JUNE 2017

NEWSLETTER

CONTENTS

PERCEPTIONS AND REALITIES OF THE DRUG PRICING DEBATE

The issue of drug pricing is neither simple nor straightforward, but here, we will break down the status quo and shed some light on the costs of doing business. We do not argue that pricing concerns are unfounded, but want to bring some transparency to the discussion. While we will not propose a fix, we hope to elucidate there is no panacea to the drug pricing conundrum as it exists given the multitude of complexities, but provide a better understanding of the current state of play.

First, it is important to have an understanding of who the players are and what they do:

- Manufacturers: pharma and biotech companies who make the drugs
- Distributors: ship and supply those drugs to...
- Retailers like pharmacies, hospitals, and doctors offices, where patients physically obtain those drugs
- Managed care organizations (MCO) provide insurance coverage to the patient for those drugs, and for some payers, the process of deciding which drugs to cover and at what cost is contracted out to Pharmacy Benefit Managers (PBM) rather than being handled by the MCO itself

The core of the drug pricing conversation tends to revolve around how manufacturers increase list prices year over year. Based on historical precedent, there is some expectation for list prices to increase once or twice a year, with an average rate of 5-10% per increase. When viewed in relief of a yearly 2-3% inflation rate, this can quickly look unreasonable. And yet, despite these sometimes double digit price increases, there has actually been a decrease in the estimated net price growth since 2010, according to a 2015 analysis by IMS.

This decrease is due to the multiple points along the chain in which manufacturers must either directly pay or provide a discount to different players. Reasons that contribute to this at times significant delta include:

- The list price may be an indicator of what companies constitute as "value" for their drug, and by proxy, their shareholders. Payers may have a different view of the value of the same drug.
- Manufacturers are under increasing pressure to negotiate discounts with commercial insurance to secure a favorable reimbursement environment i.e. preferred formulary tier status, excluded drug lists.
- These negotiated contracts typically last for a three year period and have a price protection clause for that length of time – so while list price may go up multiple times in that time period, the contracted negotiated rate does not correspondingly change.
- Some payers simply will not contract with manufacturers for products that have multiple double digit price increases. Many will put utilization management (UM) controls in place to drive usage

toward generics or less expensive branded agents instead of the offending products.

There is a wide spectrum of both list price increases and the types of discounts that are given to payers and PBMs, vis-à-vis the negotiated discount, depending on the therapeutic category. While the public may see a list price increase of 5-10%, behind the scenes there may actually be negotiated discounts anywhere from 10-50%. The average discount is about 30%, and can be as low as single digits or as high as 50% in categories like hepatitis C antivirals.

The negotiated discounts are a way for manufacturers to secure optimal formulary placement, which also serves to minimize barriers for both health care providers and patients to obtain the drug. Depending on the drug class, the discounts also:

- help facilitate the removal of UM controls (called step edits and prior authorization) that can be used to force physicians to prescribe alternative cheaper agents preferred by the plan
- drive competitive pricing among players (e.g. maximize the discounts among all products)
- ensure there is no abuse in off-label prescribing

Despite the aforementioned benefits to discounting, some manufacturers continue to pursue significant list price increases even in the face of the apparent risk of sub-optimal, if not total lack of reimbursement, as certain payers simply do not attempt to contract at all. Thus, there will be some segment of payers with which manufacturers can capture their actual list price, which then gives manufacturers more financial leeway to contract with other payers who have placed barriers up for their products. Taking together the two extremes of no contracting and deeply discounted rebates should still average out to some profitability.

On the Medicare side, manufacturer discounts for pharmacy-based agents (e.g. Part D) may need to be more aggressive because of the nature of budget available to cover those agents. In many cases, for a manufacturer to be successful in obtaining formulary coverage for a Medicare Part D plan, a 40-50% discount may be required to achieve a favorable status – whereas the same therapeutic area might only need a 30% discount for commercial plans. For Medicaid, price decreases are mandated by law, but everywhere else, free market forces are very much in effect.

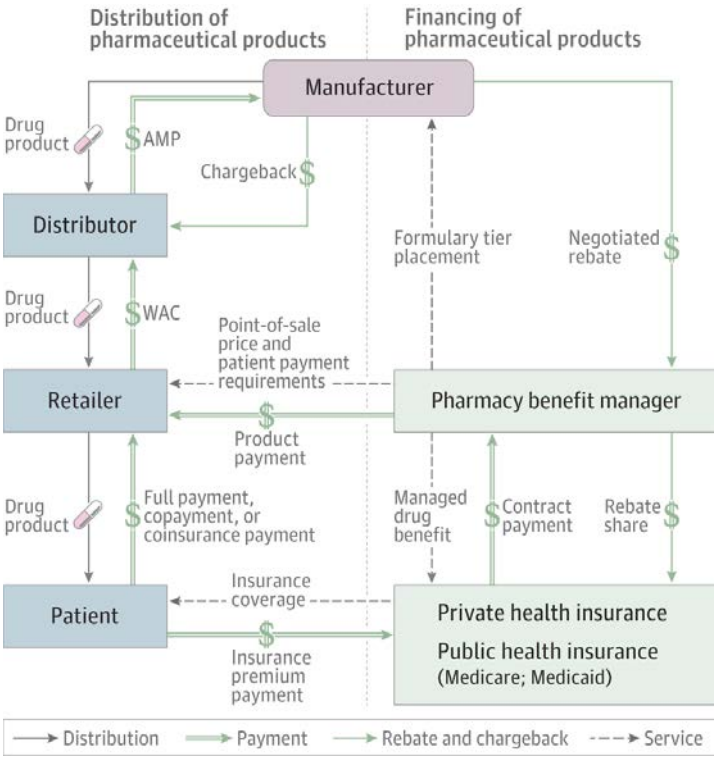

Figure 1: Flow of Pharmaceutical Funds, Products, and Services. Reproduced with permission from doi:10.1001/jama.2017.5607. Copyright © 2017 American Medical Association. All rights reserved.

Payers do note that there is "abuse" in certain therapeutic areas that occurs with price increases over the norms. One trend occurring to address these so called "abuses" in the payer community is to expand their formulary exclusion lists, adding more new, high-cost drugs to those lists. Many times payers are forcing these agents to be excluded because employers are becoming more adamant on cost-efficiencies, as well as reluctance on the part of the plan to reimburse for an agent that is no more efficacious as an older, less expensive branded or even generic agent.

As we witness more specialty products come to market, which tend to be accompanied by high price tags, high

deductible plans continue to increase premiums, and employers are indicating that they cannot sustain those increases. In turn, more cost must be borne by the patient. This "financial toxicity" to patients can result, for example, in poor prescription drug compliance and intentional skipping of doses, or waiting between refills to help manage their own out of pocket costs.

While the increasing use of discounts for payers does allow the plan to offer lower prescription costs for clients and plan members compared to list price, patients still bear the brunt of co-pays associated with the list price rather than discounted price. Patients who have commercial insurance will have out of pocket costs, which can range from $25 - $100 per prescription, depending on the type of branded product. To offset the higher co-pay, manufacturers can offer coupons to patients that, depending on the size and scope of the program, can quickly and substantially add up for the manufacturer. There are certain camps within the sector that promote the idea that co-pay card program costs require the manufacturer to increase price to recoup these extra costs. But for the most part, the impact on gross to net of these programs is in reality quite small and not the sole reason a manufacturer increases the price of an agent. Yet, there are some manufacturers that take a greater hit on co-pay program costs due to greater demand. Also of note, these co-pay cards only work for commercial plans, and not Medicare or Medicaid plans.

There are still several other dynamics at play that drive price increases, with distributors and PBMs also culprits to the pricing conundrum. When a drug company distributes their agents they use wholesalers that are paid based on a percentage of the list price, and depending on the agreement with the manufacturer, often also some percentage of sales or volume. Paradoxically, manufacturers are forced to drive higher prices on their agents because lower prices are penalized as many wholesalers will not stock or distribute a drug that does not yield a sufficiently healthy ROI. Manufacturers are somewhat stuck to price on the higher side simply to appease the wholesalers.

PBMs also are part of the problem when it comes to higher list prices. PBMs make money through various administrative fees and rebates, where the bigger the negotiated rebate, the bigger the benefit to their bottom line. Lower price products simply have less room for the negotiation of deep discounts, but a deep discount on a big ticket specialty drug is a nice win that PBMs can bring to their clients and employers. It is also advantageous for manufacturers to entertain these deep discounts with PBMs as it can secure optimal placement on formulary exclusion lists and keep out competitors in their therapeutic category. Again, in what feels like a pay to play scenario, manufacturers are forced to drive up list prices to both give themselves negotiating power but also to appease another stakeholder.

We started this article by noting this system is neither simple nor straightforward, and should rightfully sound complicated after all that we have laid out. Figure 1 depicts the various players and the relationships between them.

With all of that being said, some manufacturers are starting to take more proactive steps to neutralize the pricing conversation, rather than get stuck putting out fires in the press as has happened of late. Allergan's CEO has committed to limiting price increases to single-digit percentage increases. Novo Nordisk has said it will not raise drug prices by more than 10% in a year, and Eli Lilly has made a similar pledge. Other large players like Novartis and Amgen have started publicly engaging in value-based pricing arrangements, where they will be responsible for costs when patients do not respond as anticipated to drug. Recently Optum, the health services business of UnitedHealth Group, and Merck announced they will collaborate on outcomes-based arrangements for Merck drugs. Current pay-for-performance deals in specialty categories exist in MS, PCSK9s, oncology, diabetes, and anticoagulants. Pay-for-performance systems assess the quality and efficiency of a drug by looking at surrogate markers like blood pressure or cholesterol. These actions and others are scratching the surface at creating a more transparent pricing environment, along with finding new ways to build, demonstrate, and monetize drug value.

The key questions we are pondering and trying to solve for related to the US reimbursement and pricing are:

- Have we reached a tipping point whereby we will see a ground swell around price re-calibration and new mechanisms to deal with this issue?
- How will the influx of novel mechanisms in a myriad of therapeutic areas impact drug pricing overall?
- With the advent of biosimilars and more generics, will this help with budget management overall by freeing up dollars for other novel therapies?
- With manufacturers still needing to grow revenue with existing product portfolios, what will be the new norm by way of accepted price increases and how will other US stakeholders take part in this new modality?

As discussed in a previous issue of this newsletter, gene therapy products will also likely force more creative pricing and reimbursement strategies given anticipated high costs with unprecedented value from a single dose. There are many different levers that can be pulled that can and do affect cost – in the next article, we will explore some legislative options that have and continue to be explored to reign in drug pricing.

- by Brent Bernstein and Christine Livoti

HOW DRUG PRICING MAY FIND ITSELF IN THE CROSSHAIRS OF THE LEGISLATIVE AGENDA

In what feels like an increasingly polarized political climate, there is, perhaps surprisingly, bipartisan support for some sort of change to drug pricing. Yet, given the headline-grabbing nature of drug pricing of late, it may actually be low hanging fruit to support new mechanisms aimed at lowering healthcare costs. The lingering questions are what to do and how to do it. Here, we explore some legislative avenues for how Congress may move to bring down drug prices.

Some form of drug price negotiation has been floated by multiple politicians in recent years: both the FY16 and FY17 budgets from President Obama, as did Bernie Sanders, Hillary Clinton and Donald Trump as candidates in the most recent election cycle.

The more progressive and liberal position has generally been to allow the Centers for Medicare and Medicaid Services (CMS) to step in to Medicare Part D (prescription drug benefit) and negotiate drug prices on behalf of the government. Medicare Part D was created by 2003 legislation known as the Medicare Modernization Act, which contains a specific "noninterference" clause that stipulates the Health and Human Services (HHS) Secretary "may not interfere with the negotiations between drug manufacturers and pharmacies and PDP [prescription drug plan] sponsors, and may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs." One seemingly quick fix would be to simply strike this noninterference clause, thus allowing for direct negotiation of drug prices.

Another option would be to create a public Part D that would operate alongside a private Part D – HHS would administer the public Part D and negotiate for drugs on that formulary. A third option would be to authorize HHS to negotiate for only a limited set of relatively expensive drugs with no therapeutic alternatives – i.e. high price specialty drugs with no generic competition. This last option was what was floated under the aforementioned Obama plans.

Pushback around trying to cut costs in Part D comes from the fact that the Congressional Budget Office (CBO) has, in the past, scored negotiation of Part D as not actually saving any money. Essentially, CBO questions whether the government would be able to do any better than private plans, who are already in the business of bidding for enrollees on cost and coverage. Further, to actually find any savings, the government would need to establish a formulary that would both exclude drugs and likely also have some utilization management restrictions – which may be hard things to stomach from a public plan in the United States, though is much more the expectation in certain EU countries. The ability to set prices, along with taking action against drug companies that do not provide large enough

rebates to the government, have also been floated as other avenues for savings – though CBO has not actually provided any estimates around those ideas.

One last downside to looking for savings in Part D is that spending growth here has actually remained relatively flat compared to earlier projections – largely driven by branded drug patent expirations and the use of generics to bring costs down.

Aside from Part D negotiations, there is also some desire to fold Part B (out-patient setting) into Part D, and allowing PBMs and/or health plans to administer that program. The Medicare Payment Advisory Commission (MedPAC) has put some work into what they call the Drug Value Program, that includes letting doctors in Part B organize and create formularies that could directly negotiate with drug makers. Medicare would contract with a small number of private vendors that would negotiate drug prices, limited to no higher than Average Sales Prices (ASP); doctors would then buy drugs at negotiated rates from those vendors (which sound, in practice, much like PBMs, or at least, PBM-like), and Medicare would reimburse them. Doctors would also get an administrative fee and Medicare would pay doctors a share of what they save Medicare by participating in this scheme. This idea generates some pushback given the fact that PBMs are already seen as part of the problem around rising drug costs, and begs the question of why introduce them as a new player in a place where they do not presently exist.

2016 saw the failure of a proposed Part B demonstration project to test payment rate changes. Pulled in December, this would have changed the payment rate from ASP plus 6% to ASP plus 2.5%, plus a flat fee. A second phase was set to test value-based purchasing tools. The plan elicited criticism from industry, specialty doctor groups, patient groups, and even democratic lawmakers, before it was ultimately scrapped.

Despite campaign trail rhetoric, the recent President Trump budget proposal did not contain any of his previously mentioned ideas for tackling drug pricing, including government negotiation in Part D. However, there is a milieu of other proposals at various stages of consideration at the moment, which broadly include:

- finding ways to get generics and biosimilars to market faster, and possibly offering a period of market exclusivity for those, particularly where there is little competition
- require drug companies to give notice and provide justification when prices rise by a certain amount
- importing drugs from outside the US
- require PBMs to disclose negotiated rates for Medicare drug plans
- extend Medicaid rebates to low income Part D enrollees. Medicaid receives as much as a 23% rebate at present, according to statutory formulae. CBO has estimated this extension could achieve $145 billion in savings over a 10 year period.

Though the Trump budget punted on this issue, a drug pricing resolution was recently added to the FDA's user fee legislation, set for reauthorization this session. The added resolution urges the HHS secretary to work with Congress to "lower the cost of prescription drugs for consumers and reduce the burden of such cost on taxpayers." The specifics of implementation are not yet clear.

- by Vince Mellet and Christine Livoti

PEER-REVIEWED ABSTRACTS

As part of Deerfield's mission of advancing healthcare, the Deerfield Institute is committed to publishing its proprietary research in peer-reviewed, open access scientific journals. Below is a selection of some of our recently published work. More information on the Deerfield Institute, and copies of certain past publications are available on the web at Deerfield.com/Institute.

POSTGRADUATE MEDICINE

CONSIDERATIONS ON BRINGING WAREHOUSED HCV PATIENTS INTO ACTIVE CARE FOLLOWING INTERFERON-FREE, DIRECT-ACTING ANTIVIRAL DRUG APPROVAL

ALEKSANDRA PALAK, CHRISTINE LIVOTI, CÉLINE AUDIBERT

Abstract

Objectives: Until recently, lack of efficacious and tolerable hepatitis C virus (HCV) treatments prompted patient warehousing until better treatment options became available. We investigated whether the introduction of ledipasvir/sofosbuvir precipitated patient return to clinics, thereby changing HCV clinic dynamics.

Methods: Online questionnaire responses indicated the volume of HCV patients followed, the proportion of warehoused patients and those who were proactively offered new options, methods for identifying and contacting patients, and insurance authorization/reimbursement-related information.

Results: Of 168 practices surveyed, 19% indicated no patient warehousing in the previous 3 years; 81% had warehoused 40% of patients; 92% were able to handle their patient load; and 82% had not changed practices to accommodate more HCV patients in the previous 12 months. Of the 35% of patients who were ledipasvir/sofosbuvir-eligible, 50% already completed/are completing therapy, 21% were not treated due to insurance denial, and 19% were awaiting responses from insurance companies.

Conclusion: Launch of a new treatment did not overburden HCV practices. Patients eligible to receive new treatments were being treated, but pre-authorization processes and reimbursement denials reduced the numbers of treated patients.

THE EUROPEAN FILES

INVESTMENT AND INCENTIVES IN 21ST CENTURY PHARMACEUTICAL RESEARCH IN EUROPE: THE COST OF OPPORTUNITY

PAOLO MORGESE

Abstract: We could say that a financial reward to a successful R&D project is an investment and an investment in healthcare R&D is an opportunity. However, not all investments are successful and opportunities can be missed. And sometimes, one stakeholder's success is another's failure.

IP CORNER

Intellectual Property (IP) is a vital asset to any emerging company in the healthcare space. Here, we highlight noteworthy trends and events in the IP realm with implications for both young and established healthcare companies alike.

IN REVIEW STATE SOVEREIGN IMMUNITY PROTECTS STATE UNIVERSITY PATENTS FROM *INTER PARTES REVIEW*

In two recent *inter partes* review (IPR) proceedings, the Patent Trial and Appeal Board (PTAB) declined to review patents owned by state universities on the basis of state sovereign immunity.[1,2]

Article III of the U.S. Constitution established the federal courts to hear disputes "--between a state and citizens of another state, . . . , and between a state, or the citizens thereof, and foreign states, citizens or subjects." When the Constitution was being debated, Anti-Federalists, who generally opposed the Constitution, solicited a promise from several prominent Federalists that Article III would not permit a state to be sued without its consent. Each of the 50 American states was to be treated as a sovereign government entitled to sovereign immunity. However, several individuals sued the states in the Supreme Court shortly after ratification. In *Chisholm v. Georgia* (1793), the Supreme Court allowed the suit by a citizen of South Carolina against the state of Georgia for unpaid debts incurred during the War of Independence to proceed in the federal court. Senator Caleb Strong of Massachusetts proposed an amendment to the Constitution to override the *Chisholm* decision. Congress passed the Eleventh Amendment to the Constitution in 1794 to establish state immunity from such suits. Although the text of the amendment is limited to suits "in law or equity," the Supreme Court has interpreted the statute to preclude certain adjudicative administrative proceedings. Following Supreme Court precedents from other areas of law, the Federal Circuit held that sovereign immunity applies in interference proceedings before the Patent Office. *Vas-Cath, Inc. v. Curators of Univ. of Missouri*, 473 F.3d 1376 (Fed. Cir. 2007). A state university is considered to be an extension of the state.

The application of 11th Amendment immunity is counterintuitive in the patent context, but in two recent cases, the PTAB declined to proceed with IPRs on the grounds of state immunity. *Covidien LP v. University of Florida Research Foundation Inc.* (Jan. 27. 2017) is the first ever case on applicability of state immunity to IPRs[1]. Covidien argued that the University of Florida was claiming that "though the Patent Office has authority to issue a patent, it has no authority to reconsider that decision where the patent is held by a state entity. This is contrary to common sense and to the Patent Act itself." Indeed, patent rights are granted under an act of Congress and it should be within the power of Congress to establish review procedures. The question is how explicitly should the Congress state its intent? In this case, the PTAB did not find that there was "an unequivocal, express intent by Congress in the [America Invents Act] to abrogate immunity for the purposes of inter partes review." The PTAB also rejected arguments that an IPR is akin to an *in rem* property rights action directed at the patent rather than at the patent owner. The PTAB held that the procedural elements of IPRs and estoppel provisions make it look much like litigation.

In the second case, *Neochord, Inc. v. Univ. of Maryland* (May 23, 2017)[2] the PTAB came to the same conclusion as in *Covidien* — state sovereign immunity is available as a defense in an IPR. In this case, University of Maryland raised the sovereign immunity defense on January 30, 2017 just days after the PTAB terminated the *Covidien* IPR and one day before the oral hearing. Neochord argued that the University has waived its defense by participating in the IPR through trial. The PTAB ruled that "the Eleventh Amendment defense is in the nature of a jurisdictional bar that may be raised at any time,"

relying on the footnote in the Supreme Court's decision in *Florida Dep't of State v. Treasure Salvors, Inc.*, 458 U.S. 670, 383 n.18 (1982). However, the PTAB also held that a State may waive immunity where the State takes affirmative steps to invoke federal jurisdiction, such as filing a patent suit or seeking removal to federal court, therefore punting the decision on patent validity until later litigation in the federal court. Neochord also argued that the Supreme Court has already held that IPRs are more similar to reexaminations by the patent office of its earlier decision to grant a patent (proceedings not entitled to sovereign immunity defense) than litigations. *Cuozzo Speed Techs., LLC v. Lee*, 136 S. Ct. 2131 (2016). But, the PTAB took a narrow view that *Cuozzo* only applies the context of the claim construction standard, and not in general. Again, the PTAB reaffirmed that IPRs are more similar to litigations. PTAB recognized preferential treatment given to state universities -- "We recognize that the university's assertion of sovereign immunity creates special treatment for a state entity. Nevertheless, the Supreme Court has explained that any asymmetry is the result of the 11th Amendment itself."

The decisions of the PTAB may eventually be appealed and either affirmed or reversed. Until then, the decisions are generally recognized to provide some additional value to intellectual property owned by state universities. For example, an alleged infringer may be more likely to settle an expensive patent litigation case when a cheaper avenue to challenging patent validity is not available. However, licensees may also view the 11th Amendment protection of state immunity to be detrimental. Although licensees generally want strong patents that are not easily challenged, licensees also have an interest in invalidating weak patents where early invalidation results in reduction of royalties due to the universities. Accordingly, it is not clear if state universities would be able to monetize these decisions in the form of higher maintenance fees, milestones and royalty rates. It will take some time to fully understand any economic ramifications of these decisions.

[1] *Covidien LP v. University of Florida Research Foundation Inc.*, Case Nos. IPR 2016-01274; -01275, and -01276 (PTAB January 25, 2017).

[2] *Neochord, Inc. v. Univ. of Maryland, Baltimore and Harpoon Medical, Inc.*, Case No. IPR2016-00208 (PTAB May 23, 2017).

- by Mark Shtilerman

CAUGHT OUR EYE

An additional analysis of a large international randomized clinical trial of a heart failure drug found significant differences in clinical outcomes based on patient geography. Specifically, the trial drug performed better than placebo in patients in North and South America, but there was no difference between drug and placebo in Russia and Georgia. The findings raise concerns around the conduct of large, international, randomized controlled trials, particularly as certain geographies may be more attractive for financial reasons. *CardioBrief*

The FDA plans to create a dedicated digital health unit in its Devices review center. One agenda item is to review more than 1,400 comments left on the draft guidance for industry on software as a medical device, released in October 2016. Other priorities for the unit include artificial intelligence, advanced analytics, the cloud, wireless medical devices, telemedicine, interoperability, health IT and cybersecurity. *Regulatory Affairs Professional Society*

A coalition of universities, clinics, hospitals, and researchers known as the Undiagnosed Diseases Network is on a mission to solve the medical mysteries posed by rare disease patients. The NIH funded organization was founded in 2015 with a $43 million dollar grant. It has received nearly 1,400 applications on behalf of patients, has accepted 545 for review, but with only 74 of the cases having yet been diagnosed. *STAT News, via Kaiser Health News*

In a landmark approval, the FDA granted accelerated approval to Merck's immunotherapy drug Keytruda for treatment of any solid tumor with microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR). This is the first ever approval of a mutation-specific, rather than tissue site-specific approval based on the cancer's origin – i.e. lung or breast. The nod is being hailed as a boon for personalized medicine. *FDA*

Amazon is reportedly looking to foray into the world of mail order pharmacy. But, the complex drug distribution and reimbursement system in the US may be a high barrier to entry for such a disruptive change. Still, Amazon could have some success by going after the cash-pay market for inexpensive generic drugs or brand drugs with discount coupons from manufacturers. *Drug Channels*

Recent press reports have shed light on the somewhat dubious industry of rehab patient brokering – where middlemen find patients around the country in need of addiction recovery support and "sell" them to the center willing to pay the best finder's fee. The practice is found in areas such as Southern California and Florida where there is a geographic concentration of treatment centers vying to attract out of state patients with a change of scenery and warmer weather. The practice is coming under scrutiny of local law enforcement and regulators. *STAT News* and *The Orange County Register*

The FDA has asked for the voluntary removal of the opioid pain medication Opana ER. Injection abuse of the drug was recently tied to outbreaks of HIV and hepatitis. The move may signal new FDA commissioner Scott Gottlieb's aims to make curbs on the opioid epidemic a hallmark of his tenure. A spokesperson for the FDA could not rule out that the agency will not make similar requests of other opioid pain medications in the future. *Bloomberg*

From our Deerfield Foundation partners:
Duncan Maru, co-founder of Possible Health, recently co-authored a push for the global health community to improve its ability to collect data for interoperable electronic medical records used at any point of care. They argue the type of data that can be collected by these systems both allows for close to real time response to disease outbreaks, which can be mined at larger scales to improve health care systems performance. *The Lancet Global Health* blog

Last Mile Health CEO Dr. Raj Panjabi gave a recent *TED Talk* where he discussed the important work of community health workers and their ability to save lives. As winner of the 2017 TED Prize, Panjabi is building the Community Health Academy to modernize how CHWs learn vital skills.

DEERFIELD FOUNDATION

The Foundation has formed 34 partnerships and invested and committed over $30 million for the advancement of children's health in its 10 years, ranging from health clinics in Nepal to a mobile medical home for children in the South Bronx. In this newsletter we would like to highlight just one of the organizations that we feel is helping us fulfill our mission of advancing healthcare. We are proud to be critical supporters of Many Hopes.

MANY HOPES

Mission: Many Hopes rescues children from poverty and abuse and raises them with an imagination for justice and the tools to act on it. They provide a home, healthcare and an education to the local children and equip them to solve the problems that charity alone cannot. By rescuing, loving and educating children who have suffered the worst in life, Many Hopes is raising the generation of adults that will lead with justice and fairness and will defeat the causes of extreme poverty in Kenya.

Partner since: 2015

Description: Many Hopes was founded in 2009 by Kenyan journalist, Anthony Mulongo and UK journalist, Thomas Keown. While Anthony was working and living in Kenya, he came across a six year old girl named Gift on the street begging for food while she carried her infant brother on her back who was already dead. Gift's mother died of AIDS and she never knew her father. Anthony couldn't ignore this, so he took in and later adopted her. Anthony started helping and feeding other needy street children, but knew more had to be done. Thomas met Anthony and Gift in 2007, and later told their story in his Boston newspaper column. Readers there, in New York, and Philadelphia soon responded wanting to know how to help. Thus Many Hopes was born and has expanded with chapters in Boston, New York, Washington DC, San Francisco, London, Bristol, Belfast and Mourne. Many Hopes believes in a sustainable community and has purchased land to include a girls' home, boys' home, a school, community water tank, tilapia, fruit and vegetable farms, a playground and soccer field.

MANY HOPES
imagine you can

Total Funding: $100,000

The Deerfield Perspective: Good health is the foundation of Many Hopes' vision to raise children equipped to defeat the causes of poverty and injustice they have suffered. All the children in their homes have suffered physical and/or sexual abuse and emotional trauma before entering their care. These children are in immediate need of physical and psychological assessment, treatment and healing. This is the critical first step in being able to progress from traumatized to thriving.

Many Hopes Perspective: The partnership between Deerfield and Many Hopes has made lifesaving and life enhancing impact on the girls in our care. Together we have rescued girls from abusive situations and provided them with holistic care touching every area of their being. Deerfield's support has provided girls who have experienced severe physical and emotional trauma with medical treatment and healing from physical abuse. They have provided emotional healing through a child psychologist so children who may have suffered trauma have a chance at restoration and children who would not be in school are at the top of their class. We look forward to providing more healthy childhoods with Deerfield and we look forward to seeing the impact the children will have on others as adults.

Most Recent Project Funded: The cost of complete care from rescue to housing for each child in the Many Hopes home is $4,164 per year. The support of The Deerfield Foundation has provided holistic care and healthy childhoods to 12 of the 58 children in the Many Hopes girls home during the period of this grant by funding associated costs of the resources needed to improve their physical, emotional and intellectual health.

MEET THE FELLOWS

Beginning in 2015, Deerfield started the Deerfield Fellows program, designed to attract students with interest in pursuing healthcare or finance fields from local NYC-area colleges and universities from diverse backgrounds for an immersive summer internship program. Successful summer interns are invited to stay through a yearlong Deerfield Fellowship program, with the most successful of those graduating to become Associates at Deerfield. We are extremely proud of the work our Associates do, and here will highlight an Associate in each issue.

MEET ASHLEY KIM:

WHAT INITIALLY DREW YOU TO THE FELLOWS PROGRAM?

An advisor recommended that I apply given my strong interest in public health. Going through Deerfield's website, the charitable work that Deerfield does through the Foundation is what impressed me. "Advancing Healthcare" is our motto and knowing that we really are committed to doing so much foundation work is great. It places the onus on us to continue to work hard so that through our smart and strategic investments we can see breakthroughs and hopefully eventual cures.

WHAT IN YOUR EXPERIENCE HAS MATCHED YOUR EXPECTATIONS ABOUT BEING A DEERFIELD FELLOW AND NOW ASSOCIATE?

I didn't expect to learn so much. Graduating college is a daunting experience for people like me who really enjoy learning. As silly as it sounds, you can't help but wonder if graduating college is the equivalent to "taking the training wheels off," meaning you need to work towards applying what you learn instead of taking the time to simply learn. However, working at Deerfield has put things into perspective and helped me see that you never stop learning no matter where you are. Everyday I'm at Deerfield, I feel like I learn something new.

DESCRIBE A TIME OR TIMES YOU FOUND TO BE UNEXPECTED.

The whole concept of being an Associate is pleasantly unexpected. As Associates, we have the ability to rotate within the Deerfield Institute and at the same time be involved in the private transactions deal process. We are learning how the deal process flows and in tandem being involved in the market research group which supports the company's investment decisions and partner companies. I never heard of a creative role like that of an Associate and I genuinely appreciate this experience and opportunity.

DESCRIBE YOUR MOST MEMORABLE EXPERIENCE AT DEERFIELD.

I certainly loved the Central Park Zoo event [a day at the zoo for Deerfield'ers and their families].

WHAT ADVICE WOULD YOU GIVE TO FUTURE FELLOWS?

Never stop learning, stay humble, and give thanks to those who have helped you get to where you are today. Quoting Vincent Van Gogh, "Great things are done by a series of small things brought together."

WHEN NOT AT DEERFIELD, I CAN BE FOUND:

Reading, trying new food, snowboarding, traveling, and watching the latest movies.

ONE FUN FACT ABOUT YOU!

I really like chicken feet.

Photo courtesy of Ashley Kim

IMPORTANT NOTES AND DISCLAIMER

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