

COMMUNITY HOUSING PARTNERS

Christiansburg, Virginia



AGING WITH DIGNITY IN VIRGINIA: HOW A COLLABORATION LED BY COMMUNITY HOUSING PARTNERS IMPROVED HEALTH AND WELLBEING FOR SENIORS IN A RENTAL COMMUNITY

Headquartered in Christiansburg, Virginia, Community Housing Partners (CHP) develops and manages affordable housing in six states: Virginia, North Carolina, South Carolina, Kentucky, Maryland and Florida. With 6,584 housing units across 112 properties, green buildings and comprehensive resident services are hallmarks of CHP's approach.

CHP has a lengthy history of local and national leadership in green and healthy housing, including multiple LEED-certified rental properties, a NeighborWorks Network Green Designation and an EnergySTAR Award for Excellence in Energy-Efficient Housing. An intentional focus on other aspects of health came later.

At a NeighborWorks Training Institute in 2015, Vice President for Resident Services Angie Roberts-Dobbins attended a presentation by the County Health Rankings & Roadmaps Program on the social determinants of health, which led her to explore how CHP could do more to help its residents lead healthier lives.

This case study looks at CHP's most comprehensive health and housing project to date – a renovated multi-family property in Hopewell, Virginia, where CHP collaborated with local partners to align medical, mental and spiritual care with other resident services. Supported in part by NeighborWorks' Healthy Communities Demonstration Project, this effort included onsite monitoring and triage, meals, wellness programming and better coordination with health providers for the mostly elderly residents.

This case study examines three primary aspects of the project:

- 1 How partnerships with a variety of stakeholders led to the development of a model for Kippax Place.
- 2 Strategies for collaboration with Hopewell's John Randolph hospital, a for-profit operation owned by the Health Corporation of America (HCA)
- 3 How the project is tracking and using outcomes.

HEALTHY COMMUNITIES DEMONSTRATION PROJECT CASE STUDY SERIES

This case study is part of a series designed to share lessons learned and key findings from the Healthy Communities Demonstration Project, a collaboration between NeighborWorks America, the Robert Wood Johnson Foundation and the County Health Rankings & Roadmaps Program.

The Healthy Communities Demonstration Project supported efforts by 28 NeighborWorks organizations to leverage local partnerships to build health equity in communities across the United States. Participating organizations were provided with funding and a robust learning community.

NeighborWorks America thanks the Robert Wood Johnson Foundation and the County Health Rankings & Roadmaps Program for their generous support of the Healthy Communities Demonstration Project.

This case study was prepared by the Healthy Homes & Communities Initiative at NeighborWorks America. For courses, webinars, convenings, evaluation support and other resources designed to promote healthy homes and communities, visit: www.neighborworks.org/health

Cover photo: Kaboompics.com

COMMUNITY NEED

The oldest part of what is now Hopewell, Virginia, was settled in 1613. The community was a busy seaport during the Civil War and a thriving employment center prior to World War I, when DuPont invested in dynamite and guncotton manufacturing.

More recently, Hopewell's story has been one of disinvestment and struggle. New jobs in the community have been filled by commuters and have not provided opportunities for Hopewell residents. Elementary and middle schools lack accreditation and affordable rental housing is scarce. CHP's Roberts-Dobbins describes Hopewell as "a place with layers and layers of trauma and nothing growing for the residents."

The community of 22,501 people is located directly south of Richmond. Seventy-five percent of residents are black and 8.5 percent are Latinx. Hopewell lags behind Virginia as a whole in many areas. Sixteen percent of families live in poverty, compared to 8 percent for Virginia overall, and only 35 percent of households own their home.¹

Hopewell also falls near the bottom of Virginia communities in the County Health Rankings and Roadmaps health indicators, as shown in Table 1.² The community has higher levels of diabetes, hypertension and depression than the state average. More people die from coronary heart disease in Hopewell (170 per 100,000 people for females and 272.7 for males) than statewide (which 113.7 and 172.6, respectively).³

As Roberts-Dobbins explains, these health disparities are what led CHP to seek a more comprehensive approach to improving resident health at its Kippax Place development.

HOPEWELL,
VIRGINIA

Table 1. Hopewell City rankings on selected health indicators

<i>Factor</i>	<i>Ranking out of 133 VA counties 2018</i>	<i>Ranking out of 134 VA counties 2016</i>
<i>Health outcomes</i>	126	118
<i>Length of life</i>	125	120
<i>Quality of life</i>	121	114
<i>Health factors</i>	128	128
<i>Health behaviors</i>	121	120
<i>Clinical care</i>	117	107
<i>Social and economic factors</i>	127	131

Source: County Health Rankings & Roadmaps 2018, 2016

¹ American Community Survey 2008-2012, Policy Map

² County Health Rankings & Roadmaps, 2016, 2018

³ Institute for Health Metrics and Evaluation, University of Washington, County Profile: Hopewell City 2014, Accessed on July 16, 2018

http://www.healthdata.org/sites/default/files/files/county_profiles/US/2015/County_Report_Hopewell_City_Virginia.pdf.



KIPPAX PLACE

CHP purchased Kippax Place in 2016. The building has 100 one-bedroom units and approximately 100 residents. Most residents (68 percent) are over age 55 and 74 percent are disabled. The income limit for residents is 50 percent of the area median income (AMI), but a majority of the residents are considered “extremely low income,” earning less than 30 percent of AMI.

Kippax Place after renovation.

Photo credit: Community Housing Partners.

CHP completed a Rental Assistance Demonstration (RAD) conversion on the 50-year property in 2017. RAD allows public housing agencies, in this case the Hopewell Redevelopment and Housing Authority, to convert public housing to Section 8 housing assistance payment contracts so the rents are subsidized.

CHP’s construction and renovation program aspires to meet Viridiant Earth Craft standards for affordable multifamily properties. The standards require energy and water savings, healthy indoor air quality, and reduced maintenance and utility costs. In addition to the direct impact of indoor air quality on resident health outcomes, reducing utility costs through weatherization, lighting and appliance efficiencies often means more money is available for food, medicine and other necessities.

BUILDING PARTNERSHIPS

CHP’s approach to integrating health and housing relies on local resources and opportunities. This means strategies vary across the communities where its properties are located. For example, in Gainesville, Florida, a teaching hospital provides services to residents within a CHP-led rental community. In 2015 alone, CHP had a cadre of 540 community partners providing over \$1.6 million in resources.

When looking for local health partners in Hopewell, CHP had a unique opportunity to be part of a Hopewell community team participating in SYNC: Transforming Healthcare Leadership, a partnership of the Medical Society of Virginia, Virginia Hospital and Healthcare Association, and the Virginia Nurses Foundation. Also on the team were the Crater Health Department, local physicians, a faith-based partner and several other nonprofit organizations.

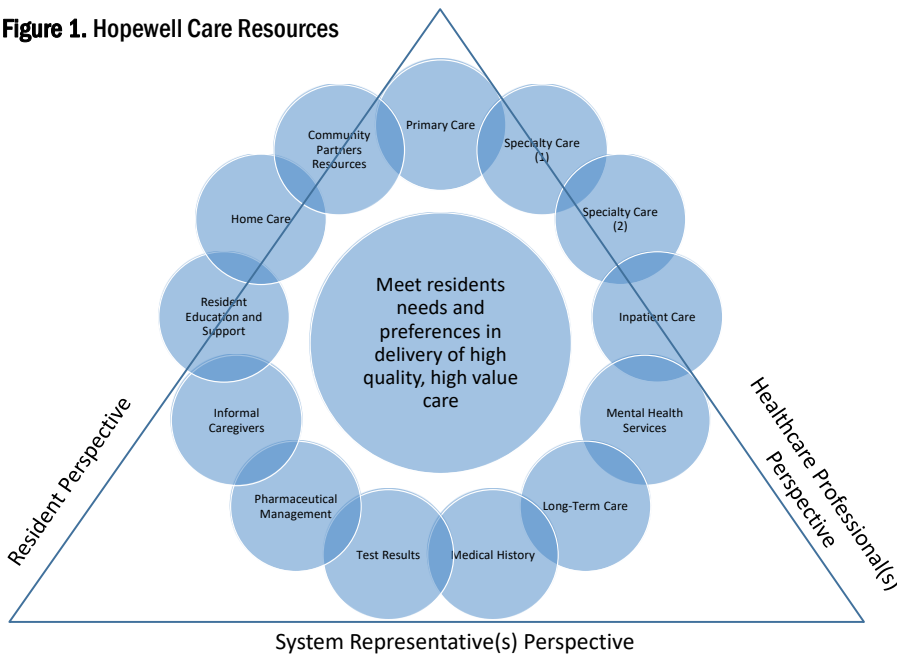
Each local team chose a community health issue for its capstone project and developed strategies to address it. The Hopewell team chose to improve the health and well-being of residents at CHP’s Hopewell properties, focusing first on Kippax Place,⁴ by developing a model to align medical, mental and spiritual care with other resident services.

At around the same time, a NeighborWorks Stable Communities Catalytic Grant helped place a resident services manager at Kippax Place in advance of pending property renovations. This gave CHP an opportunity to build trust with residents, a process that helped identify access to health-care services as a major concern.

COLLABORATIVE CARE MODEL

The Collaborative Care Model developed by the Hopewell team leverages aspects of two existing models: the Memphis Health Care Model and the Camden Coalition of Healthcare Providers Model.

Figure 1. Hopewell Care Resources



The Memphis Model draws on an established network of clergy and congregations to exemplify and promote healthy lifestyles, encourage use of community-based programs and help people transition from hospital to home successfully.⁵

The Camden Model targets “super-users” of the health-care system and works backward to identify why participants are overusing the emergency room or require repeated inpatient stays. Wrap-around care-management strategies are designed to reduce the need for repeated use of costly services.⁶

The Hopewell Collaborative Care Model identifies “super-users” and develops a

⁴ CHP owns two properties in Hopewell. The second property, The Summit, has 2-bedroom units for families.

⁵ Cutts, T. et al From the Memphis Model to the North Carolina Way, North Carolina Medical Journal July-August 2017 vol. 78, no. 4, 267-272 <http://www.ncmedicaljournal.com/content/78/4/267.full>, accessed on May 24, 2018.

⁶ US Department of Health and Human Services, Agency for Healthcare Research and Quality, <https://www.ahrq.gov/workingforquality/priorities-in-action/camden-coalition-of-healthcare-providers.html>, accessed on May 24, 2018.

community-based approach to their care management to avoid hospital recidivism and emergency room overuse. (See Figure 1.)

PROGRAM ELEMENTS

The Hopewell program includes both healthy living supports and chronic disease care management for residents. CHP contracted with Controlled Outcomes, a local nonprofit organization with experience in community health, to manage the program.

Healthy living strategies connect residents to healthy foods and nutrition through Meals on Wheels. Initially, residents also were offered an option to receive a healthy-food box with ingredients for specific meals. In 2017, however, the food-box alternative was changed from a year-round option to a seasonal offering. Controlled Outcomes also partners with local supermarkets to offer tours that include nutrition education, as well as online ordering and delivery. The latter service has provided more food shopping options, with one of the markets waiving the delivery charge.

Programming also includes monthly lunch-and-learns on health-related topics.

Kippax Place residents meet with Brian Jackson, M.D., of Controlled Outcomes. Photo courtesy of Community Housing Partners.



Kippax Place residents meet with Brian Jackson, M.D., of Controlled Outcomes
Photo credit: Community Housing Partners.

INITIAL PRESENTATION

To provide chronic disease care management, Controlled Outcomes needed aggregate discharge information from John Randolph Hospital to pinpoint the number of Kippax residents who were overusing the emergency room. John Randolph is a for-profit hospital owned by Health Corporations of America and the only hospital located in Hopewell, just a few blocks from Kippax Place.

Brian Jackson, managing partner with Controlled Outcomes, met with the CEO and board of trustees for John Randolph and gave a detailed presentation on the care-management proposal, the Collaborative Care Model and evidence supporting its success in reducing emergency department (E.D.) use.

The incentive presented to the hospital was a reduction in charity write-offs, which was a key benefit for hospitals under the Camden approach. As Jackson recalls, his audience did not seem particularly taken with the idea; they listened, but neither the incentive nor the premise seemed to resonate.

“What I didn't realize at the time,” says Jackson, “is that for a for-profit hospital reliant on billable hours and services, visits by Medicare and Medicaid users are very profitable. What I was suggesting would in fact reduce their bottom line.”

Going back to the drawing board, Jackson found allies in two physicians, the hospital's chief medical officer and a board trustee, who believed the project had merit but counseled a different approach.

While the small group strategized an alternative approach, Controlled Outcomes negotiated a similar coordination-of-care program with a primary-care clinic serving 60 percent of Kippax residents. The clinic provides Controlled Outcomes with medication schedules, diagnoses and treatment plans for patients who have consented to the release of medical information, allowing them to be monitored at home as needed. Services also include follow-up to assure that residents keep appointments for testing and other visits.

Participating physicians have been instrumental in persuading other doctors, including specialists, to work with Controlled Outcomes so residents have better coordinated care.

REFRAMING THE BENEFITS

Ultimately, the proposal to John Randolph was framed as avoiding a reduction in Medicare payments under the Centers for Medicare and Medicaid Services (CMS) Hospital Readmission Reduction Program. The program allows CMS to reduce payments to hospitals for which the number of patients readmitted within 30 days of discharge exceeds what would be expected by the average hospital with similar clients.⁷ So, the question was not “How do we save the hospital money, but rather, how can we reduce the number of readmissions?” says Jackson.

Jackson was able to show how navigators could help patients better understand their diagnosis and discharge orders, manage medication schedules to improve compliance and reduce errors, assure that patients return for follow-up physician visits, and monitor patients to monitor their status. With the two internal champions promoting the concept and explaining the benefits to the board, along with a change in hospital leadership, John Randolph finally agreed to provide medical records with signed consent forms to Controlled Outcomes.

Under the program, Controlled Outcomes receives a copy of the discharge plan when a patient is released and it then is responsible for making sure home-care services are provided. A combination of nurses, certified nursing assistants, medication aides and care aides visit those residents who elect to be a part of the program. Most of the health providers are volunteers.

Kippax residents who are not in the coordinated-care program still have access to onsite health professionals for triage, blood pressure and glucose monitoring, medication questions and advocacy services.

So, the question was not “How do we save the hospital money, but rather, how can we reduce the number of readmissions?”

⁷ Hospital Readmissions Reduction Program, <https://www.medicare.gov/hospitalcompare/readmission-reduction-program.html>, accessed May 27, 2018.

OUTCOMES

Although collaboration is certainly not a new approach for CHP, shared accountability for the well-being of residents *is* new, according to Roberts-Dobbins. Participation in the SYNC capstone project and the creation of the Collaborative Care Model led to a true partnership with transparent, participatory sharing of design, data, findings, processes and outcomes.⁸

Data provided by Controlled Outcomes show a reduction in hospital readmissions and a decrease in emergency room visits since the program was introduced in November 2016.

Specifically:

- **64 percent** of residents participated in one or more program components as of November 2017.
- **23 residents** use Meals on Wheels, an increase of 13 percent over in 2016. An average of 15 residents participated in the healthy food -box program before it was limited to seasonal offerings.
- **16 residents** participated in care management, with Controlled Outcomes providing post-hospitalization checks for another four at the request of physicians. While the number of participants is small, results are both promising and consistent. For example, the medication compliance rate has increased 48 percent since November 2016.
- Hospital readmissions within the 30-day window for Kippax residents have **declined 29%** since October 2016, according to information provided by John Randolph.⁹
- Emergency department visits for all Kippax residents **declined 61%** from November 2016 to October 2017, according to John Randolph.
- The number of fire/rescue calls to the building declined from 91 between November 2015 and October 2016 to 59 between November 2016 and October 2017. That's a **decrease of 65 %**.

An unintended benefit of the program, according to CHP, is that residents no longer feel they are a “forgotten community.” Program staff and volunteers show a vested interest in resident care, well-being and self-sufficiency, and demonstrate a level of health-care advocacy that promotes trust between the residents, medical professionals and local hospitals.

⁸ CHP NeighborWorks America Innovation Grant Application for the Healthy Communities Demonstration Project, May 24, 2016

⁹ John Randolph only provided the percentage change for both readmissions and Emergency Department visits, rather than providing the initial and final figures.

“Controlled Outcomes are the specialists; they connect residents with the people they need – to a social worker if it is about benefits or a psychiatrist for mental health. They are able to hone in on the specific need and there is no way CHP could have scaled that.”

*- Angie Roberts-Dobbins,
CHP vice president of
resident services*



LESSONS LEARNED

Following are several lessons learned from the project:

Understand each potential partner’s business perspective before presenting an approach. In this case, a SWOT analysis as part of due diligence would have shown that the traditional Camden Model incentives would not resonate with a for-profit hospital. Re-framing was necessary.

When one door fails to open, find another door. For example, Controlled Outcomes initially asked John Randolph Hospital to help identify Kippax residents who were frequent emergency department visitors. When the hospital declined, Controlled Outcomes turned to the fire department after learning that 98 percent of E.D. visits by Kippax residents come through EMT calls.

The fire department initially provided the number of calls routed to the Kippax main address and eventually provided a log with apartment numbers. Under the current agreement, the fire department calls Controlled Outcomes when an EMT is dispatched to a Kippax address and again if the resident is transported to the hospital. In the latter case, Controlled Outcomes sends someone to meet the resident at the hospital.

Partnerships can expand opportunities and resources. When entering a new market, CHP immediately begins looking for reliable partners with a commitment to the social determinants of health that can offer a range of services for residents. For Roberts-Dobbins, Controlled Outcomes stood out not only because it shared CHP’s philosophy and offered the needed level of expertise, but also because Managing Partner Brian Jackson was well connected with local government, businesses, educational institutions and other area nonprofits. A bonus advantage of contracting is that the privacy of the residents is completely protected; CHP does not hold identifying information on any of the program participants, which makes residents feel more comfortable, says Roberts-Dobbins.

CHANGING CORPORATE GOALS

“This has not been a linear journey,” says Roberts-Dobbins. Early successes in Hopewell have shaped CHP’s thinking about service delivery in other rental communities across its footprint. The resident services team began looking at health as the umbrella for other services, such as financial capability, education, and community building and engagement – an alternative to CHP’s historical “siloes” approach, in which health and wellness was one of four focus areas for service delivery.

In 2017, CHP formally committed to the principle that every line of business could impact health by including health outcomes as one of four primary goals in its 2018-2020 strategic plan.

The goal states that CHP will “optimize positive health and quality-of-life outcomes for our customers,” and will do so through the alignment of programs and services

that generate positive health outcomes. This includes real estate development, property management, resident services, asset management, energy solutions and homeownership. The next step in the journey is to continue to define what health means for the organization and what outcomes will be measured.

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HEALTHY COMMUNITIES DEMONSTRATION PROJECT KEY FINDINGS REPORT AND CASE STUDIES

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HEALTHY COMMUNITIES DEMONSTRATION PROJECT

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NEW KENSINGTON COMMUNITY DEVELOPMENT CORPORATION

Philadelphia, Pennsylvania



LESSONS LEARNED FROM NEW KENSINGTON COMMUNITY DEVELOPMENT CORPORATION'S PRACTICE OF TRAUMA-INFORMED COMMUNITY DEVELOPMENT

We know where we live affects our health. For residents in the Kensington neighborhood north of Lehigh Avenue in Philadelphia, where employment opportunities have disappeared and the empty lots would fill 30 football fields, the health challenges associated with disinvestment and trauma are significant.

Kensington has the second-highest rate of hospitalizations for childhood asthma, the third-highest mortality from cancer and the highest rate of adults diagnosed with a mental health condition in Philadelphia. Yet Kensington also has the highest number of uninsured adults in the city; 26 percent forego health care because they can't afford the cost.¹

New Kensington Community Development Corp. (NKCDC) works with residents and community partners to catalyze sustainable development, build community and create healthy homes in the neighborhood.

In 2017, NKCDC and another neighborhood-based organization, Impact Services,¹ developed a trauma-informed community-engagement model. NeighborWorks America's Healthy Homes & Communities Initiative, the Robert Wood Johnson Foundation, the County Health Rankings & Roadmaps Program, Philadelphia LISC and the Thomas Scattergood Behavioral Health Foundation provided support.

This case study describes their trauma-informed approach, including the development of a training program for resident leaders, how NKCDC's internal culture has changed as a result and the nonprofit's evaluation methodology. It also includes resources for organizations interested in applying trauma theory to foster healing and growth in disinvested communities.

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Cover photo: Leonard Street Community Garden
Photo credit: Willamette Neighborhood Housing Services

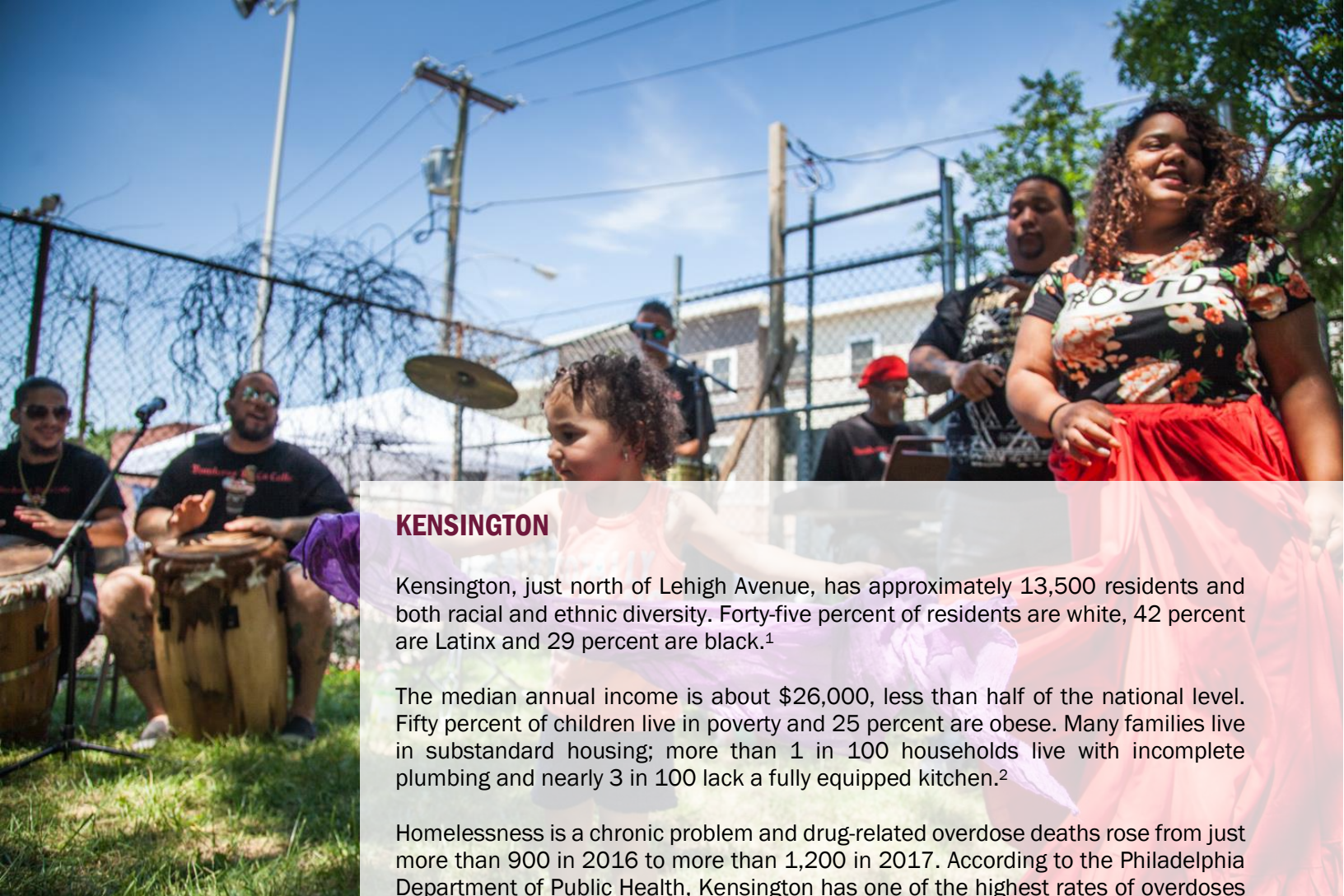


Photo credit: NKCDC

KENSINGTON

Kensington, just north of Lehigh Avenue, has approximately 13,500 residents and both racial and ethnic diversity. Forty-five percent of residents are white, 42 percent are Latinx and 29 percent are black.¹

The median annual income is about \$26,000, less than half of the national level. Fifty percent of children live in poverty and 25 percent are obese. Many families live in substandard housing; more than 1 in 100 households live with incomplete plumbing and nearly 3 in 100 lack a fully equipped kitchen.²

Homelessness is a chronic problem and drug-related overdose deaths rose from just more than 900 in 2016 to more than 1,200 in 2017. According to the Philadelphia Department of Public Health, Kensington has one of the highest rates of overdoses in the city.³ Kensington also is the site of an open-air drug market that was, as recently as 2017, the largest on the East Coast.

Despite the daily stressors, neighbors are committed to organizing and changing the perception of their community. In 2011, NKCDC began working in earnest with residents in the section of Kensington north of Lehigh Avenue. During this period, NKCDC facilitated a neighborhood-planning initiative and helped residents start their own community association. Somerset Neighbors for Better Living (SNBL) now is in its fifth year, with an entirely volunteer-run board, and holds some of the most diverse and well-attended monthly meetings in the city. NKCDC and SNBL partnered to generate higher levels of attention and resources to a long-underserved section of Kensington.

While working with SNBL, NKCDC staff realized a traditional approach to resident engagement and community development would not be sufficient.

“The community really suffers in an undue way. With all of the challenges residents are facing on a daily basis, we wanted to give them tools to organize their blocks and

¹ American Community Survey, 2012-2016.

² Ibid.

³ Philadelphia Department of Public Health. (2018). Chart: Fatal Drug Overdoses in Philadelphia, 2017. Vol. 3, No. (1), April 2018. Retrieved from <http://www.phila.gov/health/pdfs/chart%20v3e1.pdf>.

feel safer through contact with their neighbors,” says Andrew Goodman, NKCDC director of community engagement.

NKCDC believes a focus on trauma brings people together and builds confidence and resiliency in a neighborhood.

TRAUMA, HEALING AND GROWTH

Trauma-informed community development builds on lessons from the field of trauma-informed care, “an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.”⁴

Physical and emotional trauma caused by a single incident or resulting from ongoing circumstances affect both individuals and communities.⁵ Public-housing research documents the cumulative effects of trauma from poverty, poor housing, lack of social cohesion and support, racism and long-term disinvestment.⁶

Adverse childhood experiences (ACEs) are stressful or traumatic events associated with abuse, poverty and neglect and are strongly correlated with risky behaviors and significant health consequences. Recognition of the impact of experiencing or witnessing one or more traumatic events is the basis of a service model that asks “what happened to you?” rather than “what is wrong with you?”

Until recently, most trauma-informed work involved interventions to address the impact of trauma on individuals in social service, education or health settings. However, the Urban Institute and BRIDGE Housing in San Francisco recently collaborated to create a model focusing on the broader impact of both individual and community trauma.⁷ The Trauma-Informed Community-Building (TICB) model recognizes that trauma must be addressed at all levels: individual, interpersonal, community, and systems.⁸

In 2017, the Urban Institute and the Health Equity Institute used this approach to focus on system changes, such as the closing of a social-



Photo credit: NKCDC

⁴ Substance Abuse and Mental Health Services Administration. Retrieved May 15, 2018 from <http://www.samhsa.gov/nctic>.

⁵ Falkenburger, E., Arena, O. and Wolin J. (2018). *Trauma-informed Community Building and Engagement*. Metropolitan Housing and Communities Center, Urban Institute.

⁶ Ibid.

⁷ Weinstein, E. Wolin, J. and Rose, S. (2014). *Trauma-informed Community Building: A Model for Strengthening Community in Trauma Affected Neighborhoods*. San Francisco: BRIDGE Housing, Health Equity Institute.

⁸ Ibid.



SAFETY PLAN EASES TRAUMA IMPACT

One important tool in trauma-informed training asks each participant to develop a safety plan that lists various activities he or she will do when feeling overwhelmed. The objective is to replace a negative, unsafe or out-of-control response with one that is safe and soothing. NKCDC has each participant create a personal safety plan, as shown in the photo above.

“While the process was longer and more intensive than originally planned, it resulted in a more equal partnership between NKCDC, Impact Services and residents.”

service agency due to inadequate funding. They highlighted the need for accountability, transparency and healing when such events occur.⁹

The TICB model attempts to foster healthy communities through strong resident leadership and vibrant institutions. Strategies include expanding opportunities for creative expression, honoring the community’s history, encouraging resident input and leadership when identifying and implementing programs, and ensuring service consistency and sustainability.¹⁰

Additional work in the community development field has expanded the trauma-informed care model to better acknowledge existing strengths as well as the potential for growth and healing. A list of resources related to trauma-informed community-building models and strategies is provided at the end of this case study.

SANCTUARY MODEL AND CURRICULUM DEVELOPMENT

NKCDC partnered with Impact Services to develop a curriculum for training resident leaders in trauma-informed community engagement. To develop the curriculum, it engaged Sandra Bloom, developer of the Sanctuary Model¹¹, and consultants Michael O’Bryan and Joe Foderaro. The Sanctuary Model is a “trauma-informed method for creating or changing an organizational culture”¹² that originally was developed to address childhood trauma for adults in an inpatient psychiatric setting. Based on creation of a nonviolent, democratic and therapeutic environment in which staff and clients share control over decisions, the model has proven to be effective across a variety of settings.¹³

Tools from this model were adapted to develop a framework that reflects the needs articulated by Kensington residents. The design process included several sessions with approximately 20 residents participating over a three-month period. Training covered basic model concepts, trauma awareness and a variety of activities to connect trauma, stress and brain science.

The design process did not unfold as anticipated, according to Associate Community Engagement Director Tess Donie. “We thought we would create a model and curriculum for the staff who would in turn train and work with residents, but the resident

⁹ Falkenburger, E., Arena, O. and Wolin, J. (2018). *Trauma-informed Community Building and Engagement*. Metropolitan Housing and Communities Center, Urban Institute.

¹⁰ Ibid.

¹¹ Bloom, S. The Sanctuary Model. Retrieved from <http://www.sanctuaryweb.com/TheSanctuaryModel.aspx>.

¹² Ibid.

¹³ Ibid.

leaders felt strongly they needed to be the experts,” she explains. While the process was longer and more intensive than originally planned, it resulted in a more equal partnership between NKCDC, Impact Services and residents.

Seven residents completed all the sessions and will serve as instructors for future leaders. The resulting curriculum addresses:

- Stress, trauma and adverse childhood experiences. This includes brain science and how stress impacts the body, mind and behavior.
- The SELF (safety, emotions, loss and future) framework, which helps participants explore the interconnectedness of emotions, experiences and events, and explains how to use it as a problem-solving tool.
- Leadership skills, including active listening and management of conflict and stress
- Community safety and loss



Photo credit: NKCDC

RESIDENT-DRIVEN CURRICULUM DECISIONS

Residents shaped curriculum design in unexpected ways, further reinforcing the value of authentic community engagement. For example, NKCDC staff members did not expect to focus on ACEs in the curriculum and training because they believed it might be either too scientific or patronizing. Staff also feared the co-design process would trigger negative emotions, which might distress participants.

In fact, however, residents felt strongly that childhood trauma was one of the most important concepts to include in the curriculum because it provided a framework and language they could use to explain their experiences and emotions. Similarly, residents found

that learning about brain science and using the word “trauma” validated their experience and was useful in their community work.

In the summer of 2017, many participants put their training to use immediately when surveying residents door to door for NeighborWorks’ Community Impact Measurement research. If the person who answered the door was negative or unfriendly, surveyors said they often were able to recognize underlying emotions and respond with empathy and patience. They also knew not to take any hostility personally and used active listening to keep the conversation going. This more effective approach helped the surveyors collect 325 responses, compared to 200 in 2013. As a result of the training, surveyors also said they had a better understanding of resident concerns relating to safety and feelings of hopelessness.

COMMUNITY ENGAGEMENT

The trauma-informed approach has changed how NKCDC thinks about community engagement. “The traditional practice is to ask a community what it wants and then the organization goes behind a curtain and tries to figure out how to do it. We want

to get rid of that curtain,” says Goodman. “Residents want to learn and be involved in the details and this changes our approach pretty significantly.”

One of the changes is scope. In a neighborhood that is diverse in people, needs and challenges, working only at the community level can limit impact, Goodman says. By listening to residents, NKCDC learned to work with naturally formed, resident-identified micro communities. These subsections vary in size from 30 to 100 households, depending on property size, number of vacant lots and how residents self-identify.

Using a selection process and tool that recognized organic boundaries, NKCDC and its partners identified four micro communities for what it calls a “soft pilot” of trauma-informed community engagement.

ROLE OF COMMUNITY CONNECTORS

Residents who participated in the co-design process were NKCDC community connectors – resident leaders trained in engagement and outreach.¹⁴ In the pilot, the community connectors completed the trauma-informed curriculum and will receive additional training, allowing them to teach other residents about trauma and healing, including mindfulness and self-care principles.

In addition, connectors are responsible for scanning the micro-community to identify issues and needs, leading community meetings, planning activities and linking residents with services.

“Their role is an embodiment of the program name. They create links between people, places and resources in ways that NKCDC and other agencies could never do. They do more than outreach; they meet people where they are and empower them,” says Donie.

As NKCDC expands the pilot to other micro communities, resident leaders will train more community connectors using the trauma-informed curriculum.

One recent graduate of the training, Kensington resident Brenda Mosley, described how trauma robbed her of her childhood and led to a series of poor decisions. She moved to Kensington in 2014 after the death of her daughter and was isolated for several years until Donie reached out and invited her to join the trauma-informed training with NKCDC.

Mosley says, “(The training) saved me and gave me a future.” It improved her communication with her children, helped her be less judgmental about their choices, and made it easier to reach out to neighbors to “get past the results of their trauma and see the real person.” She takes great pride in her graduation from the training and told her story in a video.

¹⁴ NKCDC’s and Impact Services’ community connectors are part of a larger, city-wide program initiated by Philadelphia LISC that uses them to work with community development organizations in several neighborhoods.

Mosley’s goal is for all Kensington residents to have a vision for their own lives and a commitment to staying in the neighborhood, keeping it clean and working together to make it a better and healthier place.



EVALUATION PLAN

NKCDC and Impact Services are working with Rutgers University to evaluate the pilot’s impact on collective efficacy in the community. Research shows that increased collective efficacy leads to a reduction in crime and violence and contributes to improved health outcomes.^{15,16,17} Higher rates of collective efficacy are linked to health-related outcomes, including asthma, birth weight, self-rated health, domestic violence and heat-wave deaths.¹⁸ The partners designed the evaluation plan to focus on two components of collective efficacy: 1) social cohesion, or the strength of relationships in a community, and 2) social control, or the likelihood that residents believe others in the community will act to stop illicit activities.¹⁹

The evaluation of the pilot began in June 2018, when 150 residents completed a pre-test survey administered by community connectors and staff from NKCDC and Impact Services. The organizations will use the same survey for a post-test evaluation during the second year of the project.

Short-term outcomes for residents include greater reported feelings of safety, increased social connectedness and more hope for the future. Over the intermediate and longer term, the partners expect to see increased trust among residents and a reduction in person-to-person violence. The logic model for the evaluation is shown in Figure 1.

ORGANIZATIONAL IMPACT

NKCDC started its trauma-informed work with an external focus, which was a challenge for staff. “It can be a very emotional process that affects both individuals and organizations,” says Donie. “As with racial equity work, you can’t just do it externally or you will totally miss the picture.”

Recognizing that community development work can have a traumatic impact on employees, NKCDC began applying the principles internally.

¹⁵ Sampson R. Raudenbush S.W. and Earls F. (1997). Neighborhoods and violent crime: A multilevel study of collective efficacy. *Science*, 277:918-924.

¹⁶ Wen, M. et. al. (2003) Poverty, Affluence, and Income Inequality: Neighborhood Economic Structure and its Implications for Health. *Social Science Medicine*, Sept. 57(5) 843-60.

¹⁷ Kruger, D. J., et. al. (2007). Neighborhood Social Conditions Mediate the Associations between Physical Deterioration and Mental Health. *Am Journal of Community Psychology*, Dec. 40(3-4) 261-71.

¹⁸ Diez Roux, A.V. and Mair, C. (2010). Neighborhoods and Health, *Annals of the New York Academy of Science*. Retrieved from <https://nyaspubs.onlinelibrary.wiley.com/doi/full/10.1111/j.1749-6632.2009.05333.x>

¹⁹ New Kensington Community Development Corporation. (2018). *Evaluation Plan for Kensington TIC Micro-Communities Initiative*.

Block-Based Trauma Informed Community Development – draft rev. 10/28/2016

Problem Statement: The Kensington neighborhood has faced decades of disinvestment and cumulative trauma. Residents face daily stresses and are forced to focus resources on meeting immediate needs. Residents are also challenged to trust each other and the institutions and agencies available to help. Residents may feel disempowered and lack community ownership because they can't see how things could change for themselves or their community.

Goal: To de-escalate stress, build social cohesion and foster community resiliency by advancing resident-led micro-communities, which will lead to improvements in overall health and wellbeing.

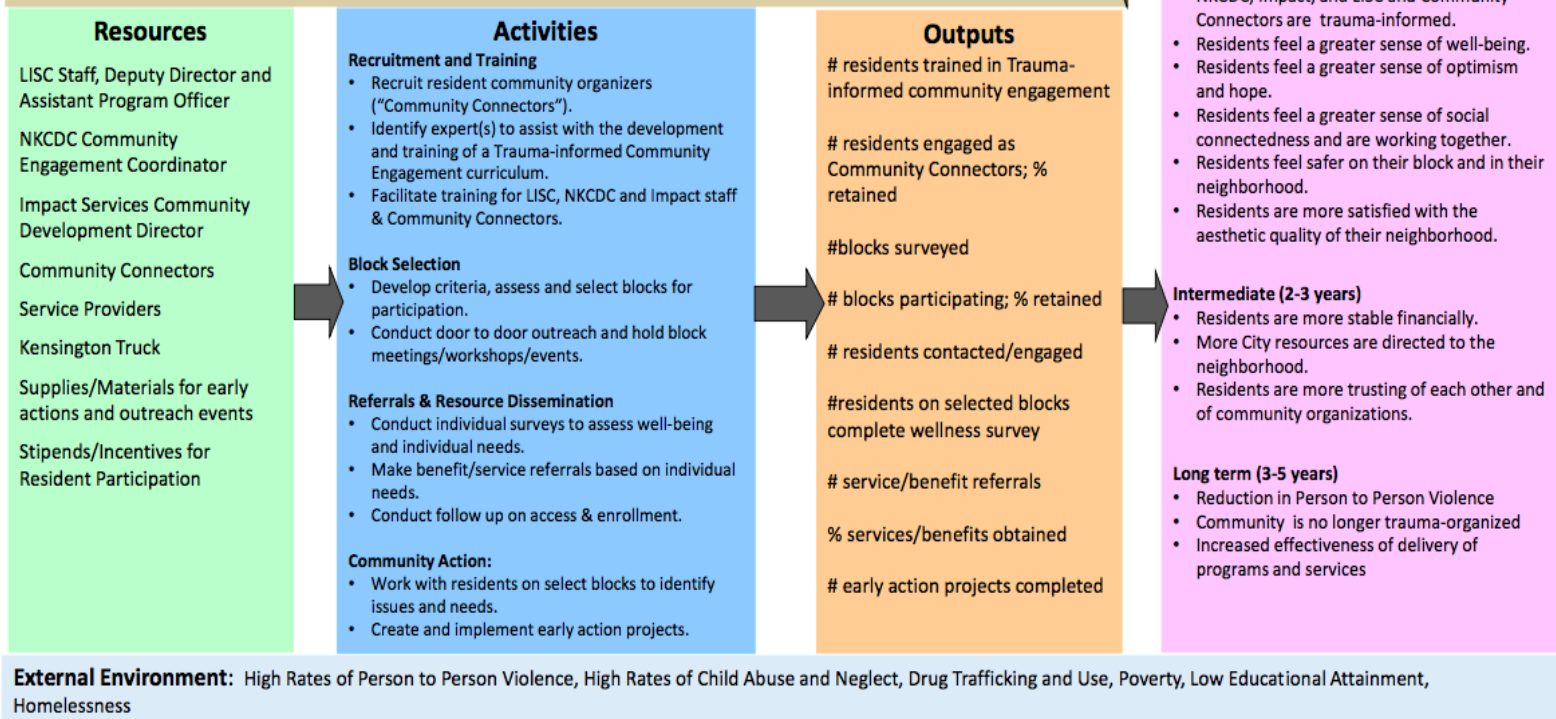


Figure 1: Logic model for the evaluation

Photo credit: NKCDC

This internal process included tactics that help employees feel comfortable and safe at work, such as development of personal safety plans, use of grounding techniques, boundary setting and regular team check-ins. Other tactics includes modifying policies and procedures to improve work environment and culture, exploring the use of power both within and outside of the organization, and cultivating employee support systems.

“You have to walk the walk and talk the talk,” says Executive Director Felix Torres-Colon. “This means changing the way you do business if you are really serious about a trauma-informed approach. You can’t share power with residents if the executive director is not sharing power with staff. So, it really requires a shift in how you run your organization.”

NKCDC is committed to ongoing staff training. Torres-Colon envisions a trauma-informed approach that permeates every department and all operations. A fully trauma-informed organization recognizes that housing counselors who are trained

to identify and address the impact of trauma will be more successful in securing home loans, preventing foreclosures and helping clients manage finances.

When developing real estate priorities and strategies, NKCDC will need to consider how land control, ownership and use reflects power and determine how that power can be shared with residents. This includes recognizing and respecting residents' desire to stay in a gentrifying neighborhood and acknowledging that any change, even a positive one, alters the history of the place and is a loss that should be honored.

Peer learning plays a large part in the model's ongoing development at both NKCDC and Impact. In the summer of 2018, NKCDC and Impact Services joined a peer-to-peer learning community on trauma and healing launched by NeighborWorks America.²⁰ NKCDC and Impact also are developing a handbook for other organizations interested in applying the principles of trauma-informed care to community development.

Ultimately, developing a trauma-informed practice has inspired staff from both organizations to reimagine the possible. And that is both daunting and exciting.

RESOURCES

Here are some resources on trauma-informed approaches to community development:

1. *Trauma-informed Community Building: A Model for Strengthening Community in Trauma Affected Neighborhoods*. San Francisco: BRIDGE Housing, Health Equity Institute. Weinstein, E. Wolin, J. and Rose, S. (2014). Available [online](#).
2. *Trauma-informed Community Building and Engagement*. Metropolitan Housing and Communities Center, Urban Institute. Falkenburger, E., Arena, O. and Wolin J. (2018). Available [online](#).
3. *Trauma-informed approaches to Community-Building*. County Health Rankings and Roadmaps. Available [online](#).
4. *Trauma-informed approaches*. What Works for Health. University of Wisconsin Population Health Institute. Available [online](#).
5. *Community Building Despite Trauma*. Shelterforce. S. Neufield. (2017). Available [online](#).

²⁰ P. Bailey, 2017. *Learning Community dives into trauma and healing*. NeighborWorks America. Available online at: <https://www.neighborworks.org/Blog-IdeaWorks/Learning-community-delves-into-trauma-and-healing>

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HEALTHY COMMUNITIES DEMONSTRATION PROJECT KEY FINDINGS REPORT AND CASE STUDIES

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HEALTHY COMMUNITIES DEMONSTRATION PROJECT

The Healthy Communities Demonstration Project was funded by NeighborWorks America and the Robert Wood Johnson Foundation. The County Health Rankings & Roadmaps Program, a collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin, provided additional resources, including coaching to six participating organizations. We would like to acknowledge the following individuals for their contributions to this collaborative project:

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WILLAMETTE NEIGHBORHOOD HOUSING SERVICES

Corvallis, Oregon



WILLAMETTE NEIGHBORHOOD HOUSING SERVICES' HOLISTIC APPROACH TO COMMUNITY HEALTH AND WELL-BEING

Willamette Neighborhood Housing Services (WNHS) has developed affordable housing in Corvallis, Oregon, and the surrounding communities for more than 25 years. In 2008, a community conversation about the documentary “Unnatural Causes: Is Inequality Making Us Sick?” catalyzed a movement to improve local health outcomes and changed the trajectory of WNHS’ work in the community.

A lot has happened in the following 10 years. WNHS has become a leader in programming and advocacy for community health. “A focus on healthy homes and communities has become a unifying theme in much of our work,” says WNHS interim Executive Director Brigetta Olson. “It is informing our approach to housing development and management, as well as resident and community engagement.”

Key components of the WNHS approach include:

- **Creation of a health-equity alliance** that builds community capacity to address social determinants of health.
- **Leverage of the alliance** to engage local systems to achieve regulatory and other system changes.
- **Use of rental housing as a platform to promote health** through housing stability, food security, community engagement and health-services navigation.
- **Investment in a community health-worker program** with support from a regional Medicaid provider.

The Healthy Communities Demonstration Project played a critical role in supporting the community health worker pilot while WNHS and the InterCommunity Health Network Coordinated Care Organization (IHC-CCO) obtain sustainable funding through Medicaid reimbursement.

HEALTHY COMMUNITIES DEMONSTRATION PROJECT CASE STUDY SERIES

This case study is part of a series designed to share lessons learned and key findings from the Healthy Communities Demonstration Project, a collaboration between NeighborWorks America, the Robert Wood Johnson Foundation and the County Health Rankings & Roadmaps Program.

The Healthy Communities Demonstration Project supported efforts by 28 NeighborWorks organizations to leverage local partnerships to build health equity in communities across the United States. Participating organizations were provided with funding and a robust learning community.

NeighborWorks America thanks the Robert Wood Johnson Foundation and the County Health Rankings & Roadmaps Program for their generous support of the Healthy Communities Demonstration Project.

This case study was prepared by the Healthy Homes & Communities Initiative at NeighborWorks America. For courses, webinars, convenings, evaluation support and other resources designed to promote healthy homes and communities, visit: www.neighborworks.org/health

Cover photo: Leonard Street Community Garden
Photo credit: Willamette Neighborhood Housing Services



Leonard Street Community Garden
Photo credit: Willamette
Neighborhood Housing Services

SETTING

Nestled between three mountain ranges, the Willamette Valley is home to 216,585 people spread across Linn and Benton counties. Corvallis (population 58,735) and Albany (52,710) are the largest communities. The residents of both counties are predominantly white. Benton County is 6.9 percent Latinx and 6.2 percent Asian; Linn County is 8.6 percent Latinx.¹ The Latinx community is growing rapidly. Between 2000 and 2015, its population increased 67 percent and 64 percent in Linn and Benton counties, respectively.²

Poverty rates are higher among Latinx residents: 37.4 percent in Linn County and 31.1 percent in Benton County, vs. 17 percent and 19.3 percent for whites.³ Disparities also exist in housing tenure: Sixty-six percent of white, non-Latinx households in Linn County and 62 percent in Benton County own their homes, compared to 41 percent and 26 percent, respectively, of Latinx households.⁴

WILLAMETTE NEIGHBORHOOD HOUSING SERVICES

WNHS is an affordable housing developer with a strong commitment to comprehensive community development that includes community building and upstream investments in public health, advocacy, leadership development and partnership-building.

As a NeighborWorks Homeownership Center, WNHS helps first-time buyers with down-payment assistance, education and counseling, foreclosure-mitigation services and home repairs.

As a real estate developer, WNHS also owns 19 affordable rental properties in Corvallis and the smaller communities of Sweet Home and Lebanon. Approximately one-third of its 382 units are located in the latter.⁵

Within its properties and communities, WNHS has identified several health priorities:

- Chronic disease prevention and management, including screening, physical activities and access to healthy food.
- Built environments that promote health.

¹ U.S. Census Bureau, American Community Survey 5-year estimates, 2011-2015, Table DP05 as reported in Linn County Community Health Assessment 2017-2021 and Benton County Community Health Assessment 2017-2021.

² Ibid.

³ Poverty rates for other racial and ethnic minorities are not reported because of the unreliability of estimates for small population sizes. See the Community Health Assessments for Linn and Benton Counties for more information.

⁴ Linn County Community Health Assessment 2017-2022; Benton County Community Health Assessment 2017-2021.

⁵ The population of Sweet Home is 9,090; Lebanon is 16,720 according to 2017 population estimates from Portland State University. Both towns are in Linn County.

- Targeted attention for frequent users of health care, including those who need behavioral health services and residents at high risk of homelessness.



CHOOSING HEALTH AS A FOCUS

WNHS' involvement in community health is fairly recent, the result of multiple partnerships and a leadership team willing to risk a new endeavor.⁶

In 2008, funding from the Robert Wood Johnson Foundation's Healthy Kids/Healthy Communities initiative allowed the Benton County Health Department (BCHD) to start *Creciendo en Salud*, a collective-impact project designed to reduce childhood obesity in South Corvallis and the surrounding rural area.

Participation in that project became a turning point for WNHS when it designated the creation of a healthier community as the common goal uniting all of its programming. The nonprofit began seeking other opportunities to become involved in the health space and focused on recruiting board members with relevant experience and a commitment to health and community development.



SUPPORTING HEALTH EQUITY

The next opportunity for WNHS came when the Oregon Health Authority approached BCHD about forming a health-equity alliance in the region. BCHD tapped WNHS as the fiscal agent for the alliance because of the organization's demonstrated interest in upstream determinants of health and its ability to take on a strong role in driving system changes.

The Linn-Benton Health Equity Alliance (LBHEA) was formed in 2011 with a mission to remove social and policy barriers that create health inequities. Fourteen organizations form the core of the alliance and are the most highly engaged in identifying and achieving common goals. Another 25 smaller organizations are connected to and consult with the alliance.

Alliance members advance health equity by supporting:

- Capacity-building for member organizations.
- Interventions in multiple social determinants of health (such as school success and parent engagement, housing quality and affordability, food access, community engagement and social cohesion, health access and navigation, racial equity and cultural inclusiveness).

⁶ Interview with Benton County Health Department staff, June 2018.

- Resident leadership, training and advocacy.
- Changes in policies, practices and culture that improve access and reduce or eliminate barriers, making healthy choices available to all members of the community.

WNHS has become the backbone organization for the alliance, a role that, according to Olson, has helped the organization shift its approach from “building houses” to “using housing as a platform for policy change and programming that creates opportunities for residents to lead healthier lives.” The WNHS board has incorporated alliance goals into its strategic plan to better align the two organizations.

“We serve as the voice of the alliance,” says Olson. This role has created opportunities for WHNS to be at the table with different sectors of the community, allowing staff members to learn each of their languages while reminding everyone that not everyone has the same opportunities.

WNHS also receives and allocates grant funds, distributing the monies to member organizations as they work to achieve collective goals. Many of the recipients are cultural organizations representing underserved and historically disinvested communities with significant health disparities.

LBHEA successes include:

- Modifying the Corvallis Property Maintenance Code to mandate healthier living conditions.
- Changing the Corvallis tobacco retail license requirements to include vaping and e-cigarettes and prohibit sales within 1,000 feet of a school or an existing tobacco retailer.
- Reducing barriers to participation in LBHEA by distributing small grants to grassroots volunteer organizations.
- Establishing a strong, collaborative relationship with IHN-CCO, with participation by alliance members in the organization’s health equity work group and Delivery System Transformation Committee.
- Partnering with the NAACP and other social-justice organizations on educational programming focusing on implicit bias and eliminating systemic/institutional racism.
- Raising community awareness about the importance of health equity through forums, partnerships and incorporation of health and health equity into local and regional government plans and needs assessments.

When LBHEA was first formed, Olson says, health equity was not a widely known concept. Thus, the use of the term in its name was strategic.

Health assessments for Benton and Linn counties now include equity, and IHN-CCO adopted a policy requiring applications for pilot projects to include contribution to equity. Housing also is included as a priority in the Benton County Health Improvement Plan.



INTEGRATING HEALTH AND HOUSING

Corvallis has one of the most robust community health-worker programs in the state, with 25 such staff members serving clients in elementary and middle schools and in primary-care clinics. The state of Oregon certifies workers who complete the curriculum requirements.

In 2016, WNHS became the first community development organization in Corvallis to use housing as a platform to deliver health services in a one-year pilot funded by IHN-CCO.

The IHN-CCO Health and Housing Planning Initiative Project funded two certified community health workers at WNHS properties who provide health-navigation services, help clients make appointments for preventive visits and screenings, and address other social determinants of health, including financial stability, eviction prevention, nutrition, and early childhood and adult education.

The move from traditional resident services to a public-health approach made sense to WNHS.

“When we looked at the role of our resident services staff, it became clear they were addressing upstream public-health issues,” says Olson. Rebecka Weinstein, community engagement manager. “Connecting someone with a neighbor or helping to prevent eviction are just as important as connecting someone with a health provider.”

The health-worker project was made possible, in part, by Oregon’s support for innovative health care policies and delivery systems. In 2012, the state reorganized its Medicaid program by creating regional coordinated care organizations that receive a fixed budget with the flexibility to target spending based on local needs. IHC-CCO’s willingness to fund the health-worker pilot is one example of the type of project the reorganization was designed to encourage.

A recent study in Portland that linked housing stability with health outcomes also helped WNHS make a convincing economic case for community health workers. The study showed a 12 percent reduction in Medicaid expenditures after participants moved into affordable housing.⁷ Emergency room visits also declined, while appointments with primary-care providers increased.

While the one-on-one health provided by WNHS health workers are for tenants only, other educational programming and activities that promote health and wellness are open to the community.

“Having the greater community come and participate at our properties is really a dignity issue,” says Weinstein. “It shows tenants that the

⁷ Center for Outcomes Research and Education. (2016). Health and Housing: Exploring the Intersection between Housing and Health Care. Enterprise Community Partners.

services and activities WNHS provides are high quality and are appealing to others, which communicates that we value and respect our residents.”



DOCUMENTING COST SAVINGS

Data collected over the project’s first two years by IHN-CCO demonstrate the success and value of the program. Emergency department (E.D.) cost per member per month declined 19 percent, from \$44.89 in 2015 (the base year) to \$35.42 in 2017 (as shown in Table 1). The number of E.D. visits declined 15 percent, from 159 in 2015 to 134 in 2017. There also was a decline in the number of primary-care visits, which was unexpected given the findings of the Portland study. The reasons for the change are unclear.

Table 1. E.D Visits and Costs: IHN-CCO Health and Housing Planning Initiative	2015	2016	2017
Number of E.D. visits	159	142	134
E.D. costs	\$133,796	\$103,387	\$97,746
E.D. visits per member per month	0.053	0.046	0.049
E.D. costs per member per month	\$44.89	\$33.64	\$35.42
<i>Source: IHN-CCO claims data pulled May 7, 2018, for CY 2015, 2016 and 2017 for 303 tenants of Willamette Neighborhood Housing at the time of the pilot’s start date, Jan. 1, 2016.</i>			

SUSTAINING COMMUNITY HEALTH-WORKER PROGRAMS

WNHS currently has 1.25 health workers serving its properties; demand for services varies depending on the resident mix. Sweet Home residents generally are 65 or older (thus qualifying for Medicare), while properties in Corvallis primarily have residents who receive Medicaid support. Some low-income individuals receive both types of assistance.

Resident services always have been difficult to sustain financially. Recognizing that resident services address social determinants of health and thus should be integrated with other services opens the door to additional funding opportunities. For example, the Centers for Medicare and Medicaid Services allows Medicaid dollars to be used for housing-related activities and services.⁸

In June 2019, IHN-CCO will begin paying for case-management services that address social determinants of health. Although the details were still pending at the time of publication, it likely will be a fee-for-service arrangement. One of the challenges facing WNHS is the complexity of

⁸ Vicki Wachino. (June 26, 2015). Coverage of Housing-Related Activities and Services for Individuals with Disabilities. Center for Medicare and Medicaid Services. Available online at: <https://www.medicare.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf>

billing for residents who receive both Medicare and Medicaid. Although IHN-CCO is the Medicaid provider, Medicare is the primary payer for these individuals.

LEADING INTO THE FUTURE

WNHS has been a pioneer in connecting housing and health in its service area. For example, it jumped into the community health-worker space before there were local opportunities for training. Today, WNHS is part of the solution; its staff will help train future community health workers to increase the local supply.

Partnerships have played a major role in WNHS' overall strategy. The LBHEA is the most prominent of these, building the capacity of small organizations and leveraging the power of the collective to secure system changes.

In addition, WNHS' partnership with BCHD has advanced the goals of both parties as well as the community's. Fortunately, both organizations think about their work from a broad, systems perspective.

According to Rocío Muñoz, equity and inclusion specialist at BCHD, the department probably would not have chosen housing as one of its priorities if it weren't for its strong relationship with WNHS. The nonprofit helped the health department understand how housing fits into a comprehensive plan for a resilient neighborhood.

Tatiana Dierwechter, BCHD's healthy communities manager, points out that it also helps that both partners have "organizational humility" — a willingness to be vulnerable.

"We don't know a lot of things about housing, but we want to learn and we don't feel we need to pretend we are experts in everything," she says. "This approach builds trust."

As with all relationships, regular communication is critical, including opportunities outside the work environment. For example, Muñoz says that every few months, WNHS and BCHD staff carve out time for an "internal huddle," where brainstorming about innovation is encouraged.

Muñoz points out that WNHS has been successful in addressing the social determinants of health because of its own organizational commitment to the approach. "They model it every day within their organization," she says.

Muñoz describes Jim Moorefield, retired WNHS executive director, and Brigetta Olson as "the best spokespeople for health in the community. They speak the language of the health sector, but their message carries a heftier weight because of their broader perspective and role."

The nonprofit helped the health department understand how housing fits into a comprehensive plan for a resilient neighborhood.

As WNHS looks to the future, more changes are on the horizon. In November 2017, WNHS announced it will merge with Neighborhood Economic Development Corp., located in Springfield, Oregon; the new, combined organization will have a greater capacity to focus on comprehensive solutions to building healthy communities.

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HEALTHY COMMUNITIES DEMONSTRATION PROJECT KEY FINDINGS REPORT AND CASE STUDIES

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