JUNE 2021

EMERGENCY DEPARTMENT RECOVERY SUPPORT SPECIALIST PILOT PROGRAM PHASE II REPORT

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Prepared for

COLORADO CONSORTIUM
for Prescription Drug Abuse Prevention

The project described in the following pages is supported by the Colorado Consortium for Prescription Drug Abuse Prevention with support from The Colorado Health Foundation.

Suggested Citation:

The Evaluation Center, University of Colorado Denver (2021). *Emergency Department Recovery Support Specialist Pilot Program Phase II Report.* Technical report submitted to the Colorado Consortium for Prescription Drug Abuse Prevention.

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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

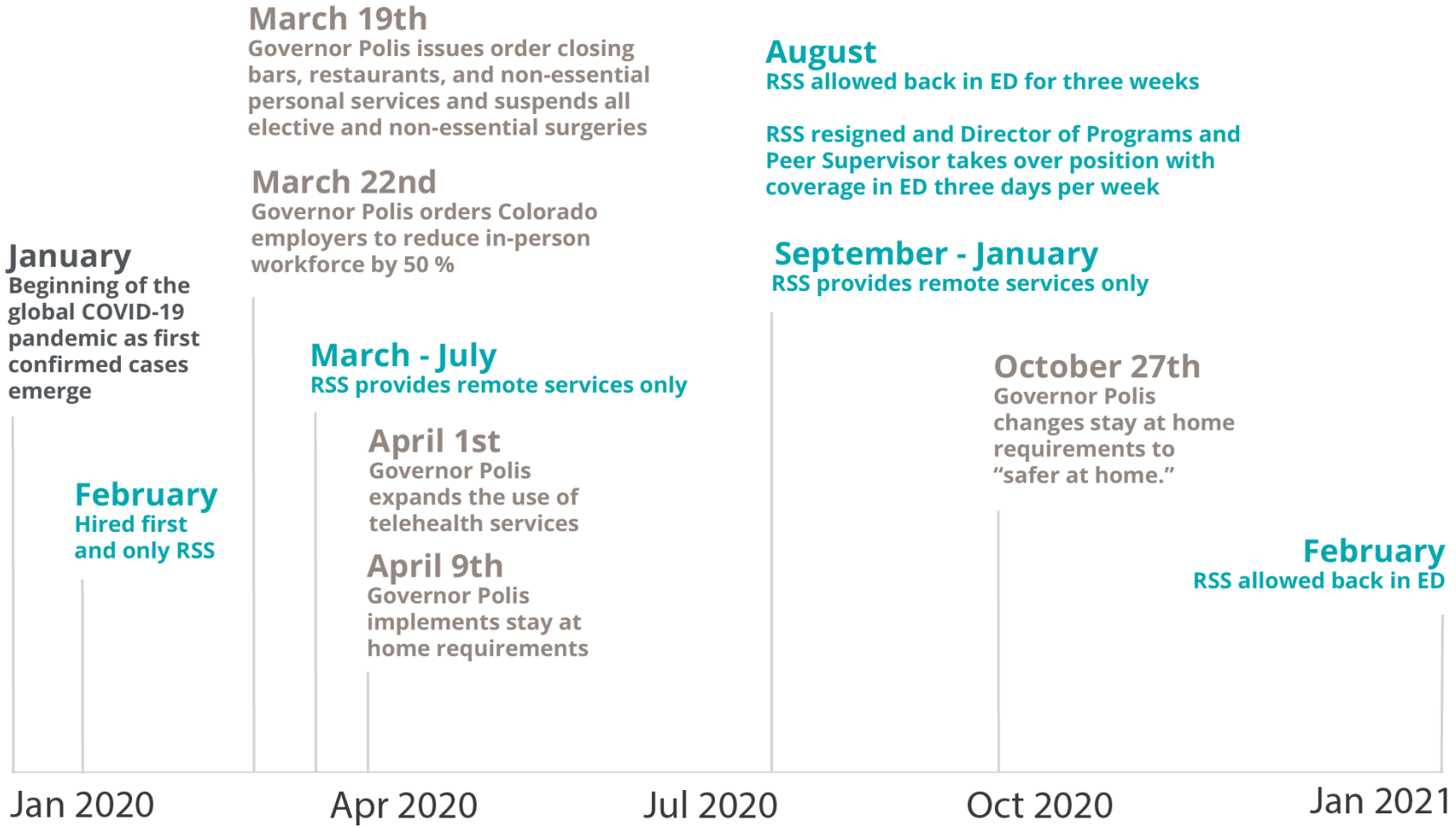
Swedish Medical Center is part of HealthOne, one of the largest hospital systems in Colorado. Health One is comprised of six major hospitals and seven freestanding emergency departments serving a geographically diverse area within the Denver Metropolitain Area. HealthOne's parent company, the Hospital 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.

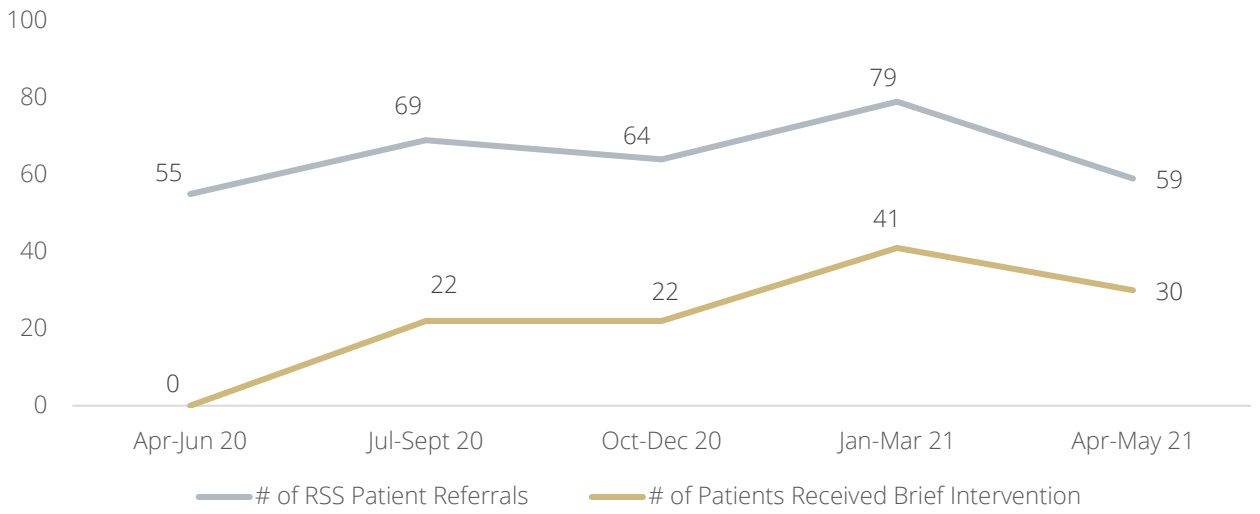
326 Patients identified with Substance Use Disorder and appropriate for RSS referral.

115 Patients received an RSS intervention.

58 Patients followed through with recovery support referrals.

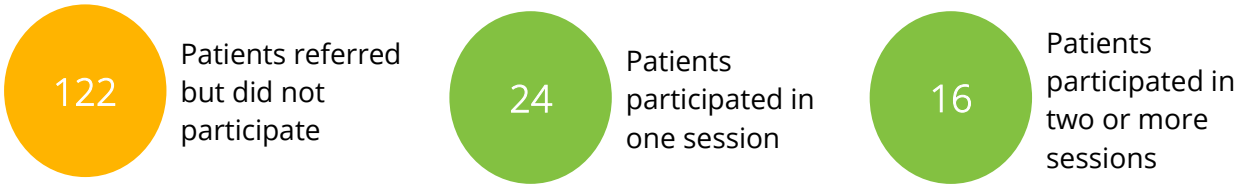
21 Patients followed through with treatment referrals.

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

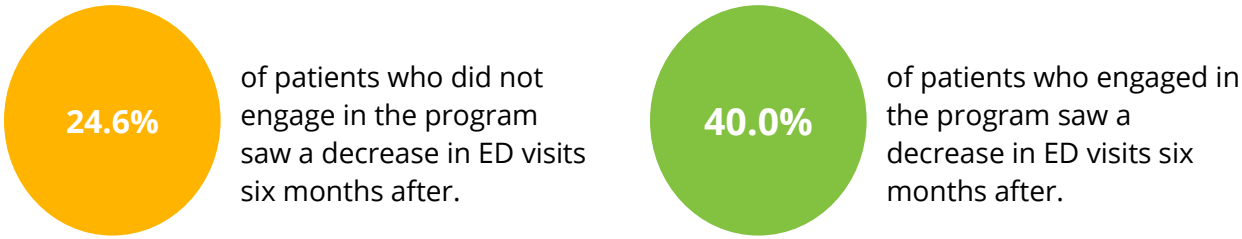
ED and RCO staff from the Denver pilot site identified and provided data for three types of patients. The first were patients who were referred but did not participate in the program. The second were patients who were referred and participated in one session with an RSS. The third were patients who were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

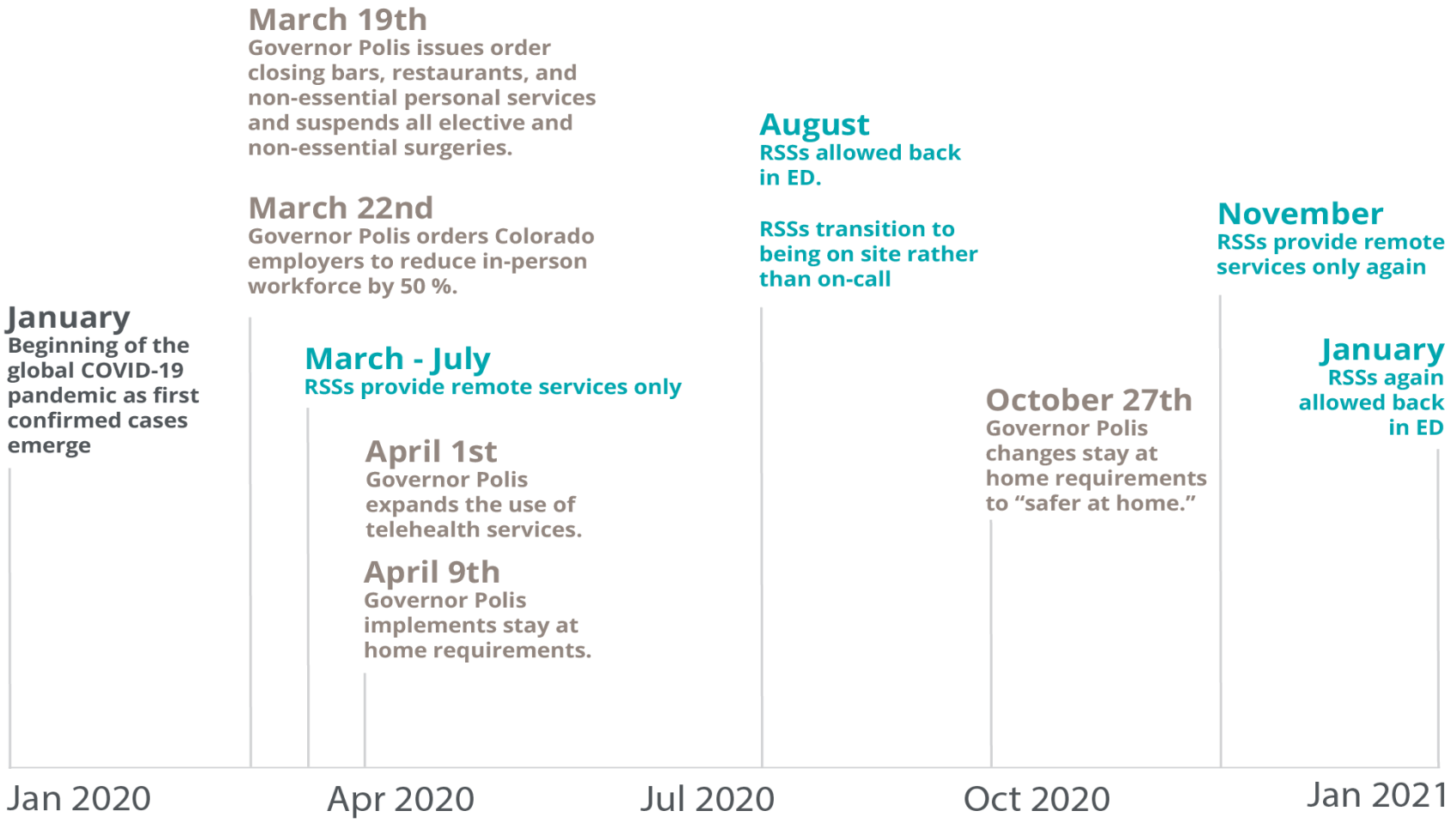
Memorial Hospital Central's ED social workers, in partnership with nursing staff and the Behavioral Health Unit, manage care coordination for patients with SUD. Additionally, community partners, such as domestic violence and sexual assault advocates, hospice organizations, and members of the local CARES (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.

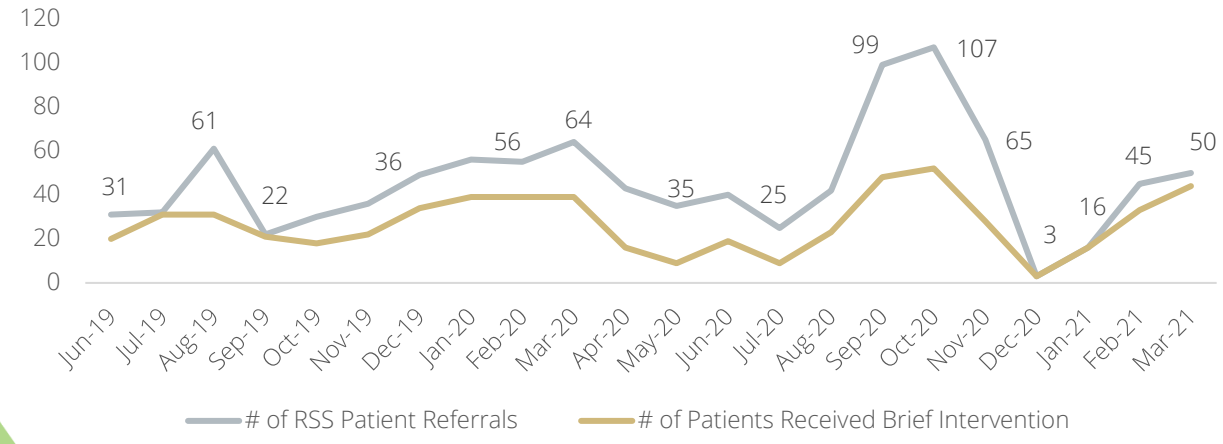
594 Patients received an RSS intervention.

389 Patients followed through with recovery support referrals.

278 Patients followed through with treatment referrals.

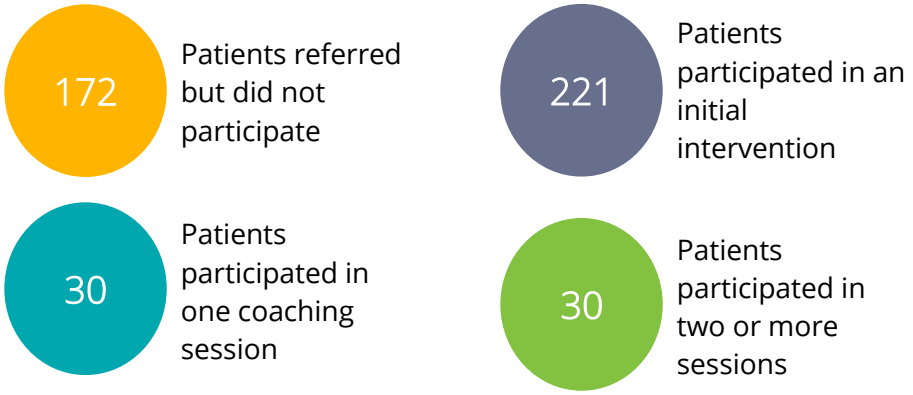
Across the pilot period, alcohol was the primary substance reported most frequently in the ED at this pilot site, followed by methamphetamine. Males accounted for two-thirds of referrals and those aged 25-59 constituted 65% of referrals. RSSs provided interventions for more than two-thirds of referrals 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

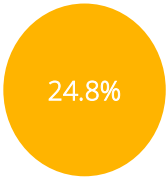
ED and RCO staff from the Colorado Springs site identified and provided data for four types of patients. The first were patients who were referred but did not participate. The second were patients who were referred and participated in an initial intervention with the RSS. The third were patients who 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.



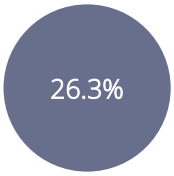
The program reduced the number of ED visits of high ED utlizers if they have a high level of engagement. Patients from all four groups vistited the ED a total of 832 times in the six months following their last engagement. Forty-two patients accounted for 50% of these ED vists. Of those patients, 31 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.

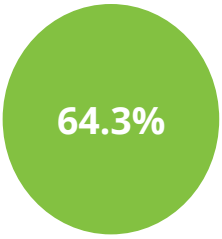


of patients who did not participate saw a decrease in ED visits 6 months after.



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

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