INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

BOARD ON POPULATION HEALTH AND PUBLIC HEALTH PRACTICE

Roundtable on Population Health Improvement
Workshop #5: Resources for Population Health Improvement

February 6, 2014

Location: Keck Center, Room 100 • 500 Fifth Street, NW, Washington, DC

"Resources" refers to many different kinds of essential ingredients needed to support the improvement of population health. Resources could be financial, human (workforce and associated education and training needs), or informational (referring to data, technology, networks, etc.) and could also refer to the broad category of assets that communities bring to the table, from social capital to cultural diversity.

The workshop will focus on financial resources, and especially on varied private sector funding sources and mechanisms that can help alter the social and environmental determinants of health.

8:30 am	Welcome and Introductions *George Isham, co-chair, Workshop Planning Committee; co-chair, Roundtable on Population Health Improvement; senior advisor, HealthPartners, senior fellow, HealthPartners Institute for Education and Research* *Terry Allan, co-chair, Workshop Planning Committee; president, National Association of County and City Health Officials; health commissioner; Cuyahoga County Board of Health*
8:45 am	Paying for population health improvement *David Kindig, co-chair, Roundtable on Population Health Improvement; professor emeritus of population health sciences, emeritus vice chancellor for health sciences, University of Wisconsin-Madison School of Medicine*
9:05 am	Discussion
9:30 am	Health care system investments in population health improvement: Opportunities, challenges, and priorities *Kevin Barnett, senior investigator, Public Health Institute*
10:00 am	Break

10:15 am	Panel I: Health care system investments in population health improvement *Moderator: Debbie Chang, member, Workshop Planning Committee; vice president, Policy and Prevention, Nemours* *Rev. Gary Gunderson, vice president, Faith and Health Ministries* *Wake Forest Baptist Medical Center* *Teresa Cutts, associate professor, Department of Social Sciences and Health Policy, Wake Forest School of Medicine* *Valerie Agostino, senior vice-president, Health and Housing Operations Initiatives, Mercy Housing*
11:00 am	Discussion
11:30 am	Community development and population health: An overview *Raphael Bostic, Judith and John Bedrosian Chair in Governance and the Public Enterprise, Sol Price School of Public Policy at the University of Southern California*
12:00 pm	Lunch
1:00 pm	Panel II: Community development and population health *Moderator: José Montero, member, Workshop Planning Committee; director, New Hampshire Division of Public Health Services* *Donald Hinkle-Brown, president and chief executive officer,* *The Reinvestment Fund* *Nancy O. Andrews, president and chief executive officer, Low Income Investment Fund*
1:45 pm	Discussion
2:15 pm	Pay for success financing and population health: An overview of the field *Megan Golden, fellow, NYU Wagner Innovation Labs*
2:45 pm	Break

3:00 pm	Panel III: Pay for success financing and population health *Moderator: Andrew Webber, member, Workshop Planning Committee; chief executive officer; Maine Health Management Coalition* *Robert H. Dugger, founder and managing partner, Hanover Provident Capital, LLC* *Rick Brush, founder and chief executive officer, Collective Health*
3:45 pm	Discussion
4:15 pm	Concluding Panel: Implications of new and emerging sources of population health funding for governmental public health, community groups, and others *Moderator: Mary Lou Goeke, member, Workshop Planning Committee; executive director, United Way of Santa Cruz County* *James A. Hester, member, Workshop Planning Committee; independent consultant, Vermont; former acting director, Population Health Models Group Innovation Center, Centers for Medicare and Medicaid Services* *Glen P. Mays, member, Workshop Planning Committee; F. Douglas Scutchfield Endowed Professor in Health Services and Systems Research, University of Kentucky College of Public Health* *Jeffrey Levi, member, Workshop Planning Committee; executive director, Trust for America's Health*
4:45 pm	Reflections on the day, discussion, and an opportunity for public comment *Terry Allan* *George Isham*
5:15 pm	Adjourn

Project website for the Roundtable on Population Health Practice: www.iom.edu/pophealthrt
The website provides listserv sign-up, information on upcoming meetings, meeting materials such as presentations and webcasts, and roundtable products.
Project email: pophealthrt@nas.edu

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Roundtable on Population Health Improvement

Workshop on Resources for Population Health Improvement

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Speaker and Moderator Biographies[1]

Valerie Agostino, is the Senior Vice President, Healthcare and Housing, for Mercy Housing, a national non-profit affordable housing organization. She was recently promoted to her current position and is focused on affordable housing as a platform for improved health outcomes for residents. Ms. Agostino also currently serves as Commissioner for the Housing Authority for the City of Berkeley, Commissioner for the City of San Francisco's Long Term Care Coordinating Council, and Member of the City of San Francisco's Dementia Task Force. Ms. Agostino began her career in affordable housing and community services in San Francisco in the late 1970's with Catholic Charities, developing opportunities for very low income, frail elders to live independently in a service enriched supportive community setting. In 1994, Ms. Agostino joined the staff of Mercy Housing California as the Director of Property Management for the then nascent California organization. In 2001, she was named Chief Operating Officer for Mercy Housing California and spent the following twelve years overseeing various community development, real estate, and resident service activities throughout the state of California. Ms. Agostino has a B.A. from the University of Massachusetts and completed the Achieving Excellence in Community Development Program at the Kennedy School of Government, a Program of Harvard University and Neighborworks.

Terry Allan, M.P.H.,[*†] has been the health commissioner at the Cuyahoga County Board of Health since 2004, which serves as the local public health authority for 885,000 citizens in 57 Greater Cleveland communities. He holds a Bachelor of Science degree in Biology from Bowling Green State University and a Master of Public Health from the University of Hawaii. Terry is an adjunct faculty member at Case Western Reserve University's School of Medicine and was a Year 13 Scholar of the National Public Health Leadership Institute. Terry is the Immediate Past President of Ohio's SACCHO, the Association of Ohio Health Commissioners, and has served as an At-Large member of the NACCHO Board of Directors since 2007. In 2009, Terry was a member of NACCHO's Structure and Governance Workgroup, charged with reviewing the Association By-Laws and making recommendations for improvement to the Board of Directors. Terry currently serves as a Member of NACCHO's Marketing Committee and is an

[1] Notes: Names appear in alphabetical order; "†" = member of the workshop planning committee; "*" = member of the IOM Roundtable on Population Health Improvement;

active member of NACCHO's Congressional Action Network (CAN). Terry had the fortunate opportunity to serve as a representative of NACCHO on the Standards Development Workgroup for the National Public Health Accreditation Board (PHAB) and chaired a local health department Site Visit Team during the Beta Test of the PHAB standards. In May of 2009, Terry had the honor of testifying before the United States House of Representatives Government Oversight and Reform Committee, concerning public health pandemic influenza preparedness and resource needs and he participated in a White House meeting on the national response to Novel H1N1 Influenza in September of 2009. In June of 2010, Terry participated on behalf of NACCHO in a Congressional briefing on local public health job losses. Terry presented in May of 2010 before the Institute of Medicine's Committee on Public Health Strategies to Improve Health on funding state and local public health systems.

Nancy O. Andrews, M.S., is the President and Chief Executive Officer of the Low Income Investment Fund (LIIF). LIIF is an approximately $800 million Community Development Financial Institution (CDFI) that has invested $1.4 billion in community projects. LIIF's investments have leveraged $7.3 billion in private capital for poor communities in 31 states across the U.S. and generated more than $32 billion in benefits for families and society. Established 30 years ago, LIIF has served 1.6 million low income people by providing capital for 60,000 affordable homes for families and children, 241,000 spaces of child care and 70,000 spaces in school facilities. LIIF is a national CDFI with staff and offices in San Francisco, Los Angeles, New York City and Washington, D.C. Ms. Andrews' career spans 30 years in the community development field. In addition to her work at LIIF, she serves on numerous boards and committees, including Housing Partnership Network, Bank of America's National Community Advisory Council, Morgan Stanley's Community Development Advisory Committee, Capital One's Community Advisory Council and the National Housing Law Project. Ms. Andrews was also previously a member of the Federal Reserve Board's Consumer Advisory Council. She is a recognized expert on the challenges facing America's neighborhoods and is frequently asked to testify before Congress and speak at conferences and events. Her most recent book, jointly edited with David Erickson, is titled *Investing in What Works for America's Communities: Essays on People, Place, and Purpose*. It is available at: http://whatworksforamerica.org. Previously, Ms. Andrews served as the Deputy Director of the Ford Foundation's Office of Program Related Investments, where she assisted in the management of a $130 million social investment portfolio. She also designed and launched the foundation's housing policy program. Ms. Andrews was the Chief Financial Officer of the International Water Management Institute, a World Bank-supported international development organization. Additionally, Ms. Andrews has been an independent consultant on community development, social investment, financial analysis and housing policy. In this capacity, she consulted for the Department of Housing and Urban Development and the Department of Treasury during the Clinton administration. Ms. Andrews received an M.S. in Urban Planning with a concentration in Real Estate Finance from Columbia University.

Raphael Bostic, Ph.D., is the Judith and John Bedrosian Chair in Governance and the Public Enterprise at the Sol Price School of Public Policy at the University of Southern California. He has recently returned to USC after serving for 3 years in the Obama Administration as the Assistant Secretary for Policy Development and Research at the U.S. Department of Housing and Urban Development. In that Senate-confirmed position, Dr. Bostic was a principal advisor to

the Secretary on policy and research, with the goal of helping the Secretary and other principal staff make informed decisions on HUD policies and programs, as well as budget and legislative proposal. Bostic led an interdisciplinary team of 150 which had expertise in all policy areas of importance to the department, including housing, housing finance, rental assistance, community development, economic development, sustainability, and homelessness, among others. During his tenure and with his leadership, PD&R funded more than $150M in new research, became an important advisory voice on departmental budget and prioritization decisions, and reestablished its position as a thought leader on policies associated with housing and urban development. Dr. Bostic arrived at USC in 2001, where he served as a professor in the University of Southern California's School of Policy, Planning, and Development. His work spans many fields including home ownership, housing finance, neighborhood change, and the role of institutions in shaping policy effectiveness. A particular emphasis has been on how the private, public, and non-profit sectors interact to influence household access to economic and social amenities. His work has appeared in the leading economic, public policy, and planning journals. He was Director of USC's Master of Real Estate Development degree program and was the founding director of the Casden Real Estate Economics Forecast. Prior to that, he worked at the Federal Reserve Board of Governors, where his work on the Community Reinvestment Act earned him a Special Achievement Award. In an earlier stint at HUD, Dr. Bostic served as a special assistant to Susan Wachter when she served as the Assistant Secretary for PD&R. He earned his Ph.D. in Economics from Stanford University and his BA from Harvard University.

Rick Brush founded Collective Health in 2011 to address the underlying causes of poor health and sustainably reduce costs. He has led strategic innovation at large corporations and start-ups for more than 20 years, primarily in the health care and financial services sectors. Most recently, Rick was chief strategy and marketing officer for the large employer segment at Cigna, the fourth-largest U.S. health insurer, where he served in a variety of executive roles from 2002 to 2011. While at Cigna, Rick co-founded the company's Communities of Health venture, launched new business units and products, and led multi-stakeholder initiatives around the country to improve population health. He has held executive positions at Ford Motor Credit Company, Bank One, KPMG, and a marketing consulting firm, and has worked extensively with communities and nonprofits to improve social and financial impact. Rick is a graduate of the University of Massachusetts at Amherst.

Debbie Chang, M.P.H.,[*†] is Vice President of Policy and Prevention at Nemours Foundation where she is leveraging expertise and innovating to spread what works through national policy and practice changes with the goal of impacting the health and well-being of children nationwide. She serves as a Corporate Officer of Nemours, an operating Foundation focused on children's health and health care. Previously at Nemours, Ms. Chang was the founding Executive Director of Nemours Health & Prevention Services, an operating division devoted to improving children's health through a comprehensive multi-sector, place-based model in Delaware (DE). Strategic initiatives include spreading and scaling Nemours' early care and education learning collaborative approach to obesity prevention through an up to $20 million cooperative agreement with the Centers on Disease Control and Prevention (CDC); working with Federal partners on integrating population health and clinical care and providing strategic direction on Nemours' Center for Medicare and Medicaid Innovation (CMMI) Health Care Innovation Challenge award that integrates population health and the medical home for children with asthma in 3 primary

care pilot sites in DE; and collaborating with the First Lady's Let's Move! Campaign on *Let's Move Child Care*, a website that Nemours created and hosts. Ms. Chang has over 26 years of federal and state government and private sector experience in the health field. She has worked on a range of key health programs and issues including Medicaid, State Children's Health Insurance Program (SCHIP), Medicare, Maternal and Child Health, national health care reform, and financing coverage for the uninsured. She has held the following federal and state positions: Deputy Secretary of Health Care Financing at the Maryland Department of Health and Mental Hygiene, with oversight for the State of Maryland's Medicaid program and the Maryland Children's Health Program; National Director of SCHIP when it was first implemented in 1997; Director of the Office of Legislation and Policy for the Health Care Financing Administration (now Centers for Medicare and Medicaid Services); and Senior Health Policy Advisor to former U.S. Senator Donald W. Riegle, Jr., former chair of the Senate Finance Subcommittee on Health for Families and the Uninsured. She serves on the Institute of Medicine (IOM) Board on Children, Youth and Families and IOM Roundtables on Population Health and Improvement and Obesity Solutions, the Agency for Healthcare Research and Quality (AHRQ) Health Care Innovation Exchange Board, the Winter Park Health Foundation Board and the University of Michigan Griffith Leadership Center Board. She has published work on population health, child health systems transformation, Medicaid, SCHIP, and Nemours' prevention-oriented health system including its CDC Pioneering Innovation award-winning statewide childhood obesity program. Nemours is a founding member of the Partnership for a Healthier America and the National Convergence Partnership, a unique collaboration of leading foundations focused on healthy people and healthy places. Debbie holds a Master's degree in Public Health Policy and Administration from the University of Michigan School of Public Health and a bachelor's degree in Chemical Engineering from the Massachusetts Institute of Technology.

Teresa Cutts, Ph.D., is an associate professor in the Department of Social Sciences and Health Policy at Wake Forest School of Medicine. Before this position, she served as Director of Research for Innovation at the Center of Excellence in Faith and Health at Methodist LeBonheur Healthcare in Memphis, TN. At Wake Forest School of Medicine, she is the academic liaison to its international global faith health partners and leads the evaluation efforts of the Congregational Health Network, integrated health, community health assets mapping, and clergy/congregational training work. Professor Cutts has a Ph.D. in psychology, and holds adjunct faculty appointments at the University of Tennessee College of Medicine, University of Memphis School of Public Health and Memphis Theological Seminary, as well as a Visiting Associate position at University of Cape Town's School of Public Health and Family Medicine.

Robert H. Dugger, Ph.D., is an expert on assessing the effects of government policy on domestic and global markets and financial institutions. He is the founder and managing partner of Hanover Investment Group, a firm specializing in helping business and government clients navigate significant changes in fiscal conditions. Prior to Hanover, Rob was a partner in Tudor Investment Corporation for fifteen years. Tudor is a hedge fund active in currency, bond, equity, and commodity market trading and venture capital investment worldwide. Prior to Tudor, Mr. Dugger served as Policy Director at the American Bankers Association, where he facilitated a panel of bank officials in developing a plan that became the RTC and the solution to the U.S. Savings & Loan problem. Mr. Dugger began his career at the Federal Reserve Board of Governors in the early 1970s and served as a senior staff member of both the House Financial

Services Committee and the Senate Banking Committee in the 1980s. To improve the quality of economic research and analysis, he participated in founding the Institute for New Economic Thinking, INETeconomics.org, and serves as vice chairman of INET's governing board and as a member of the advisory board. Together with James Heckman, University of Chicago professor and Nobel Prize winner, Mr. Dugger co-heads INET's task force on human capital and economic development. To help achieve fiscal sustainability through US workforce strengthening, Mr. Dugger co-founded the Partnership for America's Economic Success, an organization dedicated to increasing business support for investing in early child development. PartnershipforSuccess.org He is a Trustee of the Committee for Economic Development, a board member of the Virginia Early Childhood Foundation and chairman of the Alexandria/Arlington Smart Beginnings Leadership Council. Mr. Dugger helped establish Grumeti Reserves Ltd and served as its board chairman for eight years. Grumeti is a Tanzanian eco-tourism company organized to preserve the Wildebeest migration route in a 450,000 acre game reserve adjacent to the Serengeti National Park in Tanzania. Grumeti's commercial tourism activities are done in partnership with the world's number-one rated hospitality company Singita Game Reserves Singita.com. Mr. Dugger served as vice chairman of its NGO affiliate, the Grumeti Community and Conservation Fund. Mr. Dugger received his BA from Davidson College and his Ph.D. in economics from the University of North Carolina at Chapel Hill on a Federal Reserve Dissertation Fellowship.

Mary Lou Goeke, M.S.W.,[*†] has held the position of Executive Director of United Way of Santa Cruz County from 1992 to the present. She is responsible for overall management and administration for the organization including strategic planning, new program development, financial oversight, liaison with funded community agencies, the business community, and government partners. She founded and staffs the Community Assessment Project, the internationally recognized, second oldest community progress report in the United States.

From 1981 to 1992, she held positions of increasing responsibility with Catholic Charities of the Archdiocese of San Francisco, the San Francisco Bay Area's largest private human services and community development agency. Initially hired as Director of Aging Services in the San Francisco County branch agency, she then became Director of Parish and Community Services in that agency and then Executive Director of the San Francisco County agency. She then held the position of General Director and CEO of the three county agencies, which includes San Francisco, Marin and San Mateo counties. In addition, as General Director she held two other related positions: Archdiocesan Director, Catholic Relief Services and Archdiocesan Director, Campaign for Human Development.

Prior to working for Catholic Charities, she served from 1979 to 1981 with the American Society for Aging as Policy and Legislation Coordinator. Before that, she worked from 1975 to 1979 for the State of Missouri Department of Aging, starting as a Field Representative and being promoted to the position of Director of Planning, Research and Evaluation.

Megan Golden, J.D., is currently a fellow at the NYU Wagner Innovation Labs and a consultant to nonprofit organizations and governments seeking to increase their impact. She specializes in performance management, innovation, and innovative financing mechanisms for scaling and sustaining effective interventions. She recently conducted a feasibility study for South Carolina on "pay for success" financing for early childhood interventions and served on the advisory group for McKinsey & Company's work on social impact bonds. From 1999-2011, Golden was

the Director of Planning and Government Innovation at the Vera Institute of Justice, where she worked in partnership with government to implement innovations in criminal justice, juvenile justice, child welfare, school safety, mental health, and eldercare. In addition to creating and launching eight innovative programs, she led a major reform of New Orleans's criminal justice system and helped Chinese academics and officials pilot criminal justice reforms. In addition to her work at Vera, Golden directed the Fellowship for Emerging Leaders in Public Service at NYU Wagner from 2006 – 2009. Golden practiced law from 1992-1994 as a Skadden Fellow at the Neighborhood Defender Service of Harlem. In 1994, she was awarded a White House Fellowship. Golden began her career working for New York City government as an Urban Fellow. She has a BA in political science from Brown University and a J.D. *magna cum laude* from the New York University School of Law.

Reverend Gary Gunderson, is the Vice President of the Division of Faith and Health Ministries at Wake Forest Baptist Medical Center and the Professor of Faith and Health of the Public at the School of Divinty. Rev. Gunderson earned a B.A. in History from Wake Forest University, M.Div, D.min, D.Div (Honorary) from Emory University. On graduation he initiated a ministry in the basement of Oakhurst Baptist Church called Seeds, which mobilized and equipped congregations and religious networks around hunger. That led his curiosity to focus on Africa and ways of generating socially relevant economic development. This led to The Carter Center and its Africa Program of democratization. The Center established the Interfaith Health Program in 1992 which under Gary's leadership developed a new paradigm for religion and the health of the public. Gunderson was one of the three principals who launched the Africa Religious Health Assets Program in 2002 which has developed a new language and logic finding traction among global organizations from WHO to the Gates Foundation. He served seven years as Senior Vice President of Methodist LeBonheur Healthcare in Memphis, TN and helped invent the "Memphis Model" of very large scale congregational networks which has attracted White House and HHS interest as it now serves as the secretariat for a network of health systems, including Wake Forest Baptist Medical Center seeing to serve the poor and transform their communities. He became Vice President at the Wake Forest Baptist Medical Center in July 2012. He has authored five books, most recently Religion and the Health of the Public: Shifting the Paradigm (Palgrave, 2012). He is Professor of Public Health Science at the Medical Center and Professor of Faith and the Health of the Public in the School of Divinity.

James A. Hester, Ph.D., M.S.,† has been active in health reform and population health for almost four decades. His most recent position was the Acting Director of the Population Health Models Group at the Innovation Center in CMS assisting in the development of delivery system transformation and payment reform initiatives such as Pioneer ACO's, medical homes and population health models. Prior to joining CMS, he was the Director of the Health Care Reform Commission for the Vermont state legislature. The commission was charged with developing a comprehensive package of health reform legislation and recommending the long term strategy to ensure that all Vermonter's have access to affordable, quality health care. The delivery system reforms included a statewide enhanced medical home program and the development of pilot community health systems based on the ACO concept. Dr. Hester has held senior management positions with MVP Healthcare in Vermont, ChoiceCare in Cincinnati, Pilgrim Health Care in Boston, and Tufts Medical Center in Boston. He began his managed care career as Director of Applied Research for the Kaiser Permanente Medical Care Program in Los Angeles, California.

His initial introduction to analyzing complex systems came in the aerospace industry through work on the Apollo project's rocket engines and high powered gas dynamic lasers. Dr. Hester earned his Ph.D. in urban studies, and his M.S. and B.S. degrees in Aeronautics and Astronautics, all from the Massachusetts Institute of Technology. He has a continuing interest in health services research and teaching, and has held faculty appointments at the University of Vermont, University of Cincinnati, Harvard School of Public Health and the University of Massachusetts. He has served on the boards of Vermont Information Technology Leaders (VITL), the Vermont Program for Quality Health Care, and UVM's College of Nursing and Health Science. He and his family live in Burlington, Vermont where he pursues his hobbies of backpacking, photography and cross country skiing.

George Isham, M.D., M.S.[*†] is Senior Advisor to HealthPartners, responsible for working with the board of directors and the senior management team on health and quality of care improvement for patients, members and the community. Dr. Isham is also Senior Fellow, HealthPartners Research Foundation and facilitates forward progress at the intersection of population health research and public policy. Dr. Isham is active nationally and currently co-chairs the National Quality Forum convened Measurement Application Partnership, chairs the National Committee for Quality Assurances' clinical program committee and a is member of NCQA's committee on performance measurement. Dr. Isham is chair of the Institute of Medicine's Roundtable on Health Literacy and has chaired three studies in addition to serving on a number of IOM studies related to health and quality of care. In 2003 Isham was appointed as a lifetime National Associate of the National Academies of Science in recognition of his contributions to the work of the Institute of Medicine. He is a former member of the Center for Disease Control and Prevention's Task Force on Community Preventive Services and the Agency for Health Care Quality's United States Preventive Services Task Force and currently serves on the advisory committee to the director of Centers for Disease Control and Prevention. His practice experience as a general internist was with the United States Navy, at the Freeport Clinic in Freeport, Illinois, and as a clinical assistant professor of medicine at the University of Wisconsin Hospitals and Clinics in Madison, Wisconsin.

Jeffrey Levi, Ph.D.,[*†] is Executive Director of the Trust for America's Health (TFAH), where he leads the organization's advocacy efforts on behalf of a modernized public health system. He oversees TFAH's work on a range of public health policy issues, including implementation of the public health provisions of the Affordable Care Act and annual reports assessing the nation's public health preparedness, investment in public health infrastructure, and response to chronic diseases such as obesity. TFAH led the public health community's efforts to enact, and now defend, the prevention provisions of the ACA, including the Prevention and Public Health Fund and the new Community Transformation Grants. In January 2011, President Obama appointed Dr. Levi to serve as a member of the Advisory Group on Prevention, Health Promotion, and Integrative and Public Health. In April 2011, Surgeon General Benjamin appointed him chair of the Advisory Group. Dr. Levi is also Professor of Health Policy George Washington University's School of Public Health, where his research has focused on HIV/AIDS, Medicaid, and integrating public health with the healthcare delivery system. In the past, he has also served as an associate editor of the American Journal of Public Health and Deputy Director of the White House Office of National AIDS Policy. Beginning in the early 1980s, he held various leadership positions in the LGBT and HIV communities, helping to frame the early response to the HIV

epidemic. Dr. Levi received a B.A. from Oberlin College, an M.A. from Cornell University, and a Ph.D. from The George Washington University.

Glen P. Mays, Ph.D., M.P.H.,[†] serves as the F. Douglas Scutchfield Endowed Professor of Health Services and Systems Research at the University of Kentucky College of Public Health. Prior to joining the University of Kentucky in August 2011, he served as professor and chairman of the Department of Health Policy and Management in the Fay W. Boozman College of Public Health at the University of Arkansas for Medical Sciences (UAMS), where he also directed the Ph.D. program in Health Systems Research at UAMS. Dr. Mays' research focuses on strategies for organizing and financing public health services, preventive care, and chronic disease management for underserved populations. Currently, he directs the Public Health Practice-Based Research Networks Program funded by the Robert Wood Johnson Foundation, which brings together public health agencies and researchers from around the nation to study innovations in public health practice. Mays also serves as co-PI of the RWJF-funded National Coordinating Center for Public Health Services and Systems Research at the University of Kentucky. Mays also is co-PI of the CDC-funded North Carolina Preparedness and Emergency Response Research Center conducted in collaboration with UNC-Chapel Hill. Mays earned an undergraduate degree in political science from Brown University, earned M.P.H. and Ph.D. degrees in health policy and administration from UNC-Chapel Hill, and completed a postdoctoral fellowship in health economics at Harvard Medical School

José Montero, M.D., MHDCS,[*†] José Montero, director of the Division of Public Health Services at the New Hampshire Department of Health and Human Services (DHHS), was elected president of the Association of State and Territorial Health Officials in September 2012. Montero began his medical and public health career in Colombia, where he served on several public health and academic positions and as Colombia's public health director. He began his New Hampshire service in 1999 as chief of the New Hampshire Communicable Disease Section within the Division of Public Health. Before becoming director of the New Hampshire Division of Public Health Services, Montero held the position of state epidemiologist. José also fulfills several national roles. He is the president of ASTHO (Association of State and Territorial Health Officers). He serves on several committees including the federal Advisory Committee on Immunization Practices (ACIP, as ASTHO Liaison) and has been recently appointed to the CDC's board of scientific councilors for the Office of infectious diseases. José served as a board member on the NH Foundation for Healthy Communities, co-chair of the Health Promotion-Disease prevention group of the NH Citizen Initiative, and member of Dartmouth Medical School Leadership Preventive Medicine Residency Advisory Committee. José received his M.D. from the Universidad Nacional de Colombia. He specialized in Family Medicine, receiving his degree from the Universidad del Valle in Cali Colombia and a degree in Epidemiology, from the Pontificia Universidad Javeriana in Bogota Colombia. Recently he completed his Masters in Health Care Delivery Science at Dartmouth.

Andrea Phillips, M.A., is the Chief Operating Officer of 10,000 Small Businesses and a Vice President in the Urban Investment Group of Goldman Sachs. She has over 20 years of experience in developing small business, workforce and community development programs. Most recently, she was a consultant providing strategic and operational planning services to a variety of public and private sector clients. Previously, Ms. Phillips was Interim President of Seedco Financial, a

$54 million Community Development Financial Institution(CDFI) which provides affordable capital to small businesses and non-profits in disadvantaged communities. Prior to that she was Executive Vice President for Programs at Seedco, where she was responsible for developing strategies for and overseeing the implementation of all Seedco programs, totaling nearly $50 million in funding annually. Prior to her time at Seedco, she served as Deputy Director for Research and Evaluation for New York City's Victim Services Agency and as a Program Director at the Local Initiatives Support Corporation (LISC). Ms. Phillips holds a B.A. from Tufts University and a M.A. in Public Policy from the Kennedy School of Government at Harvard University.

Andrew Webber,[*†] joined the Maine Health Management Coalition as Chief Executive Officer in August of 2013 and has been a long time advocate for healthcare improvement. Before taking this position, he served the National Business Coalition on Health (NBCH) as president and CEO from June of 2003 to July 2013. NBCH is a national, not-for-profit membership organization of 56 purchaser-based coalitions on health, dedicated to improving health and transforming healthcare, community by community. As president and CEO of NBCH, Webber was responsible for overseeing all association activities including value-based purchasing programs, government and external relations, educational programs, member communications, technical assistance, and research and evaluation. Webber currently is vice chair and a board member of the National Quality Forum (NQF). He sits on the Board of Directors for the Patient Centered Primary Care Collaborative (PCPCC), The Alliance to Make US Healthiest, and the Health Care Incentives Improvement Institute (HCI3) - the combined Bridges to Excellence and Prometheus Payment organizations. He is a principal of the Quality Alliance Steering Committee (QASC) and NBCH is a member of the Ambulatory Quality Alliance (AQA). Webber is also a member of the Purchaser/Business Advisory Councils for the National Committee for Quality Assurance, the Joint Commission for the Accreditation of Healthcare Organizations, and the eHealth Initiative. Prior to joining NBCH, Webber was a Vice President for External Relations and Public Policy at the National Committee for Quality Assurance. In this role, Webber directed all government relation activities and outreach efforts to the employer and consumer communities. Previous positions also include senior associate for the Consumer Coalition for Quality Health Care and executive vice president for the American Medical Peer Review Association (currently renamed the American Health Quality Association). Webber started his health policy career in 1978 as an employee of the Washington Business Group on Health (currently renamed the National Business Group on Health), rising to the position of Vice President for Public Policy. Andrew Webber is a frequent speaker and lecturer on health policy issues. He is a graduate of Harvard University.

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Senior Advisor, HealthPartners
Senior Fellow, HealthPartners Institute for Education and Research
HealthPartners, Inc

David A. Kindig, MD, PhD (Co-chair)
Professor Emeritus of Population Health Sciences
Emeritus Vice Chancellor for Health Sciences
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President, Association of State and Territorial Health Officials
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New Hampshire Division of Public Health Services

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President and CEO
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Fellow and Vice President, Health Research, IBM Research
International Business Machines Corporation

Andrew Webber
CEO
Maine Health Management Coalition

PAYING FOR POPULATION HEALTH IMPROVEMENT

David Kindig MD, PhD

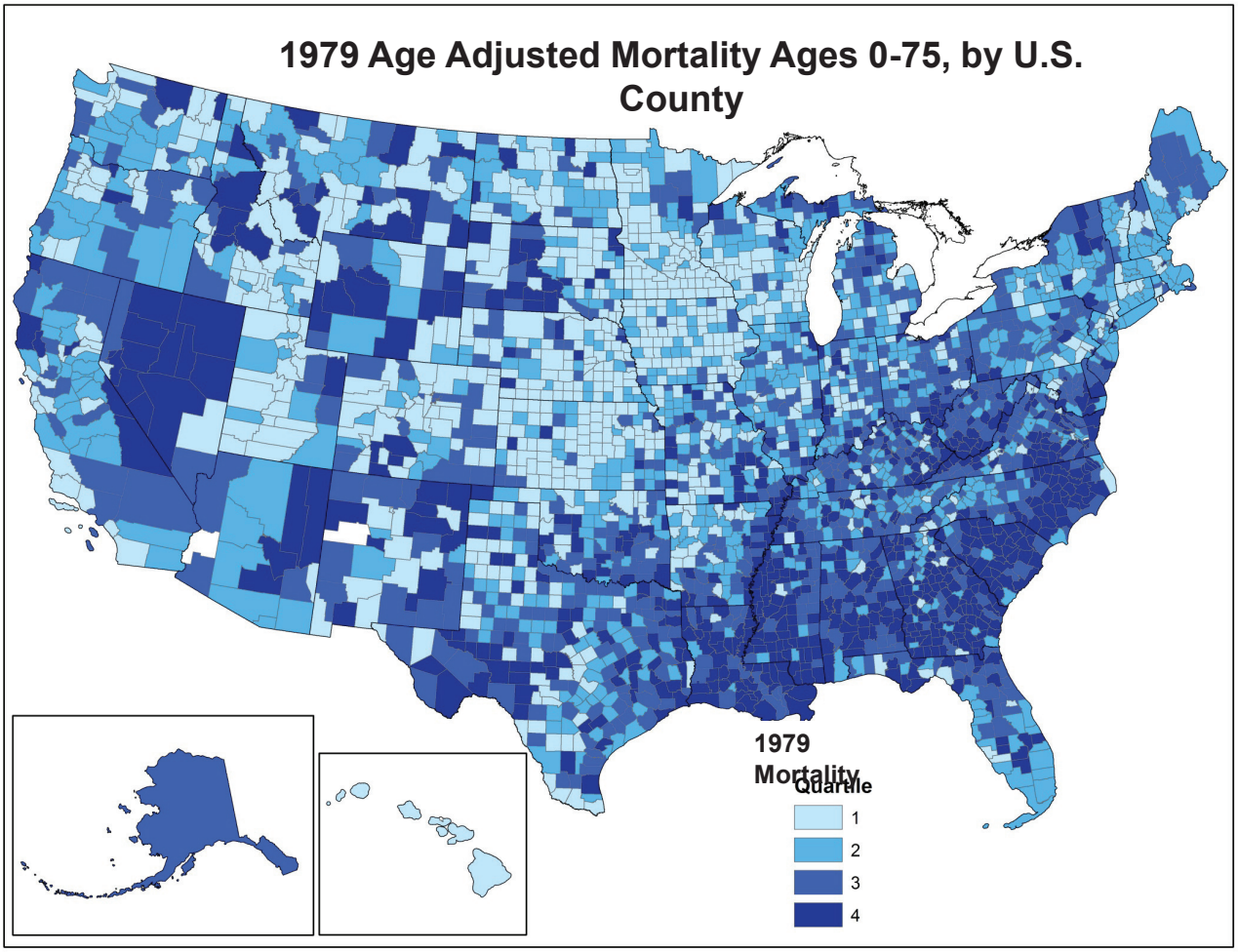
IOM Population Health Roundtable

Workshop on Resources

February 6, 2014

Paying for population health improvement

1. How much do you need and where would you put the money?
2. Where would you get it from?
3. Can local investment guidance be developed?


1979 Age Adjusted Mortality Ages 0-75, by U.S. County
1979 Mortality
Quartile
1
2
3
4

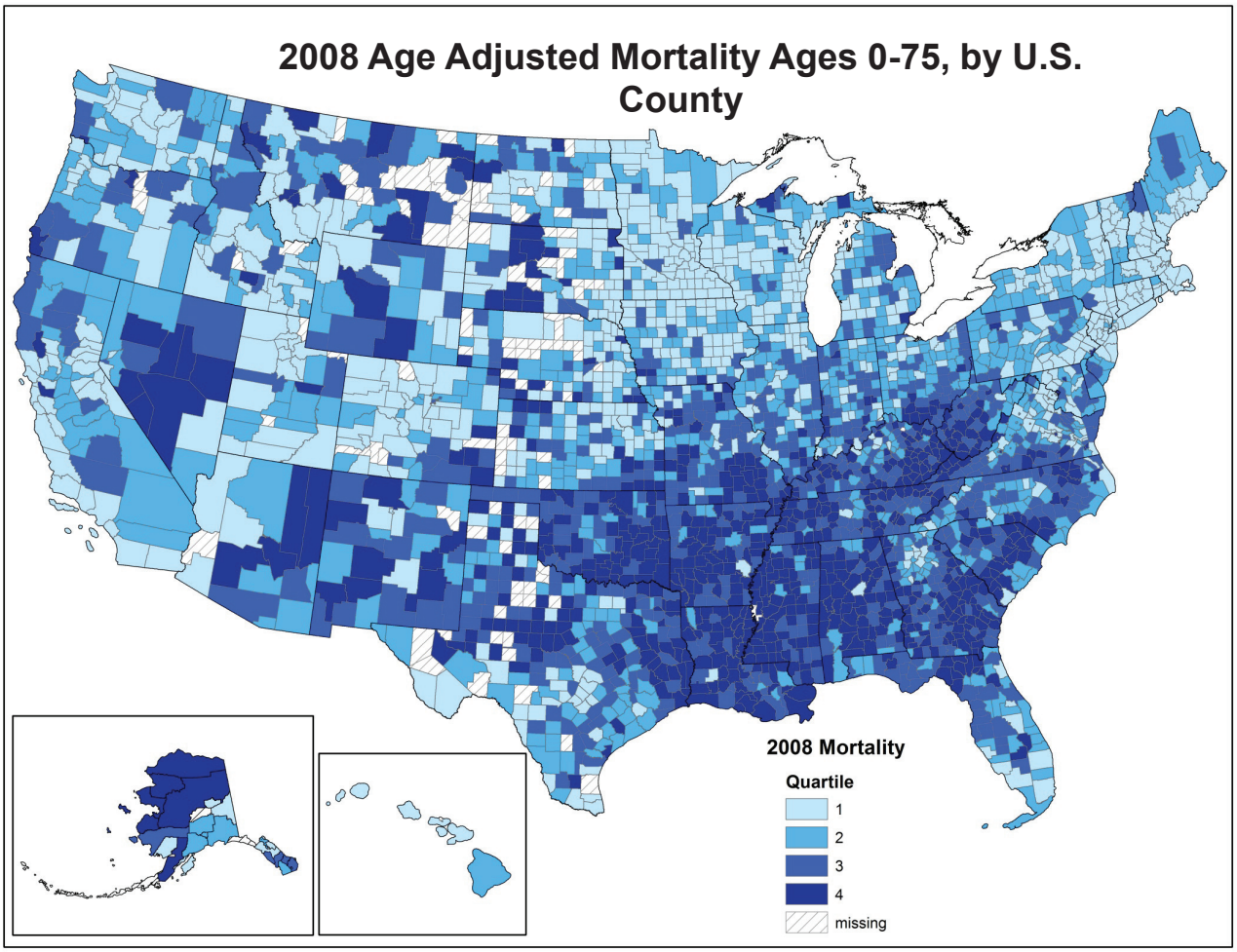
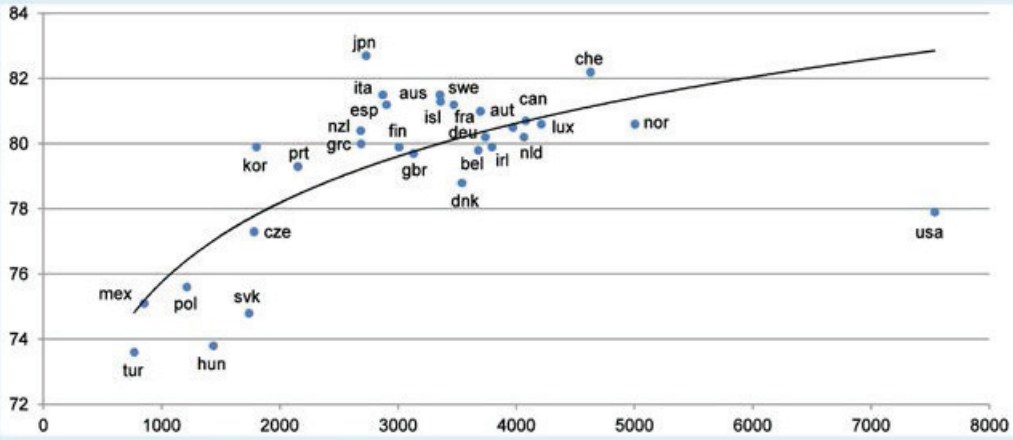

2008 Age Adjusted Mortality Ages 0-75, by U.S. County
2008 Mortality
Quartile
1
2
3
4
missing

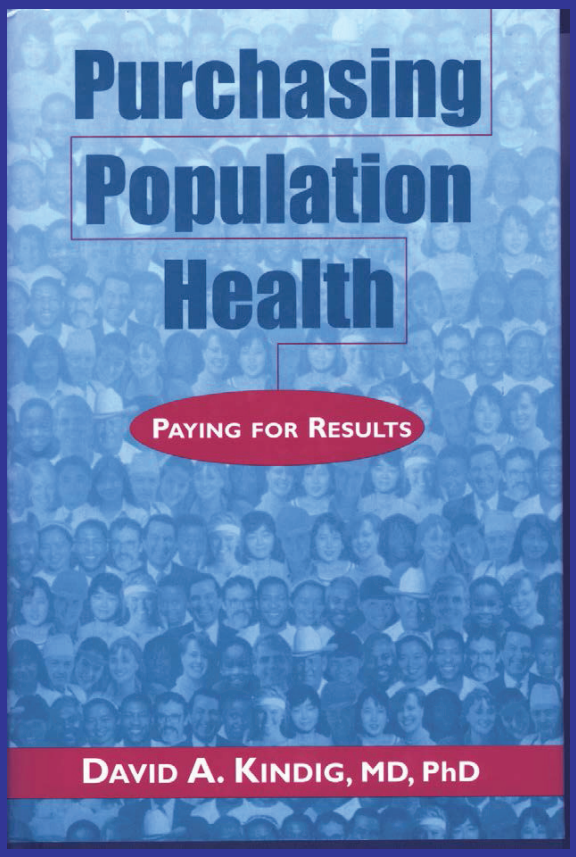
FIGURE: Life Expectancy at Birth (yrs), Health Spending by Country



Total expenditure on health per capita, U.S. $PPP

FIGURE KEY: aus is Australia, aut is Austria, bel is Belgium, can is Canada, che is Switzerland, cze is the Czech Republic, dnk is Denmark, fin is Finland, fra is France, deu is Germany, grc is Greece, hun is Hungary, irl is Ireland, isl is Iceland, ita is Italy, jpn is Japan, kor is Korea, lux is Luxembourg; mex is Mexico, nld is the Netherlands, nzl is New Zealand, nor is Norway, pol is Poland, prt is Portugal, svk is the Slovak Republic, tur is Turkey, esp is Spain, swe is Sweden, gbr is the United Kingdom, and usa is the United States.

SOURCE: Organisation for Economic Co-operation and Development 2010, "Health Care Systems: Getting More Value for Money."



"The fundamental assertion of this book is that population health improvement will not be achieved until appropriate financial incentives are designed for this outcome."

Kindig 1997

Roundtable Drivers

- **Goals and metrics**
- **Resources**
- **Science-informed interventions**
- **Policies**
- **Communication & movement-building**
- **Partnership**

"Resources" for this Roundtable

Resources refers to many different kinds of essential ingredients needed to support the improvement of population health.

- financial
- human (workforce and training)
- informational (data, technology)
- community assets such as social capital and cultural diversity

"Resources" for this workshop

This workshop will focus on financial resources, and especially on varied private sector funding sources and mechanisms that can help alter the social and environmental determinants of health.

Outline of presentation

1. To improve overall health and reduce or eliminate health disparities, significant new and reallocated resources of many kinds will be required.

2. While philanthropy and public pilot funds are critical for testing new sources and ideas, developing and aligning dependable long-term revenue streams is essential.

3. We can start by reallocating savings from ineffective health care expenditures, but will need to expand health in all policy investments as well – especially by finding the sweet spots where core missions of other sectors align with health improvement objectives.

4. New evidence is badly needed regarding relative cost effectiveness of different investments, but we can't wait decades to act.

5. This Roundtable could add value by leading the call for the development of optimal cross-sectoral financial investment or policy strength benchmarks, that are tailored to individual community outcomes and determinants profiles.

PART 1: HOW MUCH IS NEEDED, AND FOR WHAT INVESTMENTS?

"How much, then, should go for medical care and how much for other programs affecting health, such as pollution control, flouridation of water, accident prevention and the like.

There is no simple answer, partly because the question has rarely been explicitly asked."

Victor Fuchs, 1974

Do they really mean *HEALTH* expenditures?

Our national health accounts report expenditures of $2.7 trillion, but they really only count health care and governmental public health. The total cost of health is (much?) greater if the costs of the nonmedical determinants are included.

Kindig Health Affairs blog 2011

We *do not know* today what the total HEALTH budget needs to be

It would include:

- adequate resources for public health and less health care spending (do we agree with the IOM that "parity" with OECD health spending is the goal?)
- plus that share of other sector investments that are health promoting (education, housing, economic development)

What is needed for governmental public health: From the IOM Investing in a Healthier Future 2012

- Trust for Americas Health 2008
  $20 billion shortfall
- IOM 2012 "more conservative" doubling
  from $11.6 billion to $24 billion

Ratio of social service spending to medical care spending

European OECD 2.0

United States 0.9

Bradley BMJ 2010

America's Health Dividend

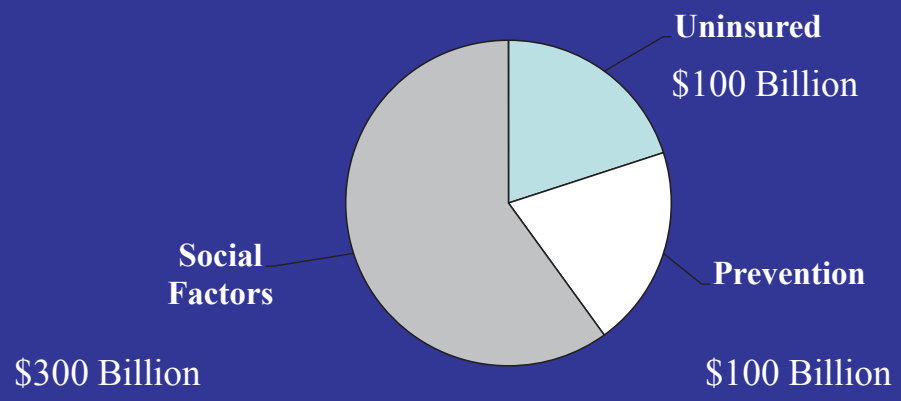
45% of the waste in health care accrues to the public sector = $337B…

To be reallocated to…..

- $168B in debt reduction
- $104B in education programs like universal pre K and smaller class sizes, smoking education, Head Start
- $61B in Infrastructure like Safe Streets, Job Corps, Food Stamps

If I were czar and had to work with existing resources…

I would take the 20% of health care expenditures that are thought to be ineffective ($500 billion), and reallocate as below:



Different places need different investments

	NORTH DAKOTA 9	UTAH 6
• Lack Health Ins	9	28
• Smoking	34	1
• HS Grad	3	26
• Binge Drinking	49	2
• Air Qual	3	25

“Is community-level financial data adequate to assess population health investments?”

Casper and Kindig

Prev Chronic Disease 2012

This Roundtable should take the lead in getting such estimates developed so we know WHAT OUR HEALTH BUDGET NEEDS TO BE.

Roundtable Drivers

- Goals and metrics
- Resources
- **Science-informed interventions**
- Policies
- Communication & movement-building
- Partnership

PART 2: WHERE CAN NEW INVESTMENTS COME FROM?

Sources of dependable financial support

1. From savings from health care: Community Benefit reform and ACO shared savings… or IOM taxes on health care?
2. Health in All Policies -- more health from what we are already spending in other sectors, including community development opportunities
3. Government and foundations
4. Businesses understanding the "business case"

Kindig and Isham 2014 in press

Community Benefit is not primarily charity care

- 25% for charity care
- 5% for community health improvement

- Almost 60% reported is for Medicaid discounts or other money losing services.
- This is probably a $100 Billion per year IRS requirement that could be redirected in more health promoting ways.

Sweet spots for business

- attracting and retaining talent
- employee engagement
- human performance
- health care costs
- product safety
- product reliability
- sustainability
- brand reputation

Dependable revenue streams

We need to move beyond grants and short term appropriations.

We need to move to dependable formula sources like crop subsidies or mortgage interest deductions or Medicare medical education payment.

For those in other sectors, like early childhood support, we need to add our political clout to their efforts for win-win opportunities.

Ray Baxter on Efficiency

PREVENTING CHRONIC DISEASE
PUBLIC HEALTH RESEARCH. PRACTICE. AND POLICY

Volume 7: No. 5, September 2010

SPECIAL TOPIC

Making Better Use of the Policies and Funding We Already Have

Raymond J. Baxter, PhD

Suggested citation for this article: Baxter RJ. Making better use of the policies and funding we already have. Prev Chronic Dis 2010;7(5):A97. http://www.cdc.gov/pcd/issues/2010/sep/10_0055.htm. Accessed [*date*].

PEER REVIEWED

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Abstract

The potential for population health reform could be enhanced by assessing whether we have made the most of policies and resources already available. Opportunities to promote population health independent of major changes in resources or public authority include the following: enforcing laws already in effect; clarifying and updating the application of long-standing policies; leveraging government's and the private sector's purchasing and investment clout; facilitating access to programs by everyone who is eligible for them; evaluating the effectiveness of population health programs, agencies, and policies; and intervening to stop agencies and policies from operating at cross-purposes.

Back to top

PART 3: MOVE BEYOND DETERMINANT BENCHMARKS TO INVESTMENT BENCHMARKS

What Works for Health
Policies and Programs to Improve Wisconsin's Health

Search Policies & Programs
Search
exact match
Display All Policies & Programs
Contribute Content

An Evidence-based Resource: Policies and Programs to Improve Wisconsin's Health

What Works for Health is a database of policies and programs that can improve health. These policies and programs address key health factors that, in turn, improve health outcomes. This database is based on a wide scan of analyses assessing evidence of effectiveness. We summarize research about what does and does not work to help different stakeholders (such as public health practitioners, community organizations, businesses, schools, and others) identify policies and programs that could improve health.

Policies and Programs

The research underlying this site is based on a model of population health that emphasizes the many factors that can make communities healthier places to live, learn, work, and play. For each health factor, this database reviews policies and programs, describing expected outcomes, implementation in Wisconsin and elsewhere, resources related to effectiveness and implementation, potential reach and impact on disparities, and other key information. It also provides opportunities to learn from communities that use these policies and programs.

To find a policy or program *click on a health factor* (in the blue boxes below), *search by keyword* (see top of left column), or *search* by one or more of the following: decision maker; evidence rating; potential population reach; or impact on disparities.

BACK TO MAP

Areas to Explore On Off

	Dane County	Error Margin	Wisconsin	National Benchmark*	Trend	Rank (of 72)
Health Outcomes						**15**
Mortality						5
Premature death	4,627	4,411-4,843	5,878	5,317		
Morbidity						29
Poor or fair health	9%	7-11%	12%	10%		
Poor physical health days	3.1	2.7-3.5	3.2	2.6		
Poor mental health days	2.8	2.4-3.2	3.0	2.3		
Low birthweight	6.2%	6.0-6.4%	7.0%	6.0%		

Different places need different investments

	NORTH DAKOTA 9	UTAH 6
• Lack Health Ins	9	28
• Smoking	34	1
• HS Grad	3	26
• Binge Drinking	49	2
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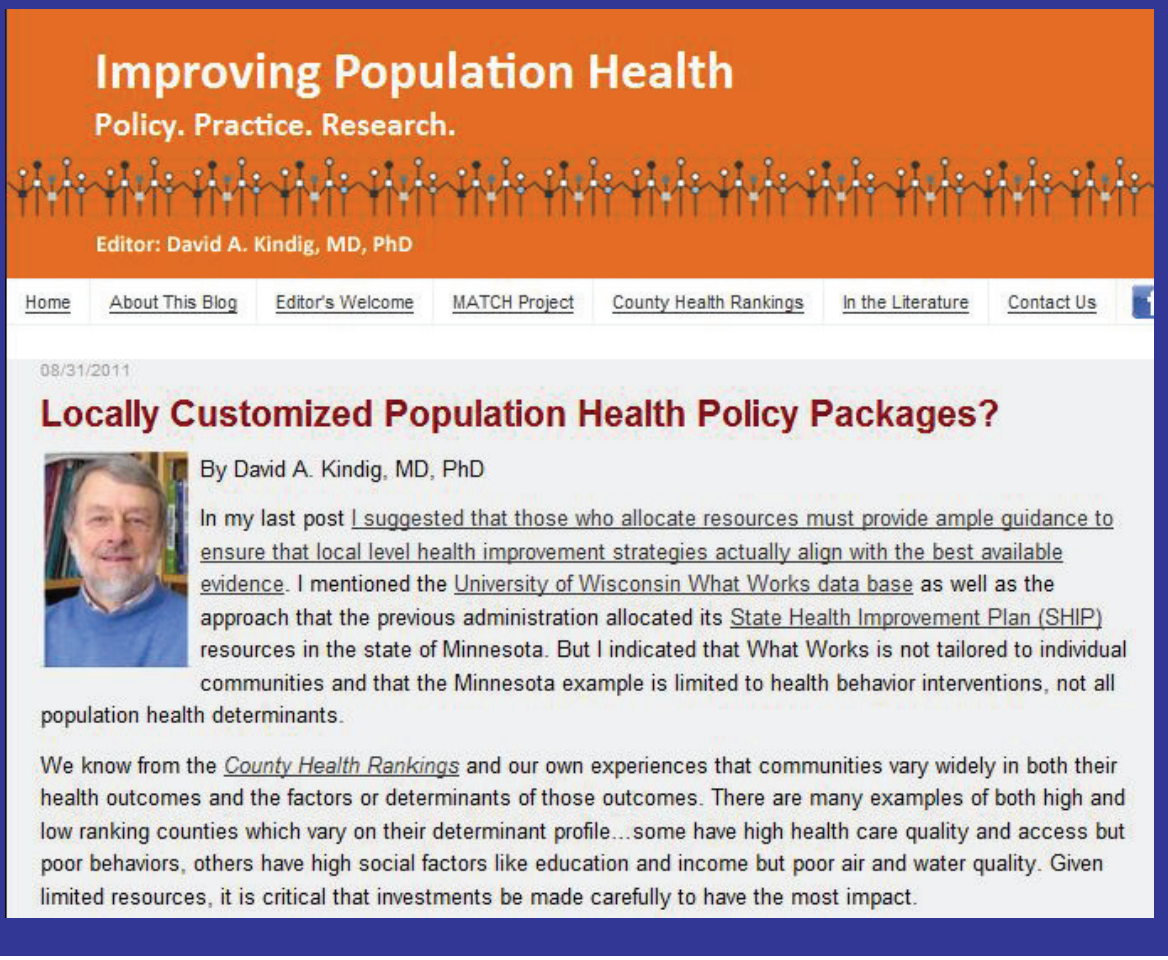


Improving Population Health

Policy. Practice. Research.

Editor: David A. Kindig, MD, PhD

Home | About This Blog | Editor's Welcome | MATCH Project | County Health Rankings | In the Literature | Contact Us

08/31/2011

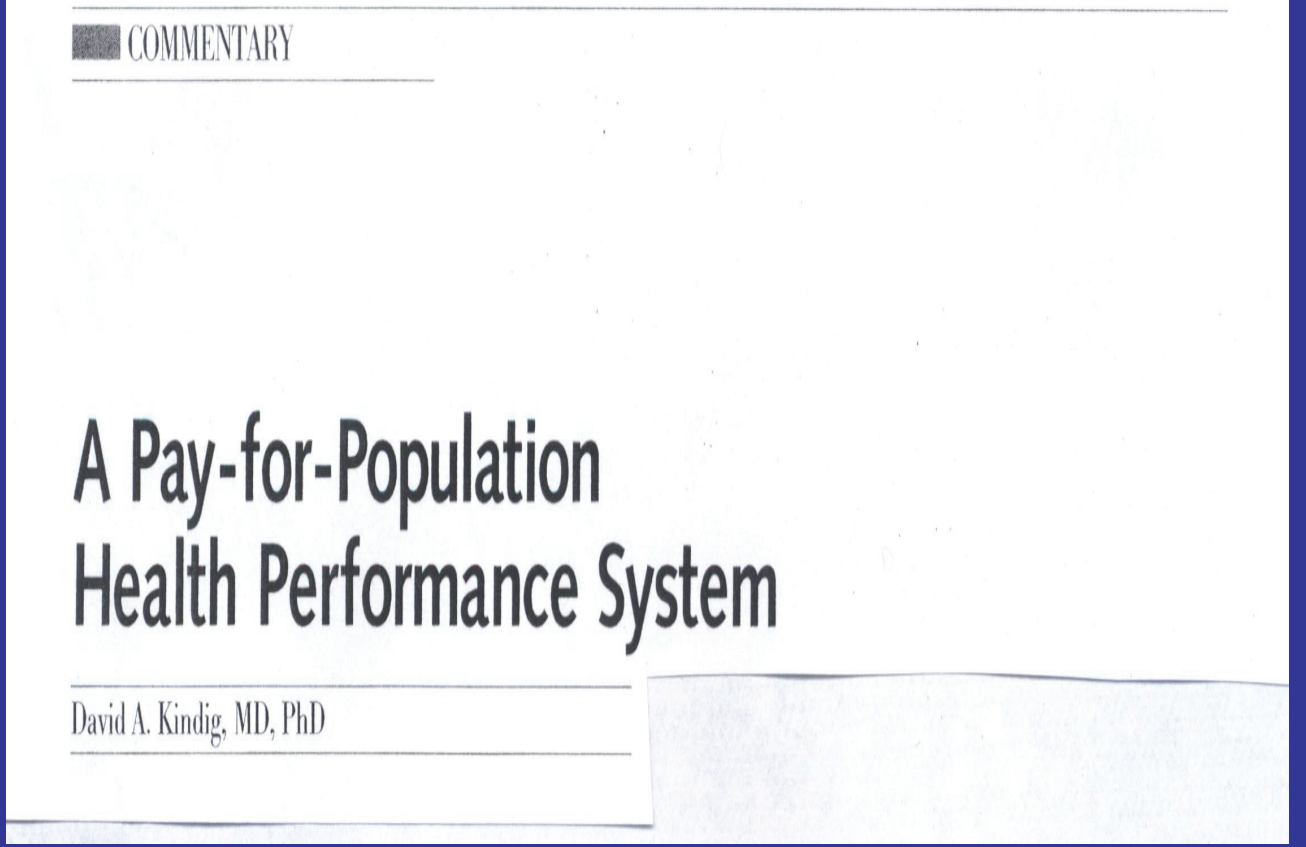
Locally Customized Population Health Policy Packages?

By David A. Kindig, MD, PhD

In my last post I suggested that those who allocate resources must provide ample guidance to ensure that local level health improvement strategies actually align with the best available evidence. I mentioned the University of Wisconsin What Works data base as well as the approach that the previous administration allocated its State Health Improvement Plan (SHIP) resources in the state of Minnesota. But I indicated that What Works is not tailored to individual communities and that the Minnesota example is limited to health behavior interventions, not all population health determinants.

We know from the *County Health Rankings* and our own experiences that communities vary widely in both their health outcomes and the factors or determinants of those outcomes. There are many examples of both high and low ranking counties which vary on their determinant profile...some have high health care quality and access but poor behaviors, others have high social factors like education and income but poor air and water quality. Given limited resources, it is critical that investments be made carefully to have the most impact.

5. This Roundtable could add value by leading the call for the development of optimal cross-sectoral financial investment or policy strength benchmarks, which are tailored to individual community outcomes and determinants profiles.



COMMENTARY

A Pay-for-Population Health Performance System

David A. Kindig, MD, PhD

Solid partnerships and real resources

"What is required is a coordinated effort across determinants between the public and private sectors, as well as financial resources and incentives to make it work."

Kindig JAMA 2006

A Community Health Business Model That Engages Partners in All Sectors is Necessary for Population Health Improvement

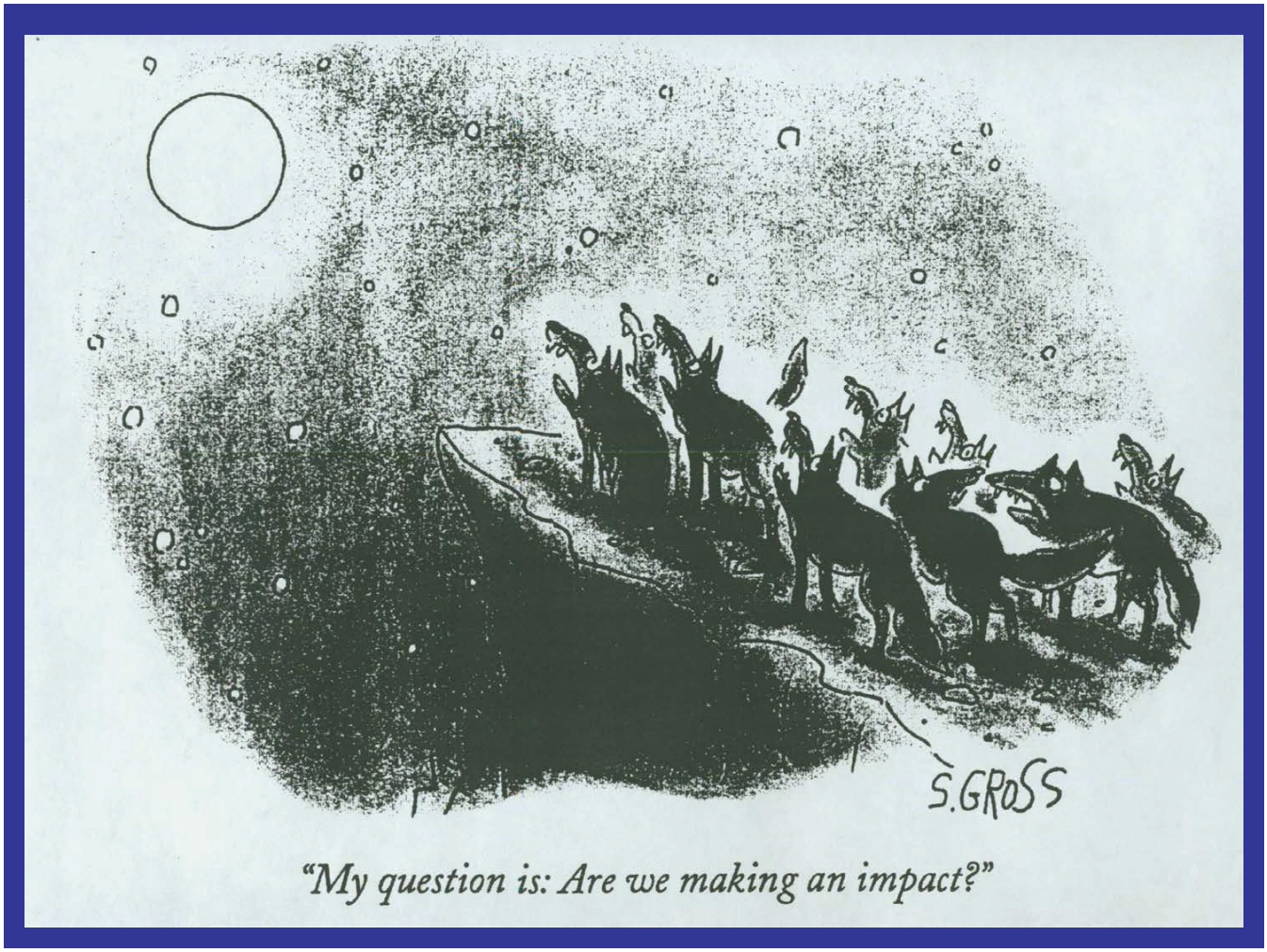
Kindig and Isham in press 2014

THE Population Health Question

In a resource limited world (nation, community) what is the optimal *national and local* per capita investment, and policy "strength", across sectors (health care, public health, health behaviors, social factors like education and income, physical environment) for improving overall health and reducing disparities?

Roundtable Drivers

- **Goals and metrics**
- **Resources**
- **Science-informed interventions**
- **Policies**
- **Communication & movement-building**
- **Partnership**



"My question is: Are we making an impact?"

Community Development and Population Health: An Overview

Professor Raphael W. Bostic

Institute of Medicine
Workshop #5: Resources for Population Health Improvement
February 6, 2014

Overview

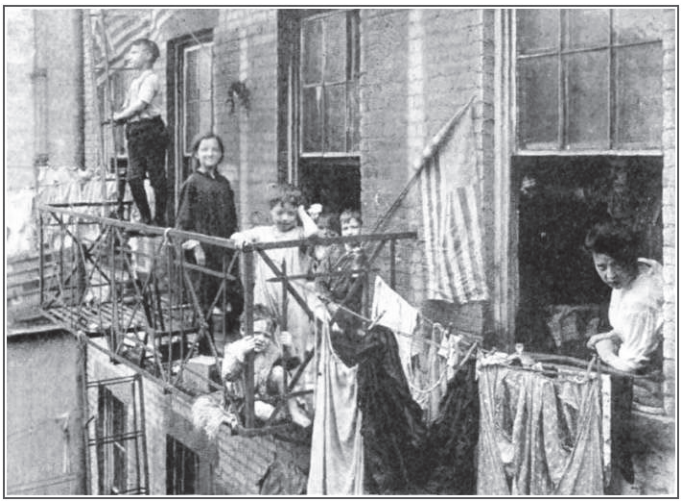
- History of community development policy (and population health)
- Dimensions of community development
- Opportunities for progress

The Punchline

- Proactive behavior to create new partnerships can lead to progress on the social determinants of health and result in better population health

Background

- Community development and population health have a long history



www.gutenberg.org/.../images/imagep010.jpg

http://images.villagevoice.com/issues/9938/lobbia6.jpg

http://historyproject.ucdavis.edu/marchandslides.bak/2000/thumbnails/ScanImage02624.jpg

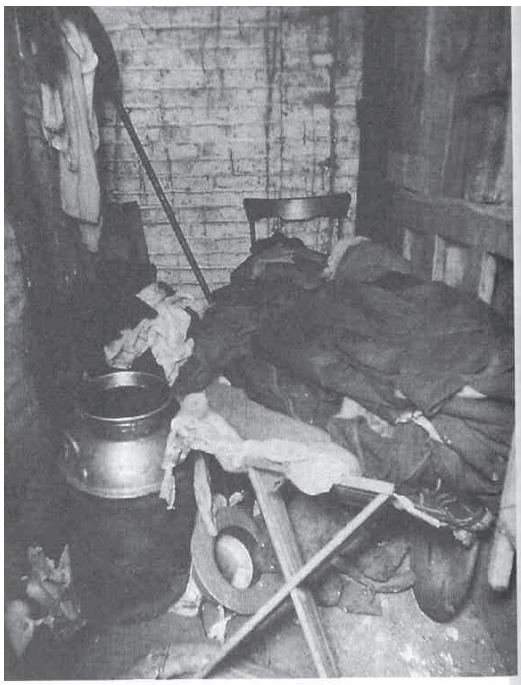
1856 inspector:

"no provision for ventilation; drainage was insufficient; the sinks in wretched condition, and the entire structure thick with nauseating smells"

-- *Urban Castles*, Jared Day, p. 17

House partly destroyed by fire but still occupied circa 1904–1905. Standard building methods created fire hazards, both obvious and hidden. Builders often applied "three months" paint. The mixture was inexpensive, and it made the apartments look good for about three months, long enough for the builder to sell the tenement. Unfortunately, not only did the paint deteriorate quickly but, as with many of the cheap materials used, it was a fire hazard. A reporter for *McClure's Magazine* noted in 1911 that "let a lamp or a candle near enough to it while it is still damp, and fire would go around the room or down the tenement hall as fast as a man could run."

Demolition site circa 1906. Even with walls missing, tenants still live here. Landlords had little to fear from injured tenants because successful lawsuits against landlords were rare



e owner of this Brooklyn tenement lived in this cellar bedroom 4 & 1/2 feet de, 8 feet long, 7 feet high, circa 1915–1916. Between 1880 and 1920, landlords d leasing agents often lived in the same rundown tenements they managed.

Real estate brokers, immigrant banks and other types of unlicensed lenders, such as this one circa 1907, acted as buyers, sellers and financiers of tenements.

NY Times Report on the plight of grocer Edward Rafter

"At two of his buildings, a baker and fish seller worked in two of the three stores on the first floor, and they shared the sink in the basement. The baker used water from the sink for his bread; the fish seller washed his fish in the sink; and the sixteen families in the two buildings used the sink as a urinal."

-- *Urban Castles*, Jared Day, p. 55

Background

- Community development and population health have a long history
  - 1890s: Slum clearance and upgrade as a public health initiative
  - 1949: National Housing Act

The National Housing Act of 1949

- Provisions
  - Title I - "Bulldozer approach"
    - $1 billion in loans to acquire slums, blighted areas for public, private devlpmt
  - Title II - Increased insurance limit

The National Housing Act of 1949

- Provisions
  - Title III - Restarted Wagner public housing
    - Build 810,000 new low-rent units over next 6 years
    - 1 slum down for each put up
    - Ceilings on tenant incomes and construction costs
      - focus is the very poor, not working poor
    - NOT real competition for private builders
  - Title IV- Established funding for research
  - Title V- Expanded rural housing program

Background

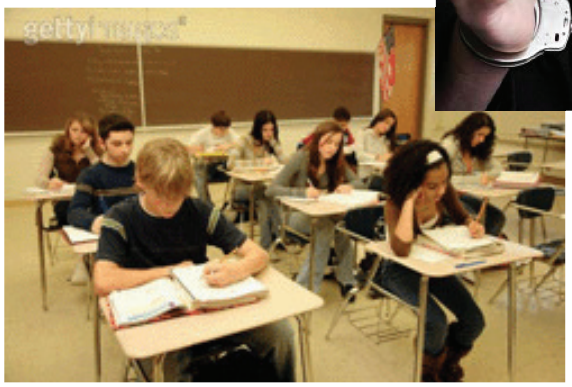
- Community development and population health have a long history
  - 1890s: Slum clearance and upgrade as a public health initiative
  - 1949: National Housing Act
  - Periodic successes since 1960s
    - Example: Investments by HUD and regulatory actions together reduced incidence of childhood lead poisoning by 70 percent

The Recent History – A Reset

- There has been renewed attention to connecting community development efforts to public health metrics
  - Health benefits are being observed as major outcomes of CD investments
    - Example: Moving to Opportunity resulted in improved psychological, depression, and stress-related outcomes, as well as lower levels of obesity
  - There is a broadening recognition that social and economic factors – social determinants of health – can drive population health outcomes
  - Budget pressures across the board have increased need to broaden funding base and leverage existing resources

Policies Shaping the Social Determinants of Health

- Policies on
  - Housing and community development
    - Mainly HUD (about $30 billion)
    - Includes Community Development Block Grants, HOME Investment Partnership grants, Housing Choice Voucher program, Choice Neighborhoods



American Foundation for AIDS Research

Policies Shaping the Social Determinants of Health II

- Policies on
  - Housing and community development
    - Mainly HUD (about $30 billion)
  - Public safety
    - DOJ ($630 million) in state, local, and tribal law enforcement
    - Community-Oriented Policing Services (COPS), Byrne Criminal Justice Innovation Program, Community-based violence prevention initiatives, substance abuse programs

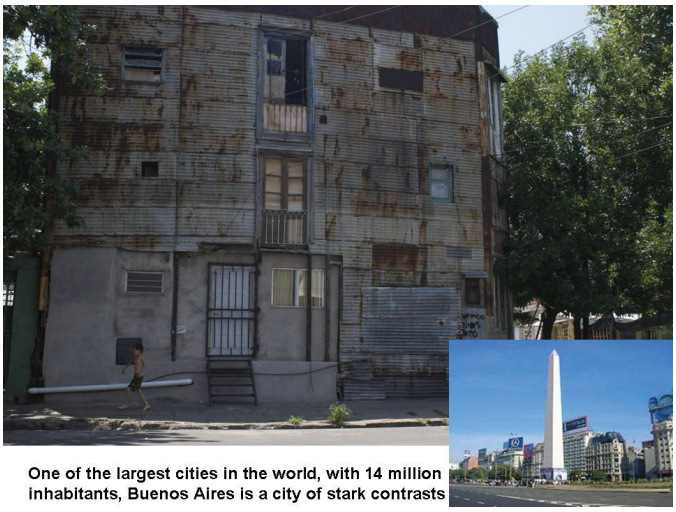
Policies Shaping the Social Determinants of Health III

- Policies on
  - Housing and community development
    - Mainly HUD (about $30 billion)
  - Public safety
    - DOJ (about $630 million)
  - Transportation
    - DOT and EPA (more than $20 billion)
    - Sustainable Communities Grants, Brownfields, Federal Transit Administration, Surface Transportation program, Metropolitan Planning Grants, MAP-21, TOD planning

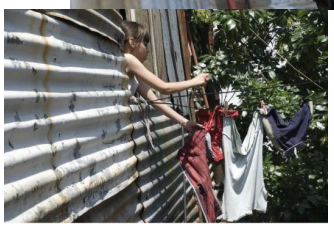
Policies Shaping the Social Determinants of Health IV

- Policies on
  - Housing and community development
    - Mainly HUD (about $30 billion)
  - Public safety
    - DOJ (about $630 million)
  - Transportation
    - DOT and EPA (more than $20 billion)
  - Capital and finance
    - Treasury and others (more than $10 billion)
    - Low-income housing tax credit, Community Reinvestment Act for depositories, CDFIs, CDFI Fund

Sustainable Urban Housing Competition Winner: Developing Real Estate for Squatters and Tenants



One of the largest cities in the world, with 14 million inhabitants, Buenos Aires is a city of stark contrasts



Recycling Urban Homes, Buenos Aires, Argentina

Policies Shaping the Social Determinants of Health V

- Policies on
  - Housing and community development
    - Mainly HUD (about $30 billion)
  - Public safety
    - DOJ (about $630 million)
  - Transportation
    - DOT and EPA (more than $20 billion)
  - Capital and finance
    - Treasury and others (more than $10 billion)
  - Education
    - Department of Education, USDA, VA, HHS (about $30 billion)
    - School meals programs, Head Start, Race to the Top, Veterans education

Applying Modified Jerry Maguire Rules

Organization of this Approach

- Will be decidedly multi-sectoral and multidisciplinary
  - Partnerships link organizations from varied sectors
    - Non-profit organizations
    - Philanthropy/foundations
    - Private sector firms
    - Public sector
  - Policy already requires this in specialized arenas
    - Affordable housing development for the homeless is one example
    - Next step is to generalize this and bring it to scale

Final Thoughts

- "A crisis is a terrible thing to waste."
  - Shaun Donovan, HUD Secretary

- "The successful people are those that learn how to take advantage of the world as it is."
  - Bill Clinton, former US President, NAHREP conference, October 2012

Institution of Medicine: Workshop on Resources for Population Health Improvement

Don Hinkle-Brown, CEO, The Reinvestment Fund

February, 2014

THE REINVESTMENT FUND
Capital at the point of impact.

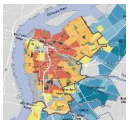
TRF Profile

The Reinvestment Fund builds wealth and opportunity for low-wealth people and places through the promotion of socially and environmentally responsible development.

- **$1.3 billion** in cumulative investments and loans throughout the mid-Atlantic.
- Currently manage **$709 million** in capital, with more than 850 investors.
- Top CARS score of AAA+1 (most recent 2012). TRF is 1 of only 5 CDFIs in the country with the top rating.

Business Lines

Lending and Investing



Policy Solutions

Real Estate Development

PolicyMap

How We Work

ORGANIZED PEOPLE

ORGANIZED MONEY

ORGANIZED CAPACITY

ORGANIZED DATA

TRF

Lending and Investment

TRF finances a variety of projects and activities including food access, health care, education and housing, to build healthy communities in under-invested places.

TRF's financial expertise in managing and delivering capital is evidenced by the number of targeted funds we manage.

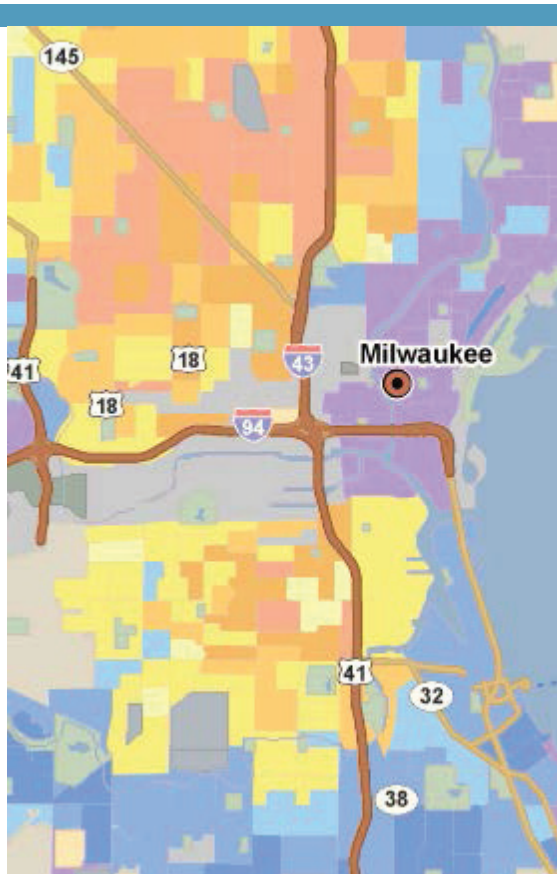
- Baltimore Integration Partnership
- Chase NMTC Charter School Fund
- PA Fresh Food Financing Initiative
- New Jersey Food Access Initiative
- PA Green Energy Loan Fund
- Sustainable Development Fund
- Collaborative Lending Initiative

Our Outcomes

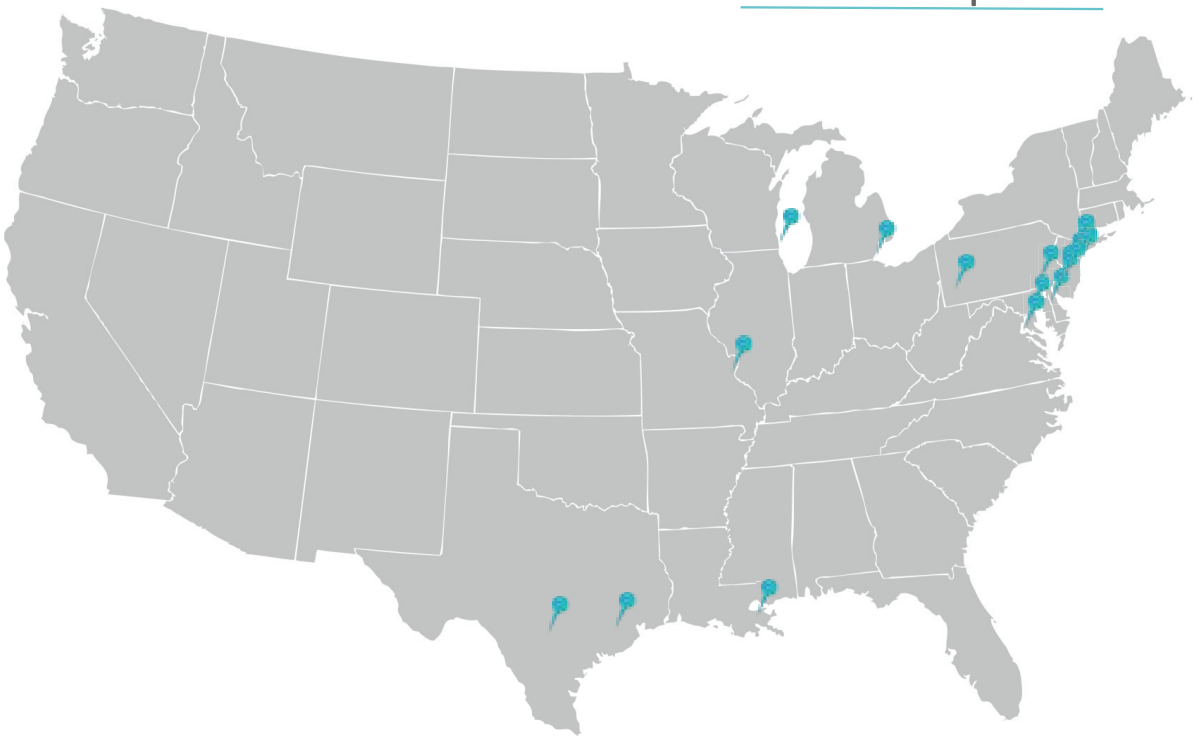
Policy Solutions

Combines rigorous data analysis with a distinctive ability to help clients think spatially.

- Real Estate Market Analysis
  - **Market Value Analysis (MVA)**
  - Limited Supermarket Access (LSA)
  - Commercial corridors analysis
  - Foreclosure analysis and prevention strategies
- Program & Social Impact Assessment
  - Estimating Supermarket Access, School Lunch Analysis, Grantmaker Advisory



MVAs completed



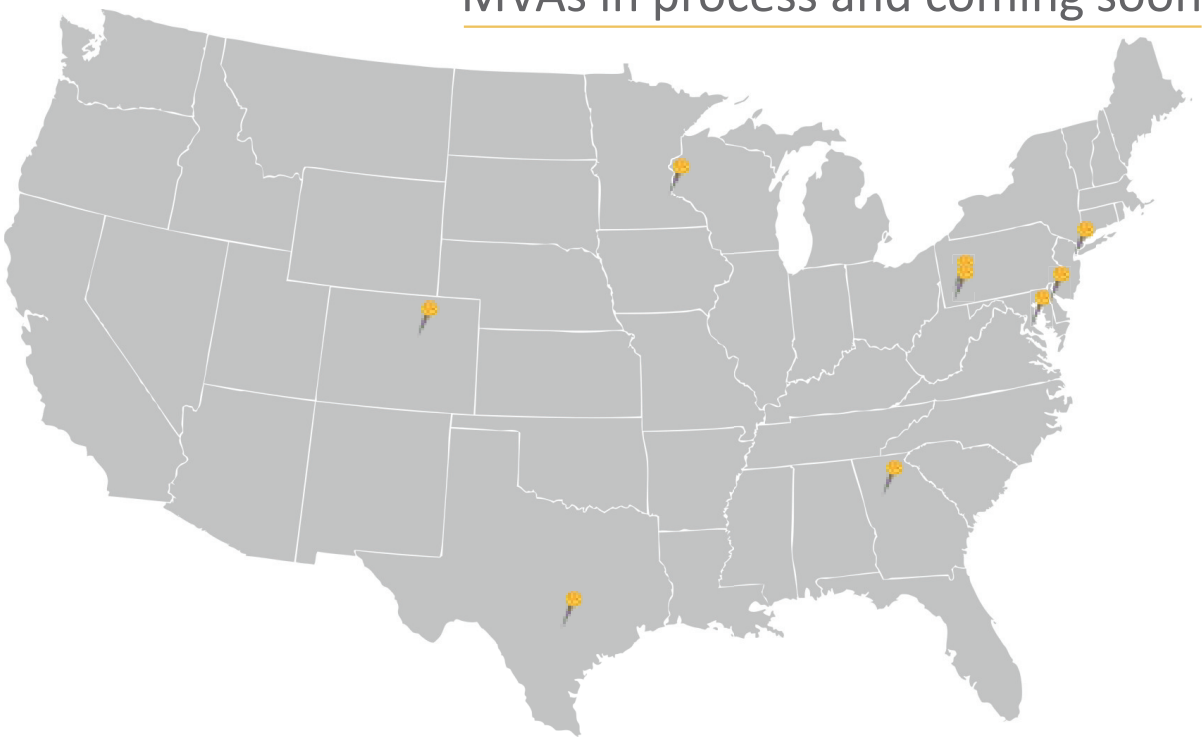
TWO OR MORE

Philadelphia, PA Baltimore, MD Pittsburgh, PA (update in process)

ONE

Washington, DC Camden, NJ Newark, NJ Highlands, NJ Meadowlands, NJ Mercer, NJ Oranges, NJ New Orleans, LA Riverline Towns, NJ Reading, PA Wilmington, DE Detroit, MI San Antonio TX Houston, TX Milwaukee, WI St. Louis, MO

MVAs in process and coming soon



IN PROCESS

Pittsburgh, PA
Prince George's County, MD

COMING SOON

Atlanta, GA Minneapolis, MN Denver, CO Monongahela Valley, PA Jersey City, NJ Wilmington, DE San Antonio, TX

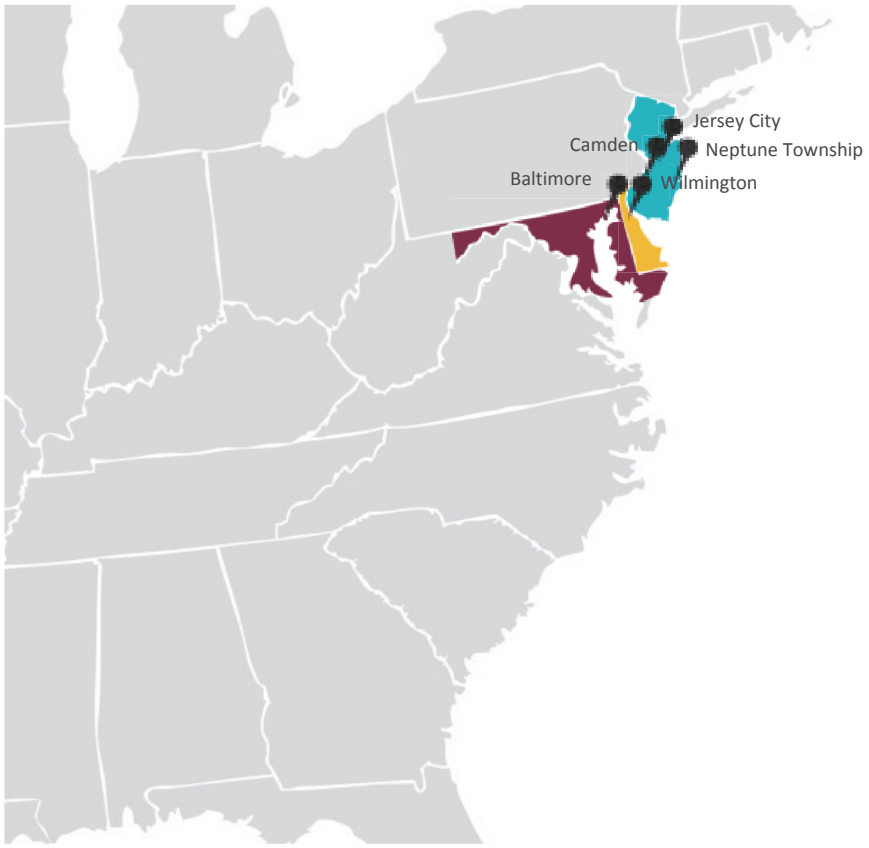
PolicyMap

- National data mapping and analysis tool
- Easy, online access to data and analytical tools in a sophisticated yet user-friendly web platform
- Over 15,000 data indicators as well as proprietary TRF analytics, with frequent additions

Real Estate Development

- TRF Development Partners works in distressed neighborhoods across the mid-Atlantic
- TRF DP's housing investments are based on three tenets:
  1. Building from strength
  2. Development with an understanding of the existing built environment
  3. Homes that are designed with eye towards quality and high design standards

Real Estate Development



Created 279 units of housing and secured over $110 million towards development in the last 5 years.

In Baltimore's Oliver neighborhood, TRF DP has teamed with IAF affiliate BUILD, and its network of community leaders. Their efforts have resulted in a 35% drop in total vacant homes.

What is a CDFI?

- A certified Community Development Financial Institution (CDFI) is a specialized financial institution that works in market niches that are underserved by traditional financial institutions.

- CDFI certification is a designation conferred by the CDFI Fund and is a requirement for accessing financial and technical award assistance from the CDFI Fund.

What is a CDFI?

- CDFIs are required to maintain accountability to their defined target markets
- CDFI also have a rating system - CARS™, the CDFI Assessment and Rating System. It is a comprehensive, third-party analysis of community development financial institutions that aids investors and donors in their investment decision-making.
- Organizations are rated based on:
  - Impact Performance
  - Policy Plus
  - Financial Strength and Performance

Convergence of Intent

Healthy Communities Meme - Made Real

Affordable Housing "plus", Accessibility, Continuum	Spatial Analysis of Human Services Supply & Demand	Transit Orientation, Livability, Walkability	Access to Healthy Fresh Foods, "Lets Move"	Environmental Focus, Sustainability, Local Economies

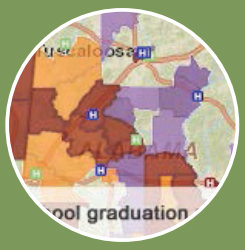
Convergence of Data

PolicyMap

Free web-based mapping and analysis tool with over 125 health data indicators for entire nation from the Centers for Disease Control, USDA, etc.

Uniform Data System

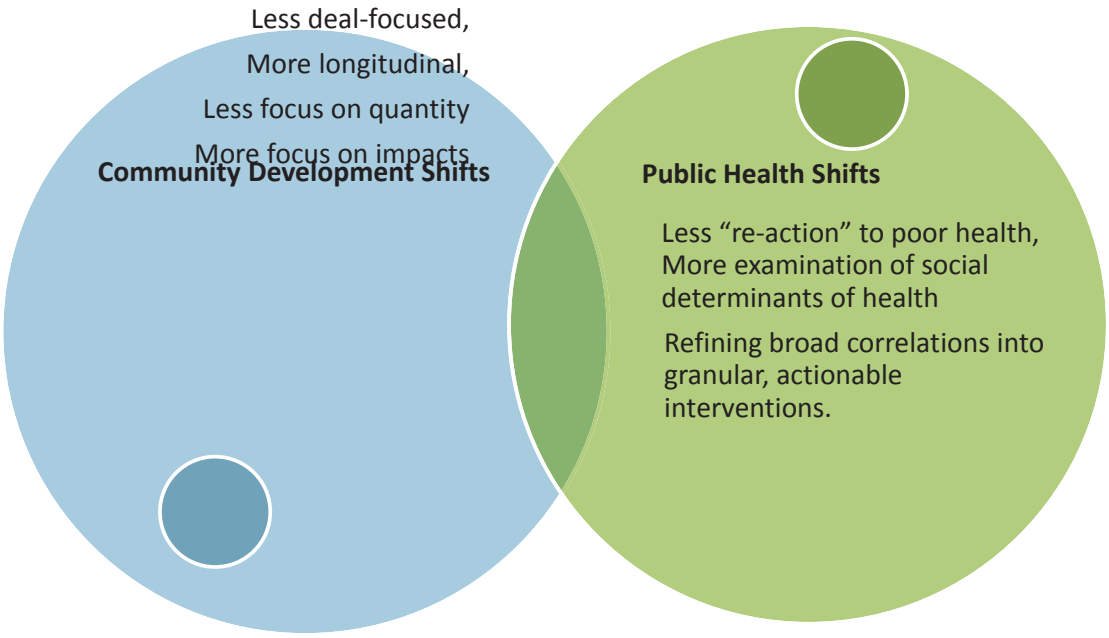
Information on operation and performance of health centers. UDS is a reporting requirement for Health Resources and Service Administration (HRSA) grantees



Community Health Needs Assessment

Free web-based platform with data to better understand the needs and assets of their communities

Convergence of Focus



Emerging Innovations

TRF and Healthy Food Access

TRF is a national leader in financing stores that provide quality fresh food at competitive prices in low-income communities

TRF works to reduce inequitable access to healthy foods by:

- **Underwriting loans and providing grants** to support viable supermarkets and projects.
- **Advocating** to increase public awareness on food accessibility.
- **Conducting policy research work** related to supermarket development, food systems and free and reduced price lunch programs.
- **Providing technical assistance services** to CDFIs, foundations and other organizations to close the gap in access/knowledge.

Healthy Food Financing

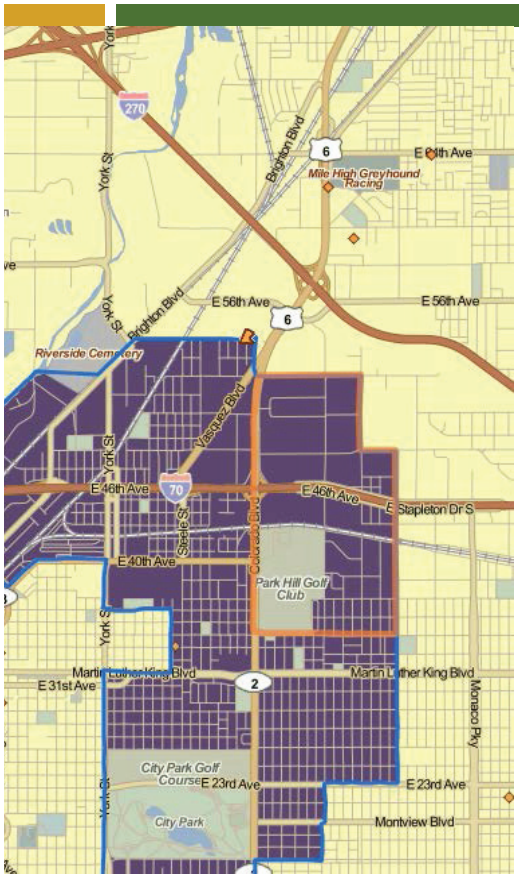
- TRF has financed **130 healthy food** projects across the mid-Atlantic totaling over **$180 million**
- TRF's healthy food financing program is designed to attract supermarkets and grocery stores to underserved urban and rural communities

Healthy Food Access Research

TRF is also a leader in research on issues related to improving access to healthier foods in distressed communities with focus on the economics the supermarket industry.

- Developed methodology to identify areas with inadequate access to supermarkets and assess potential market viability
- Developed methodology analyzing supermarket competition and barriers to entry
- Examined the economic reasons for the lack of supermarkets in distressed urban areas
- Analyzed economic impact of new supermarket development on surrounding communities
- Reviewed existing programs designed to encourage people to eat and shop for healthier foods

LSA Analysis



- Nationwide analysis of areas with inadequate and inequitable access to healthy foods.
- LSA areas are where residents must travel significantly farther to reach a supermarket than the “comparative acceptable” distance that residents in well-served areas travel to stores.
- 1,519 clusters around the US including 18,630 block groups. With an average size of 9,000 people.
- Areas with strongest need for supermarkets based on access, demand, and leakage data.

Building Capacity

- Partnered with CDFI Fund and the Opportunity Finance Network to train CDFIs as part of **Financing Healthy Food Options** initiative.

- Providing **programmatic technical assistance** to states seeking to establish supermarket financing programs. TRF was an advisor to programs in California, New York, Colorado and New Orleans.

- Partnering with PolicyLink and The Food Trust to advocate for healthy food access nationwide
  - Created **Healthy Food Access Information Portal** to support communities nationwide to implement healthy food access projects. Supported by Robert Wood Johnson Foundation, HealthyFoodAccess.org is the nation's first information portal devoted to food access.
  - Hosts annual **national convening** that brings together HFFI grantees, federal officials, public policy advocates, grantmakers and other stakeholders.

TRF

THE REINVESTMENT FUND reFRESH

New Jersey Delaware Pennsylvania Maryland District of Columbia Ohio Florida Colorado

Northern California and Central Valley

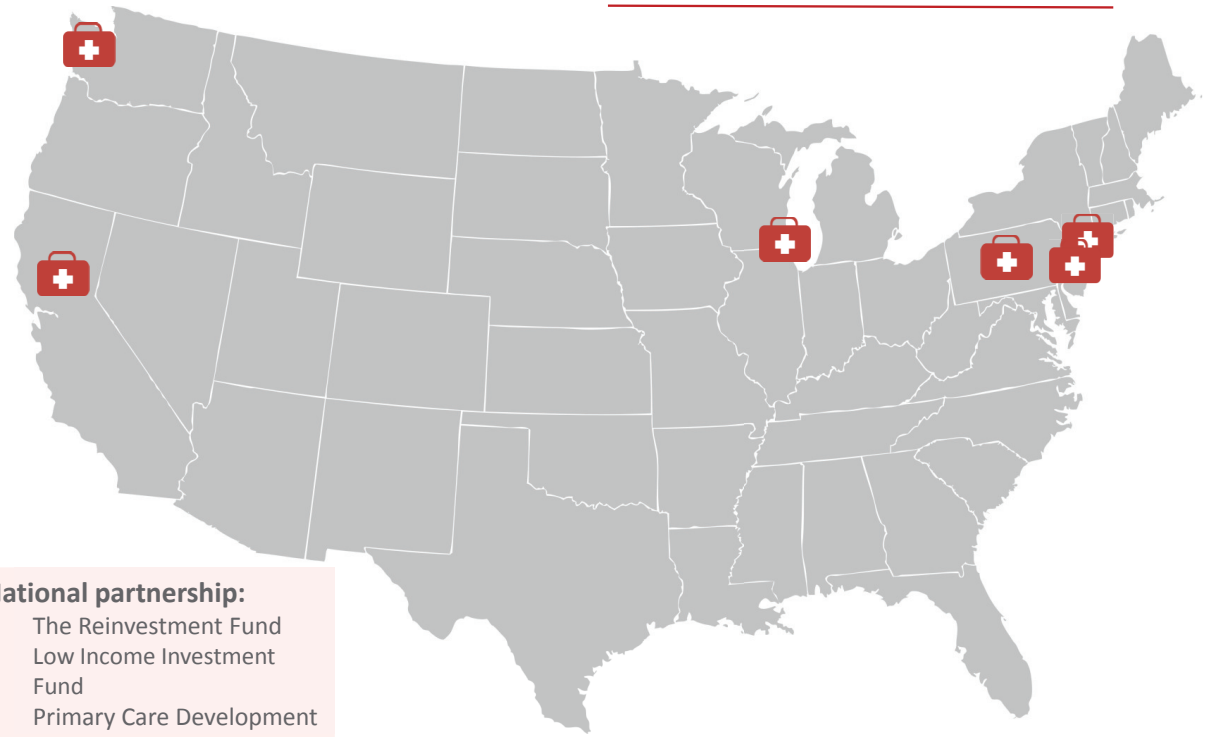
National partnership:

- The Reinvestment Fund
- Finance Fund Capital Corporation
- FL Community Loan Fund
- Northern California Community Loan Fund
- Colorado Enterprise Fund
- JPMorgan Chase

Community Health Center Financing

- According to estimates from the National Association of Community Health Centers, the Affordable Care Act (ACA) is expected effectively **double the number** of people serviced by these health centers in the next few years.
- Provides community health center operators with **affordable, flexible financing** for the construction, renovation or expansion of their facilities.

Health Centers financed



National partnership:

- The Reinvestment Fund
- Low Income Investment Fund
- Primary Care Development Corporation
- Kresge Foundation
- Goldman Sachs
- Rockefeller Foundation

Tacoma Community Health Care, WA

Punxsutawney Primary Health Network, PA

Progressive Community Health Center, WI

Newark Community Health Center, NJ

Shasta Community Health Center, CA

Family Health Services of Drexel, PA

Social Determinants Index

- Identifying a measure of community health
  - TRF is working to develop a national methodology to assess community health disparities
  - A roadmap for the intersection of community development (CRA), and the social determinates of health

Community Development Strategies for Improving Population Health

Nancy O. Andrews
President and CEO, Low Income Investment Fund (LIIF)

Institute of Medicine
Roundtable on Population Health Improvement
February 6, 2014

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Overview: Community Development and Health

How CDFIs Help

Connect Wall Street to low-income communities:

- *Break down large chunks of capital*
- *Invest in low-income places*

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LIIF's Impact

- **$1.5 billion** deployed
- **1.7 million people** served in **31 states**
- **$31 billion** in social value

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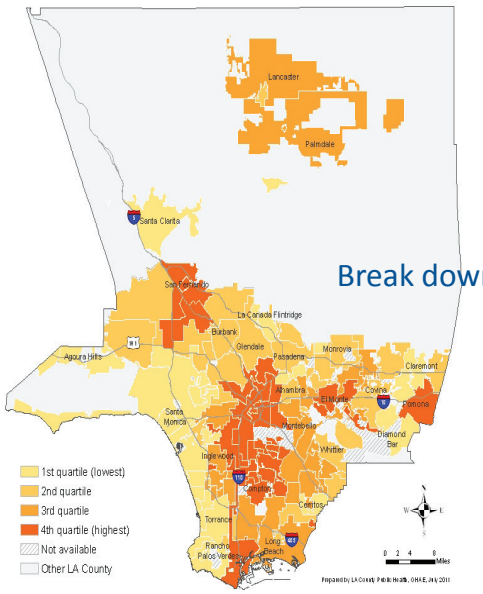
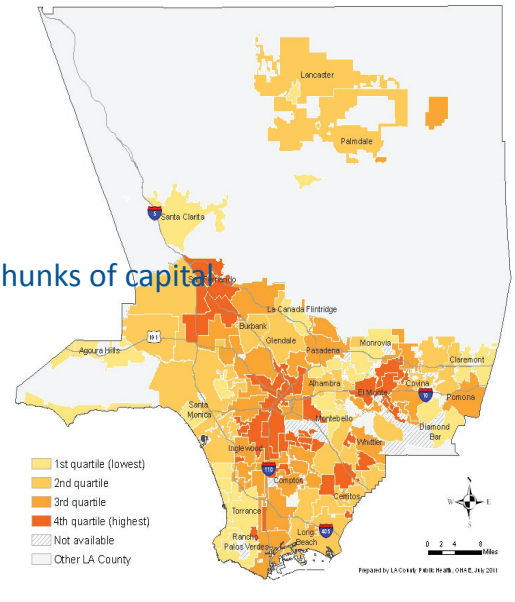
Poverty and Health

Economic Hardship Index by City/Community, Los Angeles County, 2000



Prevalence of Childhood Obesity by City/Community, Los Angeles County, 2005



Break down large chunks of capital

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A Family's Environment

- Housing quality & stability
- Neighborhood design & environment
- Neighborhood services
- Neighborhood connectivity

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Community Development Roots, Health Impacts

Housing affordability, quality and stability linked to:

- *Lower stress for parents & children*
- *Lower rates of depression*
- *Higher academic achievement for children*
- *Increased household income available for expenditures on necessities such as food*

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A New Holistic Approach

- Housing, education, health clinics, child care, transit access, and safety

- Emerging understanding of the connections between physical, social, and human capital

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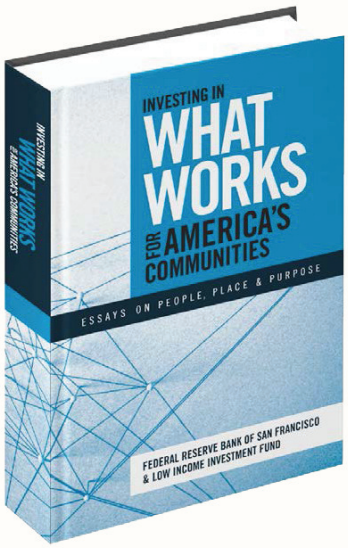
Investing in What Works for America's Communities



A call for a new, more integrated approach to antipoverty efforts that builds on what we know is working

Request the book:
www.whatworksforamerica.org

@whatworksforUSA
#IdeasThatWork

www.facebook.com/whatworksforUSA

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Quarterbacks for Healthy Communities

- Key to driving comprehensive, multi-sector, and outcomes-based community development initiatives
- Integration critical for improving population health
- Community strategies that are health-conscious, and incorporate health outcomes

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Examples of LIIF-Supported Projects and Initiatives

Booth Memorial Child Development Center (Oakland, CA)

- **63 low-income children**
- **$78,000 grant** leveraged additional investments
- Reduced asthma attacks and disability claims

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Booth Memorial Child Development Center (Oakland, CA)

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Equitable Transit-Oriented Development

- Mixed-use near transit, with affordable housing
- 6.45 lbs average weight loss
- Silo-busting

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ReFresh (New Orleans)

- Healthy food “hub” in 56% poverty neighborhood
- LIIF provided $1.5 million “glue” capital for an $18 million transaction

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Where to Next?

Next Steps

- Build the evidence base
- Quarterbacks for healthy communities
- Collaboration between community development and health sectors

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PAY FOR SUCCESS FINANCING AND POPULATION HEALTH

Overview of the Field for the Roundtable on Population Health Improvement

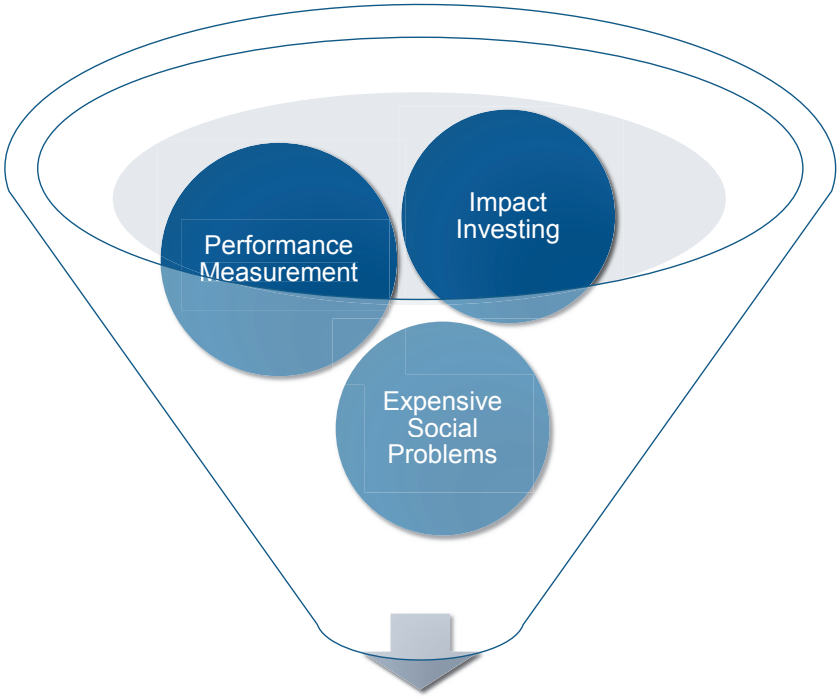
February 6, 2014

Megan Golden

Fellow, Institute for Child Success and New York University Wagner School of Public Service Innovation Labs

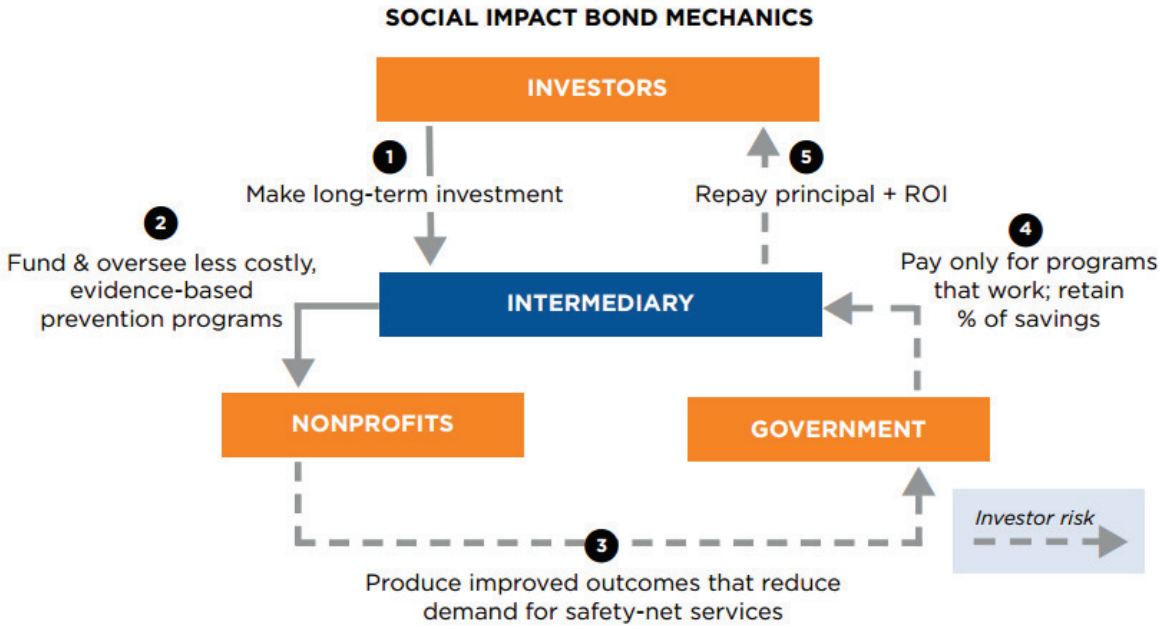
mgoldennyc@gmail.com

Social Impact Bonds: Context



Social Impact Bonds

The Social Impact Bond (SIB) Structure



Source: *A New Tool for Scaling Impact: How Social Impact Bonds Can Mobilize Private Capital to Advance Social Good,* Social Finance, Inc., 2012

Who Benefits?

Communities & Individuals	• More effective services • Better results
Nonprofits	• Up-front funding to scale programs
Government	• More cost-effective services • Better results
Investors	• Modest returns • Ability to make a positive impact

New York City SIB

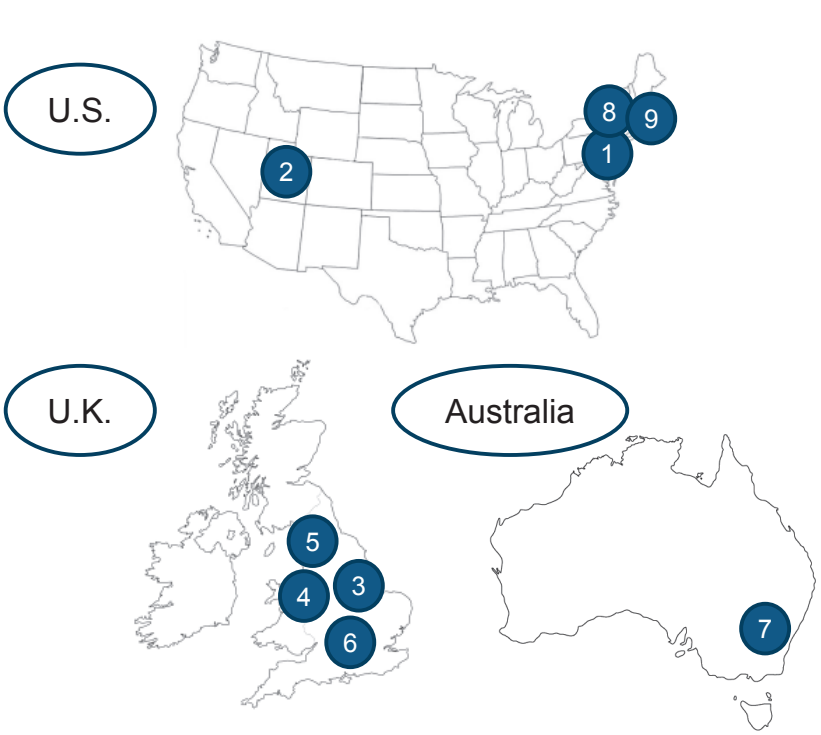
Target population	• 16-18-year olds leaving City jails
Goal	• To reduce recidivism
Intervention	• Cognitive behavioral therapy

NYC Payment Terms

Reduction in Reincarceration	City Payment
≥ 20.0%	$11,712,000
≥ 16.0%	$10,944,000
≥ 13.0%	$10,368,000
≥ 12.5%	$10,272,000
≥ 12.0%	$10,176,000
≥ 11.0%	$10,080,000
≥ 10.0%(breakeven)	$9,600,000
≥ 8.5%	$4,800,000

Source: *NYC Office of the Mayor, Bringing Social Impact Bonds to NYC, Media Presentation,* August 2012

Pay for Success Transactions Completed



1. US - New York City
   Recidivism Reduction
2. US – Salt Lake City, Utah
   Early Childhood Education
3. UK – Peterborough
   Recidivism Reduction
4. UK – West Midlands
   Workforce Development
5. UK – Manchester
   Workforce Development
6. UK – London
   Homelessness
7. Australia - New South Wales
   Child Maltreatment/Foster Care Prevention
8. US – New York State
   Recidivism Reduction & Employment
9. US – Massachusetts
   Recidivism Reduction & Employment

SOUTH CAROLINA EARLY CHILDHOOD PAY FOR SUCCESS FEASIBILITY STUDY

September 22, 2013

Megan Golden, Consultant to the
Institute for Child Success

This study was made possible by funding from:

The Duke Endowment
South Carolina Department of Health and Human Services

i(cs)
INSTITUTE *for* CHILD SUCCESS

Outcomes for South Carolina's Children

South Carolina ranks

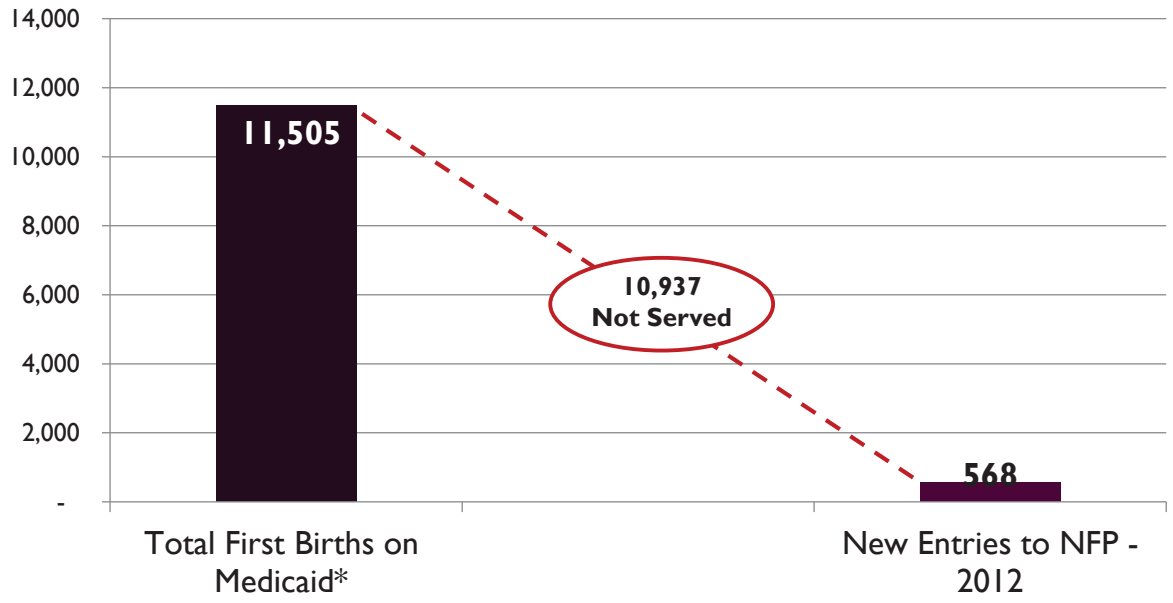
45th

in overall child well-being

Overall Rank	
1	New Hampshire
2	Vermont
3	Massachusetts
4	Minnesota
5	New Jersey
6	North Dakota
7	Iowa
8	Nebraska
9	Connecticut
10	Maryland
11	Virginia
12	Wisconsin
13	Maine
14	Utah
15	Wyoming
...	
43	Georgia
44	Alabama
45	South Carolina
46	Louisiana
47	Arizona
48	Nevada
49	Mississippi
50	New Mexico

Source: *KIDS Count Databook*, 2013

Unmet Need for NFP in SC



** 2011 Data; Michael G. Smith, SC DHEC, Bureau of MCH*
*** NFP State Nurse Consultant, South Carolina DHEC*

Expected New NFP Clients

Region	First Births Paid by Medicaid *	Number Expected to Enroll in NFP per Year	Current Capacity**	Number of New Clients from Expansion
Greenville	1,548	387	94	293
Richland	1,793	448	79	369
Charleston	1,352	338	95	243
Orangeburg	477	119	-	119
Florence	1,153	288	-	288

x 25%

Source: ** 2009-2011 Averaged data; Michael G. Smith, SC DHEC, Bureau of MCH*
***2012 Data; NFP State Nurse Consultant, South Carolina DHEC*

Estimated Costs and Savings

Number of New Clients
2,750
Average Cost of NFP per Family*
$ 7,754
Cost Over Length of Program
$ 21.3 million
Net Government Savings
$ 31.3 million

*Source: Average cost for full 2+ years of program services; *Miller, Cost Savings of Nurse-Family Partnership in South Carolina,* April 2013

Expected Pre-term Birth Reduction by Site

Assumes NFP reduces pre-term births by **27.4%**

Region	Current Rate	Post-NFP Expansion Rate
Greenville	11.2%	8.1%
Richland	11.1%	8.1%
Charleston	10.9%	7.9%
Orangeburg	9.7%	7.0%
Florence	13.8%	10.0%

Illustrative Term Sheet

Investment Required	**$24 million ($21.3 m for program + $2.7 m for intermediary and evaluation)**
Term of Financing	6 Years
Total Lifetime Government Savings [1]	$52.6 million
Government Payout	Up to $30 million
Commercial Investment	$12 million
Philanthropic Investment	$12 million (first loss position)
Investor IRR/Rate of Return	6.0%-10% [2]
Philanthropic IRR/Rate of Return	0%-4% [2]
Outcomes metrics	Reduction in pre-term births (illustrative)
Evaluation Methodology	TBD
Service Provider	Nurse-Family Partnership Implementation Agencies
Individuals Served	2,750 low-income, first time mothers and their families in South Carolina
Intervention Model	Nurse home visitation during pregnancy and after birth up to age 2

[1] Represents federal and state savings. *Source: Miller, Cost Savings of Nurse-Family Partnership in South Carolina, April 2013, p 1*
[2] Investment return dependent on various assumptions, including capital drawdown schedule and timing of investor returns.

SOCIAL FINANCE

Resources on Social Impact Bonds/ Pay for Success

- Nonprofit Finance Fund: www.payforsuccess.org
- Social Finance US: http://www.socialfinanceus.org/
- Third Sector Capital Partners: http://www.thirdsectorcap.org/
- Harvard Kennedy School SIB Lab: http://hks-siblab.org/
- The White House on Pay for Success: http://www.whitehouse.gov/blog/2013/11/20/building-smarter-more-efficient-government-through-pay-success
- Federal Reserve Bank of SF Publication: http://www.frbsf.org/community-development/publications/community-development-investment-review/2013/april/pay-for-success-financing/