IRIS Fellowship Research Project Write Up

Research project title: Peer Recovery Coaches in Healthcare: A mixed methods study assessing financial value, perceptions, and barriers for this unique role

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Introduction

Peer recovery coaching is an emerging field and over the last 10 years there has been an increasing number of positions across healthcare. Within hospitals and substance use treatment centers, Peer Recovery Coaches (PRCs) are non-clinical employees working alongside clinical professionals and often included as part of the care team for patients with or at risk for alcohol or substance use disorders (SUDs). While non-clinical, PRCs are often licensed and certified in their state or nationally or working toward licensure and/or certification. Prior to the COVID-19 pandemic, it became evident through local and national surveys that PRCs are often paid less than a livable wage, and less than other non-clinical healthcare workers. Not only does this pay disparity remain, PRC positions have also been some of the first to be eliminated or reduced despite significant increases from 2020-2022 of people meeting criteria for a substance use disorder (SAMHSA, 2022) and experiencing drug overdoses (Burgess-Hull et al, 2022, resulting in shifting workflows and changing healthcare resources.

Many patients struggling with SUD are adversely affected by Social Determinants of Health (SDoH) that need to be addressed for them to live a healthier lifestyle. Within hospitals, these needs may go unaddressed due to visits focusing on the chief medical complaint. Long-term plans are not created for a patient and patients are often not connected to follow-up care that would address these SDoH. Ecological systems theory argues that the environment you grew up in affects every facet of your life (Sincero, 2012). This theory also supports the whole-health approach to improve the lives of patients using drugs and alcohol, rather than focusing solely on substance use treatment. PRCs are trained to identify the various needs a patient may have.

Peer recovery coaching is a relatively new, continuously evolving field that does not yet fit the mold of traditional healthcare employers. PRCs are uniquely positioned to meet the needs not only of a patient's substance use, but additional SDoH needs with a whole-health approach. Unfortunately, though, this position is not 'required' by hospitals or other healthcare settings, and often at risk for being eliminated in these settings due to limited hospital budgets since hospitals are attempting to make up a financial deficit largely created by the COVID-19 pandemic. Maryland, for example, saw over a 19% decrease in state-funded PRC positions from the beginning of 2020 through July 2021, according to the Maryland Department of Health (2022). Hospitals are continuing to struggle to maintain these positions. Peer Recovery Coaches are often viewed as a cost to hospitals, additional full-time employees (FTE)s, and non-essential, non-clinical employees. In fact, PRCs have been shown to SAVE a hospital money by reducing hospital readmissions and length of stay. A study by Madigson et al. (2022) showed that in the six months following recovery coach contact with a treatment center, there was a 44% decrease in patients hospitalized and a 9% decrease in patients with an emergency department (ED) visit. There was also 66% increase in outpatient utilization across primary care, community health center visits, mental health, and laboratory visits associated with PRC services.

Considering the PRC role in the lens of the whole-health approach, in light of the increased need for social workers with increased numbers of unfilled positions, Wecker (2023) predicts that 38 of 50 states will be experiencing social work shortages by 2030. Cutting PRC positions in hospitals places more work on currently understaffed and overutilized social work and care management teams.

The aims of this study are to (1) demonstrate the financial value of peer recovery coaches in healthcare settings, (2) explore peers' perceptions of their role in healthcare settings, and (3) explore limitations and barriers for peer recovery coaches in the workplace.

Methods

Research design

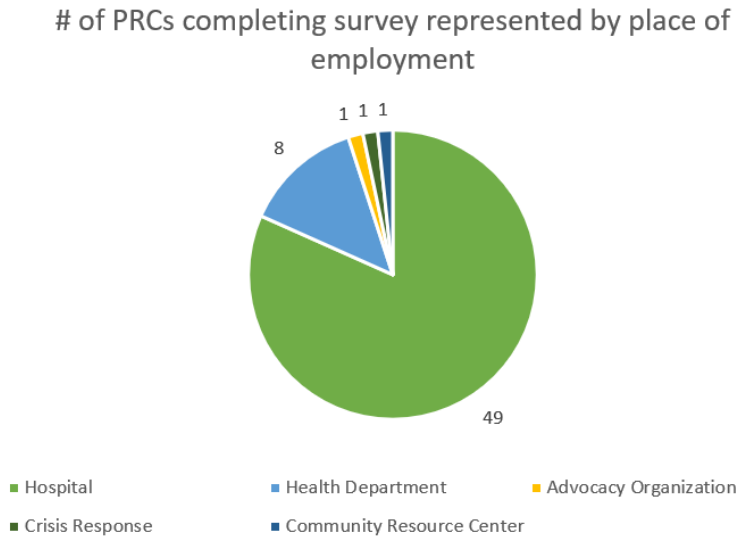
Study aims were achieved through several data sources to consider the financial and societal values that PRCs demonstrate in healthcare, elicit PRC's perceptions of their value in the workplace, and explore limitations for PRCs in healthcare. This mixed methods study involves quantitative data from primary and secondary sources.

To achieve the first aim, I utilized primary data from an anonymous survey completed by 60 current PRCs and reviewed publicly available websites including Indeed.com and specific hospital and hospital system websites on which open positions are advertised. PRC starting and maximum wage estimates were evaluated, as well as those for other hospital positions requiring comparable education and experience. Secondary data from the University of Maryland School of Social work and the Healthcare Cost and Utilization Project (HCUP; n.d.) was reviewed.

To achieve the second and third aims, primary, quantitative data from the aforementioned survey was analyzed, as well as qualitative data collected through coding free-text responses from the peer recovery coach survey and themes that emerged. PRCs were asked if they wished to include any additional information in the survey for consideration, and these responses were analyzed.

Study sample and setting

The only study inclusion criterion was that the respondent currently be working as a PRC in Maryland or Washington, DC. There were no exclusion criteria. This convenience sampling method included emailing a distribution list of 75 hospital-based PRCs, an additional 8 health department PRCs, and 10 PRCs working in various crisis and advocacy centers. There were 60 respondents and data from all 60 was included. Please see Chart 1 for the breakout of employment settings for the PRC respondents. Figure 1 below presents the sample by place of employment.



Study procedures

An online survey in a Google Form was e-mailed to PRCs working in hospitals, health departments, and other healthcare settings. This survey was designed for the purpose of collecting data regarding PRC pay, benefits, and feelings of value and worth within the healthcare setting. A non-probability sampling method was used, as an initial email was sent to Maryland and Washington DC-based PRCs, followed by 2 reminders to complete the survey if interested, and over the period of 6 weeks between January and March 2023. A snowball sampling method encouraged PRCs to forward the email to any PRCs or networks within Maryland and Washington, DC, and therefore, there is no certain way to determine the percentage of recipients completing the survey. There was no incentive offered for completing the survey. Responses were captured automatically.

Indeed.com and hospital websites were reviewed between January and March 2023 to assess starting and maximum wages for the various positions among PRCs and hospital and health care positions requiring comparable education and experience. Hospital utilization data was not accessible after 2020, so the years 2019 and 2020 were analyzed for purposes of this study. This data was retrieved from a separate source, with permission from a principal investigator. To determine the average PRC starting wage in comparison to the average cost of living, the Livable Wage Calculator was searched in March 2023 to determine the current livable wage for the Baltimore metro region.

Variables of interest and measures

Initial variables to consider the value of PRCs in healthcare included the questions to gather information on the PRC survey that was developed by the researcher and colleagues from Mosaic Group, a national consulting firm based in Towson, MD. The survey included starting wage, current wage, years working as a PRC with that specific employer, years working as a PRC overall, opportunities for overtime and pay differential, and benefits that are offered by employer. I also reviewed PRC starting wages in comparison to other comparable healthcare positions, and to the local livable wage. PRC pay was also taken into consideration when compared to the cost of ED admissions and hospital stays.

In addition to pay ranges being collected on the PRC survey, market pay for PRCs and other healthcare employees with comparable degrees and experience was collected through internet searches on

Indeed.com and hospital human resource websites advertising available positions. Search terms included "Peer Recovery", "Peer Specialist", and "Peer Coach" for PRC positions across hospitals, recreation centers, crisis response units, substance use treatment centers and wellness and recovery centers around the Baltimore-metro area. Comparable positions were reviewed in detail including but not limited to "Patient Safety Companion", "Community Health worker", "Community Health Advocate", and administrative positions such as "Administrative Assistant", and "Patient Clerical Assistant" also in the Baltimore-metro area.

Hospitalization costs for alcohol and opioid use-related admissions were reviewed for emergency departments and inpatient stays and discussed with the research team initially collecting this data, to ensure proper interpretation. Costs related to sedative and stimulant-related disorders were not analyzed due to the significantly smaller sample size and increased likeliness to be affected by outlying data points. Marijuana-related disorder costs were also not included as there is no way to differentiate legal versus illegal use. Also, this study and not all peer recovery coaches are responding to marijuana-use only patients with the same frequency. Mean cost for the state of Maryland was utilized for comparison, as opposed to specific county information.

The Livable Wage Calculator, which is available via a free website created by MIT (https://livingwage.mit.edu/) was utilized by the author to establish an average cost of living for the geographic area from where the peer recovery coaches completing the survey live and work. The Baltimore-Columbia-Towson metro area cost of living was utilized for this comparison.

The secondary purpose of this study was to review opportunities for advancement and growth, as well as PRC motivation to remain in role. The potential for a correlational relationship between wage and likeliness to have supplemental income was explored, as research shows that healthcare employees having more than one job may experience lower job satisfaction, lower productivity, and higher stress levels. Survey questions eliciting information regarding PRC opportunity for internal advancement within the workplace, history of promotion, and motivation to continue working as a PRC were assessed with close-ended questions. A final open-ended question asking, "Is there anything else you would like to add regarding the pay and benefits offered to peer recovery coaches?" was analyzed qualitatively.

The survey results are summarized to review strengths and barriers of healthcare work for PRCs.

Data analysis plan

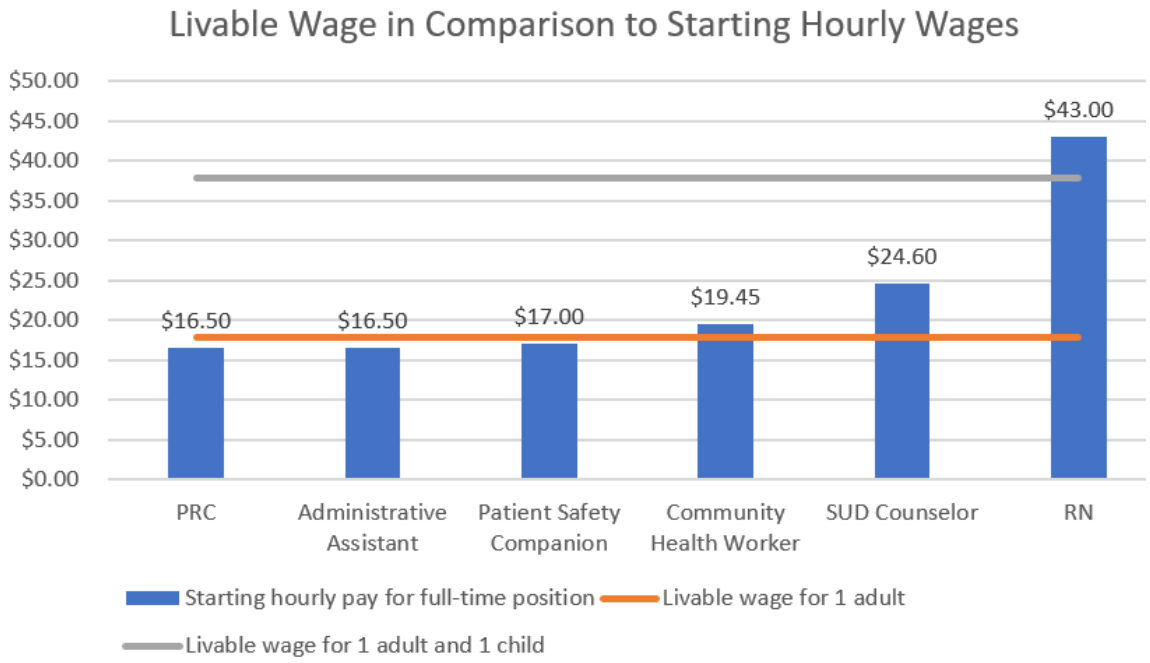
The study used various quantitative methods to analyze survey results, hospital utilization data, and salary information collected. Survey results were sorted on an excel spreadsheet and tallied by hand. Hospital utilization data was determined by calculating the mean, and salary information was calculated by averaging the low end of the hourly or salary range. A chi-square test was used to determine the relationship between PRC hourly wage and holding a second job. Open coding and thematic analysis were utilized to assess PRC feelings on current salary and benefits from qualitative responses. Descriptive statistics were utilized to review the hospital data by calculating the mean cost for ED admissions and inpatient stays for alcohol and opioid-related visits.

Results

Quantitative data showed that PRCs do make less than many other healthcare positions and less than a livable wage in the Baltimore metro region. PRCs make less than the livable wage for one person living

alone, and significantly less than the livable wage for supporting another adult or child. The average PRC starting wage is $16.50 an hour, while the living wage in the Baltimore-Towson-Columbia metro area for 1 adult without children or supporting another adult is $17.81, while the livable wage for 1 adult and 1 child is $37.85. Figure 2 summarizes starting hourly wages for various healthcare positions.

Figure 2:



A Chi-Square test was performed to examine the likelihood of a PRC holding a 2nd job for supplementary income if they make above or below $20/hour. While the results were not statistically significant, they were clinically significant in that 56% of PRCs making less than $20/hour did hold a 2nd job, while only 39% of PRCs making $20/hour or more have a 2nd job.

Hospital utilization data from 2020 in Maryland shows that ED visits for opioid or alcohol-related admissions cost an average of $1,200-$1,300 each, while inpatient admissions average 4-5 days and an average of $18,000-$21,000 (HCUP, 2019, 2020).

Almost half of PRCs report not feeling appreciated at work, less than half report not feeling security in their job and dissatisfaction with their employer, and 85% of PRCs report not being satisfied with their pay. Of PRCs working 5+ years with their current employers, 56% have not received a promotion at any point and 52% of PRCs are employed where there is no internal promotion opportunity,

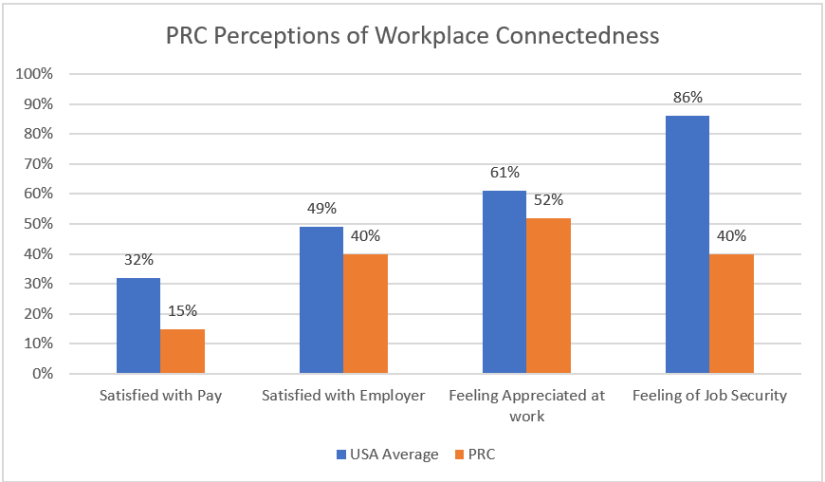
Survey results also determined that just over half (52%) of PRCs feel appreciated at work, 40% feel they have job security, 40% are satisfied with their employer and 15% are satisfied with their pay. While a nationwide survey found that 32% of workers are satisfied with their pay (CNBC, 2022), this survey reflects a far lower percentage of satisfaction among PRCs.

Discussion

Prior research shows that PRC intervention does correlate with reduced ED and hospital utilization leading to a reduction in costs to the hospital. The current study and review of information does support that as few as 2-3 PRC encounters where a high-utilization patient is connected to treatment and potentially avoids inpatient stays, saves far more than the average annual salary of a PRC. Given the average PRC starting annual salary in Maryland is $34,575 (Maryland Department of Budget and Management, 2022), it could be deduced that if each PRC could help prevent just two to three inpatient stays a year related to opioids or alcohol by supporting a patient's linkage to treatment, the positions end up saving a hospital money. This deduction is based on hospital utilization data from 2020 in Maryland that shows that ED visits for opioid or alcohol-related admissions cost an average of $1,200-$1,300 each, while inpatient admissions average 4-5 days and an average of $18,000-$21,000 (HCUP, 2019, 2020).

Through on-site experience spending hundreds of hours with PRCs working in hospital settings, they regularly report feeling as if they do not 'belong' in the hospital and that they feel they are not perceived as 'part of the team' or as 'important' at times, more often toward the beginning of their employment. Survey results also showed that when compared to the national average, PRCs experience lower satisfaction with pay (Indeed.com), have a lower sense of job security (Indeed.com), are less satisfied with their employer, and feel less appreciated at work. Figure 3 shows these data points reported by PRCs in comparison to the national average. A recent study by Pasan et al. (2022) shows that a greater workplace belongingness for PRCs was associated with lower emotional exhaustion. Promoting workplace belongingness may prevent or reduce professional burnout. The often-low pay rate only fosters feelings of lack of belonging and less worth. Our study also shows that PRCs making a higher wage are less likely to have a second job. A study by Rivard et al. (2020) has shown that emergency healthcare employees, specifically Emergency Medical Technicians (EMTs) working multiple jobs to make ends meet, is associated with unwelcome individual outcomes such as increased stress and burnout, as well as higher turnover within the workforce.

Figure 3:



Wages and benefits that are comparable to other hospital positions and allow PRCs to not require a second income to make above the livable wage may increase feelings of belongingness and reduce burnout.

PRCs take on substance use related treatment referrals that have traditionally been assigned to social work or care management staff, which data shows are currently understaffed. PRCs often take a subset of the patient load off other hospital staff, as they can work with patients struggling with primarily SUD.

The current research supports maintaining and adding PRC positions across hospital settings, while also reevaluating their pay to be in line with comparable roles. Given restrictions on hospital budgets as a result of COVID-19 recovery, Maryland has seen a reduction in PRC positions in hospitals. This despite research supporting that PRCs ultimately reduce ED utilization and hospital stays among patients with primary SUDs. When a hospital must make cuts to FTEs, this research can support the PRC role and show their social and financial value. Hospitals more often seek one-year grants to support PRC positions rather than including them as part of the hospital budget paid for by more steady public sector contracts and public and private reimbursements for services. They are one of the few hospital positions that are maintained this way and each year, are at risk of being reduced or cut completely.

Considerations for hiring and maintaining PRCs would include risks associated with low pay and having a second job such as reduced productivity, feeling less appreciated at work, increased stress and burnout and high turnover – all of which ultimately add to hospital costs, all leading to higher rates of employee turnover among those working more than one job. Economic research also consistently finds that when there is high turnover in an organization, employees experience lower morale, higher stress and reduced productivity (Charaba, 2023). While cost estimates to replace an employee vary by position, employer and location, it is shown that replacing an employee costs far more than increasing employee pay to match their market and institutional worth (Charaba, 2023).

There are policies for hospitals to maintain certain protocols for patients discharged with SUD. For example, per the STOP Act (Statewide Targeted Overdose Prevention) in Maryland, as of June 2023, all hospitals must offer Naloxone free of charge to patients who warrant a diagnosis of Opioid Use Disorder. The mounting evidence of PRCs' valuable role may lead to future policies requiring a PRC on staff within hospitals or on call in ambulatory healthcare settings to most effectively meet the needs of patients with alcohol or SUDs.

Limitations for this study include a relatively small sample size from only Maryland and Washington, DC, and therefore the information collected may not be generalizable nation-wide, or even regionally. Additionally, the sample was skewed to represent far more PRCs working in a hospital setting, which may not be fairly represent PRCs across all settings in which they are employed, equally. Hospital utilization data was also reported by the mean cost for ED and inpatient hospitalizations, and this average may be affected by outliers with very high or low costs.

Future research may gather information on pre- and post-hospital utilization and cost when intervening with PRCs in the hospital, versus no PRC intervention. PRC models that follow patients longitudinally may also be compared to models where PRCs work to connect a patient to treatment and do not follow-up beyond 1-2 weeks of discharge, to determine if longer PRC follow-up correlates with reduced hospitalization and healthcare cost.

In closing, PRCs are a valuable resource to the healthcare system and a position that has been shown to reduce utilization and cost for patients with alcohol or substance use. There are very few employers who offer a promotion system for PRCs, though these ladders exist for other hospital positions. As a result of inconsistent and lower-than-livable starting wages, most PRCs work more than one job, putting them at higher risk for burnout, increased stress, and higher turnover. PRCs, by and large, feel undervalued in healthcare and their salary supports this feeling. EDs are on the front lines of the opioid epidemic and need to be equipped to help patients who are interested in treatment, and handing a patient a list of resources often does not lead to successful treatment linkages. With care management departments often understaffed, a warm handoff to not only treatment but additional recovery resources, is often impossible. PRCs are uniquely trained in motivational interviewing and are more likely to form a bond with the patient due to their shared lived experience with SUD. Losing these positions in healthcare, as a result of hospital budget cuts, lack of support to the position, or both, may lead to increased substance use and cost of care to this vulnerable and high-risk patient population.

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