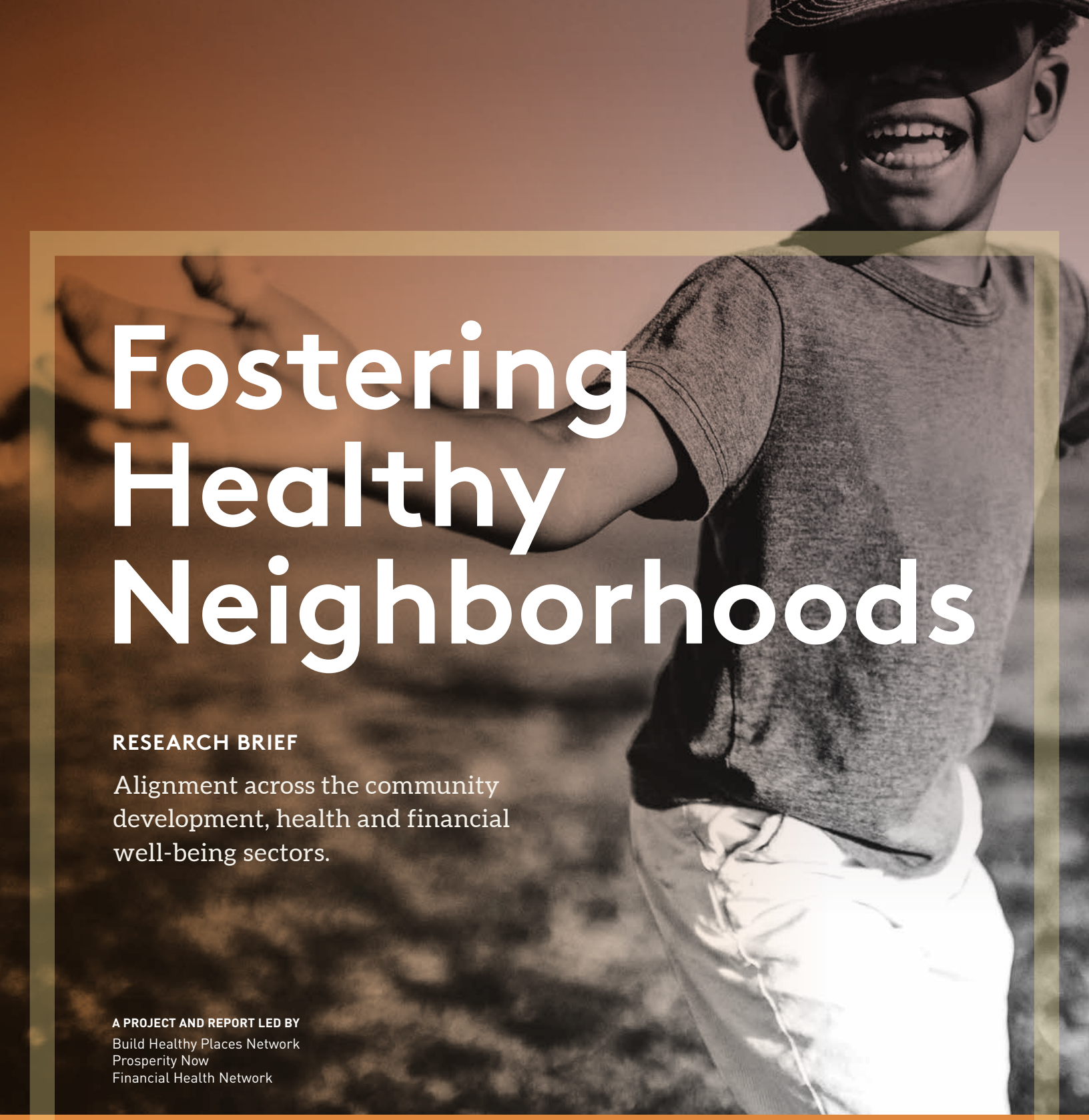

Fostering Healthy Neighborhoods

RESEARCH BRIEF

Alignment across the community development, health and financial well-being sectors.

A PROJECT AND REPORT LED BY

Build Healthy Places Network
Prosperity Now
Financial Health Network

Build Healthy Places Network

PROSPERITY NOW

FINANCIAL HEALTH NETWORK
formerly CFSI

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The views expressed here do not necessarily reflect the views of the Foundation.

Build Healthy Places Network

PROSPERITY NOW

FINANCIAL HEALTH NETWORK formerly CFSI

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SLOW
CHILDREN
AT PLAY

Overview

Substantial evidence links financial well-being and health. As income and wealth increase or decrease, so does health. Individuals and families with more wealth and higher incomes are better able to access the material and physical conditions that facilitate good health and are less likely to suffer from the mental and physical effects of financial stress caused by income volatility, insufficient savings, and unmanageable debt.

The physical, social, and economic conditions in our neighborhoods have a significant impact on both our health and financial well-being because they shape the opportunities we have and the choices that are available to us. To define a **neighborhood that supports health and financial well-being** (see Figure 1), which we call a **Healthy Neighborhood**, we adapted a definition used by the New York City Office of Financial Empowerment's Collaborative for Neighborhood Financial Health[1] to include the following characteristics that are available to all residents:

- Stable, affordable, and safe housing
- Quality community institutions
- A safe and supportive built environment
- Social capital, networks, and support
- Opportunities to build assets
- Quality jobs and income supports
- Affordable, high-quality financial services that meet the needs of residents
- Affordable, high-quality goods and services, including healthcare
- High-quality public education.

These conditions have a profound impact on how long and how well residents live—and on the future health and well-being of their children. For instance, research

FIGURE 1. FRAMEWORK FOR NEIGHBORHOODS THAT SUPPORT HEALTH AND FINANCIAL WELLBEING

[1] *How Neighborhoods Help New Yorkers Get Ahead: Findings from the Collaborative for Neighborhood Financial Health.* (2017). New York, NY: New York City Department of Consumer Affairs. https://www1.nyc.gov/assets/dca/downloads/pdf/partners/Report-HowNeighborhoodsHelpNYersGetAhead.pdf (accessed August 2019).

shows that children living in high-poverty, under-resourced neighborhoods have lower test scores and lower earnings in adulthood.[2]

Low-income communities and communities of color have historically and systematically been excluded from accessing these kinds of amenities and opportunities ("access" being determined both by proximity and a range of factors that either inhibit or allow them to benefit from that proximity). The result is that, when it comes to health outcomes, low-income people and people of color are less well off. Therefore, creating the conditions that foster healthy neighborhoods as defined above is necessary to ensure that all people can thrive.

To create these conditions (i.e., to foster healthy neighborhoods) the community development, public health, healthcare, and financial well-being sectors (see Figure 2) must better align their work (see the appendix for descriptions of each sector). These sectors have been working to address different components of healthy neighborhoods in the same places and often with the same people for decades, yet often without joining forces and leveraging each other's efforts. By aligning their work, these sectors can more effectively build neighborhoods that support health and financial well-being.

FIGURE 2. STAKEHOLDER MAP

*Many entities work in more than one sector. For instance, Community Development Corporations integrate financial capability and asset building work into neighborhood revitalization efforts.

[2] Chetty, R. and Hendren, N. (2017). *The Impacts of Neighborhoods on Intergenerational Mobility I: Childhood Exposure Effects.* Cambridge, MA: National Bureau of Economic Research. https://www.nber.org/papers/w23001.pdf (accessed August 2019).

The financial well-being sector, through policies, programs, and services that help people plan, save, borrow, spend, earn, own, and protect their financial resources, helps to build wealth for low-income individuals and households (see Figure 3). In collaboration with community development, public health, and healthcare, these interventions can improve neighborhood conditions by increasing access for low-income communities and communities of color to affordable housing, asset-building opportunities, income supports, and high-quality financial services.

FIGURE 3. CATEGORIES OF FINANCIAL WELLBEING POLICY AND PRACTICE

PLAN
- Have appropriate insurance
- Plan ahead for expenses

BORROW
- Have a sustainable debt load
- Have a prime credit score

EARN
- Have quality jobs and access to public benefits and tax credits.
- Have affordable and reliable transportation, child care, and other supports to be able to work.

SAVE
- Have sufficient liquid savings
- Have sufficient long-term savings

SPEND
- Spend less than income
- Pay bills on time and in full

OWN
- Own a home, business, investment and/or other assets that build wealth.
- Have affordable financing, incentives and supports to purchase and maintain assets.

PROTECT
- Have insurance to protect income or asset loss.
- Have consumer protections that safeguard against discriminatory and predatory practices.

With support from the Robert Wood Johnson Foundation, the Build Healthy Places Network (a program of the Public Health Institute), Prosperity Now, and the Financial Health Network partnered to explore how to foster alignment across the community development, public health, healthcare, and financial well-being sectors. This brief presents key findings and recommendations from our research.

Key Findings

We conducted focus groups, interviews, and an exhaustive scan of the published and online resources and materials at the intersection of this work (see the appendix for a list of resources, interviews, and focus groups).

Our Research Identified:

Examples of existing alignment across the sectors. There are bright spots where community development, public health, healthcare, and financial well-being work has aligned in ways that can build healthy neighborhoods.

Opportunities for increased collaboration and integration. While alignment is occurring, it is still underdeveloped. Our research identified five priority opportunities to increase alignment.

Challenges to integration across sectors. Even when there is acknowledgment of connected aims and a desire to collaborate, building effective collaboration is complex. Our research highlights four primary challenges to effective alignment.

Ways to foster alignment. There are key supports, systems changes, and institutions that would help to foster alignment across these sectors

Examples of Existing Alignment Across Sectors

We found several examples where work across the sectors is already aligned to build healthy neighborhoods.

Healthcare systems, acting in their capacity as anchor institutions, are investing in comprehensive community development efforts that address various social determinants of health within low-income neighborhoods, including access to employment, income supports, savings, housing, and healthy food (see **LISC-ProMedica** example in the appendix).

Federally Qualified Health Centers (FQHCs) in low-income neighborhoods are acting as community quarterbacks (see below) to facilitate access for their patients to a wide range of services and programs that can improve health and financial well-being (see **DotHouse Health** example in the appendix).

> *A* **Community Quarterback** *is an entity that coordinates local interventions by articulating a unifying vision and then marshalling the financial resources and managing a diverse coalition of partners to achieve that vision. A community quarterback may function as an organizer and navigator toward the shared goal of a cross-sector initiative in many ways, which could include articulating the goal itself, establishing shared metrics, bringing together knowledgeable allies and financial resources, and facilitating the work of an initiatives many community partners. In this model, the quarterback knits together the diverse abilities of formerly siloed sectors, creating a powerful integrated initiative.*

Community Development Corporations and Community-Based Organizations are using financial capability and asset-building strategies as part of their work to revitalize low-income neighborhoods through economic development, workforce development, and affordable housing strategies (see **Stronger Together Partnership** example in the appendix).

Public health departments, in collaboration with community organizations and other public sector agencies, are advocating for policies that address financial and health inequities by improving economic opportunities and access to affordable housing in low-income neighborhoods (see **Alliance for Health Equity** and **Get Healthy San Mateo County** examples in the appendix).

Municipal agencies are integrating financial coaching and savings programs into their services to improve access to affordable housing (see **Ready to Rent** and **Cities for Financial Empowerment Fund** examples in the appendix).

Public housing authorities are partnering with financial well-being organizations to provide savings and asset-building services to their residents and in the neighborhoods in which they operate (see **Tacoma Housing Authority** and **Compass Working Capital** examples in the appendix).

Opportunities for Increased Collaboration and Integration

The intersection of the sectors is nascent and there are opportunities for increasing alignment.

Expand and replicate cross-sector partnerships that build healthy neighborhoods. As the examples above highlight, there are bright spots, yet this work is still not widely practiced. Successful models of cross-sector alignment with demonstrated impact on neighborhood conditions can and should be expanded and replicated in more places. We provide suggestions, below, for what supports and systems changes are needed to achieve this.

Better connect effective cross-sector work at the individual- or family-level to neighborhood revitalization efforts. The research uncovered examples of cross-sector alignment that impact the

individuals and families they touch, but do not directly address neighborhood conditions per se. Examples include financial well-being organizations that are providing tax preparation assistance at pediatricians' offices to help families with children boost their incomes (see **StreetCred** example in the appendix); government agencies that have layered financial education and coaching onto their services and programs (see **$tand By Me** example in the appendix); and banks and credit unions partnering with healthcare organizations to provide safe and low-cost financial products to patients and clients (see **Allegacy Federal Credit Union/Wake Forest Baptist Health** and **CareSource/ Fifth Third Bank** examples in the appendix). These types of interventions can be expanded, replicated, and integrated into neighborhood revitalization work, for example, by targeting the expansion of low-cost financial products to banking deserts through partnerships with local community development corporations.

Expand and replicate efforts to build neighborhood wealth. Community land trusts and worker-owned cooperatives offer wealth-building opportunities for low-income communities.[3] In Cleveland, Ohio, the Evergreen Cooperative Initiative leverages hospital procurement dollars to start and grow worker-owned cooperative enterprises as a way to increase employment and wealth-building opportunities in the neighborhoods it serves.[4] In Richmond, Virginia, Bon Secours Health System and Virginia Credit Union have each made financial contributions to the Maggie Walker Community Land Trust (MWCLT), which is creating permanently affordable homeownership housing in a rapidly gentrifying neighborhood in Richmond.[5]

Expand cross-sector integration with technology. The integration of community development, public health, healthcare, and financial well-being work can benefit from new technological systems and tools that make referrals, client tracking and outcome reporting across partners and programs more efficient and seamless. However, deploying technology effectively requires a deep understanding of the risks and challenges faced by underserved populations. Disparities in technology access—the so-called digital divide—is a challenge, and at least initially, engaging technological solutions must be done in conjunction with high-touch approaches able to engender trust and ensure technology doesn't exacerbate existing inequities.

Create a shared policy agenda. A number of policy issues have cross-sector implications. For example: wages and benefits; short-term and long-term savings; affordable housing and homeownership; community development incentives; healthcare; government program and court fines and fees; and consumer protections, among others. In each sector, there are policy collaboratives operating at local, state, and national levels (for example, the Alliance for Health Equity, which is described in the appendix). Expanding these collaboratives strategically to include stakeholders from all sectors and to work toward cross-sector policy goals can enhance alignment.

Challenges to Integration Across Sectors

In order to advance cross-sector alignment, there are a few major challenges that need to be addressed.

Different terminology and units of focus. When it comes to defining outcomes and impact, organizations with different terminology and units of focus (i.e., neighborhood vs. individual) can struggle to align. For example, community development and public health organizations focus on neighborhood-level change, while healthcare and financial well-being organizations focus on individual-level change, making aligned outcomes difficult to articulate, work toward, and measure.

Different goals and incentives. Actors within and across the sectors have different goals and their work is shaped by different incentives. For example, public health organizations use their expertise and experience primarily to focus on improving population health (e.g., reducing rates of diabetes), whereas financial well-being organizations primarily focus on improving financial well-being (e.g., increasing credit scores). While improved financial well-being can lead to improved health, it can be challenging to get individuals and organizations to establish and work towards goals that are outside their areas of expertise, even if they are serving the same population.

Data collection and measurement. Tools for collecting and sharing data and measuring the impact of cross-sector work are lacking. Each sector collects its own data using different tools and at varying levels of sophistication. One challenge is the time, money, and expertise needed to design and implement systems to measure the influence of cross-sector work on residents' health and financial well-being. Another challenge is the sensitivity and privacy requirements associated with health information. For good reason,

[3] Holmes, T. E. (2016, October 21). *In the World of Community Wealth-Building, Ownership Has Its Privileges.* Shelterforce. https://shelterforce.org/2016/10/21/in-the-world-of-community-wealth-building-ownership-has-its-privileges/ (accessed August 2019).

[4] Wright, W., Hexter, K., and Downer, N. (2016). *Cleveland's Greater University Circle Initiative: An Anchor-Based Strategy for Change.* Washington, D.C.: The Democracy Collaborative. https://democracycollaborative.org/sites/clone.community-wealth.org/files/downloads/ClevelandGreaterUniversityCircle-web.pdf (accessed August 2019).

[5] Green, J., and Hanna, T. M. (2018). *Community Control of Land and Housing.* Washington, D.C.: The Democracy Collaborative. https://democracycollaborative.org/community-control-of-land-and-housing (accessed August 2019).

privacy laws inhibit data sharing between healthcare providers and non-healthcare organizations. However, these rules prevent community development and financial well-being organizations from accessing data they could use to develop policies and programs, and measure outcomes. These barriers limit the ability of organizations to work together to design and deliver the investments, programs, and services that would be most beneficial in the neighborhoods with the most need.

Mismatched timing and funding horizons. The impact of cross-sector work can take years—even decades—to become measurable. These long timeframes are often at odds with funder/investor expectations and needs. For example, private health insurance companies, investors, and affordable housing developers focus on innovation efforts that demonstrate short-term cost saving outcomes and impact (e.g., interventions with homeless populations and seniors). Yet research shows that reducing childhood poverty would have the greatest impact over the long term, even though that impact takes a generation to realize.

Ways to Foster Alignment

In order to take advantage of the opportunities for, and address the challenges to effective cross-sector alignment, our research identified supports and system changes that are needed, and key institutions through which alignment can be advanced.

Supports

Build relationships, knowledge, and shared outcomes across the sectors. Broadly speaking, leaders across these sectors do not know about each other or the goals they share. One of the first steps to fostering greater alignment is to build knowledge and relationships across sectors. Build relationships through convenings and fellowship opportunities for current and future leaders in each sector. Build shared knowledge through trainings and curating and disseminating the existing evidence base that highlights shared aims, outlines the "business case" for alignment and collaboration, and promotes successful models. Build shared outcomes by sharing local data on key metrics related to social determinants of health with community-based organizations and other local stakeholders in order to standardize what metrics are being tracked.

Establish more funding and financing streams for cross-sector work focused on building healthy neighborhoods. As mentioned, cross-sector work may take a long time to show measurable impact. Flexible and patient funding and financing that is invested in cross-sector collaboratives, rather than individual organizations or agencies, can facilitate new innovations, scaling of what works, and further testing of promising efforts. These funding and financing streams can and should include grants, loans, and equity investments. The Healthy Futures Fund, created by LISC, Morgan Stanley, and The Kresge Foundation, is one example of the kind of tool that can serve as a model.[6]

Create data collection and measurement tools that can capture the impact of cross-sector work on neighborhood conditions. More and better data on neighborhood-level social and economic issues is needed—both to build a common understanding of the challenges communities face and to establish a baseline against which program and policy impact can be measured across sectors.

System Changes

Align incentives across the sectors through policy changes. In the same way that the ACA has shifted healthcare incentives toward social determinants of health, thereby opening new opportunities for collaboration with the community development sector, policy changes in other areas could similarly facilitate greater alignment across sectors. For example, eliminating asset limits from public benefit programs would remove disincentives to increasing savings among program beneficiaries and increase opportunities for cross-sector collaboration between the

[6] "Healthy Futures Fund," LISC, accessed September 2019, http://www.healthyfuturesfund.org/.

community development organizations that help families access benefits and the financial well-being providers who help families build savings. More research is needed to understand where policy changes could align incentives within and across the three sectors.

Explore ways to facilitate data sharing across sectors to inform neighborhood revitalization. Given the challenges mentioned, further strides toward data sharing across the sectors, while protecting individuals' privacy, is needed in order for practitioners and researchers to evaluate the impact of cross-sector interventions on health and financial well-being and inform how and where to focus neighborhood interventions and improvement efforts.

Key Institutions for Advancing Cross-Sector Alignment

Credit unions. Credit unions' success is correlated with—and therefore they are incentivized to support—the health and well-being of their members. They provide access to services in low-income communities and banking deserts and can forge partnerships with health organizations to deliver programs and services in low-income neighborhoods. For example, Allegacy Federal Credit Union's partnership with Wake Forest Baptist Health to create WellQ™[7], which is described in the appendix.

Employers. Employers rely on a financially healthy workforce.[8] Research shows that financial stress can reduce productivity, increase absences and healthcare claims, and lead to higher turnover. Employers have important levers such as living wages, availability of benefits to contractors and part time staff, and healthy working environments to improve employee financial well-being.

Anchor institutions. Anchor institutions (such as universities, hospitals, and community-based organizations) are well positioned—often as large employers, purchasers, and landowners in communities—to serve as catalysts for cross-sector alignment by initiating new partnerships in the places where they are situated and by helping to scale up promising collaborations. Healthcare organizations, for example, including those that are part of the Healthcare Anchor Network,[9] have made important strides towards embracing an anchor mission through hiring, procurement, and investment policies and practices with a focus on low-income neighborhoods.

Trusted community-based organizations. A trusted community organization can bring together groups that do not have a history of working closely together. The community quarterback model (see sidebar, page 7) has demonstrated success aligning work across sectors. Attention to advancing equity and addressing structural barriers to racial and health inequities is key.

Financial institutions and Community Reinvestment Act (CRA) regulators. The CRA is a powerful tool for directing investment into low-income neighborhoods. While much depends on whether CRA modernization occurs and what changes it brings, banks can explore how funds, initiatives, and other resources stemming from their CRA obligations can be put towards supporting cross-sector initiatives focused on building healthy neighborhoods. Additionally, the three agencies that administer the CRA—the Federal Reserve, the Federal Deposit Insurance Corporation (FDIC), and the Office of the Comptroller of the Currency (OCC)—can administer and enforce the law in ways that provide the flexibility banks need to be more innovative in supporting cross-sector initiatives and provide clarity to banks that these investments are qualified CRA investments.

[7] "Welcome to WellQ™," wellQ, accessed September 2019, https://yourwellq.com/.

[8] Kohli, S. and Levy, R. (May 2017) *Employee Financial Health: How Companies Can Invest in Workplace Wellness.* Center for Financial Services Innovation. https://s3.amazonaws.com/cfsi-innovation-files/wp-content/uploads/2017/05/26183930/2017-Employee-FinHealth.pdf (accessed August 2019).

[9] About the Healthcare Anchor Network," Healthcare Anchor Network, accessed August 2019, https://www.healthcareanchor.network/about.html.


CATHERINE

Conclusion

Existing bright spots—like the LISC-ProMedica example—illuminate approaches for cross-sector collaboration that do create conditions for healthy communities. However, such examples are few and nascent, and the financial well-being sector is still largely isolated from the health sector despite the clear health value of its work.

There is work yet to be done to build understanding across sectors, articulate common aims, and address the barriers to collaboration. This brief highlights findings salient to the financial well-being sector, yet applicable across the community development, healthcare, and public health sectors as well. Particularly, the framework for a healthy community as defined can provide a foundation for collaborative efforts.

APPENDIX A

Examples of Existing Work

Examples of alignment across community development, public health, healthcare, and financial well-being that directly impact neighborhood conditions:

Alliance for Health Equity

In Chicago and Cook County, IL, the Illinois Public Health Institute, hospitals, health departments, and community organizations have come together to form the Alliance for Health Equity, one of the largest hospital-community partnerships in the U.S. The goal of the alliance is to develop and implement collective strategies for improving community health and advancing health equity in the region. Alliance members work together to conduct tri-annual Community Health Needs Assessments (CHNAs), which help set shared priorities for partners to work towards; to track relevant legislation and coordinate policy advocacy activities; to build their capacity through training and peer learning; and to advance housing/health partnerships.[10]

Cities for Financial Empowerment Fund

The Cities for Financial Empowerment Fund (CFE Fund) provides funding and technical assistance to mayors across the U.S. to help them embed financial empowerment into city services in order to improve their effectiveness. For example, in Lansing, MI, financial counseling was integrated into a prisoner reentry program, which improved client financial outcomes as well as reduced the amount of time it took clients to move from transitional to permanent housing.[11] To date, the CFE Fund has worked with approximately 80 cities.

Compass Working Capital

In Boston, MA, Compass Working Capital, a nonprofit financial services organization, partners with public housing agencies and multifamily property owners to improve or launch the HUD Family Self-Sufficiency (FSS) program. The Compass model for the FSS program supports residents to build assets and financial know-how by combining one-on-one financial coaching that supports and encourages participants to increase their earnings and achieve other individually identified financial goals, with the program's escrow account that captures, and saves for the residents, any rent increase that result from increased earnings. Graduates of the Compass program typically use the savings from their escrow accounts to pursue an education, buy a vehicle, purchase a home, pay down debt, open secured credit cards, or establish emergency savings. Outcomes of the partnership include increased earnings, increased credit scores, and reduced debt in collections for participants. Expansion, or replication, of the Compass FSS model can be challenging for housing authorities that lack financial capability expertise on staff. Therefore, two major ingredients are generally needed: (1) housing authorities who are willing and able to complete required HUD paperwork and manage escrow accounts, and (2) a Financial Well-being service provider to provide financial education, and coaching or counseling.

DotHouse Health

In the Dorchester neighborhood of Boston, MA, DotHouse Health, a federally qualified health center (FQHC), provides comprehensive health and wellness services to the community. DotHouse Health serves as a Community Quarterback (see sidebar, page 7) by connecting people to a range of financial capability, housing, and legal services, and partnering with other neighborhood organizations to provide additional resources. Recognizing that factors such as housing, finances, and legal issues have an impact on health, they screen patients to identify these needs as a part of the intake process. Case managers then develop a care plan for patients, which can include financial coaching, enrollment in federal and state benefits, connection to housing programs, and free legal and tax preparation assistance. In addition, DotHouse Health provides on-site access to WIC, a food pantry, a youth center, senior services, a swimming pool, a gym, and a farmer's market.[12]

Get Healthy San Mateo County

In San Mateo County, CA, community-based organizations, county agencies, cities, schools, and hospitals are working together to advance policy changes that will build healthy and equitable communities. This collaborative effort, called Get Healthy San Mateo County (GHSMC), is facilitated by the county health department, San Mateo County Health. In their current five-year strategic plan, GHSMC has identified housing, neighborhoods, schools, and the economy as key priority areas. Healthy Economy objectives include ensuring that people have the ability to increase household income and build financial security, and have access to high-quality education and well-paying job opportunities. The opportunities for action towards these objectives include supporting efforts to advance living and/or minimum wage policies and increasing access to fair and affordable financial services for low-income families and people of color. GHSMC works to achieve their objectives by developing evidence-based policy tools, engaging in city and community planning processes, providing funding opportunities for place-based health equity efforts, creating

[10] "Purpose, Vision, Values," Alliance for Health Equity, accessed August 2019, https://allhealthequity.org/purpose-vision-values/.

[11] *CFE Coalition City Expert Topics: Reentry Integration Strategies.* (2018). Cities for Financial Empowerment Fund. http://cfefund.org/wp-content/uploads/2018/10/CFE_Reentry_Integration_Strategies-10181_KB.pdf (accessed August 2019).

[12] "Social Services Case Management," DotHouse Health, accessed August 2019, http://www.dothousehealth.org/services/case_management.html

toolkits and publications to disseminate research and best practices, building the capacity of local organizations through technical assistance, and conducting public education and engagement.[13]

LISC-ProMedica

In the UpTown neighborhood of Toledo, OH, ProMedica, an integrated health system, and Local Initiatives Support Corporation (LISC), a national CDFI, are partnering to improve health outcomes by increasing neighborhood resident access to employment opportunities, affordable and healthy food, medical care, income supports, and savings. In 2017, ProMedica made a 10-year, $50-million commitment to create a new place-based, health-focused community development model in the neighborhood. This initiative, called the ProMedica Ebeid Neighborhood Promise, was created to improve health and well-being by addressing the social determinants of health in the UpTown neighborhood, where more than half of residents live in poverty and 30 percent are unemployed. Through the initiative and in collaboration with community partners, UpTown residents have access to job-training opportunities, a healthy and affordable grocery store, a health clinic, support from community health workers, and a financial opportunity center. In partnership with LISC, the ProMedica Financial Opportunity Center (FOC) provides coaching/counseling to support the financial health of clients. Additionally, it is co-located with ProMedica's not-for-profit grocery store—which enables job training opportunities and access to fresh food—with over 65,000 customer visits in year one. The initiative has brought 120 new jobs to the neighborhood and has increased incomes, credit scores, and wealth. Results among those who have received financial counseling include: 27% realized an increase in net income; 17% improved credit scores by an average of 39 points; and 18% increased their overall net worth.[14] Additionally, ProMedica reports that the initiative is beginning to yield promising results on health utilization and cost.

Ready to Rent

In New York City, the Department of Housing Preservation and Development (HPD), the Department of Consumer Affairs (DCA) Office of Financial Empowerment (OFE), and Ariva, a Bronx-based financial well-being provider, created Ready to Rent: Financial Counseling for Affordable Housing, in response to a study by the DCA that found "poor credit, a lack of savings and difficulty navigating affordable housing applications (including the complexity of accurately calculating household income to meet eligibility requirements) are key financial barriers preventing eligibility for affordable housing." The program provides financial counseling assistance to families and helps them apply for affordable housing through HPD's Housing Connect website. During the pilot phase in 2015, there were 325 program participants and a total of 141 positive financial outcomes achieved, which included increasing or establishing credit scores, reducing debt, increasing savings, and accessing affordable checking and savings accounts. Since the launch of Ready to Rent in 2017, the program has served over 500 clients, most of whom make less than $20,000 per year[15]

Stronger Together Partnership

The Fifth Avenue Committee, Inc. (FAC) is a community development corporation working in South Brooklyn, NY. FAC's comprehensive community development strategy includes building and preserving affordable housing; providing job training, placement, and counseling services; providing adult education and literacy classes; grassroots community organizing and policy advocacy; and offering benefits access assistance and financial and legal counseling services. The Stronger Together Partnership is a collaboration between FAC, Brooklyn Workforce Innovations, Red Hook Initiative, and Southwest Brooklyn

[13] *Strategies for Building Healthy, Equitable Communities. Get Healthy San Mateo County 2015-2020.* (2015). Health Policy and Planning Division, San Mateo County Health System. https://www.gethealthysmc.org/sites/main/files/file-attachments/get_healthy_smc_strategic_plan_2015-2020_final.pdf?1485905434 (accessed August 2019).

[14] Results from July 1, 2017 from program inception to June 30, 2019. (Source: ProMedica, email to authors, July 11, 2019)

[15] Salas, L. "Financial Counseling Helping New Yorkers Unlock Affordable Housing." Prosperity Now (blog). May 7, 2018. https://prosperitynow.org/blog/financial-counseling-helping-new-yorkers-unlock-affordable-housing (accessed August 2019).

Industrial Development Corporation to improve education and employment outcomes for public housing residents living in poverty in the Red Hook and Gowanus neighborhoods, many of whom are unemployed and do not have a high school diploma. The partners share intake, referral, and data tracking systems to help residents access job training, adult education, college access, financial literacy, income supports, and job placement services. As part of the effort, FAC implemented a central data hub where program data from all four Stronger Together partner organizations is uploaded, which has streamlined the referral process and allowed staff to spend more time serving clients. Over its first three and a half years, the partnership helped 289 residents secure employment. Additionally, the partnership piloted a remedial education program to help residents gain the skills needed to qualify for Brooklyn Workforce Innovations' sector-based job training programs. The initial results of the program indicate that for just $144 per participant, the remedial training program can raise the potential lifetime earnings of a person who enters the program without a high school diploma by approximately $340,000.[16][17]

Tacoma Housing Authority

In Tacoma, WA, the Tacoma Housing Authority (THA) administers a Children's Savings Account program for elementary, middle, and high school students who live in the Salishan neighborhood and attend a Tacoma Public School. THA partners with the local school district and homeowners' associations to recruit participants; a local bank to provide funding and accounts for students; and two organizations to provide financial education for adults and the students in the program. In an interim evaluation of the program, conducted by the Urban Institute, program partners highlighted the importance and value of having shared goals that the CSA program reinforced.[18] THA anticipates the program will, in the short-term, help improve students' academic performance and behavior, connect families to mainstream banking services, build savings for students. In the long-term, THA hopes the program will improve high school graduation rates, enrollment in postsecondary education, and completion of degree or certification programs.

Examples of alignment across community development, public health, healthcare, and financial well-being that directly impact individuals and families, but do not directly impact neighborhood conditions:

CareSource and Fifth Third Bank

CareSource, one of the largest Medicaid managed care plans, has established a partnership with Fifth Third Bank to facilitate access to safe and affordable financial services for its members. CareSource members are eligible for Fifth Third Express Banking, which has no monthly service charge, minimum balance, or overdraft fees. The partnership fits with CareSource's mission to improve its members' health and well-being, as they acknowledge that "financial health is an important part of well-being."[19]

$tand By Me

$tand By Me ($BM) is a statewide program in Delaware that offers one-on-one financial coaching and free VITA tax preparation through partnerships with employers, social service systems, and housing, education, and healthcare providers. The $BM model integrates financial well-being services into existing programs in order to improve outcomes across the areas those programs focus on, such as education and housing. The $BM program works with a number of partners: the Department of Social Services to embed financial coaching into TANF,

[16] *Smart Organizations, Strong Neighborhoods: Measurable, Scalable Impact.* (n.d.). New York, NY: Change Capital Fund. https://changecapitalfund.org/wp-content/uploads/2015/09/CCF_Report_FIN_031918.pdf (accessed August 2019).

[17] *"Fifth Avenue Committee," Change Capital Fund, accessed August 2019, https://changecapitalfund.org/grantee/fifth-avenue-committee/*

[19] "Fifth Third Express Banking®," Fifth Third Bank, accessed August 2019, https://www.53.com/content/fifth-third/en/mkg/lp-express-banking.html.

[18] Galvez, M., Gilbert, B., Oneto, A., and DuBois, N. (2017). *Tacoma Housing Authority's Children's Savings Account Program Evaluation Interim Report.* Urban Institute for the Tacoma Housing Authority. https://www.tacomahousing.net/sites/default/files/ui_deliverable_tha_csa_interim_report_final_november_2017.pdf (accessed August 2019)

SNAP, and other public benefits programs; the Department of Housing to build a pipeline of financially ready homebuyers; the Department of Transportation to help build the financial capacity of disadvantaged business enterprises and minority-owned businesses; the Department of Education to help increase the number of high-school students attending college; Head Start and other childcare centers to provide financial coaching to staff and families; and Christiana Care, one of the largest hospital providers in Delaware, to provide financial coaching to all employees of the hospital. Since 2011, $BM has helped more than 110,000 Delawareans—more than 5% of the population. The program has improved credit scores on average by 64 points, helped individuals save more than $3.3 million, and reduced personal debt by $19.6 million. Additionally, $BM has seen improvements in children's educational outcomes—children in Head Start whose parents received $BM services outperformed their peers. (Source: Mary Dupont, interview with authors, December 3, 2018)

StreetCred

In Boston, MA, a coalition of nonprofits, businesses, and community organizations is working with the region's largest safety-net hospital to help families increase their earnings and improve their children's health outcomes by accessing the Earned Income Tax Credit (EITC) and public benefits. Boston Medical Center created a new organization, StreetCred, in partnership with the Boston Tax Help Coalition, to address the root causes of poor child health outcomes by increasing access to the EITC. StreetCred began its work with families waiting to see a pediatrician by helping them prepare their taxes. StreetCred chose pediatrician offices for their quality as both a trusted and convenient space for families. From 2016 to 2019, StreetCred has returned over $5.3 million to about 2700 families. (Source: StreetCred, interview with authors) StreetCred has since expanded to other health services locations in eight states and plans to add additional services to help families establish savings accounts, have paid employment opportunities, and engage in financial coaching.

WellQ - Allegacy Federal Credit Union and Wake Forest Baptist Health

In 2018, Allegacy Federal Credit Union and Wake Forest Baptist Health created WellQ™, a credit union service organization (CUSO). WellQ provides members (individuals or families who join for an annual fee) with access to a bundle of health and financial services, including a clinic, pharmacy, physical and financial wellness classes, and financial products. One of the financial products, the AllHealth Wellness Savings account, rewards members for physical fitness or volunteer activities. The account offers higher interest rates based on how often members either exercise or volunteer at the YMCA of Northwest North Carolina or the UNC Greensboro Leonard J. Kaplan Center for Wellness. The purpose of WellQ™ is to "bridge the gap between physical and financial health and to offer consumers co-located health and financial advisors to facilitate information sharing, collaboration and improved outcomes."[20]

[20] Hyland, C. G., and Revere, C. J. (2018). Health and Financial Well-being: Two Good Things that Go Better Together, The Case for Credit Union and Health Care Collaboration (p. 16). The National Credit Union Foundation. https://www.ncuf.coop/media.acux/e9aea8e4-5e41-4671-b802-721073609884 (accessed August 2019).

APPENDIX B

Public Health and Healthcare Sectors Overview

In the United States, the actors involved in addressing health and well-being are vast. In a broad sense, all community actors can play a role in shaping the physical, mental, and social dimensions of health, including schools, spiritual leaders, community centers, employers, financial service providers, and others. For the purposes of this paper, this section will discuss public health and healthcare—two sectors with an interest in health outcomes (e.g., life expectancy, diabetes, etc.) and an increasing focus on well-being and the social determinants of health.

Public health is an academic discipline and accredited field within the health sector that works to prevent disease and promote the health of whole populations through educational programs, policies and regulations, services, research, and advocacy, and typically involving environmental scientists, health educators, medical professionals, and others. Public health does not usually include provision of medical or healthcare *services*[1] to individuals; it generally involves initiatives to promote healthy lifestyles, improve access to health care, control infectious diseases, and reduce environmental hazards, violence, substance abuse, and injury across populations. Public health organizations are largely funded by government; in 2017, federal, state, and local governments invested $88.9 billion in public health programs *nationwide*.[2]

Over the past two centuries, public health has undergone several paradigm shifts, from a wider population-oriented perspective focused on improving neighborhood conditions and poverty; to a more narrow view of health and disease centered around "germ theory" (individual-level risk factors and behaviors); back to a more holistic understanding of prevention and socioeconomic influences on health. In the late 80s and 90s, several seminal reports on dramatic racial and ethnic disparities emerged, and in 2000, the Minority Health and Health Disparities Research and Education Act—the first federal legislation focusing on reduction of health disparities—was signed into law.

Now, one of public health's main goals is to achieve health equity, eliminate disparities, and improve the health of all *groups*.[3] After years of documenting health disparities based on race, ethnicity, gender, education, and socioeconomic status, researchers, policy makers and advocates in public health are now shifting their focus from educating individuals on health-promoting behaviors to addressing the underlying causes of those disparities, known as the social determinants of *health*.[4]

Healthcare, one of the largest economic drivers in the U.S., is comprised of organizations and people focused on health and well-being including hospitals, healthcare systems, and other healthcare facilities, health insurers, purchasers of healthcare services, and others. Some are based in the public sector; others operate in the private sector as either for-profit or not-for- profit *entities*.[5] These entities make up what is known collectively as the health care delivery system, with the general goal of providing high quality, cost-effective medical services to maintain and restore health. However, the word "system" belies the fact that the healthcare delivery system is fragmented, oriented toward treatment of disease rather than prevention, and neither structured nor incentivized to address health and well-being holistically.

In light of multi-trillion-dollar healthcare spending and persistent health outcomes that are inequitably distributed across socioeconomic categories and lagging in international comparisons, the healthcare sector has begun to recognize that preventing illness and premature death requires going beyond focusing on single risk factors or health conditions and understanding social determinants of health affecting their patients. The Patient Protection and Affordable Care Act of 2010 (ACA) and underlying Triple Aim—a framework which emphasizes the simultaneous goals of improved patient health outcomes, reduced healthcare costs, and improved population health—has institutionalized imperatives to address these social determinants through payment reform and innovation programs, changes to Medicaid and Medicare, and new requirements for nonprofit hospitals. A number of these imperatives encourage closer alignment, collaboration, and partnership between public health, healthcare systems, and community partners to improve the health of populations (see Emerging Models and Practices, below).

Major Stakeholders

While not a comprehensive list, this section highlights the major actors in both the public health and healthcare sectors. Both public health and healthcare operate on multiple levels and sometimes straddle disciplines, ranging from local actors who interact directly with populations; to those that provide supporting services and organizing infrastructure; to organizations shaping national influencing agendas, policy, and funding sources.

Medical Providers

Health care providers include individuals who provide preventive, curative, promotional, or rehabilitative health care services in a systematic way to people, families, or communities. Medical providers represent doctors, nurses, surgeons, physical therapists, psychiatrists, etc. These providers exist within all branches of health care, including medicine, surgery, dentistry, midwifery, pharmacy, psychology, nursing, and allied health professions.

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[1] Health services provision varies; some local health departments operate as safety net care providers. Services can include mental health hospitals and outpatient clinics, substance abuse treatment programs, maternal and child health services, and clinics for the homeless.

[2] "National Health Expenditure Data, Historical," U.S. Centers for Medicare and Medicaid Services, accessed August 2019, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html.

[3] This goal is outlined in Healthy People 2020. Released in 2010 by the U.S. Department of Health and Human Services (HHS), Healthy People 2020 serves as a broad framework for national, state, regional, and local public health initiatives. Since the first Healthy People framework (released in 1990 for the year 2000), HHS has released successive frameworks every ten years to identify emerging public health priorities and align health-promotion resources, strategies, and research.

[4] Cohen, A., Grogan, C., and Horwitt, J. (October 1, 2017). *The Many Roads toward Achieving Health Equity.* Journal of Health Politics, Policy and Law, 42(5), 739-748. https://read.dukeupress.edu/jhppl/article/42/5/739/131410/The-Many-Roads-toward-Achieving-Health-Equity (accessed August 2019).

[5] Institute of Medicine. (2003). *The Future of the Public's Health in the 21st Century.* (pp. 212-267). Washington, DC: The National Academies Press. https://doi.org/10.17226/10548.

A number of other organizations—public and private—may serve a direct health service provision role (for example, Walgreens, drop-in clinics, community health workers, community development corporations or affordable housing managers that provide services to their residents, faith-based organizations, home care, social services, mental health agencies, etc.).

Safety net providers[6]

Safety net providers include public hospitals (more recently termed "essential" hospitals), community health centers/federally qualified health centers (FQHCs), community or teaching hospitals, school-based health centers, and local health departments. Safety net providers care for low-income people, the uninsured, and others who face economic and social hardships. As part of their unique role and mission, core safety net providers offer a combination of comprehensive medical or "wraparound" services (e.g., language interpretation, transportation, outreach, and nutrition and social support services) specifically targeted to the needs of vulnerable populations, who make up a majority of patients/people receiving safety net services. Safety net providers receive funds from national, state, and local governments.

Hospitals

Hospitals are health care institutions that have an organized medical and other professional staff that deliver various health services (e.g., emergency services, surgery, specialized services) 24 hours a day, 7 days a week. In 2018, there were 5,534 registered hospitals in the U.S. Those facilities can be divided into a variety of categories depending on size, location, demographics, finances, and affiliation. An important distinction is for-profit vs. nonprofit, as nonprofit hospitals are subject to certain rules under the ACA, including community benefit regulations (demonstration of unreimbursed expenditures benefiting the local community in support of tax-exempt status), while for-profit hospitals are not. Nonprofit hospitals make up over half of all hospitals. Hospitals may exist independently (e.g., Marin General Hospital), as part of a system defined as two or more hospitals owned, leased, sponsored, or contract managed by a central organization (e.g., Dignity Health), or part of a network, defined as a group of hospitals, physicians, other providers, insurers, and others that work together to coordinate and deliver a broad spectrum of services to their community (e.g., Kaiser Permanente).

Public health departments/districts (local and state)

Local health departments (county, combined city-county, or multicounty) are agencies operated by local government with oversight and direction from a local board of health, and which provide public health services throughout a defined geographic area. State health agencies have responsibility for identifying and meeting the health needs of the state's citizens and can be free standing or units of multipurpose health and human service agencies. Generally, public health departments have three main functions: (1) assessment of community conditions, health needs, and their determinants; (2) policy development, which includes advocacy, prioritization, and plans to address health needs; and (3) assurance that high quality services are available, which includes resource management, program implementation and evaluation, and public *education.*[7]

Payers

Payers are institutions that pay providers for healthcare services, including insurance carriers, private employers, the government, and also individuals. The majority of healthcare in the U.S. is paid for by two entities: employers and the government. The Centers for Medicare & Medicaid Services (CMS) is the single largest payer for healthcare in the United States, covering 33% of Americans in 2016 through two main programs: Medicare and Medicaid. Sixty percent of Americans get their healthcare from their employer. Under employer-paid plans, employees may be required to contribute part of the cost of insurance, while the employer is responsible for choosing the insurance carrier and negotiating plans and premiums.

Health Plans

Most insurers (including government) organize the delivery of care through health plans (also known as managed care organizations—MCOs—or health maintenance organizations—HMOs), which contract with health care providers and medical facilities to provide care for their members. The contractual arrangements that health plans have with the providers in their network vary based on how they are paid (e.g., on a per service basis or through a single flat rate), what incentives they have (e.g., bonus payments for providing certain screenings), and how much risk they assume (e.g., being responsible for the cost of certain tests or treatments if a patient gets sick). The details of these contractual relationships influence the level of motivation/incentive that health plans, providers, or hospitals have for keeping patients healthy and addressing social determinants of health (SDOH).

Health associations/Institutes/Schools of Public Health

These organizations teach, convene, build capacity, and share best practices and ideas among constituents. As learning institutions, they represent fertile ground to make connections between health, wealth, and other social determinants. A few key organizations include the American Public Health Association, the American Hospital Association, the National Association of City and County Health Officials (NACCHO), Association of State and Territorial Health Officials (ASTHO), the Catholic Health Association, the National Network of Public Health Institutes, and the Council on Education for Public Health.

Health policy advocates

Policies shape the social and physical conditions reflected in social determinants of health. Thus, policy advocates—who can be part of any organization and at any level—play an essential part in ensuring policies are fair and promote health equity. Health policy advocates' roles can range from policy analysis, to technical assistance, to larger national campaigns, and more. One example of a policy advocacy organization is Community Catalyst, a non-profit advocacy organization working to build the consumer and community leadership that is required to transform the American health system. Community Catalyst works in 40 states and helps organizations achieve wide-reaching reforms in areas like Medicaid

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[6] Institute of Medicine (US) Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers; Ein Lewin M, Altman S, editors. *America's Health Care Safety Net: Intact but Endangered.* Washington (DC): National Academies Press (US); 2000. 2, The Core Safety Net and the Safety Net System. Available from: https://www.ncbi.nlm.nih.gov/books/NBK224521/

[7] *Basic Duties of Local Health Departments.* (n.d.). Public Health Association of Nebraska. http://publichealthne.org/phan-sections/public-health-education-section/marketing/core-functions-of-public-health/ (accessed August 2019).

policy, prescription drug prices, and diversity in the healthcare workforce.

National Health Actors/Federal Agencies

A number of federal agencies influence health and well-being. The Centers for Disease Control and Prevention (CDC) is an operating agency of the Department of Health and Human Services (HHS) that serves as the nation's leading public health institution. The CDC's primary mission is to protect public health and safety through the control and prevention of diseases, injury, and disability. The CDC operates the Prevention and Public Health Fund, established through the Affordable Care Act, which currently serves as the primary funding source for local initiatives that address social determinants of health.

Another agency operating under *HHS is the Health Resources and Services Administration (HRSA)*. It is the primary federal agency responsible for improving health care to people who are geographically isolated, economically or medically vulnerable. HRSA also supports the training of health professionals, the distribution of providers to areas where they are needed most, and improvements in health care delivery.

HHS's *Centers for Medicare and Medicaid Services (CMS)* administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards. CMS regulates reimbursement for healthcare products and services for Medicaid and Medicare. *The Center for Medicare & Medicaid Innovation (CMMI or the Innovation Center)* was created by the ACA to support the development and testing of innovative payment and service delivery models. The goals of these efforts are to achieve the Triple Aims of 1) better care for patients, 2) better health for our communities, and 3) lower costs through improvement for our health care system.

Other HHS agencies that influence health and its social determinants include the *Food and Drug Administration (FDA); the Administration on Children and Families; and the Administration for Community Living (ACL)*. Other federal agencies that influence health and its social determinants include the *Environmental Protection Agency (EPA); the Department of Education (DOE); and the Department of Agriculture.*

Finally, the *Internal Revenue Service (IRS)* plays a dominant role in enforcing many of the laws in the Affordable Care Act. Among others, these include enforcing health insurance coverage penalties and provisions for individuals and employers and evaluating nonprofit hospitals' provision of community benefit.

[8] Easterling, D., Smart, A. and McDuffee, L. "Hospital & Health Conversion Foundations." Stakeholder Health (blog). March 14, 2016. https://stakeholderhealth.org/conversion-foundation/ (accessed August 2019)

Foundations

In addition to national foundations with a health focus (e.g., the Robert Wood Johnson Foundation, the Kresge Foundation, and others), two other types of foundations of interest are *hospital foundations* and *health conversion foundations*.[8] Many hospitals set up a foundation to raise funds from individuals and organizations. These hospital foundations channel charitable giving to projects aligned with the donors' interests and the hospital's strategic priorities, which might include an expansion of a facility, new equipment, patient support services, or subsidies for medical care.

Health conversion foundations (also called "health legacy foundations") are formed when a nonprofit hospital, health care system, or health plan is either acquired by a for-profit firm or converted to for-profit status. The proceeds from these transactions are transferred into the endowment of a foundation that maintains the general mission of the entity that was sold (that is, improving or advancing the health of the population served by the entity). The most recent census identified 306 conversion foundations nationally that submitted their annual Form 990 to the IRS in 2010. Together they held a total of $26.2 billion in assets. A more recent census is not available, but at least another 100 have been established since 2010. Examples of health conversion foundations include the Colorado Health Foundation and the California Endowment.

Key Terms

Social Determinants of Health (SDOH): "The conditions in which people are born, grow, live, work, and age, including the health system." Specific social determinants of health include economic and housing stability, employment status, educational attainment, access to health care, access to healthy foods, exposure to crime and violence, and environmental conditions. By improving neighborhood conditions, community development addresses multiple social determinants of health, thus providing a pathway and means to finance the neighborhood changes required to achieve health equity.

Health: Defined by the World Health Organization as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity." This association of health with overall well-being highlights the importance of addressing the social determinants of health.

Population Health: The study of population health emphasizes health outcomes and the social, physical, and economic factors that explain how health outcomes are distributed across populations, in contrast to an individual-level focus. The "population" in population health can be defined from several different perspectives, which can result in some confusion when using the term across components of the health sector. These definitions for population include:

- Population served by an individual provider or payer—assuring that patients are assigned correctly to a primary care provider
- Population served by the entire delivery system—e.g. primary care patients
- Population of those residing in the broader community—e.g. a geographic area or a category of persons that share specific attributes, such as a specific disease like Type 2 diabetes.

Health Equity: "The attainment of the highest level of health for all people." The Robert Wood Johnson Foundation defines health equity as follows: *"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."*

Health Disparities: A difference in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups.

Triple Aim: This is a term that has become popular recently to describe the goals of health care reform. The Institute for Healthcare Improvement defines the Triple Aim as "A simultaneous approach to optimizing health system performance using three dimensions: 1) Improving the patient experience of care (including quality and satisfaction); 2) Improving the health of populations; and 3) Reducing the per capita cost of health care.

Health Care Reform: Generally, the term "health care reform" refers to major policy change that attempts to expand health care coverage; improve access to health care specialists; improve the quality of health care; decrease health care costs, or other related goals. In the United States, the debate regarding health care reform includes questions of a right to health care, access, fairness, sustainability, quality, and funding amounts spent by government. The term "health care reform" also usually refers to changes made under the Patient Protection and Affordable Care Act (see below).

The Patient Protection and Affordable Care Act: The Patient Protection and Affordable Care Act (ACA), passed by Congress in 2010, achieves comprehensive health care reform through a focus on increasing the number of Americans covered by health insurance and improving the quality of health care, while lowering the cost of care, in part through a focus on prevention and population health. Some of the ACA's most significant changes include expanded Medicaid eligibility; tax credits to purchase insurance; funding pilots to improve delivery, cost-efficiency, and quality of health care services; providing new opportunities to partner with social service providers to address social determinants of health; and strengthening prevention services.

Payment reform: The ACA contains numerous provisions intended to resolve underlying problems in how health care is delivered and paid for in the United States. These provisions focus on three broad areas: testing new delivery models, encouraging the shift from payment based on quantity of services provided (known as **"fee for service"**) toward payment based on the quality and value (or **"value-based care"**), and developing resources for system-wide improvement.[9] See "Promising Models" for more information, or visit APHA's summary on major ACA delivery and payment reform initiatives.

[9] Abrams, M. K., Nuzum, R., Zezza, M. A., Ryan, J., Kiszla, J. and Guterman, S. (May 7, 2015). *The Affordable Care Act's Payment and Delivery System Reforms: A Progress Report at Five Years.* The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2015/may/affordable-care-acts-payment-and-delivery-system-reforms (accessed August 2019)

[10] LaPointe, J. *"Examining the Role of Financial Risk in Value-Based Care."* Revcycle Intelligence. Risk Management News (blog). July 25, 2016. https://revcycleintelligence.com/news/examining-the-role-of-financial-risk-in-value-based-care.

Risk: In healthcare, risk refers to financial loss. One of the goals of value-based care (a model used as part of payment reform) is to transition financial risk away from taxpayers and healthcare payers and instead place the burden on providers to make smarter decisions about healthcare utilization. This means that within **valued-based care**, providers are rewarded—or penalized—for how well they manage to reduce healthcare costs and improve patient outcomes.[10] For more information on how risk varies across payment models, see "Emerging Models/Practices".

Medicaid: Medicaid is an assistance program paid for by federal and state funds. It serves low-income people of every age and is run by state and local governments within federal guidelines. The services covered and the eligibility criteria vary from state to state. For example, in 2014, the ACA gave states the option to expand Medicaid to low-income adults. At this time, 33 states have taken advantage of this option and 18 have not. In most states, patients do not have any co-payments under Medicaid, but in some states, for some services, a small co-payment is required. Total Medicaid spending in 2017 was $595 billion.

Medicare: Medicare is an insurance program. Medical bills are paid from trust funds which those covered have paid into. It serves people over 65 primarily, whatever their income, and also serves younger disabled people and dialysis patients. Patients pay part of costs through deductibles for hospital and other costs. Small monthly premiums are required for non-hospital coverage. Medicare is a federal program. It is basically the same everywhere in the United States and is run by CMS. Medicare spending was 15 percent of total federal spending in 2017 ($702 billion) and is projected to rise to 18 percent by 2028.

Managed Care: See description under "Health Plans" in the section on "Major Stakeholders."

Emerging Models and Practices

Life course model/theory: Life course theory (LCT) is a conceptual framework that helps explain health and disease patterns—particularly health disparities—across populations and over time. Four key concepts of the life course model include:

» Today's experiences and exposures influence tomorrow's health, that is, experiences and exposures earlier in life influence health later in life. (Timeline)

» Health trajectories are particularly affected during critical or sensitive periods, which tend to occur early in life. (Timing)

» The broader community environment–biologic, physical, and social–strongly affects the capacity to be healthy through direct and increasingly well-understood biological mechanisms. (Environment)

» While genetic makeup and personal choice result in both protective and risk factors for disease conditions, these differences in health are also derived from profound and often inequitable variation in context able to turn on/off genes and limit personal choice. (Equity)

The life course model emerged from the field of public health, but aspects of the model have been explored in various economic studies (e.g., Raj Chetty's "Impacts of Neighborhoods on Intergenerational Mobility") and community development organizations (e.g., The Unity Council's "across-the-lifespan" approach to programs).

Toxic stress and epigenetics: The negative impacts of poverty, childhood trauma, and racism on health and opportunity have been linked to poor health outcomes. Until recently, however, the biological mechanism for these changes was not well known. In lay terms, breakthroughs in epigenetics, or the study of mechanisms that switch genes on and off, indicate that chronic, repeated, and uncontrollable stress (known as **"toxic stress"**) of social disadvantage, socioeconomic inequality, and racial discrimination affect the way that genetic "instructions" are read, which can lead to changes in the body's ability to fight disease or stay healthy. While epigenetic changes can be reversed, they also can be passed down to future generations. As healthcare is incentivized to keep patients healthy, addressing the social determinants of health takes on increased significance for both the patients themselves and their descendants.

Health in all policies (HiAP): Health in All Policies (HiAP) is a collaborative approach to improving the health of all people by incorporating health, equity, and sustainability considerations into decision-making across sectors and policy areas, especially across local and state governmental agencies and departments. The approach recognizes that our greatest health challenges—like chronic illness, climate change, health inequities between populations, and increasing health care costs—are highly complex and influenced by policies, programs, and investments across sectors. HiAP approaches have been used worldwide. One example is Richmond, California; the HiAP approach allowed residents to bring health equity to the forefront and involved agencies across local government, such as housing, transportation, parks and recreation, public health, and education.

Accountable health initiatives: Accountable health initiatives are an umbrella term for organizational models with a cross-sector approach to addressing population health disparities. Accountable health initiatives fundamentally embrace the concept that there is a shared responsibility for the health of a community or patient population across sectors. By focusing on the alignment of clinical and community-based organizations, they offer an integrated approach to health, health care, and social needs of individuals and communities to achieve equity and better population health outcomes, to reach a higher quality of health care, and to reduce costs. Some of these models include:

Accountable care organizations (ACOs) ACOs differ from accountable health initiatives slightly in that they hold providers responsible for better management of clinical conditions in a patient population. This may involve some community partners, but primarily represent organizations of healthcare providers. However, the principle of shared responsibility and coordination holds true.

Accountable care is one of seven broad categories of innovation models testing new payment and service delivery models under CMS. ACOs financially encourage providers to keep a population of patients healthy at a lower cost by improving efficiency and better coordinating care. The Centers for Medicare and Medicaid Services initially developed the ACO model for the Medicare population, but ACOs now frequently provide services for Medicaid programs and private payers as well.

Accountable Health Communities (AHC): Another CMS innovation model being tested in a number of communities nationally, the ACHC approach will explore whether identifying and addressing Medicare/Medicaid patients' health-related social needs (housing, transportation, utilities, social supports, etc.) will impact health care costs and reduce health care utilization. Over a five-year period, the model will provide support to community organizations

to test promising service delivery approaches aimed at linking beneficiaries with community services that may address these needs.

Accountable Communities for Health (ACH): An Accountable Community for Health (ACH) is a structured, cross-sectoral alliance of healthcare, public health, and other organizations that plans and implements strategies to improve population health and health equity for all residents in a geographic area (as compared to CMS AHC model, which aims to assess impact on Medicare/Medicaid patients). The Prevention Institute outlines nine core elements of an ACH: (1) mission; (2) multi-sectoral partnership; (3) an integrator organization; (4) a governance structure;(5) data and indicators to measure progress; (6) an overarching strategic framework; (7) community member engagement; (8) a communications platform; and (9) sustainable financing.

Payment reform: Various payers have been experimenting with payment reform models as reimbursement shifts from fee-for-service, the traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide, toward value-based care. Under value-based care agreements, providers are rewarded for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives in an evidence-based way. Payment reform models of interest fall on a spectrum of risk that holds providers accountable to providing quality, cost-efficient care and keeping their patients healthy. Examples include:

Pay for performance: Providers receive incentives for meeting or exceeding quality, and sometimes cost, benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of pay-for-performance programs is to improve the quality of care over time.

Payment Bundling: Providers or hospitals receive a single payment for all of the care provided for an episode of illness, or over a set period of time, rather than per service. For example, a single set rate for a pneumonia hospitalization (usually, adjusted for age or co-existing illness) instead of payment for each night's stay and every medication, doctor visit, and/or resource used. Providers then earn or lose the difference between the actual cost of care and the set cost.

Capitated payment: Providers receive a set payment per year for each person or "covered life" for whom they provide care, regardless of whether or not people use health services. The healthier patients are/remain, the more savings providers reap in the difference between the initial payment and actual costs. These payments can be adjusted based on the demographic characteristics of a provider's patient population, such as age and gender, to account for differences in expected costs.

Medicaid Waivers: Authority granted by the Secretary of Health and Human Services to allow a state to continue receiving federal Medicaid matching funds even though it is no longer in compliance with certain requirements of the Medicaid statute. States can use waivers to implement home and community-based services programs and managed care, and to expand coverage to populations such as adults without dependent children who are not otherwise eligible for Medicaid. For example, New York state has received a waiver to use a portion of its state Medicaid funds to pay for the costs of housing, which would not normally be allowed under the Medicaid statutes.

Wellness trusts: A wellness trust is a funding pool raised to support prevention and wellness interventions that improve population health outcomes. Sources of funding can include public and/or private money. The Massachusetts Prevention and Wellness Trust was established by the Massachusetts legislature in 2012 and became the first state effort to use a wellness trust as a vehicle to make a large commitment to population-based health promotion efforts.

Growing interest in wellness trusts coincides with the current transformation of the healthcare system that moves care away from traditional fee-for-service payments to value-based, global payment for the care of a population of patients. These new delivery and payment reform efforts are better aligned with community-based prevention and wellness efforts. Wellness trusts can supplement limited public resources for prevention and allow for innovative prevention efforts that target upstream drivers of health and wellness, including community infrastructure such as housing or other needed neighborhood resources.

Community Benefit, Community Health Needs Assessments (CHNAs), Community Health Improvement Plans (CHIPs), and Community Health Assessments (CHAs): To merit their federal tax-exempt status, nonprofit hospitals must report on the ***community benefits*** they have provided—previously called charity care—that contribute to the health and well-being of surrounding communities. Calculated hospital community benefits typically include unreimbursed care (free and discounted care to uninsured and low-income patients), initiatives to increase access to health care (e.g., health fairs), medical research done at their facilities, and costs associated with training for doctors, nurses, and other health professionals. However, with improved guidance from the Internal Revenue Service (IRS) which regulates this process, many hospitals are beginning to align and deploy their community benefits to address health needs arising from the social determinants of health including, in some cases, investing with community development organizations.

As part of community benefit, the ACA mandates that nonprofit hospitals conduct ***community health needs assessments (CHNAs)***. CHNAs are completed to alert the hospital to the local needs that most urgently require financial support. Hospitals must publicly report CHNA findings and community benefit expenditures every three years and solicit input from a diverse group of community members, stakeholders, and public health departments. Once a CHNA is complete, a hospital must develop a plan for how it will address the identified health challenges—the ***Community Health Implementation Plan (CHIP)***. Through this regular and intensive look at pressing health challenges, nonprofit hospitals can better target partnerships, strategies, and investment of its community benefit resources. However, there remain unresolved questions over what types of expenditures, especially related to infrastructure investments, are allowable as community benefit. There is also a wide range CHNA quality across hospitals, including the allowable re-use of CHNAs for multiple hospitals within a larger healthcare system, which limits their utility in guiding resource deployment.Similar to a CHNA, public health departments must conduct a ***community health assessment (CHA)*** every three years as part of their accreditation process. Many public health departments and hospitals are joining forces to align these efforts. Opportunity exists to link other organizations to these needs assessments, implementation plans, and community benefit opportunities to more fully address SDOH.

APPENDIX C

Community Development: Sector Overview

The community development sector is a vast, financially savvy, mission-driven industry that tackles poverty in America's most under-resourced neighborhoods. At its root, the community development sector is an anti-poverty movement. Driven by a mix of public and private resources—federal and state grants and tax incentives as well as federally mandated investments by for-profit banks—the community development sector intervenes to address many of the social determinants of health (SDOH) and inequity. Partnering with one another and using the federal and private capital described below, these mission-driven and often nimble institutions have been able to incorporate resident voices and provide the housing and other neighborhood infrastructure that responds to community needs.

Community development is a multi-billion-dollar sector of the American economy that invests in low- and moderate-income communities through the development and financing of affordable housing, schools, grocery stores, health clinics, small businesses, job training programs, and services to support children, youth, and families. The sector has its roots in the urban revitalization efforts of the late 19th century but expanded as a result of the War on Poverty programs of the 1960s. However, community development today is not the centralized urban renewal of that era, an approach that too often resulted in the industrial-scale public housing projects we associate with the urban core of many American cities. Those types of U.S. Department of Housing and Urban Development (HUD) efforts fell out of favor in the late '70s and were slashed in the '80s. In their place gradually arose a network of community-based, local and national, largely non-profit organizations that responded to the unabated need for affordable housing. There are now thousands of these organizations across the country representing communities large and small, investing $200 billion annually into low-income neighborhoods.

While the United Nations defined community development in 1955 as "a process designed to create conditions of economic and social progress for the whole community with its active participation and fullest possible reliance upon the community initiative," in the U.S., community development represents more than a process or activity. Rather, it is best viewed as a self-defined sector involving organizations from multiple fields that share a common focus on improving low-income communities. These organizations come from fields including real estate, city planning, law, social work, public policy, public health, affordable housing, and finance, and generally identify themselves as being part of the community development industry. Some of the key players (described below) provide leadership in the sector, and work alongside neighborhood residents and a combination of city agencies, philanthropic organizations, investors, real estate developers, and social-service providers.

The sector is not without its limitations. Despite the hundreds of billions of dollars invested over the years, poverty alleviation has clearly not been achieved. In part that is due to a lack of coordination or alignment in these investments to achieve their maximal impact. Too often investments are driven by immediate financial considerations or opportunities that produce one-off transactions. Measurement of impact also remains elusive. Outputs such as units of housing built or jobs created are tracked without truly examining outcomes (i.e., whether the apartment or job actually improved the resident/employee's life). Further, in some cases, particularly with inadequate planning, gentrification and subsequent displacement can undermine the goals of this work.

Major Stakeholders

Broadly, one can break down the major players into three groups: community development corporations (CDCs), affordable housing developers, and community development financial institutions (CDFIs).

Community Development Corporations

The first community development corporation (CDC) was founded in 1967 in New York City. CDCs, which are nonprofit organizations incorporated to support and promote community development efforts in struggling neighborhoods, now number over 4,000 across the country. They are in almost every urban neighborhood and many smaller cities and rural areas as well. As an example, the East Bay Asian Local Development Corporation (EBALDC) was started in 1975 by community leaders working to serve the Chinatown neighborhood of Oakland, CA. Subsequently, the organization expanded its focus to respond to the large-scale destruction of affordable housing by freeway development and other forms of urban renewal. EBALDC now owns and manages 30 residential developments and commercial spaces serving childcare and health centers, nonprofits, a resident-owned market, and popular, locally owned restaurants. They have developed and preserved 2,200 affordable homes.

Affordable Housing Developers

More narrowly focused on housing, and more often regional or national in scope than CDCs, are the nonprofit and for-profit affordable housing developers. Together, the 13 largest nonprofit affordable housing developers in the country own and operate over 130,000 rental apartments serving low-income residents. In addition, dozens of for-profit developers also provide affordable and mixed-income housing, with the ten largest companies constructing over 11,000 affordable homes in 2016 alone. Both nonprofit and for-profit affordable housing developers rely heavily on Low Income Housing Tax Credit (LIHTC) resources and investments from CRA-motivated banks to do their work.

Community Development Financial Institutions (CDFIs)

CDFIs make up a third important category of community development organizations. At root, CDFIs are non-profit banks with the mission to provide lending and financial resources to low-income neighborhoods underserved by the for-profit banking sector.

The origins of CDFIs can be traced back to the early 1970s and the mission-focused loan funds started by religious orders of nuns to provide low-interest loans to economically disadvantaged residents in their communities. At that same time, the first community development bank in the country, ShoreBank in Chicago, was founded by young, banking activists in 1973 to fight against the growing tide of racist lending practices. In 1994, President Bill Clinton, inspired by these earlier efforts, championed the creation of the Community Development Financial Institution Fund (CDFI Fund) within the U.S. Treasury Department to spread the work of CDFIs nationally. The field has grown substantially over the past 20 years with the CDFI Fund now certifying over 1,000 CDFIs across the country. The CDFI Fund itself has distributed over $2 billion since its inception, and in 2017 alone financed over 14,700 small business and microenterprise loans, nearly 28,000 affordable housing units, and served more than 470,000 individuals with financial literacy or other training.

One of the most important roles for CDFIs is to coordinate the complex financial transactions required for modern community development. Most community development investments require the braiding of multiple streams of capital: philanthropic dollars, tax credits (LIHTC and/or New Market Tax Credits, or NMTCs), CRA-motivated investments, and market-rate loans. This complex approach to obtaining necessary resources demands a high level of financial expertise, which CDFIs provide.

National Umbrella Organizations

The large, nonprofit affordable housing developers utilize SAHF as a shared organization advocating for the importance of their work at the national and regional level. The CDFI industry has a national membership body called the Opportunity Finance Network (OFN) that provides support, training, and a national forum for gathering and guiding the field. At this time, CDCs lack a national institution, but a pair of organizations fills part of that gap. The federally funded NeighborWorks America supports over 240 CDCs that meet its rigorous membership criteria, and the National Alliance of Community Economic Development Associations (NACEDA) provides a forum for the many state and regional CDC associations.

Key Terms

Affordable Housing. Housing capable of being purchased or rented by persons whose income level is categorized as very low, low, or moderate within standards set by HUD or state departments of housing/community development (for example, below 40%, 80%, or 120% of area median income, or AMI).

AMI. Area Median Income (AMI) is the household income for the median—or middle—household in a region. Each year, HUD calculates the median income for every metropolitan region in the country. This measure, which varies widely nationally, is used to determine eligibility for affordable housing programs.

Assets. Assets are useful or valuable skills, facilities or tools within a community that can lead to positive change. It is also defined as property owned by a person or company, regarded as having value and available to meet debts, commitments, or legacies.

Built Environment. Buildings, roads, parks, and all other improvements constructed by people that form the physical character of a community.

Capital. Wealth in the form of money or other assets owned by a person or organization or available for a particular purpose such as starting a company or investing.

Equity. In the finance world, equity means ownership of a share of an asset. For example, an investor could purchase shares of stock in a company or a real estate investment trust (REIT) that owns multiple buildings or properties. In the context of homeownership, equity is the value of a home or property less any remaining mortgage payments (debt). This value or equity grows over time as the property owner pays off the mortgage and the market value of the property appreciates.

Guaranteed Loan. A loan that is guaranteed partly or fully for the benefit of protecting a lender against possible losses.

Comprehensive community initiative. These are neighborhood-based efforts that seek improved outcomes for individuals and families as well as improvements in neighborhood conditions by working comprehensively across sectors.

Community Quarterback. A community quarterback is an entity that serves in a coordinating role, managing a diverse coalition of players in order to achieve

community betterment. A community quarterback may function as an organizer and navigator toward the shared goal of a cross-sector initiative in many ways, which could include articulating the goal itself, establishing shared metrics, bringing together knowledgeable allies and financial resources, and facilitating the work of an initiative's many community partners. In this model, the quarterback knits together the diverse abilities of formerly siloed community development sectors, creating a powerful integrated initiative.

Gentrification. The process of renewal and rebuilding in a deteriorating, disinvested neighborhood that can be followed by an influx of middle-class or affluent people and displacement of poorer residents.

Inclusionary Zoning. Regulations to diversify the range of housing choices constructed or offered within a development to meet the needs of low- and moderate-income families. Often such regulations require a minimum percentage of housing for low- and moderate-income households in new housing developments and in conversions of apartments to condominiums.

Neighborhood. A planning area commonly identified as such in a community's planning documents, and by the individuals residing and working within the neighborhood. Documentation may include a map prepared for planning purposes showing the names and boundaries of neighborhoods. Though neighborhoods are not legal designations, they are among the most commonly recognized and understood land use designations.

NIMBY. An acronym for "Not-In-My-Backyard" used to characterize opponents of development projects, with the implication that the opposition is based on personal self-interest as opposed to the interests of the larger community. Local agencies' alleged responsiveness to "NIMBY-ism" is one of the reasons some advocate for state laws to preempt local agencies' authority over certain kinds of land use decisions.

Supportive Housing. Housing that combines non-time-limited affordability with wrap-around supportive services for people experiencing homelessness, as well as people with disabilities.

Transit-oriented Development (TOD). Moderate- to higher-density development, located within easy walk of a major transit stop, generally with a mix of residential, employment, and shopping opportunities designed for pedestrians without excluding the auto. TOD can be new construction or redevelopment of one or more buildings whose design and orientation facilitate transit use. Equitable TOD (eTOD) focuses additionally on housing and services for individuals and families across the income spectrum.

Transitional Housing. Shelter provided to the homeless for an extended period, often as long as 18 months, and generally integrated with other social services and counseling programs to assist in the transition to self-sufficiency through the acquisition of a stable income and permanent housing.

Terms derived from the Build Healthy Places Network Jargon Buster, Institute of Local Government's Land Use and Planning glossary, and the Ball State University Community and Economic Development Glossary of Terms.

Sources of Funding

Community Reinvestment Act (CRA)

Passed in 1977, the CRA is often called an "anti-redlining" law because it responded to decades of discriminatory lending practices that created disinvestment in predominantly African American neighborhoods in cities across the U.S. The CRA requires for-profit banks to invest in the low-income neighborhoods where they take deposits. The results of the CRA have been staggering. In 2016 alone, banks made CRA investments totaling over $255 billion. This is the single greatest driver of resources into low-income neighborhoods.

Community Development Block Grant (CDBG)

A grant program administered by HUD on a formula basis for larger "entitlement" communities and by state agencies for smaller "non-entitlement" jurisdictions. This grant allots money to cities and counties for housing rehabilitation and community development, including public facilities and economic development.

Low Income Housing Tax Credit (LIHTC)

Created as part of the Tax Reform Act of 1986 to encourage private investment in affordable housing, LIHTC vouchers are distributed by the states and amounted to nearly $9 billion in 2017. Organizations allocated tax credits by their state housing finance agencies sell them to corporations who use them as payment for future taxes, saving money in the process. The organizations that sell the vouchers get cash that they can then use for production or preservation of affordable rental housing. Housing can be in the form of fully affordable or mixed-income housing and can include multi-family or, less often, single-family homes; special needs housing for the elderly or disabled; and supportive housing for homeless families and individuals. Fully 30% of the 10 million units of affordable housing in the country have been developed through the LIHTC program.

New Markets Tax Credit (NMTC)

NMTC is managed by the Treasury Department and since 2001 has provided nearly $55 billion targeted at job creation in low-income neighborhoods ($3.4B in 2017 alone). These dollars can be invested directly in small businesses or into other job-creating community facilities. In recent years community clinics have been seen as important job creators in low-income neighborhoods and, thus, are increasingly being built using NMTC funding.

Healthy Food Financing Initiative (HFFI)

HFFI has provided hundreds of millions of dollars through the U.S. Treasury, U.S. Department of Agriculture (USDA), and U.S. Department of Health & Human Services (HHS) for grants, loans, and financial assistance to community development organizations to build grocery stores in food deserts and for other efforts that increase the availability of fresh, healthy food in low-income neighborhoods.

Innovative Loan and Equity Funds

Loan funds provide private investment dollars in the form of low-interest loans for community development efforts. The innovation is either in the criteria that must be met to gain access to those dollars or the source of the funding. For example, the Healthy Futures Fund (HFF) is a $200 million loan fund developed jointly by a national CDFI, the Kresge Foundation, and Morgan Stanley, the for-profit investment bank. HFF incentivizes a particular type of investment by requiring that its resources only go towards the development of community clinics that are built in conjunction with or adjacent to affordable housing. Several hospital systems have created similar community development loan funds. Importantly, in each case the funds are derived from a small fraction of the institutions' investment portfolio, not claimed as part of required community benefit expenditures. For example, Dignity Health, one of the largest healthcare systems in the country, created a $140 million loan fund (representing about 2% of its investment portfolio) that provides financing for community development projects in low-income neighborhoods served by its member hospitals. Another large healthcare system, Trinity Health based in Michigan, has a similar loan fund of $75 million, and Kaiser Permanente announced a $200 million national

affordable housing fund in 2018. In each of these cases, the financial resources are deployed not as grants but as below-market rate loans (e.g., 2-4%) that will be paid back, thus allowing these dollars to be redistributed multiple times.

A more complex investment tool, and to date the only one of its type, is the Boston-based Healthy Neighborhoods Equity Fund (HNEF). Focused on transit-oriented development, HNEF makes equity investments into mixed-use and residential developments in low-income neighborhoods near transit that are vulnerable to gentrification. HNEF blends government tax credits, philanthropic dollars, bank capital, and other private investor dollars including investments from two area hospitals, Boston Medical Center and Boston Children's. Unlike a loan fund that provides assured repayment with interest using the development as collateral, HNEF participants are at-risk equity investors in the neighborhood with no guaranteed return. Rather, they earn revenue from rents —a portion of which are maintained affordable to those making 30-80% AMI—and from the increasing value of the property they partly own. The return is then obtained when the investor later sells their higher value share of the ownership to either the owners of the building or a new investor. This process, in effect, harnesses gentrification to provide a return to investors while preserving commercial space and homes for low-income residents and business owners.

APPENDIX D

Financial Well-being Sector Overview

Throughout the report we use the terms financial health and financial well-being interchangeably and as shorthand to describe the focus area of a diverse group of organizations and companies building financial security, stability, and economic prosperity through their work. While it cannot be technically defined as a sector, the goal of this broad ecosystem is to improve financial health and well-being for millions of households. Together these organizations have a common aim to ensure everyone in this country can have the freedom of choice to build their own financial security, effectively manage day-to-day financial issues, and build long-term financial resilience and wealth.

For many in this ecosystem, their work includes a particular focus on working with low-income people and people of color who have been denied opportunities to build wealth, access quality financial services, and access pathways to achieve financial health and well-being.

This ecosystem includes financial services providers such as banks, credit unions and community development financial institutions (CDFIs); payment providers and financial technology (fintech) innovators; non-profit social service organizations providing financial education and coaching, credit and debt management, and savings opportunities in communities; companies providing similar services to employees and clients; consumer advocates working to promote and protect fair practices and prevent unjust ones; researchers gathering evidence on what's happening in people's financial lives and which solutions work best; regulators setting the rules for consumer and wholesale finance; and policymakers at all levels intersecting with these stakeholders.

People's lives are complex and multifaceted, so addressing financial health and well-being requires a multi-pronged approach. The work of this field aligns with seven broad categories of policies and practices that support the needs of individuals, families and communities.

» **Plan** ahead for expenses, have insurance against emergencies, and be able to make financial decisions and manage resources effectively.

» **Earn** sufficient income through wages, employer benefits, business earnings, public benefits, tax credits or investments to both cover expenses and to save.

» **Spend** and store money and conduct transactions for goods, services, and other expenses safely and within their means.

» Borrow funds on reasonable terms to smooth short-term consumption and to invest in opportunities and wealth-building assets.

» **Save** income left over after covering expenses and debt payments for now, soon, and later savings needs.

» **Own** assets—such as a home, business, or investments—that help build financial stability and wealth.

While the consumer financial services sector has been in operation since the first informal loan was made in this country, a modern-day focus on consumer financial health and well-being—and in particular, what drives inequitable outcomes among lower-income people—has been more recent. The shift began with the 1990 publication of Michael Sherraden's seminal book Assets and the Poor, which highlighted the importance of helping low-income households build not just income, but wealth as a strategy for helping families escape poverty. Because traditional poverty alleviation efforts to date had focused on increasing income, this new framework showed how assets—a home, savings, an education, or a business—is necessary to create a financial buffer to weather emergencies, promote success in the labor market, and help families move up the economic ladder. From this, an entire field of practice, policy, research, product innovation, and philanthropy has developed dedicated to the idea of asset building for low-income households, and in later years, financial health and well-being.

As the field has matured in practice and our understanding of the drivers of wealth inequality have grown, so too has the focus of the work. Early on, *financial education* was the key focus area of the work, building on the notion that increasing knowledge about good financial choices would lead people to make wiser financial decisions. The field quickly realized that education alone was insufficient to address the problems of financial insecurity and wealth inequality. Next, the field focused on coupling financial education with wealth creation strategies, and in particular the creation of the *Individual Development Account (IDA)* in the 1990s, an incentivized savings product earmarked for use in buying a home, starting a business, or investing in post-secondary education.

While IDAs were a great success, the field also began to realize that for many households, it was not the appropriate product, or the right time for such a product. The framework of *financial capability* developed to denote a fuller range of institutions, products, and services that needed to be in place to build the financial security outcomes we were looking for: notably, that individuals not only needed both knowledge *and* skills, but also the opportunity to practice them, by having access to quality products and services in their daily lives. With this financial capability framework as a guide, the fields of financial counseling, coaching, credit counseling and debt management, planning and budgeting, and so much more have been honed over the last decade into a vibrant sector taking

in customer feedback and continually redefining best practice in communities across the country. Fields ranging from education to workforce development to health have integrated these practices and products. Ongoing policy work ensures consumer protections are in place to prevent predatory practices from flourishing and government programs such as the Earned Income Tax Credit (EITC) provide supplemental sources of income to those most in need.

As this field of practice has grown, the rich understanding of both the problem and the ways to address it have continued to evolve. Namely, we have begun to name the drivers of wealth inequality—and in particular the deep divides by race in the U.S.—and the ways our financial services system has existed to create those divides, not erase them. A growing practice around racial wealth inequality and race equity challenges our notions of what are the most effective solutions and the role local and federal policy currently plays in shaping a system that furthers this divide.

The latest paradigm shift in our field has been to further define the outcomes we are looking for. The definitions for *financial health and financial well-being*—distinct but overlapping concepts—were created separately by the Financial Health Network (then known as the Center for Financial Services Innovation, CFSI) and the Consumer Financial Protection Bureau (CFPB), in research published by each organization in 2015 and 2016, respectively. These terms are defined as ensuring people can be in control of their day-to-day finances, absorb financial shocks, meet financial goals (however defined), and be financially free to make choices in life.

And so, this field which has gone from financial education to asset building to financial capability, is referred to in this report as the *financial health and well-being sector.*

This choice of terminology also reflects the growing consensus from the public, non-profit, and, increasingly, the private sector that a focus on achieving financial health and well-being is a shared, mutually beneficial path forward. Early efforts by stakeholders to influence financial services providers to meet the needs of underserved individuals were largely focused on access or "financial inclusion." The terms "unbanked" and "underbanked," describing nearly a quarter of the population that either had no or limited engagement with mainstream finance, were used to highlight the challenge of financial access and encourage financial service providers to recognize the business opportunity in offering these segments financial services. It was the Great Recession, however, that revealed that the challenges facing unbanked and underbanked households were bigger and more pervasive than previously understood.

Through research conducted by CFSI and others on the financial lives of individuals and families, we learned that while access to an account is important, it is no guarantee of broader outcomes. The outcomes we seek should certainly include access to high-quality and affordable products, but also address and support families' financial resilience in the face of volatile income and expenses. Instead of just measuring how many people have an account, there is a recognition that we must consider all of the financial services and programs that people need to take control over their financial lives—from financial-planning tools to manage budgets and expenses; to access to affordable credit to start businesses, purchase homes and invest in higher education; to liquid savings to weather an emergency; to insurance to help deal with unexpected expenses; retirement accounts for long-term savings; and more.

Major Stakeholders

Because financial issues affect so many aspects of life, the major players in this field are diverse and wide-ranging. Here we outline the major categories of interested and involved stakeholders.

Financial Services Providers: Financial services providers include banks, credit unions, CDFIs, asset managers, lenders, and insurance providers. Each of these players has different regulatory frameworks and incentives to address the financial health and well-being of their clients and of the communities in which they work. They provide the backbone infrastructure of the financial health and well-being sector—the checking accounts, savings products, lending vehicles, and insurance products that people use day-to-day to manage their financial lives and achieve financial goals.

Non-Profit Service Providers: A range of direct service non-profits provide the services commonly thought of in the financial capability and asset building field of practice. Non-profit organizations serving low-income communities and individuals with a variety of social services, including emergency assistance, savings programs, wealth-building, workforce development and job training, affordable housing and homeownership may all be integrating these services. Some of these organizations also advocate for public policies at the local, state, and national level that address issues of poverty, wealth inequality, financial predation, and power in communities.

Tax preparers: Tax time is a significant financial event in the lives of low-income people, particularly because of the proportionately large tax refunds many families earn because of the EITC and other refundable tax credits. The IRS runs the Volunteer Income Tax Assistance (VITA) and Tax Counseling for the Elderly (TCE) programs to increase access to free, volunteer-run, quality tax preparation services. Paid tax preparation—an unregulated activity—provides a large share of the services in this industry, including to low-income communities.

Financial Technology Companies: Companies that provide financial services using technological innovations to increase the user-friendliness of financial services and bring financially excluded individuals into the financial system.

Local and State Government: Local and state governments provide services and establish policies that affect the ability of its citizens to improve their financial health and well-being. Increasingly, cities are implementing Offices of Financial Empowerment—often as an initiative of the Treasurer's Office—to coordinate services across city agencies that improve the financial lives of residents. This includes coordinating a Bank On campaign to increase access to banking products with low barriers to entry, embedding financial coaches into other city or state services, or expanding access to VITA sites and the EITC.

Credit Bureaus: Credit bureaus collect data on consumer financial behavior, debt, and other information that makes up a credit score, and provide it to financial institutions. They also sell these data to institutions, including players in the healthcare industry, that use it to make business decisions.

Credit Counseling and Debt Management Agencies: These organizations, both in the for-profit and nonprofit sector, assist consumers struggling with debt issues to negotiate with lenders, pay off debt, and repair credit scores.

Consumer Advocates: Advocates—sometimes single organizations and often coalitions or networks of organizations—strive to represent the consumer voice in legal and policy matters such as banking industry regulation, payday lending rules, housing affordability matters, and in other places where consumer financial issues are being regulated or affected by policy decisions at the local, state, and federal level.

Regulators: The financial services industry has a complex array of regulatory bodies at the state and federal levels, including the Federal Reserve Banks, the Federal Deposit Insurance Corporation (FDIC), the Office of the Comptroller of the Currency (OCC), the Consumer Financial Protection Bureau (CFPB), and state banking supervisors.

Benefits and Payroll Providers: Providers offering benefits including retirement, life insurance, and payroll processing are a key part of individuals' daily financial lives and a key partner for employers. For example, they may support people saving for retirement in a 401k or making tax-free payroll deductions. Increasingly, they are partnering with large employers and others to support employees' financial health.

Key Terms

Asset Building: Asset building refers to strategies that increase financial and tangible assets, such as savings, a home, and businesses of all kinds.

Children Savings Accounts (CSAs): CSAs are long-term, incentivized accounts, established for children as early as birth. Accounts are usually seeded with an initial deposit and built by contributions from family, friends, and the children themselves. Accounts are augmented by savings matches and/or other incentives, and the savings are used to purchase an asset—typically to finance postsecondary education.

Community Development Financial Institution (CDFI): CDFIs are private financial institutions that are 100% dedicated to delivering responsible, affordable lending to help low-income, low-wealth, and other disadvantaged people and communities join the economic mainstream.

Consumer Protection: Consumer protection refers to policies and practices that protect consumers from financial abuse.

Credit Building: Credit building supports clients with no credit history or a thin credit file with beginning to establish a positive credit record—such as through opening a small dollar installment loan or a secured credit card—and assisting clients with low credit scores to improve them through good credit behaviors (e.g., paying credit card bills on time).

Financial Education: Financial education is generally one or more standalone workshops or classes that involve the transfer of information, often in a group setting, on a specific set of topics such as how to budget, use mainstream financial products, save, manage credit, reduce debt, access available tax credits, and more.

Financial Capability: Financial capability is the capacity, based on knowledge, skills, and access, to manage financial resources effectively.

Financial Coaching: Financial coaching is one-on-one interactions between a coach and participant that empower participants to set and achieve their unique financial goals through behavior change and skill development.

Financial Counseling: Financial counseling is one-on-one sessions driven by a counselor to help clients address specific financial matters like managing credit or purchasing a home.

Financial Health: Financial health occurs when people's day-to-day financial systems build long-term resilience and opportunity.

Fin Tech: Fin tech refers to any technology used to provide financial products and services to consumers, including online personal finance tools, mobile payment, and virtual loans and savings products.

Financial Well-being: Financial well-being occurs when people have control over their day-to-day and month-to-month finances, financial freedom to make choices to enjoy life, and capacity to absorb a financial shock; and are on track to meet financial goals.

Individual Development Accounts (IDAs): IDAs are matched savings accounts that help low-income individuals save money to buy a home, start a business, obtain a post-secondary degree, or purchase another type of financial asset.

Lending Circles: Lending circles consist of 6-12 people that contribute a set amount of money each month, and the person who receives the pool of money, or "loan," alternates each month.

Neighborhood Financial Health: Neighborhood financial health refers to the neighborhood conditions that promote long-term financial resiliency and opportunity for residents and provide resources that residents use to spend, save, borrow, and plan for life. In turn, financial health among residents contributes to a strong and cohesive neighborhood and local economy. Neighborhood financial health can be measured by the prevalence of supportive institutions, actors, and goods and services in a community, as well as residents' collective financial health.

APPENDIX E

Interviews

Abby Hughes Holsclaw, Senior Director at Asset Funders Network on February 9, 2018

George Reuter, Director of Learning and Impact, Compass Working Capital, on December 20, 2018

Leigh Philips, President & CEO, and Tim Lucas, Director of Research, EARN, on June 4, 2019

Ashley Conners Sherwin, Vice President of External Affairs, and **Jesus Gerena**, CChief Executive Officer, Family Independence Initiative, on January 7, 2019

Bill Druliner, [former] Director of Strategic Partnerships, GreenPath Financial Wellness, on August 21, 2017

Bill Druliner, [former] Director of Strategic Partnerships, GreenPath Financial, and **Tom Jacobson**, Executive Director, Rural Dynamics, Inc. and Director of Strategic Partnerships, GreenPath Financial Wellness, on January 4, 2019

Matt Josephs, Senior Vice President, Local Initiatives Support Corporation, on February 11, 2019

Kimberly Cutcher, Executive Director, Local Initiatives Support Corporation Toledo, on December 6, 2018

Valeria Moffitt, Director of Financial Opportunities, Local Initiatives Support Corporation Toledo, on December 6, 2018

Julia Ryan, Vice President, Health Initiatives, Local Initiatives Support Corporation, on December 6, 2018

Robert Cashman, President & CEO and **Charlene Bauer**, Senior Vice President, Outreach, Advocacy & Chief Development Officer, Metro Credit Union, on February 27, 2019

Gigi Hyland, Executive Director, The National Credit Union Foundation, on August 14, 2018 and December 17, 2018

Nicole R. Perry, Deputy Commissioner for the Office of Financial Empowerment, and **Nichole Davis**, Director of Programs for the Office of Financial Empowerment, New York City Department of Consumer Affairs and New York City Office of Financial Empowerment, on January 4, 2019

Oxiris Barbot, MD, Commissioner, New York City Department of Health and Mental Hygiene, on March 27, 2019

Jennifer Talansky, Managing Director, Knowledge and Impact, Nonprofit Finance Fund, on June 3, 2019

Kate Sommerfeld, President, Social Determinants of Health, ProMedica, on December 6, 2018

Mary Dupont, Director of Financial Empowerment, $tand by Me, Delaware Department of Health and Social Services Statewide, on December 3, 2018

Lucy Marcil and **Michael Hole,** Co-Founders, StreetCred, on December 11, 2018 and January 3, 2019

Michael Mirra, Executive Director and **Amy Van**, Project Manager, Tacoma Housing Authority, on December 20, 2018

Adam Schickedanz, MD, Research Fellow, University of California, Los Angeles, on February 14, 2019

Padmini Parthasarathy, Senior Program Officer, Walter & Elise Haas Fund's Economic Security program, August 14, 2017 and February 8, 2019

APPENDIX F

Focus Groups

Health Clinic, Session September 5, 2018 at Prosperity Summit in Washington, D.C.

List of Registrants

Megan Bautista, CASH Campaign of Maryland

Denise Belser, National League of Cities

Courtnee Biscardi, Urban League of Broward County

Kelvin Boston, Moneywise TV

Candice Cambridge, TD Bank, N.A.

Samantha Canton, AHEAD Inc.

Austin Carrico, Prosperity Now

Annette Case, Asset Funders Network

Andrea Caupain Sanderson, Byrd Barr Place

Carrie Cook, GreenLight Charlotte

Kris Cooley, Ability360

Melanie Crecy, IRC

Anna Cunningham, NC Council on Developmental Disabilities

Laura D'Alessandro, Local Initiatives Support Corporation

Anagha Das, Bank of America (former)

Marvin DeJear, DMACC/Evelyn K. Davis Center for Working Families

Santra Denis, Catalyst Miami

Mathieu Despard, Washington University in St. Louis

Alison Donovan, VEIC

MC Dyalekt, Brunch & Budget Podcast

Ryan Easterly, WITH Foundation

Kendra Edlin, Montana's Credit Unions for Community Development

Kimberly Edmonds, Virginia Cooperative Extension-Henrico County

Jeannine Esposito, Self-Help Federal Credit Union

Sakuri Fears, LISC Milwaukee

Donita Fischer, Four Bands Community Fund

Philip Getz, Navicore Solutions

Nan Gibson, JPMorgan Chase

Lars Gilberts, University District Development Association

Cary Gladstone, Granite United Way

Sarah Gordon, Financial Health Network (formerly CFSI)

Michelle Gorsuch, ProMedica Health Systems

Kate Griffin, Prosperity Now

Michal Grinstein-Weiss, Washington University in St. Louis

Mario Gutierrez, New York Legal Assistance Group

Susan Harlos, Coconino County Community Services Department

Kadija Hart, Belair-Edison Neighborhoods, Inc.

Shaheen Hasan, Center for Financial Services Innovation (CFSI)

Patricia Hasson, Clarifi

Logan Herring, Kingswood Community Center

Gail Hillebrand, Consumer Financial Protection Bureau

Krista Holub, Intuit Tax and Financial Center

Amanda Hunsucker, OnTrack WNC Financial Education & Counseling

Adrian Ilchuk, American Center for Credit Education

Anneth Izquierdo, Americorps Public Allies

Tom Jacobson, Rural Dynamics, Inc.

Nicholas Jaegar, Minneapolis Urban League

Laurie Jensen-Wunder, American Cancer Society

Johannessen, Elaina LSS Financial Counseling

Don Jonas, PhD, Care Ring

Martha Kanter, College Promise Campaign

Katrin Sirje Kärk, Rural LISC

Rota Knott, Somerset County Local Management Board, Inc.

Ashley Kohlrus, Allegacy Federal Credit Union

Andrew Ladd, Communities In Schools/ Charlotte-Mecklenburg

Kate Larose, CVOEO

Angel Lee, Prosperity Now

Meg Lovejoy, Institute on Assets and Social Policy Brandeis University

Sangeetha Malaiyandi, Bureau of Consumer Financial Protection

Melody Marchese, Belmont Housing Resources for WNY, Inc.

Wil McCall, Dallas Leadership Foundation

David McGee, Build Wealth Minnesota

Regina McGee, Build Wealth Minnesota

Penny McPherson, Wells Fargo

Elsie Meeks, Lakota Funds

Monica Mitchell, Wells Fargo

Erin Moos, Intuit Financial Freedom Foundation

Greg Morishige, Wells Fargo

Mercedeh Mortazavi, JPMorgan Chase

Amy Nelson, University of Nevada, Reno

VanNhi Nguyen, LISC Houston

Cameron Nicholson, YMCA

Erin Offord, Big Thought

Becky Pakarinen, Lutheran Social Service of Minnesota

Padmini Parthasarathy, The California Wellness Foundation (former)

Sonya Passi, FreeFrom

Marjorie (Marne) Piccolomini, CFC-Cleveland Neighborhood Progress

Walkiria Pool, Centro de Apoyo Familiar

Francis Poole, Juma Ventures

Andrew Posner, Capital Good Fund

Michelle PRISM, PRISM

Roslyn Quarto, Empowering and Strengthening Ohio's People

Richard Reeve, CCCS of Savannah

Kate Reeves, The Financial Clinic

Katherine Rios, UnidosUS

Jorge Riquelme, Community Housing Works (CHW)

Stephen Roll, Washington University in St. Louis

Kelly Rome, Prudential Financial

Karina Ron, United Way of Miami Dade

Michael Roush, National Disability Institute

Luella Sanders, United Way of the Plains

Diane Sandoval,Guadalupe Credit Union

Adam Schickedanz, MD, UCLA

Donald Schwarz, Robert Wood Johnson Foundation

Gregory C. Scott, Community Action Partnership of Orange County

Anindya Sengupta, Prudential / Strategic Initiatives

Kenneth Smith,Grace Mar Services Inc

Nashila Somani-Ladha, Commonwealth

Carter Steger, American Cancer Society Cancer Action Network

Bea Stotzer, New Capital LLC

Kimberly Tang, Chinese Community Center

Kalena Thomhave, The American Prospect

Karan Tucker, Jannus, Inc.

Emy Urban, The Aspen Institute

Lindsey Vaclav, Accounting Aid Society

Tracy Wiedt, American Cancer Society

Katina Williams, United Way of Greater Richmond & Petersburg

Kenneth Worthey, National Credit Union Administration

EMERGE Financial Health Forum
June 6, 2018 at the CFSI's annual EMERGE Financial Health Forum in Los Angeles

List of Attendees

Charlene Bauer, Metro Credit Union

Katie Beacham, Fiserv

Marcus Berkowitz, Grameen America

Nathan Bidnet, Charles Schwab

Jeremy Burke, USC Center for Economic and Social Research

Michael Bush, Great Place to Work

Louis Caditz-Peck, Lending Club

Jimmy Chen, Propel

Kristin Crellin, SchoolsFirst Federal Credit Union

Laura D'Alessandro, LISC

David Derryck, EARN

Bill Druliner, GreenPath

Tracy Faleide, WEX Health

Abbie Gilbert, Humana

Melissa Gopnik, Commonwealth

Andrea Green, LaGuardia Community College

Lisa Hasegawa, National CAPACD (former)

David Kilby, FinFit

Peter Long, Blue Shield of California Foundation

Abigail Marquez, Housing and Community Investment Department, City of Los Angeles

Tom More, BCU

Rachel Van Noord, BECU

Kimberly Ostrowski, Prudential Financial

Padmini Parthasarathy, California Wellness Foundation (former)

Jake Peters, Payperks

Sabra Purifoy, Department of Consumer and Business Affairs, Los Angeles County

Michelle Rhone-Collins, LIFT-LA

Anne Romatowski, JPMorgan Chase

Kristen Simmons, Experian Health

Bea Stotzer, NEW Capital LLC

Andrew Weltman, Union Privilege

Sarah Willis, Metlife Foundation

APPENDIX G

List of Resources

Sources	Organization(s)	Author(s)
100 Million and Counting: A Portrait of Economic Insecurity in the United States	Policy Link, USC Program for Environmental & Regional Equity	
2016 SCF Chartbook	Federal Reserve	
A Municipal Policy Blueprint for a More Inclusive Path to Prosperity	Prosperity Now	Holden Weisman
Home Delinquency Rates Are Lower Among ACA Marketplace Households: Evidence From a Natural Experiment	The Center for Social Development, George Warren Brown School of Social Work	Emily A. Gallagher, Radhakrishnan Gopalan, Michal Grinstein-Weiss, Stephen P. Roll, and Genevieve Davison
The African American Financial Capability Initiative: An Implementation Blueprint	Prosperity Now African American Financial Capability Initiative	Cat Goughnour and Lillian Singh
Alliance for Health Equity	Alliance for Health Equity	
Antipoverty Impact Of Medicaid Growing With State Expansions Over Time	*Health Affairs*	Naomi Zewde and Christopher Wimer
ASPPH: Discover	Association of Schools and Programs of Public Health	
Financial Coaching: An Asset Building Strategy	Asset Funders Network	Dr. J. Michael Collins
Assets for Independence Program Report to Congress: Status at the Conclusion of the Sixteenth Year, Fiscal Year 2015	U.S. Department of Health and Human Services	
Better for Employees, Better for Business: The Case for Employers to Invest in Employee Financial Health	Financial Health Network, Morgan Stanley	
Beyond Health Care: New Directions to a Healthier America	Robert Wood Johnson Foundation	
Bound: How Race Shapes the Outcomes of American Cities	Prosperity Now	Lebaron Sims
Building Savings for Success: Early Impacts from the Assets for Independence Program Randomized Evaluation	Urban Institute	Gregory B. Mills, Signe-Mary McKernan, Caroline Ratcliffe, Sara Edelstein, Mike Pergamit, Breno Braga, Heather Hahn, Sam Elkin
Can Savings Help Overcome Income Instability?	The Urban Institute	Gregory Mills, Joe Amick
CFE Coalition City Expert Topics: Reentry Integration Strategies	Cities for Financial Empowerment Fund	
Fifth Avenue Committee (FAC)	Change Capital Fund	
Cleveland's Greater University Circle Initiative: An Anchor-Based Strategy for Change	The Democracy Collaborative	Walter Wright Kathryn W. Hexter Nick Downer
Consumer Debt: A Primer	The Aspen Institute	

Sources	Organization(s)	Author(s)
Consumer Financial Health Study: Understanding and Improving Consumer Financial Health in America	Financial Health Network	Aliza Gutman, Thea Garon, Jeanne Hogarth, Rachel Schneider
Consumer Fraud in the United States, 2011: The Third FTC Survey	Federal Trade Comission	Keith B. Anderson
Coping with Costs Big Data on Expense Volatility and Medical Payments	JPMorgan Chase & Co. Institute	Diana Farrell, Fiona Greig
County Health Rankings and Roadmaps - Policies and Programs That Can Improve Health	Robert Wood Johnson Foundation	
County Health Rankings & Roadmaps: Unemployment	Robert Wood Johnson Foundation	
Data by Issue	Prosperity Now Scorecard	
Digest of Education Statistics 2016	National Center for Education Statistics, American Institutes for Research	Thomas D. Snyder, Cristobal de Brey, Sally A. Dillow
DotHouse Health	DotHouse Health	
Economic Mobility: Research & Ideas on Strengthening Families, Communities & the Economy	Federal Reserve Bank of St. Louis, the Board of Governors of the Federal Reserve System	
Effects of a Tax-Time Savings Experiment on Material and Health Care Hardship among Low-Income Filers	*Journal of Poverty*	Mathieu R. Despard, Samuel Taylor, Chunhui Ren, Blair Russell, Michal Grinstein-Weiss, Ramesh Raghavan
Employee Financial Health: How Companies Can Invest in Workplace Wellness	Center for Financial Services Innovation (CFSI)	Sohrab Kohli, Rob Levy,
Enterprise Opportunity 360 Measurement Report	Enterprise Community Partners	
Evaluation of the Compass Family Self-Sufficiency (FSS) Programs Administered in Partnership with Public Housing Agencies in Lynn and Cambridge, Massachusetts	Abt Associates, Compass Working Capital, U.S. Department of Housing and Urban Development	Judy Geyer, Lesley Freiman, Jeffrey Lubell, Micah Villarreal
Fifth Third Express Banking	Fifth Third Bank	
U.S. Financial Health Pulse: 2019 Trends Report Baseline Survey Results	Financial Health Network	Beth Brockland, Thea Garon, Andrew Dunn, Eric Wilson, Necati Celik
Financial Well-being: The Goal of Financial Education	Consumer Financial Protection Bureau	
Health and Financial Wellbeing: Two Good Things That Go Better Together	The National Credit Union Foundation	Christiane Gigi Hyland, Christopher J. Revere
Health Care and Opportunity Zones: The Game Begins	The New Localism	Ken Gross, Evan Weiss, Bruce Katz
Healthcare Anchor Network	Healthcare Anchor Network	
Household Financial Stability and Income Volatility	Center for Household Financial Stability Federal Reserve Bank of St. Louis	Ray Boshara

Sources	Organization(s)	Author(s)
How Neighborhoods Help New Yorkers Get Ahead Findings From the Collaborative for Neighborhood Financial Health	New York City Department of Consumer Affairs	
In the World of Community Wealth-Building, Ownership Has Its Privileges	ShelterForce	Tamara E. Holmes
Key Resources to Help Your Organization Adopt and Improve Financial Capability Services	Prosperity Now	Melissa Grober-Morrow
Labor Force Statistics from the Current Population Survey	United States Department of Labor, Bureau of Labor Statistics	
Leveraging Innovation to Support the Financial Health of LMI Families with Children	Financial Health Network	Josh Sledge, Aliza Gutman, James Schintz, Rachel Schneider
National Health Expenditure Data , Historical	Centers for Medicare & Medicaid Services	
Neighborhood Network Analysis Pre Read	The Boston Consulting Group, United Way of Metro Chicago	
Neighborhood Poverty and Household Financial Security	The Pew Charitable Trusts	
New America: Overview	New America	
Paying for Healthcare in America	Wex Inc.	
Paying Out-of-Pocket: The Healthcare Spending of 2 Million US Families	JPMorgan Chase & Co. Institute	Diana Farrell, Fiona Greig
Preparing for Tomorrow by Fixing Today: Helping Low- and Moderate-Income Americans Thrive in Retirement	Center for Financial Services Innovation (CFSI)	Karen Andres, Katy Golvala
Prosperity Now, 2019 Scorecard	Prosperity Now	
Prosperity Now, Getting a Head Start	Prosperity Now	
Race Matters: The Concentration of Payday Lenders in African-American Neighborhoods in North Carolina	Center for Responsible Lending	Uriah King, Wei Li, Delvin Davis, Keith Ernst
Report on the Economic Well-Being of U.S. Households in 2017	Board of Governors of the Federal Reserve System	
Responses to and Repercussions from Income Volatility in Low- and Moderate-Income Households: Results from a National Survey	The ASPEN Institute, The Center for Social Development, George Warren Brown School of Social Work, Intuit	Stephen Roll, David S. Mitchell, Krista Holub, Sam Bufe, Michal Grinstein-Weiss
Routinizing the Extraordinary	Investing in What Works for America's Communities	David Erickson, Ian Galloway, Naomi Cytron
Scaling Financial Coaching: Critical Lessons and Effective Practices	NeighborWorks America and Citi Foundation	
Scaling Financial Development: Improving Outcomes and Influencing Impact	The Financial Clinic	Rebecca Smith, Mae Watson Grote and Karina Ron
Smart Organizations, Strong Neighborhoods: Measurable, Scalable Impact	Change Capital Fund	

Sources	Organization(s)	Author(s)
Strategies for Building Healthy, Equitable Community	Get Healthy San Mateo County	
Strengthening Santa Fe Through Affordable Home Ownership	Homewise	
Tacoma Housing Authority's Children's Savings Account Program Evaluation Interim Report	Urban Institute for theTacoma Housing Authority	Martha Galvez, Brandi Gilbert, Alyse Oneto, Nicole DuBois
The Consequences of Gentrification: A Focus on Residents' Financial Health in Philadelphia	*Cityscape,* U.S. Department of Housing and Urban Development, Office of Policy Development and Research	Lei Ding, Jackelyn Hwang.
The Experience of Volatility in Low and Moderate-Income Households: Results From a National Survey	The ASPEN Institute, The Center for Social Development, George Warren Brown School of Social Work	Stephen Roll, David S. Mitchell, Sam Bufe, Gracie Lynne, Michal Grinstein-Weiss
The Impacts of Neighborhoods on Intergenerational Mobility I: Childhood Exposure Effects.	National Bureau of Economic Research	Raj Chetty, Nathaniel Hendren
The Movement Takes Off: The State of the Children's Savings Filed 2017	Prosperity Now	
The Potential of Downpayment Assistance for Increasing Homeownership Among Minority and Low-Income Households	U.S Department of Housing and Urban Development, Office of Policy Development and Research (PD&R)	Christopher E. Herbert, Winnie Tsen
The Road to Zero Wealth How the Racial Wealth Divide is Hollowing Out America's Middle Class	Prosperity Now, Institute for Policy Studies	Emanuel Nieves, Chuck Collins, Josh Hoxie
The Role of Emergency Savings in Family Financial Security: How Do Families Cope with Financial Shocks?	The Pew Charitable Trusts	
The State of the Nation's Housing 2018	The Joint Center for Housing Studies of Harvard University	
Universal Accounts at Birth: Results from SEED for Oklahoma Kids	The Center for Social Development, George Warren Brown School of Social Work	Sondra G. Beverly, Margaret M. Clancy, Michael Sherraden
Urban Wire, Housing and Housing Finance: An Innovative Model for Reducing Gaps in Homeownership	Urban Institute	Christina Plerhoples Stacy, Brett Theodos, Bing Bai
Wage Stagnation in Nine Charts	Economic Policy Institute	Lawrence Mishel, Elise Gould, Josh Bivens
Wealth Matters for Health Equity	University of San Francisco, Robert Wood Johnson Foundation	Paula Braveman, Julia Acker, Elaine Arkin, Dwayne Proctor, Amy Gillman, Kerry Anne McGeary, Giridhar Mallya
wellQ	wellQ	
What Could We Have Expected from a $10 Minimum Wage in the City of St. Louis?	Federal Reserve Bank of St. Louis	Charles Gascon, Daniel Eubanks
What Is Health Equity? And What Difference Does a Definition Make?	University of California San Francisco, Robert Wood Johnson Foundation	Paula Braveman, Elaine Arkin, Tracy Orleans, Dwayne Proctor, Alonzo Plough
What It's Worth - Strengthening the Financial Future of Families, Communities and the Nation	Federal Reserve Bank of San Francisco, Prosperity Now	Editors: Laura Choi, David Erickson, Kate Griffin, Andrea Levere, Ellen Seidman

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