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# **Advancing the Fiscal Health of Low-Income Families: A Public and Community Health Approach**

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## **Advancing the Fiscal Health of Low-Income Families: A Public and Community Health Approach**

Working Paper March 2009

Doreen Treacy (doreen.treacy@dotwell.org)

For decades, health researchers have documented the links between individual and household income/wealth and clinical health outcomes. The research and literature consistently point to both income inequality (i.e. individual household income/wealth as compared to other households in the same state) and individual household income as predictors of diminished health and morbidity.<sup>1</sup> And yet the current framework for providing financial education, disseminating asset building information, and overall responding to the financial health of individuals and households takes no cues from public health and community health best practices. Further, the documented links between financial stress and compromised physical health<sup>2</sup> are compelling enough to suggest that health care providers, particularly comprehensive care sites such as community health centers, have a valuable perspective to lend to the conversation.

In these most challenging economic times when individuals across the economic spectrum are struggling financially, those of most modest means are particularly vulnerable. The core messages of financial education classes – how to create and manage a household budget, how to manage and improve one’s credit score, how to use a transactional financial account to the best advantage, how to maximize public and private market opportunities to manage financial stress – are messages that find resonance within an overall conversation about health and well-being. Moreover, the intrinsic message about the importance of maintaining strong financial health lends itself to the kind of broad educational campaigns that the public health field has employed successfully for decades and the type of wrap-around clinical interventions that characterize community health centers.

If the best intentions of financial education and asset building are to have widespread efficacy, the framework and lexicon of public health must be engaged both on the service delivery and policy levels, and the community health center network nationally must be seriously engaged. Community health centers are already poised by virtue of their missions, constituency, and their health delivery systems to contribute significantly to improving the financial health of individuals in low-income communities as partners in the financial education movement. Additionally, new innovations and tools that seek to bridge disciplinary divides and seamlessly integrate an evaluation of fiscal health into clinical health encounters must be explored. An assessment tool like Fiscal Health Vital Signs ©, which seeks to

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1 <http://epirev.oxfordjournals.org/cgi/content/full/26/1/78>

2 American Psychological Association “Stress in America ” 2008 annual survey  
<http://apahelpcenter.mediaroom.com/file.php/163/Stress+in+America+Executive+Summary+10-02-08+NO+Embargo.doc>

apply the format of effective evidence based screening tools in widespread use by both medical practitioners (i.e. CAGE<sup>3</sup>, PHQ-9)<sup>4</sup> and the financial world (i.e. FICO<sup>5</sup> scoring) can enable this transition of linking financial education interventions to a specifically “diagnosed” financial health problem. Coupled with a clinically informed and well-tested case management model, and a broad public health inspired awareness campaign, the work of financial education and asset building can be brought to its next dynamic iteration: creating true fiscal health.

## Economic Health and Physical Health Connections

As previously cited, there are documented links between health and wealth. This point was dramatically articulated in the 2008 PBS 10 hour series, “Unnatural Causes: Is Inequality Making Us Sick?”<sup>6</sup> In “Tackling Health Inequities Through Public Health Practice,” Anthony Iton, MD, JD, MPH unequivocally states: “In the Unites States, wealth is the strongest determinant of health.”<sup>7</sup> He further suggests that if public health as a field is committed to “eliminating health disparities” then it must be willing to build economic power on both the individual and community levels through both community based interventions and informed policy interventions that address root causes of systemic poverty in the United States.<sup>8</sup> Public health, as a field, has launched many successful campaigns to change attitudes and behaviors once thought immutable. The hallmarks of these campaigns are their bifurcated approach, tackling both individual behavior and collective policy and values. What’s more, engaging a public health framework provides a context for the financial education message that is currently lacking; namely connecting a discussion of individual and family finances with a primary health and wellness message. And this approach of connecting a potentially uncomfortable campaign message with core human values (i.e. themes of children’s health and well-being or social justice) results in behavior changes.<sup>9</sup> The public health smoking cessation campaign initiated by Surgeon General E. Everett Koop in 1984 required (1) rotated health warning labels on cigarette packs and (2) that advertising include the warning labels,<sup>10</sup> has morphed into a massive public health driven campaigns that achieved a 40%

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<sup>3</sup> <http://counsellingresource.com/quizzes/alcohol-cage/index.html>. The CAGE assessment is a tool used to determine whether an individual is in need of treatment for alcoholism.

<sup>4</sup> <http://www.phqscreeners.com/>

<sup>5</sup> <http://www.myfico.com/Company/AboutUs.aspx>

<sup>6</sup> <http://www.pbs.org/unnaturalcauses/>

<sup>7</sup> Iton, A. Tackling the Root Causes of Health Disparities Through Community Capacity Building. Tackling Health Inequities Through Public Health Practice: A Handbook for Action. Chapter 7, page 1.

<sup>8</sup> Ibid., Chapter 7, p.14

<sup>9</sup> Nicholas Freudenberg, DrPH1, Sarah Picard Bradley, MS, and Monica Serrano, MPH; “Public Health Campaigns to Change Industry Practices That Damage Health: An Analysis of 12 Case Studies.” Health Education & Behavior 2007, doi:10.1177/1090198107301330, December 12, 2007  
<http://heb.sagepub.com/cgi/content/abstract/1090198107301330v1>

<sup>10</sup> [http://en.wikipedia.org/wiki/Tobacco\\_packaging\\_warning\\_messages](http://en.wikipedia.org/wiki/Tobacco_packaging_warning_messages)

drop in smoking in the first 20 years, and continue to influence public attitude about smoking radically.<sup>11 12</sup>

To be sure, the connection between health outcomes and finances is not merely an academic correlation. Physicians who practice at community health centers routinely work with a patient population whose ability to comply with prescribed lifestyle changes for the management of a chronic disease (i.e. a diabetic patient being prescribed a diet high in fresh fruits and vegetables) is predicated on their financial means. Lack of financial resources can interfere with compliance and therefore further compromises health. So if the association between health outcomes and household wealth is so well understood, why has the participation and resources of public health and community health centers not figured prominently in discussions of asset-building and economic literacy in low and moderate-income communities? Apart from the obvious suggestions that, (1) community health centers and public health campaigns have been focusing more narrowly on clinically defined health issues, and (2) community health centers are not financially incentivized or compensated for monitoring patients financial health, perhaps the answer partially lies in the corollary question, “Who else is on the ground in low-income communities framing issues of economic literacy and asset building?”

### **The Massachusetts Approach to Asset-Building**

In Massachusetts, for example, the work of providing financial education and building assets for low and moderate income individuals is well-informed and engages a diverse number of disciplines and professions. The recently assembled Massachusetts Asset Development Commission,<sup>13</sup> a body chartered by the Massachusetts State Legislature and convened by the Department of Housing and Community Development (DHCD), is recognized as a solid example of this diversity, boasting participation from banks, regulatory agencies, institutions of higher education, community based non-profits, and representatives from all levels of government. Similarly, the Massachusetts Banking and Community Council (MCBC),<sup>14</sup> Boston Alliance for

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<sup>11</sup> <http://web.mit.edu/jeffrey/harris/SGR1989Chapt3.pdf> page 15.

<sup>12</sup> <http://healthguide.howstuffworks.com/smoking-in-depth.htm>

<sup>13</sup> [http://www.mass.gov/?pageID=eheadmodulechunk&L=4&L0=Home&L1=Economic+Analysis&L2=Executive+Office+of+Housing+and+Economic+Development&L3=Department+of+Housing+and+Community+Development&sid=Ehed&b=terminalcontent&f=dhcd\\_adc\\_adc&csid=Ehed](http://www.mass.gov/?pageID=eheadmodulechunk&L=4&L0=Home&L1=Economic+Analysis&L2=Executive+Office+of+Housing+and+Economic+Development&L3=Department+of+Housing+and+Community+Development&sid=Ehed&b=terminalcontent&f=dhcd_adc_adc&csid=Ehed)

<sup>14</sup> <http://mcbc.info/>. Notably, according to Kathleen Tullberg, MCBC Manager, MCBC first proposed a public information campaign in 2005. The proposal was developed in response to comments received at the 2005 regional meetings convened by the Fair Lending Task Force. The total price tag then for a two-year campaign was estimated at \$1.5 million. In January 2006, the MCBC Board approved seed funding to hire a consultant to develop an initial fundraising strategy and plan, conditional on the availability of other funding for the first stage of the project but matching funds were not found and the campaign was not launched.

Economic Inclusion (BAEI)<sup>15</sup> and the Boston Earned Income Tax Credit (EITC) Campaign<sup>16</sup> are examples of regional coalitions comprised of a trans-disciplinary cohort with the shared goal of promoting financial education and asset building in low-moderate income communities.

Yet despite the broad expertise represented by these groups and the diversity of their membership, noticeably under-represented are the public and community health sectors. In fact, with the exception of DotWell,<sup>17</sup> a collaboration between two Boston based neighborhood community health centers, the Codman Square Health Center and the Dorchester House Multi-Service Center, public health and community health professionals have been absent from just about all convenings in the Commonwealth where conversations on economic literacy and asset building are shared and strategic interventions and partnerships are hatched.

### **Community Crusaders or the Three C's**

A quick scan of the Massachusetts landscape suggests three key types of community based organizations (CBO'S) laboring in low-moderate income neighborhoods: Community Health Centers (CHC's), Community Action Agencies (CAPS), and Community Development Corporations (CDC's). Not surprisingly, all are progeny of the Economic Opportunity Act (EOA) of 1964, President Lyndon B. Johnson's "War on Poverty" policy that sought to eliminate the causes and consequences of poverty in the United States.<sup>18</sup> Presently, the federal Health and Human Services (HHS) office oversees and provides some manner of funding for two of the three community forces that emerged from this legislation:<sup>19</sup> Community Health Centers via the Health Resources and Services Administration (HRSA)<sup>20</sup> and Community Action Agencies via the Administration for Children and Families (ACF). The third community entity, Community Development Corporations<sup>21</sup> though birthed from the same Act,<sup>22</sup> no longer receive direct funding from the federal government but survive on competitive grants from local, state, and federal entities, as a well as private donations.<sup>23</sup> By virtue of their charters, mission, and geography, all of these

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<sup>15</sup> <http://www.fdic.gov/consumers/community/AEI/regional/Boston.html>

<sup>16</sup> <http://www.bostontaxhelp.org/>

<sup>17</sup> [www.dotwell.org](http://www.dotwell.org) DotWell is a community-based organization founded by the Codman Square Health Center (CSHC) and the Dorchester House Multi-Service Center (DHMSC). The mission of DotWell is to guarantee high-quality clinical and community services across both sites—addressing health disparities, meeting the complex needs of a changing Dorchester community, and building social capital in and across neighborhoods.

<sup>18</sup> [http://en.wikipedia.org/wiki/Economic\\_Opportunity\\_Act](http://en.wikipedia.org/wiki/Economic_Opportunity_Act)

<sup>19</sup> <http://www.hhs.gov/about/orgchart/index.html>

<sup>20</sup> <http://www.hrsa.gov/>

<sup>21</sup> Rachel G. Bratt and William M. Rohe, "Challenges and dilemmas facing community development corporations in the United States." *Community Development Journal Advance Access originally published online on August 17, 2005* *Community Development Journal* 2007 42(1):63-78; doi:10.1093/cdj/bsi092

<sup>22</sup> [http://www.communityinvestmentnetwork.org/nc/single-news-item-states/article/federal-government-funding-programs-community-development/?tx\\_ttnews%5BbackPid%5D=745&cHash=92ac94a5da](http://www.communityinvestmentnetwork.org/nc/single-news-item-states/article/federal-government-funding-programs-community-development/?tx_ttnews%5BbackPid%5D=745&cHash=92ac94a5da); and <http://www.hud.gov/>

<sup>23</sup> Joseph Kriesberg, Executive Director of the Massachusetts Association for Community Development Corporations, telephone interview 3/24/2009. According to Kriesberg, NeighborWorks America funds 240 NeighborWorks organizations or only about 10% of all CDC's nationally.

community agencies belong in the asset-building fold. And who can argue, given the high number of low net worth individuals in their communities that the need for community-based financial education and asset building services will always outstrip the combined supply of all the community purveyors? And yet, community based financial literacy classes frequently have empty seats. The four-color flyers posted on CBO windows and Laundromat bulletin boards are not in themselves compelling enough to move community members into those empty seats. In fact, where the information and advice is most critically needed --where the margin of financial error is most slim and a poor financial decision can have immediate and dire consequences on an individual's fiscal health -- there remains a disconnect between capacity and utilization. Given that the tools already exist (excellent financial education curricula and subject matter experts abound!) the challenge, arguably, is in creating the demand for the dietary equivalent of "eating one's spinach."

Early on, community development agencies recognized the need for sound, bias- free financial information to assist potential first-time homebuyers of their affordable housing units, and partnered with financial institutions to offer financial education classes. This partnership model works because class participants are incentivized by the prospect of a home purchase at the end. But homeownership is admittedly not for everyone at any given moment. So what about the other 90% of households in low-income urban and rural communities who aren't availing themselves of financial education classes? How do we reach them with the message and tools of financial education and asset building to improve their fiscal health and overall health by extension? In many communities I believe the answer lies across the street or down the block in the form of community health centers.

### **Community Health Centers - The Missing Players**

According to a recent publication of the National Association of Community Health Centers, "Health centers serve as the medical and health care home for 18 million people nationally – a number that is quickly growing."<sup>24</sup> Moreover, "Health center patients are among the nation's most vulnerable populations... patients are disproportionately low income, uninsured or publicly insured, and minority...with 71% of health center patients having family incomes at or below poverty."<sup>25</sup> The reach of community health centers is often geographically broader than other CBO's with "about half of health center patients resid[ing] in rural areas, while the other half tend to live in economically depressed inner city communities."<sup>26</sup> Finally, community health centers, in order to meet the complex needs of their patient population, have already developed the infrastructure, interventions, and systems to nurture health in their patient base.<sup>27</sup> The medical teams at

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<sup>24</sup> [http://www.nachc.com/client/documents/America's\\_Health\\_Centers\\_updated\\_8.13.08.pdf](http://www.nachc.com/client/documents/America's_Health_Centers_updated_8.13.08.pdf)

<sup>25</sup> Ibid

<sup>26</sup> Ibid

<sup>27</sup> According to The National Association of Community Health Centers, "Health centers remove common barriers to care by serving communities that otherwise confront financial, geographic, language, cultural and other barriers, making them different from most private, office-based physicians. They are located in high-need areas identified by the federal government as having elevated poverty, higher than average infant mortality, and where few physicians practice; are open to all residents, regardless of insurance status, and provide free or reduced cost care based on

community health centers play the role of the “trusted advisor” to individuals and families in need of sensitive information and guidance. Within this close relationship lie opportunities for making life-changing decisions about lifestyle and future planning.

### **Improving Health and Wealth Outcomes Through Integrated Delivery**

There is growing evidence that integrating financial education and asset-building strategies with clinical services at community health centers improves the outcomes of both. The two Boston health centers previously cited, the Codman Square Health Center and the Dorchester House Multi-Service Center, have been working to integrate financial education services into their standard of care since 2002. Advances in technology have supported their goal of caring for patients across clinical and non-clinical departments and programs. For example, both health centers use electronic medical records software that allows doctors to manage patient care across specialties via a shared medical record. This same system currently allows a doctor to write exercise “prescriptions” to a fitness center in the community for patients presenting with conditions (i.e. obesity, diabetes, hypertension, mood disorders) that respond positively to exercise. The “prescription” provides a three-month free membership to the facility and can be renewed if the patient is actively using the script. From this existing technology, one can envision a similar “prescription” being written for a credit counseling session, a financial education class, or for a Fiscal Health Vital Signs © assessment. Additionally, the non-clinical programs share and track clients and outcomes using a shared social service software application, Efforts to Outcomes (ETO).<sup>28</sup> These technologies facilitate the flow of information enabling clients and patients to receive coordinated and connected access to supports and services that improve their overall health. And when a client is referred to a financial service like credit counseling or free tax preparation by their doctor or a trusted program manager, the likelihood of engagement is much greater than if they saw a poster in a window or a placard on the bus.

The same Boston health centers are currently piloting two programs that weave the best practices of clinical care models with proven financial education concepts and methodology: “Eat Green, Save Green,” a combination healthy cooking and financial education class for diabetic patients and the Franklin Field Family Wellness Program in partnership with The Boston Housing Authority.<sup>29</sup> Since 2002, the DotWell partner health centers have invested in fiscal health initiatives to address patient’s financial needs. These initiatives include free tax preparation and asset building services, benefits screening, matched educational savings accounts, and on-site financial education and credit counseling. In 2008, DotWell initiated a program to address the health, social, and financial education needs of health center patients in one encounter. “Eat Green, Save Green” was

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ability to pay; offer services that help their patients access health care, such as transportation, translation, case management, health education, and home visitation; and tailor their services to fit the special needs and priorities of their communities, and provide services in a linguistically and culturally appropriate setting. Nearly a third of all patients are best served in languages other than English, and nearly all patients report their clinician speaks the same language they do.”

<sup>28</sup> <http://www.socialsolutions.com/>

<sup>29</sup> <http://www.bostonhousing.org/detpages/devinfo20.html>



conceived to address multiple needs of patients managing chronic diseases most prevalent in the low-income community: diabetes and obesity. Primary care physicians were eager to empower their patients to make the prescribed lifestyle and dietary changes that were necessary to manage their chronic disease conditions. A trans-disciplinary team was assembled to address the issue that included doctors, nurses, case managers, a nutritionist and the director of fiscal health programs. Operation Frontline/Share Our Strength<sup>30</sup>, a nutrition education program, and Financial Education Associates were brought in to implement the trainings.

For one evening night per week for seven weeks, a group of patients participated in a two-part training. The first component was a cooking and nutrition education class hosted by Share Our Strength, in which a guest chef provided ingredients, information, and training to create a healthy, low-cost meal. The second training component was held across the hall in a computer lab later that same evening. DotWell and Financial Education Associates developed a custom curriculum that addressed core financial education components such as goal setting and budgeting, but added innovations like “applied” on-line shopping excursions on Stop & Shop’s Peapod website<sup>31</sup>, real-time local food sources, and connection with community networking tools and with other community members. The program also integrated free tax services, a field trip to a grocery store, and referrals to additional training, in an effort to mutually promote physical and fiscal health.

The methodology and success of the former program is documented in a report prepared for the Massachusetts Community and Banking Council (MCBC) by Margaret Miley of The Midas Collaborative titled, “Expanding Financial Skills in Low-Income Communities: A Framework for Building an Effective Financial Education Program.”<sup>32</sup> The Eat Green Save Green program is cited as an example of an integrated approach to delivering financial education, Miley notes,

The results of the financial education component have been positive...students requested more time on financial literacy, specifically on the topic of credit. DotWell was able to parlay this newfound enthusiasm for personal credit information into enrollment in an 8-hour credit class. All of the learners participated in modifying the schedule with staff, reported more budgeting and planning in their lives, joined a money-saving food coop (Serve New England) and signed up for a subsequent DotWell training on understanding credit. The lessons learned were positive as well. *The trainers reported that the integration of the nutrition and fiscal themes strengthened both. They were surprised by the level of interest and subsequent demand for financial education.* The effectiveness of this program inspired a natural community demand. The connection to research is compelling in this case. All of Knowles’s recommendations on methodology were modeled in this program, as well as Cross’s Characteristics and Gardner’s Multiple Intelligences. It appeared that the learners actually made the transition from the

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<sup>30</sup> [www.strength.org/operationfrontline/courses/](http://www.strength.org/operationfrontline/courses/)

<sup>31</sup> <http://www.peapod.com/?001=1034&002=33&003=1&004=&005=&006=10010>

<sup>32</sup> <http://www.massassets.org/massaves/home.php>

Preparation Stage to the Action Stage of The Behavior Scales of the Prochaska, Norcross, & DiClemente during the course of the program and in subsequent trainings.<sup>33</sup>

### **Fiscal Health Vital Signs ©: A Tool for Assessing Fiscal Health**

The Franklin Field Family Wellness pilot is another example of an integrated services delivery model that capitalizes on the strengths of the community health center infrastructure to link financial education with established clinical care models. In this program, a case manager evaluates the fiscal health of public housing development residents using the Fiscal Health Vital Signs © assessment and assists with connecting residents with resources to improve their fiscal health. The Fiscal Health Vital Signs (FHVS) tool is an example of a trans-disciplinary informed approach to “diagnosing” an individual’s fiscal health. This tool was assembled from extensive experience training, coaching, and developing effective financial interventions for low–moderate-income households. As previously stated, it was informed by both clinical assessments used by medical practitioners (i.e. CAGE, PHQ-9) and a risk analysis evaluation popular in the financial world (i.e. FICO scoring). While there are many assessments to guide higher net worth individuals in evaluating their financial decisions to maximize their assets, no comprehensive evidence-based screening tool to evaluate the fiscal health of low net worth individuals existed. The FHVS tool was developed as a result.

In a typical clinical encounter, the provider team checks prescribed vital signs like blood pressure and weight, and ask a standard battery of questions to determine a patient’s general health. Similarly, the FHVS assessment enables a trained evaluator to efficiently triage individuals’ for compromised fiscal health. And just as in a clinical setting those with chronic disease are assisted in managing their condition by a case manager, those with chronic fiscal health problems receive on-going support. In this pilot the fiscal case manager evaluates a client, “prescribes” specific actions that an individual can take to improve fiscal health, and develops a strategic “treatment plan” to help individuals and families implement plans and stay on track. Those who move from screening into a treatment gain knowledge and improve fiscal health in a number of ways, including: (1) Recognizing and avoiding predatory financial services such as payday loans, check cashers, and some tax preparation services; (2) Understanding and using use non-predatory credit resources, including the free tax prep services and accompanying asset-building services of DotWell; (3) Establishing a relationship with a mainstream financial institution; (4) Increasing the use of available income support programs; (5) Reduced personal and/or household debt; (6) Improving individual credit score; and (7) Increased and leveraged savings.

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<sup>33</sup> According to Miley, in the 2002 symposium sponsored by the National Endowment for Financial Education (NEFE) several entities including higher education, nonprofit organizations, media, financial service firms, government agencies, corporation and foundations shared a common vision of national financial literacy. They developed a list of major consensus points on effective instruction. The Eat Green Save Green pedagogy aligns with 6 of those core best practices cited below: (1) Financial literacy is a lifelong process; (2) Educational material should be presented at a “teachable moment”; (3) No single organization can achieve the goal—a joint effort is necessary; (4) Learning must have relevancy and immediate application; (5) Learner inspired curriculum stimulates group involvement and resulting in ownership and retention; (6) Materials and topics should be organized to provide tools for life applications.

Six months into the current pilot, the two most striking observations are the extent to which individual's fiscal health is compromised and the willingness of clients who have been assessed to take the concrete actions necessary to improve their fiscal health. This latter observation is the most encouraging and supports the assertion that integrating financial education opportunities into community health settings creates a self-motivated demand for financial education and services.

### **Preliminary Observations and Recommendations:**

The work of improving the fiscal health of all Americans requires that current financial education and asset building tools and strategies reach a broader audience -- the most economically vulnerable in particular -- and connect in a compelling way to individuals' core values and well being. This requires the expertise and participation of many disciplines and fields, but must leverage the wisdom and effective practices of the public and community health fields in order to make more significant gains both in breadth (greater numbers of individuals utilizing financial education classes and improving fiscal health) and in the depth (the presence of meaningful and measurable behavior changes that improve fiscal health.) Further, the existing national community health center infrastructure can be better leveraged in this effort. Achieving the beatific vision of the "War on Poverty" and improving both the economic and physical health of America's least resourced citizens can be achieved through better integration of financial programs and services with established community health centers. Moreover, creatively allocated funding across the federal HHS program portfolio can increase both capacity and impact in improving health and wealth outcomes in low-income communities. Finally, the financial education movement would be well served by new tools and methods that seek to bridge the community health movement and financial education and asset building. With the synergistic leadership of professionals and policy-makers in the areas of community health, public health, and financial education, a new community health model to promote financial education and improve financial health is possible.

*Doreen Treacy joined the Dot Well CivicHealth Institute in 2001. Since joining Dot Well, she has collaborated with health center colleagues and external partners to develop innovative Fiscal Health initiatives including launching the first asset building and free tax site in Boston with the Boston EITC Coalition, and the "Eat Green, Save Green" program. The Fiscal Health Vital Signs © assessment tool is her latest contribution to improve fiscal health for low-moderate income households. As a consultant to the City of Boston, she authored a course book and delivered trainings for the popular Homebuying 101 program that became a benchmark for homebuyer education standards statewide, and facilitated numerous financial seminars to empower individuals. She has been a featured presenter at a HUD National Best Practices Conference, a National Tax Coalition conference, a National Community Technology conference and at numerous Federal Reserve Bank sponsored conferences and events. Additionally, her work with first-time urban homebuyers was featured in Money magazine. She currently serves on the boards of The Midas Collaborative and the Massachusetts Community and Banking Council, where she co-chairs the Banking sub-committee.*