Peer Recovery Coaches in Hospital Emergency Departments

Changing Hearts and Minds About Addiction

mosaic GROUP

FRI
FRIENDS RESEARCH INSTITUTE

IRIS

Bringing all the pieces together for a healthier community

ACKNOWLEDGEMENTS

This toolkit was developed by Friends Research Institute, Inc. and IRIS in partnership with The Mosaic Group.

DEVELOPMENT TEAM

Laura B. Monico, PhD
Friends Research Institute

Marla Oros, RN, MS, FAAN
President
The Mosaic Group

Krystal Billups, MPH
Managing Director
The Mosaic Group

Graphic Design
Ajuga, Inc.

ABOUT MOSAIC GROUP

Mosaic Group, is nationally recognized for effectively implementing community health and human services strategies to achieve health equity. Our primary focuses are:

- Community Solutions for Health Equity
- Complex Planning for Sustainable Change
- Behavioral Health Integration
- Overdose Prevention and Response
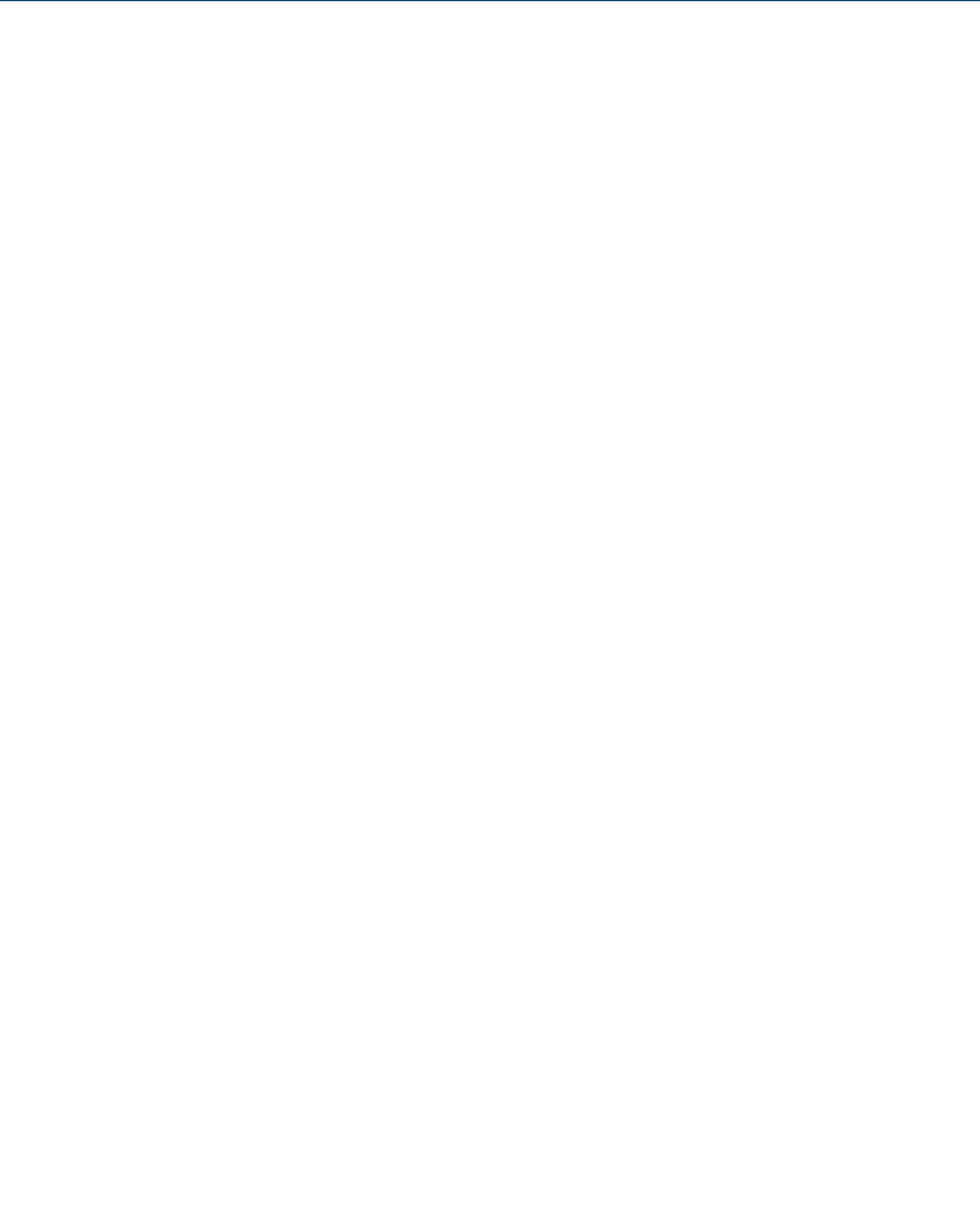
Mosaic Group
1122 Kenilworth Drive, Suite 313
Towson, MD 21204
410-852-4263
groupmosaic.com

CONTENTS

Executive Summary

This study shows that employing Mosaic Group's "Reverse The Cycle" Peer Recovery Coaches (PRCs) in hospital emergency departments can revolutionized attitudes towards addiction, improved care for individuals with substance use disorders, and fostered a more compassionate environment. The insights in this report demonstrate the potential of PRCs to significantly improve outcomes and contribute to addressing the opioid crisis with empathy and support.

About This Report

This report explores the transformative findings from a study conducted to examine the impact of implementing Peer Recovery Coaches (PRCs) in Maryland's hospital emergency departments (EDs) as part of the "Reverse the Cycle" program. The study utilized semi-structured interviews with key stakeholders from three hospitals actively involved in the program's implementation, including ED Medical Directors, Nursing Leaders, Peer Supervisors, and PRCs. By gathering perspectives on the program's impact and the critical role of PRCs in coordinating care, this study sheds light on the significant contributions of PRCs in revolutionizing attitudes towards addiction and enhancing care for individuals with substance use disorders.

PROGRAM DETAILS AND SIGNIFICANCE

Mosaic Group's "Reverse the Cycle" program represents an innovative initiative designed to expand Screening, Brief Intervention, and Referral to Treatment (SBIRT) within EDs, with a particular focus on addressing the alarming opioid crisis. PRCs have been instrumental in this program, delivering brief interventions and facilitating treatment referrals within EDs.

Additionally, PRCs offer vital training to ED staff on evidence-based approaches to treating substance use disorder, including the effective utilization of pharmacotherapy for opioid use disorder (OUD). Furthermore, the program has established a rapid referral network to connect patients promptly with community treatment providers, a process in which PRCs play a critical role by ensuring seamless and timely care for individuals struggling with OUD or experiencing overdose.

TRANSFORMATIVE IMPACT OF PRCS IN EDs

The study's findings demonstrate that the presence of PRCs has brought about a profound cultural shift within EDs. Prior to their implementation, ED staff faced significant challenges in adequately addressing the complexities of SUDs, resulting in inadequate care and referrals for patients. The burden of managing SUD-related complications overwhelmed EDs, leading to increased stigma and negative attitudes towards addiction. However, with the introduction of PRCs, the knowledge base, available resources, and overall understanding of ED staff have undergone a significant transformation.

PRCs AS CATALYSTS FOR CHANGE

PRCs have successfully bridged the knowledge gap by providing specialized expertise in addiction and recovery. They have become invaluable resources within the ED environment, alleviating the workload of other ED staff and streamlining the referral process for patients with SUDs. Moreover, PRCs have become living success stories, sharing their personal journeys of addiction

> PRCs have become invaluable resources within the ED environment, alleviating the workload of other ED staff and streamlining the referral process for patients with SUDs.

and recovery, fostering empathy, and cultivating positive relationships with their colleagues. Consequently, attitudes towards individuals with SUDs have shifted from stigmatization to empathy and support, creating a more inclusive and compassionate environment within EDs.

IMPLICATIONS AND FUTURE CONSIDERATIONS

The implementation of PRCs has yielded not only improved treatment outcomes but also a fundamental shift in the culture of care within EDs. PRCs have played a pivotal role in educating and empowering ED staff, dispelling misconceptions surrounding addiction, and promoting evidence-based interventions. Their presence has not only addressed the immediate needs of patients with SUDs but also fostered a long-term transformation in the overall approach to care within the ED environment.

The following key considerations have been identified to facilitate the successful implementation of Peer Recovery Coach (PRC) programs in the future:

- Flexible human resource policies accommodating unique requirements of hiring PRCs,
- Assessing cultural fit during the hiring process for harmonious integration,
- Comprehensive onboarding, regular check-ins, and clear role boundaries for effective management of PRCs,
- Managing time constraints and developing policies for PRC relapse,
- Ensuring transparency and support in the implementation of PRC programs.

Cultural integration emerges as a crucial factor in maximizing the impact of PRCs. This involves assisting PRCs in understanding the organizational system, managing expectations regarding support from other staff, and actively promoting proactive discussions and introductions to foster successful integration. Demonstrating the worth and productivity of PRCs requires aligning the number of PRCs with patient volume needs, cross-training them for additional tasks, and emphasizing comprehensive documentation of their interactions within electronic health record systems.

> The implementation of PRCs has yielded not only improved treatment outcomes but also a fundamental shift in the culture of care within EDs, fostering empathy and support for individuals with SUDs.

CONCLUSION

The valuable insights and lessons learned from the implementation of PRCs in EDs presented in this report provide essential guidance for future implementations in various healthcare settings. By effectively addressing the challenges faced by EDs, fostering a cultural shift towards empathy and support, and promoting compassionate care, PRCs have the potential to significantly improve outcomes for individuals with SUDs and contribute to the development of a more empathetic and supportive healthcare system. This study underscores the critical role of PRCs in transforming attitudes towards addiction and enhancing care delivery for individuals with SUDs, ultimately paving the way for a more comprehensive and holistic approach to addressing the opioid crisis in emergency healthcare settings.

Problem and Significance

Opioids and Overdoses in the U.S.

In 2019, over 21 million Americans were estimated to need treatment for alcohol or drug use disorder, yet only 1 in 10 received it.[1] The ongoing opioid epidemic exacted nearly 400,000 deaths from overdose between 1999 and 2017.[2] with a staggering 107,000 drug overdose deaths occurring in the United States in 2021, the highest number of overdose deaths ever recorded in a 12-month period according to recent provisional data from the Centers for Disease Control and Prevention.[3]

While overdose deaths were already increasing in the months preceding the 2019 novel coronavirus disease (COVID-19) pandemic, the latest numbers suggest an acceleration of overdose deaths during the pandemic.[4-6]

Emergency Departments as Front-Line Defense

Hospital Emergency Departments (EDs) are recognized as a principal venue for opioid use disorder (OUD) intervention, given patients' high rates of substance use relative to the general population.[7,8] Compared to alcohol, evidence of the effectiveness of Screening, Brief Intervention, and Referral to Treatment (SBIRT) for drug misuse in EDs has been relatively limited,[9] until efforts to add initiation of pharmacotherapy for OUDs to SBIRT.[10] In recent years, hospital EDs in various communities have begun to offer buprenorphine initiation and treatment referrals,[11] but this remains the exception, and bringing these services to scale has been an ongoing challenge for EDs with an ever-shrinking bandwidth.

PEER RECOVERY COACHES FOR SBIRT DELIVERY AND CARE COORDINATION

Starting in 2014, the state of Maryland undertook an initiative to expand SBIRT into EDs, and to leverage this approach to proactively address the opioid crisis. This effort was orchestrated by Mosaic Group, which piloted SBIRT in three Baltimore hospital EDs starting in 2014. As of 2021, this program ("Reverse the Cycle") has grown to 33 hospitals across the state, as well as 29 hospitals in 4 other states and the District of Columbia. In a recent publication, we reported that the program had reached the monumental achievement of screening over 1 million patients.[12] A key component of Mosaic Group's Reverse the Cycle program is the inclusion of at least three Peer Recovery Coaches (PRCs) in each ED to deliver brief interventions (BI's) and referrals to treatment (RT's) across all ED shifts. Additionally, Mosaic Group provides a state approved intensive peer recovery coach training leading to peer certification as well as a specialized training for ED clinical staff on the treatment of substance use disorder (SUD) as a chronic disease and the use of pharmacotherapy for OUD. To initiate services and provide continuity of care, Mosaic staff work with community treatment providers to establish a rapid referral network with programs that can accept referred OUD patients within 24 hours who initiated buprenorphine in the ED. The PRCs are instrumental in facilitating these referrals for patients presenting to the ED with signs of OUD or overdose.

THE DEVELOPMENT OF PROGRAM BUY-IN

While Reverse the Cycle has demonstrated success, with 70% of ED patients who initiated buprenorphine successfully linked to treatment in the community, Mosaic Group has noted considerable initial skepticism from hospital staff during program implementation.

As of 2021, this program ("Reverse the Cycle") has grown to 33 hospitals across the state, as well as 29 hospitals in 4 other states and the District of Columbia. In a recent publication, we reported that the program had reached the monumental achievement of screening over 1 million patients.[12]

Hospital team members involved in the program implementation were initially incredulous about the PRC's ability to impact patients' treatment utilization and progress towards recovery from opioid or other substance use. Over the months of on-going service delivery, attitudes toward SBIRT and the role of the PRC begin to shift, and these same individuals often become not just believers in the program's effectiveness, but champions of the program within the hospital and even the health care system.

Understanding how these different stakeholders define and recognize the Reverse the Cycle program's success is integral to promoting the program to new hospital systems (i.e., increasing service availability), training new staff during implementation, and ultimately in defining data collection domains for a more robust randomized trial of the program. The purpose of this exploratory pilot study is to understand how and why attitudes toward addiction and patients with SUDs changed among hospital ED staff following the implementation of PRCs, as well as present considerations for future PRC implementation efforts in other hospital ED systems.

Project Aims

Given the potential benefits of exploring the seemingly transformational attitude shifts that occurred among Reverse the Cycle program stakeholders, we conducted an exploratory qualitative study to examine these transformations utilizing direct stakeholder perspectives.

- **Aim 1:** Explore the role of Peer Recovery Coaches in shifting attitudes toward addiction and individuals with SUDs among hospital emergency department staff.

- **Aim 2:** Develop a set of considerations and lessons learned for future hospital emergency departments that plan to implement Peer Recovery Coaches.

This study sought to generate novel pilot data regarding shifting attitudes and recovery support coordination using an innovative and growing service delivery program involving PRCs that seeks to overcome barriers to treatment initiation common among people with SUDs. Given the scalable success of the Reverse the Cycle program for screening and addressing both general SUDs and OUDs,[12] qualitative data collection and analysis is necessary to understand the role of PRCs in the overall program's success.

Reverse the Cycle is paving the way for addressing the opioid epidemic and other SUDs in hospital settings, and therefore, understanding factors that may facilitate uptake among hospital staff will be pivotal to its continued expansion nationwide. By collecting stakeholder narratives directly from those hospital ED staff involved in Reverse the Cycle implementation, this study leveraged relevant voices that spoke to the concerns of future medical staffs, as well as prospective patients with SUDs in need of care.

Methods

A total of 14 phone-based semi-structured interviews were completed with key stakeholders across three hospitals that have implemented the Reverse the Cycle program; representing different community sizes, treatment capacities, and organizational characteristics.

SITE AND PARTICIPANT SELECTION

This study sampled one hospital organization to represent urban, suburban, and rural communities in the Mid-Atlantic region. Participants from each site included individuals who were directly involved with the Reverse the Cycle program at their organization during implementation including: local site leader of the initiative (e.g., ED Medical Director, Nursing Leader, or Behavioral Health Leader), ED Nursing Director, Peer Supervisor, PRC, or Behavioral Health Champion. Participant recruitment was purposive, targeting approximately 5 staff members in each hospital ED with the greatest involvement in program implementation and those exposed to the most diverse set of larger staff perspectives.

PARTICIPANT RECRUITMENT

The Mosaic team maintains on-going relationships with each of the targeted organizations, as well as contact information for the proposed study participants (even when staff are no longer in the same roles as they were during the initiation of their site's Reverse the Cycle program), and therefore facilitated the recruitment of study participants on behalf of the research team. Recruitment began with an IRB-approved introductory email from Mosaic leadership, with the research team cc'd on the communication, letting potential participants know about the research project, its specific aims, the anticipated time commitment, and the incentives provided. This message was followed by an email from the research team with a copy of the informed consent form attached for their review.

PARTICIPANT CHARACTERISTICS

Of the 14 hospital ED staff members who participated in a qualitative interview, the majority of participants identified as female (n=10) and White (n=11), with the remaining minority identifying as Black (n=3), and an average age of 49 years. By education, the sample was diverse including high school graduates (n=2), Associate's degrees (n=1), Bachelor's degrees (n=2), Master's degrees (n=6), and Medical degrees (n=3). In terms of experience, the sample had an average of 9.6 years of experience in their current hospital, 4.1 years of experience in their current position, and 17.4 years of experience in their given field.

A total of 14 phone-based semi-structured interviews were completed with key stakeholders across three hospitals that have implemented the Reverse the Cycle program, representing different community sizes, treatment capacities, and organizational characteristics.

Interviews

INTERVIEW GUIDE CONTENT

Semi-structured interview guide questions queried and probed experiences involving the Reverse the Cycle program elements (e.g., screening, assessment, treatment, and linkage), the PRCs role in facilitating these services, as well as coordinating care with other ED and community treatment providers. The interview guide also inquired about expectations of program effectiveness at inception, and the participant's current views of the program, with an emphasis on patient outcomes and related experiences that may have shaped those views.

INTERVIEW PROCEDURES

Interviews were conducted by an experienced qualitative researcher at a time and date that was most convenient for the participant. The interview guide was followed for consistency during each interview but, as is customary with a grounded theory analytic approach, we used additional questions and probes to elucidate details or delve into unexpected thematic areas. Interviews durations were approximately 60 minutes. At the conclusion of the interview, participants were emailed a $50 Amazon gift code to thank them for their time, except when hospital policy did not allow participants to accept gifts.

Data Analysis

Grounded theory methodology,[13] a qualitative research approach that systematically analyzes data and inductively builds theory, will be used throughout the data collection and analysis procedures of the proposed project. Using a constant comparative method, in which emergent themes are repeatedly revisited in the data to detect outliers and exceptions, we will generate theoretical associations and relationships using the coding process described by Glazer and Strauss.[14] Grounded theory data analysis will begin after the completion of the first interview and continue through the completion of data collection in order to continually revise the interview guide to include questions and probes related to emergent themes. Open coding is utilized during the initial phase where researchers segment the data into similar groupings, forming preliminary categories regarding the phenomenon of interest.

During the second phase, Axial coding, the team begins to assemble categories, building logical connections or relationships among codes to develop more detailed thematic construction. Finally, during Selective coding, the categories and themes are organized to articulate a theory regarding the phenomena of interest.

> The interview guide also inquired about expectations of program effectiveness at inception, and the participant's current views of the program, with an emphasis on patient outcomes and related experiences that may have shaped those views

Before Peer Recovery Coaches

Prior to the implementation of Peer Recovery Coaches (PRCs), emergency departments encountered significant challenges in meeting the needs of individuals with substance use disorders (SUDs). This section delves into the specific challenges faced by EDs and the resulting attitudes that emerged as a consequence.

What Was Happening in EDs Prior to the Implementation of Peer Recovery Coaches?

SUD PATIENTS FALLING BETWEEN THE CRACKS

Prior to the implementation of PRCs, Emergency Department staff explained that there was no expertise on-site to effectively manage the needs of a substance using population. Often, this was structured into the organization of the hospital itself, with medical providers offering expertise in the medical realm, and the psychiatry or behavioral health department offering expertise related to mental health care, but no expertise related to addiction and substance use. Without this expertise, ED staff explained that their attempts to help treat this population were significantly hindered.

ED staff noted that individuals presenting to the ED with SUDs and acute medical needs often fell through the cracks of the hospital system because there were no staff present with the appropriate knowledge related to addiction as a behavioral health issue, as well as an understanding of resources available in the community for referrals. ED physicians only felt prepared to treat the acute presenting medical issue, such as wound care or cellulitis, as well as symptoms related to opioid or alcohol withdrawal. They did not feel prepared to manage a patient presenting to the ED with such a complex set of needs where a referral to community treatment was necessary. Even the treatment of opioid withdrawal symptoms felt like a patchwork of care that was not actually treating the source of the issue. Although social work staff were available in some hospital systems, even these individuals were spread thin and often only provided patients with a single sheet of community resources and an apology that there was not more the hospital was able to do.

However, accessing treatment entry can be complicated for individuals with SUDs due to constraints related to insurance, medication, management of chronic health conditions, and demographic considerations. Without the expertise on-site to assist patients with navigating the complexity of substance use treatment systems, patients were left to approach this process on their own—often with very little success.

> ED physicians only felt prepared to treat the acute presenting medical issue, such as wound care or cellulitis, as well as symptoms related to opioid or alcohol withdrawal. They did not feel prepared to manage a patient presenting to the ED with such a complex set of needs where a referral to community treatment was necessary.

> Without the expertise on-site to assist patients with navigating the complexity of substance use treatment systems, patients were left to approach this process on their own—often with very little success.

OVERBURDENED CLINICAL TEAM

Overall, one of the biggest issues cited by ED staff in relation to treating substance using populations was the lack of time available among existing staff. The sheer volume of patients presenting in the ED with complications related to SUDs, and OUDs more specifically, overburdened clinical care teams including medical providers, nurses, social workers, and case management staff. Patients presenting to the ED with overdoses or complications related to OUD would be treated for the acute medical issue, but referrals to community treatment resources are time-consuming and were often not successful. Compound these existing bottlenecks with larger community transitions to heroin or fentanyl among their patient populations, and the increasing volume of presenting patients became overwhelming to clinical care staff.

Unfortunately, despite attempts, these hospital systems were just not able to keep up with the number of referrals that would need to be made for these substance using populations and there were very few successful referrals to treatment prior to the implementation of PRCs. Often, treatment referrals accompany a great deal of facilitation and paperwork between the treatment program and the patient in the ED, which in hospitals without as many social work or case management staff, largely fell to nursing staff to compile. With so many competing demands on their time and expertise, even PRCs noted that this ongoing stress, compounded by an increase in the volume of substance using populations with severe complications, ultimately led to an increased level of stigma among ED staff.

STIGMA

Prior to the implementation of PRCs, EDs lacked the expertise to serve the population of individuals presenting with SUDs and OUDs, and lacked the bandwidth and time to make meaningful referrals to community treatment providers. These issues coupled together ultimately led to the proliferation of stigma among ED staff. Although the root cause of these issues was structural and systemic, the patients presenting to the ED were those bearing the brunt of the consequences. The ED staff often did everything in their ability to treat the patient medically, and even coordinated with on-site psychiatric services to create treatment plans and space within the hospital for those experiencing severe withdrawal symptoms, however, without permanent resources to manage the volume of patients in need of this type of care, ED staff became cynical and worn down by the patient population resulting in negative attitudes toward addiction and those suffering from SUDs.

Over time, the volume of patients presenting to the ED with an overdose or other complication related to an SUD became overwhelming for ED staff to manage. What was even more impactful was the number of these individuals who continued to re-admit to the hospital even after receiving treatment for their acute medical concern. These readmissions led ED staff to feelings of disempowerment, frustration, and even hopelessness to have any significant or meaningful impact for these patients.

...without permanent resources to manage the volume of patients in need of this type of care, ED staff became cynical and worn down by the patient population resulting in negative attitudes toward addiction and those suffering from SUDs.

What Were the General Attitudes Toward Addiction and Suds Prior to the PRCs Coming On-Site?

MISUNDERSTANDING CARE BARRIERS

Although a lack of experience and time produced stigmatizing attitudes among ED staff toward individuals with SUDs, and ultimately inadequate care and referrals to treatment, other experiences also contributed to the development of negative attitudes toward this patient population. One of the biggest contributors was the regular experience of treating medical conditions related to SUDs, only to have patients not follow through with the care instructions for preventing further illness or injury. Following the treatment of a wound or cellulitis, patients would routinely not follow care protocols issued by ED medical staff and be non-compliant with the medical care they are presenting to receive.

This non-compliance produced frustration among ED staff, not only because it leads to additional re-admissions in the future, but also because treating these conditions feels like a futile effort when medical staff are strained to meet the ongoing demands of a busy ED. ED staff did not have a strong understanding of what barriers face individuals with SUDs and how difficult it is to care for a wound or medical condition when struggling with an active addiction. This misunderstanding ultimately led to a lack of empathy, which translated directly to increased negative attitudes.

Misunderstanding, coupled with a lack of empathy, led ED staff to place a great deal of blame on the patient for their lack of engagement in their own medical care. Although trainings related to trauma-informed care were helpful, without a strong understanding of addiction or the resources to combat the underlying issue, ED staff experienced these patients as a problem they grew to resent.

DESENSITIZATION TO SUD OUTCOMES

As a lack of knowledge and resources leads to stigma, and a lack of understanding and empathy leads to resentment, the final compounding issue generating the negative attitudes toward addiction and patients with SUDs is an underlying desensitization to the ultimate horrors of chronic SUD management and the opioid epidemic. Many ED staff members have watched countless patients be revived from overdoses only to return to the streets before medical providers can even be sure the patient is stable enough to discharge. Additionally, many of these same staff members have been on the front lines of the opioid epidemic for years, and witnessed first-hand the horrors of fatal overdose deaths on their patients and families.

> Following the treatment of a wound or cellulitis, patients would routinely not follow care protocols issued by ED medical staff and be non-compliant with the medical care they are presenting to receive.

> One of the keys to minimizing time in the ED was the speed with which the PRC could be notified to begin working directly with the patient.

What Apprehension Surrounded the Implementation of Peer Recovery Coaches?

Once leaders at each of the hospital systems realized that specialized programing for SUDs would be pivotal to the functioning of their EDs, they began to meet with ED staff and leaders and describe the program that would be implemented to address SUDs. The Reverse the Cycle program would include several components, but the placement of PRCs directly in the ED would be the most significant chance to existing workflows. Given the novelty of such a program, naturally some apprehension was reported by ED staff.

PEER RECOVERY COACHES

One of the primary concerns related to the implementation of PRCs surrounded the amount of time that PRCs might spend with patients conducting an intervention or arranging a referral to continuing care. Some of these concerns did materialize once the PRCs began seeing patients in the ED, but groups worked to optimize workflows to allow for effective referral planning, while also minimizing time in the ED. One of the keys to minimizing time in the ED was the speed with which the PRC could be notified to begin working directly with the patient. If the PRC could get in to see the patient while their medical work up is being completed, the less time was needed to complete the referral process once the patient had been treated, and the reduced likelihood that the patient would leave the ED against medical advice to avoid precipitated withdrawal brought on by the delivery of Narcan.

Other staff had different concerns, primarily related to PRCs' lack of an advanced degree or comprehensive training conducting interventions with active patients. These staff members were concerned that individuals with lived experience but no advanced, degree-level training might be ill-prepared to conduct patient-facing interventions where lives were potentially at stake. This apprehension was echoed by other behavioral health staff, but ultimately was dismissed once ED staff were able to see how PRCs interacted directly with patients following implementation.

Some manager-level ED staff members expressed some concern related to how to manage individuals with lived experience. These managers had reservations about providing adequate professional and recovery support for the PRCs who would be placed into emotionally challenging situations throughout their workday, which may position them in a vulnerable situation to experience a relapse. These are still questions that the field is still grappling with, but after having the PRC program for the last couple of years, several ED staff were able to propose possible approaches (see "Appendix: Future Implementation Consideration Summary" on page 57).

POSITION-BASED APPREHENSION

One commonality that was expressed by several ED staff included a trend that there was a direct correlation between the level of staff position and the degree of apprehension toward the PRC program. Respondents noted that higher level administrators and executives were some of the biggest proponents of the program, with the greatest degree of apprehension occurring at the frontline staff level.

PRCs often felt extremely welcomed by the highest-level directors and administrators in the hospital system, which was very encouraging as a new PRC to know that those in positions of authority were lending credibility to the program and its potential. However, PRCs did not receive that same level of acceptance from frontline nurses and providers in the ED, and as PRCs met more staff farther from the top of the hospital system, the more apprehension and pushback they received.

After Peer Recovery Coaches

The implementation of Peer Recovery Coaches (PRCs) in emergency departments transformed attitudes towards SUDs, improving understanding, knowledge, and empathy among staff, resulting in enhanced care and support for SUD patients.

How Did Attitudes Toward SUDs Change After the Implementation of Peer Recovery Coaches?

Although there were a number of ED improvements that occurred after the implementation of PRCs, one of the biggest shifts and changes attributed to the PRCs was an overall improvement in the attitudes of ED staff toward addiction, more generally, and patients presenting in the ED with SUDs, more specifically. Respondents spoke candidly about the interactions with PRCs that they had directly experienced or that they had witnessed occur since the inception of the program. For the same reasons that negative attitudes were allowed to develop and fester prior to the implementation of PRCs, placing individuals with lived experience in the middle of staff interactions actually promoted a curative effect on the stigma and resentment that existed prior to implementation by targeting the same areas that compounded to form the negative attitudes in the first place.

> For the same reasons that negative attitudes were allowed to develop and fester prior to the implementation of PRCs, placing individuals with lived experience in the middle of staff interactions actually promoted a curative effect on the stigma...

Improved Knowledge

One of the first major impacts the PRCs were able to have on ED staff attitudes related to improving the knowledge-base surrounding addiction and SUDs.

Even this ED staff member in behavioral health (quoted below) noted that the PRCs have imparted a great deal of knowledge to the other staff members, including their department, specifically as it relates to recovery as a process. Much of the frustration and fatigue in the ED revolves around seeing the same patients present to the ED for various medical issues related to their SUDs. Not only do the PRCs explain how recovery is anything but a linear process, they also demonstrate and lead by example extending patience during these interactions and not getting easily discouraged.

BEHAVIORAL HEALTH STAFF:

"It's easy to get frustrated when that's your work. And I think the people that are best at it are the people who've walked a mile in their shoes and we see the peer recovery coaches not getting frustrated and, they're just like 'yeah, that's part of the process.' Part of getting off the stuff is stumbling and falling and stumbling and falling and then finally getting it together. So I think I'm seeing them as role models, they don't get discouraged like it's never going to work and so they've been good role models for us, the rest of us, I think nurses in the ER and certainly in my department as well."

EMERGENCY DEPARTMENT DIRECTOR:

"But we have great peer recovery coaches that look at some of our new providers who come in and are like "oh they're addicts they're not going to change, this is a waste of my time." And so I had one provider who was like that and I have a great peer recovery coach who looked at him and said "is this how you would treat somebody with Cancer?" And he's like "well no, that's a disease." And he goes "well this is a disease too. And you have people who have Cancer and they go in remission and then the Cancer comes back." And he's like "and that's what happens with people who are addicts, they have their addiction and they may go into recovery and then they lapse, so why should we treat them any different?" And it was an eye opener for the physician and he's like "oh you know you're right..." It's just amazing when our recovery coaches sit down and talk about their stories of recovery with our providers and it's amazing to see their mindsets change because they have such respect for our recovery coaches and when they actually have time and sit down and listen to their stories their whole outtake on our patients has changed so much. That's all I want for them is to have them treat them with dignity compared to our Cancer patients that come in or somebody with a heart attack. That's my goal for this whole program now that I've taken over the emergency department and the program is I just want them to be treated with dignity."

This ED Director highlights the impact the PRCs have had on new providers to the ED, explaining that addiction is like any other chronic, relapsing and remitting disease that requires care and resilience to manage.

Comparing addiction to cancer was one way that this PRC attempted to reach a new provider who was discouraged about the impact they would be able to make with the SUD patient population. By the PRCs taking the time to sit down and have these conversations with providers, they have been able to improve the quality-of-care delivery and create an environment where these patients can be treated with dignity.

PEER RECOVERY COACH:

"Being able to provide the provider with information when a person is going through withdrawal versus when a person is just drug seeking. Sometimes a patient will come in and they'll be just strictly drug seeking because they know that the doctor will come in, and they'll say they're suffering from X, Y, Z and being a peer recovery coach there's the experience I can go in and I can verify whether or not they're going through withdrawal from experience or whether they're drug seeking and then we can eliminate those... Explaining to the provider what you see as peer recovery coach, as a knowledgeable person in that field. I don't want to say expert but just knowledgeable from first hand experience. Some people come into the hospital just to find shelter. Some people come into the hospital to eat. Some people come into the hospital to get financial assistance but they'll use substance disorder some of them as a means to get in."
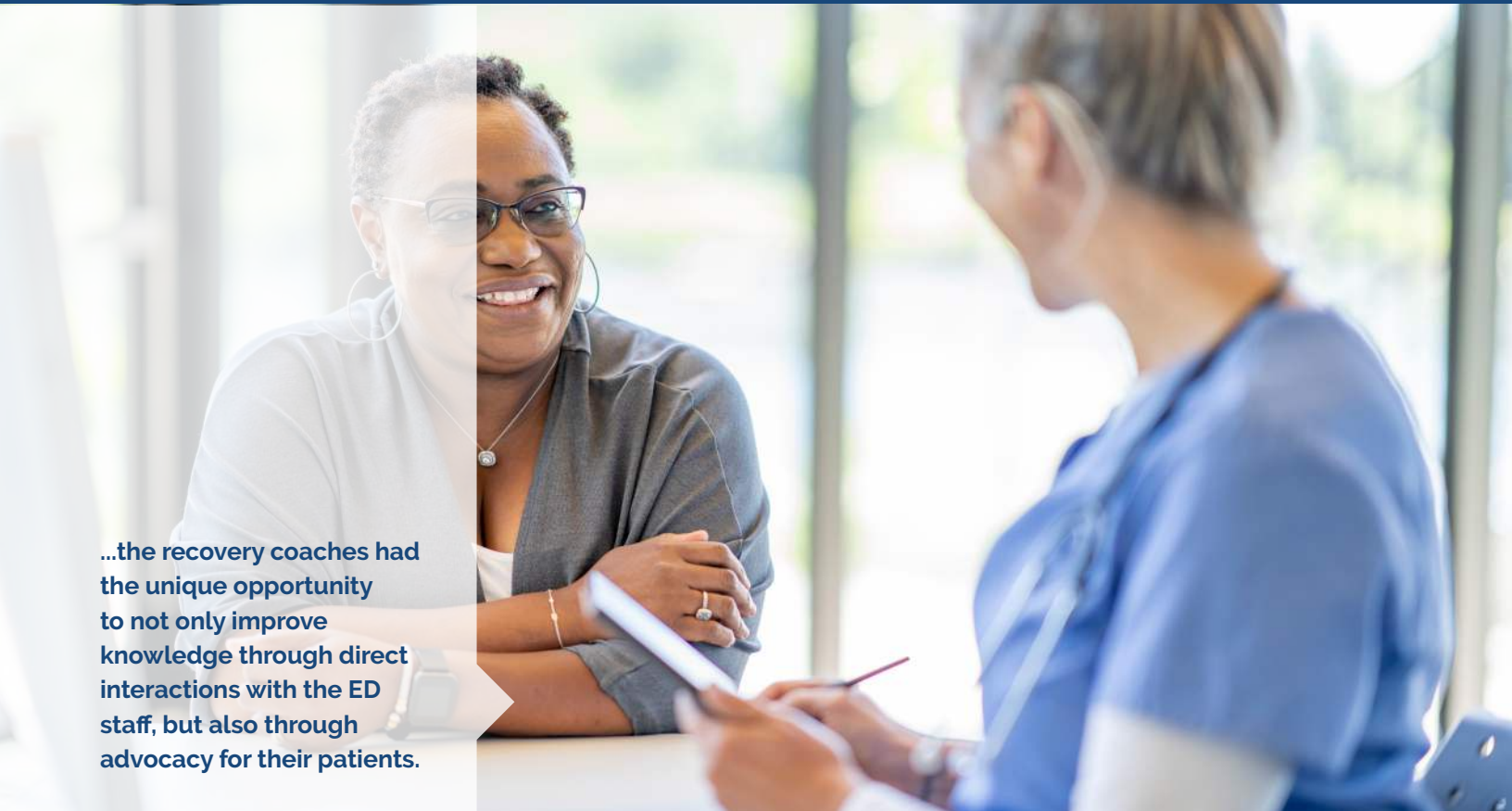
> **…the recovery coaches had the unique opportunity to not only improve knowledge through direct interactions with the ED staff, but also through advocacy for their patients.**

Similarly, this PRC recounts an interaction with a provider where they were able to explain some of the nuances involved in understanding the difference between a patient presenting to the ED who is experiencing symptoms of withdrawal, and one presenting with drug-seeking behavior. Given their lived experience, the PRCs were able to share all of the different reasons individuals with SUD may be visiting the ED, which was enlightening to medical staff.

PEER RECOVERY COACH:

"Yeah, I think there's definitely differences especially with the physicians. When we're speaking to physicians they know that we're in recovery, and they're a little softer with some of the patients than they potentially would have been before. Like hospitals are very keen on getting people in and getting people out, you come in they basically want to discharge you as soon as possible because the ER's full it's busy, they need the beds. But when we're working directly with some of these patients we're able to advocate and get the physicians to be onboard with holding these individuals longer in various instances. If we need somebody to stay longer because the treatment program doesn't open until 9am that physician might keep the patient overnight because we've advocated for it wherein before we were in the ED they would have just sent him home that night, like they wouldn't have kept them until the morning so that they could go to treatment."

As another PRC mentions, the recovery coaches had the unique opportunity to not only improve knowledge through direct interactions with the ED staff, but also through advocacy for their patients. In this example, the PRC was able to alter the existing workflow and hold this particular patient for an extended period of time to ensure a seamless referral to a community treatment provider. Prior to this type of intervention on behalf of the patient, these individuals would have been discharged from the ED as soon as their medical condition was treated.

Improved Resources

In addition to improving the knowledge of the ED staff surrounding addiction and recovery, the PRCs also became a much-needed resource for treating SUD patients in the ED.

PEER RECOVERY COACH:

"I remember one time I came in on a Saturday and a doctor had kept a patient who had come in sometime during the night who wanted help. The doctor did not discharge that patient because that doctor knew that one of us was coming in and it happened to be me. And probably not an hour of me getting there, and I got there early that day, that I go to the doctor and say "hey I need you to have this patient discharged in about an hour and a half because I've got transportation on their way to pick him up and take him to treatment." And just the look that they would have at us where we could do stuff like that like we were miracle workers and it was just based off relationships that we were building with the community, with people in the community.."

As this PRC reflects, providers were able to start planning for the PRCs presence in the ED to the point where, even if a PRC was not on-site yet for the day, providers were willing to room patients for longer periods of time anticipating the PRCs arrival. Rather than spend additional time on the case, the provider recognized that the patient would be well-served by meeting with the PRC. As these interactions continued to demonstrate successful treatment referrals, providers began to look at PRCs as if they were "miracle workers" given how effortlessly they were able to make these referrals look to the rest of the ED staff.

PEER RECOVERY COACH:

"Some days we'll walk into the ED, we have a twenty-five-room emergency department, and when seven of them are filled with people seeking treatment, all of a sudden it ain't everybody's favorite idea anymore. But we're running around smiling like, "hell yeah, fill the other four!" But I can honestly say that a lot of the providers that were big problems that I butted heads with when I started now come and say "hey, do you see that guy on the board, what are we going to do with him?" And they truly do look to us for the treatment plan and I think that's great. And I think as long as you have the proper coaches as long as there's a certain level of responsibility being met and personal recovery being met that that's great and that that's what we want… Originally they looked at it like you're adding work to me, you're adding to my plate I don't have time for this, I don't have da-da-da. Now they see that it's actually taking work off of their plate, where they don't have to focus so much on these three patients they can dedicate their time to other patients, other emergencies, other needs and we will be vigilant in taking care of our patients and I think that's a great piece."

This PRC echoes the sentiment, even during extremely busy times in the ED where the PRCs might have several patients roomed and waiting to be seen, there is an enthusiasm among the PRC staff that this is precisely the need they are positioned to fill. Once providers began to see that the PRCs were alleviating tasks from other ED staff rather than creating more of a workload, they were welcomed with open arms. PRCs allowed busy nurses and providers to tend to other patients and medical emergencies while they continued to intervene with SUD patients and make arrangements for their continued care in the community.

As this ED Director and ED Nurse Director point out, PRCs earned the respect of their colleagues due to the role they have been able to fill in the ED that previously was left to nursing and medical provider staff. Once the PRCs were in place, the staff recognized that they were a resource that could be called upon whenever they had an SUD patient.

EMERGENCY DEPARTMENT DIRECTOR:

"The outlook from the staff is not the outlook of the Debbie Downer of oh my gosh this is going to take away resources because they know that they get to do the medical piece and then there is somebody who will spend the time having a conversation with them and they'll do all of the referral piece… The atmosphere within the hospital has changed so much and it's no longer, I mean there are still of the nurses and the providers that still need to change their outlook, but it's no longer what resources are these people draining from us anymore it's become more of how can we help these people get through and get them into recovery and hopefully move them into staying into recovery as opposed to here we go again another addict."

EMERGENCY DEPARTMENT NURSE DIRECTOR:

"Because of the peer role I think that it made sense to me and I believe it made sense to the other leaders that as a medical professional, a person in scrubs, a person with a shirt and tie, whatever that looks like that is a medical professional having that conversation with the patient we knew that there was a very good chance that it would not be as effective as having someone who says I've been in your shoes I'm here just to talk to you about these behaviors or habits or what have you and they could see them as a peer knowing that yeah this could work."

Rather than spend an undetermined amount of time discussing treatment options with the patient, an area in which the ED staff did not feel equipped, they found that they could simply call upon the PRC, and return to treating the other medical emergencies presenting to the ED. PRCs helped turn the tide from seeing SUD as a resource draining problem, to active agency on the part of the ED that they now had a resource in place to start to combat the root cause of the presenting issues.

Ultimately one of the biggest resources that PRCs brought to the EDs was simply being who they were. As these hospital administrators note, the other ED staff maneuver around the hospital in scrubs or a shirt and tie, which can be intimidating to individuals presenting in the ED with an SUD. PRCs navigate through the busy hospital system in plain clothes, meeting these patients where they are and conversating with them about potential options for treatment, depending on their readiness. Providers reflected on reasons they went into emergency medicine in the first place and realized that it was not to be the face of treating an epidemic that is as much social as it is medical. Having PRCs as a guiding resource to treat the social aspect of the condition was invaluable to the ED team. Even prior to implementing PRCs, hospital leadership recognized the importance of the voice of lived experience as being much more effective to reach this patient population.

MEDICAL DIRECTOR:

"I think having the peer recovery coaches ... you know when you go into emergency medicine you're not going into it thinking oh I'm going to be this resource for the community, you're looking to treat patients with heart attacks. I didn't go into emergency medicine because I was interested in public health, right, it certainly is part of emergency medicine but that's not why people go into it. It's probably because we're a default; we're the safety net because the resources are not in the community. And so having somebody who could be that face of public health and help those patients and allow me to address the other patients I think was very appealing."

Improved Understanding

In addition to the PRCs improving knowledge and resources, which both contribute to a reduction in stigma, PRCs also improved the level of understanding that ED staff offered to patients presenting with SUDs. Prior to the implementation of PRCs, ED staff maintained a minimal level of understanding toward SUD patients in the ED and were quick to address the acute medical issue while discharging these patients back to the community as quickly as possible. After the implementation of PRCs, respondents describe a different orientation, completely.

The PRCs first improved the level of understanding among ED staff by existing in the workplace as a living success story. The PRCs walked around the ED as living proof that individuals with SUDs do recover, especially within an environment where ED staff do not see the outcome of their SUD patients once they're discharged back to the community. In an organizational system that witnesses so much of the negative impact of SUDs, PRCs offered a glimpse of the light at the end of the tunnel into what these SUD patients could become in the future.

EMERGENCY DEPARTMENT MEDICAL DIRECTOR:

"First of all they're all living examples that you've got people that are in front of you that have overcome in a sense their own struggles, their own disease with substance abuse and now their colleagues that we're working with that we respect, they have goals and ambitions. And so just appreciating the fact that you've got folks that have overcome their trials, it gives hope to the whole process that you could maybe help others and move on with their lives and accomplish their ambitions so yeah I think it's helpful just to have that living example."

The PRCs walked around the ED as living proof that individuals with SUDs do recover.

EMERGENCY DEPARTMENT NURSE DIRECTOR:

"Well when I talk about some of the biases that I think that people have, whether they admit them or recognize them, I think that they were cautious with these new team members. And having them separated we did them an injustice and so by having that need to have them physically beside them, they're conversing, they're talking about their families, they're learning they have a lot more in common than the things that are not common to them. And so the working friendships and positive relationship was a result of that and now they're just viewed as a great asset to the team and the nursing staff... And I think they care about them as people, which it's come a long way from those early discussions certainly."

Early in the implementation of PRCs, this hospital system situated the peers in an adjacent office space a short distance from the main nursing station in the ED. During COVID, however, these additional spaces were needed to accommodate a greater volume of pandemic patients and the PRCs were relocated to the main nursing station area. Once the PRCs were fully in the mix with other ED staff, that is when hospital leadership began to see a greater cultural shift in attitudes toward SUD patients. As this Nurse Director notes, the nursing and other ED staff began seeing and treating these new team members as colleagues, talking about their families, and learning that they have much more in common than they may have initially thought. Positive relationships and friendships began to develop between PRCs and other ED staff, which helped the staff view individuals with SUDs in a completely different light.

PEER MANAGER:

"But I think it was really embraced whole heartedly by the hospital which is I think is a big reason why it's been successful. The hospital staff loved the peers, I mean loved them, when they're not here they're like we need the peers back. And even just not necessarily the program itself but they'll be sitting down there and a staff person will come and say "hey my loved one is struggling, can you give me some suggestions?" Or I think it's made a difference in the kinds of conversations that are happening in the way people talk about substance use just knowing that there are people sitting right next to you that have lived through it and are in recovery and that recovery is possible and does happen."

...staff began approaching them with questions about addiction and their loved ones who may also be struggling with a use disorder.

Once the PRCs were able to be fully integrated into the hospital system, ED staff began to understand that they were a wealth of knowledge when it came to understanding SUDs and even the staff began approaching them with questions about addiction and their loved ones who may also be struggling with a use disorder. PRCs were viewed as a safe space to talk about the ways even the staff may have been struggling, and as this Peer Manager notes, PRCs impacted the kinds of conversations that the ED staff were having around addiction, recovery, and treatment. As the conversation around SUDs shifted, the staff realized that they were all impacted in some way by SUDs which became an equalizer, with PRCs at the center of bringing them together within this mutually shared experience.

PEER MANAGER:

"Oh, the providers didn't make me feel like I couldn't approach them, that I could engage them. They didn't treat us like we were a disease and that's the whole purpose is them understanding as people in recovery we are not our disease, this is what's possible. We can live and be normal people with productive lives just like anybody else. And I have to tell you the craziest things sometimes I would find out as peers we became a safe place. I can't tell you the number of times that nurses have come over and in some kind of way let us know that they were in recovery themselves, we became a safe place. I remember one doctor that I really, I don't remember his name, but I really loved, I remember him coming and spending time talking to me about his drinking and that us being there made him want to take a look at his own behaviors, we became a safe place. So talking to these doctors we were people just like they are and they treated us like we were people just like they are so it wasn't hard to talk to them."

EMERGENCY DEPARTMENT NURSE DIRECTOR:

"I have a couple of nurses that come to mind that in the early days even before we had the peer coaches I had to have conversations with about, "this patient reported to me that you appeared to be not supportive," or "they felt like you were judging them," I had a couple of conversations like that. But those same individuals that's not even anywhere on the radar now. If they have any thoughts of that, that's its well-controlled you never know what someone's thinking or what's in their heart, I would say that certainly outwardly I don't see any signs of that kind of behavior or attitude because of the team. And again I think it's because of the relationships they see that these are good people, it could be you, it could be me and very, very different now."

Prior to the implementation of PRCs, this ED Nurse Director mentions first-hand experience in addressing reports of negative attitudes towards SUD patients, but since the implementation of the PRCs, they have had no such interactions. The Nurse Director attributes this change to the PRCs existing within the hospital system as strong professionals, invoking a sense among the staff that anyone around them could have an SUD, normalizing the experience. As this Medical Director echoes, PRCs demonstrated themselves to be high functioning, responsible, and pleasant colleagues, and knowing that these same individuals might have presented in the ED as an SUD patient in years past, completely shifted the orientation toward patients with SUDs. The staff began to recognize what these patients could be in the future – shifting how they treated them in the moment.

MEDICAL DIRECTOR:

"I'm sure it can't hurt, it probably helps. I hope that you're open minded and accepting of people with substance use disorder. But certainly when we interact with the peer recovery coaches when I interact with them it's not lost on me that they are in recovery. And certainly when you deal with them on a daily basis and the interactions are so positive I guess you can relate to that better and you can say hey these people were once where our patients were and look at them now they're highly functioning and responsible and pleasant so I imagine it helps us relate to our patients better."

V.P. OF POPULATION HEALTH:

"I also think getting to know the peer recovery coaches, like walking side by side with a colleague who has lived experiences who is sober and is healthy and is alive, is almost like a walking billboard for the program because it humanizes the unknown faces that come into the ED. So recognizing that those coaches are only one drug away from being that patient and knowing that and having the respect for them. Now I think inherently there's a lot of misconceptions and a lot of disrespect and a lot of probably bias to the patients that come in that are substance using, but when you are sitting next to a colleague who has that lived experience and just respecting that colleague's presence just changes the dynamic within itself. So it's almost twofold, you're watching the magic of patients connecting with peer recovery coaches but you're also respecting and working with a colleague who has had that similar lived experience and was near death and not only survived but is thriving and is giving back. How can you not buy-in? And if you don't buy-in then you don't belong here in our culture."

Overall, ED staff reported that the PRCs became a walking billboard for the program, living as success stories that illustrate what can be possible if the ED was able to take advantage of the opportunity of having these SUD patients come in and be offered the potential for recovery. PRCs were recognized as being "one drug away from being that patient" sitting in front of the staff, and after spending day in and day out with the PRCs fighting for the lives of their patients, the ED staff could not help but see the PRCs as "humanizing the unknown faces" of this patient population.

As this hospital administrator notes, not only are the PRCs a living example of what is possible after recovery, but these individuals are also present in the ED working to give back to the community by developing meaningful connections with patients to link them to ongoing treatment. It became almost impossible for the other ED staff not to buy-in to the model.

Improving Empathy

Beyond improving the level of understanding offered to SUD patients, the PRCs also had a significant impact on improving the level of empathy extended to this patient population. Prior to the implementation of PRCs, a lack of understanding and empathy existed among the ED staff that led to increased levels of resentment toward SUD patients and a decline in the quality of care offered to patients with an underlying use disorder. After the implementation of PRCs, however, respondents reported improved levels of empathy among the staff, largely attributable to the staff placing the PRCs in the shoes of the patients presenting in front of them.

PRCs willingness to share their stories with the staff had a remarkable impact on how ED staff reflected on their own behavior and how their attitudes impact the care they provide for patients.

One of the most impactful ways that PRCs were able to elicit a greater degree of empathy among ED staff was to share their own background and testimonies of addiction and recovery. PRCs were able to share their history of developing an addiction, their non-linear path to recovery, and even their personal experiences with stigma from health care systems. Their willingness to share these stories with the staff had a remarkable impact on how ED staff reflected on their own behavior and how their attitudes impact the care they provide for patients.

V.P. OF POPULATION HEALTH:

"You know I think each of our peer recovery coaches have a unique story and I think they have been willing to share their stories with our staff as a whole here. And understanding their stories and seeing their success has been very impactful for our providers and our nurses so when they look at a patient that comes in this could be [PRC], this could be [PRC], and how could we support them. So I think a lot of our physicians don't think they can do their jobs without our peer recovery coaches now."

PEER RECOVERY COACH:

"So given the fact that I've been into so many of these very small areas what I realize in doing the work in those places is that a lot of those peers come from that community. The community knows them for getting high, they know them as what they used to do and who they used to be and so for the first time, especially in those smaller communities, a lot of the stigma that those nurses and doctors and people have in the community is because they themselves have some way personally been impacted by this disease whether it's a love one or whatever. And so for the first time these people are seeing the opposite of this disease, they're seeing the opposite of the ugliness of this disease when they see a peer. Those peers represent the hope. And so when those nurses and those doctors who only have their own experience, which probably wasn't a good experience because of whoever that person was that was using drugs and dealing with this disease whatever it caused for them; the pain, the hurt the distrust, the all of that, for the first time those peers represent hope."

As these PRCs reflect, their presence in the ED was so much more than meeting with patients to link them to care in the community. The PRCs became part of the professional family ecosystem within the ED, and the bonds and relationships that formed between the PRCs and other staff actively worked to breakdown the misunderstandings and stereotypes that prevented meaningful connections to SUD patients and build a sense of empathy for those struggling with this chronic disease. Even beyond the bonds and relationships, the PRC came to represent hope. Coming directly from these communities that they are serving, the PRCs existed as a revitalizing source of hope for the other ED staff to take on the challenge of treating this population day in and day out.

PEER RECOVERY COACH:

"I think they care a little bit more sometimes too because, we're like a family in the ER and the providers and the nurses they like us, they care about us, we've formed relationships and bonds with the people that we work with so then when we're showing empathy or we're showing that we care to those patients I'm sure that it elicits more empathic behaviors from them as well because we're like, "hey we're going to help this person, they've gone through this, this, this and this," like we can share another perspective on the individual's story that they might not usually see. The physicians and nurses often see people coming in over and over and over again but we get a different perspective, we get this person's in a domestic violence relationship, this person lost a close loved one. We get a different story than just them continuously coming in."

PRCs were able to affect cultural change in these hospital systems because their very presence combatted against all of the deficiencies highlighted initially by hospital staff.

Summary

Prior to the implementation of PRCs, these hospital systems were placed at a structural and systemic disadvantage to combat the evolving opioid and SUD epidemics. Nursing and provider staff were trained to handle acute medical emergencies, not complex social and medical cases that involved specialized expertise and a working knowledge of community treatment resources. These ED systems were not equipped with the knowledge required to treat a patient population with serious SUDs. Compounding their disadvantage was a lack of time available among busy ED staff, which was even more burdened by the steady increase in volume of patients presenting with SUDs. These issues taken together, a lack of knowledge and resources, combined to proliferate a high degree of stigma among ED staff toward patients with SUDs, which was largely the result of simply being ill-equipped to manage a health epidemic for which they were never trained or resourced to treat.

In addition to a lack knowledge and resources, ED staff had spent years treating individuals with opioid or other SUDs who would return to the ED time after time, rarely making any progress toward managing their acute medical issues or addressing the underlying use disorder that drives their ED visit frequency. This led to ED staff placing blame on SUD patients for their lack of engagement in their own medical care. Without a strong understanding of the barriers facing individuals involved in active addiction, ED staff continued to place the blame on SUD patients, limiting their ability to offer empathy and meaningful support to their struggles. This combination of a lack of understanding and empathy, coupled with a desensitization toward overdoses and overdose deaths that the staff were witnessing daily, ultimately translated directly to the generation of negative attitudes among the ED staff toward these patients.

Prior to the implementation of PRCs, these hospital systems were placed at a structural and systemic disadvantage to combat the evolving opioid and SUD epidemics. ... These ED systems were not equipped with the knowledge required to treat a patient population with serious SUDs.

Hospital administrators recognized that they were not effectively treating opioid and SUDs in the ED, and needed another tool in their arsenal to fight against the continuously evolving epidemic. Peer Recovery Coaches offered an opportunity to have staff available on-site with lived experience to spend the appropriate time with SUD patients and effectively link them to care in the community. What administrators did not expect, was a complete shift in the cultural and attitudinal relationships between SUD patients and ED staff, which they can only now attribute to the presence of PRCs.

PRCs were able to affect cultural change in these hospital systems because their very presence combatted against all of the deficiencies highlighted initially by hospital staff. Immediately following implementation, these EDs would now have individuals on-site with a specialized and working knowledge of addiction and recovery, as well as the time and bandwidth to meet with patients for as long as possible to complete interventions and link them to community care whenever possible. Their sole purpose in the ED was to be the resource of knowledge and time that the ED was lacking. Once the hospital system had these resources in place, they started to experience the beginnings of the cultural shift that reduced the level of stigma associated with SUDs and patients with SUD.

The PRCs ended up being more than a resource to fill deficiencies, however, they ended up becoming fully embraced team members who could offer an up-close-and-personal view into the life of an individual who experienced addiction and recovered to be a responsible, functioning, professional member of the ED staff. It was in these interactions, where ED staff could share their personal struggles or the struggles of their friends and family members, where PRCs could share the intimate stories of their addiction and recovery journey and the stigma they faced when seeking care in a busy hospital system, and staff could watch the ways in which PRCs returned from the nightmare of addiction to offer hope to others still struggling – it was in this safe space created by the PRCs that ED staff were able to increase their level of understanding and empathy toward use disorders and patients with SUDs. As these levels of understanding and empathy increased, the overall attitudes of the ED staff began to improve, and a new resilience emerged among the staff that encouraged the belief that they had the agency to make a meaningful impact in the lives of their patients with SUD.

Considerations for Future Implementation

The implementation of Peer Recovery Coaches in hospital emergency departments yielded valuable lessons for future implementation. These lessons cover Human Resources, Management of PRCs, Cultural and Integration Considerations, Demonstrating Worth and Productivity, and PRC Growth Opportunities, offering insights for successful integration and sustainability.

Lessons Learned

In addition to understanding how PRCs have generated an attitudinal shift among ED staff, the hospital systems that implemented the peer recovery coach program learned several lessons throughout the process that will be helpful to future hospital systems considering PRC implementation.

While these lessons were learned during implementation in a hospital ED setting, nearly all of them can apply to other organizational systems considering the use of PRCs, including jails, prisons, or primary care. The following sections are meant to serve as a learning tool for future implementation efforts, and include considerations related to: 1) Human Resources: Interviewing, Hiring, and Policies; 2) Management of Peer Recovery Coaches; 3) Cultural and Integration Considerations; 4) Demonstrating Worth and Productivity; and, 5) PRC Growth Opportunities.

Note: For an abridged version of these future considerations, please see "Appendix: Future Implementation Consideration Summary," beginning on page 57.

PEER MANAGER:

"Prior to this program we did partner with the health department so they had employed peers and we had one that was embedded here at the hospital which was great. So somebody from a peer position would come here and talk to patients, but they were a health department employee not a hospital employee so there were limitations. They couldn't document in our electronic medical record system, they didn't have access to all the information in our system so there were barriers to being able to be a comprehensive member of the treatment team, of the clinical team here and that was only one person. And with the peer program we have now, we have four people so just a lot more capacity to be very closely intertwined with the rest of the staff here at the hospital, and then to have more accessibility for patients to have access to a peer."

Human Resources: Interviewing, Hiring, and Policies

1 PRCs should be employed directly by the hospital system in which they are working to avoid issues and inefficiencies related to access to patient health records and other pertinent information.

BEHAVIORAL HEALTH STAFF:

"And I know that there were some challenges or I guess I want to say reservations on the part of HR because we were going to be hiring peer recovery coaches, and they always do a background check and they look for legal issues that you may have had before they want to hire you. And most of these people that were going to be coming in to interview for these positions were going to have legal issues. They have substance abuse pasts and they're going to be in an environment where there are a lot of substances around. And so there was some reservations on the part of HR as to how that should be handled."

2 Human resource staff should be prepared to waive traditional employment requirements, such as a clean criminal background check, when hiring for PRC positions. Organizations considering the use of PRCs should be prepared to engage in these discussions with human resources to determine which requirements are flexible within the scope of their particular workplace.

PEER MANAGER:

"At the time of implementation, there was a strict no tobacco policy across the board for associates. HR determined that they were going to waive that for this position in particular because we didn't want that to be a barrier for individuals coming in. And it was just a decision that they made that they weren't going to make that a requirement for the peer recovery position."

3 Workplace environments with tobacco-free policies should reconsider these requirements for PRC positions. While these policies are well-intentioned, organizations will want to remove as many barriers as possible to hire the best qualified individuals for the PRC role.

V.P. OF MEDICAL AFFAIRS:

"I think their pay, we've struggled with what should the pay scale be because we agreed after the grant ran out that obviously we would continue this program it's not a revenue generating program, we can't bill for them because we're not a licensed behavioral health center so we can't bill for their services so basically they can't really generate revenue. But we vowed that we would continue on with them, this service, so we applied for grants and everything else to try to do it, but their pay scale. Across the state you look at what should the pay scale be, we don't want to lose them because other places are paying more for their peer recovery coaches so that's always in flux as far as the program goes to make sure we're being competitive and paying them what the rate should be."

4 Prior to hiring PRC staff, human resource departments will want to investigate the pay scale for PRC roles locally to ensure the rate of pay is competitive with other organizations. PRCs are a relatively new role within health systems, and often this results in disparate pay scales even within the same local area or state. Competitive pay rates will help to ensure the organization is hiring and retaining the most qualified PRC staff.

EMERGENCY DEPARTMENT NURSE DIRECTOR:

"One thing I will say in hiring, it's important to get the right fit for your organization just like with any position. And so this was no different than if you're hiring a nurse, if you're hiring a tech, you still need that cultural fit for your organization. And I do think that's important because I think if you miss that then it's difficult for them to be successful… So in hindsight, that was not top of mind for me. My comfort level with understanding their background because their stories were like, oh my goodness how are they even sitting before me today and they survived all of that. And like oh my god yes I'm going to hire you and give you this job because you survived this. And I think that mistake potentially attributed to the turnover because I don't know that I was focused on that cultural fit as well as yes they have all the other qualifications for the role… So, let the staff meet them. We do job shadows for all our other roles so let somebody come in and spend the day because we done that, my current ED director has done that with the most recent peer coach that we hired, let him come in and shadow, let the entire team have an opportunity to interact and see if this person is a good fit and so that's a lesson that we learned."

5 Although hiring PRCs does require some flexibility in traditional employment requirements, ensuring a good cultural fit for the organization should still be an integral part of the hiring process just like any other position. As with other roles within the hospital setting, this director mentions having success in allowing potential PRCs shadow other PRCs in the ED before extending an employment offer.

V.P. OF POPULATION AFFAIRS:

"So, what I've learned over the years now, because I have a whole bunch of teams that work out in the community, is that PRC it takes a certain personality and type of person to really be able to be autonomous and self-directed enough to actually work within the scope of practice within the community. And we found after, I think we had two different community PRC workers that there wasn't enough accountability. And they could have been bad hires sure, but the accountability piece, was making sure that there was accountability from day one and really having it super tight until that particular person/employee proved themselves in that structure because being a community outreach worker is very unstructured… So if I was going to make a recommendation it would be hiring a community PRC that actually had experience as a PRC integrating into a hospital system first, before they're launched out into the community."

6 If PRCs will be following individuals into the community, organizations should consider characteristics such as autonomy and self-direction during the hiring process since these roles often have few mechanisms of accountability. If this is not possible, then one option is to have PRCs stationed within the organizational setting for some time before transitioning them to a role that extends into the community with little supervision.

PEER MANAGER:

"I think we had to sort of figure out the interview process because it's a weird kind of interview. We're asking people about their personal lived experiences with being in active addiction and recovery which we wouldn't do in any other position. It's a part of this role, it's a requirement that you have had the experience and be in recovery so sort of finding some of those lines of how we are still acting legally with interviewing and HR policies but still getting the information we need to make sure that a person's qualified for the position. So, we thought through that and continue to think through that as we go through additional interviews."

7 A significant amount of time should be devoted by human resources, legal, and supervisory staff to developing a guide for questioning potential PRCs during the employment interview. Due to the lived experience requirement of the role, the interview process will tread into areas of the candidate's past that are often not discussed during a traditional interview. Therefore, HR and legal departments should also be heavily involved in determining these lines of questioning.

PEER RECOVERY COACH:

"Yeah, about the hiring process in general I think it's tough because recovery is so subjective, right, I think that's the right term. Like everybody's recovery is different to them and I think it's definitely helpful to have a peer in the interview, at least one of the interviews, to give the interviewee some comfort because it's a sensitive thing to share your whole recovery story in front of a bunch of professionals that you're getting hired to, it feels a little better when there's another person in recovery sitting there like you. You know, working in the ER and hospital is a very demanding position. We've had multiple peers have like mental breakdowns in so many words. Not because of the job but just because people in recovery often have mental health diagnoses, often have a lot of things going on and the environment of the ER is stressful. You have people looking at you to have the answers and get this person in treatment, they need help. Like you've got a twenty-one-year-old and then you call around and there's no places open, they don't have any beds. Or you work with somebody who has a very close recovery story to your own and you really take on a lot of what they're telling you like we get secondhand trauma all the time. I worked with a person just the other day was missing, and I don't want to go into too much information, but was missing a whole body part. And I walked out of the room like a little bit torn up. There's just so much that goes on in the ER and the hospital that I don't think you realize when you're interviewing for the job and it's tough like dealing with people that have been in domestic violence relationships, people that just got gang raped down in the city, you're dealing with a lot. So just really stressing that in the interview and really making sure somebody is solid in their recovery is so important for a peer because you don't want to put the peer at risk for having relapse or struggling and there's a lot in this job that you don't realize when you're going into it as a peer."

8 Just as human resources should prepare for the employment interview differently than other positions in the organization, all staff involved in the interviewing process should also maintain a sensitivity to how difficult the interview process will be for the potential PRC in sharing a significant amount of personal background information with their potential future employer in a professional capacity.

"It's a hard position to hire for, it's a different interview than people are used to having, you don't usually go into an interview and share your whole life, like yeah this is all of the times I got arrested and the bad stuff I got into, you don't usually share that in an interview with somebody so it's definitely an interesting process of hiring."

9 The role of a PRC is demanding and often full of re-experiencing trauma related to their addiction history. For the health, well-being, and safety of the PRC, current PRCs should be involved and included in the hiring process of future PRCs to provide comfort during the interviewing process, but also be a voice of transparency to what the potential PRC can expect with joining the particular organization.

Management of Peer Recovery Coaches

1 New PRCs are generally entering their role in an organizational system with little to no experience in the field, and often with little to no experience with a busy healthcare environment. Comprehensive onboarding and orientation processes are important to avoid potentially costly or harmful patient complications.

PEER MANAGER:

"I think training, it's a very resource intensive onboarding and orientation process because PRCs are generally coming in with little to zero experience in the field. And there's a lot with being a peer recovery coach, it's a pretty heavy job and it's a lot of responsibility and we don't want people making costly or harmful mistakes for patients' sake, for their sake, for the hospital's sake. We don't want peers out there feeling like they don't know what they're doing and they're just trying to figure it out on their own, so there's a lot of training."

PEER MANAGER:

"We had been doing that before, we would have our normal weekly huddles, but I would go down a couple of times a week and just check in on them, but the daily huddles were great. And that's something that we've actually maintained because it's such a great opportunity to talk through any problem cases or just check to see how volumes are and just have a touch point every day, so that has continued and I kind of wished we had done that from the beginning but that was one good thing that came out of COVID."

2 **Daily check-ins, or huddles, with PRC staff were found to be extremely helpful in providing support for PRCs, discussing complex patient cases, and tracking case volumes. While Peer Managers found daily check-ins to be vital for managing PRC staff effectively, PRCs noted that these huddles were instrumental in providing significant support for the types of loss and trauma they experience in providing care to SUD patients.**

PEER RECOVERY COACH:

"I think supervision is extremely important, like peers need supervision and they need it almost on a day-to-day basis if possible. That's what we do here at the hospital and that's what's helped me to remain okay and feeling like I'm supported. We meet every day with our supervisor, if she goes on vacation, she makes sure someone else is available for us to have to reach out to. And with the supervision sometimes it's just supportive, it's like man I just worked with this guy for six months and we just found out that he overdosed and he's dead now and he's in the ER room one, he's deceased over there. Like we'll talk most things out because we lose a lot of people, we lose a ton of people in a day whether its alcohol related, whether it's opioid overdose and that's tough when you're working with somebody for a length of time and then you know that they've got family and you know it's just hard. So, like having supervision and somebody to talk to and give you support as a peer is just, I think vital."

3 **Future peer managers should give prior thought to potential management complications related to PRCs in small or rural communities where anonymity between patients and organizational staff is reduced. Many PRCs were involved in their active addiction within the communities they now serve, and managers should be cognizant of this fact and ensure there are no issues with conflict of interest or maintaining professional boundaries.**

PEER MANAGER:

"And then the supervision as well, what does supervision look like, how do we make sure that the peers are getting adequate support from a supervisory point of view and talking through the complex issues that come up. Because you can get all kinds of training and be very prepared but every situation is different and questions are going to come up. The boundaries I think are a big issue for this position. And we're in a relatively small community so everybody comes here so it's typical for anybody that works in the hospital to come across their relatives or their neighbors or a fellow soccer mom. But the peer community in this area is even smaller so the chances that you're going to have some kind of personal connection with a patient coming in are much higher for the peers. So how do we handle that? What do you do when there's another peer on duty with you? What do you do if you're the only one? How close does the relationship have to be to say I'm not going to work with you? So those are all issues that we're continuingly addressing as well."

4 **Future peer managers or supervisors should be cognizant of other support staff, such as patient navigators or case managers, that are also on-site within the organizational system and ensure that role boundaries are clearly defined, and that each set of support staff understand the types of cases that they are responsible for engaging.**

PEER MANAGER:

"Well there are scenarios; we were trying to iron out what the peer recovery coaches would be doing versus what the case managers would be doing. We wanted to make sure we didn't step on each other's toes but we didn't miss somebody that needed an intervention. We wanted to make sure that communication was smooth and we understood the types of patients that the peer recovery coaches could and could not handle and when we were expected to intervene… Well, it took a lot of discussion to iron out who would the peer recovery coaches be intervening with and who would the case managers be responsible for just because a lot of times substance abuse and mental illness go together. And they are involved for substance abuse but when there are mental health issues as well coexisting with that then they back off and we are responsible for those patients that have both. So there was some ironing out of that."

5 Once PRCs are implemented, navigating time constraints can be challenging given that PRCs are often trying to get patients linked to treatment in the community while they are still on-site. Once patients are discharged into the community, if they have not been successfully linked with ongoing care, the likelihood of care follow-up decreases. Allowing PRCs to effectively make these referrals, while also working within the time constraints of a busy organizational setting can be a challenge that peer managers or supervisors will need to address.

PEER MANAGER:

"I think concerns about relapse, we certainly thought about that, and again I think that's a continuing conversation because what happens if the current peer relapses? Are you automatically fired because your job requirement and the job description is that you're in recovery? Does the relapse mean you're no longer in recovery? How does that work? And we've fortunately not experienced that yet but certainly will I'm sure at some point so those are the kinds of things we try to anticipate and talk with our HR department about. How would we handle this, and what can we tell our peers? Because what we don't want is for somebody to feel that they can't be honest about struggles that they're having, because we want the honesty so that we can provide support and not want to disincentivize somebody from letting us know that they need something."

6 Concerns related to PRC relapse were common, and policies surrounding how to manage a PRC relapse were still part of ongoing conversations between peers and organizational leadership. As this manager notes, these conversations should start prior to PRCs coming on-site, and there are a number of important considerations to note prior to finalizing an official employment policy. While relapses are a significant concern, peer managers were also aware of the risk in creating a situation where PRCs did not feel as though they could be honest if they were in need of support.

PEER MANAGER:

"So really the only decision that was made was that it's not an automatic separation from employment because the primary goal is to make sure that people get support… So we have things like FMLA or paid time off, and other things that people can utilize. We have our employee assistance program, support in the behavioral health area that folks can utilize, but it would really depend on the situation. So what we decided was we're not going to just automatically fire somebody, we're going to have to look at things on a case by case basis. And we've not had to do that yet, we have had folks that have needed time off for behavioral health reasons but nothing specifically to a relapse. But it is very murky because part of one of the foundational tenets of the program is that recovery looks different for everybody. And even in the recovery field does a relapse mean you're no longer in recovery? Does the clock start over again or not? And there's not a clear answer for that I think in recovery in general. So I think what we have in place is to just say we're just going to talk about it and assess that individual situation and see what seems like the appropriate step."

7 While these policies are still being finalized, ultimately this hospital system decided to take PRC relapse on a case-by-case basis understanding that nuance and context to any such issue will be important to consider. To promote honesty and support for their PRC staff, this system will not immediately dismiss a peer from employment if they do experience a relapse, however, many questions remain for the future.

8 Even among PRCs there are questions surrounding what should happen to a peer in the event of a relapse during their employment, but as this PRC recommends, establishing a protocol or a safety plan for peers that is transparent and agreed upon by all parties involved can go a long way in establishing the trust necessary for peers to be open and honest about their personal and professional struggles.

PEER RECOVERY COACH:

"Yeah and we've been hearing more about it lately because a lot of peers that we know have been struggling and end up having to go to an inpatient psych unit themselves so it's really been of topic lately amongst us peers. It's like, what is the protocol? And of course it's a case by case basis, but yeah, if I were to relapse am I going to share that because that's my job, that's my livelihood? Am I just going to keep that secret because I don't want anybody to know? And then we all know that keeping a relapse secret is not good for somebody that's struggling… And we haven't quite figured it out like what are the parameters, what does happen? We have brainstormed about creating a safety plan like this is who you can go to talk to; this is potentially what could happen with your job. It's just so hard to have a concrete process because you know every situation's different. But yeah I think it's something that we're all still trying to figure out like how exactly will that work."

V.P. OF POPULATION HEALTH:

"I think the early challenges were really their nervousness, right, so these are folks that for the most part at least the PRCs that I've met aren't folks that have worked in a hospital system. And so I've had a lot of students in my career and it's very similar to having undergrad students or social work students coming into a hospital situation and understanding how overwhelming and stimulating and bureaucratic a hospital system is, but then you put them in the ED, which is the most frenetic place in all of the whole hospital within itself… so I think for them I think just sort of not underestimating the importance of the hospital culture integration so from the biggest of pictures, and I think this went really well for us, but it's definitely a vulnerability from a programming standpoint because you're taking PRCs quote-unquote certain laymen and you're putting them in a hospital system on top of teaching them a new job so it can be quite overwhelming… I've had grad students that are on the second day like in tears like I can't do it. So some of that speaks to I think from a strength perspective, the coaches ability to manage trauma because that's really what happens in the ED is all sorts of trauma. So from an integration standpoint I would say that actually went well for us because I could see where if you weren't really aware of, if you didn't remember what it was like to be green coming into an ED with no medical, like not knowing any medical terminology, never being even on a computer electronically in medical records like that kind of thing how venerable that could be… And the most intense things happen in the ED for the most part so whether it's gunshot wounds or trauma or blood or vomiting it's intense. And so luckily these three coaches took all of that in stride but I can't imagine that that would be true across the board."

Cultural and Integration Considerations

1 Helping PRCs to understand exactly what they can expect when coming onboard to a busy organizational system will help set the program up for success, but peer supervisors and managers need to remember what it was like to be "green" to such intense settings and work with peers for an extended period during the onboarding process.

PEER RECOVERY COACH:

"The ED staff is always pretty accommodating, to their ability. So like sometimes the ED is slammed and part of us is like I don't even want to ask them for this help right now because they're literally doing chest compressions all night. So me asking, hey can you make sure transportation comes? But we make it work, we make it work we'll go to the case managers or the nurse and they're always helpful, we've never gotten like no I'm not doing that, I can't do that, we've always gotten yeah I'll do the best I can, yes I'll try. Does it always get executed as we as peers may have wanted? No, but they try their best and do what they can with the ability that they have at that moment depending on all the external factors of the ER.."

2 As PRCs are onboarded to a busy organizational system, managing expectations in terms of the bandwidth of other staff to assist PRCs is an important consideration. PRCs know they can ask other ED staff for support with a patient, but they also understand that their time is significantly limited.

EMERGENCY DEPARTMENT DIRECTOR:

"And I think when I came into the role they had not really been dispersed or made part of the ER team; they were just kind of hanging out and doing their thing. And I was like "no these guys are part of our team just like the aides are and just like housekeeping is part of our team." And I was really big into making the peer recovery coaches, these are our team, they're just as much as our team as our physicians and our PAs like this is part of our ER team. And I think that that helped as well so when one of our peers had his recovery day I was like "we're celebrating, we're having a lunch for him and we're going to celebrate that he's made it thirty-three years and he's still here and this is important." And I think that the staff really appreciated it because they wouldn't have known had we not made it very important that they be considered part of our team, they're not just an addition that comes out of an office and helps put people into treatment they're part of us."

3 Creating a sense that PRCs are fully embedded as part of the organizational team was instrumental in successfully implementing the peer program within these hospital systems. As this ED Director notes, celebrating the recovery birthdays with PRC staff demonstrated the importance of these milestones and further integrating the peers with the other ED staff.

4 Placing PRCs physically in shared locations with other organizational staff helps to promote efficient and effective integration, while also reducing stigma. Additionally, this hospital system found that having PRCs assist the other staff in any small way possible during periods of downtime also promoted a sense of camaraderie and teamwork among the entire staff.

V.P. OF MEDICAL AFFAIRS:

"You know I think one of the things that we did really well was we addressed, I think it's very important to address stigma and we really incorporated our peer recovery coaches with our staff, they became a very integral part of our ED team. So they're sitting out at the desks with the nurses, they help out, if somebody needs a blanket they're going to get blankets, if a nurse needs help they're there. There was talk initially of putting them in an office somewhere in our ER, unfortunately some of the good things that came out of COVID was we needed to use spaces for other reasons so they got pushed out in the middle with everyone even before that for space reasons. And I think it's one of the best things that happened because they just became part of the team. And I just feel like there's no stigma there, nobody looks at them any different; we really wanted to preach that and make sure that that never became an issue culturally. So I think then they incorporated so well with our ED and they are providing such a valuable, they work all over the hospital even with inpatients and they're such a great resource for us and provide such a great service that they're such valued members of the team. I just think that's so important when anybody's implementing this is to make sure that culturally that that's addressed number one, and number two that they're not stuck in some remote office somewhere to work out of. Now granted sometimes they need privacy obviously to make follow-up phone calls, you don't want them doing that out in the middle of a busy ER and that's important. But I think just having them incorporated and being out there with the team and incorporating them in is just really crucial, it's something I think we did really well."

5 In addition to centrally locating PRCs with other staff, PRCs taking a proactive approach to introducing themselves to the other staff and explaining who they are and what they do was integral to successful implementation of the program.

6 While PRCs having proactive discussions with other ED staff helps to address their role on the team, having the peer supervisor also proactively talk with staff to understand any of their concerns or suggestions for how to integrate the peers more effectively, was also mentioned as a notable consideration for future implementation.

PEER RECOVERY COACH:

"So I liked the location that they had us sitting at. They had us sitting right at a nurses' station. And so they quickly learned who we were because they always passed us by. The particular nurses' station that they sat us at it put us in the middle of everything so everybody, you know curiosity, would come over and talk to us. And if we weren't seeing a patient we would be around, we would walk around and we would engage the nurses and the doctors and have conversations and take opportunities, take advantage of the opportunity to explain and introduce to them ourselves, the program and what we were there to do."

EMERGENCY DEPARTMENT NURSE DIRECTOR:

"It sounds really simple and it was very simple but it just took a lot of I guess active participation on my part in having conversation with the staff in listening to them, asking what are they seeing, any concerns, anything that they see that they have a concern about or that we could do differently. And just being opened to hearing what they had to say especially in those early weeks and months and so they could see that okay this is a benefit, this is great, they're really helping us here and we really need this so just a lot of time having those conversations."

7 As this PRC notes, proactive conversations on the part of the peers went a long way with experienced ED staff to help place their role into context. PRCs felt that it was important to convey to nurses and providers that they were not there to dictate the medical care related to their SUD patients, but to act as a support to link the patient to care in the community. Recognizing the appropriate timing of these conversations was also helpful to successful integration.

PEER RECOVERY COACH:

"Well I mean the conversation was simple, the conversation you just had to introduce yourself to the provider and tell him who you are and what you're doing and that the program is geared towards helping them create a safe environment or bring substance users to treatment and that you're experienced in the substance use field, that you have a little bit more information on that behalf, not on the medical behalf. We're not trying to do medication, we're not trying to tell you what to dose them we're just trying to tell you exactly who we are and what we do and how we get a person from point A to point B to treat them so that's how that's go. Because when you go into a place and you've not properly introduced and you're performing a service that someone else usually performs then you have to identify yourself and explain who you are and what's going on so that the person in there will know exactly what's going on… They didn't understand at first because we're just coming in there and the doctors are so busy, they were so busy and every five minutes or every few minutes we had to stop them and ask them questions and they had to get used to that. And it was a task for them to get used to me saying "doc can I speak with you?" when he's on the phone or he's on the computer trying to put a person back together again or trying to save a life. So once they understood and we started to, when times they were not busy we'd go in and we'd talk and we'd explain to doctors exactly what we're doing and now that they have a few minutes they can understand what we're saying. So now the pressure's starting to be relieved and we're not no longer in their way, we are a part of their team, we are a tool in their belt."

BEHAVIORAL HEALTH:

"We were not sure to start out with how much work the peers were going to have because it's feast or famine with these patients. And the last thing you want is somebody to be bored in their job, or on the other hand to overwhelm somebody, so we kind of started out I think we have the same number of peers that we had to begin with, but we've kind of branched out in their responsibility. Like I said they do see some of our inpatients now where they never were, that was not part of their responsibility at first."

Demonstrating Worth and Productivity

1 **Peer managers and supervisors will need to strongly consider the number of peers necessary to meet their patient volume needs. SUD patient numbers in organizational systems can fluctuate, and settings want to ensure they have enough peers to meet the volume demand, but not too many that there is considerable downtime. Cross-training peers to complete other activities around the organizational system is key for peers to continue demonstrating productivity.**

V.P. OF POPULATION HEALTH:

"So there's a lot of excitement about the work that they are doing, but I think as staffing is an issue here, and I had mentioned the nurses skipping the SBIRT assessment, there became a question of gosh the SBIRT guys aren't busy all the time is there something else they could be doing to help in the emergency department? And I think that became noticeable, there were a few times when nurses couldn't find them, we're paging them on their cell phone and they didn't respond so that became a question. Based on our volume and based on the work is that enough really for twenty hours a day of coverage in our emergency department or can we extend those peers to help with other work? And I think that has really gotten traction. Our CMO mentioned at a meeting that he couldn't find one of the peers one day when he was looking for them so it did come up as these are now not grant funded positions these are hospital funded positions we need to make sure that we are utilizing our funds to support the emergency department the best we can, do we need to add additional tasks for our peers? And that's something we're looking at now."

2 PRC downtime can be noticeable in busy organizational systems, and because peers follow patients all over the hospital, PRC absence from common workplace areas can reflect poorly on the program if the assumption is that the peers are not being productive employees. Also, struggles with nursing completing SUD screening assessments can also lower patient volume for peers contributing to increased downtime and less productivity on the part of the peers. Future implementation efforts should consider these bottlenecks and issues in advance before they contribute to questioning the utility of the peer program.

V.P. OF POPULATION HEALTH:

"So it was so interesting to be a part of a program to see the culture shift, like it was such a privilege to have seen the culture shift and even amongst COVID. But also know as a leader we have to get back to our basics because we're not as productive as we were, we're not making the impacts and we've gotten a little sloppy. We're not as geared on making sure every opioid patient presenting has Narcan in their hand and initiating Bup. It's almost like we've gotten comfortable which is pretty indicative of lots of different implemented programs but because this program is seen as it's need to, it's not revenue generating I'll put it that way. So it's not something in a hospital system and it's not required so you have to have social workers, you have to have certain disciplines, you have to have physical therapist but there's nobody telling you that you have to have PRCs except for the hospitals committed to doing that work. And obviously there's lots and lots of cost savings from a readmission standpoint but the biggest of pictures from a financial perspective there are those decisions being made all the time so it's not a program that can afford to get complacent... there's a lot of competing forces in those outcomes and a lot of competing forces around productivity. So definitely some work to do, definitely looking forward to reinvigorating the program and really making sure that our productivity is there and having very task oriented accountable... Let's put it this way, our peer recovery coaches have a lot of autonomy and none of my other staff have this level of autonomy and so I don't know if that's in our best interest."

3 Ensuring that the peer program continues to meet high quality standards for providing care over time is instrumental for successful implementation and sustainability. Given that peer programs are largely elective, program leaders and peers cannot afford to get complacent in the service delivery to patients because the program must continue to justify itself financially to be supported by organizational executives.

PEER RECOVERY COACH:

"I just think those weekly meetings, and sharing the data, and really helping the peers understand and see how the work that they do translates into the language that the executives understand, which is numbers. So the executives and the people who make decisions and who advocate for grants to keep their jobs or keep these programs going, they're not going based off of the words that are spoken between a peer and a patient, they're looking at that data that's being pulled from that documentation, that's the language. So helping the peers to become inclusive and understand that business side of this thing would be helpful, impactful and empower the peers to understand why they have to do certain things and make sure that they do certain things and don't forget to do certain things when we come back around and we're observing or we're present and supporting for months after the program gets started."

4 **Peer managers and supervisors need to take special consideration in explaining the importance of documenting peers' interactions with patients in electronic health record systems. Organizational executives do not have the opportunity to witness the meaningful work and interactions that the peers engage in daily, so the only way these decision-makers can see the value the peers bring to patients is through comprehensive chart documentation. Focusing on this type of training is an important consideration in future PRC implementation.**

PEER MANAGER:

"Yeah and that was something that we've actually always done in the navigation program and so we just transferred it over. But I do think it's really powerful and especially in a program like this. And navigation is the same where we're not generating income, we don't bill for services so we're not getting insurance payments so we need to remind the hospital of why they need to keep funding us and that's I think a really important piece of it. So yeah I strongly encourage other programs to do it. It does take time, the peers have to set aside to put those short anecdotes in but I think it's worth it and I think it's also really a satisfier for the peers because we do sometimes have to take the time to celebrate the successes because there are so many frustrations so I think it's good for morale as well."

5   **In addition to documentation within the electronic health record, this hospital system also found success in asking peers to take time to write down short anecdotal interactions with patients and some of their successes. Because this system is unable to bill for the PRC services, these anecdotes help to provide support for the program by demonstrating the value of the peers to the SUD patient population.**

PEER RECOVERY COACH:

"Sure so us specifically like us as employees at the hospital as peers we're better at figuring out resources, so that's helpful. We actually now meet with new resources that come about, new agencies and we'll go and actually meet with a new outpatient program and they learn about what we do. We didn't typically do that too much in the beginning, like we met with a couple of local agencies, like two or three but now we continuously do that when there's some new program locally. We're quicker to get people into treatment, like a lot of the kinks have been worked out so we're really quick to know the places to send somebody. We also know some of the things to think about when you're sending somebody in regards to like medical stuff so I think we're just more efficient. And like I said too, more efficient with just all the different resources that are out there because there's a ton, there's different levels of programs and really figuring out who could benefit from what."

6   **PRCs can best demonstrate value to organizational leadership and other staff by learning the entire local and non-local SUD treatment ecosystem so they are prepared to place a diversity of SUD patients.**

Peer Recovery Coach Growth Opportunities

1 **Ensuring the organization is providing ongoing education for peers is paramount to reducing peer turnover and promoting sustainable engagement on behalf of the peers. Continued professional development is as important to provide to PRCs as any other position or role within the organization.**

EMERGENCY DEPARTMENT NURSE DIRECTOR:

"Well I view it as essential as we move forward as far as budget support, and want to make sure from our budget that we're providing ongoing education for the peer coaches, giving them any opportunity for that. If an opportunity presents itself that will strengthen their ability to do their job well, make sure that they have all the support that they need, that's something that I hope we'll always have. It's kind of hard now when you think, how did we have life before the peers because like I said, the team really relies so heavily on them, and the whole organization actually at this point."

2 **One opportunity for continued educational development that this hospital system put into place is to expand the role of the PRC beyond the ED and into the inpatient areas of the hospital. If ED SUD patient admissions are slow, other departments throughout the hospital can notify PRCs that they have a patient who may benefit from meeting with a PRC.**

V.P. OF MEDICAL AFFAIRS:

"So I think overall what's happened with the program is they were doing such a good job in the ER. For awhile, our volumes weren't, like we knew that they could see more patients than what they were seeing so we actually extended them into the inpatient side. You know some people come visit the ER and they may have lied on the screening assessment and then they get up to a certain withdrawal and actually need help so we come up there and the case managers and even the physicians up there will say "hey can we get one of the peer recovery coaches to come and help talk to our patient?" So we've expanded outside of the ER. Sometimes you get a direct admit that needs some help or some coaching or something and they expand up there so I think it's something we've extended hospital-wide which is great."

V.P. OF MEDICAL AFFAIRS:

"We've opened what we call a neighborhood hospital or micro hospital in an adjacent community which is about thirty minutes down the road. It has about nine or ten ER beds and nine or ten inpatient beds. So if there's a need down there they'll remotely work with telemedicine, they'll remotely work with those patients as needed and then of course we expand it to other system hospitals so their value has been shown to really be wonderful."

3 **This hospital system expanded the service provision of their care to other community or micro hospitals in area. As SUD patient volume in their ED slowed, they were able to utilize PRCs over telehealth to provide interventions and treatment referrals to these smaller, rural communities without PRCs onsite.**

V.P. OF POPULATION HEALTH:

"Our goal in the future is, we're going to take all of our care coordinators who do social determinants of health screening and connection to primary care and cross train them so our peers will learn those skills. And then we're going to create a clinical ladder so as our peers get additional certifications, so if they've got too many health worker certifications, or other certifications that we'll be able to raise their pay."

4 **Another strategy for expanding the growth opportunities for peers is to find similar roles and responsibilities throughout the organizational system and determine whether there are cross-training opportunities for peers, such as health screenings and care continuity to primary care systems.**

5 As this peer astutely notes, providing growth and professional opportunities for PRCs is necessary for any successful implementation and sustainability of a peer program. PRCs are professionals in any organizational system and providing a care support service that has demonstrated immense value in these healthcare settings. Peers deserve the same focus on self-fulfillment and professional growth as any other position.

PEER RECOVER COACH:

"Well for me nothing changed as far as my time there as a peer. The only thing that I think is a problem that I'm seeing across the board is there's not opportunity for growth for peers. And that needs to happen because if we want to keep all these great fantastic people that we have that are passionate for doing this work and we want to keep them around and keep them doing this work, we need to create opportunities for growth for them. So if I come in as a coach and I do everything that I need to do to become a certified specialist by the state board, then there should be an opportunity and it should be recognized. We've got CNAs, we've got LPNs, and we've got RNs - there's a growth opportunity for them. Well, the same thing should start for peers, we need to start recognizing this and creating it because then that's how you're going to keep the same people invested and your program won't have such a turnover. Every time you have to start with a whole new group, because we're people too, we're always looking for ways to grow and get better in our own lives. That's just a small self-fulfillment piece, that we will always want to be the best person that we can be, and so we're always looking for that opportunity to grow so the systems need to start recognizing and creating this opportunity for coaches. If there's a requirement for them to go from a coach to a specialist, then we should recognize them. If, once you become a specialist there's an opportunity to go from a specialist to a registered peer supervisor then the system should be recognizing this."

Appendix: Future Implementation Consideration Summary

HR Interviewing, Hiring, and Policies

1. PRCs should be employed directly by the hospital system in which they are working to avoid issues and inefficiencies related to access to patient health records and other pertinent information.

2. Human resource staff should be prepared to waive traditional employment requirements, such as a clean criminal background check, when hiring for PRC positions. Organizations considering the use of PRCs should be prepared to engage in these discussions with human resources to determine which requirements are flexible within the scope of their particular workplace.

3. Workplace environments with tobacco-free policies should reconsider these requirements for PRC positions. While these policies are well-intentioned, organizations will want to remove as many barriers as possible to hire the best qualified individuals for the PRC role.

4. Prior to hiring PRC staff, human resource departments will want to investigate the pay scale for PRC roles locally to ensure the rate of pay is competitive with other organizations. PRCs are a relatively new role within health systems, and often this results in disparate pay scales even within the same local area or state. Competitive pay rates will help to ensure the organization is hiring and retaining the most qualified PRC staff.

5. Although hiring PRCs does require some flexibility in traditional employment requirements, ensuring a good cultural fit for the organization should still be an integral part of the hiring process just like any other position. As with other roles within the hospital setting, one suggestion included allowing potential PRCs shadow other PRCs in the ED before extending an employment offer.

6. If PRCs will be following individuals into the community, organizations should consider characteristics such as autonomy and self-directed during the hiring process since these roles often have few mechanisms of accountability. If this is not possible, then one option is to have PRCs stationed within the organizational setting for some time before transitioning them to a role that extends into the community with little supervision.

7. A significant amount of time should be devoted by human resources, legal, and supervisory staff to developing a guide for questioning potential PRCs during the employment interview. Due to the lived experience requirement of the role, the interview process will tread into areas of the candidate's past that are often not discussed during a traditional interview. Therefore, HR and legal departments should also be heavily involved in determining these lines of questioning.

8. Just as human resources should prepare for the employment interview differently than other positions in the organization, all staff involved in the interviewing process should also maintain a sensitivity to how difficult the interview process will be for the potential PRC in sharing a significant amount of personal background information with their potential future employer in a professional capacity.The role of a PRC is demanding and often full of re-experiencing trauma related to their addiction history. For the health, well-being, and safety of the PRC, current PRCs should be involved and included in the hiring process of future PRCs to provide comfort during the interviewing process, but also be a voice of transparency to what the potential PRC can expect with joining the particular organization.

Management of Peer Recovery Coaches

1. New PRCs are generally entering their role in an organizational system with little to no experience in the field, and often with little to no experience with a busy healthcare environment. Comprehensive onboarding and orientation processes are important to avoid potentially costly or harmful patient complications.

2. Daily check-ins, or huddles, with PRC staff were found to be extremely helpful in providing support for PRCs, discussing complex patient cases, and tracking case volumes. While Peer Managers found daily check-ins to be vital for managing PRC staff effectively, PRCs noted that these huddles were instrumental in providing significant support for the types of loss and trauma they experience in providing care to SUD patients.

3. Future peer managers should give prior thought to potential management complications related to PRCs in small or rural communities where anonymity between patients and organizational staff is reduced. Many PRCs were involved in their active addiction within the communities they now serve, and managers should be cognizant of this fact and ensure there are no issues with conflict of interest or maintaining professional boundaries.

4. Future peer managers or supervisors should be cognizant of other support staff, such as patient navigators or case managers, that are also on-site within the organizational system and ensure that role boundaries are clearly defined, and that each set of support staff understand the types of cases that they are responsible for engaging.

5. Once PRCs are implemented, navigating time constraints can be challenging given that PRCs are often trying to get patients linked to treatment in the community while they are still on-site. Once patients are discharged into the community, if they have not been successfully linked with ongoing care, the likelihood of care follow-up decreases. Allowing PRCs to effectively make these referrals, while also working within the time constraints of a busy organizational setting can be a challenge that peer managers or supervisors will need to address.

6. Concerns related to PRC relapse were common, and policies surrounding how to manage a PRC relapse were still part of ongoing conversations between peers and organizational leadership. As advised by current peer managers, these conversations should start prior to PRCs coming on-site, and there are a number of important considerations to note prior to finalizing an official employment policy. While relapses are a significant concern, peer managers were also aware of the risk in creating a situation where PRCs did not feel as though they could be honest if they were in need of support.

7. While policies are still being finalized, these hospital systems decided to take PRC relapse on a case-by-case basis understanding that nuance and context to any such issue will be important to consider. To promote honesty and support for their PRC staff, this system will not immediately dismiss a peer from employment if they do experience a relapse, however, many questions remain for the future.

8. Even among PRCs there are questions surrounding what should happen to a peer in the event of a relapse during their employment, but PRCs recommend establishing a protocol or a safety plan for peers that is transparent and agreed upon by all parties involved, which can go a long way in establishing the trust necessary for peers to be open and honest about their personal and professional struggles.

Cultural and Integration Considerations

1. Helping PRCs to understand exactly what they can expect when coming onboard to a busy organizational system will help set the program up for success, but peer supervisors and managers need to remember what it was like to be "green" to such intense settings and work with peers for an extended period during the onboarding process.

2. As PRCs are onboarded to a busy organizational system, managing expectations in terms of the bandwidth of other staff to assist PRCs is an important consideration. PRCs know they can ask other ED staff for support with a patient, but they also understand that the time of other ED staff is significantly limited.

3. Creating a sense that PRCs are fully embedded as part of the organizational team was instrumental in successfully implementing the peer program within these hospital systems. Hospital systems committed to celebrating the recovery birthdays with PRC staff to demonstrate the importance of these milestones and further integrate the peers with the other ED staff.

4. Placing PRCs physically in shared locations with other organizational staff helps to promote efficient and effective integration, while also reducing stigma. Additionally, hospital systems found that having PRCs assist the other staff in any small way possible during periods of downtime also promoted a sense of camaraderie and teamwork among the entire staff.

5. In addition to centrally locating PRCs with other staff, PRCs taking a proactive approach to introducing themselves to the other staff and explaining who they are and what they do was integral to successful implementation of the program.

6. While PRCs having proactive discussions with other ED staff helps to address their role on the team, having the peer supervisor also proactively talk with staff to understand any of their concerns or suggestions for how to integrate the peers more effectively, was also mentioned as a notable consideration for future implementation.

7. Proactive conversations on the part of the peers go a long way with experienced ED staff to help place their role into context. PRCs felt that it was important to convey to nurses and providers that they were not there to dictate the medical care related to their SUD patients, but to act as a support to link the patient to care in the community. Recognizing the appropriate timing of these conversations was also helpful to successful integration.

Demonstrating Worth and Productivity

1. Peer managers and supervisors will need to strongly consider the number of peers necessary to meet their patient volume needs. SUD patient numbers in organizational systems can fluctuate, and settings want to ensure they have enough peers to meet the volume demand, but not too many that there is considerable downtime. Cross-training peers to complete other activities around the organizational system is key for peers to continue demonstrating productivity.

2. PRC downtime can be noticeable in busy organizational systems, and because peers follow patients all over the hospital, PRC absence from common workplace areas can reflect poorly on the program if the assumption is that the peers are not being productive employees. Also, struggles with nursing completing SUD screening assessments can also lower patient volume for peers contributing to increased downtime and less productivity on the part of the peers. Future implementation efforts should consider these bottlenecks and issues in advance before they contribute to questioning the utility of the peer program.

3. Ensuring that the peer program continues to meet high quality standards for providing care over time is instrumental for successful implementation and sustainability. Given that peer programs are largely elective, program leaders and peers cannot afford to get complacent in the service delivery to patients because the program must continue to justify itself financially to be supported by organizational executives.

4. Peer managers and supervisors need to take special consideration in explaining the importance of documenting peers' interactions with patients in electronic health record systems. Organizational executives do not have the opportunity to witness the meaningful work and interactions that the peers engage in daily, so the only way these decision-makers can see the value the peers bring to patients is through comprehensive chart documentation. Focusing on this type of training is an important consideration in future PRC implementation.

5. In addition to documentation within the electronic health record, hospital systems also found success in asking peers to take time to write down short anecdotal interactions with patients and some of their patient achievements. Because this system is unable to bill for the PRC services, these anecdotes help to provide support for the program by demonstrating the value of the peers to the SUD patient population.

6. PRCs can best demonstrate value to organizational leadership and other staff by learning the entire local and non-local SUD treatment ecosystem so they are prepared to place a diversity of SUD patients.

Peer Recovery Coach Growth Opportunities

1. Ensuring the organization is providing ongoing education for peers is paramount to reducing peer turnover and promoting sustainable engagement on behalf of the peers. Continued professional development is as important to provide to PRCs as any other position or role within the organization.

2. One opportunity for continued educational development that this hospital system put into place is to expand the role of the PRC beyond the ED and into the inpatient areas of the hospital. If ED SUD patient admissions are slow, other departments throughout the hospital can notify PRCs that they have a patient who may benefit from meeting with a PRC.

3. Some hospital systems expanded the service provision of their care to other community or micro hospitals in area. As SUD patient volume in their ED slowed, they were able to utilize PRCs over telehealth to provide interventions and treatment referrals to these smaller, rural communities without PRCs onsite.

4. Another strategy for expanding the growth opportunities for peers is to find similar roles and responsibilities throughout the organizational system and determine whether there are cross-training opportunities for peers, such as health screenings and care continuity to primary care systems.

5. Providing growth and professional opportunities for PRCs is necessary for any successful implementation and sustainability of a peer program. PRCs are professionals in any organizational system and provide a care support service that has demonstrated immense value in these healthcare settings. Peers deserve the same focus on self-fulfillment and professional growth as any other position.

References

1   Administration SAMHS. Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/. Published 2020. Accessed.

2   Scholl L, Seth P, Kariisa M, Wilson N, Baldwin G. Drug and Opioid-Involved Overdose Deaths - United States, 2013-2017. *MMWR Morb Mortal Wkly Rep.* 2018;67(5152):1419-1427.

3   U.S. Overdose deaths in 2021 increased half as much in 2020 – But are still up 15%. [press release: May 11, 2022]. Center for Disease Control and Prevention 2022.

4   Linas BP, Savinkina A, Barbosa C, et al. A clash of epidemics: Impact of the COVID-19 pandemic response on opioid overdose. *Journal of Substance Abuse Treatment.* 2021;120:108158.

5   Wakeman SE, Green TC, Rich J. An overdose surge will compound the COVID-19 pandemic if urgent action is not taken. *Nature medicine.* 2020;26(6):819-820.

6   Health NIo. National Institute of Drug Abuse. Overdose death rates. Available at:)(Accessed August 10, 2016) https://www.drugabuse gov/related-topics/trends-statistics/overdose-death-rates View in Article. 2017.

7   D'Onofrio G, McCormack RP, Hawk K. Emergency Departments - A 24/7/365 Option for Combating the Opioid Crisis. *N Engl J Med.* 2018;379(26):2487-2490.

8   Wu LT, Swartz MS, Wu Z, Mannelli P, Yang C, Blazer DG. Alcohol and drug use disorders among adults in emergency department settings in the United States. *Ann Emerg Med.* 2012;60(2):172-180 e175.

9   Bogenschutz M, Donovan DM, Mandler RN, et al. Brief Intervention for patients with problematic drug use presenting in emergency departments: a randomized clinical trial. *JAMA Internal Medicine.* 2014;174(11):1736-1745.

10 D'Onofrio G, O'Connor PG, Pantalon MV, et al. Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. *JAMA.* 2015;313(16):1636-1644.

11 Goodnough A. This E.R. Treats Opioid Addiction on Demand. That's Very Rare. *The New York Times.* Available at: https://www.nytimes.com/2018/08/18/health/opioid-addiction-treatment.html. 2018.

12 Monico LB, Oros M, Smith S, Mitchell SG, Gryczynski J, Schwartz R. One million screened: Scaling up SBIRT and buprenorphine treatment in hospital emergency departments across Maryland. *The American journal of emergency medicine.* 2020;38(7):1466-1469.

13 Strauss A, Corbin J. Basics of qualitative research. Sage publications; 1990.

14 AL GBS. The discovery of grounded theory: Strategies for qualitative research. London: *Weidenfeld & Nicolson.* 1967.

mosaic GROUP