INTEGRATING AN ECONOMIC BUNDLE INTO PEDIATRIC PRIMARY CARE:

AN EVIDENCE-BASED APPROACH TO IMPROVING CHILD HEALTH

Aim: To provide practitioners with a how-to guide on how to create their own Medical Financial Partnership, which will integrate evidence-based economic services, including the Earned Income Tax Credit, into pediatric primary care.

Acknowledgement and Disclaimer: This publication was supported by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award given to ChangeLab Solutions totaling $200,000 with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.

July 21, 2023

Boston Medical Center
HEALTH SYSTEM

STREETCRED
Boston Medical Center

HEALTH × WEALTH
COLLECTIVE

TABLE OF CONTENTS

INTRODUCTION

This guide aims to provide practitioners with details on how to create their own Medical Financial Partnership, which will integrate evidence-based economic services, including the Earned Income Tax Credit, into pediatric primary care. Although finances may seem disconnected from health, they are fundamental to health and well-being. Much evidence exists around economic tools and improved health; the most robust evidence exists about the Earned Income Tax Credit. This cash transfer is associated with everything from improved birth weight to improved child and adult mental health.[1] As a health care system, providing these upstream services, then, may have the potential to actually improve both health and health care utilization[2], which has downstream effects in saving health systems money and, of course, in helping populations be healthier.

The guide is meant to be practical with easy-to-follow headings to facilitate locating the sections that will be useful at any given point in time. We hope entire document is helpful, and depending on which stage you are at in implementation, you may want to choose sections most relevant to you.

We know that circumstances vary greatly nationally – in every respect from local and state policies to capacity of (or absence of) local community-based organizations and other potential partners to funders and even health clinic cultures and leadership. No one size fits all approach exists. Rather, we hope that you will be able to adapt our lessons learned to your own circumstances. We have included some guidance on specific ways to adapt our model as well as barriers to implementation but will not have thought of everything. Our goal is to save you at least some of the many years of start-up time and experimenting that got us to our model, while empowering you to do what works best in your local environment – you are the expert! Regardless of geography, families experience financial need all over our country, and we do have strong national policies (i.e., the Earned Income Tax Credit) that can benefit families and help improve their health.

If you are interested in embarking on this journey, we would love to have you join our free national network (Health by Wealth Collective) to actively collaborate, learn from each other, and grow this movement. To connect with us, simply go to our website (www.mystreetcred.org) and click on the “Partner” tab, then fill out the application form or email info@mystreetcred.org.

WHY PROVIDE ECONOMIC SERVICES IN PRIMARY CARE?

Poverty and financial strain are associated with risk of poorer physical and mental health outcomes for children and their families.[1] It is a health problem, but not one we are trained to address in medical school. Luckily, some tools to intervene exist, and we as primary care providers can help. The evidence behind these financial tools varies.

The strongest evidence exists for the Earned Income Tax Credit (EITC), a refundable tax credit for low to moderate income working Americans with children. The EITC has been associated with everything from improved birth weight, gestational age, and child mental health to decreased child abusive head trauma and suicide rates in adults.[3–7] The health impacts of EITC are so promising that CDC highlighted it as one of 14 non-clinical, community-wide approaches that have evidence reporting 1) positive health impacts, 2) results within five years, and 3) cost effectiveness and/or cost savings over the lifetime of the population or earlier. This credit, worth up to $6,600, depending on income, marital status, and the number of children (up to three), is underutilized, with 20% of eligible families missing out entirely and 60% of those who do claim it losing hundreds of dollars to for-profit tax preparers.[8,9] Both in-person and virtual free tax preparation services, regulated and supported by the IRS, exist but can be challenging for families to access and many are unaware of this option; only 1% of families who claim the EITC use these sites, called Volunteer Income Tax Assistance (VITA).

More limited evidence supports the association between receipt of nutritional cash supports (i.e., Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC)), 529 College Savings Accounts (CSAs), paid parental leave (state-based policies), Medicaid, and Supplemental Security Income (SSI) and improved health outcomes such as decreased maternal depression and improved child social emotional development and growth.[1,10–14] Like the EITC, these tools may be underutilized due to access barriers, changing eligibility, and program restrictions but available to many low-income families nationally.

Aside from the evidence that these tools may help families be healthier, the other reason for pediatric primary care practices to incorporate financial tools into their models is that we have access and trust! From 2016-2020, approximately 80% of children received annual preventive medical visits.[15] No other location catches such a large percentage of young kids. The first year of life, when poverty potentially has highest impact on growth and development, has seven times well child visits. Equally important, parents have said they want to talk to their doctors about financial stress in studies across the country.[16,17] We may not think of ourselves as financial experts, but parents want to talk to us.

STREETCRED'S ECONOMIC BUNDLE MODEL

As New England's largest safety-net hospital, Boston Medical Center's (BMC) pediatric primary care clinic serves 14,000 patients, including approximately 1200 infants—90% Medicaid-insured, 30% immigrants, and 70% people of color. StreetCred is a BMC program that delivers financial services to promote access to underutilized policies such as the Earned Income Tax Credit (EITC) to over 300 Boston Medical Center (BMC) families annually in pediatric primary care.[18–22] We have capitalized on the longitudinal, trusting relationship between pediatric clinicians and families by universally offering enrollment supports, instead of screening for deficits. We focus on evidence-based interventions that dismantle the structural inequities we identified and help our patients advance through the lens of economic justice rather than "charity," ultimately improving their health and well-being.

StreetCred's population is 94% Black, Indigenous, people of color (BIPOC) and 54% in poverty. We founded StreetCred in 2016 in response to a realization that families were not aware of the EITC and were missing out. We initially attempted to refer to community tax prep sites but encountered barriers to access. A patient asked us why we could not just do her taxes at the clinic, which we thought was a great idea. We have since expanded to offering a bundle of seven underutilized economic supports.

What's in our bundle

We selected all economic services because they: (1) were underutilized, (2) have capacity (i.e., we can get families access to them, unlike housing in Boston, for example), and (3) have cash-value or asset building potential that will not trigger the public benefit cliff effect (i.e., leading to families losing public benefits as a result of increasing savings), and (4) are evidence-based, at least to some degree. These economic tools are:

Cash transfers

- Tax preparation to maximize tax refunds and receipt of the EITC
- Paid Family & Medical Leave: a state benefit in Massachusetts (MA)

Cash-like food resources

- SNAP
- WIC
- Boston Medical Center's food pantry

Asset-building tools

- 529 College Savings Account (MA deposits up to $170 in first year of life)
- Family Self Sufficiency (Department of Housing and Urban Development (HUD) program that allows families in federally subsidized housing to save any increases in their rent as their income increases and participate in financial coaching)

We have capitalized on the longitudinal, trusting relationship between pediatric clinicians and families by universally offering enrollment supports at well child visits, instead of screening for deficits. This proactive, opt-out approach emphasizes family strengths, rather than focusing on disclosing need and/or trauma. As members of the care team, all the roles described below access the electronic medical record (EMR) as a part of routine medical care, so do not require consent from parents unlike a research team. They have all undergone and remain up to date on the Health Insurance Portability and Accountability Act of 1996 (HIPPA) training per hospital requirements.

STREETCRED'S ECONOMIC BUNDLE MODEL (Cont.)

How we deliver it

At the newborn visit, a Patient Navigator (PN) meets with families to welcome them to the clinic, help them select a PCP and schedule well-child visits for the first six months of life. During this time, they also introduce the economic bundle, offer the timeliest resources (food resources, Paid Family & Medical Leave, and tax prep, if tax season), document the conversation in their EMR note, and add the family to a list in the EMR of families enrolled in the economic bundle (named "StreetCred Economic Bundle Patients"). The PN role is full time and funded by the clinic; however, there are only 2 PNs serving our population of 14,000 families, and they only work during normal business hours, so there are families who do not get to meet with a PN due to lack of capacity or having an evening or weekend visit and thus, are not enrolled in the economic bundle.

For the remaining six visits in the first year of life (1, 2, 4, 6, 9, and 12 months), StreetCred's part-time Financial Navigators (5-6 individuals) proactively attempt to meet with families to follow up, offer the remaining services, and assist with enrollment, tax prep, and/or account opening. They identify patients ahead of time by comparing the "StreetCred Economic Bundle Patients" list in the EMR and the clinic schedule; since they are a part of the clinical team, they do not need to request consent from parents (unlike a research team). They enter the exam room during downtime (i.e., while waiting on the medical assistant, nurse, or provider). They also offer virtual or in-person follow up as needed between visits. They communicate with parents using a dedicated cell phone and choose a mode of communication based on the patient's preference (texting, calls, email, EMR messages, video calls). They document all interactions in a note in the EMR.

IMPLEMENTATION LOGISTICS

This work can be done at many different levels. At a bare minimum, for our model, we have found that the following is needed:

Staff

A part-time seasonal tax site coordinator and volunteer tax preparers and/or year-round financial navigators. Our current model additionally requires a full-time administrative director, financial coach, and an AmeriCorps VISTA volunteer, who manages the financial navigators (part-time, paid via AmeriCorps Public Health).

Financial Resources

For a tax-only program, the main cost is the tax site manager, who is paid based on your local VITA coalition's going rate for this role, generally $20-30/hour. We have found about 20 hours a week (majority evening and weekend hours) to be an effective number of hours for our site to be open, plus about 5 hours a week of admin time, which means the salary cost is about $12,000. For a more robust year-round model like our current one, the cost is closer to $400,000.

Startup time

It took us a full year of preparation work before we were ready to launch our first tax site. This time could have been longer except for a very supportive Department Chair, who helped us cut through administrative red tape at the hospital.

Space

At a minimum, a tax site requires two tables and computers for the tax site manager and tax volunteer. These can be set up temporarily in a clinic's waiting room and broken down each day, if needed. In addition, we currently have one dedicated desk space within our clinic for our financial navigators to sit down with patients, but they generally meet with patients in the exam room.

QUALITY IMPROVEMENT & EVALUATION

We take advantage of the EMR for most of our data tracking and collection. We keep a master patient list within the EMR. We also have programmed smart phrases with checklists and questions to document during patient encounters for standardized service delivery and data tracking. We work with our hospital's Clinical Data Warehouse to extract these data to review our program metrics and to understand if we are equitably reaching families.

We additionally use an Excel tracking sheet to keep track of all visits, to anticipate the next time a patient will come in, and to track metrics in real-time. This sheet is stored in secure password protected online box.

We have a vision for building a high-quality evidence base on impact on financial well-being, health, health care utilization that could enable us to secure ongoing public funding (i.e., Medicaid, state government) and make the service more scalable for others.

HOW DO WE FUND THIS WORK?

This work is funded through a mix of federal and foundation grant support, corporate and individual donations, and hospital in-kind support. AmeriCorps is one of our most important funders. We have two AmeriCorps grants: (1) AmeriCorps Public Health, which allows members to provide direct service. This award funds our six part-time Financial Navigators, most of whom are pre-medical/health students. They receive a stipend in exchange for a commitment of a set number of hours over the course of 1 year; and (2) AmeriCorps VISTA, which is a full-time one-year commitment focused on capacity building roles. Our VISTA members have provided program management and development for us. We are currently also recruiting a VISTA to focus on internal and external communications.

We receive some IRS and state government funding specific to running a Volunteer Income Tax Assistance (VITA) tax preparation site. This money funds our part-time, seasonal tax site manager. We have accessed these funds by partnering with our city's tax help coalition. Corporate partners, from the financial services industry, and individual donors are often interested in our work as it resonates with their mission. These donations fund operational costs that are more difficult to cover with research and foundation grants. Foundation grants from regional and national organizations have mostly funded pilot innovations and research evaluation. We currently have a funded quasi-randomized longitudinal study to understand whether services impact financial well-being, parent-child health, health care utilization, connection to health care team.

WORKING WITH PARTNERS

Partners are a critical part of this work, without whom it would not be possible. Most partners whom we have approached have intuitively understood the value-add of working with a health clinic or hospital and been eager to collaborate. For partners who may be less sold on the idea, we've found that it is useful to emphasize the access we have to families and the trust they have in us. For many partners, locating families and engaging them in services can be challenging as they do not have the natural longitudinal relationships that we do. Further, for many the idea that financial services may improve health and wellbeing naturally resonates.

In respect to the EITC and tax preparation, we work with the IRS as a registered Volunteer Income Tax Assistance (VITA) site. The best way to get started with that is to search for your local VITA tax prep coalition, who can provide good technical support and guidance on getting started. We have also partnered with Code for America's Get Your Refund to offer virtual tax preparation in the past, although have concluded that for now, virtual only services are not the best fit for most of our families due to the digital divide. We still let families know they can go to the Get Your Refund website to get free virtual tax prep services if they prefer that route.

As mentioned above, AmeriCorps (Public Health and VISTA) is a key financial partner who has allowed us to move away from relying on unpaid volunteers to provide tax preparation and other economic bundle services. We have found the AmeriCorps model much more effective.

Additional important partners for us include United Way, who has provided financial coaching technical support, although many financial coaching and empowerment organizations exist and may differ in your area. We have partnered, for example, with Compass Working Capital, a local NGO promoting uptake of HUD's Family Self Sufficiency program. We have partnered with the State of MA on enrolling families in 529 College Savings Accounts (the state incentive program to open an account in the first year of life, called Baby Steps, is run through the Office of Economic Empowerment, a part of the Office of the Treasurer) and the MA Department of Paid Family and Medical Leave, under the Office of Labor and Workforce Development. As of this writing, many states offer regular or one-time 529 CSA incentives (click on your state and look under 'other features' to see incentives; this article highlights one time incentives) and 16 states have paid leave policies.

HOW TO ADAPT TO YOUR LOCAL CIRCUMSTANCES

Our model is likely not exactly right for your circumstances given variation in state policies, clinic/hospital capacity, and other factors. Our partners nationally have worked creatively to build models that work for them. Here are a few ideas to consider:

Embedding services versus closed loop referrals

While we have embedded services within our clinic, others have found success building strong community partnerships with closed loop referrals (i.e., getting feedback from the partner as to whether a family uses the service), so they can support families in accessing services without providing them onsite.

In person, hybrid, and/or virtual services

We have found it important to have at least an initial in-person touch point to build trust and relationships – and that many families appreciate virtual, especially text-based, follow up. For some sites, virtual services may be the only option and depending on the population, can also be effective.

Staffing services versus bringing in a community org to staff it

If you are offering services onsite, some local organizations may be willing to embed their own staff in your clinic (with or without shared fundraising to pay for these staff), which can substantially decrease the administrative work of hiring and supervising staff on your end. On the other hand, it can lead to decreased control of program offerings and some barriers to onboarding external staff (i.e., vaccination and TB paperwork, etc.) may still exist.

Offering one versus many services

For many years, we only offered tax preparation due to capacity and a desire to focus on reaching as many people as possible. We now offer more services but reach a fewer number of people (about 300 children annually).

Additional economic services to consider

We do not currently offer these services, but they are important, and we are investigating opportunities to incorporate them: credit building, emergency savings, and banking, among others. The main reason we do not offer them is that these are more difficult to offer as discrete services, but we have successfully piloted them as a part of more comprehensive financial coaching interventions.

State based differences and challenges

As mentioned previously, states vary dramatically in their policies, both in respect to how they implement federal policies such as Medicaid, SNAP, and WIC and any state-based policies they offer. In MA, we have a comprehensive approach to Medicaid enrollment, but in another state, it might make sense to offer Medicaid enrollment services as a part of your bundle. Tax preparation and the Earned Income Tax Credit are the economic tool that vary the least among states.

BARRIERS

Many barriers exist to setting up a Medical Financial Partnership, but it is worth it to persevere. It took us a full year of planning before we launched our first tax site and very well could have taken longer if it weren't for strong champions in our leadership (i.e., Dept Chair and Medical Director of our clinic).

Space

We have dedicated desk space for 1 person in clinic, alongside our front desk staff, which is a chaotic, not private location but all that was available. We **u**tilize folding tables in the waiting room during tax season for tax preparation with portable dividers for visual privacy. Our Financial Navigators meet with patients in exam rooms during wait time (waiting on provider or nurse) and then continue the conversation as needed in the waiting room, at our dedicated desk space, or virtually later, per patient preference and specific circumstance. Obtaining and maintaining these spaces has taken much negotiation and relationship maintenance with clinic leadership.

Time

As mentioned above, in person contact is often brief because we utilize wait time. We have found even a brief touch point is enough to build a relationship and trust that facilitates virtual follow up. The frequency of visits (seven in first year) also allows for relationship building even if interactions are brief. Finally, we have found texting can be used to accomplish a fair amount and is very acceptable to families.

Buy-in

Having buy-in at all levels is critical to success. Leadership buy-in is essential to cut red tape and advocate when high-level concerns arise. Find your champion who "gets it" and is willing to speak up for you. For example, when our hospital was initially concerned about the legal ramifications of offering tax prep, our Department Chair advocated for us with our Legal group. This concern is common but unfounded as the IRS has a good Samaritan-like law for VITA tax prep. Staff buy-in is also important as they facilitate advertising services to patients and allowing Financial Navigators into exam rooms. We offer services to staff who are lower-income and whose children use our clinic and many then share their experiences with patients. StreetCred also shows up at staff group meetings, engage them in operational questions, and work to partner with them. Similarly, providers are important partners as well. We also show up at their meetings to provide updates and get input. Many providers have shared with us that they find this service is a solution to feeling like they can't help with patient's social needs and thus, appreciate it. As a part of the routine clinical workflow, financial navigators take the onus away from other staff on referrals by making the service systematic and opt out; our team tracks our list of enrolled patients and automatically goes to see them at each visit rather than asking providers, medical assistants, nurses, etc. to make referrals.

Language

Our population is multi-lingual with Spanish, Haitian Creole, and English being the most spoken languages. We prioritize hiring bilingual/bicultural staff and AmeriCorps members whenever possible. We also utilize our hospital phone interpreter system as needed.

BARRIERS (Cont.)

Staff and volunteer retention

Retention can be challenging, particularly for temporary, seasonal and part-time positions. We previously recruited >80 volunteers annually for tax preparation with a high turnover rate, mostly because of onboarding barriers (i.e., vaccination records, tuberculosis testing). We have transitioned to mostly using our smaller team of 6 AmeriCorps Financial Navigators (who are paid a stipend). We recruit a few dedicated tax prep volunteers to supplement during tax season with a focus on those who can certify as advanced preparers, have experience, and reliable schedules (able to spend at least a 4-hour chunk of time with us weekly). We engage in volunteer appreciation and relationship building to retain volunteers and also accept that annual recruitment is required.

For staff, the pandemic has greatly increased the desire for remote work. Our administrative positions are hybrid, with everyone coming into the office at least two days a week. Our clinical service positions are 80-100% in person. We make sure to be very transparent during the hiring process about this with repeated discussion on this point. Despite these efforts, we have still found it to be a challenge for hiring and retention. When possible, we prioritize hiring those who live nearby and express an interest in work that involves much in person interaction.

CONCLUSION

Medical Financial Partnerships are feasible for any clinic or health system to create nationally! The need is everywhere. Patients and clinic staff find these services highly acceptable. This work takes effort and creativity but is extremely rewarding. Seeing families get thousands of dollars back in EITC and tax refunds and express excitement about opening an account for their child to go to college, among others, is immensely gratifying. Our very first tax client – a great grandmother with sole custody of her toddler grandchild exclaimed she was going to use her $3000 refund to buy “luxuries” – a warm winter coat for the baby and fresh fruits and vegetables. Another parent, an immigrant mother of three, excitedly announced she was going to ask her boss if she could work more hours after learning the value of the EITC increases as income increases (up to a point). Parents who have participated in our financial coaching have reported increased comfort with their finances after participating. They also highlighted the importance of the group experience: “Unfortunately, when you realize that you're not the only one struggling, that can be empowering.” And perhaps most importantly, parents have highlighted the emotional relief these services bring: “It gives you less stress. So, if you having less stress, you're not as irritable. Or you're not as aggravated. Or you're able to just bond more with your child. And just spend more time with them 'cause you're not worried about other things."

We invite you to join us! Our free national network (Health by Wealth Collective) facilitates active collaboration, community-building, and comradery in growing this national movement. To connect, simply go to our website (www.mystreetcred.org) and click on the “Partner” tab, then fill out the application form or email info@mystreetcred.org. We hope to hear from you soon!

REFERENCES

1. Duncan G, Le Menestrel S, eds. *A Roadmap to Reducing Child Poverty*. National Academies of Sciences, Engingeering, and Medicine; 2019. doi:10.17226/25246

2. Schickedanz A, Perales L, Holguin M, et al. Clinic-Based Financial Coaching and Missed Pediatric Preventive Care: A Randomized Trial. *Pediatrics*. 2023;151(3). doi:10.1542/peds.2021-054970

3. Lenhart O. The effects of state-level earned income tax credits on suicides. *Heal Econ (United Kingdom)*. 2019;(April):1476-1482. doi:10.1002/hec.3948

4. Hamad R, Rehkopf DH. Poverty and Child Development: A Longitudinal Study of the Impact of the Earned Income Tax Credit. *Am J Epidemiol*. 2016;183(9):775-784. doi:10.1093/aje/kwv317

5. Hamad R, Rehkopf DH. Poverty, Pregnancy, and Birth Outcomes: A Study of the Earned Income Tax Credit. *Paediatr Perinat Epidemiol*. 2015;29(5):444–452. doi:10.1111/ppe.12211

6. Komro KA, Markowitz S, Livingston MD, Wagenaar AC. Effects of State-Level Earned Income Tax Credit Laws on Birth Outcomes by Race and Ethnicity. *Heal Equity*. 2019;3(1):61-67. doi:10.1089/heq.2018.0061

7. Klevens J, Schmidt B, Luo F, Xu L, Ports KA, Lee RD. Effect of the earned income tax credit on hospital admissions for pediatric abusive head trauma, 1995-2013. *Public Health Rep*. 2017;132(4):505-511. doi:10.1177/0033354917710905

8. EITC Fast Facts. Internal Revenue Service. https://www.eitc.irs.gov/partner-toolkit/basic-marketing-communication-materials/eitc-fast-facts/eitc-fast-facts. Published 2021. Accessed October 23, 2020.

9. Weinstein P, Patten B. *The Price of Paying Taxes II : How Paid Tax Preparer Fees Are Diminishing the Earned Income Tax Credit (EITC)*.; 2016. https://www.progressivepolicy.org/wp-content/uploads/2016/04/2016.04-Weinstein_Patten_The-Price-of-Paying-Takes-II.pdf.

10. Ettinger de Cuba S, Chilton M, Bovell-Ammon A, et al. Loss of SNAP is associated with food insecurity and poor health in working families with young children. *Health Aff*. 2019;38(5):765-773. doi:10.1377/hlthaff.2018.05265

11. Huang J, Sherraden M, Kim Y, Clancy M. Effects of child development accounts on early social-emotional development: An experimental test. *JAMA Pediatr*. 2014;168(3):265-271. doi:10.1001/jamapediatrics.2013.4643

12. Beverly SG, Clancy M, Sherraden M. *Testing Universal College Savings Accounts at Birth: Early Research from SEED for Oklahoma Kids*. Vol CSD Resear.; 2014. https://core.ac.uk/download/pdf/233232789.pdf.

13. Currie J, Chorniy A. Medicaid and Child Health Insurance Program Improve Child Health and Reduce Poverty But Face Threats. *Acad Pediatr*. 2021;21(8):S146-S153. doi:10.1016/j.acap.2021.01.009

14. Expanding SSI Access: Understanding Asset Limits for Children with Disabilities. ChangeLab Solutions. https://www.changelabsolutions.org/product/ssi-asset-limit-requirement. Accessed November 7, 2023.

15. Lebrun-Harris LA, Ghandour RM, Kogan MD, Warren MD. Five-Year Trends in US Children's Health and Well-being, 2016-2020. *JAMA Pediatr*. 2022;176(7):2016-2020. doi:10.1001/jamapediatrics.2022.0056

REFERENCES (Cont.)

16. Rogers AJ, Hamity C, Sharp AL, Jackson AH, Schickedanz AB. Patients' Attitudes and Perceptions Regarding Social Needs Screening and Navigation: Multi-site Survey in a Large Integrated Health System. *J Gen Intern Med*. 2020;35(5):1389-1395. doi:10.1007/s11606-019-05588-1

17. Quinn C, Johnson K, Raney C, et al. "In the Clinic They Know Us": Preferences for Clinic-Based Financial and Employment Services in Urban Pediatric Primary Care. *Acad Pediatr*. 2018;18(8):912-919. doi:10.1016/j.acap.2018.06.008

18. Marcil LE, Hole MK, Wenren LM, Schuler MS, Zuckerman BS, Vinci RJ. Free tax services in pediatric clinics. *Pediatrics*. 2018;141(6). doi:10.1542/peds.2017-3608

19. Marcil, Lucy E; Thakrar MR. Association of Tax Preparation Service in a Pediatric Clinic With Increased Receipt of The Child Tax Credit. *JAMA Pediatr*. 2022;176(6):696-607. doi:10.1001/jamapediatrics.2022.0073

20. Marcil LE, Hole MK, Jackson J, et al. Anti-Poverty Medicine through Medical-Financial Partnerships: A New Approach to Child Poverty. *Acad Pediatr*. 2021.

21. Alexander SP, Kim I (Cellina), Hatcher C, Suh HS, Ha Y, Marcil LE. Embedding Financial Services in Frequented, Trusted Settings: Building on Families' Pre-existing Economic Mobility Efforts. *J Dev Behav Pediatr*. 2022;Publish Ah(00):1-10. doi:10.1097/dbp.0000000000001091

22. Marcil LE, Campbell JI, Silva KE, et al. Women's Experiences of the Effect of Financial Strain on Parenting and Mental Health. *J Obstet Gynecol Neonatal Nurs*. 2020. doi:https://doi.org/10.1016/j.jogn.2020.07.002