Rolf Taylor: Welcome to the Health Disparities Podcast, a program of Movement Is Life, an organization dedicated to eliminating health and healthcare disparities by shining a light on both the problems and solutions. I'm Rolf Taylor, your host today and producer of the series. This is the first time that the Health Disparities Podcast has focused on health equity issues for our homeless population. But homelessness is a major problem in the United States, and this is not least because of our very high poverty level. In fact, around 18% of the US population lives at or below the poverty level. Only the countries, Hungary and Costa Rica, actually have higher levels of poverty in the OECD countries. And it means that as many as one in five of our population are one or two paychecks away from being homeless. Our total national homeless population is close to being 580,000, like the entire population of a major city like Baltimore. And California has a disproportionate share of the nation's homeless population at around 161,000. Los Angeles has the greatest concentration of the state's homeless people. So, the National Health Foundation, a California based organization offering recuperative care in Los Angeles and Ventura counties offers medical respite care programs as a pathway to health and housing for people experiencing homelessness.

So today, thank you Kelly Bruno, President and CEO of the National Health Foundation for joining us to discuss healthcare for the homeless.

Kelly, you're going to share some approaches and solutions that are moving the needle. So, welcome to the podcast.

Kelly Bruno: Well, thank you so much for having me. I really, really appreciate it and look forward to the conversation.

Rolf: I mentioned, you know, this is the first time we've talked about homelessness on the podcast. So, maybe you could just frame that out for us a little bit. You know, we talk a lot about social determinants and structural drivers of health and equities. Can you talk a little bit about what are the structural drivers for homelessness?

Kelly: The number one structural driver of homelessness is without a doubt, the limited amount of affordable housing that exists across the country but most specifically in California. You know, you did mention California has the highest concentration of folks experiencing homelessness, which I'm sure we'll talk a little bit more about in greater detail as the podcast continues, but California itself has a 1.4 million shortages of affordable housing. Meaning there are a 1.4 million less affordable housing options in just the state of California than we deem as necessary when we look at the folks that live here. What has existed or what we are experiencing here in California, this shortage of affordable housing is not something that accidentally happened to us as a state. You know, we didn't just wake up

one day and it was like that. This housing crisis was absolutely designed from the beginning. When we look back historically at red lighting, banks making loans virtually impossible for our black communities to get, they created these undesirable locations and these undesirable communities that have just exacerbated our inability to create and have affordable housing. California, Los Angeles specifically, is known for its freeways and purposely placing freeways to actually bifurcate these communities purposely. So, this is not something that's just on paper, this red lining. This is stuff that is an actual reality.

So, the systemic segregation that I just described to you has just basically ensured that the number one indicator of wealth in this country, which is owning a home, is something that we as white people have experienced far greater than those that are black, and we've created this from the beginning. So, we've created this structural driver of homelessness that you're just discussing. So, what does this look like, like in Los Angeles specifically, you know, we know that in Los Angeles that a third of the black folks that are living in south LA are living in poverty and 50% of those folks are having severe rent burden. We know that over the last 50 years home ownership of our black community has gone down in the last 50 years from 44% to 36%. And most specifically here in Los Angeles, while blacks just make up 8% of our population, they make up 44% of our homeless population. So, these structural drivers of homelessness are

things that have existed for years, but it's basically rearing its ugly head in a way that we've never seen today.

Rolf: It's really remarkable when you look at things like redlining, that you can look at a map of redlined areas nationally, whether it's west coast, east coast, middle of the country, Chicago and then if you look at where you see the greatest disparities right now, whether it's food deserts or whether it's highest prevalence of diabetes, those maps really correlate closely.

Kelly: They absolutely do. And then, when you look at Los Angeles, you look at the freeways and they correlate as well. I mean, it's as if the map wasn't good enough for us, we needed to literally put freeways down the middle of these neighborhoods. It's quite amazing when you look at it, it becomes so obvious.

Rolf: And for these homeless populations, can you share with us some examples of health disparities and health outcome statistics that highlight the need for solutions for healthcare for the homeless.

Kelly: Right off the top of my head two bigger ones. When we look at folks experiencing homelessness right off the top, we know that the person experiencing homelessness on average dies about 12 years earlier than any of us housed folks. And we know that they also age at a rate of about 15 years

faster. So, for helping somebody in one of our homeless shelters or our recuperative cares, that is 55 years of age, they have the health of a 70-year-old. But then when you look at other types of just general health concerns and issues, you see big disparities. You know, the house population on average in this country, about 9% of us are diabetic, but on the street with a homeless, it's 18%. Hypertension, you know, for us housed folks, it's about 29% of us, but for homeless folks, it's 50%. Heart attacks: 17% for us housed folks, 35% when we're looking at those that are experiencing homelessness and I could go on. And depression is probably one of the biggest ones where it's 8% for us that are housed and 49% for folks living on the street. So, there are big time, health disparities and one of the major reasons for this, Rolf, is because living on the street is a health condition in and of itself. You know it's exposure to communicable diseases, exposure to violence, you know, injuries because of that violence. I mean, where does one get a clean bandage, right? You know malnutrition, obviously an issue. If you're dealing with any of these health issues that I just described, where does one get that medication and when one gets it, where does one store it? You know, just exposure to weather. I mean, imagine trying to manage all of those issues and also manage weather at the same time. You know, if you have any sort of behavioral health issues like depression or alcoholism, or even substance abuse, those things are clearly exacerbated when you're living on the street. And then, it's probably inevitable that you're going to become sick.

And when you do, I could not think of a worse place to try to recover than on a sidewalk. And that's exactly what happens. And so, the recovery from these issues when they do occur becomes virtually impossible.

Rolf: Yes, recovering from sickness is so difficult. If you are unwell, then getting back on your feet, just getting back into housing, getting a job seems like it must be almost impossible once you're kind of trapped in that situation.

Kelly: It's a different type of way of looking at things. You know, when I think about my life, and I get up in the morning and I think about what my priorities are in my head? You know, I've got to get my kids off to school, I've got to shower, get ready for work. I have to fight traffic, of course, this is post-COVID, right, when we all had offices to go to, I have to fight traffic, I may have three or four meetings on my calendar, and I have to make sure my schedule goes right, I need to get to the grocery on the way home, I don't know what I'm going to make for dinner. And then, there are other little things that I have to worry about with my kids and family, et cetera. When you're experiencing homelessness, you are thinking about, am I not going to get assaulted today? Where am I going to eat? Where can I use the restroom? If I am a female, I have other healthcare issues that I have to try to address. Is my tent going to get swept today and I have no place to go? These are basic things that we take for granted that are daily struggles for folks that are living on the street.

So then to expect them to be able to do all of that and manage that type of really food, shelter, clothing, basic needs and then also try to think about getting a job, you know, worrying about their sobriety, figuring out where -- - It's not feasible that one can do those things. It's too much for any human, much less somebody living on the street. And that's one of the things that we say about our medical respite programs, or our recuperative care is that the first thing we have to take care of is food, shelter, clothing. Food available 24 hours a day, shelter available 24 hours a day and access to clothing and the resources and the toiletries and things that they need in order to just be clean and be safe. When we can get somebody where those three things are constant again in their life, then they can start to focus on those other things.

Rolf: So, tell us a little about the National Health Foundation. What's your mission, what's your reach, who do you reach and tell us a little about your role as in your leadership role.

Kelly: Sure, I'd be happy to. So, the National Health Foundation has been around for almost 50 years. We were established in 1973. Our mission is to improve the health of under-resourced communities and we do that by taking action on the social determinants of health. So, our work primarily revolves around the social determinants of housing instability, food security, built

environment, and education. And we do most of our programs, if not all of our programs, really have a community-based focus. We recognize and realize that when helping under-resourced communities, which we use that term on purpose, is because these communities very simply just lack the resources necessary to have the same health outcomes as the communities that don't lack those resources. You know, we know that if somebody has a zip code in Beverly Hills, that regardless of their genetic code, they're going to be healthier than somebody who's living in South LA and the only reason for that is because of the lack of resources. So, our mission and our job is to try to equal the playing field, if you will, and to bring those resources into the community. We don't say that we bring in the empowerment or anything of that nature, because we feel very strongly that these communities are already empowered, they're already educated, they know what they need. They simply don't have the resources. So, that is what we do. So, even our recuperative care facilities, which I know we'll talk about a little bit later, which provides care for folks experiencing homelessness that are leaving the hospital are done from a community-based perspective. So, when we go into communities and we open these shelters in these centers, we do so with the community in mind, and oftentimes have a community group that actually meets at our site and really drives the community work that we do outside of the four walls of the shelter. So, some examples of that are health fairs that we provide. We've done vaccination clinics. We've done food distributions.

We just had a health fair and a block party just last Friday at our Pico Union facility. So, our success lies in our ability to genuinely, transparently, and continuously partner with the communities with which our centers reside or where they are located. Without that community support and that community engagement, who would not be nearly as successful.

Rolf: So, for you, a key to success is those partnerships, it's feet on the ground, it's engagement with those local community organizations that you can partner with?

Kelly: 100% and not just the community organizations, but the actual community, the residents of that community, because the needs and the barriers to health that exist in those communities have been identified by those that live there. You know, for example, in our Pico Union facility, they very much need and want local dental care, right? Local dental and local clinic care within that neighborhood that we're in. So, National Health Foundation just wrote a grant to the Ahmanson Foundation and was awarded a grant amount that's going to allow us to put a mobile clinic at our site that will be open not only to the guests of our facility, but also to the neighbors that live there. But those needs are unique to Pico Union. We can't just take that exact model and then move it over to our other site. Our site for example, in our Arlita, that community group has identified different

barriers to health. They want us to make sure that our building includes a congregate kitchen because they want to make sure the seniors that live around that building a little bit older than the other community have a place to get free lunch during the day. They've also made a request for us to see if we can start an adult daycare. So, these are completely different health barriers than Pico Union. Our leaders experiencing different ones, but these are issues that are coming up that are being raised by the people that actually live there. Our goal, our job is to help them reduce those barriers. We don't identify them. They identify them and I think that's a very important difference.

Rolf: You shared with us a case study which has just been published by the Commonwealth Fund that talks about Maureen, a diabetic who found herself homeless as a senior when she lost her income. And I was actually surprised looking at some of the statistics, just what a significant proportion of homeless people are actually seniors or over fifties. So, she's a diabetic, she ends up living in her car with her dog and she can't manage her diabetes. She ends up in hospital, that's when the hospital calls you at the National Health Foundation asking for help. Can you take up the story from there and tell us how your program works?

Kelly: First off, your point is exactly spot on. Older adults experiencing homelessness is the fastest growing subset population in the country of folks experiencing

homelessness. It's expected to raise by 75% in Los Angeles by the year 2030. It is absolutely expanding by leaps and bounds. So, Maureen, unfortunately is not the exception. At this point she's more so the rule and you absolutely describe what happened to her. And, oftentimes, that happens to Maureen and others because of affordable housing issues. A spouse passes away, rents go up, income is reduced. The results are living in their car, which is exactly what happened to Maureen.

So, the hospital calls us, and they let us know that they have somebody experiencing homelessness that does have some medical conditions that require some monitoring. So, medical respite is a program across the country that is unlicensed and unregulated for the most part across the country. But it is for folks experiencing homelessness that need a place to go and recuperate. I always say, if you and I or someone who's housed or housed neighbors fell ill and would go to the hospital and were to leave the hospital, we would not go right to work from the hospital, we would go home. We'd need to recuperate, to rest for a few days to watch some, you know, trashy television, and then go back to work in a few days. Well, when you're experiencing homelessness, you do not have that home to go to. So, medical respite or recuperative care provides that home.

So, Maureen was able to come to our facility and get a few necessary services. First, like I mentioned before, basic food, shelter and clothing.

Absolute basic food, shelter, and clothing. No need to worry about that, which allowed her the opportunity to focus on her health and her sobriety. Through our nursing department and our, and our nursing case management, she's able to learn about her medications, manage her medications, her insulin, and things of that nature, on her own. As well as from our social services team, to be able to provide and look for housing options that work for her. So, Maureen fortunately left our facility and went into a sober living facility where she stayed for the duration of that program and I'm happy to report, is now living successfully and sober with her sister in Las Vegas. So, she is now reunited with her family.

Rolf: That's wonderful. So, she's doing well and she's in a family environment. I mean, I was just thinking, as you were talking about --- You know, on this podcast, we've talked a lot about it's a challenge for anybody going in for a hospital procedure that requires a lot of recuperation that might be knee replacement, it could be a kidney transplant, and this requirement affects whether or not they can actually get that intervention. Because if it's somebody who's living alone, if it's somebody who doesn't have a social support system that can take care of them when they come out, the decision is often simply not to do the intervention. So, this is kind of one step away from the challenges for homeless people, but a similar problem.

Kelly: Exactly. And doing that on the street is impossible. I mean, one of the reasons that California has as big of an issue with homelessness as we have is because we have the highest population of unsheltered, homeless folks. States like New York, Chicago, they have something that's called the right to shelter or the right to housing, which means that they have a shelter bed or an interim housing bed for every person that's experiencing homelessness in their state or their city. Los Angeles does not have that. We have, like I said, the highest percentage of unsheltered homeless in the entire country. I believe in California, we're at like 72% of the folks experiencing homelessness are living on the street. Well, there is nothing that exacerbates health issues more than living outside. So, you live outside, you have more health issues, you experience more violence, more trauma, you have longer bouts of homelessness for things like you just described, and the cycle continues. And so, people cannot get out of homelessness in California because of those things, but the health issues, I don't think we talk enough about the health issues. I mean, housing is health, right? In order to be healthy, you must have a house. You will not be healthy without a house. And I think that we minimize that a lot, and now with the aging of this population, it's just going to become worse.

Rolf: There was so much interest in that movie, Nomadland. Looking at Maureen's case study, and this is a real person, but it really made me think of that. It's an older person, it's a senior person who is finding it very difficult to fit into the

traditional lifestyle. So much about that movie, Nomadland, seemed to resonate with what's going on with homelessness.

Kelly: Yes. I couldn't agree more. And her role like you said, it's a real person is exactly what's happening. I mean, look what happened in her life. You know, her husband passed away, if I remember correctly. You know, so her income was reduced and here she is and she's traveling. You know, at least she had a van with which to live, but still absolutely homelessness. And it was interesting in that movie just to see how one small financial setback really does make a big, you know, and her van was broken and how that can just completely derail her. And that's exactly what happens. The graying of, if you want to say, of the homeless population is something that we are --- I mean, we think we're having problems now, we're going to have massive problems as these numbers continue to rise. National Health Foundation, I think this may have even happened since we spoke last, but we were just awarded from the city of Los Angeles a brand-new building that will provide interim housing and recuperative care specifically for older adults experiencing homelessness. And it is 148 beds in a 45,000 square foot building to be able to provide specifically for this population. It'll be the first in Los Angeles to do this. But the research tells us, and we see this, that this is who is going to need our help the most, but now we face issues, policy issues, right? We face policy issues with reimbursement to take care of this vulnerable population. You know, as I mentioned earlier

in the podcast, if you're 55 years old, medically you're 70. So, think about who you know, in your life that's 70 years old and what ails them, their physical limitations, right? They're on medicines, they go see the doctor, there are things happening in their life that are different than somebody who's 25 or 30. And right now our model of care is really designed for a 35-year-old, not a 75-year-old. And so, how do we make policy changes for reimbursement rates and really quality of care designed around this population that is very rapidly be going to become the largest homeless population in the country.

Rolf: I'm presuming that part of the problem that we predicted in the future, because this is a growing population, is that we have an aging population, but we have an aging population that already has a significant degree of financial insecurity.

Kelly: Exactly. These are the baby boomers, right? These are the baby boomers that are coming up, that's exactly what's happening. And so, fiscally or financially, they're already fragile and they've lived pretty modestly if you will. And now, like I said, a spouse passes away, the loss of a job, a lack of resources, a lack of affordable housing. They get priced out of where they're living and they end up homeless, they end up in a car, they end up in their van and then they end up in a shelter and to get out of that situation is virtually impossible. The good news is when it comes to that

population, that oftentimes there are resources available for them. You know, there are, social security or there are other benefits that they may be eligible for that could help place them. But when there's a lack of affordable places to place them that also becomes difficult. It's really a horrible cycle that really doesn't get resolved unless we have places where people can afford to stay.

Rolf: It's a huge inequality problem, isn't it? Because I don't know what the median household income would be of people who are very close to homelessness, but it's probably what, $20,000 to $30,000 a year? And those people are getting priced out by people who are working in tech, working in other occupations, and they're getting paid $150,000, $200,000 a year and simply can't compete when it comes to housing.

Kelly: They absolutely can't. And then you'll look at Los Angeles and look at how diverse we are, which is one of our strengths, but then also, these are the folks that are disproportionately affected by homelessness. I mean, you go down streets in Los Angeles, even in the communities where we are, Rolf and it's like, the reason you see so many cars and these areas are so congested it's because there are four or five, six people living in a one-bedroom apartment because they can't afford otherwise. And they're kind of doing it quietly or they're not making a big to-do about it, but the reality

is that there are a lot of people living in these very small apartments or homes because they simply cannot afford to live alone.

Rolf: You mentioned reimbursement a little earlier. How important was it that California expanded Medicaid eligibility under the Affordable Care Act, in terms of improving health of homeless populations?

Kelly: The Affordable Care Act was huge. It was definitely a big move in the right direction and quite honestly, and bluntly was because it made everybody have insurance, right? If you are homeless, you are now eligible for insurance because you are low income and so you are covered for free. That's the good news, the bad news is that that little insurance card in your pocket or in your wallet does not guarantee you access to healthcare, it just guarantees that you have the coverage. And so, granting access and getting access for folks experiencing homelessness has not gotten much better. So, the insurance is there, but the access not so much so. You know, you have to choose a primary care physician. When you don't have a home, how do you choose a primary care physician? Or what happens oftentimes or how the health plans work is, if you don't make that choice as I'm sure we all know, the health plan makes it for you. That's happened to me before. You know, my insurance, I didn't choose a primary care physician and I got a letter in the mail that told me that someone had been chosen for me. Well, guess what? I got a letter in the

mail telling me someone had been chosen for me. If you're homeless, you don't have a place to receive that mail. So, you have no idea who your doctor is. Even if you did know, how do you get to that doctor? So, the card is great, but the access not so great.

What is exciting about some things that are happening, and one thing particularly in California is something called CalAIM and CalAIM is our Medi-Cal waiver that has been rewritten and will take effect in January of 2022. And this waiver or this CalAIM program includes 13 community supports that are things that were not covered by Medi-Cal that are now deemed to be reimbursable and covered services. For example, grab bars in someone's home. You know, home health has been expanded tremendously. Community health workers are now going to be covered. Medically tailored meals will now be covered. But what's most important and relevant for this conversation is that medical respite and recuperative care will now become a benefit in the Affordable Care Act in Medi-Cal. So, folks that come to us and come to our programs will now have a medical benefit that will allow them to be there. This is huge, huge, because right now, because our services are not a Medi-Cal benefit, hospitals are paying for those services, and they are determining a person's length of stay. Sometimes it's five days, sometimes it's 10. It's very rarely more than 20. And so, we can only do so much for these folks in that time period. Now that CalAIM is covering medical respite, these folks will have a 90-

day benefit every year to be able to really recuperate and get the housing navigation that they need in order to go to the next step in their housing path. So, this is a huge, huge addition to the Affordable Care Act and that California is setting the bar, I believe in this. Now, California of course has, like we said many times, has more homeless than any state in the country. And we also have more medical respite programs appropriately than any state in the country, so it makes sense that California will be the first to do this. It's been a little bit of a shuffle trying to get it ready, and I'm sure there's going to be lots of bumps in the road, but I'm very encouraged by not only the medical respite benefit, but several of the community supports that are now going to be covered by Medi-Cal.

Rolf: Will capacity be able to grow in response to that reimbursement?

Kelly: Well, that is the million-dollar question that I keep asking over and over again, is will capacity be able to keep up with need. I can tell you without a shadow of a doubt that we absolutely do not have the capacity now that we need to provide services for the 60,000 plus folks that are living on the street. I think that if we were to close our eyes and reopen them five years from now, maybe even three years from now, we'll see much more capacity as folks get their sea legs or there's going to be other, I'm sure for profits that will enter the sector. People will have the capacity to expand. I mean, right now it's very difficult. You know, I can speak from National Health

Foundation's perspective. It's very difficult to expand your services in this space when you do not have a guaranteed reimbursement structure. When you are building out facilities that really are low end, they probably are the equivalent of an assisted living. You know, somewhere between a nursing home and an assisted living. When you're building facilities with this capability with a staffing pattern that mirrors that, and you have no guaranteed revenue source, it makes it very difficult to sustain. And then also opening new ones, quite a lofty financial risk. But now that there's a consistent revenue stream, I think we will see capacity grow, but it's going to take a few years.

Rolf: Yes, it can't possibly be instant. That's all about scaling, isn't it? Scaling the solution? We see a lot of good solutions that are in search of a path to scaling.

Kelly: 100%. How do you scale what you're doing? And Medi-Cal recognizing that what we do is a service that needs to be reimbursed. I could not think of a better solution to scalability than a reimbursement structure. But I do think there's more that we need. What I talked about earlier with really recognizing that when you're talking about serving folks experiencing homelessness, you're not talking about one group of people that have the exact same needs, similarly to how we have an assisted living, that's different than a nursing home, that's different than a boarding care. We

have different levels of places where people go when they need services, because folks have different needs, and our homeless population is no different. So, looking at legislation, looking at policy, looking at reimbursement structures, even at the local level, because of course, you know, not everybody needs a medical respite. So of course, you got your local municipalities and your counties and your cities that are paying for these services as well. But how do we work with these folks to say the best way to work with the homeless is to recognize their individual needs and to provide and create service lines that directly address their unique needs. Because if we don't, we just continue to put the square peg in the round hole. People end up right back into homelessness because their issues were not identified or resolved in the first place.

Rolf: So, it sounds like you really are making progress. And we have at Movement Is Life is a pretty extended community of people who are all working in different ways to address health disparities. So, what would you say are some of the wider lessons that you could share based on your experience with National Health Foundation building out this recuperative care model?

Kelly: One of the biggest lessons we've learned is that the person absolutely has to be in the center of anything that you do. And oftentimes we as the housed community, social workers, CEOs of nonprofits, we have ideas and concepts in our biases quite honestly, that drive what we think services

should look like. Instead of doing that, we really need to engage the folks we're serving to help us provide services in a way that works for the population we're trying to serve. And that means that we have to let go of our judgements and our biases and we have to create spaces that are low barrier. Spaces where we're not judging somebody if they're using, if they're drunk or they're using drugs. We're not going to use metal detectors to scan them when they come in. We're going to make sure that there's no curfews, right? Because I always say, I'm 51 years old. No one's giving me a curfew. Why would I say I can give anybody a curfew, right? We're not checking people's bags. We're trusting the folks that we're serving. We're leaving our biases at the door and helping people where they are. That is in my opinion, the absolute biggest lesson when it comes to providing these services, because we just place our own biases and judgements on people. And I think honestly, in an attempt to make us feel better about the way of the world, but when it comes to providing services that is absolutely imperative. You know, no background checks, we don't need to do background checks, we don't do drug tests, all those kinds of things. And you create a low barrier space, and then if you treat people like that, you'll be surprised at how well they do.

I also think that another big lesson, and I had said earlier, and I'll say, again, is you absolutely have got to create these programs in conjunction with or alongside the communities with which they reside. These programs

are a part of a community. We call ourselves a neighbor in the communities that we're in and we have to act like a neighbor. We all know what it means to have a good neighbor and we all know what it means to have a bad neighbor, right? And we are neighbors. And so, how do we conduct ourselves in that way? Neighbors are not perfect, right? You know, there's good things about neighbors and bad things about neighbors, but the relationship you have with the neighbor at the end of the day is what deems it to be a successful relationship or not. And so, we as providers are neighbors in existing communities and our job is to engage that community in that process. It allows us to help them understand that the folks that we're serving are no different than them. They're not scary, they're quite literally their neighbors. So, how do we create programs that bring the folks into the building, right? Do things alongside us so that they can see that there's nothing to be afraid of, that these folks are just like them. And then they are engaged in providing those services. We solve homelessness one community at a time, and you can't do that unless you engage the surrounding community in that.

Rolf: Well, you know what, I know there's a lot of our listeners who've been involved with our Operation Change program will be applauding what you're saying. Because I think that's the philosophy that's very central to why those programs have been successful in that, they really do put, you know, humanity at the center, but the individual communities at the center and

work to serve them in developing those solutions and, and just creating a space for the communities to develop their own solutions.

Kelly: And we have to be willing to give up that power role, which I think a lot of us are not willing to do, all this sounds great on paper, but then when it comes to actually doing and giving up that power, that's where the rubber hits the road, right. We have to give up that power.

Rolf: So, do you have any questions for us at Movement Is Life, anything you're curious about that we are doing?

Kelly: Well, you had said that what I had just discussed was really your mantra as well, and really your philosophy. I would love to hear a little bit about the work that you do that aligns with them.

Rolf: Yes, so the Operation Change program is, is really something that came out of an understanding that we were seeing health disparities, particularly in women of color and older women of color, and that there were real challenges in really getting people to think about increasing their physical activity. And I think the more we looked at this, the more we realized that this was a very holistic solution that was needed and quite complex. So, what was convened was a program where we would go into communities, we'd bring together 30 to 50 older ladies. And we'd actually kind of use the

support group model to bring about increases in physical activity. And part of this was really just sitting down with these groups and saying, you know, what would you like to do if we've got 12 to 18 weeks to explore this, what are the kind of things that you'd like to learn about? What are the kind of things that you'd like to do? So, in most cases, the program grew out of the participants own ideas about, well, we should get this person to come and talk to us, I know somebody who can do this. It was very like a social network model. But I think the biggest lesson that came for us from that whole program was that what made it successful was the community that was created between the individuals in the groups that there was this kind of a bonding process that took place, you know, it was like a two or three-hour session once a week for 18 weeks. During that time, something really, really, fundamental changed. And I think there was a big surprise that actually what this was really about was how hard it is? Once you get kind of past your fifties, into your sixties, into your seventies, into your eighties, and you lose some friends, some friends pass away, some friends move away, and you find yourself being quite isolated. And then you get into a kind of routine that really isn't healthy and is a little bit kind of insular. What the program did was really kind of breakthrough that and force people together. And we've interviewed a lot of participants actually for the podcast and it kind of sounds to me like how it is when you like go away and get your first job and all the new friends you make or when you go away to college and all the new friends you make, those

bonds are very, very supportive during that period. And we don't often get that opportunity to do that again later in life, right, and I was thinking, I wonder if you've got that same kind of dynamic going on with your respite care centers that part of what's really working is that people are in the same situation, and they can be supportive to each other.

Kelly: It's so funny that you say that I think that's exactly the case. And that's actually one of the foundations of the new site that were opening in our leader that I mentioned specifically, for older adults experiencing homelessness. You know, it was an assisted living, how it was originally built to be, and the city wanted us to turn it into basically permanent supportive housing. And I pushed back on that because I said, you're going to be creating 75 isolation pods. I mean, what this population needs the most is opportunities to come out of the room opportunities, to socialize, to engage with folks that are just like them, to have space in kind of a congregate kitchen or a, you know, dining room that looks like a dining room, or somebody comes and serves them, and they get to socialize with, with their neighbors. Exactly what you just described is a sense of community. It's a sense of normality. It's developmentally necessary, right?

Rolf: And apparently, it's a very effective antidepressant. So, one thing we saw with the operation change participants is that we were doing we were doing

metrics and testing around things like, obviously increasing physical activity, but we were also looking at mental health measures as well and we definitely had a reduction in depression symptoms.

Kelly: I would expect that and so that makes sense, that's wonderful. I really thank you for sharing that, that's great news.

Rolf: It's been such a pleasure to talk to you. Thanks so much for joining us and sharing the great work you're doing at the National Health Foundation. Sounds like you're really moving the needle and really appreciate your perspectives today.

Kelly: I appreciate you having me, these opportunities, like you just provided are important for us to do our work. So, we really appreciate the opportunity.

(End of recording)