OTP Session 6 Transcript

Shaivi:

Hey, everyone. Welcome in. Welcome in. Thanks for joining us today for this session on providing culturally responsive services to BIPOC populations. Appreciate you being here. At the tail end of the day, this is the last session of the day. So thank you so much. 330 to 430 we're going to be in this little group here. I'm just going to give a minute for people to join. I know folks are hopping around from virtual reality to virtual reality. So come on video if you can, if that's available to you. Love to see y'all. Hey, Jennifer.

All right. I think we have a lot to cover today, and I'm sure we're going to have loads of questions for our speakers, so let's get into it. If the team could just keep an eye on the waiting room, that would be great. Let anyone who joins. So, like I said, thanks everyone for joining us today for the session and providing culturally responsive services to BIPOC populations.

Next slide please. We have three wonderful presenters today and it's my honor to introduce them. We have Jasmine, Decima, and Monique.

Jasmine Irvin is the senior program manager for health equity for Massachusetts General Brigham's substance use disorder programs. She is the project lead for health equity initiatives for MGBs, low-threshold bridge clinics and addiction consult teams. In her role, she seeks to provide culturally relevant, community-based substance use care and education to marginalized communities and ensures that MGB spaces are welcoming for all. She has led several health equity initiatives, including the expansion of substance use disorder mobile based care in Roxbury, Dorchester and Mattapan. And she is a Boston native who is deeply passionate about building trust between medical institutions and communities of color, and bringing awareness to marginalized populations around substance use disorder. So that's Jasmine.

Then we have Decima Prescott, who works as a nurse practitioner at the Mass General Hospital Substance Use Disorder Bridge clinic. She is originally from the Caribbean and migrated to the US as a teenager. She began her career at MGH while in high school, eventually working her way up, receiving her BSN from Curry College and then her M.S.N rom Regis College.

She has also worked at several universities and colleges as an adjunct professor in the Health and Science department. And in her work as an SUD nurse, she combines compassion and science to assist patients in achieving feasible goals and outcomes. And then, last but not least, by any means, we have Monique Horton, who is a senior

recovery coach at Mass General Hospital, Bridge Clinic and emergency department. She's specializes in meeting patients where they are at in recovery, addressing social determinants of health and helping patients navigate their social and community needs. Monique also plays a key role in the Mobile Van program, connecting community members to vital resources and services, and ensuring comprehensive support beyond the hospital setting.

So let's give it up for our speakers who have incredible experience. Thank you, everyone, for being here with us today. And, we're going to head into some session objectives on the next slide.

So session objectives for today I'm going to quickly review these, before we get started.

The first is to analyze the impact of implicit bias discrimination and historical mistrust on treatment experiences and outcomes, specifically for BIPOC communities.

And we want to apply three strategies to mitigate these factors in clinical practice.

The second second objective. The second session objective is to name at least two strategies for recruiting, retaining, and training a diverse workforce that reflects the community served, and implementing these strategies to improve workforce diversity and service delivery.

And finally, the third objective is to evaluate structural, cultural, and systemic barriers that BIPOC individuals face in accessing and remaining engaged in OTP services. And apply that understanding to implementing at least one policy or programmatic change to improve access and engagement and treatment for BIPOC individuals.

Next slide please.

Okay. So to get us started, we're going to do some poll engagement, which is super exciting. We're going to do that through Zoom's poll feature. So you should shortly see something pop up on your screen. It's a poll that asks, which area do you find most challenging in your work related to supporting BIPOC individuals and OTP services?

There you go. You should be seeing it now. You just want to click in, to answer, and we'll give it about like two minutes ish or maybe less. Even if you guys are fast clickers, we might not need that much time. Seeing the numbers go up.

Great. Okay, so I'm seeing a range. I'm going to cast the poll results to you all. Are you able to see those? Yes.

So we're seeing pretty good range across all of these, which shows us that we have many challenges in this space. Firstly, addressing implicit bias and discrimination, building trust with patients and communities, recruiting and retaining a diverse workforce, and then navigating structural or systemic barriers. So lucky for y'all, we're going to talk about all of the above today. And with that, I'm going to hand it over to our speakers.

Jasmine:

Thank you so much. Can everyone hear me okay. All right. Perfect. Thank you so much for that wonderful introduction in the poll. Was good. We're going to talk a lot about really the the trust mechanism too. So I'm glad that we saw a high number of percentage in that. So again my name is Jasmine Irvin. I'm the senior program manager of health equity for substance use disorder MBG.

So I oversee all of our health equity goals and related to substance use disorder for our clinics. And what health equity is, the actual definition, it's the state in which everyone has a fair and just opportunity to attain their highest level of health. And today, as we talk about this, we're going to talk about health equity as it relates to substance use disorder treatment.

So I am here with my two colleagues, Monique and Deci, and we are going to do our best to keep you guys awake at 3:30. I know this is the coffee time, and I know y'all have probably been in workshops and presentations all day long, so I'll try to make this as conversational as possible. So yeah, we're going to talk about the work that we've been doing over the past few years together, and community work supporting marginalized populations with substance use disorder in the Boston area.

So we'll be talking about what that journeys look like. So we're going to get into the history of substance use disorder in marginalized communities. So first, the definition of a marginalized community, is a community or population that has been systematically excluded, oppressed or disadvantaged due to factors such as race, ethnicity, gender, socioeconomic status, religion, disability or sexual orientation, etc. so some examples of this specifically are people of color.

So the BIPOC population that we're going to talk about people with limited English proficiency, etc.. So all of these populations, right. They have these, structural barriers that will actually put in place nothing to do with who they are as people that are actually contributing to these poor health outcomes. And in this case, we're talking specifically about poor health outcomes in substance use disorder in the BIPOC populations. Right. So as we all know, people of color in this country have not had the best experiences, especially when it comes to addiction and substance use disorder. That's because of systematic oppression, racism, implicit bias. Right? So there's a lot of these things that we're going to talk through that are going to prevent people maybe from seeking care.

So the first, kind of bucket here is the medical mistrust, right? Black and brown people have felt like their voices have not been heard. They've been told that they don't experience pain in the same way that their counterparts do. Their bodies have been used for medical experience. Experiments. They have been lied to. I don't know if you guys have ever heard about the Tuskegee experiment and what they did to folks, but if you haven't, you can do some history. And they are right. They they're nervous about talking to their doctor when it comes to substance use disorder, not knowing if the doctor will call the police on them, you know, and get their baby taken away. So they have this fear of going to jail if they speak up about their use. With this war on drugs,

that we went through in the 80s, in the 90s, there's a lot of shame and stigma, not wanting to talk about your substance use disorder for fear of being shamed by your family or friends.

In black and brown cultures, we're not. We're not taught to talk about our problems, right? Everything stays in the house, you know, and we kind of deal with things on our own. And so there's that. And then there's also a lot of trauma embedded in marginalized communities. And then there's still so much stigma with that within our own healthcare institutions that really don't make it feel safe for people to want to come and access care.

There's also lots of unequal access to treatment in marginalized communities. Right? They're not given the same information gate information is gatekeepered. There's a lack of funding and resources in communities of color. And I know we just saw this, with COVID, right. And when we were having, vaccine deserts and so forth. And so all of these factors lead to hesitancy to seek services.

People's trauma might be outweighing them, wanting to seek treatment. Then there's a lot of myths that need to be debunked. Around medication, around substance use disorder, and a lot of gaps in knowledge about effective treatment options and all of these things, all of these things collectively, may prevent someone from seeking care and overall keeping our overdose rates high and our treatment rates low for marginalized populations.

And an example of this is looking at the overdose rates for black men 55 and older that are the highest, that are the highest, versus their counterparts whose numbers, their white counterparts, whose the numbers are actually dropping right now.

So, you know, our crew, we know all this information, right? So it's like, what are we going to do about this? We know we have to address we need to do something to address the gaps in the care increase access to our low threshold bridge clinics at MGH. Right. We know we have this great life-saving care, but how are we going to get people to come? The people who are suffering the most and need the treatment most? How are they going to seek us out? Right. They're not coming to us. So how do we change that? So we know, like all that history that we talked about before, we're going to have to change our ways and that we're going to have to leave the walls of MGH and go to where the people are and seek out a community-based care approach.

And this honestly was like really different from MGH because we're so used to people seeking us out, right? Number one hospital in the country, everybody come see us best care. But in this case, it was very different, and we knew that we would have to go to the folks. And so, some of the first things that we did is that we looked at the overdose rates in certain zip codes and focused on the areas that had the worst rates. And we focused on those areas first, taking this community-based care approach and then, trying to embed it into our clinics with the real outreach boots on the ground outlook. So some of the things that we started to do, we hosted listening sessions. So instead of like going

into the community and telling them that what, what they need to do, tell them that we have this lifesaving care do do X, Y, and Z. This is our mission. We instead went to different community meetings and we listened. We listened to the people. And this, it did like, needs assessments. Right. And this was, we found the best way in approach for us to really strategize the work that we were trying to do, and then also really helped us to build trust with community members and partners. Because let me tell you, when we first left the walls and started going into the community, people were like, who is MGH? Why are you here? We had a really there was a really bad, perception of what we were there to do. And so we had to do just a lot of work just listening. And learning.

And so out of this came the launch of our mobile van substance use disorder sessions, which I'm proud to say that we are now in three locations Roxbury, Dorchester and Mattapan. And Monique and Lovely do a lot of have done a lot of work to really get this, jumping lots of outreach work. But we knew that with these vans it would prevent that barrier of people having to come to us, and we could go to the people and become more accessible to the community. Also allow us to kind of move around and migrate to where the people are, like a little clinic on wheels. We also learned about the importance of cultural humility and staff representation. When doing this work right, we want to make sure that the people that we're hiring and recruiting to do this work, are representative of the communities that we're trying to serve. And if we didn't have that staff representation, ensuring that the people that we are going to have work understand the need to have cultural humility and understand, the culture, you know, of the people that they're trying to serve because seeing someone who you identify with or understands your culture, it puts you at ease, and makes you more willing to trust. Right? And it's really all about the trust building. We also partnered with community-based organizations. Right. Not coming in like, hi, everyone. We're here to do all the work. We're here to be the saviors for people who've already been doing community work for years, but instead finding ways to support, collaborate, or to partner with community organizations. And it's not just about showing up and providing health care, right? We might have to tweak the things that we're offering. Sometimes it's just like providing education or thinking of ways that we can collaborate together to provide more funding to a community-based organization that might be struggling a little. So, we have actually we're three grants deep and with a community-based organization that's collaborating between MGH and a community partner. And then we really, needed to address the social determinants of health in these areas because there are a ton of non-medical things that we know are going to affect or influence a person from going to get substance use disorder care or treatment. And so we just I just put added some of the pictures of some of the work that we've done, over the years. This is Monique and Deci at like a church teaching people about substance use disorder and faith-based organizations. We have one of our providers here doing an 'Addiction 101' at a community meeting. And this is us at one of our van locations here. So, yeah, just really showing up, going to community events, consistently showing up so that people remember who we are and that we can so that we can continue to build up that trust, and let the community know that we're in this for the long haul. And yeah, so we just spent a lot of time building up trust.

And so, you know, there are a ton of barriers. That we need to address while improving care in our spaces. We don't all have access to community-based care or a mobile van. But we can still improve the care that we have in our current spaces. And so we talked to both staff and patients about some of the barriers to treatment that we wanted to, address.

And I'll kind of just walk through some of each of these barriers and how we can kind of address them in our own spaces. So first is like just having welcoming spaces that your spaces in your clinics, like when people walk into your spaces, do they feel welcomed? Is it is it welcoming to all cultures when people are looking out around on the walls, do they, if you have artwork up, do they see themselves reflected in the artwork that you have up? If you're playing like music in your space, what kind of music are you playing? If you put up fliers in your space, does it represent diversity? Right? One of the things that we did in our space and our MGH Bridge Clinic is adding monthly observances or celebration that celebrations that feel important to staff members and patients, because we want people to feel seen when they come into our clinics.

Another thing was addressing the language access barrier. You know, you really sit and think about we're so privileged to know the English language, but can you imagine how you feel if you showed up to a hospital and no one spoke your language? Right? All the information that you were given was presented to you in a language that you didn't understand.

You'd feel lost. You would not want to reach out. You maybe, you know, that would be a real barrier, to wanting to continue to seek out treatment. So some of the things that you can do are simple, right? Work on a relationship with your interpreter services department. And if you have one, and know who the people are, so that if someone comes in and they don't speak the language, you can call on this person right away or this department right away, you're not scrambling to figure out the system at the last minute, right?

Having a way to print information packets and fliers in different languages, and making it a point to hire bilingual staff so that we're able to communicate with all people who need care.

Addressing stigma. You know, we all have implicit biases. We all hold a little bit of stigma, but really addressing it head-on. And I know that, you know, this can be something that's really it's you have to be self-reflective to be able to do that stuff. But if this is the type of work that you're getting into, you have to hold yourself accountable and address your biases, right? Maybe you have workshops and stuff that you run at your clinic, your clinic, or you're implementing reporting systems where people can address areas of implicit bias or racism. Maybe you can hang up some anti-stigma materials displayed in your clinic so people know that they're in the safe space when we're talking about substance use disorder.

Having cultural competency and cultural humility, or lack of it, can be a barrier. Right. So we could we should be hiring people of color, people who are representative of the people we're trying to serve, having trainings that are addressing culture, humility. And we'll talk more about that. On the next slide. And I know a lot of people are struggling with a lack of funding, especially right now in the climate that we're in where everything is just being cut.

Especially for us do gooders who really want to do the good human services work. Right. And so, this is an opportunity for us to really be creative. There are a lot of different programs that, you can apply for grants, right? And you can apply for these grants and use them to further the community work that you're trying to do.

A patient and family advisory council is also, a really good thing. It's a council made up of like, staff, patients, community members and people with lived experience. And we really utilize them to kind of look at our systems, our workflow. We run things by them to get feedback. Because it can help us really improve the current, system and service delivery that we have.

And, having staff with lived experience. So, our recovery coaches, I say it all the time, I scream from the top of my lungs that our recovery coaches are our secret sauce. And this substance use disorder work. The recovery coaches are people who have lived experience, who work with patients, to get to their goals. And they are able to connect with the patient in a way that a clinician may not be able to do so because they really understand, what people are going through because they've they've been through it.

So that's a huge that's been a huge help. If you're having, trouble connecting with some of your patients. So, you know, not everything is really about having a ton of money and overhauling and changing your own, your whole system. It's really just about thinking creatively about things that you can change, and really being dedicated to the work and just looking for ways that you can improve every day.

So I just want to talk about staff diversity a little bit, because staff diversity is so important when we're talking about innovation and problems enhancing problem problem-solving and workflows and all that within our own staff. But it's so important for the patients because this can lead to engagement. It can lead to a comfort level, and so forth.

And so it's good to think about, Some of the systems. Sorry, I lost my notes. It's good to just think about some of the systems that we have have in place for recruiting people. Right. So how are we recruiting a diverse staff? We can look at our job descriptions. Are there things in there that we can tweak?

Are we specifically saying that we are looking to hire people who can speak a second language? Are there things on there like needing qualifications for a college degree when you may not really need that to do the role right? Where are you advertising? Are you leaving it up to just your website's career? Yeah. Career page? Or are you going into communities and letting people know about different jobs in roles that you're hiring

for?

Are you advertising in different community newspapers and so forth? So thinking creatively about that. And then when we are getting this new staff, what are we doing to retain them? Right. Because if you're used to a certain culture or a certain type of folks in your space, and now we have some new staff and new diverse, it can be really challenging. It can be challenging for the current staff, and it can be very challenging for, you know, your diverse staff who's now in your space trying to fit into a culture that they don't feel comfortable in, right. And so if you can offer any cultural humility trainings or employee resource groups, which are like safe spaces for people of color where they can share and talk with other like-minded people and people who look like them. And then also implementing reporting system. So if there are issues of racism, implicit bias, discrimination, people know where they can report and that there are reporting systems that are going to keep people safe from these, these issues. So that's some of the work that we've done. And I think that MGH has really done a lot of work of trying their best to, improve outcomes for marginalized folks.

And we've done a really good job of hiring a diverse staff. So I'm going to hand it over to Deci and Monique a little bit just to talk about, their journey of working at MGH, and the community over the past few years.

Decima:

Okay, I'll go first. Thank you. Jaz. Hi. Good afternoon. My name is Decima.

I'm the nurse practitioner under Community care van, and I just want to talk a little bit about my perspective on substance use. I said it in my bio. I was I was born in the Caribbean. And where I grew up, substance use is not a, a topic of awareness. It was built into my perspective that, consuming alcohol was, normalized by I have a bit of an understanding that crack cocaine was trafficked. And again, like the misuse was, never witnessed by, anyone like in our community. However, what I was familiar with was cannabis, right? We all know about weed. All the youngsters smoke weed. I remember as a child that, you know, this is called a shepherd girls, because we had animals. And one time I was out with my father in the hills, and, um, like, ran off and then got lost in a weed field and that I could never forget that smell. So as a child, that's what I remember migrating to America, my first job here was at MGH, and this is a predominantly non-black institution. Working as an RN for 16 years. The magnitude of patients that I care for as a nurse for substance use, I would say it was about like 10% that, actually people of color.

So bringing, those factors together. Right? My perception, I want to say for 16 years of my life, I always felt as though that people of color who, misuse heroin or crack cocaine did that infrequently. And all that changed. My perception changed when I started working at the bridge clinic. I started going into the community with Monique, and, she sort of took me into the areas of Roxbury. And so they showed me like, oh, you know

what? The people of color actually was actually going through. And I started asking Monique, like, what is going on here? Like, you know, is this for real? And I'm, like, I'm a person. Like, I, I, I live in Roxbury, I've lived in Mattapan, I've lived in Dorchester, and I've never actually witnessed, like, you know, this magnitude of substance use. So, Monique, she explained to me the, the opioid epidemic and why people of color, had to hide to, to hide, to, to how to use. I'm nervous. I'm sorry. I'm so nervous.

So, so I also remember that, Doctor Whitman was conducting a didactic. And, she specifically stated that people of color had the highest mortality rate from overdose so for my challenge, I knew that this was this was a stigma of mine. And that is something that I needed to change. Right? I needed to change my mindset if I was going to be, successful. And working in the field as a nurse practitioner, as a nurse practitioner. And so for me, I, the first thing I did was, is to just bring myself more awareness to what is going on. And I started to work on more engagement with the patients in the population. And another way I bring about change with my mindset is just, having that didactic at MGH and so we have created a didactic at MGH, and I got more involved with that. And I'll pass it on to Monique.

Monique:

Hi. Welcome to everybody that's here. I'm glad that we are able to conduct this. This forum right here.

So when Jaz was talking about everything that was going on in the community, I was born into, the community. I was raised in addiction. My mother, my, well let me say I was a generation/person that was raised in addiction. I was born addicted. And so coming up, it was so normal for me to. Education wasn't important. It was about escaping. And the reason why I talked about escaping was because of the discrimination, because of how black, how we were treated, how I was treated as a young kid growing up, how like, you know, I didn't as coming up. I didn't really and I don't even know if I got too long to talk, but I'm gonna try to do this real quick.

I didn't even know that. You know, that we really existed with white people. I thought that white people was the doctors and nurses and. And that's it. And that's what I. That's what I learned. But as growing up and as coming up and going to school and being segregated in a school system, I dealt with a lot of biases. I dealt with a lot of discrimination. I dealt with a lot of hate. Okay. So moving forward, so I used for a very, very long time, I started at a really young age and, it wasn't a good thing. It wasn't a good atmosphere for me. However, at some point, I got my life together because I wanted something different, and I seen what was going on in my family, and I wanted to break some chains. I wanted to break some, curses that were here. So I started in the in the field, like 20, 20, 20 years ago. I just turned 57. You guys, I know I like it, right? But anyways, me for us was my birthday, so, I know I don't live there, but anyway, so I got in the field like 20 to 20 years ago and I started working in “detoxes” and and stuff like that.

And I was always amazed with how we didn't get the same treatment that everyone else. You know what I'm saying? I was amazed how we weren't really educated, a lot of, black and brown are not educated on believing that it's okay to ask for the treatment. It's okay to, stand up for yourself and, ask questions and find answers. Right.

Come to Mass General. Lets just a fast forward. When I apply for this position, I never thought I would work at Mass General because I knew what Mass General was about. It was about being downtown with a whole bunch of white people that didn't like us. Right. So I never thought that I would work here, but, it was, a supervisor that I had that I met going into meetings, and she is the one that brought me in and I met, and I am so grateful that I'm here moving forward to the van.

How this came about. When it was introduced to us, no one knew what to do. No one knew what to do. They/we went into this community and I was so amazed because I'm like, okay, this is where I grew up. I know where everything is. Come on. I'm going to show you guys where the help is needed, right? Jazz talked about, Jasmine talked about having someone of color that went through, dealt with, overcame and still overcoming the diversity, the inequities. And I can go on to say more. So we go into the community and we started doing service, and at first it was a lot of pushback, things like, what are you here for? Why are you working for these people? Why you come in our community and, giving out all this stuff and nobody believed, right. So it took a minute. It took a minute of us continuing to go, continuing to be consistent, continuing to listen and provide the services as best we could. Right. And, and it turned out to be good. Numbers are really, really, really good. I was even surprised, that how many people we see in a day on one of our days when we're out there on Wednesday, from when we first began. Right. We was walking where? I don't know if anybody know, but we was walked in from the, bottom of Blue Hill Ave and Dudley Street all the way up to Blue Hill Ave and Grove Hall. Like, before you get to Mattapan. So we was walking in the 100 degrees weather to contact people.

Anyway. And it went so, so, we did a lot of work, guys. And you know, I know you guys probably have a lot of questions. I didn't have a lot of time to share I could share so much more. But it wasn't easy. And we're still dealing with a lot of things. And one of the challenges is trying to get people trying to get people, the services that are needed. Like a lot of people are struggling with housing. A lot of people are struggling with, not getting enough education about the medication that's out here to help with addiction.

You know, that's one of the hardest things. But just by being educated, just by them starting to trust us and we're so consistent, everything is turning out to be good. So that's all I have to share.

Jasmine:

You guys are so good. Every time I hear you talk about the work.

Monique:

Did we make time?

Jasmine:

Yeah, you did awesome!

Monique:

Okay.

Jasmine:

I'm glad you talked about the numbers and how many and how many patients and stuff, that we've been able to see because I just want to talk about the numbers and why it works.

You know, a lot of people like numbers folks and are like, why are we doing this? What is the point of this work? Does it even really work? And and it really does. Right.

Monique and Deci have really have put so much work into these mobile vans sessions. Right. And so over the course of July 2023 to April 2025, they've seen 157 unique patients and I would say from July to like December, January-ish, or maybe even more into 2024, they were kind of just doing outreach and building up trust. So I would say they saw 157 patients in probably a year or a very small amount of months over , So that's really that's really remarkable work, right.

That's 157 people that may not have even been able that we may not have been able to help, that now have access to quality care. Right. And they've built connections with our providers.

We've transitioned 18 patients from the mobile van to the brick and mortar MGH Bridge Clinic. And these are 18 patients that may have never felt comfortable walking into an institution like MGH, who are now going there and have access to other services there. And then I think my favorite stat is the 22, patients that we've been able to, do initiations on medically.

There's so much medication hesitancy in our communities which are affecting our outcomes. Right. And our overdose rates. And so the fact that they've been able to deliver 22 patients lifesaving treatment in medications is really a huge deal because that’s 22 lives saved.

And then, just the increase in visits for BIPOC and English, people who speak English as a second language, we've seen an increase of 117.78, visits for black patients, 73.97 for Latinx patients, and 114.29 patients with limited English proficiency.

That's a lot of work. It does take a lot of time, but it is so worth it and so rewarding. And these numbers don't even really, quantify the priceless work that, that we're doing, building like endless connections and having conversations in the work that's being done. So I know we don't have too much time, but we do have a couple of case examples that we wanted to share with you all that, Deci and Monique will kind of talk to us through just to show some really great examples of how this worked.

Shaivi:

Thanks, Jasmine. Just want to make a quick note, we will try to move into Q&A around 4:15. So just keep that in mind. Thank you.

Deci:

The first success story is a 59 year old man, father of ten, one deceased, past medical history of depression, anxiety, delusional disorder, PTSD, chronic hepatitis C, hypertension, and a history of myocardial infarction.

He presents to the community care van for harm reduction supplies and expresses interest in micro dose induction start on our first encounter. Okay.

So this is a man who was referred to the van, by another patient that we saw, and he just came out for the first time, and harm reduction supplies. And I said, hey, he did. He did express his interest to start micro, induction. I said, hey, we just give a little bit of I just get him some brief information. And he was like, you know what? I'll come back the next week. And I said, okay, fine. The next week he did show up. And that's when I did a complete initial on him. And, you know, send the medication to the pharmacy next door and, give him a lot of education and what we should do, follow bridge protocol. And he actually did amazing. Want to say about a week later, he, he was referred to the bridge clinic, with a micro dose induction. We started off with the films or pills, which are what they need. And then we start them off with, with Brixadi. And we he got his first injection weekly dose injection. And he builds up and then we got up to monthly actually he's doing great.

He's very remission. And he's actually going to come here on Thursday to get his second, monthly, Brixadi injection. So he's doing amazing. Actually, that was one of our success stories that.

Monique:

Hey, I, I say all of our patients are success stories, but this guy, he's one of the first patients that we met when we were doing outreach, a black, African-American, 52 year old with a history type two diabetes, neuropathy, insulin on insulin, severe alcohol use disorder with a history of complicated withdrawal, referred to the bridge clinic by the van by me.

Decima:

What does this say.

His first drink was at seven years old. So when we did him, so he got his first drink from his father by sipping he would just take sips, he has been drinking heavily since then. He has, his goal was to cut down in the hopes of complete abstinence.

Now, this was a patient. He was already connected elsewhere, but he just was not, meeting his, appointments at the clinic.

So, this was a person who hung out at one of the spots that we, the van parked, and formed a a bond a relationship with Monique and Monique. Kind of, like, brought him on to the van and we kind of just spoke to him and encouraged him to, continue with his medications, and that worked out well. And we brought him back to the bridge clinic had him actually met with an MAT provider, and it worked out great. So we kind of resumed him on his medication. And once we got him stabilized, we kind of, transitioned him back to the clinic where he was at. He's actually doing okay. I'm not sure we still kind of like check in with him every now and then.

Monique:

Well, I went to visit him, because I hadn't seen him in a couple of weeks there. So I went last week to check on him to see where he was. And now he's, having some issues with his diabetes. He can’t come out as often as he was because he has an ulcer on his foot that's not healing.

We talked I talked about him because when we first started coming out into the community, there was no trust.

He was just one of the people that just wanted somebody to say hi, hug him. I held his hand. I sat down with him, you know, I made him feel welcome. And that's why he was able to trust me and ask for help.

Jasmine:

Thank you. Ladies. And then, as y'all can see with both of these examples, these are not young people who they're helping. These are people who are older, upwards of 50 years old. You know, I'm pretty sure they've seen so much. There's so much trauma that they're dealing with. Probably stuck in their ways, afraid of, you know, how they've been treated over the past years.

And these two amazing ladies have been able to touch them and get them care that they needed, so.

Decima:

And more!

Jasmine:

And more! So this so this is really important work. So, I want to thank you all so much for listening to us and spending the last 45 minutes or so with us, and wanted to just put our information up here. So there's the website to our mass general, substance use disorder, mass General Brigham SUDs clinics, that's our bridge clinics. We have four clinics, one at MGH, one at the Brigham, one in Salem and one in Haverhill. And so if you go on this website, you'll be able to access information for all four of those clinics. And then if you want to connect with us after this, I placed our emails here as well.

Shaivi:

Thank you. Thanks everyone. Okay, so we have a couple questions here for y'all.

So, I was hoping we could get into those over the next 7 to 10 minutes. So let's aim for maybe 2 to 3 questions and if anyone has more, feel free to send them through the chat and we'll take note of those on our back end and hopefully on future events we can get those answered.

So the first question which might have been answered throughout the presentation is: "What outreach strategies would you suggest to attract more BIPOC to the clinic where the providers look like them? Thank you."

Jasmine:

Outreach strategies?

Shaivi:

Yeah. Outreach strategies.

Jasmine:

Did you want to say something, Deci, first? Okay. Well, I think the first thing is if if you're wanting to do this work and you wanted to connect to the community, one of the things that we did is we looked at like the zip codes of the health outcomes that we wanted to improve. And so we just focused on those zip codes like Roxbury had horrible, overdose rates. Right. And so we literally when I say boots on the ground, I'm talking about knocking on businesses doors, talking to people on the street, not being afraid, finding out who's who, building an asset map of your contact information and what community based organization that you're following, and then following up with them, not just showing up and saying, hi, this is who we are, this is what we do, but following up, right, we were dropping off Narcan to places that needed it when we found that there were like education gaps and stuff, following up with more information, tweaking our information. So it was in a more simple way, so that when we're delivering the information or the services that the people that we're talking to can, can understand it. Also like finding out like, what type of like local community meetings there are, those can be super helpful. We attend like a Nubian Square task force meeting and Eggleston Square task force meeting and introducing yourself, finding out who your local politicians are, reaching out to them, finding out you know, what areas we're lacking in and what services that they could, utilize.

And really just showing up and not just in your work hours. Right? You care about the community, show up on a Saturday, show up on in an evening, spend some money in the community. Right. And so those are some things that are helpful.

I hope I answered your question, whoever that was.

Shaivi:

Totally.

Monique:

I'm pretty sure people that people that have experience that know the community is someone that's with you, that can help you navigate through the community.

Jasmine:

Yeah, that's really important. You just don't want to. I know a lot of people, providers, you know, they want to do the right thing. They want to get out there and they want to help people. But there's a lot of work that you have to do within yourself. You don't want to just go up and show up and act like you know everything, right? Like talk to some people who are from that area and learn it and listen more then doing the talking is another big thing too.

I tell you one thing, you go into communities of color if you don't know what you're talking about or if they think you're there, yeah, they're going to be able to see right through you. So really, really being intentional, truthful, honest, and continuing to show up with the best intentions.

Monique:

It can be very sensitive. Yeah.

Shaivi:

Thank you. Our next question is a little bit more specific to the OTP context. So the question is what are some first steps that OTPs can take to evaluate internal biases and begin shifting towards that culturally responsive care.

Jasmine:

Internal biases. And you know what. You know what I say. And I know it's hard because you kind of got to get your leadership involved in stuff like this, right.

But it really has to come from up top in. Your leaders have to be serious about doing this work. We are so grateful that our leaders are so gung-ho, and they and they trust us. But you're really going to need the support of folks who are serious about this, because you might work with 20 people, and if only five people are check in there biases and it's not coming as an important thing from the very top, you know, it could get lost. And so that's what I would say. Checking in with leadership, making sure they understand the importance of it and letting them know it works. I know some people, they want to hear numbers. Well, hey, look, this is what MGH did. You know, it works. You know it, and it proves health outcomes and that saves money. I know a lot of leaders. Sometimes that's what it all comes down to, because you're not going to get everybody to check their biases. You're not going to change everybody's mind. Some people are going to continue to be racist. You know, they might not show it at work, but they might do it at home. And so I think just remaining true to yourself, speaking up when you see things and, holding your leadership accountable, I would say.

Monique:

And one of the things I do is I check my biases at the door because I have them also.

Jasmine:

Yeah. I mean, you heard Deci, right? She says she came into this space with a whole set of biases. Right. And look, she's she's a black woman, right? We all have biases. All of us. It doesn't matter what color you are. And so just continuing when you show up to check yourself, right. And hold yourself accountable.

Shaivi:

Thank you. I see a question here in the chat. Do you get funding to do outreach in the community?

Jasmine:

Kind of. And it's kind of a loaded question, right? Does MGH give us money to do any of this extra work, even though they want us to see better outcomes? No, they don't. And so we've had leaders who were serious about this work. And the reason why this work started is because we applied, for a United Against Racism grant in 2020 to address our, access issues for black and brown folks, especially during that COVID time where we really saw the inequities in health care. And so we got some initial funding to have, like a community champion or like a health equity person, which was me. And then you know, we kind of just kind of did all this work together. We also, paid initially to have a consultant, which I will say, I don't think that was the best use of our funds, because I think we had enough people who are equipped within our own space to do this work. So, yes. And then we also applied for some separate grants. We have to rise grants, which, if any of you all are looking to get some extra funding for your clinics because your departments are struggling and you want to do more. Rize is a great program. They have a ton of different, grants that are coming out. BSAS is great and so looking for these other opportunities, where you can get money if your department's not, willing to fund it. But yeah, like I said, we are in like three grants right now with a community partner. And a lot of what we wrote for in the grant is specifically to support that outreach work, because you need the extra funding, like, you know, Monique's getting some gift cards and some Lyft cards so that if patients want to come directly to the clinic, she can put them in a Lyft and get them there right away. Right. We're giving patients “T” passes so they can navigate around. Sometimes somebody is hungry. We're dealing with people who are struggling. Right. And so all of those things. Thank you, Jen. All of those things, are things that can be super helpful when we're thinking about the additional funding. Right. But sometimes it doesn't always have to be about the money. Sometimes you just got to tweak your practices. Maybe you got one person

who's spending too much money in this area. We can free them up a little bit. Like money, like, bored in this bridge clinic. I'm not seeing enough patients. Put me in the community where I can be more effective. Right. And it's worked out. Yeah, but we're pretty poor. I will say that we. But we make it work. Okay.

Shaivi:

Thank you.

Jasmine:

Yeah. We're not getting we're not getting a lot of funds poured into substance use disorder. All right. Because it doesn't make a lot of money back. Right. And so we lose “we lose” a lot of money for the hospital. So we're always finding ways to be creative.

Monique:

Hopefully one day we will though because this is very important work.

Jasmine:

Yeah.

Shaivi:

Appreciate the honesty as well with the lessons learned. Jasmine, I think we have time for one last question. And then we can head in to wrap up, how have you seen workforce diversity directly affect patient trust and engagement?

Jasmine:

Monique or Deci, do you want to talk about that at all, I mean, I think we've showed you all the numbers that we talked about the case examples, but, I mean, Monique's phones blowing up nonstop. People trust her now. Like after work, they're calling her on the weekends. It's like.

Monique:

I start referrals. I'm getting people sons. Grandmothers, daughters. They like, you know,

we heard about you. Can you be a recovery coach? Things like that. Like my name. And then that we have people that's contacting me to come out into the the clinic and do a presentation and stuff like that. So word is definitely getting around.

Jasmine:

Yeah. It's a stark contrast from when we first started, two and a half years ago. And people are like, what the hell MGH doing here? So where we are now and people are, like, calling us. Can you help me get my my daughter, you know, help. Can you help me navigate through this? You know, and even community organizations are reaching out to us to want to partner in stuff, which I think is super cool. So staying consistent and staying true to what you said you're going to do are really, really huge. To get people motivated. Yeah.

Monique:

Consistency is the is the best thing. Like making sure your there. making sure they know what you're doing.

Jasmine:

Yeah.

Monique:

But being there is the most important thing because you have someone that didn't want help when you first met them, but they know that the van is going to be there. They're coming.

Jasmine:

Yeah. Like we've had issues with our we sublet the community care van at MGH and they've tried to like cancel sessions or and we're like, no, you can cancel your sessions if you want to. Our sessions do not get canceled where they are rain or shine, snow whatever. So yeah. Yeah.

Shaivi:

Thank you. Yeah that's awesome. I do have one. I have one question for you from me,

which is cheating. It's the last question. How do you take care of yourselves in this practice as staff and as providers?

Monique:

That's really hard. That's really hard. But I'm a woman that's in recovery, so I always have to go to meetings. I have a therapist. I have these wonderful women that that I go to, and I will break down because I'm not it's not fair. And they just help hold me and let me know what's going to be okay. And then they're there to support me. And that's how I tell you.

Jasmine:

Yeah. Setting boundaries too. I mean, in this work, if you're a human services or social services, person, you know, you're most people. It's not a lot of money in this work, right? So you're doing it because you're dedicated to the work. And so you have got to set boundaries for yourself because the work doesn't stop. And so sometimes I'm like, all right, you know, it's the weekend. I'm not going to answer or I'm not going to go to every single community event that I'm invited to and just kind of trying to toe the line. But honestly, that these, these two girl, these two women who are on the call with me venting to each other, being able to talk to each other, holding a safe space, is really important.

One thing I did address with leadership was, having some sort of outside support for people who do this work, like some type of behavioral health provider embedded in our clinics, so that we can have a safe space. But I say you speak out loud and see what happens with the universe. So, so far, the things I've been asking for have come. So hopefully we'll see that down the line too.

Shaivi:

Yeah, I love that. Thank you so much. Let's give it up for our speakers today. I think we can all agree that we've learned so, so much today. Thank you for having us. Yeah. Of course. And we'd be happy to have you again. So yeah, just want to say that's a wrap on day one.

Thanks, everyone for joining us. We've had lots of different types of sessions today, so we hope you've enjoyed in whatever capacity possible, and we will hopefully see you again on day two, which is next week.