ADDRESSING OPIOID USE DISORDER IN EMERGENCY DEPARTMENTS:

EXPERT PANEL FINDINGS

NATIONAL COUNCIL for Mental Wellbeing

Opioid Response Network

Overview

In January 2020, the National Council for Mental Wellbeing hosted a technical experts' panel (TEP) to identify best and promising practices to engage individuals surviving overdose and assist individuals with opioid use disorder (OUD) presenting in emergency department (ED) settings. The TEP focused on current strategies to increase access to evidence-based medications for opioid use disorder (MOUD) and recovery supports. In collaboration with the Opioid Response Network's partners — the American Academy of Addiction Psychiatry, C4 Innovations, and the American College of Emergency Physicians — the National Council convened subject matter experts (see Appendix A), including emergency physicians, peer workers, recovery community leaders, local public health administrators, medical directors, professors, harm reduction providers and technical assistance consultants for a one-and-a-half day meeting in Washington, DC.

The panel identified existing strengths and challenges, policy and practice recommendations and ideal workflows to improve outcomes among individuals presenting in EDs with OUD. Discussion questions included:

- What does an ideal team look like for assisting individuals with OUD in the ED?
- What policies and procedures adequately support peer workers within ED settings?
- What are the training needs of ED staff to adequately support individuals with OUD?
- What are the training needs of peer workers in ED settings?

At the conclusion of the panel, recommendations were identified and prioritized, outlining the core components necessary to effectively address the needs of individuals with OUD within ED settings. This report identifies key policy and practice recommendations informed by existing research, case examples and findings from the TEP.

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Background

Each day in the United States more than 130 people die due to an opioid-related drug overdose.[1] In 2018, there were 46,802 opioid overdose deaths, representing nearly 70% of all drug overdose deaths in the U.S.[2] Provisional data for 2019 show an increase of 4.8% in drug overdose deaths compared to 2018. Among the 70,980 reported overdose deaths in 2019, 50,042 (70.5%) were opioid-related.[3]

For each fatal opioid overdose, there are numerous nonfatal overdoses in which people present to EDs for care. A survey of a majority of states show a significant increase in reported ED opioid overdoses in recent years. Between January 2019 and January 2020, on average states reported 27.59 suspected opioid overdoses per 10,000 ED visits, compared to 7.23 between January 2018 and January 2019.[4] Between January 2019 and January 2020, 14 states[5] experienced a significant increase in all reported suspected opioid overdoses while only three states experienced a significant decrease (New Hampshire, Missouri and Utah).[6]

Despite the large number of individuals presenting in EDs due to opioid overdose, few engage in treatment after release from the hospital. A study of 6,451 commercially-insured individuals discharged from an ED between 2011 and 2016 showed that only 16.6% received follow-up treatment within 90 days after the overdose.[7] Researchers found that Black patients were less likely to receive follow-up than non-Hispanic White patients and that women were less likely to receive follow-up than men.[8]

The gap between individuals presenting in the ED with suspected overdose and lack of subsequent follow-up treatment necessitates ED-based interventions aimed at stemming opioid overdose death and linking individuals to recovery services and treatment. A systematic review published in 2020 reviewed 13 studies analyzing ED-based delivery of opioid overdose prevention interventions. The study authors identified four main intervention types: 1) take home naloxone and overdose education, 2) medication safety interventions, 3) MOUD and 4) psychosocial interventions. Study authors concluded that a range of evidence-based interventions to prevent opioid overdose are feasible in ED settings and are effective on short-term outcome measures.[9]

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[1] Scholl, L., Seth, P., Kariisa, M., Wilson, N., & Baldwin, G. (2019). Drug and Opioid-Involved Overdose Deaths-United States, 2013-2017. Morbidity and Mortality Weekly Report, 67(5152), 1419-1427.

[2] Hedegaard, H., Minino, A. M., & Warner, M. (2020). Drug Overdose Deaths in the United States, 1999-2018. NCHS Data Brief no. 356. *National Center for Health Statistics*. Retrieved from https://www.cdc.gov/nchs/data/databriefs/db356-h.pdf

[3] Ahmad, F. B., Rossen, L. M., & Sutton, P. (2020). Provisional drug overdose death counts. National Center for Health Statistics.

[4] Centers for Disease Control and Prevention (CDC), National Center for Injury and Prevention Control, Drug Overdose Surveillance and Epidemiology (DOSE) System. (2020, April 21). Nonfatal Overdoses: All Opioids. Retrieved from https://www.cdc.gov/drugoverdose/data/nonfatal/nonfatal-opioids.html

[5] The 14 states that experienced a significant increase in all suspected opioid overdoses per 10,000 ED visits include Maine, New York, Massachusetts, Pennsylvania, New Jersey, Connecticut, Michigan, Illinois, Indiana, West Virginia, Virginia, Florida, Louisiana and Washington.

[6] CDC, National Center for Injury and Prevention Control, DOSE System. (2020, April 21). Nonfatal Overdoses: All Opioids. Retrieved from https://www.cdc.gov/drugoverdose/data/nonfatal/nonfatal-opioids.html

[7] Kilaru, A. S., Xiong, A., Lowenstein, M., Meisel, Z. F., Perrone, J., Khatri, U., . . . Delgado, K. (2020). Incidence of Treatment for Opioid Use Disorder Following Nonfatal Overdose in Commercially Insured Patients. *JAMA Network Open*, 3(5), e205852.

[8] Ibid.

[9] Chen, Y., Wang, Y., Nielson, S., Kuhn, L., & Lam, T. (2020). A systematic review of opioid overdose interventions delivered within emergency departments. *Drug and Alcohol Dependence*, 213, 108009.

MEDICATIONS FOR OPIOID USE DISORDER

The use of evidence-based MOUD is the most effective treatment for individuals with OUD; this treatment modality is also referred to as medications for addiction treatment, medication-assisted treatment or MAT.[10,11] There are three U.S. Food and Drug Administration (FDA)-approved medications currently available to treat OUD: methadone, buprenorphine and extended-release injectable naltrexone (XR-NTX). Each FDA-approved medication differs pharmacologically and is governed by different regulations:

- **Buprenorphine** is prescribed by physicians, nurse practitioners and physician assistants who obtain a Substance Abuse and Mental Health Services Administration (SAMHSA) waiver (commonly known as the x-waiver) after completing requisite training. The Drug Addiction Treatment Act of 2000 (DATA 2000) established that qualified providers can offer buprenorphine for OUD in various settings, including EDs.[12]
- **Methadone** is only provided within SAMHSA-certified and Drug Enforcement Administration (DEA)-regulated opioid treatment programs (OTP).[13]
- **XR-NTX** is prescribed by any clinician licensed to prescribe medication.[14] Unlike methadone and buprenorphine, both opioid agonists, XR-NTX is an opioid antagonist and not a controlled substance.

All three forms of MOUD have been shown to be effective in reducing return to illicit opioid use; however, efficacy rates and outcomes vary across the medications.[15,16,17] Methadone is the most commonly used MOUD worldwide and clinical trials have demonstrated that it reduces illicit opioid use, treats OUD and retains patients in treatment better than placebo or no medication.[18] Studies assessing buprenorphine show that it is effective in retaining patients in treatment and reducing illicit opioid use.[19] XR-NTX has demonstrated efficacy in reducing return to illicit opioid use and reducing opioid craving, once initiated. Research indicates that rates of overdose associated with XR-NTX are higher than buprenorphine at four weeks post-medication discontinuation.

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[10] American Society of Addiction Medicine (ASAM). (2015). National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. American Society of Addiction Medicine, 33, 1-64. doi:10.1073/pnas.0703993104

[11] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. (2016, November). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health. Retrieved from https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf

[12] Substance Abuse and Mental Health Services Administration (SAMHSA). (2019). Buprenorphine. Retrieved from https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine

[13] SAMHSA. (2019). Methadone. Retrieved from https://www.samhsa.gov/medication-assisted-treatment/treatment/methadone

[14] SAMHSA. (2019). Naltrexone. Retrieved from https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone

[15] Lee, J. D., Nunes, E. V., Novo, P., Bachrach, K., Bailey, G. L., Bhatt, S., . . . Rotrosen, J. (2018). Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): a multicentre, open-label, randomised controlled trial. *The Lancet*, 391(10118), 309–18.

[16] Larochelle, M. R., Bernson, D., Land, T., Stopka, T. J., Wang, N., Xuan, Z., . . . Walley, A. Y. (2018). Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association with Mortality: A Cohort Study. *Annals of Internal Medicine*, 169(3), 137-145. doi:10.7326/M17-3107

[17] Wakeman, S. E., Larochelle, M. R., Ameli, O., Chaisson, C. E., McPheeters, T. J., Crown, W. H., . . . Sanghavi, D. M. (2020). Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. *JAMA Network Open*, 3(2), e1920622.

[18] Ibid.

[19] Mattick, R. P., Breen, C., Kimber, J., & Davoli, M. (2014). Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database of Systemic Reviews*, 2(CD002207).

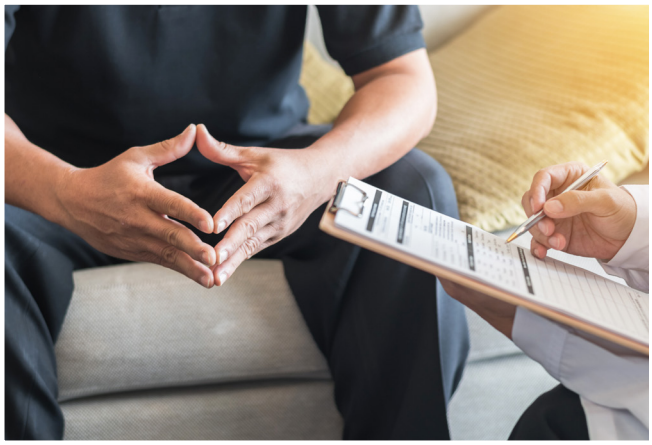
[20] Larochelle, M. R., Bernson, D., Land, T., Stopka, T. J., Wang, N., Xuan, Z., . . . Walley, A. Y. (2018). Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association with Mortality: A Cohort Study. *Annals of Internal Medicine*, 169(3), 137-145. doi:10.7326/M17-3107

[21] Morgan, J. R., Schackman, B. R., Weinstein, Z. M., Walley, A. Y. (2019). Overdose following initiation of naltrexone and buprenorphine medication treatment for opioid use disorder in a United States commercially insured cohort. *Drug and Alcohol Dependence*, 200, 34-39.

WAIVER REQUIREMENTS

To prescribe buprenorphine to treat OUD, physicians, physician assistants and nurse practitioners must complete training and become certified by SAMHSA. Physicians must complete an eight-hour waiver training, while physician assistants and advanced practice nurses must complete a 24-hour training. These trainings are available at no cost to providers through the Providers Clinical Support System (PCSS).[22] Additional resources related to waiver requirements and training are in Appendix E.

ED-BASED BUPRENORPHINE PRESCRIBING



Individuals with OUD presenting in the ED should be offered access to all three forms of MOUD, with information about each to make an informed choice. However, ED settings are ideal for prescribing buprenorphine for several reasons, including prescribing regulations and detoxification requirements prior to medication initiation. Unlike methadone, which is only dispensed by certified OTPs, buprenorphine is prescribed by any waivered provider in a variety of settings that include EDs. While XR-NTX can be prescribed by any clinician who is licensed to prescribe medication, initiating individuals on XR-NTX generally requires medically supervised withdrawal followed by a minimum of seven to 10 days without opioids, including opioid-based MOUD.[23] To avoid buprenorphine-precipitated withdrawal, buprenorphine should generally be initiated within eight to 12 hours after a patient last used short-acting opioids (e.g., heroin), 24 hours after the last use of extended-release opioids (e.g., Oxycontin) and at least 72 hours after the last use of methadone.[24] Unlike methadone or XR-NTX, patients can be prescribed take-home daily doses of buprenorphine and with guidance from prescribers, can take their first dose at home without clinical observation.[25,26]

Despite buprenorphine's demonstrated efficacy, an insufficient number of providers have obtained x-waivers to meet the needs of individuals with OUD, including ED providers.[27] To better understand ED clinicians' attitudes and perceptions related to ED-initiated buprenorphine, researchers conducted a mixed methods study in 2017 and 2018. Among 93 ED clinicians who completed an electronic survey, 88% agreed that buprenorphine should be administered in the ED for patients with OUD; however, only 44% felt they were prepared to discuss MOUD options with patients.[28] Three systems-level barriers were identified by research participants: 1) discomfort with prescribing buprenorphine in the ED without the ability to ensure outpatient follow-up, 2) financial barriers for patients to continue on buprenorphine following ED-initiation and 3) anticipated increase in ED volume due to patients requesting OUD treatment.[29]

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[22] Providers Clinical Support System (PCSS). (2020). Buprenorphine. Retrieved from https://pcssnow.org/medications-for-addiction-treatment/buprenorphine/

[23] Sullivan, M., Bisaga, A., Pavlicova, M. Choi, C. J., Mishlen, K., Carpenter, K. M., ...Nunes, E. V. (2017). Long-acting injectable naltrexone induction: A randomized trial of outpatient opioid detoxification with naltrexone versus buprenorphine. *The American Journal of Psychiatry*, 174(5):459–467.

[24] Strayer, R. J., Hawk, K., Hayes, B. D., Herring, A. A., Ketcham, E., LaPietra, A. M., . . . Nelson, L. S. (n.d.). Management of Opioid Use Disorder in the Emergency Department: A White Paper Prepared for the American Academy of Emergency Medicine. Retrieved from https://www.aaem.org/UserFiles/file/AAEMOUDWhitePaperManuscript.pdf

[25] D'Onofrio, G., O'Connor, P. G., Pantalon, M. V., Chawarski, M. C., Busch, S. H., Owens, P. H., . . . Fiellin, D. A. (2015). Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: A Randomized Clinical Trial. *JAMA*, 313(16), 1636-1644.

[26] Lee, J. D., Grossman, E., DiRocco, D., & Gourevitch, M. N. (2008). Home Buprenorphine/Naloxone Induction in Primary Care. *Journal of General Internal Medicine*, 24(2), 226-232.

[27] Jones, C. M., Campopiano, M., Baldwin, G., & McCance-Katz, E. (2015). National and State Treatment Need and Capacity for Opioid Agonist Medication-Assisted Treatment. *American Journal of Public Health*, 105(8), e55-e63.

[28] Im, D. D., Chary, A., Condella, A. L., Vongsachang, H., Carlson, L. C., Vogel, L., . . . Samuels-Kalow, M. (2020). Emergency Department Clinicians' Attitudes Toward Opioid Use Disorder and Emergency-Department-initiated Buprenorphine Treatment: a Mixed-Methods Study. *Western Journal of Emergency Medicine*, 21(2), 261-271.

[29] Ibid.

Despite identified challenges, a growing number of EDs are successfully implementing buprenorphine prescribing across the U.S. and data supports that ED-initiated buprenorphine is superior to other types of services typically offered. For example, a study conducted by D'Onofrio and colleagues found that 57% of patients (n=65) were successfully provided buprenorphine and a detailed self-medication guide for home induction, since they were not manifesting opioid withdrawal in the ED.[30] The study authors concluded that individuals who received ED-initiated buprenorphine treatment versus brief intervention and referral showed significant increased engagement in substance use disorder (SUD) treatment, reduced self-reported illicit opioid use and decreased use of inpatient SUD treatment.[31]

ED-BASED PEER RECOVERY SUPPORT SERVICES

A growing body of evidence shows the integration of peer workers within ED settings can help facilitate access to treatment and recovery supports among individuals with OUD.[32,33] The integration of peer workers within ED settings marks a transition toward a recovery-oriented system of care approach. To successfully integrate peer workers within ED settings, it is important that changes in the ED culture incorporate a commitment toward recovery-oriented values and practices.

[30] D'Onofrio, G., O'Connor, P. G., Pantalon, M. V., Chawarski, M. C., Busch, S. H., Owens, P. H., . . . Fiellin, D. A. (2015). Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: A Randomized Clinical Trial. *JAMA*, 313(16), 1636-1644.

[31] Ibid.

[32] Welch, A. E., Jeffers, A., Allen, B., Paone, D., & Kunins, H. V. (2019). Relay: A Peer-Delivered Emergency Department-Based Response to Nonfatal Opioid Overdose. *American Journal of Public Health*, 109(10), 1392-1395.

[33] McGuire, A. B., Gilmore Powell, K., Treitler, P. C., Wagner, K. D., Smith, K. P., Cooperman, N., . . . Watson, D. P. (2020). Emergency department-based peer support for opioid use disorder: Emergent functions and forms. *Journal of Substance Abuse Treatment*, 108, 82-87.

[34] SAMHSA. (2010, September). Recovery-Oriented Systems of Care (ROSC) Resource Guide. Retrieved from https://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf

[35] White, W. (2008). Recovery Management and Recovery-Oriented Systems of Care: Scientific Rationale and Promising Practices. Retrieved from http://www.williamwhitepapers.com/pr/2008RecoveryManagementMonograph.pdf

RECOVERY-ORIENTED SYSTEMS OF CARE

Recovery-oriented systems of care (ROSCs) are coordinated networks of community-based services and supports that are person-centered and build on the strengths and resiliencies of individuals, families and communities to improve the health, wellness and quality of life for those with or at risk of substance use problems.[34] Recovery-oriented systems provide long-term services and supports that are person-directed and recognize there are multiple pathways for recovery.[35] Systems that are recovery-oriented strive to include the following elements:[36,37]

- **Person-centered:** Individuals have a menu of options that fit their needs throughout the recovery process and are empowered to direct their own recovery paths.
- **Strengths-based:** Individuals' strengths, assets and resiliencies are acknowledged and drawn upon.
- **Trauma-informed:** All components of a ROSC are designed and delivered in a manner that is safe, trustworthy and transparent. Services empower individuals' voice and choice to make decisions collaboratively.
- **Inclusive of family:** ROSCs include individuals and families in recovery at every step of planning and care delivery. ROSCs also recognize that families, including chosen families, are sources of support and integrated into recovery planning, when directed by the individual receiving services.
- **Individualized and comprehensive:** Services are both individualized and comprehensive to meet the unique holistic needs of individuals. Services are also stage-appropriate, flexible and designed to support individuals across the lifespan. Linkages to treatment, recovery and other critical supports are made through a wide network of collaborating providers and organizations. ROSCs also acknowledge and support many recovery pathways and supports.
- **Connected to the community:** ROSCs are embedded in the community and enhance the availability and capacity of families, social networks and community-based organizations.
- **Outcomes-driven:** ROSCs are informed by recovery-based process and outcome measures, which are developed in collaboration with individuals in recovery and reflect long-term individual, family and community outcomes.
- **Evidence-based:** ROSCs are informed by research across multiple domains of recovery, including cultural and spiritual aspects.
- **Adequately and flexibly funded:** ROSCs are well-resourced and financed to support the full continuum of services and supports.

Because EDs primarily focus on responding to acute crises, the long-term needs of patients with SUDs often are not addressed in these settings. The integration of peer workers can be critical to bridge the gap between providing an immediate response and linking individuals to longer-term community-based treatment, services and supports.

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[36] Philadelphia Department of Behavioral Health and Intellectual disAbility Services. (2015). Transformation Practice Guidelines for Recovery and Resilience Oriented Treatment. Retrieved from https://dbhids.org/wp-content/uploads/2015/07/practice-guidelines-1-1.pdf

[37] SAMHSA. (2009, August). Guiding Principles and Elements of Recovery-Oriented Systems of Care: What do we know from the research?

PEER WORKERS

Peer workers are individuals with lived experience of recovery and specialized training that make them uniquely well positioned to support other individuals with SUDs. Peer workers provide non-clinical, peer-based activities that engage, educate and assist individuals as they make life changes necessary to support recovery from SUDs or co-occurring conditions. Generally, peer workers offer four types of support and services, including emotional, informational, instrumental and affiliational (see Table 1).

PEER WORKER

Within peer recovery support services, there are different terms for peer-based positions. Throughout this paper we will use peer worker. Related titles include peer specialist, recovery specialist, recovery coach and certified peer specialist, among others.

TABLE 1. TYPES OF SUPPORT PROVIDED BY PEER WORKERS[38]

TYPE OF SUPPORT	DESCRIPTION	EXAMPLES OF ACTIVITIES
Emotional	Demonstrates empathy, caring or concern to bolster a person's self-esteem and confidence.	• Peer mentoring • Peer-led support groups
Informational	Shares knowledge and information and/or provides life or vocational skills training.	• Parenting class • Job readiness training • Wellness seminar
Instrumental	Provides concrete assistance to help others accomplish tasks.	• Childcare • Transportation • Help accessing community health and social services
Affiliational	Facilitates contacts with other people and organizations to promote learning social and recreational skills, create community and acquire a sense of belonging.	• Recovery center activities • Sports league participation • Alcohol- and drug-free socialization opportunities

Peer workers are employed in a wide range of organizations, including hospitals, recovery community organizations, criminal justice-related organizations, public health agencies and community health centers. The roles and responsibilities of peer workers are essentially the same across organizations and settings, with slight variations. Defining peer workers' roles is important for establishing boundaries and clarity among care teams. While peer workers' roles vary, there are established guidelines for what peer workers do and don't do in practice outlined in Table 2.

[38] Center for Substance Abuse Treatment, SAMHSA. (2009). What are Peer Recovery Support Services? HHS Publication No. (SMA) 90-4454. Retrieved from http://www.dbhds.virginia.gov/assets/doc/recovery/what-are-peer-recovery-support-services-2009.pdf

TABLE 2. WHAT PEER WORKERS DO AND DON'T DO	
PEER WORKERS DO	**PEER WORKERS DON'T**
Share lived experience.	Give advice or directives.
Motivate through hope and inspiration.	Motivate through fear or shame.
Support many pathways to recovery.	Support only one pathway to recovery.
Guide others in accomplishing daily tasks.	Do tasks for others.
Use language based on common experiences.	Use clinical language or language specific to only one recovery pathway.
Teach others how to acquire needed resources, including money.	Give resources and money to others.
Help others find professional services from lawyers, doctors, psychologists and financial advisors, among others.	Provide professional services.
Share knowledge of local resources.	Provide case management services.
Encourage, support and praise.	Diagnose, assess or treat.
Help others set personal goals.	Mandate tasks and behaviors.
Role model positive recovery behaviors.	Tell others how to lead their lives in recovery.

Peer Worker Training and Certification

Most peer workers have received training and certification in advance of their onboarding process. Training and certification ensure that peer workers meet a set of established core competencies. Peer worker certification can vary by state and is also often driven by state reimbursement policies and organizational needs. The National Association of Peer Supporters, NAADAC - the Association for Addiction Professionals and International Certification and Reciprocity Consortium are examples of national accrediting bodies for peer workers.

ED-BASED PEER INITIATIVES OUTCOMES

There are a small but growing number of ED-based peer initiatives implemented to engage individuals with SUDs presenting to EDs, primarily with overdoses. Program evaluation findings and published literature support that the integration of peer workers and adoption of recovery-oriented values and strategies have yielded promising results. For example, AnchorED, a peer-based overdose response initiative in Rhode Island, found in its first year of program implementation that more than 80% of participants engaged in recovery supports following discharge from the ED. Only 5% had multiple ED visits.[39] Relay, a peer-delivered overdose response initiative in seven EDs in New York City, enrolled 74% of individuals into its recovery services through contacts with peers made in the ED.[40] Between June 2017 and January 2018, Relay peer advocates also distributed naloxone kits to 827 individuals, connected 165 individuals to harm reduction services, linked 104 individuals to ongoing MOUD, linked 72 individuals to outpatient SUD treatment and connected 66 individuals to inpatient SUD treatment. The percentage of individuals who kept appointments ranged from 53 to 79%, with 79% of individuals keeping MOUD appointments.[41]

Additionally, Ashford and colleagues conducted an evaluation of peer recovery support services intervention in EDs in rural Georgia. The Northeast Georgia Community Connections Project (NECCP) pilot, led by the Georgia Council on Substance Abuse, Northeast Georgia Medical Center and Georgia's Department of Behavioral Health and Development Services, provided peer support to individuals who experienced an opioid overdose or received a SUD diagnosis in one of three rural EDs. The study of 205 participants engaged through the pilot showed high rates of multiple engagements (77%) with a peer worker.[42]

[39] Joyce, T. F. & Bailey, B. (n.d.). Supporting recovery in acute care and emergency settings.

[40] Welch, A. E., Jeffers, A., Allen, B., Paone, D., & Kunins, H. V. (2019). Relay: A Peer-Delivered Emergency Department-Based Response to Nonfatal Opioid Overdose. *American Journal of Public Health*, 109(10), 1392-1395.

[41] Ibid.

[42] Ashford, R. D., Curtis, B., Meeks, M., & Brown, A. M. (2019). Utilization of Peer-Based Substance Use Disorder and Recovery Interventions in Rural Emergency Departments: Patient Characteristics and Exploratory Analysis. *Journal of Rural Mental Health*, 43(1), 17-29.

Recommendations

The following recommendations were informed by onsite implementation experiences, subject matter experts and existing literature.

1. IDENTIFY OVERARCHING VALUES

When establishing cross-sector partnerships, it is critical to identify the common goal toward which all parties are working; in this case, increasing treatment and recovery supports for individuals with OUD. Building a recovery-oriented workforce requires every member of the team to commit to the following values:

- Providing person-centered, choice-driven, comprehensive and compassionate care.
- Promoting and advocating for cultural intelligence and sensitivity.
- Building a culture of wellness.

Emergency department settings are often chaotic and anxiety-provoking, especially for individuals who have overdosed. It is essential that administrators and staff create a safe and welcoming environment that is recovery-oriented and trauma-informed in which individuals can get help without fear of judgment or stigma. Pervasive stigma among providers and staff toward patients with OUD and about MOUD was identified as the most common barrier to service provision in a Rhode Island Department of Health assessment on levels of care standards for OUD within EDs and hospitals.[43] Grounding the team in core recovery values at the outset is integral to successful implementation of a program promoting wellness and recovery.

[43] Samuels, E. A., McDonald, J. V., McCormick, M., Koziol, J., Friedman, C., & Alexander-Scott, N. (2019). Emergency Department and Hospital Care for Opioid Use Disorder: Implementation of Statewide Standards in Rhode Island, 2017–2018. *American Journal of Public Health*, 109(2), 263-266.

2. IMPLEMENT A RECOVERY-ORIENTED WORKFORCE

When treating OUD and other SUDs, adopting a recovery-oriented approach can be more effective than simply engaging in the treatment services offered through clinical medicine. The aim of ROSC is to involve individuals in the decision-making processes of recovery, provide a comprehensive continuum of care and recognize that recovery is defined differently for and by each person. Rather than simply treating an overdose in the ED and discharging patients, ED staff can deploy peer workers to engage individuals in long-term supports and services. By establishing a sense of connection and shared lived experience, the peer worker can suggest and provide access to resources, including MOUD, specialty treatment, harm reduction and recovery support services. This level of patient engagement has previously not existed in EDs – due to time constraints, urgency of care, the stretched roles of medical staff – and has the potential to radically shift ED culture. Further, the relationship between peer worker and patient often extends beyond the ED episode, as the individual returns to the community.

Five tips for hospitals adopting a recovery framework include:[44]

1. Develop recovery-oriented core values and principles based on input from diverse stakeholders, including people in recovery.
2. Shift the service emphasis from an acute to a chronic care model that incorporates recovery management.
3. Use evidence-based, as well as innovative and promising practices.
4. Commit to peer recovery support services.
5. Redefine service roles and the role of the patient as a full partner.

There are several tools to help organizations implement recovery-oriented practices and strategies. For example, the National Council's Trauma-informed Recovery-oriented System of Care Toolkit offers assessment, visioning and action planning tools, among others, that can be adapted for various settings. SAMHSA's Practicing Recovery: Incorporating a Recovery Orientation in Hospital Settings provides quick tips and case examples for hospitals implementing recovery-oriented practices. Additional tools and resources are in Appendix D.

3. CREATE BUY-IN AND ESTABLISH AN IMPLEMENTATION TEAM

Adapting the existing workflow of EDs to integrate peer workers can be challenging. Medical providers and peer workers typically approach treatment and recovery from different perspectives, therefore needing common ground to explore shared values and outcomes. Achieving buy-in is a multi-level process involving assessing readiness of ED staff and leadership, communicating the role of peer workers to ED clinicians and partnering with recovery community organizations. Engaging these stakeholders and establishing their respective roles is critical to implementing effective integrated workflows to coordinate care in the ED and follow-up in the community.

The ideal team is comprised of a core group of project champions working toward a common goal. This team may include physicians, hospital administrators, x-waivered prescribers, social workers, nurses, peer workers and representatives from community organizations, who are invested in supporting individuals through their treatment and recovery. Organizations can adapt their project teams in accordance with the community's strengths and needs. When establishing this type of collaborative effort, it is vital to first develop shared intention and language and build team consensus around the goals and processes of integrating and coordinating these services.

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[44] SAMHSA. (2016, January). Practicing Recovery: Incorporating a Recovery Orientation in Hospital Settings. Retrieved from https://www.ahpnet.com/files/Newsletter_5_Jan_2016.pdf

Since peer workers may be new to the ED environment, it is important for everyone to understand their role and to recognize, welcome and celebrate the value they bring. Because the peer role is relatively new, it is incumbent on all team members to create the best fit by designing an implementation plan that can move through staff resistance, reframe difficulties and achieve some early wins.

Transforming the Work Culture

In the larger picture, adding peer workers to the workforce and adapting workflows to accommodate peer roles can be a powerful vehicle to activate organizational change. As noted, EDs are chaotic environments that can be trauma-inducing for everyone, especially staff. Engaging all levels of staff to participate in imagining and creating a trauma-informed and recovery-oriented work culture is beneficial to everyone. It is important to engineer this intention through top-down communication.

A panel participant, Anthony Furiato, DO, from Brandon Regional Hospital in Florida, shared that an internal campaign, called i-3 (identify opioid withdrawal or OUD, induce opioid agonist therapy [Suboxone] and initiate a warm handoff or referral), became a vehicle to initiate a recovery-oriented culture change at Brandon.

Another element that is instrumental to create culture change is addressing stigma. Despite advancement in scientific research that determines addiction as a brain disorder and not a moral weakness, ingrained stigmatizing attitudes toward people addicted to drugs still propagate throughout society. Health care professionals are hardly immune to negative beliefs and may not have had ample opportunities to self-challenge them. Negative attitudes can be heightened by the number of people presenting at the ED with overdoses, especially those who cycle in and out in high frequency. In a recent article, Erin Winstanley explores the concept of opioid-related compassion fatigue and its links to reinforcing stigma.[4][5]

In light of the prevailing conditions in EDs that may reinforce or exacerbate existing stigma, adding peers to the ED workforce has proved to be a significant counterweight. Several of the expert panelists representing the peer workforce spoke of instances when they were able to educate medical staff – both by setting an example through their lived experience and seizing teachable moments – on issues related to addiction, recovery and harm reduction. In many cases, the way that peer workers engaged with patients that both normalized their medical condition and heightened the individual's sense of humanity exemplified this concept.

[5] Winstanley, E. L. (2020). The Bell Tolls for Thee & Thine: Compassion Fatigue & the Overdose Epidemic. *International Journal of Drug Policy*.

Field example: RWJBaranabas Health

The RWJBaranabas Health Peer Recovery Program (PRP) provides 24/7 peer recovery support to individuals with SUD, specifically OUD, in EDs and hospital inpatient settings across a network of hospitals in New Jersey.

Key positions within the PRP program include:[46]

- Recovery specialists: Provide bedside intervention and peer recovery support.
- Patient navigators: Link an individual to the appropriate level of care after the individual agrees to enter into treatment.
- Case managers: Conduct a needs assessment with the individual to identify wellness needs, create a comprehensive case management plan and coordinate with community agencies to address any needs that arise. Case managers work in conjunction with recovery specialists to support long-term recovery and overall wellness.
- Recovery support educators: Plan, develop, implement and evaluate education and training on the PRP.

4. IDENTIFY TEAM MEMBERS

Teams of peer-based programs in ED settings vary across the country; however, all teams include at least one x-waivered prescriber and a peer worker. Many teams are partnerships between hospital ED staff and community-based peer providers, but some teams are employed fully by the hospital. Furthermore, while there may be a designated team related to the integration of peer support within the ED, it is important that all ED staff are aware of and support the project.

5. ESTABLISH WORKING RELATIONSHIP BETWEEN EDS AND RECOVERY COMMUNITY ORGANIZATIONS

Because one size never fits all, there is a diversity of staffing and supervisory models among ED-based peer initiatives. One model highlights collaboration between a recovery community organization (RCO) and the hospital. In this case, peer workers are hired and supervised by the RCO, either located onsite within the ED or at an RCO and dispatched to the ED upon receiving an alert. In an alternate model, peer workers are directly employed by the hospital, working onsite as ED staff, with little or no connection with the organized recovery community. While this model may initially be easier to implement and enjoy certain efficiencies of having everything in one system and under one roof, it bypasses the potential of rich collaboration between the hospital and the community it serves. Building partnerships between institutions and community organizations takes resources and time, but the dividends over time have proven to be enormous.

For example, some programs have found partnering with RCOs beneficial because of their capacity to provide adequate and appropriate supervision, training and guidance to peer workers. Additionally, RCOs are often viewed as trusted organizations among individuals with OUD with strong connections to other community-based services and treatment providers. Finally, RCOs can serve as a guidepost to EDs in transforming to a trauma-informed and recovery-oriented environmental culture.

[46] RWJBaranabas Health. (2020). Peer Recovery Program. Retrieved from https://www.rwjbh.org/treatment-care/mental-health-and-behavioral-health/mental-health-services/institute-for-prevention-and-recovery/programs/peer-recovery-program/

Staffing Considerations

Hospitals should consider the following questions when determining whether to directly hire peer workers or partner with a recovery community organization:

- How will the peer worker receive training?
- Who will provide supervision to the peer worker?
- Will there be other peer workers on staff to provide mutual support?
- Where will the peer worker be physically located?
- How will the peer worker become notified when an eligible patient is admitted to the ED?
- Who will make patients aware of the availability of peer services?
- How will patients be engaged in treatment, recovery support services and ongoing contact after the initial referral and after discharge from the ED?

6. DEVELOP A SHARED LANGUAGE

ED providers and administrators often speak a different language than peer workers and community organizations. When developing the core project team, it is important that everyone is speaking the same language. For example, ED providers and staff may use terms that are outdated and stigmatizing toward people who use drugs and/or have SUDs. Additionally, team members may use different acronyms that are not well understood or known to everyone on the team. Practical tools, such a glossary of terms and acronyms, can be helpful to ensure everyone is on the same page. Agreeing to use person-first, non-stigmatizing language will also help build trust and respect among project team members and with clients. Table 3 provides a quick guide to person-first and non-stigmatizing language. The Philadelphia Department of Behavioral Health and Intellectual Disability Services offers expanded resources and information in its Person First Guidelines.

TABLE 3. PERSON-FIRST LANGUAGE[47,48]

USE THIS	NOT THAT
Person with substance use disorder	Addict, drug abuser
Person with alcohol use disorder	Alcoholic
Substance use disorder	Drug problem, drug habit
Drug use	Drug abuse
Not actively using	Clean
Actively using	Dirty
Testing negative for substance use	A clean drug screen
Testing positive for substance use	A dirty drug screen
Person in recovery, person in long-term recovery	Former addict
Medications for addiction treatment, medications for opioid use disorder	Drug replacement therapy
Return to use	Relapse
Not ready to engage, chooses not to have treatment	Non-compliant

[47] Philadelphia Department of Behavioral Health and Intellectual disAbility Services. (2019, January). Person First Guidelines. Retrieved from https://dbhids.org/wp-content/uploads/2015/09/Person-First-Initiative-Guidelines.pdf

[48] Shatterproof. (2020). Stigma-reducing language. Retrieved from https://www.shatterproof.org/about-addiction/stigma/stigma-reducing-language

7. PROVIDE ORIENTATION, TRAINING AND SUPERVISION

ED staff and peer workers often approach treatment and recovery from differing perspectives. Therefore, it is critical for both groups to not only understand the work that the other does, but also recognize its value in the recovery process. In the ED, staff should learn the recovery principles and role that peer workers play in promoting recovery. Similarly, peer workers should understand and adhere to the procedures of the ED. By establishing clear roles and responsibilities, providing appropriate training and setting necessary boundaries, ED staff and peer workers can more effectively work together to integrate treatment and services.

Field Example: Connecticut Community for Addiction Recovery

Recently, specialized training was developed for peer workers within ED settings. The Connecticut Community for Addiction Recovery (CCAR) offers a 12 CEU supplemental training for ED-based recovery coaches focused on the following learning objectives:[49]

- Describe the roles and functions of the recovery coach working in an ED.
- Understand and practice "staying in your lane."
- Develop skills to advocate and educate staff, patients and others to demonstrate accountability in the role.
- Use motivational interviewing to bring people through the stages of change into recovery.
- Further develop the art of recovery coaching.

Field example: AnchorED

AnchorED, a peer-based overdose response program, is a partnership between Anchor Recovery Community Center and every hospital ED throughout Rhode Island. AnchorED's certified peer recovery specialists receive mandatory supervision from AnchorED peer supervisors twice monthly and check-ins during and after their shifts.50 Additional supervision is provided as needed.51 AnchorED peer workers are trained on the following guidelines to guide their practice and presence within ED settings:

- The same rules apply working in the ED as at the RCO.
- Make no disclosures without a written consent.
- Be respectful of ED staff.
- Know you are a visitor in the ED territory.
- Do not be afraid to ask for help.
- Know your limits.

[49] Connecticut Community for Addiction Recovery (CCAR). (2020). Recovery coaching in the emergency room. Retrieved from https://addictionrecoverytraining.org/recovery-coaching-in-the-emergency-room/

[51] Joyce, T. F. & Bailey, B. (n.d.). Supporting recovery in acute care and emergency settings.

[52] Ibid.

8. ESTABLISH PROTOCOLS AND WORKFLOWS

To establish a buprenorphine induction program in the ED, adhere to a sequence of steps to adhere to the Drug Addiction and Treatment Act of 2000 (DATA 2000) and guidance from SAMHSA. Physicians, physician assistants and nurse practitioners must undergo x-waiver training to prescribe buprenorphine and protocols should be put in place to identify an appropriate, individualized and comprehensive treatment plan for each patient. In addition to medical considerations, develop a workflow that will ensure peer recovery services integration in the treatment plan. The use of technology can be instrumental in coordinating and integrating services in the ED, as well as conducting follow-up with individuals in the community.

Use of Technology

Technology plays an important role in many ED-based peer programs. For example, some programs use a HIPAA-compliant text referral app to notify peer workers when there is a patient in the ED for them to see, while other programs use their electronic health record (EHR) system to alert peer workers. It is important to develop and put in place protocols related to the use of technology and access to electronic information to ensure programs are following state and federal confidentiality and privacy regulations. Provide training to peers on the use of technology, as many peer workers may be unfamiliar with existing EHR systems or other forms of health information technology.

Due to the COVID-19 pandemic and subsequent economic shutdowns, the U.S. has seen a significant increase in emotional distress and crisis service utilization.[52] Moreover, preliminary reports indicate that opioid overdoses are continuing to surge.[53] EDs have also seen a decrease in utilization for non-COVID-19 related emergencies. People with SUDs and other behavioral health needs have been reluctant to seek in-person services. In response to these concerns, some states and the federal government have temporarily relaxed several rules and regulations related to the use and delivery of MOUD and provision of behavioral support services. Some examples include increased use and availability of telehealth services, additional "take-home" doses of methadone and home delivery of MOUD. These changes have highlighted the continual need to think more creatively and use technology to better engage and connect people with OUD with the critical prevention, treatment and harm reduction services they need.

Field Example: RWJBarnabas Health

In 2019, RWJBarnabas Health implemented an automatic referral system within its EHR system at eight hospitals in its health care system and placed referrals through a non-physician order or automatically based on criteria set in the EHR. In the first month following implementation, deployments increased by 34% in hospitals with the automatic referral system, compared to 9.6% in hospitals without the system.[54]

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[52] Hoffman, J. (2020, March 26). With Meetings Banned, Millions Struggle to Stay Sober on Their Own. *The New York Times*. Retrieved from https://www.nytimes.com/2020/03/26/health/coronavirus-alcoholics-drugs-online.html

[53] Briquelet, K. (2020, May 4). Authorities nationwide are reporting an uptick in fatal opioid overdoses during social distancing. *The Daily Beast*. Retrieved from https://www.thedailybeast.com/opioid-deaths-surge-during-coronavirus-in-americas-overdose-capitals

[54] RWJBarnabas Health, Institute for Prevention and Recovery. (2020). Peer Recovery Program 2019 Yearly Report January 1-December 31, 2019.

9. PROVIDE LINKAGES TO COMMUNITY-BASED SERVICES

While EDs provide an opportunity to reduce overdose death and initiate buprenorphine induction, the short duration of stay necessitates establishing linkages to community-based services to improve treatment retention upon release. In addition to partnering with outpatient clinics and community prescribers to ensure medication continuity, peer workers serve an important role connecting individuals to services in the community, including harm reduction and social services, which increase the likelihood of sustaining life and long-term recovery.

Linkages to Community Treatment

Following buprenorphine induction in the ED, connect individuals to community treatment providers to ensure medication continuity. This requires EDs to identify and establish relationships with outpatient clinics, community treatment centers and pharmacies who are qualified prescribers. When possible, it is best to refer individuals to prescribers whose attitudes and perceptions toward addiction treatment are recovery-oriented to provide a supportive care team in the community.

Integrating ongoing peer services at discharge is critical, as peer workers can support individuals in and outside of the ED. It is often a frightening experience to wake up in the ED following an overdose and peer workers can provide grounding and orientation, comfort and support. Because of their lived experience, a connection of trust can be established almost instantly, enabling the peer worker to advocate with the medical care team. In addition to meeting with individuals in the ED, peer workers may serve in a variety of other activities, ranging from follow-up calls to accompanying individuals to initial appointments.

Key Partnerships

Outside of treatment providers, EDs should establish partnerships with other types of services in the community that can support and promote long-term recovery. Examples of important partners include harm reduction services, recovery community organizations, social services and primary care.

Providing harm reduction supplies or connecting to harm reduction services in the community is critical following discharge from the ED, regardless of whether they were inducted on buprenorphine. Low threshold buprenorphine induction is also available at many harm reduction sites. Supplies like naloxone kits are lifesaving and should be given to every individual returning to the community. Harm reduction organizations may also offer syringe services programs (SSPs) for individuals who continue to use to help minimize the risk of infectious diseases like HIV and hepatitis C, or they may simply offer food, shelter and a clean bathroom. Because harm reduction seeks to minimize the harmful effects associated with substance use, it is important for these individuals to have access to services that promote their safety and wellbeing.

Recovery community organizations provide a variety of recovery-oriented activities, education and outreach and other support services. These peer-led organizations offer recovery support and provide individuals with recovery community resources that can help them engage in long-term recovery.

Another partnership to consider is first responders. Over the past several years, police departments across the country have implemented pre-arrest diversion and deflection programs to direct individuals to appropriate mental health or substance use care in lieu of arrest and incarceration. EDs are often the first point of contact for jurisdictions that divert individuals to treatment, providing an opportunity for EDs to help establish protocols to support individuals while avoiding further criminal justice involvement.

10. COLLECT DATA AND OUTCOMES TO SUSTAIN THE PROGRAM

Data collection and evaluation is essential to any new program's sustainability and to inform quality improvement. Programs should develop evaluation plans early in the planning process. Evaluation plans should be inclusive of all project partners and should reflect realistic and feasible data sources, data collection methods and data analysis capabilities. Table 4 describes common evaluation metrics for consideration.

TABLE 4. COMMON PROGRAM EVALUATION METRICS

PROCESS MEASURES	OUTCOMES MEASURES
Initial engagement	Engagement past first visit
Number of staff trained on addiction concepts	Follow-up rates at 6 and 12 months
Number of x-waivered ED staff	Changes in knowledge, beliefs and practice
Number of peers providing services	Number of people returning to the ED
Number of people receiving naloxone upon discharge	Engagement with peer workers
Number of ED staff prescribing 72-hour doses	Engagement in community-based services
Number of community partners	

Field Example: RWJBarnabas Health

RWJBarnabas Health is collecting and monitoring a wide range of process and outcomes data related to its Peer Recovery Program (PRP). Program process measures include:[55]

- Number of peer support deployments
- Number of naloxone deployments
- Number of follow-up interactions
- Deployment location
- Average deployments by day of the week
- Deployments by time of day
- Number of individuals who accepted referrals to levels of care
- Types of accepted referrals to levels of care
- Type of follow-up activities conducted

Program outcome measures tracked include percent of individuals in recovery at three, six, nine and 12 months post-deployment.56

In addition to metrics directly related to peer recovery services, the PRP team began assessing, documenting and addressing individuals' social determinants of health. Recovery specialists and patient navigators screen all patients for social determinants of health, including housing, transportation, education, employment, financial resources and support systems. Through this data collection, program managers learned that nearly 40% of individuals served did not have access to transportation in 2019 and 15% were homeless.[57]

[55] RWJBarnabas Health, Institute for Prevention and Recovery. (2020). Peer Recovery Program 2019 Yearly Report January 1-December 31, 2019.

[56] Ibid.

[57] Ibid.

Financing

One of the biggest barriers to implementing these programs is sustainable funding. While there are many national funding opportunities available for opioid-related programs, many of them are short-term grant programs. Most notable and recent funding has been through the Opioid State Targeted Response (STR) grants made available through the 21st Century Cures Act, routed through SAMHSA to the states. While these are instrumental in seeding pilot programs, there is little to no assurance that the programs, once up and running, will have dedicated funding to continue. Also, as hospital administrators have had less experience with addiction-specific funders, it may take time to develop ongoing collegial relationships. Additionally, because of the myriad of services that must be provided to the community, efficiency and cost containment are priorities, especially for rural hospitals and EDs.

In states that have opted for Medicaid expansion through the Affordable Care Act, reimbursement options are available. For example, in its 2019 report, RWJBarnabas Health cites the total patients eligible for Medicaid at 42%, Medicare at 10% and private insurance at 13%.[58]

EDs need to initiate a financial analysis to successfully sustain their programs that includes the following elements:

- Staffing/partnership cost
- Medication and supply cost
- Any additional training and education cost
- Analysis of services and available billing codes
- Available grants, contracts and cooperative agreements
- Cost-savings analysis

Hospitals and EDs should consider other means of financial sustainability, such as Medicaid 1115 waivers and State Plan Amendments if applicable. As health care continues towards outcome-based reimbursement models, organizations should be mindful to collect data that tracks outcomes and improvements that their peer support programs offer.[59]

Field Example: The State of Nevada and Foundation for Recovery

Nevada used STR funds to create Integrated Opioid Treatment and Recovery Centers based on the hub and spoke model, which originated in Vermont. The recovery centers were required to provide mobile recovery units to conduct services such as outreach and engagement, which included ED partnerships. Patients identified for services included those presenting in the ED with opioid overdose and anyone presenting with an OUD diagnosis. All peer workers have lived experience in recovery from substance use and each recovery center has specific requirements for the peers to receive certification through Foundation for Recovery or the International Certification and Reciprocity Consortium.[60]

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[58] Ibid.

[59] Earheart, J. & Crisanti, A. S. (2019, December). Peer Support Workers in the ED: A Report. Prepared by the Division of Community Behavioral Health, Department of Psychiatry and Behavioral Sciences, University of New Mexico.

[60] Ibid.

11. DEVELOP A STRATEGY TO INCREASE X-WAIVERED PRESCRIBERS IN THE PROGRAM

One barrier to increased access to MOUD within EDs is a lack of x-waivered ED providers. Hospitals and other health care settings have implemented incentive programs and mandates, including monetary incentives and paid time off for training, to increase the number of x-waivered staff. The University of Pennsylvania's hospital system offered ED physicians within three of its academic EDs a six-week financial incentive of $750 for obtaining an x-waiver to prescribe buprenorphine. Participants also received a $199 reimbursement for the cost of an x-waiver training course. The financial incentive program increased the number of waivered physicians from 6% to 90% and a total of 89% of eligible physicians completed the x-waiver training. Furthermore, buprenorphine prescribing rates increased 15% during the first four months of the program.[61]

Field Example: Get Waivered! Campaign at Massachusetts General Hospital

Citing the paucity (7%) of x-waivered emergency physicians in EDs across the country, Massachusetts General Hospital (Mass General) has launched the Get Waivered! campaign. Mass General was among the first hospitals in the nation to implement an ED-initiated buprenorphine protocol. The national campaign features a three-tiered approach: 1) strategies and incentives to increase x-waivered prescribers in EDs, 2) helping to develop ED-initiated buprenorphine protocols and 3) closing the gap between becoming x-waivered and actually prescribing by using non-financial incentives.62

Additionally, the Providers Clinical Support System (PCSS) is a program funded by SAMHSA in response to the opioid overdose epidemic to train primary care providers in the evidence-based prevention and treatment of OUD and treatment of chronic pain. The MAT eight-hour waiver training is offered at no cost through the PCSS web portal.[63]

[61] Foster, S. D., Lee, K. Edwards, C. Pelullo, A. P., Khatri, U. G., Lowenstein, M., & Perrone, J. (2020). Providing Incentive for Emergency Physician X-Waiver Training: An Evaluation of Program Success and Postintervention Buprenorphine Prescribing. *Annals of Emergency Medicine*, 76(2).

[62] Center for Innovation in Digital HealthCare. (2020). Get Waivered. Retrieved from https://getwaivered.com/

[63] Providers Clinical Support System. (2020). Retrieved from https://pcssnow.org/

Summary

By their very nature and location in the community, EDs continue to be vital to addressing the multiple factors present in the overdose crisis. The high number of patients presenting at EDs with or surviving overdoses offers opportunities for innovative practices to take hold and grow. One of these has been the flourishing of peer coaches working in ED environments. This began in Rhode Island in 2014, as Anchor Recovery Center deployed a roster of trained peer coaches to an ED setting. The burgeoning program, AnchorED, took root and was replicated in many other states and localities. The idea to make a solid recovery connection with someone who presented with an overdose before they left the ED not only made sense, it also worked. The second innovative practice involved the offering of buprenorphine on the spot from an x-waivered prescriber to a patient presenting with an overdose. The potential induction of buprenorphine as a stabilizer was just a beginning, often acting as an initial vehicle to any combination of specialty treatment, harm reduction services, recovery support and other health and social services.

As these two separate interventions became trends, it seemed logical to bring them together in a synergistic way. Bringing peer workers and prescribers together as components of a care coordination team allows elements of relationship, engagement and medical care to move beyond merely coexisting and towards a holistic approach that could prove to have a lasting effect on patients. The two approaches are ready-made for collaboration and synthesis in a singular but multi-faceted intervention that acknowledges the urgency of a crisis moment, moves toward stabilization and follows the patient from hospital to community with an arsenal of resources.

Bringing diverse cultures is never simple and requires a thoughtful process. Practices involving peer workers and practices involving medical professionals can be as different as night and day. However, it is a mistake to see them as oppositional, especially when combining them can have significant impact on patients receiving care. Each of our expert panelists has demonstrated that with focused attention and an eye toward practical solutions, any cultural differences between medical professionals and peer workers can be resolved for the greater good. The bottom line is that during the brief time a person presenting with an overdose is physically at the ED, there is a window of opportunity to engage before they are out the door. This requires a concerted team effort to avoid another missed opportunity and potentially save someone's life from a future overdose.

Finally, as witnessed from several of the expert panelists, this hybrid model of peer workers and medical professionals can lead to significant cultural transformation in ED environments. While ED settings by their nature will always be driven by crisis and efficiency, this does not mean that they must be traumatizing or devoid of compassion. Patients presenting with overdoses have already absorbed a litany of traumatic experiences before coming to the ED. Labeling, blame and shame only add to an already negative experience. The opportunity to develop new attitudes toward these patients, demonstrated first by peer workers and picked up by other staff, can move the work culture to one that is trauma-informed and recovery-oriented. If initiating this culture shift has already shown an impact on patients who present with an overdose, imagine what effect it can have on other patients, staff and administrators.

Appendix A. Technical Expert Panel Agenda and Participant List

WEDNESDAY, JANUARY 22, 2020	
8:30am-9:00am	Registration and welcome
9:00am-9:05am	Brief overview of agenda
9:05am-9:10am	Opening remarks and NC staff introduction
9:10am-9:20am	Recovery-oriented systems of care overview
9:20am-9:40am	Environmental scan findings
9:40am-9:45am	Overview of meeting goals and agenda
9:45am-10:30am	Introductions and overview of participant programs (part 1) • **Please be prepared to take 3 min to share:** What is the one thing that keeps you up at night about the sustainability of your project?
10:30am-10:45am	Break
10:45am-11:45am	Introductions and overview of participant programs (part 2) • **Please be prepared to take 3 min to share:** What is the one thing that keeps you up at night about the sustainability of your project?
11:45am-12:45pm	Lunch
12:45pm-1:00pm	Mapping exercise: current state
1:00pm-1:15pm	Current state report out
1:15pm-2:00pm	Promising and best strategies to reach ideal state: workforce and training
2:00pm-2:45pm	Large group report out and discussion
2:45pm-3:00pm	Break
3:00pm-3:30pm	Mapping exercise: ideal state
3:30pm-3:55pm	Ideal state report out
3:55pm-4:00pm	Day one wrap-up
THURSDAY, JANUARY 23, 2020	
8:30am-9:00am	Welcome
9:00am-9:15am	Brief recap of first day's findings
9:15am-10:00am	Promising and best strategies to reach ideal state: coordination and integration of peers in ED settings
10:00am-10:45am	Large group report out and discussion
10:45am-11:15am	Break
11:15am-12:30pm	Recommendations for action and prioritization
12:30pm-1:00pm	Wrap up and next steps

EXPERT PANEL PARTICIPANTS

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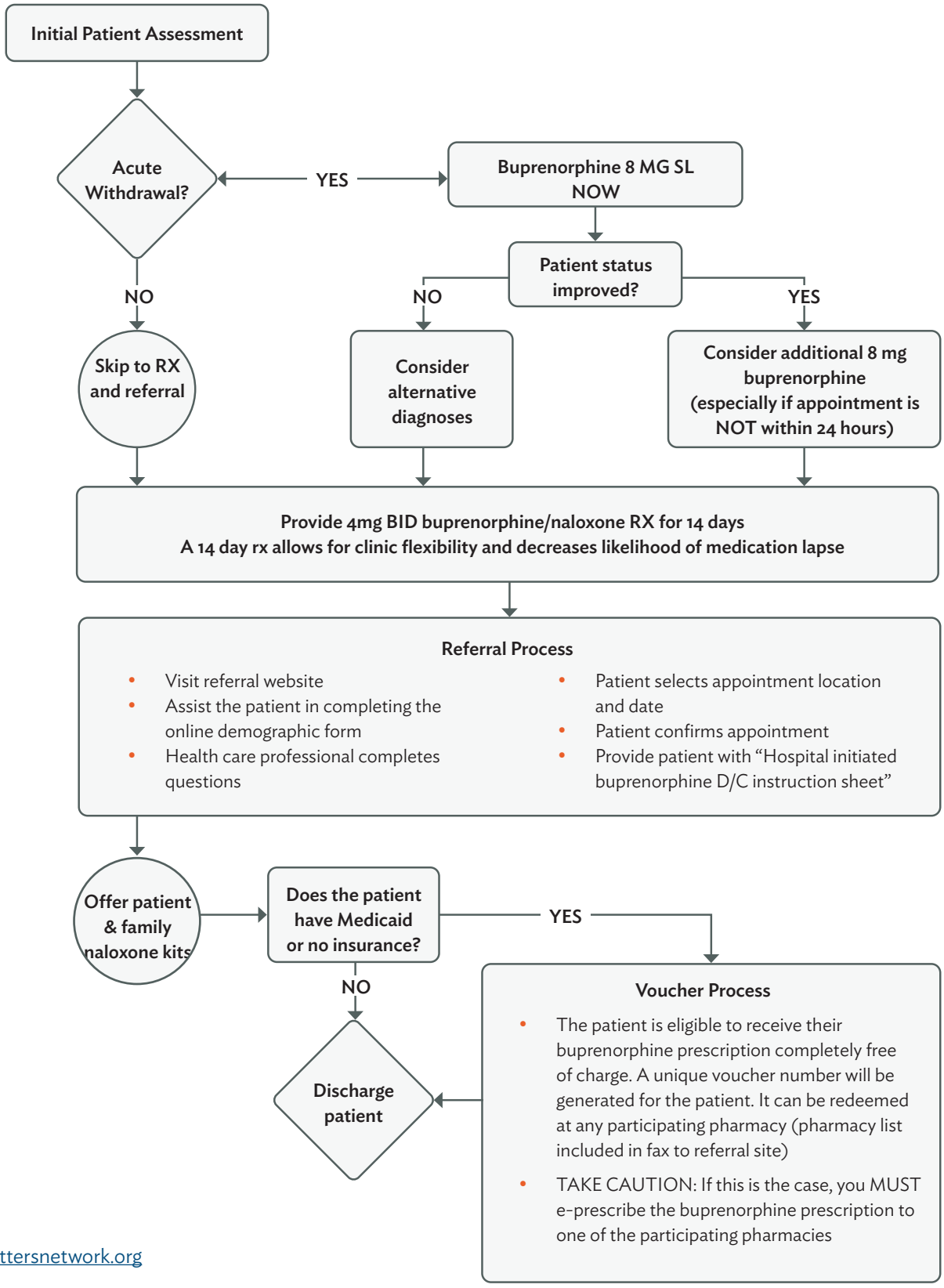
Dana Lange, MS
Project Manager

Appendix B. Workflow Examples

New York MATTERS (Medication Assisted Treatment and Emergency Referrals) patient induction workflow.



https://mattersnetwork.org

Appendix C. Model Examples

RWJBARNABAS HEALTH

The RWJBarnabas Peer Recovery Program provides recovery support to individuals with SUD presenting in EDs and other hospital departments within the RWJBarnabas Health hospital network across New Jersey. Peer recovery specialists are available to individuals 24 hours a day, seven days a week. Funding from the New Jersey Department of Health, Division of Mental Health and Addiction Services supports recovery specialists who are employed full-time and based in hospitals.[64]

In 2019, PRP recovery specialists were deployed to patient bedsides 18,586 times and PRP staff conducted 116,698 instances of follow-up with individuals. Nearly 75% of deployments occurred in the ED. A total of 3,179 individuals accepted referrals to levels of care either at the bedside or during follow-up. The most common type of referral accepted was withdrawal management (n=1,249), followed by outpatient (n=720). Follow-up interactions were primarily through telephone calls (n=102,304), but also occurred through face-to-face contact (n=14,002).[65] The PRP staff tracked outcomes by assessing the number of individuals in recovery at three, six, nine and 12 months post-deployment. In 2019, 6.4% of individuals contacted at three months post-deployment were in recovery and 3% reported being in recovery at 12 months post-deployment. The average percentage of individuals who were in recovery across the 12-month follow-up period was 5.2%.[66]

The program experienced a 38% increase in deployments in the second half of 2019 due to the implementation of an automatic referral system for recovery support services in eight participating hospitals. Referrals are placed through a non-physician order or automatically based on certain criteria in the electronic health record.

CA BRIDGE

The CA BRIDGE model has been implemented in multiple sites across California to provide SUD treatment in acute care settings. The model focuses on three main pillars:[67]

1. **Treatment:** Ensuring evidence-based SUD treatment, including MOUD, is accessible in the ED settings and in all hospital departments. Treatment is provided rapidly, on the same day and efficiently to respond to patient needs. Providers use a harm reduction approach to put patient needs at the center of the treatment plan.
2. **Culture:** The hospital culture is welcoming and does not stigmatize substance use. The hospital uses signage, flyers, pamphlets, videos and other tools to invite individuals to disclose their substance use. The hospital staff use non-stigmatizing language. One or more staff has the time and skills to engage with patients and motivate them to engage in treatment.
3. **Connection:** Linkages to ongoing care involve active support and follow-up with patients. Hospitals have at least one community provider that accepts referrals within 72 hours. Staff assist patients with follow-up and accessing outpatient treatment. Hospital staff conduct outreach to individuals who use drugs to build trust, recruit patients, offer harm reduction services and get input from the community.

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[64] RWJBaranabas Health. (2020). Peer Recovery Program. Retrieved from https://www.rwjbh.org/treatment-care/mental-health-and-behavioral-health/mental-health-services/institute-for-prevention-and-recovery/programs/peer-recovery-program/

[65] RWJBarnabas Health, Institute for Prevention and Recovery. (2020). Peer Recovery Program 2019 Yearly Report January 1-December 31, 2019.

[66] Ibid.

[67] CA BRIDGE. (2020). The CA BRIDGE Model. Retrieved from https://www.bridgetotreatment.org/cabridgeprogram

The CA BRIDGE model sites employ substance use navigators (SUNs) to assist patients with SUDs, including patients who have been prescribed MOUD. While the CA BRIDGE SUNs are not explicitly peer roles, people with lived experience, including peer workers, could be employed as SUNs. Typical roles and responsibilities of SUNs include:[68]

- Conducting brief initial assessments.
- Introducing patients to treatment programs, including MOUD programs.
- Expediting appointments in the community for MOUD and follow-up services.
- Coaching clients.
- Maintaining ongoing contact with clients.
- Helping clients access community services, including financial counseling, primary care, mental health services, social services and residential treatment facilities.

Within the CA BRIDGE model, SUNs are not required to have any specific degree, certification or training requirement. SUNs are employed by hospitals, health systems, staffing groups and clinics and are employed as full-time, part-time, contract and per diem employees within the CA BRIDGE network. Supervision models for SUNs vary by site and include:

- Nurse manager as direct manager and manager of activities, such as hiring and administrative duties with an ED champion who co-supervises day-to-day activities.
- Staffing group manages hiring and administrative duties with the county department of public health program manager providing day-to-day supervision.
- ED clinical team member provides supervision supported by grant funding.
- SUN is embedded into existing teams, including case management or social work.

A sample SUN job description is available in Appendix E.

RELAY, NEW YORK CITY

Housed in the New York City Department of Health, the Relay program provides 24/7 peer-based overdose response services to individuals and family members presenting to hospital EDs. Relay's Wellness Advocates offer a range of peer-based services and supports including overdose risk counseling, naloxone education and distribution and linkages to critical services, such as food and shelter. Wellness Advocates also provide follow-up and support for 90 days following hospital discharge. The Relay program is part of the City of New York's Mayor's initiative, HealingNYC, and is funded by the City.[69]

Between June 2017 and December 2018, Relay enrolled 649 eligible individuals into services from seven participating EDs in New York City. Forty-seven percent of participants were contacted within 48 hours after discharge and 33% were contacted during the 90-day check-in compared to 36% at 30 days. Wellness Advocates distributed 1,007 naloxone kits to 827 unique participants, nonparticipants and family/social supports. Among referrals to care and services, 165 accepted referrals to harm reduction services, 104 accepted referrals to MOUD, 72 accepted referrals for outpatient SUD treatment and 62 accepted referrals for inpatient SUD treatment.[70]

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[68] CA BRIDGE. (2019, November). Frequently Asked Questions, Substance Use Navigator (SUN). Retrieved from https://www.bridgetotreatment.org/cabridgeprogram

[69] NYC Health. (2019, May 20). Health Department Expands Lifesaving Opioid Overdose Response Program That Links Overdose Survivors With Peer Advocates. Retrieved from https://www1.nyc.gov/site/doh/about/press/pr2019/health-department-expands-opioid-overdose-program.page

[70] Welch, A. E., Jeffers, A., Allen, B., Paone, D., & Kunins, H. V. (2019). Relay: A Peer-Delivered Emergency Department-Based Response to Nonfatal Opioid Overdose. *American Journal of Public Health*, 109(10), 1392-1395

PENN MEDICINE CENTER FOR OPIOID RECOVERY AND ENGAGEMENT (CORE)

CORE provides comprehensive peer support services to individuals who experienced an overdose or who have OUD presenting to three hospitals in Philadelphia, Pennsylvania. A team of three certified recovery specialists work with a team of ED physicians, administrators, care coordinators and program managers to deliver peer support and personalized recovery services to individuals.[71]

INDIANA RECOVERY COACH AND PEER SUPPORT INITIATIVE (RCS)

RCS was supported by STR funding to provide peer support to individuals who experienced an overdose. Patients are identified for services if they are admitted to the ED and are identified as having an opioid-related issue by staff. Peer workers must either be a state certified peer recovery coach with: 1) lived experience in SUD recovery or 2) be a family member of someone with a SUD.[72]

NEVADA

Nevada used STR funds to create Integrated Opioid Treatment and Recovery Centers based on the hub and spoke model, which originated in Vermont. The recovery centers must provide mobile recovery units to conduct services such as outreach and engagement, which included ED partnerships. Patients identified for services included those presenting in the ED with opioid overdose and anyone presenting with an OUD diagnosis. All peers have lived experience in recovery from substance use and each recovery center has specific requirements for the peers to receive certification through Foundation for Recovery or the International Certification and Reciprocity Consortium.[73]

NEW JERSEY

New Jersey established an opioid overdose response program in response to a gap between naloxone administration and OUD treatment admissions. Patients identified for services are individuals who experienced an opioid overdose, were administered naloxone and were transported to the ED. Requirements for peer workers within the program are that they have at least two years of either 1) lived experience in recovery or 2) experience with a family member or loved one in recovery. Peers must also attend three days of ethics training which includes peer role functions, competencies, responsibilities and orientation to other statewide treatment initiatives.[74]

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[71] Penn Medicine. (2020). Center for Opioid Recovery and Engagement (CORE). Retrieved from https://www.pennmedicine.org/for-patients-and-visitors/find-a-program-or-service/behavioral-health/addiction-services/center-for-opioid-recovery-and-engagement

[72] McGuire, A. B., Powell, K. G., Treitler, P. C., Wagner, K. D., Smith, K. P., Cooperman, N., . . . Watson, D. P. (2020). Emergency department-based peer support for opioid use disorder: Emergent functions and forms. *Journal of Substance Abuse Treatment*, 108, 82-87.

[73] Ibid.

[74] Ibid.

Appendix D. Resources and Tools

TITLE	SOURCE	DESCRIPTION	TARGET AUDIENCE
MAT WAIVER TRAINING			
MAT Waiver Training (2020)	Providers Clinical Support System (PCSS)	Offers free training for obtaining an x-waiver to prescribe buprenorphine.	Physicians, physician assistants, nurse practitioners
BUPRENORPHINE PRESCRIBING IN THE ED			
Initiating Opioid Treatment in the Emergency Department (ED) Frequently Asked Questions (FAQs) (n.d.)	American College of Emergency Physicians (ACEP)	Provides answers to a list of FAQs related to initiating buprenorphine in ED settings.	ED physicians, physician assistants, advanced practice nurses, ED administrators
BUPE: Buprenorphine use in the emergency department tool (2020)	ACEP and American Society of Addiction Medicine (ASAM)	Point of care tool that guides prescribers in the ED through initiating buprenorphine, utilizing naloxone and linking to treatment.	ED clinicians
Emergency Quality (E-QUAL) Network Opioid Initiative (2020)	ACEP	Provides tools and resources, including virtual trainings, recorded presentations, toolkits, podcasts and other materials, to assist ED providers with implementing evidence-based interventions for OUD.	ED clinicians, ED administrators
ED-initiated Buprenorphine Algorithm (n.d.)	ACEP	Flowchart for initiating buprenorphine in the ED.	ED clinicians, ED administrators
Resources Opioid Counseling in the Emergency Department (2017)	ACEP	Provides a list of resources related to counseling, screening, naloxone, public education, safe prescribing and chronic pain for ED professionals.	ED clinicians, ED administrators
Models for Addressing Transitions of Care for Patients with Opioid Use Disorder (2019)	ACEP	Describes models for transitioning care for individuals with OUD within ED.	ED clinicians, ED administrators, community health providers, project evaluators

TITLE	SOURCE	DESCRIPTION	TARGET AUDIENCE
INTEGRATING PEER RECOVERY SUPPORT SERVICES			
Peer Support Toolkit (2017)	Philadelphia Department of Behavioral Health and Intellectual disAbility Services	A comprehensive toolkit that guides organizations through planning and implementing peer support programs.	Organizational administrators; Program managers
Person First Guidelines (2019)	Philadelphia Department of Behavioral Health and Intellectual disAbility	Recommends person first language substitutions for existing commonly used stigmatizing terms.	Health care providers, administrators, program managers
Supervision of Peer Workers (n.d.)	SAMHSA Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS)	Two-page handout with an overview of supervising peer workers, including links to more in depth resources.	Peer worker supervisors, ED administrators, ED clinicians
Substance Use Disorder Peer Supervisor Competencies (n.d.)	The Regional Facilitation Center	Provides an overview of supervising peer workers, including a self-assessment and description of competencies.	Peer worker supervisors, ED administrators, ED clinicians
PATIENT EDUCATION MATERIALS			
Wait, Withdraw, Dose: Starting Buprenorphine (Bup), "Subs," Suboxone (n.d.)	CA BRIDGE	One-page educational handout for patients initiating buprenorphine at home.	Patients, family members, ED clinicians
Buprenorphine-Naloxone: What You Need to Know (2019)	CA BRIDGE	One-page handout for patients describing buprenorphine.	Patients, family members, ED clinicians
Decisions in Recovery: Treatment for Opioid Use Disorder (n.d.)	SAMHSA	Website that describes different types of MOUD to assist individuals in making decisions about their recovery. Offers tools, recorded videos and a handbook.	Patients, family members, ED clinicians,
Waiting room signage (n.d.)	CA BRIDGE	Example signage for ED waiting rooms for MOUD services.	Patients, family members, ED clinicians, ED administrators

Appendix E. Sample Job Descriptions

1. SUBSTANCE USE NAVIGATOR (SUN) (CA BRIDGE)[75]

[Also known as Treatment Navigator, Treatment Coordinator, Medication for Opioid Use Disorder Navigator (MOUD) Navigator, MAT Navigator, Patient Navigator, Linkage Coordinator, Care Coordinator, etc.]

The navigator is a care coordinator and an integral team member of a statewide initiative to improve access to MOUD. Navigators conduct initial brief assessments, introduce patients to MOUD programs and services, expedite appointments at MOUD-capable clinics, serve as the primary coach for their clients and maintain ongoing contact with their panel. They also assist with access to other services such as financial counseling, primary care, mental health services, social services and residential treatment facilities.

Job Overview

- Member of the ED-based or Bridge clinic-based MOUD team.
- Available scheduled hours, for example Monday-Friday, 9 a.m.-5 p.m., to approach patients once acutely stabilized to discuss the program and develop realistic individualized action plans for the patients.
- During after-hours (evening/weekend hours) is on call or has a robust referral mechanism in place to follow up with patients referred to patient navigator during this timeframe.
- Become versed in a variety of substance use treatment models, patterns of substance use, effects of intoxicants and withdrawal of various substances.
- Become versed in local and regional substance use treatment options and local harm reduction services.
- Develop expertise in insurance benefits and exclusions related to treatment.
- Initiate, develop and maintain constructive relationships with community MOUD treatment providers.
- Schedule follow-up appointments, offer additional resources, networks to help achieve sustained access to care.
- Establish relationship with patient and communicate via telephone, texting and/or email to remind patients of appointments, help patients navigate any obstacles to follow-up treatment and provide encouragement.
- Support patient to access the most optimal level of care available. If patient from out of county and needs to access MOUD in their home county, assist to connect with local resources in their home county.
- May have additional duties in a Bridge clinic depending on-site.

[75] CA BRIDGE. (2020). Resources, Substance Use Navigators (SUNs). Retrieved from https://www.bridgetotreatment.org/resources

Responsibilities, Skills, Knowledge, Abilities and Duties

- Communicate with hospital staff daily during weekdays to recruit patients and provide support to staff around MOUD: Monitor the ED and inpatient patient tracking systems to screen for eligible patients; checks in with ED and inpatient clinicians and nursing staff to screen for eligible patients.
- Communicate and interact with patients in a culturally competent and relatable way.
- Identify current PMD and behavioral health providers. Works to connects patient with existing MOUD treatment available at current PMD and/or behavioral health location if available unless patient prefers an alternate MOUD treatment location. Identify primary medical home if not secured.
- Maintain updated, in-depth knowledge of local and regional SUD treatment programs including capacity, insurance requirements and additional services provided at local and regional programs (benefits assistance, housing assistance, mental health, primary care, etc.).
- Develop positive working relationships with ED staff and community agencies.
- Assess and address any barriers to attending follow-up appointments (transportation, contact phone number availability for appointment reminders, shelter needs, etc.). Engage social services to assist with any of these issues as needed.
- Arrange transportation to nearby residential treatment facilities and partner programs.
- Assist with navigating barriers to patients obtaining buprenorphine prescription from pharmacy (insurance status, copay expense, cost differences between formulations, etc.). Routinely assist patients by having the patient and/or pharmacist call from the pharmacy to sort out encountered insurance barriers in real time.
- After discharge from ED or inpatient, on the day prior to follow-up appointment contact patients to remind them of their follow-up appointment.
- Ability to use computer information systems, computer literacy and knowledge of word processing.
- Collect data related to number of buprenorphine/methadone administrations, prescriptions and referrals to care.
- Engage in scheduled California Bridge coaching calls and navigator trainings.
- If applicable, additional responsibilities and duties at Bridge clinic as delineated by supervisor.

Qualifications

- Nonjudgmental, energetic, positive approach to assisting patients with SUD.
- Understanding of SUD as a medical condition and the role of MOUD in treatment and harm reduction. Adherence to an abstinence-based social model that is not supportive of MOUD is not aligned with the goals of this position.
- Interest/proficiency in working with individuals recently released from incarceration, homeless individuals and other marginalized populations.
- Able to interact with patients in a culturally relatable manner. Any additional ability to communicate in languages spoken in local community such as Spanish, Tagalog, Hmong, etc. helpful.
- Preference for applicants with connections to, and reflecting the diversity of, the local community.
- Respect for patient confidentiality and privacy.
- Excellent written and verbal communication skills.

There is no specific degree, certification or training requirement.

Why Work Here?

Great opportunity to have a profound impact on the lives of your patients and larger community, while working in a dynamic, energetic and supportive environment. Room for significant personal and professional growth.

The California Bridge program will assist with the training and support of all SUNs in many ways, including coaching calls and in-person trainings. Please plan to have your navigator (and ED/inpatient champions and other team members) attend these trainings.

2. ANCHORED, PEER RECOVERY SPECIALIST, PER DIEM[76]

Job Title: Per Diem Peer Recovery Specialist – ED

Division: Intermediate Services

Department: AnchorED Program

Reports To: Manager of AnchorED Program

SUMMARY: Provide on-call recovery coaching support services to patients and family members in the emergency departments of participating hospitals. When full- or part-time, this staff member is housed on Anchor Recovery Community Center and also supports a caseload of members as a recovery coach.

Job Responsibilities

- Provide on-call recovery coaching for patients/and family members. Provide education and referrals to patients and family members.
- Respond to dispatcher contact right away and follow through with protocol for hospital contact and travel time.
- Obtain all necessary releases of information as needed. Abide by all 42 CFR Part 2, HIPPA, federal and state confidentiality laws and TPC policies.
- Maintain positive and respectful communications with hospital staff, as guests in their system.
- Attend all trainings as assigned and maintain HealthStream trainings as per TPC policy.
- Additional duties and/or services as assigned.

To perform this job successfully, an individual must be able to perform each essential duty satisfactorily.

- Candidate must demonstrate an understanding and belief in the recovery process.
- Must be a person with lived recovery experience, with minimum 2 years of continuous recovery.
- Must be 21 years old or older.

Education and/or Experience: Associate degree or higher preferred. High school diploma or GED required. RI State certified recovery coach or plan to complete within first year. Understanding of community resources and recovery-oriented systems of care model.

[76] Anchor Recovery Community Center. (2020). Careers. Retrieved from https://anchorrecovery.org/careers/

Certificates, Licenses, Registrations: MUST have a valid driver's license, registration and proper auto insurance. (Provide a copy to your manager.)

Other Skills and Abilities: Knowledge of basic crisis intervention, motivational interviewing and some case management techniques required. Ability to act as an advocate for the needs of the parent is required.

Physical Demands: The physical demands described are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is regularly required to sit; use hands to finger, handle or feel objects, tools or controls; and talk or hear. The employee frequently is required to reach with hands and arms. The employee is occasionally required to stand; walk; climb or balance; and stoop, kneel, crouch, or crawl. The employee must occasionally lift and/or move up to 10 pounds. Specific vision abilities required by this job include close vision, distance vision, color vision, peripheral vision, depth perception and the ability to adjust focus.

Work Environment: The work environment characteristics described are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

EOE/F/M/Vet/Disabled