# Health Care Without Walls Inc.

## GuideStar Nonprofit Profile Charting Impact Report

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This report represents Health Care Without Walls Inc.'s responses to Charting Impact, a joint project of BBB Wise Giving Alliance, GuideStar USA Inc, and Independent Sector. Charting Impact uses five simple yet powerful questions to encourage strategic thinking and help organizations share concise information about their plans and progress toward impact.

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<th>Health Care Without Walls Inc.</th>
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<td>148 Linden Street, Suite 208 , Wellesley, MA 02482</td>
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<td><a href="http://www.healthcarewithoutwalls.org">www.healthcarewithoutwalls.org</a></td>
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### Mission:

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

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1. What are we aiming to accomplish?

Health Care Without Walls (HCWW) offers free, "bridging" health care to homeless women and their children in Greater Boston area shelters, safe houses and family transitional housing sites. This model is a Free Care Program which allows our clients to be seen as walk-ins in the shelter where other survival needs are being met. Formal registration and billing are intentionally set aside in order to improve access, build trust, and reduce as many bureaucratic barriers as possible. Ultimately, our goals include: Improving the health status and quality of life of homeless women and their children; Increasing the number of clinicians trained and dedicated to treating the poor; Meeting the changing health care needs of homeless women aging in the shelter system; and Enhancing the depth of our health care management services. HCWW measures success by-- (i) meeting program utilization and medical trainee target numbers, (ii) increasing 'milestone' health behaviors such as taking medication as instructed; following through with a medical appointment; or completing a psychiatric exam; (iii) improving patients' clinical metrics such as blood pressure, blood sugar (diabetic women), or annual flu shot compliance; and (iv) setting and achieving health-related goals, such as reducing isolation and depression and improving medication understanding and compliance.

2. What are our strategies for making this happen?

Since our inception, Health Care Without Walls (HCWW) has received statewide and national recognition for our novel and cost-savings approach to the care of homeless women. We have always taken the long view, recognizing that there are no quick fixes and that the key to a successful outcome is developing a trusting relationship. The following strategies and activities are the building blocks for our success today and in the future. I. Shelter-based 'gap' health care is delivered by HCWW volunteer physicians and part-time, paid nurse care managers at Greater Boston clinics on a drop-in basis. They provide diagnostics, treatment, referrals and health education to fill the gap that exists between the needs of this population and their level of access to the health care system. In 2016, we will serve 2,500 women and children. II. Community Health Workers provide culturally competent outreach, case management, individualized health education, patient navigator services, social supports, and advocacy for our most vulnerable populations - homeless elderly women and pregnant and post-partum homeless women who are patients at Brigham and Women's Hospital. III. Patient navigator services are provided to patients with cognitive impairments and/or mobility problems who need accompaniment to appointments at hospitals, laboratories, or specialists. IV. Medical training and education are provided to over 100 medical and nursing students and medical residents each year. Each trainee receives a copy of "Medical Care for Homeless Women: A Curriculum for Novice Providers," written by HCWW. The HCWW team prepares clinicians to be compassionate caregivers who are skilled at meeting the needs of the underserved, and we emphasize the important role of volunteerism as a way to effect social change. V. HCWW's special programs meet the complex health needs of three vulnerable populations: elderly homeless women; families with young children; and pregnant and post-partum mothers and their babies. Through our Bridges to Elders Program, HCWW acts as the primary care 'medical home' to 50 Medicare and MA Medicaid eligible women. In Waltham, and beginning in Danvers in 2016, we provide 'gap' care to homeless families, primarily single mother-headed households with small children, who are being housed in motels and are disconnected from any regular medical provider for their family. Finally, this year, based on the success of Bridges to Elders, we have launched Bridges to Moms, a pilot program serving homeless pregnant and post-partum women and their babies at Brigham and Women's Hospital - with the goal of improving health outcomes and maternal bonding.

3. What are our organization's capabilities for doing this?

While there are many Boston-based social service agencies providing some services to homeless women and families, many of them operate independently, siloed by their singular missions. To our knowledge there are no programs that are focused exclusively on the holistic approach that HCWW takes with homeless women: identifying, tracking and closing the gaps between what happens to her when she walks away from the HCWW clinician at one of our sites (i.e. shelter, safe
house, etc.) until we see her again. HCWW staff are, literally, the "human passports" that link the internal and external services and programs to the client, seeing her as a whole. HCWW's staff team is led by Dr. Roseanna Means, who has practiced primary care on the staff of Brigham and Women's Hospital for 30 years and was the former medical director of Boston Health Care for the Homeless. She has been identified by the Robert Wood Johnson Foundation as a 2010 Community Health Leader for developing a model for homeless health care delivery and has also been recognized by Harvard Medical School for her dedication to teaching and mentoring medical students about the care of homeless women. Dr. Means oversees our clinical team and is spearheading HCWW's new Bridges to Moms pilot. HCWW's 17 volunteer physicians are accomplished, dedicated, and are affiliated with pre-eminent teaching institutions and health systems in the Boston area. They bring a range of specialty expertise including internal medicine, family medicine, pediatrics, psychiatry, OB/GYN, dermatology, and emergency medicine. In addition, HCWW maintains a paid staff of 16 part-time nurse care managers. The nurses support our volunteer physicians and provide responsive medical care and care management in our shelter-based clinics. The clinical staff is multilingual speaking Spanish, Portuguese, and Haitian Creole. We have two multi-lingual, community health workers, both of whom are from Boston and bring cultural competence and essential experience accessing community resources. One works with our elderly homeless women at Rosie's Place and Women's Lunch Place. She provides outreach, health education, linkages to community resources, and care management in conjunction with the nursing team. The other has just started with our Bridges to Moms program and provides assistance to pregnant and post-partum women at Brigham and Women's Hospital, with phone calls, transportation, and accompaniment to prenatal visits as well as specialist and laboratory appointments. Finally, HCWW is governed by a diverse Board of Directors who provide fiscal and administrative oversight and offer core professional skills. All ten Board members donate funds and broaden the organization's visibility. The Board meets bi-monthly and holds an Annual Meeting in January. HCWW also receives guidance from two non-voting Boards including a 28-member Advisory Board and a 3-member Executive Advisory Board that provides professional advice and connections.

4. How will we know if we're making progress?

HCWW has always taken the long view, recognizing that there are no quick fixes and that the key to a successful outcome is developing a trusting relationship with each client. HCWW measures progress in three areas by tracking utilization, clinical metrics, and 'milestone' health behaviors. -- Utilization data includes the number of health care encounters or visits, health education sessions, patient navigator visits, and referral communications. -- Clinical metrics are related to blood pressure, blood sugar (diabetic women), or annual flu shot compliance, for example. -- Health behaviors or 'milestone events' are changes in behavior that reflect an intention toward improved health, such as taking medications as prescribed, getting a cell phone from the state domestic violence program, scheduling and following through with a medical appointment, or completing a psychiatric exam, among many other health behaviors. HCWW's clients achieve improvements in their health and quality of life because our care is immediate and free, available on a walk-in basis, provided in secure and familiar settings, and delivered by clinicians who are well known to the community of homeless women and skills in treating survivors of trauma.

5. What have and haven't we accomplished so far?

In 2015, Health Care Without Walls changed its name to reflect the evolution of our organization, highlighting our commitment of bringing health care directly to where it is needed most - beyond traditional medical facilities. HCWW has created and mobilized a community of long-term serving, volunteer physicians and sustained a modest nursing staff in order to respond to the unmet health care needs of homeless women who have fallen through Boston's health care safety net, despite abundant resources. We have provided free medical care via more than 100,000 clinical encounters to homeless women and their children in up to 12 shelters and safe houses. In addition, HCWW has trained nearly 1,000 medical and nursing students and residents in the principals of trauma informed, compassionate care. As we look ahead to the future, HCWW seeks to demonstrate that contracting with an Accountable Care Organization (ACO) for program services under a global payment contract for a "Patient-Centered Medical Home" could improve health and save medical costs for special
populations, including elderly and pregnant and postpartum homeless women. We believe that this "community of services" would fit the criteria for a global payment, creating a sustainable payment model for intensive case management and comprehensive health services, leading to improved health outcomes.