2-2021

An Assessment of Quality Improvement Strategies for the Implementation of Certified Recovery Specialists in Treating Opioid Use Disorder at the Emergency Department at Jefferson

A. Cosmo Annese

Rickie Brawer, PhD, MPH, CHES

Jefferson
Philadelphia University + Thomas Jefferson University

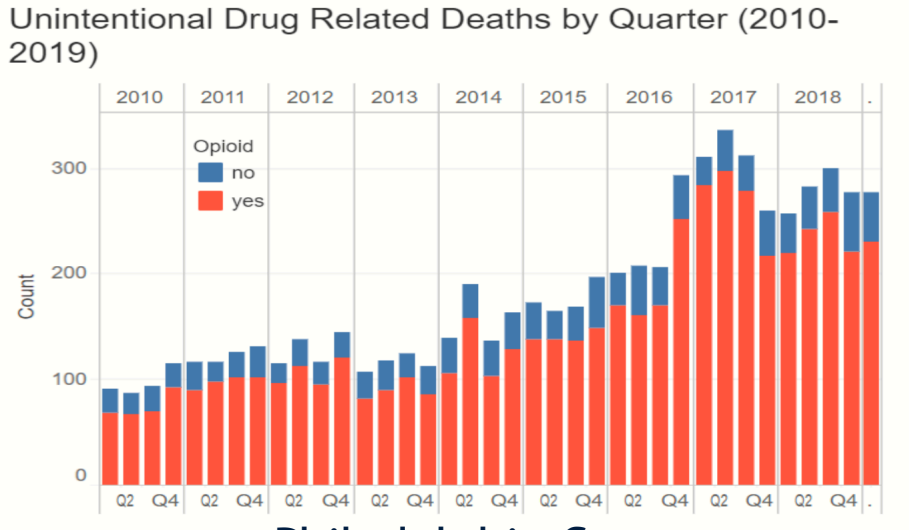
An Assessment of Quality Improvement Strategies for the Implementation of Certified Recovery Specialists in Treating Opioid Use Disorder in the Emergency Department

A. Cosmo Annese, *Rickie Brawer, PhD, MPH, MCHES

Introduction:

Study rationale:

- Opioid overdose mortality rate in U.S. keeps increasing (more than tripled from 2000-2017, up to 21.7 per 100,000)
- Barriers to proper care



Philadelphia County

Inquiry question: From the perspectives of CRSs and their respective Emergency Department healthcare teams, how can CRSs be most effectively implemented into the ED to treat OUD?

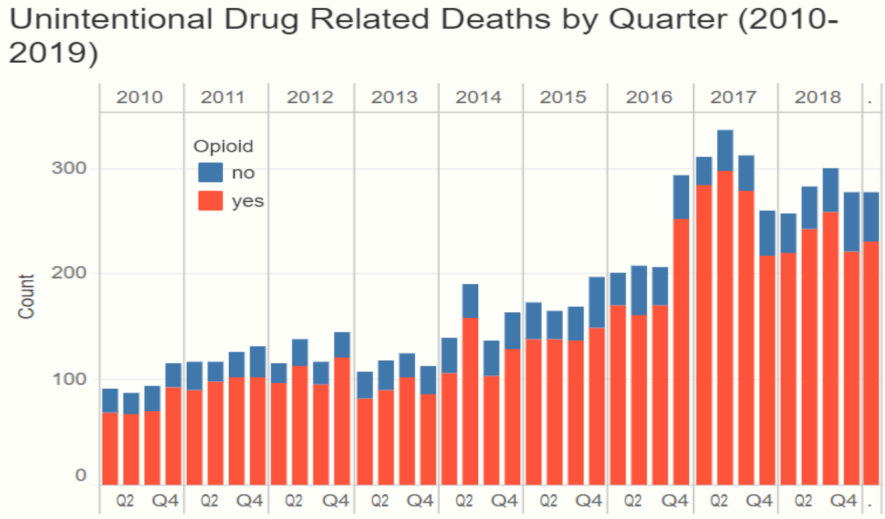
Project's major aim:

- Maximize quality of clinical CRS use in preparation for their implementation in the ED at Jefferson

Introduction (continued):

Study design:

Qualitative analysis using detailed, broad interviews of CRSs and physicians, followed by development of coding scheme



Philadelphia County

Hypotheses:

- CRSs work better in pairs/groups, improved morale.
- Effective communication with physicians is essential
- CRSs have positive impact on stigma
- Steep learning curve
- Improved outcomes and quality of care of OUD

Methods

- Study design:
  - Population:
    - Healthcare workers who have worked with CRSs.
    - CRSs employed at ED and elsewhere
      - CRSs without experience in clinical settings were not included
  - No IRB review required (quality improvement study)
- Data collection:
  - Transcribing interviews, use of NVIVO for coding

CERTIFIED RECOVERY SPECIALIST

Results

- Sample size: 8
  - 5 CRSs, 3 physicians
- Data collection incomplete:
  - Based on available data, preliminary ideas for codes include morale, stigma, roles, learning curve, effectiveness, etc.
  - Coding scheme to be revised as transcription process is completed.

Results continued:

- Codes and supporting quotes:

= CRSs

= Clinicians

Morale	Stigma	Roles	Learning curve	Effectiveness
• "I feel like I'm **part of their crew.**" • "**They treat us so well**, they ask us for advice, they know everybody's name" • "We do high 5s and **positive reinforcement** and send emails and send success stories" • "There's always a person carrying the same thing. That is why I think **it is so successful is because of our relationship"** • "Our CRSs are so **professional, friendly, and responsive"** • "[The CRSs] are really good at sharing success stories, and I think that **positively reinforces** our behavior and our thoughts"	• "There are a lot of things we can't do and a lot of things our people won't articulate to the medical staff **because of their own stigma."** • "We all came in with stigma wondering, '**who's going to listen to us and why would they?**'" • "[We] send success stories which I think helps **shift the culture** too" • "They **engage the patient in a non-stigmatizing way** to a conversation about treatment" • "I think seeing compassionate care modeled by someone else who's on the clinical team **helps with how we have historically treated patients with substance use disorders"** • "I certainly think having [CRSs] work so closely side by side with [clinicians] **has helped shift the culture a little."**	• "**Being part of the health system** and embedded in it has proven to be pretty **beneficial**" • "We **build a relationship** with the doctors, the nurses" • "We have **access to the EMRs, access to everybody's meetings and calendars and emails"** • "We're here 8-430 but we're on call **6 am-10 pm Monday-Sunday"** • "CRSs should be **present** in the ED with the patient **immediately upon them waking up.**" • "Part of our success is seeing how **committed** they are to their work and how **accessible** they are so the **burden is taken off of the provider**." • "They're **doing things for the patient that we as clinicians haven't been trained to do.**"	• "98% of it was on the fly. **You do not learn how to be in an ED from CRS school.**" • "Everything else I learned over the years - I threw that out the door. It didn't mean anything here at all. **It is a whole different experience"** • "I learned so much **more in real time from life experiences"** • "I think their role and their value is **not from having medical training**, but more from having a very specific role to play in **supporting patients** and helping them navigate the system." • "**I can't think of a situation where I've needed them to have more medical training.**" • "They understand what they need to understand about buprenorphine and withdrawal and naloxone and precipitated withdrawal. **They understand more** than our young residents even"	• "**Being part of the health system** and embedded in it has proven to be pretty **beneficial**" • "It's really been **proven to work to be part of the health system"** • "**So much positive** - I just can't - it's really a team effort for the patients" • "It's been **overwhelmingly positive**." • "I find bringing in a CRS just **changes the conversation with the patient."** • "Our CRSs are **great at forming a connection** with patients in just a few minutes"

Discussion/Conclusions:

- Take away message supported by interviews:
  - CRSs have had success being integrated into healthcare teams
    - Close relationships with clinicians
    - Working with other CRSs
  - Stigma:
    - Initial area of concern for CRSs
    - Possible culture shift along the way
  - EMR access and being hired at the hospital has been beneficial:
    - Greater CRS awareness of patient care
    - Lessened burden of clinicians
  - Learning curve:
    - Appears steep to CRSs
    - Does not appear problematic to clinicians
  - Effectiveness:
    - Establishing better connections with OUD patients
    - Better chance of post-discharge care

Discussion/Conclusions continued:

- With many programs (including Jefferson ED) in their nascent stages, there is value in documenting the successes and areas for improvement in existing programs.
- Hopefully:
  - Reduction in overdose deaths
  - Reduction in OUD patients discharged AMA
  - Improved transition to outpatient care

Limitations:

- Small sample size
- Loss of in-person interviews
- Those currently in recovery are a difficult demographic to study
- Large topic
  - Difficulty honing in on key elements to be studied

Future steps:

- Monitor early progress of CRS use at Jefferson ED
- Complete data collection and revise coding scheme as needed

Disclosures & Acknowledgments

- No disclosures

- Acknowledgements:
  - SI advisor:
    - Rickie Brawer, PhD, MPH, MCHES
  - Physicians:
    - Margaret Lowenstein, MD, MPhil, MSHP
    - Jeanmarie Perrone, MD, FACMT
    - Utsha Katri, MD
    - Judy Chertok, MD

  - Certified Recovery Specialists (CRS):
    - John Carlson - Executive Director of Transformation to Recovery
    - Kelliann O'Hare, Dorothy Lochetto, Tara Ragsdale - MATER patient navigators
    - Nicole O'Donnell, Bryant Rivera - CORE Penn Medicine
  - Students:
    - Russell Shernoff, SKMC; Aaron Kendrick, SKMC

References

- Goedel, W. C., Marshall, B., Samuels, E. A., Brinkman, M. G., Dettor, D., Langdon, K. J., Mahoney, L. A., Merchant, R. C., Nizami, T., O'Toole, G. A., Ramsey, S. E., Yedinak, J. L., & Beaudoin, F. L. (2019). Randomised clinical trial of an emergency department-based peer recovery support intervention to increase treatment uptake and reduce recurrent overdose among individuals at high risk for opioid overdose: study protocol for the navigator trial. *BMJ open*, *9*(11), e032052. https://doi.org/10.1136/bmjopen-2019-032052
- Kendrick, A.; Shernoff, R. (2020). Opioid Use Disorder (OUD) Care Pathway Optimization [PowerPoint slides].

Questions?


Jefferson
Philadelphia University +
Thomas Jefferson University
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE