Health Care Without Walls

Compassionate care for women and families in need

Framingham State University
Nonprofit Giving Course
March 28, 2019

Mission:

The mission of Health Care Without Walls is to improve the lives of women who are homeless or marginally housed through compassionate, high quality health care, education, and advocacy.

How will your organization use the funding?

Request: Health Care Without Walls (HCWW) respectfully requests $10,000 to help fund general operations for our organization. The grant will support the delivery of free, bridging health care to homeless adult women at our shelter-based clinics in Boston. Many are survivors of domestic or street violence and present complex health needs.

Organizational Background: HCWW was founded by Dr. Roseanna Means in 1999 as Women of Means. The name was changed in 2015 to reflect our wider mission. Women experiencing dire poverty, interpersonal violence and homelessness are extremely vulnerable and present unique needs. We provide free, walk-in episodic and urgent care in shelter clinics where our clients feel safe. In 2018, we provided over 8,000 visits of bridging medical care and support services to over 1600 homeless women and children in Greater Boston; one third of the women we serve are elderly (age 60 and above).

Our Approach: Because of the high prevalence of trauma in the lives of homeless women, HCWW uses a trauma-informed approach that builds trust while respecting the role that a life of chaos and uncertainty can play in eroding dependable relationships with the health care system. Medical care is provided by small teams of staff nurses and volunteer doctors, nurse practitioners and a physician assistant, supplemented by an array of common over-the-counter medicines and free point-of-care testing. The clinical staff and community health workers provide care coordination and communicate back to the clients' primary care providers in order to improve chronic disease outcomes. This low-barrier model is a key to our success.

For those whose life revolves around accessing basic needs, getting a meal or a safe place to sleep at night take precedence over mainstream medicine's goals of "planned and preventive care". The women we serve seek health care options that offer greater flexibility and less bureaucracy. This is why our model includes teams of caregivers that go to the places where the women are receiving other social services. Our interventions result in fewer inappropriate Emergency Room visits, improved health, and prevented or shorter hospital stays. Our clinical team has low turnover which leads to enhanced trust with a difficult-to-reach population. Our clinics are licensed by the state Department of Public Health, reflecting our commitment to high quality clinical care and respect for our client's privacy. The HCWW model is an important component of community collaborations that are closing access gaps for vulnerable women in Metro Boston.

Since our inception, HCWW has received national recognition for our novel and cost-savings approach to the care of homeless women, including from the Robert Wood Johnson Foundation and CNN. Dr. Means is widely recognized as a national and local leader in health care for women experiencing dire poverty and homelessness.

HCWW operates three programs:

1. *Core Program:* Launched in 1999. Provides "bridging" health care to the homeless adult women who seek basic social services at Rosie's Place and Women's Lunch Place, the two primary women's day shelters in Boston. HCWW offers seven weekday clinics and welcomes clients on a drop-in basis. We offer onsite walk-in acute episodic and urgent care, point-of-care testing, referrals and health education workshops.

2. *Bridges to Elders (BTE)*: Launched in 2013. Provides immediate medical care and intensive case management services to high-risk, elderly homeless women age 60 and above who rely on shelters for daily survival needs. Clients are identified by Core Program staff as in need of ongoing intervention. The BTE Nurse Practitioner and Community Health Worker address clients' health care needs and help them access housing, food, counseling, and transportation. They accompany clients to appointments to provide support, advocacy, and translation as needed. The program reduces ER visits and hospital admissions, connects clients with primary care and insurance, and addresses the social determinants of health to improve health outcomes. In the pilot phase of this program (2013-2016), we followed 50 women aged 65 and older and documented an 86% drop in ER use and a 77% drop in Inpatient Admissions as a result of our intense personalized care.

3. *Bridges to Moms (BTM)*: Launched in 2016 as a partnership with Brigham and Women's Hospital. Provides personal and comprehensive community-based care and care coordination for pregnant and postpartum homeless women who receive Obstetrics care at Brigham and Women's Hospital with the goal of improving health and birth outcomes and maternal bonding. Since its inception, BTM has enrolled more than 130 women and successfully carried these moms through pregnancy, delivery and the post-partum period, not only documenting improved birth outcomes, but also reduced hospital costs as evidenced by shorter NICU stays. BTM provides "bridging" services to high-risk, homeless pregnant women by supporting their prenatal care and addressing the social determinants of health that affect their birth outcomes (housing, food access, transportation, safety and access to needed community services).

What makes HCWW unique?

HCWW is the only organization in Boston focused specifically on the unique needs of homeless women--an extremely vulnerable and hard-to-reach population. Recognizing the prevalence of violence in the lives of homeless women, HCWW offers services at women-only shelter locations in order to provide a safe space for our clients to access the care they need. Homeless women rely on daily shelter visits to meet their basic needs such as food & safety; attending medical appointments can be challenging when survival needs must take precedence. In response HCWW serves women at shelter-based clinics to facilitate preventive care.

HCWW is the only organization both locally and regionally that serves homeless women by combining health and social services and addressing the social determinants of health to improve health outcomes

and reduce health care costs. Our targeted *Bridges to Elders* and *Bridges to Moms* programs have demonstrated outcomes and are therefore scalable and replicable models with the potential to impact homeless women at a city, state, or even national level.

HCWW is not a government-subsidized organization and does not bill insurance companies for its services. We have invested in the personal approach using time-tested methods of building trust in order to grow our reputation amongst the women we serve. The fee-for-service model was not structured to cover such outreach steps as sitting outside on the curb with a homeless woman suffering from psychosis, gently urging her to come into the shelter to have a meal. HCWW has taken the position that extending the hand of human kindness takes precedence over bending our clinical outreach to fit the qualifications of a "billing code". As we look to the future, we will continue to offer our unique brand of care as a component of innovative Community Partnerships that are being addressed by Medicaid as future alternatives that can successfully reach vulnerable populations.

Need and Target Population: According to the U.S. Department of Housing and Urban Development, women most often become homeless through domestic violence, loss of a partner from death or divorce, inadequate social supports, mental illness, and/or inability to afford health care during a medical crisis. Despite vigorous efforts, the rate of homelessness in MA is 31 per 10,000, one of the highest in the U.S. It is difficult to calculate the number of homeless women because many are invisible to homeless census takers. They often choose to live in overcrowded, doubled-up situations, to sleep outside, or to rent small hotel rooms to avoid shelters which can be unsafe.

HCWW serves chronically homeless women of all ages and ethnicities; some are pregnant or with children; most are survivors of domestic or street violence, and many are elderly. The number of elderly homeless women in Boston is growing dramatically. The homeless senior population age 65 and older is expected to triple in Boston by 2030 (Penn, 2019). Combined with the dire lack of statewide housing, this is a public health crisis.

According to HCWW data 84% of homeless women report at least one serious health condition. Among Boston's homeless women 94% have multiple, complex medical issues, 70% have depression and 22% have diabetes (HCWW & RW Johnson Fnd, 2008). Homeless women often have depression, PTSD, histories of abuse, incapacitating anxiety and other forms of mental illness. Because of the high prevalence of trauma amongst homeless women, effective support services need a trauma-informed approach (USDHHS, 2013). In 2018, the top reasons for client visits to HCWW clinics were chronic, disease-related illness (diabetes, hypertension), health promotion (vital sign checks, over-the-counter medicines for minor illness), muscular-skeletal illness (arthritis, sprains, fractures), respiratory illness (asthma, bronchitis, pneumonia), and psychiatric illness (depression, PTSD, anxiety).

Homeless women can't access health care as easily as housed patients. They need a safe, alternative delivery model that accounts for the context of their lives. Visits to day shelters to meet basic needs such as food and safety often mean missing out on planned, preventive health care, which can lead to overuse of emergency rooms. HCWW places clinical teams in shelters where homeless women's survival needs are met. We help manage chronic conditions reducing the need for ER visits.

HCWW was founded and designed by Dr. Means in order to meet the particular needs of homeless women that she observed working as Medical Director of Boston Healthcare for the Homeless Program. Using our 20 years of experience with homeless women, HCWW has created a replicable, sustainable model of low barrier access, community-based urgent and episodic care to meet the immediate medical

needs of homeless women. Our targeted "Bridges" programs provide intensive case management to address the housing, food, transportation, and safety needs of our clients in order to improve their health outcomes. There is vast, growing evidence supporting the achievement of improved health outcomes and cost-savings when social determinants of health (food, housing, safety, transportation, and health care) are addressed (American College of Physicians, 2018).

Evaluation: HCWW aims to achieve improvements in the health status and quality of life for each of the homeless women we serve. We measure progress in three areas tracking utilization, clinical metrics, and 'milestone' health behaviors.

- Utilization data includes number of visits, health education sessions, communications, and referrals.
- Clinical metrics are related to blood pressure, blood sugar (diabetic women), and clinic and medication compliance.
- Health behaviors or 'milestone events' (as stated above) are changes in behavior that reflect an intention toward improved health.

HCWW uses an encrypted, HIPAA-protected open source medical record system, advocated by Google and Microsoft as the best platform for data collection for mobile teams in the field. This (Open Source) free software was developed by Partners in Health for its international outreach work. HCWW expanded and modified this program to track its clients. Utilization, clinical progress and personalized milestones are tracked by reports from this clinical data base. The underlying hypothesis of our intervention is that when clients continue to achieve milestones over the long-term, there are corresponding positive healthy outcomes (i.e. reduced ER visits and hospital admissions). The Clinical Encounter Form is entered remotely into our clinical database via an iPad provided to each clinician.

Leadership experience and qualifications

HCWW's programming is guided by Dr. Roseanna Means, HCWW Founder and President. Dr. Means has been a senior attending physician at Brigham and Women's Hospital since 1984. She is a member of the Division of Women's Health and an Associate Professor of Medicine at Harvard Medical School. She has received numerous awards for her leadership and innovation in health care, most notably from the Robert Wood Johnson Foundation, who selected her as a Community Health Leader in 2010.

Our Chief Operating Officer, Linda Cundiff is a former nurse practitioner who worked as the Senior Director for Community Health Improvement at Cambridge Health Alliance for nearly 30 years. Linda joined HCWW in 2016. She brings a wealth of experience in public health administration, project management, and nursing care.

HCWW's Board of Directors is led by Karen Matjucha who brings a strong health care background to the organization. She is a Principal in Deloitte Consulting's Boston Office, the Northeast Lead for their Health Care Provider Practice, and the National Leader for the Life Sciences and Health Care Practice Women's and Diversity Initiative.

Vetting Process for hiring new employees and volunteers

All clinical volunteers and prospective employees go through the same vetting process. This includes a resume review, at least two interviews by supervisors and key staff, checking a minimum of 3 references, documentation of licensure and malpractice insurance when appropriate, a CORI check, and documentation of immunizations and medical clearance from a health care provider.

Non-clinical volunteers submit applications and are interviewed by whomever they will be working with.

Short and long term goals—include any ongoing support that recipients receive after program completion

HCWW has the following goals and objectives for 2019:

Goals

- Meet the immediate medical needs of adult and aging homeless women in the Boston shelter system;
- Deliver individual and group health education; and
- Connect homeless women to mainstream medical care.

Objectives

1. Deliver medical and nursing care at our shelter-based clinics for adult women in Boston
2. Serve a minimum of 1,600 homeless women over age 18, 600 of whom are over age 60
3. Provide targeted, intensive case management to at least 120 elderly women through the *Bridges to Elders* program
4. Provide targeted, intensive case management to at least 80 pregnant and postpartum women through the *Bridges to Moms* program
5. Complete approximately 8,000 clinical encounters
6. Link patients to primary care, specialists, and community resources
7. Provide individualized and small group health education sessions
8. Train medical and nursing students and residents in treating poor and underserved women

HCWW's long term organizational goals concern our organizational sustainability. We are working to leverage strategic partnerships with community health centers and hospitals to help us secure contracts with Accountable Care Organizations for the intensive case management we provide through our *Bridges* programs. These long-term, reliable funding contracts will help us sustain the organization. In addition, these partnerships will allow us to better track health outcomes of shared clients to better prove our impact. We will use this impact data for program replication to reach more homeless women throughout Greater Boston and around the state.

Partnerships with other organizations and how these partnerships impact your work, if applicable.

HCWW relies on our longstanding collaborative partnerships with the 2 primary women's shelters in Boston that are HCWW program sites: Women's Lunch Place and Rosie's Place.

Last fall we launched a new partnership with Mass Health / Mass Behavioral Health Partnership (MBHP). We now have a contract with their Community Support Program for People Experiencing Chronic Homelessness (CSPECH) to provide housing case management. This committed funding helps cover salaries of our Community Health Workers who provide clients with housing assistance and advocacy.

Evidence of your organization's success (statistics and personal stories) and what this evidence means

2018 Results:

- We provided 8,384 clinical visits to 1,640 homeless women and children in Greater Boston

- Our top 2 'milestone' health behaviors (changes in behavior that reflect intention toward improved health) over the past year were "followed up with a HCWW clinician" and "came to a HCWW clinic instead of the ER."
- Our clinicians and nursing students offered weekly progressive muscle relaxation classes, guided meditation classes, reiki, a walking group, and health education groups.
- *Bridges to Moms* served 55 families; 82% of the babies reached a gestational age of 37 weeks or greater (37 weeks defines prematurity); only 30% of the babies ended up in the NICU (out of a population that is extremely high risk for NICU use); 78% prenatal clinic attendance rate (very high for homeless population); 86% established primary care;100% received transportation vouchers to attend pre/postnatal appointments and/or NICU visits; 100% received referrals for SNAP, WIC, and/or food pantries and meal vouchers for Brigham & Women's Hospital cafeteria.
- *Bridges to Elders* served 92 elderly homeless women; 94% engaged in housing search; 47% found permanent housing; 96% of those without primary care at enrollment were able to access primary care; 92% lacking stable control of chronic disease are now managing symptoms; 83% of those with untreated mental health issues are now in treatment; 88% of those unenrolled and eligible for SSDI are now receiving benefits
- We trained 142 nursing students and residents in how to serve underserved, low-income populations (120 nurses from Regis College; 10 NP students from Mass General; and 10 residents).

***Bridges to Moms* Client Story**

"Rosa" found out late in her pregnancy that she was carrying quadruplets. When she delivered her babies, she was in the process of being evicted from the crowded apartment that she shared with her brother's family. She moved temporarily to a motel while HCWW's Community Health Worker and the rest of the *Bridges to Moms* team advocated for her to receive permanent housing.

"Rosa" delivered 3 girls and one boy. The babies ranged in weight from 740 grams (about 1.6 pounds) to 865 grams (about 1.9 pounds). They were cared for in the NICU, and "Rosa" visited every day. Two of the babies had severe intestinal defects and had to have corrective surgery. Unfortunately, one of the baby girls didn't survive the surgery.

HCWW's Community Health Worker arranged for taxi vouchers so Rosa and the babies' father could visit the NICU every day. She gave them meal vouchers so they could eat healthy meals when they were at the hospital. The Community Health Worker provided intense follow up care after the babies were discharged to address the families' ongoing needs. At program completion the family had moved into stable housing and the babies' health had stabilized.

Explain any recent organizational setbacks and why they occurred.

In August 2018 we realized that our data collection for *Bridges to Elders* was less than optimal. Our database wasn't designed to capture the social determinants of health which we need to track to prove our impact. In response we submitted proposals to fund a database upgrade. In December 2018 we received $2,500 from the Agnes Lindsay Trust to support this effort. We have contracted with an IT Consultant who is developing a new Intake and Client Progress Form that will allow us to track social determinants of health from baseline through program completion. The data we collect going forward will better prove our impact and position *Bridges to Elders* for program replication.