workforce in this community- based model. FAVOR provides no-cost comprehensive services for addiction recovery. We hypothesized that having FAVOR Recovery Coaches (FRC) evaluate patients during an ED visit for opioid overdose would result in a high degree of engagement from the patients and serve as an opportunity to begin treatment for addiction.

Methods: This institutional review board-approved pilot project began enrolling participants in January of 2018 within a large ED (110,000 visits/year) in partnership with FAVOR. Patients who presented to the ED for unintentional opioid overdoses were identified by the emergency physician. After identification, a 24/7 on-call FRC was paged and met with the patient in the ED. The patients were offered recovery services at the bedside by the FRC. The research team members offered voluntary participation and obtained informed consent to enroll in a longitudinal study looking into the success of this intervention. Patients did not need to participate to be eligible for counseling and resources from FAVOR. The FRCs counselled and engaged the patient along with the family to offer a variety of services including active recovery coaching, group treatment modalities, family support services and transportation. After the initial encounter in the ED, the FAVOR team re-engaged the participant by phone or in person the next day and gradually increasing intervals thereafter.

Results: To date we have approached 87 patients, of whom 82 enrolled in the study (94%) and 65 (79%) are in active recovery as defined as "actively following with peer coaching services." Eighty-three percent of the active recovery patients (54/65) have also been linked to other recovery/treatment services. It is important to note participants could be linked to more than one recovery service including: AA/NA/12 Step (42%), Intensive Outpatient Therapy (4%), SMART Recovery (1%), Detox (13%), Inpatient Rehabilitation (8%), Sober Living (10%), Medically Assisted Treatment (MAT) (9%), Attempted MAT, unable to get in (8%), and Active Recovery Coaching (35%). In addition, only 8.5% of the active participants have returned to the hospital and no participants have during the course of the study.

Conclusions: This pilot program has been highly successful and has resulted in a large percentage of patients in recovery. This degree of engagement is unusual for most studies looking at recovery services. We suspect that approaching patients after a life-threatening event is one major driver. Additionally, because the FAVOR coaches are former addicts, they have a unique ability to connect with the participants in a highly effective manner. It is also important to note the FAVOR program is supported by community donations, and thus available at no cost to the health system or patient. Anecdotally, this program has been extremely well received by the ED staff as the

FAVOR coaches provide an effective avenue to engagement in recovery services.
Funding source: South Carolina Department of Alcohol and Other Drug Abuse Services.

367 Emergency Department Warm Handoff Program: Using Peers to Improve Emergency Department Patient Engagement and Linkages to Community-Based Substance Use Disorder Services

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Study Objectives: 1) To improve emergency department (ED) patient engagement and linkages to substance-use disorder (SUD) services in the community by strengthening existing workflows 2) To move from pilot to program by integrating Certified Recovery Peer Advocates (CRPA) into ED workflow and culture 3) To reduce avoidable ED visits by moving SUD care from the ED into community settings

Methods: In the initial 6 months of the pilot phase, Certified Addiction Recovery Coaches (CARC) and Certified Recovery Peer Advocates (CRPA) were introduced and integrated in the ED as hospital staff to engage, educate, and advocate for patients and support clinicians in making connections to appropriate SUD services. Using Motivational Interviewing skills and lived experience, peers supported the enhanced workflow by engaging and connecting patients with substance use needs, who typically decline services, to the appropriate level of care. ED clinicians activated peers through in-person requests and by placing orders for peer services through the electronic health record (EHR), which ensured that patients met with the peer before discharge. In addition, peers participated in routine medical rounds to case find and engage individuals coming to the ED with falls, car crashes, and other injuries to determine if SUD was the underlying cause for their ED visit. After a successful pilot period, the implementation team scaled up the intervention to become a program of the hospital ED. The implementation team convened hospital leadership and the hospital's outpatient SUD clinic to develop a sustainability plan. This plan included guidance on reimbursement for CRPA services, enhanced CRPA responsibilities in the ED at the outpatient clinic, revised ED workflows, and guidelines for continued engagement with the SUD population. Peers, which were previously employed through an outside agency, were hired as hospital staff and re-introduced into the ED with expanded roles and responsibilities to ensure patient engagement and linkages remained person centered and patient driven.

Results: In 1 year of program implementation (November 2016 to November 2017, including the pilot phase), there have been 1,049 patient engagements of which 659 were unique patients. 16% of those engagements resulted from case finds. Over 130 handoffs (12.4% of engagements) were made to SUD providers, which is a significantly higher (p-value < 0.0001) than the Substance Abuse and Mental Health Services (SAMHSA) reported national average of people who accepted treatment (1.5%). There was a 27% reduction in avoidable ED visits for people with SUD and other behavioral health diagnoses from November 2016 to August 2017. 3 full-time peers were integrated as hospital employees (2 assigned to the ED, 1 in the outpatient clinic). To move towards integration, peers were granted access to the EHR to support clinicians in coordinating linkages between the ED and the hospital's outpatient clinic as well as additional community based programs.

Conclusions: The WHP was an innovative approach to transform ED workflow and reduce avoidable ED visits using peers. As demonstrated by positive outcomes in patient engagement, linkages to community-based care and ED visits, peers are an essential component to providing patient-driven care for the SUD population. Cross-training peers in best practices for mental health, substance use, HIV, and social determinants of health is an area for further investigation.

368 Reassessment of Violence Against Emergency Physicians

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Study Objectives: The objective of this study is to investigate the incidence of different forms of workplace violence against emergency department (ED) physicians, evaluate the perception of safety in the ED, and compare the incidence and experience of workplace violence to results of "Workplace Violence: A Survey of Emergency Physicians in the State of Michigan" by Kowalenko et al, 2005.

Methods: This study utilizes data collected from an electronic survey. The survey aims to estimate the incidence of violent acts against ED physicians such as verbal threats, physical assault, confrontations outside the ED, stalking, violence through patient satisfaction surveys, or social media contact in the past year. It also includes questions on demographics, quantity and type of violence, and physician reactions. Chi-squared and 2 sample t-test analyses were performed.

Results: The survey was sent electronically to 1,102 physicians in 1 state. 288 were returned (26.1%), and 268 (24.3%) were completed and analyzed. The respondents were predominantly male (66.5%), emergency medicine board certified (95.9%), and represented a variety of practice settings. The percent of respondents that reported experiencing any form of violence in the past year (72.4%) was not significantly different from responses in 2005 ($p=0.4$). The percent of respondents that experienced any physical assault increased to 38.1% in 2018 from 28.1% in 2005 ($p=0.01$). However, fewer physicians in 2018 obtained a knife for personal protection (5.2% versus 20%; $p<0.001$), asked for a security escort to vehicle (17.5% versus 31%; $p=0.001$), or considered leaving the hospital secondary to perceived violence threats (8.6% versus 16%; $p=0.02$). There was an increase in 2018 from 2005 in the percent of physicians that reported feeling frequently (21.9% versus 9.4%) or constantly (8.1% versus 1.2%) fearful of becoming a victim of violence in the ED ($p<0.001$). Between 2005 and 2018, more hospitals were reported to have: security personnel that perform rounds throughout the entire hospital (53% versus 27%; $p<0.001$), security personnel assigned to the ED (34.3% versus. 24%; $p=0.02$), armed security officers (30.2% versus 9%; $p<0.001$), or police/sheriff security officers in the ED (7.8% versus 2%; $p=0.01$). In 2018, 6.3% physicians reported social media violence, which was statistically associated with working in a urban-large city hospital ($p=0.038$). 17.9% reported violence through satisfaction surveys, which was not significantly associated with any specific demographic.

Conclusions: Workplace violence is still a common occurrence in the ED. Despite increased hospital security measures since 2005, emergency physicians across all demographics still experience various forms of violence, are increasingly concerned about becoming a victim of violence, and continue to take personal measures to ensure their safety.