



NORTH CAROLINA
HEALTHCARE FOUNDATION



BUILDING THE CASE FOR EMERGENCY DEPARTMENT PEER SUPPORT

Implementation Guide



The North Carolina Healthcare Foundation

The North Carolina Healthcare Foundation, a 501(c)3 affiliate of the North Carolina Healthcare Association, leads efforts to connect hospitals, health systems, care providers and communities to improve health. Current initiatives address health innovation, behavioral health needs, rural health care improvements, the opioid epidemic, and access to health care.

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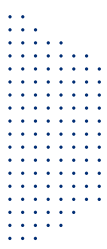
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BUILDING THE CASE FOR EMERGENCY DEPARTMENT PEER SUPPORT

Implementation Guide

The North Carolina Emergency Department (ED) Peer Support Program enables participating North Carolina hospitals to embed certified peer support specialists in their emergency departments to connect patients presenting with opioid overdose to treatment, recovery, resources and harm reduction supports. This guide is a tool for introducing an ED peer support program in a hospital setting.

This guide was produced by the North Carolina Healthcare Foundation with funding from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment and under a contract with the North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

Building the Case for ED Peer Support

Communities in Crisis

In communities across the country, hospitals have been on the front lines of the opioid epidemic acting as the safety net for patients using EDs as entry points for care. Hospital EDs are uniquely positioned to effectively alter the attitudes, and practices that define the culture of substance use disorders and their treatment. The opioid crisis has drawn much needed conversation and resources to substance use disorders and behavioral health disorders as a whole – chronic illnesses that are common and highly treatable.

THE OPIOID CRISIS AT A GLANCE

For real-time state and county level opioid surveillance data, please visit the NC DHHS Injury and Violence Prevention Branch Poisoning Data [webpage](#).



19.3 Million

adults experienced a substance use disorder in 2018



10.3 Million

with opioid use disorder in 2018



6,769 visits to NC

EDs in 2018 for opioid overdoses

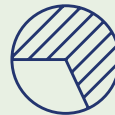


Nearly **5** North Carolinians died each day from an unintentional opioid overdose in 2018



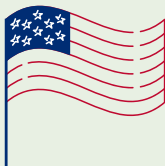
14,500+

North Carolinians died from an unintentional opioid overdose from 1999-2018



40-60%

is the relapse rates for substance use disorders similar to other chronic illness like diabetes, asthma, and hypertension



\$11 Billion

Opioid overdose is estimated to cost the U.S. Healthcare system \$11B annually – costs were across 100k patients with a combined 430k in ED visits, inpatient stays, and other medical services



2-3 times

Medical costs for treatment comorbid substance use disorder/mental illness and chronic illness is 2-3 times more costly than someone without a behavioral health condition



\$50K+

On average, one NC-based study found treatment for endocarditis patients exceeded \$50,000, with approximately 40% of those patients either Medicaid or uninsured



\$22 Million

During 2010-2015, hospital costs for SUD related endocarditis grew from \$1.1 to \$22 million

Click on the **bold number** to link to source.



Why Peers?

Our health is closely linked to areas of our life we don't think of as 'healthcare': where we live, what food we eat, and who's in our social network. For someone with a substance use disorder, virtually every aspect of their life - including some of the most crucial predictors of health - are negatively impacted and health outcomes are not equitable to their counterparts. Factor in the stigma and lack of treatment options, and you can see how individuals living with a substance use disorder have the deck stacked against them.

Peer support specialists (also commonly referred to as peer coaches or peer workers) use their lived experience in recovery to assist a patient in their own recovery journey. The evidence for peer support is growing, particularly within outcomes for patients with substance use disorder.¹ Certified to practice based on a set of core competencies, peers complement other treatment options, such as medication for opioid use disorder (MOUD), and improve the patients' engagement with treatment and treatment outcomes within the traditional treatment milieu.^{1,2} Hospitals, in an effort to provide more targeted treatment to patients with substance use, have begun embedding peers within the emergency department with promising results.³ However, there is still limited data on the effectiveness of peers within this setting, including patient outcomes and operational considerations for ED peers.

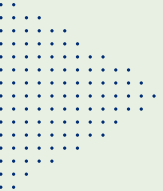
A certified peer support specialist in North Carolina:

- Commits to his/her own recovery
- Builds trust through empathetic listening and support
- Uses own personal story to provide hope and encouragement
- Supports patients as they navigate treatment, employment, housing, and relationships
- Equips patients with advocacy skills to use with their treatment team

The Peer Support Pilot Project

On May 9, 2018, the North Carolina Healthcare Foundation awarded six hospitals funding from the [North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services](#) to embed peer support specialists within their emergency departments. The ED peer support model was adapted from Wake Forest Baptist Medical Center and they served as a technical assistance provider for the pilot sites.

The pilot hospitals included Atrium Health Cabarrus* in Concord, Cone Health's Wesley Long Hospital in Greensboro, Novant Health Presbyterian Medical Center in Charlotte, Southeastern Health in Lumberton, UNC Medical Center in Chapel Hill and Wake Forest Baptist Medical Center in Winston-Salem. The pilot sites were selected through a competitive Request for Proposal (RFP) process and none of the site selected, aside from Wake Forest, had an established peer support program.



“Our peer support specialists have really become valuable members of the healthcare team. Their non-judgmental approach allows them to effectively connect with patients and show that there is hope and opportunity for recovery. They are helping us change many lives here in our community.”

Julie Ann Freischlag, MD
CEO of Wake Forest Baptist Medical Center
Dean of Wake Forest School of Medicine

Pilot Goals

- Engage with patients who are presenting to the ED with substance use disorder (SUD), particularly opioid use disorder
- Connect patients to community resources such as treatment, social service agencies, and harm reduction services
- Decrease future ED and inpatient utilization through ED-based peer services and warm handoff protocols
- Learn the benefits of peer support for patients and scale the model through systems change and policy reform

Hospital Requirements

- Hire two full-time certified peer support specialists
- Have an addiction medicine professional available for consult
- Demonstrate commitment from hospital leadership, including a physician lead for the project
- Outline sustainability for the continuation of the project after the grant funding
- Participate in all program meetings, including in-person learning sessions and site visits
- Submit program data to NCHF to evaluate pilot outcomes

*Site until October 2019.



“Certified peer support specialists are a key resource in turning the tide on the opioid crisis in our state. Peer support specialists are instrumental in connecting individuals battling the chronic disease of addiction to support services, including treatment and harm reduction.”

Mandy Cohen, MD, MPH
Secretary of North Carolina
Health and Human Services

Emergency physician Dr. Christopher “Crick” Watkins (center) confers with peer support specialists Terry Cox (right) and Bob Richardson at Wake Forest Baptist Medical Center. The North Carolina map (below) shows the site locations of the pilot project.



Policies and Practices to Prepare for Peer Support

Crafting hiring and retention strategies for the peer workforce in your hospital is a vital first step to create the firm foundation for peers to flourish. Pilot sites spent extensive time and energy with their human resources departments to create the job description and ensure eligible candidates were not screened out due to standard policies and practices. Given the preponderance of peer services in community-based settings, there are unique skillsets and training required for peers to be successful in a hospital setting.



KEY CONSIDERATIONS

- **Expect a lengthy process for hiring**, especially as your hospital is establishing a peer program. On average, it took most pilot sites 3-5 months to complete the hiring process.
- **Verify an applicant's certification** as a peer support specialist through the [NC Certified Peer Support Specialist Program](#), especially prior to onsite interviews.
- **Adjust hiring practices to reflect the criminalization of substance use disorder within our culture.** Attention must be given to ensure potential candidates are not screened out based on standard practices for hiring healthcare professionals. For example, certified peers may have criminal history that automatically disqualifies their application.
- **Diversify the peer team** with a mix of interpersonal styles, recovery duration, connectedness to community resources, and demographic factors mirrored in your community. A diverse peer workforce is valuable for building rapport with a range of patients experiencing SUD.
- **Peers should have access to the electronic health record (EHR)** by day one. This will be vital to their ability to screen potential patients.
- **Create clear policies and protocols for peers to engage in community-based work** between discharged patients and peers. This includes policies such as transporting patients and the percentage of time they should spend outside of the ED or on follow-up activities. These policies may be driven by the hospital administration - early attention to this is necessary in order to set up community work.
- **Build in flexibility to allow peers to engage in activities related to their own recovery** as needed. This can include leaving mid-day for a 12-step meeting.
- **Structure the peer role within an addiction medicine or behavioral health team**, ensuring regular supervision by a licensed behavioral health clinician. Ideally this would include creating a reporting structure where the administrative supervisor of the peer is a behavioral health clinician/provider.
- **Educate and support direct supervisors of peers** about hospital policies and procedures regarding supporting employees with a chronic health condition.
- **Establish the hours and days peers will work.** Most pilot sites staggered peers to have a larger range of coverage in the ED. Some hospitals found that working in the evenings past 8pm was not as helpful given that most community referrals are closed at that time and many patients are still metabolizing off of substances. Often patients coming into the ED in the late evening would still be in the ED the next morning.

HR Resources

[Sample Job Description](#)
from Wake Forest Baptist Health

[Sample Interview Questions](#)
from Wake Forest Baptist Health



“We learned that it is important to share with candidates that have been peers in the community how different it is in the ED versus the community. In the community they have a very different workflow. They often spend many hours each week with their clients, so they have ample opportunity to create relationships with and engage clients. In our ED, the pace is much faster and the day more structured. The point of an ED is to assess and disposition patients. Time to engage patients is limited, as are opportunities to provide concrete services. ED Peers need to have strong interpersonal skills to engage patients. They need to be able to tolerate the fast pace as well as the potential physical trauma that is visible in an ED. Peers have a set schedule, which for some, means much less flexibility. They have to be able to tolerate and work well in a stressful environment. Not all can do that.”

Robyn Hawley, EdD, MSW
Manager, Behavioral Health Services
Novant Health Presbyterian Medical Center

Educating Providers and Staff



Education of the ED staff must occur prior to the peer’s first day on the team. An inappropriate understanding of a peer’s role with patients or unfair treatment will undermine the peer’s good work.

A peer is a nuanced role: it is not a case manager nor is it a clinical role. If ED staff do not understand the role of the peer on the team, their expertise may not be fully tapped into; the last thing you want is for the peer to not practice to their full certification and become bogged down in tasks such as filling out referral packets and providing transportation for patients. The role of a peer should be explicitly discussed with staff, including what it is and what it isn’t. For more information on the role of a peer, jump to [Defining the Role of a Peer](#) section.

Another crucial component of education for ED staff includes stigma elimination. By definition, peers openly acknowledge their recovery from a substance use disorder and/or mental illness to a society that has unfairly treated people with these health conditions. Because of the pervasiveness of stigma within our society, peers will more than likely work alongside ED staff with a range of beliefs about behavioral health conditions ranging from unconscious bias to overt displays of discrimination.

Pilot sites with strong programs had robust training for providers and fully embraced peer support specialists as equal team members. For more information about stigma elimination training, refer to the [Addressing Stigma](#) section of the [ED Opioid Treatment Pathway](#).

“The peers have become such an integral, embedded part of the Emergency Department team, and their impact on the patients there has been so powerful, that we are looking to implement the same sort of Peer Support Structure for our inpatient Adult behavioral health unit.”

Akeysha Rutledge, MSN, RN-BC
Director of Nursing Services
BH Adult Inpatient Services
Cone Health



66

“Involve your ED provider leaders early in the process. Start involving them as soon as you start thinking of incorporating peers in your facility. This will allow time for the ED providers to think about the process, the impact and it will give them the ability to provide input into your facilities process. Another recommendation is to share the stories you know about the impact of peers. This will assist in connecting the role to your purpose and mission.”

Lina Varela-Gonzalez, MBA, RN
Director of Emergency Nursing
Novant Health Presbyterian Medical Center

KEY FINDINGS FROM THE PILOTS

Without education, providers risk applying the same patient stereotypes to peer support specialists.

Face time builds clinician trust in peers. A crucial initial focus for peers should be on building positive relationships with team members, with a focus on educating about their role. This relationship building should not just focus on ED clinicians, but also positions that are patient facing, such as those working at the registration desk or valet attendants. In fact, these positions are sometimes the first to alert the peer to a patient who may need support.

Physician champions are critical to encouraging providers to use peer services with their patients and to form trust with peers.

Account for **leadership turnover** and **follow up** education that will need to occur to assure role integrity and effective communication.

Concerns about role overlap are common and can add to the perceived cost of integrating peers. If specific concerns arise, address concerns head-on. Where there are not specific challenges, administrators can take a systematic approach to orienting clinicians to the ED peer role.

Resources

[UNC Stigma Elimination Training](#)

[MAHEC Stigma Elimination Training](#)

[Addressing Stigma Section](#)

Cone Health Survey for Providers
[Pre](#) and [Post](#) Survey Templates

Defining the Role of Peers

Peer support specialists are trained on [approved core concepts](#) as outlined by the North Carolina Certified Peer Support Specialist Program. However, these values and skills are utilized differently in the ED than more common settings for peers, like community-based outpatient providers:

- Although SUD patients get more attention in the ED with a peer than they would otherwise, this is still less time than if they were in an outpatient setting. The peer has less time to build rapport and engagement, requiring highly skilled relationship building skills.
- The ED is a chaotic, fast-paced environment and requires peers suited for crisis-based care including those with previous experience or professionals who demonstrate the ability to stay calm in stressful situations.
- The peer is focused on getting patients ready to start seeking treatment, recovery, or management rather than ongoing support in the community.
- Hospitals, particularly emergency departments, are highly complex, collaborative, and hierarchical structures that require training, support, and guidance from supervisors and physician champions for peer success .
- ED-based peers require clear boundary setting – peers cannot spend all their time with any single patient and need to have dedicated non-working hours where they cannot be reached by patients
- The role of self-care is vital for a peer working in the ED, as it is common for patients to be extremely sick or die in the hospital. This is one of the reasons clinical supervision by an addiction medicine profession is vital.
- Unlike most settings for peers in the community, the ED is not centered on behavioral health treatment. This requires a peer to develop strong interdisciplinary communication skills and boundary setting with role and scope, especially as the peer role is being oriented within the team.

THE PEER'S ROLE

The role of a peer in the ED:

- **Rapport building** with the patient, building engagement with the peer through sharing their lived experience
- **Support** the patient during their hospital stay with a focus on crisis-based skills and goals
- **Advocate** for and with the patient during their hospital stay with their treatment team
- **Develop** crisis plans or wellness recovery action plans (WRAP) with the patient
- **Connect** the patient with resources, harm reduction, and treatment upon discharge
- **Engage** the patient after their hospital stay in order to ensure a warm handoff to community-based resources and care
- **Educate and support** family members and others on the patient's illness and how they can support the patient

Just as important as what a peer does, a peer does NOT:

- Assess or diagnose patients
- Deliver services typically under a case manager
- Provide transportation
- Complete referrals or discharge planning
- Provide sitter services



Resources

[Peer Job Description Wake Forest Baptist Health](#)



The Role of Clinical Supervision

As a hospital begins to build a peer program within their larger addiction medicine and behavioral health service lines, weekly clinical supervision is a foundational component of a successful program. Clinical supervision refines skills and provides education to become a more effective peer. Additionally, clinical supervision is an appropriate way to support a peers' recovery plan in order to serve as a model for patients in their role. Clinical supervisors are skilled at balancing peers' recovery goals with employment performance expectations. Pilot sites were required to provide clinical supervision to peers from a licensed addiction medicine professional, generally a licensed clinical addiction specialist (LCAS) based on the success of this supervision structure at Wake Forest Baptist Medical Center.

Pilot sites with clinical supervisors off-site opted to have administrative supervisors, such as nurses, identified for general guidance and tasks related to employment. The differentiations between clinical supervision and administrative supervision are noted on the next page.

Supervision is drastically different for peer support specialists than licensed professionals, as peer support specialists are not to be confused as clinicians. Thus, supervisors should undergo training specific to the role of the peer and objectives within peer supervision. The pilots found clinical supervisors were key individuals to ensure peers did not practice outside of their scope and provided education to others within the hospital about the role of the peer on the care team in the ED.



“Clinical supervision helps me in many ways. I am able to navigate any difficult cases that arise by discussing unexpected emotion, complex barriers, etc. that I may face. I would say that it challenges me as well, to see difficult patients as more of an opportunity for growth than resistant or demanding. It helps me to identify and hone in on my skills so that I can better serve my patients.”

Renee Ultes Hines, CPSS
Peer Support Specialist
Wake Forest Baptist Health

Clinical Supervision Goals

Provided by a licensed addiction medicine professional.

- Review patient cases and provide consultation and guidance
- Provide education on diagnoses, interventions, and best practices for patient care
- Advance peers' knowledge and skills through feedback, reviewing patient cases, and observation
- Process peers' own thoughts, feelings, and reactions to patients with an emphasis on preventing burnout and improving patient care
- Support peers' recovery as part of their employment responsibilities to model to patients
- Triage patient engagement, especially for those patients who may be less priority or need more time to build rapport during slower parts of the workday
- Define what success looks like in this environment, especially given the transient and acute nature of patients

Administrative Supervision Goals

Provided by a number of clinical professionals within the hospital.

Administrative supervision may also be provided by the clinical supervisor.

- Provide guidance on administrative tasks such as policies and procedures, timesheets, processes within the organization, etc.
- Focus on performance of duties as described in job description
- Professional development

Resources

[Supervising NC Certified Peer Support Specialists' online training through the UNC School of Social Work Behavioral Health Springboard](#)

[Peer Support Supervision Training through Recovery Communities of North Carolina](#)

▶ Embedding Peers within the ED

The Workflow ▶

Hospital leadership should carefully consider where their peer program will reside within their hospital. Peers do not need to be employees within the emergency department in order to be effective. In fact, pilot sites discovered the common factor to a seamless workflow for peer services relies on the peers being integrated into the processes and structures already in place. Furthermore, it is essential for peers to be integrated into the existing treatment team for substance use disorders; a peer program will be ineffective if the peer is the sole behavioral health professional providing care to substance use disorder patients. If your hospital does not have a behavioral health service line, it is recommended for the peer role to be developed in conjunction with an overall behavioral health strategy.

The stakes are high in the ED as are the real and perceived costs of workflow changes. Clinicians within pilot sites expressed an assumption that peers are familiar with the ED setting due to going through recovery themselves. While true that peers are fluent in the culture of recovery, the ED is another culture entirely. It is encouraged for peers to shadow ED staff ahead of their start date for as much as a week to help peers become oriented to intricacies and norms of an ED. In addition to staff shadowing for peers, ED staff should be educated about the role of the ED peer prior to their first day in order to ease workflow concerns. This is especially crucial for clinicians with roles that overlap with those of peers – whether it be close collaboration with physicians and nurses for ordering peer consults or feeling threatened that the peer will be assuming responsibility for roles traditionally held by case managers or social workers.

KEY QUESTIONS TO CONSIDER FOR WORKFLOW INTEGRATION

Which department will be responsible for delivering peer services?

The peer does not need to be an ED employee in order to have effective integration in the ED. Some pilots had their peers under surgery and outpatient services with just as smooth workflow integration as those who were designated as ED employees. Integrating peer services into existing structures for your hospital is key.

Will peers have a designated workspace in the ED?

Peers need to be visible and reliably available to ED clinicians. Clinicians at pilot sites expressed it is easier to work with a peer in the ED who is visible and available for a limited amount of time than one who has broader, inconsistent availability and is difficult to locate. While a physical workspace in the ED is not necessary to accomplish this goal, it is an option. Keep in mind the importance of a space allowing a “break” from the ED to help mitigate burnout.

How will a peer be consulted for a patient in the ED?

Peers need to be easily accessible via a consult order in the electronic health record (EHR) system or pager. Relatedly, setting these systems up ahead of the peer’s first day will prove to be valuable to ease concerns about workflow disruption. This includes peers having access to the EHR on day one and verifying the peers’ contact information is integrated in the pager system.

How will concerns about workflow be addressed during initial integration?

This is where the clinical supervisor is critical to effective integration of peer services; the clinical supervisor can provide support, education, and troubleshooting during this vulnerable time. While providing support for the peer is central, it is equally important for ED clinicians to have the opportunity to air concerns or ask questions of the peer’s clinical or administrative supervisor. This two-sided communication can mitigate miscommunication as peers acclimate to the ED culture. Incorporating ED peers can initially create uncertainty, but ultimately provides greater clarity when working with patients that have SUD.

How will clinicians be educated about the peer role ahead of the peer’s first day?

Administrators can take a systematic approach to orienting clinicians to the peer role while also providing targeted communication around specific challenges, such as concerns about role overlap. Taking dedicated time to understand and correct clinician assumptions about peers may reduce snap judgments. Taking input from teams sharing the space with peers in the ED, such as social work and psychiatric clinical leadership, on decisions such as hiring may improve buy-in to the process of integrating peers.

What hours will peer services be offered?

Peers can be an effective resource without responsibility for always being available. For example, one pilot hospital doesn’t staff peers in the early morning, despite high volume, because patients are the least receptive at that time. Peers can follow up on EMR consults upon return to the ED in the morning. In addition, if peers are unable to make contact in the ED, some are flagged for follow up via phone after their discharge. Regardless of scheduling, the peer role in care continuity requires coordination with clinicians around each patient discharge.

Resources
[Workflow Site Example 1](#)
[Workflow Site Example 2](#)
[Workflow Site Example 3](#)
[Wake Forest Baptist Health Workflow Chart](#)

Screening Potential Patients

Patients presenting to the ED with overdose or substance use diagnoses would clearly benefit from a peer service, however, these patients only represent a small percentage of patients who are appropriate for a peer consult. Hospitals have an opportunity to identify patients who are not known to the behavioral health system or have yet to be diagnosed with SUD and engage with them through peer support. Hospitals should not rely on one screening method for patients; the more screening methods adopted, the increased identification of patients who may be linked to treatment and services.

Screening Methods	
EHR report	Consult order by provider
Training line-level staff	Peer initiated

EHR report

Flags should be built into the EHR to screen patients for peer services. Pilot sites used protocols developed by Wake Forest Baptist Medical Center, linked in the resources bar.

Consult order by provider

In addition to running EHR reports with flags on ED patients, providers may order a peer consult through the EHR or pager.

Training line-level staff

Staff who have some of the first patient engagement, like valet or front desk staff, should not be overlooked as eyes and ears for clinicians. Peers making contact early can make all the difference for patient engagement and consent throughout the hospital visit.

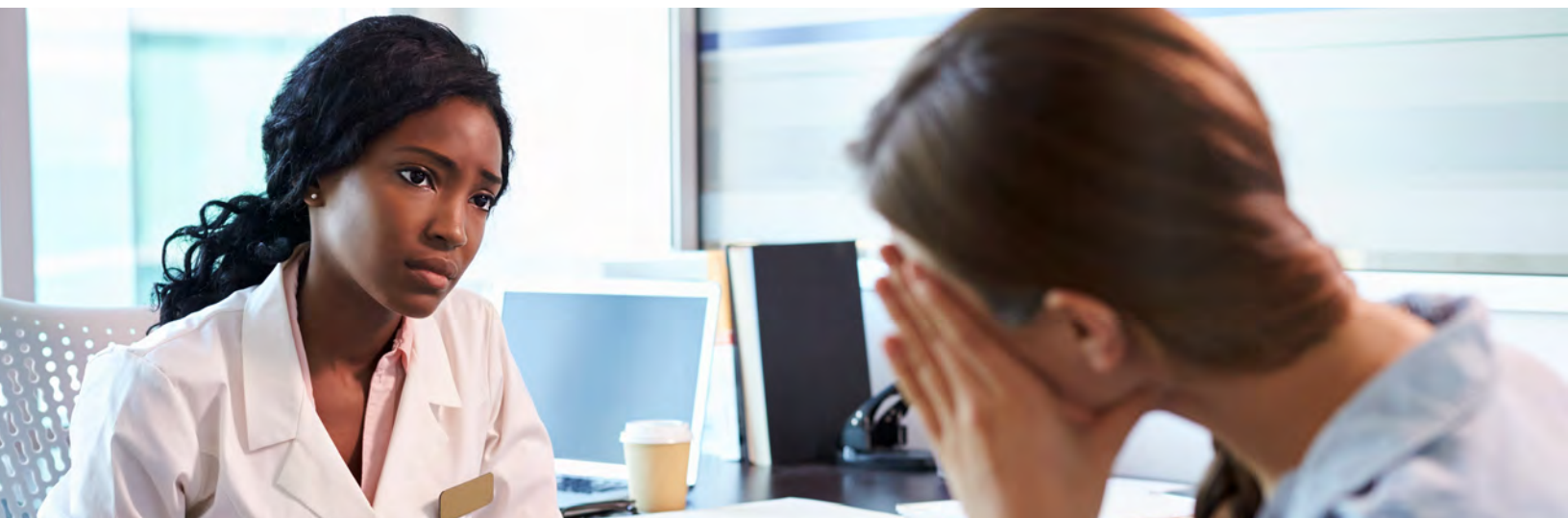
Peer initiated

Peers lived experience allows for peers to be in tune to nuances of withdrawal and use that may fall through the cracks. ED providers have shared instances where patients who would have been missed – withdrawal masking as the flu for instance – were flagged by the peer to discuss with the treatment team. Peers should not practice outside of their scope (assessing and diagnosing patients), but their training should not be underestimated. This level of screening will only occur once an equal relationship of trust and collaboration has been established between peers and providers.

Resources

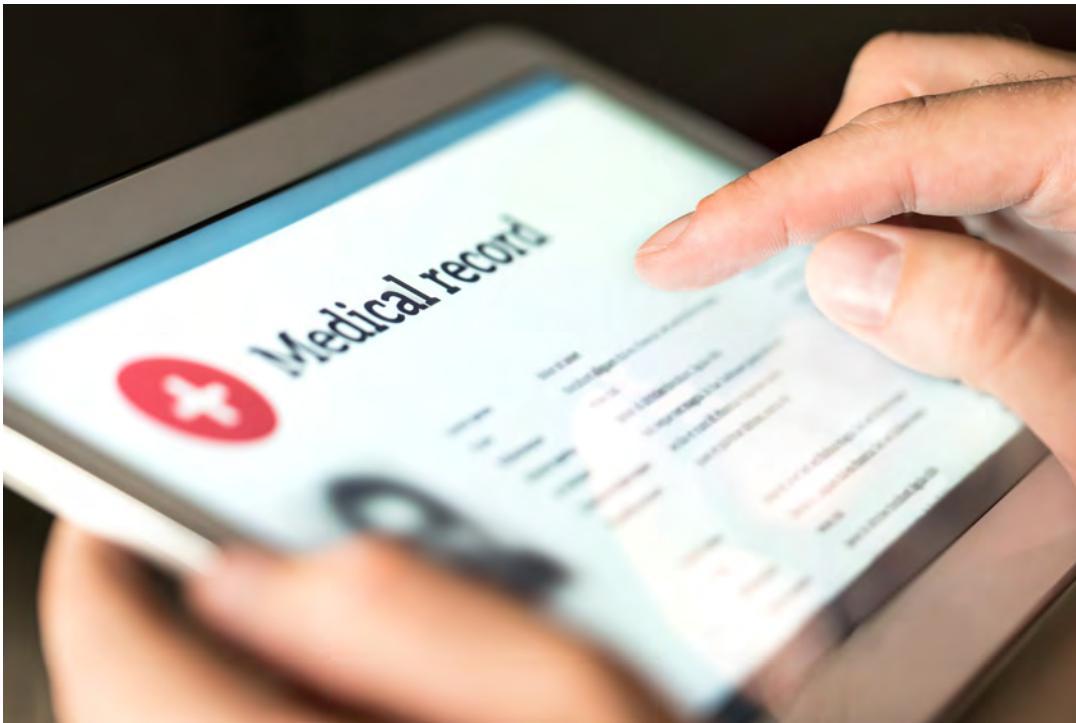
[Wake Forest Baptist Medical Center ED Peer Support Protocol](#)

[Wake Forest Baptist Daily Screening Steps](#)



“There are a number of things we look at to identify patients that may benefit from PSS services, including: admitting concerns that may indicate substance use (such as overdose, withdrawal, intoxication, hallucinations, or altered mental status), medical history that may indicate substance use or related health conditions like pancreatitis etc., patient reported substance use history (any drug use, alcohol use above 14+ drinks/week for men or 7+drinks/week for women and men over 65 years old, or reports of 4+ drinks in one sitting), and of course any positive blood alcohol levels or urine drug screens.”

Kiana Booth, MA, LCAS, LCMHCA
Project Coordinator, Substance Abuse Counselor
Wake Forest Baptist Health



The Power of the Electronic Health Record

Peers need access to the EHR on day one. While peers gaining access to the EHR as a user is time intensive, it is important to a fully integrated peer program. As administration works with IT, involve your legal department for patient information covered under [42 CFR Part 2](#).

Key EHR Functions for a Peer:

- Review reports for flagged patients
- Receive consult orders
- Documentation
- Reminders for follow up after discharge

Key EHR Builds for Peer Program:

- Consult order
- Flags for report
- Progress note
- Flowsheets

Resources

[Wake Forest Baptist Flowsheet Template](#)

[Wake Forest Baptist Redcap Assessment Template](#)

► Beyond the ED

Moving into Inpatient ►



The NCHA team and pilot sites quickly learned the importance of peers following patients admitted to inpatient services from the ED. Continued peer services helped strengthen patient rapport, treatment adherence, and engagement in recovery resources. Clinical supervisors help peers manage their caseloads to ensure peers continue to primarily engage with patients in the ED.

As providers across the hospital learned of the peer program, it was not uncommon to receive requests from inpatient providers for peer consults. For this reason, administrators and clinical supervisors must monitor the capacity of the peer program and practice boundary setting as needed. This is not to suggest that peer services are not effective within inpatient settings; Wake Forest Baptist Medical Center's ED peer program grew out of the success of peers within inpatient units. Even so, it is imperative the scope for peers is defined clearly upfront and peers have a manageable caseload.



“Our team’s work on the inpatient services has proven extremely helpful and effective in supporting patients with SUD. On the inpatient units our peers are able to spend more time with patients and develop a greater rapport. As a result, our team is able to work with case management more effectively and successfully to get patients connected with follow-up treatment or supportive services. Additionally, the peers are able to provide valuable guidance and education to staff members on these units and help address stigma. Our peers are highly valued members of our addiction medicine services within our inpatient units.”

Dr. Elizabeth Hodges Shilling, PhD, LCMHC, LCAS
Assistant Professor, Co-Director of Addiction Research
& Clinical Health, Wake Forest Baptist Health



“The former director of SRMC Behavioral Health correctly determined that giving staff face-to-face exposure to the peer support specialist’s life experience and purpose was critical for integration of this work into the medical center’s toolbox. This was facilitated by our introduction at group meetings to charge nurses, unit care managers, and even at a doctors training exercise involving an opioid abusing patient. We detailed our substance history and recovery journey to these groups, seeking to destroy stereotypes, stigmatization, and to show that life change and renewal are possible. I think it’s accurate to say we were universally successful in this regard, and we have been blessed with the opportunity to change perspectives in a hospital setting of substance use being a treatable disease rather than a lifestyle choice.”

Sam Melville, CPSS
Peer Support Specialist
Southeastern Regional Medical Center

Beyond Discharge: The Peer Role in Warm Handoffs

A major component of the ED peer model as piloted includes a portion of the peers’ time to be spent in the community to facilitate warm handoffs. Typically, peers within the pilot spent approximately 30% of their time on community-based engagement and follow-up of patients after discharge. Here are examples of peer activities beyond discharge:

- Follow up with patients after discharge to verify connection to treatment, harm reduction, or other services
- Meet with a patient after discharge to provide short-term support and connection to longer-term support in the community
- Accompany the patient to their first appointment, self-help group, or other resource
- Build relationships with SUD providers, harm reduction programs, and other services within the community
- Connect with referral sources to seamlessly transition care

PEER SUPPORT SPOTLIGHT

One pilot site maintained detailed records of patient outcomes following peer support. Here are some highlights:



6 in 10

Thirty days after meeting with a peer, 6 in 10 patients contacted reported following up with a peer referral to a program or service for SUD treatment or recovery.



8 in 10

Three weeks after meeting with a peer, more than 8 in 10 patients contacted were either in treatment or working personally on recovery.



65%

Thirty days after meeting with a peer, almost a third (65%) of patients contacted who did not initially have stable housing reported they had obtained stable housing

Demonstrating the Value of Peers through Data

As healthcare continues to move towards value-based models of care, providing peer services at this critical juncture may improve health outcomes. Even if the patient does not engage in treatment but connects with a local syringe exchange program, there is decreased risk for future complications from IV drug use, sexually transmitted infections (STIs), or overdose. Hospitals aiming to improve the efficiency of discharging patients with SUD who cannot be admitted can quickly see the value of ED peers.



“At the UNC Health ED we have a terrific partner in the UNC STAR Clinic which is part of the UNC Alcohol and Substance Abuse Program (ASAP). Through this partnership, the ED Certified Peer Support Specialist (CPSS) can provide details and recommendations to the Clinic and through the service level agreement the patient will be contacted within 24 hours to in-take discussions. During the current COVID-19 pandemic it has been critical to expand our network of “HEALS Certified” community agencies to provide quality referral solutions to our patients. This has required the CPSS’s to be “relationship farmers” all over the State. The seeds we had planted earlier in the program are now bearing fruit and providing opportunities for our patients.”

Steven Blalock, CPSS
Peer Support Specialist
UNC Health

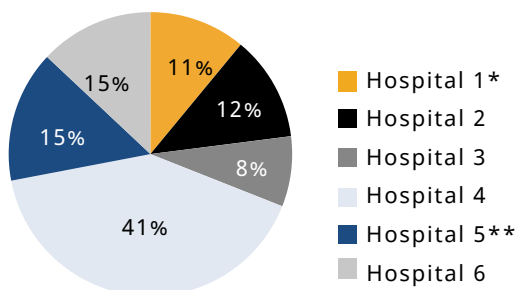
ED Peer Support Program

June 2020 Final Report

Enrollment of Adults with Substance & Opioid Use Disorder (SUD & OUD)

5213

Total Patients Served (SUD and OUD)

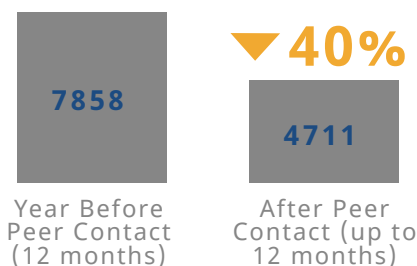


The ED Peer Support Model

A pilot initiative to combat North Carolina's opioid crisis, the ED Peer Support Program uses certified peer support specialists to connect patients presenting with opioid overdose or OUD to treatment, recovery, and harm reduction supports.

Total ED Visits

Among ED Peer Support Participants



"Re-admissions to the ED are lower because we're connecting patients with solid substance abuse treatment"

-- Clinician who works with peers

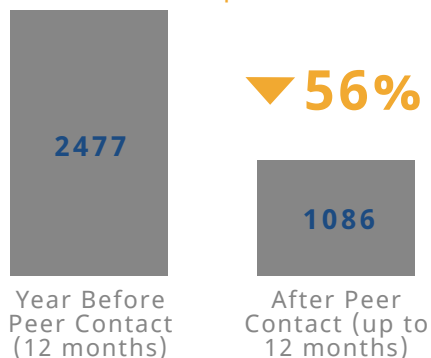
Mental Health

More than 3 in 10 received mental health care the year before peer contact.



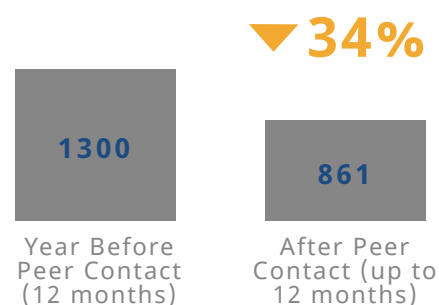
Total Hospitalizations

Among ED Peer Support Participants



Total 30-Day Readmissions

Among ED Peer Support Participants

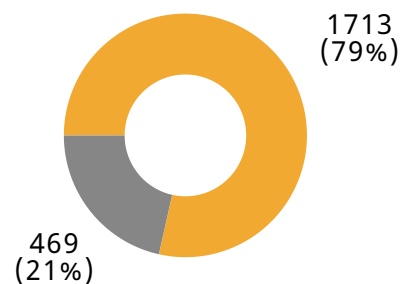


"[As patients] are evaluated in the ED...peers only have that length of time to start building rapport, seeing what that patient wants, what their needs are. Then peers need to prioritize: what is the most important need [for the peer to] be working on at this very moment?"

--Supervisor describing peer workflow

Referrals from Peers

- MAT
- Harm reduction, mental health, housing, transportation, employment, health insurance





Funding a Peer Program



Grant Funding

Generally, hospitals heavily rely on grants to initially fund a peer program. Typical start-up expenses include peer salaries and benefits, time for other professionals supporting the peer program (e.g., physicians, clinical supervisors), and equipment such as computers and cell phones. For this project, pilot sites purchased additional resources to use with patients, such as bus passes, to support warm handoffs. In absence of traditional grant dollars awarded by state or national foundations, hospitals should consider how to access county-based funding, as many counties have interest in funding supplemental programs that improve health outcomes for their residents.

Contracting with Payers

Healthcare is moving rapidly towards value-based contracting with a focus on the patient's health outcomes rather than the quantity of services performed. Using data and metrics collected during the grant funding period as the foundation, hospitals are in a strong position to negotiate rates to cover the cost of peer services. Metrics demonstrating cost-savings and improved patient care are included in the graphic on the previous page.

Reimbursement Through Medicaid & State-Funded Service Definitions

In 2019, NC DHHS added stand-alone peer support service definitions for NC Medicaid and state-funded beneficiaries; this significant policy change aligns payment with promising practice and expands access to a whole-person healthcare approach. However, even though the ED is listed as a setting where peer services can be rendered, there remains significant barriers for hospitals to bill under the current service definitions within the ED peer model described in this guide.

The restrictions within the service definitions better support outpatient providers who enter an ED to provide peer services, which is a model of ED peer support not piloted under this grant. When considering this different model for peer support, it is important to address some of the key challenges noted by the pilot sites. One significant challenge includes peers not classified as hospital employees and the fragmentation of the crucial elements that made their specific programs successful: integration within ED workflows and face-time between peers and clinicians to build trust. While not impossible, these components will require more deliberate planning and intentionality by hospital leadership and outpatient peer providers.



“When we first thought about how we wanted to integrate our peers into our Wesley Long Emergency Department, we had the goal from the beginning to help them become an identifiable part of the ED treatment team with a defined role others would recognize, just like doctors, nurses, and social workers. We wanted everyone to know and understand their role by their position name. We did some early job description survey testing of ED staff and went to an ED physician and nurses’ monthly staff meeting to identify and answer questions about the peers’ roles. As time progressed, everyone in that ED now knows what the peers do, how their connections with patients drive outcomes, and they are well respected, just as other integral members of their treatment team. If we tried to remove the peers from the ED now, as one physician told me, they ‘would come looking for us’. I think that pretty much sums up the peers worth in our healthcare system now.”

**Shawn Taylor, BSN, MSN, RNBC Clinical
Nurse Manager
Behavioral Health Outpatient Services
Cone Health**

References

¹ Reif, S., Braude, L., Lyman, D. R., Dougherty, R. H., Daniels, A. S., Ghose, S. S., ... Delphin-Rittmon, M. E. (2014). Peer Recovery Support for Individuals With Substance Use Disorders: Assessing the Evidence. *Psychiatric Services*, 65(7), 853–861. doi: 10.1176/appi.ps.201400047

² SAMHSA: <https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers>

³ National Council for Behavioral Health (2018). Peer Support Workers in Emergency Departments: Engaging Individuals Surviving Opioid Overdoses – Qualitative Assessment: <https://www.thenationalcouncil.org/wp-content/uploads/2018/12/Peer-Support-Workers-in-EDs-Issue-Brief.pdf>



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