Human Service & Health Care Organizations:
A prescription for collaboration to improve social and health outcomes

By Charles Homer, MD, MPH with Ruth J. Liberman, MPA, and Katie Kalugin, MPP
Human services organizations* strive to improve the well-being of those with the greatest need in our society. Our organizations house homeless families, provide early care and education to young children in low-income families, and provide financial counseling to those deep in debt, among numerous other activities. Many human services organizations also advocate to change the policies that get in the way of, or implement new policies to better facilitate, successful journeys out of poverty.

Economic Mobility Pathways (EMPath) transforms people's lives by helping them move out of poverty, and provides other institutions with the tools to systematically do the same. EMPath disseminates its methods through the Economic Mobility Exchange™ (The Exchange), an extensive international network of government and nonprofit agencies. EMPath and members of the Exchange use a brain science-informed framework called the Bridge to Self-Sufficiency® (Figure 1) and a specific approach to coaching program participants, Mobility Mentoring®.

Poor health can impair an individual's chances to get an education and advance their career. Indeed, the Bridge to Self Sufficiency identifies physical and mental health as one of its "pillars," meaning that health issues must be addressed in order to achieve long-term economic success. Building on this recognition, many human service providers actively facilitate access to health care for participants and their families. Yet, while human service organizations focus on how poor health can impede progress towards economic self-sufficiency, we rarely consider how the conditions in which families live harm their health and how our services, by improving the conditions in which our participants live, may improve their health as well.

For the past one hundred years, the American health care delivery system—doctors, hospitals, health insurance companies—has paid scant attention to the impact of social conditions. As a result, this system has not included addressing poverty as a tool in its activities to improve health. Rather, since the early years of the twentieth century, health care delivery organizations have focused narrowly on clinical services alone as their approach to improving health. Fortunately, the perspective of health care is beginning to change by incorporating ideas from

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* "Human services" and "social services" are used interchangeably in this brief.

† According to the World Health Organization, "social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels." To the extent that health care policy makers and delivery organizations are considering social conditions, most are more focused on "health related social needs," such as inadequate or inappropriate food for a particular medical condition or housing instability that interferes with a person's ability to follow a medical regimen, rather than the underlying "distribution of money, power, and resources."
public health and political science that recognize the critical importance of “social determinants of health.” Because health care costs continue to go up without improving the overall health and longevity of our population, health care policy leaders are beginning to explore how health care resources can better address the very conditions that have been at the core of our human services work for so long.

What does this new-found interest from the health care sector in addressing social and environmental conditions mean for human services organizations?

Can Medicaid, or other sources of payment in the health care system begin to pay for our work?

Can human services organizations partner productively with health care organizations to better serve our participants?

How do we begin to get engaged in this process?

Are there policies that need be implemented that can accelerate and improve this process?

Questions such as these are the focus of this brief.
Two overarching principles are important when dealing with health care financing. First, it is complicated. There are many players, lots of jargon, rapidly evolving rules and approaches, and a lot of money at stake. Second, it is largely state-controlled. Medicaid—the most relevant source of health care payments for those we serve—is a partnership between states and the federal government, with a great deal of state-driven flexibility. Similarly, commercial insurance is largely regulated by each state, again requiring deep local knowledge. The power dynamics among the many players involved in health care policy and practice also vary by state, making generalization dangerous. So, although we can discuss general trends, local knowledge is essential in order to first understand health systems and policy, and then to act.

Medicaid and the Child Health Insurance Program (CHIP) cover almost 73 million low-income Americans; total government expenditures for Medicaid are $600 billion, only a little less than the $700 billion spent on Medicare, the public health insurance program for the elderly. Medicaid is a health insurance program that pays for medically necessary services for individuals who are low-income. For most of its first fifty years in existence, Medicaid only insured specific low-income populations—pregnant women, children, and the elderly who had spent down their resources in nursing homes. This changed in 2010 when the Affordable Care Act (Obamacare) authorized Medicaid coverage for all low-income individuals (up to 135% of poverty line) ages 0–64. States now have the choice of whether or not to expand their Medicaid coverage to adults in poverty;

Figure 2: States with Expanded Medicaid

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<thead>
<tr>
<th>Alaska</th>
<th>Kentucky</th>
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<tr>
<td>Arizona</td>
<td>Louisiana</td>
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<td>Arkansas</td>
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<td>Iowa</td>
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*Have expanded Medicaid by ballot initiative but not yet implemented.
**BRIDGE TO SELF-SUFFICIENCY®**

<table>
<thead>
<tr>
<th>Family Stability</th>
<th>Well-Being</th>
<th>Financial Management</th>
<th>Education &amp; Training</th>
<th>Employment &amp; Career</th>
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<tr>
<td><strong>Housing</strong></td>
<td><strong>Physical &amp; Mental Health</strong></td>
<td><strong>Debts</strong></td>
<td><strong>Savings</strong></td>
<td><strong>Educational Attainment</strong></td>
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<tr>
<td>No subsidy, housing costs 1/3 or less of household gross pay</td>
<td>Fully able to engage in work, school, and family life; health and mental health needs don't get in the way</td>
<td>Can always rely on networks to provide useful advice, guidance, and support for others</td>
<td>No debt other than mortgage, education, and/or car loans, and current in all debts</td>
<td>Savings of 3 months' expenses or more</td>
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<tr>
<td>Mostly able to engage in work, school, and family life; children or family members needs rarely get in the way</td>
<td>Can often rely on networks to provide useful advice, guidance, and support</td>
<td>Current in all debts and making more than minimum payments on one or more debts</td>
<td>Savings of more than 2 months' expenses, but less than 3 months' expenses</td>
<td>Associate's degree or professional certification complete</td>
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<tr>
<td>Barely able to engage in work, school, and family life because of health or mental health needs</td>
<td>Can rarely rely on networks to provide useful advice, guidance, and support</td>
<td>Making minimum payments on all debts</td>
<td>Savings of at least one month's and up to 2 months' expenses</td>
<td>Job training or certificate complete (beyond high school)</td>
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<tr>
<td>Not able to engage in work, school, and family life because of health or mental health needs</td>
<td>Can never rely on networks to provide useful advice, guidance, and support</td>
<td>Behind in payments of 1 or more debts and making payments on at least 1 debt</td>
<td>Savings of less than one month's expenses</td>
<td>High School Diploma or GED/HISSET complete</td>
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**MAKING DECISIONS IN CONTEXT**

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*Income ranges are for Suffolk County, MA. Data from HUD's 5/14/17 AMI tables.
at this time (February 2019), 34 states have expanded Medicaid coverage and three additional states have expanded Medicaid by ballot initiative but not yet implemented expansion.\(^2\) (See Figure 2.)

Medicaid programs are also required to provide the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for children. This benefit requires that Medicaid-insured children undergo regular comprehensive screening and that Medicaid pay for medically necessary services a child needs in order to thrive.\(^3\) These services include all services that are permissible under federal Medicaid policy, even if some of these services are considered "optional" for states and are not otherwise covered by Medicaid in that state. This offers opportunities for human services programs that provide services to children (such as early care and education programs) to explore how EPSDT may cover some relevant programming and activities (such as developmental screening and case management that connect participating children with health care) in their own organizations.\(^4\)

Most states (excepting only Alaska and Connecticut) have implemented some form of managed care for their Medicaid population. That is, rather than the state Medicaid agency paying health care providers directly for the services they deliver ("fee-for-service"), the state pays a managed care organization (MCO) a set fee ("capitation") for every enrolled person, and the MCO pays the provider. If the MCO payments to providers are, in the aggregate, lower than the funds they receive from the state in a specified amount of time (usually a year), they get to keep the difference ("shared savings"), giving MCOs an incentive to offer programs that improve health and reduce costs. MCOs have more latitude in the ways they can use their funds as long as they are improving health outcomes and reducing costs.\(^4\)

As if this were not complicated enough, the federal government and its state partners are implementing other approaches to paying for health care under the broad rubric of "value-based purchasing." In these models, the health providers themselves (rather than an MCO) experience financial incentives to improve health and reduce costs. The most comprehensive value-based payment model is the "Accountable Care Organization" (ACO). ACOs receive a fixed amount of money for each assigned patient, are responsible for the delivery of services, and are also expected to provide care coordination, integrate behavioral and physical health care, and, in most settings, collaborate in some way with community-based organizations.

\(^1\) Although the design of Medicaid managed care seems to enable MCOs to be expansive in undertaking creative approaches to improve the health of their enrolled population, various policies shape this flexibility. At least 85% of an MCO’s expenses must be on medical care rather than on their administrative costs (called the "medical loss ratio"). In addition, if an MCO’s costs go down, the state will seek to lower their capitation payments in the future (allowing the government to share in the cost savings) and may or may not include expenditures for specific services when calculating future rates. Some social services, such as care coordination (including coordinating with social service organizations) are considered medical rather than administrative expenses and so are included in the numerator of the 85% calculation. Care coordination is also considered a legitimate cost when the Medicaid agency sets future capitation rates. Other services ("value added services") outside the medical benefit package, but still seeking to improve health outcomes, may also be included in the numerator of the "medical loss ratio," though are not counted in Medicaid’s calculation of the MCO’s future capitation rate. MCOs must consider how any particular social service is categorized by the Medicaid agency when making decisions about whether or not to pay for it. Despite these concerns, several managed care organizations (e.g. CityBlock) are at the leading edge of interventions to address health-related social needs.
At this time (February 2019), 14 states have implemented accountable care for at least part of their Medicaid population and many more states are exploring this approach. Accountable Care Organizations (like MCOs) are also able to use their resources to address their patients’ social needs (e.g. unstable housing, hunger, or exposure to violence) if doing so will improve their health outcomes and reduce health care costs. However, both ACOs and MCOs need to demonstrate cost savings within a relatively short period—usually one to five years—making long-term investments in addressing social conditions a harder sell.

**Figure 3: States Implementing Medicaid Accountable Care Organization**

- Colorado
- Connecticut
- Iowa
- Maine
- Massachusetts
- Minnesota
- Missouri
- Nebraska
- Nevada
- New Jersey
- New York
- Pennsylvania
- Rhode Island
- Vermont
ALTERNATIVE APPROACHES TO HEALTH CARE INVESTMENT IN HUMAN SERVICES:

COMMUNITY BENEFITS AND CERTIFICATE OF NEED

Health insurance payment for social services can provide an ongoing source of support for the essential work human services organizations do to help people move out of poverty. However, initial partnerships between health care and human services often rely on time-limited grants. One potentially powerful source of such funding is termed “community benefits.” Three quarters of hospitals are nonprofit organizations. In order to maintain their nonprofit status, hospitals are required to commit resources for the benefit of the community. Although for many years hospitals were able to consider “charity care” and writing-off bad debt on medical services as their primary contribution to “community benefit,” the standards have become tighter. The Affordable Care Act requires that hospitals undertake a community health needs assessment as the basis for their allocation of resources. Having said that, the Internal Revenue Service rules make it somewhat harder for hospitals to justify community investments as allowed expenditures when compared to charity care and educational programs. Many states have their own specific community benefit requirements, with some substantially more stringent than the Federal rules. Another avenue for obtaining health care funding for human services can happen when health care organizations are obtaining state approval for building new facilities or substantially changing their services. Many states (35 states plus the District of Columbia, Puerto Rico, and the Virgin Islands) require that health facilities to gain regulatory approval for such changes. This process is often termed “Certificate of Need” (CON). See Figure 4.

In some states, CON approval is contingent upon the health facility investing other resources to improve community health. Given the large capital investments major medical institutions often make, these certificate-of-need allocations can be quite substantial. Boston Children’s Hospital, for example, was required to commit $54 million to a variety of programs and services to benefit the health and well-being of residents of low-income neighborhoods in Boston. The current (Trump) Administration is seeking to pressure states to eliminate their certificate-of-need programs. In addition, in many states the state Attorney General has authority to examine, approve or establish conditions for health system mergers, service closures, and service expansions. Often these conditions include a substantial disbursement of funds that can be used either to provide health services for vulnerable populations or to address social needs.
As noted above, although grants and awards from community benefit and certificate-of-need programs can support time-limited initiatives and launch partnerships between health care and human services organizations, a key opportunity is securing ongoing financing and potentially a payment model for services. It may be possible in some settings for Medicaid to serve as a source of ongoing financial support for some services. The two illustrative examples noted (pages 12-13) come from health care organizations that wanted to address social conditions, motivated by their mission and by a regulatory environment that encouraged such a direction. Because both of these efforts are financed through various forms of Medicaid value-based payment (managed care and accountable care at Children’s Hospital Wisconsin and MGH, respectively), they have the potential for long-term sustainability should the program achieve goals of importance to the health system. In these two cases, the organizations were able to reach out to EMPath through a well-established mechanism, the Exchange. Through this relatively light touch and limited commitment engagement, the health system can determine how their engagement with Mobility Mentoring will meet their own needs and, ideally, the relationships can deepen. At the same time, EMPath will learn about working with health systems through these connections—what their constraints are, what their priorities are, and more.
Children's Hospital of Wisconsin (CHW) is one of the premier pediatric hospital systems in the country. In addition to its two hospital campuses (one in Milwaukee and one in northeastern Wisconsin), CHW operates a managed care plan (an MCO). CHW also serves as the child welfare agency for the Milwaukee region of the state. In addition, CHW provides home visiting to low-income families with young children. Through all of these roles, hospital leadership is deeply aware of the impact of poverty on child health and is searching for ways to help improve outcomes. The hospital was able to commit resources from its managed care organization to join EMPath’s Economic Mobility Exchange™ and receive training in Mobility Mentoring®.

Mobility Mentoring aims to overcome the extreme stresses of poverty by improving focus, planning, and decision-making. It helps people achieve future-oriented goals, despite the immediate challenges of poverty, such as obtaining permanent housing or securing government benefits. CHW is exploring how to best deploy the approach—through care managers in their managed care organization, through providing new tools to their home visitors, or through enhancing the capacity of their child welfare staff.
Massachusetts is one of the 13 states creating Accountable Care Organizations (ACOs) for its Medicaid population. This financing mechanism enables creative approaches to improve health and reduce costs. The state Medicaid agency requires that ACOs take some action to address the social determinants of health. MGH’s parent corporation (Partners Healthcare) operates one of these Medicaid ACOs. Spurred by the advocacy efforts of Alexy Arauz Boudreau, a staff pediatrician committed to community health, MGH committed resources for a pilot program to initiate Mobility Mentoring® in two of its community health centers.

These health centers are located in communities just outside of Boston (Revere and Chelsea) that serve a high number of low-income families, many of whom are immigrants and some of whom are undocumented. These community health centers already had programs targeted at this population—case managers and home visitors—but Dr. Arauz Boudreau felt that these programs could be re-aligned through the use of Mobility Mentoring to better address the “root causes” of these families’ challenges, namely, poverty. MGH plans to use its community benefits resources to create a data system that supports the mentors’ work and evaluates the impact on health and cost.

Photo Credit: Center for Community Health Improvement - MassGeneral Hospital for Children Website
Human service providers interested in engaging with health systems and obtaining support for their programs can take a number of steps to position themselves for success:

1) Get to know the health care systems in your state or community, particularly those with a mission to serve vulnerable populations. Attend and present at the conferences they are attending, participate in community needs assessments and regulatory approval processes, and build relationships.

2) Get to know the health policy and advocacy organizations and coalitions in your state or community. They may already be working on building closer connections between the social service and health care worlds, but they also can provide valuable information on, and contacts in, the health policy system in your state or community.

3) Become familiar with the health policy context in your state or community. Did your state expand Medicaid? Does your state encourage use of the EPSDT benefit? Is your state adopting value-based purchasing models in its Medicaid program? Are health systems required to screen for and address “health related social needs”? If so, are they required to partner with community based/direct social service organizations versus building their own? This is a critical issue for human services organizations if the partnerships with the health care delivery system are to be productive. Meet with the state Medicaid agency staff and leadership so that they know who you are and what you do. Show up at the health policy forums and conferences.

4) Build your data infrastructure. Health care organizations are required to account for costs and outcomes. By culture and necessity, health care systems focus a great deal on data. They will want to know not only how many people you serve but the results of your work—how many advance their education, increase their earnings, and find stable housing? They will also want to know the costs per person served to achieve your outcomes. Most human services organizations will need to develop substantial capabilities in this arena in order to be an effective partner with health care organizations.

5) Gain a seat at the health-policy-making table. In doing that, it is important not to fall into the trap of seeming to be just another group that wants Medicaid resources. Rather, policy advocates should seek to understand what the priorities of the health care agency are, and seek to align your asks with the goals of the agency. For most Medicaid agencies, these goals typically are improved health and reduced costs.
POLICY ACTION

Once you are at the table and a trusted partner with a unique voice, what policy changes might you work to advance? A number of policy levers have the potential to enable Medicaid to support the type of work human services organizations undertake.

1) If you work in one of the 16 states that does not offer an expanded Medicaid program, focus your efforts on creating Medicaid expansion. Medicaid coverage for low-income adults is extremely important, not simply as a potential source of payment for economic mobility services, but as an essential benefit to address health needs (and a protection against their incurring medical debts). The expansion campaign may also allow advocates to call for the development of value-based approaches (such as MCOs and ACOs) that encourage addressing social conditions, and doing so in a way that taps into existing services rather than having health systems duplicate community human service programs already available.

2) In expansion states, consider encouraging Medicaid to require providers to screen for the social conditions relevant to health, such as housing instability, food insecurity, joblessness, and exposure to intimate partner violence. There are various ways to implement these requirements. In some states, managed care, hospitals, and accountable care organizations need to be “certified” by the state. Sometimes certification may require health care providers to assess, address, and monitor social conditions for certification. Similarly, practically all states require health care organizations to produce performance measures; states can add screening for social determinants as one of their standard measures.

3) When health care organizations decide to tackle social conditions, they also need to decide whether to “build” or “buy” social services. State Medicaid policies can encourage and even require these health care organizations to collaborate with, rather than supplant, existing human services organizations, and can similarly support strengthening the infrastructure (leadership development and data systems) for these partnerships to be successful. Local philanthropy can also assist in this transition period. Without such requirements, health care’s focus on social conditions could result in a loss, rather than a strengthening, of resources for community driven and led efforts.

4) Advocates will need to convince policy makers and insurers that the benefits of long-term anti-poverty efforts such as Mobility Mentoring® are worth stretching the return-on-investment period. Current health policy requires that health care savings be demonstrated within one to five years for managed care and value-based purchasing. As a result, many current efforts by health care
organizations in the social condition arena focus only on addressing the needs of their highest cost patients, typically older adults with serious medical conditions complicated by homelessness or food insecurity.

5) Finally, human service providers that build relationships with health care providers and policy leaders can ask their new partners to support both greater public spending on social programs (e.g. housing vouchers, state earned income tax credits) as well as efforts to address income inequality through more progressive minimum wage, zoning, tax, and corporate governance polices. Efforts to mobilize health care government affairs’ engagement are underway in several places including the activities of the “Alliance for Community Health Improvement” in Massachusetts, coordinated by the Massachusetts Public Health Association.

These are exciting times as health policy continues to change rapidly, and as awareness of the impact of social conditions on health becomes more widespread in the health care community. Social service organizations are already working at the interface of health care and poverty disruption. We need to be at the policy-making table to ensure that our populations’ needs are met.

Advocates will need to convince policy makers and insurers that the benefits of long-term, anti-poverty efforts such as Mobility Mentoring® are worth stretching the investment period.
GLOSSARY OF KEY TERMS

**Accountable Care Organization** — Refers to a health care organization composed of doctors, hospitals, and other health care providers who voluntarily come together to provide coordinated care and agree to be held accountable for the overall costs and quality of care for an assigned population of patients. The payment model ties provider reimbursements to performance on quality measures, and reductions in the total cost of care. Under an ACO arrangement, providers in the ACO agree to take financial risk and are eligible for a share of the savings achieved through improved care delivery, provided they achieve quality and spending targets negotiated between the ACO and the payer.\(^{11}\)

**Capitation** — Providers are paid prospectively on a per-member, per-month basis, and can invest in quality improvement to improve efficiency, but bear full financial risk to any excess costs.\(^{12}\)

**Community-Based Organization** — A public or private nonprofit organization of demonstrated effectiveness that a) is representative of a community or significant segments of a community; and b) provides educational or related services to individuals in the community.\(^{13}\)

**Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** — Medicaid benefit that requires that children insured by Medicaid undergo regular comprehensive screening, and that Medicaid pay for medically necessary services that a child needs in order to thrive.\(^{14}\) These services include all those for which federal Medicaid matching funds are available, even if such services are not otherwise covered by Medicaid in that state.

**Medicaid** — Provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.\(^{15}\)

**Medical Loss Ratio (MLR)** — A basic financial measurement used in the Affordable Care Act (ACA) to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers’ medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%. A medical loss ratio of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs, and agent commissions. The ACA sets minimum medical loss ratios for different markets, as do some state laws.\(^{16}\)

**Medicare** — Federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).\(^{17}\)

**Value-Based Purchasing (VBP)** — Refers to a broad set of performance-based payment strategies that link financial incentives to health care providers’ performance on a set of defined measures in an effort to achieve better value.\(^{18}\)
REFERENCES


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Brooks and Whitener, "Leveraging Medicaid."


Brooks and Whitener, "Leveraging Medicaid."


Cheryl L. Damberg, “Measuring Success.”
Dr. Charles J. Homer
Chief Improvement Officer

Charles J. (Charlie) Homer, MD, MPH, is Chief Improvement Officer at EMPath. Prior to joining EMPath, Dr. Homer served as the Deputy Assistant Secretary for Human Services Policy, Office of the Assistant Secretary for Planning and Evaluation, US DHHS from April 2015 through December 2016. Prior to this, he co-founded the National Institute for Children’s Health Quality (NICHQ) in July 1999, and then served as the organization’s president and CEO. Under his leadership, NICHQ focused both on clinical quality of care and on using improvement science to address the broad social conditions that contribute to childhood obesity and infant mortality. A general pediatrician, he is an Associate Clinical Professor of Pediatrics at Harvard Medical School. He is a past member of the third US Preventive Services Taskforce, the Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children, as well as numerous panels devoted to child health, health care, and quality measurement. Charlie obtained his bachelor’s degree from Yale University, his medical degree from the University of Pennsylvania, and a master’s degree in public health from the University of North Carolina at Chapel Hill.

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Economic Mobility Pathways (EMPath) transforms people’s lives by helping them move out of poverty and provides other institutions with the tools to systematically do the same. EMPath directly serves more than 1,600 low-income individuals and their families each year, providing economic mobility programs for families living in EMPath shelters as well as in public and subsidized housing throughout greater Boston. EMPath disseminates its methods through the Economic Mobility Exchange™, an international network of more than 100 government and nonprofit agencies. EMPath and members of the Exchange use a brain science-informed framework called the Bridge to Self-Sufficiency® and a specific approach to coaching program participants, Mobility Mentoring®.

**Ruth J. Liberman**

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Ruthie serves as Vice President for Public Policy for EMPath. In this role she serves as the chief policy strategist on national and state policy related to economic mobility. She provides leadership in the areas of education and workforce development, affordable housing, and work supports (including child care), to create public policy leading to family economic stability. Ruthie has a bachelor’s degree from Pomona College in government and public policy as well as a master’s degree in public administration from the Kennedy School of Government at Harvard University. Ruthie has worked in major hospital settings such as Beth Israel Deaconess Medical Center and Brigham and Women’s Hospital. She also ran a Pediatric and Family AIDS program at Dimock Community Health Center in Roxbury for six years. While living in California, Ruthie served as a Senate Fellow in the California Legislature and as the Director of Public Policy for Planned Parenthood Los Angeles.