

Taking health care to the street

By [Liz Kowalczyk](#) | GLOBE STAFF | OCTOBER 14, 2013



SUZANNE KREITER/GLOBE STAFF

From left: Women of Means founder Dr. Roseanna Means, pilot program member Orga Soto, and Dr. Shaun Austin, at the Women’s Lunch Place shelter in Boston.

Orga Soto regularly comes for meals at the Women’s Lunch Place, a Boston shelter for the homeless and very poor. But on a recent morning, she was there for another reason — to see a doctor.

Soto often felt dizzy and had recently fallen, and she was upset with the medical care provided at one of the city’s teaching hospitals, she told Dr. Shaun Austin in an

improvised exam room at the shelter.

Once, Soto, 79, had stopped by for a medication refill but her doctor was in a meeting, she said. The staff accused her of becoming disruptive. She was suspicious of why medical students repeatedly withdrew her blood because she said she never got test results.

When Austin opened a crumpled paper bag to check her medicines for arthritis, insomnia, anemia, and other illnesses, he noticed the labels were in English. Soto only reads and speaks Spanish.

“Don’t worry. We can take care of this,” Austin told Soto.

This year, Soto enrolled in an experimental program that aims to improve care for impoverished women by providing intensive, coordinated services, even as it hopes to cut costs by better organizing treatment and encouraging preventive care.

Women of Means — a nonprofit founded by Dr. Roseanna Means that provides medical care at the shelter — hopes to enroll 50 homeless or “marginally housed” women age 65 and older in the pilot program, which she calls “a medical home without walls.” It is one of the first in Massachusetts to test a new model of paying for and providing medical care to this extremely challenging group.

“It’s not that people haven’t tried,” said Dr. Timothy Ferris, vice president of population health management for Partners HealthCare, a large hospital and physician network.

“But I am not sure we have ever given it the full-court press. This is a really good thing to try to do. It is really, really challenging.”

In Soto’s case, a team of health care workers immediately arranged for a pharmacy to deliver her medications, with instructions in Spanish, to her house in packs of individual doses labeled with times she should take them. Team members will regularly visit her in her subsidized apartment. And as part of the program, Soto was given a cellphone programmed with crucial numbers including a taxi service for free transportation to medical appointments and the team nurse.

On the Tuesday morning Soto met Austin, other women at the day shelter, located in a

church basement on Newbury Street, slept in chairs or enjoyed warm bowls of oatmeal. All were homeless or very poor, and many were elderly and sick. Despite the city's abundance of top-flight hospitals and physicians, the women often cannot access good primary care.

The women face complex obstacles that can include mental illness, distrust of strangers stemming from past domestic violence and sexual abuse, poor education, and lack of transportation. This makes it hard for them to schedule and keep appointments and can lead to conflict with caregivers, leaving the women to grow sicker until they end up in the hospital.

Dr. Monica Bharel, chief medical officer at Boston Health Care for the Homeless, said the organization's clients use emergency rooms an average of four times a year — 20 percent visit ERs five times or more — according to a study soon to be published in the American Journal of Public Health.

“The health care costs of these people are very high,” Ferris agreed.

Insurers are trying to control medical costs by changing how they pay providers, moving away from paying fees for every test or treatment to paying a budgeted “global” fee to cover all care for a group of patients. Global fees are believed to control medical costs by creating incentives for doctors to keep patients well, and out of emergency rooms and hospitals.

This new system is now expanding to the homeless, where the fees also help cover the cost of finding housing, the lack of which leads to medical problems in the first place.

Under the pilot program that Soto joined, the nonprofit health care organization Commonwealth Care Alliance receives a global fee from Medicare or Medicaid — or both, if a patient is “dual-eligible” — to provide all care for a group of patients. Commonwealth Care uses some of that money to pay Women of Means, so it can expand its services. Commonwealth Care providers also treat the women.

Out of
2,000
homeless women treated
by Women of Means
since the start of 2012:

65
are 65-69 years old

86
are 70-79 years old

22
are over 80 years old

“We are re-envisioning a primary care model that could potentially significantly improve the care of this group and perhaps start to move more people into housing,” said Dr. Robert Master, chief executive of Commonwealth Care. “A physician in a typical practice has 15 minutes to see a patient. It’s impossible to develop the engagement.”

The program covers glasses, dentures, and most dental services — which traditional fee-for-service Medicare and Medicaid do not — and nurses and doctors see the women in shelters, apartments, coffee shops, or public parks. Providers are trained specifically in caring for trauma victims, since over 90 percent of homeless women report having experienced physical, emotional, or sexual abuse.

The women who participate in the program must agree to get hospital care at Boston Medical Center, where Commonwealth Care Alliance has doctors who can help coordinate inpatient care.

Commonwealth Care is spending \$400 to \$500 a month on each patient for primary care and care coordination, Master said, and the ultimate test is whether this sizable investment pays off in fewer emergency room visits and admissions to hospitals and psychiatric facilities.

“This is very much a learning experience,” Master said.

The organization is expanding the pilot to other homeless programs in Boston, Worcester, and Springfield, including Boston Health Care for the Homeless, as well as to impoverished men and women under age 65. The organization also will try to determine if the global fees from Medicare and Medicaid are large enough to cover needed services; the agencies do not provide additional funds for homeless recipients.

Means said she decided to focus on elderly women in part because their health problems are more severe. About 175 of the 2,000 women the organization treats are over 65 years old; 22 are over 80.

One woman, Maureen, 74, has struggled with high blood pressure, diabetes, lung disease, and breast cancer — all while bouncing from homeless shelter to homeless shelter for four years.

With the extra money from Commonwealth Care, staff were able to get her an apartment on Sept. 1, an effort Means estimates took 100 phone calls. It also required a nurse to accompany Maureen to the Social Security office to get required documents.

“Maureen really should not be out walking the streets and exposed to elements,” Means said.

During Soto’s appointment, Austin stressed that health care providers will come to her apartment to check on her, even when she’s not sick. Soto looked surprised, but quickly warmed to the idea. “I don’t want to go out when it’s snowing,” she said through an interpreter.

“The biggest thing we can offer far and away is a personal relationship they can make with the team,” Austin said later. “We can give a lot more time.”

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