THE CONTINUUM OF CONNECTION:

Integrating Peer Support from 9-1-1 to Hospital Discharge (and Beyond)

May 21st, 2026

Presented by
Ryan Banks
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Robyn Hantelman

ABSTRACT

Integrating Peer Recovery Specialists (PRS) is an evidence-based strategy that transforms the "revolving door" of emergency care into a path of sustained wellness. Research shows that patients supported by peers are 45% more likely to start treatment (MOUD) after an overdose and experience significantly fewer repeat crises and hospital readmissions. Further, public safety-led post-overdose outreach has gained traction as a means of curbing the opioid epidemic nationwide, particularly here in central Virginia.

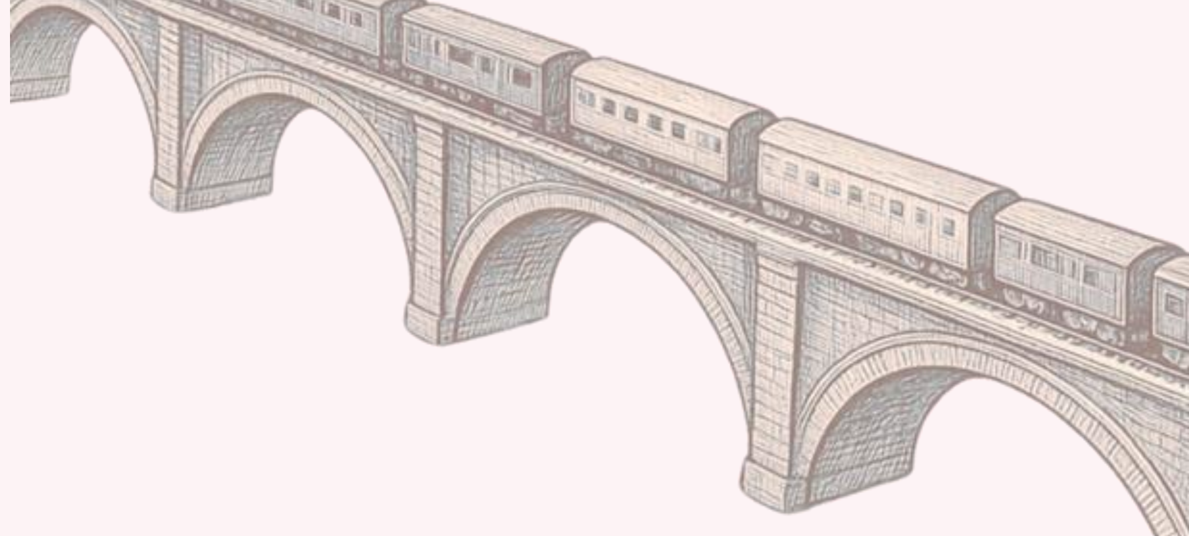
By reducing stigma and improving trust—especially in high-stakes areas like EMS response and postpartum care—peer integration lowers overall healthcare costs while significantly increasing patient engagement and hope.

This workshop will provide a visual framework for how these appropriately named "BRIDGE programs" bring a new level of connection across the Continuum of HealthCARE.

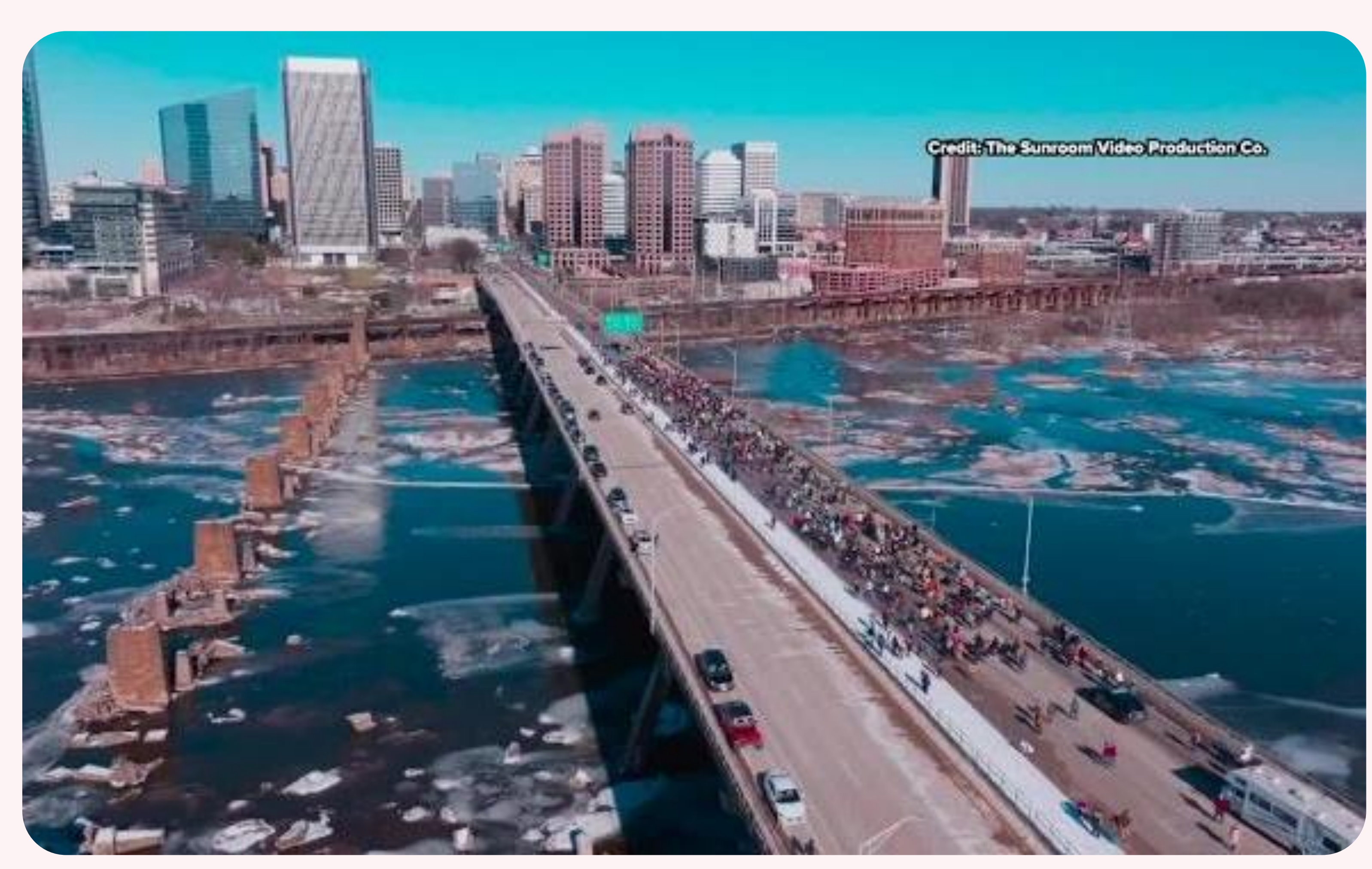
LEARNING OBJECTIVES

By the end of this workshop, participants will be able to:

- Identify Critical Gaps: Pinpoint specific "disconnects" in traditional medical trajectories (from EMS arrival to hospital discharge) where the absence of peer support leads to higher recidivism and patient disengagement.
- Analyze the Pre-Hospital Peer Model: Describe the operational benefits of integrating peers into EMS and 9-1-1 response, specifically regarding de-escalation, trust-building, and "warm handoffs" to clinical settings.
- Evaluate Peer Integration in Hospital and Community Settings: Discuss strategies for implementing and continuing peer support within specialized clinical environments, such as the Emergency Department and Postpartum Intensive Outpatient Programs (IOP).
- Apply a New Framework: Utilize and apply a new BRIDGE Continuum of HealthCARE Model to map out peer-led touchpoints within local healthcare systems to improve long-term recovery outcomes.



DISCLOSURES



Manchester Bridge, Richmond, Virginia.
Aerial photo taken on 02 February 2026 during the arrival of the Walk for Peace monks on day 100 of their 2,300-mile journey.
RPD estimates that around 10,000 individuals moved together through downtown RVA for a common purpose.

As your presenters this afternoon, we declare no financial interests or affiliations with any commercial organizations related to the content of this workshop.

Our participation today is driven solely by our professional roles at our respective organizations, combined with our shared commitment to advancing the BRIDGE Model and Continuum of HealthCARE in support of all who are pursuing health, wellness, and recovery throughout our community.

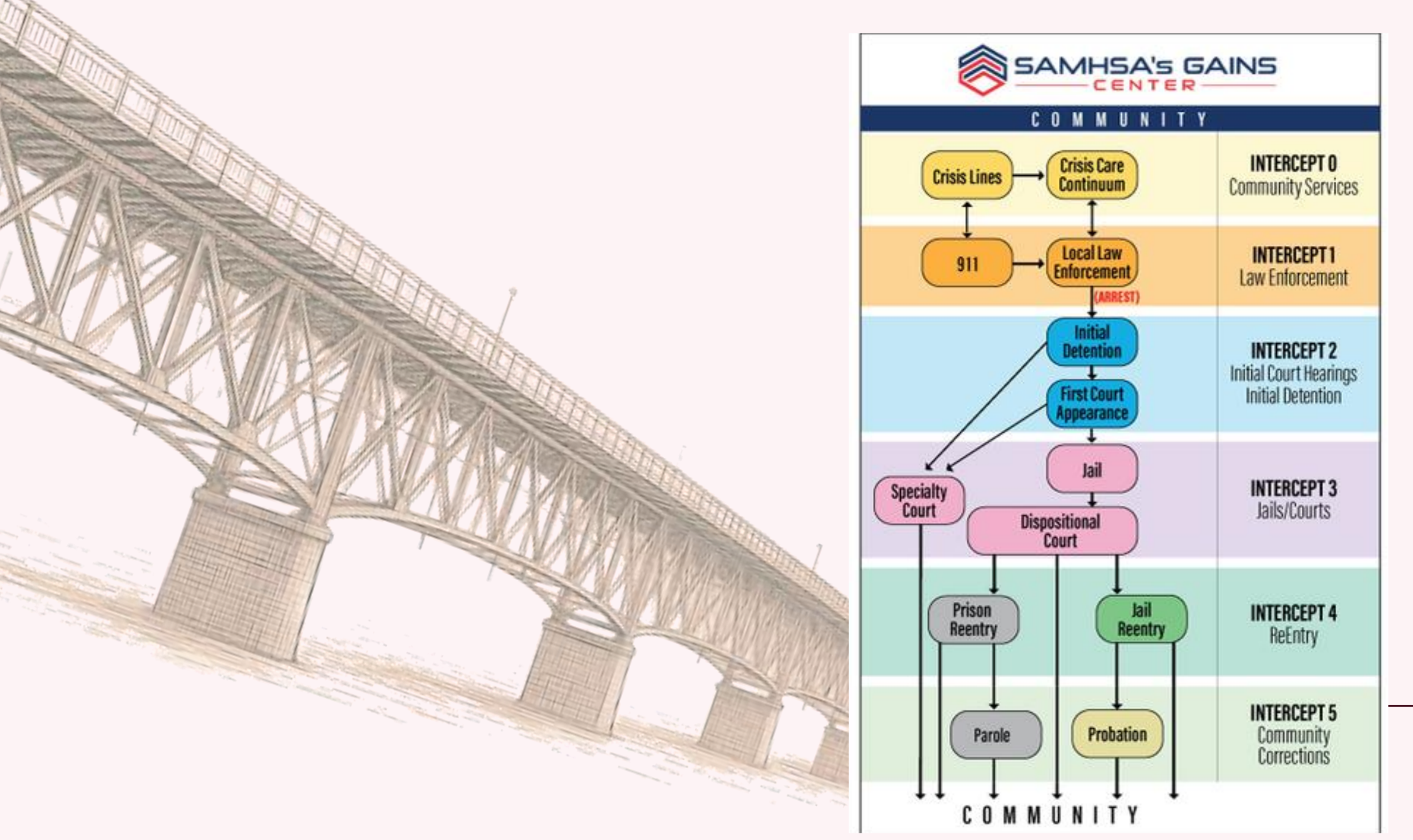
THE INSPIRATION:
From Patient to Peer

- Robyn, then and now
- The blueprint for the BRIDGE
- Just one person to CARE
- Remembering the "why"

IDENTIFYING GAPS

Where the Cord is Stretched or Broken

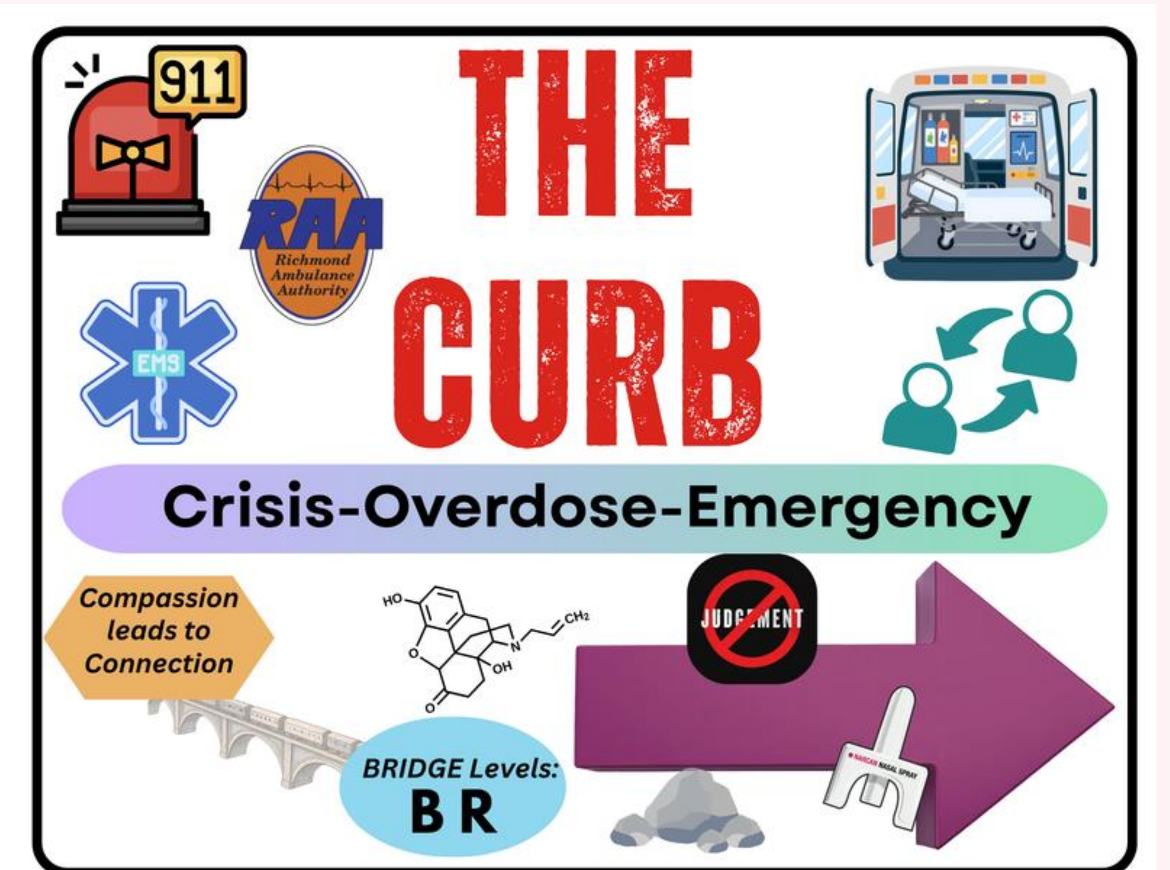
- Where are the disconnects? What areas need strengthening?
- Where are the opportunities to CARE along the continuum?
- Where do patients frequently disengage or "leave AMA"?
- Peers as the "connective tissue"

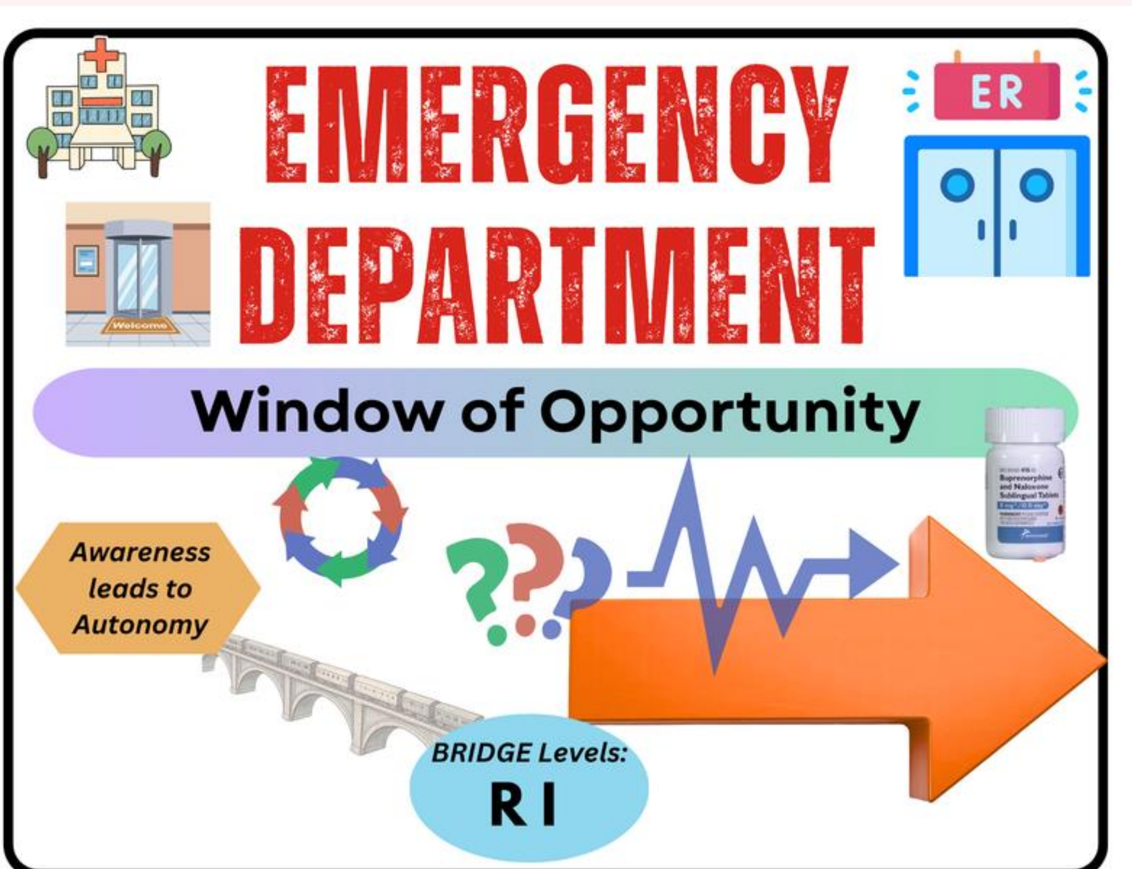


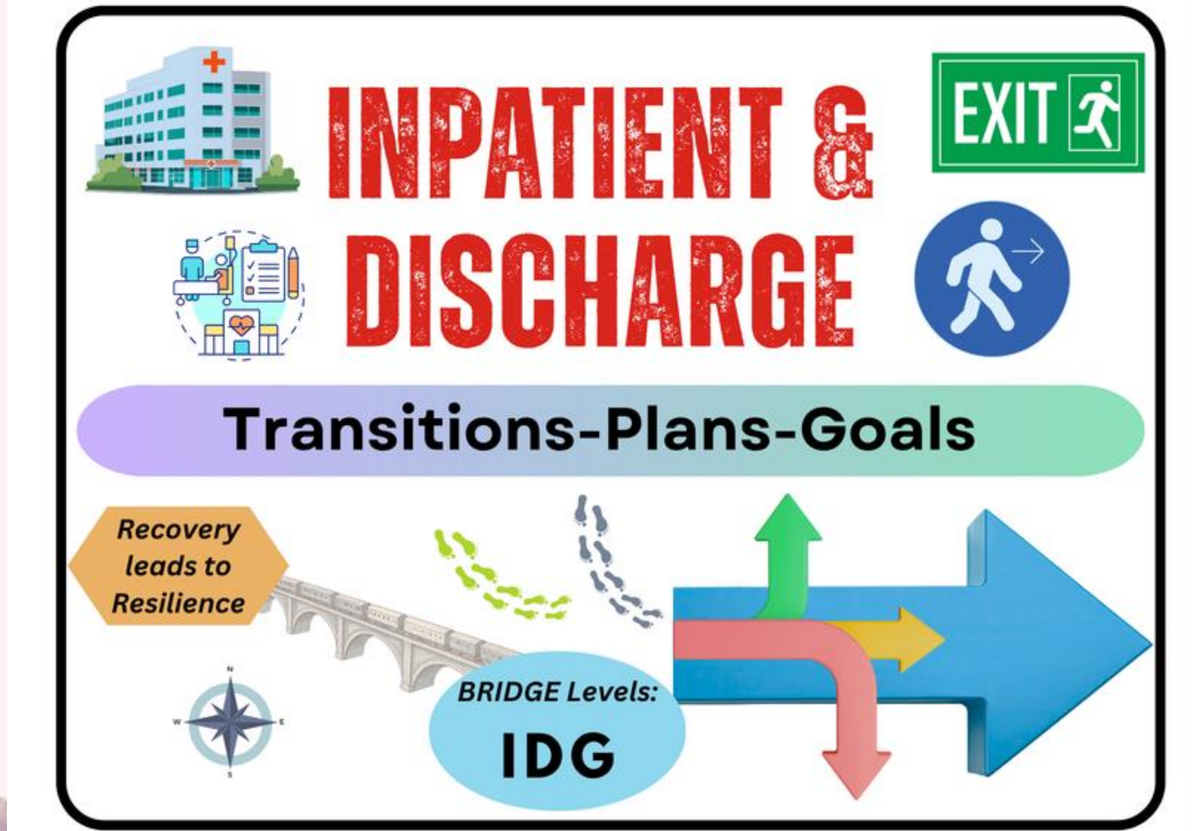
The ASAM Criteria Continuum of Care for Adult Addiction Treatment

Level			
Level 4: Inpatient			4 Medically Managed Inpatient (4 Psych)
Level 3: Residential	3.1 Clinically Managed Low-Intensity Residential	3.5 Clinically Managed High-Intensity Residential (3.5 COE)	3.7 Medically Managed Residential (3.7 BIO, 3.7 COE)
Level 2: IOP/HIOP	2.1 Intensive Outpatient (IOP)	2.5 High-Intensity Outpatient (HIOP) (2.5 COE)	2.7 Medically Managed Intensive Outpatient (2.7 COE)
Level 1: Outpatient	1.0 Long-Term Remission Monitoring	1.5 Outpatient Therapy (1.5 COE)	1.7 Medically Managed Outpatient (1.7 COE)
Recovery Residence	RR Recovery Residence		

The BRIDGE Model and the Continuum of HealthCARE


911
RAA
Richmond Ambulance Authority
THE CURB
EMS
Crisis-Overdose-Emergency
Compassion leads to Connection
JUDGEMENT
BRIDGE Levels:
B R


EMERGENCY DEPARTMENT
ER
Window of Opportunity
Awareness leads to Autonomy
BRIDGE Levels:
R I


INPATIENT & DISCHARGE
EXIT
Transitions-Plans-Goals
Recovery leads to Resilience
BRIDGE Levels:
IDG

Eight Dimensions of Wellness
HOME & COMMUNITY
Sustained Recovery and Wellness
Engagement leads to End Results
Looking for some good news? A little bit of HOPE?
SCAN HERE
BRIDGE Levels:
DGE

BUILDING TRUST:

Supporting the Individual and Simply “Meeting Them”

- Co-Response vs Post-Response for PORTs
- Two-Pronged Approach (EMS and ED staff)
- RAA Transport Rates for Overdoses
- Connection by EMS, Autonomy, Recovery/Resilience, and Engagement
- EMS as the BRIDGE to recovery and peer support

How can we build greater trust in the emergency setting?

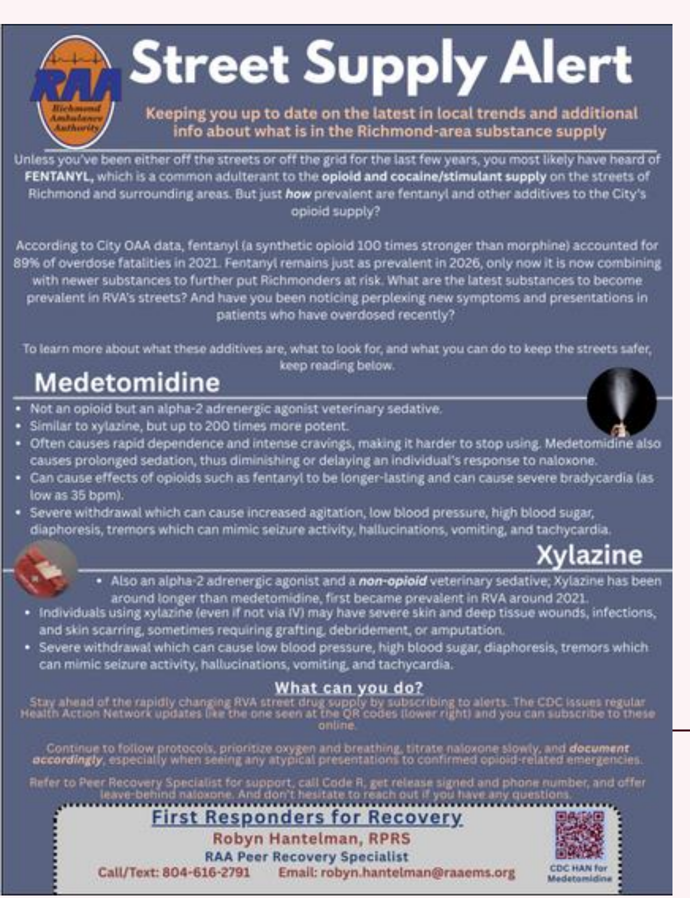
B - Building Trust in the Field

- Initial 911/EMS Response (SIM Intercepts 0-1)
- Immediate Rapport and De-escalation
- A "Warm Handoff" Begins at the Curb

Building Trust as an Inside Job:

The Peer as a Coworker

- Connection between Peer Recovery Specialist and the Field Operations team
- Parallels Between Peers and EMS
- Mutuality, Strengths Based, Solution Focused, Recovery Centered (Core Values of Peer Support)
- The RAA Uniform and Belonging



Street Supply Alert

RAA Richmond Ambulance Authority

Keeping you up to date on the latest in local trends and additional info about what is in the Richmond-area substance supply

Unless you've been either off the streets or off the grid for the last few years, you most likely have heard of **FENTANYL,** which is a common adulterant to the **opioid and cocaine/stimulant supply** on the streets of Richmond and surrounding areas. But just ***how*** prevalent are fentanyl and other additives to the City's opioid supply?

According to City OAA data, fentanyl (a synthetic opioid 100 times stronger than morphine) accounted for 89% of overdose fatalities in 2021. Fentanyl remains just as prevalent in 2026, only now it is now combining with newer substances to further put Richmonders at risk. What are the latest substances to become prevalent in RVA's streets? And have you been noticing perplexing new symptoms and presentations in patients who have overdosed recently?

To learn more about what these additives are, what to look for, and what you can do to keep the streets safer, keep reading below.

Medetomidine

- Not an opioid but an alpha-2 adrenergic agonist veterinary sedative.
- Similar to xylazine, but up to 200 times more potent.
- Often causes rapid dependence and intense cravings, making it harder to stop using. Medetomidine also causes prolonged sedation, thus diminishing or delaying an individual's response to naloxone.
- Can cause effects of opioids such as fentanyl to be longer-lasting and can cause severe bradycardia (as low as 35 bpm).
- Severe withdrawal which can cause increased agitation, low blood pressure, high blood sugar, diaphoresis, tremors which can mimic seizure activity, hallucinations, vomiting, and tachycardia.

Xylazine

- Also an alpha-2 adrenergic agonist and a ***non-opioid*** veterinary sedative; Xylazine has been around longer than medetomidine, first became prevalent in RVA around 2021.
- Individuals using xylazine (even if not via IV) may have severe skin and deep tissue wounds, infections, and skin scarring, sometimes requiring grafting, debridement, or amputation.
- Severe withdrawal which can cause low blood pressure, high blood sugar, diaphoresis, tremors which can mimic seizure activity, hallucinations, vomiting, and tachycardia.

What can you do?

Stay ahead of the rapidly changing RVA street drug supply by subscribing to alerts. The CDC issues regular Health Action Network updates like the one seen at the QR codes (lower right) and you can subscribe to these online.

Continue to follow protocols, prioritize oxygen and breathing, titrate naloxone slowly, and ***document accordingly***, especially when seeing any atypical presentations to confirmed opioid-related emergencies.

Refer to Peer Recovery Specialist for support, call Code R, get release signed and phone number, and offer leave-behind naloxone. And don't hesitate to reach out if you have any questions.

First Responders for Recovery

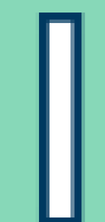
Robyn Hantelman, RPRS
RAA Peer Recovery Specialist
Call/Text: 804-616-2791 Email: robyn.hantelman@raaems.org

CDC HAN for Medetomidine

REDUCING STIGMA AND INCREASING ENGAGEMENT

R - Reducing Stigma in Clinical Settings

- Hospital ED & Inpatient Units
- The "Translational" Role (medical vs recovery)
- Modeling Hope & Respect

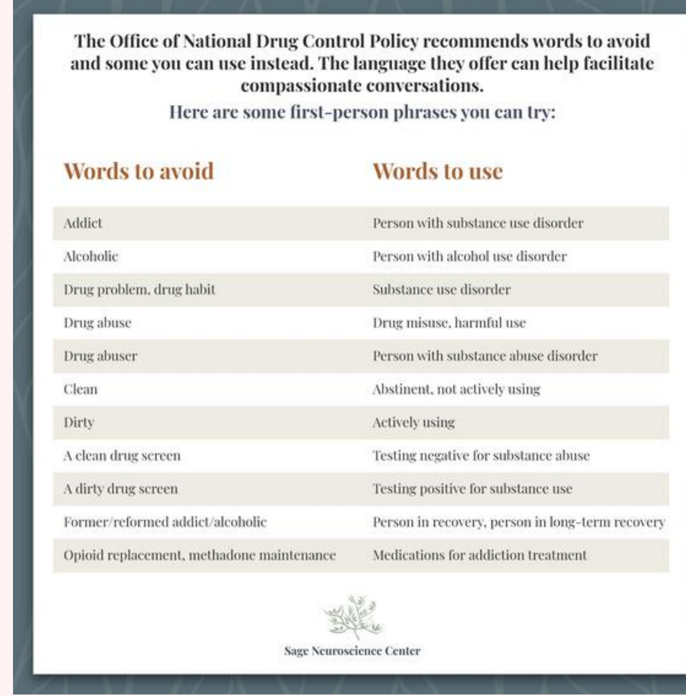


I - Increasing Engagement & Retention

- Specialized Programs (e.g., Postpartum IOP)
- Active Listening & Connection
- Reduces Fear of Judgment & Increases Commitment

Reducing Stigma

- Shared Lived Experience (the LBK letter)
- Recovery Language
- Health Equity
- Person-First



The Office of National Drug Control Policy recommends words to avoid and some you can use instead. The language they offer can help facilitate compassionate conversations.

Here are some first-person phrases you can try:

Words to avoid	Words to use
Addict	Person with substance use disorder
Alcoholic	Person with alcohol use disorder
Drug problem, drug habit	Substance use disorder
Drug abuse	Drug misuse, harmful use
Drug abuser	Person with substance abuse disorder
Clean	Abstinent, not actively using
Dirty	Actively using
A clean drug screen	Testing negative for substance abuse
A dirty drug screen	Testing positive for substance use
Former/reformed addict/alcoholic	Person in recovery, person in long-term recovery
Opioid replacement, methadone maintenance	Medications for addiction treatment

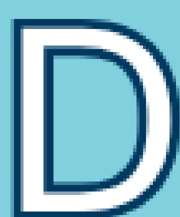
Sage Neuroscience Center

Increase Engagement/Retention:

- Nonjudgemental Support
- Hear the VOICE
- Offer the CHOICE
- Low- to NO BARRIER
- Collaborate on Goals

THE MENU OF OPTIONS:

Unique Individuals, Infinite Pathways



D - Diversifying Treatment Pathways

- Aligns with ASAM Continuum (ASAM Levels 0.5-4)
- Incorporates New and Innovative Resources
- Empowers Individual Choice

But wait… Peers are not "treatment" or "clinical", right?
So, how can the CARE of Peer Specialists help to build a BRIDGE by diversifying treatment pathways?

Peer support effectively lowers hospital readmission rates over both the short and long term while boosting engagement with community-based services, thereby increasing recovery capital.

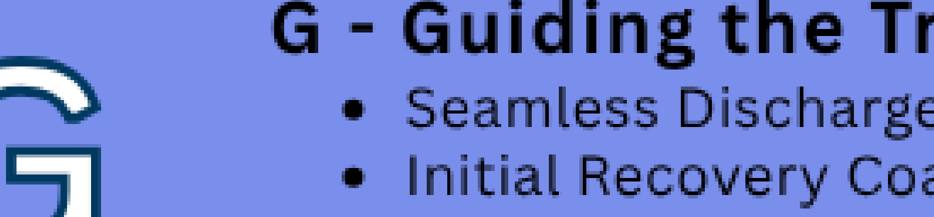
Patients who engaged with a certified peer recovery specialist during hospitalization were more likely to begin MOUD treatment post-discharge and demonstrated higher retention rates in long-term care.

Peer coaches in bridge clinics, primary care, and street medicine helped reduce acute care utilization and increased outpatient therapy engagement, leading to more positive patient outcomes overall.

HOLDING THE DOOR OPEN

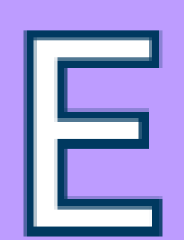
(but Disrupting the Revolving Ones!)

- Nothing changes if nothing changes.
- If we do what we have always done, we will get what we have always gotten.
- Want a new outcome? Try a new solution!



G - Guiding the Transition (Discharge)

- Seamless Discharge Planning
- Initial Recovery Coaching (First 48 Hours)
- Navigating Community Barriers



E - Elevating Health Outcomes

- Long-term Recovery Management
- Improved Metrics = Decrease Costs
- Greater Wellness Throughout Generations and Communities

The same evidence base supporting BRIDGE initiatives, such as ***Diversifying Treatment Options***, underscores the importance of introducing peer specialists early in the hospitalization process. Peer support is particularly vital in ***Guiding the Transitions***, such as the move from inpatient care to home or residential treatment to IOP, where the primary objective is to sustain recovery and prevent readmission to higher levels of care. ***Elevated Health Outcomes*** are the more positive ***End Result***.

End Results

Old Treat-and-Release Model vs. Compassionate CARE and the RAA Way

What other outcomes may shift with peers at all intercepts of CARE?

Measure/ Metric	The Old Model (Treat & Release)	The New RAA Way (Compassionate CARE approaches)
Initial Stabilization	High-dose Naloxone; sudden, traumatic reversal.	**Oxygenation First** with BVMs; gentle, trauma-informed stabilization.
Patient Interaction	Clinical, "Command-and-Control" language focused on vitals, punitive measures, and fear-based responses.	**The CARE Framework**
Disposition	Transport to ER or "No-Transport" refusal at the scene.	**Warm Handoff** to Peer Specialist, Alive RVA, or MAT providers.
Discharge Tools	Paperwork and a medical bill.	**RAA Leave-Behind Kits** *for all (transported or not)* and **Induction CARE Kits** for Bridge to Bupe to promote personal comfort and safety.
Community Presence	Present only during a 9-1-1 crisis call.	Active in **RRHA Neighborhoods**, Safe Spaces at concert and event venues, and **Community/Command Walks**.
Language Access	English-dominant; reliant on tele-interpreters.	Recovery-focused, **bilingual resources** and Spanish-language materials for resources and reducing harm on every responder unit in the city. Using bilingual members of both the PRS and EMS workforces.
Workforce View	High burnout; focus on "the next call", being trailblazers often means being the solo peer	**OPEN Network** and **AcuWellness** for peer/provider resiliency.
Long-Term Goal	Reducing the 9-1-1 call volume (Temporary).	Building an **Inclusive Recovery City** (Sustainable).

APPLYING THE FRAMEWORK

Intercept	CARE Level	Location	Action	Bridges Built
1 (C)	Compassion leads to Connection	Crisis/911 call/Back of Ambulance/During Transport/Post-Overdose	Medical Stabilization (includes Initiating Medications) & Transport to ED	***BR: Building Trust, Reducing Stigma*** Compassion, Awareness, Recovery Orientation, and Empowerment from EMS… all in two miles or less! J Warm Handoffs begin here and continue to Hospital.
2 (A)	Awareness leads to Autonomy	Hospital Emergency Department	Clinical Assessment, Initiation of Medications	***RI: Reducing Stigma, Increasing Engagement*** Emotional support, navigating "the wait," feeling like a person with choices, and starting with recovery planning.
3 (R)	Recovery Awareness leads to Resilience	Inpatient, Residential Treatment, Withdrawal Management, followed by IOP/PHP (transitions). Moving from higher to lower levels of CARE.	Treatment Plan, then Follow Through, Structure Added	***IDG: Increasing Engagement, Diversifying Pathways, Guiding Transitions*** Modeling hope, attending groups, and preparing for discharge. Setting goals, assessing eight dimensions of wellness, stage of change is MAINTENANCE.
4 (E)	Empowerment leads to better End-Results	Community, Stablity in housing/employment/benefits/ social circle/family,	Making/keeping follow-up appointments, commitments, care planning, details (i.e.--transportation), the ***mortar*** between the bricks.	***DGE: Diversifying Pathways (as many as it takes!), Guiding Transitions, and Evaluating Outcomes*** Reducing "No-Show" rates; connecting to community resources, not "out of sight – out of mind" but meaningful, intentional follow-up (and follow-through) = Integrity!
0 (constant)	***CARE*** *(All levels are practiced and reinforced)*	***SUSTAINED RECOVERY AND WELLNESS***	Breaking patterns, Achieving goals and setting new ones. Recovery flourishes. Thriving. Some may choose to commit to support others as they were supported.	***BRIDGE Maintenance****, except E becomes Elevated Outcomes (repairs to relationships, connections and processes as needed)* Long-term mentorship, community reintegration, transitional and end-of-life care may also be integrated here, with an emphasis on compassion.

YOUR TURN:

Mapping YOUR Continuum

Using the handouts given, map ***one*** gap in your own community/organization, then identify opportunities to implement a BRIDGE along the Continuum of HealthCARE.

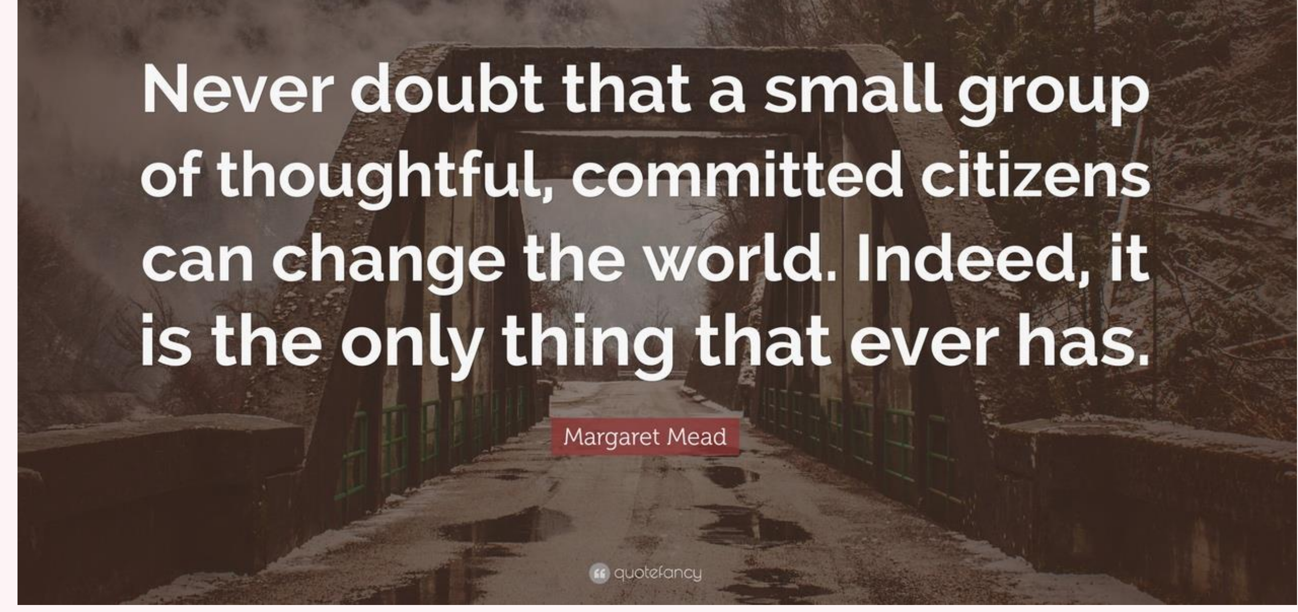
Or we may discuss as a group as time allows.

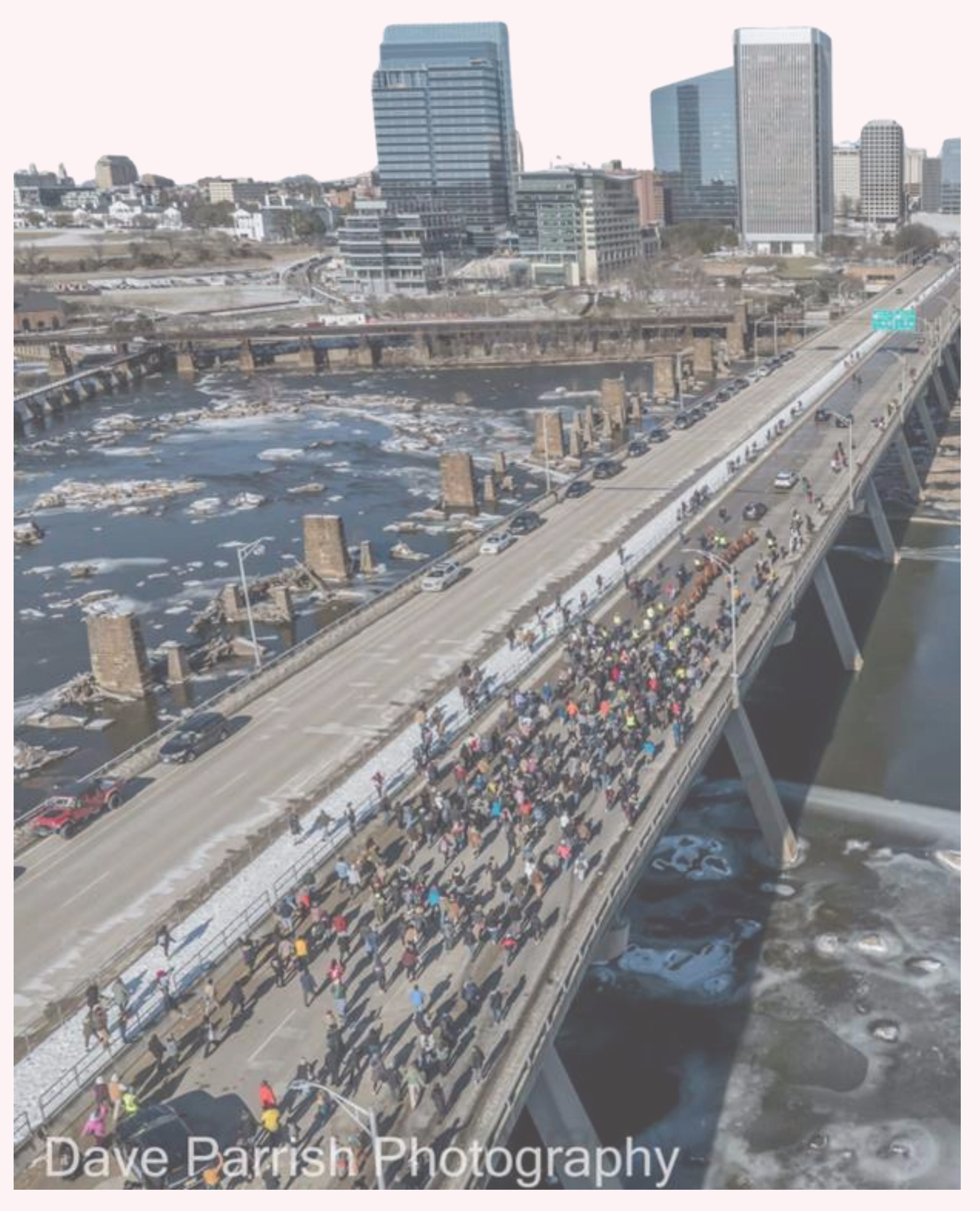
FEEDBACK AND DISCUSSION

- What part of the continuum are you in: The Curb/ Pre-Hospital, The Hub/Emergency Department, The Program, The Transitions, or The IRC/Sustained Wellness?
- What is going well currently? (The Foundation)
- Where are you already being the BRIDGE? Where are your current DISCONNECTS or GAPS? How can you show you CARE?
- Where can you implement Peer Recovery Specialists to bridge gaps?

CALLS to ACTION

What we hope you will consider next...





Questions?

Let's discuss

or feel free to reach out to us at:

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