

GEORGIA HEALTH POLICY CENTER



A HEALTH IMPACT ASSESSMENT OF THE 2015 QUALIFIED ALLOCATION PLAN FOR LOW-INCOME HOUSING TAX CREDITS IN GEORGIA

*SUMMARY BRIEF
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ABSTRACT

This health impact assessment (HIA) examined how public health perspectives could be more strongly incorporated into affordable housing policy in Georgia through the Qualified Allocation Plan (QAP), overseen by the Department of Community Affairs (DCA) and updated on an annual basis. Overall, affordable housing investments were found to improve health and quality of life, and increase opportunity for Georgia residents. To capitalize on this gain, numerous opportunities were identified through research, analysis, and stakeholder input, with suggested alterations to scoring criteria categorized into three major topic areas.

- First, the QAP could improve strategies to incentivize connections to healthy communities, particularly through the use of Demographic Cluster data developed by the Georgia Department of Public Health to provide a more robust characterization of the communities in which Low-Income Housing Tax Credit (LIHTC) development is proposed.
- Second, encouraging access to educational opportunities through more nuanced incentives for locating near quality schools would address this critical health determinant. Partnering with the Georgia Department of Education to use its College and Career Ready Performance Index (CCRPI) as a new metric for school quality is a first step in this direction.
- Third, multiple opportunities were identified for promoting healthy design and operation of affordable housing based on existing best practices. The HIA process has provided DCA with a menu of actions that could be used to improve health in communities across the state.

Addressing any one of these topic areas alone may lead to improvements in health outcomes and behaviors. Employing a holistic perspective that considers all of these topics together, in combination with the entire set of QAP criteria – each of which makes some contribution to health and quality of life – would be most likely to fully achieve the potential for affordable housing investments to improve health. A fully funded affordable housing program that is tuned to reduce injury and illness could improve wellbeing, increase productivity, and reduce health care costs in Georgia.

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SUMMARY & KEY FINDINGS

A Qualified Allocation Plan (QAP) is the federally-mandated process through which states issue Low-Income Housing Tax Credits (LIHTC) to qualified applicants. The state of Georgia allocates about \$22 million in support of affordable housing development through this process each year, using annually updated threshold and competitive scoring criteria.

The state of Georgia allocates about \$22 million in support of affordable housing each year. This report explores how this investment could be better leveraged to support health.

An extensive body of research demonstrates the strong relationship between affordable housing and health. Programs that help ensure the availability of safe and affordable housing for all income levels will improve health, especially for the most vulnerable members of society. Housing availability, location, design, and cost work in concert to influence a range of health determinants, including household resources, family stability, stress, environmental exposure, and access to health-supporting services. These determinants then contribute to health outcomes such as heart disease, asthma, and injuries. Further, health status can greatly influence an individual's success in school, career, and family life. Decision makers working to increase the supply of affordable housing therefore should consider health along with other important factors which impact policies and programs.

This Health Impact Assessment (HIA) examines the effect of LIHTC allocation policy in Georgia and its potential to influence public health. Through the HIA process, the project team built relationships with key stakeholders and utilized their input to drive the content of the assessment. Several fundamental health determinants were examined in detail, and the findings were translated into recommendations for the 2015 QAP (or its future iterations and supporting documents) to maximize potential health benefits and mitigate any possible undesired outcomes. The HIA places special emphasis on strengthening

Programs that help ensure the availability of safe and affordable housing for all income levels will improve health, especially for the most vulnerable members of society.

connections between LIHTC projects and their surrounding communities, with additional focus on facilitating access to quality educational opportunities.

Some recommendations have already been incorporated into the 2015 version of Georgia's QAP, while others are still under review by the

Department of Community Affairs (DCA), the agency responsible for overseeing many of the state's housing finance and development programs. This document presents a summary of the HIA process with key findings and recommendations. For more detail on any of the content included here, please see the forthcoming HIA Technical Report.

KEY FINDINGS AND RECOMMENDATIONS FROM THE HIA

Three topic areas are used to organize the results of this HIA and are listed below with some main findings and recommendations. More information on the HIA process, each topic area, and recommendations can be found on subsequent pages of this document. However, these findings should not be read in isolation. Interactions between housing policy and potential changes in community health are complicated and difficult to distill. Therefore, the HIA recommends employing a holistic perspective when approaching these topics, as addressing all of them in concert will most fully achieve the potential for health improvement inherent in affordable housing policy.

CONNECTING WITH HEALTHY COMMUNITIES

This topic area addresses interactions between proposed developments and the socio-demographic fabric of the surrounding areas. Neighborhood social, demographic, and economic characteristics (as opposed to physical characteristics which are discussed separately below) have significant influence on health outcomes, and though the effect may be greatest for young children, adults and seniors are also affected.

FINDING

Some elements in the QAP were intended to deconcentrate poverty—points developers could receive for building in low-poverty areas or in underinvested neighborhoods with active revitalization or housing plans. Stakeholders mainly agreed that the QAP had not yet reached the optimal formula to support this goal. This gap appears to reduce the

If the QAP could consistently steer affordable housing development toward lower risk Demographic Clusters, it could potentially save 200 lives per year.

potential for LIHTC properties to be developed in healthier communities. Of the nearly 8,300 family housing units developed with LIHTC funding over the past decade, 70 percent have been built in areas the Georgia Department of Public Health (GDPH) identifies as having the lowest socioeconomic status and some of the highest rates of premature death in the state. DCA has continued to develop and refine criteria for

deconcentrating poverty and revitalizing neighborhoods over the last several years, and more targeted efforts to steer affordable housing development toward areas identified as lower-risk Demographic Clusters could help up to 200 individuals live longer, healthier lives.

RECOMMENDATIONS

Begin using more comprehensive measures of sociodemographic context in the QAP scoring criteria concerning “Stable Communities.” This would be a shift away from relying exclusively on measures of poverty and toward measures like the GDPH Demographic Clusters, which are derived from a set of 25 indicators - many of which are not addressed elsewhere in the QAP.

Adjust scoring under “Revitalization and Redevelopment Plans” and “DCA Community Initiatives” to encourage more communities to plan for affordable housing and incentivize siting of LIHTC developments in communities engaged in

such planning. DCA has already adopted one recommendation in this area for the 2015 QAP by also allowing points for developments that further revitalization plans in areas that are economically distressed but not defined as Qualified Census Tracts (a definition based primarily on income) by the U.S. Department of Housing and Urban Development (HUD). These plans can improve the socioeconomic indicators of a neighborhood.

ENCOURAGING ACCESS TO EDUCATIONAL OPPORTUNITY

Educational attainment is one of the most critical determinants of lifelong health status. School quality is a major determinant of educational outcomes, and the quality of early learning experiences proves to be a significant predictor of future success and health.

LIHTC properties are often located near schools which score significantly lower on measures of school quality than schools in other areas.

FINDING

On average, elementary schools near LIHTC properties scored significantly lower on the College and Career Ready Performance Index (CCRPI; a measure of school quality developed by the Georgia Department of Education) than those in other areas. Also, a disproportionately high number of LIHTC properties located near schools classified as failing by this measure (scoring below 60 out of 100). DCA introduced a new scoring category in the 2014 QAP focused on encouraging development near higher-performing schools.

RECOMMENDATIONS

Use the CCRPI to determine the quality of schools near proposed development sites and provide scoring incentives for locating in the attendance zones of above average schools. This change is included in the 2015 QAP under the “Quality Education Areas” section of the scoring criteria. It offers a more straight-forward process than the educational criteria first introduced in the 2014 QAP, which required applicants to perform complex calculations based on test scores in order to determine if nearby schools met the quality threshold required for their project to receive points.

Include scoring incentives for proposed developments to locate near high quality early learning facilities. A distinction needs to be made between child care and early childhood education. Bright from the Start, a program of the Georgia Department of Early Care and Learning (DECAL) plans to have a “Quality Rated” score for every licensed child care setting by 2017. These ratings should be incorporated into future QAP scoring.

PROMOTING HEALTHY DESIGN AND OPERATION

This topic area considers attributes of the physical environment, both within and surrounding proposed housing developments. Many of the connections between this aspect of housing and public health have already been firmly established, either in the scientific literature or through other HIAs. Part of this assessment is a “desktop” HIA, which uses pre-

existing evidence reviews and population-wide data, provides little stakeholder input, and does not conduct a detailed analysis of potential health effects. It primarily summarized promising practices in the context of development and housing, and presented recommendations for applying this evidence to the 2015 QAP. The full desktop HIA is available in the Technical Report.

36 recommendations for integrating healthy community design into the QAP were made, and these adjustments could potentially improve health through active living, healthy eating, improved air quality, and reduced injury risk.

FINDING

There are many opportunities to address pressing health concerns in Georgia through the siting, design, and programming components of the QAP. The desktop HIA considered language from the 2014 QAP and identified 36 recommendations for policy adjustments that would potentially improve health, specifically in the areas of active living, healthy eating, air quality, and injury risk. One-third of these were adopted into the Draft 2015 QAP, with a smaller subset being retained in the final policy after public comment. Some priority recommendations are highlighted below.

RECOMMENDATIONS

Further incentivize developments that encourage pedestrian activity by considering design features and connectivity in addition to proximity to amenities and pedestrian facilities. Examples of this include: stipulating that existing streets should not be abandoned, with surrounding street networks extending through properties where feasible; determining proximity by considering actual walking distance, not straight-line distance; reducing parking mandates; and ensuring that sidewalks and walkways connect the property to adjacent streets.

Expand the options for meeting existing residential service requirements to include on-site health promotion and maintenance programming. LIHTC properties already offer basic amenities and services. Where appropriate, other eligible programming could include semi-regular classes on nutrition/healthy cooking, asthma management, smoking cessation, and various types of exercise and personal fitness.

Reduce potential exposures to air pollution by adjusting scoring criteria to incentivize development in locations farther than 200 meters (650 feet) from roadways carrying more than 25,000 vehicles per day. In response to developer concerns about reduced property visibility on lower traffic roads affecting marketability, solutions that balance mitigation of potential exposure to pollution and project visibility should be further explored. Examples might include increasing the threshold to 50,000 vehicles per day, designing sites to have residential buildings set further back from the busiest roadways, or planting evergreen trees to filter pollution.

BRIEF REPORT

THE PROCESS OF HEALTH IMPACT ASSESSMENT

Health Impact Assessment, or HIA, is a process for ensuring that plans and policies support healthy communities. HIA is typically used to enhance policies in non-health sectors, such as economic and community development. HIA has evolved from the awareness that many projects, policies, and initiatives formed with no explicit health goals still impact the public's health and, as such, decisions regarding these actions should be informed about these potential health impacts in a constructive and actionable way. HIA follows a six phase framework that will serve as an organizing tool for the remainder of this document:

- **Screening** determines whether a proposal is likely to have health effects and whether the HIA will provide useful information.
- **Scoping** establishes the range of health effects to be included in the HIA, the populations affected, the sources of data, and the methods to be used for assessment.
- **Assessment** is a two-step process that first describes baseline health status in the population of concern, and then characterizes potential impacts to produce findings meant to inform recommendations.
- **Recommendations** suggest policy alternatives that could be implemented to improve health or actions that could be taken to manage potential health effects.
- **Reporting** involves the presentation findings and recommendations to decision makers and stakeholders, along with identification of key assumptions and limitations.
- **Monitoring and evaluation** examine the process and short-term impacts of the HIA on decision making. Monitoring strategies are developed to follow changes in health determinants and outcomes over time.

SCREENING: AFFORDABLE HOUSING POLICY AS HEALTH POLICY

Each year, the Internal Revenue Service allocates housing tax credits to state housing finance agencies, which then award the credits to developers of qualified projects – new construction or significant renovation of residential communities that provide homes for low-income households. The state agency must develop a QAP for disbursing the credits. DCA, through their Office of Housing Finance, awards about \$22 million in LIHTC and state matching tax credits each year, creating around 2,500 new housing units. Thirty-five percent of this funding is reserved for affordable housing in rural parts of the state, with as much as half going to rural projects in recent years. The scale of the LIHTC program and its focus on lower income populations indicate that, in addition to primary goals regarding housing affordability, it likely influences health outcomes as well—especially for populations considered most vulnerable to poor health.

***“Health policy is economic policy,
and economic policy is health policy.”***

*Dean Mary Beth Walker, Andrew Young School of
Policy Studies, Georgia State University*

Connections between housing and health have been well-documented.^{1,2,3} However, a specific focus on development which creates positive health outcomes is not traditionally viewed as an integral part of QAP development. This presented the opportunity for an HIA to consider how LIHTC financing could affect community health in ways not currently considered. The yearly update of the allocation policy also provided a suitable target for HIA recommendations that could be applied in 2015 or in future iterations of the QAP.

Additionally, lessons learned from an HIA of Georgia's QAP could inform the housing tax credit allocation process in other states.

“DCA is very interested in new ways to measure our impact on health”

*Laurel Hart, Director, Housing Finance Division,
Georgia Department of Community Affairs*

Key decision makers at DCA were receptive to the idea of HIA and were willing to not only participate in the process, but to also thoughtfully consider the resulting

recommendations. Their openness to collaborative influence meant that they were willing to use HIA as a tool for learning more about how they could integrate a stronger public health perspective into their work. Industry professionals also expressed interest in applying the HIA findings in their work in community development, finance, and real estate. The annual QAP process was a particularly good fit for HIA because its use of threshold and scoring criteria presents conceptually straight-forward targets for many potential recommendations.

SCOPING: CHOOSING THE ISSUES TO EXAMINE IN DETAIL

The HIA team engaged with a steering committee of stakeholders who collaboratively guided the scope of the project. The population of concern was defined as current and future residents of LIHTC developments and their neighboring communities. In terms of geographic scope, the QAP is a single policy that covers a diverse state, limiting the feasibility of focusing the HIA on specific areas or communities. As a result, the assessment takes a statewide perspective.

Topic areas for the assessment were selected through two processes. First, a common streamlined HIA method called “desktop” assessment capitalized on existing evidence and best practices to provide input for the 2015 draft QAP. Public information sessions for the draft policy presented an early opportunity for gauging stakeholder response to potential health-based updates, but these changes had to be suggested to DCA quickly in order to be included in the draft. The desktop assessment examined language from the 2014 QAP and considered existing evidence from the literature and previous HIAs to develop proposed language for the 2015 draft. The project team chose existing HIAs from the United States that dealt with relevant housing and build environment policies, focusing in on active living, healthy eating, air quality, and injury risk as common topic areas with transferable findings. By applying the desktop approach to these topics, the HIA team was able to then devote more resources to exploring the emerging topics of interest identified by the steering committee, as discussed below.

The second method for determining topic areas to include in the scope was a collaborative process with the steering committee. After participating in DCA listening sessions (public meetings with interested parties on the upcoming QAP) and informational interviews with developers (for profit and nonprofit), community financiers, and advocates, the HIA project team developed a list of eight potential topic areas as candidates for more comprehensive assessment. The steering committee then voted on which topics would be most productive to consider in the comprehensive HIA. They chose to focus on access to educational opportunities and community connections (i.e., how the proposed developments integrate into the social fabric of existing neighborhoods).

Education and community connections underlie the most basic building blocks of health equity. One of the most reliable predictors of adult health status is educational achievement^{4,5} and emerging evidence points to early childhood education (birth through Pre-K) as a powerful community development tool for future health and prosperity.⁶ The community connections topic area refers to locating affordable homes in safe, attractive, amenity-rich communities with good job access and diverse neighbors (including those in higher income classes). Locating in these types of places contributes to eliminating health disparities and improving socioeconomic status by affording vulnerable populations greater opportunities to thrive.^{7,8,9} As noted by the steering committee, there are numerous barriers to creating affordable housing in such communities and few established best practices, justifying further exploration through the HIA process.

A series of research questions guided the analysis of these topic areas. In general they considered the location of LIHTC properties funded in prior years and how those locations may have influence on the two main topics of education and community connections. The complete list of research questions is available in the Technical Report, but the following are included here as illustrative examples:

- How is early childhood education associated with health outcomes?
- How many pre-school age children will live in LIHTC properties?
- What are the socioeconomic characteristics of the communities where LIHTC properties have been distributed?
- How does support or engagement of local government officials or community members mediate inter-demographic connections in the community?

Health equity is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.” Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.
(Centers for Disease Control and Prevention)

ASSESSMENT AND RECOMMENDATIONS: FINDINGS AND ACTIONS

Each of the two main topic areas and the desktop assessment are summarized below. For each, a brief introduction to the core concepts involved is followed by a discussion of findings and evidence regarding the topic in the context of the QAP. Each section then includes a discussion about potential health impacts and a list of recommendations developed to address them. **Recommendations (or portions thereof) that have been incorporated into the final 2015 QAP in some way are indicated in bold.**

CONNECTING WITH HEALTHY COMMUNITIES

This topic area addresses interactions between proposed LIHTC developments and the sociodemographic fabric of the surrounding areas. Neighborhood social characteristics have significant influence on health outcomes.¹⁰ The importance of physical characteristics is discussed separately under the Promoting Healthy Design and Operation section, but the social and physical environments are closely related to one another.

COMMUNITIES OF OPPORTUNITY

A major determinant of health for seniors and families, today and for their children's future, is access to communities of opportunity. There is strong evidence that multiple sociodemographic characteristics are associated with underinvestment in a given community, and that and the concentration of socially and economically disadvantaged families in neighborhoods with few amenities, struggling schools, and few business or job opportunities, surrounded by other low-income families, have much higher rates of

Communities of opportunity are places with high levels of social and civic engagement amongst neighbors. They are diverse across a range of measures including age, racial/ethnic identity, income, wealth, educational background, occupation, household tenure, and family type.

disease, injury, disability, and death.¹¹ Somewhat less clear is what types of neighborhoods are healthiest, and for whom. High poverty areas are consistently unhealthy, yet a community of opportunity is more than just an area with a low poverty rate.

In terms of sociodemographic characteristics, experts involved in this project from the community development, housing, and economic development fields have described

communities of opportunity as places where there are high levels of social and civic engagement amongst neighbors. They are also places where community members are diverse across a range of measures including age, racial/ethnic identity, income, wealth, educational background, occupation, household tenure, and family type.

FINDING

Over the past ten years, DCA has developed criteria to steer developments toward communities of opportunity. One item awarded points for locating in very low poverty Census tracts. However, many stakeholders believed that too few tracts qualified for those points and that building in these areas was too expensive or faced too much opposition from existing community members. Another strategy sought to mitigate the effects of locating in a Qualified Census Tract (QCT) by awarding points for proposals

located in QCTs that have existing revitalization plans. In considering this strategy, some stakeholders believed the plans were not powerful enough on their own to transform the socioeconomic status of a place.

Under the 2014 QAP, applicants could be awarded points or more funding for activities aimed at connecting lower income residents with communities of opportunity. These include:

- locating in a Census tract with less than 5 percent, 10 percent, or 15 percent poverty;
- contributing to an existing redevelopment plan;
- furthering a revitalization plan in a designated highest-poverty Census tract;
- working with a non-profit organization that has a demonstrated record of success;
- partnering with a community housing development organization (CHDO);
- utilizing the Georgia Initiative for Community Housing (GICH) planning process; and
- locating in a QCT, as designated by the US Department of Housing and Urban Development (HUD).

While these types of incentives are moving applications in the right direction, steps could be taken to more effectively support the transition of low opportunity and low affluence areas to more mixed socioeconomic profiles with higher levels of opportunity.

EVIDENCE

Providing affordable housing in communities of opportunity can be challenging. Although the public tends to endorse affordable housing in theory, they often object when it is proposed locally. This local opposition can negatively impact affordable housing development by reducing the number of units, by making it more costly, or by stopping projects all together. Areas with strong civic engagement and a significant number of higher-income, highly educated residents are often associated with resistance to affordable, rental, and/or multi-family housing.^{12,13,14} As a result, development that aims to increase supply of affordable housing in these places may require a more intensive and costly effort on the part of the developer. This might include more expensive design elements, more prolonged negotiation of the local planning process, or more technical assistance to develop in these areas. If development is in line with existing local plans (e.g., neighborhood plans, comprehensive plans, revitalization plans, etc.), then opposition may be less likely and approval more straightforward. After affordable housing is placed in service, it typically raises property values in both low- and high-value neighborhoods, increases economic activity, and produces more positive attitudes toward diversity by residents of market rate or owner-occupied homes.^{15,16}

One way to increase the efficacy of the QAP is in the choice of metrics used to characterize socioeconomic conditions in areas where LIHTC developments are proposed. The Demographic Cluster classification system developed by GDPH is a robust method for considering many of the sociodemographic factors that contribute to a community of opportunity.¹⁷ This metric is applied at the level of census block groups and utilizes 25

demographic and socioeconomic variables including age distribution, income, education, occupation, racial or ethnic identities, family structure, settlement type, and housing type. Block groups are categorized from highest socioeconomic status (A.1) to lowest (D.7) based on these 25 measures. **Table 1** provides sample descriptions of Demographic Clusters, and **Map 1** shows how the clusters are distributed across the state.

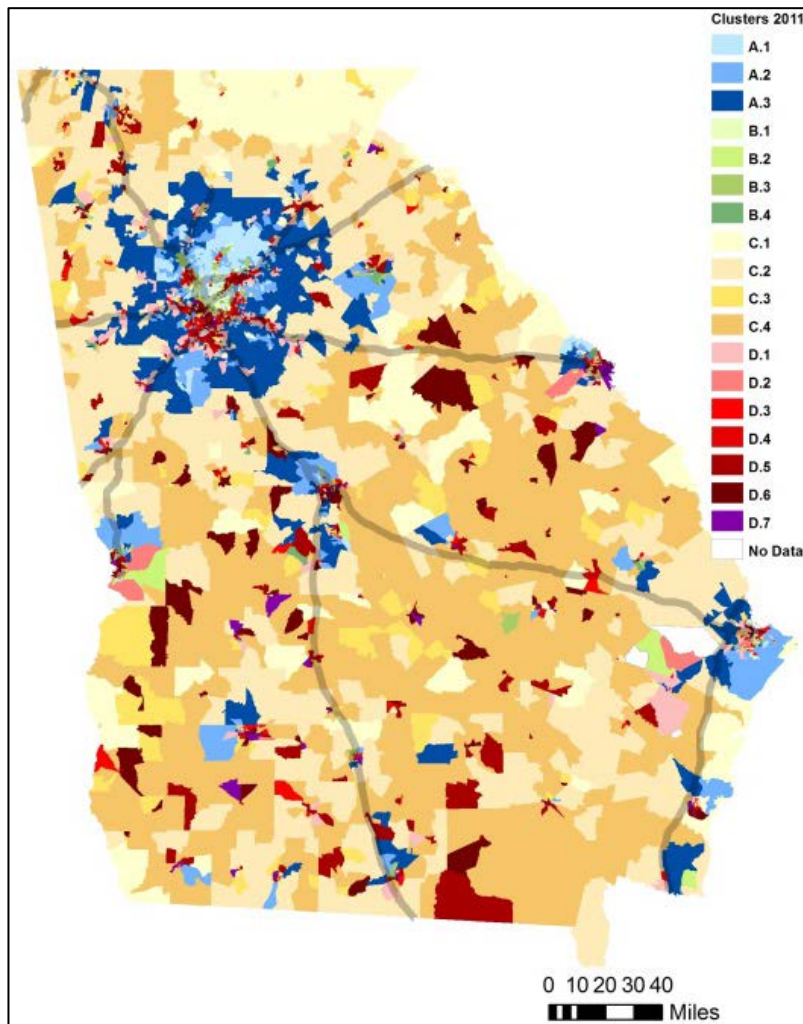
Table 1: Sample Descriptions of Georgia Department of Public Health Demographic Clusters

Cluster	Description
A.1	Georgia’s wealthiest cluster is primarily populated by “new money” executives and professionals living in tract mansions of metropolitan suburbs and exurbs. Predominantly white with an above-average index for Asians, this highly educated cluster is composed of married couples in their middle adulthood ages (45-64) with young and adolescent children.
B.3	This is a mixed-ethnicity cluster with a high index of Asian and multiracial non-family households living in middle-range value apartments in urban/suburban areas. Although many have some college degrees or are college graduates, their median income is below the state average due to their recent entry into the workforce.
C.2	This rural cluster is dominated by married families of people in their middle adulthood ages with young and adolescent children. Found widespread in rural counties of Georgia, the cluster is white with some African-American population. Many people are in construction and production jobs; their incomes are average compared to the state.
D.1	An urban cluster, this mixed-race group has a high representation of single-parent families with or without children. Most have a high school diploma or less; this group mainly works in the service industry earning lower than state average income. They live in rented apartments or old houses of low housing values.
D.7	This cluster is predominantly composed of very young African-Americans with more females than males. The cluster has the highest percentage of population less than 18 years of age in nonmilitary clusters in the state, of whom most live in female-headed households. Most have a high school diploma or less; they work in low-paying jobs and live in rental units. The median household income in this cluster is the lowest in the state.

Source: Georgia Department of Public Health: <https://oasis.state.ga.us/gis/demographiccluster/documents/DemoClusters2011Description.pdf>

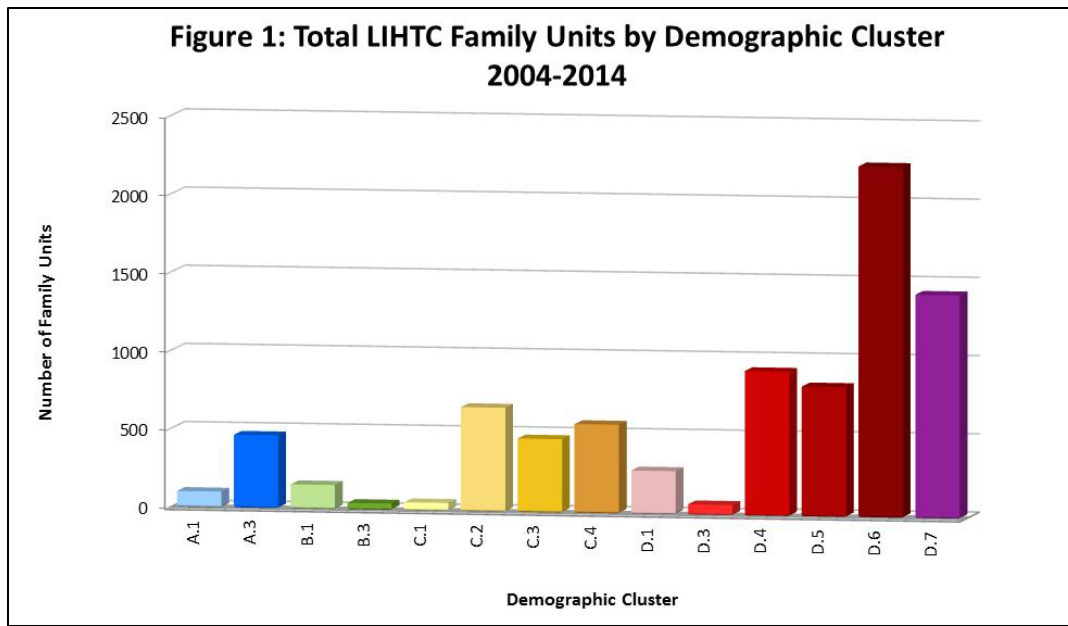
There is not much correspondence between the lowest sociodemographic clusters defined by GPH and the HUD-designated Qualified Census Tracts (QCTs) currently used to determine allocation. This suggests that relying on QCT designation does not sufficiently identify high or low opportunity places; however, the IRS requires DCA to incentivize development in the QCTs. Very low poverty rate Census tracts also do not correspond closely with the higher sociodemographic clusters with lower death rates. As illustrated in **Figure 1**, of the nearly 8,300 family housing units developed with LIHTC funding over the past decade, 70 percent have been built in areas corresponding to lower socioeconomic clusters. This concentration of LIHTC units in lower sociodemographic clusters thwarts efforts to develop in communities of opportunity.

Map 1: Demographic Clusters in Georgia, 2011



Source: Georgia Department of Public Health

There was stakeholder support for changing metrics used to characterize this aspect of proposed locations. Affordable housing and community development professionals also identified several barriers to developing in communities with higher socioeconomic status. One issue was the very limited number and location of very low poverty tracts. Another was the challenge of proposing a development that aligned with communities' visions for affordable rental property in their area. In higher income areas, affordable rental property is often viewed as undesirable. Research shows that communities with development plans that address affordable housing have better outcomes for those proposals.^{18,19}



Data Source: Georgia Department of Public Health and Department of Community Affairs

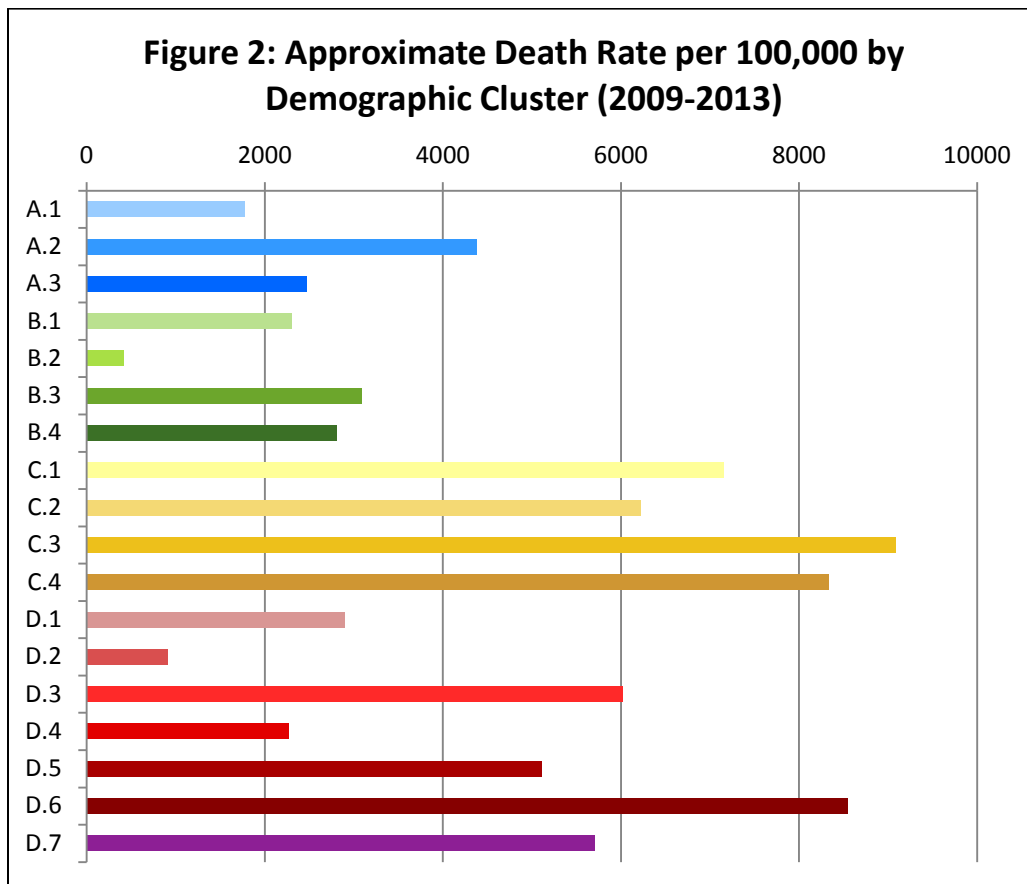
IMPORTANCE FOR HEALTH

Scientific evidence on concentrated poverty finds that only areas with more than about 20 percent of households living below 100 percent of the federal poverty level have significantly worse outcomes in health and quality of life. Below that 20 percent threshold, poverty rates are not particularly indicative of community members’ outcomes; other factors, such as diversity, education, access, and mobility are more influential.^{20,21} Research on families who moved from high to low poverty neighborhoods in the 1990s found limited, although mostly positive, effects.^{22,23} However, new research on the grown children of those families has found stark improvements in health, education, and economic status for those who moved before age twelve.²⁴

As illustrated in **Figure 2**, death rates are somewhat variable over the range of GDPH Demographic Clusters, as are years of potential life lost. For instance, clusters with a younger population have lower mortality even when they otherwise have high risk factors, and rural clusters (the C group) all exhibit elevated mortality. Generally though, higher socioeconomic clusters have lower death rates, allowing for estimations of potential reductions in mortality that might be achieved by gearing incentives in the QAP more toward siting properties in those communities.

LIHTC properties – mainly family properties – were heavily concentrated in D.6 and D.7 clusters, which could likely expose residents to more hazardous living conditions and contribute to higher mortality rates. Because of IRS stipulations which require DCA to encourage development in the QCTs, locating all development in the highest demographic clusters would be impossible; however, shifting some development out of the lowest clusters could potentially increase positive health outcomes and prevent years of life lost. Assuming that mortality levels of LIHTC residents were the same as the Demographic Clusters in which they were located, calculations of potential lives saved were made. First, if the population of LIHTC developments was distributed across Demographic Clusters in

the same proportions as the general population, roughly 400 lives of LIHTC residents could potentially have been saved from 2009 to 2013, or 80 lives per year over that period. A second hypothetical calculation considered the potential impact if the LIHTC population had been located in the highest Demographic Clusters. This second calculation estimated that 1,000 lives of LIHTC residents could potentially have been saved, or 200 per year over that same five year period.



Data Source: Georgia Department of Community Affairs and Department of Public Health

RECOMMENDATIONS:

Based on the evidence and findings relative to connecting affordable housing to healthy communities, the following recommendations were made to DCA as possible means for enhancing the ability of applicants to develop properties in stronger communities and thus improve health in those areas.

- Begin using more comprehensive measures of sociodemographic context in the QAP scoring criteria concerning “Stable Communities.” This would be a shift away from relying exclusively on measures of poverty and toward measures like the GDPH

Demographic Clusters, which are derived from a set of 25 indicators. A recommended points structure based on the Demographic Clusters includes:

- 4 points for locating in subclusters A2, A3, or B1;
 - 3 points for locating in subclusters A1, B2, or C1; and
 - 1 point for locating in subclusters B3 or C2.
- Adjust scoring under “Revitalization and Redevelopment Plans” and “DCA Community Initiatives” to encourage more communities to plan for affordable housing and incentivize siting of LIHTC developments in communities engaged in such planning. **DCA has already adopted one recommendation in this area for the 2015 QAP by allowing points for developments that further revitalization plans in areas that are economically distressed but not defined as QCTs.** Other specific changes to the QAP that could accomplish this goal include:
 - Increasing points for Georgia Initiative for Community Housing (GICH) participants from one to two under the “DCA Community Initiatives” section
 - Offering an additional point for redevelopment plans outside of QCTs, for HUD Choice Neighborhoods or for Promise Neighborhoods under the “Revitalization/Redevelopment Plans” section.
 - Allowing an additional point for plans that are created by the project team to reward applicants who have been engaged with the community and have developed their application through a community planning approach.
 - **Continuing to offer points for projects that align with other place-based investments.**
 - Expanding the role for Community Housing Development Organizations (CHDOs) in affordable housing planning
 - **Allow for innovations in proposed LIHTC projects that address issues involved with community connections. The 2015 QAP includes “Community-driven Housing Strategies” as one of the eligible topics under a new “Innovative Project Concept” award.**

ENCOURAGING ACCESS TO EDUCATIONAL OPPORTUNITY

Educational attainment is one of the most critical determinants of lifelong health status. School quality is a major determinant of educational outcomes, and the QAP can facilitate access to quality schools by considering proximity and quality in scoring criteria. Further, the quality of early learning experiences before entering school also proves to be a significant predictor of future success (and therefore of health), and the QAP can similarly be used to encourage access to these experiences.

EDUCATION, EARLY LEARNING, AND CHILD DEVELOPMENT

Early childhood experiences – from zero to five years, and even before birth - have been identified as crucial developmental factors that can determine lifelong outcomes.²⁵ In these years, children are forming the physical and cognitive building blocks they will need for future success in learning, social interactions, and other aspects of life. Decisions families make about early childhood care and learning therefore become critical in positioning future generations to thrive.

Early childhood experiences have been identified as crucial developmental factors that can determine lifelong outcomes. Decisions families make about early childhood care and learning therefore become critical in positioning future generations to thrive.

The first test after this critical early period is typically in the school setting, and the quality of those schools will likely be reflective of future quality of life. Though school quality is not the only determinant of educational performance, it does determine a significant portion of student success. Recent research has argued that less than 30 percent of academic performance is attributable to

teacher and school quality, with the remaining 70 percent influenced by a combination of factors like socioeconomic status, neighborhood context, and home environment.^{26,27} To address these more holistic influences on student achievement, high-quality schools can implement programs and services that help to overcome challenges outside the classroom. These might include:

- free breakfast for students with chaotic homes,
- health clinics,
- mental health services and behavioral skills development,
- smaller and more personalized courses,
- project-based learning,
- homework assistance or home visiting, and
- disciplinary policies designed around intervention rather than punishment.

The aim of these types of innovations is to get students on the track to success as early as possible, given evidence indicating that disparities in early achievement translate to larger gaps later in life. One in six children who are not reading proficiently in third grade does not graduate from high school on time, a rate four times greater than that for proficient readers.²⁸ The challenges become greater when dealing with lower income families: 22

percent of children who have lived in poverty do not graduate from high school, compared to 6 percent of those who have never been poor.²⁹

FINDING

2014 was the first time the Georgia QAP prominently considered local school quality in the scoring criteria, acknowledging the critical link between affordable housing location, educational opportunity, and quality of life outcomes. Stakeholder feedback identified the 2014 effort as a worthwhile attempt to address this topic, but noted that the amount of effort needed to attain the small number of available points bordered on prohibitive. Some stakeholders explained that performing a complex calculation based entirely on test scores made the points both difficult to obtain and possibly reflective of metrics that inadequately capture the complexity of factors influencing school quality.

In regards to early learning experiences, the 2014 QAP included licensed daycare services as a desirable amenity for which an applicant could receive a single point if their development site was within two miles of one. The HIA project team and stakeholders agreed there was room for improvement regarding incentives for improving access to quality early childhood learning opportunities.

EVIDENCE

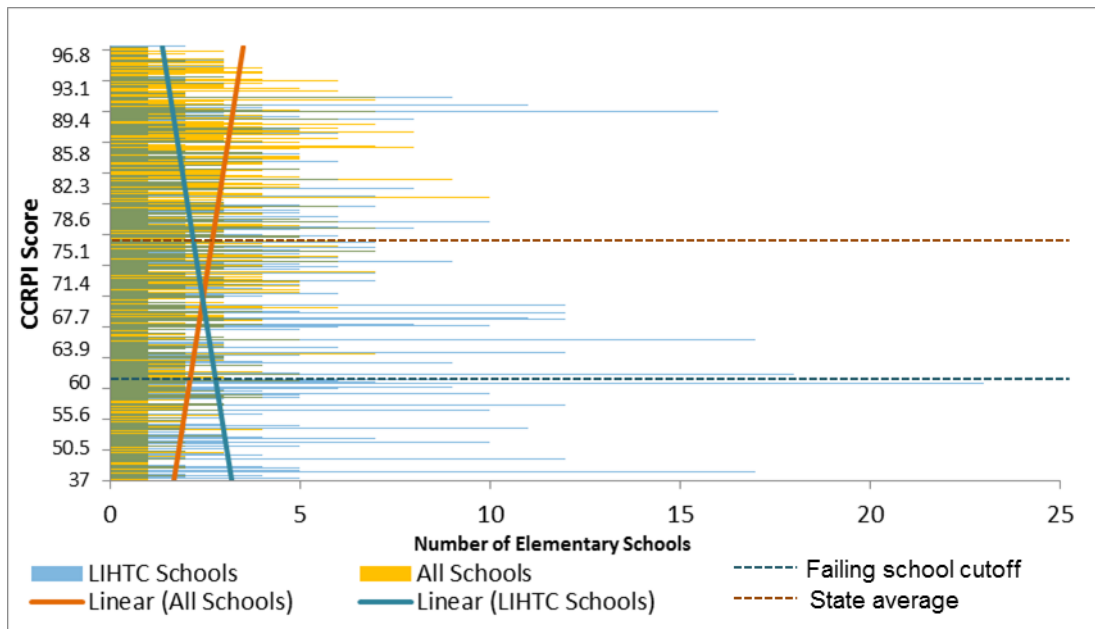
Georgia is one of ten states initially granted a waiver in February 2012 from the federal No Child Left Behind Act, which means the state is responsible for developing its own school accountability system. To this end the Georgia Department of Education developed the College and Career Ready Performance Index (CCRPI) for K-12 schools. CCRPI is a comprehensive school improvement, accountability, and communication platform for all educational stakeholders that promotes college and career readiness for all Georgia public school students. Rather than relying on test scores alone, the CCRPI scores schools across as many as 18 different items, in addition to multiple supplemental indicators.

In examining the locations of all 1,068 LIHTC properties for which address data were available, the assessment found that elementary schools near LIHTC properties had significantly lower CCRPI scores than those in other areas. There is also a disproportionately high number of LIHTC properties located near schools classified as failing by this measure (scoring below 60 out of 100). **Figure 3** shows the CCRPI scores of all Georgia elementary schools, in orange, slope upward toward high scores while LIHTC-adjacent schools, in blue, trend toward low scores. The average scores of elementary schools located closest to LIHTC properties was 70; while the average for all elementary schools was 76, a statistically significant difference. **Table 2** shows the ratio of LIHTC properties to various CCRPI-determined classes of elementary schools that would potentially serve them. There are over two LIHTC properties potentially served by each of the worst performing schools; while there is less than one property for each above-average school.

A 2010 study of Texas schools before and after new LIHTC Family properties were placed in service found that the presence of the property did not have a noticeable effect on school performance.³⁰ In light of those findings, these data from Georgia suggest it is

more likely that LIHTC development has occurred near underperforming schools, and not that the properties are causing these schools to perform poorly.³¹

Figure 3: Georgia Elementary School CCRPI Scores by School and by LIHTC Property



Data Source: Georgia Department of Community Affairs and Department of Education

Table 2: Ratios of LIHTC Properties to Classes of Elementary Schools

Type of Elementary Schools, based on CCRPI Thresholds	Number of Schools	Number of LIHTC Properties Potentially Served	Ratio of LIHTC Property to Number of Schools
All Schools	1206	1068	0.9
Above Average (score>76)	649	360	0.5
Failing (score<60)	158	159	1.6
Worst Performing (score<50)	39	85	2.2

Data Source: Georgia Department of Community Affairs and Department of Education

For early learning environments, stakeholder input and research suggested multiple benefits of better incorporating considerations of these facilities in the QAP. Many early learning programs engage parents as well as providing positive, stimulating cognitive and social development settings for children. Evaluation of these interventions found that participants had better outcomes later in life and also documented that economic benefits accrued over time.^{32,33} Savings stemmed from a host of sources, including:

- fewer remedial school interventions,
- higher educational attainment leading to higher earnings as an adult,
- lower rates of criminal justice system utilization,
- reduced medical expenses, and
- lower utilization of social services.

Over future decades, housing programs that increase access to early childhood education for low-income families could reduce the number of households that require subsidized housing through this route. One appeal of early learning strategies is that children only need a relatively brief exposure (3-5 years) to enjoy the full benefits, potentially maximizing benefits despite population mobility.^{34,35}

In Georgia, the Department of Early Care and Learning (DECAL) licenses and serves all non-exempt group childcare providers. DECAL is in the process of assessing every center-based childcare provider and giving them a Quality Rated score based on each provider's adherence to developmental and learning program standards. This scoring process is ongoing from 2013-2017. Within licensed providers, some offer lottery-funded Pre-K at no cost for all children over age four, and some accept a criteria-based state childcare subsidy for children of any age. Also, there are Head Start and Early Head Start programs in some counties. Once the Quality Rated scores become available, scoring incentives in the QAP could be updated to better reflect access to and quality of early learning opportunities.

IMPORTANCE FOR HEALTH

Early childhood represents a brief but irreplaceable developmental window that influences future outcomes. The importance of the birth to five years on child development and lifelong health, success, and wellbeing cannot be overstated. The Institute of Medicine has endorsed effective early learning programs as one of the greatest and most cost-effective ways to improve future health status.³⁶

After early childhood, educational attainment follows as one of the most important health determinants. Over 44 percent of adults who have not completed high school report that their health is fair or poor (rather than good or excellent) compared to just 7 percent of adults with a college degree. Compared with college graduates, adults over 25 without a high school degree are more than twice as likely to have diabetes or suffer heart disease, and their babies are more than twice as likely to die before their first birthday. In total, a US college graduate can expect to live eight to nine years longer than someone who had not obtained a high school degree by age 25.³⁷

Given the scientific evidence and input from stakeholders, there appears to be sufficient support to predict that changes to the QAP scoring incentives that better characterize both access to and quality of educational opportunities would improve quality of life and health for future residents of LIHTC developments.

RECOMMENDATIONS

The following recommendations were made to DCA in an effort to translate the above evidence and findings into actionable strategies that would encourage access to educational opportunity through QAP scoring for affordable housing development.

- **Use the CCRPI to determine the quality of schools near proposed development sites and provide scoring incentives for locating in the attendance zones of above average schools. This change is included in the 2015 QAP under the “Quality Education Areas” section of the scoring criteria and offers a more straight-forward process than the 2014 QAP, which required applicants to perform complex calculations based on test scores in order to determine if nearby schools met the quality threshold required for their project to receive points. Some of the specific changes recommended included:**
 - **awarding points for proposing development in the attendance zone of a school with above-average CCRPI scores for the grade level (elementary, middle, or high)**
 - including extra points if all grade levels were performing above average
 - deducting one point for proposing development in the attendance zone of a failing school (below 60 points on the CCRPI scale); and
 - **allowing a charter school to be considered as long as it served a small area and thus offered a good chance for children in LIHTC units to be selected for admittance**
- **The 2015 QAP awarded two points for family properties that were in the attendance zone of above average CCRPI scoring schools for all grade levels, and one point for a single school.** They introduced a one point deduction for all properties located in the attendance zone of schools with a CCRPI score below 60 (flexible pool) or 55 (rural pool) in the draft version, but removed this clause in the Final version. DCA should work with the Georgia Department of Education to continue to make better use of CCRPI and school planning initiatives.
- Include scoring incentives for proposed developments to locate near high quality early learning facilities. A distinction needs to be made between child care and early childhood education. Bright from the Start, a DECAL program, plans to have a “Quality Rated” rating for every licensed child care setting by 2017. These ratings should be incorporated into future QAP scoring.
 - A specific recommendation was made to award one point if there is a Quality Rated childcare facility that accepts subsidies or a Georgia’s Pre-K Program

(meaning it can accept eligible children with state lottery funding) within the same ZIP code as the property.

- LIHTC investment can also function as part of a comprehensive revitalization program that includes school transformation, child development, and housing (such as Promise Neighborhoods, or the Villages at East Lake). Applications that are contributing to such a program should also be eligible for points under the “Quality Education Areas” section. DCA should collaborate with education experts to define evidence-based ways to identify eligible initiatives, and over time, support the development of ways to measure and reward effective collaborative plans to improve access to high quality schools and early learning centers.

PROMOTING HEALTHY DESIGN AND OPERATION

This topic area mainly considers attributes of the physical environment, both within and surrounding proposed housing developments. Many of the connections between this aspect of housing and public health have already been firmly established, either in the scientific literature or through other HIAs.³⁸ To avoid duplication of previous work, this HIA includes a desktop assessment that summarizes existing evidence for relevant topics and presents recommendations for applying this evidence within the context of the 2015 QAP (the full desktop assessment is available in the Technical Report). **Table 3** presents examples of the content included the desktop assessment.

HEALTHY COMMUNITY DESIGN

Designing healthy places is a critical means for improving public health. This mostly physical component of neighborhoods and communities should be viewed as the context in which the community connections and access to educational opportunities discussed above take place. Some of the relevant environmental attributes that community development, economic development, and housing experts have used to describe healthy community design include:

- proximity to a large number and variety of employment options
- convenience to stores, restaurants, parks, recreational facilities, health care providers, child care, professional services, continuing education, and many other types of daily amenities including those that support healthy living
- access to multiple convenient transportation options including walking, bicycling, and/or transit
- safe, both objectively and subjectively
- clean, green, and well maintained, free of pollution, blight, and hazards

When well-designed affordable housing is located in communities that have many of these features, there is greater likelihood of success for both the lower income individuals who live in that housing and the community in which they are located. A goal of allocation plans in general is to distribute LIHTC with these connections in mind.

FINDING

Much of the 2014 QAP considered aspects of healthy design, and the desktop component of the HIA was intended to enhance this existing content where possible. Topics like sustainability, mixed-use development, and transit-oriented development were already present in the policy, and other areas of community design were considered in scoring criteria that promote access through proximity to amenities and discourage locations near “undesirable” community features. The desktop HIA considered language from the 2014 QAP and identified 36 recommendations for policy adjustments that would potentially improve health. One-third of these were adopted into the draft 2015 QAP, with a smaller subset being retained in the final policy after public comment.

Healthy places are those designed and built to improve the quality of life for all people who live, work, worship, learn, and play within their borders -- where every person is free to make choices amid a variety of healthy, available, accessible, and affordable options.

(Centers for Disease Control and Prevention)

EVIDENCE

The desktop analysis includes thirteen specific topics under three categories: environmental health and safety, active design and access, and healthy living. There are also general discussions about affordable housing as a health determinant and HIA as a tool for incorporating public health perspectives into housing policy. The desktop assessment includes a brief rationale for including each topic. Samples of the rationale for each of the topics are presented in **Table 3**.

IMPORTANCE FOR HEALTH

All the elements under this topic area have established links to population health, and the desktop assessment includes some relevant state-level public health statistics that illustrate the behaviors and outcomes that would potentially be impacted. **Table 3** includes samples of these statistics for each topic, and complete references to data sources can be found in the Technical Report.

RECOMMENDATIONS

Example recommendations for each healthy community design topic are included in **Table 3**. Several are explained in a little more detail below.

- **Incentivize developments that encourage pedestrian activity by considering design features and connectivity in addition to proximity to amenities and pedestrian facilities. Examples of this include: stipulating that existing streets should not be abandoned, with surrounding street networks extending through properties where feasible; determining proximity by considering actual walking distance, not straight-line distance; and ensuring that sidewalks and walkways connect the property to adjacent streets.**

- **Expand the options for meeting existing residential service requirements to include on-site health promotion and maintenance programming. Examples of this type of programming include semi-regular classes on nutrition/healthy cooking, asthma management, smoking cessation, and various types of exercise and personal fitness. This recommendation was included in the final 2015 QAP.**
- Reduce potential exposures to air pollution by adjusting scoring criteria to incentivize development in locations farther than 200 meters (650 feet) from roadways carrying more than 25,000 vehicles per day. This was included in the draft 2015 QAP but removed from the final version due to developer concerns about reduced property visibility on lower traffic roads affecting marketability. In response, solutions that balance mitigation of potential exposure to pollution and project visibility should be further explored. Examples might include increasing the threshold to 50,000 vehicles per day, designing sites to have residential buildings set further back from the busiest roadways, or planting evergreen trees to filter pollution.
- **Recommend or support the use of HIA for specific projects to encourage developers and non-profits to consider healthy development in greater detail. While HIA was not adopted into the 2015 QAP per se, the inclusion of “Integrating Health and Housing” as one of the issues that could be explored under the “Innovative Project Concept” section indicates the willingness of DCA to continue incorporating evidence-based health perspectives into their affordable housing policies.**

REPORTING: COMMUNICATING ABOUT THE HIA

Since DCA was an active partner in this HIA, a certain level of reporting occurred throughout the process as the HIA project team kept them informed of progress. This ongoing communication allowed for interim products, like the desktop assessment of healthy community design topics, to influence content of earlier drafts of the 2015 QAP. This Summary Brief and the forthcoming Technical Report present the culmination of that iterative process and will be shared with all the stakeholders involved and be readily available to the public. There are also plans for the HIA team and DCA to continue to

collaborate, beginning with a “lunch and learn” session in the summer of 2015 to share results of the HIA with DCA staff who were not directly involved in the project.

The HIA not only had primary results in the QAP, it is having secondary and tertiary effects too as we consider the way we develop our policies.

*Philip Gilman, Housing Finance Division, Georgia
Department of Community Affairs*

An important tenant of HIA is transparency, and part of that entails describing assumptions and limitations that influence the assessment and its conclusions.

These are detailed in the Technical Report, and mostly include data limitations (e.g., incomplete baseline information about the populations living in LIHTC properties) and assumptions included in analyses (e.g., an assumption in the education analysis that proximity corresponded with attendance zone).

NOTE ON EVALUATION

A process evaluation was completed on the HIA in conjunction with the evaluation of two other community development HIAs supported by the Health Impact Project. An ad hoc impact evaluation occurred as the 2015 draft and final QAP were released in order to identify where HIA-recommended changes were incorporated. Much of this information is reflected in the above discussions. Outcome evaluation will occur over the long term, based on monitoring plans included in the Technical Report.

Table 3: Sample Content from the Desktop Assessment of Healthy Community Design

Category & Topics	Rationale/Evidence	Health Statistic	Recommendation (Shading indicates some level of adoption in Final 2015 QAP)
Statement on Housing Affordability	Lack of housing and housing instability are associated with a wide range of poor health outcomes for adults and lifelong poor health for affected children	49percent of renting households in Georgia pay more than 30percent of their income for housing	Through LIHTC and other programs, continue to fund and implement effective, evidence based strategies to ensure that safe, healthy, sustainable, quality housing is available and affordable
Environmental Health and Safety			
Proximity to highways and other sources of air pollution	Studies have consistently found elevated rates of asthma and other health concerns (including infant mortality, low birth weight, and possibly autism) in populations that live or spend extended periods of time near high traffic areas.	In 2013, Georgia was 45 th out of 50 states for air quality, 34 th for infant mortality, and 45 th for low birthweight	Projects should not be accepted that propose buildings within 200 meters (650 feet) or a road with an Annual Average Daily Traffic (AADT) that exceeds 25,000 motor vehicles per day. Parking and undeveloped areas of the property may fall within that buffer.
Smoke free housing	Tobacco use, particularly smoking, is proven to be the most prevalent underlying cause of death in the US. In addition to increasing risk of death, disability, and high costs for the smoker, habitual smoking also leads to negative health outcomes for other members of the household and community that are exposed to environmental tobacco smoke.	Smoking is estimated to contribute \$3.18 billion in health care costs annually in the state of Georgia. \$537 million of that is paid by the state Medicaid program.	Properties should prohibit smoking indoors and within 25' of two-family and multi-family buildings, including inside of residential units. Properties should have an enforcement policy, however eviction should not be an enforcement method except for repeated, flagrant, and intentional violations
Flooring materials	Carpeting is a potential trigger for asthma symptoms due to the high potential for accumulation of dust mites, mold, mildew, and other irritants. Low-income households tend to have elevated asthma rates and are at greater risk for exacerbation of symptoms due to environmental conditions.	From 2008-2012, over a quarter million Georgians visited the emergency room for asthma treatment, which is significantly higher than the rest of the country. About half of the visits were children under 18	Consider permitting asthma management classes or consultations as required services, including educating residents on carpet maintenance, allergen control, and creating an asthma action plan.
Green housing	A 2014 study of residents of housing built to various "Green Housing" standards found that the self-reported health of adults improved significantly one year after moving into the housing.	16percent of Georgia adults report that they are in fair or poor health. In some counties, this number is as high as 36percent.	Maintain and update the scoring for Sustainable Development in accordance with industry best practices
Trees and greenery	A large body of research makes connections between the presence of greenery and positive measures of mental health. There is also evidence that trees and greenery can contribute to reducing violent crime.	Homicide is a top-ten cause of death from birth to age 44; suicide stays in the top ten from age 10 through 44.	Plant trees along streets, driveways, and walkways and around buildings using the 'Right Tree in the Right Place' method.
Injury hazards	The home environment can contain many injury hazards, and the lower income populations served by LIHTC developments are especially vulnerable to this risk.	Unintentional injuries (excluding falls and car crashes) are the leading cause of emergency room (ER) visits for Georgians between the ages of 1 and 19.	Allow safety classes to serve as Required Services, such as CPR, household safety, fire safety, or water safety.

Table Continues on Next Page

Table 3 Cont'd: Sample Content from the Desk-top Assessment of Healthy Community Design

Category & Topics	Rationale/Evidence	Health Statistic	Recommendation (Shading indicates some level of adoption in Final 2015 QAP)
Active Design and Access			
Pedestrian ingress/egress and circulation	Walking is one of the easiest and most cost effective ways to be physically active, lose weight, and reduce stress.	Adults with a safe and convenient place to walk were more likely to engage in regular activity (42percent) than those with no place to walk (27percent).	Pedestrian ingress and egress should be provided to all adjoining streets, including along all vehicular entrances with crosswalks at street connections.
Bicycle facilities	Like walking, increased bicycle ridership is associated with better health in many areas, most notably reductions in heart disease and obesity, and fewer traffic-related injuries	Bicycling to work is most common in small rural towns, twice the rate of large central cities.	Consider offering a point for connecting to adjacent bicycle facilities such as bike lanes, bicycle boulevards, or paths.
Mixed use developments	Proximity to a facility or business tends to increase use of that resource, particularly when it provides services or items of the type and price-range sought by the surrounding market. In addition to increasing access, proximity also promotes active travel and the associated benefits from increased daily physical activity.	Nearly 40percent of Georgians spend more than 30 minutes commuting to work.	Consider offering one additional point if the proposal is in a location zoned for mixed-use development, even if the project itself is not mixed use.
Parking	The availability and cost of parking is a major factor in travel mode selection: large amounts of free parking lead to increased driving. More driving leads to increases in determinants of ill-health like sedentary behavior, traffic-related crashes, and air pollution.	About 6percent of Georgia households own zero vehicles; 40percent own 1 vehicle or fewer. 60percent of zero vehicle households are low-income	Consider eliminating section III.B. on Parking in the Architectural Standards and rely solely on local requirements
Transit Oriented Development	Transit oriented development is associated with opportunities for better health by increasing walkability and the share of walking trips	Georgia workers living in households below 1.5 times the federal poverty level are twice as likely to commute regularly by transit (4percent versus 2percent for the entire population).	Consider increasing the number of applications that can be awarded points for a Transit Oriented Development connection
Healthy Living			
Nutrition and cooking activities	Better nutrition – defined by eating more fruits and vegetables, consuming less added sugar, and increasing dietary fiber – could significantly reduce the incidence and/or prevalence of diseases such as Type 2 diabetes, heart disease (including stroke), and some types of cancer.	Georgians consume an average of just 0.86 fruits per day and 0.79 vegetables, compared with CDC recommendations for 5 servings of fruits and vegetables daily	Include health-oriented events such as nutrition and cooking classes. Classes might involve a partnership with the local cooperative extension, food bank, or charity.
Fitness amenities and activities	On-site amenities and programs that encourage and educate residents about safe physical activity can have a significant benefit for many health outcomes, including obesity, diabetes, heart disease, and some cancers	Poor diet and physical inactivity were the underlying cause of over 10,000 deaths in Georgia in 2006, second only to tobacco use.	Include health-oriented offerings such as regular classes in popular aerobic styles, yoga or Pilates, or guidance in strength training or personal fitness.
Health Impact Assessment	Plans, projects, and policies that utilize HIA recommendations tend to implement evidence-based solutions that are attractive to government agencies, businesses, and communities and also create health-supporting physical and social environments.	A number of government entities in Georgia have adopted HIA into their planning approach, including the Atlanta Regional Commission, the Albany Housing Authority, the City of Decatur, the City of Macon, and GA Department of Public Health	HIA could potentially be added to the criteria for Community Driven Housing

RESOURCES

The following resources were consulted during this HIA process and may be of use to DCA and other stakeholders as they further their work to increase the supply of quality affordable housing in Georgia.

The Impacts of Affordable Housing on Health: A Research Summary

A 2015 report from the Center for Housing Policy, the research Division of the National Housing Conference Partners authored by Nabihah Maqbool, Janet Viveiros, and Mindy Ault. Available at:

http://www.nhc.org/HSGandHealthLitRev_2015_final.pdf

Build Healthy Places Network

A recently established network with support from the Robert Wood Johnson Foundation that aims to catalyze and support collaboration across the health and community development sectors, together working to improve low-income communities and the lives of people living in them. More information at:

<http://www.buildhealthyplaces.org/>

Building Healthy Places Toolkit: Strategies for Enhancing Health in the Built Environment.

A 2015 resource from the Urban Land Institute. Available at: <http://uli.org/research/centers-initiatives/building-healthy-places-initiative/building-healthy-places-toolkit/>

Leveraging Multi-Sector Investments: New opportunities to improve the health and vitality of communities

A 2014 report from Health Resources in Action authored by Shari Sprong and Laurie Stillman. Available at:

<http://www.hria.org/resources/reports/leveraging-multi-sector-investments-new-opportunities-to-improve-the-health-and-vitality-of-communities/>

Monetizing the Value of Social Investments: The Methodology Behind The Low-Income Investment Fund's Social Impact Calculator.

A 2014 document from the Low-Income Investment Fund. Available at: http://www.liifund.org/wp-content/uploads/2014/09/liif_social_impact_calculator_methodology.pdf

Making healthy places: designing and building for health, well-being, and sustainability.

A 2011 text edited by Andrew Dannenberg, Howard Frumkin, and Richard Jackson, published by Springer Science & Business Media.

Housing in America: The Next Decade

A 2010 report from the Urban Land Institute by John McIlwain. Available at: <http://uli.org/report/housing-in-america-the-next-decade/>

Special Issue of *Community Development Investment Review* focused on Health and Community Development

Special issue from 2009 (Volume 5 Issue 3). Summary available here: <http://www.frbsf.org/community-development/publications/community-development-investment-review/2009/december/health-community-development/>

Overcoming Obstacles to Health: report from the Robert Wood Johnson Foundation to the Commission to Build a Healthier America

A 2008 report by Paula Braveman and Susan Egarter from University of California, San Francisco, Center on Social Disparities in Health. Available at: <http://www.rwjf.org/en/library/research/2008/02/overcoming-obstacles-to-health.html>

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