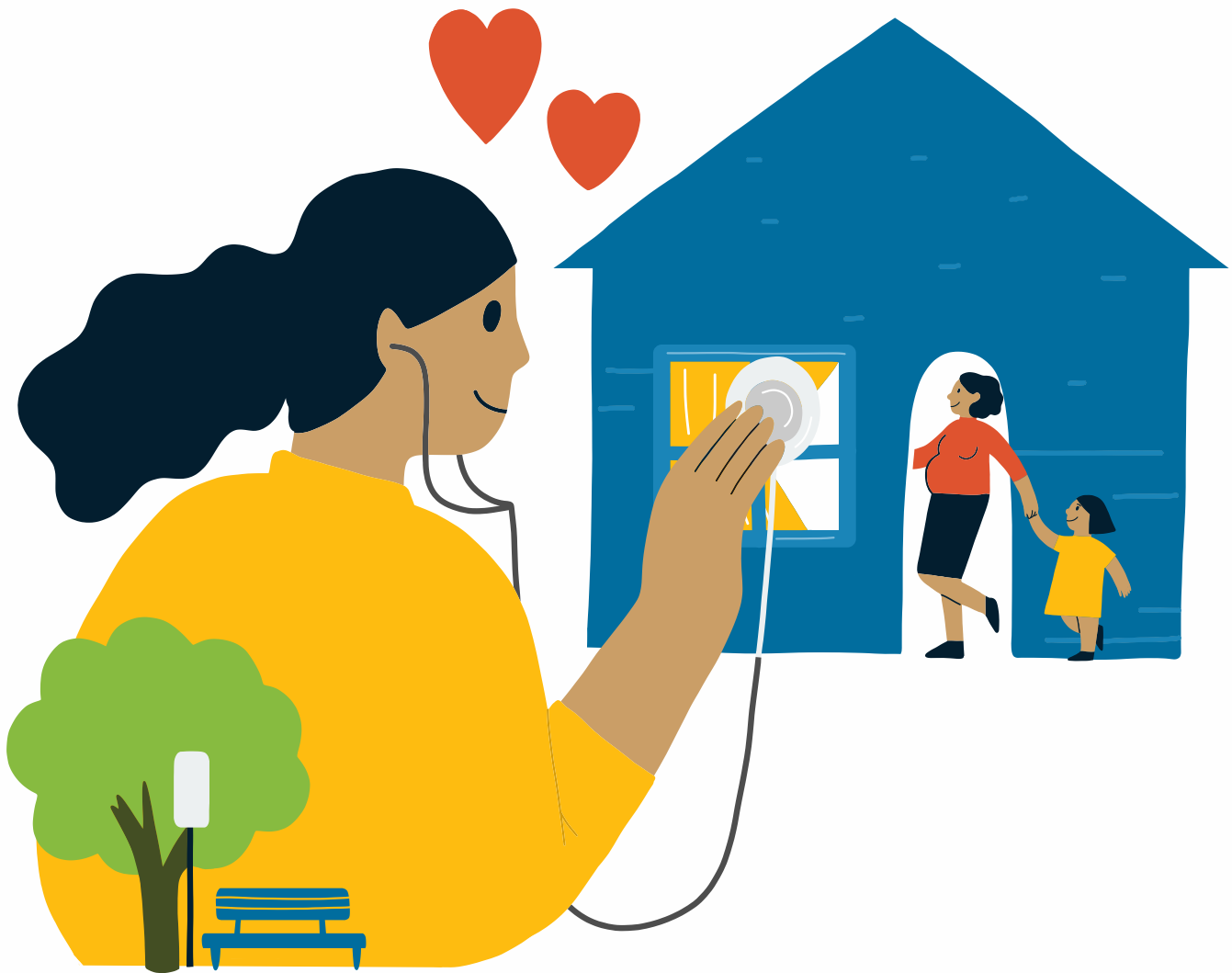


THE HEALTH & HOUSING STARTER KIT

A GUIDE FOR PUBLIC HEALTH DEPARTMENTS, HOUSING AUTHORITIES, AND HOSPITALS WORKING AT THE INTERSECTION OF HEALTH AND HOUSING



ChangeLab Solutions

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Introduction

Opening story

On a brisk fall day in 1991, Maria de la Luz, José de Jesus Garcia, and their 2 young daughters left the 1-bedroom apartment they called home in San Francisco's Portola district – for the last time. Packed into a truck, the Garcia family moved the king-sized bed they all slept in, along with an assortment of housewares and keepsakes they had gathered from swap meets and flea markets, up the crooked streets of Visitacion Valley in southeast San Francisco, to a house on a hill that overlooked the glittering bay. The girls ran through the house, passing the windows that overlooked Candlestick Park, to pick their own rooms, where in the months to come they would fall asleep to the cheers of football and baseball crowds. The house signified a great deal of achievement, risk, and sacrifice for Maria and José, who had left their hometown in Mexico to come to the United States with the same dreams and hopes that generations of immigrants have held.

Over the next 20 years, Maria and José's house would become home to their 2 daughters, 4 granddaughters, and eventually Maria's aging sister. It would be the home José would leave every day to start work as a hotel steward in downtown San Francisco, and the place Maria would return to after her own 18-hour work days. In the upstairs bedroom that overlooked the bay, their youngest daughter, Veronica, would go into labor a few months before her 17th birthday and then again just a month after her 20th. The dining room table, with a cherry wood veneer, would be the place where Veronica would contemplate college for the first time after she was laid off, and where she would celebrate her graduation from San Francisco State University 5 years later. Out of necessity and love, Maria would greet her granddaughters after school in the living room while Veronica pursued her education. It would be in this house on a hill with the gorgeous

views that Veronica would accept her first job with the City and County of San Francisco, a job that would allow her and her daughters to, as Veronica tells it, "graduate from poverty."

Veronica's graduation from poverty not only reflects her grit, determination, and accomplishment, but also points to the bundle of benefits that flow from a stable, affordable, and well-connected home. Those benefits include improved health and educational outcomes for children; reduced stress levels; increased food security; stronger connections to schools, parks, and transportation;¹⁻⁴ and for homeowners the most widespread opportunity to build wealth.¹ Yet, for a variety of reasons, these benefits remain out of reach for many Americans. While homeownership has traditionally ensured greater access to the bundle of benefits, it has become an increasingly risky proposition for many, particularly people of color who were hit especially hard by foreclosures during the Great Recession.⁵ And renters face a growing tangle of obstacles when trying to access safe, stable, affordable housing.⁶

Homeowners and renters experience differences in their relative access to the health benefits of housing, with homeowners generally faring better. Additionally, different demographic groups face different risks. Historically, communities of color have faced barriers to buying and renting homes in neighborhoods with ample resources and opportunities, limiting their access to health-promoting amenities and their ability to build wealth. In recent years, more people have been struggling to make ends meet, as living expenses – particularly housing costs – have outpaced income growth.⁷ [These challenges](#) are structural in nature, resulting from the laws and policies that govern our housing system. By recognizing the limits of the intents and outcomes – both historic and current – of these laws and policies, cities and local institutions are taking steps to mitigate the challenges that arise when people lack safe, stable, affordable housing and are even beginning to change the system.



Roles for Local Institutions in Health and Housing Initiatives

Around the time Veronica Garcia gave birth to her first daughter in the early 2000s, 3 institutions around the country began a series of experiments based on the belief that housing was fundamentally tied to the health and well-being of the families and communities they served. The Alameda County Public Health Department in California began analyzing epidemiological data that would become [Life and Death from Unnatural Causes](#), a seminal study linking social inequities, such as persistent housing discrimination, to health disparities. The Denver Housing Authority broke ground on the Curtis Homes Redevelopment, a project that would initiate a series of site redevelopments resulting in mixed-income projects in that city's Lincoln Park and Sun Valley neighborhoods. And West Baltimore's only safety-net hospital, Bon Secours, began buying and rehabilitating row houses and a vacant school to stabilize their surrounding neighborhood, ultimately creating over 800 housing units for seniors, families, and disabled people.

When local institutions like these expand access to safe, stable, affordable housing – what we call *comprehensive healthy housing* – families like the Garcias gain a foundation of stability that allows them to grow and thrive. Our guide focuses on these 3 types of local institutions – public health departments, public housing authorities, and nonprofit hospitals—because of their ability to knit together investment and community leadership and leverage their substantial resources and wide reach to improve both housing policies and health outcomes. In addition, these institutions serve populations that are particularly vulnerable to health risks associated with poor housing, including children, the elderly, and people of

color. Their attempts to improve health by increasing access to safe, stable, affordable housing therefore have a particularly strong impact on health equity.

The nation's 2800 local public health departments are working to improve health through a variety of initiatives, such as collecting data on the effects of unsafe, unstable, and unaffordable housing and supporting the development of healthy communities.⁵ Local health departments are uniquely situated to function as relationship builders to help form partnerships and address population-based health and housing challenges. In particular, health departments can draw on their data resources and build on their cross-sector work to help health and housing providers expand person-based initiatives to help address population-level challenges. Finally, given the wide range of stakeholders health departments work with, they are well placed to play a central role in educating the public about the importance of, and advocating for, health and housing initiatives.

Public housing authorities in the United States manage 1.2 million housing units, home to 2.2 million residents, and administer Section 8 vouchers, which collectively provide affordable housing to more than 5 million people.^{6,7} Public housing authorities are uniquely situated to function as place-based providers of health and housing initiatives, helping to build healthier neighborhoods in the communities they serve. Drawing on existing resources, public housing authorities can play a vital role in providing public health department and hospital partners with direct physical access to target populations and with space to implement their programs. As housing developers and managers, public housing authorities can also work to implement physical health and housing solutions, including developing healthy housing, improving active living spaces and access, and participating in local planning processes.



Nonprofit hospitals serve millions of people in the United States and spend billions in community benefits. A recent report to Congress estimated that nonprofit hospitals spent \$62.4 billion on community benefits, and over 53 million people benefited from community health improvement services, such as housing and economic development programs, in 2011 alone.⁸ Hospitals are uniquely situated to become investors in health and housing initiatives. By utilizing their scale and aligning their investment strategies, hospitals can make significant direct financial investments in upstream local health and housing programs that will improve the health of their patients and the broader community.

The Health & Housing Starter Kit is designed to help local institutions take their first steps toward creating bold and innovative health and housing initiatives. The guide begins with the stories of 3 local institutions that have been working on health and housing initiatives for over 10 years. The Building Blocks cover a range of issues that local institutions will likely wade through as they start their efforts, and are drawn from themes we pulled from nearly 2 years of field research and interviews with staff at each of our case study sites. These include leadership, financing, how to develop an orientation toward health equity, forming partnerships with communities and other institutions, scaling your work to address population outcomes, developing indicators to understand and evaluate your efforts, and crafting messages to build support.

The Health & Housing Starter Kit includes:

Introduction

- Opening Story
- The Health Effects of Safe, Stable, and Affordable Housing

Case Studies

- Alameda County
- Denver Housing Authority
- Bon Secours Hospital

Building Blocks

- Partnering with Communities
- Engaging Partner Organizations
- Using Indicators to Inform Health and Housing Initiatives
- Framing and Messaging for Health and Housing Initiatives

We are excited to see more institutions looking for opportunities to address health inequities through comprehensive housing strategies. Your work can be a seed of inspiration for your partners and decisionmakers at the state and federal levels. As you will see, even sophisticated institutions that have been working on these issues for a long time still struggle to meet the housing needs in their communities. The factors that create unsafe, unstable, and unaffordable housing are systemic in nature and have been decades in the making. Addressing the root causes of inequitable housing conditions requires a systemic response. To learn more about policy options for local jurisdictions, see ChangeLab Solutions' Healthy Housing work.



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HEALTH EFFECTS OF UNSAFE, UNSTABLE, AND UNAFFORDABLE HOUSING





As pediatrician Meagan Sandal notes, “a stable, affordable home can act like a vaccine, providing multiple long-lasting benefits on both the individual level and the community level.”¹ A lack of access to safe, stable, and affordable housing leads to stress, poor mental health, and reduced access to key health-promoting opportunities. Race, gender, income, and other intersectional factors are associated with further housing-related health risks. Over generations, these effects are compounded. Below, we briefly explore these dynamics to highlight why housing must be at the center of any strategy to improve community health and well-being.

What Are the Health Effects of Unsafe, Unstable, and Unaffordable Housing?

Aspects of housing quality such as unsafe structures; poor ventilation and climate control; and exposure to pesticides, lead, radon, carbon monoxide, and mold are harmful to health. Poorly designed homes or unsafe structures compromise the health and safety of all people, but are particularly risky for older adults whose falls may have debilitating consequences such as broken bones and head injuries.² Exposure to harmful chemicals and toxins can interfere with brain development; cause neurological and cognitive damage; and increase risk of a variety of cancers, respiratory ailments, and death.²

Current evidence demonstrates that housing instability also is associated with poor health outcomes, particularly for children and adolescents.^{3,4} The Department of Health and Human Services defines housing instability as living in housing that is unaffordable, low quality, and overcrowded, and is located in neighborhoods with high rates of crime and poverty, and/or lacking job opportunities.^{5,6} Housing instability in the form of eviction or foreclosure has such profound effects on a person's life that researchers are now beginning to see it not just a condition but a cause of poverty.⁷

Although there is no set definition of housing instability, it has been shown that homelessness, frequent moves (more than twice in the past 12 months), and being behind on rent are associated with increased risk of lower caregiver and child health levels and household material hardship.⁸ In particular, these housing issues were associated with increased likelihood of poor child health and maternal depression. Children of those who are behind on rent or are homeless were found to have an increased lifetime chance of hospitalizations, while those who were frequent movers or homeless additionally experienced increased chances of developmental risk.^{9,10} Eviction is associated with poor mental health, depression, and material hardship, which further perpetuates the cycle of poverty.¹²



What Are the Health Effects of Discriminatory Housing and Development Policies?

The public health adage that your zip code is a better predictor of health than your genetic code holds true largely because of policies that perpetuated neighborhood segregation and created concentrated pockets of disinvestment and wealth.¹³ The consequences of policies such as redlining are still evident in most American cities.^{14,15} For instance, a study by the Kirwan Institute found that people who lived in formerly redlined areas of Cleveland had higher rates of exposure to lead and toxic waste, infant mortality rates 5 to 6 times higher than those in non-redlined areas, and a 15-year reduction in life expectancy.¹⁶

Populations that historically or currently face housing discrimination experience additional barriers to health. Policies that deny people the opportunity to rent or purchase homes in resource-rich neighborhoods, or prioritize the production of market-rate housing often restrict opportunities for low-income families. With limited options, families often move to neighborhoods with poor conditions, characterized by challenges including [low-performing schools](#), [lack of access to healthy food](#), [poor-quality housing](#), and exposure to crime and violence.¹⁷

Race continues to have an outsized effect on where people live and the resources they have access to, particularly for black people. A 2012 study by the Department of Housing and Urban Development noted that potential white renters and home buyers were shown and offered more and better housing options by realtors and landlords than people of color, regardless of income levels. The study found that people of

color whose ethnicity is more readily identifiable “experience more discrimination than those who may be mistaken for whites.” The study also found that people of color who were low-income or had poor credit were often steered toward neighborhoods with higher rates of poverty and crime and lower-quality schools, even if options were available in other neighborhoods.¹⁸ Mary Patillo’s ethnographic work in Chicago points out that policies that resulted in rigid racial segregation in neighborhoods make it even more difficult for middle-class African Americans to escape intergenerational poverty by moving away from extremely poor, disadvantaged areas of the city.¹⁹

The neighborhood environment not only affects the health and life outcomes of individuals who are exposed to poor neighborhood environments during their lifetime, but also has residual effects on future generations. Sociologist Patrick Sharkey describes this phenomena with the idea of “linked lives,” where neighborhood advantages and disadvantages accumulated over a lifetime are not felt solely by the individual, but are also transmitted to some extent to the next generation.²⁰ Neighborhood poverty effects include cognitive development, educational attainment, mental health, occupational trajectories, and economic successes. These effects do not disappear when a child enters adulthood, but rather linger into adult life, shaping the family and neighborhood environment in which they raise their children, their parenting style, and the resources they are able to devote to their children.

The effects of neighborhood environments are cumulative: They are stronger when experienced by 2 consecutive generations. Additionally, the causal effects of neighborhood environments are proportional to the time spent in neighborhoods, so changes in neighborhood conditions during childhood play an important role in either reversing or perpetuating intergenerational poverty.²¹



Discriminatory housing and development policies continue to undergird a number of social determinants of health beyond housing and remain a major issue for institutions and communities as they seek to create more equitable health outcomes. See our [Medium site](#) for in-depth discussions on this topic, including the housing policies that continue to drive educational outcomes and the complex history of public health's role in promoting inequitable housing policies. See our [case studies](#) for examples of how these policies shape the contexts for local institutions.

Who Is at Risk of Living in Unsafe, Unstable, or Unaffordable Homes?

Low-income families with children are especially likely to live in unsafe, unstable, and unaffordable housing. A Milwaukee study found that tenants living with children were almost 3 times more likely to receive an eviction judgment in court.²² As sociologist Matthew Desmond [notes](#), “Children didn’t shield families from eviction; they exposed them to it.”²² It is even more difficult to find housing with an eviction on one’s record, which contributes to harmful cycles of protracted housing insecurity.

Looming risk of homelessness has especially harmful consequences for children. For young children, homelessness can have a lasting effect on mental and physical functioning and can lead to chronic diseases later in life. Studies find that young children who have experienced homelessness for longer than 6 months are significantly more likely to have developmental delays, have poor health, be overweight, or be hospitalized than children who have never experienced homelessness or have done so for less than 6 months.^{9,23} The younger a child experiences homelessness,

the greater the cumulative toll of negative health outcomes; just the stress of homelessness during early childhood can lead to higher levels of stress-related chronic diseases later in life.⁹ Mothers who experience homelessness during pregnancy were more likely to be hospitalized after birth even after receiving housing.⁹

People whose identities are subject to multiple or intersectional forms of discrimination usually face many interrelated barriers to accessing safe, stable, affordable housing.^{24,25} For instance, data show that forced displacement from housing is most prevalent among low-income black women. A study of tenants in Milwaukee found that more than 1 in 5 black female renters reported being evicted as an adult, which is triple the rate of white women.²⁶⁻²⁸ Women who face domestic violence also face barriers to safe and stable housing. [RE:Gender](#), now called the International Center for Research on Women, notes that, though women with documentation of their abuse have historically been given preferential access to federal rental assistance, the limited availability of public housing units and Section 8 Housing Choice Vouchers make this resource inaccessible to many domestic violence survivors.²⁹ A 2013 paper on the intersection of domestic violence and homelessness reports that intimate partner violence is listed as a primary cause of homelessness, and that more than 80 percent of mothers with children experiencing homelessness have experienced domestic violence.³⁰

Lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) people, particularly children, are likely to experience housing instability or homelessness. The Voices of Youth Count study from the University of Chicago found that LGBTQ youth had a 120 percent higher risk of homelessness.³¹ Similarly, the study found that unmarried parenting youth had a 200 percent higher risk. Veterans and formally incarcerated people are also at higher risk for homelessness.²⁹



Conclusion

Although the body of research linking housing and health is still growing, researchers have found that access to safe, stable, affordable housing in well-resourced neighborhoods has led to reduced chronic and infectious disease rates.³² Affordable housing leaves families and individuals with more money to spend on necessities, such as health care and nutritious food, and provides emotional and mental health benefits through greater stability and reduced stress.^{2,33} A lack of affordable housing leads to lengthy and costly commutes, scarcity of work and educational opportunities, and social isolation. Safe, stable, affordable housing located near high-quality opportunities can improve health outcomes. All of this evidence points to a need for policies to ensure that all people have access to safe, stable, affordable housing, and a need for policy interventions that target specific populations and communities that are at higher risk for insufficient housing. As Matthew Desmond notes, “If we were able to offer more affordable housing *and* provide people with a shot at stability and decency, that would be a very sturdy foothold on the way toward more economic security and a massive anti-poverty measure.”³⁴ If equitable health outcomes are the goal, then equitable housing policies and systems that focus on providing safe, stable, affordable, well-located housing for all people are vital steps toward that goal.

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 - *High housing costs* refers to housing that takes up more than thirty percent of a household's gross monthly income. Since poor families must pay higher proportions of their income on rent, high housing costs disproportionately affect this population.
 - *Poor housing quality* refers to housing that is lacking complete plumbing or a kitchen, has inadequate electricity or heating, or has “upkeep problems” (such as leaks, holes, or peeling paint).
 - *Unstable neighborhoods* are those characterized by conditions such as poverty, crime, and lack of job opportunities. Most subsidized housing is located in neighborhoods with these characteristics. Other problems that characterize unstable neighborhoods include noise, traffic, litter, poor or very limited city services, and undesirable neighbors.
 - *Overcrowding* refers to more than one person living in a room. Overcrowding is often the result of high housing costs or the lack of housing assistance.
 - *Homelessness* refers to the lack of a fixed, regular, and adequate nighttime residence.⁶
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ALAMEDA COUNTY

CASE STUDY



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Nearly 1 in 5 kids and teenagers in Alameda County (California) has been diagnosed with asthma. As in many other communities, race, class, and ZIP code are strong predictors for childhood asthma diagnoses and asthma-related emergency room admissions in the county. Low-income families who rent are particularly likely to suffer from poor air quality and substandard housing conditions, both risk factors for asthma.

[Asthma Start](#), a program of the Alameda County Public Health Department (ACPHD), provides in-home case management to families with children with asthma. The program educates families about asthma triggers, prevention of asthma attacks, and questions to ask health care providers. They also coordinate with schools, child care providers, and clinics to ensure children are getting the care they need.



Learn more by reading [“Improving Health with Local Data and Policies: A Porch Light Debate about the Alameda County Public Health Department.”](#)



Clinicians like Amy Sholinbeck, a social worker with the Asthma Start team, do their best to ensure families know how to manage their kids' asthma.⁵ But some of the reasons kids are hospitalized are beyond the family's direct control. For example, many of the root causes of asthma, including triggers like rats, mold, and dust, stem from housing problems that a landlord must address. Asthma Start case managers help renters advocate to have landlords fix issues that contribute to childhood asthma, but landlords do not always respond promptly or fully to tenant complaints.

After identifying a major mold problem in one of her client's homes in the early 2000s, Amy called the local building code enforcement office seeking help. "I did some research, and no one dealt with mold, and it was kind of, 'Oh, you know, I don't do it, they do it.' And it just went around and around, and no one did it," Amy said. She didn't have the resources to solve this problem on her own. Her job was case management, not city management.

Amy brought the mold issue to the Place Matters Housing workgroup, a team of housing-focused practitioners and advocates convened by the Public Health Department. There, she learned that California law didn't list mold as a substandard housing condition, and therefore didn't require building inspectors to cite for mold.

Members of the workgroup began to address the issue. Workgroup members worked with the Housing and Community Development Office in Oakland to develop a brochure for landlords and tenants explaining the health harms of mold, while the nonprofit Regional Asthma Management and Prevention (RAMP) started developing a policy response with state legislators. Advocacy by a broad coalition resulted in a change to state law that now allows cities to require landlords to address building issues that lead to mold, such as poor drainage or roof leaks. The workgroup gave RAMP access to a variety of perspectives and expertise. "Being able to talk to some of the attorneys and tenant legal aid groups to say, 'These are our proposed solutions, how do you think this will play out?' ... really helped us make sure that, when we were negotiating the bill, we didn't do anything that would jeopardize tenants' rights," said RAMP senior policy associate Brandon Kitagawa.⁶

Today, Amy's job is a little easier because of the Place Matters Housing workgroup. The data collection efforts, partnerships, and practices fostered by this group have yielded results beyond just mold; it has tackled other elements of a larger policy framework to improve access to safe, stable, affordable housing. The very existence of this workgroup is the result of a transformative journey that the Alameda County Public Health Department began when leadership put health equity at the center of everything it does.





History of ACPHD's Health and Housing Practice

Over the last decade, ACPHD has developed a health and housing practice aimed at eliminating the health disparities arising from unsafe, unstable, and unaffordable housing. The department has partnered with community-based organizations and leaders to identify the root causes of housing-related health risks, employing ACPHD's epidemiological expertise to build an evidence base around those risks factors. It then worked with its partners to address housing-related health risks systemically, frequently by designing or supporting policy solutions that lead to better health outcomes.

ACPHD's health and housing practice grew out of a larger institutional effort to reorient the department's work around a focus on health equity. Starting in the mid-1990s, under the direction of Arnold Perkins, department staff were encouraged to view the communities with whom they worked not simply as passive recipients of services, but as active partners in improving health outcomes. They worked with their public health nurses and community health outreach workers to develop place-based community health teams, and began focusing on neighborhoods with the greatest health disparities.

In 2007, the department received an opportunity to work with the National Collaborative for Health Equity Place Matters initiative to expand its health equity practice. ACPHD subsequently formalized its work by developing a health equity framework and strategic plan. The strategic plan had 6 goals:

- 1** Transform organizational culture and align our (department's) daily work to achieve health equity.
- 2** Enhance public health communications internally and externally.
- 3** Ensure organizational accountability through measurable outcomes and community involvement.
- 4** Support the development of a productive, creative, and accountable workforce.
- 5** Advocate for policies that address social conditions impacting health.
- 6** Cultivate and expand partnerships that are community driven and innovative!

The strategic plan grounded the department's efforts to work on upstream factors that drive health inequities, such as unequal distribution of resources and political power. Two of the outcomes of the strategic planning process—the development of new partnerships and a staff training program—laid the foundation for the health and housing practice that would flourish in the coming years. Additionally, ACPHD's Place Matters Team was formed to work collaboratively across sectors to advance health equity and use health equity data to frame and analyze key policy issues.





Community Partnerships, Community Priorities

“The [Place Matters] staff have been great partners, collaborative minded, interested in solving interagency systemic issues, and being helpful, especially as a data partner, which has been awesome. I’ve never seen anything like it.”

– Lin Chin, former strategic initiatives coordinator, Oakland Housing and Community Development⁷

ACPHD’s community partnerships form the bedrock of its health equity practice. The department’s first formal partnerships were developed by an early iteration of the evaluation unit, which would come to be known as the Community Assessment, Planning, and Evaluation (CAPE) unit. The goal of those early partnerships was to build the capacity of the department to respond to community priorities, initially by creating forums where ACPHD staff could listen to and learn from Alameda County residents. CAPE also worked with the Public Health Nursing and Community Health Outreach Worker unit to develop community outreach teams designed to combine more typical activities, like case management and home visits, with community-based assessments and evaluation.

Changing ACPHD’s institutional relationship with communities required creating space for capacity building among staff. Department leaders began asking questions about how they could change their practices to shift power toward community members and more genuinely treat them like partners instead of recipients of services. How could epidemiologists create and use participatory community assessments?

What makes community empowerment different from community betterment? These questions led them to focus on [community-based participatory research](#) as a primary mechanism for deep engagement.

The Public Health Department co-created a community assessment process with residents and community-based organizations. The assessments were used to create reports examining how the social determinants of health shaped the lives of Alameda County residents. In 2008, CAPE developed [Life and Death from Unnatural Causes](#), a report using local data to take an in-depth look at health inequities and underlying social inequities in Alameda County. The report would become the first of a series elucidating the relationship between racism, poverty, place, and health. The Place Matters team went on to tackle issues like the health effects of foreclosures, and described policies and practices that bolstered racial segregation and its resulting legacy of health inequities.

The reports also served as a foundation for a series of community workshops the Place Matters team organized to identify specific policy priorities. ACPHD staff gathered community-based organizations, residents, and leaders for a series of meetings to review their findings and discuss policy solutions to address key health disparities in the county. The meetings yielded a set of policy priorities with 6 areas for the Place Matters team: criminal justice, education, economics, land use, transportation, and housing. The team formed workgroups focused on each priority area, with the housing workgroup bringing together tenants’ rights advocates, case managers, and healthy housing advocates.



Training for Internal Change

“If we were talking about creating a more just, less racist, less sexist, less ‘-ist’ world, [then] the organization itself needed to focus on being less racist and less ‘-ist’ itself.”

– Bobby Stahl, former Place Matters policy associate⁸

As ACPHD was developing its community outreach teams, it became clear that addressing inequities inside the department was critical to achieving its externally focused health equity goals. For the department to work effectively with community partners, it needed to surface the assumptions staff members held about different communities, and create space for staff to discuss their lived experiences of inequities.

In 2007, the department developed [Public Health 101](#), an equity-focused [dialogue series](#) using interactive popular education models designed to draw from the life experience of participants. The goal of the sessions was to “create learning activities that foster a deep understanding of social determinants of health and build commitment to eliminate health inequities in the population they serve.”² The series includes 5 modules, touching on issues ranging from the core functions of public health, to undoing racism, to community and capacity building.

Using dialogues for internal change in an organization with around 600 busy employees was a significant undertaking. Staff leading the training series worked closely with the department’s leadership team to ensure they were aware of the series and were supportive. “A key role for leadership is to provide the vision and talk about why those things are important, and to keep the department accountable for moving forward on equity,” said Katherine Schaff, former Health Equity coordinator.⁹ “With competing priorities, it was important for leadership to say, ‘This is a priority.’ It was important to start with dialogues, but it took a long time to see the results, and people wanted to get to solutions.”

The training series helped ACPHD staff develop a shared language for their health equity practice and connect the department’s developing policy efforts to its other ongoing work. As clinical social worker Amy Sholinbeck said, the health equity framework and trainings “reinforce the need for both types of work: in the home, and policy ... because, we know that [there are] inequalities that I’m not necessarily going to solve on my little one-on-one visit.”

Key lessons for a successful training program:

- Foster buy-in from leadership at all levels to encourage staff participation
- Ensure that participants have a diversity of life experiences
- Adapt the curriculum to the local context
- Use experiential activities to enrich workshops
- Work with facilitators with expertise in both the content and experiential facilitation techniques
- Provide facilitators and participants a space for ongoing support and space for reflection



Building on the Foundation

The community-based priority setting and internal dialogues around health equity both informed and facilitated ACPHD's subsequent health and housing initiatives. These efforts have been wide ranging and diverse, but a key element of the department's approach has been partnering with community and organizational advocates to advance policies that address the links between housing and health. Along the way, the department's practice has evolved to chase those links further upstream.

One early entry into health and housing practice began in 2008, when ACPHD joined an effort to preserve water service to renters in foreclosed buildings in the county. Led by local housing justice organization Causa Justa :: Just Cause (CJJC), this campaign began with advocating for a single family to have its water service restored after the landlord had stopped paying the water bill (while still collecting rent). Department staff learned of the issue through their existing partnerships with community organizations. As then-local policy manager Alexandra Desautels recalls, it was "a pretty clear health issue," and a letter of support from then-director Anthony Iton was sent to the local water utility.¹⁰

The effort by CJJC, ACPHD, and other partners soon broadened from advocating for a single family to addressing the issue at a policy level. As part of the push for policy change, the department provided research and testimony about the health effects of water shut-offs in foreclosed buildings. In 2010, the East Bay Municipal Utility District board voted to keep the water on in all foreclosed buildings and multi-unit properties in which the landlord had failed to pay the water bill. The district also restored service to 600 units where water had been shut off before the change. The issue was taken to the California state

legislature and eventually resulted in the passage of a state law that created the legal mechanism to prevent water shut-offs in foreclosed buildings.^{3,4}

The foreclosure-related water shut-off campaign strengthened ACPHD's relationships with housing partners like CJJC, and pushed department staff to think more deeply about their work. Desautels said, "We could spend all of our time just responding to issues, because there's a ton of them coming at us," but the department and its partners wanted to have a more strategic approach to their health and housing practice.

Water service, mold, and pest infestations all fall under the rubric of "habitability": the qualities of a housing unit that make it fit (or unfit) to live in. Many habitability issues have obvious health risks, and ACPHD's work in health and housing initially focused on those issues. But both the department and tenants have limited power to address most habitability concerns and other issues themselves: A very limited supply of affordable housing leaves renters stuck in poor quality housing. As policy coordinator Tram Nguyen said, "The habitability conditions of a lot of our low-income clients who live in ... rental housing are so poor that they can only do so much."¹¹ They often must raise these issues with landlords for repairs and remediation, or appeal to local building code enforcement. Either approach can lead to new problems.

Raising a complaint with a landlord can prompt retaliation. According to Tram Nguyen, "Increasingly we're hearing clients cannot get any repairs because they're so afraid of getting evicted, so the choice is between having repairs done or being ousted." In addition to the problem that Amy Sholinbeck found in her asthma work, where some habitability issues



simply do not fall within the legal mandate of local building authorities, code enforcement in rental units is also traditionally complaint based, so the same retaliatory dangers may apply.

After confronting these issues, ACPHD and its partners began working to protect tenants from this kind of retaliation. The department has worked with the City of Oakland (the largest city in Alameda County) to develop pilot programs to inspect rental units for reasons other than direct complaints. One such program, developed in collaboration with many other local organizations and institutions, focuses on children with asthma. It creates a referral pipeline from medical providers who have identified children living in housing that contributes to their asthma, to county caseworkers, to a dedicated and trained team of code enforcement inspectors. The city also began a pilot program in 2015 to inspect rental units on a proactive, scheduled basis, instead of waiting for complaints.

ACPHD's efforts to improve code enforcement in turn led the department to work on tenant protections more broadly. Again in partnership with CJJC, the department contributed to an effort to strengthen legal protections for renters in Oakland. ACPHD brought its epidemiological research expertise to the partnership, helping to gather and present data about the health effects of high rents, overcrowding, eviction, and displacement. In 2014, the Oakland City Council passed an ordinance that protects against 16 types of landlord harassment, including failure to make needed repairs. Later, in 2016, Oakland voters approved a ballot measure (Measure JJ) that expands just cause eviction protections, requires landlords to petition the rent board for rent increases that exceed inflation, expands access to translation services, and requires greater transparency about evictions and rent increases. Throughout these campaigns, ACPHD helped make the case for these policies and then worked to support implementation once they passed.

Underlying many of the issues addressed by these earlier efforts is the fundamental scarcity of affordable housing in Alameda County. ACPHD has subsequently worked to support affordable housing development in the county. Department staff have provided research and testimony to elected officials about the benefits of safe, stable, and affordable housing. ACPHD also created the health framework for a \$580 million affording housing bond measure passed by county voters in 2016, and Tram Nguyen continues to work with partners on implementation.

As the Alameda County Public Health Department's health and housing practice has evolved to address upstream, policy-related drivers of the social determinants of health, it has remained focused on its partnerships. The department has worked closely at every turn with other local health institutions, housing advocates, and community organizations to share expertise, pool resources, and coordinate its impact on policy campaigns. Its internal orientation toward health equity has guided this work and given it the necessary perspective and tools to think carefully about how to spend limited time and resources. The department's work has also shown how far an institution's health equity framework can carry it, propelling ACPHD toward new and creative ways to help Alameda County residents secure safe, stable, and affordable housing.



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DENVER HOUSING AUTHORITY

CASE STUDY



The Denver Housing Authority (DHA) is a quasi-municipal institution that provides affordable housing to very low, low, and moderate-income families in the City and County of Denver, Colorado. Through a mix of authority-owned units and authority-managed housing vouchers for use in the private rental market, DHA provides housing for over 26,000 people, making it the largest landlord in Denver. The authority's recent experiences with HOPE VI redevelopment projects show how a local agency can effectively use public engagement and outreach to incorporate community health needs and generate community support.



Learn more by reading "[Housing Affordability as Preventive Medicine: A Porch Light Debate about the Denver Housing Authority.](#)"



History and Hope

The development of public housing in the United States is closely tied to “slum clearance” and demolition.¹ Beginning in the middle of the 20th century, in low-income neighborhoods around the country, buildings deemed “blighted” or otherwise sub-standard were torn down to make way for new construction, including new public housing projects.

Many of these early public housing complexes would become the next generation’s “slums.” In the mid-1990s, the federal Department of Housing and Urban Development launched the HOPE VI program to help local housing authorities redevelop “severely distressed” public housing. Motivated by the growing perception that older public housing complexes were poorly designed and led to concentrations of poverty, HOPE VI helped fund the replacement of these older units with redesigned developments that housed residents with a wide mix of income levels.²

With funding from HOPE VI, the Denver Housing Authority has spent the past 20 years redeveloping several of its older housing complexes. One of the earliest of DHA’s HOPE VI-funded redevelopments was Curtis Park, in the city’s Five Points neighborhood. Five Points, sometimes referred to as “the Harlem of the West,” was a historically African American and Hispanic neighborhood with a long and troubling history of housing demolition backed by city and federal urban renewal policies.

The Curtis Park HOPE VI project called for more demolition: the removal of 200 units of public housing (ultimately to be replaced with 300 units of mixed-income housing), calling to mind for many residents the urban renewal programs of the past. In addition, some public land was sold to private developers. As the project progressed, housing costs in the area rose as the market in the wider Denver area heated up. Although the redevelopment may have improved housing conditions for residents, many of the original residents of Curtis Park did not return. Additionally, the confluence of local history, housing market dynamics, and the rollout of the Curtis Park Hope VI project rekindled community concerns about redevelopment and its role in exacerbating gentrification and displacement.





Community Engagement

“When it came to Mariposa, we pulled out all the stops. ... You need to have buy-in. Our new projects belong to the community because they serve a need that was identified by the community.”

– Lynne Picard, DHA director of workforce development and community initiatives³

After Curtis Park, the Denver Housing Authority decided it would focus more on community and resident engagement when it began to plan its next HOPE VI redevelopment: the South Lincoln Homes, a 15-acre site in the La Alma/Lincoln Park area. Originally built in 1953, this complex was showing its age, and many residents complained that they felt unsafe in the neighborhood. Nonetheless, the residents felt a deep connection to their community, which was located near downtown and home to a mix of working-class families, immigrants, and artists.

The South Lincoln Homes redevelopment called for demolishing 250 existing units and replacing them with a new development (ultimately called Mariposa) that would increase the density and number of units and would include commercial and open spaces. An explicit, major goal of the project was neighborhood revitalization. The redevelopment area was adjacent to a station on Denver’s then-expanding light rail service.

DHA understood that proximity to a light rail stop and a redeveloped public housing complex could prime the neighborhood for additional investments and development. The authority wanted to make sure that current residents of public housing and the wider neighborhood would benefit from the potential changes brought on by its work.

For DHA, the success of this project depended on effectively engaging both the residents of the soon-to-be-demolished public housing and the broader community in its project planning and implementation. The authority was particularly concerned with ensuring that residents had input into how the units were developed, and that there was ongoing communication so residents who wanted to return when the building was complete could do so.

DHA began the project by surveying existing residents about their needs. One of the findings of this initial survey was that the residents had very high levels of chronic disease and, accordingly, high health needs. After reviewing the responses, DHA decided that it needed to place more emphasis on health in its redevelopment. It hired a firm to conduct a rapid health impact assessment, which it used to set a baseline for current public housing residents and learn more about community needs.

Although the staff at DHA had long recognized that their residents had high health needs, the process of engaging residents made them think about how they could more actively support better health through policies and programs that were not directly connected to health care. Through community input they included metrics such as access to green space, child care, and physical activity to evaluate the impacts of their redevelopment.

As they worked to incorporate their findings into the redevelopment plan, DHA staff also held meetings with residents to solicit input into the process. They found, however, that many residents remained unengaged. “Residents come to our meetings, but you often see the same people, and we know that they’re not necessarily representative of everyone,” said Lynne Picard, director of workforce development and community initiatives.⁴



One year into the process, DHA outreach staff were still struggling to reach tenants who lacked the time to attend public meetings, or who did not feel comfortable doing so. One staff person mused that it would be great if they could have a lemonade stand outside the housing complex.

So they did. Authority staff set up a table offering cold lemonade on hot Denver afternoons. Many residents with children stopped by, and the informal setting was more welcoming to people who felt uncomfortable in the official meetings. The lemonade stand was moved to different buildings over the course of the summer, providing multiple opportunities for residents to talk informally with the DHA staff about the designs that were being contemplated for the redevelopment project. By the end of planning the South Lincoln/Mariposa Redevelopment, DHA had held more than 200 meetings and informal gatherings to get input from residents.



Responding to Community Input

As important as it is that DHA worked to improve its community engagement practices, this engagement truly mattered because DHA was open to revising and adapting its plans based on the input it received. This openness to change played out on scales large and small.

For example, as the Mariposa development progressed, DHA staff realized that, although they were replacing units from the prior development, the new units were smaller. American families are smaller today than 50 years ago, and smaller units could accommodate most returning residents. But there was 1 family from the original development with 10 children. Because they were in communication with this family and knew they wanted to return, DHA staff made sure to build a 5-bedroom townhouse so the family would have a place in the new development. Dion Reisbeck, program manager, described how important this was, noting this “sort of goodwill commitment to live up to our promises and expectations to community helps us do our work.”⁵

This commitment showed up in larger ways as well. After hearing from residents that they were concerned about housing stability and wanted their kids to be able to attend the same schools during construction, the authority decided to conduct the redevelopment in phases. Phase 1 was built on land owned by the city of Denver, which served as replacement housing for existing residents before any units were demolished. This decision meant the project took longer and cost more, but in the end, 50% of South Lincoln families returned to the redevelopment, dramatically higher than the 24% national average for HOPE VI projects.



Going Beyond

For many, this would be a success story. But 7 years into the South Lincoln redevelopment, DHA is planning another redevelopment of a much larger public housing site in an area called Sun Valley. Here, DHA is continuing to use some of the outreach strategies that were developed in South Lincoln, and is incorporating new ones.

In Sun Valley, for example, the authority has hired residents to serve as community connectors. As DHA's Shaina Burkett said, "The lemonade stand is great, but we think you can take outreach a step further by having community members who are already advocates and training them to listen to their neighbors and work with them."⁶ These residents are paid by the authority and have been trained to engage with their neighbors, identify needs, and work within their community to train other residents as advocates. The connectors have formed a Sun Valley community organization, and they host community meetings to develop plans. But they're also available at the laundromat or in the park to hear the concerns of residents and bring them to DHA. Although the impetus for creating this position was the redevelopment, Burkett notes, "It's really taken off a lot faster and in more layers than I thought. I think the concept of community connectors is great and should be in every community."

Unfortunately, DHA may ultimately be a victim of its own success. DHA's redevelopment of its public housing units may be stimulating gentrification in the neighborhoods where its residents live. As Jami Duffy, executive director of Youth on Record, a nonprofit that occupies commercial space in the Mariposa redevelopment, put it, "The city is focused on Sun Valley like hawks. They are waiting for the redevelopment to happen, and then the developers will move in."⁷

"We want folks who start with the planning effort to be around to feel development benefits. We know there is an impact when there is a large-scale development in the community, and we're trying to do this without displacement or gentrification."

– Ryan Tobin, DHA's director of real estate development⁸

DHA does not have sufficient capacity to house all the qualifying low-income families in the city, and certainly could not stretch to cover those who do not qualify for public housing but are nonetheless being squeezed out by rapidly rising costs. As one of the Mariposa community residents said, "Maybe anywhere DHA goes, a community land trust has to go as well." DHA may be the largest landlord in Denver, but its ability to mitigate against market forces in a city with fast-rising housing costs is limited.

Despite these very real limitations, the work of the Denver Housing Authority offers a glimpse into the types of programs and practices that can be utilized to improve healthy housing. Although health was not the primary reason that DHA engaged in community outreach, its efforts illuminated ways that the authority could take steps to ensure greater housing stability, which has its own health benefits, as well as other practices that would improve the health and well-being of both public housing residents and members of the larger community.



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BON SECOURS HOSPITAL

CASE STUDY



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If you drive into southwest Baltimore in the summer, the first thing you might notice is the green foliage gracing the streets. Shadows of branches cast lacework patterns across the buildings. Vines either slump lazily over cracks in brick walls or bolt from the edges of boarded windows, alert, as if waiting to shake your hand. Mature trees rise up through collapsed roofs. It has been a long time since some of these houses were occupied. Scattered between children playing in makeshift basketball courts and people resting on their stoops, nature claws back property that landlords abandoned decades ago.

“Whatever the community needs, this hospital has tried to meet that need. People needed homes, safe places to live, and so the hospital saw it as their social responsibility to make their contribution to this community and started buying up the abandoned properties in the area.”

– Dr Aliya Jones, chair of the Department of Behavioral Health, Bon Secours Hospital



Learn more by reading [“Improving Health with Community Development: A Porch Light Debate about Bon Secours Hospital in Baltimore.”](#)



The Perfect Crisis

As you move toward the center of the neighborhood, the foliage thins and blue flags appear on the light posts, announcing that Bon Secours Hospital is near. The hospital, set atop a low, sloping hill, is surrounded by neatly kept, slender brick row houses. Four marble slab steps, a signature of traditional Baltimore architecture, lead up to front doors frequently bearing the branching Bon Secours logo. The small blue placard denotes that the residence is one of the more than 800 homes that Bon Secours has redeveloped in southwest Baltimore over the last 30 years.

Housing development is one of dozens of community development efforts that Bon Secours Health System has invested in over the last 3 decades under the umbrella of its Community Works initiative. While it has expanded its efforts across its system, which stretches up and down the eastern seaboard and into Kentucky, the most robust practices have been incubated at its flagship hospital in southwest Baltimore. The programs have largely grown out of an extensive community engagement process, responding directly to the needs expressed by residents. In collaboration with south Baltimoreans and community partners, [Community Works](#) has come to include a range of programs: housing and neighborhood revitalization, prisoner re-entry services, a family support center, a women's resource center, youth employment, workforce development, and financial services.

Bon Secours Hospital didn't intend to get into the housing and community development business. No study or strategic plan or consultant's report on the social determinants of health laid the groundwork for what has become one of the most innovative and robust hospital-led housing and community development initiatives in the country. Bon Secours' housing efforts were born of necessity, ongoing conversations with the residents, and a mission-driven desire to provide "good help to those in need."

Though the Sisters of Bon Secours had been operating their hospital in southwest Baltimore for over 70 years, by the 1990s, deepening disinvestment and entrenched poverty necessitated a new vision of the hospital's role in its community. In 1993, the hospital sank a significant amount of capital into the construction of a new hospital wing. Bon Secours anticipated that an increase in patients would help it recoup the costs of the expansion, but the investment coincided with a larger problematic shift happening in the neighborhood surrounding the hospital.

As George Kleb, director of Unity Properties¹, tells it, "Our patients were just disappearing. People started to leave the neighborhood because of a perception that it wasn't safe." The problem also affected the hospital's workforce. "We couldn't hire nurses," George Kleb said. "We couldn't get physicians to come here. The hospital just wasn't profitable anymore and with the massive drug issues in the city, it was ... kind of like a perfect crisis setting itself up."

It would be easy to frame the challenges Bon Secours faced in the early 1990s as a simple story of a hospital that sunk a lot of money into a neighborhood hobbled by drugs and violence and nearly went bankrupt because of it. But that would ignore the less visible but no less violent policies that shaped segregated and disinvested neighborhoods like southwest Baltimore. That perfect crisis was decades in the making.



As Antero Pietila describes in *Not in My Neighborhood*, race-based segregation was not only systemically designed and enforced but also created perilous and persistent health conditions.² In 1910, as the black population was blossoming, the Baltimore city council approved a bill that prohibited residential integration, a bill that *The New York Times* described as “so far reaching...that it may be said to mark a new era in social legislation.”³ When this bill was struck down by the US Supreme Court, in a decision nullifying residential segregation, developers and homeowners turned to private covenants to bar blacks and Jews from buying homes in white neighborhoods.⁴

In 1917, Mayor Preston used the high rates of tuberculosis to expand demolition and the relocation of black people from the area near the courthouse. The construction of Preston Gardens was part of the effort to quarantine blacks away from white neighborhoods.² Overcrowding grew worse, and, by 1934, a joint committee on housing proposed condemning 3 of those black neighborhoods due to the “high rates of tuberculosis and juvenile delinquency.”² The population throughout the city surged post-World War II, and conditions of black homes continued to worsen. By 1950, more than 40% of black homes had no bathroom, and 22% had no running water.² The slumlike conditions in black neighborhoods became a justification for federal refusal to underwrite loans in black neighborhoods through a practice that would come to be known as [redlining](#). Without access to loans, black people became susceptible to blockbusting, a practice in which speculators persuaded white homeowners to sell their homes below market rate by convincing them that black families were moving into the area and then selling them to black residents, who lacked access to conventional loans, at a markup.

As “white flight” began to peak in the 1950s and 1960s, many of southwest Baltimore’s homes became occupied by low-income renters. Absentee landlords began exploiting provisions of federal tax law to make a profit not only on the monthly rent but also on tax write-offs. The 1986 Tax Reform Act dramatically changed tax treatment of real estate. Existing owners had far less incentive to maintain their properties, and potential new buyers were discouraged from investing.⁵

By the time the new Bon Secours hospital wing opened in 1993, many of the neighborhood’s landlords had walked away from their properties. This left upkeep and maintenance to tenants, who had little means to finance repairs, and to the City of Baltimore, which had been steadily losing its tax base for decades as its population shrank. These twin declines in both housing quality and population led to an astonishingly high number of vacant homes in southwest Baltimore. Over half of the 101 homes in the block that surrounded Bon Secours were vacant by the time the new wing opened. The vacant houses, in turn, became a kind of kindling for the burgeoning crack epidemic.

Brother Art Caliman, who headed the Bon Secours of Maryland Foundation at the time, said that the hospital slowly began to realize that it needed to innovate its model of health care to remain afloat and serve the residents of southwest Baltimore. “Realistically, what this neighborhood really needed ... was some way to revitalize the community, and more acute care beds was not a crucial response to that challenge. So the question was, What do we really do?”



Responding to Community Needs

“A lot of times, health institutions are about outcomes, which are important —but process matters too.”

– Talib Horne, executive director of Bon Secours Community Works

Bon Secours’ community initiatives don’t focus on topics that usually rise to the top of community development and health conversations, like reducing hospital readmissions, creating stronger support services for high-risk patients, or slowing emergency room admissions. Bon Secours has addressed these issues, but the main focus of its Community Works program is serving the neighborhood at large rather than a specific patient population. The hospital continues to wrestle with the tension between solving patient issues that directly affect their bottom line and serving the larger community that is exposed to the same broad health risks.

Back in the 1990s, Bon Secours knew that to stay afloat, it had to look at what was happening around the hospital. “We had tons of vacant row houses within a couple blocks of the hospital,” Brother Caliman said. “The city didn’t have any strategy, at that point, for dealing with vacants. The vacant problem was significant but kind of new, so it wasn’t at the top of anybody’s radar screen... . So we said, ‘If we want the neighborhood to become a healthier neighborhood... maybe we should start redeveloping.’”

But the community wasn’t ready for a major redevelopment process. “We went out to the neighborhood and said, ‘Well, what are your needs?’ And the answer came back repeatedly ... rats and trash,” Brother Caliman noted. The hospital staff told residents that rats and trash weren’t part of their scope of practice. But as Brother Caliman recounted, the community persisted: “If you want to help with the health care, that’s your agenda, but it’s not ours.”

The hospital staff recognized that without dealing with the issues the community prioritized, they would lose their credibility. So they began developing educational materials for children, such as coloring books about the harms of playing with rats, and facilitating community cleanup days.





Integrating Community Voice into the Neighborhood Redevelopment Process

Bon Secours' early responsiveness to its community's priorities laid a foundation of trust that allowed the hospital to take on progressively more complicated redevelopment projects. The efforts that began with coloring books and cleanup days and unfolded into the programs it has today came largely from Operation ReachOut Southwest (OROSW), a resident-led group Bon Secours created to work on the neighborhood redevelopment plan.

OROSW president Joyce Smith described the neighborhood's situation when planning began: "We were not in an advantageous spot. We had too many vacant houses. We had high unemployment. ... All of those negative indicators. City leaders didn't see the importance of doing quality community improvement projects in southwest Baltimore. So Bon Secours and the community leaders put together the OROSW plan. We know what our neighborhood needs. ... That's how we started the job development, the job readiness, the homeownership classes, the GED classes."¹³ The strength of the OROSW plan came from the residents' vision.

The OROSW planning process helped train the hospital, residents, city agencies, and community partners in community-led planning processes. The hospital became a critical convener, creating a shared table for all of the people invested in the success of southwest Baltimore, and translating between residents, city staff, and organizations that lacked strong connections to the community. As Joyce said, "Bon Secours ... invited people to come [and] they listened ... They brought in people ... who knew how to navigate the system but were most interested in advancing the needs of the residents."

Building the leadership capacity of residents was a critical part of their efforts. "Until I took the leadership development training, policy never entered my mind. We learned a lot of the rules ... [and] how to utilize those rules," Joyce said. The hospital also brought credibility to the interactions community leaders had with the city. "Having Bon Secours at the table made the city more responsive in all areas," said Joyce. "It really gave community leaders that oomph to say, 'The policy needs to change'... A lot of folks focus on a program and say that program needs to change but [it's] the policies."





The Results of Its Efforts

“Twenty years and over \$100 million of development. The seed for that was a \$600,000 revolving fund from the Bon Secours Health System.”

– Brother Art Caliman, vice president of sponsorship¹²

The OROSW planning process had 2 phases: a higher-level visioning phase completed in 1998, followed by a second phase in 2002 developed in partnership with the city’s department of planning. The process became a model for the way the city created neighborhood plans. It also established a way for the hospital to authentically listen and respond to the residents of southwest Baltimore, and to build partnerships with city agencies and other organizations to bring resources to address the needs the residents articulated.

The OROSW process didn’t just generate plans that sat on a shelf. It led to tangible results in southwest Baltimore and beyond. There were lighting and facility improvements around an important transit station.² The initiatives also helped bring back community-based, on-demand drug treatment, a program that started in their neighborhood and then extended to the rest of the city.⁶ Bon Secours became the largest provider of eviction counseling in the city and began providing public benefits screening. In 2017, it prevented more than 200 evictions and connected more than 400 people to public benefits.⁷ Its behavioral health program now houses around 85% of its patients within 18 months of entry.⁸ The Community Works Clean and Green Program, a workforce development initiative focused on out-of-school youth and people reentering the community from prison, has improved 700 lots and a little over a million square feet of vacant land.⁶

As an anchor institution, the hospital is a critical cornerstone of southwest Baltimore. A 2011 [study](#) by the Jacob France Institute at the University of Baltimore estimated that the hospital system generates over \$226 million in economic activity to the City of Baltimore. It is one of the largest employers and purchasers in southwest Baltimore and provides millions of dollars in charity care for people who lack adequate insurance.

Data from the Baltimore Public Health Department shows some promising trends across the neighborhood. Between 2007 and 2017, the number of babies born with a low birth weight, infant mortality, and rates of sexually transmitted diseases all decreased, and life expectancy ticked up.^{9,10} Other indicators, though, still point to a struggling neighborhood. The neighborhood’s nearly 50% poverty rate towers over the city’s 28%.⁷ Unemployment rates remain higher than average, while median income remains lower. Southwest Baltimore remains, on the whole, one of the least healthy neighborhoods in the city.⁷

Bon Secours is building out systems to better capture the health outcomes that result from its specific efforts, but without longitudinal data it’s hard to know the exact effects. It’s clear, though, that while major strides have been made, the residents’ needs continue to outstrip the scale of the hospital and its partner’s substantial resources.



The Road Ahead

“We need multiple interventions and multiple people investing. I’m talking about infrastructure, I’m talking about housing, but I’m also talking about investing in the people. And so, it can’t just be us. It takes political will and it takes courage to go down that path.”

– Talib Horne, executive director of Bon Secours Community Works¹¹

The gulf between their impressive outcomes and the stubbornly entrenched poverty that remains in southwest Baltimore keeps the Bon Secours staff humble and looking beyond their walls for solutions. As George Kleb said, “Community [residents] come to me and say, ‘That vacant land is an eyesore. Can you help us out?’ And I can do that. I have the resources to do that ... [But] what we’re talking about is systems change, and system change takes will. ... We can add value to the conversation, but it has to be a political will ... federal, state, and local on some of these issues.”

Bon Secours and the residents of southwest Baltimore are still contending with the remnants of policies like exclusionary zoning and redlining that laid the foundation for the racial segregation and place-based disinvestment we see today. Though these policies were formally nullified decades ago, little has been done to remedy the lasting harms.

As more and more hospitals and health systems come to understand the relationship between poverty and health outcomes, there is growing interest in how their resources can help solve complex problems like neighborhood disinvestment and entrenched unemployment.

As investors, health systems can bring substantial financial resources to community development efforts. As anchor institutions, they can command the attention of decisionmakers; provide a platform; and amplify the voices of people who bear the burdens of poverty, disinvestment, and poor health outcomes.

Hospitals and health systems are important partners, but they cannot fix these problems alone. Even with their substantial resources, they will find their efforts hamstrung by larger housing, planning, and development systems not yet oriented toward ensuring all people have access to safe, stable, affordable, and well-connected housing or the foundations for long and healthy lives.

Additionally, as important as hospitals and health systems are to community development, they are fundamentally oriented toward a different mission. As George Kleb said, “Running a hospital just takes up all your time. You can add all this stuff. You can say, ‘Look. We had a hospital. Now we have housing. Now we have Community Works. Now we have a Health Enterprise Zone. We’re starting to look at population health.’ But what we really need to do ... is turn into a different thing.”

Bon Secours provides us not with a prescriptive model for health systems and hospitals to follow, but rather a source of inspiration, a tale of institutional limits, and a call to action. These institutions can and should use their resources to convene, listen, and respond to community concerns.



Like Bon Secours, [Cincinnati Children's](#), and [United Healthcare](#), hospitals can invest in place-based efforts like housing and neighborhood redevelopment on their own, in partnership with other health care systems like [Kaiser](#), or with other community development organizations like [Boston Medical Center](#). [Screening tools and standardized diagnostic codes](#) can be adapted to identify socio-economic risk factors, so hospitals can more effectively work in partnership with city agencies to track and address place-based trends. Hospitals and health systems can advocate for new models of payment and compensation that [adjust for social risk factors](#). As private entities, they can take risks that public agencies cannot. They can play a role in shifting the structural barriers to good health by establishing policy initiatives such as Nemours Children's Health System's [Moving Health Care Upstream](#) and [Kaiser Permanente's](#) Community Health Initiatives.

As hospitals and health systems increasingly become partners in truly innovative community development projects, they must hold up those efforts both to illuminate what works to bend down the cost curve in health care and to improve equitable health outcomes. These projects are also opportunities to inspire catalytic change. They can cast a spotlight on systemic factors that hold health inequities in place, and change the way community development systems operate. Generating these kinds of systemic changes requires shifting the ways priorities are set, investments are structured, and policies are adopted and implemented, moving toward ways of working that center community residents in decisionmaking processes and create structures that both remedy past harms while opening pathways to a healthier and more equitable future.

Endnotes

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12. Interview with Brother Art Caliman, conducted by Allison Allbee 09 13 2016
13. Interview with Joyce Smith, conducted by Allison Allbee 09 13 2016

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PARTNERING WITH COMMUNITIES



ChangeLab Solutions



“You can’t come in and fix it for me because you don’t know what I need to have fixed.”

– Joyce Smith, president of Operation ReachOut Southwest¹⁴

Partnering with community members is a powerful way for your institution – whether a health department, housing authority, or hospital – to learn directly from the people who will be most affected by your work, increase your potential for success, broaden your ability to reach new partners, and create advocates for policies that support your work where your own ability to advocate might be limited. Working in genuine partnership with communities is also one way to begin to remedy the harms of systemic discrimination by shifting decisionmaking power and aligning institutional priorities and practices with those who can benefit from your institution’s resources.

In the context of this guide, “community” means the intended beneficiaries¹ of the initiative or work your institution is undertaking. This is seldom limited to your institution’s direct clients, patients, or residents. The broader community often includes neighbors, faith-based groups, tenant organizing groups, and other organizations through which community members express their collective interests or will.

Community Engagement vs. Community Partnerships?

Many institutions or organizations may start their housing and community development efforts with a broad, amorphous goal to “engage the community.” Engagement is a catchall term that can be applied to activities as simple as an informational workshop or as robust as a resident-led campaign. Different levels of engagement are appropriate in different contexts.

In this guide, “community partnerships” refer to sustained engagements in which community members influence the policies, processes, and practices that drive an initiative, and how the resources of that initiative are allocated. The structure of a community partnership may depend on the context, resources, timing, and needs of a particular initiative, but one key, ongoing element is your commitment to work with community members and incorporate them into decisionmaking processes and evaluation of the work.

Why Create Community Partnerships?

Many of the communities that public health departments, housing authorities, and hospitals serve have suffered intergenerational disinvestment, discrimination, and disenfranchisement. In many cases, the experience of confronting ongoing poverty, racism, and other forms of systemic and institutional discrimination are traumatic. Creating inclusive community partnerships is one way to begin to remedy the harms of disinvestment, discrimination, and disenfranchisement.



Partnering with community members also makes your work more likely to succeed. As Talib Horne, executive director of Baltimore-based Bon Secours' Community Works said, "Very rarely do we do things unless the foundation is based on a conversation that we have with the community, because otherwise people won't show up."¹⁵ Community members bring valuable experience and insight about what's needed, what works, and how people are already navigating complex safety-net systems. Community members also have the ability to pull in new partners and resources, and to advocate for supportive policies when institutions cannot.

Investing the time to ensure that community members are not just learning about an initiative but shaping its direction not only contributes to the ultimate success of the effort, but also is itself a health-promoting activity.²⁻⁴ Building trust and cohesion in communities has been shown to reduce mortality,⁵ coronary heart disease,^{6,7} and mental disorders,⁸ as well as increase healthy behaviors.^{9,10} By shaping the direction of an institution's resources, policies, and practices, community members can work with staff to confront the inequitable conditions that cause poor health.^{11,12} Public forums that generate authentic discussions about the trade-offs of particular efforts and create pathways into decisionmaking processes are integral to individual and collective well-being.

What Do Community Partnerships Look Like?

Community partnerships vary depending on who sits at the table, the goals of the partnerships, how decisionmaking is structured, and contextual factors like political climate, geographic area, and historical relationships. Each of the 3 organizations that we followed used a variety of processes to generate and institutionalize community input and leadership.

The Alameda County (California) Public Health Department began by leading a series of community-based participatory research projects to generate health needs assessments. That needs assessment was then used to generate ACPHD's reports on the health inequities in Alameda County. The reports informed a series of gatherings where residents and community-based organizations prioritized which policy issues the health department should focus on. Those issue areas became the foundation of the housing workgroup, which meets monthly and is one of the primary ways that the department advances its health and housing initiatives.

The Denver Housing Authority engages community members as a central part of its housing redevelopment projects. This means working with both the residents within their buildings as well as people who live and work in the neighborhood where those buildings are situated. They use a variety of outreach methods, ranging from surveys to community meetings to hiring residents, to engage their neighbors. The information elicited from community outreach is used to inform their redevelopment process, define indicators for project assessment, and prioritize programs and services they support in their buildings. For example, after hearing that child care was an issue for residents of the Mariposa neighborhood, DHA focused on bringing Catholic Charities into one of its commercial spaces to provide child care.



Bon Secours Hospital in Baltimore engaged community members when it sought to address neighborhood conditions that were affecting its ability to provide health care. This led to a series of community forums to identify needs and build trust with the residents who lived around the hospital. As momentum built, the hospital staff became committed to providing community services based on their conversations with their neighbors. They supported the formation of a resident-led neighborhood organization called Operation ReachOut Southwest and supported a series of leadership training programs run by outside facilitators to build the capacity of residents to create and advocate for neighborhood plans. Those planning documents were used by the City of Baltimore, Bon Secours, and other institutions to shape redevelopment efforts and create the Bon Secours Community Works program.

Often lacking a dedicated funding stream and rarely fitting neatly into grant timelines, each of the processes took years to develop. In many cases, the process did not start with clear outcomes, and when it did, those outcomes changed over time. In each case, leadership remained fairly consistent, or when transitions took place there was an ongoing commitment to maintain the vision and existing processes and practices.

How to Partner with Communities

There isn't one way to partner with communities, but there are practices that can help institutional leaders effectively build trust and buy-in with community members and ultimately develop successful initiatives that lead to better health outcomes. While each of the institutions we followed has a different approach to community partnerships, there were several themes we drew from the 3 institutions. To understand how these ideas played out on the ground, we encourage you to [read our case studies](#).

Ensure Institutional Leaders Are Committed

Community partnerships take time and resources. Your institution's leaders must be prepared to support community partnerships as a central facet of your work. Securing institutional buy-in leads to greater sustainability and success over time. Funding may be limited, but there are many other ways leaders can demonstrate the organization's commitment, such as establishing partnerships with other organizations or conducting internal trainings on community building, cultural competency, or trauma-informed approaches to work with clients, patients, and community members.

Make Sure the Community Beneficiaries, As Well As Advocates Who Work on Their Behalf, Are Represented from the Outset of the Project

Spend time and resources getting to know the people who will be affected by your efforts. Some institutions may need to collect data through activities such as listening sessions or surveys to help identify potential beneficiaries.



Once the potential beneficiaries are identified, create a strategy to effectively reach out to them. Spend time learning about the institution's historical relationship with community members, and ask them how this partnership can be shaped and run to better meet their needs and vision for the community. Leverage relationships where trust has already been built and work to repair past or ongoing harms.

Meet community members where they are. If the institution is centrally located and has a good relationship with community members, use the institution as a gathering place. If the institution is far away or not yet trusted, or if communities are scattered, look for alternative spaces to host events. Work to remove barriers like child care and transportation, and create an inviting atmosphere by providing food or other nourishing activities. Hold meetings during times when most residents can attend, which is usually during evenings or weekends. Speak in a way that is familiar and easily understood. Use humor and storytelling to connect with your audience and translate language and technical terms when needed.

Think of community-based organizations as the doorways to wider communities. Work through organizational partnerships and trusted community leaders to connect to community members.

Clarify Your Goals and Process

Once you have strong community representation, ensure that everyone knows the goal of the initiative and the boundaries of the engagement. Is the engagement a one-night listening session? Is it an ongoing effort? Be upfront about the limits of a particular activity. Clarify how the institution will use information and how decisions will be made.

Actively Listen

Create forums where community members can openly share their experience and expertise. Prepare for instances when community input may yield divergent ideas by working through different scenarios. Ensure that institutional leaders understand that investing in community partnerships means that the outcomes or processes may need to shift. Prepare for circumstances when issues that are not directly related to the topic at hand are brought up by creating a process for follow-up with the appropriate person or agency.

Engage the Talents of Community Members and Pay Them Fairly for Their Work

Whenever possible, use your resources to engage, train, and activate new leaders from within the community. Think through all of the roles and opportunities for leadership an effort may generate – facilitating meeting activities, leading conversations with decisionmakers, staffing the initiative – and create the space for community members to step into those roles through paid employment or stipends.

Prepare to Challenge Existing Power Structures (Including Your Own)

Remember that an important goal of community partnership is to shift power and resources toward community members. The success of your efforts may require a change to a policy, system, or practice that is rooted in an existing power structure, possibly within your own institution. Sometimes these changes can happen through straightforward activities such as building stronger relationships or educating decisionmakers. In other cases, they may require strategic and sustained advocacy. Spend time with your partners assessing the barriers, whether internal or external, that the initiative may face and seek resources to overcome those barriers. Examine your own institution's policies and practices through the lens of health equity to identify potentially harmful assumptions or power dynamics.



Move at the Speed of Trust¹³

Cultivating trusting relationships with community members takes time, patience, communication, and humility. Be aware of the damage that past actions by your or other institutions may have caused the community. Use disagreements to practice building trust. Test assumptions before acting on them.

Acknowledge and challenge stereotypes partners may hold about the institution or each other. If trust has not been built, slow down.

Move with Urgency & Remain Accountable

Once your institution has built community trust, community members have been heard, and clear themes have been identified and agreed upon, start responding. Maintain clear and consistent lines of communication with community members, especially if they are leading an effort. Ensure that decisionmaking processes are transparent and that there are dedicated spaces and resources to continue to receive feedback throughout implementation.

Follow Through, Stick Around, & Celebrate

Many community engagement efforts focus on visioning activities, needs assessments, or developing plans. But change comes through the hard work of acting on the visions, needs, and plans that communities create. If the vision is big but the resources are limited, break down the plan into smaller implementation phases. Evaluate your efforts with your partners. Celebrate successes no matter the size, and recognize each contributor to keep up momentum and commitment from community members.

Stay Humble

Just because institutional leaders and staff have good intentions doesn't mean they will be received with open arms. Everyone comes with their own stories and histories that take time to learn, and misunderstandings or mistakes happen. Mistakes can be a healthy opportunity for growth.

Learn More

- [The Community Tool Box](#)
- [Nine Steps to Authentic Community Engagement](#)
- [The Center for Social Inclusion](#)
- [Community Readiness: A Handbook for Successful Change](#)

Endnotes

1. Despite an institution's best efforts, your work may have uneven effects. Some people may benefit, and whether intentional or not, others may be adversely affected. Through ongoing communication with community members, seek opportunities to reflect, adapt, and alter course to reduce the negative consequences of your actions.
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ENGAGING PARTNER ORGANIZATIONS



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“We would not be able to provide our residents with the services they need if we did not have strong partnerships with a lot of service providers.”

– Renee Nicolosi, director of resident and client services, Denver Housing Authority

Public health departments, public housing authorities, and hospitals regularly serve and interact with the people who stand to benefit the most from improving access to safe, stable, affordable housing, including low-income people and communities of color. Each institution has unique resources to address this issue, but the resources and power of these institutions can be even more profound when leveraged in partnership. This allows institutions to learn firsthand from the people they serve about their most pressing issues and needs, as well as what local assets are already in place to work toward meeting those needs, and it creates a space for sharing ideas, resources, skill sets, and diverse perspectives. When institutions engage in robust partnerships, they also increase the likelihood of achieving systemic change that might not have been possible without collaboration.

What Is Meant by Organizational Partnerships?

Organizational partnerships are collaborations between a local institution and government agencies, other local institutions, community-based organizations, or cross-sector partners, such as business, philanthropy, or academic institutions. These partnerships are essential to making healthy housing a shared vision and value, promoting multisector collaboration, and increasing a community’s capacity to effect positive change.⁹

A well-functioning organizational partnership brings diverse stakeholders together and expands available resources. It focuses on a shared problem and coordinates resources to minimize duplication of efforts. Organizational partnerships can create unique opportunities to support one another’s work, break down sector “silos,” encourage strategic and collaborative thinking, and allow partners to share costs and associated risks. In short, they allow partners to operate more efficiently and effectively.⁹

Organizational partnerships can:

- Move individual organizations from “competing to building consensus; from working alone to including others from diverse cultures, fields, and settings; from thinking mostly about activities, services, and programs to looking for complex, integrated strategies; and from focusing on short-term accomplishments to broad policy systems and environmental changes”¹⁰
- Create new or enhance existing communication channels and build trust among organizations and agencies¹⁰
- Facilitate information sharing; build stronger networks; and increase access to experts, ideas, materials, financial and social capital, and other resources¹⁰
- Break down silos and encourage strategic and collaborative thinking, and allow partners to share costs and associated risks¹⁰
- Allow partners to operate more efficiently and effectively⁹
- Achieve better results than any single group or agency could achieve on their own¹⁰



Benefits & Potential Challenges

Multisector collaborations require a strong leader and facilitator, sometimes referred to as the “quarterback,” to mobilize the diverse stakeholders and keep them engaged and coordinated.⁹ Public health departments, public housing authorities, and hospitals can make natural quarterbacks within their partnerships, bringing stability and commitment – 2 essential traits for any leader or facilitator. They can provide the necessary administrative support to sustain effective partnerships. They are also well positioned to access and analyze data to better understand community needs and evaluate the effectiveness of partnership interventions. In return for their investment as quarterbacks, these institutions improve their working understanding of community assets, build trusting relationships with partners, and gain support from the community at large, all of which are vital to effecting positive and lasting changes at the intersection of health and housing.

Organizational partnerships can be formal or informal. Informal partnerships are grounded in interactions between people who are familiar with each other’s work and/or know each other personally.³ Informal partnerships serve as a key channel for knowledge sharing and trust and consensus building that can lead to collective action and collective empowerment.³ They also play a critical role in creating a safe space for dissenting views and dialogue, prompting discussions and disagreements, and allowing for new ideas and sometimes controversial opinions to surface that may be suppressed in a formal partnership, but can be key to generating innovations in practice.³

A common challenge is funding. Partners’ involvement may wane or end completely when major problems (or high-priority opportunities) arise in their primary area of business, particularly if the partnership is not separately funded.² Even if anchor institutions fund a partnership, those institutions are susceptible to budget changes, especially when they rely on state and federal government support. For all of these reasons, strong buy-in and support from the leadership at each partner’s organization is essential to help ensure sustained engagement through possible fiscal challenges.

Another challenge that’s relevant to health and housing is how to share data. As noted by the Urban Institute, data sharing “is critical for understanding the outcomes and cost implications of housing and health care partnerships.”⁴ Some institutions may lack the infrastructure to collect and exchange information between different partners. Additionally, there may be limits on sharing sensitive information (eg, hospitals disclosing health information protected by HIPAA).⁴



Developing Successful Organizational Partnerships

“We’ve [Bon Secours] never been a housing development entity. Enterprise [Community Partners] is that kind of entity. . . . They had a good reputation. So in the beginning, we traded on their reputation when we were going after financing. They had a broader set of core competencies.”

– Brother Art Caliman, vice president, sponsorship, Bon Secours Health System

To reap the full benefits of an organizational partnership and help overcome the potential challenges, drivers of new organizational partnerships should institute a careful and deliberate planning process at the outset.⁴ This should include a needs assessment and an appraisal of existing resources to identify potential partners, their respective roles, and the assets they can bring to the partnership. Additional criteria to consider when evaluating potential partners include whether the partner is involved in health or housing work already; whether it serves overlapping populations; whether the partner can provide data or stories to illustrate impact; and whether vision, goals, and expectations for the health and housing partnership are aligned.⁵

The nascent partnership should have clearly stated vision, mission, and values agreed upon and firmly supported by all partners.² The partnership should articulate its goals and objectives, communicating them widely and making them readily accessible to all partners and the public for accountability purposes.²

How to Create and Maintain Successful Organizational Partnerships

Defining the Need for a Partnership

Step 1: Identify the added value of a partnership, and don't be afraid to think broadly about what kind of value that might be. For example, the Denver Housing Authority (DHA) has over 100 partnerships with community-based organizations that allow for the provision of additional services to residents. DHA's financial partnerships have allowed it to accomplish more than it could have on its own: “For every \$1 of public funds, we're able to leverage \$4 of private funding,” explains Kimball Crangle, former senior developer at DHA and manager for the Mariposa redevelopment project.

Step 2: Survey the field and look for any other partnerships doing similar work.⁷ When applicable, determine whether it makes more sense to form a new partnership than to join an existing one.

Step 3: Ensure buy-in from senior leadership to enter into a partnership and/or serve as its quarterback. Tammy Lee at the Alameda County Public Health Department reflects on the importance of institutional buy-in for the department's partnership with Causa Justa :: Just Cause to do housing work: “It's been key to have leadership on board with ... an epidemiologist doing this kind of work. . . . It means that they will let the community epidemiologist spend months and months and months ... looking deep in partnership with the community at this particular issue of foreclosure.”



Partnership Formation

Step 4: Identify potential partners using an assets-based approach.⁶ For each partner, think about how the organization’s mission, strengths, and resources aligns with and supports the partnership’s intended work. As an example, Brother Art Caliman at Bon Secours Hospital in Baltimore saw that Enterprise Community Partners had tremendous experience developing affordable housing, and would be more valuable as a partner than a competitor for resources. “We don’t need to come into a place where people are [developing affordable housing] and they’re good at it and become a competitor,” said Caliman. “We do need to say we’re a big health system [and we’d like to] find a way to partner with you to help develop more or better, safe, and affordable housing . . . in the particular communities that we serve.”

Step 5: Bring the selected partners together for a kick-off meeting. Talk through the purpose of the partnership. Map out the mutual benefits of the partnership for all parties to secure buy-in and commitment.⁸ Come to an agreement on the high-level vision, mission, and values of the partnership, as well as specific goals and objectives.²

Step 6: Come to an agreement on a shared framework and processes for reaching the goals and objectives of the partnership. If possible, create a shared language and terms for discussing this approach consistently across organizations.⁶ Create a formal decisionmaking process and partnership norms, “a set of shared values that act as informal guidelines on how partnership members will behave and interact with one another.”⁷ Topics may include communication, knowledge and resource management, conflict resolution, and meeting protocols.

Step 7: Talk through the capacities and limitations of each partner and begin to define roles. Take stock of skills and competencies needed to manage and support the partnership.⁷ Where necessary, provide education, training, and technical assistance to help partners meet goals and objectives.⁴ Acknowledge any differences between partners and a willingness to accept them. Address only those differences that impede on partnership success. The process of taking stock and identifying areas for additional education or training is crucial, particularly when first entering into a new line of work.

Assets Organizational Partners Bring to the Table¹

Public Health Departments, Public Housing Authorities, and Hospitals

- Subject matter expertise
- Land
- Data sharing, collection, and analysis
- Funding
- Brand value/reach
- Cultural understanding
- Meeting and event space
- Technical support
- Grant writing capabilities
- Additional staffing capacity

Other Organizational Partners

- Complementary subject matter expertise
- Provision of unique services
- Community relationships
- Established networks
- Relationships with government partners and local elected officials
- A meeting space that may be considered neutral
- The ability to openly advocate
- Additional staffing capacity



Setting up the Partnership for Success

Step 8: Determine a plan for action and priorities, including a timeline based on each activity within the plan. Clarify leadership, including your institution's potential role as the partnership quarterback. Clearly delineate individual members' roles and responsibilities. In the partnership between the Alameda County Department of Public Health and housing advocacy group Causa Justa :: Just Cause, ACDPH's Tammy Lee noted the importance of role definition in maintaining community trust. "One of the challenges is ... balancing the research and organizing," said Lee. In this case, the department crunched the numbers and decided to share its research findings with Causa Justa :: Just Cause, which would then take the data and transform it into a story that could be used for community organizing and advocacy. "So it's pretty important to ... establish some protocols and processes, so that you're able to get unbiased research, but then also push the envelope in terms of organizing."

Step 9: Establish a performance management framework that defines criteria for benchmarking achievements and allows for monitoring and measurement. Ensure that this framework provides the partnership with the opportunity to act on evaluation results and changes in internal and external demands.⁷

Step 10: Implement a robust communications strategy for the partnership, both internally and externally. Use the communications strategy to instill a culture of learning and knowledge sharing between organizations, and accountability between partners and the broader community.

Step 11: Develop a diverse fundraising plan to allow for continued operation of the partnership in the event of changes in current funding streams.

Reflect and Iterate

Step 12: Set up regular opportunities to reflect on the partnership's vision, goals, and progress. Celebrate successes. Learn from failures. Be open to making changes where necessary (eg, seeking additional partners to join, shifting goals or priorities, etc.) to become more responsive to community needs. For example, Brother Caliman of Bon Secours characterizes his team's housing work in different phases. In one of its most recent phases, it identified a new partner: churches. "A lot of our recent developments have been in partnership with either local churches that had a piece of land, and/or they had congregants who were seniors or low-income, living in terrible housing and didn't want to leave the neighborhood, didn't want to leave the church. So the church was interested in having some kind of housing, but no idea of how you'd do that." At this point, Caliman and his team could bring their working knowledge of supplying housing, and the churches could offer their land for housing their congregants.



Learn More

We strongly encourage you to also read the “Partnering with Communities” section of this guide to see how working with community members can bring its own advantages, complementing your organizational partnerships.

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USING INDICATORS TO INFORM HEALTH & HOUSING INITIATIVES



ChangeLab Solutions



“We had new buildings but the same problems, because we didn’t address the underlying economic social and health risks our residents were facing.”

– Lynne Picard, Denver Housing Authority

Many practitioners working at the intersection of health and housing are keen to understand how policies and practices are affecting community outcomes. However, this can be challenging. Even though local public health departments, housing authorities, and hospitals are accustomed to gathering data and evaluating the impacts of their more traditional work, they may be less familiar with using data to both inform health and housing initiatives, and to assess the efficacy of interventions in that arena. Additionally, since many of the policies aimed at improving health and housing conditions are geared toward long-term change, their short-term impact may be hard to measure. Despite the challenges, developing rigorous and meaningful indicators to evaluate the efficacy of health and housing efforts is vital to ensuring that the work is having the desired impact.

What Are Indicators for Action?

“The goal isn’t a report. The real goal is driving change.”

– Alexandra Desautels, program manager,
The California Endowment

Indicators are quantifiable characteristics that can both describe a current state and point the way toward useful interventions. The most effective indicators are ones that describe a particular problem.¹ Traditional health outcome indicators, such as prevalence of chronic disease and rates of low birth weight, describe the existing health status of a population. Other indicators describe the social, environmental, and economic conditions that are important “upstream” drivers of health and equity, such as access to resources and opportunities. Combining health indicators with those that describe community conditions will offer windows into different types of solutions to address identified problems.

Indicators offer a “snapshot” of information at a particular moment. When the same indicators are tracked and measured over time, they can help you see trends and show how progress, if any, is being made. This can help you identify obstacles to change and drive policy action. Because work on healthy housing is often long term, strategic use of indicators can be particularly useful in this context. For some examples of how indicators have informed health and housing practices, see the box on the next page.



The Denver Housing Authority (DHA) began actively rethinking how it could promote and incorporate health into its housing development and programs in 2007. Fueled in part by the growth of the elderly population and a resident survey that indicated a need to address health issues, DHA was interested in understanding how its redevelopments and programs could improve residents' health. This transition reflects the changing needs of public housing residents as well as new thinking and leadership at DHA. As the resident population has grown older and more diverse, meeting the mental and physical health needs of residents has become an increasingly important part of DHA's work.

When DHA was planning its Mariposa redevelopment (for more information see Denver Success Story), it hired a firm to help with community engagement and pre-planning. The firm, Mithun, suggested that DHA conduct a rapid HIA (health impact assessment) and cultural audit. The information gathered as part of the HIA included metrics that informed the built environment but also raised issues that DHA had not known were so important to their residents. The experience led the agency to become more interested in using health metrics for its development process.

DHA decided to use a tool from the San Francisco Public Health Department (formerly the Healthy Development Measurement Tool or HDMT, now known as the San Francisco Indicator Project) and adapted it for its own use. DHA knew that it wanted any indicators it used to align with the priority health outcome goals for the city of Denver, which included a 5% increase in healthy weight for children and a 15% increase in resident access to health care. DHA then tried to assess how well the indicators it was using linked to the health outcomes it was hoping to achieve and how hard it would be to obtain evidence at a relevant scale for the appropriate time frame. Once it had a list of prioritized indicators, it vetted them with a panel of residents and community stakeholders. Each indicator was matched with a partner who would support relevant actions and strategies. The result of this process was the **Mariposa Healthy Living Toolkit** which informed the Mariposa redevelopment process and continues to guide decisions about program needs.



How Do You Develop Indicators for Action?

The idea that data can be used to inform evidence-based decisions will not be new to public housing authorities, health departments, or hospitals. However, building an evidence base for an integrated health and housing practice requires some unique considerations.

Working with Partners

Just as your health and housing work should engage community and institutional partners outside of your own organization, so should your efforts to build an evidence base to support and evaluate that work. You may often find that partner organizations have direct experience working with data relevant to your health and housing practice that might be outside of your organization's typical data practice. This can both shorten the process for determining the right indicators and strengthen the resulting data gathering and evaluation.

Working with partners to develop indicators can:

- Help strengthen relationships with those partners
- Improve responsiveness to community needs and input
- Highlight the role of local public health in addressing upstream determinants of health inequities
- Increase collective investment to measure and track progress

Deciding which partners to engage should be informed by your health and housing goals. Identify your desired outcomes and find other organizations and stakeholders who share them, or those who may be affected by your work. (We offer more information about creating and maintaining successful partnerships in [“Engaging Partner Organizations.”](#)) This includes community members, as your organization's goals should reflect the health goals of your community.

It's also helpful to consider organizational capacity and skills within your institution and in partnerships. For example, many health departments, especially local health departments serving large cities and states, have epidemiologists on staff who possess expertise in evaluation, research, data management, and communications.² They may already be collecting epidemiological data that links housing interventions to health outcomes. Similarly, a city planning department could be a resource for mapping and monitoring access to resources like parks and grocery stores, or neighborhoods at risk of displacement.

Your engagement with partner institutions should come early in the process of building an evidence base to support your health and housing initiatives. When the Denver Housing Authority was figuring out how to monitor the success of its health assessment interventions in and around public housing developments, it worked with the Denver Public Health Department – a natural partner. This relationship has been vital to DHA's evaluation, but as one of the Public Health Department evaluators noted, “DHA are forerunners...but don't have a lot of capacity. We were brought in 7 months after the project started. Our results could be more robust if we had the right setup.” Early involvement is key.



Sometimes consideration of common goals may lead to partnerships that are less obvious. When the Alameda County (California) Department of Public Health (ACDPH) decided to research the health effects of the late 2000s foreclosure crisis in the county, it worked in partnership with Causa Justa :: Just Cause (CJJC), a local grassroots organization that focuses on housing and racial justice advocacy in the San Francisco Bay Area. CJJC's advocacy work complemented ACDPH's research skills and data practice, helping the department interpret findings and develop concrete actions for change based on the data.

Tammy Lee, a community epidemiologist at ACDPH, recounted meetings the department staff would have with CJJC to "look at the data and help us pick out the most important pieces that we want to lift up." CJJC's advocacy orientation helped lead from data to action. "Key to this piece," said Lee, "is what are the recommendations that should come from this? This is where CJJC took the lead. Let's not just look at the data, but what can we do from the data." The collaboration resulted in the report [Development without Displacement](#), which made 11 policy recommendations including right of first refusal, rent control, and inclusionary zoning policies.

ACDPH realized that its research could support CJJC's community organizing and base-building efforts on important housing issues with tremendous health impacts. "As an epidemiologist, I could be a partner in their organizing efforts for justice," said Lee. "The data made sense and jived with what they were trying to accomplish. This was a pivotal moment for me: that as an epidemiologist, we can be a real ally in this work."

ACDPH's partnership with a community advocacy organization was key to ensuring that the research would be used to drive community change. These interactions added an important layer to its work that helped to situate its analysis within a particular social context with the aim of achieving community goals that have important health implications.

Developing Relevant and Actionable Indicators

While engaging partners to develop indicators should be informed by what you are trying to achieve and who will be affected by those outcomes, the goal is to make sure to choose the right indicators for an assessment tool. The indicators you choose should help describe existing conditions in your community, as well as track and measure change in those conditions. Disaggregating data by race, gender, income, and other demographics can provide an understanding of the magnitude and distribution of health risks – such as unsafe, unstable, or unaffordable housing – that undergird leading causes of health disparities. For public health departments, this data can help determine which policy changes should be pursued to improve health equity. For housing authorities, this information can help determine what are the greatest health risks facing housing residents, where to focus programmatic funds, or which populations need particular interventions. For hospitals, it can help guide decisions about community investments beyond the hospital walls.

Mariposa 2012 Indicator Report Card

INDICATOR	CITY OF DENVER BASELINE	MARIPOSA PRE-REDEVELOPMENT BASELINE	MARIPOSA STATUS UPDATE	MARIPOSA TREND	
HEALTHY HOUSING	PERCENT OF POPULATION LIVING BELOW POVERTY LEVEL	14.29%	37.05%	45.05%	▲
	PERCENT OF HOUSEHOLD INCOME SPENT ON HOUSING	28.1%	12.75%	13.44%	▲
	HOUSING INDOOR ENVIRONMENT (AIR QUALITY, TEMPERATURE, HUMIDITY)	n/a	n/a	Monitoring recommended	
SUSTAINABLE AND TRANSPORTATION	AVERAGE TRANSIT COMMUTE TIME IN MINUTES	27	24.60	20.05	▼
	COST OF TRANSPORTATION AND HOUSING AS % OF AVERAGE INCOME	47.4%	26.18%	29.83%	▼
	NUMBER OF TRAFFIC INJURIES/ COLLISIONS/ FATALITIES	n/a	Data Collection in Progress	Data Collection in Progress	
ENVIRONMENTAL SUSTAINABILITY	PERCENT OF RESIDENTS WITH ACCESS TO OPEN SPACE/ NATURE WITHIN NEIGHBORHOOD	n/a	26%	32%	▲
	AIR QUALITY - PARTICULATE MATTER	n/a	n/a	<2.5 mm	
	VMT PER CAPITA PER DAY	33.6	24.4	14.7	▼
SOCIAL COHESION	PROPORTION OF POPULATION WITHIN 1/2 MILE TO COMMUNITY GATHERING SPACES	n/a	100%	100%	—
	TOTAL CRIME RATE PER 1,000 PEOPLE	68.62	247.9	157	▼
	PERCENTAGE OF POPULATION WHO FEEL SAFE ALONE AT NIGHT IN NEIGHBORHOOD	n/a	49%	Recommended survey	
PUBLIC INFRASTRUCTURE	PROPORTION OF POPULATION WITHIN 1/2 MILE KEY RETAIL	60 <small>Walkscore Update 2012</small>	100%	87 <small>Walkscore</small>	—
	NEIGHBORHOOD SCHOOL PERFORMANCE	n/a	n/a	30.8 Greenline Elementary 38 Martinez Middle School	
	% PERSONS AGE 25+ WITH LESS THAN 12TH GRADE EDUCATION	21.11%	38.57%	n/a	
	# OF HEALTHY FOOD OUTLETS WITHIN 1/2 MILE OF NEIGHBORHOOD	n/a	0	1	▲
INDUSTRY ECONOMY	UNEMPLOYMENT RATE	n/a	10.63%	15.2%	▲
	AVERAGE ANNUAL INCOME COMPARED TO THE SELF-SUFFICIENCY WAGE	1.49 / 1.0	1.04 / 1.0	1.06 / 1.0	▲
	NUMBER OF BUSINESSES AND NUMBER OF JOBS/SQ MI. IN NEIGHBORHOOD	n/a	Data Collection in Progress	551/ 308,205	

Major Considerations When Developing Indicators

Are the indicators connected to community health goals? Indicators work best in catalyzing action when they reflect collective needs and priorities determined by the community.¹ Local context should drive the selection of indicators that are closely linked to overall community health goals. Ultimately, this approach requires a shift from “data first” to “purpose first.”¹ When the Denver Housing Authority was selecting indicators, it looked to priority health goals it had developed based on resident surveys, as well as city and state initiatives, to make sure they were aligned.³ Community health needs assessments (CHNAs) and community health improvement plans (CHIPs) are 2 planning processes that local health departments can use to identify community health goals.^{4,5}

Is the data accessible over time and available at an appropriate scale? Availability and scale of data are important factors to consider when selecting indicators. Data that are inconsistently available may not be optimal, as indicators work best when used to track change in the same place or population over time (“longitudinal” data). The scale of the data

and unit of analysis also matter. If neighborhood comparisons across a city are needed, small-scale data at the neighborhood level or below, such as the census tract or block group, will be required. However, data at these scales are harder to obtain consistently and reliably. Conversely, data may be easily available at a scale that is not useful as an indicator. Don’t mistake availability for appropriateness. For example, if decreasing the disproportionate health impacts from foreclosures is a priority, as it was in Alameda County, health indicators should be selected to track this information over time and identify trends. Foreclosure rates within a city may not be a useful indicator by itself but over time or by neighborhood this indicator may show increased levels that can be addressed.

Is the data going to show change in the short term? Demonstrable changes in health outcomes are almost always difficult to detect in the short term, and may take many years to measure with significance. When determining appropriate indicators for a health and housing practice, it is good to look for some relevant data that may show change at a faster pace. For example, if your goal is to reduce obesity, you may want to data on exercise or access to health



care, knowing that you'll be unlikely to see a direct reduction in obesity rates in the short term. Keep in mind also that indicators may not signal what we think they do in the short term. After DHA implemented programs that increased resident access to health care, it saw an increase in the number of residents whose glucose levels indicated pre-diabetes. However, it saw this as a good sign: It meant residents were getting care before they developed full diabetes.

Are the indicators actionable? Relevant indicators should be identified that can motivate responsible institutions and organizations.⁶ The best indicators drive action and are linked to interventions. Additionally, the greatest opportunities to improve population health reside outside the traditional health sector, and good measures are needed to catalyze action among those sectors. Indicators should help spur action by those organizations with the greatest power to improve neighborhood conditions. They should help answer the question, "Now that we know this, what do we do?" For example, looking at excessive housing cost burden will let you know where households may be suffering from a variety of health risks associated with stress, housing instability, and food insecurity.⁷

Do the indicators help identify populations with specific health needs and vulnerabilities? Health disparities exist in most areas, and general population-based data at any scale may not help distinguish the risk factors for a population. It is therefore helpful to disaggregate data by demographics where feasible. Looking at distinctions by race, gender, and age can provide more information about the need for targeted interventions. For example, a city may have a small number of children who test for high levels of lead in their blood, but disaggregating the data may show that the rates are much higher for children of color, suggesting a need to target that population in addressing lead remediation.

Action, Evaluation, and Iteration

"Our work takes a long time and dynamics change, neighborhoods change. We need to know: Has the landscape changed? Do residents still have the same needs? We have to go back and reassess constantly. It's an iterative process throughout."

– Shaina Burkett, human services program specialist, Denver Housing Authority

Choosing relevant, actionable indicators and creating an assessment tool to evaluate your health and housing practice is one step in what is almost certain to be a long-term, iterative process. The work you do can may take years to fully bear fruit, and monitoring your community and your working environment for changes – both the changes resulting from your work and those that might affect your ability to do it – is vital. Assessment and evaluation are not one-time activities. Your institution will need to track changes over time, remain engaged with your partners and community, and even revisit the appropriateness of your indicators as your work progresses.

Over time, as you gather data about the impacts of your work, you'll find that it also helps inform your consideration of future efforts. Your evidence base, along with more general "best practices" and data from elsewhere, can help you determine which potential strategies and interventions might be most effective in your community. Many other factors, such as funding, political context, and leadership, will also affect the policies, programs, and other initiatives your institution pursues, but a robust, well-considered data practice can be a lodestar that guides you, your colleagues, and your partners.



Learn More

- [Mariposa Healthy Living Tool](#) from the Denver Public Housing Authority
- The [Housing Section of the San Francisco Indicators Project](#) (formerly Healthy Development Measurement Tool) has some good examples of indicators that are relevant to the health and housing practice.⁸
- [The Healthy Communities Index](#), from HUD's Office of Policy Development and Research, ranks city neighborhoods on 40 indicators related to community health.⁹
- [Applying Social Determinants of Health Indicator Data for Advancing Health Equity: A Guide for Local Health Department Epidemiologists and Public Health Professionals](#) provides a broad range of indicators related to the social determinants of health. This was put together by epidemiologists from the Bay Area Regional Health Inequities Initiative (BARHII), a coalition of the San Francisco Bay Area's 11 public health departments committed to advancing health equity, and shows local health department epidemiologists, data analysts, and other professionals how to collect, analyze, and display indicators and frame these data in the context of neighborhood mortality, morbidity, and social conditions.

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FRAMING & MESSAGING

FOR HEALTH AND HOUSING INITIATIVES





Strategic communication is key to advancing policies and initiatives that will support access to safe, stable, and affordable housing. Once practitioners have identified a solution and determined the steps needed to implement it, it is essential to develop messages that can build or reinforce support from decisionmakers.¹ The relationship between health and housing is complex and multidimensional, and practitioners can get bogged down in the details of their work when trying to communicate with other audiences. This section provides key steps to develop and strategically communicate values-based messages that can strengthen support for health and housing practices.

What Is Framing?

The term “framing” describes the way information is shaped and presented in order to influence the meaning people derive from it.¹ Framing an issue involves understanding people’s existing ideas and considering those as context, so that they receive new information in a way they can comprehend and integrate. The existing ideas or established way of thinking are referred to as the default frame.¹

In the culture of the United States, the default frame is often individualism.²⁻⁴ This frame attributes socioeconomic status, access, and opportunity to an individual’s own life choices – a view that is particularly salient when forming opinions related to social policy, including housing.¹ As a result, public opinion generally holds that it is solely a family’s own responsibility to work hard enough to afford a safe home in a thriving and healthy community.

Practitioners must recognize how many perspectives are rooted in an individualistic default frame to effectively reframe the benefits and burdens of comprehensive healthy housing for decisionmakers. The following findings from message framing research conducted by the Frameworks Institute demonstrate how individualism infuses many perspectives about housing, and how those perspectives lead people to conclude that healthy and affordable housing is not a public concern.

- **Self-makingness** is the perspective that people are “self-made” and have agency. Therefore, housing is a consumer choice, and people who are not satisfied with their home or neighborhood should move. If they cannot afford to move, it is because they have not worked hard enough.
- **Separate fates and zero-sum thinking** is the perspective that other people’s housing problems are “not my problem.” In this frame, issues like housing insecurity and sacrifices made to maintain housing are simply the result of unfortunate circumstances.
- **Not-in-my-backyard and natural segregation** is the perspective that efforts to create racial and economic integration are not necessary because people want to live in communities composed of people similar to themselves.
- **Facts don’t fit the frame** describes what happens when new data presented doesn’t align with a person’s existing understanding or anecdotal experiences related to housing. Often this causes the person to disbelieve or challenge the data, rather than adjusting their opinions.

Whether communicating to local officials, a school board, a foundation, community members, or their representatives, remember that many people operate according to the default frame, and almost everyone is influenced by public opinion to some extent. The individualistic perspective underpinning many people’s thinking about housing will affect how decisionmakers react to health and housing initiatives and how to message about those initiatives.



Develop Effective Messages

Move from Portrait to Landscape Frames

Not surprisingly, the default frame of individualism is often reflected in news coverage of housing issues. Many stories about affordable housing begin with an anecdote about someone struggling with housing insecurity.^{1,2,5} However, these stories rarely expand the scope of the problem to include larger factors bearing upon the subject's experience. This type of limited framing is referred to as the portrait (or episodic) frame, because it points the audience's focus toward an individual person or family. While these stories may capture attention and stir up emotion, the audience is left to determine the cause of the problem on its own, and will often fall back on a default frame of blaming the victim for his or her circumstances.²

To effectively advance health and housing initiatives, practitioners will need to use a landscape (thematic) frame when developing messages. This frame includes the individual but “pulls back the lens”² to describe contextual factors affecting the individual and to point toward systemic solutions. In other words, messages that practitioners create should illuminate the systems that prevent access to comprehensive healthy housing so the audience can begin to understand why a systemic response is required to solve what might otherwise be thought of as personal problems.¹

Address 3 Message Levels

Effective messages are crafted to address 3 conceptual levels: identify common ground with the audience around shared values, describe the issue at hand, and present solutions.^{2,6} The first level of the message is the most important. Values, not details, are a motivating force that can pull an audience out of the rugged individualism rut.² Messages that emphasize

values like shared prosperity and community health can help counter the individualistic default frame. They can present healthy housing as a way to bring us closer to achieving personal and community conditions we all consider important: cohesive families, healthy lives, safety. Rather than positioning housing issues as individual problems, anchor the issues to something we all care about and can get behind.³

3 Message Levels

- 1 Express overarching values
- 2 Share the issue being addressed
- 3 Give details about the policy proposed to address the issue

The Los Angeles County Department of Public Health (LACDPH), for example, used this structure to develop messages for staff around the connection between health and housing. It began with concise sentences establishing core values, including:

- Affordable housing is a foundation which enables people to live longer, healthier lives.
- Stable housing facilitates healthy, cohesive families and communities.
- High-quality housing is central to the health of individuals, families, and communities. All of us benefit when we have a safe place to call home.

At the second level, messages should present the issue an institution is working to solve – in this case, a dearth of safe, stable, and affordable housing. The message should link the housing problem with its contextual drivers to provide a more complete picture.³ “Pulling back the lens” by presenting the cause and effect of an issue reduces the chances that an audience will devise its own explanation, which typically leads to the familiar individualistic default frame.



Again using LACDPH as an example, the second portion of the message provides a concise explanation of how a lack of affordable housing affects a family's risk of being exposed to overcrowding and pollution:

When families have limited options for affordable housing, they are more likely to live in homes that are crowded, poorly maintained, and located in communities with higher levels of pollution.⁷

Level 3 should communicate the policy goals that will help address the issue. From LACDPH's messages:

Inclusive, transit-oriented communities can generate a range of benefits, including opportunities for physical activity, increased affordable housing, value and revitalization of existing communities, and reduced greenhouse gas emissions⁷

Advocates and practitioners, who are immersed in the issue and strongly invested in solving it, tend to get bogged down in providing data and detailing viable solutions.^{2,6} But it is critical to remember that values, not details, are stronger motivators for change.² In fact, too much data can trigger audience members to challenge the evidence if it does not fit with their existing knowledge of the issue.³ Avoid burdening them with too much detail or triggering their confirmation bias. Overall, when the message is complete, the first-level values frame should be most prominent, clear, and at the forefront, helping to galvanize an audience into supportive action.

How to Develop Effective Messages

Start with an overall strategy. It's important to understand goals and to target decisionmakers for influence. Understand who the allies and base are, and how they and the decisionmakers will be reached. This will guide other decisions about messages.

Understand the default frame in U.S. culture is individualism. Messages and talking points should provide an alternative vision and solution. While it's important to understand the default frame to engage in strategic communication planning, avoid repeating it and instead focus on reiterating the message.

Use a landscape (thematic) frame when developing messages. Messages should demonstrate how other factors besides the individual drive housing issues and help solve them.

Follow the 3-level strategy and focus on shared values. Don't get bogged down in details. Use language and examples that will resonate for the intended audience and expand their understanding of the issue.



Learn More

Learn more about evidence-based message framing in the Frameworks Institute study “[You Don’t Have to Live Here.](#)” For more information about how to identify solutions, see “[Using Indicators to Inform Health and Housing Initiatives.](#)”

Endnotes

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