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EMERGENCY DEPARTMENT RECOVERY SUPPORT SPECIALIST PILOT PROGRAM:

Phase I Report

The Evaluation Center
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DENVER | ANSCHUTZ MEDICAL CAMPUS

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TABLE OF CONTENTS

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Emergency Department Recovery Support Specialist Pilot Program

The Colorado Consortium for Prescription Drug Abuse Prevention, with funding from The Colorado Health Foundation, initiated a pilot program in April 2019 to fund two hospitals to embed one Recovery Support Specialist (RSS) position in their Emergency Departments for two years. The purpose of the pilot was to evaluate feasibility and impacts of this new position in an ED setting. A Recovery Support Specialist is a certified individual with "lived experience" with Substance Use Disorder (SUD) whose role is to connect patients struggling with SUD to resources in the community and to provide follow-up support to the patient after discharging from the Emergency Department. The Consortium contracted The Evaluation Center to conduct an evaluation in Year 1 of the pilot program to learn about implementation progress, initial successes, facilitators and barriers to implementation, and suggestions for future RSS programs.

PROCESS PHASE	MEMORIAL HOSPITAL **Program Began June 2019**	SWEDISH MEDICAL CENTER **Program pending implementation at time of evaluation**
Implementation Progress	Memorial Hospital had fully implemented the RSS program in their Emergency Department. The program had been operating for approximately seven months, with several part-time RSS positions filled to work in the ED.	Swedish Medical Center had not yet implemented the RSS Program in their Emergency Department. Advocates for Recovery was in the process of interviewing candidates for the RSS position. Swedish plans for one full-time RSS to work in the ED.
Initial Successes	• **Over 200 patients have been connected to Recovery Support Specialists in the first 7 months** • Peers and clinicians report personal and professional benefits	Program implementation pending
Challenges to Implementation	• Establishing a new process in ED • Some initial pushback from ED staff • Patient follow-up • RSS scheduling • Producing data to support the program	• Navigating the legal and liability processes amongst all the large entities involved • Hiring RSSs with lived experience but no criminal record, as several of the entities involved do not allow for employees to have a criminal record
Facilitators to Implementation	• Unit in hospital dedicated to mitigating illness in patients with chronic SUD • Prior working relationships with MAT providers • Limited social worker infrastructure • Limited referral ability to withdrawal management center	• Established MAT and naloxone programs at hospital • Identified leader in Alternatives to Opioids Practices • Robust social worker infrastructure • Intentional culture change effort to reduce stigma and promote harm reduction • Prior working relationships with treatment and recovery

IN CLOSING	MEMORIAL HOSPITAL	SWEDISH MEDICAL CENTER
Suggestions for Future Programs	• Conduct an in-person educational session with all ED staff, covering the purpose of the program and to introduce any hired peers • Have an intentional planning process that includes creating new workflow and simplifying path of patient to RSS • Have continuous check ins about refining program as lessons are learned	• Start conversations early with any departments or entities that will be involved in ensuring compliance and legal issues • Form quality, bi-directional relationships with RCOs, and allow for the program design to be informed by the various expertise from both the hospital leadership and the lived experience of the RCO leadership

Feasibility of Recovery Support Specialist Programs in Other Hospital Settings

As these programs mature, additional data will be collected that can further inform feasibility of adopting an RSS program at other hospitals. Evaluators have established some commonalities amongst the experiences of the two pilot sites that inform replicability. These include:

1. 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

2. Program implementation requires an intentional planning process that includes identifying how the RSS program is incorporated into the ED workflow

3. Continuous communication with Hospital leadership, RCO leadership, and ED staff is essential to make mid-course adjustments to streamline RSS program

4. Introduce RSS program and staff to ED staff to ensure program is rolled out efficiently

5. Work with any legal or compliance departments early in the process

BACKGROUND AND METHODS

The Colorado Consortium for Prescription Drug Abuse Prevention, with funding from The Colorado Health Foundation, initiated a pilot program to utilize Recovery Support Specialists (RSS) in Emergency Departments (ED). An RSS, also frequently referred to as a peer, is defined as a certified individual with "lived experience" whose role is to connect patients struggling with substance use disorders (SUD) to resources in the community and to provide follow up support to the patient after discharging from the ED.

As part of the two-year RSS pilot, the Consortium awarded a total of $250,000 to two large, urban hospitals at $125,000 each: UCHealth Memorial Hospital Center (Memorial Hospital) and Swedish Medical Center (Swedish Medical). The two hospitals are using slightly different employment models to implement the program and have each partnered with a local Recovery Community Organization (RCO). Memorial Hospital, in partnership with Springs Recovery Connection, pays for multiple part-time RSS stipends. RSSs are "on-call" during several shifts for the ED. Swedish Medical Center is implementing the program under the charge of a single physician, partnered with Advocates for Recovery, and will fund one full-time RSS position to work directly in the ED.

The Colorado Consortium for Prescription Drug Abuse Prevention contracted with The Evaluation Center, University of Colorado Denver in November 2019 to conduct a two-phase evaluation. During phase one, evaluators collected formative feedback about the facilitators and barriers to program implementation. Evaluators reviewed program documents and conducted 15 interviews with representatives from the pilot sites. Interviews were conducted in January and February of 2020. At the time of the interviews, Memorial Hospital (13 interviewed) had implemented the RSS program for six months. Swedish Medical (2 interviewed) had not hired an RSS or implemented the program but shared initial plans and challenges to implementation.

Phase two of the evaluation will include a summative evaluation focusing on program impact and replicability in other hospital EDs.

Acronyms Used	
Emergency Department Recovery Support Specialist, also referred to as peers	RSS
Substance Use Disorder	SUD
Hospital Corporation of America	HCA
Medication Assisted Treatment	MAT
Alternatives to Opioids	ALTO
Office Based Opioid Treatment	OBOT
Opioid Treatment Program	OTP
Recovery Community Organization	RCO
Springs Recovery Connection	SRC
Mental Health Evaluator	MHE
Substance Abuse and Mental Health Services Administration	SAMHSA

Swedish Medical Center

Hospital Context	Swedish Medical Center is an urban, Level 1 Trauma Hospital located in Englewood, Colorado. The 408-bed hospital is a part of Hospital Corporation of America (HCA) Healthcare's HealthONE for-profit system.
Program Model	Swedish Memorial Center is implementing the program under the direction of a single physician, their opioid consulting company, and under the umbrella of HCA and HealthONE. The model will fund one full-time RSS to work directly in the ED. The physician has partnered with Advocates for Recovery to hire the RSS.
Funding	$125,000 for two years

Swedish Medical Center is part of HealthOne, one of the largest hospital systems in Colorado. It is comprised of six major hospitals and seven freestanding emergency departments serving a geographically diverse area within Denver, Colorado. HealthOne's parent company, the Hospital Corporation of America, is the largest hospital corporation in the United States. Swedish Medical Center, located in Englewood, is an urban hospital that has served the south Denver metropolitan area since it opened in 1905. The Emergency Department is staffed by 22 physicians, 15 physician assistants, one nurse practitioner, and several hundred nurses, technicians, and administrative staff. Annual ED visits are around 60,000. In 2018, 2,288 patients were given an SUD discharge diagnosis.

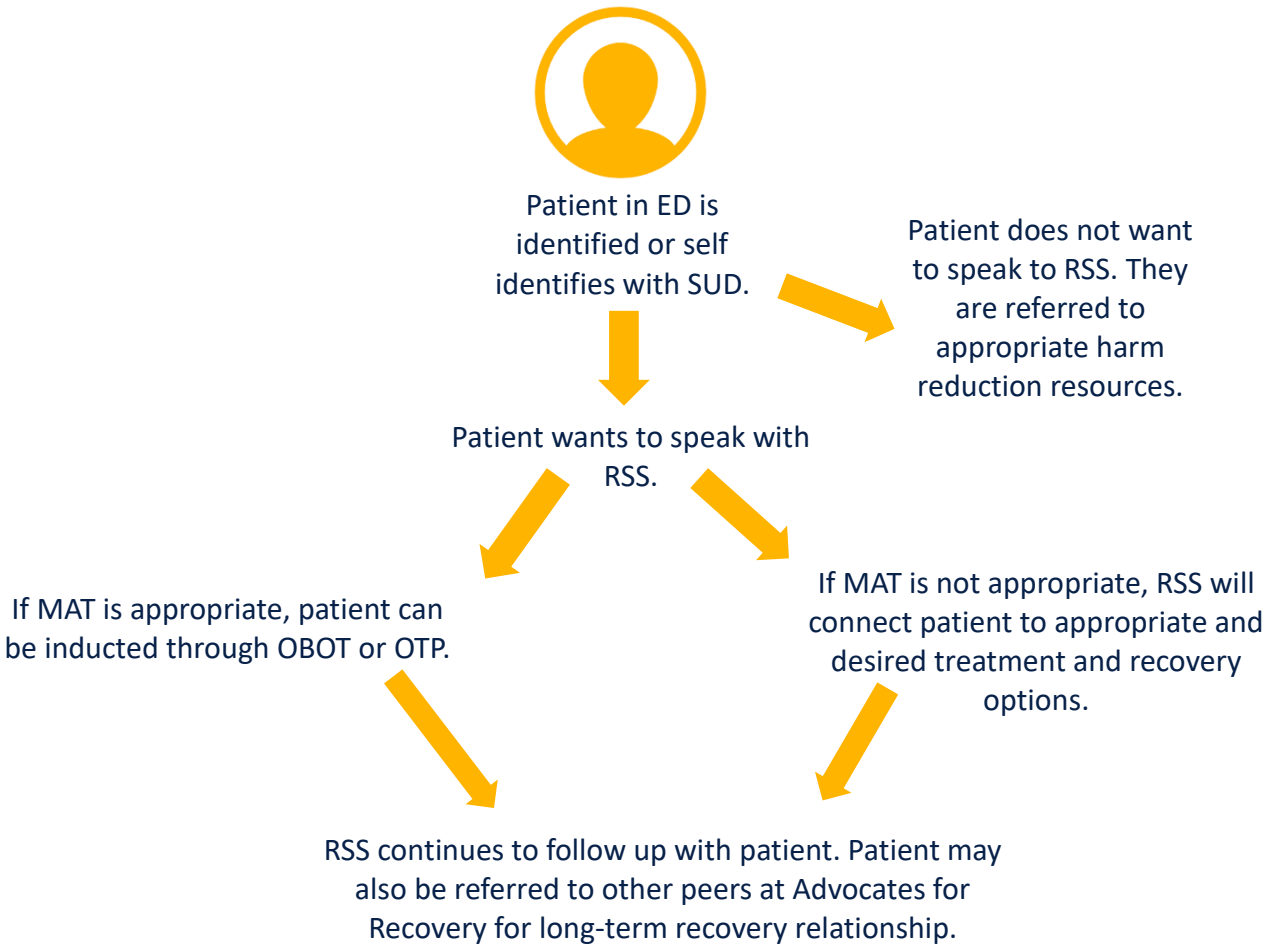
The Case Management and Social Work Departments provide care coordination. The social workers and registered nurses assist in providing resources to patients with SUDs or discharging them directly to detox facilities. For the past decade, Swedish Medical Center has operated a telehealth network with the 12 Colorado HealthOne hospitals to facilitate treatment between specialty services. Swedish has never previously employed peer-specific staff in its Emergency Department.

Proposed Workflow and Implementation Plan

Swedish Medical Center had not hired their RSS or begun to implement the program at the time of interviews. However, Swedish Medical began planning for the new program and designing the workflow, which outlines the ways a patient could interact with the program. The Implementation Plan included the following steps;

- Introduce RSS to ED staff;
- Educate ED staff how to best utilize RSS;
- Find physical space for RSS to meet with patients; and,
- Onboard all staff how to track and chart RSS program for HCA compliance.

Workflow


Patient in ED is identified or self identifies with SUD.
Patient does not want to speak to RSS. They are referred to appropriate harm reduction resources.
Patient wants to speak with RSS.
If MAT is appropriate, patient can be inducted through OBOT or OTP.
If MAT is not appropriate, RSS will connect patient to appropriate and desired treatment and recovery options.
RSS continues to follow up with patient. Patient may also be referred to other peers at Advocates for Recovery for long-term recovery relationship.

Prior Efforts and Resources to Address Substance Use Disorder at Swedish Medical

The RSS program at Swedish expands upon previous efforts and resources within the hospital to address SUD in the community. Prior to introducing the RSS program, the hospital inducted patients into Medication Assisted Treatment (MAT), provided hospital funded naloxone to some patients to take home, and was a leader in Alternatives to Opioid Practices (ALTO). Additionally, Swedish Medical Center had a robust social worker infrastructure to assist with discharge planning, and it established relationships with local treatment and recovery groups. Hospital staff and leadership strived to intentionally shift workplace culture to reduce stigma around SUD and promote harm reduction. Program leadership felt prior efforts created a solid foundation in which to launch the RSS program.

"I'm really proud of our nurses and staff that bought into harm reduction and compassion in our treatment of patients with opioid use disorder. We are proud of the culture that we have around trying to help patients, and that's been a culture that's really been built on the last five years that we've been transforming our practice."

-Physician at Swedish Medical.

Challenges to Implementation

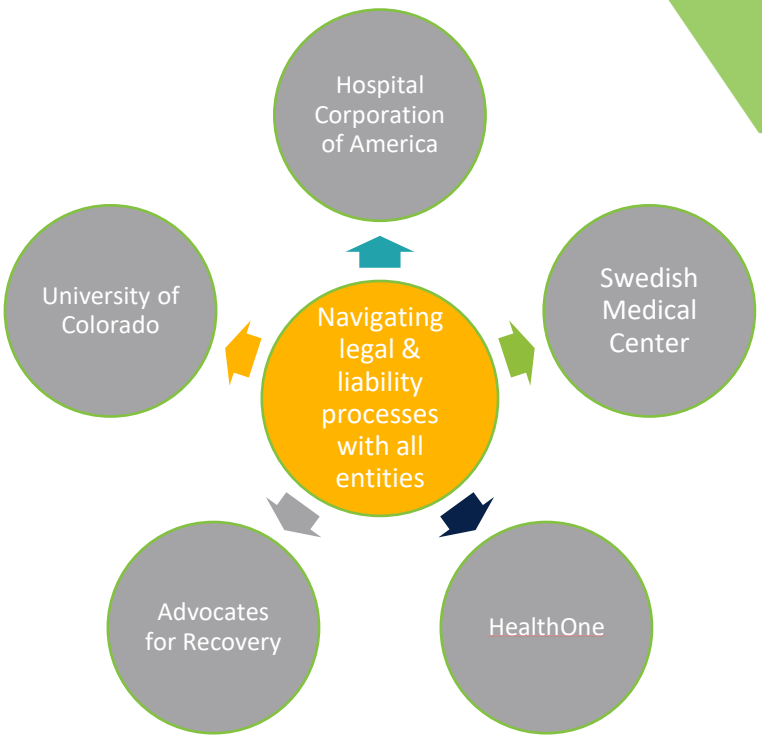
The primary challenge to implementing the RSS program at Swedish Medical has been navigating the legal and liability processes amongst all the large entities involved.

Swedish Medical's model required several major entities to establish new contractual agreements with clearly defined relationships. Employing non-clinical individuals with lived experience to work with ED patients is a novel model. Swedish had to establish new agreements that aligned with the five different entities' legal and liability requirements. This posed significant challenges moving the program forward and resulted in significant delays. Program approval from HealthONE took approximately one year. Communication amongst the various entities' legal teams took a considerable amount of time and effort.

"The thing that is a big obstacle has been just getting this approved from HCA- the Hospital Corporation of America is the largest owner of hospitals in the world, and there's a significant amount of bureaucracy that comes with that. A lot of this has been bogged down by the need to get approval from compliance and from legal, and they need to get a sign-off that we have these relationships between the university, Swedish Hospital, myself as a physician, and Advocates for Recovery. I think once you get lawyers involved, it gets much more complicated…The University of Colorado is also a large bureaucratic system, so there are a lot of things that I've had to go back and forth for approval from their compliance to Swedish and then to HCA."

-Physician at Swedish Medical.

Additionally, this complex, multi-faceted legal process made filling the RSS position even more challenging, as several entities do not allow employees to have a criminal record. Because the United States criminalizes substance use, it is difficult to hire an individual with lived experience with SUD and no criminal record. One physician shared, *"People who are RSS have to have lived experience. Lived experienced sometimes involves a criminal record. One of the barriers for HCA is that a criminal record would probably disqualify them from being able to be credentialed to come see patients at Swedish. There are barriers—a large system like HealthONE is a bit more risk adverse, especially with the large legal firms they contract with. They're a lot more risk adverse in something that's really innovative."*



Additional Resources Needed at Swedish Medical Center

Swedish Medical identified sustainable funding as the one additional resource needed to support the program. One individual shared that while grant dollars are extremely helpful for programs like this, longer-term, sustainable funding needs to be established to support RSS programming beyond the grant.

> *"How do we continue to fund something like this? It can get difficult because the patient goes to the emergency department, they have Medicaid, and that pays for all their medical services. Recovery community organizations that are independent and peer run—we're not connected to a bigger treatment system—we don't have the ability to bill Medicaid for peer services. There has to be a way to maintain the funding for the RCO to be able to put people in these positions and then be able to pay them for the services. I think that we have to work out those kinks in the system. I think there are all kinds of ways to make this happen."*
>
> *-RCO Leadership*

Suggestions for Future Programs

While Swedish Medical Center had not implemented the RSS program, program leadership had suggestions for hospitals looking to adopt similar programming. First, champions of peer programming within the hospital should start conversations early with any departments or entities that will be involved in ensuring compliance and legal issues. One physician shared that starting these conversations early and ensuring hospital and RCO leadership commitment to program implementation is crucial to successfully starting the program. Additionally, program leadership shared that clearly articulating the benefits of the RSS program is necessary when working with "risk-adverse" hospital corporate legal teams.

The final suggestion shared by Swedish was to form quality, bi-directional relationships with RCOs, and allow for the program design to be informed by the various expertise from both the hospital leadership and the lived experience of RCO leadership.

Allowing leadership from the hospital and RCO to co-design how the RSS program works leads to greater patient benefits and fully leverages the capabilities of the RSSs

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 part-time 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

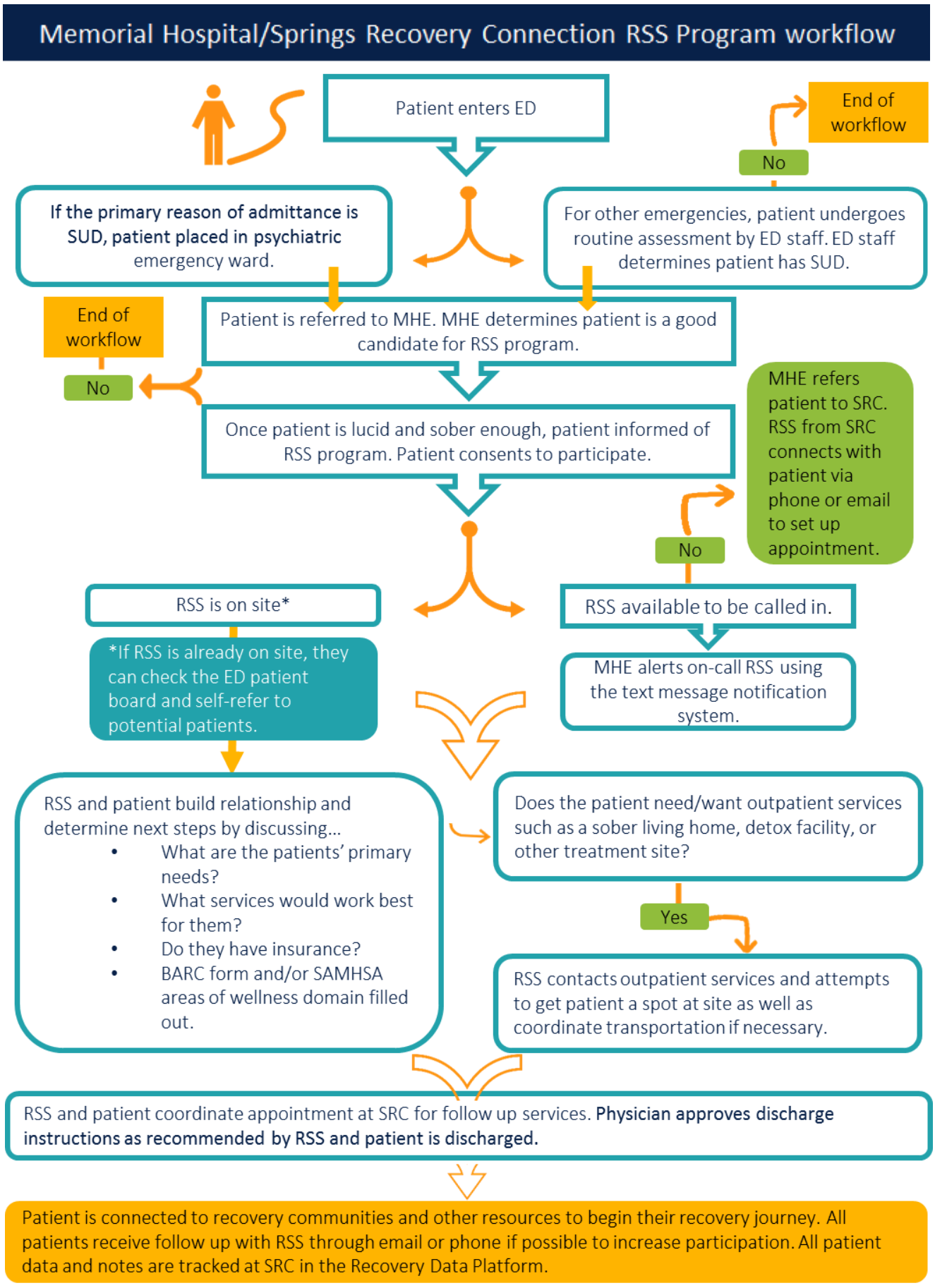
6 interviewees reported some initial push-back or hesitation about program in the beginning, but now all staff are in full support of the program.

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/Springs Recovery Connection 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 Springs Recovery Connection detail the reach of the RSS Program at Memorial Hospital. Data below was collected from June 2019 to January 2020. This partnership 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

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EMERGENCY DEPARTMENT RECOVERY SUPPORT SPECIALIST PILOT PROGRAM PHASE II REPORT

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Prepared for

COLORADO CONSORTIUM
for Prescription Drug Abuse Prevention

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Table of Contents

Executive Summary

The Colorado Consortium for Prescription Drug Abuse Prevention, with funding from The Colorado Health Foundation, initiated a pilot program to use Recovery Support Specialists (RSS) in Emergency Departments (ED) in 2019. An RSS, also frequently referred to as a "peer," is defined as a certified individual with "lived experience" whose role is to connect patients struggling with substance use disorder (SUD) to resources in the community and to provide follow up support to the patient after discharging from the ED. As part of the two-year RSS pilot, the Consortium awarded a total of $250,000 to two large, urban hospitals at $125,000 each: UCHealth Memorial Hospital Central and Swedish Medical Center. The two hospitals employ slightly different models to implement the program and each partner with a different local Recovery Community Organization (RCO). The following summary provides key highlights from the pilot program, including impacts unique to each site.

Pilot Program Overview

- RSS referrals frequently outpaced the RCO's ability to meet the demand, indicating a need for additional peers.
- Alcohol, followed by methamphetamine, were the most common primary substances reported across the two EDs.
- Males and individuals aged 25-59 constituted a large majority of referrals.

COVID-19 Pandemic

- The largest impact of the COVID-19 pandemic to the ED-RSS programs was that RSSs were restricted from being physically present in the ED. Peers felt connecting with patients face-to-face in the ED was a critical component to successfully establishing a positive relationship.
- Each site used remote technology to support recovery when RSSs could not physically be in the ED; however, coordinating telehealth support was burdensome for ED staff.

Impact

Advocates For Recovery Colorado

Health ONE Swedish Medical Center

- The majority of patients who participated in the program decreased the number of ED visits in the six months after referral compared to patients who did not participate.
- A small number of patients accounted for over half of ED visits six months after referral suggesting the importance of identifying and focusing on high use patients.

Impact

- Of the patients who had a high level of participation in the program, 64.3% decreased their ED visits in the six months following engagement compared to 24.8% of patients who did not participate.
- Patients who had a high level of participation in the program had an average reduction of almost one ED visit in the six months following the last engagement.

Implementation & Replicability

- It is important to have RSSs physically onsite and available to meet with patients promptly.
- It is essential for clinicians and ED staff to thoroughly understand the role of the RSS, why they are there, and how an RSS can complement and support patient care.
- Hospitals should integrate RSSs into the ED by having them attend staff meetings and providing a physical workspace.
- ED-RSS program partners should hold regular meetings to plan, reflect, and identify ways to improve the program.
- It is difficult to connect with patients who do not have reliable access to communication resources (phone, internet) or stable housing.
- An ED-RSS program allows partners to reach more patients and provide an additional level and quality of care.
- It is important that a patient consents to engage with an RSS before making a referral.
- It is important the program is free, begins at the ED, and support comes from someone with lived experience.

Background

The Colorado Consortium for Prescription Drug Abuse Prevention, with funding from The Colorado Health Foundation, initiated a pilot program to utilize Recovery Support Specialists (RSS) in Emergency Departments (ED) in 2019. An RSS, also frequently referred to as a peer, is defined as a certified individual with "lived experience" whose role is to connect patients struggling with substance use disorder (SUD) to resources in the community and to provide follow up support to the patient after discharging from the ED.

As part of the two-year RSS pilot, the Consortium awarded a total of $250,000 to two large, urban hospitals at $125,000 each: UCHealth Memorial Hospital Central and Swedish Medical Center. The two hospitals employ slightly different models to implement the program, and each partner with a different local Recovery Community Organization (RCO). The Memorial Hospital Central grant funding, in partnership with Springs Recovery Connection, pays for multiple RSS stipends. RSSs are "on-call" during several shifts in the ED and implementation began in June 2019. Swedish Medical Center implemented the program under the charge of a single physician, partnering with Advocates for Recovery Colorado. Swedish funds one RSS to work directly in the ED and implementation began in February 2020.

The Colorado Consortium for Prescription Drug Abuse Prevention contracted with The Evaluation Center, University of Colorado Denver in November 2019 to conduct a two-phase evaluation. During phase one, evaluators collected formative feedback about the facilitators and barriers to program implementation. For more information on phase one results, please contact the Colorado Consortium for Prescription Drug Abuse Prevention (pm@cuanschutz.edu).

IMPACT OF THE COVID-19 PANDEMIC

Beginning in March 2020, both pilot program sites experienced challenges due to the COVID-19 pandemic. Staff discussed adaptations on program implementation, which impacted the referral process, communication, program capacity, and ED workflow.

The largest impact of the pandemic to the ED-RSS programs was that RSSs were restricted from being physically present in the EDs. Peers felt connecting with patients face-to-face in the ED was a critical component to successfully establishing a positive relationship. At both sites, RSSs were forced to work remotely from March to July and again from late August into early 2021. During this time, both programs attempted to fulfill referrals using telehealth via video and/or telephone. Details about the impact of the pandemic for each site, as well as important events during that time, are included in subsequent sections of this report specific to each site.

Acronyms Used	
Emergency Department Recovery Support Specialist, also referred to as peers	RSS
Substance Use Disorder	SUD
Hospital Corporation of America	HCA
Medication-assisted Treatment	MAT
Alternatives to Opioids	ALTO
Opioid Treatment Program	OTP
Recovery Community Organization	RCO
Springs Recovery Connection	SRC
Mental Health Evaluator	MHE
Substance Abuse and Mental Health Services Administration	SAMHSA

Swedish Medical Center & Advocates for Recovery Colorado

Hospital Context	Swedish Medical Center is an urban, Level 1 Trauma Hospital located in Englewood, Colorado. The 408-bed hospital is a part of Hospital Corporation of America (HCA) Healthcare's HealthONE for-profit system.
Program Model	Swedish Medical Center is implementing the program under the direction of a single physician, their opioid consulting company, and under the umbrella of HCA and HealthONE. The model will fund one full-time RSS to work directly in the ED. The physician has partnered with Advocates for Recovery Colorado to provide the RSS.
Funding	$125,000 for two years

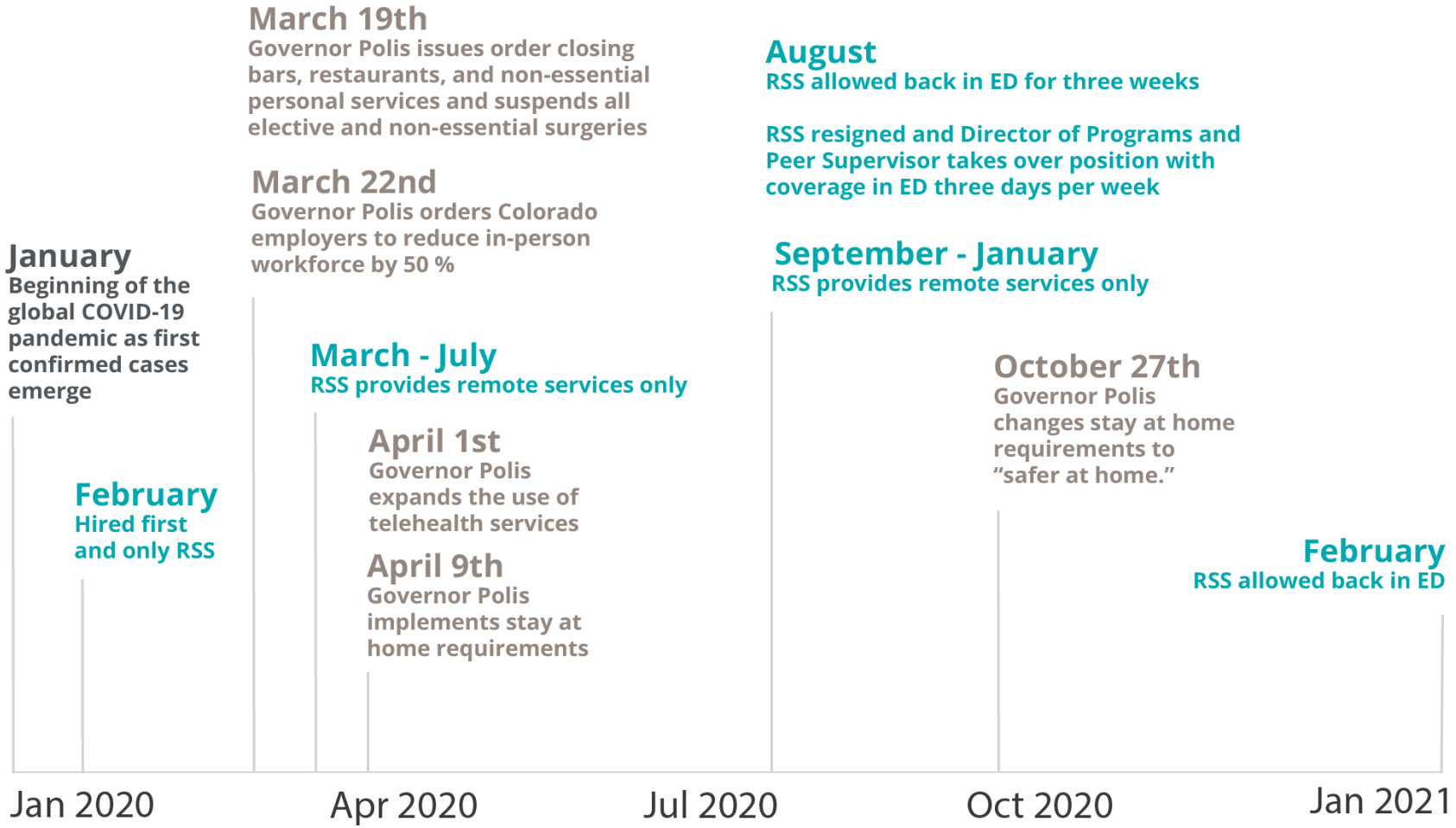
Swedish Medical Center is part of HealthOne, one of the largest hospital systems in Colorado. Health One is comprised of six major hospitals and seven freestanding emergency departments serving a geographically diverse area within the Denver Metropolitain Area. HealthOne's parent company, the Hospital Corporation of America, is the largest hospital corporation in the United States. Swedish Medical Center, located in Englewood, is an urban hospital that has served the south Denver area since it opened in 1905. The Emergency Department is staffed by 22 physicians, 15 physician assistants, one nurse practitioner, and several hundred nurses, technicians, and administrative staff. Annual ED visits are around 60,000. In 2018, 2,288 patients were identified with an SUD.

The Case Management and Social Work Departments provide care coordination for patients with SUD. The social workers and registered nurses assist in providing resources to patients with SUDs or discharging them directly to detox facilities. For the past decade, Swedish Medical Center has operated a telehealth network with the 12 Colorado HealthOne hospitals to facilitate treatment between specialty services. Swedish had never previously employed peer-specific staff in its Emergency Department. Its recovery community organization (RCO) partner, Advocates for Recovery Colorado is a prominent nonprofit RCO in Colorado that is heavily involved in state and national advocacy work, community engagement, peer training, and providing recovery supports for individuals and families.

Swedish Medical Center and Advocates for Recovery Colorado implemented the pilot program in Feb 2020, adding one full-time RSS position to the ED team. Due to a delay in initial implementation of the position, the site will continue to implement the program through March 31, 2022. As explained in the year-one report, the implementation delay was navigating legal and liability issues. As of the time of the publication of this report, RSS shifts were increasing from an average of three days per week to five. ED staff identify patients appropriate for an RSS intervention, obtain patient consent, and refer the patient to an RSS with Advocates for Recovery Colorado. If an RSS is on-site they connect with the patient in the ED as soon as possible. If the RSS is not available on-site, ED staff will enter the patient referral into a Google form that is added to a Google sheet and the RSS follows up as soon as possible. Follow-up is by phone and typically within 24-48 hours. The following information comes from monthly reports from April 2020 to May 2021 and were significantly shaped by the COVID-19 pandemic.

Denver Site Timeline

The ED-RSS program was implemented by ED and RCO staff beginning in February 2020. The COVID-19 pandemic affected individuals and communities across the world and Coloradans were no exception. The following timeline displays major events during the pandemic, which impacted the ED-RSS pilot program and the RSSs ability to support patients who needed peer services. Particularly, the inability for RSSs to be physically present in the ED during COVID lockdowns made connecting with patients difficult. The Denver pilot program period has been extended due to a delayed implementation start.



Denver Site & COVID -19 Impacts

"[The pandemic] kept us from serving as many people as we could have served. People lived in fear … especially in those first few months." – RCO staff

Changes to referrals

- Loss of RSS in ED, who had been a reminder to ED staff to use them as a resource for patients with SUD
- Anticipated rise in need in around mental health and substance use as the pandemic subsides and people emerge from isolation

"[Some patients] did not have a phone. They did not have internet. The libraries were closed. It really limited the resources you give somebody [for] support." - RSS

Silver Linings

- Continued use of remote tech for recovery support, especially for new offices in rural sites where in-person options might be minimal
- Continued use of referral list in Google Drive when peer is not physically present in ED

Adaptations

- Used shared Google Doc to track and follow up on referrals
- Became "Zoom experts"
- Used iPads for real time meetings between patient and RSS

Challenges

- Coincided with the initial implementation of the program, which made it difficult to roll out
- Following up with patients who do not have access to a phone or internet has been very difficult when peers were not physically present in ED
- Virtual peer support not the same or as successful as face-to-face support.
- Coordinating an iPad meeting was difficult for ED staff – found more success in follow-up phone calls

"Not only could you not be in the ED and meet [patients] that first time in-person, but then any ongoing peer support services had [to be] virtual … so there was a huge gap in feeling that connection, true connection with somebody you have never met." – RSS

"People's minds were elsewhere often … with their own anxieties and worries about what was going to happen to staff and letting people go. Some of the attention to clinical improvements project [like ED-RSS] waned as those worries bubbled to the forefront of people's minds." - Clinician

Denver Site Program Impacts

Monthly Progress Reports

The following data come from monthly progress reports submitted between April 2020 and May 2021.

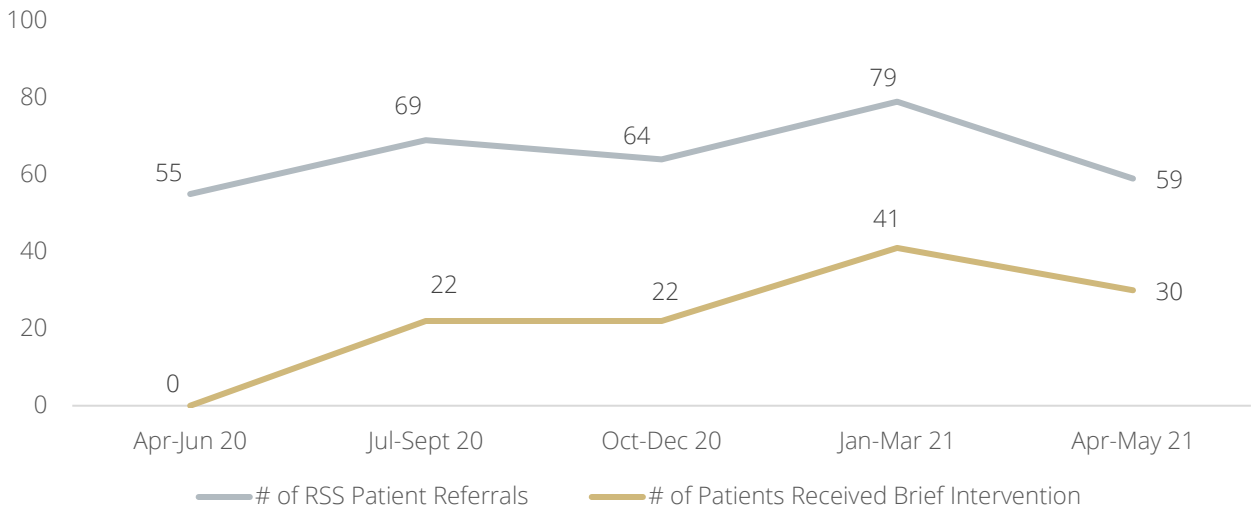
326 Patients identified with Substance Use Disorder and appropriate for RSS referral.

115 Patients received an RSS intervention.

58 Patients followed through with recovery support referrals.

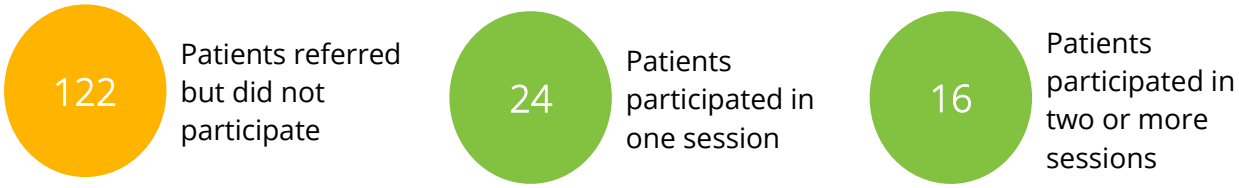
21 Patients followed through with treatment referrals.

Across the implementation period, alcohol was the primary substance reported most frequently in the ED at this pilot site, followed by heroin and methamphetamine. Males accounted for more than two-thirds of referrals and those aged 25-59 constituted nearly 70% of referrals. RSSs from Advocates for Recovery Colorado increased the number of interventions provided for patient referrals in February, March, April, and May of 2021. RSS referrals frequently outpaced the RCO's ability to meet the demand, indicating a need for additional peers.



Emergency Department visits

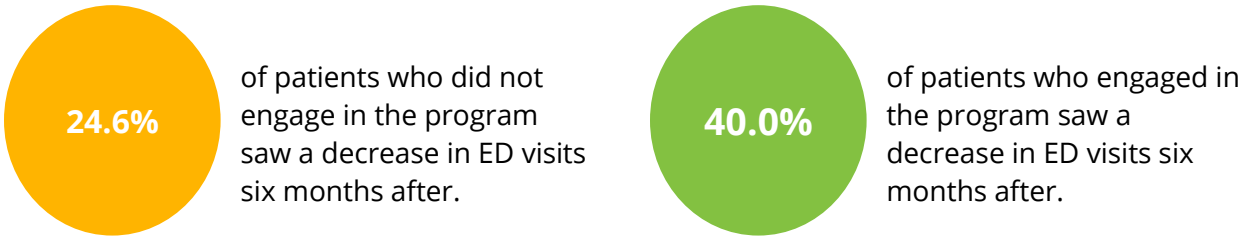
ED and RCO staff from the Denver pilot site identified and provided data for three types of patients. The first were patients who were referred but did not participate in the program. The second were patients who were referred and participated in one session with an RSS. The third were patients who were referred and participated in two or more sessions with an RSS. Evaluators included 162 patients in subsequent analyses.



Patients from all three groups visited the ED a total of 250 times in the six months following referral. Ten patients accounted for 50% of these ED visits. Of those patients, four participated in the program and six did not. The six who did not participate accounted for over a third (35%) of the 250 ED visits following referral.

The average number of ED visits six months after engagement in one, two, or more than two sessions (*n*=40) was 1.32 visits. Patients who did not participate in the program (*n*=122) averaged 1.06 visits in the six months following referral.

Among patients who engaged with the program, 40.0% decreased the number of ED visits in the six months after. This compared to 24.6% of patients who were referred but did not participate.



Evaluators found no statistically significant differences in ED visits six months after referral among patients with different levels of program participation. Due to the small sample of patients and short period of implementation, evaluators recommend conducting further analyses once additional data have been collected.

UCHealth Memorial Hospital Central & Springs Recovery Connection

Hospital Context	UCHealth Memorial Hospital Central is an urban, 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 Central grant funding pays for multiple RSS stipends. RSSs are "on-call" during several shifts for the ED and employed by Springs Recovery Connection.
Funding	$125,000 for two years

Memorial Hospital is a 501(c)3 nonprofit organization established in 1904. Memorial Hospital is a part of UCHealth, which is a multi-state healthcare system with hospitals, clinics, and healthcare providers throughout Colorado, southern Wyoming, and western Nebraska. Memorial Hospital 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 in the urban center of Colorado Springs, has the busiest ED in Colorado, and is the seventh busiest in the country. The Memorial Hospital Central ED has over 150 employees and served more than 60,000 patients in fiscal year 2018 – 587 of whom were identified with an SUD.

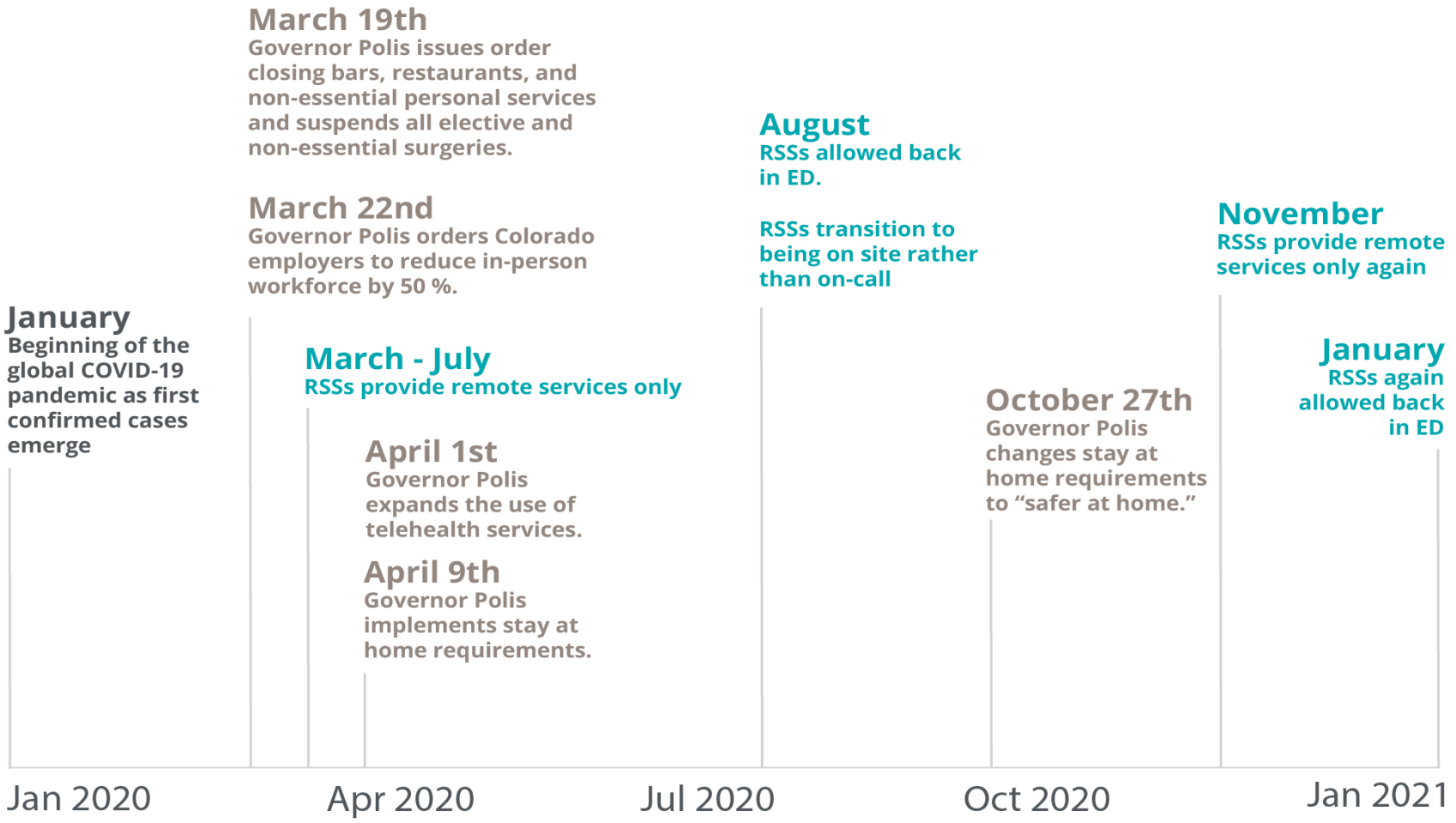
Memorial Hospital Central's ED social workers, in partnership with nursing staff and the Behavioral Health Unit, manage care coordination for patients with SUD. Additionally, community partners, such as domestic violence and sexual assault advocates, hospice organizations, and members of the local CARES (Community Assistance, Referral and Education Services) Program, contribute to care coordination. Memorial Hospital Central did not use RSS services in the ED prior to the pilot program. However, Memorial Hospital Central had an inpatient unit for patients experiencing substance withdrawal and requiring acute medical care due to withdrawal or medical concerns unrelated to SUD. Springs Recovery Connection (SRC) is a nonprofit RCO located in Colorado Springs who partners with ED staff to implement the program. SRC provides peer recovery coaching in a variety of settings, classes for families, and support groups for individuals.

As of the time of report writing, RSSs are in the hospital from 8-11 a.m. and 6-9 p.m. six days per week (except Thursdays). SRC currently has four permanent RSSs and one RSS to fill in when needed.

If an RSS is unavailable for an intervention, ED staff fill out a referral form, which authorizes the hospital to release patient information to SRC and permits SRC to attempt contact with the patient via telephone. The patient can sign the document, or if unable to, ED staff indicate that verbal authorization was given.

Colorado Springs Site Timeline

The ED-RSS program was implemented by ED and RCO staff beginning in June 2019. The COVID-19 pandemic affected individuals and communities across the world and Coloradans were no exception. The following timeline displays major events during the pandemic, which impacted the ED-RSS pilot program and the RSSs ability to support patients who needed peer services. Particularly, the inability for RSSs to be physically present in the ED during COVID lockdowns made connecting with patients difficult.



Colorado Springs Site & COVID -19

"We are seeing very sick people that have sat home and are drinking more, are using more substances, so that is definitely a change." – ED Staff

Changes to referrals

- Less success engaging patients initally following referral
- Fewer referrals during pandemic because RSSs were not physically in ED
- Increased number of patients in ED with acute issues resulting from substance use

"I feel like when we were talking to people through the iPad, we weren't getting the same reaction that we would if we were in the room." – RCO staff

Adaptations

- Increased Telephone Recovery Support calls
- Used an iPad to connect patients and RSSs in real time
- Meet outdoors while socially distanced

Silver Linings

- While meeting virtually among project partners felt odd initially, the meetings were more efficient as time went on
- Many patients were home due to the pandemic, so they were more available to take a call from an RSS

Challenges

- Adapting to remote peer support (RSSs)
- Taking on responsibility of setting up virtual RSS visits (ED staff)
- Communication between ED and RCO staff regarding patient consent
- Communication between ED and RCO staff following patient referral

"We wanted to make sure we reached out to [patients] because we know during a pandemic it is horrible for people [with] addiction because you are isolated. When you are isolated, you are in your own thoughts. It is really hard on [individuals with addiction]." – RCO Staff

"If [patient referrals] take [ED staff] 20 extra steps, then it doesn't work well. We are so busy as it is that the easier the referral process ..., the easier the process goes." – Clinician

Colorado Springs Site Program Impact

Monthly Progress Reports

The following data come from monthly progress reports submitted between June 2019 and March 2021.

979 Patients identified with Substance Use Disorder and appropriate for RSS referral.

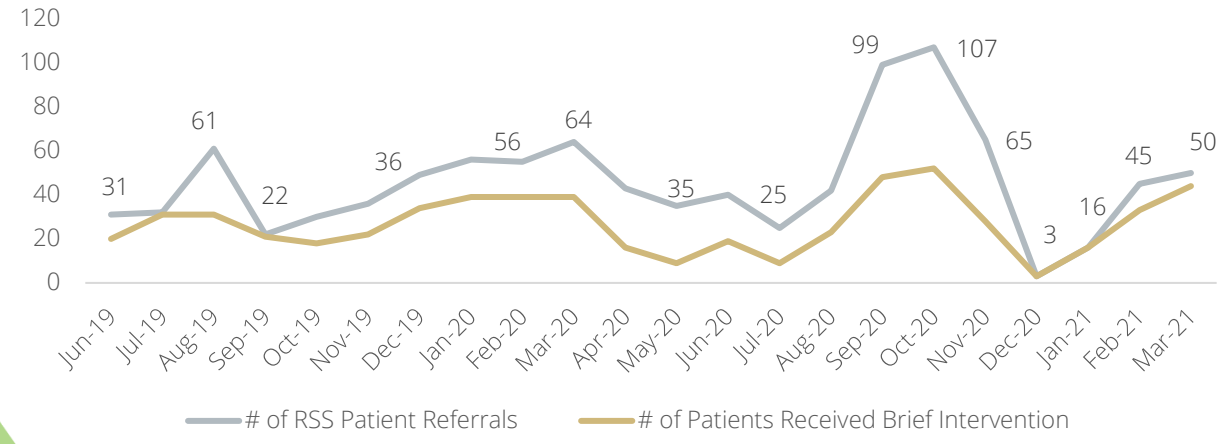
594 Patients received an RSS intervention.

389 Patients followed through with recovery support referrals.

278 Patients followed through with treatment referrals.

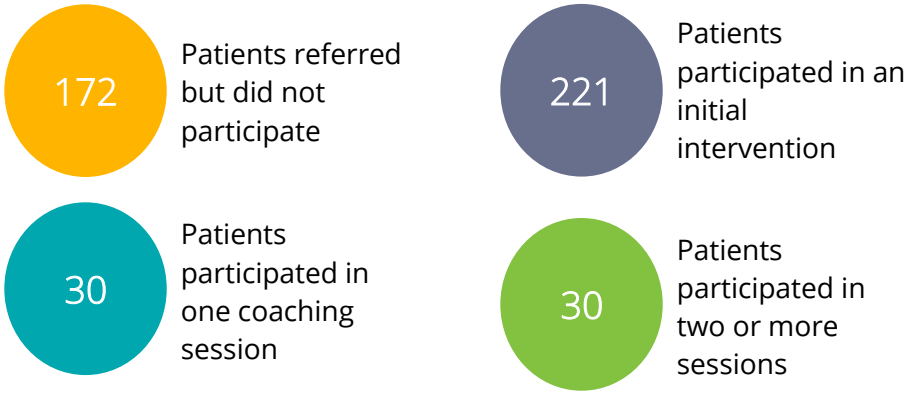
Across the pilot period, alcohol was the primary substance reported most frequently in the ED at this pilot site, followed by methamphetamine. Males accounted for two-thirds of referrals and those aged 25-59 constituted 65% of referrals. RSSs provided interventions for more than two-thirds of referrals across the pilot period. RSS referrals frequently outpaced Springs Recovery Connection's ability to meet the demand, indicating a need for additional peers.

Figure 2: Number of RSS Patient Referrals and Interventions



Emergency Department Visits

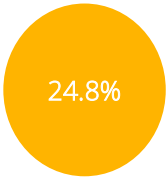
ED and RCO staff from the Colorado Springs site identified and provided data for four types of patients. The first were patients who were referred but did not participate. The second were patients who were referred and participated in an initial intervention with the RSS. The third were patients who were referred, participated in the initial intervention and one coaching session. The fourth were patients who were referred, participated in the initial intervention and two or more coaching sessions. Evaluators included 453 patients in the subsequent analysis.



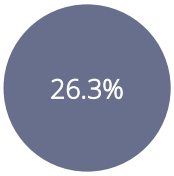
The program reduced the number of ED visits of high ED utlizers if they have a high level of engagement. Patients from all four groups vistited the ED a total of 832 times in the six months following their last engagement. Forty-two patients accounted for 50% of these ED vists. Of those patients, 31 participated in the program either with an initial intervention or one or more coaching sessions, and 11 did not participate in the program. The 11 who did not participate in the program accounted for 16% of the 832 ED visits. Although 31 patients who did participate in the program accounted for 36% of the total ED visits following their last engagement, patients who participated in the program decreased their average number of ED visits six months following last engagement compared to the six months prior.

Patients who had two or more coaching sessions had an average reduction of almost one ED visit in the six months following the last engagement. The average change of ED visits from six months prior the last engagement compared to six months after for patients who were referred but did not participate was +0.15 visits. This, compared to -0.89 visits for patients who had two or more coaching sessions. This difference is statistically significant (*p*-value of .009) with a medium effect size of 0.54.

Amongh patients who participated in two or more coaching sessions, 64.3% decreased their number of ED visits in the six months after. This, compared to 24.8% of patients who were referred but did not participate. This difference is statistically significant (*p*-value of .002) with a medium effect size of 0.45.

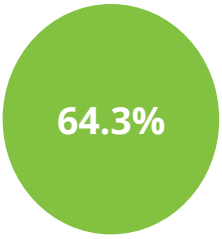


of patients who did not participate saw a decrease in ED visits 6 months after.



of patients who participated in an initial intervention saw a decrease in ED visits 6 months after.

of patients who participated in one coaching sessions saw a decrease in ED visits six months after.



of patients who participated in two or more coaching sessions saw a decrease in ED visits six months after.

The data collection process for each pilot site was unique. Although Evaluators found statistical significance in the difference of ED visits at the Colorado Springs site and not at the Denver site, this does not mean the Denver site's program had a lesser impact. For more information on the unique data collection processes of each site, see the Methods section.

Patient Feedback

Evaluators interviewed two patient participants in the ED-RSS program in Colorado Springs. They emphasized it was important the program was free, began at the ED, and that support came from someone with lived experience. According to one participant, "I have come to the conclusion that [people with SUD] don't want to listen to someone that hasn't been through what they've been through." Additionally, both patients felt the RSS was available and always listened to their concerns.

"An [RSS] gets you plugged into the recovery movement. They advocate for you. They find you resources. They make themselves available .... [They] are a fantastic resource for [individuals with SUD] who face ridiculously low odds of recovering and staying sober."

– Program Participant (Patient)

"The [ED staff] got me level again and then connected me with [an RSS] for follow up .... I didn't even know who [the RCO] was or what they did. If [the RSSS] hadn't met me there in the ED, I wouldn't have known at all."

– Program Participant (Patient)

Implementation and Replicability

Staff from the EDs and RCOs at both sites (*n*=14) were asked about what is needed to replicate an ED-RSS program in other hospitals, the challenges they faced as they continued implementation in year two, and the benefits they observed. The following reflections and recommendations were common across both pilot sites. Themes unique to each site are presented following common themes.

CONNECTING PATIENTS TO RECOVERY SUPPORT SPECIALISTS

A challenge with any peer support program is connecting with patients. ED and RSS staff from both sites mentioned the importance of having RSSs physically onsite and available to meet with patients promptly. If an RSS is not available, it can be difficult to connect with a patient after they have left the ED. However, having a good digital process for ED staff to capture patient information and forward to RSSs can help minimize this challenge. Alternatively, an ED can use virtual technology, like a tablet, to connect a patient to an RSS if the RSS is not physically present but available. This is not ideal as it puts additional burden on ED staff to establish the connection.

It is also important for RSSs, nurses, social workers, and clinicians to work together closely and to make sure ED staff understand the RSS role and how to refer a patient to an RSS.

"It certainly makes a difference when you are sitting across from [a patient]. You make a commitment. You know that person. They are going to follow up and call you tomorrow."

-RSS

INTEGRATING RECOVERY SUPPORT SPECIALISTS

Integrating RSSs into the ED is an important part of implementing the program. Staff from both sites recommended RSSs join ED staff meetings, share success stories, and have a physical workspace within the ED.

"Have [RSSs] on-site and present. Literally we feel they are an extension of our clinical team, and they are integrated within our team. If they were present all the time … the number of lives we could touch would double, if not triple or more."

-ED Staff

MAINTAINING COMMUNICATION

Collaboration among partners from ED staff, recovery community organization staff, and hospital leadership is critical. It is important to hold regular meetings among partners to plan, reflect, and identify ways to improve the program. Several partners reported monthly meetings were sufficient; however, weekly meetings in the beginning were helpful to support initial implementation. Partner meetings are a time to share data and success stories.

Given that the RSS is a bridge between ED and RCO staff, it is important to hire high-quality peers who can communicate between partners.

"It's helpful to have monthly meetings [with] myself, the peers, and the management team to talk and give feedback about what is and is not working … we need to make sure [partners] have a space to have their voices [heard].

-Clinician

GENERAL CHALLENGES

Staff from both sites mentioned the challenge in obtaining sustainable funding knowing the pilot program was coming to an end. Additionally, both sites found it difficult to connect with patients who do not have reliable access to communication resources (phone, internet) or a regular place to live.

"I met with a patient ten times using motivational interviewing – trying to help them in the next step to their sobriety – but I couldn't get anywhere. I watched one meeting with a peer - same conversation with the same patient - and the impact was life changing … the look in that patient's eyes.

-Clinician

BENEFITS OF AN ED-RSS PROGRAM

The greatest benefit identified by staff from both pilot sites was the ability to reach more patients and provide an additional level and quality of care. An ED-RSS program benefits the larger community by helping to stabilize vulnerable individuals. The program allows ED staff to see and hear successful recovery stories, whereas prior to implementation, ED staff rarely had an avenue for following up with patients.

ADVICE FOR HOSPITALS IMPLEMENTING AN ED-RSS PROGRAM

It is essential for clinicians and ED staff to thoroughly understand the role of the RSS, why they are there, and how an RSS can complement and support patient care. Furthermore, it is important for clinicians and ED staff to understand the value of an RSS's lived experience in reaching a patient, understanding a patient's substance abuse disorder, and supporting a patient's recovery journey.

Providing training for all partners is important and particularly so for ED staff. High turnover among ED staff necessitates providing regular training about addiction science, the role of RSSs, and the ED-RSS program generally. Gaining buy-in from leaders within the hospital and RCO is important to program success. Having multiple dedicated staff for the program helps implementation.

In communicating with a patient, it is important to make sure the patient *wants to* engage with an RSS. RSSs have found little success in engaging with patients who do not wish to receive RSS support.

"It's important to understand people in recovery … not all of us go to Alcoholics Anonymous. Not all of us have been through treatment. We have all gone through recovery in a different way and it's important to understand about recovery before you jump in and start talking.

I think compassion and grace and being able to learn different things is important to an [ED-RSS program]. The staff at Memorial Hospital [Central] do that with us. They are just amazing … they treat us like we are a part of them."

-RSS

Unique Themes by Pilot Site

	Denver	Colorado Springs
CONNECTING PATIENTS TO RECOVERY SUPPORT SPECIALISTS	A social worker in Denver emphasized the importance of telling patients the RSS service is free and that talking to an RSS is not a commitment. A patient is free to participate as much or little as they choose.	RCO staff in Colorado Springs developed a variety of print materials available in the ED to increase the pilot program visibility among patients and clinicians.
INTEGRATING RSS INTO ED	RCO staff from the Denver site recommended peers have non-clinical supervision, namely a more senior RSS. A peer is not a counselor or a medical assistant/provider and the roles and responsibilities of each job are different. It is important to ensure a peer is staying within their role and can connect a patient to resources and supports as needed.	N/A
MAINTAINING COMMUNICATION	It is crucial for RCO staff to have a physical presence in the hospital for building and maintaining relationships with hospital staff and for implementing the program effectively.	RCO staff need access to various hospital staff who can help answer questions and work through RCO needs
GENERAL CHALLENGES	Staff from the Denver site felt the approval process for bringing an RSS on was lengthy and created obstacles when RSS turnover happened.	Staff from Colorado Springs found it challenging but crucial to provide ongoing training and support to RSSs. Like social workers, there can be a high burnout rate among peers. It is challenging but important for RSSs to separate their personal and professional lives and to maintain boundaries, professionalism, and ethics.

CHANGING THE WORKFLOW Partners from both sites made several unique changes to the ED workflow to improve program effectiveness.	• Expanded patient referrals beyond social workers to include clinicians, nurses, and providers • Required RSSs to check in with charge nurse when they arrived • Entered patient referrals in Google Drive for RSS follow-up • Expanded RSS availability on different days	• Expanded program so RSSs could walk around other medical units • Shifted from faxing to emailing "face sheets" when RSSs are not present • Provided RSSs a physical space with the entire behavioral health team
ADVICE FOR HOSPITALS IMPLEMENTING AN ED-RSS PROGRAM	• Provide quality supervision for RSSs by establishing goals, reflecting on challenges, and identifying strategies for improvement. • Establish an easy referral process • Provide physical space in ED for RSS • Partner with RSSs who are stable in their recovery given how re-traumatizing the work can be. • Consider RSS safety (provide company phone for female RSSs; hire male and female RSSs) • Know that RSS programs improve the quality of patient care	• Train with a hospital that has already implemented • Convene regular meetings with all partners • Recognize that patients may need multiple attempts at treatment/recovery before they find success • Focus efforts on ready who are ready and want recovery

RSS Programs in Rural Emergency Departments

Evaluators interviewed ED staff from two rural hospitals located in western Colorado to understand the potential for implementing an ED-RSS program in EDs outside major metropolitan areas. One rural ED currently has RSSs on site while the other partners and makes referrals to a local health clinic which employ RSSs. The EDs, community context, considerations for implementation, and challenges discussed were unique to each site.

	Rural Site #1	Rural Site #2
Community/ED Context	ED staff partner and refer to local health clinics who provide medication assisted treatment (MAT) for opioid use disorder treatment and alcohol detox. There are no peers physically in the ED although it is being discussed. The hospital has a compassionate culture amongst ED staff around SUD. There is often "one degree of separation" between patients and ED staff given the small size of their community. ED staff receive training on Screening, Brief Intervention, and Referral to Treatment (SBIRT) and MAT.	There are peers in ED through the partnership with a local health clinic. ED staff are open to supporting patients with SUD, although community stigma exists. No physician in ED has obtained a waiver to provide MAT.
Considerations & Challenges	A peer in the ED would help eliminate barriers to treatment and recovery; however, it might be more feasible to have a "consortium of peers" for remote areas in western Colorado so they can cover a larger area via telehealth. Hospitals should obtain buy-in from leaders and staff before implementing an RSS program. Community partnerships are critical to supporting an RSS program.	Transportation is a big challenge as ambulance and law enforcement capacity is limited. ED staff and peers provide transportation regularly. There is a need for more transportation resources and insurance reimbursement to support the program. Peers should be compensated similarly to other behavioral health professionals. It is important to develop supports, supervision, and training for peers; to develop connections in the community and across the state to understand what others are doing in this area; and, to hire adequately trained peers.

Methods

Phase two was a summative evaluation focusing on program impact and replicability in other EDs.

The primary evaluation questions were:

1. What impact has the ED-RSS pilot program had since implementation?
2. How has COVID-19 impacted the ED-RSS program?
3. What is needed to replicate the ED-RSS program in other hospitals, including rural hospitals?

Evaluators received monthly reports from RCO staff, which included the number of patient referrals received from the ED, RSS interventions provided, and patients who followed through on referrals to recovery support and treatment services. Reports also included the primary substances reported by patients and patient demographic data. Evaluators reviewed and compiled data from monthly reports to summarize the numbers of total referrals, RSS interventions, follow through activities, primary substances used, and patient demographic characteristics.

ED and RCO staff at each site compiled and merged patient data to provide evaluators a dataset of de-identified individuals who were referred to the ED-RSS program, the number of peer coaching sessions an individual received, and the number of emergency department visits six months before and after the last interaction. Patients who had visited an ED at a count of more than three standard deviations from the mean were considered outliers and excluded from inferential analyses. Data from each site was compiled and merged differently depending on each site's electronic health record and implementation approach. Evaluators analyzed data from each site separately and present site-specific results.

Evaluators categorized patients into groups.

- Patients who were referred to an RSS but not contacted.
- Patients who received an initial screening but no follow up contact with an RSS.
- Patients who received an initial screening and engaged with an RSS one subsequent time.
- Patients who received an initial screening and engaged with an RSS two or more times.

Evaluators used IBM© SPSS Statistical Software to conduct exploratory data analysis to understand abnormalities in the data, identify outliers, and check assumptions required for statistical testing. Evaluators conducted Chi-Square tests, independent samples T-tests, and one-way Anova. Evaluators used a 95% confidence interval and a *p*-value of .05 to assess significance. Statistically significant findings include effect sizes to support interpretation.

To answer evaluation questions two and three, evaluators conducted interviews with staff from each ED and RCO as well as patients from Colorado Springs. Interviewees were asked what factors were essential for implementation and maintenance of an ED-RSS program, how the pandemic impacted the ED workflow, RSS/patient communication, and the number of patient referrals. Interviews were conducted by phone or Zoom video conferencing and typically lasted 30-45 minutes. Interviews were recorded and transcribed. Transcriptions were uploaded and analyzed using QSR International

NVivo© software. Evaluators used constant comparison, which is an inductive approach for identifying common themes across interviewees.

LIMITATIONS

The quantitative analysis of ED/RCO data has several limitations.

First, data were collected differently at each pilot site. For the Denver site, the date used to separate pre/post ED visits was the date the patient was referred or seen in the ED by the RSS regardless of if they continued to engage with an RSS after this date. For the Colorado Springs site, the date used was the date of referral in the ED for patients who did not participate, and the last date of engagement with an RSS for patients who did participate.

Evaluators noticed that often three months or even one year could pass between when a patient is referred to an RSS in the ED and when they actively begin participating in coaching sessions with an RSS. This difference in data collection allowed evaluators to explore how different levels of engagement with an RSS after the initial referral in the ED impact recidivism specifically at the Colorado Springs pilot site.

Second, and specific to the Colorado Springs site, the number of emergency department visits six months before and after an intervention are not specific to SUD *or* SUD was not the primary diagnosis. It is possible that visits may have been for different medical reasons.

Third, patients at both sites who engage with an RSS self-select into the program. The resulting dataset was not a random sample, and it is possible that self-selection bias explains any impact the program experienced.

Fourth, the overall sample of patients for each pilot site was small. It is not the intention of the pilot program or its evaluators to generalize results to all peer programs. Results are specific to each pilot site and demonstrate the impact the program had within each ED and related community.

Fifth, it is possible that patients visited a variety of EDs within a given locality, thus providing an undercounting of actual ED visits. Additionally, there is a possibility that a patient moved or died following a visit to an ED and therefore has no subsequent ED visits to the pilot site.

Finally, the COVID-19 pandemic affected individuals and communities around the world. Colorado communities were no exception. The ED-RSS pilot program staff, including RSSs, faced many challenges to continuing to provide support to patients in the ED. It is likely that RSSs could have had increased impact if they could have been physically present throughout the pilot period.

Additionally, it is impossible to fully separate the impacts of the pandemic on the pilot program or to understand how the pilot sites may have matured in the absence of this public health crisis.

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.

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