2019

COMMUNITY DEVELOPMENT MATTERS FOR HEALTH & WELL-BEING

Key Findings & Case Studies from the Healthy Communities Demonstration Project

Working Together for Strong Communities®

NeighborWorks® AMERICA

THANK YOU

Thanks to support from the
Robert Wood Johnson Foundation and the
County Health Rankings & Roadmaps Program

COVER PHOTO
Photo credit: pexels.com

CONTENTS

CREDITS

Lead writer: Sarah Norman, director of healthy homes and communities, NeighborWorks America

Contributors: Deborah Dehab, Enquire Research
Melissa Nemon, Nemon Consulting
Pamela Bailey, former storyteller, NeighborWorks America
Paul Singh, acting vice president of Community Initiatives, NeighborWorks America

Healthy Communities Demonstration Project

The Healthy Communities Demonstration Project was funded by NeighborWorks America and the Robert Wood Johnson Foundation. The County Health Rankings Roadmaps Program, a collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin, provided additional resources, including coaching to six participating organizations.

We would like to acknowledge the following individuals for their contributions to this collaborative project:

Ericka Burroughs-Girardi, community coach, County Health Rankings & Roadmaps Program

Thomas P. Deyo, former vice president of real estate, NeighborWorks America

Andrea Ducas, senior program officer, Robert Wood Johnson Foundation

Maggie Grieve, vice president of Success Measures, NeighborWorks America

Aliana Havrilla, community coach, County Health Rankings & and Roadmaps Program

Astra Iheukumere, assistant director of community networks and national partnerships, County Health Rankings & Roadmaps Program

Kitty Jerome, action team center director, County Health Rankings & Roadmaps Program

Susan Jouard, health champion and senior manager for the Field Division, NeighborWorks America

Nancy Kopf, director for Success Measures, NeighborWorks America

Lauren Hornett, health champion and senior director for the Field Division, NeighborWorks America

Kate Kingery, deputy director of community transformation, County Health Rankings and Roadmaps Program

Rachel Malis, former manager for resource development, NeighborWorks America

Christy Metzler, director for corporate strategy and impact, NeighborWorks America

Jessica Mulcahy, director for Success Measures, NeighborWorks America

Lynn Peterson, health champion and senior manager for the Field Division, NeighborWorks America

Justin Rivas, community coach, County Health Rankings & Roadmaps Program

Angela Rohs, health champion and senior manager for the Field Division, NeighborWorks America

Hillary Rowe Wiley, health champion and senior manager for the Field Division, NeighborWorks America

Paul Singh, acting vice president of community initiatives, NeighborWorks America

Ascala Sisk, former vice president of community initiatives, NeighborWorks America

Hieu Truong, senior project manager for community initiatives, NeighborWorks America

Katie Wehr, senior program officer, Robert Wood Johnson Foundation

CHAPTER 1

EXECUTIVE SUMMARY: KEY FINDINGS

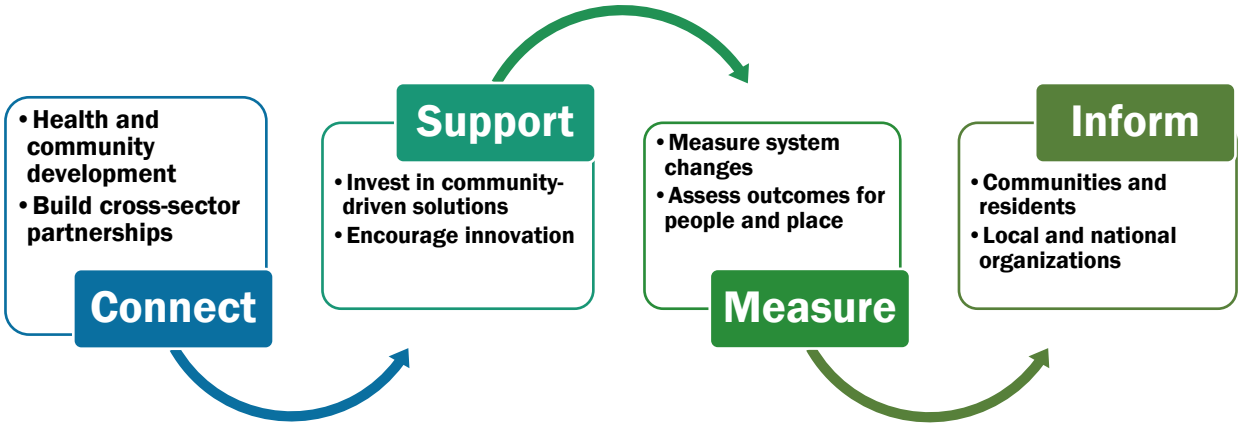
We know that where we live affects our health. Life expectancies can differ by more than 20 years between neighborhoods. But how do you change that? In other words, how do residents, community-based organizations and cross-sector partners start to close the life expectancy gap between our healthiest neighborhoods and our least healthy neighborhoods?

In 2015, NeighborWorks America, the Robert Wood Johnson Foundation and the County Health Rankings & Roadmaps Program launched a collaboration designed to help NeighborWorks member organizations develop their own answers to those questions. Along the way, NeighborWorks and our partners hoped to better understand how organizations tackled this question, what it meant for their communities, and how national organizations can support and scale these strategies to meet local needs.

With these goals in mind, our collective effort – known as the Healthy Communities Demonstration Project – supported 28 organizations in rural, urban and suburban communities across the United States. While advancing measurable outcomes was important, we also wanted to build the next generation of leaders and partnerships. Accordingly, we engaged organizations at three different stages in this journey, starting with early efforts where much was unclear and progressing through to mature efforts with partners, systems and metrics in place.

The 28 participating organizations received a total of $1.3 million in grants, in addition to participating in a robust learning community, during a 13-month period. This report examines the results, outcomes and impacts of this work to community health, to cross-sector partners, and to the organizations themselves. It is intended to help organizations who are interested in building health and equity, and the grant-makers and funders who want them to be successful. And if you're new to this conversation, we have provided a glossary of some common terms to help you along this journey.

Figure 1: Healthy Communities Demonstration Project Design



RESULTS

Together, the 28 participating projects leveraged $1.3 million to achieve impressive results. **Organizations combined and layered strategies to develop comprehensive approaches to large-scale health challenges.** All organizations addressed at least two different categories of social determinants of health (e.g., housing and access to health services). At least 17 organizations addressed four categories: community context; housing; access to health services; and food and wellness.

Collectively, the participating organizations demonstrated their ability to leverage funds, achieve scale and engage diverse community members:

- **Leverage:** $22.8 million was attracted from local and state partners, representing a leverage ratio of approximately 17:1.

- **Scale:** The participants engaged 43,164 residents in strategies to promote community health and well-being. Many of the efforts were designed, co-created and led by resident leaders; all were shaped by extensive consultation with community members.

- **Inclusion:** 52 percent of activities engaged individuals who are homeless and/or formerly homeless; 52 percent engaged individuals who were uninsured; and 56 percent engaged individuals who were immigrants or refugees. In terms of race and ethnicity, organizations most commonly reported engaging White (81.5 percent of organizations), Latinx (81.5 percent), and Black (77.8 percent) community members. In addition, almost one-third of organizations reported that Native American/Alaskan Native (29.6 percent) and Asian American/Pacific Island (29.6 percent) community members were among primary populations served.

- **Geography:** The efforts spanned 17 states, serving urban, suburban and rural communities. 22 percent of projects primarily engaged rural communities.

Appendix 1 provides brief summaries of all 28 projects; and the case studies included in this report take a deeper look at lessons learned by three participating organizations. These case studies explore efforts in major cities, small towns as well as rural communities:

- **Community Housing Partners** (Christiansburg, Virginia) collaborated with local nonprofits and a for-profit hospital to help seniors to age with dignity in one of their rental communities in Hopewell, Virginia. Project elements included certified green and healthy buildings; better access to healthy, affordable food; care coordination; and social connection. Outcomes included a 29 percent reduction in 30-day hospital readmissions, a 61 percent reduction in emergency department visits, and a 65 percent decrease in 911 calls, when comparing a one-year period in 2016 and the same period in 2017.[1]

[1] Data was provided by local hospital John Randolph; more data and analysis are available in the case study on Community Housing Partners included in this report.

- **New Kensington Community Development Corporation** (NKCDC; Philadelphia, Pennsylvania) co-created with residents a model for trauma-informed community development in a neighborhood struggling with historic disinvestment and the rising opioid epidemic. The case study describes their trauma-informed approach, including the development of a resident leader training curriculum, how NKCDC's internal culture has changed, as well as how they are assessing and evaluating impact.

- **Willamette Neighborhood Housing Services** (Corvallis, Oregon) leads a health equity alliance that has engaged multiple systems to achieve regulatory changes, including new property maintenance codes that promote healthy housing. A specific focus of the case study is the effort by Willamette Neighborhood Housing Services to partner with residents to build a healthy rental community. As part of that effort, they developed a community health worker program in partnership with a regional Medicaid provider. Their efforts reduced emergency department usage and costs, resulting in a long-term partnership with the Medicaid provider.

Collectively, the participating organizations demonstrated the ability of community development organizations to lead and support multisector efforts that achieve measurable improvements in community health and well-being.

- **Outcomes documented:** Of the 15 organizations that completed preliminary or final-outcome evaluations, all 15 demonstrated improvements in health and/or social determinant of health indicators. While the project design and length meant that not all organizations completed outcome evaluations during the project period, 15 organizations completed evaluations that demonstrated improvements in food security and access, police-community relations, housing stability, park usage, collective and individual self-efficacy, physical fitness, self-reported health status, as well as diverse clinical measures.

- **Emergency department usage:** Of the six organizations who analyzed emergency department usage, all of them reported reductions in emergency department usage.

Participating organizations, in collaboration with cross-sector partners, also catalyzed meaningful shifts to the systems that influence where and how you live, work, learn and play. **Indeed, this project created shifts in the local community development systems and in other external systems.**

- **External systems:** The project documented shifts in practice, programs, and policies in seven external systems (health, social services, food, infrastructure, education, transportation and employment).

- **Investment in prevention:** Externally, these partnerships redirected investments from "sick care" toward "well care" – prioritizing investment in the upstream determinants of health that prevent illness and support length and quality of life.

- **Resident leadership:** Cross-sector efforts amplified resident voices, reshaping health and other institutions based on community needs, assets and priorities.

As for the community development field, cross-sector partnerships and a focus on health equity influenced board governance, strategic direction, as well as program delivery, development and evaluation.

- **Holistic approach**: By investing in the capacity necessary to support cross-sector partnerships, the Healthy Communities Demonstration Project strengthened organizations' ability to understand and respond to residents' priorities in a more holistic way by incorporating health into their mission, strategic plans and core operations. Moreover, some organizations used a health equity framework to respond to the legacy and current experiences of segregation, racism and other discrimination.

- **Sustainability:** Cross-sector partnerships bolstered the sustainability and viability of community-based organizations, expanding their visibility, policy presence, and financial position. Among other benefits, more than half (57 percent) of participating organizations diversified their investments and obtained funding from a new health partner by the conclusion of the grant period.

Over the last several years, NeighborWorks America increasingly has recognized that health is both a core focus and outcome of comprehensive community development. The Healthy Communities Demonstration Project reaffirmed that belief and provided evidence as to the ways in which community development organizations support the evolution of systems to better reflect residents' priorities and improve health outcomes.

Ultimately, this project both reinforced our commitment to community health as well as providing direction to our future work. To achieve our vision, we have developed a roadmap for our healthy communities' work over the next several years. The plan calls for us to:

- **Embed health equity:** Integrate health equity into our way of doing business.

- **Innovate and evaluate:** Advance the future of community development by incubating, evaluating, and scaling approaches that promote housing stability, community leadership and health equity.

- **Partner:** Develop national collaborations with health and other cross-sector partners to support local partnerships and system integration.

- **Build capacity and learning:** Support the advancement of this work in the network and the larger community development field through learning collaboratives, training, investment and other capacity-building strategies.

- **Raise visibility:** Participate strategically in the national conversation and elevate the importance of community-based, community development strategies to improve health and well-being.

This plan responds to the needs we heard from community-based organizations in our network for tools, partnerships, and resources to build cross-sector partnerships. We invite like-minded organizations to work with us to build a future where every community is a community of health and opportunity.

CHAPTER 2

PROJECT OVERVIEW: BACKGROUND AND PROJECT DESIGN

SETTING THE CONTEXT

At NeighborWorks America, our commitment to community health and well-being has its roots in 40 years of work in disinvested neighborhoods. NeighborWorks America was created in 1978 to build community-driven solutions to stabilize and strengthen neighborhoods. Over the past 40 years, NeighborWorks organizations have led community building and engagement, neighborhood planning, and community revitalization strategies in disinvested communities across the country. And our funding, technical assistance, training and other capacity-building programs have evolved to support diverse strategies to build thriving communities.

While NeighborWorks America and our nearly 250 member organizations have long contributed to the health of communities across the nation, we recognized that we could do more several years ago.

What do we mean by health equity?

"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."[1]

— The Robert Wood Johnson Foundation

Starting in 2013, NeighborWorks deepened our focus on community health through two major investments. The first investment was in the development of a comprehensive set of data collection tools designed to capture the health outcomes of community development. Informed by a literature review, we developed an evaluation framework and a set of 68 data collection tools that were field-tested in eleven diverse communities. This set the stage for the Health Outcomes Demonstration Project, a collaboration of NeighborWorks America and Enterprise Community Partners, supported by the Robert Wood Johnson Foundation (RWJF) , Kresge Foundation and Hearst Foundation.

In 2014, NeighborWorks created the Healthy Homes & Communities Initiative to design corporate strategies to leverage our interconnected systems to improve health and well-being.

NeighborWorks launched this effort with a survey of our membership on their work at the nexus of health, housing and community development. These results revealed the NeighborWorks Network was already prioritizing health at levels greater than expected, but also highlighted opportunities for additional impact. Preliminary results were published as a working paper with Harvard's Joint Center on Housing, with final results in peer-reviewed journal *Cities and Health*.[2]

To ground our work, we convened an advisory committee of senior leadership from community development organizations from across the nation. Collectively, they identified the need for national partnerships that supported local partnerships. Collaboration with the RWJF and the County Health Rankings & Roadmaps (CHR&R) Program brought this strategy to life.

HEALTHY COMMUNITIES DEMONSTRATION PROJECT

In 2016, NeighborWorks, CHR&R and RWJF launched an effort to spur cross-sector partnerships that promote health equity. By pairing investments from RWJF with grant funds from NeighborWorks, 28 network organizations were provided a total of $1.3 million to develop and implement community and data driven strategies to improve health outcomes. We called this effort the "Healthy Communities Demonstration Project." To complement the funds, we developed a robust learning community called the "Health Learning Community."

GOALS AND FRAME

The Healthy Communities Demonstration Project was designed to promote health equity at three levels: community, organizational and national. More specifically, the goals were:

- To more closely connect community development to health in order to improve the lives of the people that we serve
- To build the capacity of community development organizations and strengthen cross-sector partnerships that promote community health and well-being
- To promote and measure the health impact of community development
- To inform NeighborWorks America and national partners as we deepen our commitment to holistic approaches to community development that improve health and well-being.

To achieve these goals, we organized the project into three levels of organizational readiness and used five primary selection criteria to select participants. These included: 1) use of data for learning and improvement, 2) community engagement and leadership, 3) cross-sector collaboration, 4) sustainability, and 5) potential to advance health equity. For applicants in the most advanced category, we also considered the reach, scale, inclusion and innovation of the approach.

---

[2] Schnake-Mahl, A. & Norman, S. (2017). Building healthy places: how are community development organizations contributing? *Cities & Health, 1*(1), 47-58. doi: 10.1080/23748834.2017.1327921

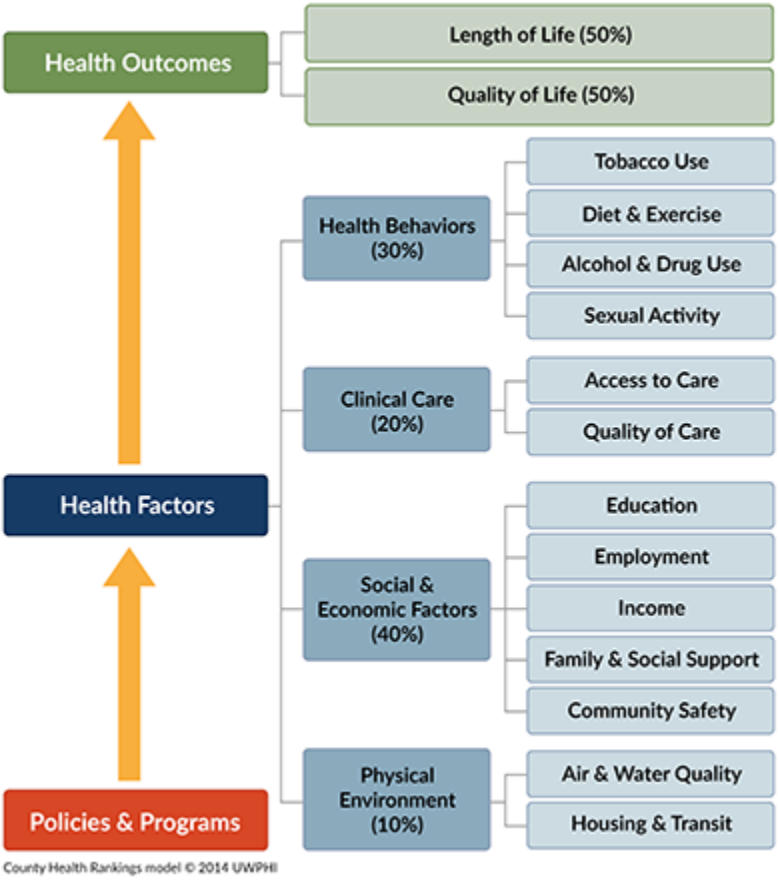


Figure 1. County Health Rankings model: social determinants of health

We used the social determinants of health framework to shape a broad definition of health, as shown in Figure 1. This model highlights the role of nonmedical factors, including housing, employment, income, transportation and education, in shaping the length and quality of life. A literature review and other resources supplemented the rankings model and highlighted the critical role that housing and community development play in addressing the social determinants of health.

In the project launch, three key roles were articulated for community development to align its work with the social determinants of health and the ultimate goal of health equity.

- Community development builds affordable housing, community assets and community leadership that stabilize communities.
- Community development incorporates principles of health into the design, development and maintenance of housing and other community assets.
- Housing and community development serve as a platform for services that improve health outcomes. By developing community-led, locally oriented services and strategies, we help individuals to maximize their health.

DESIGN: ORGANIZATIONAL READINESS

To support capacity at different stages of development, the project was organized into three levels of organizational readiness: 11 "seed" grants of $25,000 supported nascent efforts, six mid-level "roadmaps to action" grants of $35,000, and finally 11 "innovation" grants of $75,000 for mature efforts.

TABLE 1. FUNDING AND DESCRIPTION OF THREE-TIERED GRANT-MAKING APPROACH

Category	Number	Description	Funding
Seed	11	Seed grants were designed for organizations that had begun exploring the intersection of health and community development but had not necessarily identified all relevant cross-sector partners or selected strategy(s). The grant funds, thus, supported efforts to plan and pilot multisector initiatives to build health equity.	$25,000
Roadmaps to Action	6	Roadmap grants were designed for organizations with cross-sector teams in place who were looking to pivot from ad hoc collaboration to systematic partnership. These grants supported local action through cross-sector partnerships to reduce health disparities in their communities. Participating organizations were supported by CHR&R coaching, in addition to the Health Learning Community.	$35,000
Innovation	11	Innovation grants were designed for organizations strong cross-sector partnerships and evidence-informed joint initiatives that were entering or currently in the implementation phase.	$75,000

KEY PROJECT RESOURCES: "THE HEALTH LEARNING COMMUNITY"

The Healthy Communities Demonstration Project provided layered and customized skill-building resources, collectively titled the Health Learning Community. This included:

- *Peer-to-peer learning*: Peer-to-peer learning, including three meet-ups and seven peer-to-peer calls, supported both knowledge exchange and relationship building. Virtual cohort calls focused peer exchange on timely topics, while an in-person meet-up and a capstone convening fostered new relationships that persisted beyond the grant period.

- *Webinars:* Webinars were tailored to participants' priorities and needs. For instance, the number and complexity of questions around health care financing that emerged during our first in-person meet-up prompted a two-part webinar series on health care financing.

"We have evolved as an organization where we are not just housing, we are about neighborhoods, communities, creating a place where everyone can thrive. The Healthy Communities Demonstration Project helped us further that. Phone calls with groups were helpful, but more than that, the Healthy Communities Initiative at NeighborWorks was connecting people behind the scenes by email, providing information about resources, and helping to network."
– Brigetta Olson, Neighborhood Housing Services of Willamette

- *Coaching*: CHR&R coaches supported six organizations participating in the "Roadmaps to Action to Improve Health" cohort. Coaches met monthly with the organizations and their community partners, in addition to providing ad hoc consultation.

- *Evaluation technical assistance:* Three months after the project launched, eight participating organizations joined a cohort for Success Measures evaluation assistance, including receiving coaching on Success Measures Health Outcomes Tools. This was designed to address any unanticipated or new evaluation or assessment needs. A focus of the cohort coaching was the use of focus groups to better understand the priorities of residents and partners. For example, NeighborWorks Great Falls designed a focus group to better understand the needs of nurses and discharge coordinators at local hospitals.

- *Convening:* A capstone convening offered organizations the opportunity to meet in person to share successes and challenges as well as to learn from national leaders in the health field. The capstone convening was designed by a committee of practitioners from participating organizations.

- *Network-weaving*: We performed both systematic and customized network-weaving. On the systematic side, we connected network organizations located in the 10 states with the most significant health needs with CHR&R coaches and resources. From a customized perspective, we connected network organizations based on specific local priorities with both external stakeholders (e.g., city officials, national health experts, insurance providers) and their peers (e.g., other organizations that are using the same case management software).

- *List-serve*: We launched a list-serve to share resources among project participants, designed to support grantee discussions around timely topics as well as to introduce project

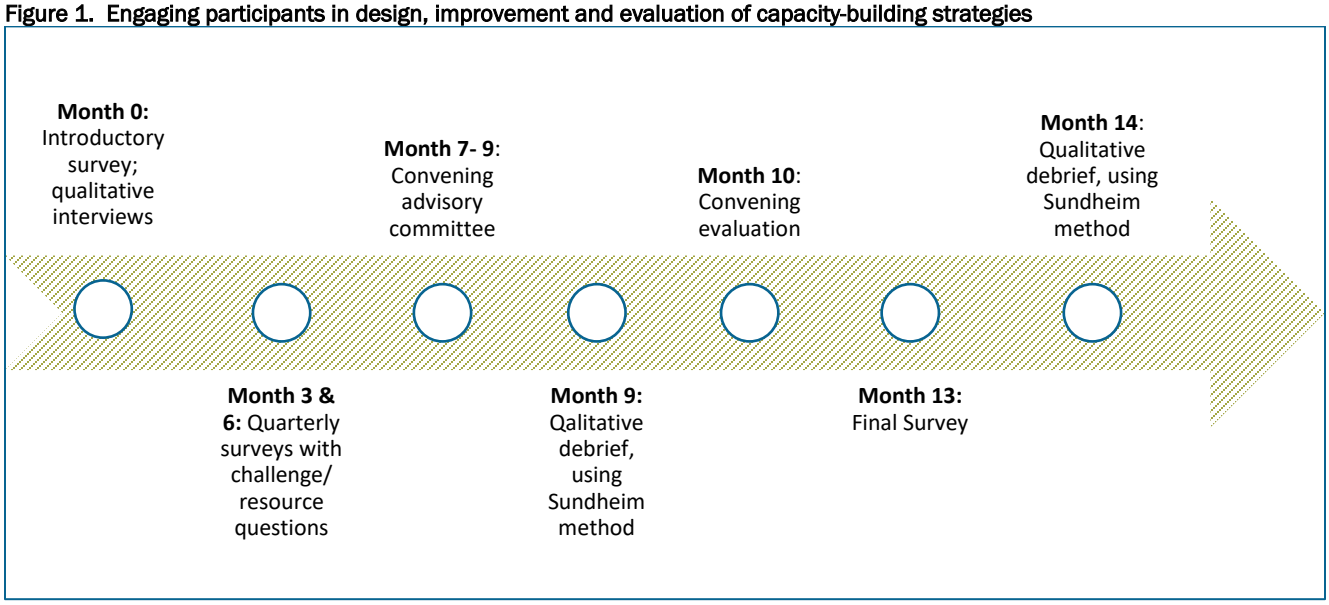
participants to a wide range of resources from diverse national leaders in the field. Funding opportunities, training, webinars, toolkits and reports were common resources.

- *Highlighting best practices:* During the project, we developed publications, blog posts, and presentations as we worked with NeighborWorks organizations to disseminate best practices through national and regional platforms in the health and community development fields.[3] This national engagement provided benefits to both the audience and the presenting network organizations; network organizations received valuable feedback and new visibility. It also helped network organizations to refine their story as they shared it with additional partners and audiences.

- *Other technical assistance:* Program staff also provided one-on-one technical assistance on varied partnership and operational strategies.

Throughout the Project, capacity-building strategies were designed, refined and expanded with input from grantees throughout the project through nine qualitative and quantitative feedback channels (Figure 2).

Figure 1. Engaging participants in design, improvement and evaluation of capacity-building strategies



[4] County Health Rankings model, 2014. Available online at: http://www.countyhealthrankings.org/what-is-health

CHAPTER 3

APPROACHES AND STRATEGIES: USING THE SOCIAL DETERMINANTS OF HEALTH TO IMPROVE HEALTH AND WELL-BEING

OVERVIEW

Supported by the Health Learning Community and other investments, the 28 participating organizations collectively addressed all social determinants of health through interconnected, holistic strategies. By supporting community-led approaches to health equity – as opposed to one national approach – we were able to surface approaches that work across diverse geographies and contexts.

To reflect this work, we developed an adapted social determinants of health framework that crystalizes the most common ways in which community development organizations are building health equity. At least 17 organizations addressed housing, health services and food as well as community and social context. Organizations combined and layered strategies to develop comprehensive approaches to large-scale health challenges.

Although organizations pursued diverse strategies, four common models emerged from the project that combined multiple social determinants of health:

- Collective solutions-building;
- Housing as a platform for health and well-being;
- Investment and maintenance to create healthy homes; and
- Food as a facilitator for health and opportunity.

These models represent a break from traditional health strategies, which are often more narrowly focused. All models elevate community leadership in shaping and implementing strategies. Understanding emerging models helps us to interpret their outcomes as well as to identify models that are ready to scale nationally.

Of course, it is important to acknowledge that this field is still evolving. Even during the project, organizations adjusted their approaches. For instance, organizations often integrated economic stability strategies — such as financial coaching, job training, and small business development – during the project. This represents an ongoing shift by multiple fields towards root causes of poor health (such as jobs and housing), rather than addressing the symptoms (such as hypertension).

APPROACHES AND STRATEGIES

As described in Chapter 2, we framed the project using existing frameworks for the social determinants of health.[4] During the course of this project, the collective work of participants inspired us to modify existing frameworks to reflect the most common levers of action used by community-based organizations. Figure 1 uses this updated framework to provide an overview of the work performed by participating organizations. Community and social context, housing, health services and food were the most common categories, with between 17 and 20 organizations addressing each determinant. All organizations addressed at least two major categories, with most addressing three through layered approaches that braided varied funding streams. To show what these efforts looked like on the ground, we have provided a project summary for each organization in Appendix 1.

[4] County Health Rankings model, 2014. Available online at: http://www.countyhealthrankings.org/what-is-health

Figure 1. Project approaches organized in a modified social determinants of health framework

HEALTH DETERMINANT	MOST COMMON STRATEGIES	# OF GRANTEES REPORTING STRATEGY
ECONOMIC OPPORTUNITY	• Financial coaching and literacy • Small business development • Income support enrollment • Job training & placement	9
HOUSING	• Stable, healthy rental homes • Healthy, secure and affordable home ownership • Eviction prevention and housing stability • Fall prevention and safety inspections in senior housing • Green/healthy construction, rehab and management of rental homes and/or owner occupant homes • Health equity considerations when locating new sites for affordable housing	18
NEIGHBORHOOD ENVIRONMENT	• New and improved green spaces, playgrounds and recreational facilities • Neighborhood safety initiatives • New or redesigned infrastructure investments (sidewalks, crosswalks, storefronts, vacant lot upgrades) • Property maintenance codes and enforcement	11
FOOD & WELLNESS	• Grocery stores • Farmers markets and community gardens • Community sustainable agriculture • Food hubs and/or kitchen incubators • Cooking demonstrations or classes • Food distribution or shared meals • Exercise classes	17
COMMUNITY ENGAGEMENT & CULTURE	• Resident-led programming and planning: co-design • Civic engagement • Diversity and inclusion interventions • Arts and cultural activities • Trauma-informed community building	20
EDUCATION & YOUTH DEV.	• After school, summer school or camp • Youth leadership development • Higher education	6
HEALTH SYSTEMS: ACCESS, QUALITY AND INTEGRATION	• Integrated health and behavioral health services • Health needs assessment • New health facilities • Community health workers	19

The totals shown in Figure 1 reveal the summation of work by project participants at project completion. This is a critical distinction, as organizations evolved their approaches and partnerships to better address health equity over the course of project. Most commonly, organizations incorporated financial coaching strategies over the course of their project.

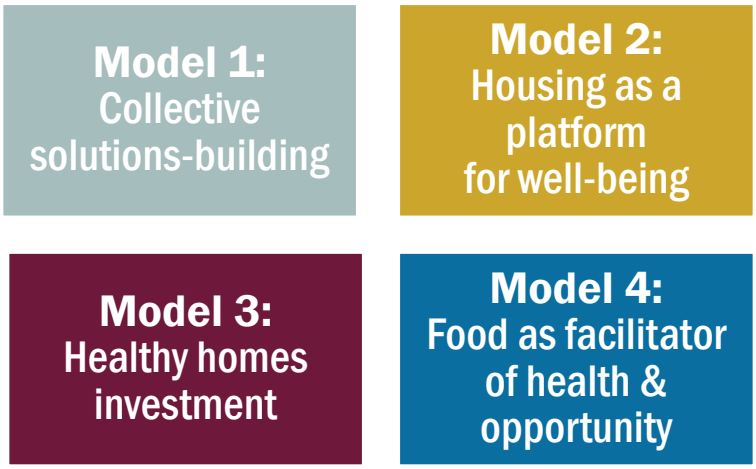
In Hempstead, New York, that's exactly what happened. Community Development Corporation of Long Island Inc. (CDCLI) developed a peer health ambassador program for seniors, which initially focused on falls prevention, safety, and navigation of health and social services in a public housing development. After several months, they recognized the opportunity to better connect the residents with the financial capability services that CDCLI provides. As a result, they developed new programming and workflows to integrate their financial coaching with their work in Hempstead.

The adoption of new strategies reflects a broader evolution of approaches during the project, which is explored further in Chapter 5, "System Changes: Evolution of Practices and Partnerships to Prioritize Health."

SCALABLE MODELS

While organizations' approaches were all different, we identified four models of how organizations combined social determinants (see Figure 2). Each of these models engaged multiple determinants of health, with their category name focusing on the primary role and focus of the community development organization. Understanding these emerging models helps us to interpret their outcomes as well as to identify emerging models that are potentially scalable.

Figure 2. Most common models and roles of community development organizations in cross-sector strategies designed to promote community health and well-being



Naturally, some projects did not neatly align with these general categories, such as the effort by Lawrence Community Works Inc., in Lawrence, Massachusetts, to partner with a local federally qualified health center to create an integrated system that supports both physical and financial health.

MODEL 1: COLLECTIVE SOLUTIONS-BUILDING

The first model, which we called "collective solutions-building," encompasses the most expansive approach. We developed the term since organizations were influenced by a broad range of national and local models that have distinct philosophies and originated in different fields. This model is aligned with the participatory planning processes foundational to comprehensive community development as well as urban and regional design. It also shares characters with the collective impact model that originated in the social services sector, in which community leaders deprioritize their individual agendas in service to a broader collective agenda with clearly defined outcome goals.[5] And from the health sector, this work is most closely aligned with "Health Equity Zones," which are intentional efforts to leverage various federal, state, and local sources of prevention, categorical disease, and population health funding to better serve specific geographic areas and eliminate health disparities. Indeed, two participating organizations — ONE Neighborhood and NeighborWorks Blackstone River Valley — were leaders in health equity zones, in this case those designated by the Rhode Island State Department of Health.

In general, these efforts started with a resident engagement process and resulting plan, with community members determining priorities, making critical decisions and leading activities. Structured coalitions were common components, with the NeighborWorks organizations frequently serving as the backbone entity for the coalition. While some of these efforts were linked to specific neighborhoods, others focused on larger geographic areas, such as counties or regions.

An example of a holistic approach in two largely rural counties can be found in the case study on Willamette Neighborhood Housing Services. The organization serves as the backbone entity for a Health Equity Alliance that engaged seven systems — from education to transportation — to build health and well-being in the Linn and Benton counties of Oregon.

A second example is the work led by Avenue Community Development Corporation in Houston, Texas, where Avenue CDC developed a neighborhood vision and plan, shaped by the residents of a largely low-income neighborhood. This plan prioritized better access to healthy foods, improved mental health services and support, better access to health care resources, and expanded pedestrian, bicycle, and recreational amenities and programs. Driven by a collective vision, Avenue CDC worked with 500 residents and community partners to develop 12 new and improved green spaces and playgrounds, finance a new Federally Qualified Health Center, and set healthy community goals for 2020, all while leveraging more than $2.1 million.

[5] Kania, J. and Kramer, M. (Winter, 2011). Collective Impact. *Stanford Social Impact Review*. Available online at: https://ssir.org/articles/entry/collective_impact#

MODEL 2: HOUSING AS A PLATFORM

This second model amplified the impact of affordable housing by improving all the elements of housing that influence health, including design and siting decisions, construction and maintenance, resident services and engagement, as well as partnership development and neighborhood context.

The housing anchor for these efforts typically were organizations with significant rental portfolios and sophisticated resident services programs. In this scenario, organizations engaged residents and partners to improve health outcomes for residents, generally focusing on one of three populations: 1) families, 2) seniors, and/or 3) frequent utilizers of health care. The case study on Community Housing Partners (CHP) in Hopewell, Virginia, provides an example of an affordable housing provider collaborating with health and social service organizations to improving care coordination, build social connections and improve access to food for seniors living in their rental community. Collaboration with a local for-profit hospital allowed CHP to document reduction in hospital readmission rates and emergency department usage.

Less frequently, organizations applied their housing expertise to connect unstably housed individuals to affordable housing that they didn't necessarily own or manage. In Camden, New Jersey, St. Joseph's Carpenter Society served as a liaison with varied landlords to support placement of frequent users of the health care system in housing, using Housing Choice Vouchers. In Chelsea, Massachusetts, The Neighborhood Developers worked with housing insecure families with young families to find them housing and address other critical needs. Thus, NeighborWorks organizations leveraged their housing knowledge and credibility to encourage other housing providers to house community members who may have been perceived as "risky" by other rental providers.

MODEL 3: INVESTMENT IN HEALTHY HOMES: REPAIR AND REHAB

Like the second model, this model also focuses on housing as foundational to health. Unlike the second model, NeighborWorks organizations focused their approach on the quality of the physical structure. More specifically, this model uses repairs and maintenance to improve housing quality and health outcomes, and health and social services were addressed by health partners.

While players in the health sector long have understood the connection between housing quality and health, a renewed focus on this relationship is supporting new investments. Medicaid waivers, Medicaid state plan amendments and hospital endowment funds represent some of the new funding sources.

NeighborWorks Western Vermont, for instance, developed and implemented the practice of "doctor-prescribed" home improvements to improve health throughout Western Vermont. This work grew from a partnership with the local hospital, Rutland Regional Medical Center. As a Community Development Financial Institution (CDFI), NeighborWorks Western Vermont blended hospital endowment funds and Community Development Block Grants to expand the reach and scale of doctor-prescribed healthy homes rehab for recent patients of the medical center.

MODEL 4: FOOD AS AN ENGINE FOR HEALTH AND OPPORTUNITY

The final scalable model uses food as a catalyst for nurturing health and opportunity. While these efforts center on food access, quality and affordability, they also address other determinants of health. A conscious focus on the connection between food, culture and community promotes social cohesion and collective efficacy. And critically, job training and entrepreneurship are common priorities in this model.

One example of a food-oriented strategy comes from Woonsocket, Rhode Island. During an assessment of the local food environment, 43 percent of residents reported they had run out of money to buy food at least once over the past year, and 75 percent of respondents used some sort of food-assistance program.[6] In response to these challenges, as well as opportunities created by growth in the regional food sector, NeighborWorks Blackstone River Valley developed a headquarters for food-related activities. This hub includes a community café, farmers market, as well as a kitchen incubator and small business development center.

MOVING TO OUTCOMES AND SYSTEM CHANGES

The Healthy Communities Demonstration Project surfaced four common models for cross-sector partnerships designed to promote community health and well-being. Each of these models integrated and layered multiple upstream social determinants of health. This represents a break from traditional health strategies, which are often more narrowly focused and hence more easily evaluated.

In Chapter 4, we will explore the available outcome data, addressing both challenges and successes of participants' holistic evaluative strategies. And in Chapter 5, we will investigate how these efforts are addressing the root causes of poor health through system changes in the health and housing systems and beyond.

[6] KK&P. (March 31, 2016). *Woonsocket HEZ Food Access Plan*. Woonsocket, RI. Available online at: http://www.health.ri.gov/materialbyothers/hez/WoonsocketHealthEquityZoneFoodAccess.pdf

CHAPTER 4

BUILDING THE EVIDENCE BASE: OUTCOMES & IMPACT

OVERVIEW

Can community-based organizations partner with cross-sector partners to build health equity and demonstrate results? And can holistic strategies — rather than the narrowly defined approaches typical in the health and medical field — generate outcomes?

The Healthy Communities Demonstration Project suggests that the answer to both questions is "yes."

The 28 participating organizations improved indicators across key health determinants as well as health outcomes. Given the range of approaches and community priorities, organizations used varied outcome indicators, with the most common health indicators being emergency eepartment (ED) usage as well as self-reported health and well-being. Six organizations demonstrated reductions in emergency services; others reported improvement in food security and access, financial security, housing quality, housing stability, primary care usage, vaccination rates, collective and individual efficacy, physical fitness, among others. Ultimately, 15 organizations reported outcome improvements. And all 28 organizations reported system changes, which is explored further in Chapter 5, "Systems Change: Evolution of Practice and Partnerships to Prioritize Health."

These outcomes are occurring at significant scale (43,164 people served) and investment level (18:1 investment ratio). Moreover, the 28 participating organizations engaged diverse community members in diverse settings, including race/ethnicity, insurance status, housing status, and geography (e.g., rural, urban or suburban).

While these results are encouraging, the Healthy Communities Demonstration Project was not designed solely to demonstrate improvements in health outcomes. This project primarily was a capacity-building effort designed to support new leaders and partnerships. In addition, the short project period meant that longer-term outcomes were not captured. This makes the breadth and extent of outcomes even more impressive.

METHODOLOGY: APPROACH AND CONSTRAINTS

As described in Chapter 2, the Healthy Communities Demonstration Project provided funding and robust capacity-building to 28 organizations across 13 months. To seed new partnerships and strategies, the Healthy Communities Demonstration Project was organized in three tiers, supporting nascent, mid-level and mature efforts. The project prioritized evaluation design in selection and provided specific technical resources around evaluation. For example,

participating organizations with gaps in their evaluation strategies were offered support in implementing NeighborWorks America's Success Measures tools via the accompanying learning community.

There are significant challenges to assessing health outcomes associated with community development. As researchers Schuchter and Jutte explain, "There is no clear guidance for reconciling the established systems for measuring community development activities and outputs — such as housing units built, jobs created and people served — with the outcomes and impacts of health."[7] Different stakeholders have different perceptions of what characterizes a meaningful outcome. Moreover, effective place-based strategies require a complex interweaving of multiple systems, stakeholders and community-level conditions, which often means progress is nonlinear.[8]

Accordingly, we did not collect standardized outcome indicators, allowing organizations to tailor indicators to the approach and community priorities. At a national level data, standardized data primarily focused on activities, approaches and system changes.

Recognizing these constraints, this chapter looks at health-related outcomes by examining data

> Outcomes were defined as changes in individuals' knowledge, status or behavior, or in community conditions, quality of life, health or well-being.

and documents that were in the public domain, submitted by project participants and/or developed for this project. For our analysis, we looked for outcomes that indicate changes in collective community conditions or individuals' health knowledge, status or behavior.

Despite these and other challenges, project participants successfully employed diverse measurement strategies to document improvements in health and well-being, as well as their key determinants.

COMMUNITY AND PROGRAM OUTCOMES

Organizations used community-level and program-level evaluations to document and enhance outcomes:

- 86 percent (24 organizations) have started or completed program evaluations.
- 43 percent (12 organizations) have started or completed community-level change assessments.

[7] Schuchter, J. &Jutte, D.P. (2014). A Framework to Extend Community Development Measurement to Health and Well-Being. *Health Affairs, 33*(11), 1930-1938.
[8] Auspos P. & Kubisch A.C. (2012). Performance Management in Complex, Place-Based Work: What it is, what it isn't, and why it matters. Washington, DC: The Aspen Institute.

Fifteen organizations completed an outcome evaluation prior to project completion, with results in the following categories: 1) housing, 2) economic well-being, 3) neighborhood environment, 4) education, 5) food, 6) social context and community cohesion, and 7) health and well-being. All demonstrated improvements in one or more category.

Table 1 provides health and well-being outcomes, including: self-reported knowledge, attitude, behaviors, symptoms and status; health care cost and use; and clinical characteristics. As the project supported programs at varying levels of maturity, the tables include preliminary results as well as final metrics. Many of the evaluations addressed a subset of the overall strategies of participating organizations.
Additional detail can be found in Appendix I, which provides a summary of all organizations' strategies and results, the three case studies, as well as reports listed in the footnotes.

TABLE 1. CHANGES IN HEALTH OUTCOMES, UTILIZATION AND COST

Health care utilization, costs and clinical outcomes (using clinical records)	• In Camden, New Jersey, a "Housing First" supportive housing strategy resulted in a 63 percent reduction in hospital use for 47 formerly homeless individuals. Program sponsors included Saint Joseph's Carpenter Society and the Camden Coalition of Health Providers. • In Portland, Oregon, Housing With Services LLC (affiliated with REACH CDC) partnered with Portland State University to document statistically significant increases in resident access to primary care clinics (91 percent), flu vaccinations (80 percent) and preventive screening (89 percent).[9] This effort provide enhanced health and social service coordination for 1,400 residents at 11 federally subsidized, independent living, affordable housing properties. Project elements include culturally specific services for non-English-speaking residents; food distribution for homebound residents and other residents experiencing food insecurity; health navigators; and free mental health consultations. • In Corvallis, Oregon, a community health worker program led by Willamette Neighborhood Housing Services documented a reduction of ED visits and related per-member, per-month costs among residents of Willamette NHS' rental communities.[10] These data were provided by local partner Intercommunity Health Network Coordinated Care Organization. • In Phoenix, Chicanos Por La Causa and United Health Care Group conducted a six-month pilot involving 50 individuals with diabetes and reporting at least three ER visits over one year. Blood sugar levels and ED visits decreased among participants who received healthy foods and nutrition education from the partnership's pantry. This pilot was the precursor of a similar efforted supported by the Healthy Communities Demonstration Project.[11]

[9] Carder, P.C., Luhr, G., West, M., & Morgan, B. (2016). *Housing with Services Program Evaluation.* Portland, OR: Institute on Aging, Portland State University.
[10] The Willamette Neighborhood Housing Services Case Study provides three years of per-member, per-month data for Emergency Department Visits and costs.
[11] Duffrin, E. "Playing Matchmaker for UnitedHealthcare and an Arizona Neighborhood," Build Healthy Places Network, Nov. 14, 2016. Available online at:
https://www.buildhealthyplaces.org/whats-new/playing-matchmaker-unitedhealthcare-arizona-neighborhood/

	• In Hopewell, Virginia, a partnership between Community Housing Partners and local nonprofit Controlled Outcomes was associated with a 29 percent reduction in 30-day hospital readmissions, a 61 percent reduction in emergency department visits, and a 65 percent decrease in 911 calls, when comparing a one year period in 2016 and the same period in 2017.[12] Collectively, the partners embedded new access to healthy food, care coordination, and activities designed to promote community cohesion into a multi-family residence with 100 rental homes serving seniors and/or individuals with disabilities.
Health knowledge, attitude, behaviors and symptoms (using self-reports)	• In San Diego, Community HousingWorks (CHW) together with the Scripps Whittier Diabetes Institute implemented an evidence-based diabetes prevention strategy, which was associated with documented improvements in self-reported diabetes knowledge, physical fitness, strength, flexibility and weight among participants.[13] (In the program, 22-33 percent of participants in two cohorts reported weight loss of at least 5 percent.) The program was based on the Center for Disease Control's Diabetes Prevention Program. To address all social determinants of health, CHW layered resident-led activities as well as environmental strategies on top of the lifestyle program. • In Great Falls, Montana, a move from older to newer housing facilitated by the NeighborWorks affiliate was associated with several health benefits, including an elimination of injuries from falls and chronic headaches and a reduction in asthma symptoms (50 percent of participants reported two or less days with symptoms per month).[14]
Well-being (self-reported health, perceptions of stress, purpose and/or meaning)	• In San Diego, participants in the Community HousingWorks/Scripps Diabetes Prevention Program reported reduced stress, as measured through pre- and post-tests of participating residents in five CHW rental communities. For the two prevention cohorts, this represented a decrease in the average reported perceived stress level; for the diabetes management cohorts, this represented a reduction in the number of participants reporting feeling overwhelmed due to diabetes distress. • In Hempstead, New York, CDC Long Island's evaluation of a falls prevention intervention in a rental community documented multiple health and well-being improvements among a representative sample (n=15) of the mostly elderly, Black female participants. The overwhelming majority (99%) reported feeling more satisfied with their lives. In addition, participants reported incorporating specific exercises into their daily lives (93%), assessing and remediating fall hazards (53%), among other fall prevention techniques.

In addition to health outcomes, organizations also reported outcomes across the social determinants of health, including economic opportunity, housing, neighborhood environment, education, food, and community engagement and culture. (See Table 2. As in Table 1, this table includes both preliminary and final results.)

[12] Data was provided by local hospital John Randolph; more data and analysis are available in the case study on Community Housing Partners included in this report.
[13] Data analyzed and reported by Scripps Wittier Institute, 2018.
[14] Data derived from Success Measures Health Outcomes Pilot, a collaboration of NeighborWorks' Healthy Homes & Communities Initiative and Success Measures, conducted in 2017.

TABLE 2. OUTCOMES USING A SOCIAL DETERMINANTS OF HEALTH FRAMEWORK

Economic opportunity (Income, debt, credit scores, investment)	• In Chelsea, Massachusetts, preliminary data from the Health Starts at Home Project run by The Neighborhood Developers and three other organizations showed a decrease in the number of families spending 50 percent or more of their incomes on housing costs, a decline in those staying in shelters or with friends and an increase in those living in quality housing. The Health Starts at Home Project serves housing insecure families referred by health providers; it integrates housing stability services, employment opportunities, financial coaching, and other social services to improve both housing and health outcomes.[15] • Over the course of 2017, Lawrence CommunityWorks (Massachusetts) evaluated its financial coaching services. After financial coaching, a greater proportion of participants reported setting aside money for savings, feeling secure about their financial position and maintaining a budget.[16]
Housing (stability, quality, affordability and inclusion)	• In Corvallis, Oregon, Willamette Neighborhood Housing Services improved eviction prevention policies, procedures, and practices in their rental communities – preventing 97 evictions between January 2016 and August 2017. New eviction prevention strategies, including trauma-informed approaches and greater coordination between property management and resident services staff, also prevented the issuance of eviction notices. • In Camden, New Jersey, Saint Joseph's Carpenter Society provided rental homes to 47 chronically homeless individuals, of which 78 percent had co-occurring mental health and substance abuse disorders. Through its Housing First collaboration with the Camden Coalition of Health Providers, 89 percent of these clients have remained stably housed.
Neighborhood environment (parks, infrastructure, transportation)	• In Montana, NeighborWorks Great Falls partnered with the Great Falls Parks Department to provide "play in the park" activities as well as communal meals in parks located in four low-income neighborhoods. Directly engaging 1,040 children during a one-year period, the strategy was associated with an overall 22 percent increase in use of four parks. • In Providence, Rhode Island, ONE Neighborhood Builders and 13 community partners in the Olneyville Health Equity Zone doubled the number of safe walking routes in the Olneyville neighborhood through "Walking School Buses," street assessments and improvements as well as other strategies; this in turn doubled the number of children able and willing to walk to school.
Food (hunger, food access, inclusive regional food system indicators,	• In the Olneyville neighborhood of Providence, ONE and its health equity zone partners increased by 24 percent the number of residents reporting no barrier to obtaining healthy food. Food-related strategies in their health equity zone included Veggie Vans and community meals.

[15] Health Resources in Action (2018). *Health Starts at Home Initiative – Summary of Core Measure Outcomes as of 09/30/17*. Preliminary report not yet published.
[16] This data includes all financial coaching clients, not just those referred by the local health partner. As a Level 2 "Roadmaps" grantee, Lawrence CommunityWorks has framed its evaluation model and referral strategy, but has not completed a separate evaluation of the partnership strategy.

healthy eating behavior)	• In its Oak Park neighborhood, NeighborWorks Sacramento (California) increased the accessibility of its farmers market to low-income individuals, averaging five new customers per week using its matched incentive program for electronic bank transfer (food stamp) purchases. Quarterly, they averaged $10,000 in electronic bank transfer purchases for healthy food. Outreach strategies included: outreach flyers and doorhangers as well as partnerships with local cultural organizations, libraries, community centers and other neighborhood institutions.
Community context (social cohesion, community engagement, discrimination and inclusion)	• A community health worker program led by Community Development Corporation in Hempstead, Long Island, New York, was associated with an improvement in self-efficacy and social cohesion measures for the residents who served as peer health ambassadors. Specifically, community health workers reported increased capacity to organize and lead events as well as improved connections with their peers/fellow residents in post-test assessments, in comparison to baseline. • In Providence, Rhode Island, ONE Neighborhood Builders and community partners documented increases in police-community relations through pre- and post- surveys in the Olneyville neighborhood. 65 percent of residents in the Olneyville neighborhood reported to ONE Neighborhood Builders that they are comfortable working closely with the police.

While project evaluation methodologies were tailored to each organization's approach and thus differed significantly, some broad themes emerged:

- **Trends in emergency department usage were among the most commonly reported outcomes**, with reductions in emergency departmentusage documented by six of the 28 organizations (Community Housing Partners, Willamette Neighborhood Housing Services, Chicanos Por La Causa, REACH, St. Joseph's Carpenter Society and The Neighborhood Developers).[17] Emergency department visits and calls are routinely collected and geographically analyzed, and thus are among the most easily evaluated outcomes, particularly for organizations integrated into the local health system. In addition, they are available from multiple sources, making them easier to access for community development organizations. Some organizations sought ED-related data from one source, were rebuffed, and then were able to obtain it from a second source. Ultimately, participating organizations obtained these data from local hospitals, fire department services, all-payer claim databases, and accountable care organizations.

- **Broad measures of well-being and/or stress were common**. Indeed, a focus group of seven participating organizations selected self-reported health as the most universally applicable health indicator. However, fewer organizations reported results using this indicator prior to project completion — for reasons ranging from the sensitivities of the issues involved to the necessity of collecting pre- and post-intervention data. For example, some community development practitioners considered stress a challenging issue to address in their dual role as housing providers. Alternative approaches were used effectively by Community

[17] Additional organizations reported reductions in emergency department usage after project close, including AHC of Greater Baltimore.

HousingWorks and CDC Long Island, which launched initiatives led by residents or community health workers that documented improvements in self-reported stress.

- Within this project, organizations were more likely to document outcomes at the program-level, rather than at the community-level. **Community-level outcomes require long-term, sustained and significant investment, and may become more common as the field matures.**

- **Community residents often were engaged in the design, collection, evaluation and dissemination of results**. Significant engagement of residents in evaluation design resulted in greater participation in surveys and focus groups — and ultimately, more meaningful evaluation results.

- While the outcomes are significant, it is also important to acknowledge that **resident engagement pushed organizations to redefine success**. Indeed, several organizations changed their definition of success — based on deepening understanding of resident priorities. As Jorge Riquelme, vice president at Community HousingWorks (CHW) explains, "Until recently, success was defined in terms of homeownership. CHW conducted focus groups with residents from a sampling of our properties, including multifamily developments and those for the elderly, across different geographies. The focus groups revealed that while some residents did want homeownership, most seniors wanted to age in place — whether that meant a home they owned or a rental community." As for individuals who were formerly homeless, their primary goal was simply a stable home. As a result, CHW redefined success to prioritize a stable, healthy, affordable home (of any type); improved financial capability among clients; and development of a strong resident community.

SCALE AND INCLUSION

These outcomes are occurring at significant scale and investment level as well as engaging diverse community members. The participating NeighborWorks members leveraged a relatively small investment ($1.3 million across 28 organizations) to achieve significant scale:

- $22.8 million was attracted from local and state partners, representing an approximately 18:1 leverage ratio.
- 43,164 residents were engaged in efforts to build health equity.

Figure 1. Scale, Reach and Inclusion of the Healthy Communities Demonstration Project

$28.8 million	43,164 residents	Reach & inclusion
• 28 CDOs leveraged $22.8 million from local and state partners. • 18:1 ratio.	• 28 CDOs engaged 43,164 residents to build health equity.	• 52 percent of activities engaged individuals who are **homeless** and/or formerly homeless. • 22 percent served **rural** communities.

DIVERSITY AND INCLUSION, STARTING WITH RACE AND ETHNICITY

As the project was designed to build health equity, understanding whether and how participating organizations engaged diverse community members was critical. At the most basic level, the project surveyed participants to understand engagement across the following categories: race, ethnicity, insurance status, income, housing status, and geography (rural, suburban, and urban).

In terms of race and ethnicity, organizations most commonly reported engaging white (81.5 percent of organizations), Latinx (81.5 percent), and black (77.8 percent) community members. In addition, almost one-third of organizations reported that Native American/Alaskan native (29.6%) and Asian American/Pacific Islander (29.6 percent) community members were among primary populations served.

A health equity lens supported shared work by the community development and other sectors to address some of the deepest causes of inequity — including racism, segregation, and other discrimination. Multiple participating organizations used a health equity lens to address a range of discrimination, from racism to marginalization of the LGBTQ+ community.

Willamette Neighborhood Housing Services, for example, engaged more than 800 community members in discussion about cultural competency, racism and health equity in the Linn and Benton counties of Oregon. It hosted a series of implicit bias workshops in two communities, attracting over 100 attendees; provided health equity training for 300 people and community leaders. It also co-sponsored a three-part "Living the Black Experience" workshop with the local NAACP and supported the local elementary school in its programs to integrate Spanish- and Arabic-speaking families into the broader community. This work is described further in our case study on Willamette Neighborhood Housing Services.

In Philadelphia, New Kensington Community Development Corporation's (NKCDC) trauma-informed community development approach similarly explicitly addressed racism and other structural discrimination. Their trauma-informed community development model recognizes that low-income residents often are impacted by "daily stressors of violence and concentrated poverty, as well as

historic and structural conditions of racism and disenfranchisement." This effort is further described in our case study on NKCDC.

INCOME, INSURANCE COVERAGE AND RESOURCE STATUS

In general, participating organizations engaged underserved individuals. More than half of nonprofits described reaching individuals who were uninsured (52 percent) as well as homeless and/or formerly homeless (52 percent).

For some organizations, this represented a continuation of their typical focus. For others, it represented a shift of engagement strategies with corresponding challenges. The latter most commonly occurred among organizations that expanded their homeownership, financial coaching and/or loan programs to serve patients referred by health providers. In general, the new clients had fewer resources than the clients the organizations traditionally served.

For example, the financial capability programs offered by The Neighborhood Developers (TND) in Chelsea typically are very effective at improving assets and credit scores among homeownership clients and rental residents. However, these services were less accessible for the unstably housed individuals referred by Massachusetts General Hospital. In response, TND expanded its focus on employment and housing connection services, rather than relying on financial coaching alone. In addition, the organization is exploring ways to extend financial coaching services to patients who are housing secure, but financially insecure.

LOCATION: RURAL, URBAN AND SUBURBAN

Twenty-two percent of programs offered by participating organizations served rural communities, which reflects the overall distribution of the U.S. population. (Approximately 20 percent of Americans live in rural communities.[18]) Several project participants described experiencing additional challenges in rural environments, including fewer partners with less resources as well as difficulties serving and engaging individuals who were more spread out geographically. As documented elsewhere, hospital closures, inadequate provider networks, and transportation were more common challenges for organizations working in rural areas than those in suburban or urban areas.

Still, shared concerns — across urban, rural and suburban communities — challenge the common narrative that urban and rural communities face an unbridgeable divide. Indeed, multiple project participants emphasized the power of developing strategies that prioritized shared rural and urban needs.

Charlie Hopper, director of the Hardesty Renaissance Economic Development Corp., run by Asian Americans for Equality (AAFE), explained why this strategy was critical, in the context of their multi-million-dollar effort to develop a food and economic development hub in Kansas City, Missouri. "The biggest challenge this project always faces is its complexity, but in the end, its biodiversity is what has allowed it to survive at a time when many similar efforts are struggling," explains Hopper. "The

[18] U.S. Census Bureau (2016). New Census Data Show Differences Between Urban and Rural Populations. Release number: CB16-210. Retrieved at https://www.census.gov/newsroom/press-releases/2016/cb16-210.html

fact that this project is rooted in shared urban and rural community and economic needs (not agendas) has allowed it to grow a cross-cultural movement behind it."

Participants emphasized the common experience of disinvestment among the communities they served located in urban, suburban *and* rural geographies. The application of trauma theory[19], along with related community-building practices[20], thus was embraced by urban, suburban and rural participants as an overdue acknowledgment of individual and collective trauma in disinvested communities. Staff at some rural organizations, such as the Lakes Region Developers in New Hampshire, have extensive experience with trauma-informed healing approaches.

According to Kerri Lowe, resident services director for Lakes Region Developers, "Trauma theory resonated with me because it explicitly addressed discrimination that our residents face — largely because they are poor. Organizations and systems have repeatedly closed their doors on our residents, and they know it." This narrative of trauma and healing resonated powerfully across diverse geographies.

Distilling the commonalities in rural, urban and suburban contexts has informed NeighborWorks' vision for the future, which we describe in Chapter 6, "Building Healthy Communities – At NeighborWorks and Beyond."

PATHWAYS TO SCALING

We started this chapter with two questions. First, can community-based organizations effectively partner with multiple stakeholders to advance health equity and document meaningful improvements in health outcomes? And second, can holistic strategies — rather than the narrowly defined approaches typical in the health and medical field — generate significant outcomes?

The answer is a resounding yes.

From meaningful improvements in housing stability to reductions in emergency department visits, NeighborWorks organizations are demonstrating the power of community-based efforts when partnered with the technical and sometimes financial resources of larger institutions. These results are necessarily limited by sample size and other methodological constraints. While the project was not designed to evaluate outcome improvements for all efforts, we nonetheless documented measurable advances in community conditions and health outcomes in 15 communities.

Organizations supported by the Health Communities Demonstration Project used varied strategies to assure quality and improve results, from focus groups to healthy-home standards, and from community health worker certificate programs to NeighborWorks Training Institute courses. While some quality improvement approaches (such as construction standards) are well established, others

[19] Substance Abuse and Mental Health Services Administration. Retrieved May 15, 2018 from http://www.samhsa.gov/nctic.
[20] Weinstein, E. Wolin, J. and Rose, S. (2014). Trauma-informed Community Building: A Model for Strengthening Community in Trauma Affected Neighborhoods. San Francisco: BRIDGE Housing, Health Equity Institute.

are less so. Community health worker certificate programs are still evolving, for example. Likewise, approaches to resident services vary significantly, with only one national standard and certificate program available.

Moreover, organizations from the health and community development fields often are stymied by the complexity of evaluating strategies that tackle multiple, interconnected social determinants of health. Furthermore, there are significant challenges in quantifying return on investment.

To move this work forward, NeighborWorks plans to continue to:

1) Strengthen the capacity of community-based organizations and residents to assess and understand community priorities;

2) Prioritize community-led strategies to both build the evidence base as well as to adapt the evidence base to varied local contexts and community priorities;

3) Support standards, certificates, and other strategies that demonstrate the power of community development organizations to improve health and equity; and

4) Partner with like-minded national organizations to align frameworks and better support cross-sector strategies to use data for learning and impact.

Ultimately, greater investments in data and evaluation will propel investment in the system changes that tackle the root causes underlying the inequities in health outcomes.

CHAPTER 5

SYSTEM CHANGES EVOLUTION OF PRACTICE AND PARTNERSHIPS TO PRIORITIZE HEALTH

OVERVIEW

Systems-level changes address the root causes of social challenges, which are often stubborn, complex and interrelated. While individuals play a part, so do institutions, policies and cultural norms. For example, ending homelessness cannot be accomplished by assisting homeless individuals in isolation. It requires working across systems — health, housing, education and economic development — to address the multiple, underlying causes of homelessness.

The Healthy Communities Demonstration Project allowed us to better understand how community-based organizations can both lead and support efforts to change system changes that promote health. This chapter explores the experience of project participants to answer the following questions:

- Are community development organizations – in partnership with residents and partners — able to catalyze system changes, particularly in the health arena?
- If so, how and what makes those improvements possible?
- What does this mean for the way community development organizations operate?

During this project, we observed seven key changes spurred by cross-sector partnership efforts, both for our member affiliates and for external fields. In the health sector and other fields external to community development, the project enhanced four trends:

1. Expansion of upstream investments in social determinants of health in under-invested communities;
2. Deeper integration of social systems, facilitating a “whole person” approach that improved outcomes;
3. Amplification of resident voices, thus reshaping health and other institutions based on community priorities; and
4. Shifting of resources and leadership from large institutions to community-based organizations.

As for the community development field, cross-sector partnerships and a focus on health equity influenced board governance, strategic direction, as well as program delivery, development and evaluation. Three themes emerged in those changes:

1. By investing in the capacity necessary to support cross-sector partnerships, the Healthy Communities Demonstration Project strengthened organizations’ commitment to understand

and respond to residents' priorities in a more holistic way by incorporating health equity into their mission, strategic plans, and core operations.

2. Better cross-sector partnerships resulted in increased understanding and use of data and evidence to improve work in communities.
3. Organizations used a health equity framework to respond to the legacy and current experiences of segregation, racism and other discrimination.

Figure 1 illustrates the two interrelated developments that occurred during the project: *External system changes,* including increased levels of cross-sector engagement, collective response to community priorities, and upstream investments and joint ventures focused on social determinants of health; and *Internal system changes,* including shifts in the organizations' board engagement, strategic direction, business practices, approaches to evaluation and skills development.

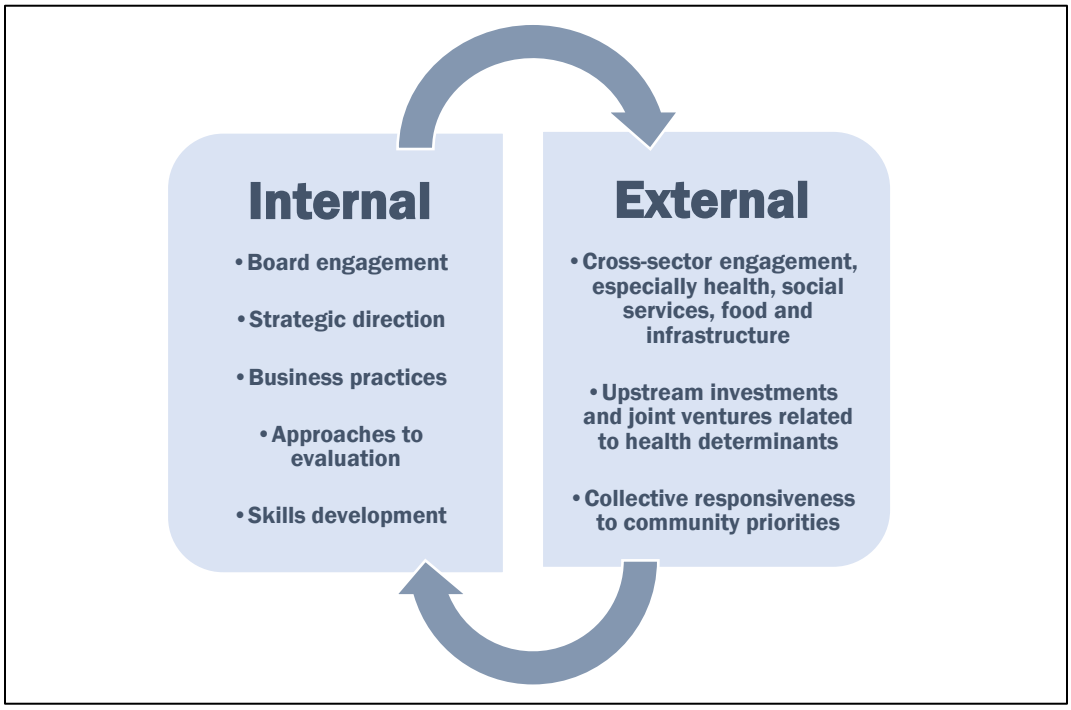


Figure 1. Internal and external system changes observed from increased engagement of housing and community development strategies focused on social determinants of health

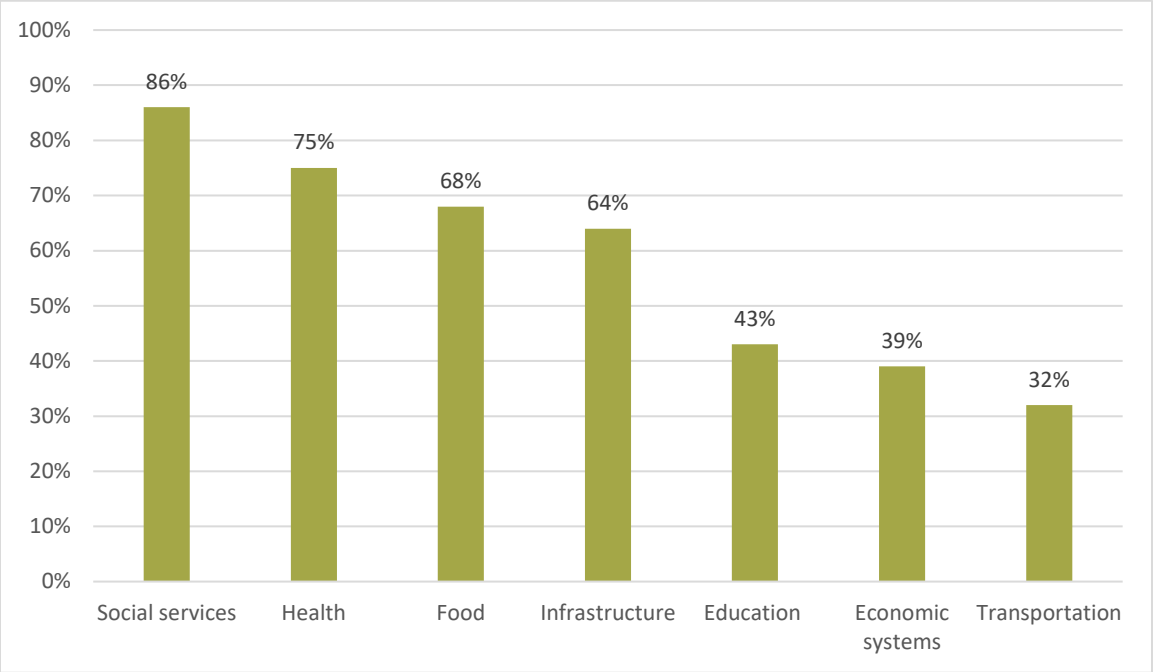
While this chapter documented significant shifts in systems that promoted health and opportunity, it is critical to note that these changes required substantial, long-term investment at both the national and the local level. This included both national funding and technical assistance, as well as consistent, committed community leadership. Furthermore, systems change is not linear or neat. Engaging community members and external stakeholders sometimes required dramatic shifts in strategy to accommodate new thinking on priorities, challenges and opportunities.

PARTNERSHIP DEVELOPMENT: CROSS-SECTOR IMPACT

The primary driver of system changes — inboth community development and external systems — was the development and deepening of cross-sector partnerships. **During the project, partnerships improved in both number and quality, with organizations reporting a large or moderate improvement in the number of partners (96 percent), diversity of partners (93 percent) and trust between parties (92 percent).**

As shown in Figure 2, participants reported increased collaborations with stakeholders across seven sectors: social services, health, food, parks, recreation and infrastructure, education, economic systems and transportation.

Figure 2. Percentage of organizations that increased collaboration with stakeholders in seven systems



Within the health sector, participating organizations reported deepening partnerships with the "usual suspects" (public health agencies and health centers, for example), but also with more complex, larger institutions. During the project, these organizations created new partnerships with health insurance companies (14 percent), nonprofit and for-profit hospitals (25 percent and 21 percent, respectively), public health departments (25 percent) and other government agencies (25 percent).

The project helped us better understand the process required for maturation of such partnerships, from early collaborations with assessments and pilots, yielding more diverse coalitions and joint enterprises, which then set the stage for system changes that support sustainable business models. (See Figure 2.)

TABLE 2. MODEL OF MATURATION OF PARTNERSHIPS

Stage 1: Early	Stage 2: Middle	Stage 3: Mature
Development of partnerships with nontraditional allies • Map and learn about external stakeholders' systems, priorities, goals and language. • Cultivate new relationships with stakeholders from both internal and external sectors; explore shared values. • Explore internal capacity, limits and roles. • Form and engage in coalitions. • Design and implement pilot(s) that support partnership goals.	**Improvement in the quality, diversity and efficacy of partnerships** • Convene nontraditional partners to develop a shared vision, approach and desired outcomes, and/or identify shared interests and solutions. • Deepen relationships and build trust. • Adjust core business practices based on stakeholder input; strengthen internal capacity. • Develop sustainability strategies. • Engage in joint endeavors.	**Deepening of partnerships and setting the stage for sustainability** • Lead/engage in collective-impact efforts. • Serve as backbone organization for community-based, cross-sector partnerships. • Support or encourage changes based on priorities developed with another sector/system. • Move partnership to sustainability. • Form and sustain formal structure for coordinating efforts, such as an LLC.
Early success indicators • Quality/efficacy of partnerships • Community need/asset-assessment results • *Pilots*: quality-of-life improvements	**Mid-level indicators** • Investments • System changes • Achievement of shared goals or solutions • Quality-of-life improvements	**Maturity indicators** • Investments • System changes • Achievement of shared goals or solutions • Formalized partnerships • Development of sustainability indicators • Quality-of-life improvements

While this model was informed by frameworks developed by ReThink Health, Meadows and the County Health Ranking & Roadmap Action Center,[21] our typology primarily reflects the findings from the 28 organizations participating in the Healthy Communities Demonstration Project.

Two characteristics distinguish these typologies from other similar typologies. First, it highlights the potential to document measurable outcomes at an earlier stage. For example, Community Housing Works in San Diego, California, was able to work with the Scripps Whittier Diabetes Institute to develop, recruit, implement and evaluate a diabetes prevention and management strategy in their rental communities during this project. As a result, they documented measurable improvements in body mass index, diabetes knowledge and physical fitness.

Acknowledging the potential for early measurable outcomes does not deny the need for time to obtain large-scale, sustained change. Rather, it acknowledges the urgency of addressing significant health disparities, the potential to move the needle quickly in certain limited situations and —

[21] "How Multi-Sector Health Partnerships Evolve", available online at: https://www.rethinkhealth.org/the-rethinkers-blog/how-multi-sector-health-partnerships-evolve/

perhaps most importantly — the need to obtain early wins to attract the support needed to sustain longer-term efforts.

The second element that distinguishes this partnership typology from others is the acknowledgment that a shared vision may not be necessary for success. Partners may come to the table to achieve different outcomes. While mission-driven organizations care generally about overall quality of life for residents, specific goals may differ. A housing organization may be motivated primarily by housing stability, while a health stakeholder may see housing merely as a means to prevent hospital readmissions. In the case of for-profit partners, understanding and accommodating this fundamental difference in goals is particularly critical. Peggy Bailey who directs the Connecting the Dots Project at the Center for Budget and Policy has also observed this trend in her work, which similarly seeks to align health and housing systems in cross-sector efforts; and she has characterized this approach as "looking for shared solutions, rather than a shared vision."

Ultimately, this project helped us to both propel and better understand cross-sector partnerships. This leads to a very simple but important set of questions: how did these partnerships help to build community health? How did they shift systems to hold them accountable to residents? To understand this better, we will explore the impact of these cross-sector partnerships on external systems first, and on the community development field second.

IMPACT OF CROSS-SECTOR PARTNERSHIPS ON EXTERNAL SYSTEMS

Cross-sector partnerships supported four changes across seven external systems, from health and social services to transportation and infrastructure.

➢ External Systems Change 1: Greater integration of health and human services with housing

The Healthy Communities Demonstration Project was designed, in part, to facilitate deeper integration of health, housing and human services. At the most basic level, this was manifested by embedding medical staff in housing or other community-based organizations. Almost 20 percent of participating organizations reported that health care providers located services at housing complexes or in their community centers. On-site health services were central to the strategies of REACH CDC in Portland, Oregon; Chicanos Por La Causa in Maryvale, Arizona; AHC of Greater Baltimore in Maryland; and CDC of Long Island, New York.

Many of these efforts went beyond simple colocation strategies to fully integrate health, housing and social services for varied populations.

In New Jersey, NeighborWorks member St. Joseph's Carpenter Society partnered with the Camden Coalition of Health Providers and other local partners on a Housing First effort for patients of an aaccountable care organization that were medically complex and housing-insecure or homeless. In this program, homeless individuals who have been hospitalized at least twice in six months, or have excessive emergency room utilization, and have two or more chronic conditions are identified by a

team of providers who connect the individual to housing-choice vouchers and help them secure a safe place to call home with dedicated medical and behavioral health services provided. This root-cause approach has resulted in a 63 percent reduction in hospital use for 47 formerly homeless individuals and 89% of clients stably and safely housed with services.

Housing with Services LLC, affiliated with REACH CDC, integrated health, housing and social services for 1,400 residents at 11 federally subsidized, low-income, independent-living rental communities. Through a comprehensive assessment system, the program tracks housing stability, health status, and access to health and social services. The result is a comprehensive approach that has produced statistically significant improvements in primary-care access, food insecurity and vaccination rates.[22]

However, integration of health and housing comes with significant challenges. For example, Housing with Services was forced to end on-site mental and behavioral health services because the number of clients was not large enough to justify the expense to health providers. As the Housing with Services team learned, it is crucial to determine the patient-visit volume necessary to make on-site services feasible.

➢ External Systems Change 2: Increase in investment and joint ventures

One of the most consistently observed changes during the project was a shift in resources from large institutions to community-based organizations. These smaller, local organizations have deep, long-standing ties to the neighborhoods and communities they serve and offer a unique bridge between residents and systems. **More than half (57 percent) of participating organizations diversified their investments and obtained funding from a new health partner by the conclusion of the grant period.**

In Montana, for example, NeighborWorks Great Falls partnered with hospitals to file a joint application to the Montana Health Care Foundation. Sixteen institutions and agencies signed memoranda of understanding for the grant, which will help the partners develop a continuum of care plan for Cascade County to provide housing with supportive services to vulnerable individuals, particularly people who are homeless or housing-insecure.

A very different example comes from California, where NeighborWorks Sacramento developed a partnership with University of California-Davis Medical Center (UCMC) and assumed leadership of the school's farmers market. This shift in leadership was driven by UCMC's recognition that the market's success depended on the deep relationship between NeighborWorks Sacramento and the surrounding community.

Meanwhile, NeighborWorks Orange County in California forged new partnerships that brought sustainability to a resident-led social enterprise, Santa Ana Active Streets (SAAS). The alliance obtained new funding by winning a city-administered, state-funded contract for a bicycle and pedestrian safety education program.

---

[22] Carder, P.C., Luhr, G., West, M. & Morgan, B. (2016). *Housing With Services LLC Program Evaluation*. Portland, OR: Institute on Aging, Portland State University.

Marina Ramirez, a community building coach from NeighborWorks Orange County, explains the power of shifting to community-based organizations. Ramirez says, "Traditional projects are contracted to private firms that do not have existing relationships or familiarity with the community. Contractors come into a community for a set period, expecting to effectively engage residents who are unfamiliar with the agency and therefore are less willing to engage honestly, such as by answering questions without fear or shame. Most project coordinators understand the need to build bridges with residents, but SAAS recognizes that building trust is essential."

➢ External Systems Change 3: Increased investment in prevention

Multiple Healthy Communities Demonstration Project participants partnered with organizations in other sectors to increase investment in the upstream social determinants of health — most commonly, housing. Upstream investments support disease prevention and community well-being, which over time will decrease the demand for downstream services such as acute care and clinic-based services. This pay-now, save-later approach was the foundation for projects at Chicanos Por La Causa (Arizona) and NeighborWorks Western Vermont. Both organizations built significant partnerships in which large health institutions invested in housing, recognizing its importance to better health outcomes.

In the case of Chicanos Por La Causa (CPLC), United Health Group invested $22 million primarily in affordable housing with built-in community services. This investment built on an earlier collaborative effort in 2015, when United Health invested in and designed technology infrastructure to facilitate sharing of data related to clients of Maryvale Community Center, a CPLC hub for social services. This initial effort led to another investment in a CPLC-led project, a 500-unit apartment building. When complete, the complex will be a mix of market-rate and affordable housing, with many of the affordable-rate apartments serving low-income Maryvale Community Center clients.[23]

Elsewhere, NeighborWorks Western Vermont formed a partnership with the Rutland Regional Medical Center to support the Healthy Homes for Western Vermont project, which funds the repair of homes for elderly residents as well as people with chronic illnesses and/or disabilities. The purpose is to reduce the number of preventable accidents and injuries at home, as well as allow more individuals to safely age in place longer. The medical center has invested $75,000 in home repair, with the potential for the allocation of additional resources. In addition, center staff is evaluating health care use and outcomes, with the goal of persuading Medicaid to support home repairs.

While the investments of CPLC and NeighborWorks Western Vermont vary in size and type, several broad themes were observed among participants and the NeighborWorks network.

In many of the Healthy Communities Demonstration Project participants, investment began with philanthropy or public health partners. Over time, as the results were evaluated and shared, new

---

[23] Viveiros, J. (2016). *Investing in Affordable Housing to Promote Community Health: A profile on the UnitedHealthcare Community & State partnership with Chicanos Por La Causa*. Washington, DC: National Housing Conference. Retrieved from https://www.nhc.org/wp-content/uploads/2017/03/Investing-in-Affordable-Housing-to-Promote-Community-Health.pdf

partnerships were formed with increasingly complex, larger-scale institutions and supported by longer-term, more sustainable funding approaches.

Health systems such as Medicaid and managed care organizations continue to focus their financial investments primarily on individuals who are frequent and high-cost service users — typically those with multiple, chronic conditions. Each year, a fraction of the population accounts for more than half (59 percent) of U.S. health care costs; these individuals are frequently homeless or housing insecure and struggle with addiction and/or mental illness.[24] As a result, supportive housing remains the most frequent beneficiary of long-term investment by health care systems.

➢ External Systems Change 4: Amplified community voices in institutional decision making

Community engagement was critical to the Healthy Communities Demonstration Project. Indeed, it was one of the selection criteria for the project. This helped ensure residents were represented, heard and respected — especially when large, complex systems like health, transportation and infrastructure are involved.

Marina Ramirez, a community coach with NeighborWorks Orange County, shared her approach to equitable community engagement: "SAAS uses the following principles to incorporate resident engagement in each program and to guide the coalition: define and prioritize equitable engagement, incorporate engagement throughout the entire project, create opportunities to engage people with all levels of interest, recognize strengths and challenges, accept uncertainty and controversy, and build trust between project coordinators and residents."

Many organizations entrusted residents with decision-making authority over resource allocation. This doesn't mean that evidence or data were neglected or ignored. Indeed, organizations often structured decision-making processes so that external data and other forms of evidence informed residents as they made decisions.

Community Partners in Riviera Beach, Florida, provides one example of that approach: The RWJF Roadmaps to Action Grant and coaching from CHR&R supported a planning and early-engagement phase that led to a $1 million investment from the Palm Health Foundation. This latter investment was designed to improve health outcomes in three underserved communities in South Florida.

Community Partners held focus groups with the residents of Lake Worth to understand resident priorities as well as gaps in knowledge, resources and services. Community Partners learned that residents wanted better parks and other resources to support a healthy lifestyle but also recognized that they didn't know all the available local resources. The team held two "Party in the Park" events where residents learned about neighborhood recreational spaces. And they encouraged the development of a resident-led action team to shape and implement residents' recommendations.

---

[24] Cohen, S.B. (2014). *Differentials in the concentration of health expenditures across population subgroups in the U.S., 2012* (Agency for Health Care Research and Quality — Statistical Brief 448). Washington, DC: U.S. Department of Health & Human Services.

As trust grew, residents were asked: "What does a healthier Lake Worth look like?" Three core strategies were identified to achieve that vision: diabetes prevention and management, support for family caregiving and a focus on behavioral/mental health. Ultimately, residents selected behavioral as the most pressing challenge — meaning that **the $1 million investment will focus on this resident selected priority.**

Likewise, NeighborWorks member Willamette Neighborhood Housing Services (NHS) provided a platform to elevate resident voices. Willamette NHS provides small grants to smaller grassroots and cultural organizations to engage in the Linn Benton Health Equity alliance, shaping their priorities. For example, residents and community-based organizations successfully changed the city's property maintenance code to support healthier living conditions. Our case study on Willamette Neighborhood Housing Services provides more detail on the ways in which Willamette NHS amplifies resident voice to shape local systems.

One of the outcomes of this project was a deeper understanding of how community engagement can be harnessed to systems change efforts. (Table 1 describes the ways in which project participants deepened community engagement, supported collective decision making and cultivated resident leadership.)

TABLE 1. COMMUNITY ENGAGEMENT APPROACHES

Approach 1: Engage and understand	Approach 2: Empower	Approach 3: Encourage resident ownership
Amplify resident voice; assess needs, priorities and resources • Amplify resident voice through focus groups, qualitative interviews, surveys, art or photo essays and community events. • Form resident steering committees (or incorporate health into existing resident advisory committees). • Build resident capacity with training and other tactics. • Design equitable engagement strategies to support varying work schedules, etc. • Build trust between project coordinators and residents.	**Engage residents in program design and delivery; support volunteer efforts** • Inform program design with resident input. • Invite residents to serve as participants or volunteers in program delivery or data collection. • Invest in resident capacity through training and leadership development. • Foster multiple degrees and types of engagement tailored to varying interest levels and schedules. • Assure resident engagement is ongoing and repeated, rather than sporadic or time-limited. • Accept and adapt to uncertainty and controversy. • Build trust between project coordinators and residents.	**Foster resident-led/owned approaches** • Create resident-led programs and/or social enterprises • Enable residents to make key resource-allocation decisions. • Provide multiple levels of involvement to suit varying degrees of engagement. • Assure that resident engagement is ongoing and repeated, rather than sporadic or time-limited • Accept and adapt to uncertainty and controversy. • Use strategies such as trauma-informed community development to support and honor resident voices and leadership.

SPOTLIGHT: Community Engagement by the Santa Ana Active Streets Alliance and NeighborWorks Orange County

By Marina Ramirez, Community Coach

Santa Ana Active Streets (SAAS) is a resident-led social enterprise that centers our work around resident voice and decision-making. Our work goes beyond traditional community engagement in multiple ways. While traditional community engagement provides opportunities to collect resident input during project formation, SAAS goes further and consistently engages residents during the planning, implementation and evaluation phases of its projects.

SAAS understands that residents vary in their preferred way to engage. As a result, we support different ways for residents to influence decisions and lead projects. Traditionally, residents are sent a survey or invited to a community meeting. Although these methods reach some residents, they fail to engage others and thus further perpetuate the power imbalance between organizational staff and community members. Before disseminating a survey, SAAS includes residents in its creation and seeks advice on how and when it should be administered. This approach creates more work for project coordinators, but the effort is worth it in terms of the level and type of community response.

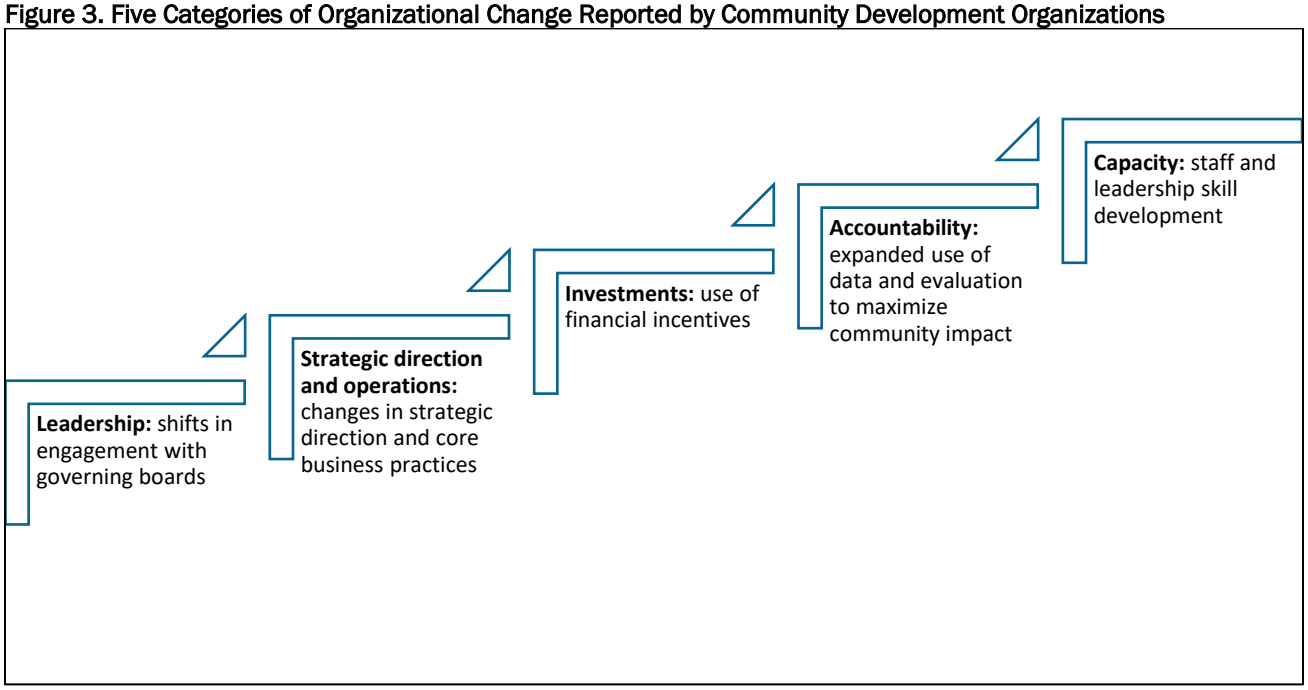
The active community engagement strategies differ from traditional electronic surveys and daytime meetings that too often produce controlled and stale resident engagement. When meetings are characterized by quiet, nonresponsive participants, that may signify that residents do not understand the issue or that they disagree and have shut down. SAAS, instead, encourages resident engagement that sparks honest discussion, questions and even disagreement. This signals that true learning and growing are occurring.

INTERNAL CHANGES: IMPACT IN THE COMMUNITY DEVELOPMENT SECTOR

In addition to promoting change in external systems, the demonstration project fueled a series of internal, organizational- and field-level changes in the community development field. It facilitated the development of a broader mission in which comprehensive community development is used as a vehicle to promote health and opportunity. As Brigetta Olson, deputy director from Willamette NHS, says, "We have evolved as an organization to the point where we are not just about housing; we are about neighborhoods and communities, creating a place where everyone can thrive."

Ultimately, we concluded that five major structural shifts occurred among participating organizations over the course of the project, outlined in Figure 3.

Figure 3. Five Categories of Organizational Change Reported by Community Development Organizations



➢ Internal Systems Change 1: Leadership

For many of the participating organizations, their approach to board membership and engagement reflects a deepening commitment to community health and well-being. **Sixty-four percent reported developing new board-related strategies**, including recruitment of members from the health world and/or the addition of health-focused briefings on board of directors' meeting agendas.

Many organizations already had board members from the health sector when the project started; however, several expanded the number. An even greater number changed board agendas and accountability systems.

Sheila Rice, former executive director at NeighborWorks Great Falls, tells the following story about a board meeting: "At a recent board meeting, the board members had a generative discussion around the connection between housing and health. One member, a realtor, spoke of the stress of a customer who was in foreclosure after her husband's death. He helped her sell the home to capture some of her equity and noted that when he saw her later she looked like a different person because the stress was gone. Another member, a legal-services attorney, spoke of the difficulty homeless people when trying to get an ID and secure benefits because they do not have an address."

Anecdotally, participants also reported *they* were invited to join the boards of health institutions. For instance, Kaia Peterson, assistant director of NeighborWorks Montana, was invited to join the board of Providence St. Joseph starting in the fall of 2018.

The addition of community development staff to health systems boards may be as critical to systems change as the shift in community development boards. Peterson explains, "Joining the board of Providence St Joseph will allow us to work together more closely — spurring more innovation around upstream health strategies that link to community development."

➢ Internal Systems Change 2: Strategic direction and operations

Almost two-thirds (61 percent) of participating organizations reported changes to their strategic plan and/or approach to better incorporate health goals and outcomes.

Staff of REACH Community Development, for instance, described how the board not only requested regular updates on the Housing With Services initiative, but also identified strategies related to resident aging and health as "critical success factors for REACH in the long term."

Likewise, in Christiansburg, Virginia, Community Housing Partners adopted the stance that all lines of business — from construction to property management to community engagement — impact health. As a result, the board included health outcomes in the four main goals for the organization's C18-2020 strategic plan.

In New Hampshire, the Lakes Region Community Developers developed an entirely new strategic plan with goals that connect community development to health. These goals include identifying and pursuing financial resources and partnerships that enable the organization to add amenities to older properties (playgrounds, community gardens, gathering spaces, etc.), improving the tenant experience, and establishing community building and engagement programming across 85 percent of its portfolio by 2020.

Participating organizations reported an expanded focus on health across many business lines and programs: community building and engagement (82 percent), health services (43 percent), multifamily-rental resident services (39 percent), multifamily rental development (35 percent), homeownership (32 percent), financial capability (32 percent), and other social services (32 percent).

In some cases, this shift in strategic focus resulted in better synergy between organizational departments. As staff of AHC Greater Baltimore noted, "What [this] means from an organizational perspective is that health is now a distinct section of our annual business plan, along with budget support. Two staff members have received additional training relative to their work in this field. It has also become a focus for our fundraising efforts, and it resulted in the successful receipt of a health-services support grant from Enterprise Community Partners."

Internal Systems Change 3: Investments

In the community development field, a more explicit focus on health equity is spurring targeted investments based on health equity concerns as well as encouraging efforts to braid and leverage dollars. This demonstration project documented new approaches for use of community development block grants (CDBG), tax credits, community development financial institution (CDFI) investments and Community Reinvestment Act (CRA) allocations.

NeighborWorks Montana's work illustrates how such investments can be braided for greater impact, as well as how investments are being prioritized based on health and equity concerns. This effort, also part of an InvestHealth project, included an initial data analysis that revealed that three of Missoula's lowest-income neighborhoods had the highest rates of asthma, obesity and mental health challenges. A combination of surveys and focus groups suggested that residents' highest health priority was addressing the lack of safe sidewalks. (Forty-two percent of the streets in these three neighborhoods lacked sidewalks, compared to 22 percent elsewhere in Missoula.)

Kaia Peterson, assistant director of NeighborWorks Montana, says, "Prior to this project, sidewalk planning in our community was driven primarily by calculations of population and major transportation corridors, and sidewalks were built when a property was redeveloped. Most of the redevelopment was happening outside of our low-wealth neighborhoods, so sidewalks were largely built elsewhere. Through this project, we developed a new way to look at sidewalk-development priorities based on community hubs, concentrated lack of sidewalks and greatest opportunity to impact residents."

This initiative secured $820,000 – $260,000 in CDBG funds and $560,000 from the city of Missoula.[25] As a result, two low-income neighborhoods are getting sidewalks, with expected completion in 2019.[26]

➢ Internal Systems Change 4: Accountability

One of the most critical capacity shifts reported by project participants was related to the use of data to assess needs, improve strategies and document impact. **More than two-thirds (68 percent) of participants stated that they have increased the integration of health outcomes into their evaluation activities or continuous-improvement strategies because of this project**. 86 percent of participants reported conducting related program evaluations and 43 percent are engaged in community-level outcomes evaluation.

One such group that engaged experts to collect and analyze neighborhood level data is New Kensington CDC in Philadelphia, who, in a community-based survey in collaboration with community partners, analyzed social capital and health. In partnership with Jefferson Medical College and Rutgers University, they examined neighborhood-level associations between social capital and other health variables, as well as completed regression analyses to determine the predictability of social capital. For organizations focused on creating better social cohesion, the ability to create predictive analytics is groundbreaking for the field of community development.[27]

The way that organizations incorporated health and other data occurred can be characterized according to three models, illustrated in table 3.

[25] Peterson, K. (2018, February 22). Where were all the sidewalks built? *Shelterforce*. Retrieved from https://shelterforce.org/2018/02/22/where-were-all-the-sidewalks-built/
[26] Millburn, S. (2018, May 10). Missoula upgrades its sidewalk curb ramps. *NBC Montana*. Retrieved from http://nbcmontana.com/news/local/missoula-upgrades-its-sidewalk-curb-ramps
[27] New Kensington Community Development Corporation (2018). *Evaluation Plan for Kensington TIC Micro-Communities Initiative*. Philadelphia, PA: NKCDC.

Table 3. Community development organizations' use of data to facilitate learning and increase impact

Model 1: Assessment	Model 2: Evaluation and data-sharing	Model 3: Research and/or use of clinical indicators
Identification of needs and community assets • Conduct and analyze baseline surveys and/or focus groups. • Engage in community health needs assessments (for example, serve on a community advisory board). • Use secondary data to inform priorities. • Connect primary and secondary data to inform programming and evaluation strategies.	**Implementation of program evaluations; enhanced capacity for data collection** • Develop evaluation plans (at the program or community/population level). • Share data among partners. • Develop shared outcomes/targets with other sectors. • Coordinate/integrate data collection across partners. • Develop (or support the development of) data collection systems.	**Evaluation of health outcomes** • Evaluate (or support the evaluation of) outcomes and costs at a population/community level. • Evaluate outcomes in partnership with university researchers. • Use of clinical data in addition to self-reported measures.

➢ Internal Systems Change 5: Capacity-building

Finally, investment in staff to enhance skills is a significant result of this project, with **82 percent of participants indicating that as a result of this project, they implemented new training or other skill-development activities to connect their community development work to health**. For example, Neighborhood Housing Services of Greater Cleveland tackled lead abatement as one of its core projects. Early on, the organization realized that a key contributor to its success would be education of all program staff members — not just construction or property management teams — on lead risks and safety in housing. Thus, the nonprofit enrolled eight staff members in the Environmental Protection Agency's lead-safe renovator, remodeler and painter certification program.

Ultimately, training, technical assistance, peer-to-peer learning and other capacity-building strategies supported many of the structural shifts described earlier in this chapter. Altogether, this organizational growth has implications for each nonprofit, the field as a whole and community residents. Yet it is critical to acknowledge that these systems change relied on long-term investment; significant capacity-building; consistent, committed, high-level leadership; and a deep, diverse bench of partners. This understanding will frame our future work to support community-centric strategies to promote health equity.

TAKING THE NEXT STEP

Today, health and community development professionals have a unique opportunity to collaboratively address one of our most consequential challenges — the gap in life expectancy

between our most and least healthy neighborhoods. This report has shown how organizations across the country are addressing critical barriers to good health by repairing systems. As opportunities for cross-sector collaboration increase, NeighborWorks America and our network of community-based organizations can play a critical role in building health equity.

As we look forward to the next several years, we plan to engage external partners to develop, test and scale approaches that assist community development organizations to support health and opportunity. Our commitment is reflected by multiple new investments by NeighborWorks described in Chapter 6, "Building Healthy Communities: At NeighborWorks and Beyond."

While NeighborWorks America cannot singlehandedly close the gap in life expectancy between our healthiest neighborhoods and least healthy neighborhoods, we are eager to join with like-minded partners on a journey to better community health and well-being.

CHAPTER 6

BUILDING HEALTHY COMMUNITIES: AT NEIGHBORWORKS AND BEYOND

OVERVIEW

Over the last several years, NeighborWorks America has increasingly recognized that health is both a core focus and outcome of comprehensive community development. The Healthy Communities Demonstration Project reaffirmed that belief and provided evidence as to the ways in which community development organizations support the evolution of systems to better reflect residents' priorities and improve health outcomes.

The demonstration project highlighted the breadth of strategies that community development organizations are using to promote health, well-being and opportunity. This work cuts across the social determinants of health, from food access to new homes, and from social services to community leadership.

A broad definition of health equity, therefore, is intrinsic to our work. Still, certain crosscutting themes emerged in the demonstration project and we anticipate digging deeper in five specific and interconnected focus areas. A more refined focus will allow us to develop the tools and roadmaps that our network has called for, while at the same time providing broad-based capacity-building that encompasses the holistic strategies of comprehensive community development.

Based on the Healthy Communities Demonstration Project, our survey, and consultation with our member organizations, we recommend the following focus areas:

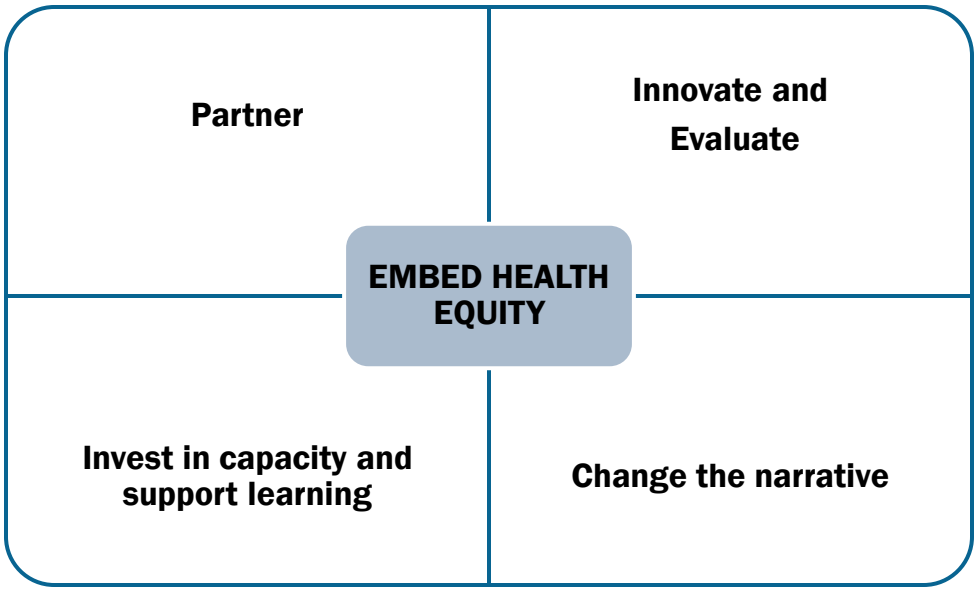
- Housing: Promoting high-quality, stable, service-enriched housing as the foundation of health and opportunity
- Community engagement: Developing collective solutions for community health and well-being
- Multi-generational strategies: Building health equity by focusing on critical transition points in the lifespan, with a focus on strategies that support two-generational success for children, families and seniors
- Trauma, healing and equity: Supporting healing and holistic well-being by addressing the interconnected elements of health, including mental, physical, cognitive and spiritual health. This requires an intentional equity lens, cognizant of historic and current traumas, that addresses structural racism and other barriers to good health.
- Systems integration & change: Promoting systems change and integration to improve outcomes and build more equitable opportunity

These focus areas reflect the crosscutting themes that emerged in the Healthy Communities Demonstration Project and the underlying strengths and assets of NeighborWorks America. These focus areas represent early thoughts on strategic direction and we will engage with our members and partners to refine and adjust this approach.

To achieve this vision, we have developed a roadmap for our healthy communities work over the next several years. The plan calls for us to:

- **Embed health equity:** Integrate health equity into our way of doing business
- **Innovate and evaluate:** Advance the future of community development by incubating, evaluating, and scaling approaches that promote housing stability, community leadership and health equity
- **Partner:** Develop national collaborations with health and other cross-sector partners to support local partnerships and system integration
- **Build capacity and learning:** Support the advancement of this work in the network and the larger community development field through learning collaboratives, training, investment and other capacity-building strategies
- **Raise visibility:** Strategically participate in the national conversation and elevate the importance of community-based, community development strategies to improve health and well-being

This plan responds to the needs we heard from community-based organizations in our network for tools, partnerships, and resources to build cross-sector partnerships.



OBJECTIVES

OBJECTIVE 1: Integrate health equity into our way of doing business.

We strongly believe that the goal of improving community health and well-being inspires and strengthens the work of our membership, the community development field as a whole, as well as NeighborWorks itself. Our exploratory process has engaged community development practitioners, residents, partner organizations, as well as participation across various NeighborWorks divisions, which has helped ensure our findings and our plans are appropriate for and relevant to our entire organization, the community development field, as well as cross-sector partners. An internal team of "health champions" is enthusiastic about supporting health equity work within our network, as well as by adopting practices that further health and well-being within our organization. We also heard from network members that closing the life expectancy gap between neighborhoods resonates deeply with their missions and lifework.

Going forward, we will seek to create intentional opportunities to include health strategies into our planning processes, investment strategies, technical assistance, and communications vehicles. We plan to engage our advisory committees comprised of senior leadership of community development organizations to shape the next phase of health equity work. We will expand and deepen our cadre of health champions across NeighborWorks America, by strengthening their expertise, role, and leadership internally and externally. We will promote the use of Success Measures Health Outcome Tools among network organizations and the broader field. As a vital part of this objective, we also will explore funding and re-granting opportunities to directly support network organizations' efforts to build community health and well-being. And we will embed health equity into the work of our Rural Initiative, as we tackle persistent poverty in rural communities from Appalachia on the east coast to the colonias in the southwest.

Ultimately, we will seek to bring health into our day to day ways of doing business.

OBJECTIVE 2: Support the advancement of this work in the network and the larger community development field through learning collaboratives, training, investment, and other capacity-building strategies.

As trainers of 17,000 community development practitioners every year, NeighborWorks America has a unique opportunity to orient the community development and other fields toward health equity. Over the past four years, we have focused national symposia, new courses, webinars, learning communities, and convenings on the connections between health, housing and community development.

As we move forward, we plan to explore ways to more systematically support health equity through our training and other capacity-building platforms. We will explore gaps in our training offerings, develop new courses, and adjust current courses. Peer-to-peer site visits will highlight critical strategies that bridge the health and community development sectors, including community health worker models. We also will explore the potential to support place-based and other trainings on

housing and community development for other sectors that are increasingly understanding the importance of housing and community development to their mission, goals, and business models.

OBJECTIVE 3: Develop national collaborations with health and other cross-sector partners to support local partnerships and system integration.

While the extent of health-focused strategies revealed by both our survey and the Healthy Communities Demonstration Project are significant, network organizations consistently articulated the need for greater collaboration and sustained partnerships to deepen their work. National partnerships play an especially critical role for community-based organizations, as they engage with significantly larger regional and even national health systems.

Fortunately, partnerships are embedded into NeighborWorks America's DNA, and our work to build health equity in particular. The Robert Wood Johnson Foundation, Kresge Foundation, Hearst Foundation and Morgan Stanley have invested, both financially and through other in-kind resources, in our efforts to build community health and well-being. And many other organizations have provided critical expertise or other in-kind assistance, including network-weaving, shared communications, and training.

As we move forward, we are excited to build and deepen partnerships to promote health equity.

We continue to seek and develop other new partnerships to develop shared tools, integrate networks, and effectively seed local partnerships. We also are exploring the potential to develop an external advisory committee to sharpen our understanding of the evidence base and national landscape.

OBJECTIVE 4: Advance the future of community development by incubating, evaluating, and scaling best practices to promote housing stability, community leadership and health.

To build this field, we need to develop the tools and systems that encourage partnership and investment and make it easier for emerging leaders. As we move forward, we plan to develop evidence translation and communication tools, as well as other toolboxes, roadmaps, and technology solutions for community development organizations. We will investigate new strategies and innovation bubbling up from the network.

Our newly launched learning communities exemplify our efforts to incubate innovation and support scaling across the community development field.

In August of 2018, we launched two learning communities designed to promote health equity — one on trauma and healing, and the other designed to support health partnership development. Both learning communities are co-led by community development practitioners and will support skill-building and tool development for participating organizations, for our network organizations, and for the broader community development field.

These learning communities are examples of broader strategies that rely on principles of co-design, innovation, and the development of locally adaptable tools to support scaling. Indeed, we are actively

exploring other strategies designed to engage community development practitioners in the incubation, evaluation and scaling of practices that promote community health and well-being.

OBJECTIVE 5: Strategically participate in the national conversation and elevate the profile of housing and community development as critical components of community health and well-being.

The Healthy Communities Demonstration Project reinforced and deepened our commitment to support strategic efforts to shift narratives nationally and locally. Multiple participants in the Healthy Communities Demonstration Project highlighted their increasing understanding that changing the narrative on housing was critical to their work to build health equity.

NeighborWorks America has heeded that call by publishing working papers and peer-reviewed journals, as well as advising the development of publications and case studies by the Brookings Institute, Urban Institute, the County Health Rankings & Roadmaps Program, and the National Collaborative for Health Equity. National convenings on asset management, resident services, community building and engagement, and real estate have explored the ways in which community development can promote health and equity; and they will continue to do so.

As we move forward, we will continue to build evidence base and demonstrate how community development improves health and opportunity, through research, evaluation, publications, speaking engagements, and white papers.

A national symposium in August 2019 will convene national and local stakeholders from multiple fields in New Orleans to explore how community development builds health equity through community-led solutions with housing as foundational to multi-generational success.

By shifting narratives and systems, NeighborWorks America can support community-led efforts to close the life expectancy gap between neighborhoods. This journey requires partners, and we look forward to creating new and deepening existing national partnerships that tackle the barriers to good health in communities across the country.

Together, we can build a future so that where you live does not determine how long you live.

REFERENCES

Andrews, N.O. & Erickson, D.J. (2012). *Investing in What Works for America's Communities: Essays on People, Place and Purpose*. San Francisco, CA: Federal Reserve Bank of San Francisco and Low Income Investment Fund.

Arcaya, M. & Briggs, X.de S. (2011). Despite obstacles, considerable potential exists for more robust federal policy on community development and health. *Health Affairs, 30*(11), 2064–2071. doi: 10.1377/hlthaff.2011.0778

Arkin, E., Braveman, P., Egerter, S. & Williams, D. (2014). *Time to Act: Investing in the Health of Our Children and Communities*. Princeton, NJ: Robert Wood Johnson Foundation Commission to Build a Healthier America.

Auspos P. & Kubisch A.C. (2012). *Performance Management in Complex, Place-Based Work: What it is, what it isn't, and why it matters*. Washington, DC: The Aspen Institute.

Bailey, P. (2016). Location, location, location: county health rankings. *NeighborWorks America*. Retrieved from http://www.neighborworks.org/Blog/Location-location-location-county-health-rankings

Bloom, S.L. (n.d.). The Sanctuary Model. Retrieved from http://www.sanctuaryweb.com/TheSanctuaryModel.aspx

Braveman, P., Arkin, E., Orleans, T., Proctor, D. & Plough, A. (2017). What is health equity? *Robert Wood Johnson Foundation*. Retrieved from https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html

Carder, P.C., Luhr, G., West, M. & Morgan, B. (2016). *Housing With Services LLC Program Evaluation*. Portland, OR: Institute on Aging, Portland State University.

Cohen, S.B. (2014). *Differentials in the concentration of health expenditures across population subgroups in the U.S., 2012* (Agency for Health Care Research and Quality -- Statistical Brief 448). Washington, DC: US Department of Health & Human Services.

County Health Rankings & Roadmaps (2017). How community development organizations improve well-being in under-invested communities. *Robert Wood Johnson Foundation*. Retrieved from http://www.countyhealthrankings.org/news-events/how-community-development-organizations-improve-well-being-in-under-invested-communities

County Health Rankings & Roadmaps (2018). What Works for Health: Our Ratings. *Robert Wood Johnson Foundation*. Retrieved from http://www.countyhealthrankings.org/take-action-improve-health/what-works-health/our-ratings

Cutts, T., Gunderson, G., Carter, D., Childers, M., Long, P., Marisiddaiah, L., Milleson, H., Stamper, D., Archie, A., Moseley, J., Viverette, E. & Baker, B. (2017). From the Memphis Model to the North Carolina Way: Lessons learned from emerging health system and faith community partnerships. *North Carolina Medical Journal, 78*(4), 267-272. doi: 10.18043/ncm.78.4.267

Diez Roux, A.V. & Mair, C. (2010). Neighborhoods and health. *Annals of the New York Academy of Sciences, 1186*(1), 125-145. doi: 10.1111/j.1749-6632.2009.05333.x

Duffrin, E. (2016). Playing matchmaker for UnitedHealthcare and an Arizona neighborhood. *Build Healthy Places Network*. Retrieved from https://www.buildhealthyplaces.org/whats-new/playing-matchmaker-unitedhealthcare-arizona-neighborhood/

Falkenburger, E., Arena, O. & Wolin J. (2018). *Trauma-Informed Community Building and Engagement*. Washington, DC: Metropolitan Housing and Communities Center, Urban Institute.

Greenberg, D., Williams, S., Karlström, M., Quiroz-Becerra, V. & Festen, M. (2014). *The Promise of Comprehensive Community Development: Ten Years of Chicago's New Communities Program*. New York, NY: MDRC.

Health Resources in Action (2018). *Health Starts at Home initiative – Summary of core measure outcomes as of 09/30/17*. Unpublished raw data.

Kania, J. and Kramer, M. (Winter, 2011). Collective Impact. *Stanford Social Impact Review*. Available online at: https://ssir.org/articles/entry/collective_impact#

Heifetz, R.A. (1998). *Leadership Without Easy Answers*. Cambridge, MA: Belknap Press, Harvard University Press.

Heiman, H.J. & Artiga, S. (2015). *Beyond health care: The role of social determinants in promoting health and health equity*. The Kaiser Commission on Medicaid and the Uninsured – Issue Brief, November 2015. Retrieved from https://www.issuelab.org/resources/22899/22899.pdf

KK&P. (March 31, 2016). *Woonsocket HEZ Food Access Plan.* Woonsocket, RI. Available online at: http://www.health.ri.gov/materialbyothers/hez/WoonsocketHealthEquityZoneFoodAccess.pdf

Kopf, N., Welch, C. & Brown, J.L. (2017). *Proceedings from the 2017 National Conference of the Association for Community Health Improvement*. Denver, CO.

Kruger, D.J., Reischl, T.M. & Gee, G.C. (2007). Neighborhood social conditions mediate the association between physical deterioration and mental health. *American Journal of Community Psychology, 40*(3-4), 261-271. doi: 10.1007/s10464-007-9139-7

Mather, M., Jacobsen, L.A. & Pollard, K.M. (2015). Population Bulletin: Aging in the United States. *Population Reference Bureau, 70*, 1-18.

Mattessich, P.W. & Rausch, E.J. (2013). *Collaboration to build healthier communities, a report for the Robert Wood Johnson Foundation commission to build a healthier America*. Saint Paul, MN: Wilder Research.

Mattessich, P.W. & Rausch, E.J. (2014). Cross-sector collaboration to improve community health: A view of the current landscape. *Health Affairs, 33*(11), 1968-1974.

Millburn, S. (2018, May 10). Missoula upgrades its sidewalk curb ramps. *NBC Montana*. Retrieved from http://nbcmontana.com/news/local/missoula-upgrades-its-sidewalk-curb-ramps

National Center for Healthy Housing (2008). *Creating a Health Home: A Field Guide for Clean-Up of Flooded Homes*. Retrieved from http://nchh.org/resource-library/FloodCleanupGuide_screen_.pdf

New Kensington Community Development Corporation (2018). *Evaluation Plan for Kensington TIC Micro-Communities Initiative*. Philadelphia, PA: NKCDC.

Peterson, K. (2018, February 22). Where were all the sidewalks built? *Shelterforce*. Retrieved from https://shelterforce.org/2018/02/22/where-were-all-the-sidewalks-built/

Philadelphia Department of Public Health (2015). *2015 Community Health Assessment (CHA) Philadelphia, PA*. Retrieved from http://www.phila.gov/health/pdfs/CommunityHealthAssessment2015.pdf

Philadelphia Department of Public Health (2018). Fatal drug overdoses in Philadelphia, 2017. *CHART, 3*(1), 1-4. Retrieved from http://www.phila.gov/health/pdfs/chart%20v3e1.pdf

Sampson, R., Raudenbush, S.W. & Earls, F. (1997). Neighborhoods and violent crime: A multilevel study of collective efficacy. *Science, 277*, 918-924. doi: 10.1126/science.277.5328.918

Schnake-Mahl, A. & Norman, S. (2017). Building healthy places: how are community development organizations contributing? *Cities & Health, 1*(1), 47-58. doi: 10.1080/23748834.2017.1327921

Schuchter, J. & Jutte, D.P. (2014). A framework to extend community development measurement to health and well-being. *Health Affairs, 33*(11), 1930-1938.

Substance Abuse and Mental Health Services Administration (2017). National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (NCTIC). Retrieved from http://www.samhsa.gov/nctic

Sundheim, D. (2015, July 02). Debriefing: A simple tool to help your team tackle tough problems. *Harvard Business Review*. Retrieved from https://hbr.org/2015/07/debriefing-a-simple-tool-to-help-your-team-tackle-tough-problems

The Colorado Health Foundation (2016). *Summarizing the Landscape of Healthy Communities: A review of demonstration programs working towards health equity*. San Francisco, CA: Build Healthy Places Network.

U.S. Census Bureau (2016). *New census data show differences between urban and rural populations* (Release number: CB16-210). Washington, DC: U.S. Census Bureau. Retrieved from https://www.census.gov/newsroom/press-releases/2016/cb16-210.html

U.S. Department of Health and Human Services (2015). *CMCS Informational Bulletin: Coverage of Housing-Related Activities and Services for Individuals with Disabilities*. Baltimore, MD: Centers for Medicare & Medicaid Services. Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf

U.S. Department of Health and Human Services (2017). *Camden Coalition of Healthcare Providers*. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from https://www.ahrq.gov/workingforquality/priorities-in-action/camden-coalition-of-healthcare-providers.html

U.S. Department of Health and Human Services (2018). *Hospital Readmissions Reduction Program.* Baltimore, MD: Centers for Medicare & Medicaid Services. Retrieved from https://www.medicare.gov/hospitalcompare/readmission-reduction-program.html

Vartanian, K., Weller, M. & Saul, A. (2015). *Health in Housing: Exploring the Intersection Between Housing and Health Care*. Columbia, MD: Center for Outcomes Research and Education, Enterprise Community Investment.

Viveiros, J. (2016). *Investing in Affordable Housing to Promote Community Health: A profile on the UnitedHealthcare Community & State partnership with Chicanos Por La Causa*. Washington, DC: National Housing Conference. Retrieved from https://www.nhc.org/wp-

content/uploads/2017/03/Investing-in-Affordable-Housing-to-Promote-Community-Health.pdf

Wahowiak, L. (2016). Medicaid, Medicare making the move toward social determinants. *The Nation's Health, 46*(7), 18.

Weinstein, E., Wolin, J. & Rose, S. (2014). *Trauma-informed community building: A model for strengthening community in trauma affected neighborhood*s. San Francisco, CA: BRIDGE Housing, Health Equity Institute.

Wen, M., Browning, C.R. & Cagney, K.A. (2003). Poverty, affluence, and income inequality: Neighborhood economic structure and its implications for health. Social Science & Medicine, 57(5), 843-860. doi: 10.1016/S0277-9536(02)00457-4

Williams, D.R. & Marks, J. (2011). Community development efforts offer a major opportunity to advance Americans' health. *Health Affairs, 30*(11), 2052–2055. doi: 10.1377/hlthaff.2011.0987

Williams, D.R., McClellan, M.B. & Rivlin, A.M. (2010). Beyond the affordable care act: achieving real improvements in Americans' health. *Health Affairs, 29*(8), 1481–1488. doi: 10.1377/hlthaff.2010.0071

Wong Croal, N., Smedley, B., Andrulis, D., Woolf, S., Siddiqui, N., Wilson, K., Turner, M. & Stelter, A. (2018). *The HOPE Initiative: Advancing Health Opportunity and Equity Across the United States: A State-By-State Comparison*. Washington, DC: National Collaborative for Health Equity.

999 North Capitol Street NE, Suite 900
Washington, DC 20002
202-760-4000

Working Together for Strong Communities®

NeighborWorks® AMERICA