Economic Studies at BROOKINGS

A Series of Discussion Papers on Building Healthy Neighborhoods No. 4| November 2015

Intermediaries in Integrated Approaches to Health and Economic Mobility

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Executive Summary

For individuals to achieve upward economic mobility they must live in a supportive neighborhood with, among other things, high quality primary care and good public schools. But even when the key ingredients of success are present, households often find it hard to navigate services. A variety of intermediaries help address that problem.

Some are "embedded" in such organizations as hospitals or schools and help clients to obtain a range of supplementary services. Examples include Health Leads, City Health Works, and Grand Aids, along with local community health workers and school nurse programs.

Others are the result of hospital-led population health systems. Examples include the Parkland Health system in Texas, the Montefiore and the Mount Sinai health systems in New York, and Washington Adventist Hospital in Maryland.

Others still are organizations linking together institutions focused on the same goal by providing data sharing services, financing, or organizational support. Examples include community development financial institutions, but also integrated service systems, such as the Harlem Children's Zone that organizes wraparound services for the families of its school students.

While intermediaries help households and can add value, they also face challenges in their operations. Often they are underfunded because budgets do not reflect their broad community value. Many regulatory and technical barriers impede information sharing with intermediaries, which is necessary to credibly show improved outcomes. There can also be a clash of culture between intermediaries and other organizations.

Policymakers in both the public and private sectors need to address these challenges so that intermediary institutions can demonstrate their value and fulfill their crucial role.

For individuals to achieve good health and upward economic mobility, they must live in a supportive neighborhood. As the Urban Institute puts it in a recent study, neighborhoods "are not simply geographic footprints but units of social organization that have meaning as places to live, work, and go about daily life."[1] These ingredients include, among other things, a high quality primary health care system, high performing public schools, and the individual skills and neighborhood scaffolds that translate opportunity and resources into broad-based economic mobility. It is commonly understood that in low-income neighborhoods and poor rural areas many of these core ingredients are of low quality or missing altogether.

What is less commonly recognized is that even if all of these ingredients are present, households must be able to navigate them and discern what combination of resources their family requires, and the effort needed to obtain or integrate them must be within their capacity. Those who most need resources may have the least capacity to navigate and access them. Research in the fields of behavioral economics and health care shows that stress and perceived scarcity often result in poor short-term decision making that can lead to worse long-term health status and

[1] Kingsley, Thomas, Coulton, Claudia and Pettit, Kathryn, 2014.

inadequate financial planning.[2] When households face such challenges in navigating the resources available to them, even a neighborhood with high health care and social spending in the form of government and philanthropic initiatives can remain sick and stagnant. Therefore, creative approaches are needed to get the best impact from the resources that *are* present as well as to complement them in targeted ways where necessary.

Across the country, intermediaries are emerging to address this challenging problem. Different types of intermediaries operate at different levels. At the level of an individual or family, an intermediary can be a professional who assists them as clients, helping them navigate their neighborhood and harnessing the best available assets to address their needs. At the level of the neighborhood, an intermediary can be a local institution such as a school or local health care system, which serves as a "hub" that integrates multiple services. At the level of a region or state, an intermediary might provide coordinated financial or organizational support to multiple organizations working toward a multi-sector goal, such as a community development finance institution that leverages its investments to advance early childhood development.

By their nature, intermediaries work across both the health care and social sectors. But different types of intermediaries are positioned at different points across these sectors. They can be based in the health care sector (such as a hospital or clinic), based in the social sector (such as a school or community finance institution), or at the interface of these two and other sectors. How organizations are positioned plays a significant role in determining the assets they bring to the table as well as the specific challenges they face in successfully integrating with organizations across the spectrum.

Intermediaries can address specific challenges of coordination where budget walls thwart cooperation and optimal outcomes, or where collecting and sharing information to improve services and evaluate results across silos is difficult. When successful, they can add significant leadership capabilities and organizational skill sets to achieve community goals.

In this paper we briefly describe a variety of intermediaries and how they operate. We also look at the challenges they face, with the goal of fostering discussion and encouraging further research on the value of intermediaries in the health system.

"Embedded" Extenders

Created to provide service to individuals at the interface of the health care and social sectors, some intermediaries are organizations or individuals that reside within another institution and serve to link the host organization and its clients more effectively to services outside the institution. In this sense the intermediary acts as an extender for the host organization, providing special skills and capacity. In some cases, such as school nurses, these embedded extenders enable the host organization to become a hub for a range of different services while concentrating on its primary focus.

Clinic-Based and Hospital-Based Extenders

Health Leads[3] is a nationally recognized non-profit, headquartered in Boston, that staffs clinic and hospital waiting rooms with trained college students who can connect patients to a host of social services in their neighborhoods, ranging from food security to housing and other benefits. The Health Leads staff use computer resources to locate services and enroll individuals and households into these services, which are directly connected to the transition needs of discharged patients. The Health Lead staff helps fill "prescriptions" from physicians for mainly non-health services and report back to the physicians on their patients' progress. The services can also help patients and their families with longer-term needs, such as: job placement assistance, income supports, and housing. Community volunteers carry out a similar embedding function at Washington Adventist Hospital in Maryland, helping to arrange a variety of services.[4] Similarly, Grand- Aides is a nurse extender program whose goal is to improve health and the quality of care while reducing unnecessary emergency, clinic, and hospital visits, resulting in reduced costs—they are said to have the "temperaments and personalities of a good grandparent." [5] Grand-Aides have some medical training, such as a nurse aide or community health worker, and then complete a Grand-Aide curriculum.

Community Health Workers

[2] Mullainathan, Sendhil, and Eldar Shafir. 2014.

[3] "Home." *Health Leads*. https://healthleadsusa.org.

[4] Butler, Stuart, Jonathan Grabinsky, and Domitilla Masi. 2015a.

[5] "Grand-Aides Summary." *Grand Aides.* http://www.grand-aides.com

Community health workers have long existed in the hazy space between the health sector and community advocacy. Their roles range from health promotion to direct participation in health care pathways. A particularly interesting example of using community health workers in a creative and effective way is City Health Works[6] in New York City. City Health Works is a social enterprise that is developing a financial model to sustain a full time workforce of health coaches that aligns the goals of health care systems, such as Mount Sinai Health System, with their shared clients/patients in the Harlem neighborhoods. These coaches work with clients to identify and address both clinical and non-clinical needs and to ensure information is shared across service providers. Beyond the support given to individual patients, a high quality community health worker system embedded in the neighborhood creates jobs that actively link together scattered workforces into systems of support that simplify and improve a client's experience.

School Nurses

School nurses provide important health services within most school systems. In some cases they are employees of the school system while in others they are employed by health systems but provide their services within schools. These services range from health education and interventions for acute and chronic illnesses to dispensing and monitoring medication. According to the National Association of School Nurses, a key role of the school nurse is to act as a caseworker and liaison between the school, the student, the family, and the medical community.[7]

Shared Challenges facing Extenders

Organizations lack full accountability or credit: A significant problem for most extenders is that the underlying business model of the organization in which they are embedded is rarely aligned with the integrated challenges they are solving. One common consequence of this is the "wrong pocket" problem. This means that the host organization sees the extenders as a cost center, while many of the financial benefits accrue to other organizations and individuals in the community. For example, while school nurses do improve the school-readiness of a student, they are a direct cost to the school system; much of the value of their services is in the form of the long-term health of children and their families with savings to public or private health plans.

Budgetary support is siloed: Even if the general community benefit of having these extenders is appreciated, their overall impact is rarely identified and incorporated into government budgeting. While agency heads recognize that embedded intermediaries have interagency benefits, there is often a bureaucratic reluctance to "share" budgets to maximize community benefits. That is why school nurse positions are always vulnerable to school district budget cuts even if there are major health benefits to local households.

Information firewalls: Another significant challenge for extenders who cross systems (e.g. health care to education to housing) in support of the same client is barriers to information sharing. Sometimes these barriers result from the interoperability of data systems. But often, federal regulations designed to protect privacy also hamper cooperation to achieve good care (e.g. HIPAA and FERPA[8]). So a school nurse employed by a school district will face barriers seeking information about, say, the hospitalization of a student.

Respect and stature: Even though these extenders are in a primary position to lead actionable change, they often lack the professional stature to drive it. Community health workers, for instance, typically are trusted by families in a community and yet find it difficult to gain the cooperation of others in the health system.

Lack of tailored training pathways: There is usually little formal cross-sector education for individuals who can play the role of an embedded intermediary in an institution. Usually they must learn on the job. Still, the rising interest in population health and the social determinants of health is leading more schools of nursing to

[6] "Home." *City Health Works*. http://cityhealthworks.com. Disclosure: City Health Works Executive Director Manmeet Kaur is married to paper co-author Prabhjot Singh.

[7] "Role of the School Nurse. " *National Association of School Nurses."* https://www.nasn.org/PolicyAdvocacy/

[8] The Health Insurance Portability and Accountability Act, enacted in 1996, and the Family Educational Rights and Privacy Act, enacted in 1974. For more information, see "Health Information Privacy." *U.S. Department of Health & Human Services: Improving the Health, Safety, and Well-being of America.* http://www.hhs.gov/ocr/privacy and "Family Educational Rights and Privacy Act (FERPA)." *U.S. Department of Education*. http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html.

introduce students to other fields, such as sociology and urban policy. Some colleges and universities are also introducing cross-training. For instance, The University of Virginia's School of Education now offers a youth and social innovation major designed to equip graduates to work effectively in non-school settings.[9]

Hospital-Led Population Health Systems

Interest in population health and the social determinants of health led to many hospital systems exploring roles as neighborhood-level intermediaries, embracing their potential as leaders in helping coordinate a range of services, beyond health, that contribute to a vibrant and healthy neighborhood. The requirements of the Community Health Needs Assessment, enacted as part of the Affordable Care Act, have encouraged tax-exempt hospitals to identify the health needs of their communities and to examine ways to address those needs.[10] At the individual level, hospital readmission penalties have also provided a strong incentive for hospitals to work closely with community organizations and social services to help ensure that discharged patients have a successful transition back into their homes and regular lives.[11]

Still, many hospitals struggle with the role of community intermediary. Their internal management culture and business model does not easily fit that role. But some have embraced it well and have adopted practices that could serve as models for other health systems.

Parkland Health System

The Parkland Health and Hospital System serves Dallas County in Texas as its primary health care safety net health care system.[12] In 2014 the Parkland Center for Clinical Innovations, a non-profit organization related to the system, developed the Information Exchange Portal (IEP)[13] to connect the nearly 400 community based organizations who share clients with the health care system. The goal of the IEP is to exchange and seamlessly share contextually sensitive information about a patient with multiple other organizations that also are addressing his or her needs. In return, the IEP provides community based organizations with high quality client-management software and is prototyping a financial incentive system to ensure that high need patients do not slip through the cracks. For example, using the IEP the Parkland Hospital can seamlessly alert a partner, such as The Bridge, a homeless recovery center that emphasizes job training and transition to affordable housing that, in order to get better, a shared client needs a specific set of supports outside of the hospital setting.

Montefiore Health System

The Montefiore Health System is located in the Bronx section of New York City and serves some of the nation's poorest zip codes.[14] The health system has a long-standing, multi-decade tradition of recognizing that the social needs of their patients are intertwined with their health. As a result, Montefiore has recognized its important role as an anchor institution in the economic development of the Bronx as well as its role as an intermediary that actively organizes and connects social services to serve their patients. In particular, Montefiore is one of the Pioneer Accountable Care Organizations (ACO) that aims to simultaneously improve outcomes and reduce costs for elderly patients through a greater emphasis on care coordination, individual performance monitoring, and flexible spending by aligning partners in the neighborhood. Based in part upon Montefiore's impressive performance, the ACO model was the first alternative payment model that was officially endorsed by Health and Human Services.

Mount Sinai Health System

Also located in New York City, Mount Sinai Health System, which recently became one of the

[9] "Youth & Social Innovation Major." *Curry School of Education*. http://curry.virginia.edu/academics/degrees/bachelor-of-science-in-education/youth-social-innovation.

[10] The Affordable Care Act added a new requirement for non-profit hospitals to produce a Community Health Needs Assessment every three years, at a minimum. The aim is to require these hospitals to conduct an in-depth analysis of the health needs of their community and develop a strategy for addressing those needs. For more information see "New Requirements for 501(c) (3) Hospitals Under the Affordable Care Act. *"Internal Revenue Service*. 2015. https://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501(c)

[11] Butler, Stuart, Jonathan Grabinsky, and Domitilla Masi. 2015a.

[12] "About Us." *Parkland Hospital*. http://www.parklandhospital.com/phhs/about-us.aspx.

[13] "Watch How PCCI Is Reengineering Healthcare Delivery through the Dallas IEP." *The Dallas Information Exchange Portal (IEP)*. http://iep.pccipieces.org

[14] "Home." *Montefiore Health System.* http://www.montefiorehealthsystem.org

largest non-profit health care systems in the country through a merger with another multi-hospital system, is relatively new to population health. However, it has taken a lead role in a New York statewide Medicaid redesign effort, where it is organizing two hundred other health and social sector partners into what is called a Performing Provider System (PPS). The timeline for this redesign completion is between 2015 and 2020 (Montefiore also leads a separate PPS), and the health system is making significant investments into population health infrastructure, technology, and workforce to simultaneously shift the commercial market towards population-based payments. Because there are hundreds of care delivery and social service partners involved in this process, forums, such as town halls, working committees, and other collaborative forums, are crucial to success, and provide an opportunity to share perspectives on caring for the same people that would not arise naturally.

Washington Adventist Hospital[15]

Located in the Maryland suburbs of Washington D.C., Washington Adventist Hospital (WAH) has become a local leader in developing creative approaches to population health.[16] For example, WAH has developed networks with the parish nurse system and local churches. It has also identified housing projects responsible for a disproportionate number of 911 calls and has organized services to tackle the underlying causes of those calls. Aiming to reduce readmissions for the homeless population, WAH is even in discussion with Maryland's Montgomery County government officials to help manage a transitional housing facility for homeless men discharged from the hospital.. In order to help arrange social services, housing, and jobs for discharged low-income patients, WAH has also established formal partnerships with Seedco, a nonprofit organization designed to advance economic opportunity for communities in need.[17]

Shared Challenges of Hospital Health Systems

There are multiple challenges that such health systems face in serving as effective intermediaries that integrate the social and economic needs of their patients into the care they provide:

Wrong pocket problem*:* A general issue affecting most of these institutions arises from the "wrong pocket" problem, noted earlier in the context of embedded intermediaries. This problem occurs when an institution engages in an activity that assists an individual, often incurring costs as well as revenues, but a third party (another "pocket") also gains a significant benefit. Because the value to the third party is not figured into the institution's accounting of the return on investment, the activity—which benefits a wider community —tends to be underfunded. Health care systems generate revenue from health care processes, in this instance, while opportunities to improve health outcomes and prevent illness are "upstream" from health care processes, and the broad benefits of greater health don't usually accrue to the hospital. For example, investment in early childhood development leads to healthier adults, but there are no accounting feedback loops to encourage health care dollars to be spent on earlier and potentially more effective non-health care processes.

Data transparency and interoperability**:** Even if health care systems were interested in thinking more expansively about the health of a population, their ability to share information with other services and organizations that help their patients is significantly limited. Some of these limitations are regulatory (e.g. HIPAA privacy regulations), while others include the lack of interoperability of data systems.

Inexperience with communities: While the success of the examples mentioned is due in significant part to the careful steps each has taken to build relationships and trust in the community, this is not an easy task for most hospitals. Because health care systems focus upon business processes and the application of biomedical technologies, their core competencies are significantly removed from those required to understand and engage communities. In many respects there is a clash of culture. This may change as non-profit health care systems are required to develop and use Community Health Needs Assessments to match services to neighborhood needs, similar to how the Community Reinvestment Act encourages financial institutions in low- and moderate-income areas to improve lending and investment in their communities.

[15] "About Us." *Washington Adventist Hospital*. 2015. http://www.adventisthealthcare.com/locations/washington-adventist-hospital/#.VdovrflVhBc

[16] Butler, Stuart, Jonathan Grabinsky, and Domitilla Masi. 2015a.

[17] "Seedco: Improving Lives and Growing Communities." *Seedco*. http://www.seedco.org

Consequences of control: Because aspects of health care services require significant quality control, ongoing monitoring, and continuous improvement, health care systems often work to maintain control over the activities of their partner institutions because of the perceived danger that *their* mission may be altered.

Although shifts in the underlying business model of health systems towards value-based payments for health improvement are a source of optimism, the rate of change has been uneven. Health care systems and insurers are moving cautiously to understand the business and operational implications of new financing arrangements. Even if their pace accelerates, as the federal government's new timelines for shifting Medicare payments in the value-based direction may indicate, most health care systems—even with a population health orientation—are not very knowledgeable about what constitutes a high value integration of local partners. Furthermore, any effective model of integration requires that frontline workforces, in both the health care system and the neighborhood, have the training and experience to work effectively together. But that's often not the case. So the entrance of population health into the neighborhood is a significant opportunity, but one that requires the presence of other intermediaries and mechanisms of accountability to shared end-users to truly be effective beyond traditional health care interests.

Serve-the-Server Coordinating Organizations

As the efforts of health care and social service organizations to improve coordination have come up against barriers, another form of intermediary has emerged to link together organizations working toward a shared objective by providing services, such as data sharing, financing streams, or organizational supports. Positioned mainly within the social sector and operating at the neighborhood or regional level, these serve-the-server organizations are often member-based and reflect the linked nature of their members' needs.

Community Development Institutions

Both Community Development Financial Institutions (CDFIs) and Community Development Corporations (CDCs) specifically focus on increasing access to credit and financial services to underserved communities. As a result, they have accrued unique expertise in identifying opportunities to optimize existing resources as well as methods to layer in new ones. The Nonprofit Finance Fund[18] is an example of a CDFI that works with a range of mission-oriented organizations to develop sustainable financing streams. These institutions are increasingly asking themselves how related organizations in their portfolios are part of "value chains" in which integrated activities can improve the health and economic status of clients they share or places they work in common. The Primary Care Development Corporation,[19] for example, makes investments in primary health care infrastructure that creates jobs and directs investments into low-income areas that need better access and that will benefit from new economic opportunities.

Integrated Social Service Organizations

The Harlem Children's Zone[20] is an intermediary in a one hundred square block zone of Central Harlem. It has a strong education emphasis, but also functions as a coordinator of many different services and programs that constitute an integrated approach to developing "cradle-to-college" pathways to break multi-generational cycles of low economic mobility. Just a few blocks to the east, STRIVE International,[21] which operates in dozens of American cities and international locations, is a highly regarded career development program that initially earned its distinction for providing reentry pathways for citizens returning from incarceration. Meanwhile, Seedco develops partnerships with community-based organizations, collects data to measure performance, and leverages funding for organizations. It is an intermediary, but also is a service provider and technical consultant.[22] In Maryland, the Family League of Baltimore[23] similarly acts as an agent of change in the city by strengthening and helping to fund community-based organizations while also using data to measure outcomes and refine its strategies.

Each of these organizations forms a unique bridge between multiple sectors and organizations to solve the challenges that their members face as

[18] "What We Do." *Nonprofit Finance Fund | Where Money Meets Mission*. http://nonprofitfinancefund.org

[19] "Stay in Touch." *Primary Care Development Corporation*. http://www.pcdc.org

[20] "Home." *Harlem Children's Zone*. http://hcz.org

[21] "Who We Are." *STRIVE RSS*. http://striveinternational.org.

[22] "Seedco: Improving Lives and Growing Communities." *Seedco*. http://www.seedco.org

[23] "Home." *Family League of Baltimore*. http://www.familyleague.org

they gain new capabilities and enter new stages of mobility.

Shared Challenges of Coordinating Organizations

Philanthropy dependence: Most of these intermediaries and the organizations they serve have business models that rely upon significant philanthropy, often with additional public financing support. As a result, their underlying business models are susceptible to economic downturn and contractions in social sector funding.

Need for continuous improvement infrastructure: Many intermediaries work to solve specific local problems or have local subsidiaries that operate as part of a larger "franchise." Success requires an explicit emphasis on continuous learning and improvement, including sharing experiences and insights across the component elements of the intermediary and its partner organizations. National networks such as Building Health Places[24] are working to build exchanges between community development organizations and health financing to stabilize funding.

Inadequate organizational controls: Many organizations lack basic financial control procedures and data collection for operations management and evaluation, which puts a limit on the number, variety, and complexity of interactions. The specific skills these organizations require to be effective intermediaries are poorly defined and rarely reflected in educational pathways, which means there are few training programs specific to these roles.

Overlapping services and streamlining services: End-users are often inundated by services of "coordinators" that are not in contact with each other. The entrance of health care systems into the neighborhood space, trying to achieve population health goals, amplifies these challenges. A related issue concerns control. When a local community institution, such as a school or community group, is part of a network including a service intermediary, the community institution will often have to cede some control of its operations in order to fit with the overall strategy and funding stream of the intermediary. This is not necessarily a bad thing in that the intermediary may be better positioned to address the needs of households in the community, but it does alter the locus of control.[25]

Looking Ahead – Addressing the Challenges

Intermediaries play a crucial role in communities and are likely to be used more extensively in the future. But as intermediaries continue to develop, attention needs to be paid to the challenges as well as the value they create for communities. As we have noted, in order to be effective, intermediaries must have sufficient organizational and information ties to the services and providers they work to integrate. For example, consider an embedded extender model where a service coordination professional is placed in a hospital to directly serve patients. If the extender lacks access to information, like patient records, or understanding of the organizational structures within the hospital, they can easily become just one more in a long list of service providers that hospital staff need to coordinate with, rather than being seen as a truly integrated and valuable member of the care team. From the patient's perspective, a poorly integrated extender is simply a middleman, creating a confusing and burdensome new point of contact without improving access to services.

Intermediaries may also fail to create value when their goals are too narrowly defined. In these cases, the organization is functionally closer to a traditional service provider than it is to that of a true integrator. For example, an intermediary that focuses exclusively on helping patients navigate a chronic illness like diabetes may effectively coordinate resources needed to control that disease, but fail to address other factors that impact the patients overall health. Here, the intermediary becomes one more in a mosaic of organizations the patient works with to address his/her disparate needs.

At the neighborhood level, the work of intermediary organizations and the challenge of integrating services at the end-user level are concrete and specific. However, their work is difficult to generalize into "cookie cutter" solutions, perhaps appropriately so. This leads to challenges in scale-up and replication, particularly if the most potent reasons why an intermediary may work well, such as its contextual history, strength of relationships, and a customized financial model, are poorly understood. Too often, the active

[24] "Working at the Intersection of Community Development and Health." *Build Healthy Places Network*. http://www.buildhealthyplaces.org.

[25] Butler, Stuart M., Michael B. Horn, and Julia Freeland. 2015.

ingredient is difficult to identify, even for those who created and manage the model. As a result, the value proposition of an intermediary often diminishes or narrows when a model is scaled up and the intermediary merely becomes another piece of an increasingly, densely scattered local environment.

Intermediaries have considerable potential in integrating the disjointed public financing streams between health care, public health, and social spending. As we have shown, many such organizations are engaged in innovative ways of realizing that potential. But as we have noted, they also face obstacles to fulfilling that potential. Almost uniformly, these challenges at multiple levels reflect the explicit role of intermediaries in overcoming barriers that frustrate and discourage the people who need services and often the providers who seek to help them. Because of their boundary-spanning role, the business models of intermediaries are often contextual and complex or overly reliant upon philanthropic support for working capital, and data systems and other requirements often don't adequately fit their bridging and coordinating role. Thus, policymakers in both the public and private sectors need to address these challenges so that intermediary institutions can play their full role in coordinating health and other services for those most in need.

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