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Addressing a rapidly changing service landscape during the COVID-19 pandemic: Creation of the Oregon substance use disorder resource collaborative

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ARTICLE INFO

Keywords:
Substance use disorder
COVID-19
Safety-net programs
Health systems
Treatment capacity

ABSTRACT

Following the rising crisis of COVID-19 and the Oregon governor’s stay-at-home orders, members of the Oregon Health and Science University (OHSU) inpatient addiction consult service recognized that local addiction treatment and recovery organizations were operating at limited capacity. As a result, discharge planning, patient access to local community-based treatment, and safety-net programming were affected. Given structural and intersectional risk vulnerabilities of people with substance use disorders (SUDs), the OHSU members felt that COVID-19 would disproportionately impact chronically marginalized members of our community. These inequities inspired the formation of the Oregon substance use disorder resources collaborative (ORSUD) led by four medical students. ORSUD’s mission is to support the efforts of local safety-net organizations and front-line providers who serve chronically marginalized community members in the midst of the global pandemic. We operationalized our mission through: 1) collecting and disseminating operational and capacity changes in local addiction and harm reduction services to the broader treatment community, and 2) identifying and addressing immediate resource needs for local safety-net programs. Our program uses a real-time public-facing document to collate local programmatic updates and general community resources. COVID-19 disproportionately burdens people with SUDs; thus, ORSUD exists to support programs serving people with SUDs and will continue to evolve to meet their needs and the needs of those who serve them.

1. Background

Even in a world without a global pandemic, people with substance use disorder (SUDs) often receive fractured, stigmatized, and lower quality health care (Druss et al., 2002; Madden, 2019; Tsai et al., 2019); they have decreased access to treatment (SAMHSA, 2019); and they experience racial inequities in treatment (Lagisetty et al., 2019). As the COVID-19 pandemic rippled through the health and social service delivery landscape, it became clear that chronically marginalized members of society would be most impacted (Alexander et al., 2019). As the COVID-19 pandemic rippled through the health and social service delivery landscape, it became clear that chronically marginalized members of society would be most impacted (Alexander et al., 2019; Lagisetty et al., 2019). As the COVID-19 pandemic rippled through the health and social service delivery landscape, it became clear that chronically marginalized members of society would be most impacted (Alexander et al., 2019; Lagisetty et al., 2019). As the COVID-19 pandemic rippled through the health and social service delivery landscape, it became clear that chronically marginalized members of society would be most impacted (Alexander et al., 2019; Lagisetty et al., 2019). As the COVID-19 pandemic rippled through the health and social service delivery landscape, it became clear that chronically marginalized members of society would be most impacted (Alexander et al., 2019; Lagisetty et al., 2019). As the COVID-19 pandemic rippled through the health and social service delivery landscape, it became clear that chronically marginalized members of society would be most impacted (Alexander et al., 2019; Lagisetty et al., 2019).

Individuals living with serious mental illness or SUDs often rely on safety-net organizations and experience increased barriers when preparing for and adjusting to disasters (Morganstein, 2019). Reallocation of community resources to lifesaving activities (e.g., medical care, food, water, sanitation) can disrupt critical sources of support (e.g., counseling, social services, supportive housing, jobs) (Morganstein, 2019). At the start of the COVID-19 pandemic, access to treatment and social services became increasingly limited, as a recent survey of more than 800 behavioral health organizations evinced (NCBH, 2020). In that study, 93% of organizations reported reduced operations and 31% reported cancelling, rescheduling, or turning patients away (NCBH, 2020). Diminished treatment capacity follows trends of previous natural disasters, such as Hurricanes Katrina, Rita (Maxwell et al., 2009), and Sandy (Pouget et al., 2015). During these environmental crises, individuals with SUDs experienced excess harm due to barriers accessing medical care, disruptions in drug supply, increased symptoms of withdrawal, and increased unsafe substance use behaviors (Maxwell et al., 2009).
Reduced access to medications for opioid use disorder (MOURD) following these complex emergencies resulted in loss of tolerance and an increased risk of overdose following return to use (Pouget et al., 2015). Thus, in a time of increasing need, access to life-saving services decreased.

As Oregon’s governor issued stay-at-home orders on March 23, 2020, the Oregon Health and Science University (OHSU) Addiction Consult Service (IMPACT) (Englander et al., 2017) observed rapid changes in access to community addiction and recovery services. Outpatient treatment programs stopped operating or were operating with decreased service capacity, often with limited ability to communicate changes to external stakeholders. Discharge planning for people with SUDs became increasingly challenging as fewer inpatient treatment and housing opportunities were available. In line with physical distancing measures, medical students transitioned to virtual classes and delayed clinical rotations. The IMPACT Director (HE), recognized that we (AG, KP, PB, and RL) were ready and able to help. This culminated in the formation of the Oregon substance use disorder (ORSUD) resource collaborative. The founding team consists of four medical students with backgrounds in community-based organizations. To date, the public-facing resource (ORSUD, 2020). At the beginning of the epidemic, due to rapid changes in their service capacity, ORSUD student leaders (AG, KP, PB, and RL) added these updates in real-time to a public-facing document (ORSUD, 2020). At the beginning of the epidemic, due to rapid changes in capacity, the student leaders updated the document daily (we sent the survey 5–6 days per week). As service availability stabilized, we transitioned to updates and survey emails 2–4 times a week, and then to once a week in August 2020. We have more than 100 individuals, organizations, and agencies on our email list. Since our launch on March 28, 2020, we have received approximately 122 survey submissions from community-based organizations. To date, the public-facing resource guide includes information on more than 140 organizations and information on local and national policy changes, health insurance, mutual aid, personal protective equipment (PPE), criminal/legal aid, shelter/housing, harm reduction, national SUD resources, and links to online recovery resources.

To address immediate resource needs that safety-net programs identified, donations were crowdsourced through gift registries and direct monetary contributions from our personal and professional networks. Front-line community organizations frequently requested PPE and support with telemedicine technology to reach physically distanced participants. We partnered with local student-run Bridges Collaborative Care Clinic (Bridges Collaborative Care Clinic (BCCC), 2020) and connected our community-partners to their resources and volunteers, which resulted in our providing 50 meals and delivering more than 5000 masks to a homeless resource center. We also donated a cellphone and tablet to facilitate low-barrier telemedicine connections with participants receiving community-based services.

The ORSUD daily needs assessments along with an “SUD COVID-19 Response” ECHO telementoring program (Komaromy et al., 2018) informed the creation of additional resource projects that stakeholders identified. These projects included pharmacy mapping and low-barrier telemedicine projects. The pharmacy mapping project, championed by a public health student, was designed to identify potential barriers to buprenorphine and naloxone dispensing at local retail pharmacies. The project assessed restrictions related to supply shortages, insurance, whether a government-issued ID is needed for Schedule III medication dispensing, if third-party pickup is allowed, and if pharmacies allowed nonprescription syringe purchase. Additionally, the ORSUD team explored how to support telemedicine and virtual visit expansion. We partnered with local harm reduction and syringe exchange services and a walk-in buprenorphine clinic (Robinson, 2019). Second, we aimed to develop a low-barrier/low-threshold buprenorphine/naloxone provider, agency, and organization list—inspired by the work of No More Deaths Missouri (NoMoDeaths, 2020).

3. Lessons learned

Medical students across the country mobilized and organized to fill unmet needs in the midst of an unprecedented public health crisis, including providing community support through childcare, and grocery or medication delivery (Soled et al., 2020). The ORSUD project demonstrates that during times of crisis, students can play a role in supporting access to treatment and services for people with SUDs through physically distanced engagement with safety-net organizations and treatment programs by assessing and addressing immediate programmatic needs.

State-level advocates, local news outlets (Silverman, 2020), and an accountable care organization with interest in folding this work into their ongoing efforts have all recognized the value of this work. To reduce burden on overworked front-line providers, we made survey responses optional and reduced email outreach from daily to once weekly emails, based on less frequent submissions from community providers. To encourage sustainability of the project, we are looking at potential partnerships with local nonprofits whose missions are to help connect people to social services.

We created ORSUD to fill structural and institutionally identified gaps that people with SUDs, safety-net programs, and treatment providers have experienced during the COVID-19 pandemic. We plan to continue ORSUD through our partnerships with existing programs at OHSU and across the SUD community. Our project will continue to evolve and change over time to meet the needs of our local community-based treatment organizations, and, most importantly, to support marginalized people with SUDs.

CRediT authorship contribution statement

Rachel Lockard: Writing- Original draft preparation, Conceptualization. Kelsey C. Priest: Conceptualization, Writing- Reviewing and Editing. Patrick C. M. Brown: Conceptualization, Writing- Reviewing and Editing. Amanda Graveson: Conceptualization, Visualization. Honora Englander: Supervision, Conceptualization, Writing- Reviewing and Editing.
Declaration of competing interest

Authors have no competing interests to declare.

Acknowledgements

We thank public health student Armando Jimenez, participants of the SUD COVID-19 Response ECHO, and Bridges Collaborative Care Clinic PPE Team, and our many community partners.

Sources of support

This work was supported by the National Institute on Drug Abuse (F30 DA044700) (KP).

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