Foundation Communities is a nonprofit affordable housing developer in Texas that serves over 3,000 individuals and families with permanent supportive housing and affordable family units. In 2012, Foundation Communities launched its Health Initiatives project to provide free nutrition, exercise, and chronic disease management classes to its Austin residents. By providing housing and health services in a central location, Foundation Communities aims to promote a Culture of Health, increase its residents’ access to care, and empower them to live healthier lives. This case study highlights how an affordable housing developer can work with a variety of health and community partners to improve the lives of vulnerable individuals and families.

Introduction

Foundation Communities (FC) is a Texas-based, nonprofit housing developer that provides affordable housing, tax preparation assistance, and free on-site social services to its residents. Foundation Communities has 19 properties in Austin and three additional properties in the Dallas area. Foundation Communities has been rooted in the Austin community since the early 1990s and is one of the largest affordable housing developers within the city. Austin has an increasing rate of homelessness and a poverty rate of 18 percent, and FC aims to address these problems in a holistic manner (box 1). Its properties include two types of housing: permanent supportive housing (PSH) for single adults who were previously homeless, and garden-style apartments with one to three bedrooms for families. Currently, it provides affordable housing for over 2,800 families and an additional 600 efficiency apartments for single adults.
BOX 1

**Community Context: Austin, Texas**

Population: 887,061

Poverty rate: 18.0 percent

Unemployment rate: 4.3 percent

Individuals without health insurance coverage (noninstitutionalized): 18.2 percent

Homelessness: The rate of homelessness increased by 20 percent between 2014 and 2015. As of 2015, there were 7,054 chronically homeless individuals in Austin.


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**Recognizing a Need**

A core aspect of FC’s mission is to provide the wraparound services necessary to ensure that residents can reach self-sufficiency. Like many aspects of the program, FC’s focus on health was initially motivated by direct feedback from residents who had indicated an interest in health-related exercise classes and nutrition education. As a result, FC started working with local partners to host one-off cooking and exercise classes.

But it was another year before a more extensive health promotion model was adopted. Foundation Communities employees had noticed that many residents in their PSH units had poorly managed chronic diseases, such as diabetes, HIV, and hypertension. Residents also had high rates of mental illness, which sometimes undermined their ability to be respectful community members. When residents with chronic mental illnesses would act out violently or heavily use substances, it reverberated throughout the community. This was reflected through especially high rates of “negative turnover,” or the number of residents who are forced to leave because they are considered too disruptive, most often because of behavioral issues. The high turnover rate made it clear that to help these residents be more stable, FC had to help increase residents’ access to mental health and chronic care management services.

"A big part of helping these residents have a better life and a better chance at stability was to address those health concerns." – Julian Huerta, Foundation Communities
Foundation Communities leadership sought to better understand which health promotion services their PSH residents could benefit from, embarking on an exploratory pilot program. They quickly realized that the public systems available to help were overloaded, particularly around mental health, substance abuse, and primary care services. Recognizing that FC could play a role in creating partnerships and connecting residents with health care services, they began looking for health care partners and connected with a federally qualified health center (FQHC) that was located near a couple of their PSH properties. With federal funding through the Substance Abuse and Mental Health Services Administration (SAMHSA), FC could provide transportation and secure dedicated time at this FQHC for its residents. Through this partnership, FC leadership noticed that when their residents had access to integrated care, they were healthier and more stable. After implementing this pilot program, the rate of negative turnover decreased from 20 percent to near 5 percent for PSH residents.
From this early entrance into health provision, FC leadership realized the impact that preventive health care and health education could play in bettering the lives of their residents and community. Determined to improve self-sufficiency and access to social services for their PSH and family unit residents, FC decided to increase its organizational capacity for health interventions. In 2012, FC formally launched its Health Initiatives, which provides chronic care management and preventive care services. This work, along with more recent programmatic efforts to increase health insurance enrollment, aims to address the social determinants of health that negatively affect residents and FC neighbors.

Activities

Foundation Communities’ Health Initiatives (HI) work focuses on creating a Culture of Health by promoting physical activity, nutrition, and health education classes. Because many residents have chronic illnesses or behavioral health challenges, the HI designed its programs to focus on preventive care, chronic disease management, and support groups. The programmatic activities rely heavily on community health workers (CHW), with CHWs running numerous exercise, nutrition, and health education classes every week. Community health workers and the larger HI team also collaborate with health-focused organizations in Austin to help provide services residents need to live healthier lives.

Everyone is at FC because they want to help residents, and everyone has the best interests of our residents at heart. – Paige Menking, Foundation Communities

Community Health Worker Model

When HI began, it relied on “resident health champions” to provide health education services. These champions were FC residents enthusiastic about improving the health of their community. But as the program expanded, the HI leadership realized that these residents did not have the time necessary to support FC’s growing health programming. In addition, while these individuals provided important peer support and acted as role models in the community, the model also led to some interpersonal conflicts and counterproductive power dynamics, which hindered the program’s success. As a result, the HI team decided to build a dedicated CHW team to take on those health education services.

Community health workers are increasingly seen as valuable members of the health care system, and the services they provide can be reimbursable under Medicaid. But because Texas chose not to expand Medicaid coverage under the Affordable Care Act (ACA), funding must be found elsewhere. Yet, Texas is one of just three states that offer a formal CHW certification process through the Department of State Health Services. This course includes 20 contact hours and a standardized curriculum.
Foundation Communities employees believe that this certification process ensures "a baseline of knowledge and skills" among the CHWs, which creates a consistent and helpful layer of expertise to their work.

Today, FC employs five CHWs who provide tailored health education to residents and act as liaisons between the residents and service providers. Along with the two resident health champions, the CHWs schedule all activities, coordinate with local partners, reach out to residents to ensure high attendance and assist them in achieving their health goals, and connect residents to other FC programs to help them thrive in all aspects of their lives.

BOX 2

What Is a Community Health Worker?

Community health workers (CHWs) help low-income individuals overcome barriers to accessing health care and educate community members on prevention techniques. Community health workers take on different roles based on the need of community members, but generally act as a liaison between clients and the larger health care system. Emerging research on CHWs highlights how this type of provider can improve health access and even health outcomes. Across the field, however, some have found it challenging to show a clear return on investment for the model, making it challenging to find permanent financing for CHWs. Further research is needed to understand how investing in the CHW model can provide significant returns for a community.

Source: Bovbjerg, Randall, Lauren Eyster, Barbara A. Ormond, Theresa Anderson, and Elizabeth Richardson, The Evolution, Expansion, and Effectiveness of Community Health Workers (Washington, DC: Urban Institute, 2013); authors' compilation of stakeholder interviews.

The CHW team organizes activities that include weekly aerobics classes, group exercise walks, dance classes, cooking classes, nutrition education courses, chronic disease management classes, safety education classes, self-compassion workshops, case management work, and support group meetings. Some of these activities (e.g., exercise and cooking classes) happen weekly, while other events (e.g., healthy food Mexican Independence Day celebration or 5K walkathons) are annual. The CHWs are, as one CHW explained, "responsible for designing programs that are responsive to community needs." To ensure that residents feel excited about the programming, CHWs listen carefully to informal resident feedback and draw on conversations with their residents when deciding what programs to offer. For example, CHWs tailor their weekly cooking classes to incorporate ingredients from that week's food pantry offerings.
An important part of their work is integrating health programming into preexisting initiatives. For example, during monthly family nights at FC learning centers, the CHWs will do blood pressure screenings and help parents set health goals. By coordinating these efforts, CHWs can reach a broader audience and be more efficient in their outreach strategies. Although CHWs are on the front line of organizing and delivering on-site programmatic activities, their capacity is increased through local partnerships. As table 1 shows, in 2016, the HI consistently worked with over 10 community partners. As one FC employee noted while discussing their partnership with Planned Parenthood, “having these partnerships is definitely helpful because we cannot answer questions about puberty like someone from Planned Parenthood can.” Local partnerships allow the CHWs to provide their residents classes and health education that reaches beyond their own scope of knowledge, increasing FC’s capacity, and allowing them to more flexibly respond to resident requests for health programming. Each partnership includes discrete tasks for the CHWs and for the external partners, leading to efficient and effective collaborations.
TABLE 1
Foundation Communities’ Local Health and Community Partners in 2016

<table>
<thead>
<tr>
<th>Partner</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Texas Food Bank</td>
<td>Has an on-site food pantry that provides residents with fresh, healthy foods every day. Funds FC to purchase more infrastructures for storing food.</td>
</tr>
<tr>
<td>City of Austin Department of Health and Human Services (HHS)</td>
<td>Offers a diabetes prevention and management curriculum (DEPP) to FC residents. Some aspects of this class are taught by external HHS employees, and supplemental portions of the course (such as healthy food demonstrations) are conducted by the CHWs.</td>
</tr>
<tr>
<td>City of Austin Police Department</td>
<td>Attended a parent support group to discuss what rights FC residents have when stopped by the police and how that differs for minors.</td>
</tr>
<tr>
<td>Dell Medical School</td>
<td>Currently creating a partnership for medical school residents to provide on-site support for FC residents in achieving their health education goals.</td>
</tr>
<tr>
<td>Go! Austin/Vamos! Austin (GAVA)</td>
<td>Provides weekly activities for parents and teens to play soccer. In addition, it has a strong leadership component that empowers FC participants to help make their communities safer and healthier places to live.</td>
</tr>
<tr>
<td>Kids Vision CTX Mobile Clinic</td>
<td>Participates in family property health fairs to test children’s vision and provide free glasses when needed.</td>
</tr>
<tr>
<td>Keep Austin Fed</td>
<td>Collects nutritious surplus food from commercial kitchens and distributes it to seven FC properties.</td>
</tr>
<tr>
<td>Planned Parenthood</td>
<td>Teaches classes on puberty and sexual health for both children and adults.</td>
</tr>
<tr>
<td>Pure Action Yoga</td>
<td>Provides holistic approach to yoga through a “yoga is medicine” philosophy.</td>
</tr>
<tr>
<td>Sustainable Food Center</td>
<td>Provides a farm stand at several properties throughout the year and helps conduct cooking classes that feature local produce.</td>
</tr>
<tr>
<td>University of Texas School of Public Health</td>
<td>Provides internship opportunities to work at FC and helps with the after-school programmatic efforts. In addition, they provide metrics and evaluation support.</td>
</tr>
<tr>
<td>Wesley Nurse Center</td>
<td>Sends registered mental health professionals to the supportive housing developments to provide on-site care. Nurses are stationed at five PSH properties and one family property.</td>
</tr>
<tr>
<td>WeViva</td>
<td>Provides on-site Zumba and aerobics classes for residents at seven family properties on a weekly basis.</td>
</tr>
</tbody>
</table>

Source: Authors’ compilation from stakeholder interviews.
Notes: FC = Foundation Communities; PSH = permanent supportive housing.

PARTNERSHIP SPOTLIGHTS

- **Physical activity.** Every week, CHWs coordinate a variety of physical activity programs to meet the interests of their residents, such as yoga, strength training, walking groups, running clubs, and Zumba classes. The CHWs partner with WeViva, a local nonprofit organization in Austin that offers free exercise classes to low-income communities, to provide Zumba, yoga, and strength training classes to their participants. The CHW team secures the space and alerts the residents of the schedule, and the WeViva team provides the professional dance trainer. In 2016, 878 individuals participated in a WeViva class. In addition to WeViva, CHWs work with Pure Action Yoga to provide their residents with low-impact exercise opportunities.

- **Nutrition.** Recognizing that individuals experiencing food insecurity are at a greater risk of diet-related health conditions such as hypertension, diabetes, and other cardiovascular diseases, FC partners with the Central Texas Food Bank to provide access to quality produce. Although the
Food Bank had worked with FC before the HI, the adoption of this work by the HI catalyzed an emphasis on healthy produce instead of nonperishables. On a weekly basis, FC volunteers pick up about 500 pounds of food per property and distribute it to seven different properties. This year, the Food Bank provided grant money through their ReThink Hunger initiative to support FC in the purchase of transportation vehicles to pick up the food. This capacity-building grant provided funding for a cargo van, freezer, and dolly to help transport and store the food. Unlike previously, when FC volunteers had picked up the food in their own vehicles, this grant money allows the HI to centralize the process to ensure continued success.

Community health. Weekly community health programming efforts include chronic disease prevention and management, stress management classes, smoking cessation classes, and violence prevention programs. For diabetes management education, CHWs have paired with Austin’s Department of Health and Human Services, which has a diabetes prevention arm that funds FC’s Diabetes Education and Prevention curriculum. In addition, the CHWs hold weekly “resident office hours,” where residents can come and discuss their health goals and get blood pressure screenings. During these office hours, CHWs fill out client referral forms, where they ask residents basic health questions, if they want their blood pressure taken, and discuss potential ways to participate in community health programming.

Health Insurance Enrollment

Because Texas did not expand Medicaid under the ACA, FC has seen firsthand how challenging it can be when its residents fall into the “Medicaid hole.” When FC realized that many of its low-income residents had not enrolled for health insurance through the exchanges, it began providing health insurance enrollment to both its residents and other individuals living in Austin. Foundation Communities already had a large roster of volunteers helping with tax preparation; these volunteers could be easily trained in health insurance enrollment.

The organization received a Federal Navigator grant and funding from the St. David’s Foundation for outreach efforts and set a goal of insuring at least 5,000 people in 2015. Foundation Communities surpassed this goal, enrolling 6,346 individuals in health insurance in 2015 through its Insure Central Texas program. Of the enrolled households, 64 percent included individuals who spoke a language other than English, with 55 percent speaking Spanish. In addition, 69 percent of the enrolled households had at least one uninsured adult, with 49 percent of these adults having been uninsured for more than five years.

Resident Engagement

Resident engagement and participation is a key component of the HI’s programmatic activities. Each prong of the HI began with a pilot program and, pending its effectiveness and community feedback, was then scaled to a more comprehensive intervention. The CHWs provide this feedback based on resident feedback surveys or focus groups. By seeking early feedback, the HI can appropriately tweak programs before they become too large and operationalized. The resident office hours that CHWs hold also serve
as an opportunity to receive individualized feedback, which the CHWs use to tailor their programs to meet the unique needs and goals of different residents.

Resident feedback often helps chart new programs and offerings. For example, according to one CHW, residents asked to learn more about puberty and sexually transmitted diseases, which led this CHW to reach out to health educators at Planned Parenthood. As the respondent noted, “this was a direct result of the survey.” In addition to the annual survey, CHWs conduct meetings every three months to ask what the residents need in the short term. During these meetings, residents often voice desires for classes that cover current issues that residents are facing, and the CHW team works to respond to these requests within a couple of weeks. In the wake of the recent election, for example, some undocumented FC residents expressed fear and confusion over how their immigration status would affect their life, so CHW put together a class on immigration status and provided support group space for these conversations.

In addition to these feedback mechanisms, resident participation is baked into the organizational leadership of the HI team. The two senior health specialists who oversee family properties and PSH properties are both FC residents, so there is a direct line of oversight from residents in strategy and programming discussions. Both residents bring professional and lived experience to their position, which “really helps integrate the work to make sure the needs of their residents are being met.”

To ensure resident participation in the programmatic activities, the CHWs use varied outreach approaches with the goal of attracting a wide audience. Community health workers, who say they have close relationships with the residents, use WhatsApp (a free texting application that sends messages over WiFi, which residents have unlimited access to in common spaces) to text potential participants. In addition, they post the schedules as flyers at key locations, such as resident mailboxes, the leasing office, and learning centers. According to the CHW team, however, the best way to promote the offerings is through word of mouth, so they rely heavily on residents to help spread the word. Although the CHWs feel they have many channels through which to contact residents, they continue to face challenges engaging PSH residents in their health programming. Respondents believe this lack of engagement is because of significant behavioral health challenges and disabilities that prevent residents from feeling comfortable and able to engage in exercise classes.

Funding

Foundation Communities generates between 75-80 percent of its annual operating budget through rent payments, and it relies on philanthropy, government funding, and individual donors for the remaining 20-25 percent. For its housing developments, FC uses the Low-Income Housing Tax Credit (LIHTC) to fund about 60 percent of its capital need, and supplements this with bond financing that was set aside by city voters in 2013 to support the development of affordable housing in Austin.

The total budget for the HI, not including health insurance enrollment or integrated care for PSH residents, is approximately $500,000. This work is funded by a mix of philanthropy, private
organizations, and personal donations. The St. David’s Foundation, a local foundation in Austin, is its biggest investor. This foundation has been involved in the HI’s programmatic activities since the beginning, and currently invests around $3 million annually (box 3). Foundation Communities also receives funding from the Dell Foundation, a portion of which goes to the HI. In addition, FC organizes an annual fundraiser luncheon; of the $1 million that FC receives from this annual event, approximately $100,000 is put towards HI operations. Lastly, the HI receives direct support from UnitedHealthcare, which serves as the managed care organization (MCO) for many of FC’s Medicaid residents.

BOX 3

St. David’s Foundation

The HI’s primary funder is the St. David’s Foundation, the second largest foundation in Austin. As a health foundation, St. David’s Foundation had some initial trepidation over funding FC, a housing developer. But after some internal conversations, the St. David’s Foundation board and employees agreed that addressing housing as a social determinant of health stayed true to their health-centric mission.

Its first investment was through a $20,000 grant to test the concept of placing psychiatric nurse assistance in permanent supportive housing developments. As a local foundation, it did not issue an request for proposals or have strict criteria for this investment, but rather liked the organization’s leadership and felt that FC was filling an unmet need. The pilot resulted in fewer calls to emergency medical services, a good indicator of improved health management. As a result, St. David’s was eager to continue working with FC.

Today, the foundation funds FC’s mental health counseling and case management work, as well as the HI programs. Foundation Communities employees feel “lucky to have such a strong foundation presence in Austin,” and feel as though this is a key to their success. This investment story highlights how local foundations can work with community nonprofits to achieve shared goals and bridge the fields of health and housing.

Source: Authors’ compilation of stakeholder interviews.

Evaluating Success

Foundation Communities and the HI put a strong emphasis on measurement and evaluation to determine the success of their activities, tracking housing-related metrics, program-related metrics, and health-related metrics. The HI team includes a data analyst, whose job it is to ensure metrics are being collected and analyzed in an effective and efficient manner. On the housing side, FC measures rates of negative turnover for its PSH units. At the programmatic level, the CHWs track attendance, duplicate touches, and outreach efforts. They send this information to the director of the HI monthly, and these metrics then get reported to funders and are used to set benchmarks for the following year. They also influence outreach efforts, as CHWs are continuously working to reach a broader range of individuals. On the health front, the HI helps residents track their blood sugar levels and cholesterol, but does not
keep track of this data because of Health Insurance Portability and Accountability Act compliance
protocols. But it does track the number of people who come back for a follow-up screening, which is
used to think about the longer-term effects of the program.

### BOX 4

**Program Participation and Screening Metrics, 2016**

**Programmatic metrics for HI Initiative**

- Served 2,097 adults and 513 children
- 54 percent of participants are residents of a Foundation Communities property
- 47 percent of adult participants attended more than one class within a single programming series
- 70 percent of HI participants are female

**Blood pressure and screenings**

- 793 people screened (unduplicated number)
- 1,081 overall attendance (duplicated number)
- 169 individuals screened at least two times
- 64 individuals screened at least three times

Source: Foundation Communities Health Initiatives.

In addition to these metrics, FC has worked with the University of Texas School of Public Health to
perform a formal evaluation of an after-school program strategy that aimed to increase peer-led activity
play and provide more active time for children. Researchers at the university evaluated the effects of
FC’s after-school physical activity program, blood pressure initiative, and healthy food pantry. This
evaluation process is key to FC’s scalability strategy; because FC starts with pilot programs before
scaling them up, it relies on evaluations to understand how to change programs before investing
significant resources in them. This evaluation was useful both to FC and to the School of Public Health,
as the university was championing this method and wanting to roll it out in a setting like FC.

### Successes

Across the board, respondents highlighted how successful FC has been at incorporating resident
engagement in the design and roll-out of its HI programs. Foundation Communities employees noted
that their close relationships with residents has allowed them to better tailor programs to meet
participants’ needs. Respondents believe that this has in turn empowered residents to take further
control over their own health. As one interviewee said, “the idea that people are not invested in their life
has been debunked.” Similarly, another respondent noted that “the community is much more aware of
health issues, conducting walks independent of regularly scheduled activities and eating healthier.”

In addition, through FC’s interaction with a variety of health care organizations in Austin, it has
proved to key stakeholders how important health and housing interventions are for addressing chronic
health problems and stability. This has in turn catalyzed momentum among local actors to participate in
and fund more interventions like the HI and to raise awareness about these issues. For example, a local partner noted that “working with FC has helped [their organization] learn the power of the supportive housing model and housing being tied to health.”

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**While housing is not a direct health care intervention, it can be more powerful than access to a really good doctor. If 80 percent of health outcomes are dictated by what happens outside of the walls of a clinic, where else do [people] spend their time? Houses and neighborhoods.**

– Kimberly McPherson, St. David’s Foundation

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**Challenges**

As previously mentioned, one of FC’s main challenges is engaging PSH residents in its health programming. These individuals tend to socialize less, feel burdened by stigma, and many have significant disabilities or behavioral issues. As a result, the CHWs have focused on healthy eating and disease management, offering classes on hypertension and diabetes, and tailoring cooking classes to the needs of the residents. Many of the PSH residents lack an individual kitchen, so the CHWs demonstrate how to prepare healthy meals using hotplates or crock pots, and occasionally raffle off George Foreman grills or other kitchen supplies. Numerous respondents identified this as an evolving challenge that they were trying to address with more creative solutions.

Another roadblock to FC’s work is the policy context in which it operates. As previously mentioned, Texas did not expand access to Medicaid under the ACA. This creates significant barriers for residents to receive the care they need. In addition, under the new administration, the fear of deportation has increased for undocumented immigrants, forcing FC to grapple with how to best provide support through health promotion activities.

Lastly, while FC has a robust data tracking system to monitor attendance and duplicate touches, it has not been able to track many health-related metrics. Ideally, the HI would be able to track changes in weight, blood pressure, chronic illness, and hospitalization rates. Although FC employees do not want to be "invasive" in their tracking mechanism and pride themselves on respecting the privacy of their residents, they also recognize that tracking more health outcomes will allow them to see what works and help them make the case for replicability and scalability. In response to this challenge, the HI staff is looking to get Health Insurance Portability and Accountability Act compliance protocols in place by the end of the year, which will allow them to track health outcomes more comprehensively.
Looking Forward

In the past several years, Austin has struggled with growing income inequality, and respondents believe that a confluence of policies at the federal, state, and local level are responsible. In response, the city has convened a task force on permanent supportive housing, composed of the city, county, hospital, and nonprofits. Foundation Communities is not part of the task force, choosing instead to focus on its long-term programmatic efforts.

Foundation Communities is continuing to grow, opening three new properties at the end of 2016. The organization hopes to expand 25 percent over the next three years. As it scales its housing work, it recognizes that it also must prioritize scaling its supportive services to ensure that new residents can thrive. Employees are confident that the HI programs will expand to more FC properties, allowing all FC residents to participate in a suite of on-site services without having to travel. In addition, FC is beginning to set aside units for refugees, which will increase its need for CHWs who can speak Arabic, so the HI team is working to actively address language barriers. In doing so, respondents believe they will increase their potential for scalability.

Key Take-Aways

The lessons learned from FC’s model of providing on-site, free health programming to residents living in affordable housing developments can be applied to other affordable housing developers looking to address the intersection between health and housing. This case study outlined the importance of resident engagement in designing and executing programmatic efforts, the value of collaborating with a variety of health care organizations across one city, and the importance of tracking outcomes.

- **Resident engagement.** Having both formal and informal mechanisms for engaging residents in the design and outreach efforts of its programmatic activities has allowed FC to cultivate a trusting and mutually beneficial relationships with its participants. The CHW model facilitates relationship-building efforts, and quarterly meetings provide space for residents to suggest programmatic efforts. This case offers strategies to other sites looking to enhance their community engagement strategies, emphasizing the need for both formal and informal communication strategies between residents and service providers, as well as the power of flexible programming in meeting the needs of residents.

- **Citywide partnerships.** The HI team has cultivated relationships with dozens of partners citywide to help provide services to their residents. Because of these unique partnerships, FC can be more flexible in its programming activities, often relying on its partners to provide the expertise and on-site services. In addition, by engaging so many different actors across the health sector, FC can promote a Culture of Health throughout the city and elevate the conversation around the intersection of housing and health care.
● **Tracking outcomes.** Foundation Communities tracks housing, health, and program-level outcomes, allowing the organization to regularly assess the effectiveness of its interventions. To track outcomes, the HI relies on CHWs to collect data related to residents’ health, which is then relayed up to the director of the HI. It uses a social data management and case management system to centralize this process. Lastly, by having clear roles for the employees involved, the data collection process can proceed smoothly and efficiently.

### Notes

1. While FC has properties in both Austin and Dallas, its health work centers on its Austin community. This case study focuses solely on its Austin developments and health partnerships.

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