

The Evolution and Future of the Healthy Communities Movement

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Over the past four decades, the Healthy Communities movement has transformed traditional definitions and approaches to health. Driven by the disconnect between health spending and health outcomes, growing awareness of the importance of the social determinants of health,¹ and the need to address poverty as a means of improving health, philanthropic organizations, nonprofits, and government agencies are leading efforts to ensure that good health is happening where we live, learn, work, and play.

Since it began, the Healthy Communities movement has been driven largely by public health. However, the movement's efforts in the past two decades have been marked by a convergence of sectors that are collectively revitalizing communities with health equity and economic opportunity in mind. Healthy Communities 2.0—what we are calling the current era of place-based efforts to improve health—marks a transition from a previous focus on multi-sector movement building to cross-sector action with broader definitions of health. “Community quarterbacks,” or backbone organizations, are still critical to implementation and are bringing new partners to the table, while innovations in community development finance are enabling neighborhoods and regions to leverage public and private financing in new ways. However, current efforts only scratch the surface of the system-wide changes necessary to truly reverse inequities in health and well-being. Challenges remain in meeting needs for funding, ensuring sustainability of efforts, and approaching community health improvement in a context-specific, sensitive way.

In looking ahead to Healthy Communities 3.0, local and regional initiatives play an important role in moving their health equity goals forward in light of changing political and economic environments. Key priorities for the field include coordinating efforts across cities and regions, connecting rural and non-urban communities to capital, routinizing measurement, and leveraging private investment. This article draws upon an environmental

¹ This paper defines social determinants of health in line with the World Health Organization's definition: “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 (see healthypeople.gov). 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 (Jargon Buster, Build Healthy Places Network).

scan of 38 Healthy Communities demonstration programs² and provides an overview of the history, progress, and future implications of the Healthy Communities movement.

The Origins of the Healthy Communities Movement

The Healthy Communities movement in America has its roots in the international Healthy Cities movement, spearheaded by the World Health Organization in the 1970s and 1980s (see Figure 1). Early efforts emphasized cross-sector collaboration, community participation, and empowerment of communities to build healthier cities, with a critical role for government agencies in particular.³ By the late 1980s and early 1990s, federal agencies, national nonprofits, health foundations, and health care systems formalized the Healthy Communities concept through initiatives of varying scale but with a common focus on “place” and the impact of neighborhoods on health. It is important to note that these early efforts, what we call Healthy Communities 1.0, aspired toward cross-sector collaboration but often resulted in parallel efforts without integration across sectors.

Truly coordinated cross-sector efforts proliferated in the 2000s under the leadership of health foundations, such as the Robert Wood Johnson Foundation (RWJF), and health care systems, such as Kaiser Permanente. RWJF’s Commission to Build a Healthier America, established in 2008, and the Foundation’s subsequent grantmaking to support cross-sector Healthy Communities efforts nationwide nurtured collaboration across the community development, public health, and health care sectors. A case in point is the Federal Reserve’s national Healthy Communities Initiative, which convenes community development financial institutions (CDFIs) and health practitioners to strategize cross-sector collaborations. In addition, philanthropic organizations and the community development sector have emerged as leading partners in Healthy Communities work. For example, The California Endowment’s Building Healthy Communities Initiative (launched in 2010) set the stage for numerous grant programs nationwide that support the development of local coalitions to implement Healthy Communities efforts.⁴

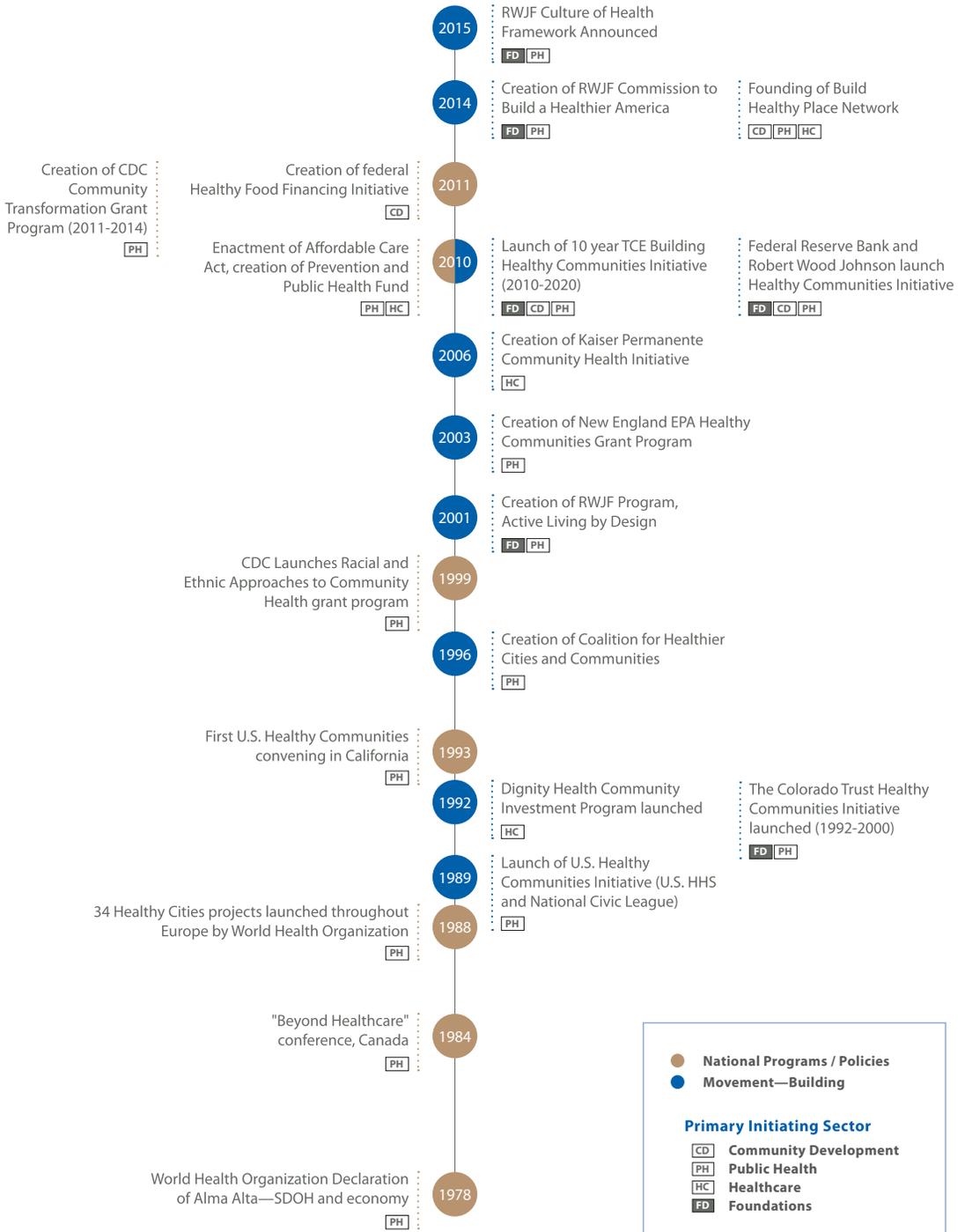
Health care reform has also played a key role in bridging sectors for place-based health initiatives. Most notably, the Affordable Care Act of 2010 catalyzed Healthy Communities efforts across sectors through its focus on health care access, preventive health, and its new requirements for hospitals to engage with and reinvest in the communities they serve. Leveraging the momentum of expanding cross-sector collaborations and significant policy reform, RWJF established the Build Healthy Places Network (BHP Network) in 2014 to actualize the Commission’s goals to “fundamentally change the way we revitalize neighborhoods by fully integrating health and community development.”

2 Refer to the larger report for additional details: Colby Dailey, Renee Roy Elias, and Alison Moore, “Summarizing the Landscape of Healthy Communities: A Review of Demonstration Programs Working Towards Health Equity.” A Report for The Colorado Health Foundation by Build Healthy Places Network (2016).

3 See Jason Cornburn, *Toward the Healthy City: People, Places, and the Politics of Urban Planning* (Boston: MIT Press, 2009).

4 The California Endowment, “Building Healthy Communities.” (Los Angeles: The California Endowment, 2016).

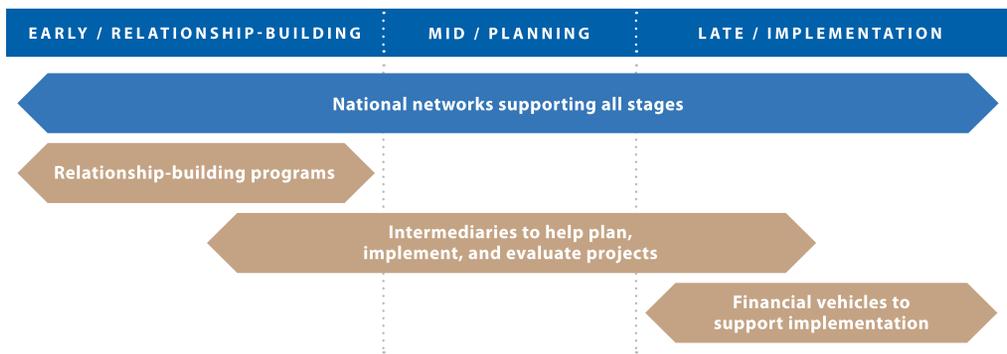
Figure 1: Selected Healthy Communities Milestones, 1970s-Present



Healthy Communities 2.0: Cross-Sector Action as a Pathway

Healthy Communities 2.0 reflects the idea that no one organization has all the assets, resources, knowledge of—and relationships in—the community, and expertise needed to fully achieve Healthy Community goals. Cross-sector partnerships are crucial to the success of these efforts. Although the specific goals of Healthy Communities initiatives vary widely, the efforts can be broadly categorized by their relative position along an “implementation pathway,” which is divided into three stages: (1) early stage, which focuses on relationship-building; (2) middle stage, where intermediaries help to plan, implement, and evaluate efforts; and (3) late stage, where financial vehicles play a role in supporting implementation (see Figure 2). Across all stages, national networks are critical for sharing learning, connecting partners, and generating new ideas.

Figure 2: Healthy Communities Implementation Pathway



Early Stage: Relationship-Building Programs

In the early stages, collaborative partners benefit from supports that help them collectively define problems, create a vision, and build relationships. Such efforts can take many forms. For example, the BUILD Health Challenge funds neighborhood initiatives that strengthen existing partnerships among local nonprofit organizations, health systems, and local health departments. Relationship-building could also involve cultivating trust and mutual understanding across key individuals in a more decentralized fashion. For example, the Kate B. Reynolds Charitable Trust’s Healthy Places NC program invests in efforts to deepen relationships across local, regional, and state-level stakeholders with the goal of developing a diverse infrastructure to address health-related issues. Healthy Places NC tailors its relationship-building approach to the unique context and availability of human capital within small rural communities.

Middle Stage: Intermediaries Support the Work

Once communities have built relationships across the health and community development sectors and established commitment to a shared vision, intermediaries can help to plan, implement, and evaluate projects. For example, Purpose Built Communities supports communities that have made a commitment to implementing the Purpose Built model, initiated or secured a community quarterback to coordinate the program, and have assets like land or other real estate available for development.⁵ Another intermediary program, ReThink Health, engages more developed regional coalitions who have the capacity to move from aligning stakeholders to “altering current business models, redesigning core practices and policies, allocating resources, and forming new partnerships.”⁶

Late Stage: Financial Vehicles to Support Implementation

Larger investment programs (namely, new financial vehicles)—for example, Dignity Health’s Community Investments—support the implementation process, such as capital investments for affordable housing or grocery stores. Another example is Equity with a Twist, which provides flexible capital to grantees that are already in the middle to late stages of planning and implementation and must demonstrate “exceptional organizational capacity, a stable financial history, and strong financial position.”⁷ The Healthy Futures Fund provides grant, loan, and equity capital to build co-located affordable housing and community health centers. Finally, Invest Health is a new initiative that helps leaders of mid-sized cities leverage private and public investments to accelerate health improvements.

Across All Stages: National Networks

National networks, such as BHP Network and County Health Rankings and Roadmaps, provide general support across all stages through technical assistance and the production of tools and resources. Although technical assistance varies across programs, frequently mentioned activities include data collection and evaluation; convening, facilitation, and network support; and measurement. A critical component of national networks is the formation of learning communities, which are an invaluable part of the Healthy Communities process, even beyond program or grant terms. Learning communities aid in relationship-building, help partners establish trust with funders, and provide a place to share best practices as communities progress along the pathway.

Although Healthy Communities efforts generally fall at different stages of the pathway, it is important to note that cross-sector action is dynamic—communities and their initiatives may need to cycle back to earlier stages as the vision and planning for Healthy Communities evolves.

5 See the article by Carol Naughton in this issue for more on Purpose Built Communities.

6 ReThink Health, “Pathway for Transforming Regional Health.” ReThink Health Tools.

7 Low Income Investment Fund, “The Low Income Investment Fund and JPMorgan Chase Pilot Innovative \$6 Million Social Investment in Nation’s Distressed Communities.” Media release (San Francisco: Low Income Investment Fund, February 2, 2016).

The Role of the Community Quarterback

The continued leadership of community quarterbacks, “trusted and established organizations that can articulate a vision, marshal funding sources, and align the efforts of multiple efforts towards common goals” is a hallmark of Healthy Communities 2.0.⁸ Many early community quarterbacks represented the community development sector (such as community development corporations, community foundations, or social service providers), but increasingly, representatives from the public health and health care sectors are stepping into this role.⁹ For example, the Harris County Public Health and Environmental Services Department in Pasadena, TX, received two national investment program grants: BUILD Health Challenge and the BHP Network’s Joining Forces Grant. Both grants are supporting the department’s efforts to lead the development of a Healthy Food Financing Plan that explores alternatives for scaling up commercial urban farms in Pasadena.

Additionally, hospitals and health care systems are expanding their role as anchor institutions to assume a community quarterback role in local and regional health equity efforts.¹⁰ Not unlike community quarterbacks, hospitals and health care systems are rooted in their local communities by mission, invested capital, or relationships. For example, the Cleveland Foundation continues to serve as an anchor and convener of other anchor institutions—bringing together the Cleveland Clinic and University Hospital, Case Western Reserve University, and other community groups to implement neighborhood revitalization efforts. Providing a neutral platform and leadership for a common vision, the Cleveland Foundation enabled an innovative partnership among institutions that might have otherwise been competitors in the project’s early relationship-building stages. Anchor institutions are powerful potential partners in a community quarterback’s network. They can demonstrate leadership through real estate development, workforce training and local hiring, local procurement practices that impact local economies, investment, potential for capital, and low-interest loan financing to CDFIs, and other functions that address a community’s social determinants of health.

However, the community quarterback’s ability to marshal resources and align multiple efforts depends heavily on the local context and organizational infrastructure present in a region. For example, many community development and Healthy Communities efforts tend to focus on urban areas; these examples of community quarterbacks must be adapted to the local context of rural Healthy Communities efforts. The Kate B. Reynolds Charitable Trust’s Healthy Places NC program tailors its relationship-building approach to the specific needs of small, rural communities in North Carolina. As an alternative to traditional funder-driven approaches, Healthy Places NC instead facilitates a more spontaneous collaboration,

8 Partners in Progress, “The Community Quarterback Model: A Valuable Asset for Cities.” 2016.

9 Dailey, Elias, and Moore, “Summarizing the Landscape of Healthy Communities.”

10 Tyler Norris and Ted Howard, “Can Hospitals Heal America’s Communities?” (Washington, DC: Democracy Collaborative, 2015).

building upon long-standing, informal relationships that already exist in communities and helping individuals and organizations decide if partnership is feasible.¹¹

Community Development as a Partner to Public Health and Health Care

In contrast with the early days of the Healthy Communities movement, today the community development sector is increasingly at the table, both as an investor and an implementation partner. For example, CDFIs are now serving as co-investors alongside private banks, health foundations, and hospitals and health care systems. The BHP Network's Joining Forces grant program has supported partnerships between CDFIs and BUILD Health Challenge grantees in the middle stages of their efforts, which have largely involved closing deals and financing for new development. Finally, the Healthy Futures Fund is a partnership between the Local Initiatives Support Corporation (LISC, a national CDFI), Morgan Stanley, and the Kresge Foundation, which helps close funding gaps and leverage new capital in the late stages of Healthy Communities implementation.

With new awareness of the importance of measuring the health-related outcomes of community development efforts, the sector is increasingly partnering with public health on measurement strategies. For example, BUILD Health grantee East Bay Asian Local Development Corporation is partnering with the Alameda County Department of Public Health to devise a measurement strategy as it implements a commercial revitalization effort in Oakland, CA. At the federal level, the Centers for Disease Control (CDC)'s subcommittee, the National Committee on Vital and Health Statistics (NCVHS), is working to develop a measurement framework that incorporates the social determinants of health. This framework seeks to align federal initiatives and investment to support communities working with data at the neighborhood level. Additionally, the recently released 500 Cities Project provides city- and census tract-level, small-area estimates for chronic disease risk factors, health outcomes, and clinical preventive service use for the largest 500 cities in the United States. A project of the CDC Foundation and RWJF, these new data will help cities and local health departments understand health outcomes at the neighborhood level, and how they fit in a larger context of social determinants.¹² There are still opportunities for the public health sector to understand how community development can be part of its ongoing efforts, but these pilot initiatives are a significant step in the right direction.

11 The idea of a more spontaneous collective impact comes from Douglas Easterling's article, "Getting to Collective Impact: How Funders Can Contribute Over the Life Course of the Work," *The Foundation Review* 5 (2) (2013).

12 Centers for Disease Control and Prevention (CDC), "500 Cities: Local Data for Better Health." (Atlanta, GA: CDC, 2017).

Looking Ahead to Healthy Communities 3.0

Though the Healthy Communities movement has evolved significantly over the past four decades, the basic principles remain: Place matters, health is influenced by social determinants, and everyone must work together to truly build a healthy community. Looking ahead, Healthy Communities 3.0 must build on the successes of past efforts and confront new challenges and opportunities that come with changing political and economic times. Key priorities for the movement include coordinating efforts across cities and regions; connecting rural and non-urban communities to capital; routinizing measurement; and leveraging private investment.

Coordinating Efforts Across Cities and Regions

There are often multiple Healthy Communities efforts taking place within cities and regions, often with untapped opportunities for coordination. For example, BHP Network's environmental scan found that 20 cities nationwide have three or more sites that are part of national Healthy Communities initiatives. Local leaders can support Healthy Communities work by coordinating and aligning the work, perhaps even introducing communities at certain stages of the pathway with organizations that could help carry the work forward. For example, the Colorado-based Pueblo Triple Aim Corporation (PTAC) was established after an inspiring Triple Aim workshop facilitated by the Institute for Healthcare Improvement (IHI), a key entity providing early- to mid-stage program support. In 2010, after its visioning and partnership-building process, PTAC began work with ReThink Health to understand the impacts of various interventions on its "triple aim" of improving population health, patient experience, and cost of care. Now a full-fledged nonprofit backbone and support entity for health efforts in Pueblo, PTAC is participating in Invest Health to learn new strategies for increasing and leveraging private and public investments.

Although awareness of other organizations is a first step, the resources included in most grants are not sufficient for organizations to invest in partner relationships and collaborative work. Funders can help by introducing funded demonstration programs to each other; building in resources that support collaborative work; providing a "roadmap" for successful collaboration; and, in some cases, serving as a convener.¹³ Other entities, such as the regional Federal Reserve banks, are increasingly sharing programs' best practices, opportunities, and regional connections with one another. For the community development sector, especially CDFIs at the regional and national level that fund multiple cities, there are perhaps even more opportunities to play a role in connecting like-minded organizations and forming new partnerships.

13 U.S. Department of Agriculture (USDA), "USDA Announces Investments in Rural Community Facilities to Enhance Rural Health and Public Safety." Press Release, November 17, 2015.

Connecting Rural and Non-Urban Communities to Capital

As we learned from Cynthia (Mil) Duncan's chapter in *What Works*,¹⁴ the conditions surrounding rural poverty are unique in that communities are geographically isolated and human and financial capital are often limited. Nationally, from 2005 to 2010, only 6–7 percent of foundation grant money went to rural towns.¹⁵ Traditional financial institutions are also largely absent in rural communities, and approximately 40 percent of American rural counties do not have a bank branch.¹⁶ At the same time, residents tend to experience higher rates of disease, lower life expectancies, and disproportionately poor access to health care services and coverage, compared with their urban counterparts.¹⁷ How can under-resourced communities be better connected to the human and financial capital necessary to improve health and well-being? Where will new investments come from, especially in under-resourced, high-need communities that are not within the traditional catchment areas of existing investors?

To be sure, the U.S. Department of Agriculture (USDA) has made significant investments to improve the health and well-being of rural communities. For example, since 2009, the USDA's Rural Housing Service has leveraged \$6.2 billion to build or revitalize nearly 86,000 rural rental housing units and has helped more than 1.2 million rural families (many of whom are first-time homeowners) to buy, repair, or refinance their homes.¹⁸ During this same period, the program awarded \$9.7 billion in grants and loans to CDFIs and other financial institutions through its Community Facilities program.¹⁹ This initiative has helped fund health clinics, schools, libraries, day care centers, and public safety facilities.

However, ever-changing policy and economic environments underscore the need for diverse cross-sector financing strategies to address long-term health equity. Program-related investments (PRIs) might be one mechanism for doing so. Unlike grants, PRIs are below-market loans from foundations that require repayment only if an income stream is available. Once repaid, foundations can reallocate funds into new charitable investments.²⁰ PRIs deployed to CDFIs can be particularly impactful by increasing the flow of low-cost financing programs to projects that address the social determinants of health, from affordable housing with onsite services to health clinics and grocery stores.

14 Cynthia M. Duncan, "Community Development in Rural America: Collaborative, Regional, and Comprehensive," in *Investing in What Works for America's Communities: Essays on People, Place, & Purpose*, ed. Nancy O. Andrews et al. (San Francisco: Federal Reserve Bank of San Francisco, 2012), 162–69.

15 John L. Pender, "Foundation Grants to Rural Areas from 2005 to 2010: Trends and Patterns" (Washington, DC: Economic Research Service, United States Department of Agriculture, June 2015).

16 Meredith Covington and Josh Courtney, "Banking in Rural America: Insight from a Community Development Financial Institution (CDFI)." (Little Rock, AR: Southern Bancorp, 2014).

17 Rural Health Information Hub, "Rural Health Disparities." (Grand Forks, ND: Rural Health Information Hub, 2014).

18 U.S. Department of Agriculture (USDA), "USDA Results: Rural Economic and Community Development." (Washington, DC: USDA, 2016).

19 USDA, "USDA Announces Investments."

20 Lucia Benabentos et al., "Strategies to Maximize Your Philanthropic Capital: A Guide to Program-Related Investments (Primer)." (Seattle, WA: Mission Investors Exchange, 2012).

For example, as part of its 10-year Building Healthy Communities program, The California Endowment provided a PRI to Capital Impact Partners (a CDFI) to increase access to community clinics, catalyze economic development, and encourage innovation in health care delivery.²¹ Another example is Kresge Community Finance, a \$30 million PRI introduced as part of the Kresge Foundation's impact investing portfolio. Piloted in 2016, the program provides PRIs to certified CDFIs and quasi-public or private Development Finance Agencies to expand opportunities for low-income people in U.S. cities. Finally, Village Capital Corporation is a CDFI that was established in 1992 with leadership and long-term PRI funding from the Cleveland Foundation. Over its history, Village Capital has provided over \$65 million in loans to support over \$873 million in total development costs for more than 200 separate real estate projects in Northeast Ohio. These types of strategies could be replicated by other regional foundations and CDFIs outside of urban centers. Further exploration is necessary to determine appropriate PRI models for foundations and CDFIs of all sizes and scopes.

Routinizing Measurement

As the Healthy Communities movement matures, measurement and evidence of impact is essential to make the case for future investment. Because changes in health outcomes sometimes take decades to realize, funders will need to monitor progress of their grantmaking with a long-range view in mind. Actionable data are critical in helping community quarterbacks to monitor the progress of this work. However, challenges remain, such as the lack of appropriate data (particularly local health data), limited experience with impact measurement (namely, the community development sector), and the extra time and resources required to thoroughly monitor progress and outcomes.

The field is making progress on all of these fronts. The aforementioned 500 Cities Project provides neighborhood-level health data that will strengthen communities' capacity to devise cross-sector measurement strategies. Efforts like the National Neighborhoods Indicators Partnership and networks like Data Across Sectors for Health (DASH) are enabling better and more effective use of health data. Launched by RWJF, DASH supports multi-sector collaborations to connect information systems and share data for community health improvement.

Additionally, BHP Network has launched a number of programs to support collaborative measurement strategies involving the community development, public health, and health sectors. For example, MeasureUp is a resource offering successful case studies, measurement tools, and data sources linked to the health value of investments in at-risk, low-income neighborhoods. Further, BHP Network is working with national experts in metrics and measurement to align indicators for social determinants of health across community development and health sectors, contributing to a national metrics framework for measuring

21 Mission Investors Exchange, "The California Endowment and Two CDFIs Search for California-Based Community Clinics and Health Centers to Provide PRIs." (Seattle, WA: Mission Investors Exchange, 2014).

the health value of neighborhood-level interventions. Finally, initiatives such as the Strong, Prosperous, and Resilient Communities Challenge (SPARCC) will help communities connect the dots between social, environmental, economic, and health equity goals and outcomes.²²

The tools for effective measurement are taking shape, but more evidence is needed to show whether existing efforts are working. Such baseline evidence is necessary in forging new cross-sector partnerships that produce measurable economic and health outcomes.

Leveraging Private Investment

Healthy Communities investments from leading sectors represent a small fraction of annual U.S. health care expenditures, which amounted to \$3.2 trillion in 2015.²³ Although exact figures are not available, annual investments by the sector's leading Healthy Communities efforts amount to less than 6 percent of total health care expenditures, not including public investments in transportation, infrastructure, housing, and city planning.²⁴ How can efforts be sustained over time, particularly those dependent on grant and/or public funds subject to fiscal changes? Overall, existing investments must be more strategically aligned through cross-sector partnerships, but there also must be a strong business case for Healthy Communities work. Similar to the way the sustainability movement has monetized environmental returns through mechanisms like cap and trade and energy incentives, Healthy Communities 3.0 must build a market that values health. Private investment is key to this approach, and CDFIs and impact investors play a particularly important role.

By design, CDFIs leverage private investments to revitalize low-income communities. But beyond their own operations, partnerships with private investors are essential to developing creative financing strategies to sustain efforts over time. As previously mentioned, a growing number of Healthy Communities investment programs involve collaborations among CDFIs, private banks, and/or philanthropic arms of private banks. Impact investors—which include both private and nonprofit entities—already fund various Healthy Communities efforts through mechanisms such as Pay for Success financing and social impact bonds. Although their market size has not been fully quantified, it is estimated that impact investors managed \$77.4 billion in assets as of 2015.²⁵ Moving forward, impact investors must continue to engage in Healthy Communities work through national networks, like the Global Impact Investing Network (GIIN), and new investment platforms, like the ImpactUs Marketplace, which help connect investments to social and health-related causes.

22 See the article by Chris Kabel, Amy Kenyon, and Sharon Roerty in this issue for more information.

23 Centers for Medicare & Medicaid Services (CMS), “NHE Fact Sheet.” (Baltimore, MD: CMS, 2015).

24 This is based on the latest data on annual investments in community development (\$200 billion), public health (\$75.4 billion), and hospital community benefit investments (\$2.7 billion).

25 These numbers are based on 158 respondents to the Global Impact Investing Network (GIIN)'s annual survey, which includes 60 percent fund managers, 13 percent foundations, and the remaining banks, development finance institutions, family offices, and pension funds/insurance companies. For further details, see: GIIN, “Annual Impact Investor Survey,” (New York: GIIN, 2016).

Conclusion

The Healthy Communities movement is inherently complex and multifaceted, due to the underlying causes of health disparities, and it may take decades to see the fruits of these efforts in the form of improved health outcomes. As the movement continues to evolve, challenges and questions remain around how to best address unmet needs and leverage resources to sustain efforts over time. Community development is a fairly new partner in these efforts but will be increasingly important as the movement transitions to Healthy Communities 3.0., where regional coordination, addressing the needs of rural communities, routinizing measurement, and leveraging private investment will be key. Moving forward, the sector will continue to play a vital role as an action arm for advancing health equity and creating opportunities for all.

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