NYC HEALTH+ HOSPITALS | BEHAVIORAL HEALTH

NYACH

Emergency Department Peer Pilot Program

EVALUATING PEER COUNSELOR SUPPORT FOR EMERGENCY DEPARTMENT PATIENTS WITH SUBSTANCE USE DISORDER SUMMARY OF FINDINGS

NEW YORK CITY HEALTH + HOSPITALS, OFFICE OF BEHAVIORAL HEALTH

Context

NYC Health + Hospitals (NYC H+H), the largest public health care system in the United States, provides essential inpatient, outpatient, and home-based services to more than one million New Yorkers every year in more than 70 locations across the city's five boroughs. Among NYC H+H's patient population, substance use disorders (SUDs) are the most common diagnoses. NYC H+H has four New York State Office of Alcoholism and Substance Abuse Services (OASAS) licensed methadone clinics, eleven outpatient drug and alcohol treatment clinics, one residential treatment program, as well as a growing cohort of doctors in primary care prescribing buprenorphine. Each year NYC H+H sees approximately **90,000 unique patients with at least one substance use disorder (SUD), 20,000 of whom have an Opioid Use Disorder (OUD)**[1]**.** Patients with SUDs have 3x more Emergency Department (ED) visits compared to non-SUD patients[1] and EDs see the highest volume of patients with OUDs[1] compared to other services. Annually, there are approximately **13,000 OUD patients served by NYC H+H EDs, accounting for approximately 44,000 visits.** While NYC H+H EDs have the highest percentage of patients with OUD of any health system in NYC,[2] H+H treats **only 13%** of patients with OUD via in-house OASAS-licensed outpatient **addiction services**. NYC H+H faces significant opportunity to fight the current epidemic of opioid overdose death, but only if there is sufficient capacity to engage patients with OUD (and other SUDs) in EDs and navigate them to ongoing care. Indeed, it is in moments of crisis, precipitating visits to the ED, that patients with SUDs may be most effectively engaged in appropriate ongoing addiction care.

One way of providing supplemental services and navigation to patients with SUDs is to integrate peer support services into the service delivery model. A peer counselor is a *non-clinical* worker who has lived experience with a specific health condition and is trained and employed to use their experience to support others with that condition through their health journey. While peers have been part of care models in New York and across the country for many years (such as in HIV care), peer work was traditionally left out of the wider healthcare delivery system especially for those with SUD. In 2015, OASAS announced a new statewide certification for peers working with SUD patients and, shortly thereafter, Certified Recovery Peer Advocate (CRPA) services became reimbursable by New York State Medicaid at an increased rate.

After this regulatory change, the New York Alliance for Careers in Healthcare (NYACH), the healthcare industry partnership at the New York City Department of Small Business Services, in collaboration with NYC H+H, NYS OASAS, NYC DOHMH, The Peer Network of New York, other behavioral health providers, and Queensborough Community College (QCC) began work creating what became the first comprehensive training program in the state that mapped to the new regulations and certification process. In late 2017, NYC H+H Office of Behavioral Health (OBH) and NYACH announced the hiring of 14 graduates of the CRPA program at QCC as part of an innovative pilot program that employed this new workforce pipeline to help support the navigation of SUD patients in H+H EDs. In principle, this new program would be a financially viable model to improve the lives of H+H patients while at the same time provide meaningful employment opportunities for New Yorkers with some lived experience with SUD and recovery. As part of the pilot program, NYC H+H employed Peer Counselors (the H+H corporate title for CRPAs) at NYC H+H/Harlem, NYC H+H/Metropolitan, and NYC H+H/Woodhull, each with a significant number of annual visits from patients with SUDs.

The goal of the ED Peer pilot program is to engage patients with or at risk of SUD and navigate them to ongoing addiction services after discharge. Peer Counselors can use their lived experiences to

[1] NYC H+H Corporate Planning FY16

[2] Statewide Planning and Research Cooperative System, 2015

establish trust, mutual understanding, and open communication with patients to improve their overall hospital experience.[3] A 2019 study of peers in a hospital-based addiction consult model suggest positive impacts related to peers including better engagement of SUD patients and improved patient and provider experiences.[3] Peers serve as a bridge between patients and providers, reframing the provider's understanding of the patient's experiences, reducing stigma, and translating provider recommendations to improve acceptance of recommended care among patients.[3]

NYC H+H and NYACH are proud to collaborate on this pioneering model in the field of peer recovery services, to provide quality services to participants in the program, and to contribute to the evidence-base for the use of peer support work in clinical settings. This brief and the accompanying academic report provides insight into how this program worked, what can be learned from the experience, and generally what the implications are for the clinical departments, the workforce, and patients. It is our hope that this research enables other behavioral health leaders around NYC to expand the use of CRPAs in staffing models, replicate H+H's best practices, and be thoughtful about recruiting, preparing, and supporting this workforce. We also believe it is important to highlight the contribution of this valuable workforce, without whom this program could not have been successful.

NYC H+H ED Peer Program Model

Peer Counselors are dedicated to providing services in the ED and serving as an introductory bridge from the ED to the SUD treatment clinic. NYC H+H hired Peer Counselors into the OASAS-licensed outpatient SUD clinics, rather than the EDs, at each of the three facilities so that the staff with specialized addiction experience would supervise Peer Counselors. Additionally, SUD clinics can bill for peer services in the ED via their OASAS license. When planning for implementation, core program operational components considered were space, shifts, supervision/training, and integration into preexisting ED workflows. In collaboration with facility staff, NYC H+H Central Office of Behavioral Health (OBH) developed a "Scope of Program" which outlined these components, and roles and responsibilities of the program.

NYC H+H peer program is designed to function with a "consult-style" workflow. Peers approach patients flagged through various worklists or ED team rounding. This includes an Electronic Medical Record (EMR) worklist that automatically generates with patients who screened positive for risky substance on Single Item Screening Questions[4] at triage, and an 'admitted patients' whiteboard. Peer Counselors may also be called/paged by ED staff. When meeting with patients, Peer Counselors scope of practice must fall within that set forth by OASAS[5] and OBH. The OASAS/OBH model includes utilizing lived experience to engage patients, educating about treatment options, distributing a Naloxone kit, arranging appointments with treatment programs, and escorting the patient to the treatment program–a "warm hand-off". It is important to note that determining the level of care needed by a patient is out of scope. They may, however, encourage or advocate for a conversation between the patient and the ED Attending or ED Social Worker, or may refer the patient to the facility's in-house treatment program for further specialty assessment. Peer Counselors are advised to address the immediate needs of patients in the ED, but are also encouraged to follow up by phone or make a follow-up appointment with patients they encountered. Peer Counselors document their encounters in a standardized progress note when there was any contact, or attempted contact, with a patient.

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[3] Collins D, Alla J, Nicolaidis C, et al. (2019). "If It Wasn't for Him, I Wouldn't Have Talked to Them": Qualitative Study of Addiction Peer Mentorship in the Hospital. *Journal of General Internal Medicine*. doi:10.1007/s11606-019-05311-0

[4] Smith, P. C., Schmidt, S. M., Allensworth-Davies, D., & Saitz, R. (2009). Primary Care Validation of a Single-Question Alcohol Screening Test. *Journal of General Internal Medicine*, *24*(7), 783-788.

[5] https://www.oasas.ny.gov/ManCare/documents/PeerSupportServicesGuidanceFINALDraft2017.pdf

When considering coverage hours, OBH consulted with ED Chiefs. Across all three facilities, there was preference to have Peer Counselors begin their shifts in the early mornings (5-7am) to meet with patients who would soon be discharged. Other times highlighted were late afternoon and evenings (2pm-midnight), and Saturdays. Peer Counselors were assigned to 8-hour shifts with 2 Peer Counselors per shift. Coverage remains dependent on the number of Peer Counselors hired at each facility, and the availability of physical space in or close to the ED during desired shifts. This variable, however, has changed throughout the course of the pilot, as more space was made available.

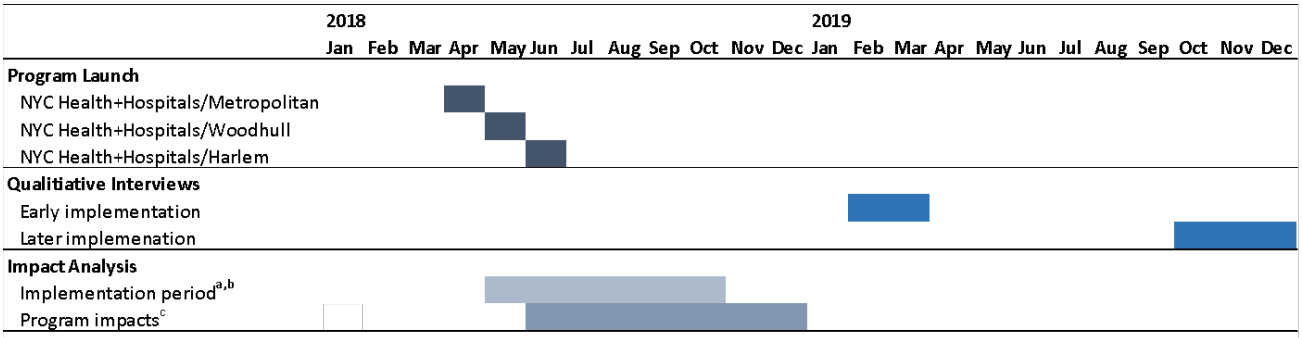
Each facility has an assigned supervisor from the SUD program. The facility supervisor's responsibility is to integrate the Peer Counselors into the SUD clinic, and provide, at a minimum, weekly individual or group supervision, and oversee the day to day activities of the Peer Counselors. Additionally, an OBH supervisor is assigned. The OBH supervisor, experienced in supervising mental health Peer Counselors, is responsible for providing an additional 1-hour weekly group supervision to Peer Counselors. Supervision is split into two sessions to accommodate staff's morning and evening shifts across the three facilities.

Evaluation Overview

In close partnership with NYACH, NYC H+H contracted with an evaluation team at New York University's Steinhardt School. This brief is based on a report prepared by Tod Mijanovich, PhD, who led the overall evaluation and Beth Weitzman, PhD, who conducted all staff interviews with assistance from other team members. Funding of the research for this report was provided by the JPMorgan Chase Foundation, through NYACH, and NYC H+H.

The evaluation of the ED Peers Pilot Program included:

1. In-depth interviews with Peer Counselors, supervisory staff, ED staff and administrators to evaluate fidelity to the program model in the early and later stage of implementation (February-March 2019 and October-December 2019), as well as to identify program challenges and offer midcourse corrections
2. A Medicaid data analysis to evaluate patient outcomes pre- and post-implementation of the program (January-December 2018)



[a] the baseline period for each patient was 12 calendar months prior to the month of their index visit; [b] an index visit to the ED Peer pilot program was defined as an ED visit between program launch and October 31, 2018; [c] program outcomes were evaluated for 6 months after an index visit up until December 31, 2019

Findings

1. Interview Findings

Recruiting and Supervising the Peer Workforce

As an emerging workforce, identification, recruitment, and training Peer Counselors has been demanding for participating employers. Each of the three pilot sites expressed challenges recruiting a full complement of Peers and staff turnover is ongoing. Nonetheless, when comparing early to later stage implementation, Peer Counselors expressed increased job satisfaction related to busier shifts with more patient encounters. Some Peer Counselors were without 'lived experience', although interviewees differed in the extent and impact of their concern about this.

Determination of the best complement of trainings to support the workforce is still in progress. Most peers hired at NYC H+H received their training at QCC and, in addition, received NYC H+H specific training from OBH and onsite at the hospital. Peers and other staff expressed that additional training would be useful, particularly around ED policies/protocols, patient resources and referrals.

The importance of quality supervision was highlighted in interviews with Peer Counselors. Because of complex staffing structures at the hospitals, supervision for some Peer Counselors was divided between a clinical and an administrative/task supervisor. This created some confusion for the peers and, at some sites, led to more unstructured supervision. At sites with more structured supervision, Peer Counselors felt that scheduled supervision sessions were critical for team cohesion.

Suitability to ED Workflows

As may be expected with any new process or program, the evaluation findings indicated a need for several areas of operational improvement. First, there is a need for additional messaging and clarity regarding the roles and responsibilities of the Peer Counselors. For example, some interviewees indicated confusion about the Peer Counselors' role in follow up post-discharge. While some supervisors advised Peer Counselors to follow up with patients by phone or in-person after discharge, others believed this was out of scope for the program. Additionally, some ED staff were unclear of the boundaries between the ED medical team social workers' roles and that of the Peer Counselors when it came to providing addiction services. However, in all sites, interviewees were clear that patients who needed social services, public benefits, or housing were referred to the ED medical social work team, while Peer Counselors focused specifically on issues of substance use.

Second, something as simple as where the Peer Counselors were stationed had a major impact on Peer Counselor integration, patient engagement, and experience. In a fast-paced environment such as an ED, it was essential for Peers to be close to or stationed inside the ED during shifts. Peer Counselors were more readily present and able to respond quickly to pages, the EMR worklist, or walk around and engage patients not necessarily identified through these formal channels. As such, physical presence may potentially lead to improved Peer Counselor team integration and better patient engagement in the ED. In later stage implementation, ED staff noted changes in the designated physical office space proximate to the ED significantly increased the availability of Peer Counselors.

Program Effectiveness

ED staff reported that prior to the ED Peer pilot program, EDs struggled to meet the needs of patients with SUDs. Most of those interviewed spoke of the lack of time for ED staff, including social workers, to deal with this population's special needs. Social workers repeatedly noted that issues of discharge planning (e.g., to nursing homes) or mandated reporting (e.g., in domestic violence cases) took up most of their time, leaving little opportunity to engage patients with substance use disorders

and discuss possible treatment, and even less time for post-discharge follow up. These scenarios are likely universal to EDs and were indeed the catalyst for OBH developing the ED Peer program.

In the later stages of implementation, the program adopted mental health counselors or social workers as part of the model, and in one of the EDs, peers and counseling staff were paired most of the time. During interviews, staff expressed that their work was complementary, but not distinguished, yet peer and counselor staff called on each other to provide additional support when engaging patients. Where facilities introduced counseling staff in later implementation, interviewees expressed some issues with role confusion. Shared supervision (meaning peers and counselors reporting to the same supervisor) was valuable for team spirit and role clarity.

Despite many operational issues related to implementing a new program into an existing system, the majority of the Peer Counselors and clinicians interviewed expressed a generally positive attitude towards the ED Peers program, even as they shared many things that they believe can and should be changed or improved. As the program progressed from early to later implementation, a majority of Peer Counselors expressed their increasing acceptance by others in the ED. Most of the clinicians and staff interviewed indicated that they felt the Peer Counselors were well suited to patient needs and well suited to the needs of the ED.

2. Program Impacts

A long-term outcome of the ED Peer Pilot Program is to improve patient linkage to, and ultimately, maintenance in substance use services (SUS). Using New York State Department of Health (NYSDOH) Medicaid Data Warehouse data, the evaluators compared SUS utilization between patients visiting the ED pre- and post-implementation of the ED Peer pilot program. Approximately 2,500 Medicaid patients with a primary or secondary substance use disorder who had visited any of the three EDs between the official program start dates and October 31, 2018 were included in the 'treatment' group.

Overall, the ED Peer pilot program had modest, yet positive impacts, particularly for patients with no history of substance use treatment in the last 12 months (herein referred to as 'untreated'). The likelihood of 'untreated' patients entering rehab/detox treatment within the first 2 months post-ED visit increased from 4.2% to 8.1%. The proportion of patients attending counseling sessions also substantially increased, from 9.9% to 13.1% within 2 months and 11.5% to 17.4% within 3-6 months, post-ED visit. In comparing initiation of medications for addiction treatment (MAT), the program almost doubled the proportion of untreated patients who received MAT from 2.5% to 4.6% within 3-6 months post-ED visit. Finally, the proportion of patients receiving methadone increased from .4% to .9% and .7% to 1.9% in months 1-2 and 3-6 months post-ED visit, respectively. Of importance, these positive findings reflect impacts during the earliest stages of implementation. As the program continues to strengthen, the program may yield different impacts.

Implications for the field

NYC H+H and NYACH, with thanks to Dr. Mijanovich, Dr. Weitzman and their team, learned a number of key lessons to share with industry partners:

- Overall, Peer Counselors were an important resource in the ED, helping to address the needs of patients with SUD and encouraging engagement in treatment services;
- The evaluation suggests the implementation of an ED Peer Program may lead to an increase in treatment utilization, particularly for those patients without recent treatment;
- When recruiting staff for the program, attention to preparation pre-hire and training post-hire is needed to ensure staff have adequate "soft" skills like time management and concrete skills such as office computing;

- A significant amount of upfront time is needed to setup and stabilize program operations including Peer Counselor and staff training, liaising and educating multidisciplinary stakeholders, and securing logistics such as space and shifts;
- Roles and responsibilities of Peer Counselors need to be well-defined and understood by Peer Counselors, counselor staff and supervisors alike, with structures in place for continuous quality improvement of team performance;
- Peer Counselors need a supervisor with the ability to provide traditional supervision, but also liaise with ED colleagues to clarify roles and responsibilities and set expectations of the Peer Counselors;
- Peer Counselors must be able to spend a significant amount of time physically present in the ED; the further the Peer Counselors' office space is located from the ED, the longer the gap between patient identification and engagement;
- The role of the Peer Counselors in referral and follow up must be carefully defined;
- And while there are benefits to standardization, adaptations must be anticipated in implementation, which vary according to an organization's complex matrix of resources and culture

In summary, large, complex, urban hospital EDs are extraordinarily busy places serving patients with diverse health needs. Where staff, especially social work staff, are taxed, Peer Counselors are an additional resource to help the ED function more smoothly. Peer Counselors can help ensure that substance use issues, and the patients who face them, are not neglected or sidelined, and significantly contribute to an increasing proportion of patients engaging in SUS, including detox/rehab, counseling and MAT.

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For more information about the New York Alliance for Careers in Healthcare (NYACH), please visit www.nyachnyc.org. In December 2018, NYACH convened a behavioral health conference focused on the integration of CRPAs into NYC's healthcare workforce. An industry brief on the conference can be found here.