Season 5 Episode 1
Houselessness: A Prism for Understanding Healthcare Disparities, Part 2
Transcript

Guests: James O'Connell MD MACP, Rachael Solotaroff MD, FACP
Co-Hosts: Dr. Marianne Parshley, Dr. Elisa Choi
Editor/Assistant Producer: Clara Baek
Production Assistants: Nilgoun Farhadi, Leyna Nguyen

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

Learning Objectives:

1. Identify challenges and lessons for both clinical teams and people experiencing houselessness in providing and accessing healthcare.
2. Describe different models of housing support and healthcare delivery for which clinicians can advocate in order to support those experiencing and emerging out of houselessness, and to ultimately reach the goal of ending houselessness.
3. Discuss some of the challenges facing houseless individuals who are seriously ill and/or at end-of-life, and facing those who are providing their end-of-life healthcare.

[0:00-1:11] Welcome and Introduction

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'm Marianne Parshley, and my co-host is Dr. Elisa Choi. Today we're excited to continue our conversation with our two guests from Boston, Massachusetts and Portland, Oregon, founder of the Boston Healthcare for the Homeless, Dr. James O'Connell and Dr. Rachel Soloff, medical director and CEO of Central City

Concern in Portland. This is our second episode featuring these two champions and providing healthcare for the houseless or living with housing insecurity. Last episode, we talked about the definitions of houselessness and housing insecurity, the root causes of houselessness in this country, and challenges to providing healthcare to this underserved population.

This episode, we will talk about the nuts and bolts of providing care, access to care, different intersecting models of Healthcare and what we should all be working for in our advocacy efforts.

[1:11-10:26] Providing Care in the Houseless Community and Action Steps

Elisa Choi: Thanks Marianne. Jim and Rachel, we have so appreciated hearing your perspectives and have learned so much already. And what I'd like to redirect a little bit of our conversation now to is a bit more in terms of solutions and maybe action steps. What might be the challenges? Jim, I'd like to start with you.

Jim O'Connell: Thank you Elisa, and you've opened up in a wide world of interest and concern and discussion. So we clearly know if you're taking care of people living on the streets or in the shelters or having encampments, that it's a very dangerous place to be that needs a huge, and that without housing, we're never really gonna solve any of this problem. And I think that has to be upfront and really foremost that it's hard to imagine that we live in a world [where] housing isn't a right of everybody, and that we see income inequality just growing. And I would underscore particularly in urban centers like Portland, where Rachel is, in Boston where I am, and then you look at LA and San Francisco and you know, as you probably know, somewhere around 80% of all the adult homeless folks are living in these urban areas. So we really need better ways to approach all the obstacles to housing in those particular cities. But that said, there's also the, I, you know, since we're clinicians and looking at it through that thing, it is, I can't tell you how often we just celebrate people who've been on the streets for 20 years that've been following and then finally, with all the low threshold housing programs that are really spectacular, particularly permanent supportive housing, they get into housing.

And then the challenges are fascinating. The vice chair of our board, a homeless man who lived on the streets for years and recently died when he was placed in housing after all those years on the street, he would describe at the board level, he got into his beautiful single one bedroom apartment. It was in an area of town he didn't know very well and he couldn't go to sleep because it was just too quiet. So, you know what he did? He went down to where our main offices are crossing the emergency room and he sat outside and recorded the sounds of ambulances and police and people yelling.

And he plays that recording at nighttime to get him to sleep cuz that was what he needed. And it started to make us realize, wow, you know, to see this through the eyes of the person going into housing is a little different than our eyes who are used to being in housing. And the other thing, what he did though, was he also became very depressed.

He found that when he was all alone and he did a video along with many of the, and Rachel probably has seen this, he did a video with the national healthcare for the homeless council's advisory board to help other homeless people from when you get into housing, to here's what you gotta be careful of, to the loneliness, you're not on the street anymore. Your skills on the streets that you had honed so well are now useless and you don't have a community around you. And he said, those are things to struggle with. One of the things that our board also said, and I just want to share this with you, is since we had basically, we're a healthcare for the homeless program and as people got housed, the question is, do we continue to follow them?

And our board members read us through our medical team and home for the last 10 or 15 years, "You can't abandon us just cause I'm now placed in the house". So we've had to develop our, how our team, and particularly the street team that I work on, how we do home visits, just as Rachel was mentioning before and doing home visits has opened up a whole other world. You know, people have a hard time coming to us. We have to go to them because they're trying to structure their lives in new ways. The challenges of being alone are immense. The mental health issues or the behavioral health issues are huge.

And also the substance abuse issues, you know, we found it was so refreshing when people got housed. Many of them could get sober. You know, they had a place to be sober and all that. But one gentleman, I came in one day and he was back drinking again and he said "Look, Doc, leave me alone." He said, "I got sober. And then when I realized what my life was, I didn't wanna live like that. I had to get high just so I could bear it." And you realize that filling someone's life or giving them a community or a sense of hope or a sense of purpose is another job that is very much related to the healthcare you provide.

So I think there's a ton of challenges and, I think we could talk more about this, but I think the support that people need once they get into housing has probably got to be emphasized just like the housing has been emphasized. And, that's where I turn again to Rachel and realize that Central City's concern has probably been the best in the country at learning what this support should be.

But I would dare say it's rare to find that kind of support funded anywhere else without a lot of work. It's certainly not part of a Medicaid or a Medicare package, and that's what we've gotta work on.

EC: Thanks so much, Jim. That was really fascinating to hear that we think we have a solution for people who are experiencing houselessness, but we may actually create secondary issues. Rachel, I wonder if you could also comment as well.

Rachel Solotaroff: Thanks. We touched in the earlier episode, and I was thinking about this as Jim has been talking on the idea of mentorship. And particularly in medicine, we think of mentorship as, "Oh, the chair of my department" or "My attending physician". To your question about how to understand people's experience, my mentors have actually been both my patients, but that's a difficult position to put people in, but also the people I work alongside with.

So one feature of Central City Concern where I work is that we're a second chance employer or third chance employer, or fourth chance, fifth chance. About half of our staff have lived experience of homelessness. And that is at the senior level of the organization, at the front lines of the organization, managers, directors. And I learned very early on in my career at Central City Concern, having made some major blunders, that I needed that mentorship from those colleagues.

One I'll mention, a fellow named Gary Cobb, who remains a mentor today, a really prominent community leader, prominent in the national healthcare for the homeless, you know, advisory board and other capabilities. He's now on our policy team, but at the time I think he was working as one of the janitors, but he was my first mentor at the Old Town Clinic. He would come see patients with me, which is not really fair to him, he had a whole other job to do. But often having somebody helping to kind of, you know, kind of shake me and say, “Hey, the traditional ways that you're asking these questions, or how you're receiving them, the responses, or what sorts of things you're suggesting, that's not gonna work here.”

So again, I don't ever want to put undue burden on other people who have a lot of other things to manage to also be explaining and teaching, but to have that environment where your colleagues are really invested in that and can be mentors. That has been the privilege of a lifetime for me.

You know, when you asked about challenges, Elisa, my head went straight to the last two years with the pandemic and that idea that what few community supports and places to gather that people had, all of a sudden started to shut down. You know, we used to have a kind of a community space called the Living Room, which you could drop in, you could make a sandwich, there was programming, you know. Sometimes it was run by a mental health person, sometimes it was run by a peer. A wonderful communal space that shut down for the better part of two years. Libraries, other day centers, some of the places where people often gather to eat and get meals, they now could stand outside, but they weren't allowed to come in. And the amount of distress that we started to see, in our neighborhood and in our sort of homeless community members, I think is directly indexed to so many other things that we've already talked about. But this new profound social isolation that is hard enough to begin with, but then was really exacerbated by COVID.

And then I think your last question was about sort of how you care for the people who are caring for the people. As a CEO, that's one of my biggest jobs: how to support those support people, particularly on the front lines. That's a humongous issue that I think gets to some of the structural issues around, how do we fund and support the workforce that cares for people who are homeless. Which are not just physicians, I mean, this is a huge swath of a workforce that I think we just haven't invested in properly. Not just in terms of compensation, but in terms of loan repayment and professional development. And, you know, we have such a need for culturally specific services, so ensuring that we're developing a workforce that can provide those services. So I think that's a really huge topic that's part of our solutions focus here in this section.

EC: Well, thank you so much Rachel. And I agree there definitely will need to be a system based focus for solutions. And Marianne?

[10:26-15:13] Discussing the best model for improving access to care

MP: Thanks, Elisa. I was struck by two things in the last comment. Number one, the gathering spaces disappeared. But what we saw out of the window of our clinic, which is in East Portland, was that then led to congregations of people living on the street in tents, in their cars, in their campers. And they would gather around, particularly at the beginning and the end of the days, and communicate with each other. I watched them help each other out, commuting on our max train. I sat and listened to people early in the morning who are waking, and I remember in particular one conversation between two guys, one older and one younger. They're both experiencing homelessness. And the older one was giving the younger one a list of people he needed to go wake up and remind to take their medicine and make sure they were okay. And I thought, there are strengths in that community. There's strength in the community that gathered together in 2020. There's strength in the community that looks out for each other.

So thinking about that, access to care. I've heard about a bunch of different models. the two programs that you guys lead and have started. There's also the Housing First model. There's street medicine, it's part of an international consortium. What do you think works? What should we advocate for? What doesn't work? Rachel, why don't you go first?

RS: The main thing that I would want to communicate is, similar to how we use population health in medicine to sort of segment populations, I think about, I use that model and apply it to the population of people who are homeless and the kind of care that includes housing access and medical care and peer support, apply the same model in this sphere. Because we can fall into a trap, lo and behold, of ideology or even, you know, sometimes polarizing points of view around what's the best? You know, what's the one thing we should do? And I think that's partly out of, as Jim mentioned earlier, a search for a simplistic answer. But I think it's also because people, you know, can get very, entrenched in, “I saw this work and something else is not as good.” The analogy I often use is, “Hey, homelessness is a big tent and there's plenty of room under it for everyone.” So what I would say in terms of access is to think about, and engage with the people who have lived experience so that you're co-creating these models, what are different desires and environments that different populations require? Cause we do need to think about economies of scale. It's not one size fits all, but you also can’t invent a new model for each of, what, 5,200 people who are homeless in our most recent street count here. You can't create a new model for each of those.

So we think along, at Central City Concern, and we do have the luxury of having worked on this for 40 some years so that there are resources there. But for instance, around a model of housing choice, and how that housing choice intersects with people's choices around their healthcare. Some people want housing first. It's the best thing for them. There are absolutely no restrictions, which makes perfect sense around there's no requirement for treatment. For

engagement, the most important thing is to get that person into a supported housing environment. And then as Jim mentioned earlier, they may be using, they may continue to use, or they may have a cessation or a decrease of use. For some people, they would say, I'm actually interested in decreasing use now, and I want to be in an environment where there's a community of other people and peer support and case management that's helping me on that pathway to recovery. For some people, that's transitional. For some, that's permanent housing. Same in a Housing First model.

We do stabilization housing, for instance, for people who may be sort of coming out of institutional settings, often corrections where, two years in a setting where they're provided a lot of support, let's say, around, you know, mental health and interaction with parole and probation, and then that helps to launch them to the next space. So again, we can go on and on about the models. I think the key point is, it's not one size fits all, and it's not creating an individual program for each person, but start to think even qualitatively about different segments of the population. This is particularly true with culturally specific services and designing housing and services and peer support, with your colleagues, if possible that meet the needs of that particular group of people with them as part of that co-creative process.

[15:13-21:15] Improving Solutions for Housing Disparities

JO: I would underscore and heavily underline the big tent that Rachel is mentioning. That this problem that I think all of us who've been in for a while, I used to think I had good ideas about how to solve homelessness. The longer I'm in it, the more I realize how difficult it really would be. I sometimes muse, if we really were going to take this seriously, we should look at it like a university problem. And really at the table there should be the school: the medical school, the law school, the business school, the policy school, the school of architecture, you name it, school of education. Because all of those schools and the thoughts of the university together are probably what need to be involved in the mosaic of a solution we need to come up with.

So one of the things that's striking, just cause you know the experience of Central City Concern goes back 40 years and they are really way ahead of the curve. There are several places around the country where you've seen these remarkable housing programs. I'm part of the Corporation of Supportive Housing Board, and they, you know, have been around and, you know, there's just stunning things going on.

I think about a step back though, I would say the problem is that the scale of these solutions is tiny. And so we learn what works for different segments, but we are not able to scale it to where we have. And that's, I think, our big political, you know, and societal problem. That, to say we need to invest in a solution that might take 20 years for the outcomes to come through does not help a mayor or a politician. So we consequently get really a lot of emphasis on these wonderful small programs we know works, but then you can't scale it. I don't know if you saw the, one of the things that was quite astonishing to me, and it's happened in Boston, in San Francisco and in LA, when you build these really good units that worked for people in a nice housing, the average of a unit, most recent one was 800, over $800,000 per unit in LA by the time you get

through all the zoning and the legal stuff. So, you know, if you have $20 million, you get 20 or 21 people housed and that just doesn't help when you've got 60,000 people homeless in LA.

So how do we get us to say this is a big problem and it's gonna be solved? Not in the, you know, in the million or billion, maybe in the trillions. And I don't see right now in the current atmosphere how we do that. And so in the meantime, we're all stuck. What I think, we're like the people going in to do the disaster medicine from the earthquake that we haven't been able to fix the structures on yet. And I think we just gotta start not accepting that we know the solution, you know, and that's enough. We don't know the solution. It has to be very varied. It has to be a choice in housing. Rachel said something that is stunningly evident to us in Boston. When there is an apartment available, the next person up has a choice of that apartment or nothing . So it's not a house designed for what your needs might be or an environment designed for you. So we just aren't there yet.

The scale of housing just isn't up in many urban centers like San Francisco, and Boston in particular, in probably Seattle. So new solutions and tolerance for people being willing to try new solutions and not, you know, get in fights. This, I think that's what Rachel was pointing out. We tend to be very iconoclastic about what we think works and then get mad at the other people that don't.

I'll give you an example. In Boston, we had a really rich, really wonderful, developed shelter system that goes back 100, 120 years. And 94% of everybody who's homeless adults, who's homeless in Boston, stays in a shelter at night time. And it's been kind of a godsend in many ways. And only about 5% of the people are on the street. You know, other cities, you know, like LA it'll be reversed, most of them on the street. But when we do mortality studies, if you are on the streets in Boston, your risk of dying is three times out of someone who's willing to stay in shelters.

So streets are deadly. Shelters are kind of life preserving, but then you have to deal with the paradox of here comes COVID. And COVID is going to spread in any place that has many people. And so the shelters in Boston, and this was our nightmare, as it was for Rachel's over the last several years, 40% of everybody in the shelter's got COVID. And then you try to isolate somebody who's got COVID and there is no place to isolate them unless you create new places. And that you can see around the country there's been a fury of creative solutions about how you isolate someone. But then the problem with isolating someone who has no money, no food, no any access, you've gotta also provide all of those things. You can't just say “Go home.”

And there's another challenge to that. That the shelter is all contracted in Boston, because it was safer to be that way, and then the streets flooded with new people. And then also now you have a street problem that didn't exist before that. So it gets very complicated and how to have everybody sitting in the same room looking at, progressive solutions.

And I, you know, see lots of hope in cities like ours where a mayor is now very invested in bringing the police and the schools together and the public health commissions; trying to work

on a citywide solution rather than each individual trying to come up with what's going on. So I would just underscore, this is really tough and I think we need the best and the brightest of people coming into all of our professions to look at this as a really, you know, as really a societal tragedy that demands we do something about it soon.

EC: Well, thank you so much, Jim and Rachel, and one through line I heard on both of your responses to Marianne's question is that we need solutions that are not in isolation. Advocacy is a big way to help come up with solutions and also to empower those who are on the front lines to feel like there is some progress. So I actually wanted to ask each of you if you can share with us what you might view as the top advocacy issues for all of us. Jim, I'd like to start with you.

[21:15-28:45] Top Advocacy Issues

JO: Advocacy is a really interesting issue for us and how to be a good advocate when you are also taking care of a very excluded population is a, I think, very, very important skill and art for all of us to learn. In Massachusetts, I think how you would advocate is probably very different than how you would advocate if I were in Arizona or if I were in Seattle. So I think much of the advocacy we should recognize has to take into account the environment you're in. Just like I would say almost all homeless healthcare programs have to reflect the healthcare environment in which they grow. Sort of, a version of all politics is local. I think much of this is true for homelessness.

We have found, and I could give you an experience, for example, when we first started, the homeless people that put us together and described us, were so angry with some recent research that had come out looking at homeless families, had been done by a really wonderful Harvard group. And it showed that the families that were experiencing homelessness back then had lived through unspeakable trauma and the kids, a good percentage of the kids, were in need of immediate psychiatric care.

I thought that that research was incredibly powerful and was a clarion call to do something. The advocates at the time, who I cherish and were part of the people that we really work closely with, hated that. And they hated it because at the time they were focused on a government that had divested itself from anything that had to do with poor housing or low income housing. And the result of that was, you know, what I would say, the burgeoning of this modern era of homelessness in the early eighties. And they read that study as a "blame the victim". Rather than not having enough housing, the government was able to say, "No, this is a problem of broken people, not a problem of housing."

And so they said to us, and I look back on this now with some, you know, trepidation. We were not allowed to do any research for five years. We could not do it. Because they did not like when research veered from advocacy. And I've thought about that for a long time because it's a very fine line to walk. And I think now that we work together, everybody works together, there's an understanding that, you know, this is complicated. We're gonna find some things work and some things don't. We have to be ready to acknowledge that. But the lesson was learned.

So for example, right now in Boston, you know, there was a whole movement to sort of get rid of the shelter, shelter system and go into less congregate places, et cetera. All very good. But the shelters up until now have been kind of a life lifeline and to get rid of them as failed social policy, which indeed they are, doesn't acknowledge that they were also a life preserving mechanism. So advocacy is again, veering a little bit from what the research is showing. And we're trying to figure out how do we, as good advocates and clinicians witnessing what we see each day, work together with the policy makers so that it isn't an either-or, but you can hold complicated things in both hands.

EC: Thanks, Jim. Rachel, I wonder if you could weigh in as well.

RS: Sure. And this is a super active space in Portland right now because there has been a historic investment particularly at the regional level, both in the bricks and mortar of housing, and then what they call supportive services, behavioral health, employment services, rent support, all those sorts of things. At a high level, from an advocacy standpoint, you just always want to be thinking about, “I'm interested in ending homelessness”. Which I know was lofty ideal, but, you know, it's a journey that we're always on and, you know, we're always becoming and never arriving, but, so any advocacy that addresses some of the structural issues that we've been talking about, you know, the need for affordable housing, for meaningful wage employment, for eliminating despair disparities and advancing equity in all of these fears, criminal justice reform.

So, you know, I think for a listener to keep your ear out for, you know, what is ending homelessness. Now that doesn't mean that that's the only thing, that there are no shorter term solutions. There are pathways to ending homelessness, which as Jim pointed out, often start, you know, in a camp which may lead to a shelter, which may lead then later to housing. I mean, there is a pathway to that. But just from thinking about good policy and not good politics, does the step that is being proposed advance an individual or a group of people on the path to ending homelessness? So that's kind of a big picture thing.

Another area of real concern for me is the workforce, which I spoke about earlier. I have deep concerns about just even compensation for these folks. A lot of this work often happens in cities, which as Jim mentioned, are expensive cities to live in. I mean, the cost of living in Portland's going up 8 to 10% this year. And I'll do my best to give our staff an eight to 10% salary increase, but I don't know that I can totally get there.

At the same time, this is often a workforce that I don't understand why has been historically disinvested. A colleague of mine, who's a public health researcher, pointed out recently, you know, if you go to grad, if you go to undergrad and then you go to grad school for two years to become a physical therapist, you walk out and you earn 100, 120,000 dollars a year, let’s say. You go to undergrad, you go to two years of grad school and become a mental health counselor, a licensed mental health counselor. You're gonna make, maybe, probably in community mental health, 40, 50,000 dollars a year. So just starting to think about, in the healthcare sphere in

particular, but the supplies in housing as well, just our colleagues who are on the front side, on the front lines doing this work, and what is really an economic and compensation model that's in support of them. Particularly in the cities, the pretty expensive cities in which we're living and doing this work.

The other thing I would focus on in advocacy is not just what bills are passed, but “How do they get implemented?”. We've actually passed some pretty historic legislation in the state of Oregon in the last few years around increasing the building of housing. You know, we changed zoning laws so that you can actually build more densely. And I'm not a real estate or, you know, construction expert. But I think it's really important to say, “Okay, who's telling me now? Did we do it? Did we make the policy change? But like, how many new units of middle income housing, of low income housing, of extremely low income housing, are being built as a result of that measure?” It doesn't just have to be a funding measure. You know, just a policy measure just to try to expand the availability of housing.

So I think that's really important for folks to keep in mind. You could do the advocacy to get that thing passed, but then making sure that whatever the intent of that bill was or that measure was, is actually being followed up on in a nice way. You don't want to bark at anybody . We have plenty of demands for accountability. But just asking good, curious questions, how is that going? I think that's important for people to be aware of.

[28:45-33:53] Palliative and End of Life Care for Houseless Patients

MP: Thanks to both of you. I'm going to ask one more question that somebody gave me yesterday at our All City Palliative Care meeting, which is: what do you guys do, and I think Jim, you referenced this, for palliative care and end of life care for people who are experiencing houselessness?

JO: We just underscored Marianne, that it’s been a passion of ours. And I think almost everyone who gets involved in this work, and I'm sure Rachel will underscore this, has to get used to the fact that death is ubiquitous. That in the population we're taking care of, it's horrifying how frequently people die prematurely and what I would say, needlessly, of hypothermia, you know, of infections, of out of control diabetes that they never would be able to take their medicine for, of hypertension.

But, I worry a lot. And Rachel will probably underscore cause they have a fabulous recuperative care center, and we have what we call our Barbara McGinnis house. Where we can bring people who probably should be in the hospital or in a facility somewhere else, we can bring them in, provide the kind of care for them that gives them a little bit more freedom. And it can be just as acute, but gives them a lot more. Like, for example, you can leave your room and go downstairs. You can go out on the patio. You can move around rather than feel constricted the way you are when you're in either a nursing home or a hospital. But we've learned that care for people.

When you ask homeless people, “Where do they wanna die? What do they want?” They don't wanna be sent to some facility where they don't know anyone. They wanna be in a place. Many of them choose the shelter because that's where their friends are. But, they want to be around people that care for them. And so the challenge though, is it's incredibly tedious and difficult work for staff and for other people, other patients around to win. There is a sort of a general belief by our homeless people on the board, that the knowledge that they can die among their friends is an important one to share with them.

So we've been pretty committed. We will keep people through their chemotherapy and radiation and into their end of life care. But it's a challenge and there's not much in our healthcare system that makes that easy for any of us,

EC: Rachel.

RS: Wow. That's a beautiful formulation, Jim. You know, it reminds me, if I might for a moment, a story of, this was not my patient, but the patient of a colleague of mine who was in the situation that Jim described. Where he was put into a facility and he was in, more or less, end stage COPD, and was separated from his wife who was living in a single room, occupancy hotel downtown. And he was so distraught by being there. He left and he went and he'd lived in a park across the street. He wasn't allowed to live with his wife anymore because he'd been evicted from that space. And she couldn't lose her housing by having him back in. And he went and he lived in a park across the street from her so that he could be close to her.

And she came down every day and helped to feed him and bathe him and try to give him a nebulizer on the street. But it reminds me of the dignity with which everybody should be able to have at any time, but particularly at the end of life, and how we don't have the systems or a place like Barbara McGinness does. That's where we all learned how to do this, but we don't really have across our society systems to do this. And so we end up in a situation like the one I described.

Structurally speaking, the one thing we developed about, oh gosh, eight or nine years ago or so, was the development of a particular care team in one of our clinics. There was a high burden that's placed upon patients, the burden of navigating systems, of getting to appointments, you know, engaging with specialists, all that stuff, which is hard under any circumstances. So we created a team called the Summit Team kind of grounded in this ambulatory intensive care unit model that had come out of Stanford but adapted for our population. That basically with the help of a really wonderful payer partner, gave a lot more flexibility to that care team to do home visits, should people have, cause we don't have this kind of embedded model that Boston Healthcare for The Homeless does.

But to be able to provide additional housing support and assistance to do home visits, to do care coordination, to have better medication reconciliation, hospital transitions, all of that. And what we rapidly found is that it had evolved into basically a palliative care team that had sort of evolved into an almost a population specific palliative care team. And they're again, heroes of

mine, cause I think they're doing some of the hardest work that there is. I believe a lot in population health and often that means designing; not asking people to fit into a traditional healthcare system that we've designed, but to design systems and programs that meet the needs of those populations and reduce disparities between groups.

[33:53-16:07] Closing

EC: I have learned so much and I feel like I got a master tutorial in the care of our patients with houselessness by listening to both of you. So thank you for your generosity and your time and sharing your wisdom. The experiences that you've had over your careers really can't be matched in learning from what it's like and how can we be better physicians taking care of our patients who have houselessness, and how can we be better advocates?

MP: Thanks Jim and Rachel, for your inspiration, for sharing your wisdom with us and for giving us our marching orders to advocate for change and to cultivate curiosity such as about how legislation is implemented and where the funding is appropriated. The work we do with and for our housing insecure neighbors is like responding to canaries and coal mines. What impacts them impacts us.

I heard a recent speaker say that what happened in our houseless population regarding morbidity and mortality often predicts what will happen in the larger community. For instance, in the 1980s at the beginning of the HIV/AIDS epidemic, we saw increasing morbidity and mortality from HIV/AIDS in the houseless population before it got to the broader community. Same thing with the opioid and meth epidemics, and now with the COVID epidemic. Jim, yes, let's call on our best and brightest the young people who are listening to this to take charge, to advocate for and to do the work at local and systems levels as many already are. And Rachel, I agree. This is an interprofessional team sport, and there should be adequate compensation for all. We should continue to advocate for reducing that disparity as well. I have great hope that if our best and brightest continue to step forward, good change will come.

And now we invite you all to continue this discussion online. We'd love to hear your stories to do with this topic, your questions, and the specific barriers and challenges you have faced. We have additional resources and a transcript of this discussion on our website. Get in touch with us. We are also on social media at Twitter and Instagram. Let's stay in touch.

[36:07-37:19] Outro

by The DEI Shift team are those of each individual, and do not necessarily reflect the views or opinions of The DEI Shift team and its guests, employers, sponsors, or organizations we are affiliated with.

Twitter and Instagram: @TheDEIshift
Email: thedeishift@gmail.com
Website: www.thedeishift.com
Instagram and Twitter: @TheDEIshift
Email: thedeishift@gmail.com
Website: www.thedeishift.com

Credits:

Guests: James O'Connell, MD, MACP (Boston Healthcare for the Homeless) and Rachael Solotaroff, MD, FACP (Central City Concern PDX)
Co-Hosts: Marianne Parshley, MD, FACP and Dr. Elisa Choi MD, FACP
Executive Producer: Dr. Tammy Lin
Co-Executive Producers: Dr. Pooja Jaeel, Dr. Tiffany Leung
Senior Producers: Dr. Maggie Kozman, Dr. DJ Gaines
Editor/Assistant Producer: Clara Baek
Production Assistants: Nilgoun Farhadi, Leyna Nguyen
Website/Art Design: Ann Truong
Music: Chris Dingman

Season 4 of The DEI Shift podcast is proudly sponsored by the American College of Physicians Southern California Region III Chapter.

The DEI Shift theme music is by Chris Dingman. Learn more at www.chrisdingman.com.

Contact us: thedeishift@gmail.com, @thedeishift, thedeishift.com