ABSTRACT
The Rhode Island Medical Navigator Partnership (RIMNP) is an interdisciplinary student organization homed at the Warren Alpert Medical School of Brown University with the tripartite mission of (1) improving access to care for patients experiencing homelessness, (2) sensitizing students to issues of homelessness through experiential learning, and (3) providing educational opportunities for providers. Centered on the lived experiences of people who are homeless, the RIMNP aims to combat structural violence and foster providers’ structural competence through integrated direct service and advocacy. This article describes the RIMNP’s efforts to bridge gaps in the health and social services landscape in Rhode Island, and ultimately concludes with a discussion of how similar models may be implemented at other academic institutions.

INTRODUCTION: A VIEW OF HEALTHCARE FROM THE STREET
The emergency department paperwork she showed the outreach worker was still soggy from yesterday’s rain. Luckily the ink hadn’t run, and the bold font was easy enough to read. It said, “Abnormal result. Please follow up with your OB/GYN as soon as possible.” The date on it was from five months previous.

“Have you gone?” the outreach worker asked.

“No,” she said. “I’ve been out here. And I don’t have an OB/GYN. Besides, I know it’s gonna be bad news, like I said they’re gonna say I have cancer. And whatever they’re gonna want to do to me they won’t be able to anyway cuz I’m out here.”

Her statement, matched with a dismissive wave, belied her evident worry. She’d kept this paper for five months, and she’d willingly shown it to the outreach worker after shouting from across the street that she had cancer.

A month later, standing in an OB/GYN’s office with the outreach worker and a first-year medical student working with the Rhode Island Medical Navigator Partnership (RIMNP), she learned that she did in fact have metastatic ovarian cancer. She was accompanied through further testing, surgery, and chemotherapy – and several transitions between housing and homelessness – by that same student, now in her third year, and by other students of medicine and social work who subsequently joined her RIMNP team.

While the last three years have seen her become connected with other supports, none have been as enduring as her RIMNP team. Some, like her oncologist, have featured more or less prominently as her health has fluctuated. Others, like her outreach worker, changed roles as she transitioned from homelessness to housing. Her RIMNP team is the group that knows her medical and social history most intricately, and this longitudinal connection has been both supportive for her and inspiring and educative for the students.

Although the RIMNP is limited in scope, its unique structure – which aligns an agile model of social support for individuals experiencing homelessness with an interdisciplinary educational opportunity for students – fills a gap in Rhode Island’s healthcare and social service systems. In what follows, we describe the structural context of the RIMNP, the program itself, and how its core components can inform initiatives to train structurally competency providers at other academic institutions.

Central to the RIMNP is the organizational belief that the health of our partnered participants is shaped by structures, defined broadly as the economic, political, and societal conditions that produce inequalities in health and otherwise. In identifying health and social inequities at the structural level, we recognize that partnered participants’ experiences often involve structural violence, or the damage inflicted upon them by societally-constructed systems. This can manifest in the organization of institutions, policies, neighborhoods, and cities, extending beyond specific communities or individuals. Viewing our work through this structural lens, the RIMNP works to build structural competency amongst students and providers, thereby developing member capacity to both appreciate the texture of structural violence and help partnered participants navigate oppressive structures that influence their lives. The RIMNP believes that we must understand partnered participants’ experiences as the products of societal structures – and meet them on their terms – if we are to meaningfully help partnered participants inside or outside of the clinic.

THE STRUCTURAL CONTEXT OF THE RIMNP
Over half a million people experienced homelessness in the United States during 2018, including approximately 4,500
in Rhode Island. Oppressed minorities, particularly African Americans and Latinos, are overrepresented. Homelessness is also fundamentally about economics: low-wage employment and SSI benefits are simply inadequate to make rent. In Rhode Island, a person would have to work almost 120 hours per week at minimum wage in order to afford an apartment.

Homelessness is linked to dramatically worse health outcomes. People experiencing homelessness disproportionately experience accidental and violent injuries, chronic health conditions, and mental and behavioral health challenges. All of this contributes to premature mortality: the average age of death of a person who is homeless in the United States today is between 42 and 52 years, some 25 years less than the national average.

Homelessness is a reflection of both structural oppression and structural failings, as well as a lack of support for people with personal risk factors – including inadequate and sometimes harmful interactions with our fragmented healthcare and social service systems. Established community resources – such as health and mental health centers, housing authorities, and community action programs – often cannot go wide enough or deep enough. Health care and social service providers are often forced to choose between attempting to offer services outside their scope, competence, or logistical capacity, and making an external referral that may or may not be actualized.

The RIMNP exists alongside other innovations combating the fragmentation and inadequacy of this service landscape, including initiatives that incorporate community health workers and resource hubs into primary care settings and that integrate interprofessional students into free clinic sites. Unlike many more formalized [and billed-for] supports, the RIMNP has the capacity to remain connected with individuals as they transition from homelessness to housing [and sometimes back to homelessness again], as insurance and immigration status changes, and as they are admitted as an inpatient and referred to out-of-network specialists. In walking with individuals through these settings of care – and co-navigating the chasms between them – students become powerful advocates for the public education and structural changes needed to create a system that renders such hands-on navigation unnecessary.

THE RIMNP MODEL

Founded in 2014, the RIMNP is a collaboration between the House of Hope Community Development Corporation, Warren Alpert Medical School of Brown University, the Rhode Island College School of Social Work, the College of Nursing at the University of Rhode Island, Roger Williams Law School, and Brown University. The RIMNP offers additional support to persons experiencing homelessness or housing insecurity who have complex medical needs and face barriers to navigating the healthcare system (termed “partnered participants”). The program connects interdisciplinary teams – comprised of students from the institutions listed above – with a partnered participant and their providers in the community, including a case manager and an anchoring medical provider. As navigators, students on RIMNP teams help partnered participants connect with the healthcare system by attending medical appointments, assisting the scheduling of follow-up care, and engaging in collaborative patient advocacy and education. [See Figure 1.]

Figure 1. The RIMNP’s partnered participant-centered model.

During the 2018–2019 academic year, the RIMNP supported 18 teams centered on 21 partnered participants (17 individuals and one family of 4). A total of 42 medical students, 8 social work students, 10 undergraduates, and 1 pharmacy student were involved. All students participate voluntarily. The RIMNP’s operating budget, comprised of small grants from the Alpert Medical School, directly supports the specific needs of partnered participants and community members. Funded initiatives include a local health fair, the purchase of essential documents like municipal identification cards, a bi-monthly mobile foot health and hygiene clinic, a furniture drive, and a “Welcome Home” program that offers cleaning supplies and other necessities to newly housed individuals. Importantly, access to these funds is not limited by the eligibility requirements often associated with federal or insurance-based programs.

The organizational philosophy of the RIMNP is guided by the program’s primary goals, which are to: [1] improve partnered participants’ access to healthcare and their interactions with the healthcare system, [2] provide students with an
experiential learning opportunity to sensitize them to issues of care that impact the homeless community, and [3] create educational and immersion opportunities related to health care for homeless communities for residents, attendings, and other current and future providers across professions. RIMNP students are coached to consider their role as walking with partnered participants to support and advocate for their self-identified needs. This culture of partnership aims to give students a window into the unique lived experiences of partnered participants and to encourage inductive learning – namely, becoming familiar with broad, systems-level issues affecting people experiencing homelessness from the ground up – while moving towards the partnered participant’s specific goals. By meeting partnered participants on their terms, appreciating the context in which they live, and recognizing the power of being present, students organically develop skills in structural competency that will inform their practices as future providers.

The RIMNP achieves its goal of promoting access to healthcare for individuals experiencing homelessness through several community-based, advocacy, and educational initiatives. In addition to the aforementioned patient navigation, the RIMNP engages with the broader homeless community through “street rounds,” which are daily early morning and late evening walks that focus on outreach to individuals who are experiencing street homelessness. These nondirective contacts emphasize the engagement process and include meeting immediate needs and coordinating referral and follow-up.

Emerging from contact with and exposure to systemic barriers to health for partnered participants, the RIMNP has engaged in advocacy efforts and developed educational initiatives targeted at both providers-in-training and current providers. Through RIMNP’s advocacy at the local and state levels, students have supported proposed legislation to increase access to affordable housing and oppose legislation that criminalizes people experiencing homelessness. By centering legislative testimony on partnered participants’ lived experiences, students can use the privilege and power afforded to them as members of the medical community to advocate for more responsive and just policies.

Complementing this community-based learning, the Health and Housing Pre-Clerkship Elective at Alpert Medical School introduces students to the unique resiliencies of and challenges faced by those experiencing homelessness. Led by RIMNP students and faculty, the elective creates space for critical discussion of homelessness-related issues, and connects students with street outreach teams for shadowing. As third and fourth years, students can participate in the Health Care for Homeless Communities Clinical Elective. In the three years that the clinical elective has been offered, nearly all of its participants had taken part in the RIMNP during their preclinical years. This continuity of involvement is rare given the segmented nature of medical education, and allows students to continue to build their structural competency across multiple years.

The RIMNP’s second educational initiative focuses on medical providers who treat people experiencing homelessness. These training sessions educate practitioners about issues from documentation to discharge that intimately affect the lives of housing-insecure patients. Currently designed for physicians in several of Brown University’s residency programs, this initiative outlines how physician documentation of medical encounters and illness affects patients’ capacity to secure essential safety net benefits, including housing, bus passes, disability income, and follow-up care. Practitioners also develop strategies to support patients as they follow through on medical care and navigate the structural violence present in their lives.

RIMNP’s organizational approach lends itself to a pedagogical model centered on structural competency and attunement to structural violence, expanding the frame beyond individual encounters to include the institutions and policies that influence health outcomes. The experiential learning central to RIMNP patient navigation ensures students see the human impacts of policy. RIMNP values this exposure to the “ground truth” as a critical prerequisite and complement to didactic education. The process of observing, “being with,” and understanding social inequity as lived becomes a thread that extends through conversations on outreach, classroom-based discussions and trainings, and natural reflection with one another. It provides space for questioning the status quo of our healthcare system and social safety net, and invites consideration of how to incorporate addressing such inequities into future medical or social practice. In doing so, RIMNP incubates and fosters the co-generation of knowledge by students and community partners.

CONCLUSION: WHERE FROM HERE? EXPANDING THE RIMNP MODEL OF STRUCTURAL EDUCATION

The organizational model pioneered by the RIMNP has demonstrated clear benefits for both partnered participants and students, making the prospect of developing it in both scope and scale promising. In addition to calling for other medical schools to adopt models that incorporate person-centered, longitudinal, experiential, and interdisciplinary elements, we also call for such institutions to pay greater attention to structural education and competence in the curriculum. We must ensure that all of tomorrow’s providers enter their practice with grounded and operational knowledge about the systems-level forces that shape patients’ health. Such education will prepare them to engage with structures of oppression both in the clinical context and through broader advocacy.

However, in considering scaling this work, the RIMNP
runs the risk of making invisible the very structural deficiencies it is seeking both to navigate and to correct. The potential harms are twofold. First, the RIMNP will never be large enough to completely fill the gaps that exist [and propagate] among various providers and systems. In some respects, therefore, it masks the issue’s scale while not meeting the complete need. Second, by utilizing students to provide continuity of care, the RIMNP provides a temporary fix for what needs to be a radical overhaul of our tattered social safety net. By adding a measure of stability to a deeply inequitable system, the lessened sense of urgency to establish systemic change could ultimately work against the organization’s mission.

While these critiques are valid and should be borne consistently in mind, the rejoinder cannot be to abdicate our collective responsibility to act. Rather, this tension demands that concurrent with our direct work, we join the effort to catalyze systemic change in Rhode Island and beyond. In leaning into rather than shying away from the ethical dilemmas and competing priorities implicated in this work, students start developing their own identities as structurally competent healthcare providers.

We must model within our systems of education those interventions we wish to implement within our broader systems of care, and the RIMNP – in centering a culture of partnership that embodies structurally-informed service, education, and advocacy – offers one such path forward.

References

Authors
Megan Smith, MSW, Boston University School of Social Work.
Pranav J. Sharma, BA, MD’22, The Warren Alpert Medical School of Brown University.
Gabrielle Dressler, MBE, MD’22, The Warren Alpert Medical School of Brown University.

Correspondence
Megan Smith, MSW
msmith2@bu.edu