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## The Family Team at Boston Healthcare for the Homeless Program: an integrated approach to care in outreach settings

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### ABSTRACT

Since 1986, the Family Team at Boston Health Care for the Homeless Program has implemented an integrated, inter-professional, team-based model of care to serve families experiencing homelessness. The Family Team employs key strategies delineated by the well-established Health Care for the Homeless model, which emphasizes the importance of outreach medicine and a case management “one-stop shop approach”. We include an account of a specific case where the Family Team’s unique model helped a refugee family in Massachusetts access medical and social services otherwise more difficult to obtain. The Family Team’s onsite presence in the hotel-shelter and the team-based approach facilitated diagnosis of and successful treatment for cervical cancer in a mother of eight children. This case report suggests that the Health Care for the Homeless model of care should be more widely adopted in order to best serve homeless families.

**Abbreviations:** Boston Health Care for the Homeless Program (BHCHP); Emergency Assistance (EA); Health Care for the Homeless (HCH); Massachusetts General Hospital (MGH)

### ARTICLE HISTORY

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### KEYWORDS

Homelessness; inter-professional team; outreach medicine

### Family homelessness in Massachusetts

At the end of March 2017 there were a total of 3579 families experiencing homelessness in Massachusetts. In May 2017, 815 families experiencing homelessness in Massachusetts applied for shelter through the Emergency Assistance (EA) program (Department of Housing and Community Development [DHCD], 2017). To be eligible for EA, individuals must be “Massachusetts residents, meet the gross income for EA, have needy children under the age of 21 or be pregnant.” The reason for homelessness must be no-fault fire, flood, natural disaster, condemnation, foreclosure, fleeing domestic violence, no-fault eviction, or that the children are exposed to a significant health or safety risk (Mass.gov, 2018). Of those 815 families who applied in May 2017, 401 were accepted and placed into a shelter, a hotel or motel contracted by the state, or an apartment through the state voucher program (DHCD, 2017). Since 2008, the number of families receiving EA in shelters and hotel/motels in Massachusetts has more than doubled while the numbers trend downward in most other states in the nation. Between 2015 and 2016 there was a slight decrease in the homeless family population for the state, but in the city of Boston this decrease was only a reduction of 19 families. Boston itself has seen an increase in its family homeless population of 46% since 2008 (Rog, Henderson, Greer, Kulbicki, & Weinreb, 2017).

### Cervical cancer and homelessness

According to the Centers for Disease Control (2017), the most recent numbers from 2014 indicate that 12,578 women in the US were diagnosed with cervical cancer. The American Cancer Society (2018) predicted that in 2018, 13,240 women will be diagnosed with cervical cancer in the US and 210 in Massachusetts. Although all women with a cervix are at risk, the incidence among homeless women is 4.4 times greater than in the general population and homeless women are 6 times more likely to die from cervical cancer than the general population (Baggett et al., 2015). These numbers may be due to lack of education, limited access to care, cost, or difficulty adhering to cancer treatments. However, previous studies have shown that about 38% of women experiencing homelessness are likely to decline cervical cancer screening even when access and cost barriers are removed, which could lead to delayed or missed diagnoses (Bharel, Casey, & Wittenberg, 2009).

### A health care for the homeless (HCH) model for health care and social services

Caring for the health of families experiencing the stress and transience of homelessness can be overwhelming. However, the Family Team at Boston Healthcare for the Homeless Program (BHCHP) has developed a

model for providing medical care and social services to this vulnerable population since 1986. BHCHP's Family Team consists of medical providers, behavioral health clinicians, and case managers who serve at eleven different shelter- and motel/hotel-based clinics throughout the greater Boston area. In addition to primary and urgent care, the team provides addiction services, mental health counseling, health education, and parenting support groups.

In 2015, the Family Team provided care to 1329 individual patients: 848 adults and 481 children. Of the 1329 patients, 75.2% were English speaking, 15.4% were Spanish speaking, and the remainder reported speaking a variety of different languages, including Arabic, Somali, and Swahili. Four hundred and sixty-nine (35.3%) self-identified as Hispanic.

Along with many other Health Care for the Homeless (HCH) programs developed in the 1980's, BHCHP employs a specific model to best serve the homeless of Boston. The HCH model cites five "key strategies and innovations" at the heart of the practice: outreach and engagement, community collaborations, case management "one-stop shopping," medical respite care, and consumer advisory boards. In particular, the Family Team's successful implementation of one-stop shopping and outreach has been key to its successful care delivery model. One-stop shopping emphasizes the importance of an interdisciplinary team that can tend to a variety of needs of a patient in a single location, and outreach means meeting patients where they are physically (Zlotnick, Zerger, & Wolfe, 2013). We will describe how these tools particularly aided the team in providing quality care for this family who faced significant obstacles to care in the setting of a life-threatening medical condition.

### **A family in crisis – case report**

In the winter of 2015, a 39-year old woman, a refugee from a war-torn African country found herself and her eight children in Massachusetts, homeless and placed in a hotel-shelter a few towns away from her original resettlement placement. Providing safety, shelter, education, and food for her family were daily, demanding tasks, but health care was an additional, long-term stressor. Seeking care for her and her family's chronic health care needs, she came to an onsite, shelter-based clinic at the hotel-shelter operated by the Family Team at BHCHP.

Her first visit to the clinic lasted almost two hours. With the assistance of a Swahili telephone-interpreter, the onsite case manager and physician completed a comprehensive intake. The team physician became the primary care provider for the mother and her two older daughters. The mother continued treatment for her latent tuberculosis and other chronic medical conditions, which involved

the laborious search for medical records from numerous other providers.

Significantly, the onsite physician performed this women's first ever cervical cancer screening test in March 2015 using a head lamp for visualization in the hotel room clinic and carrying the sample herself back to the health center to be processed. Unfortunately, this exam led to the diagnosis of cervical cancer: FIGO stage IIB squamous cell carcinoma of the cervix, for which the five-year survival rate is 58% (American Cancer Society, 2017). This is difficult news for anyone, but for a non-English speaking, single mother of eight with limited resources, this was devastating.

With this new, potentially fatal diagnosis and the family's psychosocial needs in mind, the Family Team treated this patient utilizing their team-based, integrative outreach model to help the family receive the highest quality care and to overcome the barriers that lay ahead.

## **Impact of the HCH model on provision of health care and social services**

### ***Health literacy and language***

During the patient's first visit, her limited understanding of certain aspects of health care in the US was apparent. For instance, the physician discovered that the patient was taking double the dose of her latent tuberculosis medications (which caused mild liver injury) because she wanted to complete the nine-month treatment course more rapidly. The Family Team responded to such differences in understanding by allotting time to explain medications and procedures more thoroughly and with a telephone interpreter.

Indeed, although this patient was resilient and resourceful, language was constantly an obstacle. Difficulty communicating with hospital staff and taxi drivers and her inability to read signs in English inevitably made traveling to appointments more complex. Therefore, it was crucial that a team member outline all aspects of her visits – medical and logistical – prior to her departure. When she began cancer treatment, the case manager gave the patient pre-written letters, which she would present at the hospital in Boston explaining her limited English and asking for assistance finding the location of each appointment.

### ***Coordination of care and resources***

Because distance and transportation can often limit access to care among families experiencing homelessness the team worked closely with the oncology team at Massachusetts General Hospital (MGH) to coordinate her treatment schedule and transportation needs (Campbell, O'Neill, Gibson, & Thurston, 2015). The

team physician communicated frequently with the oncologist and radiation oncologist to coordinate medication changes, to help with managing side effects of chemotherapy, and most importantly, to contextualize her living situation. The environment in which homeless patients live can often be overlooked; therefore, she explained what resources were available locally and conveyed the limitations of living in the hotel-shelter setting (Campbell et al., 2015). Being a family of nine in a hotel room required sharing beds and being confined to a space filled with children and cluttered with belongings. Coin-operated laundry machines meant that a family of nine often did not have enough change to wash their clothes and sheets. The exposure to germs from the outside world alone can be detrimental to a patient undergoing chemotherapy.

The team nurse and case manager were also in near daily communication with the oncology social worker to better coordinate care. With two children under the age of five, childcare during medical appointments was a chief concern – particularly when the patient required lengthy diagnostic testing such as MRIs. The case manager searched for options outside of the hospital and even helped obtain an emergency childcare voucher for the family before connecting with MGH social workers. After much discussion, the hospital allowed the children to utilize the employee childcare center during their mother's appointments. In this way, the team prevented delays to the patient's treatment plan and inability to see certain providers due to lack of childcare.

### **Cost and insurance**

The most significant systems-level change that assisted the Family Team in taking care of this patient was the Massachusetts Health Care reform and Medicaid expansion in 2006, which mandated that all residents obtain a minimum level of benefits. With these new laws enacted, the patient was able to qualify for high-quality insurance that provided services otherwise financially unattainable. The family had qualified for health insurance upon their arrival to Massachusetts, but the case manager on the team ensured that this coverage would not be lost. Notices of renewal come via mail every year – which is difficult for the transient homeless population with frequently new addresses – but this patient brought down her mail to the clinic every week to have it translated by our case manager, so she would not miss any important letters. Since this time, the Family Team has also added a Benefits Coordinator to the team who provides remote or, if needed, onsite assistance with insurance applications.

Additionally, she used the services of the MasHealth (Massachusetts Medicaid program) Prescription for Transportation (PT1) system. Through this

system, the case manager was able to arrange rides covered by insurance for the patient and her two youngest children to be driven to appointments in Boston and then back to the hotel-shelter when they were finished. This service was essential, as the patient did not own a vehicle and was living in a hotel twenty miles – up to a two hour bus ride – from the medical center providing her subspecialty care.

### **Maintaining care and support**

By the fall of 2015, doctors informed the patient that there was no longer any evidence of cancer. Despite this reassuring news, she continued to visit the hotel clinic weekly. She came to check-in about her family's medical needs, ask for assistance with social services, have mail translated, or say hello to familiar faces. In November of 2015, the family was overjoyed to receive notice that they would receive housing in Boston through a rental voucher program. The family had no support, however, for the move and no means to acquire furniture or other household necessities. Through telephone calls and occasional home visits, the team helped the family transition into their new home: arranging volunteer movers, coordinating the delivery of furniture from a local organization, explaining how the appliances functioned, and assisting the mother in enrolling her children in Boston Public Schools. Additionally, the physician helped the mother transition her primary care to a local health center. The shift to housing was challenging, but the team worked to ease the family through the process.

### **Implications for clinical practice, research, and teaching**

The Family Team at BHCHP uses the HCH approach to provide the highest-quality care for families experiencing homelessness in greater Boston. They are successful in their ability not only to provide clinical services to patients, but also to build relationships, connect, and support the families they serve. Many cases are just as complex as the one delineated above, but some are easier to navigate as families may have outside support or may be well acquainted with the area in which they are placed. This allows time and resources to be allocated more reasonably, and the model to be sustainable within BHCHP. Additionally, it is essential to have all members of the team present at any given site because it would be nearly impossible to take on multiple roles (i.e. the physician acting as both a doctor and case manager). Time spent with individual families is also crucial to accomplishing the tasks described above, and some sites may be too crowded or have too many urgent medical cases to allow for such time. Furthermore, in a place where Medicaid coverage is not as expansive, a model like this may not be as

robust. Medical and transportation services would be limited and adjustments to the model would have to be made to account for this.

With these limitations in mind, it is our recommendation to widely disseminate, research, and teach about the HCH model in clinical practice in order to best serve homeless families. As depicted in this case, this intervention aided the team in facilitating the patient's trajectory from diagnosis of life-threatening cancer, to treatment, to housing. Emphasizing outreach care and one-stop shopping mitigates the significant challenges vulnerable families face in attempting to access high-quality healthcare.

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## Disclosure statement

No potential conflict of interest was reported by the authors.

## Patient consent

Patient consent to publication was obtained.

## Notes on contributors

**Ariana Nestler** received her B.S. in Biopsychology from Tufts University. She then served with the AmeriCorps/Community HealthCorps at Boston Healthcare for the Homeless Program as a Care Coordinator on the Family Team. In this role, she worked in outreach settings to help connect homeless families with social services and healthcare. She is now a second year medical student (MD Candidate 2020) at Tufts University School of Medicine.

**Aura Obando**, MD received her B.S. in Biology from Duke University and subsequently served in the United States Peace Corps in Paraguay. She received her M.D. from the University of Pennsylvania and completed her residency in internal medicine and pediatrics at Massachusetts General Hospital. Dr. Obando is also an instructor in medicine at Harvard Medical School. As the Family Team Medical Director at Boston Health Care for the Homeless Program, she provides shelter-based care to families experiencing homelessness in the Boston area. Dr. Obando's primary interests lie in immigration, women's health, childhood poverty, youth homelessness, and addiction.

**Terri LaCoursiere-Zucchero**, PhD, RN, FNP is a board certified family nurse practitioner, the former director of the BHCHP's Family Team, and a Professor of Practice at the School of Nursing and Health Sciences, Simmons College. With 25 years of nursing experience working with vulnerable populations, Dr. Zucchero's clinical and scholarly work focuses on improving the quality of life and health outcomes of homeless and unstably housed individuals and families.

She believes that housing *is* health care and together these rights are vital for ending homelessness.

**Avik Chatterjee**, MD, MPH is a physician at Boston Health Care for the Homeless Program and Instructor at Harvard Medical School. Dr. Chatterjee attended Harvard College and then taught high school for two years in Newark, NJ. He then attended medical school at UNC-Chapel Hill and completed residency in internal medicine and pediatrics at Yale. Dr. Chatterjee completed a general internal medicine fellowship at Harvard Medical School doing research on health disparities and child overweight. His current research interests include the impact of the opioid epidemic on homeless families, as well as nutrition and nutrition status among homeless individuals.

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