I was in high school the Spring that Martin Luther King, Jr. and Bobby Kennedy were assassinated. Violence broke out across the country. There were riots at the Democratic Convention that year, multiple demonstrations against the Vietnam War, and my teenage world felt troubled, uncertain, scary, the future unknowable. The sense of national chaos went on through my graduation in 1970 and the Nixon Presidency, and up to and including the end of the Vietnam War in 1975. My worldview was that it was up to my generation, and me personally, to change the world for the better. I’ve been on that path ever since. Today, our society still struggles with institutional racism, divisiveness, intolerance, violence and massive economic inequities, but look closely and you can find pockets of human kindness and social justice. We are one example of that. One person at a time, we are changing the world. We are unscripting healthcare so that it takes into account the whole person and what her life is like. We are addressing huge gaps in access to not only healthcare but food, personal safety, and transportation. We are calling our medical colleagues’ attention to the importance of having a team of knowledgeable and seasoned caregivers (“Community Partners”) embedded within specific vulnerable communities. And we are embracing these women and children with love, dignity, respect, and encouragement so that each one of them has the chance to reach her fullest potential. We’re not just taking blood pressures and handing out a few aspirin—we are offering each client a whole new approach that respects the challenges of trying to survive a life of complexity, fear and uncertainty. Each year we have added new layers of care to our model, and the impact has been spectacular in the improved health and personal gains we have seen. You are part of this revolution in healthcare. We couldn’t do it without you. Thank you for your faith in us and the extraordinary work of Health Care Without Walls. We need you more than ever. Please give as generously as you can!

— Roseanna Means, MD

“...the women with diabetes or at risk for diabetes are seeking information and tools to do the best they can to manage their diabetes. They are so strong - I am inspired everyday by their resilience.”

- Cathy Carver
Nurse Practitioner

Monitor your blood sugar. Watch what you eat. Take your medications, which may include insulin. Refrigerate your insulin. Exercise. See your doctor regularly.

These steps, so familiar to anyone with diabetes, can seem insurmountable if you are homeless. Measuring the extent of diabetes among the homeless is challenging, but it is estimated to be as high as, and possibly even double, the 9.4% rate found in the overall population.

A complex condition under the best of circumstances, coping with life’s daily challenges are often more pressing than diet, exercise, medicine, and regular doctor’s visits. And many of our guests who have diabetes often have multiple health conditions to worry about — hypertension in particular. For the homeless, priorities of safety, shelter, and food security take precedence.

That’s where Nurse Cathy steps in. An HCWW clinician who built a career around diabetes care, Cathy holds monthly diabetes workshops at WLP. The group has grown from 4 to 10 members in just 3 months. Together they consider strategies for coping with diabetes in the face of homelessness.
**Tackling Transportation Needs**

Studies show that somewhere between 60% and 80% of one’s health is determined by social determinants and other economic factors. Housing and homelessness is one critical factor. So is transportation.

Overall, 3.6 million people in the U.S. do not obtain medical care due to transportation barriers. Transportation barriers—no access to public transportation, no money for transportation, no car—is the third most commonly cited barrier to accessing health services for older adults. And 4% of children miss health care appointments each year due to unavailable transportation.

Throughout the country, there are medical centers that are beginning to provide transportation services to patients to ensure they receive follow-up care. Our Bridges to Moms program includes transportation for pre- and post-partum medical appointments which has led to an impressive 80% attendance rate for prenatal appointments by our moms. Under the circumstances, these results are exceptional.

With future funding, we hope to offer similar transportation support in our Bridges to Elders program. For so many, the challenge of getting to the doctor can outweigh the benefits of getting care before it becomes an emergency.

**Source:** Health Research & Educational Trust (2017, November) “Transportation and the Role of Hospitals” Chicago, IL. [www.aha.org/transportation](http://www.aha.org/transportation)

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**One Family’s Journey to Bridges to Moms**

**Homeless and Pregnant**

At referral, only **10%** of women have stable housing

With **Bridges to Moms** support **38%** are able to find someplace to call home

*An image of a BTM family from Somalia welcomed a healthy baby boy. Born in March, he weighed 7 pounds, 5 ounces. Mom and the entire family are doing well.*

Sometimes, transportation is the easiest part of the journey. With Bridges to Moms, women come to us from near and far, under a range of circumstances.

One such family started their journey in Somalia. After losing one son in the civil war and spending two years in a Kenyan refugee camp, this family of 9 received political asylum and arrived in Boston in 2017. We can only guess at the horrors they experienced along the way.

Thankful to be alive and safe, they were placed in a Boston area shelter and received an allowance of food stamps. This particular shelter provided a place to sleep—but no cooking facilities whatsoever. The food support received was typical for a family of four - insufficient but much better than nothing.

And there was another reason to be thankful — mom was expecting!

She went to the Brigham and Women’s Hospital clinic, where a Social Worker referred her to our Bridges to Moms team. Our goal was to help mom care for herself so she could deliver a healthy baby.

It became immediately clear to our team that the current situation was not working for this family. The food support was not enough to feed everyone — the food stamps often ran out before the next allotment, and without cooking facilities, the family was dependent on fast food and take-out. This type of food did not agree with the mom’s digestive system, especially during the early part of her pregnancy. Whatever nutritious food she did have, she gave to her other children, unknowingly starving herself and her unborn child. The mom became anemic and had lost a significant amount of weight — her unborn baby was growing, but very slowly.

HCWW Nurse Coordinator Jo-Anna expressed the concerns of the whole team—

“The baby was not developing, and the mom was losing weight. We had to address their most basic need for food and shelter if there was to be hope for a healthy newborn.”

Together with our Community Health Workers and Social Workers from BWH, we were able to relocate the family to a site that provided reasonable living space and, importantly, a kitchen for preparing meals for the family. The ration of food support was increased to accommodate the entire family. And because of the support of our generous donors, we were able to provide additional food support so that mom got adequate food for her and her unborn child.

Additionally, a group of caring individuals got together and purchased winter coats for all of the children, as well as a crib to provide a safe sleeping space for the baby.

Successful health outcomes are determined by many factors. Our Bridges program demonstrates that to improve health, we must address other important social determinants as well. Our interventions worked to make this pregnancy a success and to give this baby a healthy start in life.
THE INTERSECTION OF DATA AND HEALTH CARE

Some of the most important innovations in health care for the homeless have little to do with traditional health care.

Doctors and nurses know how to care for many common chronic diseases, treat acute illness, and run tests. But that just isn’t enough to save lives or save money. Factors such as housing, transportation, safety and food security can be just as important as blood pressure or temperature when it comes to one’s health.

The more we know about our clients, the more we can help. The challenge is to collect and use a broad set of data to address problems and improve health. It sounds simple, but it is not. The act of gathering data and using it in a coordinated fashion with providers of services requires a brand new approach to the definition of medical record keeping.

Around the country, there are several important pilot programs that are expanding the boundaries of traditional record keeping to not only gather pertinent data about living conditions but to be in a position to use the information to effect change.

In 2016 HCWW took the first step in creating an integrated clinical database and reporting system. In 2017, we were able to see how and where our services were being used, and the impact we were having.

To illustrate, some of what we learned from more than 10,500 encounters in 2017 includes:

- Out of 40 possible diagnoses, Hypertension, Diabetes, and Musculoskeletal Pain are chronic conditions treated most frequently at HCWW.
- Women came to HCWW clinics for care 367 times instead of going to the ER.
- 19% of our work involves addressing social determinants such as housing, food, transportation, and safety needs.

This spring, we will be rolling out several important enhancements to our database. Our clinicians will be able to see a medical ‘dashboard’ displaying vitals and other pertinent information over time, as well as a detailed list of medications being taken. And all guest encounters will include tools to focus on four key social determinants: housing, food, transportation and safety. This is something currently used with our Bridges programs, but it is key to helping all of our shelter clinic guests. The ability to address these factors in a seamless, compassionate manner will go a long way towards improving the lives of our clients.

Down the road, we will gather additional information that will help us coordinate care with primary and specialist providers. By ‘connecting the dots’ we can better manage the health care needs of those for whom we care so deeply.

MEET THE VOLUNTEER CLINICAL DATABASE TEAM

Doug Johnston made a career of building medical startups. He has donated countless hours, experience and insight leading the team that created the HCWW clinical database. From his dealings with investors, Doug knows that donors need to see proof that their funds were indeed making a difference.

“As a member of the [HCWW] Advisory Board, I watched caregivers address the needs of an anxious client, reach out to a service agency, and squeeze in a moment of reassurance while needing to document their progress and move on to the next woman in need of care. Now, only a few touches on a tablet are needed to capture the data for most encounters.”

Hussein Abdallah led a student health organization called GlobeMed. Along with a handful of other students, he helped in the launch of the new medical records software providing staff training and troubleshooting. Doug and Hussein then collaborated to create a ‘dashboard’ to generate reports and analysis using the vast amounts of data now being collected.

“I have had a lot of fun working on this project and it has been an honor to work with someone with as big a heart and compassion for others as Dr. Means. I hope the analytics that our software is now enabling can be used to help HCWW tackle their noble mission even more powerfully!”

The Parkland Health & Hospital System (Dallas, Texas) launched a data bridge in 2015 linking 87 organizations and 148,751 unique clients, providing more than 800,000 services to date including housing, job training, and food support.

“We’re getting to really understand the body of knowledge of what our homeless clients are experiencing, where the encounters are happening and where we’re losing them.”

-Cindy Crain
President and CEO of the Metro Dallas Homeless Alliance
**Bridges to Moms**

Helps women who are homeless and pregnant

Since 2016, we have welcomed more than 80 babies with love and support, helping mom and baby cope in the face of overwhelming challenges. Our clinical team helps homeless moms-to-be care for themselves and their newborn; see their doctor and pediatrician; secure safe, clean housing; and take steps to improve their lives for the wellbeing of their babies.

We send babies home with a Baby Goes Home Kit full of all the basics a newborn needs, plus a little bit of love — handmade baby blankets and hats. Additionally, we provide transportation vouchers for attending doctor’s appointments or visiting the newborn if NICU time is required, food vouchers for access to healthy meals, and additional items or emergency support as warranted.

On average, moms receive up to $750 in material support throughout their pregnancy and first year caring for their baby.

**How can you help?**

Sponsor a Baby Goes Home Kit
Click [here](#) to sponsor Baby Goes Home

Collect money or items in support of Baby Goes Home and Bridges to Moms
Call (781) 239-0290 for tips on holding a collection drive

Donate!
Click [here](#) to make a donation

Or send by mail to
Health Care Without Walls
148 Linden Street, Suite 208
Wellesley, MA 02482

At Health Care Without Walls, our mission is to improve the lives of women and families who are homeless or marginally housed through quality healthcare, education and advocacy.

www.healthcarenow.org
781-239-0290
Wellesley, MA 02482
148 Linden Street, Suite 208

Compassionate care for women and families in need