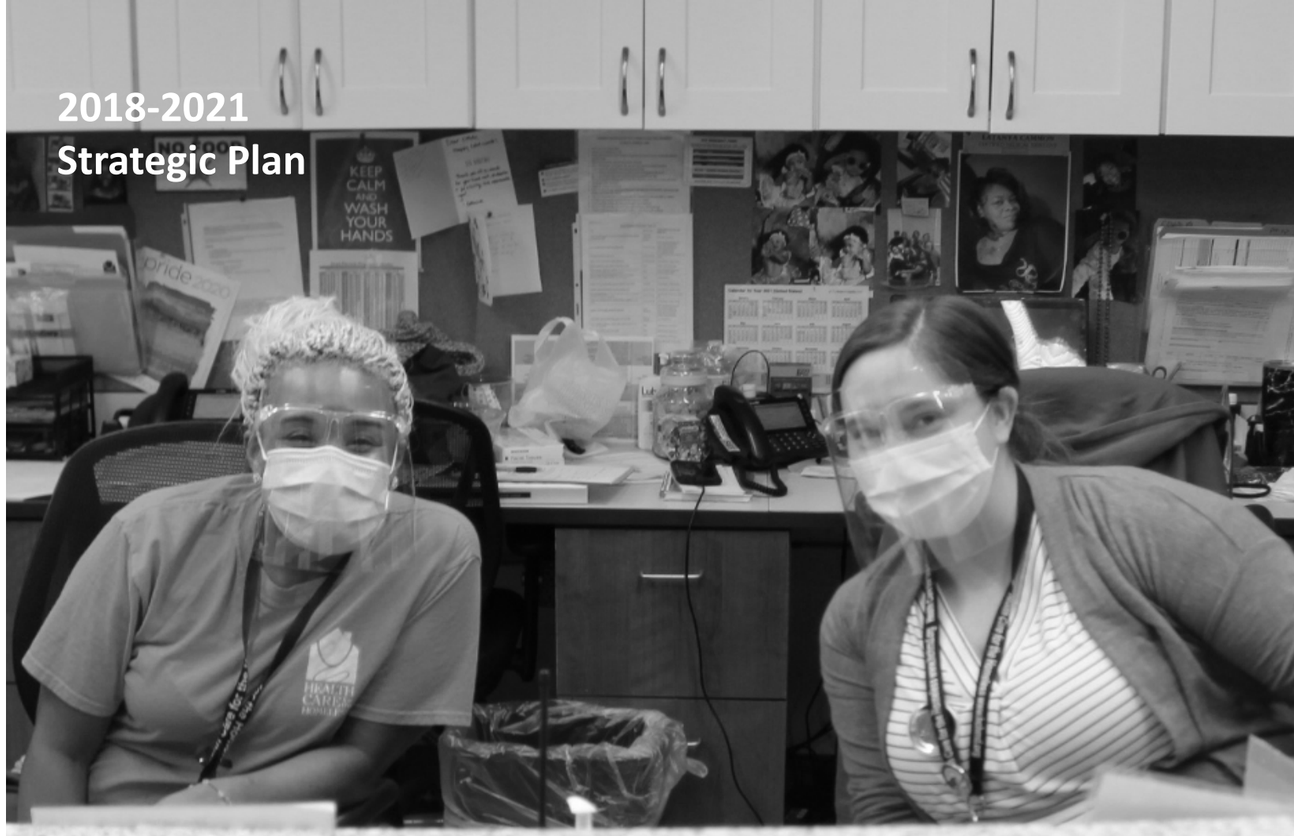
HEALTH CARE for the HOMELESS

Everyone deserves to go home.

www.hchmd.org/2018-2021-strategic-plan

Baltimore, MD
410-837-5533 | hchmd.org | @hchomeless



Year Three

A Look Back at 2020

Strategic Initiatives

HEALTH CARE for the HOMELESS

"I believe what COVID-19 made very clear is inequity in health care. It has reaffirmed that quality care cannot be provided in silos without looking at the entire community you are serving."

Tolulope "Tolu" Thomas, RN, MS

Chief Quality Officer

2018-2021 Strategic Goals

Three years ago, we set out on a path to drastically increase quality, access and services for clients. And each year since, we develop strategic initiatives that bring us closer to achieving our three strategic goals.

Goal 1

100% of the people we serve will have timely access to quality, whole-person health care and affordable housing.

Goal 2

We will design and implement sustainable business models for affordable housing development and supportive housing.

Goal 3

As a result of our care, the health outcomes of our clients will rival the health outcomes of a stable population.

A Note on 2020

No one could have imagined the roller coaster that was 2020.

What started off as a seemingly "normal" year turned into one of the worst pandemics the world has ever seen. We've lost friends, family and neighbors. Our lives have been turned upside down.

Individuals without housing have been particularly hard hit. How can you "stay home" without a home? Clustered in shelters or living on the streets, people were managing life-threatening chronic conditions made even more dangerous when combined with COVID-19 – diabetes, heart disease and respiratory problems. Even worse, they were isolated from the services they needed most.

Over 85% of the people we serve are People of Color, an indication that hundreds of years of racist policies have created systems that are working as designed, denying Black and brown people basic resources and economic mobility. Layering a global pandemic across these existing inequities has had devastating results, with Black and Latinx people dying at twice the rate of white individuals.

Through it all, our community has responded with strength and resolve:
When we rolled out COVID-19 testing, doctors, nurses, security guards, therapists and others put their heads together to make the clinic safer for every person who walked through our doors. From virtual appointments to socially-distanced home visits on front lawns, we met clients where they were. And we redoubled our commitment to affordable housing and racial equity – because **the work of creating a more fair and just society cannot wait.**

Clients have taken the pandemic seriously and with great care. They have navigated service changes and embraced safety protocols with patience and understanding. And their feedback and advocacy have helped shape not just our response, but Baltimore City's efforts to slow the spread and keep everyone safe.

In the midst of crisis, we looked to our core values and focused on our most critical priorities: access to trusted care, housing, racial equity and community partnerships. In the report that follows, you'll see that we shifted our approach to our strategic initiatives to align with those priorities and meet the urgency of the moment.

Have a read through these pages to learn more about that work. And thank you for sticking with us through this unprecedented year.

Kevin Lindamood, President and CEO

2020 Strategic Initiatives Scorecard

The below report reflects our progress from January to December 2020. Initiatives are complete (green), in process (yellow) or on hold (red).

Goal 1

Improve client access

Original Goals	2020 Actual Goals
• Meet 80% utilization goal with a focus on timely service availability • Identify a sustainable opportunity for the expansion of the convalescent care program	• Maintain access to services while promoting staff and client safety • Provide safe, ongoing care for convalescent care clients

Improve clinical quality

Original Goals	2020 Actual Goals
• Increase positive provider experience scores to 85% (baseline 78%; nat'l average: 88%) • Live answer of 80% of phone calls to call center (baseline: 56%) • Decrease medication errors by 20% (baseline: 15) • Physical co-location of Case Manager and Therapist members of the Green, Purple and Steel care teams	• Increase positive provider experience scores to 85% (baseline 78%; nat'l average: 88%) • Live answer of 80% of phone calls to call center (baseline: 56%) • Ensure safe access to prescription medications for chronically-ill clients • Ensure care coordination while focusing on infection control and social distancing

Prepare and support staff to provide excellent care, and advance their careers

Original Goals	2020 Actual Goals
• 20% improvement in Copenhagen Burnout Inventory measure • 20% improvement in "Good day, bad day" monthly measure • Develop four clinical competencies for licensed behavioral health therapists and addictions counselors (baseline: 0)	• Maintain budgeted staff positions and support employees as they navigate life/work challenges

Goal 2

Expand housing in the Greater Baltimore region with new housing projects

Original Goals	2020 Actual Goals
• Multi-year Housing Plan complete • Prepare to break ground on Sojourner Place • Secure one LIHTC (low income housing tax credit) award	No changes

Expand capacity and relationships to engage in housing development

Original Goals	2020 Actual Goals
• Add new members with community development and business development expertise to the Board of Directors Housing Committee • Build 40 strategic organizational (25) and individual (15) partnerships	• Maintain an active Housing Committee throughout the pandemic • Build 40 strategic organizational (25) and individual (15) partnerships

Demonstrate sustainable revenue for housing-related supportive services

Original Goals	2020 Actual Goals
• 75% of clients meeting qualifying visit numbers per month (baseline: 50%) • Demonstrate clinical success of the Assistance in Community Integration Services (ACIS) pilot program with pre and post intervention hospitalization data • Secure favorable renewal of ACIS pilot waiver	• Utilize telehealth to ensure health and safety of supportive housing clients • Demonstrate clinical success of the Assistance in Community Integration Services (ACIS) pilot program • Secure favorable renewal of ACIS pilot waiver

Goal 3

Utilize national data sets to drive improvements in client outcomes

Original Goals	2020 Actual Goals
• 85% of clients receive depression screening and follow up plan (baselines: 82%; 12-17 yo: 59%; nat'l average: 71%) • 65% of women 50-74 receive mammogram (baseline 45%; nat'l average: 72%)	No changes

Collect and utilize clients' social determinants of health surveys to improve care and outcomes

Original Goals	2020 Actual Goals
• 90% of clients who identify as having food insecurity will be connected to Case Management • 80% of eligible clients will be screened for medication adherence barriers	• Assist clients with safe access to healthy food

Establish institutional structures to address racial equity in clinical care

Original Goals	2020 Actual Goals
• Form Board and staff structures to create scope • Establish benchmarks and goals for staff recruitment, professional development and promotion	• Form Board and staff structures to create scope

Goal 1

IMPROVE CLIENT ACCESS

Maintain access to services while protecting staff and client safety. | COMPLETE

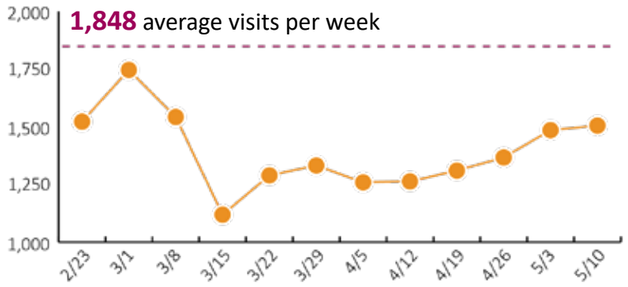
This year, we faced the unprecedented challenge of providing timely care to clients with limited face-to-face contact. We ensured clients had reliable access to primary care, therapy, addictions treatment, case management and housing support in-person, by video conference and by phone. We kept our doors open, and we did it safely.

Telehealth: As soon as COVID-19 hit, we assembled a Telehealth Workgroup that quickly identified a telehealth platform and developed workflows and procedures. In total, we provided over 40,000 telehealth visits in 2020. We also successfully advocated for state and federal policy to recognize that provider visits conducted by phone, regardless of the client's location, are a reimbursable health care service.

With the introduction of telehealth, we also saw our missed appointment rate significantly decrease—from around 30% average beforehand to 17.9% for telehealth appointments and 18.5% for in-clinic appointments (April through mid-December).

While we experienced a drastic dip in our numbers during the first months of the pandemic, these emergency efforts opened up safe avenues for care in person and over the phone.

Client visits: February 23-May 10, 2020



"Health Care for the Homeless staff sat with me and made me feel so supported. They've helped my kids cope, too."

Ranette Coates, reflecting on quarantining at Lord Baltimore Hotel

Keeping 421 Fallsway Open: Our largest clinic remained open throughout the pandemic. To consolidate staffing and resources, we temporarily closed all other clinical sites for in-person appointments, and transitioned clients to telehealth appointments. We reopened our West Baltimore and Baltimore County clinics for limited in-person appointments in October.

Mobile Clinic: In March, the Mobile clinic was converted into the clean space necessary for running a COVID testing program in our 421 Fallsway building garage. As a result, we suspended community-based services provided by our Mobile Clinic for most of 2020. In January and February 2020, we had seen promising engagement at new outreach locations in West Baltimore, Brooklyn and by the Port of Baltimore/Dundalk. We have restarted the Mobile Clinic as of mid 2021**.**

Dental Care: In 2019, our dental clinics served more people than ever before (nearly 1,500), and we were on pace to continue in 2020; however, we had to suspend dental services in March. Our dental department staff transitioned to the front lines of our COVID response: managing PPE, training staff in PPE usage and coordinating evolving screening processes. We resumed limited dental services in October and will continue opening dental services across locations as it is safe to do so.

COVID-19 Testing: Our staff trained up in COVID-19 testing guidelines and regulations to help meet overwhelming demand in Baltimore City. Through December, we tested over 1,300 people on-site at 421 Fallsway and in shelters across the city. Our average positivity rate is 19% - more than three times the state average (5%).

Whenever someone tests positive, we assess whether they have a safe place to quarantine and if so, we ensured that they had enough food for at least two weeks. If they couldn't safely quarantine, we worked with city officials to find space within a designated hotel with access to medical care and support.

COVID-19 doesn't affect everyone equally

Latinx/Hispanic neighbors are more likely to work in "essential" jobs with limited protection. Many are denied insurance and have nowhere else to go for care or tests.

Client positivity rates:

Latinx clients make up:

Marketing: During the summer, we advertised in West Baltimore and at Fallsway to increase community awareness that our doors remained open. We also reached out to dozens of journalists and community groups. *The Baltimore Sun, Latin Opinion, WBAL-TV, Baltimore Magazine* and local neighborhood newsletters helped us let the community know that they could rely on us during the pandemic.

Goal 1

Provide safe, ongoing care for convalescent care clients | COMPLETE

Our convalescent care program (CCP) is the only place in Baltimore that provides a bed, three meals a day and physician-supervised care to individuals recovering from a hospital stay who have no place to call home. In 2020, we moved residents from our 24-bed dormitory within the Weinberg Housing and Resource Center shelter because of the high risk of outbreak. We worked with Catholic Charities, the Mayor's Office of Homeless Services, and city and state health departments to move clients into a hotel. We began operating CCP services at reduced capacity. As of publication date, clients remain in hotel rooms and our staff make daily rounds to provide medical and behavioral health services. We also provide vaccines to every CCP client who wants one.

We have learned some lessons during the pandemic that could be useful as we reconsider CCP expansion. For example, clients greatly appreciate the privacy of individual rooms, but this arrangement also makes it harder for staff to identify when clients are having a health crisis.

IMPROVE CLINICAL QUALITY

Increase positive provider experience scores to 85% and assess the effectiveness of telehealth. | IN PROCESS

Typically we conduct a nationally-benchmarked client experience survey twice a year, both in-person and over the phone. This year, we administered one survey in November via telephone. We reached 372 clients, including 132 Spanish-speaking clients.

Here is what we learned:	
Telehealth-only clients were more likely to:	**In-person only clients were more likely to:**
• Get a medical question answered the same day over the phone	• Feel that their providers spent more time with them
• Feel that their providers listened to them more carefully	• Be asked about their health goals more often
• Have a provider talk to them about their medication(s)	• Feel respected by intake staff

Overall, we saw significant positive results and moved many indicators from the bottom two quartiles in 2019 to the top two in 2020. Notably we saw the biggest increase yet in our multi-year effort to improve client experience with their provider(+6%). The positive telehealth-only survey results became key supporting data for our successful advocacy to secure Medicaid reimbursement for telehealth visits in the 2021 legislative session (more details on page 12).

*View survey results at **www.hchmd.org/performance-improvement-0***

Live answer of 80% of phone calls to call center (baseline: 56%) | IN PROCESS

When the pandemic began, the phone became the safest (and in most instances, preferred) way for clients to reach us.

We struggled to get consistent access to the networked phone lines from staff homes. While we worked to solve this issue, phone call volume skyrocketed. We instituted a new nurse triage line and 24/7 behavioral health support line. And once we resolved staff access to our phone system, we also eliminated our central phone tree—instead directly connecting calls to live staff to provide faster access.

We fell short of our 80% live answer rate but we answered more calls in 2020 than in 2019. Over the course of the year, we had a median rate of 58% live answers across the agency and just 30% on our Spanish-speaking line. This initiative remains a priority in 2021, with substantial investment in new technology, more bilingual staffing and more training.

Ensure safe access to prescription medications for chronically-ill clients| COMPLETE

The pandemic laid bare obstacles that clients have long faced to getting their prescription medication—like transportation and long waits at the pharmacy. By covering delivery costs and providing 90-day prescriptions, we ensured that hundreds of clients with chronic illnesses had safe access to their prescription medications. As of publication date, Community Health Workers continue to deliver medications to 10-15 individuals and families each week, typically clients and families with young children.

"I don't think I've ever felt so good about staying home until now."

Kim Hawkins on safely accessing telehealth from her new home

Goal 1

Ensure care coordination while focusing on infection control and social distancing I COMPLETE

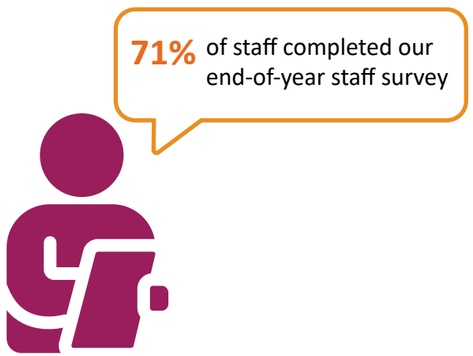
2020 forced us to completely reimagine our clinical and office spaces through a hyper-vigilant lens of safety. Effective communication remained important—if not more so—in this distanced environment, and we took many steps to keep our teams connected. We held weekly, half-hour care team meetings via Zoom a few months into the pandemic. This gave each team a reliable time to interact and discuss shared clients. We have been conducting a series of pilot projects with care teams for the purposes of improving chronic disease management and cancer screening rates within the emergency measures imposed during COVID-19.

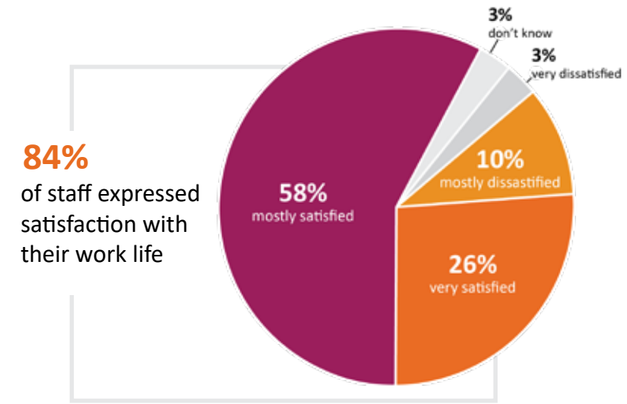
PREPARE AND SUPPORT STAFF TO PROVIDE EXCELLENT CARE AND ADVANCE THEIR CAREERS

Maintain budgeted staff positions and support employees as they navigate life/work challenges | COMPLETE

This year, it was more important than ever to take care of our staff. We maintained all budgeted positions throughout the pandemic. We retained generous health and wellness benefits. We provided both equity adjustments and merit pay in 2020. We provided additional supports for staff, including new telework policies and resources, emergency Family and Medical Leave, virtual yoga classes and optional all-staff gatherings on self-care topics.

Our annual end-of year staff engagement survey, found that we met or exceeded 8 out of 9 nationally benchmarked categories, including scoring well above the national average in the categories of “Immediate Supervisor Relationship” and “Co-Worker Relationships." In 2021, we will work towards improving areas that fell below national rates (e.g. “I would like to be working here two or three years from now” and “I know what is expected of me at work”).





Goal 2

This year underscored that housing should be a human right. As many of us shifted to being at home through telework, our neighbors without homes faced substantially limited options. Therefore, our housing work gained even greater urgency throughout the pandemic.

EXPAND HOUSING IN THE GREATER BALTIMORE REGION WITH NEW HOUSING PROJECTS

Complete multi-year housing plan | IN PROCESS

Together with agency leadership, the Committee spent the first half of 2020 mapping out housing business models to meet the needs of our Board of Directors Housing Committee. We researched and discussed components to affordable housing, including supportive housing services, housing development and property management. The Committee developed a resolution that uniquely fits our mission and expertise and made recommendations to the Executive Team on how to move forward.

First up in 2021: We hired a Real Estate Developer to support housing development projects. And we will assemble and draft the multi-year housing plan with oversight by committee members.

Prepare to break ground on Sojourner Place | IN PROCESS

Sojourner Place at Oliver, a collaboration with Episcopal Housing Corporation to build a 70-unit apartment building in the Oliver neighborhood of Baltimore City, is nearing construction. This new building will be home to 35 residents exiting homelessness and 35 individuals with incomes below 50% of area median income. While the pandemic delayed the process of securing land required to start construction, we closed on the financing of the project in the summer of 2021 and began construction immediately thereafter. We will apply for additional capital grants through the Federal Home Loan Bank Affordable Housing Program to make the project debt-free — the project already secured Low-Income Housing Tax credits from the state of Maryland, HOME Funds from Baltimore City and a private grant from the Harry and Jeanette Weinberg Foundation.

*Follow our housing progress at **www.hchmd.org/supportive-housing***

“This project creates a new standard for housing quality in Oliver. It sets an expectation that everybody serves good housing.”
Earl Johnson, Immediate past Board President of the Oliver Community Association, on our new housing development, Sojourner Place at Oliver

Secure one LIHTC (low-income housing tax credit) award | IN PROCESS

To address Baltimore's housing crisis, we must develop new affordable housing. We have the ambitious goal of applying for one LIHTC award to finance one housing project each year. 2020 was the first year we tried balancing an on-going project with applying for a new one, and we learned that LIHTC applications require substantial time and resources. Finding a location for a new project alone takes months. To help us manage this new workload, we engaged a real estate broker to help identify locations ripe for affordable housing development. To help lead this work, we have added a new Real Estate Developer position to our staff. Since we were still ironing out our process, we weren't able to secure a LIHTC award in 2020. However, we are well-prepared to submit a joint application with Episcopal Housing Corporation for an award in 2021.

EXPAND CAPACITY AND RELATIONSHIPS TO ENGAGE IN HOUSING DEVELOPMENT

Maintain an active Housing Committee throughout the pandemic | IN PROCESS

The Board of Directors Housing Committee include leaders from:

- Bon Secours Community Development
- Cross Street Partners
- Enterprise Homes, Johns Hopkins
- Kimco Realty Corporation
- Medstar Health
- Osprey Property
- Southway Builders

An expert Housing Committee of our Board of Directors guides our evolution toward housing development. Through regular meetings, they focused on two key priorities:

- Mapping out housing development business model
- Advancing a multi-year housing plan

The business model is based on our Sojourner Place at Oliver development, where supportive services will be sustainably funded through development revenue. The multi-year housing plan will be completed in 2021.

Build 40 strategic organizational (25) and individual (15) partnerships | IN PROCESS

Building on the connections made during our inaugural *Community Convening on Homelessness* in October 2019, we launched a *Community of Practice on Homelessness* virtual series in response to the COVID-19 pandemic and in alignment with Goal 3. These virtual gatherings featured a series of conversations that brought together community, institutional and corporate leaders from across the region. Over 200 people have attended each event. These conversations aim to develop strategic alliances to end homelessness and address racial disparities. By squarely addressing difficult issues that plague the communities we serve, the *Community of Practice* pushes us to examine and address structural and systemic issues, while understanding how we as an institution contribute to the existing inequities that exacerbate homelessness.

In 2020, we held four Community of Practice sessions on topics including:

- Addressing Racial Inequities in Health Care Amid Emergencies and Disasters
- Addressing Housing Inequities, Race and Health
- Building Community Trust – Race, Policing and Community Trauma

First time relationships established included:

- Faith-based institutions
- New foundations
- Federally qualified health centers
- Hospital institutions
- City and county health department leaders
- Insurance companies
- Non-profits
- Community activists
- Entrepreneurs
- Elected and appointed government officials
- Homeless service providers
- Development corporations

In total, 65 organizations were represented over these four sessions.

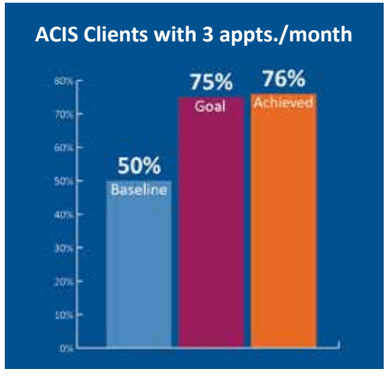
Because we recognize that partnerships are not built out of a single engagement, we also launched an online forum where the discussions will continue beyond the events themselves. Our Equity and Engagement Department continues to cultivate relationships with participants to address our strategic and operational initiatives in the areas of housing, health care, criminal justice and more.

*Watch the recorded conversations at **www.hchmd.org/community-practice-homelessness***

DEMONSTRATE SUSTAINABLE REVENUE FOR HOUSING-RELATED SUPPORTIVE SERVICES

Utilize telehealth to ensure health and safety of supportive housing clients | COMPLETE

Moving into a home after years of living on the streets or in shelters can feel disorienting and isolating. Our Housing Services Department makes sure newly housed clients remain connected to our community and that they receive the care they need in their new homes.



We started this year off with a goal that 75% of clients in our Assistance in Community Integration Services (ACIS) program would have at least three visits from our staff per month. Buoyed by telehealth, we achieved a 76% average for the year.

Telehealth has been particularly helpful for supportive housing participants. Because the program has traditionally relied on home visits and in-clinic visits, we were concerned about how the COVID-19 disruption would impact clients. But we were able to regularly check-in over the phone with surprising success. In fact, telehealth as an option could shape the future of care delivery in supportive housing if made permanent. And this spring we took a step closer to that reality through our legislative advocacy work. Housing Services staff members submitted testimony in support of HB 123/SB 3, the Preserve Telehealth Access Act of 2021. The bill passed and was signed into law, allowing the continued reimbursement for audio-only telehealth. This new law changes the landscape for care delivery in Maryland and helps make sure more people can easily access the support they need.

Goal 2

Demonstrate clinical success of the Assistance in Community Integration Services (ACIS) pilot program | IN PROCESS

Our Supportive Housing Department helps people retain their housing and thrive. One way to evaluate the success of these interventions is examining reductions in hospital visits, admissions and cost after 12 months of housing.

The 400+ clients served by the Housing Department experienced:

54% decrease in the number of hospital visits

19% decrease in the total number of individuals with visits

Post Intervention, clients experienced:

87% decrease in hospital re-admissions

69% decrease in emergency department visits

59% decrease in inpatient admissions

The Hilltop Institute at the University of Maryland, Baltimore County is evaluating the ACIS program and will issue a report in 2022.

Secure favorable renewal of ACIS pilot waiver | COMPLETE

Despite everything that happened this year, the ACIS program is flourishing and will continue through 2021. We started 2020 with 100 ACIS clients and saw that number almost double to 170. In 2021, the pilot reached a full 200 households. In December, we also received a rapid rehousing grant that will enable us to house 35 clients who, because of preexisting conditions, are particularly vulnerable to COVID-19. The grant provides housing for 18 to 21 months, with the goal of linking each client to permanent supportive housing at the end of that period.

"It means stability. It means that I can take this time to be the woman I know I can be."

Koumba Yasin on her new home through the ACIS program

Goal 3

UTILIZE NATIONAL DATA SETS TO DRIVE IMPROVEMENTS IN CLIENT OUTCOMES

85% of clients receive depression screening and follow up plan (baselines: 82%; national average: 71%) | COMPLETE

The loss, isolation and disruption of the pandemic, combined with an economic downturn, have had a dramatic impact on mental health throughout the country. During the pandemic, about 4 in 10 adults in the U.S. have reported symptoms of anxiety or depressive disorder, up from 1 in 10 adults who reported these symptoms previously.

The mental health impacts of COVID-19 are particularly concerning for people without homes, who already suffered from depression at rates as high as 10 times the national average.* This year, we improved our systems to make it easier to administer a mental health screening tool and track results. On average, 87% of clients received a depression screening and a treatment plan, exceeding our goal of 85%. While identifying depression is important, it is only the first step. Our 2021 strategic goal focuses on improving client depression remission rates.

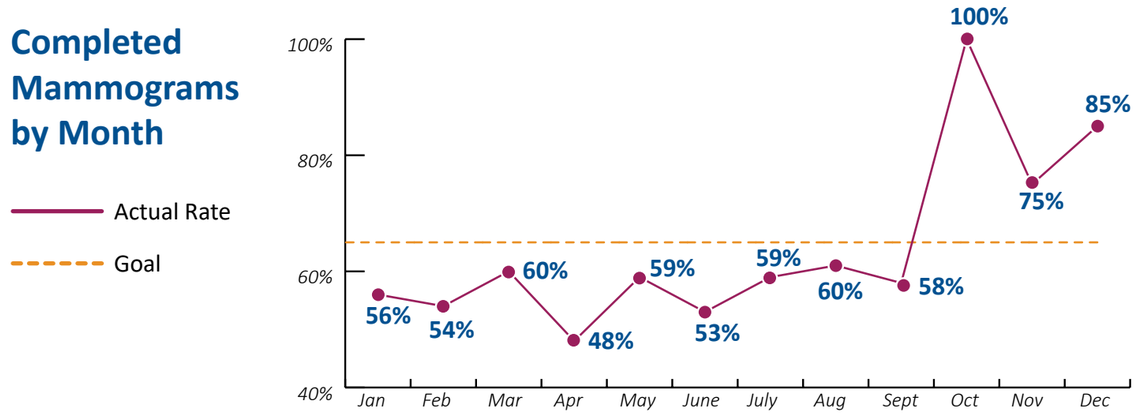
**Source: CDC American Psychological Association, National Association of Social Workers*

65% of women aged 50-74 receive mammogram (baseline 45%; national average: 72%) | IN PROCESS

For the first several months of the pandemic, we made the difficult decision to not have clients come in for prevention-only appointments (e.g., screenings). Our referral partners drastically reduced capacity for mammogram appointments early in the pandemic. Despite these challenges, we increased our average baseline for mammogram completion from 45% to 55%.

That annual average masks the significant successes we saw in October when we resumed proactive outreach to clients who were overdue for a mammogram. This resulted in a 100% completion rate of mammograms for the month. With continued high rates in November and December (75% and 85%, respectively), we are poised to hit our goal of 65% in 2021.

Completed Mammograms by Month



COLLECT AND UTILIZE CLIENT SOCIAL DETERMINANTS OF HEALTH SURVEYS TO IMPROVE CARE AND OUTCOMES

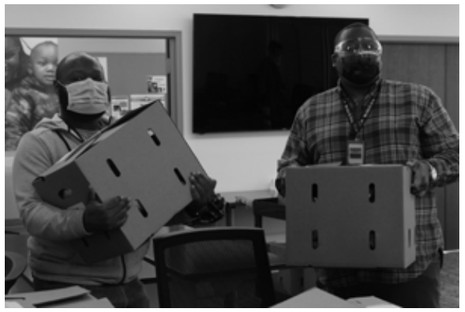
Assist clients with getting safe access to healthy food | COMPLETE

In the 2020 client needs assessment, clients identified access to food among their top three challenges. Many clients rely on long rides on public transit to access groceries. In addition to adding increased health risk to these journeys, the pandemic vastly increased demand for community food resources. And with food prices rising—as much as 20% in some areas—the result was deeply concerning.

Since the start of the pandemic:

46% of Latinx clients listed food as their primary need

The Baltimore Sun noted that even before the coronavirus, 25% of Marylanders (roughly 1.5 million people) were food insecure. With the virus and the accompanying economic downturn, that number is estimated to have increased by 1 million.



In July 2020 we began delivering food directly to clients:

- We provided a two-week supply of food for clients testing positive for COVID-19 who needed to quarantine.
- We partnered with the Maryland Food Bank to deliver boxes of fresh produce every week to dozens of clients in our supportive housing program.
- Our community health workers and outreach workers began delivering food staples to hundreds of client households each month.
- We created an on-site food pantry at our Fallsway clinic for clients with emergency food needs.

Given the challenges that existed in accessing healthy food even before the pandemic—particularly for elderly clients and families with small children—we are continuing to provide some of these services as of publication.

"I add vegetables I get from the boxes to make roasted chicken, rice and gravy. This reminds me that people care enough to help someone like me. That really means a lot."
Ryan Saunders, client, musician and poet

ESTABLISH INSTITUTIONAL STRUCTURES TO ADDRESS RACIAL EQUITY IN CLINICAL CARE

Form Board and staff structures to create scope | Complete

It's no surprise that the greatest burdens of a global pandemic fall on Black and brown people. White families possess 41x more wealth than Black families and 22x more than Latinx families. Black individuals have died from COVID-19 at 2.5x the rate of whites. The poverty rate for white men stands at 7%, whereas it is 20% for Black women. American public health crises, including homelessness, have always hurt these communities hardest. In 2020, we made the commitment to pursue racial equity and inclusion in all we do—from clinical care to culture and operations. And we affirm that we will never end homelessness without becoming an anti-racist agency.

An initial step in this effort was the creation, late in the year, of a Staff REI Committee and an REI Subcommittee of the Board of Directors. Both committees met monthly.

- The staff committee advises the Executive Team on racial equity vision, strategy and transformation within our agency.
- The Board sub-committee is tasked to recommend and oversee Board racial equity strategies, content and practices that are systemic, race-explicit and outcome-oriented.

In 2020, we also partnered with Center for Urban and Racial Equity (CURE) to conduct a 2021 comprehensive agency assessment. Through staff focus groups, leadership training and policy review, CURE will help to create the foundation for a more inclusive and racially-conscious workplace at Health Care for the Homeless.

Phase 1: Examination (January-June 2021)
Hiring of additional staff, weekly management meetings and organizational assessment by CURE. Assessment includes surveys, focus groups, policy review and workshops.

Phase 2: Implementation (April 2021-August 2022)
Presentations of assessment; implementation of metrics and action plan; anti-racist trainings; mentorship program and affinity group formation.

Phase 3: Execution (June 2022-Ongoing)
Formal integration of REI approach across clinical, administrative and cultural practices; 2022 Strategic Plan design and implementation.

Learn about our approach to racial equity and inclusion: ***www.hchmd.org/REI***

"As a conscious African American male working at an agency with a majority of African American clients, I am excited to lend my voice to tackling racial inequities in order to build organizational growth."
Malcolm Williams, LSCW-C - Client Relations Coordinator on joining the staff Racial Equity and Inclusion Committee