

# Mixed-Income Communities as a Strategic Lever to Impact Health Equity: Lessons from the Field and Implications for Strategy and Investment

Mixed-Income Strategic Alliance  
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## Executive Summary

The potential health benefits of deconcentrating poverty and promoting mixed-income communities seem evident. However, the limitations and potential downsides of mixed-income living for the urban poor, including affordability challenges, social isolation and stigmatization, are increasingly clear. A critical question for the community development field is **how can mixed-income community interventions best be used as a transformational lever for creating thriving, equitable, healthy places to live?**

This report provides an overview of the current state of knowledge about how mixed-income community interventions could help achieve greater health equity. The report culminates an eighteen-month inquiry on mixed-income communities and health and focuses on implications from profiles of five mixed-income community interventions that have a strategic emphasis on improving health and wellness.

The report was produced by the Mixed-Income Strategic Alliance, a partnership among the National Initiative on Mixed-Income Communities, a university-based research and technical assistance center; the Center for the Study of Social Policy, a DC-based research and technical assistance center; and Urban Strategies, Inc., a national mixed-income practitioner based in St. Louis. Based on our research and experience, our point of view regarding mixed-income community interventions is that quality mixed-income housing and comprehensive social services alone will not achieve health equity and might leave some households socially isolated and economically marginalized. The additional “unfinished business” of mixed-income community development includes managing the challenging social dynamics of mixed-income communities and incorporating strategies that enable all who live and work there to thrive economically and socially.

We developed site profiles of mixed-income community interventions in five cities, including Cincinnati, Denver, Richmond, San Francisco,

and Seattle. Four of the five sites made health outcomes an early central focus of the redevelopment effort, and the fifth, Yesler Terrace in Seattle, has included health as a core component of its multi-faceted strategy. All five sites have incorporated a variety of direct health interventions such as health clinics and wellness centers, increased access to healthcare, peer health leaders, and health education activities. And all five have also implemented a number of efforts that are expected to promote better health indirectly through physical improvements in housing and infrastructure, increased economic opportunities and inclusive social activities. **Common themes across the sites include:**

- The enduring challenge of stressors in the neighborhood context;
- Difficulties moving beyond programmatic efforts to achieve systemic changes to promote health equity;
- An absence of strategies to leverage social mix itself as a social determinant of health;
- A lack of explicit focus on racial equity; and
- Difficulties achieving resident engagement and participation.

## Implications for Strategy and Action

**Conceptualization and design.** Mixed-income communities are a platform within which to embed direct health interventions (clinics, health education, community health workers) focused on physical, mental, emotional and behavioral health. To maximize health equity through mixed-income communities, they should also be seen as a strategic opportunity for a range of indirect health interventions (physical infrastructure and design, employment and financial education support, community-building activities) that can also have significant effects on health.

- For planners and stakeholders, focus on health as a key outcome of a successful mixed-income community and also be

attentive to ways that poor health can be a barrier to full engagement in the potential benefits of a mixed-income community.

- Be highly cognizant that in addition to the expected positive health outcomes, mixed-income communities can have negative effects on the health of low-income residents, for example the psychological toll of disruptions to the existing community, sudden disconnection from social supports and known resources, and feelings of isolation amidst new racial and economic diversity.

**Practice and implementation.** As planners of mixed-income communities develop strategies to improve health outcomes, they should consider ways to leverage social mix for additional benefit to all residents.

- Finance, design, and manage on-site health facilities and activities to serve as broad a spectrum of residents as possible. Avoid the perception that health facilities and programs are limited to “low-income” residents.
- Consider physical design as a key opportunity to promote more inclusive social dynamics in residential buildings and other amenities.
- Consider ways to more intentionally design, implement, and measure economic opportunities to have meaningful impacts on physical, emotional and behavioral health.
- Develop clear strategies to promote inclusive social dynamics at three levels:
  - Individual level: address **perceptual dynamics**, e.g., strategies that promote a sense of belonging, that help shift narratives about who is a valued member of the community, and that set a tone of aspiration and possibility.
  - Social level: address **relational dynamics**, e.g., strategies that make it easy for individuals to make and deepen connections across lines of difference such as race, class, and housing tenure.
  - Structural level: address **influence and power dynamics**, e.g., governance strategies and mechanisms that provide

inclusive opportunities for input, decision-making, and authority.

**Policy implications.** Use policy deliberations to: elevate the focus on a broader range of equitable outcomes from mixed-income communities, including health equity; incorporate financial support for more comprehensive approaches to mixed-income interventions; and establish higher expectations and performance measures for mixed-income communities.

- Incentivize greater intentionality, creativity and innovation in the design and management of mixed-income strategies through funding stipulations, selection criteria, program guidelines, and monitoring priorities.
- Support aligned strategies beyond housing to promote economic opportunity and social cohesion through collaborative planning, braided funding from public and private sources and technical assistance and capacity building.
- Identify ways in which broader systems are complicit in maintaining inequitable practices and constraining efforts to promote broader inclusion, for example funding streams that complicate the design and marketing of health services for a mixed-income population.
- Attend proactively to the long-term sustainability of income mix by incorporating strategies to hard-wire affordability into housing options in the community, protect low-income households and provide a ladder of housing options to accommodate economic mobility.

**Data and research implications.** Given the limited evidence base on mixed-income communities and health, it is imperative that mixed-income interventions be given support to access and manage health data, to carefully track and document their efforts to promote health equity and to help advance research to measure the role of social mix in promoting and constraining health outcomes.

## Introduction & Motivation

A core problem faced in the United States today is the health inequity generated and reinforced by housing instability, growing inequality, concentrated poverty, and racial segregation. Across the country, the disparities in health and social conditions and outcomes are worsening and are being reinforced by market forces, policies and an increasing culture of polarization. On the other hand, there is a tremendous opportunity presented by other prevalent social trends such as an increasing taste for urban living, walkability, and the social vibrancy of greater cultural diversity. There are also economic imperatives such as the benefits of agglomeration economies that are driving renewed population growth in urban and metropolitan areas. Mixed-income communities represent a possible strategic leverage point for healthier and more equitable communities. Mixed-income environments can both meet the new preferences for urban living of the affluent and also address enduring issues of residential segregation and social and economic isolation in low-income communities. There is increasing recognition of the risks of neighborhood revitalization that does not attend to the needs and aspirations of longstanding residents, especially low-income households of color.

### **The imperative of promoting more equitable and inclusive mixed-income communities.**

There have been over twenty-five years of place-based mixed-income policy efforts in the U.S. aimed to promote mixed-income communities either through housing development in low-income neighborhoods or inclusionary development in low-poverty areas. Increasingly, a third approach to generate mixed-income communities involves preserving affordable housing in gentrifying low-income neighborhoods. Unlike in the housing mobility field where strong evidence exists about the impacts when a family moves from a high-poverty to a low-poverty community, there is limited research on the impact of place-based approaches to poverty deconcentration.<sup>1</sup> Most available

place-based mixed-income research is on the mixed-income transformation of public housing developments and it suggests that, while there are indeed benefits to low-income households from the physical revitalization of these communities, there is often enduring or increased social exclusion and limited economic opportunity generated.<sup>2</sup> Thus, there remains a clear imperative to determine how to promote and sustain more equitable and inclusive mixed-income communities where all families can feel a sense of belonging and efficacy and can thrive economically.

### **Core question: How can interventions to promote mixed-income communities best be a transformational lever for creating thriving, equitable, healthy places to live?**

While the potential benefits of deconcentrating poverty seem clear based on evidence about the negative outcomes associated with living in high-poverty communities, the limitations and potential downsides of mixed-income communities for the urban poor are increasingly evident. Specifically, with regards to health outcomes, while the research is clear about the negative impacts of segregation, deprivation and economic isolation on health, too little is known about whether mixed-income communities promote better health outcomes. And, if they do, in what ways, under what circumstances, and for which populations? Ultimately, given the increasing investment in cities across the United States and in other countries in mixed-income development along with growing waves of gentrification, the critical question is how can we more effectively leverage mixed-income communities as a positive social determinant of health for all residents? Key elements of the answer to that question involve how to better promote inclusive social dynamics and economic opportunity in mixed-income communities and how to maintain the investment and activities necessary to enable all families to be stable and thriving.

This report provides an overview of the current state of knowledge about how mixed-income community interventions could help achieve

**Figure 1**  
**Map of Planned Mixed-Income Developments in the U.S.**

Source: National Initiative on Mixed-Income Communities



greater health equity. The report culminates an eighteen-month inquiry on mixed-income communities and health and focuses on implications from profiles of five mixed-income community efforts that have a strategic emphasis on improving health and wellness.<sup>3</sup> After defining the context and scale of mixed-income community interventions and reviewing existing literature on mixed-income communities and health, we describe the five site profiles and discuss cross-cutting themes that emerged from that investigation. We close with implications for action and investment by funders, policymakers, practitioners and other stakeholders in the mixed-income arena that have a particular interest in health outcomes.

## Mixed-Income Communities Context and Scale

Ultimately, we are interested in a broad definition of “mixed-income communities” that refers to neighborhoods with a population that is economically and racially diverse, including a significant proportion of housing for those in poverty as well as affordable housing for those on moderate incomes. These communities can be planned and managed through specific public-private initiatives as well as more naturally-occurring through local market forces and social trends. The most high-profile planned mixed-income communities are the federally-funded HOPE VI and Choice Neighborhoods Initiative grantees. There are 259 HOPE VI grantees and over 100 Choice Neighborhood grantees.<sup>4</sup> The National Initiative on Mixed-In-

come Communities database<sup>5</sup> identifies over 50 additional planned major mixed-income complexes that are not HOPE VI or Choice funded. A conservative estimate, based on the number of planned developments and their average unit count, would be that there are well over 100,000 extremely low-income households in these planned developments and a projected total mixed-income population of about three times that. Adding in the population in the neighborhoods around the redevelopment sites, which is often a target of impact as well, generates a population in the millions affected by planned mixed-income developments.

Inclusionary housing is another form of planned mixed-income community where developers are incentivized or required to set aside a proportion of their building's units, often ten to twenty percent, for low- or moderate-income households. More than 500 local jurisdictions in the United States have implemented inclusionary housing policies across 27 states and the District of Columbia, and by 2010, these efforts had produced up to 150,000 affordable units.<sup>6</sup>

As for more “naturally-occurring” mixed-income neighborhoods that are not managed by a planned intervention, forthcoming research by Elizabeth Kneebone and Carolina Reid from the Turner Center for Housing Innovation at UC Berkeley reports that just under 5,000 census tracts (about 10 percent of all tracts) in the 100 largest metropolitan areas in the U.S. are “mixed-income.”<sup>7</sup> These mixed-income tracts were home to 23 million people, 11 percent of the population of those metropolitan areas. Interestingly, within these areas, they find twice as many mixed-income tracts in the suburbs as in the cities.

The focus of the Mixed-Income Strategic Alliance partners' mixed-income community research, practice and technical assistance has been on planned mixed-income communities, and that is the focus of our inquiry and information-gathering here. In this report we draw from

two types of planned communities: first, public housing developments that have progressed through several, if not all, phases of redevelopment and occupancy and are now experiencing the impacts and dynamics of a mixed-income community, and second, communities that are on a mixed-income transformation trajectory but are still largely low-income with redevelopment and mixed-income occupancy still to come.

## Evidence from Literature Reviews

Unlike the strong research and evidence about the impact of housing mobility on health outcomes, there is extremely limited evidence about mixed-income community interventions and health. Gibson and colleagues' (2011, p. 177) review encompassed 130 studies of housing and health; they report a systematic literature review that “searched for evaluations of mixed income housing developments in areas of high poverty, but found none of sufficient quality for inclusion.” The most complete study to date of systematic reviews of mixed-income community interventions was conducted in the UK by Bond, Sautkina and Kearns (2011). Though the reviewed studies present findings on outcomes such as economic effects, social cohesion, crime, residential stability and neighborhood revitalization, they report:

***“None of the reviews provided evidence for or against changes in health or well-being, health behaviours (drinking, exercise, diet) or psychosocial benefits (pride in area; sense of progress; feeling calm and peaceful; positive identity; raised status or self-esteem), indicating a likely absence of evidence for these effects” (Bond, Sautkina, and Kearns, p. 82).***

## Our Point of View

Mixed-Income Strategic Alliance. The Alliance is a partnership among a research and technical assistance center, the National Initiative on Mixed-Income Communities (NIMC), a policy

and technical assistance center, the Center for the Study of Social Policy (CSSP), and a mixed-income practitioner, Urban Strategies Inc. (USI). Together, we can draw upon several decades of experience implementing, advising, and studying planned mixed-income communities. USI has been directly involved in 13 federal Choice Neighborhood implementation grants and has an overall portfolio that serves over 27,000 households. NIMC has been engaged as researcher or consultant in mixed-income developments in many cities including major multi-site mixed-income transformation efforts in Washington, DC and San Francisco, CA. CSSP is a policy and technical assistance organization and was a technical assistance provider for each program of the Neighborhood Revitalization Initiative (i.e. Choice, Promise, and Byrne) and currently provides capacity building for Promise Neighborhoods grantees.

Based on our research and experience, our point of view regarding mixed-income community interventions is:

- Mixed-income communities can be transformational but also exclusionary. They represent an important and promising platform for a health equity strategy.
- There is strong capacity and know-how to create amenity-rich and service-rich mixed-income housing in high-poverty neighborhoods, but quality mixed-income housing and comprehensive social services alone will not achieve health equity.
- The additional “unfinished business” of mixed-income community development includes:
  - Ensuring that a higher proportion of low-income households can achieve and sustain residence in mixed-income communities without involuntary displacement during relocation and gentrification processes;
  - Promoting belonging and social inclusion and managing the challenging social dynamics of mixed-income communities;
  - Explicitly confronting the enduring ways in which race and racism shape percep-

tions and practice and lead to disparate experiences and outcomes;

- Incorporating strategies that enable all households to thrive economically and socially, including a focus on health, education, employment, and transportation;
- Focusing on three levels of action and change: individual, interpersonal as well as structural;
- Attending to the long-term sustainability of the socioeconomic mix in these communities through greater protections against adverse market and social forces that could tip communities toward re-segregation into concentrated affluence or poverty.

To sum up, our research and experience suggests that while mixed-income community interventions have been successful in achieving dramatic physical transformations and generating greater housing stability and community safety for residents of the revitalized communities, the newly-integrated settings have not led to broader shifts in the economic or social status quo. Low-income households who have been able to remain in the communities remain largely in tenuous economic circumstances with fragile connections to the mainstream labor market and little base of savings or long-term financial stability. Not enough is happening to ensure that mixed-income communities are a platform for housing stability and economic opportunity. On the social side, across income levels, residents’ mental models, social networks, civic engagement or commitment to promoting and stewarding social mix have generally not shifted.

We believe much more could and should be leveraged at an individual and societal level from mixed-income communities, and we are collectively failing to do so. The imperative of mixed-income communities is to demonstrate that people of different socio-economic backgrounds can live together in inclusive ways in communities that remain stably mixed over time—and that all benefit from this, including higher-income, non-minority populations. We

**Table 1**  
**Site Summary Table**

<b>Mixed-Income Intervention</b>	<b>Potrero Hill/Sunnydale (HOPE SF)</b>	<b>Mariposa</b>	<b>Church Hill North</b>	<b>Avondale</b>	<b>Yesler Terrace</b>
<b>Location</b>	San Francisco, CA	Denver, CO	Richmond, VA	Cincinnati, OH	Seattle, WA
<b>Mixed-Income Occupancy</b>	Pre-occupancy	Post-occupancy	Pre-occupancy	Post-occupancy	Post-occupancy
<b>Projected Total Units</b>	1,400/1,400	900	1,038	319	5,000
<b>Neighborhood Population</b>	35,890/31,793	6,029	26,985	12,500	9,328
<b>Overall Health Strategy</b>	A multifaceted, trauma-informed approach guided by a theory of change that prioritizes racial equity, resident engagement and systems change, with on-site wellness centers.	A highly systematic, comprehensive approach, building from a health impact assessment to a healthy living toolkit and campaigns.	A family-based approach that emphasizes access to services and more informed resident choices and behavior, to be centered around on-site health center and community center.	Health as a core element of the redevelopment strategy, with a focus on access to healthcare and improved neighborhood infrastructure.	A multi-level focus on the built environment, access to services and supportive social connections.
<b>Key Direct Health Interventions</b>	<ul style="list-style-type: none"> <li>• HOPE SF Wellness Centers</li> <li>• Peer Health Leaders</li> <li>• Trauma-informed community building</li> </ul>	<ul style="list-style-type: none"> <li>• Health Impact Assessment</li> <li>• Healthy Living Initiative and Toolkit</li> <li>• Healthy Living Coordinator and Campaigns</li> <li>• Patient Navigator</li> </ul>	<ul style="list-style-type: none"> <li>• Health and Wellness Center</li> <li>• Resource Centers</li> </ul>	<ul style="list-style-type: none"> <li>• Federally Qualified Health Center</li> <li>• Health Champions</li> <li>• Health Chats</li> <li>• Health Fairs</li> </ul>	<ul style="list-style-type: none"> <li>• Community Health Workers</li> <li>• Nutrition and cooking workshops</li> <li>• Yesler Breathe Easy program</li> </ul>
<b>Key Indirect Health Interventions</b>	<ul style="list-style-type: none"> <li>• Higher quality, healthy housing</li> <li>• Site improvements for safety and walkability</li> <li>• Employment programs</li> <li>• Community Hub</li> </ul>	<ul style="list-style-type: none"> <li>• Higher quality, healthy housing</li> <li>• Site improvements for safety and walkability</li> <li>• Community gardens</li> <li>• Transit station promenade</li> <li>• Financial literacy programs</li> <li>• Employment programs</li> <li>• Restaurant</li> </ul>	<ul style="list-style-type: none"> <li>• Higher quality, healthy housing</li> <li>• Site improvements for safety and walkability</li> <li>• Family Transition Coaches (case management)</li> <li>• Employment programs</li> </ul>	<ul style="list-style-type: none"> <li>• Higher quality, healthy housing</li> <li>• Site improvements for safety and walkability</li> <li>• Community Gardens</li> <li>• Grocery store</li> <li>• Employment programs</li> <li>• Community WiFi</li> </ul>	<ul style="list-style-type: none"> <li>• Higher quality, healthy housing</li> <li>• Site improvements for safety and walkability</li> <li>• Community Gardens</li> <li>• JobLink program</li> <li>• Financial literacy programs</li> <li>• Community Builder</li> </ul>

know of no way to break down the “us versus them” mentality, so instinctive to humankind, without a direct experience of the “other” that changes the prevailing narrative and demonstrates greater commonalities and shared destinies. Stable, successful, truly inclusive mixed-income communities are one key platform for promoting a more equitable society.

## Findings from the Site Profiles about Mixed-Income Interventions and Health

**Site backgrounds.** We conducted site profiles of mixed-income community interventions in five cities of varying sizes including Avondale in Cincinnati, Ohio; Church Hill North in Richmond, Virginia; Mariposa in Denver, Colorado; Sunnydale and Potrero Hill in San Francisco, California; and Yesler Terrace in Seattle, Washington. Three of the mixed-income communities—in Cincinnati, in Denver and in Seattle—are post-mixed-income occupancy with phases of redevelopment complete and a mix of residents on site. The Richmond and San Francisco sites are still in pre-occupancy, with mixed-income occupancy yet to come. These five sites were selected based on the presence of an intentional mixed-income strategy and a significant focus by designers and planners on issues of health and wellness.

**Site theories of change.** The sites we profiled had varying levels of comprehensiveness in the models that guided their health strategies. Avondale in Cincinnati had a strong core focus on health with a relatively straightforward approach that included housing redevelopment, access to healthcare, and neighborhood infrastructure investments. The HOPE SF initiative in San Francisco and the Mariposa development in Denver developed more comprehensive theories of change about how the redevelopment would be used to improve health outcomes and included an explicit focus on the role of the social environment in shaping individual behavior. Mariposa in Denver and

the Yesler Terrace site in Seattle both include environmental stewardship in their approach to promoting a longer and better quality of life for residents. The Denver site includes a healthy economy as an explicit part of its theory of change.

In San Francisco, the HOPE SF approach to health impact adds several strategic frames to its initiative design: equitable mixed-income housing, using a trauma-informed approach to services and community building, cultivating resident leadership and stewardship and engineering collaboration and systems change through a collective impact approach. HOPE SF also has an explicit commitment to promoting racial equity and considers itself as a “reparations initiative.” The HOPE SF theory of change to achieve positive health outcomes is that increased social engagement and a changed attitude, increased knowledge and skills and changed behavior will lead to good management of chronic disease, strengthened social cohesion, improved mental health and reduced harm from substance abuse.

At Church Hill North in Richmond, the “people plan” developed as part of the Choice Neighborhoods Initiative<sup>8</sup> application takes a family-based approach that aims for children, youth and adults to be physically and mentally healthy through strategies that expand the network of health and wellness services and improve health literacy and behaviors. In Yesler Terrace in Seattle, the approach to health has a multi-level focus on the built environment, better access to services facilitated by a community health worker and an emphasis on community building to promote supportive connections and decrease pervasive feelings of isolation among residents.

**Getting started and developing a health roadmap.** Both the Denver and San Francisco sites used formal health assessments to devise their health strategies. In Denver, a Health Impact Assessment was conducted by the Denver Housing Authority, the redevelopment design

firm and an environmental health consulting firm. Following the assessment, the Denver collaborators developed a very systematic methodology for selecting and launching health strategies and activities. Using a Healthy Living Toolkit (modeled after a tool used by the Department of Public Health in San Francisco), the process started with collecting and reviewing health indicator data and mapping local assets and resources, then determining priority issues through an extensive community engagement process, then launching campaigns to develop action plans, and finally devising a report card to track progress. In San Francisco, the Department of Public Health partnered with the Health Equity Institute at San Francisco State to conduct the health assessments at each of the four public housing developments in the initiative.

**Direct health interventions.** Most of the sites deployed a range of direct health interventions as part of their efforts to use the redevelopment to promote positive health outcomes.

**Health clinics, wellness centers, and other on-site care.** Three of the sites—in Cincinnati, Richmond, and San Francisco—include on-site health centers as part of their health strategy. Avondale in Cincinnati is the only site to have established a Federally Qualified Health Center (FQHC), currently under construction with the support of the Cincinnati Children’s Hospital Medical Center with plans to open in 2019. The Richmond site plans also call for future development of an FQHC. The San Francisco sites piloted Wellness Centers, which provide on-site access to behavioral health services, nursing and primary care for chronic conditions, and a Peer Health Leadership Program, with the support of a major grant from the Kaiser Foundation. The successful take-up at those Centers led to them being hard-wired into long-term funding from the City’s general fund. In Denver at Mariposa, there was a Patient Navigator deployed on site to improve health connections and access. All of these on-site entities worked to promote better access to healthcare through connections to a primary care physi-

cian, referrals to other specialists, support for Medicaid enrollment and promoting annual well-care visits.

**Formal and informal peer support.** Called peer health leaders in San Francisco, community health workers in Seattle and health champions in Cincinnati (with a special focus on young families in that site), these are similar approaches to engaging and educating residents about healthy living through the work of a fellow community member. There were also support groups held in some of the sites for more informal, communal peer-to-peer mutual support and accountability.

**Health education and fitness activities for healthy living.** Through the peer health leaders and other local staff and partners, a variety of educational activities were held, including health awareness fairs and cooking and nutrition classes. At Yesler Terrace in Seattle, the nutrition and cooking workshops are held at a community kitchen. At Avondale in Cincinnati, a series of mini health awareness fairs geared toward children have been held in the school, and live health chats have been hosted by residents on Facebook. There were also a range of fitness activities across the sites including walking clubs, zumba, yoga, and mindfulness and meditation. There were also health screenings held on site. In Seattle, the Breathe Easy Program at Yesler Terrace includes one-on-one health education through appointments with the community health worker to learn about how to protect households from allergens, toxins, and pests, and to receive free resources to help maintain a healthy, clean household. If there is a respiratory illness present in the household, Breathe Easy participants receive free mattress covers and pillowcases and HE-PA-filtered vacuums.

**Health campaigns.** At Mariposa in Denver, there was an extensive series of healthy living campaigns to promote health education and support behavioral change. These campaigns were a central part of the site’s major priority of helping residents live healthier lives and

brought a high profile, consistency and durability to the heightened focus on health. The themes of the campaigns, chosen with community input, were Get Connected, Healthy Places, Healthy Eating, Health Care and Wellness and Lifelong Learning.

**Indirect health interventions.** In addition to the direct health interventions, there were also a number of interventions that were expected to indirectly promote better health outcomes through improvement in social determinants of health. These indirect interventions can be categorized into physical, economic and social domains.

**Physical revitalization.** All of the mixed-income sites have incorporated housing improvements that are intended to promote better health. This includes, for example, removing asthma contributors such as carpet, installing central air and instituting better safety measures such as carbon monoxide detectors, electrical outlet covers and non-slip tub adhesives. There are also often improved on-site amenities geared toward wellness and health such as walking paths, wider sidewalks and bike lanes. In Denver, a promenade was incorporated into the site redesign to facilitate easier walking access to the light rail transit station, and in Seattle, the site was redesigned for greater connectivity to surrounding neighborhoods and public transit. Sites are also making public safety improvements such as visible and well-trafficked public spaces, better lighting and security cameras. Some of the sites have community gardens and promote urban farming for healthy fruits and vegetables. In Cincinnati, there will be a new grocery store and arrangements have been made for area-wide Wi-Fi to increase access to information. There has also been intentionality at the Cincinnati site about promoting a hospitable environment for breastfeeding mothers. At the Denver site, there is a new restaurant that emphasizes healthy menu items. At both Church Hill North in Richmond and Sunnydale in San Francisco, there are plans underway to construct major

community centers to house local services and amenities and as gathering space for community members.

*Economic opportunity.* Each of the sites have developed various programs to increase resident employment including job training, job referrals and internship programs for youth. Some, such as the sites in San Francisco and Seattle, have been able to secure jobs for residents in the construction efforts. The Seattle site recently restructured its adult employment support into a more streamlined JobLink program with comprehensive job coaching and barrier removal, skill development at the community college and connections with local neighborhood and downtown employers. The Denver and Seattle sites have developed financial literacy programs. In Richmond, the Family Transition Coaches that provide case management and service referrals during the redevelopment process include a focus on employment and financial literacy. None of these economic opportunity efforts have been explicitly tied to health outcomes, nor to emerging social mix at the sites.

**Social connections.** The San Francisco sites have the most well-structured strategies to promote social connections among residents. At Potrero there is integrated fitness programming including a walking club and Zumba classes that are marketed to both the redevelopment site and surrounding more affluent neighborhood. At Sunnydale, there are monthly NeighborUp Nights that promote community network-building among residents on-site and also monthly community game nights. There is a neighborhood hub being designed at Sunnydale to connect the future mixed-income site to the broader Visitacion Valley neighborhood. The hub will include a community center, Boys and Girls club and YMCA. In Richmond, a spacious community center is planned with programming that will offer children, youth, and families a cradle to career pipeline of support while also providing activities designed to strengthen relationships among communi-

ty residents. In Seattle, a community builder was hired to focus expressly on activities to strengthen connections among neighbors, such as through establishing the Neighborhood Connectors, a regular gathering of resident leaders that focuses on addressing issues related to social cohesion. The community builder has also begun working with property managers at the privately-owned buildings to begin collaborating on strategies to connect market-rate residents to the rest of the Yesler community.

**Tracking outcomes.** The rigor of available data from each of the sites on resident health outcomes varies widely. The most systematic data collection and reporting is being done at the Denver site through the regular updating of a health indicators report card. The Denver site report card has documented a decrease in smoking, improved self-reported health, decreased crime rate, reduced transit commute time, and improved access to public space. Seattle also has an annual resident survey implemented by community health workers at Yesler Terrace as part of the requirements for the Choice Neighborhoods grant. In most instances, however, there is a reliance on anecdotal evidence to provide a sense of progress. For example, anecdotally, site staff in both Denver and San Francisco report that emergency room visits by residents have decreased. In Denver, despite the indicator tracking, there is a concern that the site is not able to build evidence of the impact of its redevelopment strategy. The most rigorous evidence on health outcomes in these sites will be generated by researchers in San Francisco and in Seattle. Leslie Dubbins and Irene Yen of the University of California San Francisco are funded through an Evidence for Action grant from the Robert Wood Johnson Foundation (RWJF) to measure health outcomes in the HOPE SF initiative. Through in-depth interviews with residents, analysis of public health data on health status and service utilization and analysis of comparison group data, Dubbins and Yen are studying the impact of the HOPE SF mixed-income redevelopment on residents' social lives and

perceived health and well-being. In Seattle, Stephanie A. Farquhar, Roxana Chen, Alastair Matheson, John Forsyth and Maria Ursua also have an RWJF Evidence for Action grant to use annual resident surveys to assess impact of the redevelopment strategies on residents' health and well-being.<sup>9</sup>

## Emerging Lessons Learned from Site Profiles

In many respects, the site profiles provide reassuring evidence that health concerns rank high in the planning, design and implementation of mixed-income interventions. Each of the communities whose strategies were examined include solid efforts to improve access to and quality of health care services, recognizing that these are essential for any health community and particularly important for populations, such as many of the residents in these developments, with health conditions and chronic diseases that occur at higher rates than the norm. All of the developments recognize as well that health is affected by more than health care. While only some use an explicit social determinants framework in their planning, all incorporate strategies that go beyond a narrow range of health-related services (for example, community engagement activities, social networking strategies, community health workers who link residents to a wide range of resources, access to healthy food) that demonstrate an expansive view of health and wellness. Finally, in several sites – Mariposa in Denver and Potrero in San Francisco, particularly – local leaders are trying to act even more intentionally on a recognition of the root causes underlying health and behavioral health issues for too many residents, using the well-researched linkages between trauma and health to develop innovative strategies seeking to prevent or mitigate the negative effects of environment and experience that can affect residents' present-day and lifelong health.

Along with these encouraging signs, however, are challenges still to be addressed. The data,

local leaders' reflections and our observations emerging from the site profile process suggest lessons learned and frontiers still to be crossed if population health is to be further improved. Five seem particularly important.

**Stressors of the neighborhood context.** The stressors experienced by families in poverty are profound and enduring and can be exacerbated by a mixed-income transformation, at least in the short term. Thus, mixed-income interventions should anticipate and address both existing and new health and mental health issues that will emerge directly from the redevelopment process while also attending to current and past trauma. Fear of displacement and the relocation process itself may cause psychological distress. In San Francisco, for example, while HOPE SF has explicitly committed to having as many residents as possible return to the completed mixed-income developments, there remains a high degree of anxiety and uncertainty around relocation and return. Resident stress also stems from the logistics of the move itself and the loss of social connections during the move and potentially upon return (due to families separated into different units to fit their appropriate unit sizes, or friends and families not returning at all). In Yesler Terrace, it was noted that some features of the physical redevelopment have increased social isolation. Prior to redevelopment, neighbors in garden style units were able to easily visit other units by walking over and knocking on neighbors' doors, and it was easier to run into neighbors in the daily routine of coming in and out of units. The new design and security features of the higher density apartment buildings, with elevators and secure entry with fobs or key cards, have restricted informal interactions.

**Challenge of moving beyond programmatic achievements to broader systemic change.** At the sites in Cincinnati, Denver, and San Francisco there has been explicit recognition that while programs and services could address the short and medium term needs of a portion of the current resident population, more durable changes for a wider population would require

broader structural changes that would make the existing systems work more effectively for low-income populations of color in marginalized neighborhoods. However, despite this recognition, these sites have had difficulty achieving meaningful systems change. One effort that has had some modest success is the Avondale Children Thrive effort, described earlier, that is focused on both programmatic and policy solutions. Initial focus areas for local policy change have been promoting smoke-free housing and policies to better accommodate nursing mothers. Related to the need to focus on broader systemic change is the need to broaden for greater intentionality about social determinants of health.

**Lack of focus on the potential benefits and complexities of social mix.** While all the site strategies included programming aimed to directly promote better health outcomes among residents, besides the physical improvements, there was surprisingly little consideration across sites about how the mixed-income environment itself could be a factor in promoting better health and wellness. Although millions of dollars were being spent to create a residential setting where low-income families would live among higher-income residents, those involved with the interventions were not focused on how the social mix itself might be leveraged to be a positive social determinant of health. Instead, the focus was largely on programs and services. A prime example was the Mariposa development in Denver where the strategic focus is on healthy living programming particularly targeted to low-income residents. However, there were no strategies aimed at ensuring that the social mix benefits low-income residents by enhancing economic and social opportunities. In some communities, the profiles document instances of attention to engaging residents across income levels, though not necessarily with intentionality about the health benefits of that mix. For example, the Avondale Children Thrive initiative in the Avondale community in Cincinnati, a partnership of Cincinnati Children's Hospital Medical Center (CCHMC), the Cincinnati Health Department (CHD), and

the site developer The Community Builders, includes an effort to engage a broad population of residents, including market-rate residents, to plan and design a wide continuum of health care needs. BRIDGE Housing, in San Francisco, has also expressed a particular desire for residents' activities to be indistinguishable by income and found some success in mixed-participation in its wellness activities at Potrero, in particular the walking club and Zumba classes; these have been intentionally promoted as activities to facilitate interaction between public housing residents and residents of the surrounding high-income neighborhood. It is also very possible that low-income residents could benefit indirectly from the social mix through local improvements generated by the economic and political influence of higher-income residents. However, there has been little intentionality to make sure that the new external actions and resources—for example policing, services, amenities—benefit residents of all income levels and racial/ethnic backgrounds.

There has also been little proactive attention across the sites to the potential challenges of a mixed-income environment and the stress, stigmatization and social isolation that it might cause for residents of all income levels. Residents of diverse racial and socioeconomic backgrounds bring differing norms and habits as well as assumptions about those who are different from them. How will the inevitable social friction be resolved? Some efforts have been made in Seattle to help Yesler Terrace residents consider what it means to live next to someone who is culturally different and to consider the openness and tolerance it takes to live in a diverse community. There has been an effort to educate new residents of market-rate units about the history of the neighborhood - that they are not moving into a "new" neighborhood, but rather one with a rich history that many of their neighbors have been a part of for years.

Collaborators at the Cincinnati site have been most intentional about funding and designing

health programs to cater to a mixed-income population, through the Avondale Children Thrive initiative. In Denver, by contrast, the focus at Mariposa has been on providing services geared to the low-income households. In San Francisco, Seattle and Richmond where the income-mixing is only now beginning to take shape, there remain many outstanding questions about the implications of a mixed-income population for the health services and amenities on site. Who are the services intended to serve? Will the needs of residents in market-rate and tax-credit units be met through separate strategies and activities? To what extent will service cost be matched to ability to pay? Who will make decisions about receipt of those services?

At Sunnydale in San Francisco, for example, there is not yet official policy or protocol identified around these questions, and conversations are just beginning about the future mixed-income community. It is thought that residents who are living in the market-rate housing will not have access to the clinical services the Department of Public Health is currently providing at the wellness center, simply because the City wants to make sure those services are available to the most in need and the current financing structure only has enough funds for those residents.

Across the sites, given that many higher-income residents will likely be reticent to receive medical care in a facility that also serves a low-income population, there will need to be a premium on marketing, customer service and quality services to attract a diverse constituency. There will need to be vigilance to avoid double standards in treatment based on ability to pay. Future funding structures may accept private insurance from higher-income residents to subsidize the care for low-income patients. Federally-qualified health centers and academic primary care clinics often use this business model and may be a particularly strong partner for mixed-income sites with the need to attract and serve an economically diverse patient base.

Site staff and initiative leaders have not yet confronted how aims of inclusive services and facilities will be communicated or operationalized when the time comes. Although direct clinical services are planned to be just for subsidized and public housing residents at this point, it is hoped that the entire community will come together through health fairs and events for all residents. As each of these sites have demonstrated, one major challenge to leveraging the mixed-income characteristics of the community is that the redevelopment process is such an extended process over multiple years and requires such an intense focus and a heavy lift of resources and planning. This leaves little time and space for planning for the post-occupancy phase in which low-income residents will face the opportunity and challenge of living and thriving in a mixed-income community.

**Lack of explicit attention to race.** While structural racism and racial segregation are acknowledged as fundamental drivers of the health disparities that existed in these communities before the revitalization efforts, most mixed-income transformations lack explicit strategies to promote race equity. Any success in closing health gaps for racial minorities is expected to be a by-product of the general efforts to improve the physical surroundings and promote better opportunities for the low-income households. The HOPE SF initiative in San Francisco stands out as an exception for its self-designation as a “reparations initiative” and its explicit aspiration of promoting racial equity. However, even in HOPE SF, there is little detail about the specific efforts and approaches that will be required to achieve meaningful and enduring changes in the racial disparities in health and other measures of well-being. It is not clear, for example, to what extent African Americans are a priority target, given the diversity among minority groups in the public housing communities. Tensions and stereotypes among minority groups make this an especially complicated issue. And beyond targeted engagement and service delivery, a deeper imperative for promoting racial equity is building

voice and power among people of color. The incremental progress at HOPE SF demonstrates the magnitude and complexity of this task.

**Resident participation and engagement.** An early and consistent commitment to strong resident inclusion in initiative design and implementation is essential and can be seen in all the communities for which site profiles were developed. What is also clear, however, is that sustained engagement and resident leadership requires persistence and creativity in environments characterized by such high distrust, isolation and fear. Low utilization of health programs and services by residents is an ongoing challenge. There are a number of identified barriers that limit or prevent participation, from feelings of stigmatization to high levels of social isolation (which, as previously noted, is often exacerbated by neighborhood redevelopment and revitalization) to cultural and language barriers. In Seattle, the extensive engagement of a local citizen’s review committee, the resident advisory council for Yesler, and other Yesler residents who wanted to participate in revitalization efforts have yielded services and events that authentically reflect resident needs. The community builder hired in Seattle has been intentional about making sure residents feel they have collective influence to initiate activity ideas.

In mixed-occupancy sites, it is also hard to get participation from residents of market-rate units, and activities and programs on site tend to be segregated. Certain efforts to better facilitate social mixing have been successful, though. Among the health activities in place at Potrero in San Francisco, Zumba is one of the most popular, and it is held in a location that attracts public housing residents as well as residents of the broader neighborhood, resulting in the most mixed attendance of all their activities. Staff have noted that as people continue to see each other over time at Zumba class, they have begun to say hello to each other when they meet outside the development. Similarly, the community garden at Mariposa in Denver has been a shared space where

residents of subsidized and market-rate units interact regularly and have an opportunity to make meaningful connections.

## Implications for Strategy and Action

Our review of the five mixed-income community interventions and reflections based on our other research and experience suggest a number of ways to more effectively leverage social mix to promote greater health equity. We now consider implications for how to conceptualize and design mixed-income community interventions and for how to strengthen practice and policy.

### Implications for Conceptualization and Design

**Establish a conceptual framework that considers how social mix can both enhance and challenge health interventions.** Maximizing mixed-income communities as a strategic lever for health equity requires more strategic thinking about the role of social mix. This means a focus not only on the mixed-income community as a platform within which to embed direct health interventions—access to healthcare, health and wellness facilities, health education activities—but also a focus on the implications of social mix for the design and functioning of those interventions. Perhaps even more consequential is the potential role of social mix on indirect health interventions. Planners and stakeholders should be highly cognizant that indirect interventions—physical improvements, economic opportunity and social activities—can have both positive and negative effects on health for a mixed-income population (see Figure 2 on the following page).

For example, on the positive side, buildings can be designed to promote more opportunities for interaction among residents of different income levels and housing types and more space for communal activity. Employment and financial literacy programs can be designed

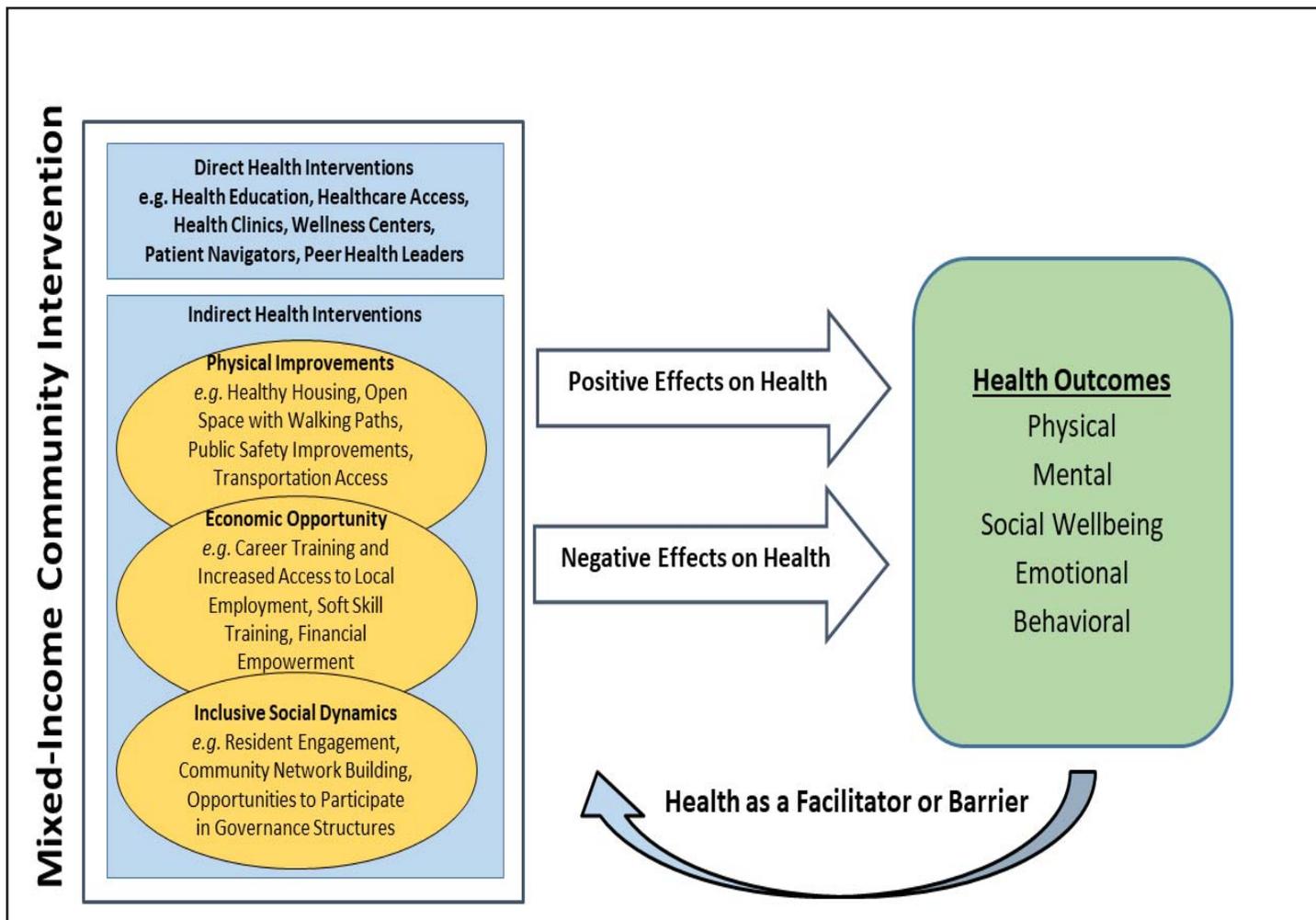
and marketed to include higher-income residents as participants and resources. On the negative side however, if public safety improvements, for example, include more stringent policing and racial profiling which generates increased anxiety and stigmatization of the low-income population of color, that could lead to worse health outcomes. Or, if uncomfortable or contentious social relations emerge at the mixed-income community causing residents to “hunker down” from each other, this increased isolation could lead to worse health outcomes. Finally, it is important to recognize that health status has an influence on residents’ abilities to participate in and benefit from the community activities and resources associated with a mixed-income intervention (see Figure 2). Thus health is relevant not only as an outcome but also as a determinant of the extent to which residents benefit from living in mixed-income communities.

### Implications for Practice

**Leverage the positives of social mix for direct health interventions.** As planners of mixed-income communities develop strategies to develop on-site health facilities, increase access to healthcare and promote health awareness and education, they should consider ways to leverage social mix for additional benefit to all residents.

- Finance, design and manage on-site facilities to serve as broad a spectrum of residents as possible. Prioritize partnerships with institutions, such as university-affiliated clinics and federally-qualified health centers, that have a track record, orientation and expertise in serving economically-diverse constituencies and cross-subsidizing low-income populations. Take extra care to gather ideas and needs assessments from a socioeconomically diverse population in order take into account a wide range of needs and interests.
- Orient and train health facilities staff and peer health workers to understand the vi-

**Figure 2**  
**Mixed-Income Interventions and Health Outcomes**



sion for an inclusive, mixed-income community, to provide services and support across income levels and to perform their health roles in a way that promote belonging, connection and a strong sense of agency for all residents.

- Design and market health education activities to cater to all income groups within a mixed-income development so that residents can learn from each other’s experiences and to generate cross-income social ties.
- Devise ways to leverage the political capital, social networks and market demand of higher-income residents to advance direct health interventions that benefit residents across the economic spectrum.

**Anticipate and prevent the negatives of social mix for direct health interventions.** While direct health interventions are certainly an essential component of a health strategy within a mixed-income community intervention, it is essential to anticipate ways that social mix complicates the delivery and impact of these efforts.

- Avoid perception that health resources and facilities are limited to “low-income” residents.
- Establish flexible hours of operation to accommodate the diverse schedules and needs of a mixed-income population.
- Anticipate and address the potential stigma

of using services at an on-site location, especially in a racially and economically mixed setting where stereotypes abound, by offering a wide range of resources and services and putting a premium on privacy and discretion. With a variety of services available, it would be harder to pinpoint what support a particular person is receiving.

**Leverage the positives of social mix for indirect health interventions.** The success of indirect health interventions in a mixed-income community through physical improvements, economic opportunities and social activities can also be enhanced with greater attention to social mix.

- In addition to providing affordable housing for low-income families, create a balanced housing portfolio to provide a ladder of housing opportunities at various income levels to promote stability in place even as households' economic circumstances improve.
- Developers, planners, architects and others should consider physical design as a key opportunity to promote more inclusive social dynamics. This includes the design of buildings, the housing complex and landscaping, amenities and open space, mixed-use and retail development as well as the integration of building and housing complexes into the broader neighborhood.
- Design and market employment services, financial literacy programs and other economic opportunities to attract participation from a diverse population. Consider ways to more intentionally design, implement and measure economic opportunities as social determinants of health with possibly meaningful impacts on physical, emotional and behavioral health.
- Carefully design and implement social activities to promote opportunities for meaningful connection among residents of different races, cultural backgrounds and income levels that facilitate mutually supportive relationships across race and class
- Develop creative and compelling ways to

convey and sustain the history and cultural heritage of the community.

**Anticipate and prevent the negatives of social mix for indirect health interventions.** Social mix can complicate the best-intentioned programs and strategies if there are not proactive efforts to avoid exclusion and divisions which can naturally emerge in mixed-income communities.

- Avoid the use of physical design to segregate populations and uses within mixed-income environments which is often done to minimize social friction and to increase social desirability and marketability (for example, the New York City “poor door” controversy where developers created separate entrances for low-income renters). Take care to consider how common spaces will be used and monitored to promote a comfortable and welcoming environment.
- Avoid the inequitable management, patrolling and monitoring of low-income residents in disparate ways under the guise of public safety and social control. Be attentive to possible double standards and differential rules. Maintain high vigilance to prevent actions that may reinforce stereotypes and perpetuate damage imagery among residents.

**Develop an overall operating culture for the mixed-income community intervention that promotes inclusive social dynamics.**<sup>10</sup> Ideally, in addition to specific efforts to promote inclusion as a part of various direct and indirect health strategies, there will be efforts to ground attention to mixed-income inclusion into the overall “operating culture” of the community, the ways things work among residents, staff and other stakeholders on a day-to-day basis. This is the best way to make sure that a consistent approach to cultivating a positive social mix is incorporated as broadly and durably as possible.

- Develop a shared vision for and commitment to promoting inclusive social dynam-

ics among key stakeholders, partners, residents, and community members.

- Build skills and knowledge base among staff and partners. Institute trainings, workshops and other learning opportunities to provide a platform for shared understanding and common language among staff and partners. Maintain ongoing discussions about historical and current marginalization on the basis of race, class and other lines of difference and the implications for the current efforts.
- Develop clarity around roles, responsibilities and accountability. Determine organizational and individual staff roles in cultivating and supporting an ongoing process of promoting inclusive social dynamics. Determine roles of residents and community members in cultivating and supporting an ongoing process of promoting inclusive social dynamics.
- Develop clear strategies to promote inclusive social dynamics at three levels:
  - Individual level: address perceptual dynamics, e.g. strategies that promote a sense of belonging, that help shift narratives about who is valued member of community, that set a tone of aspiration and possibility.
  - Social level: address relational dynamics, e.g. strategies that make it easy for individuals to make and deepen connections across lines of difference such as race, class, and housing category.
  - Structural level: address influence and power dynamics, e.g. governance strategies and mechanisms that provide inclusive opportunities for input, decision-making and authority.

**Build evidence through stronger documentation and evaluation.** Given the limited evidence base on mixed-income communities and health, it is imperative that mixed-income interventions are given support to access and manage health data, to carefully track and document their efforts to promote health equity

and to help advance research to measure the role of social mix in promoting and constraining health outcomes. Strategic and proactive partnerships with local academic and policy researchers can identify areas of mutual research interest and leverage time and resources for data analysis and evaluation that may be beyond the capacity of the intervention team.

## **Implications for Policy**

**Use policy discussions and deliberations to elevate the focus on a broader range of equitable outcomes from mixed-income communities, including health equity.** Both within government and in public-private partnerships, discussions of mixed-income policy often focus on real estate transactions, affordable housing production and sometimes supportive services. These policy discussions are an important arena to articulate a more aspirational vision for the role of mixed-income communities in fostering a more inclusive society, promoting more healthy households and reducing health and well-being gaps by income and race. Policy deliberations are also a key opportunity to clarify both the potential benefits and the possible downsides of increased social mix. The conceptual framework proposed earlier could be a useful conversation-starter and guide for policy enhancement.

**Incorporate support for more comprehensive approaches to mixed-income interventions in financing and funding.** As policymakers strive to deconcentrate poverty, promote inclusionary housing and preserve affordable housing in the face of gentrification pressures, they should incentivize greater intentionality, creativity and innovation in the design and management of mixed-income strategies. Funding stipulations, selection criteria, program guidelines, and monitoring priorities are all means of elevating attention to an enhanced approach. Along with investments in physical transformation, there should be support for aligned strategies to promote economic opportunity and social cohesion through collaborative planning and braided

funding from public and private sources. There should also be technical assistance and capacity building to develop the staff capacity and organizational infrastructure to design, promote and sustain more equitable and inclusive community efforts.

**Establish and disseminate a standard set of priority performance measures for mixed-income communities.** The growing emphasis in government and philanthropy on performance measures and results metrics should be leveraged to establish a comprehensive set of measures to be incorporated in mixed-income community interventions. Beyond housing outputs, measures of economic well-being, social connectedness and health status should be included and analyses should look at whether disparities by income and race are decreasing. There should also be government and philanthropic support for evaluation, research and learning exchange efforts that help integrate lessons into policy improvement.

**Be attentive to necessary systemic change as well as programmatic strategies and neighborhood initiatives.** The experience of cultivating inclusive mixed-income communities should be used to identify ways in which broader systems are complicit in maintaining inequitable practices and constraining efforts to promote broader inclusion, for example funding streams that complicate the design and marketing of health services for a mixed-income population. Neighborhood initiatives and their associated programming must operate within broader systems of governance and service delivery that often have proscribed modes of engaging and serving low-income populations. Durable, larger-scale change will require attention to shifts in policies and protocols that can incentivize and facilitate more equitable strategies and practice.

**Attend proactively to the long-term sustainability of income mix.** While promoting an inclusive mixed-income community is a complex endeavor, the benefits will be short-lived if the income mix is not sustained over time

or if low-income households are not able to maintain their housing eligibility and stay in the community as their economic circumstances improve. Policymakers should identify and incorporate strategies to hard-wire affordability into housing options in the community, protect low-income households and provide a ladder of housing options to accommodate economic mobility. This could include rent regulation, eviction prevention, support for owners of existing affordable rental buildings, inclusionary zoning and other incentives for new affordable housing, and subsidies to promote affordable home ownership.

## Conclusion

Our inquiry into mixed-income community interventions and health outcomes has confirmed that this is an important arena for more strategic attention and there are several actionable implications for more effective practice and policy. At its core, using mixed-income communities as a strategic lever for greater health equity requires attention to the positive and negative influences of social mix, establishing a shared vision and commitment to more equitable and inclusive mixed-income communities, seeding and sustaining activities to engender more inclusion, and maintaining vigilance to prevent activities and dynamics that impede a sense of belonging and agency among low-income residents.

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<sup>2</sup> See, for example, Joseph and Yoon, 2017; Levy et. al 2013.

<sup>3</sup> Please see associated site profile reports for more detailed descriptions of each of the mixed-income community interventions.

<sup>4</sup> Of the Choice Neighborhoods grantees only about 20 have multi-million implementation grants and the rest have six-figure planning grants.

<sup>5</sup> <https://case.edu/socialwork/nimc/database>.

<sup>6</sup> Sturtevant, 2016.

<sup>7</sup> Kneebone and Reid (2018) define mixed-income as at least 20% and not more than 50% in three income bands: under 80% Area Median Income (AMI), between 80% to 120% AMI and over 120% AMI and at least 10% under the poverty level. Cited with permission of authors.

<sup>8</sup> The Richmond site applied for but did not receive a federally-funded Choice Neighborhoods planning grant. The two San Francisco sites each received Choice Neighborhoods Initiative planning grants in the \$500,000 range. The Cincinnati and Seattle sites both received Choice Neighborhoods Initiative implementation grants in the \$30 million range.

<sup>9</sup> Stephanie A. Farquhar, Roxana Chen, Alastair Matheson, John Forsyth & Maria Ursua (2018): Seattle's Yesler Terrace Redevelopment: Assessing the Impact of Multisector Strategies on Redevelopment Plans and Community Health, Housing Policy Debate, DOI: 10.1080/10511482.2018.1490795.

<sup>10</sup> See Promoting Inclusive Social Dynamics in Mixed-Income Communities: Implications for Action for more detailed social dynamics implications.

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