CONNECTING CARE PODCAST // EPISODE #18 // TRANSCRIPTS

Harm Reduction Housing: Meeting People Where They Are

Alex Walley:

Access to safe and reliable housing has an enormous influence on a person's health outcomes and ability to meet their needs. However, structural inequities and discriminatory practices associated with substance use can prevent or deter many people who use drugs from participating in formal housing programs and compound the lack of affordable housing.

Dr. Karin Khan:

I think that public health departments and cities and policy makers are really central to this and very instrumental and can change an approach from basically throwing people in jail and throwing lawn enforcement at homeless tent encampments to refocusing and trying to get people into treatment, into housing, into healthcare, and provide folks with their basic needs.

Alex Walley:

You're listening to Connecting Care. I'm Alex Walley, an HIV primary care doctor and addiction medicine specialist in Boston, Massachusetts. This month, Jess, Sim and I had a deep conversation with Dr. Karim Khan about his experience practicing street medicine and providing care at a local harm reduction housing program. We dive into why Karim believes in this model of care for meeting people's diverse needs, the challenges in and successes of this approach to care, and the multitude of considerations that providers and people navigate when providing and accessing harm reduction housing services.

You're listening to Connecting Care, the intersection of HIV and opioid use disorder. I'm an HIV primary care doctor and addiction specialist in Boston, Massachusetts. I'm joined again by my colleague Sim Kimmel and Jess Taylor. We're thrilled to be joined by Dr. Karim Khan from Boston Medical Center. Karim recently completed an infectious disease and addiction medicine clinical fellowship, that's two fellowships. He is currently receiving additional research training and providing clinical care in harm reduction housing. Karim, thanks so much for joining us today.

Dr. Karin Khan:

Thanks, Alex. It's a pleasure to be here with you all and all of you folks that I've learned so much from.

Jess Taylor:

Well, Karim, no surprise, we have a lot of questions for you, so we're just going to get right to it and jump right in. You've been interested in the topic that we're discussing today, which is outreach medicine and harm reduction housing for quite a long time, and I'm wondering if you could talk to the group a little bit about your journey from how you thought about these clinical roles and perhaps starting with our reach medicine to doing fellowships like Alex mentioned, to get additional clinical training and now having a role doing clinical care and harm reduction housing.

Dr. Karin Khan:

Definitely. So I might actually go back a little bit further in time in my journey to the beginning of medical school on the end of college because I think for me, all of this actually started back then and it started with a lot of community organizing and activism. I grew up mostly in Florida and went to college down in Florida in a small college town, and initially it was involved in a lot of activism around student rights and workers' rights and anti-war activism, and found that I really wanted to be doing direct hands on service and direct action more. And that led me to doing a lot of work with the local homeless community in the town where I went to college and introduced me to the marriage of service and policy advocacy. And so I went into medical school having some sense of the type of medicine that I wanted to learn and practice.

That being said, I also went into medical school alongside a lot of folks who didn't come to medicine with that perspective, and I found myself a little bit lonely and frustrated at times in the beginning, in the preclinical years of medical school, wondering what I was doing and why I was doing this. And it was around that time that I actually got introduced to the idea of street medicine, which came to us, came to a group of students down in Florida from Boston Healthcare for the homeless and some of the other street medicine organizations in Pittsburgh and around the country, and really introduced this idea of making home visits and for the homeless and going out and doing outreach that way. And so my journey started out basically just doing volunteer work and service work and introducing other students to a more varied clinical settings and going out on the streets and meeting folks in parks and in their tents and just chatting to them and getting to know a whole different side of our patients who we see in clinic or in the hospital and have very different experiences with and interactions with.

And so from there I went into internal medicine and got to do my training in Chicago and explore another very new environment to me. And basically the first thing that I did when I got to Chicago was I reached out to other folks who were doing street medicine and outreach medicine, having very little idea of what I wanted to do, but just knowing that if I got my feet on the ground, I'd find myself going somewhere. And so I was fortunate enough to link up with some folks in organizations that had a lot of experience working in Chicago. Groups like the Night Ministry and the Chicago Recovery Alliance, which are amazing and have done so much for our patients and our communities. And I had the opportunity to just learn from them and learn some of the skills of what it looks like to be doing street medicine and outreach medicine.

And so in Chicago, I worked with a lot of other trainees and medical staff and social workers and occupational therapists to build up a program of street medicine that functions across four different university campuses and different hospitals and really focused on starting to link care for a population of folks who were housing insecure and oftentimes moved between different hospitals and had different health issues. And most of the work that I was doing was in the downtown Chicago loop area going around Lower Wacker and spending a lot of time in these small parks dotting the landscape and then in train stations and just meeting people in all kinds of different areas and learning what it is to do wound care in a downtown train station bathroom versus a food court and being told by security guards that we can't do wound care changes in this food court because people are trying to eat and learning how to respectfully do outreach medicine and do street medicine for folks.

One of the really big takeaways that I got from this experience was knowing and having more clarity around a passion to do street medicine and outreach medicine and then seeing what the needs are and realizing what I need to get trained in. And so I came to fellowship, so I did clinical infectious disease fellowship and addiction medicine fellowship, really rooted in a desire to be a better street medicine practitioner and outreach medicine doctor. I found that I enjoyed a lot of different parts of medicine.

My infectious disease colleagues may not enjoy hearing this, but I enjoyed infectious diseases. I don't know that I can really say I enjoyed it more than any other field of medicine, but what I saw was so much need for infectious diseases in HIV and Hep C treatment out on the streets. This was coupled

along with addiction medicine and really I had no experience of addiction medicine through medical school and in Florida.

And coming to Chicago, I was introduced to a world of injection drug use and fentanyl and felt this really burning need for more addiction care and found myself working in spaces which had no addiction specialists, had a lot of people asking for help and really struggling through different hospitals to get addiction treatment and to get supported. And I remember having so many frantic phone calls for patients that were admitted who various pharmacies and various hospitals would say it's illegal to give methadone, it's illegal to treat withdrawal, and having to just navigate all these conversations. And so one of the big takeaways that I had from this experience was just, I don't know anything about addiction medicine and I need to know more if this is the type of work that I want to do.

So that brought me to Boston to get this training. And what I found, what I really loved about addiction medicine honestly, is that it's a medium for me to work around health inequities and systems of oppression and circle back to what I initially enjoyed back in college, which is community organizing and activism and link all of these things together. And so definitely just grateful to have stumbled my way into being able to work around all these different issues.

And so having completed the fellowships and gotten clinical training in HIV and Hep C treatment, I had the opportunities to start doing outreach medicine in harm reduction housing, low barrier housing in Boston, which started up roughly a little less than a year ago now as part of a city response to a lot of open air drug use and tent encampments in a particular part of Boston. And so for the past close to a year now, I've been working in what used to be a commercial hotel and now is low barrier harm reduction housing. And it's been another tremendous period of growth, learning how to work in this environment and building relationships

Jess Taylor:

And Karim, we'll talk a little bit later about interdisciplinary teams in this work, but I just want to reflect on something I heard as a thread through all of the stages of career that you just described, which is your incredible humility and learning from people who have been doing the work for many years who are interdisciplinary colleagues and non physicians. And I think that's something that we as physicians really stand to learn a lot from. And just wanted to amplify that and name it for listeners because I think we as health systems, as physicians, as public health systems often have a tremendous amount to learn from the people who have been on the ground for many years and often long before the attention was shined on fentanyl the way that it has been most recently.

Dr. Karin Khan:

I remember being on the residency interview trail and reading Foucault's Birth of the Clinic and Discipline and Punish, and I was thinking about power a lot. And that's been something that's really interested me through as my early career is evolving, recognizing the position of power that I hold and the position of privilege that I hold and really questioning the systems of power and how I can deconstruct power and help build a more equitable society. And I don't know that I have any great answers, but I like thinking about it a lot.

Jess Taylor:

Absolutely. And you've described doing clinical care in a number of different settings that would probably be unfamiliar to providers that may be listening in. So you've talked about doing clinical care in food courts and train station bathrooms during street outreach and then most recently as part of harm reduction housing. And I'm wondering if you could just share a little bit more about key differences that

you've noticed when you're doing outreach based work as opposed to when you are in perhaps more structured, although you can tell us if that's not the case, but in the harm reduction housing model and how your approach and practice has adapted over the last nine months to a year.

Dr. Karin Khan:

Yeah, definitely. I think I've had to spend a lot of time thinking about it because the harm reduction housing model is something that's new to me and working in that is new to me and blends aspects of a traditional clinic and aspects of street medicine and street outreach in a very novel way I think. And so I did a traditional medical training and I had clinic on a university campus with a lot of barriers that folks who have difficulty with transportation, language, immigration, what have you, typically they have barriers to engaging in traditional medical care. And so being able to go out on the street and meet with folks at their tents was the first big different clinical environment that I worked in. And that really reminded me of doing home visits.

I've never really done a lot of traditional home visits. I think I did a couple through medical school and through residency, but this is what I imagine home visits to be like is, I'll just describe a setting that I worked in Chicago was, I became really close to a couple patients who lived in a tent encampment underneath the highway system in the loop area, which five years ago was just forever under construction and I'm sure probably is still forever under construction now. And you could always find these little pockets of space of empty land that were un-trafficked really could only be seen if you were in a car driving down the highway and happened to look in your rear view mirror. And so made for a relatively private safe space to put up a tent and to be able to stay.

And I remember A, first having to have a guide to the area, not being able to just show up, but I always had to have some connection to the area and someone who had done outreach. And so I always partnered with people in other organizations and they would maybe text me or call me the day before an outreach session and say, "Hey, Karim, there's so and so, they have a really swollen leg. We think they're in bad shape. They don't want to go into the hospital, Could you come take a look?" And so it gives me some idea of what I need to pack into my bag, what wound care or medications. At the time I was a trainee, so I'd also think about what attending I need to let know, I'm going to go out and do this and what supervision, who I need on call for a phone consult if I need it. I was lucky to have an infectious disease mentor who I could call about antibiotics and wound care folks.

And so that all went into the preparation to show up to a site and then with the help of a guide, navigate through to a very private public space, if that makes sense. And I would always announce myself, we'd announce ourselves from a distance basically as soon as we were within earshot, we'd be announcing ourselves as a street medicine team and really try to approach with the respect that you would go to someone's house and that you would never just walk into someone's house and go into their kitchen and start doing whatever. And so just because a tent doesn't necessarily have a doorbell doesn't mean you don't need to announce yourself. And so that was of one of the big things that I noticed and had to learn was just how to approach a tent encampment as someone's house and respect it and recognize when I was not welcome or when people and might not be home and when not to go any further and to really just be open and receptive to the community that was there and always communicating with them to the best that we could.

And I think that laid the foundation for a lot of the street medicine perspective that I had in residency and in training. And then there would be these different environments like a train station or basically doing a clinical visit in a public area. Which oftentimes that would be, I had a street guide who would bring me to someone who was out busking or stemming or whatever, and they knew that they needed some medical care. And so a lot of the times it would be someone has an abscess or someone has a wound and they need it to be looked at and they're wondering if they need antibiotics. And so I would

meet someone on a street corner and then we'd find the closest McDonald's or find the closest food court, find the closest public space, which we could temporarily transition into a private clinic space perhaps before we got kicked out by security.

But that brought on a whole other perspective of just viewing public spaces and trying to see where you could safely set up your supplies, where you would be able to talk to a patient and afford them some privacy, where you would be able to create a safe space that you weren't anticipating police or security to show up and harass you. And that really informed a lot of how I would practice. And so I would maybe meet someone on a street corner but not do a whole lot on the street corner. We would go and find somewhere more private and more safe to do the clinical encounter and visit. And so that street medicine experience and then that traditional clinical experience were two very opposite ends of a spectrum, which I became very familiar with. And then as I started doing the harm reduction housing work, it was a very interesting and new space for me to work in because it blends components of both of these in a very new way.

And so the hotel where I work has 40 some odd beds that are generally all filled and it's single rooms occupied by one person at a time. They all have their own bathroom. There's a couple common spaces where meals are served, but for the most part, people are up in their rooms. There's a couple offices which are not really offices, there's like an old hotel room, which is converted into an office and houses case managers. Then there's the old fitness room, which is down in the basement, which has folded up treadmills and some desks and some computers where the housing case managers and myself reside. And starting out initially it was a very new environment to me and very foreign environment. And I started I think with the same general approach of just wanting to quiet my presence, be available and have folks know that I'm there, but also not impose and see how people interact with me and what things they want from me.

And what that looked like was in the very first weeks or month or two, I was basically based in the basement and waiting for people to come down and see me. And I would have interactions with people as I entered the hotel and as I left the hotel. And I'd say I probably saw a couple patients per session, nothing crazy, and certainly a lot less than I thought I needed to be seeing or that I thought needed medical care in this facility. As I realized that I went back, I left this more traditional clinic setup of this is a clinical space, I'm going to wait behind a desk, I'm going to have my stethoscope and I'm going to wait for people to come talk to me, and I'm a doctor. I started to leave that and go back to the street medicine mentality, which is going to find folks, and really just asking them how they are and starting out with their... And having no expectations of any type of primary care that I can do and a good day is if I'm just chatting with people.

And so for maybe a month or so that looked like me going upstairs and meeting with folks and just chatting with people and talking to them, starting out my clinic sessions and being set up in the basement and then going upstairs, I got to know the harm reduction folks that work upstairs and with them as guides, starting to meet folks around their rooms and in the public spaces. And what I realized fast was that a lot of people just didn't know what resources were available within this site, and that there's a very significant barrier that still exists with asking people to leave their room. Really, it's not even leave their room, they leave their room all the time, but if you're going to house all of your services in the basement in a part of the hotel or in general, if any site is going to house all of your services in a part of the facility, which no one frequents unless they need those services, it sets it up for a model where if you don't know that the services are there, you're never going to walk by and find those services either.

And yeah, I started to approach it with a lot more of the street medicine mentality of recognizing that this is someone's home. It may not be what a traditional home looks like for wider society, but it is someone's home and I can apply these same principles of showing up, knocking on the door,

announcing myself, introducing myself, just asking what people need, and then taking time to have conversations with them.

Sim Kimmel:

You've started to describe what these places look like, but could you tell us a little bit more? So there's shelters, there's assisted living facilities, there's drug treatment programs, there's recovery housing, there's sober homes. What is harm reduction housing? What makes it distinct from other forms of housing? What is the gap that you see it filling?

Dr. Karin Khan:

Yeah. So I will preface this by saying that I think what one of the things that's so exciting about harm reduction housing, at least where I am, is that it looks very different in the different sites that it exists, and we're all learning what harm reduction housing is as we're making it. We're learning from other folks around the world and around the country, but there's a lot of fluidity. And so just within the organization where I work, speaking with some of the case managers, some of them will describe it as low barrier housing, some of them will describe it as harm reduction housing, and some of them will describe it as no barrier housing in frustration at times.

And what this looks like is essentially folks who are in tent encampments were eligible to go into "low barrier housing sites" that the city partnered with other nonprofit organizations and healthcare organizations to run. And they are basically rooms where people can stay and there are relatively low to no expectations that someone needs to engage in care to have that room. However, that being said, there is housing case management, there's general case management, and then all of the facilities also have healthcare available.

The facility where I work is primarily run by a housing agency and then contracts out with a healthcare agency, which I'm contracted with to work in. And so seven days a week they have case management on site and they have housing case managers, two days a week they have a MD, myself, going to do medical care. They have a harm reduction team that does counseling and testing for sexually transmitted infections and will bring harm reduction works and supplies like clean needles and pipes. And they also work with a couple smaller, more specialized harm reduction oriented medical teams that work around Hep C treatment, preexposure prophylaxis for HIV, and then HIV treatment as well.

In addition to all of this, they have some groups that they run on site. Granted, I think there's been some irregularity in how frequently the groups are attended and how they're run. There are recovery coaches and there are staff who do room checks, which are essentially hourly room checks where a pair of staff members will go room to room, knock on the door, announce themselves. If they don't get a reply, they will open the door to check and see if anyone is in the room and make sure that there's no medical crisis going on. Essentially, they're looking for overdoses and it's an attempt to do overdose prevention. So there's a team, generally they pair up, and it'll be two outreach workers who go door to door every hour checking on rooms and checking on folks.

In addition to all of this more specialized harm reduction staffing, there's also just general security. And I think one of the things that we've seen in running a 24/7 low barrier housing harm reduction housing model is that you need staffing around the clock. And we have a general lack of harm reduction staffing. And it takes a lot to be able to staff an organization with harm reduction specialists around the clock, seven days a week. Really what prompted our housing site to contract with a medical organization and the city to really support that for all of these sites is this idea that most folks are interested in housing, and if you can provide them with a room and provide them with access to housing case managers, then

they can get on the various housing lists and start working their way towards longer term housing. But a lot of people are in active substance use, specifically severe opiate use disorder.

And the theory behind having me work in this low barrier housing site initially came from basically being able to provide addiction oriented urgent care and addiction medicine. So having a Suboxone prescriber on site to be able to prescribe for folks. So if they didn't want to have to go out and find opiates, they would potentially have an easy access to MOUD outside of their room. And I would say that that's been a success. It hasn't been overall like a success for every single client, but in my experience, there's been a lot of people who engage with treatment for opiate use disorder.

And interestingly, I feel like of the different clinical sites that I work in, which basically include a hospital and then a traditional clinic, the low barrier housing site is where people are most interested in Suboxone. I found that a lot of my patients in the other sites are not interested in Suboxone. And I think that there's a huge question and that there's a lot of different ideas and thoughts behind why that might be and how that has changed with fentanyl becoming prevalent. But what I have found very interesting, and I think one of the successes of the program is the number of people who at the site are interested in Suboxone and are getting on MOUD. They may not stay on MOUD forever. They may be on Suboxone for a couple of weeks and then relapse and then be off. But overall, I'm having a much larger proportion of my patients at this site engaging with Suboxone then and my other medical sites. And I think that's very interesting.

Sim Kimmel:

You've described who ends up in these programs and why they end up in these programs. And in previous episodes we've also talked about the limitations of the existing shelter system that people don't feel safe, don't feel comfortable going into shelters. And so this filling a gap where people have no access to housing unless they either enter into an addiction treatment system or are willing to go to a shelter. When you think about policy makers and public health departments, what do you want them to know? What do you want them to be doing to try to better serve the patients that you're taking care of?

Dr. Karin Khan:

Like you said, I think first and foremost is a recognition that there are multiple ongoing crises, and that what we have historically been doing is not enough and not working. And I think that there are lessons certainly to be learned from what we've done in the past, but also time and space to reflect and think about what new things we can be trying. And I think low barrier harm, reduction oriented housing is one of those relatively new things, at least for us. And I suspect for much of the rest of the country to be trying. I think it takes a lot of buy-in from the policy makers. It takes a lot of buy-in from public health departments and from the city. I'm a very low level person in all of this, but to my knowledge, this would not have been possible without the city's backing and without funding coming from the Department of Public Health. And essentially the Department of Public Health and the city being the central actor in this, and then contracting with other agencies and other organizations and hospitals to help facilitate all of this.

And so I think it's super important for us to be thinking about harm reduction education and outreach, not just for medical staff or people who are directly working in these environments, but for people working in the health department, people working in the city, and housing in all aspects of our civil society. I think we need to be doing more harm reduction education. I think having funding available for these programs. What we are now starting to see is more and more people engaging in addiction care, more and more people starting to get housed and we're also starting to see really what some of the structural issues and gaps are with respect to having enough housing for people, and what do we do once we give someone transitional low barrier housing? How do we find them long-term housing and

what does that look like and how do we bolster supports and how do we think about what harm reduction housing in a more long-term setting could look like?

And so, yeah, I think that public health departments and cities and policy makers are really central to this and very instrumental and can change an approach from basically throwing people in jail and throwing law enforcement at homeless tent encampments to refocusing and trying to get people into treatment, into housing, into healthcare, and provide folks with their basic needs.

Alex Walley:

Karim, thank you so much for sharing your story and your journey. Thank you for the work that you're doing. I was excited to do this topic because my own experience during COVID pandemic, especially in the beginning, was that just housing people with services worked really well, which was a revelation to me. I think you've appropriately told us a deeper story here that has a lot of nuance and some substantial challenges that require our own ongoing attention to figure out. So thank you again for joining us today and sharing this with the Connecting Care audience. You certainly hit on the overlap of HIV risk, at least in opioid use disorder, as well as the larger issues of housing, substance use disorder in general, and infections in general. So thank you very much.

Dr. Karin Khan:

It's a pleasure. Thanks for having me.

Alex Walley:

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