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Journal of Substance Abuse Treatment 129 (2021) 108390

Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

journal homepage: www.elsevier.com/locate/jsat

Adaptations to Indiana's 21st Century Cures–funded recovery coaching initiative in the wake of COVID-19

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A R T I C L E I N F O

Keywords:
Opioid use disorder
Opioid overdose
Emergency departments
Peer recovery coaches
Medication for opioid use disorder

A B S T R A C T

This brief commentary discusses how provider organizations from Indiana's Recovery Coach and Peer Support Initiative (RCPSI) adapted their practices in response to the COVID-19 pandemic and associated restrictions. The RCPSI, which is funded through the 21st Century Cures Act, placed peer recovery coaches (PRCs) in emergency departments (EDs) to link opioid overdose patients to medication for opioid use disorder. This commentary discusses how COVID-19 restrictions increased use of telehealth to replace in-person PRC contacts with patients, affected the timing of initial PRC contacts with patients, and led to allowances for Medicaid billing of recovery coach support sessions conducted via telehealth. Future research should further determine the effects of these changes on PRC services in the ED.

1. Introduction

The 21st Century Cures Act made federal funding available for states to address the U.S. opioid epidemic (Watson, Andraka-Christou, Clarke, & Wiegandt, 2020). One of Indiana's Cures-supported programs is the Recovery Coach and Peer Support Initiative (RCPSI), which funded twelve provider organizations (nine hospitals and three community-based mental health agencies) to implement novel emergency department (ED)-based peer recovery coach (PRC) services for patients presenting with opioid use disorder (OUD). A primary goal of the RCPSI was to link patients with medications for opioid use disorder (MOUD) and other supports. While other programs have widely implemented such interventions in recent years, research has provided limited but promising evidence for these interventions (Powell, Treitler, Peterson, Borys, & Hallcom, 2019; Samuels et al., 2018; Samuels, Baird, Yang, & Mello, 2019; McGuire et al., 2020; Watson, Brucker et al., 2020; Waye et al., 2019). The RCPSI was rooted partially in such a promising intervention (see Watson et al., 2020); however, the twelve provider organizations were given broad implementation guidelines (i.e., provide ED-based PRC services to patients with OUD) that resulted in various program models. Funding for the RCPSI, which began implementation in spring 2017, was coming to an end in early 2020 when the coronavirus disease 2019 (COVID-19) pandemic was starting. The focus of this brief commentary is to describe adaptations of RCPSI provider organizations during initial months of the pandemic to highlight implications for practice and areas for future investigation.

2. Impact of COVID-19 on PRC in ED implementation and practice

On March 23, 2020, Indiana issued a stay-at-home order in response to the pandemic. The RCPSI provider organizations made numerous adaptations in response to state directives and an influx of COVID-19 patients. Our documentation of the provider organizations' adaptations comes from data collected as part of the evaluation of RCPSI services (Paquet et al., 2019). Evaluation participants included ED doctors, ED nurses, clinical social workers, hospital and mental health agency administrators, and PRCs. We collected data specifically reflecting COVID-19 issues in March and April 2020 and they include: (a) open-ended questions about sustainability of the intervention from seven surveys emailed to provider organization representatives and (b) transcripts from three RCPSI teleconference meetings. The data reflect adaptations from seven of the eight provider organizations still receiving RCPSI funding and located in various areas of the state. As an evaluation, the project was not considered human subjects research, but staff did inform all participants of data collection activities, such as the

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https://doi.org/10.1016/j.jsat.2021.108390
Received 14 June 2020; Received in revised form 10 February 2021; Accepted 23 March 2021
Available online 8 April 2021
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recording of meetings. The analysis focused on describing provider organizations' adaptations and evaluating participants' experiences during the pandemic, rather than attempting to make any evaluative judgements regarding RCPSI effectiveness. We identified portions of surveys and transcripts related to COVID-19, performed deductive coding focused on COVID-related limitations, and developed categories of data reflecting how the pandemic impacted PRC practice (Saldaña, 2016).

Before the COVID pandemic, six of the seven provider organizations had PRCs approach patients in the ED, while the seventh used a telehealth model in which PRCs used telephone or, where possible, video conference, to contact patients in the ED who ED staff had identified as appropriate for PRC services. After COVID-19 restrictions, four of the six provider organizations moved to telehealth PRC service provision, and only one organization continued in-person contact. The four new telehealth provider organizations instructed PRCs to work at home by maintaining communication with ED staff and contacting patients via telephone or video conference. The sixth organization suspended RCPSI services and reassigned PRCs' work while considering a possible move to telehealth.

Evaluation participants highlighted how sustainability of the RCPSI would be improved at the end of grant funding due to a COVID-19-related policy change allowing them to bill Medicaid for telehealth PRC services. They also reported a perceived increase in success linking patients with MOUD due to another recent federal policy change allowing telemedicine buprenorphine prescribing and ongoing treatment.

The move to telehealth also resulted in some challenges. For instance, telehealth changed the timing of patient interactions, as PRCs previously worked with patients at the bedside and now had to follow-up with them by phone after discharge. This change meant PRCs were not able to take advantage of the "teachable moment" immediately after an overdose when patients are thought to be more receptive to treatment (see Powell et al., 2019). Furthermore, some PRCs lost access to electronic health records and other information systems that facilitated their work. However, one provider organization had implemented telehealth at the initiation of the RCPSI, and already had a robust system that facilitated their system's adjustments to cope with pandemic-related issues.

Finally, evaluation participants stated that a dramatic drop had occurred in the number of eligible patients presenting to the EDs by the end of March; however, PRC services were still greatly needed, as those OUD patients who were admitted received less individualized care as ED staff were becoming overwhelmed with COVID-19 patients. In response to the reduced number, one provider organization assigned PRCs to call and follow-up with patients who had previously declined MOUD linkage in the ED, finding that many of these patients were now amenable to beginning treatment, which resulted in plans to increase follow-up efforts.

3. Implications for the future of PRCs in ED practices

Indiana RCPSI provider organizations' pandemic adaptations have several implications for the future. While employees of those provider organizations that moved to telehealth experienced challenges due to information access and patient interaction timing, these challenges resulted largely because they had to engage in a rapid transition without supporting infrastructure. The single provider organization that had a telehealth model from the start of the RCPSI supports this hypothesis, as their transition to serving patients during the pandemic was relatively seamless. The shift to telehealth is happening across the OUD treatment sector, and providers must collect data to both inform quality improvement and assess outcomes. If PRC and other OUD supports and treatment can be successful through telehealth, then there might be little need to transition back to an in-person modality. Indeed, many patients might prefer to interact with PRCs and doctors through telehealth since it reduces known barriers to engagement such as transportation needs and internalized stigma that might prevent patients from willingly seeking help (Huskamp et al., 2018; Rakita, Giacobbe, & Cavacuiti, 2016). Telehealth also helps to eliminate noted difficulties integrating PRCs into the ED workflow (McGuire et al., 2020), although some patients may lack telehealth access beyond the ED. Rigorous outcome data are needed to understand the effectiveness of telehealth PRC supports compared to in-person services.

Research should also explore the timing of initial PRC contact with an overdose patient to determine if ED time following overdose is truly the best time to discuss treatment options. Perhaps patients declining treatment at the ED and contacted through follow-up became amenable to MOUD because the pandemic created difficulty in procuring illicit drugs and increased isolation in their home environment. Regardless of the reason, Powell et al. (2019) have argued that post-ED-discharge follow-up is critical for such services.

Finally, the ability to bill Medicaid for peer support through telehealth is an important development, as is increased use of telehealth by physicians prescribing MOUD. The Cures Act did not provide permanent funding for PRC services in Indiana. Sustainability of telehealth approaches depends on continued reimbursement from Medicaid and/or other payor sources. Evidence of effectiveness in terms of both outcomes and cost will likely be necessary to convince payors to continue to reimburse for such services after the pandemic's end.

CRediT authorship contribution statement

Monte D. Staton: Conceptualization, Writing- Original draft preparation, Formal analysis

Dennis P. Watson: Writing - Review & Editing, Supervision, Investigation, Funding acquisition

Lisa Robison: Project administration

Noah Tye: Formal analysis

Declaration of competing interest

None to declare

Acknowledgements

Evaluation of the RCPSI initiative was supported by the Indiana Family and Social Services Administration, Division of Mental Health and Addiction and the U.S. Substance Abuse and Mental Health Services Administration (TI080233). The content of this article is solely the responsibility of the authors and does not represent the official views of any of the funding agencies listed.

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