, talk to people, and really understand what the program is about and what it's based on, [we can] try to push them through those judgments, and get past them before [the peers come] in."*

Another challenged faced by program staff at Memorial Hospital has been following up with patients after ED visits. While many felt that RSSs are better able to follow up with patients, in general the patient population with SUD can be challenging to reach after discharge from the ED. Particularly, patient follow-up can be extremely challenging when an individual is experiencing chronic or acute homelessness, housing instability, or scarcity in resources like cell phones or computer access.

The RSS program at Memorial Hospital also faced some challenges related to aligning the scheduling and availability of peers to the needs of the ED. Based on information collected through constant communication and monitoring of the program, RSS shifts were rearranged iteratively to maximize the availability of peers. At program rollout, RSSs were only available three to four days a week. At the time of evaluation interviews, RSSs were available six days a week, with hospital leadership starting conversations about how to increase peer availability to seven days a week in the ED.

A significant challenge mentioned by a few individuals, was accounting for program activity and producing data to support the program. Due to patient coding in hospital databases, attempting to pull data related to the number of patients with SUD can be challenging if the primary reason for the visit was unrelated to SUD. While many hospitals implementing an RSS program would experience this challenge, Memorial Hospital will continue to look for strategies to resolve the issue. One individual shared, *"I think the big issue is the importance of the outcome data showing results to make the program sustainable. That's the worry that I have now, how to make that happen. It's somewhat not obtainable- to pull from our EMR the exact data that's requested -that's something that our data people are still working on, and I hope to achieve it. How do we know really what the opioid crisis is in El Paso County? Patients come in and they're not coded as 'opioid'. They could be respiratory failure or a numerous assortment of diagnostic codes and to find those patients in the data is not easy."*

"I think the biggest challenges honestly came on our end, which was just making sure that our staff didn't get so busy that they neglected to actually make the referrals. Because it's easy, when you have 10 mental health evaluations to complete, to forget to send that piece of paper or to make that phone call sometimes.

-ED Staff Member

Additional Resources Needed at Memorial Hospital

Similar to Swedish Medical Center, representatives from Memorial Hospital's RSS program felt that additional, sustainable funding was needed to support program improvement and longevity. Specifically, that the program needs additional funding to bolster RSS compensation. One ED staff member shared, *"Right now we pay our peers a stipend. I would like to be able to pay them hourly to be employees rather than contractors. I think they have so much value that the return on investment is huge for our community, for society, and so I would love for these peers all to be paid well: to be paid so that they can afford to live. Of course right now we're giving them a little tiny stipend, and they're here out of the goodness of their hearts."*

Many representatives from the Memorial RSS program also identified the need for additional treatment, recovery, and harm reduction resources in the community. While this is well outside the purview of the grant, these individuals strongly felt that the availability of community resources heavily impacted how the program could operate. Within the context of Colorado Springs, Colorado, harm reduction resources are extremely limited, and treatment and recovery resources are strained. Many felt that increasing available community resources would aid in improving how the RSSs could support patients struggling with SUD.

Finally, interview participants reported they wanted RSSs to be available "around-the-clock" and to be available to work with patients in other hospital departments. One mental health evaluator shared, *"I would love to have them around the clock. Because I think they would be able to stay busy, not just in the emergency room, but hospital wide. We have people with substance use issues all over the hospital for different reasons. We have people who come in for surgery and are upfront about their drinking issue. … We have so many people that are here for accidental heroin overdoses, or opioids, or alcohol throughout the whole system. It would be so fantastic to have them engaged in that process. I'd even like to see it as a good referral process for our primary cares."*

Hospital leadership responded that conversations had started on how to use some internal funds to support expanding the RSS program to cover additional shifts in the ED.

"I think [the RSSs] have so much value that the return on investment is huge for our community, for society, and so I would love for these peers all to be paid well."

- ED Staff Member

Suggestions for Program Improvement

Representatives with Memorial Hospital's RSS program had several suggestions to continue to streamline and refine the program.

First, many suggested the availability of RSSs and the process for scheduling them could continue to improve. Since implementing the program in June 2019, Memorial's ED made several adjustments to maximize peer availability. Additionally, Memorial Hospital has explored using internal funding to support peer availability "around- the- clock."

Next, several interviewees, including several RSSs, identified that patients with SUD frequently end up in other departments of the hospital. Currently, RSSs can only see patients in the ED. Allowing peers to make connections with patients throughout the hospital would further increase the benefits of having RSSs on staff. One RSS shared, *"It would be great if we could begin to outreach a little bit more into other parts of the hospital if we don't have anything to do in the ED... We don't see a portion of patients with SUD because they end up in different floors for different things. They have other things happening. I hope someday we get to branch out."*

Finally, while Memorial Hospital has put considerable effort into understanding and defining all the potential ways an ED patient could interact with the RSS program, several interviewed felt that additional work could be done to further streamline the workflow and integrate the new program into the natural pace of operations.

Suggestions for Future Programs

At the time of phase 1 evaluation interview, Memorial Hospital had been running its RSS program for just over 6 months. In that time, many interviewed reported some lessons learned regarding efficiently implementing a peer-based RSS program in their ED.

The primary recommendation interviewees had for other hospitals looking to implement similar programming was to conduct an in-person educational session with all ED staff, covering the purpose of the program and to introduce any hired peers. While coordinating all ED staff to be present for a single event poses its own challenges, ED staff, ED leadership, and RCO leadership felt that conducting an in-person information session and meet- and-greet with some of the Recovery Support Specialists in the ED would have prevented some initial challenges and helped to get the program running efficiently more quickly. One RSS shared, *"I would suggest that they lay the groundwork as soon as possible in the process. Because a lot of times, it all boils down to communication. Everything was being done by emails and I would give advice to try to meet in person more with anyone who's involved with the program. Because that communication right there can get it shored up and make it into a good working machine quicker."*

Furthermore, representatives from the Memorial Hospital RSS program highly recommended other sites have an intentional planning process that outlines a few key areas. First, program leaders need to establish a process or workflow that identifies how a patient would interact with the program and the multiple decision points that could affect a patient's experience in the ED. Creating this model before program implementation was seen as a crucial step in supporting an efficient implementation and reducing possible points of confusion or disorganization in a busy environment.

Additionally, program representatives recommended that the process to get a patient to an RSS needs to be fairly simple, as a cumbersome or paperwork-heavy process would likely reduce how often a patient gets referred to an RSS. One hospital leader shared, *"[Leadership] has to be bought in and once that's in place, you can work out the operationalizing... It's just talking through so it's not a disruptive workflow to whatever you have going on already because if a nurse or a doctor or even a social worker, if it causes too many steps to happen to be*

able to get the patient to a recovery specialist, it's not going to be used well because it's too hard. I would say that it has to be a very simple process to get a patient to a peer specialist."

Related to the creation of a workflow, those interviewed reported that Memorial Hospital benefited from having constant and regular communication about how the program was working once it was implemented. This allowed leaders and staff to make adjustments to the design of the program as lessons were learned. Representatives from Memorial Hospital highly recommended other hospitals looking to implement peer-based programming have continuous communication about refining the process and workflow as lessons are learned, to not be too tied to the initial design if steps are not working well, and to be open to making adjustments and refinements to better connect patients to the program.

CONCLUSION

Based on the interviews conducted, evaluators identified some commonalities across the experiences of the two pilot sites that may be useful for other sites considering adopting an RSS program. These include:

- Hospitals and RCOs need to form a quality, bi-directional relationship, and allow for an RSS program to be designed together and be informed by the expertise of both entities.
- Program implementation requires an intentional planning process that includes identifying how the RSS program is incorporated into the ED workflow.
- Hospital leadership, RCO leadership, and ED staff should engage in continuous communication to make mid-course adjustments to streamline RSS program.
- Program Leaders should introduce RSS program and staff to ED staff to ensure program is rolled-out efficiently.
- Program champions should work with any legal or compliance departments early in the process.

Additional data will need to be collected during phase 2 to further determine feasibility and replicability of this program at other hospital sites, particularly as Swedish Medical implements their RSS program and Memorial further establishes their program. Evaluators recommend including the following in phase 2 of the evaluation plan to further determine feasibility at additional sites:

- Conduct more interviews with program representatives from Swedish Medical once the program is operational;
- Interview representatives from rural hospitals interested in RSS programming about existing capacities and resources as well as potential barriers to adoption; and
- Interview hospital administrative staff experienced in helping move the legal and liability portions through hospital systems prior to program implementation.

MISSION

We strive to make evaluation a valued and widely accepted practice by increasing the use and understanding of evaluation. We collaborate with our clients to support evidence-informed programs, practices, and policies in schools, institutions of higher education, governmental agencies, and nonprofit organizations.

The Evaluation Center
UNIVERSITY OF COLORADO
DENVER | ANSCHUTZ MEDICAL CAMPUS

999 18th Street, Suite 805N | Denver, CO 80202

w: the-evaluation-center.org | e: TheEvaluationCenter@udenver.edu