"REAL-TIME SYSTEMS REPAIR": INSTITUTIONAL DIMENSIONS OF AN EMERGENCY DEPARTMENT COMMUNITY HEALTH WORKER/PEER RECOVERY SPECIALIST PROGRAM

Soske J[1], Merrick C[1], Goodman GR[2], Gaipo A[1], Wilson T[1,3], Karb R[1,3], Diaz R[2], Macmadu A[4], Naeem A[5], Wagner K[6], Samuels EA[2]

[1] Brown University Health, Providence, RI, USA [2] Department of Emergency Medicine, David Geffen School of Medicine, University of California, Los Angeles, CA, USA [3] Department of Emergency Medicine, Alpert Medical School of Brown University, Providence, RI, USA [4] Department of Epidemiology, Brown School of Public Health, Brown University, Providence, RI, USA [5] Department of Medicine, Beth Israel Deaconess Medical Center, Boston, MA, USA [6] School of Public Health, University of Nevada, Reno, NV, USA

Background

Emergency departments (EDs) serve as critical points of post-overdose intervention and primary access to care for people who use drugs (PWUD), including those who are unhoused, uninsured, or experiencing severe mental illness. To address rising opioid overdose visits and underlying social determinants of health, EDs increasingly employ Community Health Workers and Peer Recovery Specialists (Peer-CHWs) to engage patients with substance use disorder (SUD), facilitate harm reduction, and link patients to treatment. Existing frameworks conceptualize these roles primarily as "systems navigation." For structurally vulnerable populations, however, healthcare and social service systems are often effectively absent—characterized by ghost networks, unpredictable closures, shifting eligibility, and recurring gaps.

Methods

WE used a qualitative, ethnographic design at a Level I trauma center and safety-net hospital in Providence, RI. We conducted semi-structured interviews with 45 participants (6 CHW-peers, 15 patients, 20 clinical staff, 4 program founders), a focus group with Black and Hispanic CHW-peers, and participant observation over five months. Analysis combined theory-driven coding and inductive subcode generation, with CHW-peer advisory board oversight.

Results

We identified 55 recurring points of institutional breakdown across organizational levels and five strategic repertoires through which CHW-peers responded: (1) resistance and self-protection against stigma and discrimination; (2) improvisation when protocols failed; (3) accompaniment across sustained patient relationships; (4) building and mobilizing informal networks to bypass formal referral channels; and (5) moral repair to restore ethical care norms. Together, these repertoires constitute what we term *real-time systems repair*: ongoing, improvisational responses to predictable institutional breakdown. CHW-peers also described a "double burden of stigma"—witnessing discriminatory treatment of patients while experiencing parallel discrimination tied to their own recovery status, race, and outsider position.

Conclusion

CHW-peers function less as navigators than as emergency responders to chronic institutional failure. Recognizing real-time repair as a core function explains persistent implementation challenges, reveals

unacknowledged labor, and raises urgent ethical questions about institutionalizing roles defined by compensating for systemic failures.

Disclosure of Interest Statement

The authors have no conflicts of interest to disclose.