CONNECTING CARE PODCAST // EPIDSODE #4 // TRANSCRIPT

Meeting Clients Where They Are: Providing HIV Prevention and Treatment on the Frontlines

Alex Walley:

For Boston Health Care for the Homeless nurse Megan Sonderegger, providing patient centered care means literally meeting her patients where they are.

Megan Sonderegger:

I'm physically there, and I'm walking around and greeting people, talking to them. I'm always with my eye on my patients who need medications. In the mornings, I pack up about 70 people's worth of meds, but I have them in my pocket in little envelopes, they're fairly discreet. As I'm circulating throughout the day, I'm looking for all the folks who need medications. Primarily it is Truvada, but we also have people who are on ARVs, and also some folks who just take psych meds or maybe they take antihypertensives or antidepressants, a host of medications. But primarily I give out Truvada and some ARVs.-During the day I'm circulating... It's not a kind of thing where they come up to me and line up in a row or anything like that to get their meds, I just sidle up to them, greet them, say hello, I hand them their meds, I hand them a juice box or a Capri Sun, they take the meds in front of me and depending on what they want, I either stay and chat longer about what else is going on with them or other needs they may have or I move on.

Alex Walley:

You're listening to Connecting Care, I'm Alex Walley. I'm an HIV primary care doctor and addiction specialist in Boston, Massachusetts. I'm joined again by my colleagues, Dr. Jessica Taylor and Dr. Sim Kimmel. On today's podcast, we are going to speak with two clinicians who share their experiences on the front lines, delivering innovative substance use treatment, HIV prevention and HIV treatment where patients are.

Alex Walley:

Welcome back to Connecting Care. I'm really excited about this podcast today. My name's Alex Walley. I'm a general internist addiction specialist at Boston Medical Center in Massachusetts. Why am I excited today? Well, we have had two of our last podcasts focused on the CDC guidelines for pre-exposure prophylaxis among people who inject drugs, and those were fantastic. We went over a case that went well, and a case that didn't go so well. And today we're going to try something new. We have our first podcast with guest stars, Jen Brody and Meagan Sonderegger. They're actively working on a program to deliver pre-exposure prophylaxis and anti-retroviral therapy directly through street-based outreach. So, get excited. It's going to be a new experience for us and let's get on with our introductions. Like in the past, I'm joined with my good friends, Sim Kimmel and Jessica Taylor, I'll let them introduce themselves.

Jessica Taylor:

Hi everybody, Jessica Taylor, I'm a primary care and addiction doc at Boston Medical Center and run our bridge clinic. So excited to be here and to have Jen and Megan today.

Sim Kimmel:

I'm Sim Kimmel, I'm an infectious disease and addiction medicine specialist and HIV primary care doctor and work at a drop-in center for people who use drugs.

Alex Walley:

Okay, great. Jen, please introduce yourself.

Jen Brody:

Hi everyone. I'm so happy to be here today. My name is Jen Brody. I am also an HIV primary care doc and an addictions doc and I am the Director of HIV Services at Boston Health Care for the Homeless program.

Alex Walley:

And Megan.

Megan Sonderegger:

Hello. I'm Megan Sonderegger. I am a nurse with Boston Health Care for the Homeless program, and my specialty is substance use disorders and I work in a straight based setting with a lot of folks who are actively injecting substances.

Alex Walley:

Welcome. I'd like to hear our guests explain where they work, what the setting is, and their efforts around street-based outreach to provide pre-exposure prophylaxis and antiretroviral therapy to people who inject drugs.

Jen Brody:

I can start, this is Jen. At first I thought I'd tell you a little bit about Boston Health Care for the Homeless program which is a pretty unique place. We're a federally qualified health center with a mission to take care of people experiencing homelessness. And we are among the largest and I think the most robust programs in the country. Within that framework, we have an HIV team, that for most of its existence, it's been in existence since the early epidemic in the 1980s, has been primarily clinic based. We have a Ryan White funded program and also received funding from the department of public health at the state level to provide multidisciplinary HIV care. So we have HIV providers, nurses, integrated behavioral health social workers and Ryan White funded medical case managers. But like I said, most of the years we've been working, it's been primarily clinic-based. And over the past several years, it has become very clear that we really needed to increase dramatically our outreach services, partnering with shelters in other settings, but not really in a street context.

Jen Brody:

And over the past really year or two, we've been experiencing an uptake in HIV cases among people experiencing homelessness and injecting and using drugs. And it was a real call to respond, to really rethink the way that we're delivering care, which has led us to really evolve, to provide more street-level services, to provide care where people are literally injecting substances and where they're hanging out and where they're spending time. And in the current moment, that place is a very small geographic area of Boston. And for various reasons, political reasons, kind of criminal justice reasons and others, that group of people has been moved into a particular zone. And there's a space there where people are able to use substances with a little bit less concern that they're going to be incarcerated for that use. And we're focusing a lot of our efforts in terms of HIV treatment and prevention in those spaces.

Megan Sonderegger:

Like Jen mentioned, for a number of reasons, folks who inject drugs and are experiencing homelessness, many of whom are not shelter users, they're actual street dwelling, they spend the night on the street. It's kind of been herded into this one particular neighborhood, and it's been a part of Boston that... It's like an industrial area, there's not really any residences. And there's one little street that's called Atkinson Street and it runs alongside the largest men's shelter in Boston. So behind that shelter, there's a huge tent. If you want to think about it, it's more like, not like a camping tent, more like a circus tent, it holds about a hundred people.

Megan Sonderegger:

For the past four years, we've had our little clinic in there that I have worked out of. I started the week it opened and I've been one of the nurses in there since it opened. So I've gotten to know these folks very well. In the past, like Jen mentioned, maybe a year or so, the city has kind of carved out a space, which is a part of a parking lot, it's not a large space at all. It's just part of a parking lot, it's kind of fenced in, and there's some outreach workers in there. And basically the police just turn a blind eye to the substance use in there.

Megan Sonderegger:

On a daily basis, it's very weather dependent. So today it's nice outside, there's probably 150 people in there, but it's tight quarters. There are a few tables and chairs and there are three portable restrooms for folks to use. People hang out in there and they are actively injecting drugs, some smoking, some sniffing, but a lot of injecting of heroin, methamphetamine, a lot of smoking of crack cocaine. And there's also, of course, people selling the drugs to these individuals. And there's just a lot of hanging out, using drugs, and I hang out there with them. The main thing that I do is circulate, but I always think, if you've ever been to a cocktail party where there's a politician, they're talking, but they're also always eyeing the crowd. And that's kind of the model that I use. I'm physically there, and I'm walking around and greeting people, talking to them. I'm always with my eye on my patients who need medications.

Megan Sonderegger:

In the mornings, I pack up about 70 people's worth of meds, but I have them in my pocket in little envelopes, they're fairly discreet. As I'm circulating throughout the day, I'm looking for all the folks who need medications. Primarily it is Truvada, but we also have people who are on ARVs, and also some folks who just take psych meds or maybe they take antihypertensives or antidepressants, a host of medications. But primarily I give out Truvada and some ARVs. During the day I'm circulating... It's not a kind of thing where they come up to me and line up in a row or anything like that to get their meds, I

just sidle up to them, greet them, say hello, I hand them their meds, I hand them a juice box or a Capri Sun, they take the meds in front of me and depending on what they want, I either stay and chat longer about what else is going on with them or other needs they may have or I move on if they're in the middle of something and they don't want to chit-chat much.

Alex Walley:

Megan, thanks so much for giving us a view of what the environment is, such a clear picture of what the environment is and what your day is like. You said most of the medication that you're distributing is Truvada, which is PrEP. Of the 70 people, what's your best guess as to how much of that is PreP?

Megan Sonderegger:

I would guess around 50 people are PrEP. The other remaining 20 are a combination of ARVs. We do have a few people who are just taking regular non HIV related medications from me.

Alex Walley:

On previous podcasts, we've discussed the challenges in delivering PrEP for people who inject drugs and the opportunities. I personally have seen in my practice how there's been a real attitude change among a lot of my patients being much more open to PrEP than they have years ago. And so, you're the tip of the spear of that effort each day. Can you talk a little bit about your patients' interest in PrEP and is it something you're driving? Is it's something they're driving? How do you engage with the patients around the decision to take PrEP?

Megan Sonderegger:

It varies. A lot of our patients are really outside of the medical system. Many of them don't have a primary care. Their primary place they've gotten any healthcare whatsoever has been the emergency room. So they're just like out of the system totally. Many of them, I get to know them on other matters. Like they need help with case management, they need to call their DCF worker and they borrow my phone. They need to call their lawyer. They need housing help. They're barred from the shelter, they want someone to advocate for their bar to be lifted.

Megan Sonderegger:

So frequently I engage with them on non-Truvada issues, more case management or typical nursing, more generalized nursing tasks. And then as they trust me, and I talk to them about what's going on and what are the things that are holding you back, what are you happy with about your life, what are you unhappy with about, I will bring it up with them in a gentle way. I'll say, "I know you're injecting and we've had some new HIV diagnoses out here. Would you ever want to consider a medication that would help you from getting HIV?"

Megan Sonderegger:

It's a delicate dance because for the most part, these are folks who have been really poorly treated by everyone in society basically. They feel excluded from... This stuff, it kind of scaffolds their lives together, families, maybe houses of worship, jobs, the medical establishment, they feel really excluded, and they have a lot of fear and resentment. The police are an ever present threat to them basically, many have open warrants. So it really is kind of a gentle lead in, in most cases. In some instances,

someone that they know will have recently been diagnosed with HIV, and so it's fresh on their mind and they will come to me. But for the most part, I work with them to figure out what it is that makes them tick, what is it that they fear, how do they view things, and slowly we work into a place where they're willing to consider.

Megan Sonderegger:

To want to take PrEP, you have to have some hope for your future. If you have no hope and you don't have any idea that you're going to live past the next year, there's no reason to take Truvada. It just doesn't matter. So we have to start from these other places of finding out what in the past has made their life meaningful, or what would make them want to stay healthy. It's a longer process, it's not something that I can easily replicate. Truvada is one way to prevent the spread of HIV.

Megan Sonderegger:

The other way is to help them need to inject less often. Every day I send people to detoxes and stuff, but perhaps more importantly, I work with them to get on methadone. Suboxone isn't always as viable for people who stay on the street, just because of safe storage issues and it gets stolen and whatever. But I spent a lot of time with them working through the hassle and the rigmarole to get them on methadone. If they feel like, "Wow, maybe I don't need to inject as often, maybe there's hope for me. The drug abuse is what drove my family away. The drug abuse is what made me lose my job. The drug abuse is what landed me in prison and gave me these open warrants." They all kind of work together I think in the patient's mind. I never march up to them and say like, "You're shooting up, let's get you on Truvada." It's much more like knowing them and understanding their life and finding out, how can we make you want to stay healthy for the future?

Alex Walley:

It takes a relationship that you have to build, and this is just one part of it. I want to check in with Jessica and Sam, if you have some questions for Megan.

Jessica Taylor:

I know the work that you do is amazing, but hearing you talk about it firsthand just really drives home how much the relationship piece is incredibly important. And that makes me wonder how we can scale programs like this. Because even patients that are a little bit more inclined to come into a traditional medical setting or come to our bridge clinic, like where I practice, which is really a medical model, very commonly we're talking about PrEP or starting PrEP. And we worry that that navigation support piece, the daily support to stay on PrEP, it may be a challenge. I'm wondering if you and Jen both have ideas about what concrete resources would be needed to scale a model like this. Because it is remarkable that you're serving 70 patients, managing all of their daily medications and the number of patients that could benefit is probably many, many, many fold over 70 patients. I would love to hear thoughts on how a model like this could grow and be more broadly available.

Jen Brody:

This is Jen. As Megan was speaking, I wanted to insert that really none of the interventions that we've been able to roll out with the directly observed therapy work with PrEP and in HIV therapy would be possible without her laying this amazing foundation, this groundwork of trust of really centering in a very non-judgemental way the express needs of the people who are using these spaces to really address

their immediate survival needs, finding out what makes them tick, what makes life worth living right now? What do you want your recovery for? What do you want to stay alive for? How do we understand who you are and what's important to you, and then how do we address those needs. And then the HIV treatment or prevention happens down the road. We can't rush that piece. And in our current medical model, that's a fairly... It has to be concerned about bottom lines. And sometimes there's a business model in operation that oftentimes doesn't allow for these relationships to be built, which do take time.

Jen Brody:

That said, there's so much that Megan does that is replicable using a lot of existing resources. I mean, many, many programs utilize nurses in their programming. And to think about how do we repurpose existing staff with interest and expertise in a sensitivity and cultural humility to be used in different ways when thinking about embedding nurses and other clinical staff in settings where there's already infrastructure for harm reduction, there's, in certain service programs, where there's already infrastructure in place, where there's already some of that foundational trust in place, and how do we partner with people who are already doing that work, who the community of people who are using drugs and injecting drugs already trust, and then leverage that to insert maybe initially small clinical components. And maybe it starts with, "Let's just find out, what are your emergent medical needs today?" And we know, in our spaces, it's skin and soft tissue infections.

Jen Brody:

And so just embedding a nurse to address the kind of urgent medical needs that we know come up and then using that to build trust, address survival needs, leverage those initial successes, that resiliency, and then build more clinical services hopefully eventually, including HIV prevention with PrEP and non-occupational post-exposure prophylaxis as well, and then HIV therapy, if that's relevant and appropriate for the space.

Alex Walley:

I want to reiterate. I think both Jen and Meagan mentioned a lot of the key elements to the complicated web of challenges that these folks face. So you are Boston Health Care for the Homeless, so homelessness is upfront and center. You are HIV and HIV prevention medical provider, so where our entree into this topic is through PrEP. I thought you really made the case for mental health by asking, "What do people have to live for?" Which I think is the key mental health question, like, what's the motivation to move forward with one's life and how to take care of your mood and your thinking. And then the other concrete needs. You also talked about methadone, which has come up on this program before, and Jen and I have a long history of talking about. So, you are bridging people to these services, to these individualized goals, through your work by building trust. What happens when you do engage them in housing for example, or a methadone program, and they're not coming to the engagement center or to the comfort station anymore?

Megan Sonderegger:

It's rare. We've had people get housing and they still want to get their meds from us. I have a few people that I'm trying to move them into getting their meds from home because they have housing. It is pretty, fairly rare though. There are so many people who are out here for years on end, and even if I get them on the clinic, it's such a struggle to get them to a therapeutic dose, then they are incarcerated and they come back out. So it's not something that I run into terribly frequently, but when I do... We have a few

people who have HIV, who have gotten housing recently, and we're working with them very gently to... We have two guys, I've encouraged them to take a few pills home with them each day. Rather than see me every day I've said, "Why don't you come see me on Mondays and Thursdays, we start slowly." But they really do learn to depend on the relationships that they have with us.

Megan Sonderegger:

And also the case management piece cannot be underestimated. Just the fact that they need a lot of help. Like I said, the scaffolding that the rest of us would rely on if we all of a sudden got sick.

Alex Walley:

It seems like the scaffolding is the relationship that you're building. Once you move people a little bit or closer to their goals, you can't just pull the scaffolding away, you have to continue. Sim, what are your reflections on what you've heard? I know you know Megan's work and Jen's work well.

Sim Kimmel:

It's amazing to hear you talk about the care that you take with building these relationships. And I was wondering if you could talk a little bit about how you care for yourself. It's a kind of intense space to be in and I think, for a lot of people who take care of patients, you want to feel like people are getting better. Obviously, you're really reducing harm here, but you also just talked a little bit about how you feel like a lot of people, they're there for a long time. And so I was just wondering if you could talk a little bit about how you take care of yourself and stay motivated.

Megan Sonderegger:

It's a complicated question. It's certainly in flux, I think different times in my career. I've been a nurse for about 20 years, different times I've done it differently I would say. I do have the most amazing coworkers, the nurses, and the HIV prevention testing folks out here are really phenomenal. And we do provide each other with a lot of after hours social support, friendship, and so forth. And I think that's really helpful to me anyway, just to process and to be able to talk about the deep sadness that we feel when patients have losses. Unfortunately, we've had some deaths or if someone is incarcerated and it looks like we're not going to see them for a long time, or... People get terrible injuries. We've had gunshot wounds and stabbings and all kind of stuff. We do process a lot of that stuff as a group informally, and that is very helpful to me.

Megan Sonderegger:

I try to keep a pretty robust life outside of healthcare for the homeless as well. I'm married, I have four kids. I'm very involved with my church. I try to keep myself with other stuff that has nothing to do with myself also. On my phone that I use, my work phone I'm talking about, there's hundreds of patients who have that work phone number, I get pictures and letters and notes from people who've moved on from here, it's going to have my glasses out. You won't see that I tear up. One woman who had just the worst time out here, just absolutely was a victim of some of the worst men out here. We snuck her off one day, we came up with an elaborate plan to ferry her out of here. We took her to Mass General, we got her in under an assumed name. We had a very difficult time. I visited her multiple times every day during COVID. They let me in to keep her there.

Megan Sonderegger:

She's on the Cape now, she is reunited with her child. She got a scholarship to do a lay down program at a community college on the Cape. And she sends me pictures of herself with her baby or her a young child. I look at that picture a couple of times a week probably, because she came from a really tough spot. She had it really bad out here, not just her use of substances, but also just what she went through to get the substances was absolutely brutalizing. She has managed to escape. And I know sobriety is fragile, but she's enjoying life right now. She's reconnected, she lives with her parents who are supportive, and her child. I have multiple patients like that, and I really try to remember. I don't know which patients are going to, I don't say succeed, but which ones are going to get out of here and get a life that looks more appealing to me.

Megan Sonderegger:

Wednesdays, I do not work here. And I drove to Billerica to visit another patient who is in Billerica House of Corrections, and he's going to be there for a little bit, so that was kind of sad. But we talked and he said, "Megan, you guys love me. I don't have any family." He said, "I know I can count on you nurses. And I know when I get out, you guys are going to help me." I don't like to gauge if people are successes, he's had a rough life. He has a very difficult substance use disorder, kind of combination with his trauma, but he knows we care about him, and I take great comfort in that.

Alex Walley:

People get better. That's important message that I give to the trainees that I work with, whenever we have the opportunity to work with people who are working in substance use, people get better. The other thing that you remind me of is that it takes so much more than the healthcare system to help people move forward. And we already know this. The whole Ryan White program is based on this idea of a patient centered medical home that does much more than provides medical care. We know that that's succeeded, not for all communities everywhere, we still have huge disparities in HIV, but we know that that has succeeded with a large group of people in the United States and resulted in better care. The medicines are key, and methadone is key and buprenorphine is key, but it takes so much more than that. We need that same investment to wrap around care, which you guys are demonstrating with addiction and overdose risk.

Jen Brody:

I wanted to make a comment about, just to kind of follow some of the threads that Megan raised. Just about all of the different forms of structural vulnerability that are expressed to us in a few patient cases that she shared, that these are folks that really are suffering from structural violence of all kinds, in ways that are intersectional and overlapping. She talked about incarceration, she talked about the lack of housing, gender based violence, et cetera. And I think one of the things that is so critical about our work is that it's not just about understanding those force at the individual level, but then leveraging our resources to bring services to bear on that structural vulnerability. So, how do we push for more resources for more housing advocacy, for these individuals, for legal services? Because a lot of these folks have criminal records that could actually be addressed, they could be sealed so that they could have better access to jobs and housing.

Jen Brody:

How do we bring better telecommunications? Our patients don't have phones, the most basic way of staying in touch with people. How do we bring phones to these folks? How do we get them food and

mental health services, and to really address this intersectional and overlapping structural vulnerability. And so that is some of the work that we're doing in this space, through the Ryan White program, through the End HIV Epidemic funding that's become available. We've pushed very hard on our health department to actually fund housing, which they are doing. There was just funding through the state of Massachusetts through the Bureau of Substance Abuse Services to actually fund, it's $2 million a year, to fund housing opportunities, low threshold supportive housing for the patients that we're caring for in these spaces, both living with HIV and importantly, not with HIV. Someone shouldn't have to get HIV to have access to these really important life saving services.

Jen Brody:

So I think to your point about, we really do need the vision of a Ryan White type of program for people with substance use disorder and other structural vulnerability. That really is what it's going to take. It's not just about a pill. Preventing HIV is not a priority for most people, we can talk to people about it after we're addressing these more basic needs. But people are more worried about dying on overdose. They're worried about where they're going to rest their head, all these other very primary needs that must be addressed. We're not only looking at making sure they don't die of any HIV complication or preventing HIV, we want to care for the whole person in front of us and their wellness, long-term. I think there's a lot of policies that could be put into place that leverage the amazing work that Megan and so many others are doing with individual patients that would make her work much more supported and sustainable.

Alex Walley:

Are there policy idea? Jen, you asked the hard questions and I was going to say, "We invited you here not to ask questions but to provide the answers," then you did offer many of the answers. And they're are answers that are both real, happening right now, that we have the opportunity to address in ways we haven't because of funding, because more communities are willing to take some these issues head on in ways that they haven't. But then there's also things that we can dream of now that are down the road. So Megan, are there policies that you really feel that are coming into play right now or that you wish were there that you think could make a difference, beyond what Jen has already laid out for us?

Speaker 2:

Yeah. This is kind of a big one, but in my estimation, getting rid of the whole war on drugs, legalizing drugs, making a safer supply would be huge, kind of a larger topic than maybe than we want to cover on this phone call. But in the event that our society chooses to continue with criminalizing substance use and incarcerating these huge numbers of people... If we're going to do that, if my tax dollars and your tax dollars are going to be used to incarcerate people, I wish that while they were incarcerated, we would view that as a time to stabilize their substance use disorder. And not say, if you come in on methadone or suboxone, we'll grudgingly continue it. I wish that every person going into jail, they would say, "Would you like methadone? Can we get you on a therapeutic dose of methadone while you're in here? So that when you leave here, you have a chance of achieving some stability in your life."

Speaker 2:

But our patients, we worked so hard to get them stabilized out here, when they're arrested and they go to jail, it's hard to hold that together, especially if they're in for a few weeks, not long enough to really achieve anything, their life is completely destabilized. All the housing supports we tried to put into place,

all that stuff falls apart. If we're going to use this model, which I think is lousy, I wish we weren't incarcerating so many of these people certainly, if we're going to use it though, I wish we would have a lot of supports offered while they're in there so that when they come out, we have a chance of stabilizing them further and reducing recidivism. And I don't know if this is a specific policy, this falls under the stigmatizing and making substance use illegal. But our whole system that we take care of homeless people with is very punitive, particularly for folks who use substances. And this is just an example, a local issue.

Speaker 2:

Our shelter system really, I believe, was designed to deal with the old folks who drink a lot of alcohol or just straight mentally ill and don't have a substance use disorder. The folks who now are on Atkinson Street are outdoors because they inject drugs. And until very recently, if you were caught with a clean needle in the shelter, a clean needle that the City of Boston Needle Exchange provided to you, if you have that clean unused needle and you went into the shelter where... You used to be barred. I think it originally was indefinite. I think it went to six months. Now you're barred for a month from shelter because you had a clean needle, which we provided to you so that you could be safe. These kinds of policies that end up barring people from shelter. And again, keeping people sleeping outdoors at night and keeping them further on the fringes of society. It's not just that you are experiencing homelessness, but now you can't even access the emergency shelter, the emergency system that we have in place. Those kinds of punitive calls these.

Speaker 2:

First of all, they're inhumane. There's no excuse for treating people with that level of unkindness and brutality I don't think. But it also makes stabilizing them, it makes getting them on medications, it makes it keeping them engaged with care so much harder. And I think we just need to look, even as a city, certainly we do as a nation, but even as a city, we need to examine those policies in our systems that are just punitive. They don't serve our public safety. I don't think they keep anyone healthier or happier or anything else, I think they're just punitive. There's a lot of room for improvement in the shelter system in particular.

Alex Walley:

Yeah. Thank you for that stance around criminalizing not just drug use, but the paraphernalia around drug use that stretches into the housing system, beyond the shelter as well. So the public housing authorities regularly exclude and discriminate people who use drugs. That's a great point. Are there policies that we didn't cover that come to mind?

Jen Brody:

Can I touch on one?

Alex Walley:

Yes, of course.

Jen Brody:

First of all, the issue of stigma and how to really tackle stigma and really structural racism that is tied into stigma and sort of thinking about some of our policies around, say methadone, for example, which is a treatment modality that was developed in the seventies with a particular population in mind, largely people of color and the punitive stigmatizing way in which that treatment modality is still offered, I think is a real barrier to treating people effectively and humanely, as Megan said.

Jen Brody:

There's so many federal regulations around the use of methadone, which is a very effective treatment, but it's sometimes very, very hard to get people on. People get kicked off for all kinds of punitive reasons. Many states across the country we know do not provide medication for abuse disorder inside jails and prisons, and people are very afraid of being forced to withdraw. So providing medication for abuse disorder in all incarcerated settings is key, but also re-looking and thinking critically about federal regulation around methadone, I think is huge. It would be wonderful if we could treat methadone in a similar fashion than we treat buprenorphine. I would love to prescribe methadone to my patients out of a primary care clinic, thinking about those policy changes.

Jen Brody:

And then as Megan said, a lot of our patients really do need the protection and the safety of an overdose prevention center, not just a parking lot where cops will look the other way, that is wholly insufficient to address the real risk and need and safety of this population. And I think an overdose prevention center that's supported and funded with sterile conditions and well-lit and clinical staff available would really go a long way in terms of not only reducing overdose deaths, but also reducing all of the communicable diseases that we're seeing, Hep-C, HIV and all the skin and soft tissue infections, endocarditis, all of these infectious complications. I think we'd seen these decline dramatically and that really will take policy change at the federal level, not just simply prosecuting. Cities had decided to try this by actually changing federal legislation around the controlled substances act.

Jen Brody:

So I do think there's really a lot of opportunity now to really rethink that legislation, which, again, comes from the structural racism around differential policies towards crack, et cetera. So I really think it's a time, especially in this moment of racial justice reckoning, to really rethink these policies that came from a place of, in my opinion, deep racism.

Alex Walley:

I want to thank Megan and Jen for taking us on a really amazing journey through the Boston Health Care for the Homeless, the program that you have built, the work that you're doing, Megan, and the people who you all are caring for. It's just really humbling and inspiring for me, and I know it is for Sim and for Jess. We're out of time. I want to give you guys a chance for a last word, and I hope that sometime in the future we can ask you to come back. Megan, why don't you give us your last word?

Megan Sonderegger:

I think I mentioned I've been a nurse for about 20 years, I worked in an ICU and then inpatient psych for 10 years. And this is my favorite job. I find the patients to be absolutely intriguing. I laugh till I nearly cry every day, because they're a funny, funny bunch. I really love them. But I also, along with that enjoyment, the ill treatment that they receive from so many of our societal structures, the police and

just housing and racism and all this stuff, particularly gender based violence against some of the women, stands and is stuck. It's two things in my head at the same time, one how much I've grown to really love this population and two, how much room there is for improvement or how much as a society we really need to rethink how we engage with people who use substances, but particularly those who are experiencing homelessness and are using substances.

Megan Sonderegger:

I hope that there will be some kind of a reckoning and that we will work as a society to change the way that we interact with them, to change the way we view them, to remove the stigma and the things that prevent us from really engaging them fully in society. These are a gifted bunch of people. We've got welders and artists and carpenters and teachers and all kind of... There's a dental hygienist out there. I hope as a society, we can work to unburden them of our stigma so they can re-engage with us and fully use all their gifts in our society.

Alex Walley:

Jen, last word.

Jen Brody:

It's hard to follow that. I would just echo what Megan said. We can do so much better as a public health community and as a society to help this group of folks where there's so much lost human potential. These are some of the most resilient, incredible people who have survived so much and we can do better by them if we apply a more robust equity lens and social justice lens unto this issue. Thanks for the opportunity to be here.

Alex Walley:

You're listening to Connecting Care. Our program was produced today by JSI and Boston Medical Center. Connecting Care is supported by the HRSA funded project, Strengthening Systems of Care for People with HIV and Opioid Use Disorder. The project aims to enhance system level coordination and networks of care among Ryan White HIV AIDS program recipients and other federal state and local entities. You can learn more about the project and find resources at www.ssc.jsi.com.