Confronted with Overdoses, Rhode Island's Emergency Departments Employ Peer Services to Promote Treatment

By Jodi Manz and Kitty Purington

Drug overdose deaths nationwide have continued to rise during the COVID-19 pandemic, exceeding 88,000 between August 2019 and August 2020, signalling a critical need for substance use disorder (SUD) treatment services and the workforce to provide them. Non-fatal overdoses, which are a predictor of future fatal overdoses, also rose, leading to an increase in opioid-related emergency department (ED) visits even as overall ED visits declined during the pandemic.

While overdose-related ED incidents are traumatizing to individuals and costly to payers – especially state Medicaid programs – Rhode Island has found that hospital emergency rooms can be low-barrier and successful access points to SUD treatment with the right crisis response – including peer services – in place.

Background

Rhode Island, and 38 other states, have integrated the use of peers as care team members who can provide Medicaid-reimbursable, non-clinical treatment and recovery support services. In 2014, the state developed an innovative model, AnchorED, that introduced peers into hospital EDs to link patients who experienced overdoses with treatment and recovery. This program is the result of cross-agency collaboration among Rhode Island's Department of Health (RIDOH), Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH), the Providence Center (a community behavioral health provider), and Anchor Recovery Community Centers.

> **Peer recovery services** for substance use disorder (SUD) have been demonstrated to help individuals stay in treatment, increase satisfaction with treatment experiences, and reduce rates of return to use.
> Responding to existing and projected behavioral health workforce shortages, states are building capacity for SUD treatment by developing certification pathways and reimbursement structures for peers as a non-licensed, supportive workforce.

Currently, post-overdose peer services are accessible at all hospitals in the state – with the exception of a Veterans' Affairs hospital – and peers who provide services are available 24 hours a day, seven days a week. Early evaluation of AnchorED showed that in the program's first year, peers had contact with 1,329 patients. Among those patients, 88.7 percent were trained to use naloxone and 86.8 percent agreed to engage with a peer after hospital discharge. Further evaluation showed that ED providers consulted with peers in over 85 percent of overdose cases, and referral to treatment upon discharge increased from 9 to nearly 21 percent.

Building Blocks for Rhode Island's AnchorED Program

State Leadership

State leadership ensures that peer services are recognized as a valuable component of opioid/substance use disorder (OUD/SUD) systems in Rhode Island. The Rhode Island Governor's Overdose Prevention and Intervention Task Force, established through an Executive Order in 2015, provides a forum for consistent communication related to all SUD-related initiatives and has been important in promoting the peer workforce. This group, composed of stakeholders as well as state policy leaders, is co-chaired by the directors of the RIDOH and BHDDH, the two agencies that were instrumental in implementing policy for peer services in hospital EDs. In 2017, the governor signed another Executive Order making additional policy actions in response to the needs of the state emerging from the task force, including several initiatives supporting peer services that align to the task force's Action Plan. Outcomes, including data on the number of peer recovery specialists (PRS) in the state and the number of services they provide, are reported on regularly updated public dashboards.

Data for 2020 showed an increase in the number of newly trained PRS, which reached 958 by September, and new client enrollments in services, which has increased steadily from a low point in April, 2020, likely related to the COVID-19 pandemic. The task force, which continues to hold open monthly meetings, recently issued an updated strategic plan that includes goals to further expand and enhance the peer recovery workforce. Task force meeting notes and presentation archives are also publicly posted.

Rhode Island state leaders were also engaged in concurrent efforts on workforce development as a component of their State Innovation Model (SIM) project. The state's Health System Transformation Program published a Healthcare Workforce Transformation report that advocated expanding the role of peers as members of integrated behavioral health teams. The report recommended providing a pathway for state certification for peers as a strategy to build behavioral health workforce capacity with non-clinical team members in supportive roles.

Infrastructure

Rhode Island, through a number of policy actions, has created a regulatory framework that supports delivery of peer services in hospital EDs. In 2016, the state passed legislation that requires hospitals to submit comprehensive discharge plans to its health department director and outlines specific requirements for post-overdose patient care. Aligning with this statute, RIDOH and BHDDH developed standards for hospital EDs, requiring integration of peer services into ED overdose response across all state hospitals, as well as Freestanding Emergency Care Facilities (FECF) that provide emergency services outside of a hospital's structure. The agencies delineated these standards in the Levels of Care for Rhode Island Emergency Departments and Hospitals for Treating Overdose and Opioid Use Disorder, creating three levels of certification for EDs across the state. In order to gain certification at any of these levels, hospitals and EDs

are required to complete and submit a self-assessment that reviews where each facility falls on the continuum of services identified in the standards.

Rhode Island Hospital Levels of Care Standards

Level 3: Minimum standards - indicating readiness and capacity to:	**Level 2:** These certified facilities must meet Level 3 criteria, and also show capacity to:	**Level 1** In addition to meeting levels 1 and 2 criteria, these certified facilities must:
1. **Offer peer recovery support services in their emergency departments.** 2. Follow the discharge planning standards as stated in current law. 3. Administer standardized substance use disorder screening to all patients. 4. Educate all patients who are prescribed opioids on safe storage and disposal. 5. Dispense naloxone for patients who are at risk, according to a clear protocol. 6. Provide active referral to appropriate community provider(s). 7. Comply with requirements to report overdoses within 48 hours to RIDOH. 8. Perform laboratory drug screening that includes fentanyl on patients who overdose.	1. Conduct comprehensive standardized substance use assessments. 2. Maintain capacity for evaluation and treatment of opioid use disorder using support from addiction specialty services.	1. Maintain a Center of Excellence or comparable arrangement for initiating, stabilizing, and re-stabilizing patients on medication-assisted treatment: • Evaluate and manage medication assisted treatment, and • Ensure transitioning to/from community care to facilitate recovery.

These standards for EDs also inform licensing regulations for both hospitals and Freestanding Emergency Care Facilities (FECF) in Rhode Island. Those regulations require that overdose patients and/or patients who are evaluated and found to have SUD are informed of available treatment services and that those patients are offered an opportunity to speak with a PRS. RIDOH also encourages hospitals in Rhode Island to use the BHDDS model consent form

language for peer services, facilitating patient consent to both peer and medical services simultaneously. This approach to incorporating peer services into hospital consent forms was mandated by the legislature in 2018.

At this time, the standards are currently under revision by a workgroup of state leaders and stakeholders to identify and address gaps in alignment between the standards and the provider experience. These revisions, however, are not expected to lead to changes in the regulations.

Workforce Development

The state began laying the groundwork for peer certification in 2012 when BHDDH began trainings for mental health peer recovery specialists through certification planning developed as part of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Transformation Transfer Initiative (TTI). In 2014, the Rhode Island Certification Board (RICB) – not a state entity – began certifying SUD peer recovery specialists as well, this led to BHDDH ultimately integrating mental health and SUD peer recovery trainings after the state brought together stakeholders through SAMHSA's Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) program.

Peer certification in Rhode Island begins with the state's integrated peer recovery and mental health training provided through Anchor Recovery. Requirements include:

- 46 hours of didactic learning across four domains (advocacy, mentoring/education, recovery/wellness support, and ethical responsibility)
- 500 internship hours, including or in addition to 25 supervised hours.
- Evidence of passing the International Certification and Reciprocity Consortium (IC&RC) peer recovery certification exam. To prepare for the exam, IC&RC provides a Candidate Guide, and BHDDH contracted with JSI International to develop the Rhode Island Peer Recovery Specialist Certification Study Guide.

> As officials developed certification requirements for peers, members of the peer community and people in recovery from SUD explained that being paid to help others conflicted with an important tenet of their personal journeys, which is to give freely of their time helping others with SUD and "pay it forward."

Peers delivering services in Rhode Island must receive ongoing supervision from either licensed health care practitioners or certified peers who provided peer services for at least two years. Supervisors must also complete BHDDH-approved core competency training provided through a contract with Anchor Recovery. Agencies providing peer services must maintain a ratio of 1 supervisor for every 10 peer full-time-equivalents, and document provision of supervision totaling at least two hours per month or 30 minutes per week. Agencies must also provide at least a monthly opportunity for group meetings for working peers. In order to deliver services, these agencies must also be certified by BHDDH as Peer Based Recovery Support Services (PBRSS) providers and can use the PBRSS Provider Billing Manual to bill for services.

State Investment and Resources

Initial grant funding. Peers initially began meeting with overdose patients in hospital EDs as a volunteer engagement opportunity supported by Providence Center's Anchor Recovery, a community recovery organization established in 2010 and funded through the state's Substance Abuse Prevention and Treatment (SAPT) block grant.

Direct patient crisis response in partnership with a community organization was a familiar approach for the first Rhode Island hospital site to provide SUD peer services. The hospital already had an agreement with a local intimate partner violence organization that allowed volunteers to connect with patients in the ED. The hospital also maintained an agreement with the Providence Center to provide a clinician to triage and assess patients who came into the ED indicating mental health and SUD-related needs. Initial grant funding and existing relationships helped to facilitate development of peer integration.

Medicaid reimbursement. In the long term, paying for peers meant developing a source of sustainable funding for the program, and Rhode Island's health policy leaders saw an opportunity to reimburse for peer services in Medicaid. While states have a variety of authority options to cover recovery support services in Medicaid, including health home models and 1915(b) and 1915(c) waivers, Rhode Island is one of nine states to provide these services under an 1115 demonstration waiver, submitted to the Centers for Medicare & Medicaid Services (CMS) in 2016 and approved in 2018. The waiver specifies that reimbursable services under the authorized Recovery Navigation Program (RNP) and Peer Recovery Specialist (PRS) Program include "an array of interventions that promote socialization, long-term recovery, wellness, self-advocacy, and connections in the community," delivered as part of a care team.

Rhode Island's waiver requires the state to credential peers using the International Certification & Reciprocity Consortium (IC&RC) exam and to develop standards for peer supervisors, as outlined in the previous section. The Rhode Island waiver created a bundled payment, which incorporates services provided by peer recovery specialists as part of the Recovery Navigation Programs. Services outside of such programs, which include those provided in EDs, are billed by the Medicaid-enrolled provider organization employing the PRS and are paid as a flat fee – peer services are reimbursed by Medicaid at rates of $13.50/15 minute unit for one-on-one services and $4/15 minute unit for up to 10 participants for group services.

Reporting and Outcomes

State regulations require that hospitals must report all opioid overdoses to RIDOH within 48 hours through a case report form that captures information about the patient and the overdose event. Additionally, AnchorED captures and reports on each unique patient contact, including data describing whether peer or other counseling services were accepted by the patient. Patients may also be referred to outpatient MOUD treatment, admitted to detox, or refuse engagement altoghter. This data is reported to the state by each hospital as de-identified, aggregate demographic and incident data. This is used to inform state leaders about who is seeking services and what factors may be leading to overdose, and how services are being initiated by PRS.

AnchorED reports:

- Average minutes between contact and team connection to a patient;
- Whether naloxone training was done;
- Whether an individual agreed to see a PRS;
- Whether an individual agrees to a treatment referral; and
- Whether an individual agrees to initiating MOUD that day.

State agencies use these data sets to track outcomes and understand how hospitals are engaging individuals after an overdose to ensure connections to treatment are made. Rhode Island's overall SUD response strategy includes collection and analysis of treatment and recovery data, and the state uses its Prevent Overdose RI website as a platform to publicly report on measures. ED overdose visits are reported publicly on a monthly basis, along with location and naloxone provision data, and the AnchorED outcomes of patient engagement. Reports include quarterly numbers showing total ED visits, as well as post-overdose counseling, which was accepted by 26 percent of overdose patients in the most recent data reported for the fourth quarter of 2020. Data for that time period also shows that of a total 267 overdose patients, with 45 percent receiving naloxone before being discharged from the hospital.

Anchor Recovery peer specialist services include:

- Linking individuals to treatment and recovery resources;
- Educating about overdose, prevention, and how to obtain naloxone, a drug that reverses the effects of an opioid overdose when administered quickly;
- Providing additional resources to individuals and family members; and
- Contacting the individual after release from the ED with a follow-up phone call.

Source: Anchor Recovery

Challenges and Considerations in Maximizing Peer Workforce

Engage stakeholders. Peer stakeholders have been engaged with policymakers since the inception of the AnchorED program. These relationships helped to develop the policies that support the program, particularly for peer certification requirements. Stakeholder and cross-agency communication continues to drive policy in Rhode Island; regular informal communication through weekly calls among PRS contractors/peer recovery organizations, ED

providers, law enforcement, detox centers, and state agencies has been key to identifying emerging trends and resulting needs.

Build workforce diversity. Several state leaders and stakeholders noted that diversity is lacking in the existing peer workforce and suggested that targeted recruitment of peers who are people of color, are bilingual, and/or identify as LGBTQ may help better meet the state population's needs. A February 2021 update to the Governor's Task Force – which has recently created a Racial Equity Workgroup – prioritizes this as a goal for the state's recovery work, listing recruitment and training of people of color and those who speak languages other than English as a short-term recommendation.

Delineate peer roles. While the goals of peer engagement include patient retention and continuity of care, ED providers and stakeholders repeatedly stressed that connecting overdose patients to medications to treat opioid use disorder (MOUD) was the most important intervention to reduce overdose death. Providers noted concern regarding peers advocating for patients to choose either MOUD or abstinence-based recovery, a clinical decision that may test role definition and boundaries.
While they emphasized that most peer-to-patient interactions are not clinical in nature and do not include discussions of medical interventions, there have been occasions when providers felt that peers may be overstepping in their roles by dissuading overdose patients from initiating MOUD. Providers and peers alike are mindful of existing tension in the recovery community regarding the use of medications. Abstinence-based recovery programming sometimes discourages medications, though this perspective is far from universal. In the most recent Governor's Task Force strategic plan update, Rhode Island included a goal to develop PRS who focus on supporting patients in MOUD treatment, and to integrate these specialty PRS into services across the SUD continuum of care.

Identify hiring barriers. When Rhode Island first shifted toward employing peers to work within the hospital, leaders within the recovery organization and the hospital system had to decide whether peers would need to go through hospital system human resources checks and procedures, which may have posed barriers to peers being able to work in the hospital environment due to felony backgrounds or other prior issues. Rhode Island determined that the best course of action was to have peer candidates evaluated as part of the the recovery organization's human resources to avoid this. Within some health systems, internal hospital policies can prevent the hiring of individuals with felony records, a challenge for some people in recovery who had past convictions. To mitigate this, states can consider approaches in which peers are hired by the organizations that bill for peer services rather than directly by hospitals.

Conclusion

The importance of relationships across systems and among team members in developing and integrating peer services in EDs was a dominant theme in interviews with state leaders and stakeholders. Relationships between the recovery community and hospital clinicians were already in place before AnchorED became a Medicaid-reimbursable model, and leaning on

those relationships was key to licensure and Medicaid policy creation. Further, the relationships that develop between team members when providing peer services in the ED help to reduce stigma. As one peer leader said, integrating "education along the way" by talking with providers about the realities of active use and the fears that emerge from it helped humanize recovery for ED providers. Rhode Island's leaders routinely pointed to the small size of the state and the opportunity that affords them to develop such relationships across systems. While the state's small size is a unique factor that cannot be replicated, it suggests that states can support regional relationships among community behavioral health, community recovery organizations, and hospital systems through formal regional networks and activities.

Acknowledgements

This brief was supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) as part of a financial assistance award under the National Organizations of State and Local Officials cooperative agreement. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement, by HRSA/HHS, or the US government. The authors would like to thank HRSA project officer Diba Rab for her support and guidance. Further, the authors would like to acknowledge the dedication, leadership, and input of Rhode Island state agency leaders and staff, as well as providers, stakeholders, and peers who contributed to this brief.