Season 4 Episode 6
Houselessness: A Prism for Understanding Healthcare Disparities, Part 1
Transcript

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Failure to eliminate homelessness can be
attributed to a profound failure of imagination
— The International Street Medicine Institute

Learning Objectives:
Part 1:
1. Define houselessness/homelessness and housing insecurity.
2. Explore and define root causes of the crisis of houselessness in the U.S.
3. Understand the challenges to access and provision of healthcare to houseless folks.

[0:00-1:58] Welcome and Introductions

Marianne Parshley: Welcome to The DEI Shift, a podcast focusing on shifting the way we think and talk about diversity, equity, and inclusion in the medical field. I am Marianne Parshley, a general internist practicing primary care medicine with a geriatric focus in Portland, Oregon. I serve as a Regent of the American College of Physicians (ACP). I'm a past governor of the Oregon chapter of ACP and a healthcare advocacy enthusiast. I also love commuting and travel by bike and on foot at a human pace.

Elisa Choi: Hello, everyone. My name is Elisa Choi. I am an internal medicine specialist, and I also am an infectious disease subspecialist practicing in HIV medicine and management of chronic infectious diseases. I am the immediate past Governor of the Massachusetts ACP chapter, and I have stepped into a new role as the Chair of the American College of Physicians Board of Governors. I love to read. I'm an aspiring writer, and I am fiercely passionate about healthcare equity, health policy advocacy, and Asian food.

MP: Today we are excited to bring you an episode featuring two amazing guests who have set the standard on providing healthcare for the houseless in a systematic way at opposite ends of the country: Portland, Oregon, and Boston, Massachusetts. The COVID-19 pandemic showed a spotlight on many areas of healthcare disparity that existed pre-pandemic and which led to significantly increased suffering during the pandemic. One of these areas of disparity is in the care of people experiencing houselessness. To paraphrase a hero of mine, Ida B. Wells, it is time to shine the light of truth on these disparities and to focus on addressing them.

[1:58-6:13] Introduction to Guests: Dr. Jim O'Connell and Dr. Rachel Solotaroff

EC: So we have two guests for our episode, and I have the privilege of introducing the first of our two guests. Dr. Jim O'Connell currently serves as the President of Boston Health Care for the Homeless Program. Dr. O'Connell is an Assistant Professor of Medicine at Harvard Medical School. Dr. O'Connell received his medical degree from Harvard University in 1982 and completed residency in Internal Medicine at Massachusetts General Hospital (MGH).

In 1985, he began full-time clinical work with individuals experiencing houselessness as the founding physician of this program. He also established the nation's first medical respite program in 1985, and he has been working with the MGH Laboratory of Computer Science where he's designed and implemented the nation's first computerized medical record for a program serving individuals experiencing houselessness.

In addition to many other accolades that Dr O'Connell has received throughout his illustrious career, he is also a member of the ACP Massachusetts chapter serving on the Governor's Council and he is a master of ACP having received the MACP honorary achievement designation recently. He is also an author and he has written a book, *Stories from the Shadows: Reflections of a Street Doctor*, which was published in 2015 and has been featured on NPR's *Fresh Air* with Terry Gross.

We are excited and honored to have you join us, Dr. O'Connell.

Jim O'Connell: Thank you very much, Elisa.

MP: And it is my privilege to introduce Dr. Rachel Solotaroff, who has served as Central City Concern's President and CEO since October, 2017, overseeing all aspects of the organization. Central City Concern has 2,000 housing units and provides care to 3,500 individuals each year, as well as operating comprehensive medical care through its clinics. Central City Concern and

Dr. Solotaroff have won numerous local, regional, and national awards for their work. Dr. Solotaroff started her Central City Concern tenure in 2006 as medical director of the Old Town Clinic, which provides primary care to low-income individuals, many facing the impact of homelessness.

Rachel oversaw the delivery and quality of care provided by both allopathic and naturopathic primary care clinicians at Old Town Clinic in addition to supervising the medical practices at the Letty Owings Center and Recuperative Care Program. Dr. Solotaroff received her undergraduate degree at Brown University, her medical degree from Dartmouth Medical School, and completed her internal medicine residency at the University of Virginia.

Prior to joining Central City Concern, Dr. Solotaroff served as Medical Director of the Charlottesville Free Clinic in Charlottesville, Virginia. She then completed an ambulatory care fellowship at the Portland VA Medical Center, where her research focused on how disruptions and fundamental components of healthcare access, such as insurance, might affect a chronically ill person's ability to effectively self-manage their chronic illness. Based on this research, she completed her Masters of Clinical Research at Oregon Health and Sciences University (OHSU), and in partnership with OHSU, Dr. Solotaroff designed and implemented a social medicine curriculum for OHSU internal medicine residents, providing an opportunity for physicians in training to learn from the unique Central City Concern model of healthcare. I know many residents and former residents who did this program, and they all speak very highly of it.

Dr. O'Connell and Dr. Solotaroff, is it okay if we use first names? We often do on The DEI Shift.

Rachel Solotaroff: Most definitely. Thank you, Marianne.

MP: And Dr. O'Connell, I see you nodding your head, so I assume that's okay.

[6:13-12:02] “Be the Change” Segment

MP: We want to begin the next section of our podcast, which is “Be the Change” and hear a little bit from each of you about how you started your journey to doing this work. Dr. O'Connell?

JO: In truth, I'm here entirely by accident. I was a senior resident in medicine looking forward to doing an oncology fellowship back in 1985 when the city of Boston received a four-year grant from the Robert Johnson Foundation to reach out and try to integrate the care of homeless people into the mainstream of Boston's healthcare system. And part of the requirement of the foundation was that there needed to be a coalition of stakeholders to work with the mayor to try to come up with how they wanted to be served. And interestingly, the coalition in Boston insisted on having full-time doctors, people who would be there all the time. They did not want any volunteers, of which I was a big believer, and they didn't want any students. And I had been a student forever. They wanted full-time doctors just like everybody else would have. And so interestingly, they couldn't find one. And my Chief of Medicine, a wonderful man named Dr. John Potts, and the Vice President of the hospital at the time, Dr. Tom Durant, called me into the

office. I remember this was March of my senior year and he made me one of those offers you can't refuse. And all of us know when you get called into the Chief's office, usually the questions are all rhetorical. And, of course, I said yes, but I thought I would do this just for a year and they would delete my fellowship for a year. So I decided to take this on as my year of doing good work, of giving back, probably absolving my late 60s' conscience. But I thought it would be really something that would be good to do in the long run.

So I started and we ran into all sorts of interesting issues that I had no idea about, what homeless people were struggling to go through, the kinds of issues that were running through the shelters and on the streets. It was the beginning of the AIDS epidemic involving the poor and homeless community. We had an outbreak of multidrug-resistant tuberculosis in our largest shelter, and I was overwhelmed and working in a wonderful group with a nurse practitioner and a social worker. And our team was working probably a hundred hours a week and by the end of that first year, I asked Dr. Potts whether he would delay my fellowship for one more year because it was just too busy and too much going on. So, I did delay it for a second year and by the time the second year was over, I was hooked and this has now been my life for the last 37 or 38 years.

MP: Thank you, Jim. How about you, Rachel?

RS: That's fascinating. I think that idea of being an accidental tourist or being graced with this opportunity without really planning it is my own experience. I went to medical school in my late twenties, having done some, actually done kind of an urban Peace Corps experience for about five years with the dream of being a rural family practice doctor in Maine. I'd read John McPhee's book, *Heirs of General Practice*, and I thought, "I want to do that! I want to go barter hogs in return for medical care, this fantastical vision."

Then life happens. I met my now husband and found myself no longer in Northern New England, but in Portland, Oregon. And, kind of a similar situation. This is the power of mentorship. A mentor of mine, she was our Section Chief in the Division of General Internal Medicine, a physician named Judy Bowen. I was sort of bumbling around in her research fellowship. I'm not a researcher by nature. And she said, you know, I have this idea. This organization that I know in Portland, Central City Concern, is interested in setting up an academic partnership to bring learners as well as resources from Oregon Health and Science University (OHSU) into the community setting in the, you know, sort of the, what was formerly this skid row, old town neighborhood of Portland.

So it was sort of a side project in my research career to start this social medicine curriculum between OHSU and Central City Concern, and I just never went back. I think something about it, that feeling of being in community that I had actually sought in wanting to be a small town family practice doctor in Maine. I actually felt that sense of community for the very first time being in Old Town. And that idea of a community without resources still showing extraordinary resilience and this power to use their own experience and knowledge to care for themselves, to

design the best possible care for themselves, that blew me away. And I thought, “Gosh, I'm home.” And so it's been my only job since I've been here in Portland.

EC: Jim and Rachel, thank you so much for sharing your personal stories about how you became involved in caring for our patients who experience houselessness. Listening to you both, it does make me realize just how much serendipity can play a role in what ultimately ends up being our future career paths. And we're both very grateful, Marianne and I, to have you both realize that this was your calling to take care of patients who are in need, who also are houseless.

[12:02-18:35] Different Terminology for Houseless Patients

EC: So speaking of houselessness, I've come to realize that there's several different terminologies that refer to our patients. Sometimes referred to as homeless. Sometimes referred to as experiencing housing insecurity, and sometimes referred to as having houselessness. I've also become aware that the term homeless has been associated with some stigma, and I would be interested to hear each of your thoughts on the different terms. Jim, I wonder if you could start.

JO: I think this is a fascinating issue related to the intractable and sort of complex issue of homelessness over time. So if you go back to the early ‘80s, when we first started advocating on behalf of people who were homeless, it was the National Coalition for the Homeless. It was the Healthcare for the Homeless program. So, it was thought back then that the homeless, the noun “the homeless” was an acceptable word to use, and much of this included homeless people, as you know.

But as the problem went on, it was so clear the stigmatization that came along the appalling disparities in both health and economics faced by homeless people. And then, of course, the racial issues in classism. And what we've seen is this evolution of trying to find the correct way to talk about people and not, in any way, disparage the experience they're going through or disparage them. And so we've got into what I think is really kind of a pickle because, for example, we have on our Board of Directors, many homeless people. And over time, we've tried to, we're called the Boston Health Care for the Homeless Program after the Robert Johnson Healthcare.

And so we've thought about, “How do we get the noun “homeless” out of our thing?” And our consumer board said, “Don't do that because then no one will know who we are.” And then among themselves, they have really interesting discussions that have fascinated me. They, for example, if you say behavioral health, we used to always say “mental health” and “substance use disorders”. If you say “behavioral health” to them, they get annoyed because it sounds like we're impugning their behavior when it's their thoughts or their emotions, and it's not their behavior. So we have to be very careful about not saying “behavioral health”, even though the proper thing to do is to say “behavioral”. The other thing that has been fascinating to me is that currently, if you read most things now, we will refer to PEH, persons experiencing

homelessness, as kind of the good way to say it. And a lot of our homeless folks hate that because they feel like we're sort of glorifying the experience of homelessness and they don't think of it as that. They think of themselves as homeless. What we've learned is that there's no right thing that assumes everyone.

So, you know, we have a lot of people on our board who say, “We are homeless and we don't want to become the noun ‘the homeless’, but we are going through homelessness. That's it.” And then there's a whole argument about houselessness versus homelessness, and they were all, I think, important arguments to make sure none of us are falling into the trap of, you know, inadvertently stigmatizing people or putting them into a pejorative stance. And I think that's the important thing. What we're learning is this is all about how we appreciate the dignity and the courage of the people we're serving and who are going through all that. And whatever words we use have to kind of encapsulate that. But I can just share with you, I'm sure Rachel will say the same thing, over these last, you know, 25 or 35 years, we've had so many iterations of how to say it so that we would be careful with people and the homeless folks themselves kind of see that as bemusing them.

EC: So clearly, this is still evolving actively. Rachel, I'd love to hear your thoughts on this debate over words.

RS: I don't know that I can add much more to that really elegant retrospective that Jim provided. I can provide a bit more of some of the concrete definitions that are worth knowing about. It comes along, for instance, HUD funding for housing. HUD has a particular definition, let's say, of chronic homelessness. And then there are also definitions around housing insecurity, which might just be helpful just to give a broad background. So the HUD definition of chronic homelessness is quite specific. It means that someone lives in a place not meant for human habitation, or they're in a safe haven or some emergency shelter. And then there's a time course associated with that, that they have been living as described, call it homeless, for at least 12 months consecutively or on four separate occasions in the past three years as long as those three combined occasions equal at least 12 months. So there are some parameters that are set around this, which come up when, for instance, we'll talk about this later I'm sure, we do our point-in-time counts. We do them every two years here in Multnomah County and how those definitions are created and then what sort of funding flows as a result of those definitions. The issue of housing insecurity is also a really interesting one. I don't know that I have a formal definition of that, but it's really important to understand how much rent burden keeps people in a very liminal space between having a roof over their head or falling into this definition I just provided for you. So the definition of being rent burdened is that more than 30% of an individual's income goes toward their rent. The definition of being extremely rent-burdened is that more than 50% of an individual's or a household's income goes toward rent. And that's a really important definition to know, because as you see those statistics on rent burden and housing insecurity go up, you see correlations in how many people are homeless going up in a given community. And I think that's important, again, when we get into the conversation about root causes, that understanding of what the availability is of affordable housing to people in a

community is a key driver of how many people are going to be homeless in that community at a given time.

EC: Well, thanks so much, Rachel.

[18:35-25:29] Root Causes of Houselessness

MP: One of the things I learned being an overnight volunteer host at the family shelter in Portland, when my kids were teenagers, was there are many reasons why people or families end up houseless or housing insecure. And yet, I think in the press and in a lot of people's minds, it's simply mental health, substance abuse, or maybe disability. So, I'd love to hear from you guys what you see as some of the root causes for houselessness.

RS: There is this idea that root causes and drivers of houselessness fall into two categories, ones that are structural, that are really baked into the way we function as a society, which take a lot of active policy and structure and systems change to redress. And the other are drivers of individual experience. And I use the term experience as opposed to individual desire because I think there is such a strong interplay between those structural factors and those individual experiences. So under those structural factors we've talked about already is the absence of affordable housing and there's evidence to support all of these. The absence of meaningful wage employment, structural racism and discrimination, and we see that in vastly disproportionate numbers of BIPOC communities who are houseless. And interaction with the criminal justice system, which in and of itself becomes a driver of future houselessness and then the disinvestment of a strong, and I'm gonna use this term, sorry Jim, I just learned that about behavioral health, but the disinvestment and sort of the fissuring of a robust behavioral health system over the last 50 years.

And then on the individual sides are the ones that we might hear of more commonly, that somebody does have serious mental illness or does have substance use disorder. But there are other ones which we might not think about as much, which are having been in the foster care system as a child, trauma, particularly traumatic brain injury. And now age over 50 is now an independent risk factor for homelessness.

And what's really interesting about this model is one, it shows how complex and dynamic the drivers of houselessness are, that those structural factors really influence those individual factors. But also what the evidence shows is that as those structural factors become more pronounced, as we've seen, particularly relative to COVID and other situations around affordable housing and access to care in the last decade and more, as those structural factors become more pronounced, it takes fewer and fewer, if any, of those individual factors to drive somebody into houselessness and often makes it very difficult for that to change. So we want as a society to say, “Oh, it's just up to the person or it's up to their individual experience. They're

down on their luck or they didn't go to enough doctor's appointments." But the evidence doesn't really tell us that. The evidence really tells us that it is these structural factors that are driving houselessness in the United States.

MP: Thanks, Rachel. Jim?

JO: I think Rachel has brilliantly summarized the root causes of homelessness as I understand them and as I think most of us who have been in this work for so long have come to understand it. And I salute Rachel for that analysis. It's quite extraordinary. From my perspective, I would just add that the longer I spend time taking care of people who are homeless and understanding the families and the adults and the many, many eclectic types of people who end up living on the streets or in shelters, I realized that this is a truly complex societal problem. I used to think that I understood back in 1985 what would be the solution to homelessness because I was seeing what was in front of me. What I did not understand was precisely the issues, were precisely the issues that Rachel has pointed out: the really root causes of poverty and racism, poor education, growing up in belated neighborhoods, poor inadequate housing that caused more ill health than health. All of those things I realize now contribute to what we have as our modern tragedy of homelessness in America.

And I have come to think of it as, you know, a good way to think of homelessness, I guess is it's a prism that we hold up to society and what gets refracted are the weaknesses in each of the main sectors of our society. And I think of health and public health. Think of housing, think also though of law and education, and welfare. All of the weaknesses in those parts of our society become refracted in today's homelessness population and problem.

So I think we have to, I think just as Rachel is hinting, we have to look at the root causes as really fundamental to understanding the problem of homelessness and then learning what we can do to solve it. I used to, for example, think that, you know, we could do good healthcare for people who are homeless, but that doesn't really, you know, I'm a doctor and that doesn't end the homelessness. You can try your best to take good care of them. And even as we've learned, getting someone a place to live, a house, an apartment or something, is really fundamentally necessary for solving the problem, but it is not always sufficient to solving the problem because of all the complex factors at play. People who have been through the foster care system, people suffering from delusions and all sorts of mental health issues. People struggling with substance abuse issues, many of which have emanated from the structural flaws that they had to live with. Many of those now need to also be addressed once you're in housing. So I'm beginning to think that we all have to rally and understand that while housing is fundamentally necessary and good healthcare and good care for substance abuse disorders is necessary, we also have to address all the things, the trauma that people have been through, and continue to support them once they're in housing. And I think that's probably the frontier that I see now. It is a very complicated problem, and I would urge everyone to listen carefully to what Rachel said.

[25:29-32:56] Providing Help with the Social Determinants of Health

MP: Thank you for that. That image of a prism that we can hold up, the prism of houselessness, we can hold up to society and break down the different players, is really important. You started talking, Jim, about the social determinants of health, as well as medical care and how it impacts those who are living in houselessness. I'm wondering, and we can think about Maslow's hierarchy of needs that we all need, like food and shelter, etc. My question is, is it just medical care you provide? Rachel, can I turn that to you?

RS: Yeah, thanks, Marianne. I feel so fortunate to have sort of grown up and been mentored in an organization whose mission is to provide comprehensive solutions to ending homelessness, to help people who are struggling with what a colleague calls "life's biggest problems", to build health, housing, economic resiliency, and social connectedness. And so, Central City Concern, and I'll say now me because that's where I've learned all these things, really thinks about caring for an individual or even a population, addressing across all those fronts. And sometimes that does come in sequence, but there is often a combination of housing. We have a housing choice model that we think about, which we can talk more about later, but there's no one right type of housing for somebody. It really depends on what their own preferences are at that time. It involves healthcare, which sometimes might be just initial sort of stabilization. Do you just need to be treated for your, you know, tooth abscess today? But then often, it will grow into helping with substance use, with mental health, with the physical health condition. There's that economic resiliency piece. So some people, whoever wants to work, can work. That's the supported employment model.

There's a wonderful model that Central City Concern didn't design, but that we have been trained in to help get people onto social security and benefits. And then that idea of social connection, that everybody needs that, and that can come in the form of peer support. It can come in a housing community. We have a place called "the living room" where people can sort of drop in. There's the clubhouse model. So, the sequencing of those kind of depends on where a person is at at that time and I don't think that's something that's prescribed. I think that just what's important is if the goal is around, again, building health, housing, connectedness, and economic resiliency. You're going to want to kind of assemble those things at the right time.

I think you referenced Maslow's hierarchy of needs. And one of my favorite things about Maslow's hierarchy of needs is what's at the top, which is about self-actualization. And often for many people, what that means is, how am I giving back? You know, as I've sort of been able to put my life together, I've reconnected with family, with friends. And what I've seen is that it comes in so many different ways. Like Jim mentioned, this incredibly robust board that he has. So people who are now have been participants in that care are helping to design it. We have a wonderful program at Central City Concern designed by this genius former colleague of mine, a woman named Frida Caesar, called "Flip the Script". And that's for Black and African-American men and women exiting incarceration and getting housing and employment. But then also, they developed a public policy advocacy coalition, which has done a lot in criminal justice reform in the state of Oregon. So I think part of that, and for some people, the giving back is "I'm gonna raise my kids", you know, or "I'm gonna be able to go to their parent teacher conferences". Or "I'm working again". It can take many different forms, but I'm so pleased you referenced

Maslow's hierarchy of needs because I think that moment of self-actualization is a really beautiful part of what happens in ending homelessness.

And it, as a colleague often says to me, it gets us to avoid that soft bigotry of low expectations. You know, that fact that the best you can do is sort of be, you know, maybe not be on the street anymore, but not really be achieving your full potential and giving back, and nothing could be less true.

MP: Thank you, Rachel. Jim, do you have comments about that or any reflections on how we meld medical care with providing help with the social determinants of health?

JO: I would salute what folks at Central City Concern have been doing for many years, which is integrating, you know, integrating all of these things. I would also though bring up, there's another tricky part that I would love to get a discussion on because when I first started, I remember I learned everything from a nurse whose name was Barbara McInnis. We named our program after her and she was this fabulous nurse working in the shelter. She knew every homeless person in Boston at the time. And I started working in the clinic with her and she basically taught me everything I knew, and was not shy about telling me what I was doing wrong. And I'll never forget when people would ask Barbara, you know, “What do you think we have to do to stop all this? What's going on?” And she would turn around and say, “Will you leave me alone? I'm too busy taking care of people to think about all that.” And there's a fundamental struggle that we have every day. There are very sick people in front of us who have huge needs that they're looking for. At the same time, the solution is a whole lot more outside of our domain or we need to work with them.

But I worry a little bit about how we focus on this. Some of the people who are stuck in that situation of homelessness for the amount of time it's going to take until we can get them housed and everything, you know, are dying of cancer. And our board continues to remind us, the homeless people on our board, you know, when you're in the hospital and sick, that's when you want to see your team. That's when you want to see your doctor, your nurse or something, because that's when you're most scared and the biggest things are going on. When I look around, I realize as we go more and more to the streets and to the shelters, do we really keep in touch with them when they're really sick? And how do we balance that need and you all, we all know whenever you get sick, you call a specialist, you find someone. How do we get specialty care to be involved? How do we really have good palliative care? If you take care of a group of homeless people, as Rachel will underscore with me, they will teach us the weaknesses in our healthcare system long before you realize it anywhere else. And I think that's been the theme of these last years of, like wow, we have some major weaknesses in our system, particularly with continuity of care for a very fragmented and excluded population.

[32:30-33:09] Closing

MP: Thank you for this discussion, Part 1. This is one of two episodes, and we want to acknowledge and direct our audience to Part 2, which will be released a little bit later. And we

also want you to continue this discussion online. We definitely would love to hear from you. We also have additional resources and a transcript, and a summary will be available for this on our website. Get in touch with us through our website, through social media, and continue the conversation!

[33:10-34:13] Outro

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