# BUILDING HEALTHY COMMUNITIES: AN EXPLORATION OF A PLACE-BASED INITIATIVE, PARTICIPANT CHARACTERISTICS, AND PRELIMINARY Outcomes

by

Jacqueline M. Tynan, M.A.

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Approved by:

_____
Dr. James R. Cook

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Dr. Ryan P. Kilmer

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Dr. Joanne G. Carman

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Dr. Michael Dulin

# ABSTRACT

JACQUELINE M. TYNAN. Building healthy communities: An exploration of a place-based initiative, participant characteristics, and preliminary outcomes. (Under the direction of DR. JAMES R. COOK)

Decades of discriminatory housing policies have resulted in geographic segregation, forcing low-income minorities into areas of concentrated poverty (Massey & Kanaiaupuni, 1993; Stoloff, 2004). Areas of concentrated poverty are typically marked by poor housing quality, under performing schools, high crime rates, and limited access to resources such as healthcare and grocery stores, lack of social cohesion, and poor health outcomes (Crump, 2002; Dutko, Ver Ploeg, & Farrigan, 2012; Kawachi & Berkman, 2000; Massey, 1990). To combat the challenges associated with concentrated poverty and build healthy communities, place-based interventions have become increasingly popular (Arias, Escobedo, Kennedy, Fu, & Cisewski, 2018; Diez-Roux, 2017; Jutte, Miller, & Erickson, 2015). Several place-based models (e.g., Harlem Children's Zone, Purpose Built Communities) have shown positive outcomes (Bridgespan 2004; 2011), however, evaluations to guide replication and the identification of best practices have lagged.

This study examined data from a nonprofit replicating the Purpose Built Communities model in the southeastern U.S. Renaissance West Community Initiative (RWCI) is a place-based nonprofit that coordinates activities and services for residents living in a newly redeveloped mixed-income community and an adjacent low-income community. Activities coordinated by RWCI include college and career readiness programs, health education programs, health resources, community engagement

activities, and children's programs. Data from program participation and community surveys were assessed to understand the characteristics of adult residents, such as their education level, employment status, income, health, social networks, perceptions of their neighbors, participation in the nonprofit's activities, and the degree to which each of these variables are related. Additionally, longitudinal analyses examined changes in these variables over a twelve to eighteen-month period.

Findings show that residents' socioeconomic status (SES) and social network size were the primary predictors of the types of RWCI activities in which they participated and the frequency of participation. Participation in RWCI's activities was not related to changes in SES, health, or neighborhood perceptions, but participation in activities was related to increased social network size. Social networks were also related to neighborhood perceptions, such that residents with stronger neighborhood social networks had more positive perceptions of their neighbors overall. Residents with a disability had the lowest perceptions of their neighbors and reported worse health status.

The present study provides an example of how even limited quantitative data can be used by place-based nonprofits to understand the characteristics and experiences of adults living in their service area to monitor implementation and outcomes, and provide guidance for improvements in use of resources to improve the community. . The findings have implications for RWCI and their ongoing efforts to revitalize this low-income neighborhood into a healthy mixed-income community. Recommendations for ongoing data collection and analyses, targeting of services, and community building strategies are provided.

# DEDICATION

This dissertation is dedicated to all of the children in the U.S. who face constant adversity due to the color of their skin and the neighborhoods where they are raised. I hope that one day, a child's zip code will no longer limit their access to the resources and opportunities they deserve and need. I would like to specifically dedicate this to the families I have had the privilege of serving, working with, and learning from over the past six years with Renaissance West Community Initiative.

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| | |
|---|---|
| BUF | Building Uplifted Families |
| CHA | Charlotte Housing Authority |
| CNA | Community Needs Assessment |
| CQB | Community Quarterback |
| DSNI | Dudley Street Neighborhood Initiative |
| ELF | East Lake Foundation |
| FSS | Family Self Sufficiency |
| GED | General Education Diploma |
| HCZ | Harlem Children's Zone |
| HOH | Head of Household |
| HOPE VI | Housing Opportunities for People Everywhere |
| HS | High School |
| HUD | Department of Housing and Urban Development |
| MTO | Moving to Opportunity |
| PBC | Purpose Built Communities |
| RWCI | Renaissance West Community Initiative |
| SDOH | Social Determinants of Health |
| SES | Socioeconomic Status |

# CHAPTER 1: INTRODUCTION

Throughout the last century, policy, social, and economic shifts have shaped urban poverty in the U.S., leading to inextricable links among geography, race, socioeconomic status (SES), and health (Bailey, Krieger, Agenor, Graves, Linos, & Bassett, 2017; Cattell, 2001; Gustafsson et al., 2014; Hahn, Truman, & Williams, 2018; Singh & Yu, 1995). An abundance of research shows that gender, race, education level, employment status, and income are predictive of life expectancy, with women having a greater life expectancy than men, and white adults having greater life expectancy than their Black peers with similar education levels (Meara, Richards, & Cutler, 2008; Olshansky et al., 2012). SES plays a role such that highly educated black men and women have a greater life expectancy than white men and women, respectively, with lower education levels (Olshansky et al., 2012). Trends among income, employment status, and morbidity and mortality have also been documented such that higher incomes and fulltime employment are correlated with each other and associated with greater life expectancy and lower morbidity rates (Roelfs, Shor, Davidson, & Schwartz, 2011; Rose et al., 2004; Sorlie, Backlund, & Keller, 1995). As these relationships have been examined, public and population health practitioners also recognized similar health disparities at the geographic level, which strongly overlapped with racial and SES segregation (Acevedo-Garcia & Lochner, 2003; Cole, 2017; Subramanian, Acevedo-Garcia, & Osypuk, 2005).

As the connection among SES, race, gender, health, and geography, or *place*, have becoming increasingly recognized and understood, place-based interventions to

combat geographic disparities, particularly in health, have grown in popularity (Arias, Escobedo, Kennedy, Fu, & Cisewski, 2018; Diez-Roux, 2017; Jutte, Miller, & Erickson, 2015). Place-based interventions aim to concentrate resources known to improve SES and health outcomes such as high-quality education, employment opportunities, quality affordable housing, positive social networks, social supports, and access to healthcare into specific geographic areas that were previously under-resourced. In the following sections, the historical context and factors leading to the linkages among race, geography, and SES, specifically in public housing, are reviewed along with disparities in morbidity and mortality rates across racial, SES, and geographic lines. Finally, current trends in place-based interventions are reviewed.

## 1.1 Study Context

In the present study, secondary data collected from a place-based initiative in the southeastern U.S. were examined. The initiative aims to end the cycle of intergenerational poverty through a holistic neighborhood revitalization centered on mixed-income housing, education, health, wellness, and opportunity (www.rwci.org). An exploratory analysis of cross-sectional and longitudinal data was used to examine the status of residents' SES, health, social networks, neighborhood perceptions, and participation in neighborhood activities as well as potential relationships among these factors. To help understand the need for place-based interventions and outcomes of interest, the historical context that led to geographic disparities is reviewed in the following sections.

### *1.1.1 Geographic Segregation*

In 1937, towards the end of the Great Depression, Congress enacted the Public Housing program in an effort to support working class families experiencing temporary financial hardships (Stoloff, 2004). During early implementation of public housing, the built environment included desirable low-rise facilities, with upkeep funded through bonds and rental payment from the working class tenants. The goal was to provide quality, safe, affordable housing to those who were temporarily experiencing hardships in a poor economy. This implementation of public housing would be short-lived, as social, economic, and housing policies and practices over the next two decades changed the landscape, demographics, and purpose of public housing (Stoloff, 2004).

Well-intentioned policies – along with individual and systemic racism – led to a decrease in racial and socioeconomic diversity in public housing from the late 1940s through the 1960s. For instance, discriminatory employment practices yielded greater employment rates and income for white households, perpetuating a racial disparity in household incomes (Massey & Denton, 1993; Pager & Shepherd, 2008). In addition, as white families rebounded from the Depression era, changes to public housing policies drove the white working class out. For example, rent ceilings, which restricted the amount of rent a tenant would pay in public housing, were eliminated. Because tenants could then find better housing for the same rent, white working class families (who had greater housing options due to racial discrimination) left public housing to live in more desirable locations (Stoloff, 2004). Furthermore, income ceilings were put into place for public housing to help ensure that it was available for America's poorest families, which made the working class – for whom public housing was originally created – ineligible altogether. With white families having more employment options, greater income, and

more housing options, unemployed or underemployed black and other minority families became the primary tenants of public housing (Marcuse, 1995; Massey & Kanaiaupuni, 1993; Stoloff, 2004; Vale & Freemark, 2012).

As housing rental policies segregated renters along both racial and SES lines, discrimination in home ownership opportunities compounded the extent of segregation. Following World War II, white families were disproportionately able to purchase homes through Federal Housing Administration and Veterans Affairs mortgages (Massey & Denton, 1993; Munnell, Tootell, Browne, & McEneany, 1996). Additionally, discriminatory practices in mortgage lending (e.g., redlining), combined with racially restricted zoning laws and covenants in which minorities were legally ineligible to purchase property in specific areas, and real estate agents' discriminatory practices in showing properties all perpetuated geographic racial segregation (LaCour-Little, 1999; Tretter & Sounny-Slitine, 2012). Even after the Civil Rights Act of 1964, which banned discriminatory policies, and the Fair Housing Act of 1968, which banned "race-based housing patterns," white families fled neighborhoods with increasing minority residents, believing the growing proportion of minority residents would decrease their home value (Pais, South, & Crowder, 2009). Residents in majority white neighborhoods also actively fought the development of public housing nearby, leaving public housing geographically segregated from thriving neighborhoods and resources. While racial discrimination contributed to the disparities in SES and housing opportunities, the challenges of public housing were even further compounded when developers replaced the low-rise housing model with high-rises (Corbett, 2003; Stoloff, 2004).

Throughout the 1940s and 1950s, developers began opting to build high-rises to maximize the number of housing units available on a plot of land and offer more affordable housing options. Because income ceilings were instituted, the income of the tenant population was much lower than earlier implementations of public housing and yielded a lower per-person revenue stream for property managers (Stoloff, 2004). By offering more units, developers hoped a greater need would be met and their revenue would not be impacted. Unfortunately, the layout and density of high-rises were conducive to drug dealing and other criminal activity (Carter, Schill, & Wachter, 1998). The high-rise facilities were also more difficult and costly to maintain, leading to dilapidated, unsafe, and unsanitary living conditions, with a large proportion of units abandoned. In fact, conditions became so bleak, The Housing and Urban Development Act of 1968 banned construction of subsidized high-rise complexes for families with children.

This perfect storm of changes in the housing, social, and economic sectors left low-income black families isolated in poorly kempt housing with few supportive services, low quality educational opportunities, little economic investment (e.g., neighborhood infrastructure, employment opportunities, grocery stores, hospitals, amenities), and high crime rates (Crump, 2002; Dutko, Ver Ploeg, & Farrigan, 2012; Massey, 1990). Cultural, physical, social, and economic conditions, such as those present in public housing and low-income neighborhoods, have been examined and described as *social determinants* related to higher rates of mortality and morbidity in the black community, particularly for those living in poverty (Kunitz, 2007; Olshanksy et al., 2012; Wilkinson & Marmot, 2003)

### *1.1.2 Social Determinants of Health*

The connections among race, SES, and health in the U.S. have been well-documented since the 1970s (Assari, 2018; Blane, 1995; Irwin & Scali, 2007; Kunitz, 2007; Singh & Yu, 1995). Longitudinal analyses comparing mortality and morbidity rates across race, education level, and income have indicated disparities in health outcomes independent of one another and compounded when examined together (Singh & Yu, 1995). As social and biological scientists sought to better understand the underlying factors of health disparities along racial and socioeconomic lines, recurring social and community indicators were identified as common factors, leading the World Health Organization to create the Commission on Social Determinants of Health in 2005. Social Determinants of Health (SDOH) include accessibility to resources that meet daily needs (e.g., safe housing, grocery stores, healthcare, etc.), education and literacy, childhood experiences, income and social status, public safety, social supports and coping skills, health behaviors, gender, and race (Lavizzo-Mourey, 2012; Wilkinson & Marmot, 2003).

Because SES, race, and housing opportunities in the 20$^{th}$ century were so intertwined, it is not surprising that a person's health, which was previously linked to SES and race, is also strongly linked to where people live. While an indirect relationship between neighborhood and health via race and SES exists, there are also direct causal pathways between the built environment and health and health behaviors (Franzini, Caughy, Spears, & Esquer, 2005; Subramanian, Acevedo-Garcia, & Osypuk, 2005). For example, poor housing quality, poor ventilation, and the presence of cockroaches have been linked to higher rates of asthma (Northridge, Ramirez, Stingone, & Claudio, 2010).

Higher neighborhood crime rates like those seen in public housing complexes, are related to stress, depression, anxiety, and negative health behaviors such as smoking, and chronic diseases such as hypertension (Fauth, Leventhal, & Brooks-Gunn, 2004; Manfredi, Lacey, Warnecke, & Buis, 2013). Chronic stress, limited access to prenatal care, and negative health behaviors (e.g., smoking) have led to more preterm births, higher rates of low birth weights, and higher rates of infant mortality among the low-income Black community relative to their higher income and White peers (Culhane & Elo, 2005), leading to early disadvantages for children born into poverty. Similarly, living in neighborhoods without access to fresh, unprocessed food is linked to diabetes and hypertension (Hill et al., 2013; Suarez et al., 2015). In addition, unsafe neighborhoods and poor infrastructure (e.g., lack of sidewalks, parks, etc.), which can limit exercise, have led to greater rates of obesity and morbidity (Lovasi et al., 2013). Many of these negative factors such as high crime rate, inaccessibility to grocery stores and health care, and low-quality housing are standard in areas of concentrated poverty. In fact, the relationships between neighborhoods and health are so compelling, researchers have indicated that the zip code in which a person lives is a better predictor of mortality and morbidity than their genetic code (Cole, 2017).

With increased understanding that the built environments of housing, neighborhoods, and cities were impacting public health, renovations and programs to improve the quality of public housing and low-income neighborhoods emerged and re-emerged over several decades under different variations. As one example, in the early 1990s there was recognition that concentrating poverty yielded little neighborhood investment or upward mobility, low performing schools, limited access to resources, and

social norms that devalued employment, healthy behaviors, and positive socialization, leading to a cycle of intergenerational poverty (Harper, Marcus, & Moore, 2009). Place-based interventions aim to undo these social and economic challenges caused by concentrating poverty. One iteration of a place-based intervention to deconcentrate poverty came from the Department of Housing and Urban Development (HUD), which moved away from public housing projects in the early 1990s to using a mixed-income housing model with the HOPE VI program, described in the next section.

### *1.1.3 Deconcentrating Poverty*

The HOPE VI program funded local housing authorities to redevelop dilapidated public housing into mixed-income communities beginning in 1993. With mixed-income housing designed to attract market-rate renters, the quality and appearance was much more desirable than public housing developed during the previous twenty or thirty years. In fact, the design and quality of mixed-income neighborhoods tended to improve public housing residents' self-worth and reduce the stress and shame of living in an "undesirable" neighborhood or "the projects" (McCormick, Joseph, & Chaskin, 2012). With the built environment attracting "market rate" renters, or those renting without subsidies, the overall median income would increase, providing revenue for enhanced security and safety, and promote neighborhood investments such as grocery stores and employment opportunities (Fraser & Kick, 2007; McCormick et al., 2012; Powell, Slater, Mirtcheva, Bao, & Chaloupka, 2007). Not only would the built environment improve, but early pioneers of the mixed-income model hoped the market rate renters would act as role models for their lower-income neighbors to promote new, positive behaviors that differed from the norms of concentrated poverty. For example, it was expected that low-

income renters would model the work ethic, parenting styles, exercise regiments, and social norms of their higher income neighbors, creating a culture of achievement and prosperity (McCormick et al., 2012). While the potential benefits of mixed-income housing are clear, the actual outcomes are still ambiguous nearly thirty years later (Fraser & Kick, 2007; McCormick et al., 2012).

The ambiguity in outcomes of the mixed-income model is, in part, a result of the term "mixed-income" not being clearly defined, resulting in varying implementations of the model. With no guidelines for the distribution of residents' income levels, or the number of units per income level, the true mix of income is not uniform across sites. For example, some sites do not serve those earning below 60% of the Area Median Income (AMI), while others do (Brophy & Smith, 2009). Similarly, some sites may not allow residents earning above 200% AMI while others do, leaving the income distributions vastly different across the mixed-income sites in the U.S. (Brophy & Smith, 2009; Joseph & Chaskin, 2010; Schwartz & Tajbakhsh, 1997). Further, some mixed-income neighborhoods do not provide equal quality or types of housing for different income levels, while others are uniform. Some sites even spatially segregate income levels by floors or buildings, while others integrate income levels within floors or buildings (Schwartz & Tajbakhsh, 1997). Regardless of implementation, there are clear criticisms of the model. Critics of the mixed-income model point to the negative consequences of gentrification and the reduction in the number of affordable housing units (Lipman, 2009). They argue that, by including units for families with higher incomes, low-income families would be displaced, leaving them vulnerable to homelessness, low-quality housing opportunities, and loss of existing social networks (Curley, 2009; Joseph &

Chaskin, 2010). Further criticisms of mixed-income housing are outside the scope of the present review and can be accessed elsewhere (see Lipman, 2009; McCormick et al., 2012). That said, evaluating the intended benefits of promoting "mixed-income social networks" is a critical component of the present study and warrants further consideration.

Social supports and social networks have been identified as critical buffers that reduce the impact of chronic stress and other health conditions associated with poverty (Berkman, 1984; Florez et al., 2016; Israel, Farquhar, Schulz, James, & Parker, 2002; Kawachi, Kennedy, & Glass, 1999; Kawachi, Submaranian, & Kim, 2008). The impact of redevelopment and displacement on social networks is mixed (see Curley, 2009). Studies have specifically examined changes in social networks from HUD relocation programs including HOPE VI and Moving To Opportunity (MTO), which relocates low-income residents from high-poverty neighborhoods to low-poverty neighborhoods (de souza Briggs, 1998; Leventhal & Brooks-Gunn, 2003). Studies examining displacement, or relocation, suggest some residents may lose long-term supportive social networks in their community. Losing connections with long-term supportive neighbors and gaining new neighbors who may create discomfort for public housing residents may exacerbate the stress of living in poverty (McCormick et al., 2012). For others it allows them to cut "draining ties" or relationships that are non-reciprocal and create burden without support for individuals and their families (Kleit, 2010). While there are pros and cons associated with the loss of existing networks, research has also examined the formation and impact of new social networks resulting from relocation and redevelopment.

Supporters of mixed-income housing programs such as HOPE VI and MTO point to the benefits of role modeling and relationship building with neighbors across varying

backgrounds to create *bridging* social capital, or social capital between people of different races, classes, religions, or genders (Kim, Submaranian, & Kawachi, 2006; Putnam, 2000). Through bridging social capital, it was expected that market rate residents would create connections to better employment opportunities for their neighbors in the affordable housing units (Curley, 2010). However, researchers have pointed out that even when bridging ties exist, higher income individuals may only have connections to employment that low-skilled workers are not qualified to obtain, or may not feel obligated to make such connections for their new neighbors (Curley, 2009). More often, however, those bridging ties never develop because of the homophily principle – that is, people tend to be drawn to others like themselves (Centola, Gonzalez-Avella, Eguiluz, & San Miguel, 2007; Curley, 2010). Existing evidence suggests that low-income residents of mixed income communities have naturally gravitated to people like themselves within the community rather than their new higher-income neighbors (McCormick, et al., 2012). In fact, research indicates public housing residents living in mixed-income communities feel uncomfortable or stigmatized by their higher income neighbors, leading to intentional avoidance and isolation by those with lower incomes (McCormick et al., 2012). Thus, additional resources may be needed to alleviate the stress associated with changes in neighborhood composition and intentionally promote bridging social capital.

Because diverse relationships may not occur naturally, or may be less likely to occur, researchers have suggested using intentional community building activities during which all members have equal status (Kleit, 2001; Kleit, 2005; Rosenbaum, Stroh, & Flynn, 1998). This suggestion aligns with the idea that in order for place-based approaches to be successful, they also require a person-centered approach (Erickson,

Galloway, & Cytron, 2012). A person-centered approach goes beyond simply changing the built environment and community demographics, and supplements those changes with individual- or group-level interventions informed by the community members living within the identified geographic boundary. One method used to drive person-centered programming within place-based initiatives and ensure that intentional community-building activities occur is the establishment of a *community quarterback*, or backbone organization. The community quarterback (CQB) model refers to a nonprofit or other entity responsible for aligning and coordinating cross-sector partnerships for person-centered interventions linked to educational attainment, workforce development, and access to healthcare within community developments (Erickson et al., 2012). Examples of place-based initiatives, the growth of the CQB model, and related person-centered programs are discussed in the following section. Successes, challenges, and strategies among place-based initiatives are important to understand as the place-based intervention model grows in popularity.

### *1.1.4 Place-based Initiatives*

Place-based initiatives have grown in popularity and taken varying forms across the U.S. over the past several decades, driven by forces ranging from grassroots movements to direction of the federal government (Al-Turk, 2016; Jennings, 2012). The catalyst for place-based initiatives will often determine the goals and resources available for neighborhood transformation. The goals and resources, in turn, often determine the implementation of place-based initiatives. Dreier (1996) identified three key components used by place-based initiatives to varying degrees based on goals and resources: 1) community development, which focuses on the built environment, 2) community or

social services (e.g., education, employment, childcare), and 3) community organizing, which focuses on building trust, social capital, and skills within the neighborhood to mobilize residents to solve their problems collectively. Historically, community development, specifically housing development, has been the primary focus of place-based initiatives (Erickson et al., 2012; Jutte et al., 2015). More recently, with the emphasis on the CQB model, place-based initiatives moved beyond the built environment to provide social services such as education, childcare, workforce development, and parenting classes. In this section, resources, drivers, and characteristics of place-based initiatives and CQBs are reviewed.

Following the end of the HOPE VI program in 2010, HUD promoted place-based initiatives via Choice Neighborhoods, Promise Neighborhoods, and EnVision Centers, which are federal designations that give CQBs priority for federal funding to support distressed neighborhoods. Each of the HUD programs has different foci, with Promise Neighborhoods focusing on children's education, Choice Neighborhoods focusing on housing, and EnVision Centers focusing on wraparound services related to health, leadership, and economic empowerment. Although the federal government has provided substantial funding to promote these place-based programs, local governments and community organizations have also developed their own models for place-based initiatives throughout the U.S. and tapped a variety of local and national funding sources to enable their implementation.

The most well-known examples of the CQB model are the Harlem Children's Zone (HCZ), which focuses primarily on education and also provides family support (Dobbie & Fryer, 2011); the Magnolia Community Initiative, which focuses on

preventing adverse childhood experiences (Jutte, Miller, & Erickson, 2015); and the East Lake Foundation (ELF), which uses a holistic, two-generation approach to combat poverty. Following the success of ELF – including increases in neighborhood income, commercial investments, higher performing schools, and dramatic decreases in crime (Franklin & Edwards, 2012; Jutte et al., 2015) – the Purpose Built Communities network was formed to provide assistance to other CQBs interested in replicating ELF. Since formalizing the Purpose Built Communities (PBC) model, which encompasses mixed-income housing, cradle-to-college education, and community wellness (https://purposebuiltcommunities.org/), over twenty communities across the U.S. have joined the PBC network to replicate its model and ideally, its success, including the nonprofit examined in the present study.

The successful creation and growth of place-based models like PBC or HCZ has often involved three critical elements: leadership and vision from charismatic, well-connected persons or groups; an influx of millions of dollars in capital; and persistence of these efforts over time. Socially influential leaders are important for promoting the vision and keeping other community members engaged. It is more likely for government and business leaders to become and remain politically and financially invested when the initiative has well-connected champions. HCZ, for example was thrust into the spotlight with the visionary, charismatic leadership of Geoffrey Canada, who received an average of $18 million per year from 1999 to 2003 from government grants and foundations (Bridgespan, 2004). Canada also received support from billionaire, and Harvard classmate, Stanley Druckenmiller, who donated nearly $100 million to HCZ between 2011-2015 (https://www.influencewatch.org/non-profit/druckenmiller-foundation/).

Similarly, the ELF in Atlanta was envisioned by millionaire Tom Cousins. ELF also received $33 million from HUD to revitalize the neighborhood and $25 million from the Cousins Foundation, and it also earns $5 million to $30 million each year from the East Lake Golf Course, purchased by Cousins as an asset for the neighborhood. Cousins was later joined by billionaire Warren Buffet in the development of PBC to replicate the ELF's success. The backing of major benefactors and government contracts has certainly contributed to the success and notoriety of some place-based initiatives, particularly when the physical infrastructure or built environment is visibly improved.

While top-down funding and leadership can help ensure that the needed community development and social services components of these initiatives are developed, persistence over time is critical for creating and sustaining the community organizing essential for these initiatives to be successful long-term. Community organizing and sustained efforts are needed to promote community trust and participation, which then can lead to social cohesion, or a strong sense of community for residents. Community organizing can reduce neighborhood disorder and promote civic participation, empowerment, social capital, and advocacy - key factors that separate thriving, safe neighborhoods from hopeless, unsafe neighborhoods (Mair, Kaplan, & Everson-Rose, 2012; South & Crowder, 1999) and lead to a higher quality of life (Intravia, Stewart, Warren, & Wolff, 2016; Kawachi et al., 2008).

Although charismatic and well-connected leadership can certainly facilitate the financial backing essential for the physical infrastructure improvements in place-based initiatives, there are also instances in which grass-roots community organizing is the catalyst for creating place-based initiatives. One example is the Dudley Street

Neighborhood Initiative (DSNI; Taylor, 1995), a grassroots effort by residents in a disinvested Boston neighborhood. The DSNI successfully used advocacy and civic participation to gain the ability to use eminent domain to revitalize their dilapidated and abandoned neighborhood, prevent gentrification, increase commercial investment, and preserve the positive aspects of their community culture (Taylor, 1995). While community organizing can be much less expensive than the rebuilding of infrastructure and large-scale provision of services, it still requires funding or extensive volunteering over a substantial period of time to address the needs and concerns of neighbors, which can then promote social cohesion (Kawachi & Berkman, 2000). Particularly in mixed-income housing models, residents with negative perceptions about the neighborhood based on stigma from a neighborhood's history may self-isolate and disengage from community affairs. With time and persistent engagement, however those residents' perceptions of the neighborhood can be improved, promoting greater investment in community safety, cleanliness, and socialization expected from mixed-income communities (Tach, 2009).

Regardless of the resources, catalysts, and components employed by place-based initiatives, neighborhood transformation is a long-term process that requires ongoing investment for decades if generational changes are an expected outcome (Harlem Children's Zone, 2009). It took more than half a century of policies and social shifts to create the problems of urban poverty, and it can be expected the solutions to these problems will take considerable time as well. The long-term nature of place-based initiatives can be challenging without a well-connected CQB or champion to keep the larger community financially invested. For instance, many investors expect or prefer to

see immediate returns on their investment, which is difficult given the complex nature of place-based initiatives. As one prime case in point, the creation or enhancement of physical infrastructure can take three to five years to complete under aggressive development plans with high levels of funding. Moreover, the provision of services and establishment of relationships and social capital, especially in newly developed, or redeveloped neighborhoods can also take years. One review of HCZ suggests CQBs should plan to implement their model for 10-15 years before expecting outcomes - with about ten years building the program and another three to five years to see the impact (Harlem Children's Zone, 2009). Similarly, a review of the PBC model by Bridgespan (2011) suggests a ten-year planning and development phase. Early outcomes of the PBC model in Atlanta began ten years into implementation, roughly fourteen years after planning began (Franklin & Edwards, 2012). Because true transformation can take a decade or more, the number of place-based program evaluations to guide successful replication are limited.

As the PBC model and other place-based initiatives expand across the U.S., research and evaluation examining processes and outcomes have lagged. While the PBC model is grounded in research and theory, there is limited evaluation available to share best practices for specific outcomes or guide the processes for replication in different cities. Further, much of the extant literature examining quantitative outcomes of place-based interventions focuses on overall economic outcomes, the physical infrastructure, and outcomes for children in those neighborhoods, with little focus on the adults (Jutte et al., 2015). In fact, the limited literature examining adult outcomes is also largely qualitative in nature (McCormick et al., 2012). While qualitative work can surely

provide a rich narrative of the factors and conditions at play and the outcomes evidenced in a population of interest, the addition of quantitative methodology can better capture data points over time and pinpoint community-level changes, the activities or processes associated with those changes, and average timelines needed to reach intended outcomes. Such information is critical for effective replication of successful place-based models.

The present study aims to expand the understanding of the characteristics of adults living in one community replicating the PBC model in the Southeastern U.S., and how those characteristics are related to their participation in the person-centered programs and activities coordinated by the CQB. The CQB provided programs and services to offer training and education, but also to build bridging and bonding social capital within the neighborhood through programs in which all participants had equal status. Their participation in CQB programs and activities will also be examined to identify relationships with changes in social networks, neighborhood perceptions, education, employment, income, and health.

## 1.2 Study Background

Renaissance West Community Initiative (RWCI) is a place-based nonprofit founded in 2013 to lead the revitalization of the Boulevard Homes public housing project in Charlotte, NC. Boulevard Homes was a traditional public housing complex built in 1969. By the 1990s, the predominantly Black community became notorious for concentrated poverty, violent crime, low educational attainment, and poor health outcomes – like so many other public housing sites across the country. By the early 2000s, the conditions of the neighborhood and housing were bleak (Rohe, Nguyen, Han, Donegan & Frescoln, 2013). Local philanthropists interested in improving the

educational opportunities in the area connected with the local housing authority to plan a revitalization for the neighborhood. The Charlotte Housing Authority (CHA) received one of the final HOPE VI grants, about $22 million, to revitalize Boulevard Homes into a mixed-income community with an education village. CHA oversaw the building demolition and relocation of Boulevard Homes residents in 2010-2011. [More information about the relocation efforts, which are outside the scope of the present study, can be found in Rohe and colleagues' 2013 interim report]. With demolition of Boulevard Homes and construction of the new mixed-income facilities underway, CHA created RWCI to act as the CQB overseeing the revitalization efforts. In 2014, RWCI became the eighth CQB in the U.S. to become a Purpose Built Communities network member to replicate the PBC model of mixed-income housing, cradle-to-college education pipeline, and community wellness in an effort to break the cycle of intergenerational poverty in a specified geographic location (https://www.rwci.org/general-news/purpose-built-communities-2/).

Much of the early revitalization efforts focused on changing the built environment of the community, with the housing construction finishing in the summer of 2016. The housing includes 224 apartments and townhomes, with 44% public housing units, 29% low-moderate income units subsidized through tax credits, 27% unsubsidized or market-rate units, and a 110-unit complex for seniors with fixed-incomes. A new public school was built in the neighborhood on land donated by CHA as part of the revitalization. The school opened as a pre-k through fifth grade school in 2017, with plans to add a grade level each year through fall 2020. To complete the education village, RWCI used funds

from the HOPE VI grant and a $15 million capital campaign to build an on-site child development center, which opened in early 2018.

RWCI recognized early in development that the success of the neighborhood revitalization would be dependent on the neighboring community, which includes 242 affordable housing units constructed in 1970 on the adjacent plot of land. The housing was privately owned, and therefore not part of the mixed-income housing redevelopment. The residents would, however, be districted for the new school included in the redevelopment. The two housing developments have different eligibility criteria related to employment and income, resulting in the new development consisting largely of working poor and moderate income families, while the older units house largely of unemployed, extremely low-income families.

As a HUD site, the majority of public housing units in the redevelopment were designated for the Family Self-Sufficiency (FSS) program. The program requires residents to meet regularly with a case manager. In the first three years of implementation, RWCI outsourced the case management work before eventually bringing the services in-house in 2019. In the first few years, aside from the FSS program, person-centered programs were sparse, particularly among residents in the adjacent housing complex, as building the facilities was a priority.

In late 2016, RWCI hired two staff to focus on programs and engagement with the residents living in both housing complexes. Staff spent the first several months getting to know the residents, and learning from the FSS case managers, who had been there for about a year, about FSS participants' needs and interests to guide the programming. In 2017, RWCI expanded relationships with residents of both housing sites and received

increased interest from residents outside of the FSS program in having a case manager to support them. RWCI expanded its capacity after receiving a national grant in 2018, by increasing program staff from three to seven people to meet this demand. The pilot, Building Uplifted Families (BUF) program was a care coordination program modeled after FSS. Similarities and differences between the two programs are described in the next section.

RWCI staff used existing relationships with residents to develop programs and activities for adults and children, with the intent to engage more residents in the activities and expand relationships. The present study will focus on the adult programs and resident engagement from 2016-2019, including but not limited to both care coordination programs (i.e., FSS and BUF), adult education, health and wellness workshops and activities, financial literacy, workforce development training, parenting support, and community building activities.

### *1.2.1 Program Descriptions*

As the community quarterback (CQB), RWCI provides few direct services, but works with local partners to meet the needs and interest of residents. The exception is RWCI's two Care Coordination programs focused on heads of household – Family Self Sufficiency (FSS) and Building Uplifted Families (BUF). Each program connects the head of household (HOH; the primary participant) with an RWCI staff member to set HOH-directed personal and family goals and access resources and information in a streamlined, coordinated way to avoid duplication of services. Each program has different eligibility and participation criteria, as described below.

The FSS program is a national HUD program for public housing authorities to provide rent subsidies while preparing their public housing residents for financial self-sufficiency (U.S. Department of Housing and Urban Development, 2016). FSS is a five-year program to help residents maintain and improve their employment and income and prepare to move out of subsidized housing. Eligibility criteria require participants to have a six-month employment history and either have earned a high school diploma, GED, or be able to earn it within the first year of the program. Residents' participation in FSS is tied to their housing, such that noncompliance with the education and employment requirements of the program could lead to the termination of their housing. Each public housing site has an FSS case manager, typically under contract with a third party (i.e., not the Housing Authority) to support residents and monitor program compliance. RWCI received a contract from the Housing Authority to provide case management and oversite of the FSS program in April 2015. The FSS program was only available at the new public housing site, and not the privately-owned apartments in the adjacent complex.

In 2018, RWCI received a national grant and matching funds from two local hospital systems to expand care coordination to more residents, particularly those in the adjacent affordable housing complex. Any resident living in the two communities and not enrolled in the FSS program was eligible to participate in BUF, regardless of income, employment, and education status. Similar to the FSS program, BUF focused on supporting residents' goals related to employment and education; however, BUF had a greater emphasis on social determinants of health, such as access to healthcare, health behaviors, empowerment, and leadership, than the FSS program. The BUF program

differed from FSS in that it was largely voluntary for participants and not required to maintain their housing or to receive a housing subsidy.

About two-thirds of BUF participants enrolled voluntarily in the program, with no consequence for non-participation. However, the BUF program was also tied to RWCI's childcare subsidy for children to attend their on-site child development center. In order to maintain RWCI's childcare subsidy, caregivers were required to participate in BUF (unless they were in the FSS program) and maintain employment or enrollment in school themselves. The employment and education requirements were modeled after the FSS program for consistency. Voluntary participants were recruited through canvassing, pre-existing relationships with RWCI staff, referrals from partners, and word of mouth. Outside of the direct care coordination services, RWCI used partners to provide other programs and activities.

RWCI partnered with over fifty local nonprofit, for-profit, and government organizations between August 11, 2016 and December 31, 2019. The partners provided 231 workshops, activities, and events (hereafter referred to as "activities") for adults (note: additional activities for children were offered, but are outside the scope of the present study). These activities encompassed a diverse range of opportunities for engagement and connection, with varying goals. They included, but were not limited to financial literacy workshops, group workouts, farmers markets, block parties, GED classes, parenting classes, information sessions and activities for caregivers and their children, workforce development readiness, health fairs, arts and crafts, job fairs, and more. Some activities were one-time events, others were series distributed across months, and others such as the GED classes were semester-long programs that met twice

per week. Most activities were drop-in and did not require pre-registration or have attendance requirements. All activities were open to the public, with priority for residents living in the RWCI service area when attendance was capped due to resources. Resident feedback was solicited directly from residents, through RWCI's Care Coordinators, property management, and the neighborhood schools to determine the types and times of activities. RWCI staff maintained relationships with all partners and coordinated the activities to ensure a variety of activities at different times to meet the schedules and needs of residents.

### 1.3 Study Overview

Evaluation capacity within the nonprofit sector has been plagued by challenges such as lack of time, resources (i.e., human and technology), and expertise to guide data collection and analyses (Mitchell & Berlan, 2016). These challenges can be amplified for place-based initiatives attempting to evaluate long-term, complex interventions involving multiple programs and partners, with shifting populations and strategies over time (Cytron, 2010). Evaluation is not only important for identifying impact, but for understanding and improving processes to achieve the intended outcomes.

The present study aims to advance the understanding of place-based initiatives through the examination of data collected by RWCI from 2016-2019. As a start-up nonprofit, the delivery of services, documentation of activities and outcomes, and approach to data collection developed rapidly and were modified multiple times over the three-year period being examined. As a result, the data from residents have been collected in various ways, in separate tracking systems, limiting the ability to tie activities to outcomes. Such limitations with data collection and evaluation planning are not

uncommon in large-scale initiatives or social innovations such as place-based initiatives, which often do not have clear or established paths forward (Preskill & Beer, 2012), and may have limited staff capacity to focus on evaluation over program implementation more critical to the mission. Human service strategies often require multiple data tracking systems, creating issues with connecting the sources of data or linking data for analyses; further, the variability of needs and characteristics across individual participants raises challenges with identifying uniform client outcomes (Carnochan, Samples, Myers, & Austin, 2014). In the present study, multiple data sources from RWCI will be combined to learn more about the characteristics of residents who participate in RWCI's activities and services, and the outcomes of those participants. The study will not only inform RWCI's ongoing implementation planning, but contribute to the extant literature by providing a deeper understanding of residents' characteristics and participation in place-based interventions.

The present study is an exploratory analysis aimed to better understand an array of complex relationships among residents' characteristics, their participation in RWCI's activities, and the outcomes of their participation. The research questions are described below.

### *1.3.1 Research Question 1*

As the community quarterback (CQB), RWCI serves residents living in two adjacent communities. To date, there is little understanding of the similarities and differences in the resident characteristics across the two community, and their levels of engagement in RWCI activities and with their neighbors. Within mixed-income communities, one role of the CQB is to create opportunities for residents of different

backgrounds to socialize, bond, and support one another to create a thriving, safe community. It would benefit RWCI to understand the relationships between and among residents' SES and their social networks, neighborhood perceptions, and level of participation in RWCI activities. The nature and extent of these relationships will provide insight about whether there are differing perceptions of, and experiences in, the neighborhood based on SES or length of time residents have lived in this specific neighborhood. The findings from research question one will inform RWCI's understanding of whether they are reaching target audiences and the degree to which they are supporting integration among residents across SES.

The first research question in the present study will also examine the extent to which SES and other resident characteristics are related to self-reported health to determine the extent to which findings from prior studies about SES and health are true of the population RWCI serves. Research question one provides baseline information important for the context of research questions two and three.

Research question 1: *To what degree are residents' baseline SES and housing characteristics (i.e., housing complex, age, income, employment status, education level, length of time living in the neighborhood) related to residents':*

a. *Social Networks*
b. *Program Participation*
c. *Neighborhood Perceptions*
d. *Self-reported health*

### *1.3.2 Research Question 2*

While Research Question 1 focused on the relationships between SES and social network, neighborhood perceptions, program participation, and self-reported health, research question two aims to understand the extent of the relationships among social networks, program participation, neighborhood perceptions, and self-reported health, independent of SES. In particular, understanding the extent to which social networks, neighborhood perceptions, and health are related to program participation will help RWCI better understand potential barriers or facilitators of resident participation. Enhancing understanding of potential barriers and facilitators (e.g., education level or health status) will inform the recruitment approach of RWCI and foster a greater understanding of neighborhood dynamics and where additional community engagement interventions may be needed.

Research Question 2: *To what degree are residents' baseline characteristics (i.e., self-reported health, social networks, neighborhood perceptions, and program participation) related to one another, independent of baseline SES characteristics?*

### *1.3.3 Research Question 3*

The first two questions in the present study will provide contextual information about relationships among individual resident characteristics and their level of engagement in RWCI activities and with their neighbors. The study's final question will examine the degree to which participation in RWCI's activities relates to changes in SES, health, or engagement in the neighborhood. These preliminary analyses will provide insight into whether residents with greater levels of participation experience greater positive changes in their lives. This will be the most comprehensive assessment of the

potential impact of RWCI on the residents they serve, to date, and can inform future implementation, foci, and evaluation practices of the organization.

Research Question 3: *To what degree is resident participation in RWCI activities associated with improvements in their:*

a. *Income*
b. *Education*
c. *Employment status*
d. *Self-reported health*
e. *Neighborhood perceptions*
f. *Social Networks*

# CHAPTER 2: METHOD

The present study is an exploratory examination of secondary data collected by Renaissance West Community Initiative (RWCI), a place-based nonprofit, from August 2016 through December 2019. The purpose of the study is to 1) provide preliminary understanding of the characteristics of residents participating in RWCI's programs and services, and 2) examine the potential impact of program participation on residents' income, employment, health, social networks, and perceptions of the neighborhood. The findings from this study will be used to inform RWCI's future program recruitment and implementation, and add to the limited existing literature examining the processes and outcomes of place-based interventions.

## 2.1 Participants

The eligible population in the present study includes heads of household (HOH) living in the 466 units in the RWCI service area between November 2017 and August 2019. The sample for the present study includes 106 HOH who provided data for at least one time point in the Community Needs Assessment (CNA), described below.

Ninety-five HOH completed the CNA in 2018, and 58 completed it in 2019. Income, employment, and health data available from the BUF data system were added for five participants, for a total of 63 HOH with 2019 data available. A total of 52 HOH have data available for both years by combining the CNA and BUF data. Two participants who completed the CNA both years moved out of the neighborhood prior to completing the 2019 CNA and will be excluded from analyses, leaving 50 participants with data from two time points.

### *2.1.1 Representativeness*

Due to low racial diversity in the overall population (96% of HOH identify as non-Hispanic Black), race and ethnicity were not collected in the survey. Based on aggregate level data provided by property managers in both communities, about 75% of HOH in 2018 were between the ages of 21 and 39. Granular breakdown of ages was not possible without individual-level information, making data collection through the CNA and RWCI programs critical for understanding the population being served. In 2018, among the 94 participants with valid responses for age, the median age was 34.9 years. Among the 63 residents with 2019 data available and the 50 participants with both time points available, the median age was 36.4 years. Overall, the median ages appear reasonably representative of the overall population, with a possible skew towards older residents. Without more specific data from the overall neighborhood, it is difficult to confirm the representativeness of ages. About 89% of participants were female, which is consistent with the neighborhood demographics provided by the property managers. Demographic details are available in Table 1.

The sample in the present study represents about 21% of the total neighborhood population served by RWCI. While the response rate yields a lower level of statistical power and representativeness than is desirable, given the limited resources (staff, funding, time), the response rate is adequate for RWCI to gain some initial understanding that can provide justification for additional funding for future evaluation that would allow an increase in sample size. The distribution of income across survey takers is slightly over-representative of lower income households, with 12.9% of households in the

neighborhood being market rate (i.e., unsubsidized) and 10.4% of survey takers being market rate renters. As a result, there were outliers in the income distribution, which makes sense for a mixed-income neighborhood; that said, consistent with the overall housing income requirements, most participants (74%) fell below the federal poverty level. In addition, there was representation from both neighborhoods, but there was a higher response rate and over-representation from residents living in the new housing development. On average across both years of survey administration, 60% of survey participants lived in the new, mixed income community, which makes up only 48% of households between the two complexes.

About 16% of survey participants did not participate in any RWCI activities during the timeframe assessed; that is, those participants only engaged with RWCI for the survey and did not take part in any other tracked activity during the three year period examined. Those who did not attend any of RWCI's activities had higher incomes ($p$=.056) than survey completers who participated in one or more activities. The difference in income between those who did and did not participate in RWCI activities likely represents the fact that residents with higher incomes likely need fewer resources, or are working more than their lower-income neighbors. The inclusion of residents who did not participate in any activities is a positive indicator of representativeness since the sample is not exclusively made up of residents already engaged with RWCI. However, the sample is still likely under-representative of residents who were not engaged with RWCI.

Despite a less than optimal sample size and skewed participation rates, it is important for organizations, particularly nonprofits, to use the data they have available to

understand the people in their service area, modify and improve service delivery, and identify early outcome trends. Using the available data, the present study explores residents' characteristics and assesses whether those characteristics relate to their participation in different RWCI activities, as well as the degree to which social networks within the neighborhood were related to participation, neighborhood perceptions, and health. The present study provides an example of how community data, even with its limitations, can be used to draw conclusions about service delivery and identify areas of focus in implementation and future data collection for nonprofits.

## 2.2 Measures

Multiple sources of secondary data were combined and examined including sign-in sheets from RWCI's activities, surveys, and documentation from RWCI's two care coordination programs. Data collection methods for each source are described in the following sections.

### *2.2.1 Community Needs Assessment (CNA)*

In late 2017 through 2018, RWCI administered its first annual CNA to gain a better understanding of residents' needs, assets, and interests, regardless of participation in their programs and activities. The CNA was extensive and captured information including SES metrics (age, family size, employment, education, income); self-reported health; access to resources including transportation, technology, bank accounts, childcare, and healthcare; and interest in activities such as parenting support and financial management classes. Information about residents' social networks, and perceptions of the neighborhood, described below, were also captured. A shorter version of the CNA was administered as a follow-up in 2019 to capture SES metrics, access to healthcare,

self-reported health, and information about their social networks and perceptions of the neighborhood. On average (for those participants who completed both), 18 months passed between administration of the 2018 CNA and the 2019 CNA, with a range of 11 to 23 months. Many questions on the CNA were used or adapted from publicly available surveys including the CDC's National Survey of Children's Health (Blumberg et al., 2007) and Behavioral Risk Factor Surveillance System (2016).

Self-reported physical and mental health were each examined on the same five-point Likert scale (excellent, very good, good, fair, poor). The single-item scale of self-rated physical health has been shown to be a valid and reliable indicator of overall health and mortality (Crossley & Kennedy, 2002; Idler & Benyamini, 1997; Lundberg & Manderbacka, 1996; Zajacova & Dowd, 2011).

The social networks of CNA participants were examined through a series of questions about the bidirectionality of relationships with up to three neighbors. Participants were asked to name up to three residents in the neighborhood (i.e., residents of either of the two housing communities) who do not live with them, whom they talk to or trust. They were then asked a series of six questions using a seven-point Likert scale (with scores ranging from zero to six) about how often they give and receive information and advice from each person, how often they talk with the person, and how likely they were to seek support from each person. Cronbach's alphas were assessed to determine the internal consistency among the social network questions, with excellent internal consistency ($\alpha = .92$ in 2018 and $\alpha = .90$ in 2019). The mean of these items was used to calculate up to three 'social network' subscale scores, one for each neighbor identified by participants. For example, a survey participant who identified three neighbors would

have three separate social network scores, one for each neighbor based on participant responses specific to each person they identified. In the present study, only the highest social network score will be examined along with the number of neighbors each participant identified (zero to three). Strength and number of relationships are both important, as strong relationships tend to support coping, while number of relationships have been linked to increased information transfer and access to resources (Henly, Danziger, & Offer, 2005; Levin, Cross, & Abrams, 2002).

Twenty-nine survey participants had no responses to the social network questions in 2018, and twenty-one had no responses in 2019. In order to maximize the sample and include survey participants without neighborhood social networks in the analyses, zeroes were entered as the number of ties and strength of relationships for any participant who did not identify a neighbor in their social network. The decision to treat those participants as having no social network rather than as missing data was based on qualitative feedback from survey administrators, who indicated many participants could not think of a neighbor. All survey participants also completed the questions following the social network questions, meaning they did not stop the survey. It is possible some participants elected to skip the social network questions, however it was not possible to differentiate skips from no network.

Finally, residents' perceptions of the neighborhood were assessed across four questions using a 4-point Likert Scale in which participants were asked to strongly disagree, disagree, agree, or strongly agree. The four items ('We watch out for each other's children in this neighborhood,' 'People in this neighborhood help each other out,' 'There are neighbors I can count on in this neighborhood,' and 'If my child were outside

playing and got hurt or scared, there are adults nearby who I trust to help my child'), from the National Study of Children's Health were summed to create a Social Capital Index (SCI), as previously described by Singh and colleagues (2008). The SCI has been linked to childhood obesity and oral health (Iida & Rozier, 2013; Singh et al., 2008). Analysis of item responses in the present study showed good internal consistency ($\alpha = .83$ in 2018 and $\alpha = .82$ in 2019). The SCI score was correlated with participants perceptions of neighborhood trust ($r = .64$, $p < .001$) and safety ($r = .42$, $p < .001$), which were excluded from analyses to avoid covariance and maintain the integrity of the SCI score.

*2.2.2 Care Coordination Data*

The Family Self Sufficiency (FSS) program data measures were developed by the local Housing Authority to measure consistent metrics at FSS sites across the county. Data from the FSS program for the present study include the start date of participation in the program (i.e., the resident's move-in date) as well as demographics including age, income, education, and employment at the start of the program and at follow-up.

The Building Uplifted Families (BUF) program data measures were developed by RWCI and faculty and staff at the local university who were contracted to evaluate the program. Data from the BUF program for the present study include the start date of participation in the program; which community participants reside; demographics including age, income, education, and employment; and self-reported health at the start of the program and at follow-up. Education, employment, and self-reported health questions from the CNA were used for consistency of tracking. Income was calculated using the number of hours participants worked multiplied by their hourly rate.

*2.2.3 Activities Data*

Activities data include the number, type, and dates of activities residents participated in between August 2016 and December 2019. Residents' participation in 231 activities was coded by RWCI staff into one of seven categories used by the organization for reporting: 1) Children's Education, 2) College / Career, 3) Community Engagement, 4) Financial, 5) Health Activities, 6) Health Education, and 7) Supportive Services.

## 2.3 Data Collection Methods

All data in the present study are from existing data collected by RWCI. Original data collection methods for each measure are described below.

### *2.3.1 CNA Collection*

Residents were given multiple opportunities to complete each CNA survey, using different methods. In late 2017-2018, a class from the local university was trained in survey administration. The students went door-to-door with tablets to administer the survey and were present at large community activities (e.g., a health fair) to recruit survey participants. In addition, RWCI staff set up office hours for residents to stop by and have the survey administered to them, and residents were emailed a link to take the survey themselves. Names and addresses were collected to avoid duplicate responses. In 2019, all surveys were administered by RWCI staff during office hours or by trained volunteers at a large RWCI summer activity. Both years, residents were given the option to receive a $10 gift card or to be entered into a drawing for a $150 gift card for their participation.

### *2.3.2 Care Coordination Data Collection*

The FSS program participant data were captured in the Tracking At-A-Glance® (TAAG) system developed by the Housing Authority. FSS case managers entered employment, income, and education information at move-in, and when changes occur based on monthly check stubs and other documentation submitted by participants. A different system was used for the Building Uplifted Families (BUF) program.

RWCI partnered with the local university to provide external evaluation of the BUF program. The cloud-based REDCap Cloud (Harris et al., 2009) data collection system was used to document participation and outcomes of the program. Unlike FSS, data collection in BUF was based on self-report, and verification documents were not required unless they were also recipients of the childcare subsidy. Questions about employment, education, and health in the BUF system were the same as those in the CNA (see Table 2 and Appendices A and B for more details). More information about FSS and BUF data are available in Table 3.

*2.3.3 Activities Data Collection*

Information about residents' participation in RWCI activities was collected in different ways over time. During the first two years of implementation, residents signed themselves in on a sheet of paper before each activity, which was later entered into an Excel spreadsheet. During the third year, in an effort to avoid the challenges of illegible handwriting from the paper sign-ins and the backlog of data entry, RWCI began to capture attendance electronically via the Qualtrics Offline app downloaded onto tablets. In some cases (e.g., at large busy activities like block parties, or when technology was not working appropriately), paper sign-ins were used and later entered into Qualtrics. Activity categories were determined by RWCI staff at the time of data entry.

## 2.4 Analytic Plan

The present study examined data from multiple data sets provided by RWCI. The goals of the exploratory analyses were to understand the extent of relationships among a variety of participants characteristics (i.e., SES, neighborhood perceptions, social networks, health, and program participation) and the relationship between program participation and changes in those characteristics. Binary and ordinal logistic regression were used in instances in which dependent variables were categorical. Linear regression was used when continuous dependent variables were examined. Analyses for each research question are described in the following sections.

### *2.4.1 Research Question 1*

Research question one (RQ1) examines *to what degree are residents' baseline SES and housing characteristics (i.e., housing complex, age, income, employment status, education level, length of time living in the neighborhood) related to residents':*

a. *Social Networks*
b. *Program Participation*
c. *Neighborhood Perceptions*
d. *Self-reported health*

Among the independent variables (IVs), age, income, and length of time in the neighborhood are continuous variables. Housing complex, employment status, and education level are categorical; categorical variables were dummy coded for each analysis. The *mixed income housing*, *employed*, and *high school graduate* responses were selected as the base groups for the dummy coded variables, respectively, because they were the largest subgroups in each category. Participants' characteristics including age, education, employment status, income, housing complex, and length of time in the

neighborhood (respectively) were entered as IVs for all components (*part a* through *part d*) of RQ1.

*Part a* of RQ1 included two analyses. Ordinal logistic regression was used in the first analysis to understand the extent of relationships between participants' characteristics and their strongest social network subscale score. The highest score (from the three neighbors identified on the CNA) was selected as the dependent variable of interest, because it reflected the strongest relationship a participant reported. The highest score was selected because previous research indicates one strong and supportive relationships may support coping with challenges of living in poverty (Henly et al., 2005) and may be more beneficial for individuals' well-being than several weak ties (de Souza Briggs, 1998). The social network score is on a scale from 0 to 6, with 0 reflecting the weakest relationships and 6 the strongest.

For the second question in *part a* of RQ1, the dependent variable was the number of neighbors each participant identified in the social network questions (range 0 to 3). The number of ties, regardless of the strength of the relationship is important because weak ties tend to be related to employment and economic mobility for low-income families (Henly et al., 2005). Given the dependent variable is count (integer) data with restricted range and excess zero-count responses, a One-sample Kolmogorov-Smirnov Test was run to test for appropriateness of Poisson regression analysis (Walters, 2007). Poisson regression is recommended for use when appropriate to avoid Type I errors that may occur in ordinary least squares (OLS) regression analyses (Huang & Cornell, 2012). The assessment indicated Poisson analysis was not appropriate ($p<.05$), and as a result, the data were examined using an OLS regression model.

In *part b* of RQ1, eight analyses using linear regression were conducted to understand the extent of any relationships between residents' characteristics and their attendance at RWCI activities. The eight dependent variables include the total number of activities attended as well as indicators reflecting the seven types of activities (i.e., health education, health resources, children's programs, college/career, financial, supportive services, and community engagement) attended (see Table 4 for more details about activities). A slightly different sample was used to examine participation in children's programs than all other activity types. The sample used to examine attendance at children's programs was reduced to include only participants with at least one child living in the home (n=64).

*Part c* of RQ1 examined the extent of the relationship between residents' characteristics and their neighborhood perceptions via ordinal logistic regression models. In the first model, residents' Social Capital Index (SCI) score was the dependent variable.

Finally, in *part d* of RQ1, binary logistic regression was used with the IVs to examine the extent of their relationships with residents' self-reported physical and mental health. Based on the approach used in previous studies (Lundberg & Manderbacka, 1996), self-reported health was transformed to a dichotomous variable for this analysis, capturing excellent/very good/good versus fair/poor responses, rather than the five-point Likert scale.

### *2.4.2 Research Question 2*

Research question two (RQ2) in the present study aimed to inform RWCI's recruitment and engagement strategies by better understanding: *to what degree are*

*residents' baseline characteristics (a through d) related to one another, independent of baseline SES characteristics?*

a. *self-reported health*
b. *social networks*
c. *neighborhood perceptions*
d. *program participation*

This research question was examined using hierarchical linear regression. The same IVs from RQ1 were entered in the first step of each *part* (*a* through *d)* of RQ2. For *part a* of RQ2 both physical and mental health were added as IVs in the second step of the regression to identify the relationships above and beyond SES. Thirteen dependent variables were assessed, similar to those described in RQ1 (i.e., SCI score, number of relationships, highest social network subscale score, and number of activities attended overall, and the seven types of activities).

In *part b* of RQ2, social network subscale scores and number of relationships were used as IVs predicting SCI and activity attendance. Finally, in *part c*, SCI was used as the IV predicting activity attendance, after accounting for SES.

### *2.4.3 Research Question 3*

Research question three (RQ3) was a longitudinal analysis examining the degree to which resident participation in RWCI activities were related to positive changes in:

a. *Income*
b. *Education*
c. *Employment status*
d. *Self-reported health*
e. *Neighborhood perceptions*
f. *Social Networks*

In RQ3, hierarchical linear regression was used to examine the relationship between activity attendance and changes in residents' characteristics or perceptions (income, education, employment, health, neighborhood perceptions, and social networks) from 2018-2019 characteristics.

In *parts a* through *c* of RQ3, three analyses examined changes in residents' income, education, and employment status (respectively) from 2018 to 2019. The first analysis in each *part* examined the relationship between participants' attendance in college/career activities and their 2019 income, education, and employment status, while controlling for their 2018 status in each SES characteristic.

*Part d* of RQ3 examined the relationships between participation in health and wellness activities/resources and education activities on residents' self-reported physical and mental health in 2019, controlling for their 2018 self-reported health. While self-reported health was dichotomized for the analysis described for the present study's prior research questions, it was examined as both a dichotomous and five-point categorical variable in RQ3 in order to detect any subtle changes between fair and poor or between good to excellent health that may be lost in the dichotomy. This method is consistent with Schnittker and Bacak's (2014) recommendation.

*Part e* of RQ3 included a three-step hierarchical linear regression analyses for each of two independent variables. In the first component of RQ3 *part e*, 2019 SES (income and education) characteristics were accounted for in the first step of the regression analysis. Then, 2018 neighborhood perceptions were accounted for in step two of the regression analysis, and finally participation in community engagement activities were the final IV of interest to examine the relationship between attendance at

community engagement activities and changes in neighborhood perceptions from 2018 to 2019 (SCI). A structurally similar approach was used for the second component of *part e*, which examined the relationship of total activity attendance and changes in neighborhood perceptions.

*Part f* of RQ3 will use hierarchical regression to examine the effect of residents' attendance in community engagement activities and total activities on their 2019 social networks (highest social network subscale score and number of relationships), after controlling for their 2018 social networks.

# CHAPTER 3: RESULTS

Descriptive statistics for the present study are provided in Tables 5 and 6. The following sections summarize significant findings for each by research question. Correlations for the independent variables (age, years in the neighborhood, residence, education, income, and employment) are presented in Table 7. The findings discussed for research questions one through three reflect existing relationships among residents' characteristics, their participation in RWCI's activities, their social networks, neighborhood perceptions, and health.

## 3.1 Research Question 1

Research Question 1 (RQ1) examined the degree to which residents' SES and housing, and other characteristics (i.e., age, income, education level, employment status, disability status, community of residence, and years in the neighborhood; referred to as *characteristics*) related to their social networks ($n$=78), participation in activities ($n$=78), neighborhood perceptions ($n$=75), and self-reported health ($n$=78). There were no significant relationships between the characteristics and participants' social networks. Relationships between the residents' characteristics and self-reported health, neighborhood perceptions, and participation in activities are described below.

### *3.1.1 Self-Reported Health*

Residents' self-reported physical and mental health were examined in relation to their characteristics. Participants with a disability were eleven times more likely to report poor physical health ($\theta$=0.09, $p$<.05) and twenty-nine times more likely to report poor

mental health ($\theta$=0.03, $p$<.01) than good physical or mental health, respectively. No other characteristics were related to residents' self-reported health.

*3.1.2 Neighborhood Perceptions*

The regression model using the participants' characteristics to predict their neighborhood perceptions (measured via the Social Capital Index Score) explained 13.5% of the variance in neighborhood perceptions ($p$<.05). Participants with a disability ($\beta$= -0.3, $p$<.05), and those who lived in the older housing ($\beta$= -0.39, $p$<.01) had more negative perceptions of the neighborhood than those without a disability or living in the new housing, respectively. No other resident characteristics were related to their perceptions of the neighborhood.

*3.1.3 Participation in Activities*

There were no significant relationships between residents' characteristics and their participation in RWCI's supportive services or community engagement activities based on attendance data. There were significant relationships among one or more characteristics and their participation in all other activity types. Standardized regression coefficients for models with significant findings are presented in Table 8.

The models predicting participation in health ($p$<.05), college/career ($p$<.01), and financial activities ($p$<.05) were statistically significant, predicting 12%, 30%, and 13% of the variance in participation, respectively. Education level was the best predictor of residents' participation in activities, with education level having significant relationships with participation in college/career, health education, financial, and total number of activities. Specifically, residents without a high school diploma attended more college/career activities than those with a high school diploma. Residents with some

college credits or who completed a degree after high school participated in more health education activities than those with only a high school diploma. Residents with a degree or certificate beyond high school also attended more financial and total activities than those with only a high school diploma.

Employment status was significantly related to participation in activities. Individuals unable to work due to a disability attended more health resource activities than those without a disability. Work eligible participants who were unemployed attended more college/career activities than those who were employed. Income was significantly related to attendance at children's activities such that adults with higher income (and with children living in the home) attended more children's activities than caregivers with lower incomes.

### *3.1.4 Summary of RQ1 Findings*

Overall, the primary resident characteristics related to activity participation were their employment status (employed, unemployed, disabled) and education level (i.e., having less than high school, high school diploma, some post-secondary education without earning a degree or certificate, and having a degree or certificate above high school). Participants without a high school diploma (or who were unemployed) were more likely to attend college/career focused activities, while those with any post-secondary education were more likely to attend activities related to financial management and health education, and they attended more total activities. Education was not related to any other outcomes of interest. Age, residence, and tenure in the neighborhood were not related to participation in RWCI's activities.

Disability status was related to more dependent variables than anything else examined for RQ1. Participants with a disability attended more health resource activities and had worse self-reported physical and mental health. In addition, participants with a disability had more negative perceptions of the neighborhood than those without a disability. Moreover, residents in the newer, mixed-income housing had more positive neighborhood perceptions than those in the older housing units.

Income was only related to caregivers' attendance at children's activities, with higher incomes associated with more attendance. It was not related to participation in any other activities, nor was it related to health, social networks, or neighborhood perceptions.

### 3.2 Research Question 2

Research Question 2 (RQ2) expanded on RQ1 by examining the relationships among residents' self-reported health, social networks, activity attendance, and neighborhood perceptions after controlling for the participant characteristics (i.e., employment, education, income, disability status, housing, age, years in the neighborhood) examined in RQ1. There were no significant relationships between self-reported physical or mental health and activity attendance, neighborhood perceptions, or social networks. There were also no significant relationships between neighborhood perceptions and activity attendance. There were significant relationships between social networks and neighborhood perceptions and attendance.

Social networks were significantly related to neighborhood perceptions, such that residents with stronger social network scores (i.e., stronger relationships) had more positive views of their neighbors (neighborhood perceptions) than those with weaker

relationships ($\beta$= 0.49, $p$<.01), with the model predicting 26.8% ($p$<.01) of the variance in neighborhood perceptions. In addition, residents with larger social networks attended more health activities ($\beta$= 0.52, $p$<.01) and total activities ($\beta$= 0.41, $p$<.05) than those with fewer people in their social networks. These models explained 22.4% ($p$<.01) of the variance in attendance at health activities and 13.5% ($p$<.05) of the variance in total activity attendance.

Overall, social network size and strength were the only variables related to any outcomes of interest in RQ2. Residents with larger social networks attended more activities, while residents with stronger social networks had more positive neighborhood perceptions.

3.3 Research Question 3

Research Question 3 (RQ3) examined the degree to which participation in activities was related to changes in income, education, employment, self-reported health, neighborhood perceptions, and social networks over the span of a year. There were no significant findings between activity attendance and changes in participants' SES (education, income, education), self-reported health, or neighborhood perceptions. However, residents who attended more activities also had greater gains in the size of their social networks.

Residents who attended more total activities ($\beta$= 0.33, $p$<.01) and more community engagement activities ($\beta$= 0.22, $p$<.05) had more growth in the size of their social networks than those who attended fewer activities. The total number of activities attended accounted for 8.8% of the variance in social network growth ($p$<.01). Total activity attendance was not only related to growth in network size, but also to increases in

the strength of relationships. The strength of participants' social networks increased more for participants who attended more total activities ($\beta$= 0.28, $p$<.01) and the number of total activities accounted for 8.5% of the variance in the strength of social networks ($p$<.01).

# CHAPTER 4: DISCUSSION

The present study examined early implementation data from Renaissance West Community Initiative (RWCI), a place-based initiative using a holistic approach to community revitalization via the Purpose Built Communities model. The findings in this study will be used to directly inform RWCI and provide an example for other place-based interventions regarding the ways that data can be used to understand, monitor, improve, and target service delivery to reach outcomes of interest. This study provides an understanding of how residents' characteristics, social networks, neighborhood perceptions, and health are related to their participation in activities offered by RWCI as it works to build a healthy, thriving community. It further examines how residents' level of participation in RWCI's activities relates to any changes in characteristics, social networks, neighborhood perceptions, and health.

RWCI utilizes all three of the place-based intervention methods described by Dreier (1996) – community development, community services, and community organizing. These methods, whether intentionally or not, address social determinants of health (SDOH) and promote healthy communities. A healthy community is one in which people sharing a place (e.g., a neighborhood, workplace, or city) experience collective physical and mental well-being through access to employment, housing, safety, and caring relationships, as well as the absence of disease (Fawcett, 2000). The present study largely focuses on the community services and early stages of community organizing activities of RWCI and the intersection of the two on the path to building a healthy

community. The following sections further examine the meaning of the findings in the present study.

## 4.1 Community Services

One role of community quarterbacks like RWCI is to provide community services such as education, family support programs, and opportunities that are often lacking in low-income neighborhoods (Erickson et al., 2012). RWCI offered over 200 activities or services for adults living in its service area during the three-year period examined in the present study. In this section, residents' characteristics and how those relate to their participation in RWCI's activities, or services are examined.

### *4.1.1 Activity Participation and Educational Attainment*

Educational attainment was the primary predictor of survey participants' attendance at RWCI's different activity types. Those without a high school diploma were more likely to attend activities focused on adult education, workforce development, and job opportunities, while those with degrees above a high school diploma (i.e., certificate, associate's, bachelor's degrees) attended more health education and financial literacy activities. In this section, I explore the meaning of differences in participation and how RWCI can use this information to target program recruitment, retention, and ultimately increase educational attainment.

Connecting residents who have lower levels of education with opportunities to increase their educational attainment or earn credentials is the first step in increasing their household incomes and may be beneficial to their overall health and wellness (Meara et al., 2008; Olshansky et al., 2012). Although RWCI and the local community college offered free GED classes for residents without a high school diploma, there were not

significant increases in educational attainment. One reason for nonsignificant increases in education level may be the timing of the classes in relation to survey administration. That is, GED classes did not start until late 2018, after participants without a GED completed the survey, allowing for about two or three semesters of classes prior to the 2019 survey administration. During the period before the 2019 survey was administered, survey participants who attended RWCI's GED classes received between 3 and 30 hours of instruction. Comings (2007) indicates about 100 hours of instruction are needed to pass the GED exam. Given the gap between hours needed and hours completed, it is not surprising that participants did not complete the program and increase their educational attainment during the period examined in the present study.

RWCI should continue to monitor participants' hours in the GED program for two reasons. First, monitoring hours allows RWCI to provide feedback to participants about their program status using the 100-hour recommendation as a preliminary target. This tracking and feedback may help alleviate some fatigue and promote retention among participants who have been engaged for a long period of time and may begin to feel defeated (Petty & Thomas, 2014). Secondly, the median age of RWCI's participants without a high school diploma was 34 years old. There is little to no data about completion rates or time to completion for participants over 30 years old. Since RWCI is serving an older population than is typical for GED programs, additional considerations and expectations may need to be made for their participants. For example, older adults have been out of the formal education system for 10-20 years and may need more instruction time than younger adults who have not been out of formal education as long. Monitoring participation hours will not only inform the participants of their status using

the 100-hour benchmark, but will provide a new baseline for RWCI to understand the average hours needed and time to completion for older adults. Knowledge of participants' average completion time will help RWCI with fundraising and evaluation of the GED program. Specifically, many grant cycles fund one year of programming and require annual outcome reports. If the average time to completion for the GED program is greater than twelve months, RWCI leadership and staff can use these data to help funders set appropriate expectations for outcomes and possibly obtain funding for a longer duration to allow participants ample time to graduate. Although RWCI has removed common barriers to participation (i.e., childcare, transportation, food, and access to technology) RWCI can also examine additional barriers to (faster) completion and work to mitigate those barriers. RWCI can also use this knowledge to contribute recommendations to other place-based initiatives serving older adults who have not completed high school and want to earn their credentials.

GED classes are not the only way to increase educational attainment among residents in the RWCI service area. RWCI's adult educational activities have focused largely on helping adults without a high school diploma earn their diploma through on-site (i.e., in the neighborhood) activities, while connecting those with a high school diploma to post-secondary opportunities such as trades, certificates, and higher education opportunities that are offered elsewhere in the city. To date, RWCI has not offered any on-site opportunities for certifications for those with a high school diploma to earn credentials for trades or specialties. Adding short-term on-site (as opposed to off-site referrals) certificate/technical programs may also help RWCI increase the educational attainment and employment prospects among residents with high school diplomas who

do not want to attend college. The types of on-site certificate trainings offered should be based on residents' interests. Increasing opportunities for certifications will allow residents to build their resumes and increase prospects for employment and higher wages than low-skilled jobs. By providing more opportunities on-site rather than making off-site referrals, RWCI can better monitor recruitment and participation. On-site trainings are also accessible to more residents because they eliminate transportation barriers that off-site trainings may create. Ongoing longitudinal evaluation of adult educational opportunities and interests should be utilized for RWCI to determine what is most effective, the length of time it takes to increase residents' educational attainment, and the barriers preventing them from completion. While residents with lower levels of education are likely to participate in activities that would increase their educational attainment, participants with higher levels of education appear interested in learning opportunities, regardless of earning any certification or increasing their educational attainment.

For instance, residents with higher levels of education were more likely to participate in financial literacy and health education activities than those with a high school diploma or less. The relationship between education level and types of activities residents participated in may be related to residents' availability or interests. For example, residents with lower levels of educational attainment may not have the availability or desire to attend activities like health and financial education programs while attending GED or certificate programs to increase their educational attainment, and raising their families and working. Their educational focus or priority may be to complete the program that will give them credentials, while those who already have

credentials have no need or desire to participate in activities to increase their educational attainment, allowing more time to participate in activities that interest them such as financial literacy or health. Residents with degrees beyond a high school diploma may have an internal motivation to learn, which drives them to seek additional educational opportunities regardless of the topic (see Merriam & Baumgartner, 2020, pp 82-112).

Because residents' education level is significantly related to the types of RWCI activities in which they participate, RWCI leadership and staff should reflect on whether the differences in participation align with their mission and target audiences for the activities. That is, RWCI should examine such questions as: Who is the target audience for financial education and health education activities? Is there an expectation that residents with lower levels of education attend these activities, or are residents with higher SES the target audience? Is their target audience interested in the content being provided? The answers to these questions will determine what course of action RWCI should take with program planning and recruitment for participation in the future.

Under current operations, RWCI promotes all activities to all residents without specific target populations. The open invitations allow residents to self-select into the activities they want. With the information yielded from the present study about the types of programs into which residents self-select, it might benefit RWCI to group residents based on characteristics like education level and target specific programs to each group, rather than broadly promoting all activities to all residents. For example, residents with advanced degrees would receive flyers for financial literacy programs while residents without a high school diploma would not, but would receive flyers for college/career activities. Theodos and colleagues (2012) recommended developing resident groups

based on characteristics like SES, age, and health to maximize participation and impact in low income neighborhoods. This could be done by manual grouping based on education level, employment, or income, or residents could be grouped statistically via principal component or cluster analyses. This strategy of targeting groups of residents could help increase resident engagement in the activities that would benefit them the most given their current status. Using a data-informed approach to meeting residents where they are in terms of individual family needs and assets can help streamline programming and make monitoring outcomes easier across the different groups of residents.

### *4.1.2 Activity Participation and Employment*

Survey participants who were unemployed attended more college/career and total activities than those who were employed. Not being in the workforce allows more free time to attend activities, which may partially explain the higher levels of attendance among unemployed residents. It is a positive finding that unemployed residents are attending more college/career activities than those who are employed. This finding suggests those who are unemployed are actively engaged in opportunities to return to school or re-enter the workforce. Although there were significant increases in employment in the study sample from 2018 to 2019, participation in RWCI's activities was not related to those increases.

The lack of relationship between participation in RWCI's activities and employment may be attributable, at least in part, to the way employment status was measured. It is not uncommon for adults living in poverty to experience job instability (Anderson, Halter, Julnes, & Schuldt, 2000), and the present study examined employment status at the time of survey administration. By examining employment status at a single

point in time, the analysis does not account for participants who may have lost and re-gained employment between the two survey administrations and their level of engagement in RWCI's activities. Further, it misses any upward changes in employment such as career shifts or promotions among those who maintained employment. Additional examination of participants' employment and unemployment tenure over an extended period might provide more insight regarding a potential relationship between increases in employment and participation in college/career activities.

Other factors that may explain the null relationship between employment gains and participation in RWCI's activities are the types of activities offered and attended. There are two types of career-readiness programs offered by RWCI. One includes job fairs and job search support, which could link an unemployed resident to employment in as little as one session, negating the need for ongoing participation in college/career activities. The other type of college/career activities, such as resume writing, computer training, and other soft skills, may require greater length of engagement (i.e., participants attend multiple classes). Such activities are intended to prepare participants for employment opportunities, but do not necessarily directly link them to employment.

RWCI may benefit from following up with participants of specific career readiness programs to determine whether those programs are linked to employment or income gains rather than rely on information obtained through the broad examination of participation done in the present study. Accounting for the amount of time a resident was employed and unemployed or changed jobs within a year will also provide greater insight into employment changes that occur more frequently than would be captured in an annual assessment. Tracking individuals' changes in employment, employer, and income to

reflect job (in)stability, promotions, and demotions on a more frequent basis (e.g., monthly) will allow future evaluations to examine attendance in RWCI's college/career activities more specifically during periods of unemployment and identify any causal relationships between employment and participation in RWCI's activities. While such frequent data collection may be untenable for the entire neighborhood, participants in RWCI's Care Coordination could be asked regularly and participants at college/career activities could also be asked at each activity.

*4.1.3 Activity Participation and Income*

Across the entire study sample, there were not significant increases in income from 2018-2019, however there were significant increases among the lowest income group (earning less than $15,000 in 2018). This is a positive finding, and makes sense as workers on the lowest end of the spectrum may be more likely to experience changes such as increasing hours from part time to full time. Changes such as an increase in hours make income increases more attainable within a year, than someone who is already working fulltime.

The increases in income detected were not related to participation in RWCI's activities. The fact that participation in RWCI's college/career activities was not related to increases in income may be due to measurement and analysis issues similar to those discussed for employment. Specifically, attending more activities will not necessarily yield greater gains in income because some activities may connect residents to higher paying jobs in one day, whereas others that require longer term attendance (e.g., GED classes) may not necessarily yield immediate income increases. Despite gains in income for the lowest earners, the median income is still only minimum wage, and based on the

median income of all participants, most are working full-time at minimum wage jobs or possibly part-time at higher paying jobs. These low wages indicate a need for RWCI to modify their activities to focus more strictly on career programs related to upward economic mobility. A focus on promoting higher paying employment opportunities, job stability, and promotions beyond minimum wage should remain a priority for RWCI. As previously discussed, increases in educational attainment will create more opportunities for higher wage employment. In the meantime, RWCI should ensure residents are either working on increasing educational attainment or are seeking employment opportunities that pay above minimum wage despite low educational attainment. Similar to the recommendation above that RWCI monitor changes in employment status to identify any causal relationships between participation in RWCI's activities and changes in employment, RWCI should do the same for changes in income.

There was one significant relationship between income and participation in activities – there was greater parental (caregiver) attendance at children's activities among those with higher incomes. This finding is consistent with prior research, which often attributes lower rates of attendance among lower-income families to barriers such as cost and transportation (Sanderson & Richards, 2010). These barriers did not exist for RWCI's low-income families, as there was no cost and no need for transportation for children's activities; therefore, that explanation does not apply here.

In low-income communities, parental disengagement from their children's educational activities is not atypical, however at RWCI this could be because lower income caregivers do not have as much flexibility in their employment to attend programs with their children (Luet, 2015). Moreover, data regarding activities offered by

the neighborhood school, recreation center, and other sources were not available for this study. Therefore, the data in the present study may not be capturing lower-income caregivers' attendance at school programs or other children's activities that were not hosted by RWCI. The present study also only accounts for the caregivers' attendance and not the children's attendance. RWCI should examine children's attendance to glean greater insight into whether children themselves participate at different rates based on the families' income levels, combined with parents' engagement in those activities, which may provide a clearer picture for the organization. While the children's attendance may provide a clearer picture of whether parents across income levels enroll their children less often, parental engagement in out of school time activities is important because it has been linked to increased engagement with their children's schools and teachers (Kane, 2004) which can improve academic outcomes for their children (Kraft & Rogers, 2015). Therefore, both children's participation and their parents' level of engagement are areas of potential focus for RWCI as they work to understand differences across income levels given their two-generation approach. Further understanding why lower-income parents are less engaged will allow RWCI to problem solve with caregivers, particularly lower-income caregivers, and identify strategies to foster more engagement in their children's activities and education.

*4.1.4 Activity Participation and Health*

Survey participants who reported having a disability attended more health resource activities such as the farmers market and workouts. Perhaps participants with disabilities are more likely to attend these activities because they have greater challenges going to the grocery store or utilizing other facilities outside the neighborhood, making

these on-site resources more important and better utilized by them. Health challenges may also be more salient among residents with disabilities, leading to a greater interest in steps for promote positive health. Residents with disabilities may also be what Theodos and colleagues (2012) described as *severely distressed*. Severely distressed residents are often older and have the worst health among public housing residents, therefore it is especially important for them to have these health resources to support themselves and their families.

Access to health resources is especially important for residents with a disability who are raising children (Schwartz, Buliung, & Wilson, 2019). It is important for the children to have access to nutritious foods at home that promote healthy development, and for caregivers to role model healthy behaviors such as working out and healthy eating (Griffith et al., 2007; Morawska & Mitchell, 2018, pp 295-296). Because the neighborhood served by RWCI is located in a food desert (i.e., there is limited access to fresh, affordable food), ensuring the children have access to healthy food is an important part of RWCI's two generation approach. These resources (e.g., farmer's market and workouts) can help prevent chronic conditions associated with poverty – such as diabetes and hypertension (Hill et al., 2013; Sabanayagam & Shankar, 2012; Suarez et al., 2015). Additional targeted promotion of the market or workouts to caregivers with a disability could support increased utilization and access to health resources for themselves, and the children in their households.

Another consideration for RWCI to make, outside of promotional strategies to encourage caregivers with disabilities to take advantage of these resources, is the timing of the markets and workouts. The market and workouts occurred during the afternoon or

early evening on weekdays. These times may be a barrier for employed residents to attend, however the lack of significant differences between attendance of employed and unemployed residents implies timing may not be a critical factor.

Participants who indicated they had poor health did not access these health resources or health education activities more than others in better health. There may be physical and mental barriers caused by poor health preventing residents from attending such activities. For example, those with poor mental health may avoid group settings due to stress or anxiety. In other instances, exhaustion from health conditions may cause residents to feel too tired to attend activities and, for some individuals, limited mobility may be a barrier.

The lack of significant differences in participation between those in good and poor health could be due to the variety of health education topics offered. Topics touched on in different health education activities included family planning, HIV prevention, chronic disease management, nutrition, stress management, healthy relationships, and more. The diversity of topics was intentional to cover the broad sets of health topics residents experience or in which they might be interested, which could explain the lack of differences in participation rates. For example, topics such as chronic disease management may draw residents who are living with chronic diseases, and therefore may report poorer health, while a topic like family planning may draw younger, healthier participants. A topic such as nutrition may equally draw participants in poor health seeking ways to become healthier, or participants in good health who enjoy learning new information about staying healthy. Similarly, the market and workouts may be equally appealing to residents regardless of their health status. Further examination of residents'

characteristics and the types of health education and resources they participated in might help RWCI better target the promotions for the population for which the activity is aimed.

*4.1.5 Community Services Summary*

The community services offered by RWCI were broad and appealed to different socio-economic groups. This study highlights which residents, historically, were more likely to attend certain types of activities. RWCI staff should examine the relationships identified in the present study between residents' characteristics and participation to determine whether their target audiences are being reached. RWCI leadership and staff might consider using more targeted advertising to promote specific opportunities to different groups of residents to ensure their target audience(s) are aware and encouraged to attend. Further, more frequent monitoring of changes in employment and income should be assessed and examined in relation to residents' participation in college/career activities to better understand the level of impact of these programs. Health and education may take longer to improve than employment, but intermediate outcomes like hours of education completed or improved nutrition can be examined. Over time, RWCI should be able to identify timelines for key outcomes such as increased educational attainment in order to set benchmarks and provide data-informed expectations for future residents and other place-based initiatives.

In this section the relationship between activity participation and primary outcomes (e.g., increased education, improved health) was examined. As the community quarterback, RWCI offers activities as opportunities for residents to learn and access resources, which align with the community services described by Dreier (1996).

However, RWCI's activities also provide opportunities for residents to have positive social experiences with their neighbors, and ideally promote social cohesion and community organizing over time. In the following section, the role of RWCI's community services in building a sense community among residents as a byproduct of the community services and why that is important are examined.

4.2 Community Building

Part of RWCI's mission is to "promote a collaborative community." This concept is consistent with Dreier's (1996) description of community quarterbacks' (CQBs) role in *community organizing,* which refers to the development of neighborhood bonds and social capital for the purpose of community mobilization, empowerment, and advocacy. Building these characteristics of residents and the community can then enable residents to successfully lead change efforts in their community. Because neighborhood transformation can take a decade or more, CQBs without extensive long-term funding streams such as those seen in Harlem Children's Zone or the East Lake Foundation in Atlanta may need to rely more heavily on the residents themselves leading and sustaining positive changes within their neighborhood, as seen in the Dudley Street Neighborhood Initiative (Taylor, 1995). Building relationships and developing social cohesion are critical first steps towards the community organizing necessary for RWCI's sustainability and success (Dreier, 1996; Kawachi & Berkman, 2000). Not only will social capital, social cohesion, and ultimately community organizing drive and sustain RWCI's ongoing efforts, they are key elements of individual well-being and healthy communities (Kawachi & Berkman, 2000; Kawachi et al., 2008, pp16). In this section, I review the

existing relationships in the present study among residents' characteristics, their social networks, and their neighborhood perceptions and RWCI's role in building community.

### *4.2.1 Social Networks*

The number and strength of relationships reported by residents in this study were not related to SES, length of time in the neighborhood, or living in the older versus newer housing. Though the range was restricted, the fact that residents with higher SES do not have different social network sizes than their lower SES neighbors is a positive indicator based on past research, which has shown that higher income neighbors tend to keep to themselves in mixed-income communities (McCormick et al., 2012). Mixed-income housing, like the newer housing provided by RWCI, was intended to facilitate bridging social capital, or connections among individuals from different SES backgrounds, and weak ties or acquaintanceships, which are often associated with information sharing (Kavanaugh, Reese, Carroll, & Rosson, 2003) and upward mobility (de Souza Briggs, 1998; Curley, 2010). However, it has become clear that CQBs need to be more intentional in creating opportunities for bridging relationships to form (McCormick et al., 2012). Although the present study did not identify a socio-economic difference in relationship building or neighborhood perceptions, it is clear RWCI will need to be more intentional in promoting both bridging and bonding social capital.

The number of relationships reported by participants was low, with an average of 2 neighbors in each participants' network. It should be noted that network size may be skewed by the limit of naming three neighbors in the survey which may necessitate some caution in interpreting the finding on the page above; however, one third of survey respondents did not identify a single neighbor they talk to or trust. This low level of

engagement among neighbors is similar to findings from a 2015 study by Cortright and City Observatory (p. 6), in which about one third of people in the study did not know or interact with any neighbors. It is important to note that low and mixed-income neighborhoods will likely not develop greater engagement among neighbors than a typical neighborhood, contrary to hopes expressed by researchers, Housing Authorities, community quarterbacks, and developers (Chaskin & Joseph, 2010). In fact, community members of other mixed-income or revitalized neighborhoods have cautioned against the notion of communal living or "building a village," and tempered researchers' and community planners' expectations for greater levels of engagement in their neighborhood relative to that in other neighborhoods (Chaskin & Joseph, 2010). Although it is unlikely RWCI will create a neighborhood where all residents get along and support one another, a focus on ensuring most residents at least know one another is feasible. Taking steps toward helping residents meet one another can be as simple as requiring name tags and introductions at all RWCI activities.

In the present study, residents with larger neighborhood social networks attended more total activities and more health activities. This suggests that residents with larger networks may receive more information about activities, or they may attend more activities because the activities provide opportunities to socialize with their neighbors. In fact, participation in community engagement activities and total activities was related to increases in the size of residents' social networks. The potential bidirectionality between social networks and activity (i.e., having more relationships is linked to more participation and more participation is related to greater network growth) highlights the

importance of social networking for potential information sharing and participation as well as the role that RWCI's activities can play in increasing residents' local networks.

Still, that roughly one third of survey respondents reported no neighbors in their social networks is noteworthy. Some participants with zero network members attended activities, while others did not. Therefore, there is a sector of the population attending activities but not engaging with their neighbors, and there is also a subset of residents who neither attended any activities nor engaged with neighbors on their own. RWCI staff should identify and look out for residents who have remained isolated from their neighbors to ensure they have an adequate support system and are encouraged to access the resources provided by RWCI as needed. As RWCI continues offering activities, they should ensure there is some time built in for residents to socialize, and that they are encouraged to do so through ice breakers or other interactive programs. Network size is a good indicator of weak and/or bridging ties, which may be beneficial for information sharing; having at least one strong relationship (strong ties/ bonding social capital) within the neighborhood can have an overall positive impact on individual and community wellness.

Among residents who identified at least one neighbor to whom they talk, their strongest relationship was relatively strong. The average rating was four on a 0-to-6 point Likert scale, indicating participants shared information/talked with their closest neighbor *a few times per month*. This frequency of communication is similar to national findings in urban areas by the Pew Research Center (Parker et al., 2018). Although not replicated in this study, an abundance of literature indicates strong positive relationships and social support are beneficial for overall well-being (Berkman, 1984; Florez et al.,

2016; Israel et al., 2002; Kawachi et al., 2008; Kawachi et al., 1999). The present study does suggest having at least one strong relationship may improve one's overall experience living in the neighborhood. In the next section, the importance of bonding social capital and overall neighborhood perceptions are discussed.

*4.2.2 Neighborhood Perceptions*

Based on the community needs assessment, residents' neighborhood perceptions, specifically their perceptions about their neighbors, were low (i.e., negative) both years, based on the Social Capital Index score. The SCI index score was strongly correlated with participants' perception of neighborhood safety and trust. Nearly 85% of participants had negative perceptions about their neighbors, with about one third of residents scoring in the *lowest* score range and about half of residents falling into the *low* perception score range as defined by Singh (2008). There were not significant changes in perception from 2018 to 2019, but overall perceptions were slightly more negative in 2019 than 2018. It is not uncommon for residents of low-income or mixed-income neighborhoods to have negative perceptions about their neighbors, however perceptions can be changed with intentionality and persistence (Tach, 2009).

Although participants did not have positive perceptions of their neighbors, the strength of participants' strongest relationship with a neighbor was associated with more positive overall perceptions of their neighbors based on the Social Capital Index score. Ross and Jang (2000) found a similar mediating relationship between social ties and overall neighborhood perceptions. The relationship between participants' social network strength and perceptions about neighbors suggests ensuring residents have at least one strong neighborhood bond may improve their overall experience in the neighborhood.

Neighborhood perceptions are important as they have been linked to adults' and children's behaviors and health through indirect and direct pathways (Iida & Rozier, 2013; Singh et al., 2008). For example, negative experiences with a neighbor can lead to negative feelings about the neighborhood and impact the level of perceived safety, which can be traumatic to children raised in such an environment (Duhal, Swahn, & Hayat, 2018; Lima, Caughy, Nettles, & O'Campo, 2010). In fact, negative neighborhood perceptions have been associated with increased allostatic load (Gustafsson et al., 2014; van Duerzan et al., 2016) and chronic conditions associated with stress such as hypertension (Al-Bayan, Islam, Edwards, & Duncan, 2016; Mujahid, Roux, Cooper, Shea, & Williams, 2011). Previous studies have also linked caregivers' negative neighborhood perceptions to higher levels of television viewing, and reduced physical activity among children (Datar, Nicosia, & Shier, 2013; Singh et al., 2008; Tappe, Glanz, Sallis, Zhou, & Saelens, 2013), which can have a negative impact on their education, development, and health (Goran, Reynolds, & Lindquist, 1999; Strong et al., 2005). Although there was no relationship between neighborhood perceptions and health in the present study, prior studies have shown neighborhood perceptions to play a role in individual well-being. Since neighborhood perceptions could be linked to well-being, particularly among children, RWCI would benefit from learning more about residents' neighborhood perceptions and how to improve them. There were group differences in neighborhood perceptions among participants in the present study. These group differences are discussed below, and provide some insight that can be used to guide future efforts to improve neighborhood perceptions.

Relative to those in the older housing, residents living in the newer, mixed-income housing had more positive perceptions of their neighbors in 2018. The physical conditions and appearance of the newer housing might play a role in these differences in perceptions. The built environment of the newer housing is brighter, more spacious, and better lit than the older housing. Such characteristics of the built environment have been linked to a greater sense of safety among residents (Austin, Furr, & Spine, 2002) and lower levels of mistrust (Ross & Jang, 2000). Residents are also aware that the newer housing is mixed-income, which may lead to a more positive perceptions of the reliability of their neighbors than the stigma associated with low-income or public housing (McCormick et al., 2012). Although there were differences in neighborhood perceptions related to housing, there were not significant differences across SES, which could be a positive finding for the mixed-income housing, since previous research has indicated higher income or market rate residents in mixed-income neighborhoods tend to have more negative perceptions about their neighbors (Joseph & Chaskin, 2010; McCormick et al., 2012). Further examination using open-ended qualitative questions about neighborhood perceptions could shed light on why the perceptions of residents in the newer housing differ from those in the older housing. Open-ended questions can help determine if the negative perceptions are based on experiences, assumptions (i.e., biases), the built environment, or all three. Understanding whether the perceptions are based on experiences or assumptions can help RWCI identify potential interventions to improve residents' relationships and perceptions, particularly for residents in the older housing. Aside from housing, the only other characteristic related to residents' neighborhood perceptions was their disability status.

Residents with a disability had lower perceptions of the neighborhood than those without one. The relationship between disability and neighborhood perceptions is an unexpected finding, and is difficult to interpret without a full understanding of the disabilities experienced by respondents. The type of disability (i.e., physical or mental) and the degree to which the disability impacts daily life may lead to different explanations of the negative neighborhood perceptions. One possible takeaway from this relationship comes from Kloos and Townley (2011), who found that among individuals with severe mental illness, those with greater levels of psychiatric distress had more negative perceptions about their *belonging* in their neighborhood. Previous research also indicates individuals with psychological disabilities are more likely to experience microaggressions (i.e., subtle or unintentional acts of discrimination) from their neighbors in low-income neighborhoods (Gonzales et al., 2018). The experience of microaggressions and a lack of sense of belonging may explain the negative perceptions among participants with mental disabilities about their neighbors.

Similarly, residents with a physical disability may also experience microaggressions leading to negative perceptions. They may also have different needs or expectations of support than their able-bodied neighbors. Not having those needs met might lead to negative perceptions about their neighbors' intent to support them and their family. RWCI staff should learn more about why residents with disabilities have more negative experiences, and take advantage of their attendance at health activities to support positive interactions and engagement. RWCI might consider conducting an educational campaign to destigmatize disabilities and promote more supportive

relationships for residents with disabilities, which may ultimately improve their experiences in the neighborhood, and their neighborhood perceptions.

### *4.2.3 Community Building Recommendations*

RWCI's community engagement (e.g., community cookouts, block parties) and other activities seem to already support some relationship building among residents. However, since neighborhood perceptions are overall low, and having at least one strong relationship may change that perception, continuation of such activities is a positive way to allow natural relationships and bonds to form, driven by individual interests. Adding structured socialization to those activities such as team building games or ice breakers may facilitate faster relationship building than might naturally occur. RWCI may also consider implementing an optional neighborhood-based peer mentoring program, which would provide residents with opportunities for both bridging and bonding social capital. Peer mentoring has been a successful strategy in schools, universities, and employment settings (Colvin & Ashman, 2010; Ensher, Thomas, & Murphy, 2001), but its use in neighborhoods has not been examined. A peer mentoring program might also benefit mentors' self-esteem by highlighting and allowing them to share their strengths and skills, and also provides a supportive resource for mentees (Colvin & Ashman, 2010; Karcher, 2009). Being in a peer mentoring position can be therapeutic for the mentor as described in the "helper therapy principle" (HTP; Reissman, 1965), which refers to the benefit a "helper" receives when helping a peer navigate a shared challenge or issue, that is currently less severe for the helper. The most prominent example of HTP is in Alcoholics Anonymous (AA), where a more seasoned member of AA acts as a sponsor for a newer member, but it has been replicated in other settings (e.g., cancer support

groups, navigating child protective services). Another less-direct approach RWCI could use would be making residents more cognizant of the positive qualities of their neighbors.

One potential way to improve residents' perceptions of one another is for RWCI to reward and highlight acts of kindness or prosocial behaviors within the neighborhood to make residents more aware of positive behaviors among their neighbors. RWCI could use social media or the neighborhood newsletter to highlight the positive behaviors and characteristics. RWCI could potentially shift residents' focus away from negative behaviors and encourage them to display acts of kindness for each other. Residents are likely aware of negative behaviors within the neighborhood, and highlighting positive behaviors may help balance or improve residents' perceptions of one another. The goal for RWCI is not necessarily to have all residents connect and develop strong bonds with all of their neighbors, rather to ensure residents have a general sense of trust and safety within the neighborhood, have a least one strong relationship, and have a few weak ties, preferably that cross SES.

Special attention may need to be paid to improve the experiences of residents with disabilities or low-income residents who remain isolated from neighborhood activities and neighbors. RWCI should determine whether residents with disabilities and those who are isolated from their neighbors have strong external social support systems and encourage them to engage with RWCI's services to have their needs met.

### 4.3 Health and Wellness

While the majority of residents reported good to excellent physical and mental health, roughly one third of residents reported fair or poor physical or mental health, and there was a significant correlation between physical and mental health. Those with fair

or poor physical health were likely to also experience poor mental health (and vice versa). Although SES and other factors have been associated with health in prior literature (Olshanky et al., 2012; Roelfs et al., 2011), there were not significant relationships between SES and self-reported health in this study. The small sample size and/or restricted variability across income and education levels may explain the null findings.

That said, Dowd and Zajacova (2007; 2010) suggested researchers use caution when examining self-reported health in lower SES populations, due to their finding that relationships between biomarkers and self-reported health were less consistent in participants with lower SES levels. They suggest assessing specific risk factors, such as chronic pain in addition to self-reported health to best understand health inequities across the SES spectrum.

Participants with a disability were eleven times more likely to report their physical health was fair/poor and twenty-nine times more likely to report poor mental health. This is not surprising since disabilities themselves are linked to physical and mental wellness, but they can also create secondary health issues such as obesity, hypertension, and cardiovascular disease associated with limited physical activity (Moss, 2009; Schroeder, DuBois, Sadowsky, & Hilgenkamp, 2020). As discussed in the previous section, additional consideration of supports for individuals with disabilities, particularly if they are raising children, should be made. Children's physical activity is often associated with their parents' (Griffith et al., 2007), and living with a caregiver in poor physical and mental health can create additional stressors and barriers impacting children's success in school without appropriate resources and support (Bratti &

Mendola, 2011; Currie, 2005). The role of caregivers' well-being and behavior on their children is another important consideration for RWCI as they continue planning supports and services for residents with disabilities.

There were no significant relationships between social networks or neighborhood perceptions and self-reported health. This is also inconsistent with prior research, which suggests supportive relationships and positive neighborhood perceptions are related to health (Franzini et al., 2005). Again, restricted range and sample size may have played a role in the null findings. Nevertheless, there are known benefits of having supportive relationships on health (Berkman, 1984; Florez et al., 2016; Israel et al., 2002; Kawachi & Berkman, 2000; Kawachi et al., 2008) and as discussed in the previous section on community building, RWCI should still consider additional ways to expand and strengthen relationships among residents for their overall well-being.

There are direct actions RWCI can, and already does, take to improve residents' health, through their activities (e.g., workouts), referrals (e.g., access to primary care), and efforts to support the development of social networks as described above. Additional recruitment strategies and more regimented wellness programming with biometric data collection (for greater reliability of health status) may yield improvements in individuals' health. Although there were not significant changes in self-reported health in the present study, it is important to note the role RWCI plays in addressing the known social determinants of health, such as SES, housing, child care, social supports, and neighborhood perceptions. Because of their holistic approach, RWCI should continue to monitor the individual impact of the activities and resources provided on individual health, but also anticipate and monitor longer-term improvements in population health.

# CHAPTER 5: LIMITATIONS AND FUTURE DIRECTIONS

There are several limitations in the present study, including the small sample size, limited variability across some metrics, and skewed data. Data limitations are not uncommon in the nonprofit sector (Carnochan et al., 2014) and create challenges with generalizability, impact the types of analyses that can be used and the power of the analyses. Such limitations also influence interpretations of findings and their implications. Despite its limitations, the present study provides an example of how nonprofits, particularly place-based nonprofits, can use limited data and data collection resources to understand differences in service utilization based on residents' characteristics, relationships among key components of healthy communities (e.g., SES, health, social capital), and the degree to which service utilization impacts those key components and other outcomes of interest. Future data collection should focus on increasing sample size and representativeness to include residents in RWCI's service area who do not utilize the services and who reside in the market rate apartments. In addition to increasing sample size, RWCI should also ensure that the timing and frequency of data collection provides an accurate representation of volatile metrics such as employment status or includes questions about recent employment transitions or changes.

Employment status in the present study was examined as a single point in time – the time of survey completion – which creates a gap in residents' employment experiences throughout the year (i.e., job or income changes). Employment data should be collected monthly from residents who participate in RWCI's Care Coordination and college/career activities to better capture job (in)stability and income changes.

Additionally, the manner in which activity participation was collected and assessed should be modified. Specifically, activities that directly link residents to employment (e.g., job fairs) should be documented and assessed separately from those that indirectly bolster employment opportunities (e.g., resume writing) to understand their impact, since the former involves a one-time direct link to employment while the latter involves longer-term involvement and does not provide a direct link to employment. Combining the two, as done for the present study, may mask the relationship between participation and changes in employment. RWCI should follow up with participants of those indirect employment supports to gather qualitative information about the degree to which the activity helped their employment status or prospects. By monitoring employment status more regularly and differentiating the types of college/career activities offered, RWCI may be better able to detect the degree to which their college/career activities yield positive changes in employment, particularly given that some residents only minimally engaged in activities that might be expected to cause these changes.

Although employment status may have changed more rapidly and required more frequent monitoring, education level may necessitate more time to detect significant changes. The 18-month timeframe assessed in the present study may have limited the ability to detect changes in education level and relationships among these changes and participation in RWCI's activities. Better data regarding hours of participation in educational programs (i.e., programs that would award diplomas or certifications) would inform RWCI about short-term educational achievements that could serve as building blocks for longer-term changes in educational attainment. Better data about participation in long-term educational activities will also inform RWCI about retention, completion

rates, and time to completion, which in turn should inform outcome targets, implementation changes, and funding strategies for these activities. Although changes and increases in data collection procedures are needed, RWCI should manage their need for data without creating a burden or survey fatigue among residents. This can be done through a more centralized data system rather than ongoing surveys.

A centralized data collection system, such as a Customer Relationship Management (CRM) or case management software, would allow for better ongoing data collection from regular program participants, rather than relying on a once-per-year assessment of residents' income, employment, and health status and separate collection of participation in activities. With a CRM, RWCI would be able to monitor care coordination program referrals and activities, resident engagement, demographics, SES, more granular activity participation (e.g., hours of adult education completed), children's program participation, contact information, and more in one location. Currently, some of this information is collected via surveys, some is entered into Excel spreadsheets, and some is entered into REDCap Cloud. Having all the data in one location will allow RWCI to more easily examine whether their services are related to positive changes in residents' SES, health, neighborhood perceptions, social networks and more. By collecting data regularly, in a centralized system, RWCI can directly connect any changes in SES to participation in different types of RWCI's activities.

Using a centralized system also removes the need to collect survey data within a certain time frame each year for many residents, since the data can be gathered regularly through care coordination programs and activity attendance. The use of ongoing data collection will likely increase the number of residents from whom RWCI is able to gather

the data since there will not be a time restriction. With a centralized system, RWCI staff could quickly ask simple questions related to the activity type and anticipated outcomes (e.g., participants at college/career activities could be asked about employment status at each event). Since addresses would be included in the CRM, the system could also be used to more easily identify residents who do not participate in activities by examining which households (i.e., addresses) have not yet engaged with RWCI. RWCI could then actively engage those residents who do not participate to learn more about their needs and interests and document those in the CRM.

By using a CRM, RWCI would have a larger, more representative sample, which would allow RWCI to group residents by their characteristics, similar to the work of Theodos and colleagues (2012). Clustering will allow RWCI to better manage service promotion and recommendations for residents based on their cluster status and individual goals. Clustering or grouping residents will not only help with program promotion, but can also benefit future analyses examining changes in SES, health, social networks, and neighborhood perceptions across distinct groups of residents. Using clusters can help eliminate skewed data, particularly in income level, so that RWCI leadership and staff can better understand how their work impacts different groups of residents. Although there were limitations to the present study, the information learned can be used by RWCI to improve services, outcomes, data collection, and fundraising.

# CHAPTER 6: CONCLUSION AND IMPLICATIONS

The present study examined data collected from adults living in a neighborhood in the early stages of revitalization through a place-based approach via the Purpose Built Communities (PBC) model. One overarching goal for place-based initiatives like RWCI is to build a healthy community (Dupre et al., 2016) by promoting educational achievement, economic mobility, social capital, and individual health. Although RWCI uses a two-generation approach, the present study solely focused on data collected from adults in the neighborhood. The focus on quantitative data from adults is an important addition to the existing literature of place-based interventions because much of it focuses on children or qualitative experiences of the adults. By examining adults' participation in RWCI's activities, existing relationships among their characteristics, their attendance, social networks, health, perceptions of their neighbors, and some changes in these variables over time were identified. Although the present study focused on adults, several of the variables and findings also have implications for the well-being and success of the children living in the neighborhood, which is important for the two-generation approach of PBC and RWCI.

## 6.1 Economic Mobility

Based on the present study, RWCI's activities have not yet yielded substantial gains in the primary outcomes of interest (e.g., increased income, employment, education). Better, more frequent data collection and monitoring of activity participation over an extended period of time will help RWCI better understand the degree of impact of their activities, and inform changes to improve or expedite outcomes. In particular,

RWCI should focus on whether college/career activities are increasing residents' SES, the length of time RWCI and other place-based interventions might expect those changes to take, what activities yield the greatest impact, and which residents benefit the most from each activity. RWCI can use the findings in the present study about residents' characteristics and participation to determine if they are reaching their target audiences, and potentially group residents based on those characteristics, particularly SES, to target promotions for specific activities.

6.2 Community Engagement

Resident engagement with RWCI is a key area on which RWCI must focus for long-term sustainability. Many low-income residents are not engaged at all in RWCI's activities or with their neighbors. Additional work engaging isolated residents to determine if their needs are met and they have adequate social support is warranted. Having a better understanding of why residents remain disengaged can inform the Initiative and will determine what, if anything, RWCI staff need to do. For example, residents not knowing about RWCI's activities and residents knowing, but being disinterested in RWCI's activities require two different responses. Follow-up with residents who are disengaged will help RWCI either support a larger portion of the neighborhood, or have information to suggest those residents will not engage with RWCI and redirect resources to other community members who will.

Intentional engagement strategies among residents themselves is also necessary. Residents' perceptions of one another are negative. RWCI should learn more about those negative perceptions and work with residents with the biggest social networks to help improve residents' experiences with one another. Adults' perceptions of the

neighborhood have important implications for building social cohesion and for children's experiences within the neighborhood. Place-based interventions are long-term and can be challenging without extensive funding and collaboration among community members living in the *place*. Therefore, building strong and weak ties within the neighborhood, especially among residents with disabilities, may be an area in which more resources are needed.

## 6.3 Conclusion

Minimal data exist to guide early efforts of place-based interventions around achieving outcomes for adults and building a sense of community among residents. RWCI has an opportunity to collect and use data to guide their own interventions and inform funders and other place-based initiatives about timelines and strategies to maximize impact with limited resources.

Table 1. *Participant Demographics*

| | Min Age | Max Age | Median Age (Mean; SD) | Female | Housing* |
|---|---|---|---|---|---|
| 2018 Only (n=95) | 18.2 years | 96.3 years | 34.9 (40.1; 14.8) years | 89.5% | 62.1% |
| 2019 Only (n=63) | 20.4 years | 80.7 years | 36.4 (40.1; 13.8) years | 88.9% | 59% |
| 2018 and 2019** (n=50) | 25.5 years | 80.7 years | 36.4 (40.7; 13.4) years | 90% | 56% |

* Reflects the percentage of participants living in the newer housing
** 2019 values were selected for this table

Table 2. *Metrics of Interest by Data Source*

| | CNA | BUF | FSS |
|---|---|---|---|
| Age | X | X | X |
| Education Level | X | X | X |
| Employment Status | X | X | X |
| Gender | X | X | X |
| Income | X | X | X |
| Move-in Date | | | X |
| Program Enrollment Date | | X | X |
| Self-Reported Health Status | X | X | |
| Social Networks | X | | |
| Neighborhood Perceptions | X | | |

*Note:* CNA is Community Needs Assessment; BUF is Building Uplifted Families; and FSS is Family Self Sufficiency. The latter two are case management programs with their own data collection processes.

Table 3. *Descriptions of Data Sources*

| **Data Source** | **Description** | **Data Collection Method** | **System Used** | **Key Variables** |
|---|---|---|---|---|
| Building Uplifted Families (BUF) Program | Care Coordination program available for any HOH not participating in FSS | Care Coordinator administered questions at enrollment and at three- to six-month intervals | REDCap Cloud | Income, Education Level, Employment Status, Self-Reported Health, Program Start Date |
| Family Self Sufficiency (FSS) Program | Care Coordination program tied to the mixed-income housing development | Care Coordinator collections check stubs and other documentation to enter information into the system | Tracking-At-A-Glance (TAAG) | Income, Education Level, Employment Status, Program Start Date |
| Community Needs Assessment (CNA) | Annual survey administered to Heads of Household (HOH) in 2018 and 2019 | Electronic survey administered by RWCI staff, volunteers, or self-administered by HOH | Qualtrics | Income, Education Level, Employment Status, Self-Reported Health, Social Networks, Social Capital |
| Activity Participation | List of RWCI activities each resident attended | Paper or electronic sign-in administered at entry to each activity | Excel; Qualtrics | Number, Date, and Type of activities attended by each participant |

Table 4. *Renaissance West Community Initiative (RWCI) Activity Types*

| Categories | Number Offered | Category Description | Examples of Activities |
|---|---|---|---|
| Children's / Education | 23 | Children's activities with parental engagement components, or information / registration sessions for children's programs. Aimed to promote parental engagement | Parent meeting for Big Brothers, Big Sisters program; Girl Scouts Registration; Navigating the School System info Session |
| College/Career | 73 | Skill-building activities and resource / informational activities for adults seeking to increase their education level, find employment, or advance their careers. | GED Classes; Job Fairs; Computer Classes |
| Community Engagement | 14 | Community-wide events aimed to provide fun, family friendly activities and food to promote community building among neighbors and RWCI. | Block Party; Easter Egg Hunt |
| Financial | 15 | Financial literacy and management workshops aimed to increase financial responsibility. | Budgeting Workshops; Credit Counseling; Financial Management Workshops |
| Health Activity / Resource | 60 | Activities aimed to promote healthy lifestyles and access to resources. | Farmer's Market; Workouts |
| Health Education | 29 | Educational programs aimed to increase understanding and awareness of the importance of healthy living. | Cooking Classes; Health Fairs; Mental Health Workshops; Chronic Disease Management Workshops |
| Supportive Service | 17 | Wraparound services related family support such as parenting classes, case management aimed to meet additional family needs and promote healthy relationships. | Domestic Violence Info Sessions; FSS Program Meetings; |
| **TOTAL** | 231 | | |

Table 5. *Descriptive Statistics for 2018 Continuous Variables*

| | *n* | *Range* | *Mean* | *Median* | *SD* | *Cronbach's Alpha* |
|---|---|---|---|---|---|---|
| Age | 92 | 18.2 - 96.3 | 40.1 | 34.9 | 14.9 | |
| Years in Neighborhood | 89 | 0.25 - 16.0 | 4 | 3.4 | 3.4 | |
| Income | 83 | $0 - $70,000 | $14,338 | $12,000 | $11,223 | |
| Activities Attended | 93 | | | | | |
| Health Resources | | 0.0 - 28.0 | 3.4 | 1.0 | 5.5 | |
| Health Education | | 0.0 - 9.0 | 1.0 | 0.0 | 1.8 | |
| College/Career | | 0.0 - 18.0 | 1.2 | 0.0 | 2.8 | |
| Supportive Services | | 0.0 - 5.0 | 0.7 | 0.0 | 1.1 | |
| Community Engagement | | 0.0 - 7.0 | 0.9 | 0.0 | 1.3 | |
| Children's Programs | | 0.0 - 5.0 | 0.5 | 0.0 | 1.1 | |
| Financial Literacy | | 0.0 - 6.0 | 0.3 | 0.0 | 0.9 | |
| Total Programs | | 0.0 - 53.0 | 8.0 | 5.0 | 10.0 | |
| Social Networks | 93 | | | | | |
| Number People in Network | | 0.0 - 3.0 | 1.5 | 1.0 | 0.9 | |
| Strength of Relationship | | 0.0 - 6.0 | 2.8 | 3.2 | 2.3 | 0.92 |
| Neighborhood Perceptions | 89 | 0.0 - 12.0 | 6.6 | 7 | 2.8 | 0.83 |

Table 6. *Descriptive Statistics for 2018 Categorical Variables*

| | n | % |
|---|---|---|
| Gender | 93 | |
| Female | | 89.2% |
| Male | | 9.7% |
| Other | | 1.1% |
| Housing | 93 | |
| Older Housing | | 38.7% |
| New Housing | | 61.3% |
| Education Level | 89 | |
| Less than High School | | 23.6% |
| High School Diploma | | 32.6% |
| Some College | | 30.3% |
| Higher Degree | | 13.5% |
| Employment Status | 93 | |
| Employed | | 47.3% |
| Unemployed | | 26.9% |
| Disabled | | 25.8% |
| Physical Health | 93 | |
| Poor (0) | | 9.7% |
| Fair (1) | | 26.9% |
| Good (2) | | 16.1% |
| Very Good (3) | | 24.7% |
| Excellent (4) | | 22.6% |

Table 7. *Correlation Table*

| Variable | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Age | Pearson's r | | | | | | | | | | | | |
| | n | | | | | | | | | | | | |
| 2. Housing[a] | Pearson's r | -0.16 | | | | | | | | | | | |
| | n | 92 | | | | | | | | | | | |
| 3. Years in Neighborhood | Pearson's r | 0.05 | .41** | | | | | | | | | | |
| | n | 88 | 89 | | | | | | | | | | |
| 4. Income | Pearson's r | -0.04 | -.24* | -0.15 | | | | | | | | | |
| | n | 82 | 83 | 82 | | | | | | | | | |
| 5. Education Level | Pearson's r | 0.02 | -.47** | -.29** | .29* | | | | | | | | |
| | n | 89 | 89 | 85 | 79 | | | | | | | | |
| 6. Employmen[tb] | Pearson's r | 0.09 | -.43** | -.27* | .34** | .39** | | | | | | | |
| | n | 68 | 69 | 68 | 63 | 65 | | | | | | | |
| 7. Disability[c] | Pearson's r | .47** | -0.17 | -0.00 | -0.12 | -0.05 | -- [d] | | | | | | |
| | n | 92 | 93 | 89 | 83 | 89 | | | | | | | |
| 8. Physical Health | Pearson's r | -.30** | 0.08 | 0.04 | 0.18 | -0.02 | -0.09 | -.55** | | | | | |
| | n | 92 | 93 | 89 | 83 | 89 | 69 | 93 | | | | | |
| 9. Mental Health | Pearson's r | -0.07 | -0.06 | -0.13 | 0.18 | 0.14 | -0.03 | -.41** | .47** | | | | |
| | n | 92 | 93 | 89 | 83 | 89 | 69 | 93 | 93 | | | | |
| 10. Social Network Size | Pearson's r | 0.06 | 0.06 | 0.14 | 0.06 | 0.02 | -0.15 | 0.07 | -0.12 | -0.02 | | | |
| | n | 92 | 93 | 89 | 83 | 89 | 69 | 93 | 93 | 93 | | | |
| 11. Social Network Strength | Pearson's r | 0.09 | .26* | .27* | 0.02 | -0.15 | -0.19 | 0.06 | -0.06 | 0.00 | .73** | | |
| | n | 92 | 93 | 89 | 83 | 89 | 69 | 93 | 93 | 93 | 93 | 93 | |
| 12. Neighborhood Perceptions | Pearson's r | -0.00 | -.32** | -0.09 | -0.01 | .35** | 0.19 | -0.07 | 0.01 | 0.07 | 0.13 | 0.21 | |
| | n | 88 | 89 | 85 | 80 | 85 | 65 | 89 | 89 | 89 | 89 | 89 | 89 |
| 13. Total Activities Attended | Pearson's r | 0.05 | -0.12 | -0.08 | -0.11 | 0.07 | -0.14 | 0.14 | -0.12 | -0.16 | .29** | 0.14 | 0.08 |
| | n | 92 | 93 | 89 | 83 | 89 | 69 | 93 | 93 | 93 | 93 | 93 | 89 |

* Correlation is significant at the 0.05 level (2-tailed) **Correlation is significant at the 0.01 level (2-tailed)

[a] 0 = Newer Housing; 1 = Older Housing [b] 0 = Unemployed; 1 = Employed [c] 0 = No Disability; 1 = Has Disability

[d] Employment and disability status are mutually exclusive

Table 8. *Standardized Regression Coefficients for Residents' Characteristics and Activity Attendance by Type*

| | Model 1 | Model 2 | Model 3 | Model 4 | Model 5 | Model 6 |
|---|---|---|---|---|---|---|
| | Health Activities | Health Education | College / Career | Children's Activities | Financial Management | Total Activities |
| | *β (SE)* | *β (SE)* | *β (SE)* | *β (SE)* | *β (SE)* | *β (SE)* |
| Age | 0.04 (0.04) | -0.09 (.01) | -0.09 (0.02) | -0.10 (0.02) | -0.18 (0.41) | -0.11 (0.08) |
| No High School (HS) Diploma | -0.05 (1.59) | 0.12 (0.53) | **0.58** (0.82)** | 0.21 (0.43) | 0.18 (0.01) | 0.24 (3.00) |
| Some College, No Degree | 0.18 (1.52) | **0.30* (0.51)** | 0.15 (0.79) | 0.09 (0.40) | 0.10 (0.19) | 0.23 (2.86) |
| Degree Above HS Diploma | 0.25 (1.88) | **0.31* (0.62)** | 0.10 (0.97) | 0.12 (0.60) | **0.40** (0.33)** | **0.31* (3.54)** |
| Has a Disability | **0.35* (1.59)** | -0.00 (0.53) | -0.12 (0.82) | -0.03 (0.51) | -0.09 (0.28) | 0.16 (2.99) |
| Unemployed | 0.22 (1.54) | 0.17 (0.51) | **0.33** (0.80)** | 0.27 (0.42) | -0.00 (0.27) | **0.29* (2.89)** |
| Income | -0.17 (1.52) | -0.06 (0.00) | 0.04 (0.00) | **0.39* (0.00)** | -0.01 (0.00) | -0.10 (0.00) |
| Older Housing | -0.09 (1.50) | 0.05 (0.50) | -0.06 (0.78) | -0.29 (0.40) | -0.24 (0.27) | -0.18 (2.82) |
| Years in Neighborhood | 0.04 (0.17) | -0.12 (0.06) | -0.14 (0.09) | -0.07 (0.05) | -0.05 (0.03) | -0.07 (0.32) |

*Note:* SE is Standard Error; *indicates $p<.05$; ** indicates $p<.01$.

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# APPENDIX A: COMMUNITY NEEDS ASSESSMENT

Note: additional items from the Community Needs Assessment that were not relevant to the present study have been excluded

**Selected Items from Renaissance West Community Initiative (RWCI) Needs Assessment**

- **What is your date of birth? (mm/dd/yyyy)**

- **What is your gender identity?**
  - Male (1)
  - Female (2)
  - Other (3)

- **What is your marital status?** Married, Widowed, Divorced, Separated, Never Married

- **How many adults, ages 18 and older live in this household? (including participant)**
- **Are you unable to work due to a disability?**

- Yes (1)
- No (2)

- **Are you currently employed?**

- Yes (1)
- No (2)

- **What is your approximate annual income?**

- **Which of the following best describes your highest level of education completed?**
- Less than high school (1)
- Some high school (2)
- High school graduate / GED (3)
- Some college (4)
- Technical / Vocational Certificate (5)
- 2 year associates degree (6)
- 4 year / bachelor's degree (7)
- Professional / Masters degree (8)
- Doctorate (9)

- **Are you currently enrolled in an educational program (GED, college, vocational)?**
  - Yes (1)
  - No (2)

- **In general, would you say your physical health is:**
  - Excellent (1)
  - Very Good (2)
  - Good (3)
  - Fair (4)
  - Poor (5)

- **Compared to one year ago, how would you rate your physical health now?**
  - Much better now (1)
  - Somewhat better now (2)
  - About the same (3)
  - Somewhat worse now (4)
  - Much worse now (5)

- **In general, would you say your mental health (emotional well-being) is**: *(*
  - Excellent (1)
  - Very good (2)
  - Good (3)
  - Fair (4)
  - Poor (5)

- **Do you currently have health insurance?**
  - Yes (1)
  - No (2)
  - Don't know (3)

- **Which of the following best describes your insurance provider?**

○ Insurance through your (or your spouse's) employer (1)

○ Medicare (2)

○ Medicaid (3)

○ Affordable Care Act / Obamacare (4)

○ Private Insurance (5)

○ Other (6)

- **How many children under the age of 18 live in this household?**
- **Please tell me the age of each child living in your home**
- **For this next part, think of three adults who live in Renaissance or Little Rock - who do not live with you - that you talk to or trust.**
- **How much would you say you trust .... ?**

| | Completely (1) | Alot (2) | Somewhat (3) | A Little (4) | Not at All (5) |
|---|---|---|---|---|---|
| Person (1) | ○ | ○ | ○ | ○ | ○ |
| Person (2) | ○ | ○ | ○ | ○ | ○ |
| Person (3) | ○ | ○ | ○ | ○ | ○ |

- **How often do you…**

| | |
|---|---|
| Share information about upcoming events with Person 1 (1) | ▼ Never or almost never (1) ... Every day (7) |
| Share information about upcoming events with Person 2(6) | ▼ Never or almost never (1) ... Every day (7) |
| Share information about upcoming events with Person 3 (7) | ▼ Never or almost never (1) ... Every day (7) |
| Receive information about upcoming events from Person 1 (2) | ▼ Never or almost never (1) ... Every day (7) |
| Receive information about upcoming events from Person 2 (8) | ▼ Never or almost never (1) ... Every day (7) |
| Receive information about upcoming events from Person 3 (9) | ▼ Never or almost never (1) ... Every day (7) |
| Give advice to Person 1 (3) | ▼ Never or almost never (1) ... Every day (7) |
| Give advice to Person 2 (10) | ▼ Never or almost never (1) ... Every day (7) |
| Give advice to Person 3 (11) | ▼ Never or almost never (1) ... Every day (7) |
| Get advice from Person 1 (4) | ▼ Never or almost never (1) ... Every day (7) |
| Get advice from Person 2 (12) | ▼ Never or almost never (1) ... Every day (7) |
| Get advice from Person 3 (13) | ▼ Never or almost never (1) ... Every day (7) |
| Talk / text with Person 1 (5) | ▼ Never or almost never (1) ... Every day (7) |
| Talk/text with Person 2 (14) | ▼ Never or almost never (1) ... Every day (7) |
| Talk/text with Person 3 (15) | ▼ Never or almost never (1) ... Every day (7) |

- **How likely are you to seek support from each person...**

| | Extremely Likely (1) | Moderately Likely (2) | Slightly Likely (3) | Neither Likely nor Unlikely (4) | Slightly Unlikely (5) | Moderately Unlikely (6) | Extremely Unlikely (7) |
|---|---|---|---|---|---|---|---|
| Person (1) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Person (2) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Person (3) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

- **How much do you agree or disagree with the following statements:**

| | Definitely agree (1) | Agree (2) | Disagree (3) | Definitely disagree (4) |
|---|---|---|---|---|
| I get most of my support from friends or family who do not live in my neighborhood (1) | ○ | ○ | ○ | ○ |
| I am satisfied with the level of support I get from people who do not live in my neighborhood (2) | ○ | ○ | ○ | ○ |
| I am interested in better relationships with people who live in my neighborhood (3) | ○ | ○ | ○ | ○ |
| In general, I trust my neighbors (4) | ○ | ○ | ○ | ○ |
| I feel safe in my neighborhood (5) | ○ | ○ | ○ | ○ |
| If I had an emergency I would rely on someone who does not live in my neighborhood to help me before asking a neighbor (6) | ○ | ○ | ○ | ○ |
| People in this neighborhood help each other out* (7) | ○ | ○ | ○ | ○ |
| We watch out for each other's children in this neighborhood* (8) | ○ | ○ | ○ | ○ |
| There are people I can count on in this neighborhood* (9) | ○ | ○ | ○ | ○ |
| If my child were outside playing and got hurt or scared, there are adults nearby who I trust to help my child* (10) | ○ | ○ | ○ | ○ |
| There are people in this neighborhood who might be a bad influence on my child/children* [note this is a negatively worded question) (11) | ○ | ○ | ○ | ○ |

*Item included in Social Capital Index (SCI) score

- Which community do you live in?
  - ○ Renaissance (1)
  - ○ Little Rock (2)

- How long have you lived in the neighborhood?

## APPENDIX B: BUILDING UPLIFTED FAMILIES DATA

For participants with missing data from the Community Needs Assessment (CNA), data from the Building Uplifted Families (BUF) data collection system were used to maximize the sample. Items from the REDCap Cloud BUF data collection system included:

- **What is your date of birth? (mm/dd/yyyy)**

- **What is your gender identity?**
  - Male (1)
  - Female (2)
  - Other (3)

- **Are you currently employed?**
- Yes (1)
- No (2)

- **What is your approximate annual income?**

- **Which of the following best describes your highest level of education completed?**
- Less than high school (1)
- Some high school (2)
- High school graduate / GED (3)
- Some college (4)
- Technical / Vocational Certificate (5)
- 2 year associates degree (6)
- 4 year / bachelor's degree (7)
- Professional / Masters degree (8)
- Doctorate (9)

- **In general, would you say your physical health is:**
- Excellent (1)
- Very Good (2)
- Good (3)
- Fair (4)
- Poor (5)

- **In general, would you say your mental health (emotional well-being) is**:
- Excellent (1)
- Very good (2)
- Good (3)
- Fair (4)
- Poor (5)

APPENDIX C: SIGNIFICANT FINDINGS FROM SUPPLEMENTAL ANALYSES

Table A. *Significant Results from Paired Sample t-test Comparing 2018 and 2019 Data*

| Variable | Mean | SD | SE | t | df | *p* |
|---|---|---|---|---|---|---|
| Employment Status 2018 - 2019 | (0.25) | 0.55 | 0.09 | (2.71) | 35.00 | 0.01 |
| Income 2018 -2019* | (3801.76) | 7565.68 | 1404.91 | (2.71) | 28.00 | 0.01 |

Note. SD = Standard Deviation; SE = Standard Error; df = Degrees of Freedom
*Income limited to residents earning $15,000 or less

Table B. *Employment Status 2018 and 2019 Crosstabulation*

| | | 2019 | | | | Total |
|---|---|---|---|---|---|---|
| | | Unemployed | | Employed | | |
| | | n | % | n | % | |
| 2018 | Unemployed | 3 | 21% | 11 | 79% | 14 |
| | Employed | 2 | 9% | 20 | 91% | 22 |
| Total | | 5 | 14% | 31 | 86% | 36 |