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INSIDE

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Case Managers Can Help Patients With Traumatic Brain Injuries

Higher level of care needed

Millions of people survive brain injuries each year, but when the concussion is severe, recovery can be slow and challenging. This population might not always receive case management, which can help with recovery.

"The number one psychiatric condition after brain injury is depression, and almost 50% of people with a brain injury will develop significant depression, which can lead to other problems like alcohol abuse and drug abuse," says **Nancy Weber**, MA, CBIS, brain injury case manager and clinical evaluator for the Neurologic Rehabilitation Institute at Brookhaven Hospital in Tulsa, OK.

Traumatic brain injury (TBI) affects about 2.5 million people per year, hospitalizing more than 280,000 and killing more than 52,000, according to a 2015 CDC report to Congress titled "Traumatic Brain Injury in the United States: Epidemiology and Rehabilitation."[1]

PEOPLE WHO HAVE SUFFERED SEVERE BRAIN INJURIES SOMETIMES NEED A HIGHER LEVEL OF CARE THAN IS AVAILABLE IN THEIR COMMUNITIES, AND THIS IS WHERE CASE MANAGEMENT CAN HELP.

People who have suffered severe brain injuries sometimes need a higher level of care than is available in their communities, and this is where case management can help, Weber says.

When working with a person who has suffered a brain injury, Weber will first assess the person's local resources and ensure every option has been employed.

Case managers have an important

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skill of identifying resources, and they must put this in practice with brain injury patients, says **Janet Mott**, PhD, CRC, CCM, rehabilitation counselor/case manager. Mott contracts with the Brain Injury Alliance of Washington in Mount Vernon, VA. *(For tips on best practices in helping TBI patients, see related story on page 87.)*

"We provide help for their families and loved ones and caregivers," Mott says. "I've always viewed this role as looking at the whole person, and that's an important thing that case management needs to bring to the table."

The case management goal is to address social-behavioral problems that can result from brain injuries to reduce the chance TBI patients will end up in prison. An estimated 60% of people who are incarcerated have been affected by TBI, according to the CDC report.[1]

If the local community and even the state do not offer enough help, Weber will suggest the brain injury survivor seek help in another state.

"If there's nothing in the state to help them, I talk with the family about how they feel about their loved one leaving the state to receive treatment," Weber says.

"I need the family on board," she adds. "I know this is awkward, and they're concerned about their well-being, but how can we help this person and keep them from ending up in prison?"

This case management process can begin in a hospital, including a psychiatric unit, and it might work with alternative payment structures.

"I work with case management at the hospital, and we bring in other stakeholders," Weber says. "For example, the insurance company and Medicaid folks, and we take self-pay, negotiating the rate for the family."

Since it's difficult to determine how long a patient will be in the psych unit, case managers do everything they can to be cost-effective, she adds.

Case managers also can help brain injury patients by analyzing and identifying their specific needs and how these might match with community resources, Mott says.

This can be challenging. For example, one of Mott's clients has a long history of significant brain injuries that have taken their toll.

"Eventually, he was diagnosed with frontal temporal dementia," Mott says.

The brain injury affected his behavior, resulting in his being hospitalized in a state mental institution that is unable to provide him with the services he needs, Mott says.

EXECUTIVE SUMMARY

Millions of people suffer from traumatic brain injuries each year, and about 280,000 of them are hospitalized. The impact of their severe brain injuries and long recoveries can result in ongoing mental health and behavioral issues. Case managers can help them with this recovery.

- The first step is to assess the person's local resources.
- One goal is to address social-behavioral issues that arise from brain injury.
- Case managers can help brain injury patients analyze and identify their specific needs.

In some states, anyone who exhibits even mild aggressive behaviors would have trouble being accepted in a skilled nursing facility or adult family home, leaving too few options for such TBI patients, she notes.

Also, people who experience significant neurobehavioral issues might need help when meeting with social workers and psychiatric counselors.

"They don't always know what to do next because the brain injury client doesn't fit into the services they offer," Mott says. "When you get into the world of behavioral health, we have a long way to go from the case management perspective to understanding the world of brain injury and all of these other spheres."

People with brain injuries and behavioral trauma need additional help in healthcare facilities. They might have periods of psychotic or hyperaggressive behavior, she adds.

Treatment of brain-injured patients with these behavioral issues will be more successful if case managers and other healthcare professionals take into account how the mental health issues impact the brain injury, and vice versa.

"That's how I get involved," Mott says.

Many TBI associations have a resource center, as does the Brain Injury Alliance of Washington. *(For more information, visit: https://bit.ly/2tKxkQp.)*

"Anyone can call in and ask us a question, and we try to find them an answer and resource," Mott says. "If it's a complex case, then I'm asked to work with them virtually." ■

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Best Practices for Case Management of Brain Injury Patients

It takes a village to help

Case managers have a great deal to offer people who have survived traumatic brain injuries (TBIs).

To help patients improve quality of life, case managers must be extremely creative with resources, and flexible with where to find these resources.

"When I evaluate a patient who's had a severe brain injury, I look at the transition piece from us — when they leave us and what's going to happen," says **Nancy Weber**, MA, CBIS, brain injury case manager and clinical evaluator for the Neurologic Rehabilitation Institute at Brookhaven Hospital in Tulsa, OK.

"Recognizing they'll only stay with us for a certain length of time, collaborative case management becomes vitally important," Weber says. "Everyone has to understand the roles they play."

With brain-injured patients, it truly takes a village to help them, says **Janet Mott**, PhD, CRC, CCM, rehabilitation counselor/case manager. Mott contracts with the Brain Injury Alliance of Washington in Mount Vernon, VA.

"I think it takes a village of a high population of individuals that might be on the list of who's going to be there to help this individual, who has significant neurological problems, function in life," Mott says.

Mott and Weber offer the following additional tips on how case managers can help TBI patients:

• Meet with other service providers to discuss cases. Meetings can include service providers, healthcare professionals, law enforcement, and others. They can discuss cases, subject to HIPAA rules, and problem-solve together, Mott says.

"To me, that's the essence of case management," she says. "I know lots of case managers who are viewed as the gatekeepers and have responsibilities for this population. We're not naïve, but if we all work together, we can make things better for this population."

Team members can learn from one another and problem-solve together, she adds.

• Provide collaborative case management. There are many people involved in care of a brain injury patient, including the family, patient, social worker, people involved in the patient's Medicaid or insurance, people in their group home when applicable, and sometimes even attorneys and judges, Weber says.

"So when people say, 'Are you primarily working with the patient?' I say, 'No, that's our clinical team in

the hospital,'" she explains. "I work with everybody else. I do see the patient and evaluate the patient, but that's all the time I spend. The rest of the time is collaborating with all of the other stakeholders and with other case managers, as well."

• Keep brain-injured patients out of jails and psychiatric hospitals. One of the tragedies that case managers can help brain-injured patients avoid involves their behavior landing them in prison or a psychiatric hospital.

Sometimes a patient will have been kicked out of group homes because of behavior issues. The patient's family might have young children at home and not want them exposed to physical and verbal aggression, Weber says.

"When there is damage to certain areas of the brain, there is an impact on planning, emotional control, and inhibition," she explains. "We might see people with intermittent explosive disorder, and the person might be hypersexual, aggressive, and have delusions."

If someone in the community calls the police on a patient who has a speech issue related to the brain injury, the patient might be jailed for being disruptive and angry, Weber adds.

The best prevention would be for case management to focus on finding a stable living situation for the patient.

• Find creative resources. Mott has worked with family members to find resources that will accommodate the brain-injured patient's unique behaviors.

"You have to know it's a revolving door and there might not be a permanent solution, so you'll have to be open to that fact," Mott says.

"I'm working with a young man in his 30s who has had several significant brain injuries and is in the process of having a seizure problem," she explains. "He has behavior problems and has lost his car because he couldn't make the payment."

He also needed housing. So Mott reached out to community organizations, looking for a place he could stay within his disability check budget.

> "THE AVERAGE LENGTH OF STAY AFTER A SEVERE BRAIN INJURY WAS 57 DAYS, AND NOW IT'S 17 DAYS, SO PEOPLE ARE GOING HOME QUICKER AND SICKER."

Mott found a retired school teacher who was willing to rent out a spare room and bathroom in her house. "She said she was willing to try it, and he pays her part of his Social Security disability money, and it's kind of working out, although it's not perfect," she says.

The man's case management also entails finding him a medical solution to his seizures.

"We're on that mission now to see if things can be solved with medication or whether it would have to be surgery," Mott says.

• Address the person's current care needs. "What level of care does this person need at this point?" Weber says. "Sometimes, a family member calls me and says, 'They're not the same, driving us all crazy,' and when I arrive on the scene, I realize we have a case of family burnout."

The patient might be doing as well as expected, performing activities of daily living, but still need transportation.

"For the most part they're functioning, but they may get angry," Weber explains. "Then I say, 'Let's look at what resources are available for you as a family unit, so we can get you what you need.'"

• Help the families of people with brain injuries. Burnout is a major issue for caregivers of people with brain injury.

Burnout leads to health and behavioral problems, including substance abuse, neglect, and abandonment, Weber says.

"We've had people who wanted to drop off their loved one and never come back again," she says. "The average length of stay after a severe brain injury was 57 days, and now it's 17 days, so people are going home quicker and sicker."

This shifting of care from a healthcare setting to the home and family is putting an enormous burden on patients' families. "Who is addressing that with the family and offering them guidance?" Weber says.

• Use brain injury alliances as a resource. "All of the active brain injury alliances and associations, I give them a huge shout-out because they are ones that can provide resources to families in states and locally," Weber says.

"I work closely with the Brain Injury Alliance of Iowa and Washington, going there first and foremost," she says. "Some are more active than others and also have support groups that can be incredibly helpful."

When families experience crisis, the alliances might have case managers who can help people face those challenges, she adds. ■

Conversations Can Be a Good Way to Improve Transitions

Ask patient clarifying questions

Case managers play an important role in providing information to patients and caregivers. They also provide training and follow-up with patients during transitions following a health crisis. They could perform all of their responsibilities very well and still miss the mark that leads to optimal outcomes.

Why? One answer: underdeveloped communication strategies.

"If you have an opportunity as a case manager at any stage to have a comprehensive conversation with a patient and the family, it's always the ideal," says **Eboni Green**, RN, PhD, co-founder of Caregiver Support Services in Omaha, NE.

"Sometimes you collect data in bits and pieces," Green says.

For a holistic picture of what's going on, ask the patient more clarifying questions to identify the overall goal.

"We know very few people actually communicate their decisions," Green says. "If you have a good idea of what the goals are for the caregiver and patient, then you have the opportunity to advocate for what you feel like will work, what you know their wishes are, resulting in fewer regrets from the family's perspective."

Case managers are in a good position to advocate for patients, but they need information about what the patient wants — as well as what health providers want for the patient. The way to find out what they want is to develop a rapport with patients and listen to what they say they need.

This is especially important when patients have not spelled out their decisions and plans in advance directives.

"We have the ability as case managers to explain to our client the variety of options that are available, which can be overwhelming for families," Green explains. "We give them a couple of options to assess their situation."

Case managers with conversational skills can help families find resolutions that bring peace to stressful situations.

For example, Green experienced the difference communication makes when her husband and

Brochure Shows How to Plan Care Discussions

Set realistic goals

Case managers can access a free, downloadable guide about how to improve communication with families during stressful health events.

The guide, called RightConversations, offers 10 tips for effective communication, plus a communication planner, a family action planner, and an information journal.

The guide is available at: http://bit.ly/2KapBGz.

Here are some tips on how to help plan the conversation:

- prepare to help the loved one be ready and open to the discussion;
- set realistic goals, looking at what each family member hopes to accomplish;
- identify the discussion leader and encourage others to provide moral support;
- determine the best setting in which to hold the discussion. The setting sets the tone for a comfortable conversation, which should last no more than an hour. Placing a time limit on the conversation helps to prevent it from unraveling;
- plan and practice key messages for the conversation;
- address facts and concerns;
- accept that the discussion could be difficult and be ready for it;
- use open-ended questions, which are effective in gathering information;
- thank everyone for their time;
- practice the conversation to ensure words are chosen carefully and thoughtfully. ■

she were caregivers for his stepfather. When the stepfather was hospitalized after a terminal diagnosis, Green and her husband knew that he wanted to be home because they had spent time talking with him. But his other adult children were unaware of his wishes.

"For him to articulate what his wishes were, we had to have a family meeting at the hospital," Green says.

"So you have varying views from my mother-in-law — his wife of 40-plus years — and four children, who were involved in the situation," Green explains. "The biological children felt they should be making the decisions, but my father-in-law wanted my husband to oversee his care."

To make this difficult family meeting work, they had a nurse practitioner case manager facilitate a conversation with all family members. The case manager helped people understand that the patriarch wanted Green's husband to make decisions and that he didn't want any additional treatment to prolong his life.

There were compromises: Green's father-in-law wanted to die at home. Hospice workers could have visited his home and helped provide care, but his wife was not emotionally able to handle that decision. So he went to a long-term care setting for end-of-life services.

"We were able to assist my father-in-law with the outcomes he wanted, and there wasn't all of the family drama," she says. "We worked with the case manager to set expectations and to work through that process to make sure things were done the way he wanted them done."

The experience led to Green helping to create a conversational guide, called RightConversations. It features several downloadable resources and videos to help families hold these difficult conversations. *(The guide is available at: http://bit.ly/2KapBGz.)*

"It is a comprehensive conversation guide," she says. *(See related story on how to plan the conversation, page 89.)*

The guide offers tips on improving a family's understanding of the loved one's behavior and illness. One tip about involving siblings suggests:

- involve the right people in the conversation with the loved one from the beginning;
- help siblings who live at a distance truly understand the magnitude of the situation;
- understand how the loved one may share different information with different members of the family, creating information gaps among siblings; these differences should be addressed quickly to keep lines of communication open;
- be aware of self-interest, setting it aside and focusing on the loved one's well-being to avoid distorting the decision-making process.

Case managers also can work on developing conversational skills for communicating with other healthcare professionals.

"In the best-case scenario, you have an opportunity, if you have adequate information, to communicate what the overall goal is for the family," Green says. ■

EXECUTIVE SUMMARY

Poorly developed communication strategies can undermine case management efforts to inform and train patients.

- One strategy to improve communication and conversations with patients is to ask the patient more clarifying questions to identify the overall goal.
- Case managers can help families find resolutions that bring peace to stressful situations.
- Case managers can advocate for patients.

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The Joint Commission Issues Advisory on Human Trafficking Victims in Healthcare

Safety actions listed

The Joint Commission recently issued an advisory titled "Quick Safety 42: Identifying Human Trafficking Victims."

According to the organization's alert, the United States had 40,200 reports of human trafficking cases between 2007 and 2017. Human trafficking is the fastest-growing criminal industry in the world and a major source of income for organized crime.[1,2]

Recognize the Signs

The advisory gives healthcare professionals tips on recognizing the signs of human trafficking in patients, including the following:

- patient appears fearful, anxious, depressed, submissive, tense, nervous, or paranoid;
- avoids eye contact, refuses to change into a gown or cooperate with a physical exam;
- the patient's behavior or demeanor do not align with the injury or complaint, such as the person saying "it's no big deal" when the injury is serious;
- refuses to go to a specialist;
- unable to speak for him- or herself due to a third party insisting on being present or interpreting;
- the patient doesn't have an ID;
- he or she cannot clarify home address;
- exhibits a loss of sense of time and place;
- inconsistencies in his or her story;
- the patient appears malnourished;
- shows signs of physical abuse, physical restraint, confinement, torture, and/or sexual abuse.[2]

"Quick Safety 42" encourages medical providers to give trafficking victims information and options while supporting them as they connect with service providers, if they are ready to report their situation.

THE ADVISORY ENCOURAGES MEDICAL PROVIDERS TO GIVE TRAFFICKING VICTIMS INFORMATION AND OPTIONS WHILE SUPPORTING THEM AS THEY CONNECT WITH SERVICE PROVIDERS, IF THEY ARE READY TO REPORT.

Offer Support, Resources

When healthcare professionals believe it's a situation with immediate and life-threatening danger, they should follow institutional policies for reporting to law enforcement. Also, they should provide patients with the National Human Trafficking Resource Center hotline number. They can help the patient memorize the number in the event that it would be dangerous to hang on to the information.

Other actions to take include the following:

- give the patient options for services, reporting, and resources, and ensure that safety planning is part of the discharge planning process;
- if the patient is a minor, follow mandatory state reporting laws and institutional policies for child abuse or serving unaccompanied youth;
- gain permission and consent from adult patients who have been trafficked before disclosing personal information about the patient to other service providers;
- ask social workers to help patients get the support and resources they need, including using resources from the National Human Trafficking Hotline, United Nations Office on Drugs and Crime, the U.S. Department of Health and Human Services, and others.

Quick Safety 42 is available on The Joint Commission website at: http://bit.ly/2lFPO14. ■

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Emergency Clinicians Steer Patients With Substance Use Problems Into Effective Treatment

ED-based peer recovery coaches are part of a comprehensive approach

Baltimore has struggled mightily with substance misuse, and much of this burden has fallen on EDs in the region. Indeed, statistics from 2014 suggest that the city registered the highest rate of ED use due to opioid use disorder in the country, and the volume has not let up.

This has prompted hospitals and public health authorities to create innovative solutions to address the problem in a comprehensive way. For example, two years ago, the ED at University of Maryland Medical Center (UMMC) in Baltimore decided it needed a fresh approach toward connecting patients with effective treatment. The impetus for action on this front stemmed from the realization that substance use was a key contributing factor to a growing number of diagnoses.

"Many of the patients ... were coming in with a medical complaint, but really when we got studies done and [figured out] why they were there, we recognized that substance use was ... at the heart of whatever their medical issue was," explains **Andrea Smith**, DNP, CRNP, the director of urgent care and advanced practice emergency services at UMMC.

Eric Weintraub, MD, director of the division of alcohol and drug abuse and co-director of adult psychiatry at UMMC, notes that some of these patients presented with psychiatric issues while others arrived with medical concerns, but they were not treated for substance misuse.

"They were getting patched up and sent on their way, and we were seeing high rates of recidivism," Weintraub says.

Part of the problem was that many of these patients were reluctant to discuss their issues around substance use with the emergency clinicians. "When I would try to approach this subject with patients, they just weren't opening up to me, and I wasn't able to build that relationship," Smith observes.

To get around this barrier, UMMC became the first hospital in Maryland selected to pilot the idea of leveraging peer recovery coaches — people who are in long-term recovery themselves and have received training in how to assess the readiness of patients to consider treatment. Peer recovery coaches work with patients to find a solution most likely to succeed, and facilitate patients' transition into an appropriate program.

"I was able to secure funding for our hospital to hire three peer recovery coaches, and that is how [the program] started," Weintraub observes. "They have been working here for two years now, doing SBIRT [screening, brief intervention, and referral to treatment]. [Coaches] see anybody in the ED who screens positive for substance misuse, and it has worked pretty well. We have seen thousands of patients and gotten people into treatment, which has been really helpful."

Meanwhile, the need for such services has only grown. "As a university-owned medical system, we have gone from a couple of years ago seeing an overdose every other day to having two overdoses per day now," Weintraub laments.

In the beginning stages of this effort, the focus was on embedding the peer recovery coaches into the emergency team.

"When [coaches] came in to train and orient, one of the things I did strategically ... was have them shadow a resident, a nurse, and an attending [physician]," Smith shares. "This was to have a walk-through so that they could see the workflow, but also start to ... build the relationships so that the clinical team understood what the peer coaches were all about and vice versa."

Still, it was challenging to integrate the peer recovery coaches and their work with patients into the overall flow of the ED.

"That was difficult because this is a fast-paced environment," Smith explains. "You've got a million things going on at once, and a lot of times [in the past] ... substance use was something we would maybe bring up once and then not talk about [again], but we really put that [issue] at the forefront."

Now, every patient who comes through the door of the ED undergoes a brief screening at triage that includes four questions regarding drug and alcohol use.

"Based on the responses, if a patient's score is above seven, then the peer recovery coach will get a flag to go see that patient," Smith says. "About 25% of the patients we see in the ED in Baltimore have a positive screen, and that means their

substance use or their risk of harm is so great that we need to [have them seen]."

Use Disclosure to Open Doors

Archie Rhyne, a peer recovery coach at UMMC, notes that the flag, indicating that a patient needs to be seen, appears on a computer screen in his office.

"That is when I will first talk to the nurse [caring for the patient] and find out if there is anything [he or she] needs to let me know about the patient," he explains. For example, the patient may be sedated or irritable, or it may be best to wait a few minutes because the patient is about to go to radiology for X-rays. The nurse will convey any information that can help the peer recovery coach engage in a more productive discussion with the patient.

"Also, the nurse will always let the patient know the hospital has a peer recovery coach that would like to come around and talk to them and may be of some assistance," Rhyne says.

Typically, Rhyne will introduce himself to the patient and ask if it is acceptable if he provides the patient with some self-disclosure. "That is my door in because I start disclosing that I have been exactly where they are. It loosens the patient up a little bit, and they will start talking," he says.

Rhyne explains that his conversation always has to be about what the patient wants, but he will guide the patient toward questions relating to what his or her life might be like without the drugs or alcohol that the patient is misusing. "A lot of times patients just take a moment to think," he says. "Me being in recovery myself, I know that when I was caught up, there were moments I couldn't have ... because it was always about where I was going to get my next [fix], and I was always filled with shame about what I did to get one."

When patients hear about Rhyne's experiences, he says they tend to relax and share more information with him. "I will find a patient who may have been in treatment four or five times, and then gave up on himself. Then, I will disclose that it took me 40 [attempts], and we talk," he says. "When I get that one moment when a patient starts to feel something for himself again, that's when I will [ask] what was the last type of treatment that he had."

Rhyne will explore with the patient how the treatment worked, and whether an alternative approach might be worth a try. "A lot of times, for a person who has been in and out of treatment, and has tried the same thing over and over, a different approach will work better," he says. "Basically, though, it is always about what the patient thinks will work for them because [treatment] is not being imposed or forced on them. If it is what they think will work ... I know from experience they will give it their best shot."

Rhyne emphasizes to patients that there are many resources available to them — a reality that many patients have not experienced.

"Most addicts are out of touch with what is going on as far as what is available to them," he says. For example, they may have called treatment centers in the past and learned that they would be put on a four-week waiting list. But for this program, UMMC has connected with treatment facilities throughout Baltimore, including 11 fast-track treatment providers that will accept patients right away or the very next day.

Consequently, once Rhyne and a patient have decided on a treatment path, Rhyne will leave the room and start making calls.

"Sometimes, we can get the patient into treatment as soon as he or she is discharged from the ED," Rhyne observes. "We have funds here at the hospital where we can send them by Lyft or Uber because a lot of times, if we put them on public transportation by themselves, they will change their mind before they get there. If we can get [patients] right there and sign them up, they will stay."

Before taking any action on treatment, Rhyne always confers with the patient's emergency providers to share what he has learned from the patient and offer his recommendations.

"I may have been able to get more information from the patient than [the clinicians] did ... and then they are able to understand the patient a little bit better," he says. "They work right along with us. The physicians, nurses — everybody. It is like one big team now. And we have a great relationship with the outside providers — the treatment centers and the IOPs [intensive outpatient programs]."

Among the treatment options available to appropriate patients is ED-based induction of Suboxone, a prescription medication that includes buprenorphine and naloxone. Under this approach, patients receive their first dose while they are still in the ED, and then they are connected to a treatment facility for subsequent doses. In fact, Weintraub obtained a grant for UMMC to train emergency physicians throughout Baltimore to provide this intervention, and he is trying to get the approach expanded to EDs throughout the state.

"Part of it depends on the willingness of emergency physicians to follow the protocols," he says. "And

it is work trying to destigmatize and encourage physicians to do this type of treatment."

Smith observes that peer recovery coaches can connect on a deep level with patients who have substance use problems.

"They can get from these patients in five minutes what it would take me hours to get just because of the lived experience that they share with them," she says, adding that there is constant demand for their services. "It is not uncommon to have 10 to 15 patients on the board that the peer recovery coaches need to go see. We have three peer recovery coaches on staff in the ED, and one peer recovery coach is in our psych ED."

The peer recovery coaches cover the ED from 6:30 a.m. to 1 a.m. Monday through Friday, and from 11 a.m. to 9 p.m. on the weekends.

"They work in 10-hour shifts, and we are actually in the process of hiring more individuals so that we can offer 24/7 coverage," Smith adds. "The peer recovery coach in the psych ED covers 8 a.m. to 5 p.m., Monday through Friday."

However, for patients who have been brought to the ED because of an overdose, it is often difficult to engage them in discussions regarding treatment while they are in the hospital, Weintraub explains. "They have received Narcan [naloxone], and it will wake them up and reverse the overdose, and it frequently puts them into pretty severe withdrawal," he says. "They are very angry and irritable, and oftentimes are not that interested in talking to anybody."

Consequently, in cases in which these patients decline interactions with the ED-based peer recovery coaches, they are referred to an outreach worker who is part of the Overdose Survivors Outreach Program (OSOP), an effort supported by the Maryland Department of Health's Behavioral Health Administration. *(For more information on the program, visit: https://bit.ly/2J0b13U.)*

The OSOP workers have a similar background and similar responsibilities to the ED-based peer recovery coaches, but will primarily follow and work with overdose survivors who have been discharged.

"We provide a spot for [the outreach workers] in the hospital, and they are employed by the hospital ... but most of their time is spent out in the community," Weintraub shares.

> "THEY CAN GET FROM THESE PATIENTS IN FIVE MINUTES WHAT IT WOULD TAKE ME HOURS TO GET JUST BECAUSE OF THE LIVED EXPERIENCE THAT THEY SHARE WITH THEM."

The goal of the outreach workers is to stay in touch with overdose survivors and eventually link survivors into needed treatment for their addiction. The outreach workers also follow up with overdose patients originally referred into treatment by the ED-based peer recovery coaches.

"Anyone who overdoses is automatically transitioned to the outreach worker," Weintraub notes. "If you have someone who is actually cooperative and feels like they want treatment after the overdose while they are still in the ED, then our in-house peer recovery coaches can refer the person for treatment, but the follow-up is done by an outreach worker."

However, many overdose patients initially decline any discussions about treatment, leave the ED, and then the outreach worker tracks them down in the community. There is some blurring of the responsibilities between the peer recovery coaches and the outreach workers, Weintraub acknowledges.

"We try not to be too rigid. We just want to make sure the patients get the treatment they need."

Usually within 30 days of discharge, an outreach worker is able to link overdose survivors with some type of assistance, whether that involves transitional housing or another appropriate program, Smith says. "The program has been very successful."

Smith acknowledges that she was initially very concerned about the prospects of integrating the peer recovery coaches and the outreach workers into the ED. "Being involved in emergency medicine for almost 15 years, I knew how difficult it is to say that, 'oh, by the way, we are now going to be adding [something] else to the care of patients,'" she says.

However, Smith's concerns were dispelled quickly. "We were very strategic and very careful in how we implemented the program, and it was well-received almost immediately because there was such a need," she says, adding that collaborating with the peer recovery coaches and the outreach workers has delivered dividends over time.

Smith says that emergency staff members have seen the difference the program has made in patients, including some who have been coming in for years and are now in long-term recovery. "The peer recovery coaches and outreach workers are

part of the medical team now, and if they are not there for some reason, it is noticeable." In fact, Smith says providers sometimes ask for peer recovery consults for patients who have not screened positive during triage. In the past year, peer recovery coaches have seen just shy of 30,000 patients who have presented to the ED. Roughly 3,000 of those patients have gone on to receive some type of intervention.

"We have confirmed entry for 433 patients ... which means they are active in recovery," she says, adding that at least one of the patients who has been referred into treatment through this program has become a peer recovery coach himself.

While peer recovery coaches have worked well in the ED at UMMC, Smith notes that other EDs interested in implementing a similar approach should first consider some of the hurdles involved.

For example, hiring recovering addicts raises all kinds of red flags to the people in human resources, so the issue must be addressed beforehand.

"Usually, everybody goes through drug tests and things like that, so we had to be very sensitive to how we onboard these individuals and what that process looks like," Smith recalls. "Make sure there is a close relationship with your human resources partners in starting this program because [these individuals] are not going to look like your [typical] employees, and that is very important to understand at the beginning. It was a lesson learned for me." Further, Smith reiterates that it is hard work integrating the peer recovery coaches into the medical team to ensure there is effective collaboration.

"You have to embed these peer coaches as part of the team or it will be just another service that is underutilized," Smith cautions.

Funding the peer recovery coaches is a challenge, too, and UMMC has not yet found a way to bill for their services, although treatment typically is covered by public and private payers. To date, the peer recovery coaches have been supported through grant funding.

Smith notes that any ED that implements a peer coaching model with the idea that it will reduce readmissions should not be looking for quick returns.

"When we initially brought this program on, we thought it would help us reduce our readmissions," Smith says. "What we found is that if patients were seen by our peer recovery coaches, they were actually three times more likely to return to the ED."

Investigators discovered the reason for the return trips was simply that the patients had received help in the ED for their substance use, so they were returning to the same place for help with their other health issues.

"Once patients are engaged, they will come back to you," Smith says. "What we found is that after the third visit, generally, there is a steep decline in the number of times the patient will return to the ED."

Now, ED staff are working toward connecting patients with a primary care physician and other needed social or behavioral health resources as part of the initial recovery piece so that they won't feel the need to come back to the ED for subsequent healthcare needs.

"That was a really important lesson learned for us," Smith adds.

Weintraub's advice to his emergency medicine colleagues is that before they implement peer recovery into the ED workflow, they first should consider whether the area has adequate resources for treatment of substance use disorders.

"It is all good and well to have an intervention ... but if you don't have anyone to refer patients to, that is a problem," he says. "We have a fair amount of treatment in Baltimore, so getting someone into treatment is generally doable."

Weintraub adds that it is important not to oversell the potential benefits or outcomes from a peer recovery coach program.

"The literature on the effectiveness and outcomes of peer recovery coaches in severely dependent opioid use disorder patients is pretty weak or nonexistent," he says. "There is a general sense that this is effective, and that it helps get people into treatment, but I don't think there is a good study on economic outcomes and things like that ... so you don't want to oversell what you are going to get."

However, the peer recovery coaches at UMMC have made a positive impact on morale in the ED because staff see patients getting help for their substance use disorders when they haven't been able to help those patients before, says Weintraub, adding that there are not as many hostile interactions with patients. Further, Weintraub says data show that SBIRT interventions can significantly affect recidivism.

Rhyne advises that on the front end of any program implementation, physicians and nurses need to better understand the people who present with opioid use disorders. "I know from my own experience, because I have been there, that [addicts] reach a point where all we hear is the stigma and all we get is the neglect ... we are just a problem to the world," he says. "The biggest thing peer [recovery coaches] have working for them is their experience and their ability for self-disclosure ... because patients can't deny the truth once you start speaking it, and it works." ■

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CE QUESTIONS

1. **According to 2015 CDC data, about how many people are affected by traumatic brain injuries each year?**
   a. 2.5 million experience TBIs; 280,000 are hospitalized, and 52,000 die
   b. 4 million experience TBIs, and 110,000 die from them
   c. 980,272 experience TBIs, and 12,212 die from them
   d. 1.7 million experience TBIs; 119,000 are hospitalized, and 43,000 die

2. **Which of the following is a consequence of severe brain injury?**
   a. Inability to have sexual relationships
   b. Constant need for a guardian
   c. Difficulty controlling emotions and behavior
   d. All of the above

3. **When planning a family conversation about a patient's health issues, which of the following is a tip that could help improve a family's understanding of the loved one's behavior and illness?**
   a. Involve the right people in the conversation with the loved one from the beginning.
   b. Help siblings who live at a distance understand the magnitude of the situation.
   c. Understand how the loved one may share different information with different members of the family, creating information gaps among siblings.
   d. All of the above

4. **The Joint Commission recently issued a human trafficking advisory. Which of the following is *not* a warning sign that it says healthcare professionals should learn to recognize?**
   a. An obese patient who appears to have diabetes
   b. A patient who appears fearful, anxious, depressed, submissive, tense, nervous, or paranoid
   c. A patient who avoids eye contact and refuses to change into a gown or cooperate with a physical exam
   d. A patient whose behavior or demeanor does not align with the injury or complaint