Health Leads Helps Fill Gap Between Unmet Social Needs and Good Health

Four out of five physicians say unmet social needs are directly leading to worse health for Americans, according to a new Robert Wood Johnson Foundation survey conducted in fall 2011. Health Leads, a grantee of the Robert Wood Johnson Foundation, has pioneered a model for enabling physicians and other clinicians to “prescribe” the basic resources their patients need to be healthy. Health Leads Co-founder and Chief Executive Officer Rebecca Onie discusses the poll findings.

Human Capital Blog: According to the survey, doctors believe unmet social needs are directly leading to worse health for Americans, and within the current health care system, they are not confident they have the capacity to address those social needs. How does Health Leads help to address this gap?

Rebecca Onie: For Health Leads, this survey validates and quantifies what we’ve been hearing from doctors anecdotally for years. Every day in America, doctors prescribe medications to patients who might have no food at home or are living in a car—many of these patients will return with more serious and often more costly illnesses. This survey documents physicians’ frustrations with this reality on the front lines of our health care system.

Health Leads envisions a new model for health care delivery that addresses those very frustrations in which patients’ basic resource needs — such as food, housing, and heating assistance — are addressed as a standard part of patient care. In the clinics where we work, Health Leads enables physicians and other health care providers to “prescribe” such resources just as they do medication. Patients take their “prescriptions” to the clinic waiting room, where Health Leads’ college volunteers work with patients to help “fill” them by connecting patients to resources.

HCB: Three out of four physicians surveyed wish the health care system would help pay for the costs associated with connecting patients to services that would address their social living needs. What is Health Leads’ perspective?

Onie: We agree that the health care system should help pay for resource connections — as it does for any other specialty referral. There are a number of ways in which creating patient resource connections adds real value to hospitals and health centers. For example, by empowering physicians to address the real drivers of patient health, Health Leads improves provider satisfaction and patient satisfaction. In addition,
by deploying Health Leads or models like it, physicians and other health care providers can do what they are uniquely trained to do – and not dedicate their valuable time to tracking down the nearest exercise program or food pantry. Indeed, recent research at the Dimock Center, one of Health Leads’ partner clinics, indicates the social worker gained 50 percent more therapeutic billable hours with the introduction of the Health Leads model.

**HCB**: How is Health Leads helping to shape a new health care workforce?

**Onie**: Since launching in 1996, Health Leads has recruited, trained, and deployed thousands of college volunteers to enable hospitals and health centers to improve health, not just manage disease. This year, our corps of nearly 1,000 volunteers is projected to assist 9,500 low-income patients and their families in accessing the resources they need to be healthy.

Health Leads is producing a pipeline of new leaders who will have both the conviction and the ability to tackle the most challenging questions in health care — especially those facing the most vulnerable patient populations. In 2011, 86 percent of Health Leads graduates entered jobs or graduate study in the fields of health and poverty.

As they become front-line providers serving low-income patients – as well as clinic directors and health care administrators – our alumni reach out to us, wanting to know why there are no Health Leads desks in their clinics, asking, “how can I practice medicine without it?” At the same time, Health Leads is also producing hundreds of public health practitioners, social entrepreneurs, nonprofit professionals, and policymakers who bring a shared vision for health care to their respective roles.

*Photo credit: Michael Collopy, Skoll World Forum

The survey was conducted online by Harris Interactive on behalf of the Robert Wood Johnson Foundation between September 16 and October 13, 2011 among 1,000 physicians.

The original blog post appeared on Robert Wood Johnson Foundation’s Human Capital Blog on December 8 and can be found at: http://blog.rwjf.org/humancapital/2011/12/08/physicians-poll-social-needs-and-health/?cid=xpr_pp_001
Forbes’ List of the Top 30 Social Entrepreneurs

Darell Hammond read a Washington Post article about children who suffocated while playing in an abandoned car because they had nowhere else to play. Willy Foote met vanilla farmers in Mexico who didn’t have access to credit and couldn’t connect to markets. Sara Horowitz was working at a lawyer, didn’t qualify for health insurance because she was considered a “freelancer,” and started thinking about other people who faced the same problem. While working in Argentina, Linda Rottenberg wondered why more Latin American entrepreneurs didn’t create global companies.

And then— unlike millions of us who recognize some kind of problem, feel a pang of hopelessness, and move on— Hammond, Foote and others shifted careers and set about fixing the problems they saw in the world.

For the first time in Forbes’ 94-year history, we’ve assembled the Impact 30: a list of the world’s leading social entrepreneurs. We’re defining “social entrepreneur” as a person who uses business to solve social issues.

Take Jordan Kassalow, for example. An optometrist by training, Kassalow now runs an organization that sells ready-made reading glasses to people in the developing world. (Check out a longer profile here.)

Sam Goldman and Ned Tozun, of D.Light Design, manufacture inexpensive lamps and sell them in communities that don’t have reliable electricity.

Tom Skazy dropped out of Princeton to create Terracycle, which sells fertilizer and over 250 products made from 60 waste streams.

Jane Chen’s company manufactures a sleeping bag-like device called the “Thermpod,” which warms low-birth weight babies in hospitals and clinics that have unreliable electricity and heat lamps that don’t always work.

Some of the people on our list run nonprofits, so the market-based approach doesn’t apply. But we’ve included them anyway, because they’re creating innovative, new solutions to a host of old problems.

To select our list, we recruited a blue-ribbon panel of experts, including:

Ashoka founder and chief executive Bill Drayton;

Yale economics professor and MIT Poverty Action Lab research fellow Dean Karlan;

Deb Nelson, executive director of the Social Venture Network;

Antony Bugg-Levine, the chief executive of the Nonprofit Finance Fund; and

Jed Emerson, the executive vice president of ImpactAssets.

(Emerson and Bugg-Levine just co-wrote a great book: “Impact Investing: Transforming How We Make Money While Making a Difference.” Karlan’s “More Than Good Intentions: How a New Economics is Helping to Solve Global Poverty” is a must-read.)
Our panelists helped us identify the leading innovators across health, education, finance and other sectors. They also provided good insights for my cover story on Acumen Fund founder Jacqueline Novogratz.

My hope is that years from now, our list members will be out of work, their organizations so successful that the problem they set out to solve no longer exists. Until then, we showcase their efforts.

Rebecca Onie, Health Leads
Age: 34  Headquarters: Boston  2010 budget: $7 million

Getting healthy isn’t just about pills and doctors—lots of sick poor people can’t really get well unless they also address basic issues, like having enough food, getting someone to watch the kids or turning the heat back on. That’s where Health Leads comes in. The program’s 1,000 or so volunteers (all college undergrads) work with hospitals and clinics to help patients navigate language barriers and the bureaucratic jungle to get the services they need.

Rafael Alvarez  44  Genesys Works  Houston
Alvaro Rodriguez Arregui  44  Ignia  Monterrey, Mexico
Richard Barth  45  KIPP Foundation  San Francisco
Jane Chen  32  Embrace  San Francisco
Jean Desravines  40  New Leaders  New York City
Daniel Epstein  26  Unreasonable Institute  Boulder, Colo.
Martin Fisher and Nick Moon  53, 57  KickStart  Nairobi, Kenya
Jay Coen Gilbert, Bart Houlahan, and Andrew Kassoy  44, 44, 42  B Lab  Berwyn, PA
Sam Goldman and Ned Tozun  32, 32  d.light design  San Francisco
Darell Hammond  40  KaBoom  Washington, D.C.
Scott Harrison  36  charity: water  New York City
Sara Horowitz  48  Freelancers Union  New York City
Jordan Kassalow  50  VisionSpring  New York City
Wendy Kopp  44  Teach for America  New York City
Terri Ludwig  48  Enterprise Community Partners  Columbia, MD.
Jeff Mendelsohn  44  New Leaf Paper  San Francisco
Josh Nesbit  24  Medic Mobile  San Francisco
Jacqueline Novogratz  50  Acumen Fund  New York City

Rebecca Onie  34  Health Leads  Boston
Bob Pattillo  51  Gray Ghost Ventures  Atlanta
John Rice  46  Management Leadership for Tomorrow  New York City
Linda Rottenberg  43  Endeavor  New York City
J.B. Schramm  48  College Summit  Washington, D.C.
Beth Sirull  48  Pacific Community Ventures  San Francisco
Tom Szaky  29  Terracycle  Trenton, N.J.
Jill Viallet  47  Playworks  Oakland, Calif.
John Wood  47  Room to Read  San Francisco
Daniel Yates  34  Opower  Arlington, Va.
Andrew Youn  33  One Acre Fund  Bungoma, Kenya
As health care costs continue to spiral out of control, it’s often forgotten that one of the best ways to lower health care expenditures is to reduce the amount of medical care that’s needed to keep people healthy. This is no revelation. However, because of the financial incentives in our health system, the things we can do to promote health, and prevent illness, are not prioritized.

On Friday, I wrote about an organization called Health Leads, which is addressing this problem. Health Leads mobilizes student volunteers in 23 health centers and hospitals who help low-income families gain access to resources that doctors and other health care providers deem vital. The volunteers complement the social workers (who can focus on problems like mental health, abuse and neglect) by providing families with connections to housing services, food supplements, exercise programs and fuel assistance. They also help patients’ family members get access to things like subsidized child care, English language classes, transportation vouchers and quality after school programs — making it easier for them to find work so they can afford to live healthier lives.

Most readers thought that it made good sense to address the social factors behind illnesses at the same time that we treat the illnesses themselves. Sarah Bachman from California (20) wrote: “The United States could use more of this kind of wide-angle thinking about how to address health symptoms that are really symptoms of broader problems.” And BEW from Colorado (29) added: “The right food and environment are generally a lot less expensive than the medical care and remedial social services required to fix the problems if these factors are ignored.”

One reader suggested widening the angle even further. “Consider the coal plant,” wrote Niko Segal-Wright from Arlington, Mass. (46). “Studies have shown that the health care costs of a coal plant are far larger than its revenue.”

Whenever I write about poverty, a number of readers send in comments (some unprintable) suggesting that the problems of poor people are largely due to their own irresponsible behavior. If they would just stop eating junk food, smoking, watching TV and taking drugs, they wouldn’t be so sick. I don’t buy the argument that wealthier people are inherently more health conscious than poor people. (I am happily writing this column from an outdoor café in Barcelona where a half dozen well-attired patrons are chain smoking cigarettes.)

There are obviously many factors that influence health-related behavior, including culture, access to education and perhaps even one’s overall sense of control in life. But one thing is certain: it’s far easier to make healthy decisions if you are not poor. As Geraldine from Palm Coast, Fla., (22) commented, with regard to examples given in Friday’s column: “Why does [a] mother have to work two jobs and still she has no money for food? Why do landlords not fix up their buildings,
even though they get their rent? Why do doctors not have enough face-time with their patients to discuss nutrition?”

We know the answers. In the United States, if you are the sole breadwinner for a family of four and you are earning minimum wage — even if you work 60 hours a week — you live in poverty. If you reside in a low-income neighborhood, you may not have a grocery store selling vegetables within walking distance. If you are a low-income tenant, you are far more likely than a middle class tenant to live in a moldy, cockroach infested apartment and to be served by an over-crowded public hospital, where doctors indeed have little face-time with their patients.

There is nothing mysterious about this problem. Most medical professionals and health care decision makers say that we could make substantial gains in public health, and save lots of money if we addressed the social determinants of health more consistently and systematically.

Indeed, one of the pioneering organizations working in this area, the Associação Saúde Criança (Child Health Association), headquartered in Rio de Janeiro, has been doing this kind of work for 20 years — and it has compiled strong evidence to demonstrate the power of prevention.

Like Health Leads, the Child Health Association was established to break the cycle of re-hospitalization that occurs among poor children when the social causes of their illnesses go untreated. It was founded in 1991 by Vera Cordeiro, a Brazilian physician, who worked at a large public hospital that served families from the surrounding favelas, or slums.

The Child Health Association has a network of 22 partners that link with hospitals in a number of Brazilian cities. They have assisted 40,000 patients and family members. They provide nutritional supplements and mobilize volunteers who help families develop action plans that include improving housing conditions, pursuing vocational training and adopting healthier behaviors. A sample of patient data from 107 families revealed that the organization was able to decrease the annual average number of days children were hospitalized from 28 to 11, a 60 percent drop. The associated savings is a big reason why the municipal government of Belo Horizonte formed a partnership with the organization and why Rio de Janeiro is considering a similar arrangement.

In the United States, this kind of reduction in health care usage would save far more money and, of course, relieve untold stress and suffering among children and their parents. As Ellen from Boston (1) writes: “It’s just something society chooses not to pay for up front, so we pay for it in poorer health outcomes.”

So how do we change the incentives to make it easier for the health system to function the way it should? At a time when the majority in Congress are against any new spending, how do we demonstrate that Medicaid should start paying for the kind of work that Health Leads’ volunteers perform?

One idea, suggested by Rick Brush from Hartford, Conn., (17) is to develop “new financing mechanisms like social impact bonds” — bonds that only pay off only if you are successful in producing a positive social result. “The key will be to demonstrate to those who pay for health care
costs (e.g., insurance companies, employers, hospitals, government, and citizens) that it’s more efficient to invest $1 in upstream prevention than it is to pay $6 in downstream treatment.”

Health Leads frequently assists single mothers who don’t have computers or cars. Many work double shifts; some speak no English; some live in shelters. It takes confidence to reach public agencies and find the right service. Health Leads’ founder Rebecca Onie told me a story about a grandmother in Providence, R.I., who needed help.

“She had a developmentally delayed daughter who had an autistic son. The grandmother needed supportive housing and the social worker just didn’t have the time to work the system,” Onie recalled. “So our volunteer calls the department of housing in Rhode Island, and the department of housing says talk to the department of health and the department of health says talk to the department of mental health, the department of mental health says talk to the department of housing. The volunteer ends up making 14 phone calls.”

After many hours, the volunteer found the right program for the grandmother and got her connected to it. Without that assistance, her daughter and grandson would have likely run into a cascade of health problems in the years ahead. “If you look at the landscape of the clinic and then the landscape of the patients, you recognize what’s missing,” added Onie. “It takes an incredible degree of persistence and tenacity — and energy — to figure this stuff out. And it needs to be done.”

David Bornstein is the author of “How to Change the World,” which has been published in 20 languages, and “The Price of a Dream: The Story of the Grameen Bank,” and is co-author of “Social Entrepreneurship: What Everyone Needs to Know.” He is the founder of dowser.org, a media site that reports on social innovation.
Treating the Cause, Not the Illness

By DAVID BORNSTEIN
Fixes column looks at solutions to social problems and why they work.

In 1965, in an impoverished rural county in the Mississippi Delta, the pioneering physician Jack Geiger co-founded the nation’s first community health center. Many of the children Geiger treated were seriously malnourished, so he began writing “prescriptions” for food — stipulating quantities of milk, vegetables, meat, and fruit that could be “filled” at grocery stores, which were instructed to send the bills to the health center, where they were paid out of the pharmacy budget. When word of this reached the Office of Economic Opportunity in Washington, which financed the center, an official was dispatched to Mississippi to reprimand Geiger and make sure he understood that the center’s money could be used only for medical purposes. Geiger replied: “The last time I looked in my textbooks, the specific therapy for malnutrition was food.” The official had nothing to say and returned to Washington.

In some ways, the United States has come a long way since Lyndon Johnson declared the “war on poverty.” But in others, we’re still at square one. We now have a variety of federally-supported nutrition programs, but the health care system remains senselessly disconnected from the “social determinants of health.” In this regard, the United States has fallen behind the rest of the world. If a politician in India announced a public health plan that neglected malnutrition, he would be ridiculed. Here, leaders make this kind of omission all the time. Almost all of the debate about the 2010 Affordable Care Act was consumed with questions about health care access and quality. But if we really want to improve the health of millions of people, we have to address the conditions that make them sick.

One of the most impressive organizations in the country that is developing an approach to do this is Health Leads, which mobilizes and trains about 1000 volunteers each year who staff resource desks located in the waiting rooms of 23 hospital clinics or health centers in Baltimore, Boston, Chicago, New York, Providence, R.I., and Washington. At these sites, doctors now regularly “prescribe” a wide range of basic resources — like food assistance, housing improvements, or heating fuel subsidies — which Health Leads’ volunteers “fill” — applying their problem solving skills (and tenacity) to identify resources anywhere they may be available.

Health Leads was co-founded by Rebecca Onie in 1996, while she was an undergraduate student at Harvard University. Onie had first witnessed the intimate relationship between poverty and health while volunteering at Greater Boston Legal Services, where she assisted low-income clients who had housing problems. Many lived in dilapidated apartments with leaky pipes, broken windows, rooms full of mold, and walls infested with cockroaches and rats. Often families couldn’t afford to pay for heat. Towards the end of the month, some ran out of food. Onie found herself interviewing mothers whose children came to the office wheezing and coughing from asthma and lung infections — health problems caused or triggered by bad housing. Often, the children had been in and out of hospitals for years; many had fallen far behind in school. One day, she read a magazine story about Barry Zuckerman, chairman of pediatrics at Boston Medical
Center (B.M.C.), who had established the Medical-Legal Partnership for Children, a program that connected doctors with lawyers to assist patients (it has since spread to more than 235 health institutions nationally). Close to 70 percent of the patients at B.M.C. are poor and Zuckerman, like Geiger, had grown tired of treating children, only to see them readmitted to the hospital because nothing was done to address the causes of their illnesses. In some cases — as when a child has chronic asthma attacks because the landlord refuses to clean up mold — a lawyer could be more effective than a doctor.

“I thought bringing lawyers into the hospital was brilliant,” recalled Onie. She called Zuckerman to see how she could help and he invited her to spend six months talking to people in the unit. There Onie found doctors who were “smart, passionate and totally committed to their patients” and yet “stymied in terms of their ability to bring about the health outcomes they wanted.” Some physicians told her they knew they should be asking more about food, housing or social issues, but they were afraid of opening a “pandora’s box.” “I have no idea where to begin to address the problems,” one physician told Onie. “I have 13 minutes with each patient.” (Studies reveal that doctors are reluctant to inquire about issues — domestic violence, for example — when they feel powerless to intervene.)

Onie thought that students could help. With Zuckerman, she founded Health Leads (formerly Project Health) to recruit and train students to provide patients with connections to resources deemed necessary by doctors and other health care providers. “What are college students built to do?” asks Onie. “Track down information!” She adds: “Say your client is a Latina mother working two jobs. She needs food supplements. She has no transportation. Your job is to locate a food pantry within walking distance of her home that’s open after 8:00 p.m. and has a Spanish speaker on staff. That’s a perfect problem for a college student. It’s like a really fancy Google search.”

From the outset, Onie made the decision to work only with students who demonstrated high levels of motivation and commitment. In some of Health Lead’s sites today, as few as 10 percent of students who apply get selected. This has had the effect of attracting serious volunteers. In 2010, the organization reported that in 57 percent of cases its volunteers secured a needed resource within 90 days. This year, Health Leads will serve 9,300 patients and families — not a huge number given the scope of the problem it seeks to address — but the approach is gaining momentum.

One indication is that, where Health Leads works, doctors are changing their behavior. In the Children’s National Medical Center, in Washington, for example, over the past year, there has been a 300 percent increase in doctors “prescribing” Health Leads through the hospital’s Electronic Medical Record. The resources they request for patients include things like exercise or summer meal programs for children or subsidized child care for mothers, so they can find work and afford better food and housing.

Health Leads is also demonstrating that it can improve the efficiency of social workers. In some of the large urban hospitals where the program operates, the ratio of patient visits to social workers is close to 25,000 to 1. Because students can handle basic — but time consuming — cases, social workers can concentrate on what they’re trained for. At The Dimock Center, in Roxbury, Mass., initial data suggests that the program has doubled the time social workers can devote to therapeutic work.

Health Leads is also preparing a pipeline of new health care leaders. Two thirds of its students are either in pre-med tracks or pursuing careers in health, and the exposures they are getting are likely to shape
the way they think about health care. As one volunteer said: “When I’m a doctor, I will never prescribe antibiotics that say ‘take with food’ without making sure that the family actually has food in the house.”

Many health care professionals know that social conditions impact health more than medical care. In a survey conducted by Health Leads at Bellevue Hospital in New York, almost every pediatric primary care provider said the failure to address social and psychological needs “impairs” their ability to treat patients effectively. The vast majority said that the hospital needed a standardized system to screen for these needs on routine well-child visits. But 80 percent said it lacked the capacity to do it.

There is very little money available for this work. Medicaid doesn’t generally reimburse social workers for non-therapeutic tasks. Most of the time, this kind of assistance falls through the cracks. Society then spends oodles of money treating the crises that follow. “There is a tension between what we all know, and agree, needs to be done, and what we are doing,” says Onie. “As a society, we haven’t yet decided that we actually want less emergency room visits.”

Just a year ago, Onie thought that Health Leads’ biggest obstacle would be getting doctors to pay attention to patients’ social needs — given all the demands on their time. Today, the organization is getting so many referrals from doctors, for the first time in its history it has long waiting lists. Five decades after the war on poverty, a work force that can systematically address the social causes of illness is still to be built. Health Leads offers a model of how it might work. A broader system could incorporate students, community health workers, and lay workers. It need not be a perfect solution, nor an expensive one. But something has to be done. And the big challenge is getting health care decision makers to prioritize and pay for it. As Onie says: “How would we ever think that we’re going to secure a return on our health care dollar until we start dealing with these social factors?”

David Bornstein is the author of “How to Change the World,” which has been published in 20 languages, and “The Price of a Dream: The Story of the Grameen Bank,” and is co-author of “Social Entrepreneurship: What Everyone Needs to Know.” He is the founder of dowser.org, a media site that reports on social innovation.
A Conversation With Rebecca Onie, CEO of Health Leads
By Samantha Michaels
JUL 21 2011, 4:30 PM ET

As a sophomore at Harvard, Rebecca Onie was already revolutionizing Boston’s health care system by co-founding Project HEALTH, now called Health Leads, at Boston Medical Center. Fifteen years later, as Health Leads’s CEO, she’s breaking the link between poor health and poverty by mobilizing an energetic yet unusual group of health workers: ambitious college students. Her organization, which today serves six cities, teaches student volunteers to help low-income patients fill social “prescriptions” such as better food, housing, and job training.

Onie also received a degree from Harvard Law and worked briefly as an attorney in Chicago. Since returning to Health Leads in 2006, she has been honored as one of TIME magazine’s 100 most influential people, a MacArthur Fellow, and a member of O, the Oprah Magazine’s “Power List” of women who are “changing the world for the better.” Here, she discusses non-medical needs that are nonetheless critical to health, how young people can improve patient care, and her perfect pump-up song.

What do you say when people ask you, “What do you do?”

Health Leads’ ultimate goal is a health care system in which doctors are able to prescribe solutions that improve health, not just manage disease. Every day, doctors in poor communities across the U.S. prescribe antibiotics to patients who have no food at home or are living in a car. Of course, medicine alone won’t solve these problems, and many of these patients will return with more serious—and more expensive—illnesses.

In the hospitals and health centers where Health Leads operates, doctors can “prescribe” healthy food, safe housing, exercise programs, or other key resources—just as they would medication. Families then take their prescriptions to the clinic waiting room, where Health Leads’s corps of 1,000 college volunteers work with them to access these resources in their communities. Nearly 60 percent of Health Leads patients secure at least one critical resource—receiving food, getting their heat turned back on, finding a job—within 90 days of getting their “prescription.”

What new idea or innovation is having the most significant impact on medicine or public health?

The medical home model—now a darling of the national health care dialogue—is not new in concept, but is being embraced by health care institutions in ways that may give it real life. The rather obvious idea that patients must be treated comprehensively to achieve better health outcomes is revolutionizing the way that clinics structure their care protocols, their staffing structures, and even their physical design. In many ways, medical homes represent the long overdue integration of “medicine” and “public health,” bringing services that address the non-medical but health-critical needs of patients into the clinic itself.

What’s something that most people just don’t understand about your field?

These days, health care in the U.S. seems so messy: expensive, impenetrable, bureaucratic, and partisan. What people don’t see as readily is that what is needed to move the needle on health outcomes is often quite simple. Health Leads’s model, for example, is straightforward, cheap, and effective: We’re demonstrating that a desk in a clinic waiting room
staffed by a couple of college volunteers can empower health care providers to ask their patients a whole new set of questions—and begin to transform the health care system into one that is actually responsive to the full set of factors that impact health.

What’s an emerging trend that you think will shake up the health care sector?

With millions of new patients entering the health care system with coverage provided by the Affordable Care Act, the primary care workforce shortage is increasingly dire. At the same time, clinic infrastructure to address the complex needs of those patients is nearly non-existent: At New York-Presbyterian’s Washington Heights Family Health Center, for example, there is one social worker for 47,000 low-income patients. Faced with this profound capacity constraint, the U.S. has the opportunity to tap a trend long utilized in global health but only recently gaining momentum domestically: clinic extenders. From community health workers to Health Leads’s own college volunteers, the emergence of non-traditional health care workforces could be game-changing.

What’s a health trend that you wish would go away?

The health care system continues to focus disproportionately on “care” at the expense of “health.” Because Medicaid does not generally reimburse for social workers, case managers, or community health workers under the prevailing “fee for service” payment structure, each clinic must carve out precious discretionary funds from its operating budget for this purpose—resulting in limited capacity to address the real factors impacting patient health.

The challenge becomes self-perpetuating. Overburdened case management staff focus on crisis cases, lacking the time and capacity to attend to other patients and document their needs (and resolutions of their problems). Absent this data, it is impossible to build the business case for these activities.

Over the past two years, certain forces have been set in motion that create an unprecedented window to redefine what the U.S. health care system pays for and thus the scope of care provided. I would like to see a system that is willing to make preliminary investments in interventions that stretch the boundaries of what we currently understand as health care.

What’s an idea you became fascinated with but that ended up taking you off track?

When Health Leads launched in 1996, the notion of obesity and asthma epidemics was just creeping into the public consciousness. At the time, Health Leads created and implemented novel disease education programs for youth with asthma, diabetes, sickle cell anemia, and other chronic medical conditions. While popular with our volunteers and physician partners, the programs did not yield the compelling, cost-effective results necessary to justify their costs. Eliminating these programs was a painful decision, but ultimately empowered us to focus our resources on the work of creating patient resource connections and to be as deliberate about what we choose not to do as what we choose to do.

Who are three people in the fields of medicine or public health that you’d put in a Hall of Fame?

Dr. Atul Gawande: An extraordinary narrative storyteller for the health care field, Dr. Gawande makes the opaque and arcane aspects of health care comprehensible to the public, policymakers, and thought leaders alike. When we are tempted to turn and run from the onslaught of the health care debate, he coaxes all of us back into the conversation.

The Mayo Clinic Center for Innovation Team: In 2008, the Mayo Clinic made the unconventional move of hiring a team of architects, graphic and product designers, and other systems thinkers to re-imagine health care delivery. Already, this team has produced innovations that could dramatically alter the way all patients experience health care.

Dr. Barry Solomon, Medical Director at Harriet Lane Clinic, John Hopkins Children’s Center: One of my mentors often says, “Ideas don’t change the world. Execution does.” Dr. Solomon’s tenacity in translating the concept of a medical home into front-line clinical practice is unparalleled. His in-the-trenches tactics—such as ensuring that pro-
providers complete Health Leads’s patient resource needs screening tool by stapling it to the patient billing sheet—exemplifies the kind of leadership necessary to change health care delivery.

**What other field or occupation did you consider going into?**

When I founded Health Leads as a sophomore in college, I thought I wanted to be a lawyer. After deferring law school for three years to grow Health leads from Boston to Providence and Harlem—and with my LSATs about to expire—I reluctantly left for law school, hungry for expertise and enamored with the legitimacy I thought a degree could provide. After a brief stint as a lawyer, I realized that a discipline that assumed the inevitability of conflict and insisted on incremental change was not for me. And so I returned to Health Leads, with the aspiration to leverage my outsider’s perspective to disrupt “business-as-usual” in the health care system.

**What’s one website or app you wish more people knew about?**

Check out the website for the Robert Wood Johnson Foundation’s Commission for a Healthier America (http://www.commissiononhealth.org/). Brimming with useful research and models that work, it is a powerful reminder that so many solutions are already at our fingertips.

**What song’s been stuck in your head lately?**

Usher’s “Yeah”—a song worth dancing to! Changing health care requires a great soundtrack.

Image: Courtesy of Rebecca Onie
March 15, 2011 [Palo Alto, CA] The Skoll Foundation announced today the 2011 recipients of the Skoll Awards for Social Entrepreneurship. Each year the Skoll Foundation chooses a select group of top social entrepreneurs and their organizations working around the world in the areas of tolerance and human rights, health, environmental sustainability, peace and security, and economic and social equity. Skoll Award recipients receive a three-year grant and join the growing global network of now 85 Skoll social entrepreneurs from 70 organizations who are tackling the world's most pressing problems.

"Many of the most challenging problems we face – access to clean water, effective and affordable healthcare, and literacy and education – are rooted in poverty. But looking at our 2011 Skoll Award winners, I see great hope for the future," said Sally Osberg, President and CEO of the Skoll Foundation. "The four social entrepreneurs we honor this year offer scalable, proven solutions to these truly daunting problems."

The Skoll Awards program provides social entrepreneurs who have achieved significant impact with unrestricted funding to further extend their reach. These new Skoll entrepreneurs have proven their innovations and are delivering results across issues and geographies. The four 2011 Skoll Awardees are:

**Rebecca Onie, Health Leads**

Onie founded Health Leads (formerly Project HEALTH) with Dr. Barry Zuckerman, Chair of Pediatrics at Boston Medical Center, to expand the capacity of clinics to connect patients with food, housing and other resources that they need to be healthy and to build a pipeline of new leaders in the health care system. In the clinics where Health Leads operates, doctors can “prescribe” these critical resources just as they would medication. Patients take their prescriptions to the clinic waiting room, where Health Leads’ college volunteers connect them to the necessary resources. In 2010, 57 percent of Health Leads’ patients obtained at least one resource in 90 days (e.g., a family with an asthmatic child needs help getting heat in the winter) and 83 percent of volunteer graduates entered jobs or advanced study in the fields of health and poverty.

**Ned Breslin, Water For People**

Breslin spent more than 16 years in Africa working on water and sanitation before joining Water For People and introducing bold, systemic solutions to critical issues facing the sector. Water For People partners with communities in developing countries to create sustainable, locally-maintained drinking water solutions and supports market-driven sanitation solutions, such as its Sanitation as a Business program. Accountability and sustainability are major focuses for the organization. It recently developed a new monitoring and evaluation technology called FLOW (Field Level Operations Watch,) which leverages Android technology and Google Earth software for tracking the status of water points at least 10 years after implementation.
Ellen Moir, New Teacher Center

Moir, a longtime teacher and educator of teachers, founded the New Teacher Center (NTC), which improves student achievement in American public schools. NTC does this by accelerating the effectiveness of new teachers, specifically those who work with low-income, minority and English as a second language (ESL) students. Its mentorship and professional development programs provide support and guidance to novice teachers in the early stages of their careers, as well as to principals and administrators. NTC also influences policy at the district, state, and federal levels. It is the only national nonprofit in the US that is focused on new teacher effectiveness and inducted 26,818 teachers and 1,762 new and experienced principals (reaching 1.84 million students) in 2009-10.

Madhav Chavan, Pratham

Chavan leads Pratham, whose goal is to ensure that every child is in school and learning well. Pratham works across urban and rural India, mobilizing volunteers to execute low-cost solutions to maximize government efforts. Starting by setting up pre-schools in community spaces or people’s homes in slums, Pratham introduces remedial literacy learning in Indian schools and focuses on measuring outcomes. It launched Read India, which has trained over a million volunteers and teachers, reaching more than 34 million children. Pratham also created partnerships that publish children’s books and provide computer and English learning. It developed the Annual Status of Education Report, a nationwide household survey that assesses the impact of government spending on education. Visit PrathamUSA.

The Skoll Awards will be presented by Jeff Skoll, Skoll Foundation founder and Chairman, and Sally Osberg, Skoll Foundation President and CEO, on March 30 at the University of Oxford at the eighth annual Skoll World Forum. The Skoll World Forum on Social Entrepreneurship is the premier, international platform for accelerating entrepreneurial approaches and innovative solutions to the world’s most pressing social issues. The Forum is being held this year March 28-April 1.
Eliminate the "Health Gap"

James R. Knickman, President & and CEO, New York State Health Foundation
Posted: February 28, 2011 02:11 PM

As we mark Black History Month in February, I think about the progress that has been made to eliminate racial inequities, but also about the work that still needs to be done. When it comes to reducing disparities in health -- rates of diabetes, asthma, even premature death -- New York State still has a long way to go.

Statewide, hospitalization rates resulting from diabetes complications are four times higher for black people than for whites, according to the State Department of Health. Black New Yorkers are nearly five times more likely than whites to be hospitalized for asthma complications.

We see geographic difference in health layered with racial and ethnic disparities. People who live in East Harlem are four times more likely to be obese than those who live just a few blocks away on the Upper East Side. In the Williamsburg/Bushwick area of Brooklyn, rates of diabetes are nearly four times higher than in Greenwich Village.

So what is the solution? In a recent New Yorker article, “The Hot Spotters”, Atul Gawande wrote compellingly about the efforts that some committed health care providers in Camden, NJ, are making to improve the health of their sickest, costliest patients. These health care teams must not only address the health care issues facing their patients (for example, a lack of regular access to care or an inability to pay for needed medications) but also the nonmedical factors that influence health -- poverty, poor housing, smoking, a lack of access to affordable healthy foods.

Similarly, in New York City (as well as in Baltimore, Boston, Chicago, Providence, and Washington, D.C.), a program called Health Leads operates in health centers and hospitals to fill non-medical “prescriptions” for patients who need assistance with food, housing, utilities, child care, jobs, health insurance, or a range of other factors that affect health.

Whole communities are also coming together to tackle the environmental and social factors that influence health, through federal Promise Neighborhood grants. For example, Lutheran Family Health Centers -- the grantee for the Brooklyn Promise Neighborhood in Sunset Park -- is working with the community service and child welfare agency, the community board, providers of early childhood services, and academic institutions to improve children’s education and development. (It seems worth noting that three of the 21 planning grants for Promise Neighborhoods support community coalitions in New York: Brooklyn, Harlem and Buffalo.)

Promise Neighborhoods are primarily about improving education, but take a holistic approach that recognizes that issues related to education, housing, and health are linked inextricably. Children need to be healthy if they are going to succeed in school and in life. Families need to have safe places to live, to be able to pay for their medications, to have access to affordable healthy foods, to have their basic human needs met if they are going to be healthy. If a person with asthma can’t afford an inhaler, or lives in a poorly-maintained building that triggers asthma symptoms, of course that patient will be more likely to end up in the hospital than someone who has the basic tools to manage the disease.

If we fail to address these basic disparities in resources and access, we will never eliminate disparities in health outcomes. There are promising models and approaches underway in New York State and across the country to do so. Let’s use Black History Month as a jumping-off point to make health disparities part of the past rather than the future.
Power of One.
By assembling a corps of college volunteers, Rebecca Onie is helping physicians address the connection between health and poverty.

By Gilbert Cruz

It started with a simple question: “If you had unlimited resources, what would you give your patients?” For Rebecca Onie, who asked this of physicians during her weekly visits to Boston Medical Center as a Harvard sophomore, the answers were illuminating. “I have a kid who comes in with an ear infection, and I prescribe antibiotics,” says Onie, paraphrasing one of the doctors. “Meanwhile, the real issue is that there’s no food at home, or the family is living in a car.” It is that connection between health and poverty, all too often unaddressed, that pushed Onie to found Project Health.

The nonprofit places some 600 undergraduate volunteers a year in hospitals and community health centers, where they assist physicians who realize that their patients are grappling with such problems as hunger or homelessness. “The idea is that these factors should be treated like any other clinical indicator,” says Onie. “Access to food and access to housing are just as critical to a patient’s health and likewise should be screened for as a standard part of every patient visit.”

Doctors at participating clinics in six cities can write nonmedical prescriptions for assistance with utilities or other factors that may be underlying reasons for low-income patients’ health problems. Patients then take their prescriptions to a Project Health desk, where a volunteer will help them find government or community resources (housing vouchers, child care, etc.). The process is meant to bridge what Onie calls an information gap, which exists both for patients who don’t know where to go for help and for doctors who are equally clueless about where to send them.

Founded in 1996, the program now helps about 4,000 families a year in clinics where social workers are few or nonexistent. Says Onie: “We’re an example of how a very simple solution can have a real impact on health.”
MacArthur Foundation Announces New Fellowship Winners

By Ian Wilhelm

The John D. and Catherine T. MacArthur Foundation has named a nonprofit health worker, a poet, a paper maker, and 21 other people as new MacArthur Fellows.

The fellowships, which are commonly referred to as “genius grants,” recognize individuals from a wide range of disciplines who, according to the Chicago foundation, have demonstrated creativity and the potential to make important contributions to the world.

Twelve women and 12 men were selected this year, ranging in age from 32 to 69. Each one will receive $500,000 over five years with no strings attached. Fifteen of the fellows work at academic institutions or other nonprofit organizations. They include Jill Seaman and Rebecca Onie, who have both sought to improve the health of impoverished people.

Ms. Seaman, a 57-year-old doctor, has worked in Sudan helping to prevent the spread of diseases among the Nuer tribe in the country’s Upper Nile province. She began her work in the region in 1989 with Doctors Without Borders. When the aid group left Sudan due to security concerns in the late 1990s, Ms. Seaman stayed and established a medical charity to continue her health work.

On the domestic front, Ms. Onie, 32, co-founded Project Health, a Boston group that recruits and trains college volunteers to assist hospitals and medical clinics.

As an undergraduate student at Harvard University in the late 1990s, Ms. Onie volunteered for the housing unit of a legal-services group, where she saw that the problems of its impoverished clients were often tied to health issues.

“Families would come in and they were about to be evicted because they hadn’t paid their rent,” she says. “They hadn’t paid their rent because they were paying for their medication.”

Ms. Onie co-founded Project Health to ameliorate some of those nonmedical problems that lead to bad health conditions.

The group’s primary program is operating Family Health Desks at 10 hospitals in six cities. Doctors can write “prescriptions” for food, housing assistance, or other aid for patients. At the desks, college students connect the patients with various government and nonprofit social services.

With MacArthur’s monetary windfall, Ms. Onie says she will donate a portion of it to her group, which is about to start a $10-million fund-raising campaign. But while she is thankful for the
money, she emphasizes that the MacArthur fellowship is more valuable for the chance it provides her to speak out on pressing issues.

“It’s the most profound opportunity to be able to have a forum to talk about our work,” she says, “and the role it can play in the unfolding health-care discussion in this country.”

Following are the 2009 fellows, along with a summary of their accomplishments as provided by the MacArthur Foundation:

- **Lynsey Addario**, 35, photojournalist, in Istanbul. She is creating a visual record of the most pressing conflicts and humanitarian crises of the 21st century.

- **Maneesh Agrawala**, 37, associate professor of electrical engineering and computer science, University of California at Berkeley. He is designing visual interfaces that enhance users’ ability to synthesize and comprehend large quantities of complex, digital information.

- **Timothy Barrett**, 59, research scientist, University of Iowa, in Iowa City. He is reinvigorating the art of hand papermaking and leading the preservation of traditional Western and Japanese techniques and practices.

- **Mark Bradford**, 47, mixed-media artist, in Los Angeles. He is incorporating ephemera from urban environments into richly textured, abstract compositions that evoke a multitude of metaphors.

- **Edwidge Danticat**, 40, novelist, in Miami. She is chronicling the power of human resistance and endurance through moving and insightful depictions of the Haitian immigrant experience.

- **Rackstraw Downes**, 69, painter, in New York. He is rendering minutely detailed landscapes of unexpected vistas that reconsider the interaction between the built and natural worlds.

- **Esther Duflo**, 36, professor of poverty alleviation and development economics, Massachusetts Institute of Technology, in Cambridge. She is analyzing the forces perpetuating cycles of poverty in South Asia and Africa.

- **Deborah Eisenberg**, 63, short-story writer, in New York. She is crafting portraits of contemporary American life in tales of striking precision, fluency, and moral depth.

- **Lin He**, 35, assistant professor of cell and developmental biology, University of California at Berkeley. She is advancing our understanding of the role of microRNA’s in the development of cancer and laying the groundwork for future cancer treatments.
• **Peter Huybers**, 35, assistant professor of climate, Harvard University, in Cambridge. He is mining a wealth of often-conflicting experimental observations to develop compelling theories that explain global climate change over time.

• **James Longley**, 37, filmmaker, Daylight Factory, in Seattle. He is deepening our understanding of the conflicts in the Middle East through intimate portraits of communities living under extremely challenging conditions.

• **L. Mahadevan**, 44, professor of applied mathematics, Harvard University, in Cambridge. He is investigating principles underlying the behavior of complex systems to address such accessible but vexing questions as how flags flutter, how skin wrinkles, and how Venus flytraps snap closed.

• **Heather McHugh**, 61, professor of English, University of Washington, in Seattle. She is a poet composing richly layered verse that unabashedly embraces such wordplay as puns, rhymes, and syntactical twists to explore the human condition.

• **Jerry Mitchell**, 50, investigative reporter, Clarion-Ledger, in Jackson, Miss. He is ensuring that unsolved murders from the civil-rights era are finally prosecuted by uncovering largely unknown details of decades-old stories of thwarted justice.

• **Richard Prum**, 48, professor of ornithology, Yale University, in New Haven, Conn. He is drawing from developmental biology, optical physics, and paleontology to address central questions about avian development, evolution, and behavior.

• **John A. Rogers**, 42, professor of materials science and engineering, University of Illinois at Urbana-Champaign. He is inventing flexible electronic devices that lay the foundation for a revolution in manufacture of industrial, consumer, and biocompatible technologies.

• **Elyn Saks**, 53, professor of law, psychology, and psychiatry and the behavioral sciences, University of Southern California, in Los Angeles. She is expanding the options for those suffering from severe mental illness through scholarship, practice, and policy informed by a life story that adds uncommon depth and insight.

• **Beth Shapiro**, 33, assistant professor of biology, Pennsylvania State University, in University Park. She is using molecular phylogenetics and biostatistics to reconstruct the influences on population dynamics of extinct or severely challenged species.

• **Daniel Sigman**, 40, professor of geological and geophysical sciences, at Princeton University, in N.J. He is unraveling the interrelated physical, chemical, geological, and biological forces that have shaped the oceans’ fertility and the earth’s climate over the past two million years.

• **Mary Tinetti**, 58, professor of medicine and epidemiology and public health, Yale University School of Medicine, in New Haven, Conn. She is challenging prevailing
notions of falls as unavoidable accidents associated with advanced age and identifying risk factors that contribute to morbidity due to falls.

- **Camille Utterback**, 39, digital artist, in San Francisco. She is redefining how viewers experience and interact with art through pictorial compositions that are activated by human presence and movement.

- **Theodore Zoli**, 43, bridge engineer, HNTB Corporation, in New York. He is making major technological advances to protect transportation infrastructure in the event of natural disasters or crises people create.
IN 1996, as a prelaw student at Harvard, Rebecca Onie began working in the housing unit at Greater Boston Legal Services, where she quickly learned that poverty and poor health are often intertined. "A client would be facing eviction, and we'd realize that the real problem was that he was HIV-positive and couldn't afford his medication—much less his rent," she says. Frustrated that she was intervening too far downstream, Onie set out to help impoverished patients get the resources they needed to become healthier. The result: Project Health, a nonprofit that places student volunteers in urban clinics, where they assist patients in filling “prescriptions” for housing, food, legal aid, and other basic needs. After starting out with ten volunteers, the program now has 600 students serving 5,000 families. Of course, even that’s too small for the big-thinking Onie: Her goal is 23,000 families by 2014.

"At Project Health, we look at all the barriers families face on the path to good health, because good health doesn’t happen in a vacuum. For instance, a physician might say to a patient, ‘You’re at risk of becoming obese. You need to eat healthier and exercise.’ But the patient may not have money to buy nutritious food. And if the local parks are unsafe, where will that exercise take place? These broader issues affect patients’ ability to follow doctors’ orders—and doctors get this. They’ll say, ‘I know that good food and housing will have a bigger impact on my patients than, frankly, anything I can do in 13 minutes in the office. But I don’t know where to find the resources, and I don’t have the infrastructure to help.’ That’s where we come in. The doctor can write a prescription not just for antibiotics, but also for help in finding stable housing or a farmers’ market that accepts food stamps—and our volunteers make it happen. A simple solution, but it changes everything.”

The power of love is so great that all it takes is an image. A snippet. A snapshot. A girl’s face in a passing train, a desperate embrace in the street, bear witness to love, even from afar, and it changes you, sets a bird free in your chest.

Filmmakers know this. And thank God for that. Because watching something as gorgeous and powerful as Annette Bening and Julianne Moore wrestle in their ocean of love onscreen in The Kids Are All Right does more than make a political statement; it blasts politics to atoms. In the film, as in life, when it comes to love, the particulars are irrelevant. Recently U.S. district judge Joseph Tauro wrote, "To further divide the class of married individuals into those with spouses of the same sex and those with spouses of the opposite sex is to create a distinction without meaning.”
He's right, of course. The power of love is not dependent upon anything as prosaic as gender or age. What matters is the connection of one soul to another, the elemental magic that convinces you that you matter. That you are seen. That you are not alone. —ALLISON GLOCK-COOPER