

Building Healthy Communities



2019-2020 Impact Report



A Message from the CEO

When I think about Health Leads, our work, and its potential for impact, I think about community. Everything in our lives is interconnected and interdependent, from education and policy to the environment and technology. **So why is it that something as important as health continues to be thought of as an issue that individuals have to tackle alone?**

We know that 70% of what determines our health is based on social, environmental, and behavioral factors. Yet, in this country, so much of our energy is focused on changing individual actions. If only someone would exercise more, eat better, and minimize stress, then they'd be healthier. But that thinking misses the point: **if 70% of health outcomes are determined by what happens outside of our bodies, then health isn't a personal issue – it's a community issue.**

That's why we see vast differences in disease rates, wellness indicators, and life expectancy mere miles apart. It's also why the healthcare sector is increasingly focused on addressing all of patients' essential needs – from medical care to housing to food insecurity.

But if we want to truly transform health in this country, we must think beyond healthcare. Systemic racism, discrimination, and the legacy of historically inequitable practices continue to prevent people from accessing the essentials we all need to thrive.

Our evolved mission, vision, and strategy, Building Healthy Communities, enable us to directly address these systemic barriers to improve health not just for individuals but for whole communities.

Our programs are driven by the belief that communities should have a voice in decisions that impact their health, resource and health data should be open and accessible, and paid and unpaid caregiv-

ers should have the support they need to provide compassionate whole-person care:

- In New York City, we helped identify barriers to the WIC enrollment process. Now, New York State WIC offices are acting on our recommendations to make accessing this life-saving program easier for all eligible women and children.
- The Collaborative to Advance Social Health Integration convened 20 primary care teams from across the country to accelerate their efforts to improve, spread, and sustain their social health programs – scaling to 50+ new sites in just 18 months!
- Working with the Department of Health and Human Services in North Carolina, we supported the development of an ambitious statewide strategy to improve health and well-being by addressing housing and food insecurity, lack of access to transportation, and improving interpersonal safety.

These and other partnerships highlighted in this report reflect what's at the heart of our new strategy: centering community, innovation, and learning in all we do so that a difference of miles doesn't equal a difference in health. And while it will take time to realize this vision, I know that together we're already on our way to a new reality where every person in every community lives with health, well-being, and dignity.



Alexandra Quinn
Chief Executive Officer
Health Leads

Mission, Vision, Values ...

At Health Leads, we envision a future where **every person in every community lives with health, well-being, and dignity.**

To make this vision a reality, **we partner with communities and health systems to address the systemic causes of inequity and disease.** We do this by removing barriers that keep people from identifying, accessing, and choosing the resources we all need to be healthy.

We're committed to improving health equity, not just through what we do but how we do it. That's why each and every aspect of our work is informed by our organizational values.

Shared Leadership

We understand that strong leadership calls us to respect and honor the lived experiences and strengths each of person brings to the table — and believe that effective collaboration to advance community health is firmly rooted in mutual trust.

Justice through Equity & Inclusion

We recognize that systems of oppression continue to shape our society and health equity is not possible without social and racial justice. We commit to 'call in' our partners and each other to learn, embrace and practice equity and inclusion in all of our efforts.

Empathy & Genuine Relationships

We know that empathy and strong, genuine relationships are fundamental to our daily work. These attributes allow us to find joy and partnership to break down barriers that drive inequity — both on an individual level and across communities. We respect and appreciate the different strengths each of us brings, we embrace moments of conflict, and we celebrate each other's accomplishments in both big and small moments.

Constant & Courageous Learning

We contribute to bold change and innovation by learning in partnership with communities. We bring passionate curiosity, reflection and humility to continuously build on what we have learned from our experiences. By learning from each other, we fulfil our commitment to promote addressing health inequities so that all people can achieve health.

...And Commitment to Diversity, Equity, and Inclusion

"Health Leads started our Diversity, Equity, and Inclusion journey nearly seven years ago. While the journey has had many ups and downs, our commitment has never wavered. We've moved from being internally focused with the work to now having equity named in our mission and DEI being an explicit part of our partnerships. We will not rest until our vision of health, dignity and well-being for every person in every community is fulfilled."



Jennifer Valenzuela,
Chief People Officer



Building Healthy Communities

Despite spending more than any other industrialized country on healthcare, the U.S. experiences far worse health outcomes – not because we don't have good medical treatment, but because where we live, work, and raise our families has a greater impact on health. Because of high costs and underinvestment in neighborhoods, far too often people are forced to make choices between essentials like food and housing. **The result is that each year millions of people struggle to manage their health because they lack access to the resources that everyone needs to be healthy.**

For over 20 years Health Leads has worked in communities across the country to directly connect people with essentials. **But, true health equity must look beyond these individual connections.**

Achieving health equity requires building new multi-sector partnerships and collaboratively investing in efforts that address not just the symptoms, but the root causes of poor health.



Our Work

Our new strategy, **Building Healthy Communities**, is designed to create a new standard for how we define, build, and pay for health in this country. Our efforts are grounded in three key strategies we've seen improve health at the local level:

- 1) Promoting Shared Decision-Making:** supporting health systems to measure and improve the impact of their social health efforts in partnership with inclusive and representative cross-sector collaborations;
- 2) Strengthening Caregivers:** supporting locally based paid and unpaid caregivers, like community health workers, in providing whole-person care to community members, and;
- 3) Improving Measurement & Data:** making sure that everyone has access to real-time data about community resources and health so that the community knows if initiatives are working.

We're excited to share the impact of our work and grateful to our growing community of champions for helping create a future where every person in every community lives with health, well-being, and dignity.

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WHO WE ARE

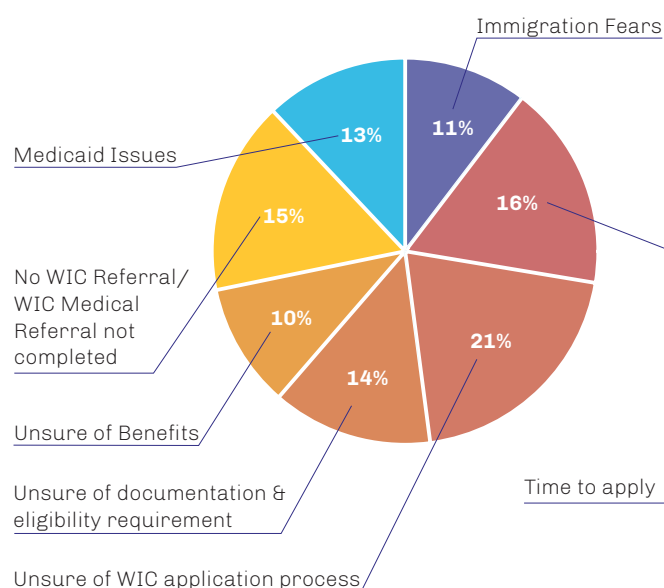


Leveraging Patient-Level Data for System-Wide Change

THE NYC MATERNAL HEALTH INITIATIVE

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) ensures that pregnant women and their children have access to free healthy food, nutrition counseling, and breastfeeding support during the critical stages of early childhood development. Early enrollment in WIC has been proven to save lives – reducing the risk of premature births resulting in fewer infant deaths. But only 57% of the eligible women and children in New York are currently enrolled in the program.

Barriers to WIC enrolleement as reported by eligible women.



PATIENT FEEDBACK DRIVES SOLUTIONS

In 2017, Health Leads was invited by the Robin Hood Foundation to support a two-year pilot with New York City to alleviate poverty by closing the gap in enrollment in WIC. Three Health Leads Community Health Workers (CHWs), working in five NYC Health + Hospitals clinics (NYC H+H), connected over 2,400 women to WIC benefits while collecting data and patient stories to support an evidence-based advocacy effort to improve the New York State WIC program. Alongside enrollment data, we also sought to directly engage community residents in identifying and recommending improvements to increase enrollment and retention.

OUR IMPACT

- Reduced the enrollment gap by 44% among our patients in NYC Health + Hospitals clinics.
- New York State WIC made ensuring consistency in enrollment processes a quality-assurance priority based on our recommendations.
- Hosted a community feedback session to share the outcomes of the focus groups back with participants and collectively prioritize opportunities for future improvement efforts.



"When it was time to recertify, I had to work, and I missed my appointment because they told me my mother could not recertify for me. So, she was my proxy, but I spoke to one person, and he told me she could go, and then when she got there with my daughter, it was like, no."

- 2019 Health Leads NYC Maternal Health Focus Group Participant

IMPROVING MATERNAL HEALTH OUTCOMES: A PATHWAY FORWARD

Today, a baby born to a family living in the Brownsville neighborhood of NYC has a life expectancy that is 11 years shorter than a baby born to a family living just 10 miles away in the Upper East Side. Leveraging our experiences with the WIC pilot project – and the cross-sector partnerships we have developed with NYS WIC, Robin Hood, NYC H+H, community organizations and residents, and WIC recipients, over the next four years we are striving to change this reality and reduce health inequities in New York.

Reducing the Impact of Racism on Women's Health

THE BOSTON HEALTHY START INITIATIVE'S COMMUNITY ACTION NETWORK

For generations, Black communities in Boston have organized against systemic underinvestment and racism in their communities. Because of these inequities, Black residents experience higher rates of infant mortality and premature birth than any other racial group in the city. In 2019, Health Leads partnered with the Boston Health Start Initiative's Community Action Network (BHSI CAN) to address this inequity by putting the voices of Boston's Black women at the center of the conversation to rethink public health policy and community-health solutions.

"Black women felt like if there was something wrong, they couldn't speak out because they didn't want their doctor to give them bad [care]"

– 2019 CAN Focus Group Participant

"Here we are training to facilitate a group of women that are just like [us]. [We] come from the same neighborhoods that they come from, have many of the same issues. People are hungry for this kind of work."

–Zakiya Alake, Community Liaison for Massachusetts, Health Leads





OUR IMPACT

- Trained 13 BHSI CAN participants in the Community Based Participatory Research methodology to lead the facilitation of peer research teams.
- Conducted 11 focus groups and 6 key stakeholder interviews with 100+ Black women of all ages.
- Co-analyzed focus group data with community residents to inform the design of a policy strategy for addressing racial inequities.

COMMUNITY-LED; INSTITUTION SUPPORTED

The BHSI CAN is a coalition of Boston residents committed to eliminating racial and ethnic inequities in infant mortality and poor birth outcomes through outreach, education, and policy change. **Alongside BHSI CAN members, we evaluated existing data on health inequities and engaged residents in identifying the ways that racism has impacted their health and/or the health of their community.** This process uncovered specific themes in women's experiences of racism and elevated new ways to address and reduce the racism experienced by Black women – especially within specific health systems and school districts where there is an opportunity for small changes to have big impact. Over the next year we will work on co-creating institutional and policy solutions based on the findings to address the racial inequalities in preconception health.

COMMUNITY, DATA, POLICY: A PATHWAY FORWARD

Through our work with the BHSI CAN we're centering the lived experiences and expertise of residents to develop a coordinated effort between community organizations, public health agencies, and health systems. Not only will this effort improve the health and well-being for Black women and children in Boston, but it also establishes a new model for community engagement that can be replicated by public health agencies and health systems across the city, state, and country.



Expanding Social Health Initiatives

JOHNS HOPKINS EXPANDS EFFORTS SYSTEM-WIDE

FROM WHY TO HOW

Twelve years ago, Health Leads launched our first Help Desk at Johns Hopkins Health System in the Harriet Lane Clinic. At the time the Health System had just begun investing in teams of social workers to respond to urgent unmet social needs. But, with a small team and many immediate needs, they did not have capacity to address social needs as a standard part of care. With the launch of the co-located Help Desk, volunteer advocates from Johns Hopkins University provided the additional capacity necessary to implement universal screening for social needs and provide tailored support based on patient's needs. **Since launching, Advocates have helped over 25,000 patients or caregivers connect with the essential resources they and their families need to be healthy.**

As one of our oldest partnerships, Johns Hopkins Health System has helped prove that it is not only possible to address patients' unmet social needs as standard of care, but that it's critical for supporting the health of the community. Under the leadership of champions like Dr. Barry Solomon and Anne Langley, Johns Hopkins Health System embraced innovation to improve care – partnering to develop and test ways to better support a student volunteer workforce, strengthening the programs through the addition of full-time professional Program Associates and Patient Navigators, and testing a new integration with EPIC to share case notes between their social needs caregivers and their medical providers. These innovations enabled us to provide not only our local patients a more consistent, higher quality experience, but influenced how we delivered care across the nation. **In 2019, Hopkins became our first partner to integrate the entirety of the program directly into their operations.**

Advocates at John Hopkins have helped over 25,000 patients or caregivers connect with the essential resources they and their families need to be healthy.

OUR IMPACT

Over the past year, we've worked with Johns Hopkins to ensure a smooth transition of our programs in three of their clinics, by:

- Collaboratively defining a vision of success grounded in building a model that continued to engage student volunteers to provide excellent patient services with the potential for replication enterprise wide.
- Providing guidance on operationalizing their vision and improving upon the existing infrastructure.
- Supporting the official launch of Hopkins Community Connection – their expanded social needs program – in June 2019.



CENTERING COMMUNITY: A PATHWAY FORWARD

In the few short months since transitioning, Hopkins Community Connection leaders were able to secure several new funding sources to support student engagement and sustain the program – demonstrating that health systems can find sustainable funding for their social needs programs – and have expanded and enhanced their community-based organization partnerships. They have begun integrating an on-site food pantry, partnering with a regional university to provide free tax-prep services, and have built the capacity for on-site enrollment in Head Start programs. Because of their commitment, thousands more of their patients will have access to the essentials.



Working Together to Spread Social Health Integration Faster And Better

THE COLLABORATIVE TO ADVANCE SOCIAL HEALTH INTEGRATION

When it comes to addressing the social determinants of health in our healthcare system, no one can argue that a lot has changed in the past five years. But even as little as two years ago, most of the efforts from healthcare systems to address their patients' essential resource needs have consisted of small, pilot programs with enormous potential but little sustainability.

That's why we set out to explore and understand how to both improve and spread these existing pilots with the Collaborative to Advance Social Health Integration (CASHI), a community of 21 innovative primary care teams and community partners across the country committed to increasing the number of people who have the essential resources they need to be healthy.

To say we learned a lot is an understatement. The innovations tested by these teams laid the foundation for each of them to move beyond "addressing social needs" to supporting health equity.

These innovations include:

- Adopting a "no wrong door" approach to building a cross-sector care coordination network;
- Integrating an empathic inquiry approach to assessing clients' resource priorities;
- Developing a trauma-informed racial equity supervision toolkit;
- Creating a range of approaches to making a business case.

CASHI, one of three learning collaboratives we completed this year, is a testament to the power of a supportive community of innovators. We have proven we can move faster and smarter with ongoing, collective learning and peer support. We are committed to continuing to change the systems that are contributing to poor and inequitable health – together.

REFLECTIONS FROM THE CASHI COMMUNITY

"We were coming off a three-year pilot when joining CASHI. CASHI helped inform where we were and where we wanted to go to next- especially in terms of sustainability."

"We came in as a successful pilot and we are leaving with a system-level strategy."

"We have learned so much together and are hitting our stride. We are collectively addressing big questions in the field."

"We are all gaining significant ground now and are establishing some really good relationships with one another. There is great opportunity within this group to innovate and not only spread, but also deepen the impact of this work!"

OUR IMPACT

- 15 teams spread their social health approach to over 70 new clinics in just 18 months, demonstrating an unprecedented level of spread over a short time period;
- Tested and implemented over 200+ improvements to their essential needs programs;
- Supported the accelerated adoption of best practices by developing dozens of practical tools and case studies based on the learnings shared by members of the collaborative.



LOOKING FORWARD: BUILDING A PATHWAY TO A HEALTHIER NATION

"I am most proud of this work when I get to watch people's minds change about what is possible."

Chloe Green, Director, Health Leads Collaboratives

There are so many questions left unanswered about how to create holistic health systems that ensure that every person has access to the essentials they need to thrive, but collectively it is possible to solve the most pressing challenges and accelerate innovation for a better future. Over the next four years, we aim to continue building this network of committed social health leaders, learning from each other, and ensuring communities receive the support they need to become healthier and more equitable.



Making Open, Accessible Resource Data a Reality

THE COMMUNITY INFORMATION EXCHANGE

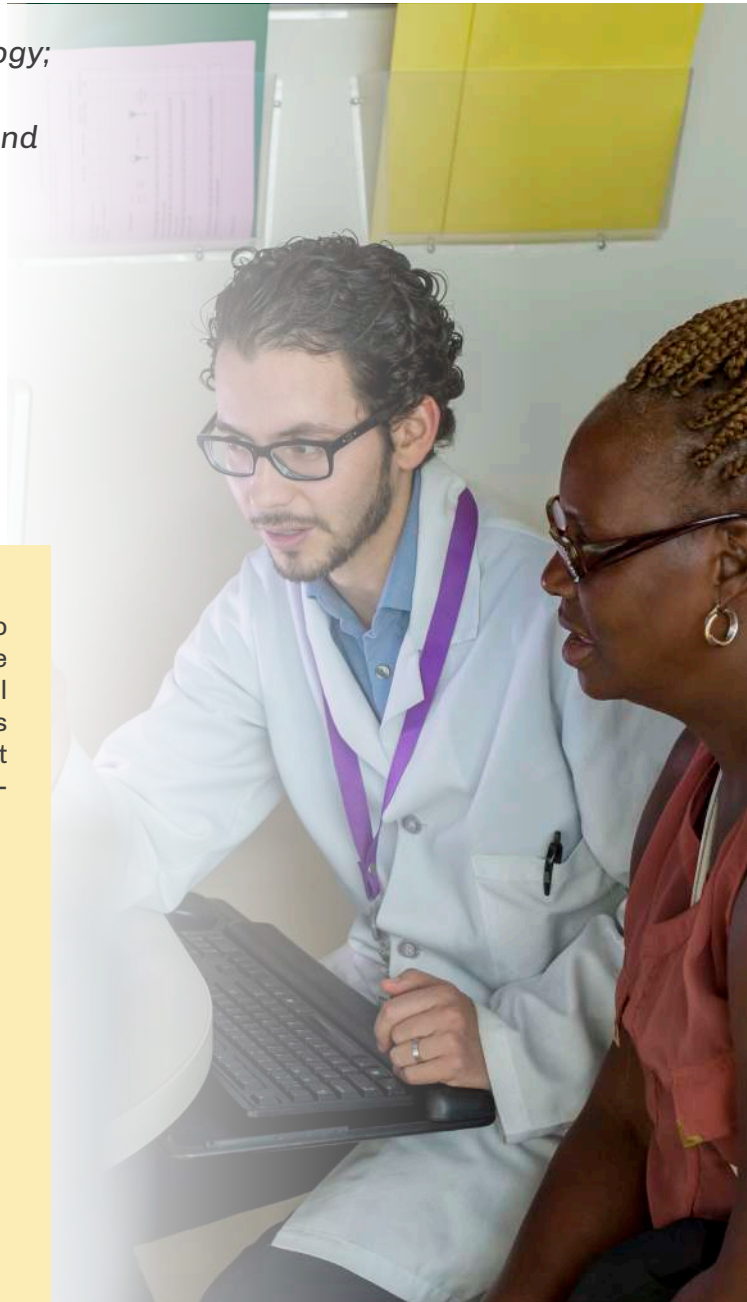
Community caregivers help connect us to important local resources – food banks, utility support, and more – that are essential to keeping us healthy. But, the ability to provide this critical service relies on access to accurate resource data. While hundreds of new technology companies have entered the market with the goal of providing accurate and timely local resource data, most exist behind expensive paywalls. There is a real risk of critical information becoming privatized and monetized. **At Health Leads, we know there is an urgent need to create models of community information sharing that keep this resource data open and accessible to those who need it the most.**

That's why we're partnering with 2-1-1 San Diego to support the creation of a Community Information Exchange (CIE)— a shared, technology-enabled system that supports resource data sharing between health and human service organizations to enhance community care. A CIE breaks down silos between care providers by utilizing the same assessment tools, databases, and shared caregiving language to better coordinate care. Even though the CIE is a technology-enabled platform, what's at its center is community—and a deep commitment to making sure that innovative technology always works for people.

“Incredible innovation is being made in data-sharing and cross-sector technology; the most important thing is centering it around people. And by centering it around people, we’re actually deepening the innovation.”



Sheena Nahm,
Vice President, Research
and Development



OUR IMPACT

In 2019, Health Leads and 2-1-1 San Diego worked together to refine and assess the CIE, and to explore how to make this model of care sustainable so other communities can build similar systems. Our assessment uncovered some core elements that dramatically improve client experience and care:

- Building deep trusting relationships between CIE partners is crucial to ensuring the success of the model and of treating clients.
- Having a shared language all partners use helps us work together more effectively and ensures that our clients have better care experiences.
- Community resource databases and new technology don’t work if they’re not designed with and for the people who will use them.

WHAT COMES NEXT? PUTTING DATA IN THE RIGHT HANDS

Health Leads and 2-1-1 San Diego are continuing to assess the CIE model and identify not just how to build great open data systems that support people, but how to make them sustainable so that other communities can do the same. Through partnerships with 2-1-1 San Diego and others, we hope to help spread this promising model of care across the country—ensuring that vital information about community resources stays right where it should: in the hands of community members.

Advancing a State-Wide Vision to Improve Health

PARTNERSHIP WITH NORTH CAROLINA DEPARTMENT OF HEALTH & HUMAN SERVICES

Driving along Highway 64 in North Carolina from Williamson to Raleigh you cross through five different counties. Depending on which county you call home, your life expectancy can range from 73 to 80 years – a seven-year difference in just 100 short miles.

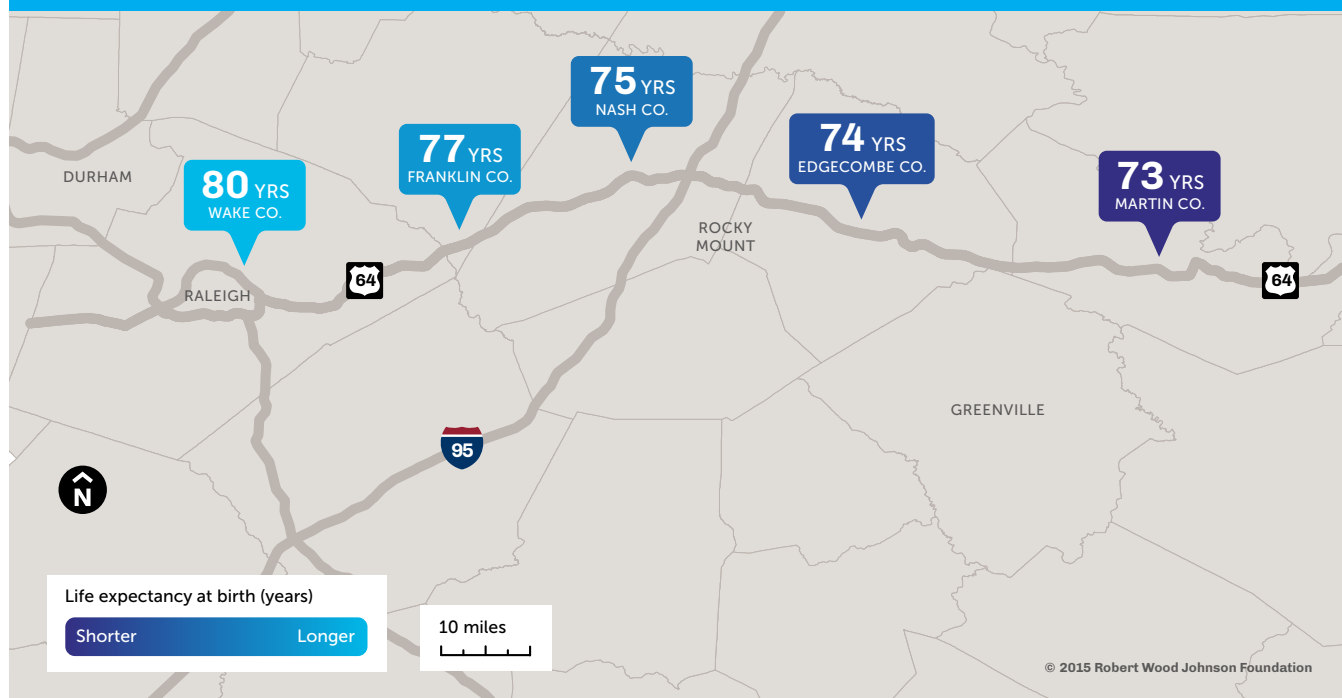
While North Carolina is home to some of the best healthcare systems in the country, many residents still experience both medical and non-medical barriers to health. These barriers have a profound impact on health outcomes and the cost of delivering care.

“Good health is important, but it's also required to grow our state's economy.”

- Secretary Mandy Cohen, Department of Health and Human Services, North Carolina

NORTH CAROLINA

1 Highway, 5 Counties, 7 Years of Life





OUR IMPACT

Leads provided guidance and advice on three DHHS priority areas:

- Designing and implementing the waiver pilots and developing a learning model to support shared learning and results within and across pilot regions.
- Co-creating a screening question guide and field testing the use of standardized screening questions with 804 patients across 18 clinical settings.
- Developing a philanthropic strategy to raise private dollars to complement public funding and support the success of pilots.

BUYING HEALTH, NOT JUST HEALTHCARE

In 2017, the newly appointed Department of Health and Human Services (DHHS) Secretary, Dr. Mandy Cohen, made addressing these barriers to health a key state-level priority. Her vision is to make North Carolina a leader in addressing unmet health-related resource needs state-wide. After securing a 1115 Waiver via the Centers for Medicare and Medicaid Services (CMS), North Carolina launched a pioneering five-year pilot aimed at identifying interventions that improve lives and reduce the costs of care for Medicaid enrollees. Through initiatives in 2-4 regions, DHHS aims to test ways of addressing the four most pressing unmet health related needs – housing, food, transportation, and interpersonal violence. **If proven to be effective, the pilots have the potential to shape how Medicaid managed care services are delivered across the entire state.**

WHAT COMES NEXT? IMPROVING HEALTH; REDUCING COSTS

At the end of the five-year waiver pilot period, North Carolina aims to be positioned as a national leader in cost-effective use of resources that optimizes the health and well-being of all people. This vision unites health-care systems, community organizations, and residents to ensure that every North Carolinian has access to all the essentials they need to thrive.

Community-Led, Equity-Centered Paths To Health:

JOIN THE RESPOND & REBUILD IMPACT FUND

Today, the economic fallout of Covid-19 is exposing the deepest flaws, fractures, and inequities within our health care and social service systems, with a growing gap between the need for essential resources and the capacity to coordinate and meet those needs (see graph below).

Communities of color which continue to experience the impact of historic and institutional racism and community disinvestment are suffering from COVID-19 at nearly three times the rate of white people, and face unprecedented and persistent economic hardship.

Similar to the global and multi-disciplinary call to action to “flatten the curve” of infections, Health Leads is working alongside many others to meet this increased demand and strengthen our essential resources infrastructure to ensure that our most vulnerable have food, housing, health, mental health, and other resources they need when they need them most.

Launched in March 2020 in response to the COVID-19 pandemic, Health Leads’ “Respond & Rebuild” effort is designed to deeply and authentically engage the

communities hardest hit by COVID-19 in order to develop effective, sustainable, and equity-oriented models for the delivery of critical essential resources now and restructure our systems to address societal roots of racial inequity that impact health. Core initiatives include:

- **Build lasting partnerships and change power structures** between health care, community-based organizations and community members to enable community members to make decisions about the living conditions that impact their health.
- **Expand, train and support community-based workforces** who help provide food, housing, and other essential resources to families and communities that need it most.
- **Design and implement shared, crisis-resilient community resource governance** and data networks to offer a complete, real-time picture of essential resource availability and access.
- **Fill knowledge gaps** with promising practices from our innovations and others to spread adoption of racial health equity and influence long-standing policy changes.

ILLUSTRATION OF TOTAL DEMAND FOR SOCIAL SERVICES AS COMPARED TO SOCIAL SERVICE CAPACITY OVER TIME THROUGH THE COVID-19 CRISIS AND RECOVERY.



- 1 Social distancing and shelter in place policies begin. Non-essential businesses close. Unemployment claims spike. Increased need for food, childcare for essential workers. Increase in abuse and domestic violence.
- 2 Shelter in place lifted and non-essential businesses can reopen. Some people are rehired, return from furlough or can quickly find a new job, but unemployment remains elevated.
- 3 Increased shelter demand as evictions and foreclosures rise. Public benefits regulations re-enacted. Some people will lose access. Longer-term economic recession leads to more job loss.
- 4 Workforce shortage. Some organizations close or reduce hours for quarantine and because of lack of funding.
- 5 Some organizations close permanently.

The Health Leads Respond and Rebuild strategy has garnered support from values-aligned philanthropic partners including Robert Wood Johnson Foundation, the Merck Foundation, Robin Hood Foundation, the Claneil Foundation, the Shaws Foundation and Star Market Foundation (part of the Albertsons Companies Foundation), Novartis US Foundation, The Boston Foundation, The Boston Resiliency Fund, the Lucile Packard Foundation for Children's Health, and the Rx Foundation, among others.

To learn more about Health Leads Respond and Rebuild efforts or become a Respond & Rebuild Impact Fund Investor, please contact Aziza Musa, Vice President of Development, at AMusa@healthleadsusa.org or visit www.healthleadsusa.org/respond-and-rebuild for more information.

"Health Leads and its partners are creating smarter, more equitable, community-centric design processes and innovations in health equity. As an early investor in Health Leads, I am proud of our work over the past 20 years to champion health systems change around essential health resources at scale. In order to rebuild a better future, we must make critical investments in people, nurture great leadership, and facilitate strategy. Only then can we create the transformational change necessary to prepare our essential health systems to be resilient, agile and equitable in the face of future crises."

- John Mandile, Board Member at Health Leads and Founding Partner of Social Ventures



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We are grateful for our philanthropic supporters that make this work possible. **Thank you!**

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