



Health Leads: Mobilizing a Pipeline of New Leaders to Improve Health Care Delivery



1

HealthCare Providers routinely prescribe medications to low-income patients living in a car or with no food at home that night.

-Children who experience food insecurity are 30% more likely to be hospitalized by age 3.¹

2

HealthCare Providers lack time & knowledge to address patients' basic resource needs – even though they directly impact health outcomes & costs.

-A Johns Hopkins study found that 98% of pediatric providers identified addressing social issues of housing and food could positively improve child health, but only 11% routinely screened for food, and only 18% routinely screened for housing.²

3

Clinics do not have sufficient infrastructure to address resource needs

- Boston Medical Center Pediatric Outpatient Clinic serves over 24,000 patients a year with an average family income of \$20,420, and has 2 full-time social workers.³

4

Poor health further entrenches families in poverty by jeopardizing educational attainment, economic stability, & life opportunities.

- Medical problems caused 62% of all personal bankruptcies filed in the U.S. in 2007, and 78% of those filers had medical insurance at the start of their illness.⁴

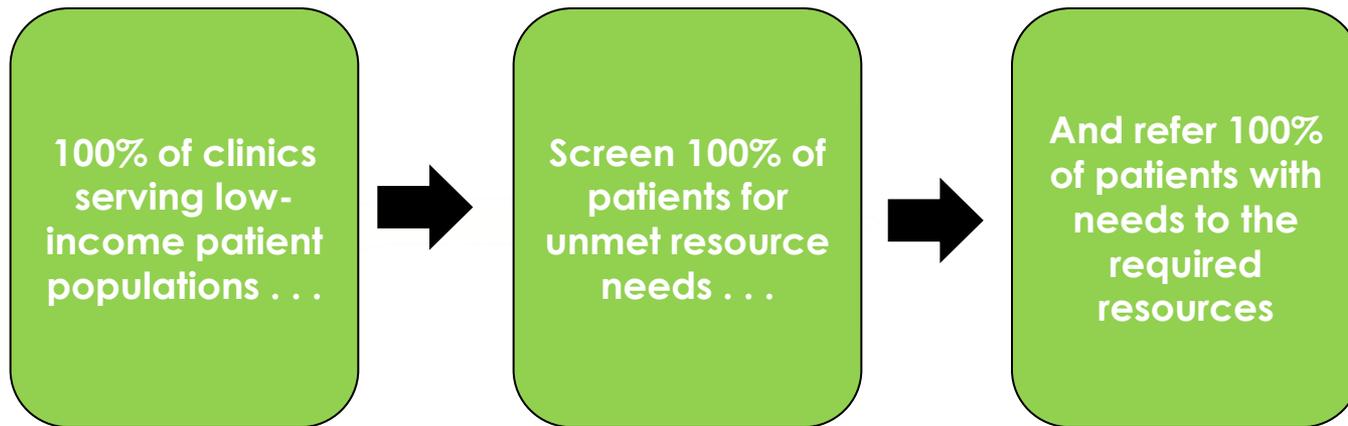
1 Cook, J.T., et al., "Food Insecurity is Associated with Adverse Health Outcomes Among Human Infants and Toddlers." *Journal of Nutrition*, 2004. 134:1432-1438.

2 Garg, A., et al., "Improving the Management of Family Psychosocial Problems at Low-Income Children's Well-Child Care visit: The WE CARE Project." *Pediatrics*, 2007. 120(3): 547 – 558

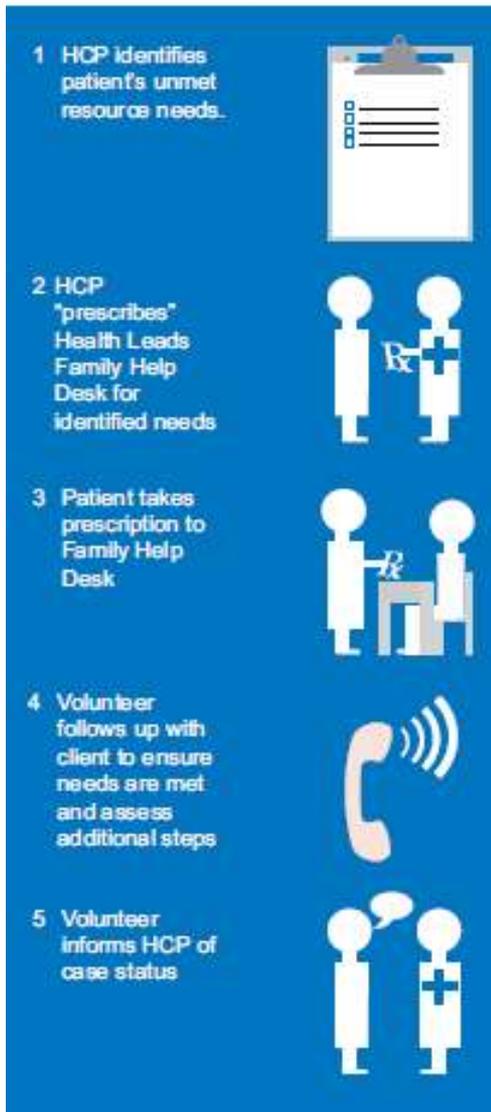
3 Boston Medical Center Annual Report, 2010

4 Himmelstein, D.U., et al., "Medical Bankruptcy in the United States, 2007: Results of a National Study." *The American Journal of Medicine*, 2009. 122(8): 741-746

To improve health outcomes & reduce health care costs, “health care” must be redefined to include access to food, housing, and other basic resources as a standard part of patient care.



Health Leads' Model



Health Leads

Patient Name: _____

Client (Parent) Name: _____

Medical Record Number: _____

Date: _____

Patient Phone: _____

Referring Provider is (circle): Nurse Doctor Social Worker

Referring Provider Name: _____

<input type="checkbox"/> Food Assistance	<input type="checkbox"/> Job Search / Training
<input type="checkbox"/> Housing Search / Conditions	<input type="checkbox"/> Adult Education
<input type="checkbox"/> Income Supports	<input type="checkbox"/> Childcare
<input type="checkbox"/> Fuel / Utilities Assistance	<input type="checkbox"/> Clothing
<input type="checkbox"/> Health Insurance	<input type="checkbox"/> After School Programs

Health Leads hours and 24-hour voicemail are available at (617) 414-4349.



Key Strategies for Achieving Health Leads' Goal

To achieve a health care system that addresses patient resource needs as a standard of care:

Provide model of effective, affordable infrastructure to create clinic-based resource connections

Create leadership pipeline to champion new model of health care delivery

Establish business case for creating patient resource connections

Population Characteristics

Sept. 1st, 2010 – Aug. 31st, 2011

6 Cities – Boston, New York, Chicago, DC, Baltimore, and Providence

21 clinic-based programs – FQHCs, Academic Medical Centers, OB/GYN, Pediatrics, newborn nurseries, Emergency Departments.

Unique Patients

- 9,428 households
- 29,226 children and adults

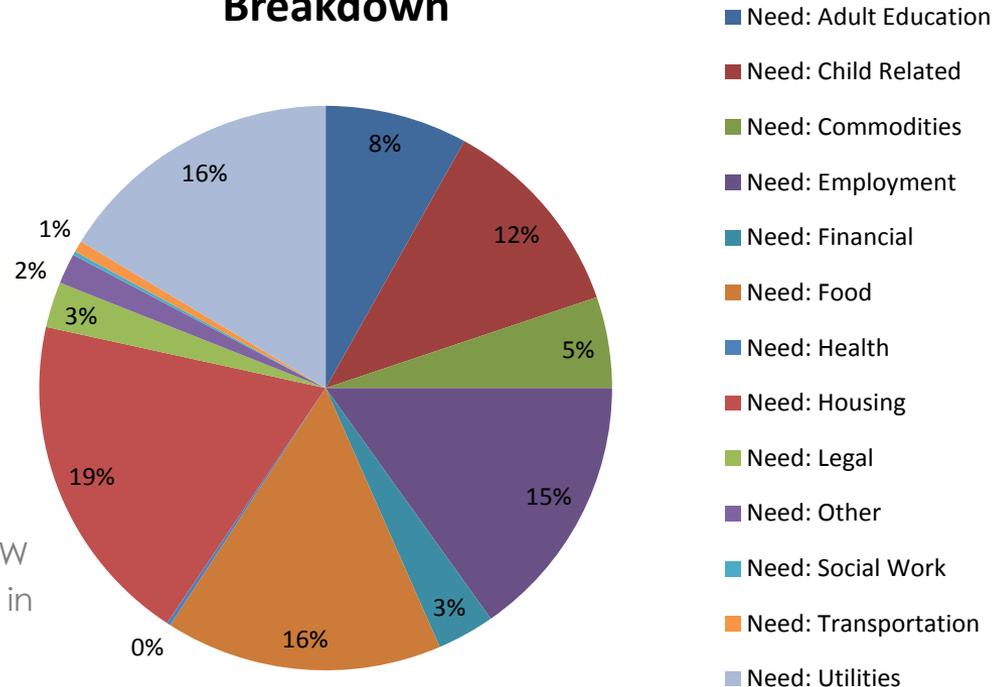
Number of Presenting Needs

- 19,800 presenting social needs

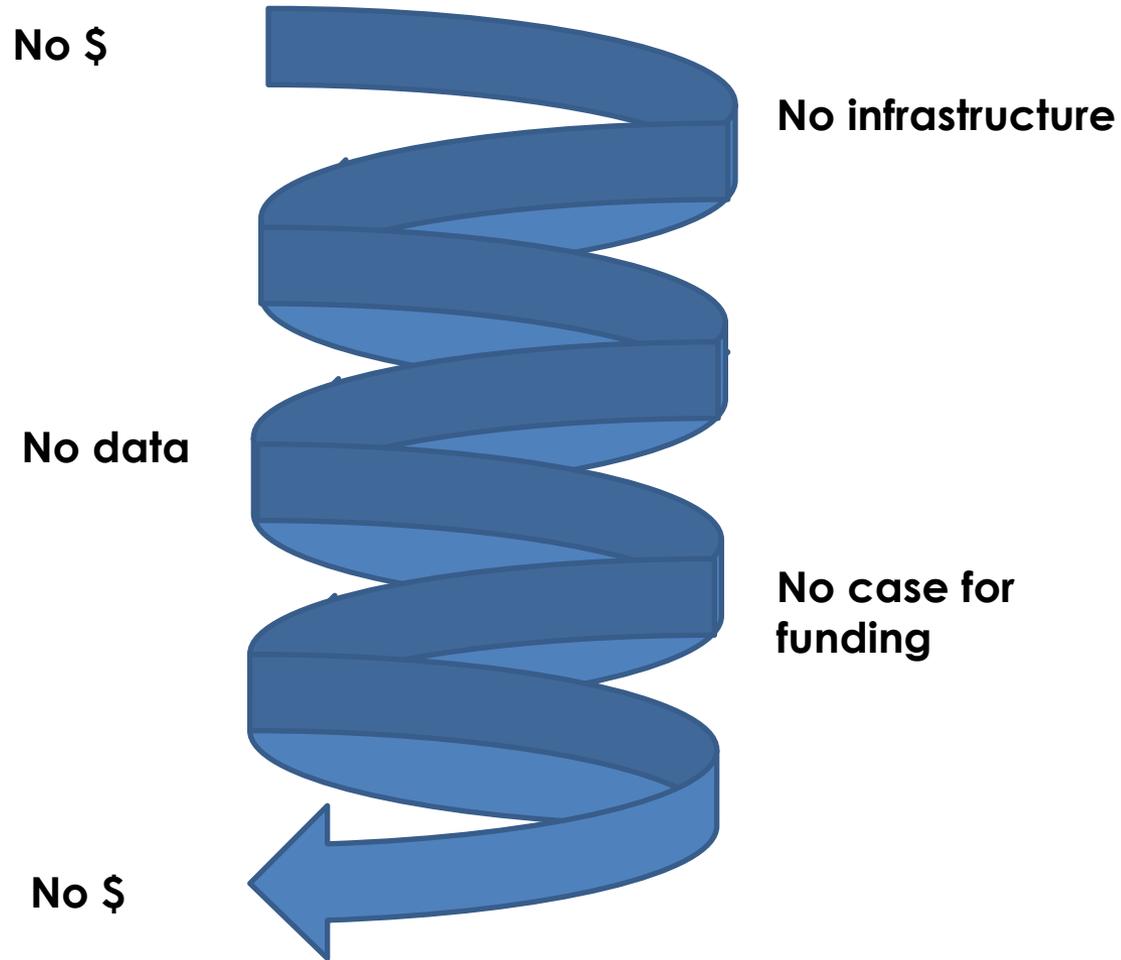
Outcomes

- 57% of Health Leads clients obtain at least one resource they need within 90 days
- 83% of Health Leads' grads enter fields of health or poverty.
- 94% grads say Health Leads had impact on post graduate plans
- Reimbursable therapy sessions performed by LICSW increased by over 200% upon Health Leads arrival in Community Health Center

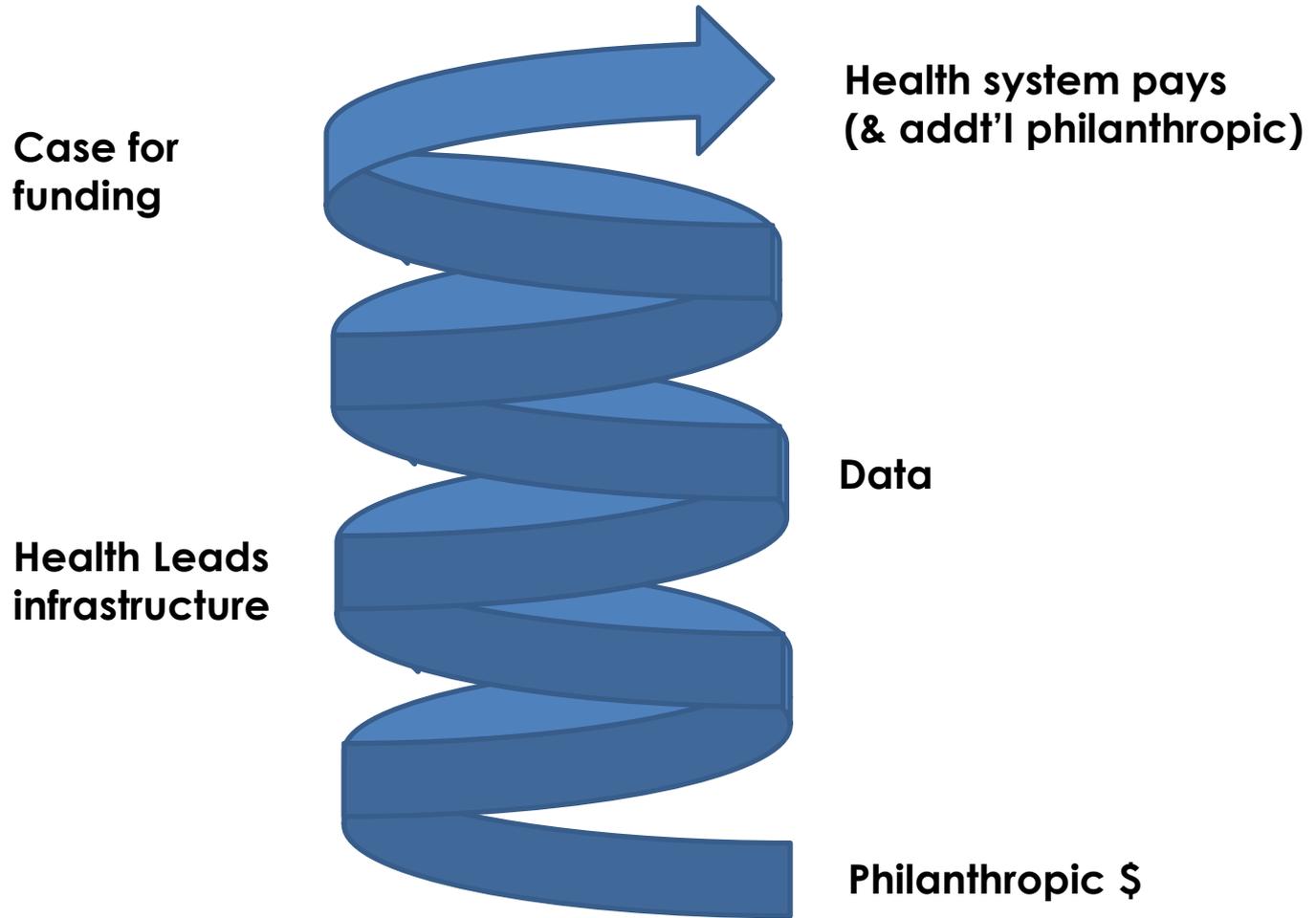
Health Leads Presenting Needs Breakdown



Challenge: Payment for Basic Resource Connections for Patients



Solution: Payment for Basic Resource Connections for Patients



Health Leads and Community Partnership Case Study: Regina

Regina had been coming to Codman Square Community Health Center for over a decade. This past year, she gave birth to her third child, and was seeking post-partum services with her OB/GYN provider at Codman. Given Regina's income and the fact she was recently pregnant, she was receiving intense case-management services for pregnant women known as Healthy Start, who supported her throughout her pregnancy and provided post-partum support and resources. Her Health Care Provider uncovered various mental health and behavior health concerns with Regina at this visit, and enrolled her in a program called Project Launch, which provided direct mental health consultation and other resources. In addition, Regina explained to her provider that she also received a shut-off notice from the gas company, because she had been unable to pay her utility bill for the past three months. Her provider referred her to Health Leads to assist with her utility issue as well.

Regina explained to Health Leads students that she was receiving a section 8 voucher for rent subsidies, but she could no longer afford to even cover her portion of the rent because her income change when she lost her job three months ago. Because of this increase rent burden, Regina fell behind in paying her utilities bill, and was incurring high utility debt. Health Leads students worked with the health care provider and submitted the paperwork to receive utility shut-off protection. She also submitted the application to LIHEAP for utility payment assistance.

Regina was also a great candidate to receive support that could potentially assist with both the rental burden, utility debt and overall financial health, and was referred to Fiscal Health Vital Signs.

