

**County Administration Workshop: May 26, 2016**

**9:00 a.m. – Board Conference Room**

Attending: Commissioners Cheryl Walker, Keith Heck, and Simon G. Hare; Terri Wharton, Recorder

Chair Cheryl Walker called the meeting to order at 9:00 a.m.

**1. LEGAL COUNSEL**

**A. Order No. 2016-0xx; In the Matter of Regulation of Motor Vehicle Parking on Galice Road**

**B. Order No. 2016-0xx; In the Matter of Regulation of Motor Vehicle Parking on Pearce Park Road**  
Wally Hicks, County Legal Counsel, explained the Orders are to address hazardous situations around County parks and the Board has statutory authorization to create a no parking zone and the ability to enforce it. Commissioner Heck asked if there would be a grace period once the signs were placed. Commissioner Hare said no, that citations would be written as soon as the signs were installed. Commissioner Heck advised he would be voting no because he felt it should be eased in. *Staff was directed to place the item under Administrative Actions on next week's Weekly Business Session Agenda.*

**2. DEPARTMENT BUSINESS and QUARTERLY UPDATES**

**Department Business**

**A. Sheriff's Office**

- 1) **Contract with PROPERTYROOM.com for Auction Services for Unclaimed Property in the Possession of the Sheriff (Lee)**

Kari Lee, Property Control Specialist, distributed **Exhibit 1 – Questionnaire Regarding On-Line Auctions** and reviewed Liska Auctions response saying they charge 20% commission, 10% fee, and they do not barcode items and did not provide a sample of their reporting system. *Staff was directed to place the item under Administrative Actions on next week's Weekly Business Session Agenda.*

**B. Forestry**

- 1) **Timber Sale Contract with Greg Liles Logging: Walker Complex 2016T-3 (Streeter)**  
2) **Timber Sale Contract with Swanson Group Manufacturing, L.L.C.: Bear Gulch 2016T-7 (Streeter)**

David Streeter, Forestry Program Manager, advised these were the last two timber sales from the April 15, 2016 timber sale. *Staff was directed to place the item under Administrative Actions on next week's Weekly Business Session Agenda.*

**Department Quarterly Updates**

**A. Public Health**

Diane Hoover, Public Health Director, introduced Casandra Allen and Michelle Vasquez, OHSU Nursing Students. Casandra and Michelle distributed **Exhibit 2 – The Homeless Youth in Josephine County** and reviewed it with the Board. They mentioned their focus was on graduation rates of homeless youth and said Three Rivers School District has a greater drop-out rate than District 7. They believe that the higher dropout rate is due to the very limited time of a Family Advocate.

Diane Hoover distributed **Exhibit 3 – Public Health Update May 2016** and reviewed it with the Board.

**3. FINANCE REPORT and BUSINESS UPDATE**

Arthur O'Hare, Finance Director, advised the 2015-16 budget adjustments would be coming to the Board in the next several weeks for approval by June 30, 2016.

Arthur reported the Grant Accountant position has closed, four of the applicants look qualified, and interviews will be scheduled.

Arthur mentioned the interview he had with the Stanford Law Professor that was in Josephine County doing interviews regarding the loss of timber in the County. He said she is traveling throughout the United States visiting areas where their major source of revenue has gone away.

**4. BOARD BUSINESS (ORS 192.640(1) “. . . notice shall include a list of the principal subjects anticipated to be considered at the meeting, but this requirement shall not limit the ability of a governing body to consider additional subjects.”)**

**A. Matters from Commissioners**

The Board agreed to move forward with the project list for the FMAG-HMGP Grant application. *Staff was directed to place the item under Administrative Actions on next week's Weekly Business Session Agenda. (Following the meeting it was determined the item did not need to move forward.)*

**B. Liaison Update**

Commissioner Heck mentioned Rogue Valley Council of Governments (RVCOG) was continuing to seek funding for the Food and Friends program to meet the grant requirements for the November 1, 2016 deadline.

Commissioner Heck referred to the Carpenter Foundation and their \$118,500 in donations to organizations in Josephine County.

Commissioner Hare discussed the Lifejacket Project proposed by the Josephine County Foundation and advised the Parks Advisory Board will be making a recommendation to the Board that Parks cannot take responsibility for maintaining the lifejackets.

**C. Miscellaneous Items**

Commissioner Hare reported River City BMX came to an agreement regarding the monthly rent and he is in full support of it and suggested the lease be moved to the Weekly Business Session when it is ready since they are breaking ground on June 1, 2016. *Staff was directed to place the item under Administrative Actions on next week's Weekly Business Session Agenda. (Following the meeting it was determined the item was not ready to move forward).*

Commissioner Walker mentioned she met with Allen Bollschweiler, BLM Field Manager, to discuss the restroom project near the Galice Boat Ramp. Allen reported BLM has to get an easement approval through their Property Department and that should be done the first week in June and the project may require the County to plant bushes or trees in the area. Commissioner Walker said BLM will be working with Sarah Wright, Parks Manager, regarding the boat ramp at Whitehorse Park. Commissioner Hare asked Commissioner Walker if she would be the liaison to BLM for all issues other than forestry. Commissioner Walker agreed and asked him to forward her the list of projects she needs to work on.

Commissioner Hare discussed an e-mail Larry Graves, Airport Manager, sent out regarding increasing hangar lease rates at the airports. Commissioner Walker advised if the provision for increases is in the lease Larry can increase the rates and the leases that do not include the provision will need to come to the Board for approval.

Meeting adjourned at 10:24 a.m.

**EXHIBITS:**

**Exhibit 1 – Questionnaire Regarding On-Line Auctions**

**Exhibit 2 – The Homeless Youth in Josephine County**

**Exhibit 3 – Public Health Update May 2016**

EXHIBIT #1  
ADMIN  
5/26/16

Questionnaire regarding On-Line auctions



Please complete the questions below regarding the sale of property via your program. I am in receipt of some basic information on your sites; this is an attempt to compare "apples to apples" and present to decision makers. Once completed, please fax to 541-476-1741 or e-mail to iree@odot.oregon.gov or Josephine@odot.oregon.gov.

Thanks Liska Oregon Auction Co.  
GRANTS PASS OR

Do we have to pay any type of annual or monthly membership fee to sell items thru you? No

What do you charge the seller for commissions on items sold? 30% personal Property  
15% Firearms/Vehicles

What do you charge the buyer for commissions on items sold? 10% + Expenses  
Buyers Premium

Do you charge a commission to the seller even if the item does not sell? No Just Expenses

Do you offer pick up from the seller's warehouse to your warehouse for processing?  
Yes

Do your auctions times increase when "last second" bidders jump in to allow others to increase their bids?  
It varies Depending on the items  
Being Auctioned. This would only happen  
w/ online only Auctions

Do you sell firearms to anyone but licensed FFL holders? yes we sell to qualified  
Buyers. we conduct background checks on site at the auction

Who enters the item(s) onto the auction site? OFFICE MANAGER FOR  
Liska Oregon Auction Co.  
AND HER ASSISTANT.

Provide a sample of an auction report containing at least 10 items

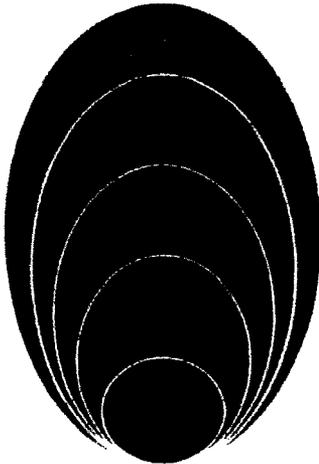
How many buyers do you currently have registered? The number varies with  
Every Auction.

What is the stand amount of time an item is up for auction? Varies

What items will you not accept for auction? Anything illegalk to sell  
AND Anything that our experience tells us  
wont do well @ Auction

Simulcast - Audio + Video  
Advertising based on items

Multiple Levels of Influences on Adolescent Behavior



Retrieved from [www.cdc.gov/cdc-grandrounds/archives/2015/august2015.htm](http://www.cdc.gov/cdc-grandrounds/archives/2015/august2015.htm)

**Levels of Supporting Youth**

- Intrapersonal**
  - Self esteem
  - Self-worth
- Interpersonal**
  - Positive relationships with peers and adults.
- Institutional**
  - Hearts With A Mission
  - Joe's Place
  - UCAN
  - Positive after school activities.
  - Mentorship
- Community**
  - Neighborhood characteristics
  - Community resource availability
  - Community involvement
- Society and Policy**
  - Media to inform community and change cultural beliefs towards the homeless youth.
  - Policy changes (CDC, 2015).

REFERENCES

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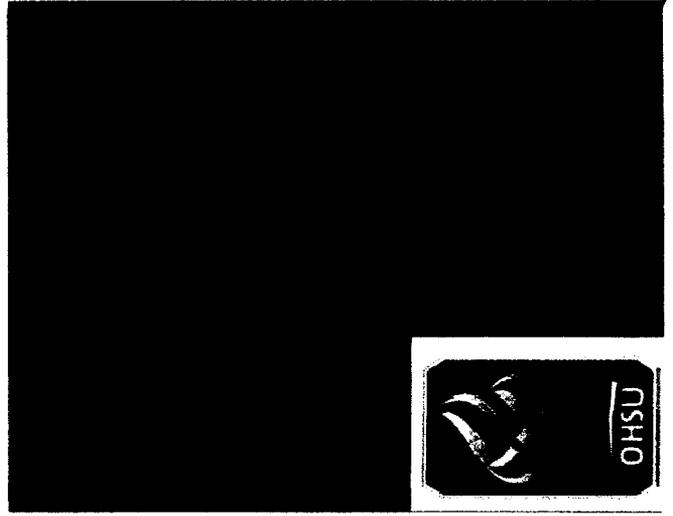
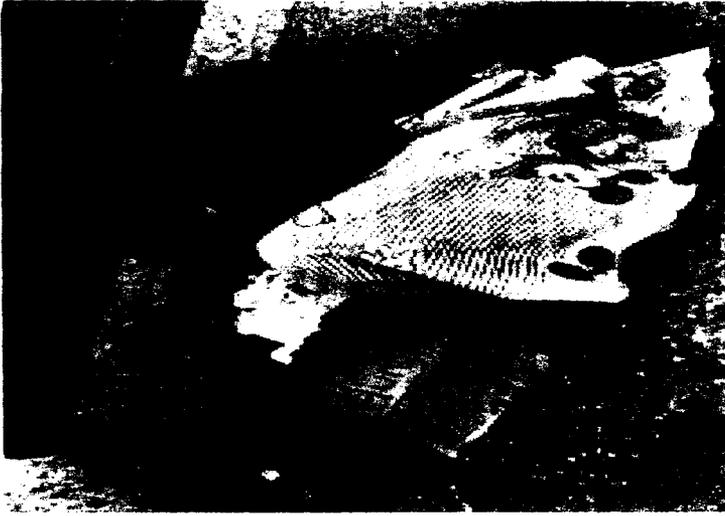


EXHIBIT 2  
ADMIN 5/26/16

## Implications if not supported

- Without safe shelters and strong social support for our youth, particularly the teens, these graduation rates will continue to be lower and the homeless and poverty rates will increase (National Network for Youth, 2016 & National Coalition for the Homeless, 2008).
- The suicide rate is higher for homeless youth due to higher emotional trauma, societal stigma in school and the community, and high rates of drug and alcohol abuse (Community Health Assessment, 2013 & National Network for Youth, 2016).
- Approximately 80% of unaccompanied homeless youth have serious mental health issues like depression, PTSD, and anxiety (Abdul, Turner & Elbedour, 2015) due to witnessing violence in their family units or on the streets (National Coalition for the Homeless, 2008).

## Donation sites

### **Grants Pass High School**

830 NE 9th Street Grants Pass, OR 97526

### **Hearts With A Mission**

1504 NE 9th St. Grants Pass, OR 97526

### **Hidden Valley High School**

651 Murphy Creek Rd. Grants Pass, OR 97527

### **Illinois Valley High School**

625 E River St. Cave Junction, OR 97523

### **Joe's Place**

130 SE K St. Grants Pass, OR 97526

### **North Valley High School**

1641 Monument Dr. Grants Pass, OR 97526

## Support through positive School Climate

*"Self-esteem is an important factor associated with resilience among adolescent and homeless youth" (Dang, 2014).*

Homeless youth who had positive connections through school, community or neighborhoods had far better outcomes than those youth who did not (Dang, 2014 & Roy et al., 2016).

Higher education achievement is clearly linked with higher employment and wage rates (U.S. Labor and Statistics Bureau, 2015).

## What can be done to help locally?

- Donate clothing, shoes, coats, ect. To listed organizations who help Josephine County homeless youth
- Volunteer as a mentor to teach life skills/recreation like hiking, fishing, cooking, and budgeting ect. that the youth are not taught.



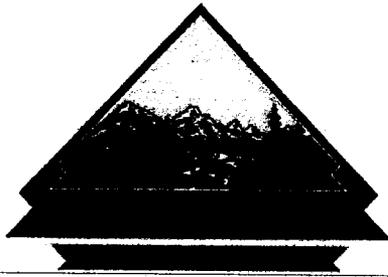
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## The Background

- There are 1551 homeless people in Josephine County. 17% increase from the 2015 PTT count (Josephine County Homeless Taskforce, 2016).
- Approximately 37% are youth under 18 years old.
- There are currently no overnight facilities to house unaccompanied homeless youth under 18.

**Surveyed Homeless Youth in Josephine County were asked "What resources would you feel that would be helpful to you?"**

- "24/7 shelter and internet access for job search purposes"-homeless youth
- "More access to food without tweakers"-homeless youth
- "A safe place to stay"- homeless youth



# Josephine County, Oregon

EXHIBIT 3  
ADMIN 5/26/16

TTD# 1-800-735-2900

**Diane L. Hoover, Ph.D., FACHE**

Josephine County Public Health Director

715 NW Dimmick

Grants Pass, OR 97526

(541) 474-5325

Fax (541) 474-5353

E-mail : publichealth@co.josephine.or.us

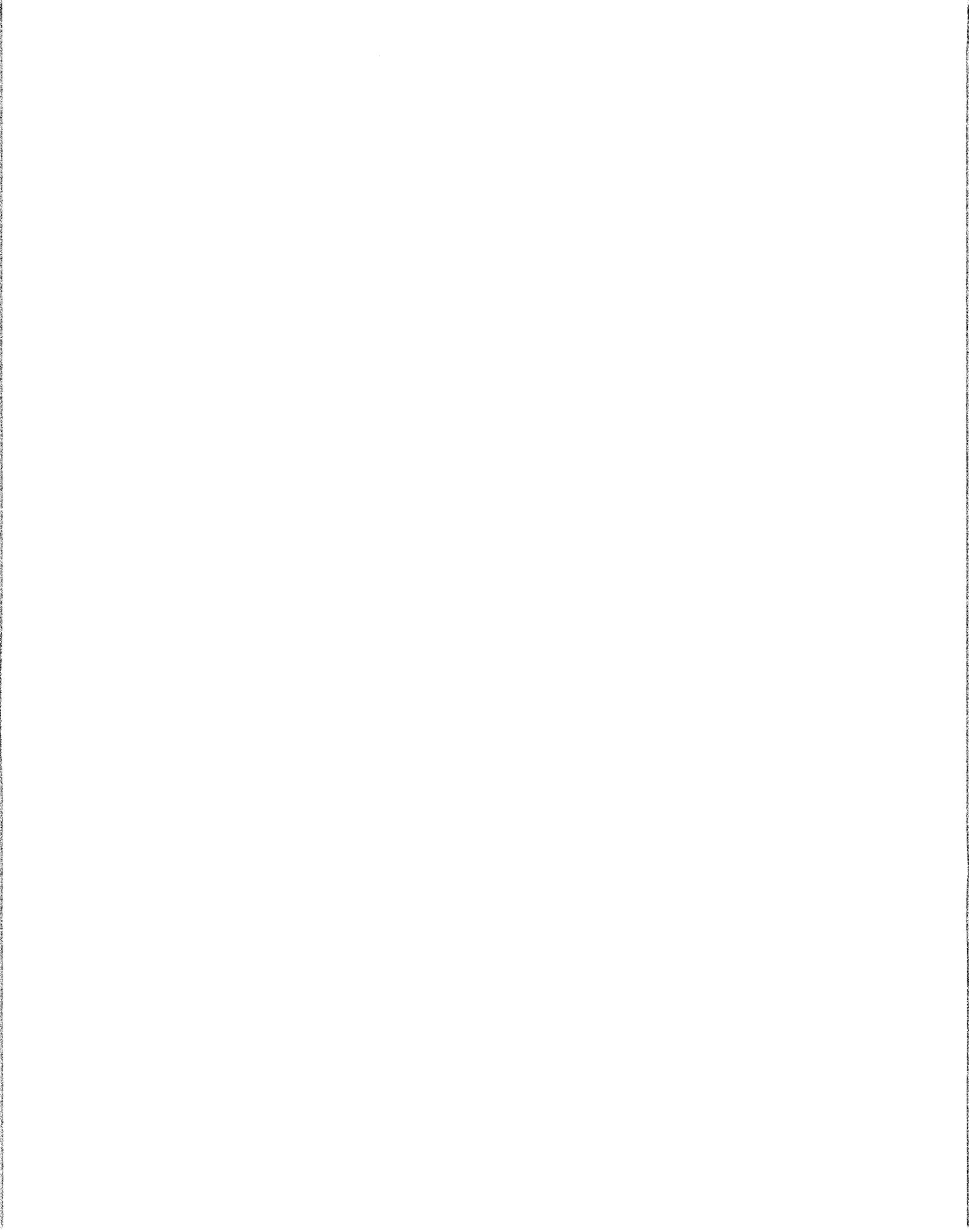
May 26, 2016

To: Board of County Commissioners

Subj: UPDATE MAY 2016

1. OHSU School of Nursing student report out on Homeless Youth Project report out.
2. In the last quarter the public health department conducted 143 communicable disease investigations. 98 of these were for sexually transmitted diseases.
3. In looking at total revenues & expenses thru April, the department was at 99% of budgeted revenue, and at 72% of anticipated expenses. The straight-line percentage for this time period is 80%. I am anticipating more accounts receivable than budgeted due to improved billing practices and increased visits. Therefore, I anticipate closing the fiscal year in the black.
4. The Animal Shelter Advisory Board has been painstakingly working on providing the BCC with a suggested update to the County Animal Ordinances. The current county animal ordinance has not been updated since 1996. The Advisory Board is following the guidelines of the National Animal Interest Alliance's (NAIA) Guide to Pet-Friendly Ordinances as a starting point.
5. The cat building is coming along. Interior drywall started to go up this week. It took a while to get going on the building because we had to wait to get the septic system approved by the DEQ. To keep costs down, some windows were donated by Gary & Courtney Buckmaster & siding donated by Ken Hannum Construction.
6. Discuss non-binding Letter of Intent and possible move to the Allcare Health site in Phase 2 of project.

Respectfully Submitted,



May 23, 2016

Josephine County Public Health

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RE: AllCare Development, LLC  
Letter of Intent to Lease  
"Phase 2 medical office building, AllCare Medical Campus"

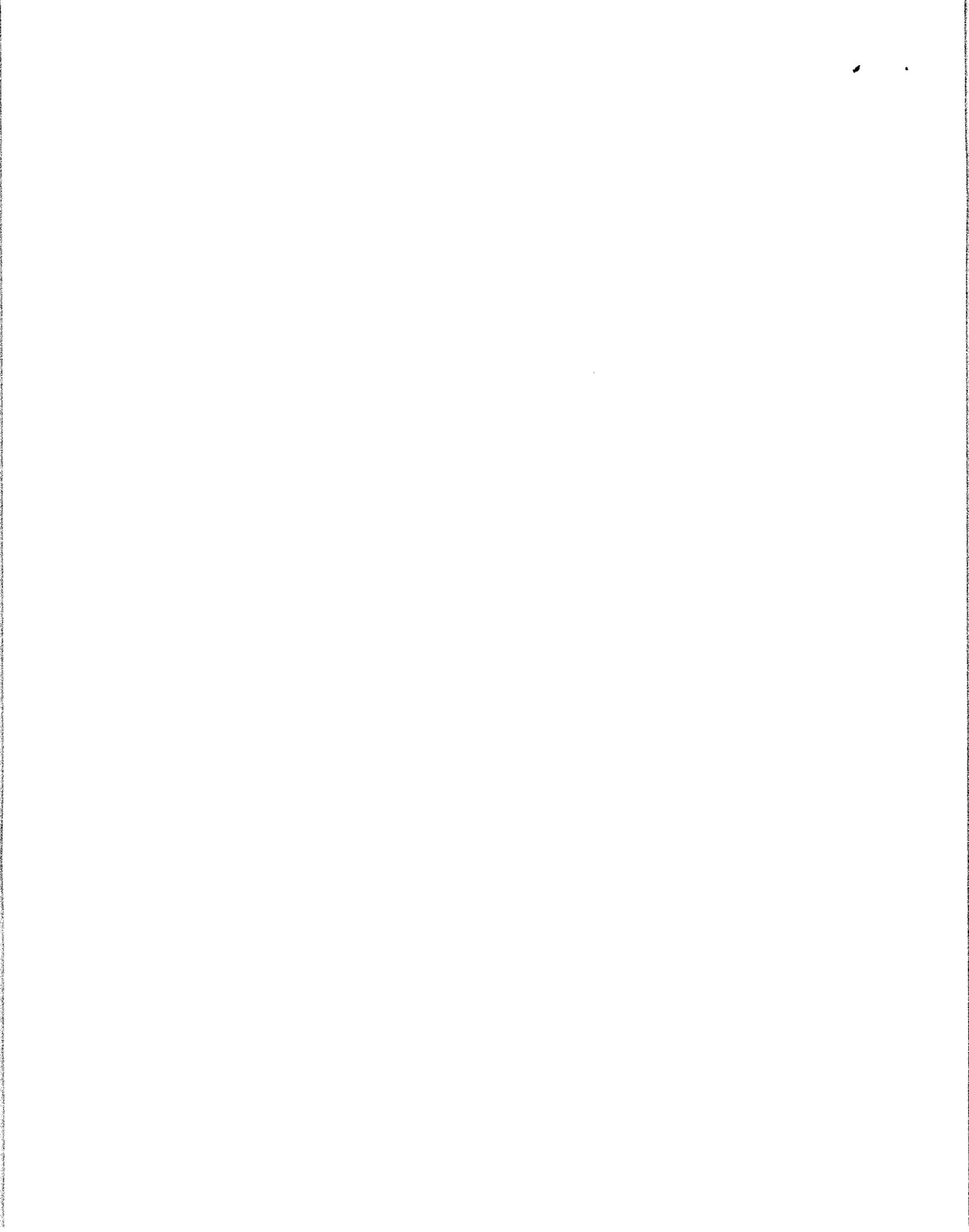
We are pleased to present to you this Letter of Intent to Lease setting forth the basic terms and conditions upon which Josephine County Public Health ("**Tenant**") and AllCare Development, LLC ("**Landlord**") intend to include in a definitive Commercial Lease Agreement to be negotiated and executed by and between the parties ("**Lease**"), for that portion of the premises described below, which will be situated in Phase 2 Medical Office Building ("**Building**").

This Letter of Intent to Lease does not create a binding contractual obligation between the parties. A binding obligation between the parties will exist only upon mutual execution of a definitive Lease. Tenant understands that the Building is still under development and that the Lease will be negotiated and executed once the Building project is closer to completion. Landlord reserves the right to modify the basic terms described herein as reflected in the Lease, without prior notice, and further reserves the right to withdraw the offer to lease in its entirety.

**Premises.** Tenant desires to lease approximately 6,500 rentable square feet on the 1<sup>st</sup> floor of the Building, situated on real property owned by Landlord and commonly referred to as Phase 2 AllCare Medical Campus, Grants Pass, OR 97526 ("**Premises**").

**Permitted Use.** Tenant shall use the Premises for public health office, and for no other use without Landlord's prior written consent.

**Lease Term;  
Renewal Options.** Landlord will rent the Premises to Tenant for an Initial Lease Term of 10 years. Tenant shall have the Option to Extend the Lease for two (2) additional terms of five (5) years, by providing Landlord with six (6) months prior written notice. The Base Rent shall be adjusted to the prevailing market terms, but not less than the Base Rent for the previous 12 months.



**Lease Commencement.**

The Lease shall commence upon the substantial completion of Tenant's Tenant Improvements as will be more fully described and defined in the Lease.

**Rent.**

Base rent is calculated by multiplying the actual, rentable square feet of the Premises times the anticipated rental rate per square foot set forth below ("**Base Rate**").

| <u>Lease Year</u> | <u>Base Rate/Year</u> | <u>Anticipated Base Monthly Rent</u> |
|-------------------|-----------------------|--------------------------------------|
| 1                 | \$2.00/SF             | \$ 13,000.00                         |
| 2                 | \$2.05/SF             | \$ 13,325.00                         |
| 3                 | \$2.10/SF             | \$ 13,650.00                         |
| 4                 | \$2.15/SF             | \$ 13,975.00                         |
| 5                 | \$2.20/SF             | \$ 14,300.00                         |

The anticipated Base Monthly Rental amount assumes the rentable square footage of the Premises is as described above.

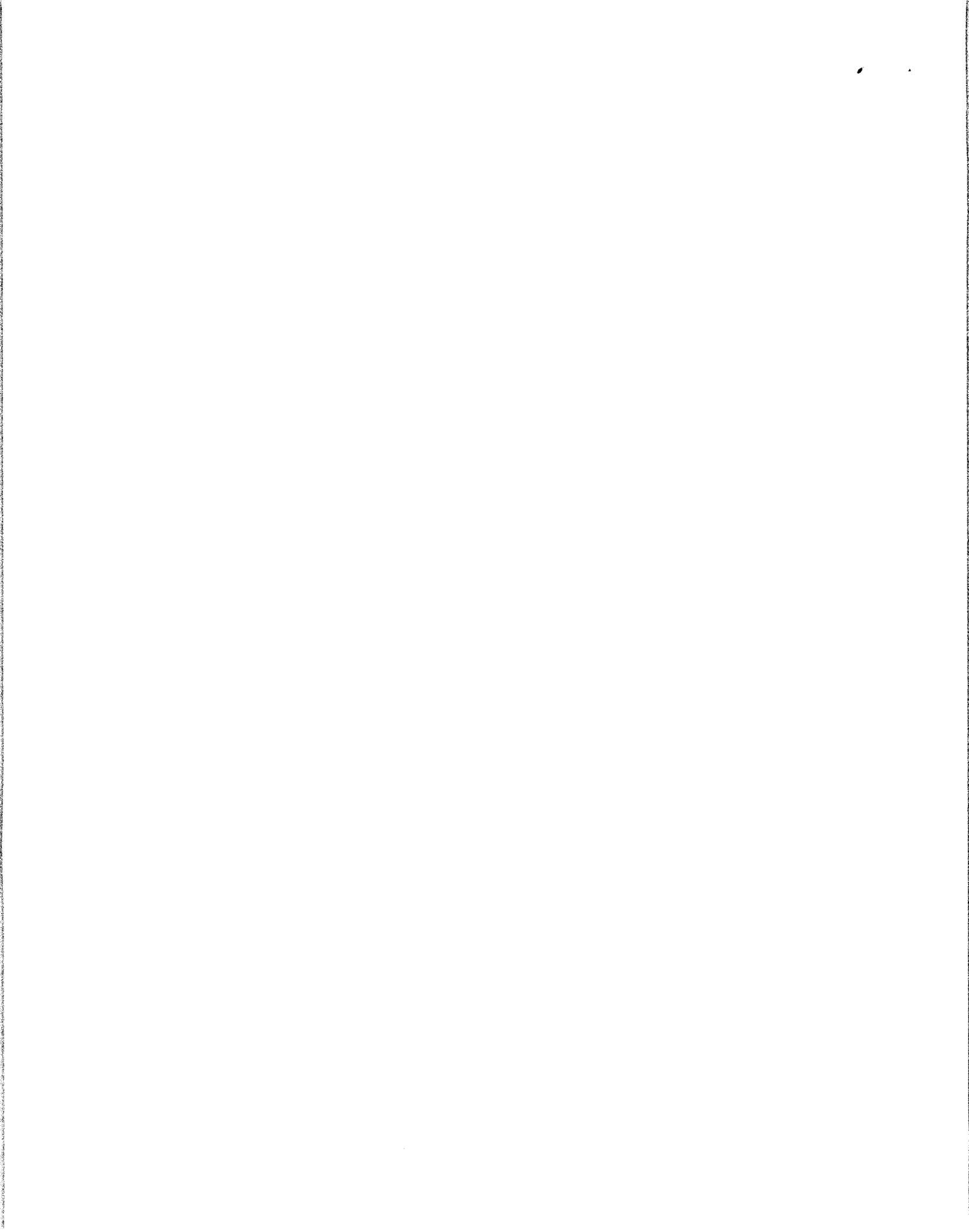
Rent increases are 2.5% per year and shall continue throughout the term of the lease.

**Additional Rent.**

The Lease will be a "triple net" lease agreement. Tenant, along with all other tenants of the Building, will be required to pay their pro rata share of any and all Building operating expenses, which includes but is not limited to, property taxes; insurance; maintenance and repair costs of the Building, parking areas and interior and adjacent exterior common areas; management expenses; and all other operating costs associated with the Building ("**Additional Rent**"). In addition, Tenant shall be responsible for their own utilities and janitorial within the premises. The amount of Additional Rent due from Tenant will be determined by multiplying the total annual operating costs of the Building times a fraction where the numerator is Tenant's rentable square footage of the Building (the Premises) and the denominator is the total rentable square footage of the Building.

**Deposits.**

Within thirty days of the execution of this Letter of Intent by Tenant, Tenant shall pay a security deposit equal to the lesser of \$13,000 or the first month's rent ("**Deposit**"), if known with reasonable accuracy, in order to ensure that Tenant is committed to exploring the Lease arrangement including the proposed Tenant Improvements. In the event Tenant determines not to proceed



with the Lease prior to commencement of formal design drawings for the Tenant Improvements, Tenant will be refunded the Deposit, minus the amount of the design allowance incurred by Landlord, described further below. If Tenant proceeds to execution of the Lease Agreement, the Deposit will (without offset for the design allowance) applied to the deposits due upon execution of the Lease.

**Tenant  
Improvements.**

Tenant may request such improvements, fixtures and finishes in the Premises, as Tenant deems necessary or desirable for Tenant's use. Landlord shall construct the same, for Tenant's benefit, in accordance with the design documents and Tenant Allowance amounts agreed upon by the parties.

**Tenant  
Improvement  
Allowance**

Landlord will provide Tenant with a Tenant Improvement Allowance equal to eighty dollars (\$80) per square foot (the "TI Allowance"). In the event that the actual cost of the Tenant Improvements exceeds the TI Allowance, Tenant shall have the option of (i) paying the difference during the construction phase of the Tenant Improvements, as needed, but in all events prior to the "commencement date" of the Lease, or (ii) requesting that Landlord pay for the additional cost over and above the TI Allowance.

The overall amount expended by Landlord for the Tenant Improvements will be amortized over the initial term of the Lease, and will include an interest component that accrues on the TI Allowance, the amount of which shall be the greater of (i) the then prime interest rate as published in the Wall Street Journal plus one point, or (ii) the amount required to be charged by Landlord's lender.

**Design Allowance**

Upon execution of this LOI Landlord will provide a design allowance of one dollar (\$1.00) per rentable square foot ("Design Allowance") to assist tenant in the space planning and test fit in the building. In the event Tenant decides to not proceed with the Lease, the Design Allowance will be subtracted from the deposit paid by Tenant.

**Signage**

Tenant shall have the right to install signage on the building monument sign, building directory and suite entrance. Signage expense shall be at Tenant's sole cost. All signage installed by Tenant shall have Landlord's prior approval, which shall not be unreasonably withheld.

**Brokerage Fees.**

Landlord shall not be required to pay any brokerage fee to a Tenant representative unless first agreed to in writing by Landlord.

**Financial  
Information;  
Lease Guaranty.**

As a condition to Landlord's agreement to enter into the Lease, Tenant will be required to demonstrate Tenant's creditworthiness to Landlord's reasonable satisfaction. After execution of this Letter of Intent to Lease, Tenant shall provide documents reasonably requested by Landlord which may include but not be limited to, (i) copies of Tenant's tax returns and CPA-prepared financial statements for the previous three years, and (ii) completion of such documents or forms as reasonably necessary to enable Landlord to obtain a credit report pertaining to Tenant and all guarantors as applicable.

If Tenant is not an individual, the shareholder(s), partner(s) or member(s) of Tenant shall be required to personally guarantee Tenant's performance under the Lease.

Sincerely,

\_\_\_\_\_  
**XXX**  
**XXX**

If the terms set forth in this Letter of Intent to Lease are satisfactory to you, please have an individual authorized to sign this agreement on behalf of Josephine County Public Health sign below and return this to the attention of \_\_\_\_\_ at \_\_\_\_\_.

AGREED TO AND ACCEPTED:

Josephine County Public Health

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Date*

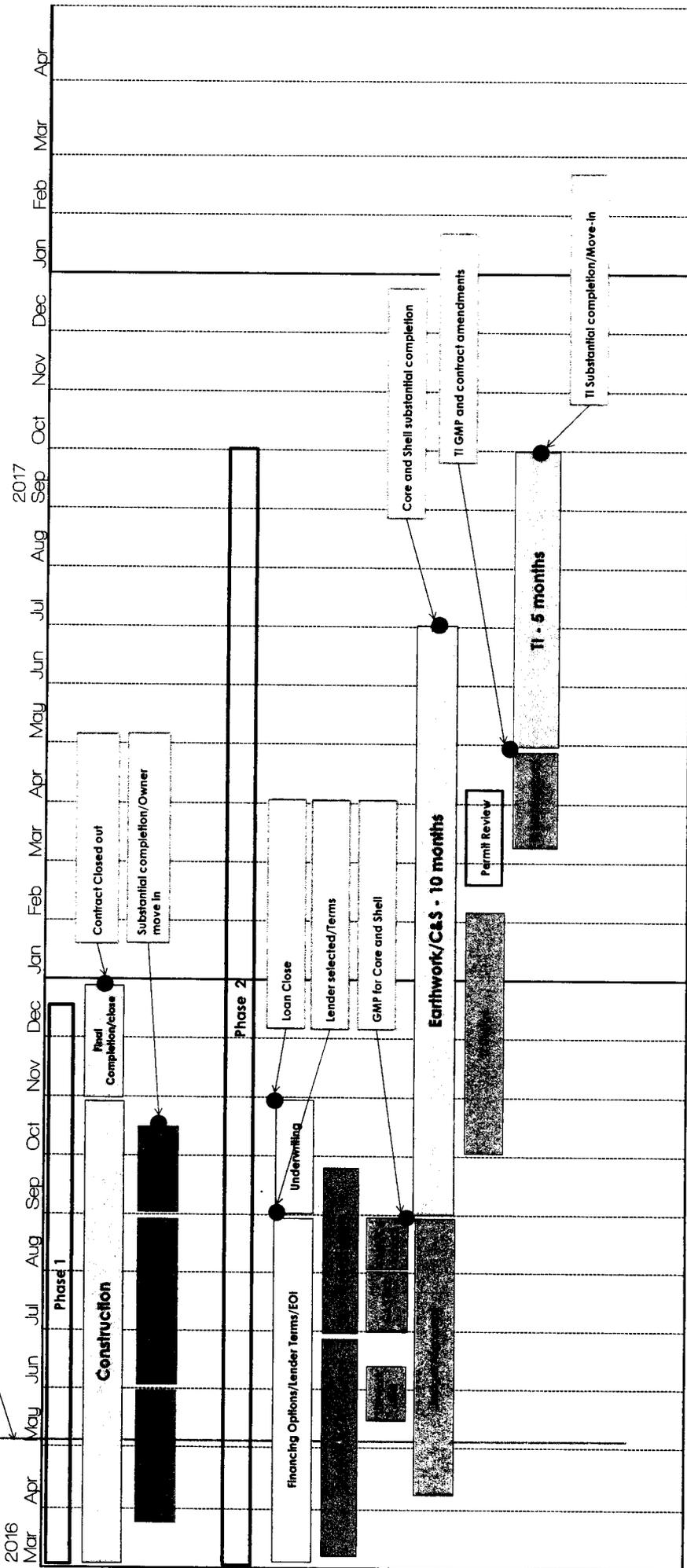


# PROJECT SCHEDULE

AllCare Health

Date 5/4/2016 7:06

Current Progress



# Housing as a Health Care Investment

## Affordable Housing Supports Children's Health

By Megan Sandel, MD, MPH; John Cook, PhD, MAEd; Ana Poblacion, MSc; Richard Sheward, MPP; Sharon Coleman, MS, MPH; Janet Viveiros, MPP; and Lisa Sturtevant, PhD

MARCH 2016

Affordable and stable housing plays a critical role in supporting the health and well-being of children. Research from Children's HealthWatch shows public investment in housing—including housing for homeless families and rental assistance for food-insecure families—improves the health outcomes of vulnerable infants and young children and lowers health care spending.

Previous research from Children's HealthWatch demonstrated the harmful impact homelessness has on the health of young children and that the negative health outcomes are compounded when a mother is homeless both before and after her child is born.<sup>1</sup> New findings from Children's HealthWatch researchers show affordable and stable housing made possible through rental assistance is associated with better health outcomes for infants in vulnerable families.

Investments in programs that house families in need and have the potential to reduce public spending on health care can be a double win for public policy. Given the significant impact stable

and affordable housing has on the health of children, policymakers should consider how to expand investment in affordable housing and services for vulnerable families to improve the health outcomes of young children and reduce health care spending.

### Homelessness Harms Young Children's Health

Previous research from Children's HealthWatch illustrates the devastating impact of homelessness on children's health. While pre- and post-natal child homelessness are each separately associated with poor health outcomes for children, the combination of pre- and post-natal homelessness demonstrates a "dose-response" effect that compounds the health risks linked individually to pre- and post-natal homelessness.<sup>2</sup>

When compared to children who were never homeless:

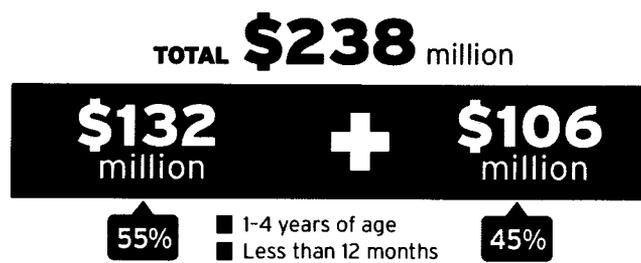
- Children who experienced pre-natal homelessness (i.e., their mothers were homeless during pregnancy but were housed after their birth) were **20 percent more likely to have been hospitalized** since birth.
- Children who experienced post-natal homelessness (i.e., their mothers were housed during pregnancy but were homeless when the children were infants and/or toddlers) were **22 percent more likely to have been hospitalized** since birth.
- Children who experienced both pre- and post-natal homelessness were **41 percent more likely to have been hospitalized** since birth.



## Child Homelessness Contributes to High Health Care Spending

Homelessness is extremely harmful to the health of young children and leads to higher health care costs, a large share of which is paid by publicly funded health insurance.<sup>3</sup> In 2014 an estimated 671,000 children age four or under had been homeless at some point or were born to a mother who was homeless when she was pregnant.<sup>4</sup> **Children's HealthWatch estimated that these children, as a group, experienced 18,600 additional hospitalizations attributable to their experience of homelessness.**<sup>5</sup> The average cost of one hospital stay for an infant was \$16,248 and \$10,139 for a toddler age 1-4 years old in 2015. **The estimated total annual cost of hospitalizations attributable to homelessness among children age four and under in 2015 alone were over \$238 million nationally**, with more than half of those costs associated with hospitalizations of infants under the age of one (Figure 1).

**FIGURE 1.** Hospitalization Costs Associated with Children's Homelessness, 2015 (in 2015 dollars)



Source: Children's HealthWatch Calculations.

Hospitalization costs attributable to homelessness represent just one of the many ways that homelessness leads to worse health among children and increased pediatric health care costs. There are other health care costs not included in this research, such as prescription medications for physical and mental health conditions, and there is medical care related to long-term health conditions associated with children's exposure to homelessness that require additional health care services. Aside from health care costs, homelessness also negatively impacts children's educational achievement.<sup>6</sup>

## Many Low-Income Families Have Complex Needs

Homelessness is costly for families and society, keeping many young children from getting a healthy start in life. Rental assistance can make a significant difference for infants, especially those from highly vulnerable families.

Food-insecurity is a valuable indicator of vulnerability among low-income families and was measured in Children's HealthWatch research to identify families with complex social needs. Previous Children's HealthWatch research demonstrates that young children in families with multiple hardships, such as food-insecurity and unstable or unaffordable housing, are at higher risk for poor health outcomes than those experiencing only one hardship,

## Definition of Household Food-Insecurity

When families lack access to sufficient food for all members to lead active, healthy lives because of insufficient family resources, they are considered to be food-insecure. Using the U.S. Food Security Survey Module, households are categorized as food-insecure when they report that they do not regularly have access to adequate food.

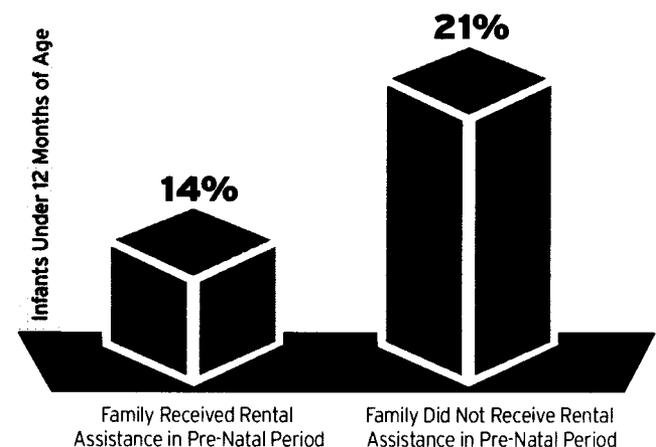
or none at all.<sup>7</sup> Based on the evidence that infants from food-insecure families are an exceptionally high risk population, Children's HealthWatch examined the relationship between rental assistance and child health outcomes among infants and young children in food-insecure families to help clarify the role of housing in sustaining good health.

In their new study findings, researchers from Children's HealthWatch collected data from over 2,000 low-income, food-insecure households with infants under 12 months of age from 2009 through 2014. The infants' caregivers were interviewed in urban pediatric clinics and emergency departments. Nearly one quarter of these households received some form of rental assistance during pregnancy. Interview data were analyzed to assess infants' health and development and to compare outcomes for infants in food-insecure families receiving rental assistance with families eligible for, but not receiving, rental assistance.

## Affordable Housing Reduces Infant Hospitalizations

After adjusting for family characteristics and other factors, Children's HealthWatch researchers found that infants in **food-insecure families with rental assistance during the pre-natal period were 43 percent less likely to have been hospitalized** compared to infants in food-insecure families eligible for but not receiving rental assistance. The reduced rate of hospitalization among the infants whose family had rental assistance in the pre-natal period resulted from better overall health and fewer instances of serious illness.

**FIGURE 2.** Prevalence of Hospitalization Among Food-Insecure Infants, 2015



All findings statistically significant at p<.05.  
Source: Children's HealthWatch Data, May 2009-December 2015.

This research found that health care cost savings associated with avoided hospitalizations among infants in food-insecure families with rental assistance were an estimated \$20 million—or 1,200 avoided hospitalizations—in 2015. These infant health care savings were attributable to their families' living in affordable housing in the pre-natal period. These hospitalization cost savings are just one example of how ensuring that vulnerable families live in stable, affordable housing during the pre-natal period can lead to pediatric health care cost savings over time.

## Policy Solutions

Research from Children's HealthWatch presented in this brief shows the important role that housing plays in supporting the health of young children. Not only is homelessness associated with more frequent and costly hospitalizations among young children, but when vulnerable families have stable, affordable housing—versus potentially inadequate or unaffordable housing—their infants experience fewer hospitalizations. Affordable housing created with rental assistance can have a significant and positive impact on health for infants in vulnerable families. Their improved health reduces health care spending that can be invested in other areas such as the expansion of public resources for affordable housing programs.

The following strategies can expand access to affordable housing for vulnerable, low-income families and help them overcome many of the challenges they face:

**Expanding funding for rental assistance programs** can reduce the number of homeless and vulnerable families by increasing the number of eligible families who receive housing vouchers or live in homes made affordable by rental assistance. The results of this study and other research, including HUD's Family Options Study, show that rental assistance is an effective tool for helping families secure stable and affordable housing and improve their well-being.<sup>8</sup> However, only one in four families who qualify for federal housing vouchers or other federal rental assistance actually receives it.<sup>9</sup> Increasing funding for the federal Housing Choice Voucher, HOME Investment Partnerships, and other HUD and USDA rental assistance programs will allow them to reach more vulnerable families across the country. Some state and local governments also offer their own rental assistance programs to serve individuals and families who do not receive but qualify for federal rental assistance programs. Expanding the size of existing state and local programs, in addition to creating similar programs in other jurisdictions currently without rental assistance programs, can fill the gap between the need and availability of housing vouchers in order to reduce the number of at-risk and homeless families and offer stability to vulnerable families.

Increasing funding for existing public housing developments will enable public housing authorities to better maintain existing public housing units. Also, increased funding for initiatives like the Choice Neighborhoods and Rental Assistance Demonstration programs will allow additional communities

to redevelop distressed public and private affordable housing and improve living conditions for residents.

**Creating more affordable housing suitable for families** can help families with vouchers find a place to land. Families can encounter difficulty finding units large enough because most rental assistance program rules prevent families from moving into units with too few bedrooms for their family size. Addressing the need for family-sized units should help guide allocation of project-based vouchers to developments. Local planning decisions on proposed housing developments can encourage the development of family-sized units to provide more housing options to families with or without housing vouchers. Expanding capital subsidies such as the Low Income Housing Tax Credit, HOME Investment Partnerships, the National Housing Trust Fund, and others for creation and preservation of affordable housing are also essential.

**Making housing voucher programs easier for families to navigate** can improve the ability of families who do receive vouchers to secure a home to rent before their voucher expires and becomes unavailable. For a variety of reasons it is often difficult for families to find homes to rent with their housing vouchers once they receive them. Many families with housing vouchers searching for a home to rent encounter discrimination among landlords who refuse to rent to voucher holders either to avoid administrative burdens of the program or because of negative stereotypes of families with housing vouchers.<sup>10</sup> Enacting local laws prohibiting discrimination against housing voucher holders can reduce this barrier to using housing vouchers. Improving voucher program administration to reduce barriers for property owners will also help.

**Ensuring access to supportive services for families receiving rental assistance** can help vulnerable families resolve their complex needs. Case management programs and service coordination offered in many affordable housing developments for older adults and individuals with disabilities are good models for addressing the complex social needs of vulnerable individuals. Offering supportive and case management services to vulnerable families living in public housing, private

## What is Rental Assistance?

Rental assistance is help for low-income families and individuals to live in rental housing they can afford—meaning rent does not exceed 30 percent of their income. Rental assistance programs are offered by the federal government, along with some state and local governments. The most common rental assistance programs are:

- housing vouchers, which allow people to live in private rental housing they choose
- public housing, which comprises affordable housing developments managed by public housing authorities
- project-based rental assistance, which contracts with private building owners to make apartments affordable

housing with rental assistance, or using housing vouchers, can enhance a family's ability to connect to other social services that can reduce their vulnerability.

**Considering vulnerable families to be a special population**, similar to chronically ill and homeless individuals, can make the rationale for incorporating housing into comprehensive health care plans clearer to policymakers. The reform of the health care system through the Affordable Care Act and other initiatives has created momentum for investing in housing interventions for "high utilizers" of the health care system, typically vulnerable homeless individuals and older adults with complex and expensive health needs. Recent research has shown incorporating housing into comprehensive care plans for these individuals can be effective in improving health outcomes and significantly reducing public spending on health care.<sup>11</sup> Creating similar programs and incentives to offer affordable housing to homeless and vulnerable families can foster better health outcomes and reduce hospitalizations and other health care services for young children and infants. In turn, public health care savings achieved by these better health outcomes can be reinvested in to expand access to housing vouchers and other affordable housing programs for vulnerable families.

## Conclusion

Research from Children's HealthWatch shows the significant harmful impact homelessness and unaffordable or unstable housing has on the health of infants and children during their most critical development stages. It can also lead to costly hospitalizations and increased health care needs. Expanding access and improving rental assistance programs and other affordable housing programs are key strategies in improving health outcomes and lowering health care costs for children.

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Children's HealthWatch is a nonpartisan network of pediatricians, public health researchers, and children's health and policy experts. Our network is committed to improving children's health in America. We do that by first collecting real-time data in urban hospitals across the country on infants and toddlers from families facing economic hardship. Our findings help policymakers and the public better understand the social and economic factors that impact children's health so they can make well-informed policy decisions that can give all children equal opportunities for healthy, successful lives.

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Formed in 1931, the nonprofit National Housing Conference is dedicated to helping ensure safe, decent and affordable housing for all in America. As the research division of NHC, the Center for Housing Policy specializes in solutions through research, working to broaden understanding of America's affordable housing challenges and examine the impact of policies and programs developed to address these needs. Through evidence-based advocacy for the continuum of housing, NHC develops ideas, resources and policy solutions to shape an improved housing landscape.

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# Neighborhood-Level Interventions to Improve Childhood Opportunity and Lift Children Out of Poverty



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## ABSTRACT

Population health is associated with the socioeconomic characteristics of neighborhoods. There is considerable scientific and policy interest in community-level interventions to alleviate child poverty. Intergenerational poverty is associated with inequitable access to opportunities. Improving opportunity structures within neighborhoods may contribute to improved child health and development. Neighborhood-level efforts to alleviate poverty for all children require alignment of cross-sector efforts, community engagement, and multifactorial approaches that consider the role of people as well as place. We highlight several accessible tools and strategies that health practitioners can engage to improve regional and local systems that influence

child opportunity. The Child Opportunity Index is a population-level surveillance tool to describe community-level resources and inequities in US metropolitan areas. The case studies reviewed outline strategies for creating higher opportunity neighborhoods for pediatricians interested in working across sectors to address the impact of neighborhood opportunity on child health and well-being.

**KEYWORDS:** child poverty; collective efficacy; community engagement; equity; neighborhood; opportunity

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CHILDHOOD POVERTY IS an enduring social determinant of health over the life course.<sup>1</sup> Research has shown that childhood poverty is associated with poverty in adulthood,<sup>2</sup> and socioeconomic status is a strong and durable predictor of health and well-being.<sup>3</sup>

While poverty's influence on health is well understood on the individual level, the mechanisms by which neighborhoods perpetuate child poverty are less clear. Area deprivation is associated with fewer opportunity structures and adverse health and developmental outcomes for children.<sup>4</sup> A well-established research literature<sup>5</sup> has found that neighborhoods are inequitable in multiple socioeconomic dimensions and health problems therefore cluster geographically. New research links these deprivations and inequities to early life adversities and the biological consequences of toxic stress.<sup>6</sup> Adverse childhood experiences have been correlated with health behaviors in adulthood as well as poor physical and mental health outcomes<sup>7–10</sup> in a dose–response relationship. The cumulative adverse experiences encountered change the

allostatic load of physiologic systems and may be a critical pathway to explain the higher morbidity and mortality rates seen in populations of lower socioeconomic status.<sup>11–14</sup>

From Bronfenbrenner's<sup>15</sup> ecological framework, one can see how multiple environmental systems are nested together and work to influence individual human development and allostatic load. The interplay between the micro and meso systems of families and neighbors and the macro systems of concentrated poverty and racism belie the complexity of changing neighborhoods as a way to improve health. While neighborhoods may contain adversities that can perpetuate poverty, they may also have consistent and supportive relationships to help the child cope and mitigate toxic stress.<sup>16</sup> Conversely, children moving to lower concentration of poverty may have higher economic mobility, despite often staying in the same dysfunctional family systems.<sup>17</sup>

Here we aim to describe briefly the role place, defined by both people and geography, can play in health as well as a

tool that can be used to define neighborhood opportunities. We describe the essential components of community engagement in building collective efficacy and provide 3 case studies of multisector, multifaceted interventions.

### DEFINING PLACE FOR INTERVENTION

While maximizing opportunities is important in shaping the well-being of families and children,<sup>4</sup> the primary strategies to address this issue emerge from what can feel like dueling ideologies. As Turner has noted, there is a false dichotomy between mobility assistance to move low-income children to higher opportunity neighborhoods and "place-based" neighborhood revitalization to improve opportunity structures within impoverished neighborhoods.<sup>18</sup> Turner argues that to address neighborhood-level poverty and lack of opportunity, both approaches must be used as complementary strategies for "place-conscious" interventions. Here we review evidence for both but will focus on case examples of pediatric involvement in place-based neighborhood level interventions specifically.

The Moving to Opportunity (MTO) study, in which children were moved out of concentrated-poverty, low-opportunity neighborhoods into less-concentrated-poverty, higher-opportunity neighborhoods, was among the largest experimental demonstration studies aimed at alleviating poverty by changing neighborhood environment.<sup>19</sup> Recent analyses of the MTO study<sup>17</sup> revealed that children whose families moved to a higher-opportunity neighborhood when they were age 13 years or younger (about 8 years old on average) had a significant increase in total lifetime earnings and were significantly more likely to attend college; further, female participants were less likely to be single parents. Every year of childhood spent in a higher-opportunity neighborhood was associated with an increased benefit, suggesting both a dose-response and critical-period effect for young children. However, there was no effect seen for adults, and a negative effect was seen for youth older than 13 years of age. Additional research on MTO has also found mixed results, with studies showing that women in households with mobile vouchers to less-concentrated-poverty neighborhoods had lower hemoglobin A1C values and lower rates of morbid obesity,<sup>20</sup> while teenage boys in comparative households had higher rates of mental illness.<sup>21</sup> Despite evidence of mixed effects, most research supports mobility interventions as one important approach to improving place for children in poverty by moving to less-concentrated-poverty neighborhoods with higher opportunities.

### DEFINING PLACE BY BOTH PEOPLE AND GEOGRAPHY

When considering how to intervene within a neighborhood, it is essential to define where to do the intervention by people as much as geography. While concentrated poverty influences health through a neighborhood-level effect, the influence of neighborhoods can also be felt through networks of social support or social cohesion. One example of this is neighborhood collective efficacy,

which is defined as the linkage of mutual trust and the willingness to intervene for the common good.<sup>22</sup> Examples of collective efficacy include whether neighbors feel like they have someone to borrow \$20 from, someone to watch their child in an emergency, or, if they witness a crime, they are willing to call the police. A higher rate of collective efficacy is associated with lower rates of violent crime and appears to mediate the association between neighborhood characteristics, such as concentrated disadvantage, residential instability, and violence. Collective efficacy has also been associated with measurable health outcomes. The MTO study demonstrated that adults who moved to lower-poverty neighborhoods reported higher levels of collective efficacy despite having fewer social connections,<sup>23</sup> and they experienced decreased levels of depression as a result.<sup>24</sup>

Acknowledging the contribution of Bronfenbrenner's social ecology to child well-being, collective efficacy may be a critical determinant of improving neighborhoods to achieve greater levels of supportive relationships and enriched environments for children. Effective neighborhood-level interventions to address concentrated poverty therefore need to tie to increasing the numbers and types of opportunity with improving neighborhood collective efficacy. The evidence for using collective efficacy to improve health outcomes has focused predominantly in single-faceted interventions, such as community gardens,<sup>25</sup> or in targeted populations, such as youth empowerment.<sup>26</sup> Large-scale evaluations of collective efficacy as part of multifaceted, place-based initiatives are underway, as the case studies that follow demonstrate.

### OPPORTUNITY MAPPING

In addition to defining place by the people who live there, it is also essential to target interventions geographically. One tool for this is the Child Opportunity Index (COI).<sup>27</sup> Developed by Diversity Data Kids (<http://www.diversitydatakids.org/>) at Brandeis University and the Kirwan Institute on Race and Ethnicity at Ohio State University, this tool integrates multiple indicators of child-relevant neighborhood opportunity in a composite index by neighborhood in each of the 100 largest metropolitan areas in the United States. Opportunity mapping can be used as a visual depiction of the location of neighborhood opportunity and of inequities in opportunity across neighborhoods. The COI incorporates 19 indicators into the 3 domains of educational, health and environmental, and social and economic in order to map opportunity at the neighborhood level (Fig. 1). Consistent with Bronfenbrenner's framework for understanding the interplay of systems, this index can then be used to consider ways to enhance existing opportunities, create new ones, and explore the ways in which policy in the geographic area can be leveraged to support this endeavor. Successful and sustainable interventions are those that address the multidimensional aspects of communities that influence both absolute and relative measures of poverty. The COI is one tool that can also be useful for tracking change over time and for understanding the impact of social policies

| Opportunity Indicators In The Child Opportunity Index             |
|---|
| School poverty rate (eligibility for free or reduced-price lunch) |
| Student math proficiency level                                    |
| Student reading proficiency level                                 |
| Proximity to licensed early childhood education centers           |
| Proximity to high-quality early childhood education centers       |
| Early childhood education participation                           |
| High school graduation rate                                       |
| Adult educational attainment                                      |
| <b>Health and Environmental Opportunities</b>                     |
| Proximity to health care facilities                               |
| Retail healthy food environment index                             |
| Proximity to toxic waste release sites                            |
| Volume of nearby toxic waste release                              |
| Proximity to parks and open spaces                                |
| Housing vacancy rate  |
| <b>Social and Economic Opportunities</b>                          |
| Foreclosure rate  |
| Poverty rate  |
| Unemployment rate   |
| Public assistance rate  |
| Proximity to employment   |

**Figure 1.** Opportunity indicators in the child opportunity index. Adapted from: Acevedo-Garcia D, McArdle N, et al. Acevedo-Garcia D, McArdle N, Hardy E, et al. *The Child Opportunity Index: improving collaboration between community development and public health.* Health Aff. 2015;33:1948–1957.

and interventions on health. Further evaluation will be crucial in demonstrating its utility.

### IMPORTANCE OF COMMUNITY ENGAGEMENT AND LEADERSHIP DEVELOPMENT

Community engagement is a central component of community-level interventions. Thoughtful engagement of community members at every stage of planning, implementation, and evaluation can create greater equity and potential for success. While an anchor institution such as a hospital, university, or local nonprofit may be the driving agent of change for the neighborhood-level intervention, the process must not be a solely top-down approach but rather must engage in bottom-up methods. Neighborhood-level interventions must focus on a community-identified problem with a community-driven solution. The COI may guide identification of areas for intervention within a previously defined neighborhood, but it is essential that efforts are made to engage with key community stakeholders to complete a needs assessment with the community, with prioritization of community needs. An effective change agent will assess a community from the perspective of its strengths rather than a deficit-only perspective in order to empower and mobilize communities' assets toward a common and sustainable goal.<sup>28</sup>

Several guiding principles are relevant to consider. 1) Throughout the intervention process, stakeholders within the community should be represented on all committees,

with special attention taken to include those who are commonly underrepresented or marginalized. 2) Communities will vary widely in their assets and ability to mobilize collectively around them for a common goal. A community's baseline collective efficacy should be assessed, and enhancement of this should be a primary goal through leadership development and other interventions. 3) Clinicians and institutions should be mindful of the investment of time such interventions require and plan accordingly for engagement. 4) Power dynamics exist between anchor institutions, government and community members, particularly around who is funding these initiatives and to what purpose. Transparency and diversified funding streams for community development are essential to ensuring all stakeholders remain a true part of the process.

### CASE STUDIES IN NEIGHBORHOOD-LEVEL INTERVENTIONS

The following case studies illustrate different community-engaged, multisector, multifactorial partnerships to improve opportunity and collective efficacy in neighborhoods. These are not meant to replace the pioneering work of Geoffrey Canada and the Harlem Children's Zone or to be an exhaustive list. Other excellent examples exist from across the country, such as University California at San Francisco, led by Anda Kuo. The Build Healthy Places Network, led by Doug Jutte, provides many additional examples. Rather, these case studies are meant to illustrate key take-home lessons for future collaborations.

The Dudley Street Neighborhood Initiative's strength is as an example of community members' coming together to define their place and problem and to own their own neighborhood revitalization. Strong governance and community engagement for ongoing community-driven voice has led to their decades of success. Healthy Neighborhoods Healthy Families' strength is in focusing first on housing revitalization, then expanding to other facets of intervention, such as workforce development, educational interventions, public safety, and community wellness. It has brought cross-sector investment from city and state agencies, and it has invested in community-based organization and leaders to ensure equity and transparency among stakeholders. The Vital Village Network's strength is in multifaceted interventions designed and tested by community-driven innovation, using shared data, leadership development, and microfinancing of pilot projects as driving forces for cross-sector collaboration. It adopts a trauma informed approach and defines the focus of their work through corridors of people and geography.

#### DUDLEY STREET NEIGHBORHOOD INITIATIVE

One example of a grassroots, community organization-led initiative is the Dudley Street Neighborhood Initiative (DSNI; <http://www.dudleyneigh.org>). DSNI began in 1984 with support from the Riley Foundation in response to the issues of concentrated poverty, disinvestment from the city, and environmental injustices that were occurring in this Boston, Massachusetts, neighborhood. DSNI

organizes residents and other stakeholders for their collective power to realize a shared vision; implementation is achieved through partnership and collaborations. Governance is exercised through DSNI's community-elected representative and resident-led collaborative board of directors. Initiatives are supported through active committees consisting of community members and other stakeholders, such as parents, affordable housing developers, hospitals, schools, and city agencies.

One of DSNI's first projects was Don't Dump on Us, a campaign to address the illegal dumping on vacant lots, trash transfer stations, and the city's lax garbage collection. Door knocking and petitions allowed DSNI to hear residents' concerns and publicize the campaign. Several community meetings were held, to which city officials were invited; the overwhelming turnout by the neighborhood residents garnered an immediate press release by the mayor promising his commitment to the cause. The mayor eventually followed through by shutting down the trash transfer stations after declaring them a public health hazard.<sup>29</sup> The Don't Dump on Us campaign allowed the community to come together over an immediate concern and brought positive media attention to a community that had previously been only either ignored or negatively portrayed. By harnessing their collective efficacy, the community capitalized on political power and used it to change a system.

With a newfound collective vision, DSNI worked with consultants to create a neighborhood revitalization plan that was then adopted by the City of Boston. In keeping with the value of "development without displacement," DSNI made history by gaining eminent domain authority from the city of Boston and established a community land trust, which allowed them to fill the previously vacant lots with affordable housing, community gardens, playgrounds, and new businesses, as well as fight against displacement due to recent gentrification efforts.

The communities in Roxbury and North Dorchester that DSNI serve became a Promise Neighborhood when DSNI, as the lead agency, was awarded a US Department of Education Promise Neighborhood planning grant in 2010 and implementation grant in 2013. As a Promise Neighborhood, under the name Boston Promise Initiative (BPI), DSNI is taking a cradle-to-career approach to supporting healthy families, school success, and career advancement toward the ultimate goal of breaking the cycle of intergenerational poverty. The programs and policy efforts that are being implemented through BPI are created in collaboration with residents, schools, and partner agencies. Their efforts include addressing how housing instability affects school attendance through No Child Goes Homeless; partnering around policy advocacy and providing expanded learning support to the neighborhood's 10 Boston public schools; and through the DSNI Education Committee, hosting community education or Learning Our Value in Education (LOVE) events. DSNI's BPI has a specific focus on early childhood (0–5 years) through the Dudley Children Thrive (DCT). DCT partners with multiple agencies to create a network of early education providers and

parents working together as their child's first teacher. The areas of early literacy and parents reading to their children are emphasized to achieve the goal of school readiness by age 5 years. Similar to the founding Don't Dump on Us campaign, DSNI is working to create a Dudley Village Campus that collectively supports resident and parent leadership, provides quality early learning experiences, and addresses barriers to learning through involvement of all community members.

### HEALTHY NEIGHBORHOODS HEALTHY FAMILIES

Through a place-based initiative called Healthy Neighborhoods Healthy Families (HNHF), Nationwide Children's Hospital leads a multisector partnership to support community wellness and create neighborhoods of opportunity by focusing on the revitalization of 3 zip codes surrounding the hospital. It has taken a multifaceted approach coordinating across sectors with strong community engagement and leveraged millions of dollars of city and state funding.

Recognizing the community's desire for safe and affordable housing in its surrounding neighborhood, the HNHF initiative was initially launched as a comprehensive housing initiative in partnership with Community Development for All People (CD4AP), a faith-based organization whose mission is to improve quality of life for low- and middle-income individuals on the South Side. CD4AP brought important assets, as they had experience redeveloping blighted houses in the neighborhood and strong relationships with neighborhood residents. By combining their strengths and shared vision, Nationwide Children's and CD4AP formed the Healthy Neighborhoods Healthy Families Realty Collaborative and together worked to transform the neighborhood, one home at a time.

As Nationwide Children's and CD4AP increased their investments, additional partners stepped forward, including United Way of Central Ohio, Franklin County Land Bank, the Affordable Housing Trust, and the city of Columbus. Currently more than \$16 million has been invested to eliminate substandard housing and improve existing housing stock in the South Side community, and improvements have been made to more than 100 homes in the target area, rebranded as Healthy Homes (Fig. 2).

As the Healthy Homes housing efforts continues to progress, the HNHF initiative has evolved to incorporate complementing work already taking place in other areas. To truly improve and integrate systems that support people where they live, Nationwide Children's began to expand partnerships in the areas of education, workforce development, health and wellness, and safety.

One example occurred in 2015, when CD4AP and Healthy Homes, working in collaboration with the NRP Group, the Ohio Capital Corporation for Housing, and Chase Bank, were awarded \$11.7 million in tax credits to build new affordable housing units with job training space for the residents and community. Another example of this focus in other areas is the hospital's goal to increase the number of employees hired from the South Side



**Figure 2.** Example of Healthy Home renovations from Healthy Neighborhoods Healthy Families.

neighborhood. Nationwide Children's has hired more than 400 South Side residents since 2013, and more than 540 are employed throughout the hospital. In support of these efforts, the HNHF workforce development programming includes job preparation training and access to opportunities through workshops and job fairs. Nationwide Children's has also partnered with Columbus State Community College on FastPath, a program designed to identify, recruit, and connect unemployed and underemployed adults with technical and employability training that prepares them for in-demand jobs that can create pathways to long-term careers.

Other transformative work to ensure children and families have well-rounded support includes a focus on education and health and wellness through the implementation of school-based and community programs in the HNHF zip codes. The initiative delivers and supports programs that promote social and emotional well-being through prevention programming that teaches children self-regulation and coping skills as well as programming that teaches children and adults about the signs of suicide. School-based programming with Columbus city schools also includes services to address the comprehensive physical health of children and adolescents via nurse practitioners. Last, as part of neighborhood engagement in wellness, the hospital partnered with the United Way of Central Ohio and CD4AP to create the South Side Neighborhood Leadership Academy (SS NLA). The program includes 8 leadership sessions and additional work pursuing a community-based team project designed to propel transformative change in the neighborhood.

#### **VITAL VILLAGE NETWORK**

The Vital Village Network is a place-based, community engagement network that mobilizes collective investment

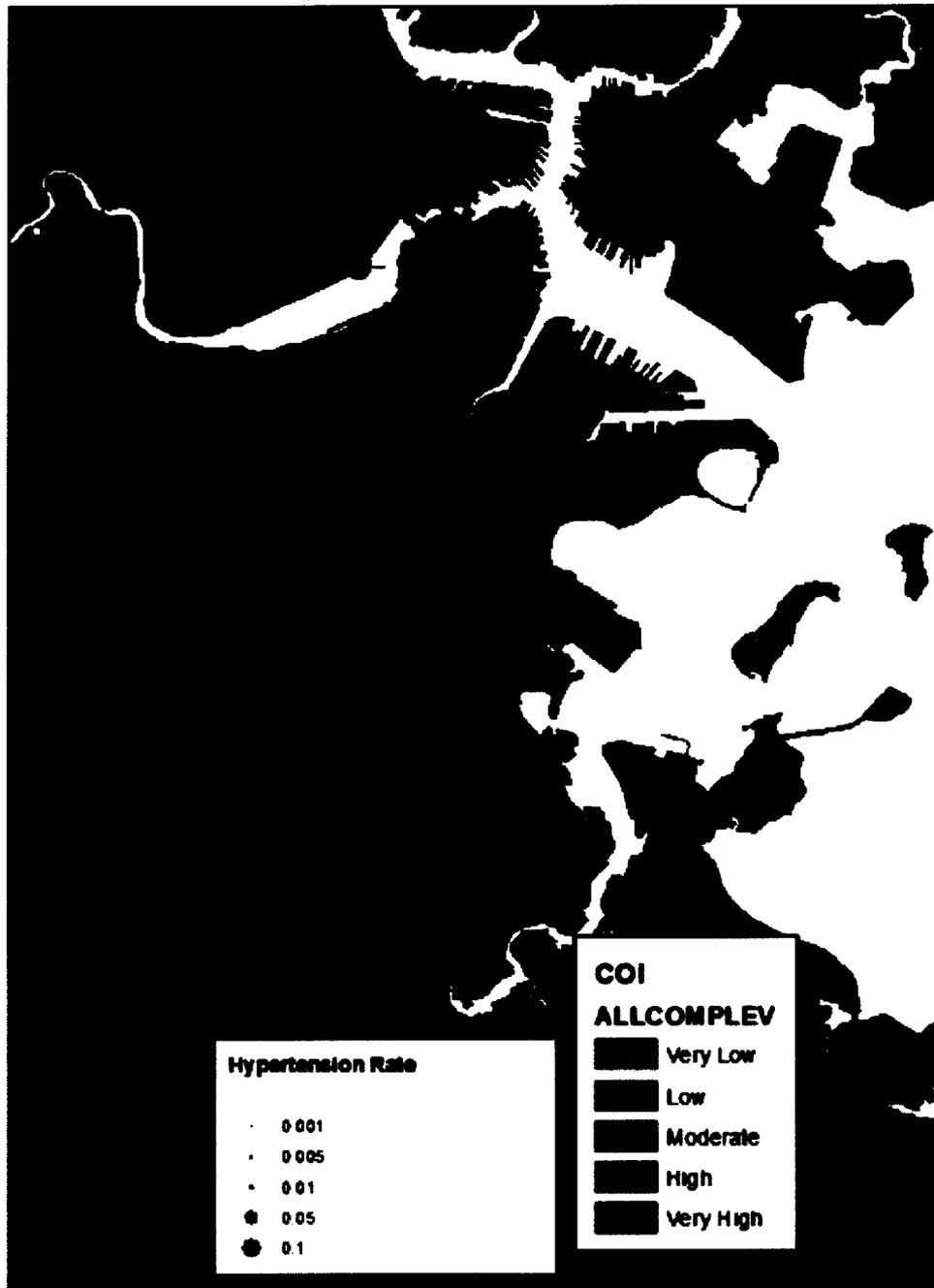
from residents, community organizations, and institutions to seed scalable and sustainable community change around child protection and promoting healthy social and emotional development in early childhood. Vital Village was established in 2010 when an interdisciplinary group of practitioners at Boston Medical Center, New England's largest safety-net hospital, sought new approaches to improving health equity by partnering both with residents with lived experience and community-based agencies. Over a 2-year period, the team engaged in conversations to learn more about the solutions to complex social threats to child well-being that community stakeholders were leading.

Given the emerging understanding of the far-reaching consequences of early-life adversities and toxic stressors on child development, health, and educational outcomes, a paradigm shift toward the use of innovative approaches that harness collective capacities and build collective efficacy is needed. Through a rigorous community engagement approach, the Vital Village Network seeks to use a collective impact approach to support deeper collaboration among educators, clinicians, social service providers, legal advocates, and residents. The focus of this cross-sector collaboration has evolved to include not only the footprint of each neighborhood, but the corridors—routes of social networks, commerce, and information—between these places. The Vital Village Network has then developed hubs of innovation within and a formal collaborative network across 3 community-identified Boston neighborhoods: Dudley (Roxbury/North Dorchester), Mattapan, and Codman Square (Dorchester).

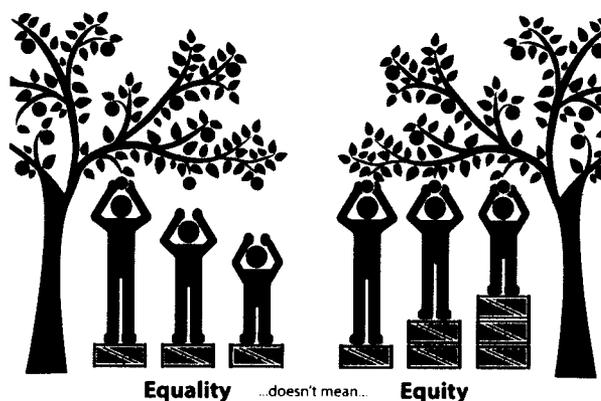
The Vital Village Network uses shared data as a tool to further deepen alignment and collaboration across diverse sectors. In this effort, Vital Village has used the COI to document the association between inequities in child

opportunity, neighborhood crime, and child health outcomes. Acevedo-Garcia et al<sup>27</sup> showed that Boston ranked among the top 6 worst US metropolitan areas with the highest concentration of black (57.8%) and Hispanic (57.6%) children living in very low-opportunity neighborhoods. By utilizing the COI and pairing it with deidentified patient data from Boston Medical Center and aligned community health centers, the Vital Village Network was able to identify these neighborhoods of low opportunity and examine the health effects of children living in those neighborhoods, such as elevated blood pressure rates (Fig. 3).

In 2013, with the support of the Doris Duke Charitable Foundation, Vital Village launched a formal strategic planning year and supported 10 pilot innovative collaboration projects with microgrants, each focusing on 1 of 3 priority areas: 1) promoting family strengths during the prenatal through early childhood period; 2) providing peer-to-peer legal advocacy aimed at addressing material hardships; and 3) innovating in early childhood education. By coupling improvement science methods and community-based participatory research, they began to support an iterative learning process for improving settings to promote child well-being. This active planning process led to the



**Figure 3.** Child opportunity maps using hypertension rates from Vital Village Network. COI indicates Childhood Opportunity Index; ALLCOMPLEV, all comprehensive levels in child opportunity index (range, very low to very high). Hypertension rates are defined as above 95th percentile for age and adjusted rates per 1000 children.



**Figure 4.** Visual representation of the concept of equality versus equity. Adapted from: Neudorf C, Kryzanowski J, Turner H, et al. *Better Health for All, Series 3: Advancing Health Equity in Health Care. Saskatoon: Saskatoon Health Region; 2014. Available at: [https://www.saskatoonhealthregion.ca/locations\\_services/Services/Health-Observatory/Pages/ReportsPublicatlions.aspx](https://www.saskatoonhealthregion.ca/locations_services/Services/Health-Observatory/Pages/ReportsPublicatlions.aspx).*

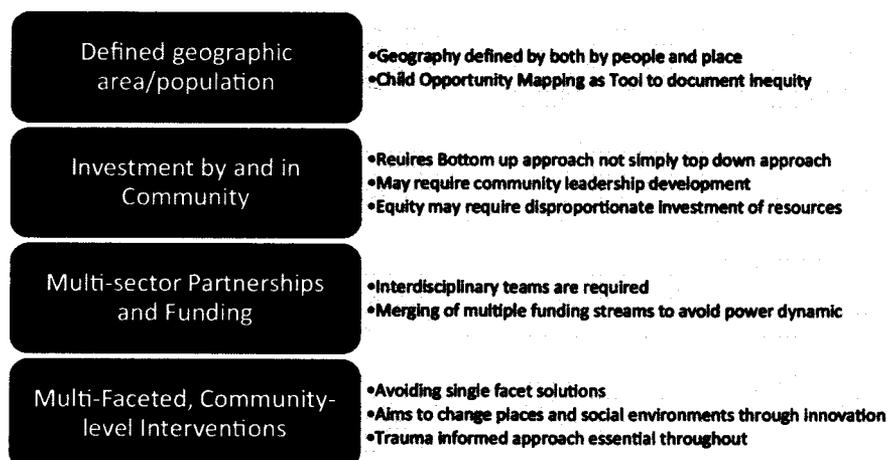
growth of the network partners to over 75 agency partners and 200 active participants and catalyzed the evolution of the Network from a collaborative group into a community of practice. Using a 90-day challenge model, the network encourages broad participation in ongoing improvement of programs that build community capacity to support child well-being. This community of practice supported the cocreation and design of innovations between resident partners and community-based agency partners with shared accountability. More important than any individual project is the potential to support shared learning and collaboration across sectors, within and across neighborhoods, and between community agencies and residents.

## DISCUSSION

Addressing neighborhood inequities through mobility to higher opportunity and neighborhood revitalization both remain important strategies to improve child health. Place-based neighborhood level interventions that focus on building equity of opportunity and collective efficacy are crucial to lifting children out of poverty. This approach acknowledges regional differences in housing and labor

markets, driven by racial/ethnic and socioeconomic inequities, lead to disparate amounts of opportunities in neighborhood resources to support children. Beyond poverty rates, this includes the availability of high-quality early education centers, safe and affordable housing, and access to health care. Therefore, policies and programs that offer equal distribution of resources fail to alleviate systemic inequities. To ensure an equitable likelihood of success, a different approach is needed. Neighborhood revitalization efforts are examples of disproportionate investment to address inequities; in order to break the cycle of generational poverty, high-poverty neighborhoods will require additional support and funding. As demonstrated in Figure 4, treating neighborhoods equally may not address the underlying differences between neighborhoods. Some neighborhoods begin at a disadvantage and therefore may need more to reach the same potential.

Equity-focused investments in neighborhoods have created important lessons learned thus far (Fig. 5). First, these interventions must be defined both by geography of people as well as place. Defining the area of interest ensures a focus on both and increases the likelihood that a sufficient dose will be applied to the intervention. Tools like COI mapping can further define areas of intervention and document inequities that must be addressed. Second, community-level interventions must be community driven and have continuous community engagement throughout the process, as described through work pioneered by John McKnight (<http://www.abcdinstitute.org/publications/index.html>). Third, the marrying of different funding streams, such as city, philanthropy, and anchor institutions, is essential to long-term success and sustainability. Acknowledging that funding often drives the agenda and creates a power dynamic is important, and diversification ensures that no one partner is driving too much of the process. Fourth, single faceted approaches do not provide the comprehensive solutions needed to address complex problems and make communities better. Making healthier food options available while not addressing violent crime rates will not result in lower obesity rates in a given neighborhood. Multifaceted approaches to increasing opportunity are essential and must be informed by an equity lens,



**Figure 5.** Take-home messages of successful community-level interventions.

Bronfenbrenner's ecological framework, an understanding of intergenerational processes, and the risk attributable to adverse early childhood experiences. Local community environments have a broad influence on health outcomes and enduring and durable effects over the life course; therefore, complex solutions are required that involve the alignment of multiple sectors and systems of care.

## CONCLUSION

Socioeconomic characteristics of neighborhoods are a well-established pathway through which poverty contributes to child health outcomes. Understanding the contribution of collective attributes of neighborhood environments to child health offers a deeper opportunity to influence population health and well-being by transforming environments where children live, learn, and play. As opposed to disease-specific interventions that target individual health behaviors, community-level prevention aims to change places and social environments. Focusing on addressing structural inequities in opportunity has a critical and potentially higher payoff for improving child health, development, and well-being. By following these lessons, neighborhood-level interventions can become the ultimate opportunity for pediatricians working in interdisciplinary teams to address these inequities. These multifaceted partnerships are critical opportunities for policy makers and health institutions to meaningfully contribute to cross-sector efforts to promote equity of opportunities for children in an effort to improve population health. Only then will we reach the goal to lift children out of poverty and reap the societal benefit and savings from having a healthier generation of adults.

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