Strengthening Systems of Care for People with HIV & Opioid Use Disorder
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CONNECTING CARE PODCAST // EPISODE #19 // TRANSCRIPT

Harm Reduction Housing Part II: Meeting People Where They Are

Alex Walley:

Having access to secure and safe housing can have substantially positive effects on the health and wellbeing of people with HIV and people who use drugs. Harm reduction housing programs have seen success when they prioritize the dignity, respect, and unique needs of each person seeking services. By taking this human-centered approach to harm reduction housing, people are more likely to stay engaged in care.

Dr. Miriam Komaromy:

Harm reduction is a really broad concept, and one of the things that we do is monitor people who are in an overdose situation or over intoxicated and would have to go to the emergency department or be administered Narcan/naloxone if they couldn't be monitored. And so we have space for them to rest, to be monitored, to be on a pulse oximeter so that we can detect if they're getting into trouble, but just allow them to rest and recover naturally. And when we treat people gently and with dignity in a situation like that, we are building trust with them and that allows us to do a lot of other harm reduction interventions.

Alex Walley:

You are 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 continue our conversation about harm reduction housing by talking with Dr. Miriam Komaromy, medical director for the Grayken Center for Addiction at Boston Medical Center. During our conversation, Dr. Komaromy shares her experience helping start and sustain the Roundhouse program in Boston and how this model of care can be life-changing for the communities who need it.

You're listening to Connecting Care, the intersection of HIV and opioid use disorder. I'm an HIV primary care doctor and addiction medicine specialist in Boston, Massachusetts. I'm joined again by my colleagues, Sim Kimmel and Jess Taylor. Today, we are grateful to host our colleague and friend, Dr. Miriam Komaromy, medical director of the Grayken Center for Addiction at Boston Medical Center. And this is our second episode on harm reduction housing, which is something Miriam knows a lot about.

In our last episode, we spoke with Dr. Karim Khan about his interest in training to be a street medicine care provider and training to deliver integrated addiction and infectious disease care in a harm reduction housing setting. In this episode, we are excited to talk with Miriam, a national leader in developing programs that expand access to care and engagement for people with substance use disorders, including people experiencing homelessness. In 2022, Miriam spearheaded Boston Medical Center's effort at the Roundhouse building to develop a low threshold housing program that includes medical services on site. Welcome, Miriam, and thank you for joining us.

Dr. Miriam Komaromy:

Thank you so much, Alex. I'm really excited to have a chance to talk with you and Jess and Sim about these issues. This is one of my favorite projects I've been involved in during my time in Boston.

Sim Kimmel:

Miriam, thanks so much for joining us. Can you tell us the origin story of the Roundhouse program? What is it? How did it start?

Dr. Miriam Komaromy:

Sure. So the Roundhouse program started about a year ago in response to the fact that Boston for the first time had developed large tent encampments that were persisting through the winter. The Boston weather in the winter is pretty legendary, and so I think it had discouraged, even prevented people from staying outdoors all year in the past. But the various stressors of the pandemic and what people were coping with on the street prompted them to set up tent encampments and stay in those encampments. And understandably, there was a lot of concern about how can we keep people safe through the winter, people were getting frostbite, there were rodent infestations, a lot of public health concerns about what was happening to people in those encampments, as well as a lot of pushback from the neighborhood about having these large tent encampments. So the city of Boston, the mayor's administration decided that they wanted to take steps to address this.

Unlike previous administrations, they didn't think that a law and order approach was the way to go, and instead they said, "Well, what can we do to create housing that would work for the folks living in the tent encampments?" When you think about why people were living in these encampments, obviously they didn't have acceptable housing. The vast, vast majority of them were experiencing substance use disorder and many of them had co-occurring mental health problems and physical health problems. But the reason that they were staying in tents rather than going into the shelters was probably at least twofold. One, the shelters had contracted capacity somewhat due to trying to reduce risk of COVID contagion. But two, the shelters have an approach that makes it very, very difficult for somebody with active addiction to stay in the shelter overnight.

If someone comes in and brings substances with them, they'll have them confiscated. And if they go into withdrawal in the night and leave to try to use, they won't be allowed back in, and they may even be barred from returning for a week or more. So folks were not utilizing shelters and instead were staying outdoors. So that's what prompted the administration to decide to fund housing that they thought would actually be suitable and accessible for this population to help get them off the street. And that's the origin of how we started the housing in the Roundhouse.

Alex Walley:

Miriam, how and why did BMC get involved, Boston Medical Center's hospital?

Dr. Miriam Komaromy:

Yeah, I know it's a good question. So Boston Medical Center is the oldest and largest safety net hospital in the northeast part of the United States. And we've historically had a role of trying to address some of the social barriers to people getting healthy. And housing is obviously a huge issue and in Boston it's a particularly challenging issue because housing and land are so expensive. So folks who are not wealthy have trouble finding housing in Boston, and people who are experiencing active substance use disorder have a really hard time finding housing where they can fit in with the rules of the organization and be able to stay. We've really known for a long time that this is part of the patient population that we choose to serve, we have a lot of programs to help people, but we know that people who are living unhoused have a much, much harder time being healthy, addressing substance use disorder, mental health disorders, physical health disorders, and that if we can't overcome those barriers to housing, we're going to have a hard time making progress on any of these other fronts.

So BMC decided to take the challenge from the city and partner with the city in setting up harm reduction focused housing, as well as some clinical services in the building that we can talk about.

Jess Taylor:

Miriam, you were just mentioning, "We've been open a year," which is really pretty hard to believe, and I think it would be fair to say it's been a really exciting and at times wild and sometimes challenging ride over the last 11 months or so. But I'm wondering if you could talk about what you're the most proud of.

Dr. Miriam Komaromy:

Thanks, Jess. That's a great question. It's one thing to decide to create a housing model that operates really on a fully harm reduction sort of set of principles, but it is definitely challenging to figure out how to cope with all of the kind of chaotic things that happen in a setting like that. So figuring out how do we do that in a way that respects the choices people make the needs that they have, but also how to keep people safe was really, really challenging. And over the course of the year, I feel like we figured out what kind of staffing is needed, what kinds of guidelines and roles are needed, what kinds of safety measures and checks to help prevent overdose are needed to really keep the residents in the housing pretty darn safe. It's been really exciting to put that into action and figure out through trial and error how to do it right. And I'm really proud that we've been able to do that.

Jess Taylor:

Absolutely. I think the impacts as far as transitions and retention are also something that I hope you're really proud of. Could you talk to the group about what that has looked like as far as numbers and the outcomes of the program?

Dr. Miriam Komaromy:

Yeah. So the city and the state authorized us to operate 60 rooms of what was referred to as transitional housing, and most of the folks who have been there came out of those tent encampments back last January. And then we've had some additional residents come in that the Public Health Commission has selected and admitted to the program. To date, we've had nobody choose to go back to living on the street, which to me is really remarkable and a refutation of what we sometimes hear that, "Oh, those people, they like living outdoors, they don't want to be inside, they don't want to be housed." Quite the contrary, people have been incredibly grateful for the housing. We didn't know how long it would take to help people to then transition to permanent supportive housing, but we put a lot of effort into that with case management and help with everything from helping people get identity documentation through addressing pending legal issues and helping people just get comfortable living indoors and tolerating being close around other people, but it has been a slow process to move people into permanent supportive housing.

To date, we've had about 20 people transition out of a total of 84 who have lived in the residence. And we've also had a few deaths, one overdose death and a couple of medical deaths that were probably related to physical consequences of substance use. So, I wish it had been faster to help people move into a permanent home, but I think the experience they've had in the Roundhouse, living there has been a pretty overwhelmingly positive one according to what the residents say. And also, we're taking our time to do it right, to get them into the permanent supportive housing to try and do our best to ensure that they'll be able to be successful there and persist.

Alex Walley:

Miriam, you really explained, I think, poignantly why people choose not to go into shelter, particularly those who are using substances. And so, why do they choose to come to the Roundhouse and stay and not go back to encampments? I mean, just one thing I can think of based on my experience with my own patients in primary care are the patients who have supportive relationships and they want to be with the person they care about or they love, and shelters typically don't allow people to maintain those relationships, they can't stay together. So I mean, that's one thing I think of, but I'm sure there's more to it. So can you elaborate a little bit on what's the secret sauce that brings people to the Roundhouse to stay?

Dr. Miriam Komaromy:

Sure. I think we were surprised to realize after people moved in how much of a factor it was that we accept couples and that they can be housed together because there are very few places where people who have been experiencing homelessness can go, where they can be together as a couple. And when you think about it, that really exemplifies the stigma that we inflict on people who have substance use disorders and who are homeless that where else in society do we say you can't be with your life partner if you want to be housed or if you want to have your basic needs met, it's pretty crazy. So people were very, very grateful for that.

And I think the Roundhouse has been operated as a harm reduction facility, so we ask the people not use substances indoors, and we provide them with external private lockers where they can keep whatever they want to in the locker. In fact, people do end up using in their private rooms, and so we do everything we can to help them to stay safe in that setting. We have harm reduction on staff 24/7, we provide naloxone, sterile consumption equipment, and we make a full range of treatment available to them as well if they choose to engage with treatment. So they have kind of a menu of options for how to take steps to keep themselves safe. I think that's huge for people.

Alex Walley:

Jess, you partnered closely with Miriam to develop the onsite addiction medical services and medical services at the Roundhouse. So not just addiction medicine, but there's also some medical care there. From your perspective as an HIV care provider, expert, champion for access to medication for opioid use disorder, what are your proudest moments at the Roundhouse this year?

Jess Taylor:

Oh, man. I'll try not to go on. It's a long list. So I think in addiction medicine and in medicine overall, we talk a lot about low barrier care. It's a phrase that gets thrown around low threshold, low barrier, pick your term. And truly at the Roundhouse, which is a former hotel building where the housing units that Miriam was describing are on the upper floors and the clinical services are in the basement. Truly, this is the most low barrier model that I've been a part of. And I like to think that I run a bridge clinic that's so low barrier, but here we are in the basement of a hotel that is really adjacent to the former tent encampments that Miriam was describing. And I think one of the most humbling parts has been realizing the extent to which at the Roundhouse we care for patients that were not even making it a block down the street to the medical center and how just the one block and the formality of a formal clinical space in a medical center is truly a barrier to a lot of people.

So that's just one reflection. I think the other things that have been really remarkable and rewarding to me about the work have been being able to replicate low barrier MOUD delivery in this new site that is so well-located, including 72-hour methadone for opioid withdrawal management.

Alex Walley:

We have multiple podcasts where we talk about methadone and specifically 72-hour methadone, so please check the podcast website and go listen to those episodes.

Jess Taylor:

We do love to talk about 72-hour methadone and its featured routinely on these podcasts. It's one of the most rewarding parts of our work. The ability to be caring for someone who is in opioid withdrawal, who is suffering and not from something that is just uncomfortable as many of us were incorrectly taught in our training, but something that actually puts them at very high risk of returning to use and overdose. Being able to treat that with an evidence-based medication in the moment and then arrange linkage to a methadone clinic has really been incredible. And we've been able to treat and link many members of the housing units and also people who've walked in as walk-in outpatients off the street where we've talked to their long-term medical teams, their case management teams, and they've really said, "Wow, this patient has been trying for two years to get into the methadone clinic, or this is someone that we've referred a half dozen times to the methadone clinic and they have not been able to link and be retained at the methadone clinic because of all these barriers."

And so the combination of the low threshold entry and also the housing support and everything that comes with that, which could be wake-up calls to support someone in getting down the street to the methadone clinic, it's support from an onsite case manager, it's organizing other needs so that they don't interfere with the OTP visits. Those pieces can come together and really create clinical gains that we're not always able to do as outpatient providers. And the second thing I'll say just relates to HIV and HIV prevention. So this is a podcast that's also about HIV medicine and how it intersects with opioid use disorder and COVID. We've had some amazing collaborations with our patients in the housing units as a cohort. The prevalence of HIV is high in the people that we serve both as outpatients and in the housing units.

And we've been able to do things like do directly observe therapy for HIV treatment. We had one patient in particular who had been off of ART for several years and really needed a lot of support to get back on, but also had privacy concerns. Because one of the great advantages of the program for many people is that our housing guests are able to stay with a partner that can also create challenges and challenges that were new to us, being new to the housing space around privacy, maintaining privacy from a partner who's living in a hotel room with you. And so, we took care of someone who'd been off HIV treatment for several years and was staying with a partner who was not aware of their HIV status, and they were able to come downstairs to the basement every day, get a dose of HIV medication every day and suppress their viral load.

And in doing that, we were able to start Suboxone, get an injection of injectable buprenorphine, and it just, it's felt like this unbelievable series of gains for a lot of patients that have faced so many barriers. There's definitely a lot more that we want to do, and so I think what's exciting to me about looking back in the last 11 months is that we've learned so much, but we've also just scratched the surface of what scaling a model like this could look like and really leaning into the co-location of the housing and the low barrier services.

Dr. Miriam Komaromy:

For me, it's been an experience too of really seeing the ways that harm reduction is a really broad concept. And one of the things that we do is monitor people who are in an overdose situation, are over intoxicated and would have to go to the emergency department or be administered Narcan/naloxone if they couldn't be monitored. And so, we have space for them to rest, to be monitored, to be on a pulse oximeter so that we can detect if they're getting into trouble, but just allow them to rest and recover naturally. You might wonder, "Well, why is this such a big deal?" I mean, it's a pretty horrible experience

to be given Narcan, and when we treat people gently and with dignity in a situation like that, we are building trust with them, and that allows us to do a lot of other harm reduction interventions and to offer treatment. And I think we're a lot more successful doing that because we have met them in exactly the situation that they're in and met their need at the moment.

Sim Kimmel:

That concept of trust seems so essential. And I was just wondering if you could talk a little bit about how long does it take for that to happen? You have somebody living in the upstairs floors of this hotel walking down past the harm reduction workers, walking down past the door that leads to the medical services, how many times does that patient have to walk past that door knowing what's behind there before they actually give it a shot and head down there? I imagine the experiences are variable, but...

Dr. Miriam Komaromy:

Yeah. That's exactly what I was going to say, Sim, that I think a remarkable number of people actually accessed the clinical services in the first week that they were living at the Roundhouse. So that was interesting because these are all people who could have been, as Jess was saying, going a couple more blocks down the street and getting started on treatment at the hospital, but they felt much more comfortable there in their own building. But then there are other people who many months later have had a life experience that made them decide it's time or have seen a partner get treatment and decided to pursue it, or as you said, just realizing that, "hey, people are treating me decently. I have a safe, calm place to live. And now maybe I both trust the medical providers and treatment providers here, and I have the mental and emotional bandwidth to think about treatment as opposed to focusing on where am I going to get my next meal, where am I going to sleep tonight, where I won't be assaulted, etc."

Jess Taylor:

And Miriam, you've looked at the numbers and the majority of people in the housing services do get clinical care from the clinical services downstairs.

Dr. Miriam Komaromy:

That's right. Yeah, the majority do. And on average, they access the clinical services about once a month for one reason or another, the group that has been utilizing the Roundhouse clinical services, and it can be for a whole variety of reasons. We do work with them to try to transition them to other longer term treatment programs because we're really more of an urgent care. But it is, I think, very helpful if the harm reductionists are doing room checks and discover a patient who's very agitated and not thinking straight or who is very sedated, they can just bring them downstairs to the clinical program for monitoring and assessment. And oftentimes we can turn things around there without them having to go to the emergency department for care.

Jess Taylor:

And that's definitely been a really important outcome and impact is avoidance of unnecessary emergency department visits, which can be traumatic, certainly strain a system. This is a national podcast, but I think across the country, all emergency departments are feeling this crisis of crowding that we're certainly really struggling with in Massachusetts. But I think there's also another benefit that's hard to measure, which is providing care to someone who would've declined an emergency department visit. So certainly some emergency department visits are avoided, but we're talking about caring for a lot of people who really need acute care. You're talking about putting on an oxygen monitor, checking unstable vital signs, really doing high acuity care that otherwise without a service like this would've gone

by the wayside and people could have been in an alley and in a space without monitoring. And so, I think that speaks to some of the overdose prevention benefit, the engagement benefits that the services can have.

Dr. Miriam Komaromy:

Absolutely.

Jess Taylor:

Miriam, on that front, can we talk about our partnership with Emergency Medical Services and what that's bringing to the table as just a new pathway for people who might not wish to go to the emergency department?

Dr. Miriam Komaromy:

Yeah, it's an exciting opportunity that Boston Emergency Medical Services, their leadership applied for a waiver to the state to be allowed to actually bring folks directly to the Roundhouse after they've responded to a 911 call if the person meets certain criteria and the EMS crew believes that a substance related issue is the primary issue. They don't bring people to the Roundhouse if they look like they've had any kind of physical trauma or if they have a fever, a variety of different contraindications. But for patients who substances appear to be the primary problem, we are starting to accept ambulance deliveries, which is terrific, then we really know we've avoided an emergency department visit.

Alex Walley:

Wow, that's super exciting.

Sim Kimmel:

Miriam, I imagine one of the biggest challenges has been to convene and engage community stakeholders. Can you tell us about the key categories of stakeholders, how they were convened, how they were engaged?

Dr. Miriam Komaromy:

Sure. So one thing that's been pretty critical here is we're a stakeholder, BMC, we're part of this neighborhood. My office is a couple blocks from the Roundhouse and our medical center is right adjacent to this area that has been where a large population of people experiencing homelessness have congregated, and there's a lot of pretty open substance use. So it's an environment where other people looking for substances are drawn because they know they're available. So there's a lot of traffic in and out of the neighborhood. So this is an issue. These are our patients, and it's also unstable situation in the neighborhood that where we're seeing a lot of people at high risk and in distress on the street. So it's been in our interest to engage with the problem and try and offer solutions. And also, in our neighborhood is the Boston Department of Public Health, Boston Healthcare for the Homeless Programs and a lot of community organizations that are focused on providing services to people who are experiencing homelessness and/or struggling with substance use.

There are also other housed residents in the neighborhood. Boston is made up of some very poor neighborhoods and some very wealthy neighborhoods, and we have one of those on one side of us and the other extreme on the other side of our hospital. So trying to have a dialogue that includes everybody and respects the needs and opinions of everybody has definitely been a challenge. There's no question that there's been a pretty substantial coalition within the residents of the wealthier neighborhoods

around us that haven't been too happy about the location of the Roundhouse services. How we've addressed it is just to show up, we show up to community meetings again and again and again and talk about what we're doing and why we're doing it, and help people understand the need that we're addressing and talk about the successes that we're having, and also respond to their concerns about if they're feeling like there's too much traffic or too many people out in front of the building, etc., we work very hard to try to respond to those concerns and address them.

Alex Walley:

As medical providers that work in a so-called safety net system, all of us regularly encounter in the traditional medical setting, people who've been disempowered, who are poor, who are facing really substantial stigma that includes people who use substances, who are facing a lot of stigma. And so, the Roundhouse program is specifically designed for a group of people who bear some of the largest brunt of that stigma. And so, you mentioned them as a key stakeholder. When you were describing that, it just reminds me that they are specifically disempowered by the nature of their stigma and their poverty and the politics. And so, I think as medical providers, we have a role to help elevate their voices. It's hard for us, it's hard for me, I'll speak for myself. It's hard for me to not speak for them and try to figure out how to get them to speak for themselves. So I don't know if there's an answer to this question, but how have you thought about that? How's that represented in how the Roundhouse is run?

Dr. Miriam Komaromy:

Yes. Thank you, Alex for raising that. The residents of the Roundhouse have found their voice. There are pretty regular community meetings of the residents of the Roundhouse where people give input, make requests, talk about their needs and what they're seeing around them. We also have had a number of efforts where colleagues of ours have done interviews and focus groups with people living in the Roundhouse and the other transitional housing settings that the city established at the same time a year ago in order to get their feedback and hear what people's experience has been. So I think there's a pretty good feedback loop going on where those issues are brought to people's attention. I also really have been impressed by the folks who are on the harm reduction and operations team at the Roundhouse that they regularly are hosting community barbecues, game nights, opportunities for structured and unstructured conversations to try to open up dialogue and give folks an opportunity to really have input into the way that the Roundhouse operates and what their experiences are.

Jess Taylor:

Well, and that's actually a great segue into something else we wanted to talk about, which was the approach to overdose prevention in a facility like the Roundhouse. And reason I say a good segue is that I think there can be a lot of tension between safety and traditional or more cautious approaches to preventing overdose and respect for autonomy and independence and the reality that we're talking about a place where people live, we're talking about their homes here. And so Miriam, can you maybe share what we've learned over the last 11 months as far as best practices for overdose prevention, perhaps how we've evolved, and maybe we could talk about where we go from here as we think about how to continue to improve and prevent overdoses in the best way possible?

Dr. Miriam Komaromy:

Yeah, it is an evolution, just as you know that we have tried and are trying a lot of different strategies because the residents of the Roundhouse are aware of their very high risk of overdose. The vast majority of them are at very high risk of overdose and overdose death, but it can be intrusive to have

somebody knocking on your door many, many times a day to make sure that you're okay. So we've tried to the extent possible to customize interventions according to people's wishes.

They are regularly scheduled rounds where staff go around to every door and try and get a response from the person inside to make sure they're okay. But we've offered a few alternatives for folks who don't want a door knock, all kinds of unique situations. Some residents have requested that someone sing a song to them and then they'll respond to that. Others have said, "I'd rather you just use a key open the door to my room and make sure that I'm breathing and then leave." So trying different ways to let people have control over their experience to the extent possible, balancing that with knowing how great the overdose risk is and trying to minimize that.

Jess Taylor:

Yeah, a patient I visited this afternoon and actually has a doorbell that plays a really pleasant song and is much nicer for her than a loud door knock. So I think the spirit of what you're saying, which is have a policy, which we do, but also demonstrate some flexibility and willingness to adapt and individualize has really been what we've tried to do. But it is hard, and it can be scary to think about the overdose risk in the era fentanyl in a housing setting where there are closed doors. It's different than specifically a tent encampment where there are a lot of people around and sort of by design, a baked in overdose prevention response team around people at all times. Looking ahead Sim, Alex, I know you've thought about this a lot too. Are there any virtual models or new technologies you've heard about that you're excited about as we think about preventing overdose and housing settings like this?

Alex Walley:

I think that this is a really important public health issue. Housing is good in and of itself. People's in general, their health is better, they feel better when they have a home, they have that security. Most people who die from overdose die at home alone. And so, one of the conundrums with low threshold housing, housing first, and this is I think apparent in most of the studies that have been done on these programs, is that while they reduce unnecessary or high-cost medical utilization and people's quality of life improves, overdose risk does not necessarily improve unless you provide support. And so, that's really what's driving, and Miriam mentioned the really high risk. So not only are the room checks intrusive, they're also expensive, so how sustainable or scalable, that is I think an open question. And so that brings, I think, kind of two thoughts.

One is technology, you mentioned. So there are call in lines where people call to be monitored by somebody else on a phone line, one example is Never Use Alone. And then there are also virtual monitoring systems that can be set up. So I think we've talked in a previous episode about motionless detectors that can be put in public bathrooms. So if people are using in the bathroom, an alarm will set off if the person stops moving. So you could imagine some sort of technology fix like that.

One of the things as I've been thinking about this that strikes me that's important across these technologies is to try to couple them with some sort of community connection. So it means trying to build a culture of connection within a housing unit where people are looking out for each other. Similar to what you described in the encampments, Jess, that I think the irony, while encampments are not necessarily safe from a public health standpoint or they're not humane as far as what we're all striving for people, from an overdose perspective, they can actually be protective of fatal overdose because people are watching out for each other.

So how do you create that culture in a housing unit? And I think that's where we really need to think about, and I think basically, I worry about just putting it up to technology. I think we need to figure out how to have technology sort of support a culture of connection. You said, what do you see in the future?

That's what I hope to see. I'm not sure we're exactly there yet, but that's what I'm hoping for. And maybe the Roundhouse is a place where some of those things can be tried out or thought about with the participation of the people who live there. So the more places like the Roundhouse, I think the more innovation will happen to try to address this issue.

Miriam, we have a lot of public health practitioners who listen to this podcast. So before we go, I want to see if you have any lessons learned targeted for them. What do you want your public health partners to think about when they're thinking about harm reduction housing, low threshold programs like the Roundhouse?

Dr. Miriam Komaromy:

Thanks, Alex. When we were getting ready to launch this program, we talked to a lot of different people running housing programs across the country, and frankly, I heard a lot of sort of nay-saying that, "Oh, you can't really operate harm reduction housing, it's too hard. You can't really have couples together, it's too complicated." And I guess I just want people to hear that it works. We have a year under our belts now of doing this, and I think it really has been quite a wonderful success. It's also really hard and it's expensive, and it takes a long time to get people transitioned into permanent supportive housing, especially in a city like Boston with such a terrific shortage of suitable housing, and it's pretty staffing intensive to operate building like this safely. So I think I'd both like to see public health organizations invest in this and support this and to be realistic about the need for funding, I think typically from city governments to make it work.

Jess Taylor:

Miriam, just to amplify something you said, I am so struck that anyone on the ground who does housing work or this type of integrated clinical care work, who hears that 20 people out of 84 have been placed in permanent housing in 11 months would be just as amazed as I think our team is and see that as such a tremendous success. Talking about a group of people who exited tent encampments 11 months ago, and in many cases less than 11 months ago, to me, knowing how many hours, how much hard work on behalf of those guests themselves, most importantly, but also the case management team operations, the clinical folks, what goes into that, it's so clear that that's a success, and I think we can continue to try to, I guess, educate our other partners in what it means to help someone transition to permanent housing and in a way that's safe for them.

Because we know that if we just drop people off in unsupported apartments in various far-flung parts of our city or state, their risk of overdose will be very high. We're not talking about doing that. And so, even though the numbers may sound small, I think we're talking about a problem that is structural, that is very long standing, that is incredibly challenging to solve, and this is one of the most successful models I've seen or heard as far as supporting people exiting tent encampments into long-term appropriate levels of care. So just want to amplify that. I think we're talking about a lot of success here, even though the numbers themselves may sound small.

Dr. Miriam Komaromy:

Absolutely.

Sim Kimmel:

Miriam, thank you so much for joining us and for everything that you're doing. Jess, thank you for sharing your experiences as well. We really are rooting for the continued success of your program. Is there anything else that you want to add with the last minute that we have?

Dr. Miriam Komaromy:

Just I appreciate the opportunity to highlight this work. We're really proud of, and that feels like we're making a difference, so I appreciate it.

Sim Kimmel:

Thank you so much for being here.

Jess Taylor:

Thanks, Miriam.

Alex Walley:

Yeah, thank you.

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.