Speaker 1: Welcome to Conversations on Health Care. This week, we welcome Dr. Jim O'Connell, founder of Boston Healthcare for the Homeless, featured in The New York Times Bestseller by Tracy Kidder, Rough Sleepers. Now, here are your hosts, Mark Masselli and Margaret Flinter.

Mark Masselli: The mayor of Los Angeles has declared homeless emergency in New York City. The mayor wants to take more mentally ill people from the streets to the hospital. In Washington, D. [00:00:30] C., case workers just cleared dozens of unhoused citizens from a park right near the White House. Data shows that on any given night in the United States, about a half a million people are experiencing homelessness.

Margaret Flinte...: Dr. Jim O'Connell is the subject of The New York Times bestselling book. It's titled Rough Sleepers. The new book focuses on his urgent mission to bring health and healing to homeless people, and it's written by Pulitzer Prize winner, Tracy Kidder.

Mark Masselli: Dr. [00:01:00] O'Connell, or Dr. Jim, if we may, welcome to Conversations on Health Care.

Dr. Jim O'Conne...: Oh, I'm actually very thrilled to be here. Thanks for having me.

Mark Masselli: Oh, great. I think about people who are walking down streets all across the country and asking themselves if our homeless problem is getting worse, and if it is, what caused the increase? Was it the pandemic? Or what do you have to say [00:01:30] about the question?

Dr. Jim O'Conne...: First of all, I feel a little bit sheepish because I've long admired what you both have been doing and the Community Health Center we all look to for guidance and inspiration has been yours, so let me start by just saying that and making it clear.

Mark Masselli: Oh, you're too kind.

Dr. Jim O'Conne...: I'm a newcomer compared to the two of you. I think what's contributing to the growing numbers of homelessness, and it tends to fluctuate a little bit, but what continues [00:02:00] to feed it, I think, is the things we all know all too well. There's a growing disparity in income. Rents are getting very high. Finding new housing is expensive and difficult to do and the scale at which we need help with both the rental units and with housing is really a scale that we haven't achieved yet, so I think as we work very hard, many, many cities around the country are being incredibly creative along with [00:02:30] help from HUD and their state governments to find new housing, but the rate at which they can find new housing doesn't seem to be able to keep up with the numbers of people that are coming in newly homeless, so I think we have a big challenge ahead of us.

Mark Masselli: Yeah, I think I just saw today's paper that the year-over-year cost for housing had increased 7.9%, probably creating more people who are facing homelessness as well.

Dr. Jim O'Conne...: That's correct. [00:03:00] I realize that medicine is what I know and I think it's kind of complicated, but when I look at housing and the issues around housing with community development and all the rules and regulations, it's probably even more complicated than housing, so I am by no means an expert, but I do know that my friends that are involved in doing housing projects in big cities like L.A. and San Francisco and Seattle, and to some degree in Boston, when you go through the whole process of trying to build new housing [00:03:30] for formerly homeless people, once you get through all of the rules and regulations, the legal fees, the community things, it takes a very long time to create it, and by the time you get there, the average plus of housing, for example, of a unit in San Francisco now is about six or $700,000 by the time all is said and done, marginally less in L.A., and about the same in some other cities, so the expense of creating new housing is kind of overwhelming, and we need to understand that.

Margaret Flinte...: [00:04:00] Well, Boston is no stranger to those escalating prices or the shortage of housing, and certainly, you've been engaged with this work for decades. Of course, you're joining us from Boston where you're the president of Boston Healthcare for the Homeless, certainly a program to advocates around the state who try and address the needs of people who are homeless. You're also an assistant professor of medicine at Harvard Medical School and I think it's probably safe to say that [00:04:30] your practice is not exactly like the models of care that you were trained to when you were a medical student and then a resident. I thought one of the comments in the book that was really interesting was that your medical degree is often less valuable than your bartending skills, that bartending made you a good listener. One of our physicians told me the same thing years ago. But take us through your treatment approach. In all seriousness, certainly listening and communication is at the heart of what you've needed to do to build this program, [00:05:00] but tell us about what it means to treat people in this context of homelessness.

Dr. Jim O'Conne...: Yeah, and I appreciate the way you phrased that, Margaret, but certainly I'm an accidental tourist in this world. I was planning to do something completely different. I wanted to stay hospital-based medicine, wanted to become a specialist in oncology, and I had no inkling of what it meant to go to the community and try to take care of populations that we were traditionally [00:05:30] excluding from the mainstream. When I got sent as a one year, "Please go do this," by my chief of medicine, I remember getting to this shelter and realizing it was completely foreign to me, even though it was only six blocks away from where I had just finished being the senior resident in charge of the intensive care unit, and I kept thinking, "How hard can a shelter clinic be after you do that?" It turns out it's immensely more difficult because you have so

little control over [00:06:00] so many factors. I realized with some joy in the intensive care unit, you control lots and lots of things, but not in the shelter.

I remember the first thing that the nurses who were already working there told me was on no uncertain terms... By the way, I have an older sister who's a nurse, so I know when nurses are getting very, very precise, and so they basically told me I had to relearn how to approach people. I had to soak feet, for example, for about two months before they would let me do any [00:06:30] doctoring. I think the lessons I learned from the nurses back then are still the lessons that have lived through all of these years. That's that you have to take time to get to know people who have been really disenfranchised and they are vulnerable, fragile, often very chary of the mainstream system, so for me to go march in as I wanted to do and get their chief complaint and write a script and do all that within the first 10 or 15 minutes was just not possible.

I remember [00:07:00] that experience of how to take time to earn trust, have coffee with your patients, talk to them, share a little bit, all the things that I think that kind of time had not been treasured or valued when we were in the hospital training. We learned that was the only way to begin doing any kind of long-term continuity of really good care was to take a lot of time upfront, so that more than anything I remember stands out. The homeless people that put us together and designed [00:07:30] the model of care, which I could claim we did that, but we did not, they did. But they insisted that they really wanted continuity of care, that they didn't want fragmented care. They said their lives were already fragmented enough and people were coming and going. They wanted consistency in their doctors and their nurses, so they wanted to know if I saw somebody on Monday night, if they were sick on Thursday, they could call, and I would answer the phone.

Mark Masselli: There's so many challenges that you face, certainly managing [00:08:00] individuals with addiction and mental illness or the combination and wondering, how did you acquire those skills? Certainly, you also have a pretty good team with a wide range of skill sets, but take us through your own learning process about addiction and mental illness.

Dr. Jim O'Conne...: No, it's a really poignant point because I was clearly trained in medicine and I did not have much sense [00:08:30] of social medicine or of addiction care or care for substance use disorders and very little experience in caring for people with severe and persistent mental illness. They were always people we referred to another system to be cared for. But as all of you probably know all too well, the people who have been chronically living in our city streets and in our shelters tend to bear a very, very high burden of co-occurring medical, [00:09:00] psychiatric, and substance use disorders, and if you really want to care for them, you have to learn how to integrate the care, not only theoretically, but co-locate the care if you're really going to do care well.

They were skills we had to learn. We now have a psychiatrist on, we have had for 20 years a psychiatrist on our team whose panel of patients is the same panel that we all care for. We've learned that has been critical, so when [00:09:30] I'm seeing someone for their medical problems to know, the psychiatrist that's with me on the team is the person that can see them if they need help. Then we also have a wonderful recovery coach who helps us integrate our substance use care into the mainstream so we can do all of the, as many people are doing now, make sure we offer all the medications for opioid and other dependencies and make sure people have easy access to that. I think finally it was learning that you [00:10:00] can't silo this care. You really have to learn how to integrate. I've often thought that homeless people when you reach out to take care of them will teach you before we realize that ourselves the real weaknesses in our mainstream healthcare system. The lack of integration coordination was certainly one of them.

Margaret Flinte...: Well, I think you're absolutely right about how much we have to learn from people. I'm going to ask you in a minute to comment on this phrase, the rough sleepers that you talk about [00:10:30] in your book and what that means. It's such a great phrase, but I don't think it necessarily is clear to people what you mean. I want to preface that by saying when people see homeless people on the street, when they read about it, they often ask, "Why? There's shelters they could go to. There's housing vouchers in the city. There's some hotels sometimes," and it is true in our experience that some people will not go to a shelter [00:11:00] facility. What have you learned about why we have so many of what's called these "rough sleepers" and what is a rough sleeper?

Dr. Jim O'Conne...: All of my preconceptions turned out to be very wrong, as you can imagine. In Boston, at any rate, the mayors and the governors for years have made sure there have been shelter beds for any adult that really wants one. In our clinics, our Boston Healthcare for the Homeless Program, which is our FQHC, has for year since [00:11:30] the beginning done clinics and all of the shelters, and so we thought we were getting out to be exactly where people were.

The first winter I was working, remember, I remember thinking, "Wow, people are dying, but they're the people who are staying outside, not even coming into the shelter," so as much as we thought we were doing a great job of reaching out to be where people were, we had to get to know this in Boston, a relatively small population of what they called themselves to be "rough sleepers." They were sleeping the rough. Looks like it's an old English word. I know [00:12:00] I worked for a little bit in London trying to understand what was going on there. They actually had a department of rough sleepers in the government. But they had the folks who, as I've learned, they will get upset if you say, "Why do you choose to live on the streets?" 'Cause they'll laugh at me and say, "I'm not choosing to live on the streets. I'm choosing not to go to a 500-bed shelter where I have to sleep with a lot of other people or where someone's going to tell me when I can go to the bathroom and when I have to turn the lights off."

[00:12:30] Other reasons are a little bit more complicated. I'd like to say the biggest lesson I had was one night, it's freezing cold, it was -10 degrees, there was a northeaster predicted, and I was trying to get this poor man who had pretty severe schizophrenia living under a bridge trying to get him to come in. We had gotten to know him slowly, but he put his hand up to me, and when I said, "Come on, please come in," he said, "No, I can't go in there." He said, "You don't understand. When I go into the shelter, I can't tell which voices are mine, [00:13:00] but when I'm here under the bridge, I know the voice is mine, and I can contain it and control it," so I started to realize there are immensely complicated reasons why people, or their individual reasons, cannot go into a shelter. By the way, we've learned that all of them, if you offer them a place to live, a house, they'll say yes, but a shelter, they'll say no.

Mark Masselli: I want to talk a little bit about I started at top of the show referencing Mayor Adams, who's called for more [00:13:30] homeless to be hospitalized, and so this whole issue of hospitalization, we're talking to you from Middletown, Connecticut, which has the last psychiatric hospital in the state. When we were starting back in the '70s, the deinstitutionalization was occurring, and so we had lots of patients coming out. Now, there's this whole initiative around hospitalizing patients. I'm wondering, and of course, the probate judges, [00:14:00] at least in this area, are not inclined to just simply say, "Somebody should be hospitalized because they're homeless." It's a complicated issue. I'm wondering where you come down on the use of hospitalization for homeless in severe need.

Dr. Jim O'Conne...: I concur completely that it's a very complicated situation and I can think over the years of how much we've tortured over the decisions [00:14:30] you make about whether you can just allow someone to make their own decisions and stay out in the bitter cold when they're vulnerable or when you take away their rights. What I can say is that, and I would love to hear your experiences with deinstitutionalization, I didn't get to medical school till the late '70s when it already happened, but hadn't quite filtered into the streets yet.

But what is our experience is that even when you bring somebody in, which is a very difficult thing to do [00:15:00] against their will, the availability of treatment afterwards is so limited that more often than not that person ends back up on the street after several days or several weeks without the long-term care I think they really need and deserve, so I'm always hesitant to talk about committing people unless we know what's on the other side, that there is a real plan for treatment afterwards. I think that's the big gap in the system. As you were saying it, now we've during deinstitutionalization, we've lost [00:15:30] whatever it was. I think we went from 800,000 beds in the country down to less than 200,000. Now, when we bring somebody to the emergency room, there's really no place for them to go. They often will be committed and hang out or languish in the emergency room for days before they can find any place to go, and often by that time, they're ready to be discharged, so I think we have a challenge as a country.

I think first of all, I think Mayor Adams is absolutely correct to point to the problem. This is a terrible problem. When I think of the people we see night after [00:16:00] night who have thought disorders and are outside, very vulnerable living what I think are really difficult lives because of a thought disorder, not because of a real choice, and you think you really want to do whatever you can to help that person, but that means you have treatment options, and so we only do it on rare occasions now when we know somebody's in imminent danger of harm to themselves or others. We do it trying hard to work with the emergency room and everyone in the Department of Mental Health to make sure that [00:16:30] that person has a treatment plan on the other side. But it is a really, really difficult problem.

I don't know if it's fair to say, but I learned my lesson when I've been working on a van that goes out at nighttime. Every night, it goes out from 9:00 at night till 5:00 in the morning run by these amazing people from Pine Street Inn with money from the State Department of Public Health. They've gotten to know everybody outside and the van serves soup and sandwich and blankets. The homeless people didn't want a medical van, they wanted something... I've been writing on that for [00:17:00] years and learning how to, with the help of these folks, to get to know people, slowly give them soup, and get to know them.

I remember one woman who we tried hard. She was very crusty and really tough, but we worked hard, and finally, she started taking soup from us and a blanket. We thought that was really good. She was living on a stoop. One day something happened and the police had to commit her against her will and I didn't see her till about two years later. Was at a meeting on the South Shore [00:17:30] and there she was looking really together, dressed, and really literally on the board of one of the shelters at that point, and I went up and I wanted to hug her and I said, "Wow, you look great. It's been so long." She turned and looked at me and she said, "Get away from me, you [inaudible 00:17:46]." She said, "You left me out there for 10 years and never did anything."

Margaret Flinte...: Wow.

Dr. Jim O'Conne...: I always balance, I don't know what is the right thing to do, and I think we should all drop down the tenor of it all and try to understand this is a tough [00:18:00] argument we should all be discussing.

Mark Masselli: Right, a little humility. Yeah.

Margaret Flinte...: Yeah. Wow. That is a great story. Maybe I can pull a few threads together. Your patient who was under the bridge who said, "No, I'm not going to a shelter, but if he gave me a place to live, I'd come out from under this bridge where I would be in someplace where I don't have all the voices in my head." I was thinking that something that the COVID pandemic presented to us was that [00:18:30] all of these large congregate shelters suddenly, which have always been intolerable to me to see them, 20, 30, 40 men sharing a dormitory room, they suddenly

were untenable from the public health department's perspective, too. Where was their space? Whether there was space in hotels, Super 8 being one of my most favorite here in Connecticut.

These hotels were taken over by the systems of care and the health department, at least in Connecticut, and became [00:19:00] the most civilized, comfortable logical place for people to be sheltering one person to a room or two people to a room, the most that we'd seen. I was 100% convinced when the pandemic ended that that model would persist, but chalk up naivete for me. I'm really curious what your experience was throughout. How did it change things for our homeless population? Did it make it better in some ways because we had [00:19:30] to protect them and protect the population, I suppose from them as well.

Dr. Jim O'Conne...: COVID, we are still, I think, suffering from the lingering effects of COVID from just from how we approach life point of view. But in Boston where we have shelters, some of our shelters are not... Many of them, like Pine Street Inn was four or 500 beds and the city's shelter was about 400 beds, so we were panicked when COVID came [00:20:00] that once anyone with COVID got into that, it would be nightmare, so we converted ourselves, as did most healthcare things, into really becoming a COVID prevention and treatment kind of operation, we thought temporarily.

What we found is when one person with COVID was in the shelter, we needed to get them somewhere and we didn't have the advantage of hotels the way you did. I looked with great admiration and respect [00:20:30] with Connecticut and California where they really did really creative hotels. We couldn't do that in Boston, I don't think. I don't know what the story was, so we had to come up with other ideas, but isolating somebody during COVID, we learned a lot. One is we learned that COVID was a great equalizer. Everybody in the city was equally affected, and so there was a lot of sympathy toward homeless people, or empathy maybe toward homeless people that had not been done before. [00:21:00] But then there was a difficulty of if you have no money and you're living on the edge in homelessness and you need to be isolated or quarantined, it's impossible if you don't have food and money and more than just the shelter, so we learned a lot about, I think all of us in our particular city, learned a lot about the needs of homeless people. I think that was really good. People started to understand how complicated and difficult this was.

A good story to come [00:21:30] from COVID, though, is what we found is that 40% of everybody in the shelters got COVID, so it was along with one other city in Massachusetts, the highest incidents of COVID. But much to our surprise, we were the ones that had to do, because we have clinics and all the shelters and people out on the streets, we did the vaccinating ourselves, and much to our surprise, there were very few people who refused the vaccine from us. I think they had a very clear idea among themselves [00:22:00] as a community of that they needed to protect each other. It was striking to us you didn't run into any

of the issues I thought we were going to run into. Some of that, I think, was because the nurses they know and the doctors they know were giving them the shots. It wasn't some stranger coming in. But I do know that it's a real sense of community that most of us don't appreciate exists within the homeless population.

Mark Masselli: Thank you. Thinking of things that we don't appreciate, you started off by noting in San Francisco [00:22:30] that the cost of a unit of housing is 600,000-plus. I had the opportunity of chairing a housing authority and would always tell my friends, "Why not just build housing?" It is very expensive and we simply don't have the resources to do it, nor do we have the right sizing for Section 8 that we need to have and at a price point that's going to build housing.

But I'm interested [00:23:00] in two other things. One, the tiny house movement and what your thought is about that, and then also just sort of the, you've mentioned four or five cities, but I didn't hear Houston, which seems to me to have probably one of the best success rates for doing that. I was thinking about tiny housing in Houston. Houston has one of the most liberal planning and zoning regulations in the United States. You can sort of do anything anywhere, which is kind of exciting. [00:23:30] But how do you put together, what are your thoughts about this structural reform that needs to take place so that we can start to do in addition to the support services, which you all have done just a fantastic job in developing and being a role model for, but the physical building of these housing, any thoughts or people that you're working with are devoting time to that?

Dr. Jim O'Conne...: Oh, yeah, no, [00:24:00] there are lots of really creative people working on this problem overall. In Boston, they've done some immensely creative thing, and I think we're starting to see progress be made toward bringing the numbers down. But it is painful in places like L.A. or San Francisco or Boston, there are very complicated community processes you have to go through before you can get something approved and there's a lot of zoning variances [00:24:30] you have to do and a lot... You have to have enough parking spots per unit. You realize all of those things, while done with all the best intentions to protect the citizens, also mitigate against the ability to build very low-income housing in any kind of density.

I've been fascinated by Houston, they've done extraordinary things. But it is true, if I owned a piece of land in Houston right now and I wanted to build a shelter, I could just do it tomorrow. If I tried to do that [00:25:00] in Boston, it would take, as we've already experienced, about four and a half years to even get to break in the ground. That gives you the cities that have done a lot to protect each other with zoning and stuff like that also then suffer a lot when it comes time to low-income housing, so I think we have to figure out how to bring all of those together.

I'm more deeply admiring of you now to know that you were part of a housing authority because [00:25:30] those issues come up and they are so complicated and so difficult and I think we all as a society have to come together and figure out how do we break through this log jam and come up with something reasonable that protects everybody's concerns.

Margaret Flinte...: Well, Dr. Jim, I know that you are probably connected to everybody around the country who's engaged with this issue, but I was surprised to learn that the United States is really for the first time devoting funds and resources specifically to the issue of homelessness [00:26:00] in rural areas. The focus has really been on urban areas. What do we know, or do you have any insights into the unique challenges of helping those who are homeless in rural America?

Dr. Jim O'Conne...: I don't have any unique insight, but I have been with friends who work in rural areas and I realize where I can go down to Pine Street Inn six blocks away and see two or 300 people, they will take two weeks to be able to see that number of people because of the spread out [00:26:30] area, so there are very different challenges for urban homelessness from rural homelessness. I think we have a lot to learn from our colleagues, for example, that have worked on the reservations, for example, where we've long had community workers when I say that and public health nursing that goes out into the hills and sees people. There are models there that we could probably learn a lot from. Not to say that everyone is resource-poor right now, but with enough [00:27:00] resources, I think we know what we would work.

One of the issues that confounds everybody, just to point out, is that when you step back and look at the numbers, big numbers, if you look at the main urban centers is in the country, that's about 80 to 85% of all homeless people, and the other numbers, even though they're significant, are smaller in respect to that, so it's always been difficult to get funding to go to the smaller places, which need it equally much, just that they're not as [00:27:30] visible as the big city places.

Mark Masselli: Now, I wonder if you could talk a little bit about your team. You've built a really incredible network, a medical alliance, employs 400, serves 11,000 homeless a year. Just a little bit about the struggle to keep operations alive. I don't think people realize, just doesn't come from heaven, but it takes a lot [00:28:00] of work of partnerships that you have to cultivate. But you've also attracted people who believe in your mission and believe in the mission of providing dignity and respect to people who are facing difficult times. But tell us a little more about your team.

Dr. Jim O'Conne...: Sure. I would sort of put the mirror up to the two of you and say you more than anyone know what this struggle is all about and about behind the scenes [00:28:30] to provide the funding to allow your clinicians to do the kind of work that you need to do to care for these very vulnerable populations. But I would

say it was difficult for me because I was a doctor, I didn't know anything about the financing of these things.

In truth, which you would appreciate, we were a grant from the Rob Wood Johnson Foundation back in 1985, so we had this four years' worth of grant money. We didn't even have a finance department. I used to be able to write a two-page thing to the foundation at the end of the year saying we saw this number of people in this [00:29:00] many places. Then, come 1988, that grant funding ended, and I remember being panicked about, "What are we going to do? We've got this program going but no money." Then we were grandfathered in under OBRA '87 or something like that to become an FQHC, and you know the thing then, so we all of a sudden had to think of ourselves as we needed a finance department. We had to learn how to bill Medicaid. We had to learn how to look at our visits in ways of, "How do [00:29:30] you produce revenue to keep us going?"

We always knew that that would never be enough revenue to really allow us the time we needed to be people, so we also had to figure out how to get the grants and the foundation money to balance it out. But I remember those were a hundred-plus hour weeks for years trying to figure out the foundation on which the funding came from. We had a lot of help in that. What I did learn is that Massachusetts has a remarkably wonderful creative and generous Medicaid [00:30:00] program who really feels, and has over the years, who really feel dedicated to making sure they reach to the real Medicaid population. We were expanded, as you know, under RomneyCare back in the late 1990s, so that almost people essentially all became insured, and that allowed us to continue to build.

Then there were two other challenges. One, we had to be part of the shelters where we are guests. We're guests in these 30-some shelters where we run the clinics from every day [00:30:30] to once a week depending on the size of the shelter and then we also were mandated by the homeless people who were many of whom were on a board now to stay part of the hospital community because the homeless folks in Boston anyway knew when they got very sick they ended up in one of the big academic hospitals and they wanted their doctors and nurses to be involved in their care, so we had to stay part of the hospitals, be part of the shelters, and then get funding from the city, the state, and the feds, so it was this learning to be a partner with all [00:31:00] of them.

I think the years of just doing our work and then appealing to them is what I think helped us out in the long run. It's really about a collaborative approach that's both public health and medicine and we had to be integrated with the substance use care. In our state, the Department of Public Health does substance use disorders, departmental health does the mental health issues, and then Medicaid does the medical stuff for the most part, so we had to learn to bring all of those [00:31:30] together, and they were great. They were great about doing that. But as I look back now, it seems simple, but it was incredibly

difficult. I don't talk about that very much, but that's the legacy we have, I guess.

Mark Masselli: That's great.

Margaret Flinte...: We remember some of those transitions well from our own history. Dr. Jim, you're an inspiration to all those who provide healthcare to persons who are homeless and all those who are working to end homelessness and I'm so glad that Tracy [00:32:00] Kidder has captured your work so wonderfully and really brings to people the hope that you bring to Americans who face all these challenges, so thank you for joining us, and thank you to our audience. There's more online about Conversations on Health Care, including a way to sign up for email updates. Our web address is chchradio.com. Dr. Jim, thank you so much. Continued good luck with your work.

Dr. Jim O'Conne...: Okay, and thank you both for being such heroes for so long. I appreciate it.

Mark Masselli: Well, thank you so much, and [00:32:30] we look forward to being in person, not in Zoom, and connect with you and with your team, so thank you so much again for all that you do for this country.

Margaret Flinte...: Yeah.

Dr. Jim O'Conne...: Thank you so much. I appreciate it.

Margaret Flinte...: Take care.

Mark Masselli: Yeah.