CODE RECOVER

Peer Connection Protocol (Clinician) — Quick Reference

What a Peer Navigator is, and when to bring one in

A care team member whose primary credential is lived experience with substance use and recovery, supplemented by formal training (crisis intervention, motivational interviewing, resource connection). Not clinical staff — does not diagnose, prescribe, or perform clinical tasks.

Bring a peer in as soon as available at any Code Recover activation; optimal moments are immediately post-overdose-reversal, during withdrawal management, and before discharge planning.

Why it works

ED-based peer programs are associated with significantly increased MOUD initiation within 60 days of discharge (NJ study, 12,000+ Medicaid patients), though effect size depends on how well the program is implemented.

Peer support across the OUD treatment cascade improves engagement and retention, and peers help address the highest-risk period right after overdose through warm handoff and follow-up.

Working with your peer

- The peer's role: building rapport, easing fear, explaining what happens next in plain language, troubleshooting housing/transportation/SDoH barriers, and securing the warm handoff and follow-up connection.
- Stays with clinical staff: diagnosis, prescribing, and all clinical decision-making. During an agitated or escalating patient encounter, the peer can help de-escalate alongside the team, but clinical and security staff must always remain the ones responding — a peer is never the sole response to that situation.
- Introduce the peer directly, by name, in person — one sentence is enough: this person has lived experience and is here to help. Avoid stigmatizing terms ("junkie," "frequent flyer") — they land differently on a colleague with lived experience, and peers' read on patient readiness is worth taking seriously.

Confidentiality and keeping the program running

Peers typically get restricted EHR access, and SUD records carry 42 CFR Part 2 protections beyond standard HIPAA — make sure peers are trained on redisclosure rules before they start documenting.

Separately, watch the program itself: burnout, role confusion, and poor integration with the clinical team are the leading reasons peer programs fail, so protecting peers' boundaries and time isn't just collegiality — it's what keeps the program alive.