Journal of Applied Research on Children: Informing Policy for Children at Risk

Volume 5
Issue 2 *Legal Safety Nets: The Law as a Change Agent for Children*
Article 3

2014

Housing and Child Health: Safety Net Strategies, Regulations and Neighborhood Challenges

Daniel Skinner Ph.D.
Ohio University, skinnerd@ohio.edu

Jenelle Donovan-Lyle
Nationwide Children's Hospital, Jenelle.DonovanLyle@nationwidechildrens.org

Kelly J. Kelleher M.D., M.P.H.
The Ohio State University, Kelly.Kelleher@nationwidechildrens.org

Introduction

The promotion of high-quality and affordable housing, with its myriad legal and sociological challenges, is an essential and often overlooked component of health promotion, in general, and the promotion of child health in particular. Affordable homes are associated with better outcomes for families and children. At least as importantly, affordable housing initiatives are an innovative way for non-profit hospitals to meet their community benefit requirements for tax purposes. Plus, housing development may lead to reduced costs of care for high-risk Medicaid populations. These issues are both stretching and revolutionizing the bounds of what it means to engage patients and families in the neighborhood as health care professionals come to realize that the attainment of healthy communities requires reaching out into communities and thinking more deeply about the origins of wellness. This motivation is being fueled by the emergence of new health delivery systems sanctioned by the Patient Protection and Affordable Care Act of 2010 (PPACA), which provided new incentives for investing in wellness, preventative care and screening, and population health.[1]

This article examines possibilities as well as challenges in healthcare-sponsored housing partnerships for high-risk neighborhoods, with particular attention to understanding how the law shapes the nature of non-profit housing work. Our goal is to examine critical dimensions of housing initiatives undertaken by healthcare organizations to guide future efforts.

First, we discuss the literature on the relationship between health and housing to consider why healthcare institutions generally and children's hospitals specifically might enter into the challenging fray of housing advocacy for the poor. Safe and decent housing is important to the health and wellness of children and adolescents.[2] Safety, employment, nutrition and exercise are also highly correlated with health outcomes.[3] We then briefly assess evidence regarding the relationship between stable, affordable housing and health among children.[4] Finally, we discuss one initiative undertaken by a children's hospital to increase housing stock and stability—the Healthy Homes (HH) initiative sponsored by Nationwide Children's Hospital (NCH) in Columbus, Ohio and carried out under the umbrella of the hospital's "Healthy Neighborhoods, Healthy Families" program. [5] Healthy Neighborhoods, Healthy Families' mission is comprehensive, moving on five interrelated prongs: affordable housing, health and wellness, education, safe and accessible neighborhoods, and workforce and economic development. Healthy Neighborhoods, Healthy Families is its own entity which has its own board to watch over the

integrity of and direct the program, a community benefit for the not-for-profit hospital. While the program is comprised of five prongs, however, administrators regard HH to be its "anchor" and "tangible hub."

Next, we discuss what hospitals must do to actualize such a program. Using HH as a case study, we examine the key mechanisms that NCH and its partners have found to be critical for acquiring, building and rehabilitating, and ultimately getting new owners into stable, high-quality homes. We use as the basis for our analysis a series of interviews with key stakeholders,* a walking tour of the primary neighborhood impacted by the program, as well as analysis of HH-related web sites. Along the way we catalog best practices and lessons learned, within existing legal mechanisms and more informally, from the HH project to provide readers with a sense of the challenges of such programs.

The Connection between Healthcare Institutions and Housing

Although often overlooked as a key factor in health status, stable and affordable housing plays a critical role in protecting children and adolescents. A wide-ranging literature over the past three decades underscores the diverse ways that lack of either stable or affordable housing can adversely influence health.[6] Unfortunately, this literature is neither well known nor consistent in its findings because of widely divergent samples, definitions of terms, and policy considerations. It barely—if ever—addresses the legal, bureaucratic, and policy challenges of developing high quality and affordable housing itself.

Housing and health studies diverge in their findings to some extent because of their focus.[7] As Buckner notes, the earliest studies focused on young families that were homeless, but many newer studies focus on the poor and near-poor with unstable housing or unaffordable housing.[8] While the former is often marked by frequent moves or overcrowded conditions,[9] the latter is often defined by the amount—over 30% according to the Department of Housing and Urban Development—of household income devoted to monthly housing costs.[10] Affordable housing is the extent to which families spend resources on housing. For poor families, a subset of affordable housing is public housing provided by the state, city, or county usually through vouchers or public housing units. However, private entities can aim to provide affordable housing for low income populations through innovative building programs, special subsidies, and grants.

* These interviews, conducted in July 2014, included HH administrators, government officials, and community leaders.

Children are affected by housing instability, unaffordability, and homelessness differently at different ages. The youngest children seem to be most adversely effected, although academic performance and the potential resilience effects of good student-teacher relationships can be blunted for children in the early stages of school. Less clear is how the persistence of high-risk housing accumulates risk for children and their families. There is little to no longitudinal information about families that are persistently homeless or that have unstable housing. Similarly, research on health and housing is confounded by the samples examined for specific policies. Many studies focus on particular public or governmental housing policies such as Section 8 housing vouchers, rent stabilization programs, or rent supplement programs. The particular sampling frames and outcomes measures as a result often do not allow comparison with other high-risk populations because of the narrow eligibility requirements for each program and the lack of comparison data with other populations. Little has been written about the broader category of affordable housing of which public housing is one subset.

Nevertheless, there is consensus from the field that families in unaffordable or unstable housing situations or those that are homeless see worsening of health status for their children.[11] These negative effects occur through both direct and indirect means. The direct effects can be a result of any of five mechanisms or combinations thereof:

- Children living in poor housing stock or who are homeless are more likely to be exposed to toxins and chemicals that diminish their health. The most well known of these is lead which continues to haunt low-income children with anemia and developmental problems in numerous neighborhoods across the country. Lead poisoning in children causes anemia, developmental delays, intellectual retardation, and probably increases aggression. However, the list of problematic agents extends beyond lead and ranges from pesticides to heavy metals. These agents cause increases in asthma, headaches, anemia, allergies, and sleep problems.
- Children living in poor housing stock or who are homeless are often congregate in overcrowded settings and are exposed to higher than expected numbers of communicable diseases. Some of these are garden variety colds and pneumonia which add to the burden of illness that poor children experience, but others are more serious including tuberculosis.
- Injuries, burns, sleep, and malnutrition problems are more common among children who are affected by housing problems. Unsafe

housing stock may increase exposure to wires, unrepaired materials, and fire risk.[12] Similarly, children with unaffordable housing live in families that sacrifice food for housing with adverse consequences.

- Developmental delays among young children and emotional and behavioral disorders among older children are much more common among housing challenged children and their families.
- Finally, relationships that normally buffer children from stress and adversity are hurt by residential instability, homelessness, and stress of unaffordable housing. Parents overwhelmed with financial issues, depression, and declining prospects may be emotionally unavailable to their children. Teachers are unable to engage students who are frequently moving, just as pediatricians and other primary care providers may struggle to maintain contact with these families.

Indirect costs of homelessness and housing instability are also high for children and adolescents.[13] For youths with chronic medical conditions, ongoing access to specialists, home services, and local agencies can be disjointed due to frequent moves. Neighborhood resources for youth development are often similarly limited by housing instability and transience. Interventions in the education or healthcare settings are frequently truncated for high mobility families and children.[14]

The Center for Housing Policy identified three separate projects that tracked hundreds of participants over the span of ten years in order to see the changes in their lives in relation to housing interventions. Specifically, "the availability of high-quality affordable homes enables families to spend a greater share of household income on nutritious food, healthcare expenditures, and other essentials that promote good health" and "allows families to achieve greater residential stability, reducing the stress and disruptions associated with frequent or unwanted moves and providing a platform for individuals with chronic illnesses and other conditions to receive needed care."[17] The long-term investment in affordable housing has far-reaching consequences not only for physical child health, but mental health as well, especially when housing investments are matched with decreases in crime and improvements in education.

Healthy Homes: Policy Contexts and Early Developments

The PPACA was not the only recent federal activity with significant implications for child health. The Federal Neighborhood Stabilization Program, established in 2008 as part of the Housing and Economic

Recovery Act, [15] aimed to revitalize American neighborhoods with significant blight, most due to foreclosures and abandonment. The program employs federal funds to buy and develop foreclosed or abandoned homes in partnership with cities and states. Resources can be used to:

- Establish financing mechanisms for purchase and redevelopment of foreclosed homes and residential properties;
- Purchase and rehabilitate homes and residential properties abandoned or foreclosed;
- Establish land banks for foreclosed homes;
- Demolish blighted structures;
- Redevelop demolished or vacant properties

The early development of NCH's Healthy Neighborhoods, Healthy Families was inspired by other programs working in related areas, each of which offered a different look at the legal and political challenges of neighborhood-based development and horizontal integration: the Harlem Children's Zone and Columbus's "Home Again" program. Prior to launching HH, a delegation, including representatives from the City of Columbus, representatives from Nationwide Children's, and other key stakeholders visited Harlem to understand how the New Yorkers were addressing the social determinants of health for children. Seeing the Harlem Children's Zone first hand gave Columbus area leadership and their key funding partners the opportunity to understand that when addressing children's well being, a holistic approach, including affordable housing, is necessary. The Harlem Children's Zone is premised on the idea that if children are provided a safe community and home, proper educational foundation, and proactive health care, then their opportunities moving forward will improve dramatically. Though NCH learned much from the Harlem Children's Zone model, the latter's goals are not cast in health terms, but rather "to give our kids the individualized support they need to get to and through college and become productive, self-sustaining adults."[16]

The second inspiration, Home Again, was launched in 2006. Home Again is run out of the City of Columbus's Department of Development, and funded by bonds. Its primary focus is a "comprehensive approach for reducing or eliminating vacant and abandoned housing in targeted Columbus neighborhoods."[17] In addition to major rebuild projects, Home Again also facilitates external repairs for committed, current homeowners. Home Again was developed with the intent of clustering new properties in blighted neighborhoods to serve as a catalyst, with the goal of "providing a high quality, green standard housing product, and ridding neighborhoods

of blight through code enforcement, rehabilitation and demolition." As the hospital began developing a plan with the neighborhood for improving quality of life and expanding the hospital, the Mayor suggested that housing be a core component of community development.

Hospitals and Housing

Two primary motivations drove NCH's decision to become a central player in the neighborhood's re-development. As noted previously, the first motivation for HH was the decision in the early 2000s to renovate and expand NCH's previously existing campus to the modern and growing campus it now sits on, which includes 750,000 square feet of new clinical space within a 12-story hospital. The footprint of the new campus includes a new building for a research institute, underground parking, and six acres of new green space—totaling over 2.1 million square feet. Given its scope and the predictable anxiety it would raise in surrounding communities about the impact on the community and the need for more parking, key players felt strongly that they couldn't build a new hospital without working more closely with the community. This was compounded by past criticism NCH received in the media and from some community members over prior acquisitions and buildings about insufficient notice and community conversation. With the expansion of the new hospital, the hospital board and administrators knew there was concern about the safety and appearance of the surrounding area. As one program administrator put it, "Investors said, 'you must clean up your neighborhood too.'"

Yet, while managing community relations and "giving back" might have been immediate motivations, the project had other benefits. The largely Medicaid population in the area had high rates of emergency department and hospital use. Improving the neighborhood and educational opportunities was seen as a long-term solution to the high costs of healthcare. In fact, one outcome being monitored by the hospital is the cost of care among residents in Medicaid. NCH has been a leader in taking clinical and financial risk through global capitation for Medicaid children in central and southeast Ohio through an insurance intermediary entitled "Partners for Kids." With data documenting extremely high use of emergency room and inpatient services by the children in the high-risk neighborhoods around NCH, neighborhood improvements were believed to be one solution to the expensive care being delivered. NCH's expanded footprint and renewed commitment to population health made developmental work with surrounding communities a natural fit. Clearly, then, HH is not a purely philanthropic venture, as the hospital benefits in many ways from these better relations and improved perceptions by

surrounding communities, the broader city, and possibly even the national attention its horizontal integration efforts afford the NCH brand.

There are also tax implications. For example, money spent on HH becomes part of NCH's community benefit accounting, which is measured in accordance with IRS instructions.* As the Children's Hospital Association explains, "Hospitals' community benefits are programs that respond to identified community needs and whose primary beneficiary is the community rather than the hospital." The importance of investing in community benefits has intensified as the IRS and Congress, as well state authorities are "increasingly questioning hospitals' qualification for tax exemption, particularly the validity of hospitals' community benefits reporting." Accordingly, "Children's hospitals need to be able to demonstrate the benefits they provide to the community in order to respond to this scrutiny."[18]

With NCH in the lead, HH found it critical to work with "consensus builders" to cultivate a high level of trust in the community. Community Development for All People (known colloquially as CD4AP), a local community development organization formed at the Church for All People, had already put in place an early housing model that was tailored for very poor populations.

HH was launched in 2009. Along with a local elementary school, the hospital serves as an "anchor institution" for the HH project.[19] These two institutions serve as well-known points of contact within the community itself and also are points of contact on the project as a whole, with the intent to find a common ground between the community and the project. The idea of an "anchor institution" has gained traction over past years, fueled in part by the federal department of Housing and Urban Development's (HUD) "Anchor Institution Task Force."[20] Anchor institutions have been defined as "nonprofit institutions that once established tend not to move location," underscoring their potentially stabilizing force in the communities in which they reside.[21] Anchor institutions often have capital as well as incentives to invest in their neighborhoods. Scale is therefore a critical component of successful

* Statutory requirements for hospital-based community benefit work is located in several places. Most recently, the Patient Protection and Affordable Care Act (PUBLIC LAW 111–148—MAR. 23, 2010) altered requirements for 501(C)(3) tax exempt status. See. SEC. 9007. "ADDITIONAL REQUIREMENTS FOR CHARITABLE HOSPITALS." For organizations like NCH, various programs work toward meeting community benefit requirements, such charity care program, community health education, mobile units, obesity prevention, hospital research support, and a variety of support provided to community events via donations, in-kind support, and table sponsorships.

housing development projects, and many participants note the difficulty a small non-profit would have in launching and seeing through a project such as HH. Specifically, the fact that HH is well capitalized allows it to lose money on particular buys, with an eye to the larger picture. It also allows HH to build truly quality homes with superior price-points to surrounding structures, which poorly capitalized non-profits and even private builders would be unlikely to be able to do in a place such as Columbus's Southside. The end goal of such a well-capitalized project is to use attractive price-points to convince people to buy into the neighborhood. The hope is that good deals on the housing side will offset other problems with the neighborhood, buying time as those issues are addressed.

Birth pangs were immediate. Some residents were initially upset with NCH because some felt as though the hospital disproportionately focused on razing homes. This fear is unsurprising considering the concerns about gentrification in the neighborhood as well as the common approach many municipal governments take toward blighted neighborhoods. Though incorrect in the case of HH, these perceptions intensified the need for a truly engaged and impactful community relations office.

Such concerns were intensified because HH launched right on the heels of the "Great Recession" of 2008. As Columbus mayor Michael Coleman noted in the media, "When the financial crisis hit, you saw, overnight, houses become vacant and abandoned and become eyesores…We've been recovering ever since."[22] Yet, while the recession wreaked havoc on U.S.—and Columbus's—housing markets, it also provided opportunities for addressing blight by lowering the price of foreclosures. Before the initiative progressed beyond preliminary planning stages, HH met with a range of community leaders to discuss the project to establish an ethos of collaboration from the start. HH began its operations with a set of basic principles. Above all, HH drew upon well-documented research in urban development suggesting that mixed-income neighborhoods were the strongest in ensuring the healthy development of young families and children.[23] The initiative's key personnel wanted the program to not only encourage home ownership, but to ensure that the homes were of similar quality to some of Columbus's finest neighborhoods, such as Clintonville and Victorian Village. To meet various needs, however, one non-profit participant noted, "What we want is a spectrum of housing."

These meetings also made clear that HH would seek to work within the neighborhood's history and aesthetic. Though neighborhoods may be

blighted, they also have heydays that appear long in the past to outsiders but nonetheless frame residents' present memories. In the HH zone, for example, one can see through the cracks of pavement evidence of formerly brick-lined streets. Only blocks from the HH's south-side zone, is the German Village section of Columbus, a mostly well-to-do and beautifully brick-lined community recognized by the National Register of Historic Places, and is thus afforded extensive resources for preservation. Accordingly, HH administrators note not only sensitivity regarding the HH zone's past and roots when working with community members, but great care and passion with regard to its future development. Increasingly, South-siders—and especially those living in the HH zone—are engaged directly in reclaiming their neighborhoods from years of neglect. Much of the activity today is a result of direct input and participation by Southside residents, including those working on the housing initiatives.

What is to be done?

In this section we review specific steps required to carry out a project such as HH. Here we catalog specific legal mechanisms within state and federal law; best practices for acquiring, rehabilitating, building, and selling new homes; and strategies for working with the communities in which organizations work. We distinguish general principles from the particular and unique needs of a community such as the one in which HH operates.

Boundaries, Licenses, and Budgets

HH began with an initial set of boundaries including almost all of one census tract and a fixed budget. Presently, its budget grows annually and the progression of boundaries (currently at 38 square blocks, see Figure 1) extends a few blocks every other year. It has expanded twice already. Over its inaugural years HH has evolved and grown, both conceptually and physically. HH personnel also report receiving myriad requests for the hospital and its partners to expand its boundaries to include new neighborhoods. HH expands its boundaries carefully, with particular consideration to density, as each house alters the dynamic in its immediate vicinity. If homes are too spread out, the intensification effect could be reduced. In other words, HH only expands its boundaries when it believes it will achieve a critical mass.

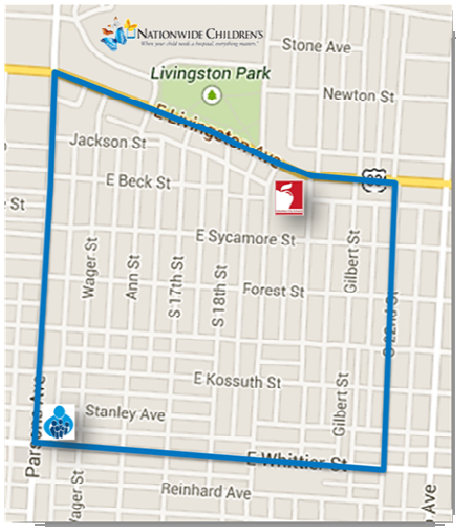

Figure 1.
HH boundaries as of 2014

Changes in the original scope of the project pose legal as well as social challenges. When boundaries change, HH involves the neighborhood civic association and consults with community members. It is here that community partners play especially critical roles. Given the scope of the project, there is a paradox: HH not only serves a particular, existing community, but radically alters it by reworking the economics and identities that exist within its boundaries. For example, substantial commercial development in the service industry has occurred on the nearby thoroughfare serving the neighborhood as construction from the new hospital and the renovated and rebuilt homes continues to grow.

A key step in launching housing initiatives such as HH is the acquisition of Community Housing Development Organization (CHDO) licensure, a city-sanctioned certification that allows non-profit organizations to work in the housing sector to receive state or federal funds. CHDO is a legal designation for a nonprofit organization that is doing housing development, and is available only to organizations that are state certified through the Ohio Housing Financing Agency.[24] As a condition of licensure, organizations must establish clear geographical boundaries.

The terms of the CHDO do not mean, however, that NCH is not engaged with neighborhoods falling outside of the boundaries of HH. To the contrary, NCH has entered into "good neighbor agreements" with ten

surrounding neighborhoods. A key part of the cultivation of these relationships centers on quarterly meetings to discuss initiatives that will be beneficial to the general area. In addition, over five hundred hospital employees live in three zip codes contiguous to the hospital and the hospital intentionally seeks out employees from the neighborhood, tracking new hires from the HH area as an employment metric.

NCH is currently developing "home and garden" tours and actively seeks out ways to participate in and facilitate neighborhood events. The hospital is also working with civic associations and other neighborhood partners to develop "block watch" procedures and platforms, including a phone system, mail alert, and the training of a block watch captain. Yet, there is a ways to go toward generating civic engagement— after several meetings no community members have "stepped up" to serve as coordinator for the watch.[25] One community member who bought his home without HH support described the neighborhood as a "warzone," but noted that the "only shred of optimism" was that "If NCH does what it says it will, there is hope."

It is important that HH funding is multi-source, from large federal contributions to a sprinkling of private donations. NCH is vested in the program, but grants from United Way of Central Ohio as well as funding from the City of Columbus are also integral pieces. All of the strategic partners—most prominently United Way—had a hand in determining HH's boundaries, which were set collaboratively. Funds from the federal Neighborhood Stabilization Program were required to track certain pieces to maintain funding, such as income requirements and adherence to all notices and rules, which are updated regularly on HUD's website.[26] Careful compliance, however, has additional benefits, such as opening doors for additional city funds. This underscores the long-term fiscal benefits of complying with relevant legal codes and rules, as clean compliance records make organizations more attractive to future partners. Yet, partnering with the federal and state governments also comes with challenges. In many ways, governmental agencies are more organized and easier to work with than private entities, but organizations must be willing to follow guidelines or restrictions—especially income eligibility guidelines. Non-profits such as United Way have stringent reporting requirements. Since initiatives aim to open multiple and diverse funding streams, record keeping and compliance are similarly variable.

Acquiring Properties: Procedures and Challenges

From the outset, acquisition of delinquent or abandoned property was the biggest challenge for HH. This, as many HH administrators report, was the

part of the process with the steepest "learning curve," considering that the hospital had no previous experience in residential housing. This learning curve spans from the specific day-to-day details of who needs to sign which documents and at what stage, to the larger questions of simply finding out who owns which properties and what their status is.

Despite lessons learned, acquisition remains the key barrier for HH in its negotiations with sellers (private banks, owners, or the Land Bank). Over the initial months, administrators experienced the comparative difficulties of dealing with private banks, individual sellers, and the city of Columbus's land bank. Every house and situation is unique, so administrators report the absence of standard acquisition practices and procedures. Nonetheless, some basic themes arose from our interviews. Multiple interviewees—from non-profit developers to government administrators—reported that banks don't always follow proper protocols for non-profit rules and regulations. Properties acquired from private banks also tend to suffer from comparatively poor upkeep since banks have little stake in improving properties in significantly blighted neighborhoods. As one non-profit administrator put it, "private banks are the worst landlords."

Predictably, there is also a good deal of resistance on the part of banks in dealing with blighted neighborhoods. Oftentimes, they simply do not want to loan money because of the risks inherent in working in blighted neighborhoods and ongoing costs, the difficulties of insuring vacant homes, dealing with tax delinquency, and the challenges of getting houses up to "suburb" quality. When it can be arranged, insuring vacant lots is still extremely costly, which adds to the cost of the home. Working within these systems sometimes requires that HH and its partners slash prices to make the deal work. Given the challenges of private banks, HH focuses on cultivating relationships with "people, not banks" to steer new homeowners toward good institutions. In addition, about 25% of HH properties have been purchased directly from owners. Though a comparatively smaller percentage of HH homes are acquired in this way administrators say it is by far the easiest route—at least until realtors get involved. As one administrator noted, "About a total of three realtors understand what we're trying to do with the project and are willing to take on work in that area."

As noted, HH often utilizes the city's land bank. The American institution of land banks dates back at least to the colonial period when their "chief function consisted of lending out provincial paper money to citizens on the security of their land, farms, town houses, or other forms of real estate."[27] In contrast, today's land banks are municipal mechanisms intended to solve the modern problem of abandoned properties and

neighborhood blight. HUD defines contemporary land banks as, "public or community-owned entities created for a single purpose: to acquire, manage, maintain, and repurpose vacant, abandoned, and foreclosed properties –the worst abandoned houses, forgotten buildings, and empty lots."[28]

For organizations like HH, the city land bank is usually easier to work with than private banks, but this route also comes with its own challenges. The process can at times be tedious, but the city pays for the demolition and the lot maintenance so HH ends up purchasing lots for approximately $1500. All land bank properties have been abandoned, which raises issues about upkeep. Oftentimes, the land bank—which one administrator described as the "owner of last resort"—is the only answer. Most properties end up in the control of the land bank through tax foreclosures. Much depends on how local code is written—an important variable for other hospital contemplating their own programs. Sec 5722 of Ohio Code, which addresses the state's "Land Reutilization Program," allows cities and counties to request transfer of "nonproductive" properties.[29] If there is no movement on a property after public auctions (usually under the aegis of the sheriff's department), land banks may receive title. While this acquisition is generally not free—there are some costs associated with taking a property—such costs are minimal. Additional policy and legal mechanisms are critical to the land bank's work. For example, in Ohio, tax foreclosure law allows land bank property to be transferred with existing mortgages wiped clean. The land bank's direct knowledge of the current state of all of its properties often allows it to work in ways that private banks cannot and its procedures are streamlined in ways that more complex and multi-tiered private banking systems are not.

Sometimes the city land bank finds it useful to work with the county land bank because of special legal routes afforded them. Under Ohio Code, the city land bank cannot waive delinquent taxes, whereas county land banks can. Ohio county law also allows for "alternative redemption periods" for unoccupied and delinquent land wherein, forty-five days after a parcel of land is deemed delinquent and meets other strict criteria (boarded up, no utilities, etc.), "the right and equity of redemption of any owner or party shall terminate without further order of the court or board of revision."[30] This allows for a process in which blight can be dealt with more expeditiously. Similarly, Ohio code allows for "Expedited foreclosure by board of revision on unoccupied land." This provision allows counties to circumvent often times lengthy judicial foreclosure proceedings and move straight to auctions or other means of making vacant properties available for transfer and development.[31]

Legal specifics aside, the most significant philosophical difference between land banks and other banks is that land banks truly want to revitalize neighborhoods. The Columbus land bank regards groups such as HH as critical partners in a civic mission. The land bank, like HH, strives to work as closely as is practical with the community. The land bank understands that there is particular sensitivity concerning demolition (as this writing—August 2014—the land bank has demolished 230 existing houses this year within its boundaries of the City of Columbus). In the case of the Southside, residents are notified in advance, and comment is solicited on all major projects, not only those in which demolition will play a prominent role.

Though not a major issue in significantly blighted neighborhoods, it is worth noting that—unlike private sellers—the land bank must sell for fair market value, based largely on comparative prices. As one government official put it, "Asking people to buy the most expensive house in the neighborhood is a big investment," and the kind of confidence necessary to receive buy-in from potential buyers requires the steady presence of an anchor institution. A critical distinction between individual sales and bank foreclosures is that city-funded development is prioritized in land bank sales. The land bank, in fact, holds properties specifically for HH, which eases the acquisition process.

Post-Acquisition Challenges

Purchasing homes is, of course, only the beginning. In general, subsequent construction of this nature requires something of a balancing act, trying to find a "happy medium" between the hospital budget and the budget required to construct appropriate houses that will sell. One persistent legal hurdle that is often encountered at the beginning of the process is posed by the fact that zoning variances are almost always needed in the properties. As one of HH's legal staff members explained, many of the homes are not zoned correctly, so once a new home is to be built on that lot, a variance is required. Also, existing lots are not always suited for the quality of homes HH strives to bring to the neighborhood, which requires a lengthy legal process. Though most variances are eventually approved, the process extends the average time period for development and requires extensive effort on the part of HH personnel. HH's construction philosophy centers on producing quality homes that will provide sustainable opportunities for new home owners, but also seeking to minimize costs when possible (see Figure 2). The process of building the kind of homes that will both meet code and allow low-income families to thrive there requires navigating a series of particular challenges.

Figure 2.
An example of a blighted Southside property (left) and an HH build (right)

Commitment to Green and Energy Efficient Houses

Given the comprehensiveness of Healthy Neighborhoods, Healthy Families' multi-pronged strategy, the health features of HH houses are closely bound up with building design. The promise that stable housing will result in healthier communities is only met when sustainable living within those homes is achieved. Lead and asbestos abatement on properties is a challenge, in large part because of their impact on cost, but HH ensures that all homes are built to the most recent codes. HH also tries to add green features to homes as much as is practicable within budget. Many of these green features are in fact *required* for new buyers to qualify for low-income tax credits.[32] Among these features are Low Volatile Organic Compounds Paint, Recyclable Carpet, Tankless Water Heaters, Solar Tube Skylights, and 95% Energy-Efficient Furnaces.

Smith et al's 2007 study of 400,000 Massachusetts children living in low-income housing found that high energy costs are highly correlated with worsening health suggesting that smart energy choices are in themselves health decisions. Accordingly, HH is committed to promoting energy efficiency in the homes it renovates. Sometimes, it appears, simply living in a blighted neighborhood results in disproportionately higher energy costs, leading to budgetary trade-offs resulting in food insecurity.[33]

Energy insecurity, moreover, is correlated with risk behaviors such as the use of kerosene, open flame, and—worse—oven heating. These pose risks such as burns, fires, and exposure to carbon monoxide. In short, difficulties in affording basic home energy costs are likely to result in short cuts in other areas, most of which impact health. Inadequate energy can also lead to corner cutting in food procurement, a problem compounded by the fact that America's most blighted communities tend also be food deserts. The final possible result of unaffordable energy, of course, is eviction and even homelessness. HH knows that investments in these features are likely to have a positive impact on homeowners' stability, particularly considering the close relationship between energy costs and health.[34]

Restrictive Covenants and Eligibility

Beyond building considerations, programs such as HH require eligibility requirements and mechanisms—both legal and social—for ensuring that new buyers stay in their homes for some time. One such mechanism is the "restrictive covenant." Under HH's covenant, which all buyers must accept as a condition of purchase, buyers must occupy the house as their primary residency for a certain amount of time (usually five years) before they can sell or rent. This prevents speculators from purchasing HH-subsidized homes and re-selling them for profits. For properties in which HH grants are used to provide partial rehabilitation, usually limited to exteriors rather than full rehabilitations or rebuilds, HH currently requires a 3-year restrictive covenant to prevent grantees from using the program to increase property value with the intention of selling. In all cases, these covenants are intended to stabilize. To date, only one waiver to the restrictive covenant was granted in a case in which the owner had to relocate for employment purposes. These regulations arose under the Neighborhood Stabilization Program. Section 92.254 of the Code of Federal Regulations addresses the qualification criteria for affordable housing for homeownership:

> (3) The housing must be acquired by a homebuyer whose family qualifies as a low-income family and the housing must be the principal residence of the family throughout the period described in paragraph (a)(4)…"[35]

Section (a)(4) establishes a schedule by which transfer is prohibited (5 years) and then regulates the financial benefits available to sellers in years 10 and 15. Initially, since HH homes were built with federal stimulus dollars, these required a ten-year restrictive covenant to reflect that program's requirements. Originally, buyers had to meet the stringent

income eligibility criteria of being at or below 80% of the median income in Columbus.* Once the funding sources expanded to NCH and United Way, the restrictive covenant was decreased to 5 years, and the financial requirement was moved to 120% of median income, or approximately $70k for a family of four. CD4AP verifies the income requirements, as NCH's role is primarily one of planning— including acquisition and renovation—but is rarely involved in transactional work.

Strategies for Neighborhood Relations: Cooperation and Resistance

While acquisition, renovation and sales are critical issues, engagement and partnership are equally essential. Initially, HH reached out to key groups to establish a range of partners, including CD4AP, which was already working on improving some housing in the area and held a CHDO license. HH also sought out key participants in the city-run Home Again Initiative, which possessed know-how regarding renovation specifications and how to buy and sell houses. In many ways HH serves as a good example of ideal collaboration, where NCH's considerable resources and commitment to the community are married with CD4AP's knowledge of the housing needs of the neighborhood and status as a CHDO.

The careful attention to neighborhood relations was driven by a basic but often overlooked fact about the relationship between health care services and housing: the former are located in and alongside neighborhoods.[36] For those living in surrounding communities, the fancy sheen of the modern children's hospital can appear as a massive class divide. Access to the hospital and its services provided by Medicaid, which serves as the lifeblood of children's hospitals,[37] is the key conduit through which this divide is bridged. Philanthropy and other forms of inexpensive or donated services to the community fill a critical role as well.

Resistance to projects such as HH is predictable. This is especially true given historical tensions—racially-charged and not—responsible for distrust in philanthropic and other kinds of "outreach" and "development" projects—especially those of a large hospital with corporate sponsorship—promising to "fix" neighborhoods. Many attempts to address

* SEC. 1334. DISCRETIONARY ADJUSTMENT OF HOUSING GOALS. (28) LOW-INCOME AREA.—The term "low-income area" means a census tract or block numbering area in which the median income does not exceed 80 percent of the median income for the area in which such census tract or block numbering area is located, and, for the purposes of section 1332(a)(1)(B), shall include families having incomes not greater than 100 percent of the area median income who reside in minority census tracts and shall include families having incomes not greater than 100 percent of the area median income who reside in designated disaster areas.

urban blight have resulted in the displacement of people with long-standing ties to blighted communities, gentrifying rather than improving.[38]

Given the inherently disruptive as well as emotional nature of development in blighted neighborhoods, it is critical to learn to anticipate responses before they happen, which is also evidence of true concern for community needs. To illustrate this understanding, an HH administrator noted an example of a large, four-unit brick building that was in extremely poor condition. The unit was across from houses that HH had redeveloped, but couldn't sell because of the large eyesore they faced. Though HH did not want to demolish the building, and explored many options (multi-family, condo, etc.), they decided that demolition was the only viable option. When HH consulted with the president of the civic association, and explained why demolition was the best option for the building, the community requested that the new buildings be brick as well to restore the block's classic look. The compromise regarding the new, two-family home was a cost-effective and modern wood construction with a brick front. The new homes were under contract prior to even being finished, and the homes across the street sold as construction was being completed.

In many cases, existing structures cannot be salvaged, leaving demolition as the only viable option. But demolition is also an extreme and emotional solution of concern to the community. Accordingly, HH tries to avoid demolition if possible, asking for community opinions about alternatives along the way. Communities are understandably sentimental about their histories and unique features, which HH sees as both a constraint and opportunity for communication and collaboration in the interest of developing a sustainable community. Accordingly, if homes must be demolished, due to either coding issues or cost-prohibitiveness, HH attempts to replace them with similar structures. In cases where this simply is not possible, HH works especially hard with the community to find an acceptable alternative.

Despite this commitment to collaboration, however, there are challenges. Significant hurdles arise from the fact that the process of buying homes is lengthy and involved—perhaps as it should be for the protection of all parties. Logistically, however, it is hard to keep pace with the process—especially as the recent housing crisis and mortgage crises have lead to increased oversight of lenders and municipal land banks. Questions arise: for example, when, amidst this difficult process, should the community become involved? While there are few legal obligations to consult, there are a multitude of reasons why early consultation is wise. Usually, however, the process of purchasing is already in motion when the community is consulted, raising questions about whether true

collaboration is really at work. As one administrator advised, if a plan is already in place, developers should "be honest" or risk blowback.

Whenever it is possible to fuse community engagement with development goals, HH attempts to draw upon existing strengths and resources within the community. It prioritizes local, small business, and minority contractors, many with which it now has ongoing and strong relationships. Since NCH purchases only a few homes at a time, small contractors have appropriate capacity. Again this strategy is intended to strike a balance between social appropriateness and HH's logistical needs. This aspect of HH also feeds into the larger Healthy Neighborhoods, Healthy Families program by addressing workforce development issues. This is especially important since Columbus's large businesses have largely refused to participate. In addition, HH is also committed to supporting existing homeowners as the neighborhood around them is improved. Specifically, HH provides up to $20,000 for exterior improvements for currently owner-occupied homes, bounded by a three-year restrictive covenant. Obviously, these grants serve a dual purpose of providing a service to current homeowners while improving the appearance of the neighborhood, which in turn drives the value and attractiveness, in real estate terms, of the neighborhood as a whole. NCH also provides down-payment assistance for any employees purchasing new homes as part of the program. To date, 12 employees have purchased a new home or modified the exterior of their homes.

Our interviews suggest that the early development of strong community relations was critical to getting the project off the ground, and key personnel understand its centrality to long-term success. A few themes arise from the interviews. First, it is rare that an entire group of residents resist the basic thrust of programs such as HH. Instead, the most critical focal points appear to be a few vocal individuals, especially when they serve community leadership roles, formal or informal. Nonetheless, HH personnel emphasize their commitment to communicating "everything thoroughly" to the community, viewing civic association meetings as critical forums for explaining why non-profit development projects are doing what they are doing. At these events, in particular, HH has found pictures to be extremely useful for helping visualize options. Transparency can be aided by charts and data to alleviate anxieties about profiteering and cost cutting. Particularly challenging is the question of how to package the story, rhetorically and visually, so that community members can get a sense of the big picture. It is understandably difficult to explain why NCH, which projects a high-level corporate image, might have limited resources when rehabilitating or

rebuilding homes that will need to function on a market that is slowly starting to improve but has not yet fully arrived. In the shadow of NCH's $800M renovation, it is sometimes hard to convince community members that HH—a non-profit housing initiative—operates at a loss.

While civic associations are important, however, some interviewees raised the possibility that the civic association may not be as representative as is called for in a truly collaborative and democratic development project. For example, some in the community feel that the civic association doesn't represent them, and point to internal neighborhood disagreements that don't get captured by the civic association, especially regarding who does and does not speak for the community. Some residents feel that one or two charismatic people drive the civic association, and do so without consulting the broader community. HH has begun to address this by consulting other informal leaders in the neighborhood as well as the neighborhood's city-established "area commission," the purpose of which is "to act as a liaison between neighborhood groups, property owners, residents, developers and city officials."[39] Nonetheless, some administrators and residents expressed an interest in including neighborhood representatives more fully in formal roles—perhaps on boards—so that non-NCH personnel could be part of the actual decision-making process. In an effort to continue outreach efforts, the hospital will be holding focus groups, run by a local community and public relations group to get input into various prongs.

It is clear that the true integration of community partners into planning must overcome significant barriers. Predictably, HH has learned that it is nearly impossible to predict and prepare for all of the barriers that will arise in the course of such a large project. This underscores the importance of flexibility in program implementation and outreach. Despite this variability and unpredictability, however, our finds suggest some persistent themes.

First, community partners may experience high anxiety about the norms of the hospital setting. It is easy for health professionals to forget that the etiquette and professionalism of hospitals can be daunting to the uninitiated. While, on the one hand, one might think that bringing the community into the hospital could mitigate this divide, it is also likely—even probable—that doing so will intensify alienation. As one interviewee notes, NCH "doesn't tend to invite community to the hospital," but prefers to "go to them." The reasons for this decision range from logistics—sparse, paid parking—to broader cultural concerns, especially owing to the hospital's sterile and business-oriented aesthetic. One notices, however, that this language of "going into the community" betrays the very "us and

them" divide that horizontal integration seeks to break down.

Second, cultural competency problems exist on both the community and hospital sides. NCH, for its part, has made some strides in addressing these, but understands that doing so must be an on-going, long-term commitment. Among the dynamics of this cultural divide is the fact that public health employees at the Hospital and in the community remain largely dominated by white middle class females, which provides a stark contrast with the core demographic of HH's boundaries, and even more so with the key leaders who are African-American.

More generally, while housing is one key piece of Healthy Neighborhoods, Healthy Families, the problems are systemic and require the systemic approach intended by the programs additional prongs (health and wellness, education, safe and accessible neighborhoods, and workforce and economic development). As a testament to dynamic sociological basis of housing and neighborhood revival, the other pieces including job training, education reform, and safety, eventually need to be in place to support housing and vice versa. Some administrators and community advocates lamented the fact that the other pieces were not pursued aggressively at the outset, and felt that the housing component suffered as a result. The fact that planning for other prongs is only really beginning to gain traction some six years later is a challenge. That said, this is an example of the necessarily unpredictable nature of such development projects, as HH came along faster than the other prongs for the simple fact that external matching funds came faster for housing than for other components. To be successful, other social determinants of health will need to receive attention and support on par with the housing component. After all, in terms of the social determinates of health, housing is only one slice of the broader challenges of combatting the poverty that is almost always accompanied by poor education, malnutrition, crime, and beyond. Nobody at HH is under the illusion that increasing housing stock is a catch-all solution, or enough, so the hospital has embarked on a ten year campaign with neighborhood leaders to address common goals in safety, employment and early childhood education.

Despite the challenges, some general strategies for better relations during the acquisition and building stages can be culled from HH's experience. HH has sought to implement strategies intended to ensure that new homeowners are successful in their homes. While HH's restrictive covenant ensures certain continuity from year to year, additional provisions are intended to give them security within the early years. HH identifies as the "cornerstone" of HH is its eight-hour HUD-certified homebuyer course, facilitated by non-profit partners, usually either the

Columbus Housing Partnership or the Columbus Urban League (Figure 3).

Figure 3.
The Columbus Urban League's Homebuyer Education Course

The Columbus Urban League's Homebuyer Education Course is a HUD approved housing education and counseling program. This eight hour course will provide you with information regarding budgets, understanding credit scoring, mortgage loan products, loan analysis and the closing process.

The Curriculum is divided into six sections:

- **Are You Ready to Buy a Home**- This section gives you an overview of the home buying process.
- **Managing Your Money**- This section gives you tips on how to manage your money.
- **Understanding Credit**-This section discusses the importance of maintaining good credit and tips on how to improve your credit score.
- **Obtaining a Mortgage Loan**-This section explains the steps involved in obtaining a mortgage loan.
- **Shopping for A Home**-This section goes over Home buying team and information you need to be a smart home buyer.
- **Protecting Your Investment**- This section was designed to help take care of your investment, tips on becoming energy efficient, maintaining your finances and who to contact for foreclosure prevention.

Upon completion of the class each participant will receive their HUD certified certificate.

These courses feature visiting speakers such as appraisers, lenders, inspectors, and real estate agents. The six-part curriculum of the Columbus Urban League course addresses topics such as an overview of the home buying process to assess individual readiness for buying a home; money management tips; a discussion about credit with an emphasis on the importance of maintaining good credit and tips for improve credit scores; how to obtain a home mortgage loan; how to be a

smart home buyer; and "Protecting Your Investment," which teaches new buyers how to care for their investment, provides tips for energy efficiency, financial success, and preventing foreclosure.[*] Attendees receive a certificate—good for one year from the date of the class—as long as they are present for all eight hours of the class. There is no formal assessment of learning outcomes.

HH also offers a one-year craftsmanship warrantee on all new homes to ensure that HH stands behind the quality of the homes. This feature is intended to instill confidence in new buyers regarding the quality of the homes—which is part response to the concern that low-income housing is often substandard as well as part of HH's concern with trust-building. At the same time, the very idea of follow-up can raise issues. For example, some city and HH administrators spoke of the challenges of transitioning from a "rental mentality" to the "owner's mentality" they believe to be required of successful first-time homeowners.[40] Since the HH process is not a standard process in that buyers receive help that non-HH buyers would not, the former sometimes come to think of HH and its various collaborators as partners in ways that can postpone the move to a "home owner mentality." On several occasions, for example, new homeowners have called the hospital regarding repairs and financing for repairs rather than address these issues as owners. Administrators find these conversations challenging given the sensitivity of the neighborhood politics. The goal is to help the new owners to learn to deal with issues, but the transition can be slow. A first step is to reiterate the legal dimension—that these homeowners are now fully homeowners—but also to be sensitive and helpful wherever possible with regard to directing them to resources.

HH champions its commitment to ensuring that its efforts add to and fortify the community but does not displace. In recent decades, the Southside's transient population has been high. HH's goal includes supporting existing residents by turning blight surrounding their homes into assets rather than liabilities. One key to stabilization, according to HH is diversifying the neighborhood's income profile. HH and government administrators argue, however, that city-financed projects can actually serve as effective safeguards against gentrification. HH aims to increase the value of properties for the simple reason that property values must increase to attract buyers—but this does not mean that gentrification

[*] The organization describes itself as "a HUD-certified counseling agency that has met the National Industry Standard's Code of Ethics and Conduct for Homeownership Professionals" with staff that "has over 60 years of experience in providing high quality housing programs and services." http://www.cul.org/cul-housing-services/

follows. A focus on exterior beautification for existing owners is intended to reduce the fear of gentrification by insuring that an increasingly attractive neighborhood is accompanied with supports to enable existing homeowners to remain there. To a degree, the legal requirements of the Neighborhood Stabilization Program itself ensures that new and rehabilitated houses will end up owned and occupied by those falling into the neighborhood's existing demographic, though with the goal of facilitating stability and mobility.

Visually one can see evidence of a stabilizing neighborhood just by walking down its streets. The numbers bear this out, as well, as HH sold its first home for $92,500, but sales now reach upwards of $132,000 because of steadily improving property values. HH reports that their program has impacted one out of four homes in the area. Additionally, the sustainability of the program has altered the original plan, as HH had originally planned to spend 5-7 years to impact 100 homes, but reached that goal in four years. Blight, the number of abandoned properties in the census tract, has been reduced by 50% in the area since HH's inception in 2008. There is substantial evidence that the renovations have transformed the *perception* of safety for hospital employees, patients, and outside entities bringing businesses to the area.*

Beyond perceptions, however, tracking will be key to evaluating the program's success and making necessary changes in the future. Unfortunately, this is a crucial area in which the current program needs to focus more intently. Investing in the relationship between health and housing is one thing, but documenting its real-time, real-world effects would be powerful. To truly take the relationship between the availability of affordable housing and the impact on the health of low-income families beyond the realm of intuition to the realm of hard numbers, institutions are going to have to more fully dedicate themselves to both short-term and long-term data collection.

Such a rededication is also likely to provoke discussions about appropriate measures for child health that are circumvented when data

* Many neighborhood revitalization programs have made a goal of convincing employees to live in close proximity to the anchor institutions at which they are employed. Developers in Cincinnati, OH, for example, "Hope that enough change can be shown in [the blighted neighborhood of] Avondale to persuade suburbanites who work within a mile or two at Cincinnati Children's or University hospitals that their time and money would be better spent rehabbing an empty Victorian than on long commutes." Enquirer In-Depth: Saving Avondale, Mar. 18, 2012, http://archive.cincinnati.com/article/20120317/NEWS/303180007/ENQUIRER-DEPTH-Saving-Avondale.

collection is not a primary concern. Ideally, such discussions would renew discussions about the value of housing for kids. Unfortunately, these discussions are unlikely to be able to utilize commonly existing measures, such as those of the National Survey of Children's Health (http://www.childhealthdata.org) which, though including several measures of neighborhood stability and safety, does not include housing stock data. The investment by institutions in such data collection and synthesis is likely to serve as an additional sign that institutions have undertaken these initiatives with long-view outcomes in mind.

Conclusion

Stable and affordable housing are core components of the community safety net with direct and indirect effects on the health of children and young families. The growing appreciation for these facts by large healthcare organizations and hospitals combined with an understanding of the role of anchor institutions in impoverished communities has led to a 'horizontal integration' of healthcare and social/human services in many communities. Those interested in population health for children will increasingly seek ways to achieve this horizontal integration and influence affordable housing stock in high-risk neighborhoods.

NCH partnered with a local community development organization and the city of Columbus to launch HH as part of a larger neighborhood development project in one blighted community. Over the past five years, more than one hundred new homes have been developed on abandoned properties and numerous low interest homeowner loans have improved the exteriors of existing properties. In the process, important lessons for other communities have emerged.

First, regulatory and legal barriers to home acquisition, renovation and sales are the key technical issues to neighborhood development even when capital is available. There are federal, state and local requirements for determining property tax delinquency, buyer acceptability and building code. Relationships with municipal and state governments and their processes for property tax tracking and land banking are critical. Corporations such as hospitals with large government relations and legal departments are well equipped to navigate this process even if it is slow.

More importantly, the success of housing development hinges on the ability to navigate informal/social dynamics among partners and community residents. Health-based horizontal integration must master complex and constantly shifting sociological conditions, only some of which existing legal structures can facilitate. There are also existing neighborhood relationships and reputations that organizations such as hospitals must consider when wading into the waters of housing. The

burden of communication necessarily falls disproportionately on the largest partners in such coalitions.

In addition to housing, of course, the true revitalization of a neighborhood requires a longer-term, comprehensive vision that includes education, nutrition, safety and employment. As child advocates would surely emphasize, graduation rates, employment, infant mortality and other key indicators will not improve solely with improvements in housing stock. In the case of HH, the speed with which external matching resources were able to be obtained dictated the order of focus and operations, a reminder of the fact that master visions cannot usually be implemented rationally, but often arise piecemeal, depending on variables that often out of administrators' hands and highly dependent upon local economic and political conditions. Our goal here is to encourage advocates of child health to consider housing as a key part of the broader puzzles they seek to solve.

Finally, organizations seeking asset-based community development require awareness that it is well suited to address some aspects of community development head on, while other aspects restrict their role to that of a catalyst. Knowing limits is critical, not only to the scope of horizontal integration projects in which hospitals might engage, but to helping coordinate partners in the non-profit and for-profit sectors. Awareness of limits also helps anchor institutions navigate the complex legal and social terrain that accompanies large-scale development projects.

References

1. Abrams M, Nuzum R, Mika S, Lawlor G. The Commonwealth Fund. Realizing health reforms potential: how the Affordable Care Act will strengthen primary care and benefit patients, providers, and payers. http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/Jan/1466_Abrams_how_ACA_will_strengthen_primary_care_reform_brief_v3.pdf. Published January 2011. Accessed September 16, 2014.
2. Weitzman M, Baten A, Rosenthal DG, Hoshino R, Tohn E, Jacobs DE, Housing and child health. *Curr Probl Pediatr Adolesc Health Care*. 2013;43(8):187-224.
3. See e.g., Haan P, Myck M. Dynamics of Poor Health and Non-Employment, Discussion Paper Series, Forschungsinstitut zur Zukunft der Arbeit, Institute for the Study of Labor, April 2009.
4. University of Pittsburgh Office of Child Development. Unstable living situations and early childhood mental health. University of Pittsburgh. http://www.ocd.pitt.edu/Files/PDF/ECMH-unstableliving.pdf. Published 2010. Accessed July 31, 2014 .
5. Nationwide Children's Hospital. Affordable housing. http://www.nationwidechildrens.org/healthy-neighborhoods-healthy-families-affordable-housing. Accessed July 31, 2014.
6. Child Health Impact Working Group; Boston Medical Center. A child health impact assessment of the Massachusetts Rental Voucher Program. Boston Medical Center. http://www.hiaguide.org/sites/default/files/HIAofhousingrentalvoucherschildhealth.pdf. Published June 2005. Accessed July 31, 2014.
7. Rog DJ, Bruckner JC. Homeless families and children. The 2007 National Symposium of Homeless Research. U.S. Department of Health and Human Services, Assistant Secretary of Planning and Evaluation and U.S. Department of Housing and Urban Development, Office of Policy Development and Research. http://aspe.hhs.gov/hsp/homelessness/symposium07/rog/. March 2007. Accessed July 31, 2014.
8. Buckner, JC. Impact of homelessness on children: an analytic review of the literature. In Characteristics and Dynamics of Homeless Families with Children: Final Report, eds: Rog D, Holupka S, Patton C. Washington, DC: U.S. Department of Health and Human Services, Office of Human Services Policy, Office of the Assistant Secretary for Planning and Evaluation.

http://aspe.hhs.gov/hsp/homelessness/improving-data08/apa.htm. 2008.
9. Kushel MB, Gupta R, Gee L, Haas JS. Housing instability and food insecurity as barriers to health care among low-income americans. *J Gen Intern Med*. 2006;21(1):71–77.
10. U.S. Department of Affording Housing and Urban Development. Affordable housing. http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/affordablehousing. Accessed July 31, 2014.
11. Cohen R. Center for Housing Policy. The impacts of affordable housing on health: a research summary. Insights from housing policy research. Published May 2011. Accessed July 31, 2014.
12. Istre GR, McCoy MA, Osborn L, Barnard JJ, Bolton A. Deaths and injuries from house fires. *N Engl J Medicine* 2001;344(25):1911-1916.
13. Coley RJ, Bake B. Poverty and education: finding the way forward. http://www.ets.org/s/research/pdf/poverty_and_education_report.pdf. Educational Testing Service Center for Research On Human Capital And Education. Published July 2013. Accessed July 31, 2014
14. Cohen R, Wardrip K. Should I stay or should I go?: exploring the effects of housing instability and mobility on children. http://www.nhc.org/media/files/HsgInstablityandMobility.pdf. Center for Housing Policy. Published February 2011. Accessed July 31, 2014.
15. Housing and Economic Recovery Act of 2008. http://www.gpo.gov/fdsys/pkg/PLAW-110publ289/pdf/PLAW-110publ289.pdf. Published July 30, 2008. Accessed July 31, 2014.
16. Harlem Children's Zone. http://hcz.org. Harlem Children's Zone. Accessed July 31, 2014.
17. The Columbus and Franklin County Consortium. Factor 1 need and extent of the problem. http://columbus.gov/uploadedfiles%5CFinance_and_Management%5CFinancial_Management_Division%5CGrants_Management%5CColumbus%20NSP2%20Application.pdf. Accessed July 31, 2014. See also Evans W. Home Again—Updates. *Columbus Underground*. http://www.columbusunderground.com/home-again-initiative-updates.
18. Children's Hospital Association. Community benefit reporting. Children's Hospital Association.

http://www.childrenshospitals.net/AM/Template.cfm?Section=Community_Benefit_Reporting2. Accessed July 31, 2014.
19. Webber H, Karlström M. Why community investment is good for nonprofit anchor institutions: understanding costs, benefits, and the range of strategic options. Chicago, IL: University of Chicago, Chapin Hall: 2009. Birch E, Perry DC, Taylor Jr, HL, Universities as Anchor Institutions. *J Higher Education Outreach and Engagement* 2013;(17)3.
20. Anchor Institution Task Force (AITF). Chapter 8 Anchor institutions as partners in building successful communities and local economies. Washington, DC: U.S. Department of Housing and Urban Development. Penn Institute for Urban Research. http://community-wealth.org/sites/clone.community-wealth.org/files/downloads/chapter-harkavy-et-al.pdf. 2009.
21. Democracy Collaborative. Overview: anchor institutions. Democracy Collaborative. http://community-wealth.org/strategies/panel/anchors/index.html. Accessed July 31, 2014.
22. Wagner M, Ferenchik M, Riepenhoff J. Neighbors of neglected homes feel forgotten. *The Columbus Dispatch*. http://www.dispatch.com/content/stories/local/2013/11/13/neighbors-of-neglected-homes-feel-forgotten.html. Published November 13, 2013.
23. Rohe WM, Stewart LS. Homeownership and neighborhood stability. *Housing Policy Debate* 1996;7(1):37-81.
24. Ohio Housing Finance Agency. https://www.ohiohome.org. Ohio Housing Finance Agency.
25. Rohe WM, Stegman MA. The impact of home ownership on the social and political involvement of low-income people. *Urban Aff Rev* 1994;30(1):152-72.
26. HUD Exchange. NSP laws, regulations, and federal register notices. https://www.onecpd.info/nsp/nsp-laws-regulations-and-federal-register-notices. Accessed July 31, 2014.
27. Thayer T. The Land-Bank System in the American Colonies. *J Econ Hist*. 1953;13(2):145-159.
28. Center for Community Progress, U.S. Department of Housing and Urban Development. Land banking 101: What is a land bank? https://www.onecpd.info/resources/documents/LandBankingBasics.pdf. Accessed July 31, 2014.

29. Ohio Revised Code, Chapter 5722; Land Reutilization Program. http://codes.ohio.gov/orc/5722. Accessed July 31, 2014.
30. Ohio Revised Code, Title III ("Counties") section 323.65, Expedited foreclosure on unoccupied land definitions. http://codes.ohio.gov/orc/323.65. Accessed July 31, 2014.
31. Ohio Revised Code, Title III ("Counties") section 323.66, Expedited foreclosure by board of revision on unoccupied land. http://codes.ohio.gov/orc/323.66. Accessed July 31, 2014.
32. Fuhry L, DeCoursey J, Bardacke T, Wells W. Progress and possibility: green building criteria in low-income housing tax credit programs, 2012 qap analysis. http://www.globalgreen.org/i/2012QAP_Final.pdf. Accessed July 31, 2014.
33. Cook JT, Frank DA, Berkowitz C, et al. Food insecurity is associated with adverse health outcomes among human infants and toddlers. *J Nutr*. 2004;134(6):1432-1438.
34. Child Health Impact Working Group. Unhealthy consequences: energy costs and child health (a child health impact assessment of energy costs and the Low Income Home Energy Assistance Program). Boston Medical Center. Published April 2007.
35. 24 CFR Subtitle A (4–1–10 Edition). http://portal.hud.gov/hudportal/documents/huddoc?id=hud_regs.pdf. Accessed July 31, 2014.
36. Brooks-Gunn J, Duncan GJ, Klebanov PK, Sealand N. Do neighborhoods influence child and adolescent development? *Am J Sociol*. 1993;99(2):353-395
37. Ohio Children's Hospital Association. Medicaid is the single most important public policy issue affecting the stability of children's health care access and coverage in Ohio. http://www.ohiochildrenshospitals.org/advocacy-and-issues/medicaid. Accessed July 31, 2014.
38. Knox PL. The Restless Urban Landscape: Economic and Sociocultural Change and the Transformation of Metropolitan Washington, DC. *Ann Assoc Am Geographers*. 1991;81(2):181-209.
39. City of Columbus. Development - area commissions. http://columbus.gov/areacommissions/. Accessed December 14, 2014.
40. Van Zandt SM, Rohe WM. Do first-time home buyers improve their neighborhood quality? *J Urban Aff*. 2006;28(5): 491-510.