

HEALTH

SHELTERFORCE

HEALTH

& COMMUNITY DEVELOPMENT



Communities need more than just housing. They need good schools, safe streets, adequate transportation, arts and culture, and, of course, equitable access to health services and an environment that promotes physical and psychological wellbeing. We've been writing about the health outcomes of housing and community development since our founding in 1975, however, we now have a way of understanding the outcomes of our work and a language to describe it. We launched our health and community development desk in the Winter 2018 issue, and we continue to delve into the intersection with this supplement. For more, go to Shelterforce.org. You can also sign up for our weekly newsletter at bit.ly/SFWeeklySignUp.

Getting on Board

What was once rare is now becoming an industry standard for community development corporations and grassroots housing organizations: board members from the health care sector. **By Katy Reckdahl**

THE GRASSROOTS-HOUSING WORLD hasn't always been a place known for whiz-bang presentations and comprehensive data.

Only nine years ago, in 2009, the U.S. Department of Housing and Urban Development made it mandatory for shelters and other agencies to use the Homelessness Management Information System to track homeless clients.

But now, housing administrators are often asked to partner with the health care sector, which is known for deep data and sophisticated financial analyses.

"It does feel a little like when an older classmate would ask me to dance: 'Who? Oh, me? I'm happy to do that,'" says Joan Serviss, executive director of the Arizona Housing Coalition. Serviss finds the new interest flattering, but she isn't sure how to measure up.

She recently added two new members to the coalition's board, both of whom were from the health care sector. Over the past several years, it seems, that's becoming almost an industry standard for community development corporations (CDCs) and grassroots housing organizations like hers.

Two years ago, in a survey of its members, the Massachusetts Association for Community Development Corporations found that there is "a growing movement

toward health programming among CDCs" and that many CDCs were already doing health-related work. About one-third of responding CDCs had a board member from a health-related field.

Twice as many of the CDCs, roughly two-thirds, had partnered with health care providers such as clinics and hospitals. The survey also found that CDCs were also involved in a broader range of efforts that might fall under the umbrella of public health, a wide variety of activities like community gardens to basketball programs for youth, to meal delivery for seniors and food access for families.

In Arizona, Serviss wanted to know more about the intersection of health and housing, as she prepared to head up a new board, the result of a merger that combined two previous boards, one that dealt with homelessness and the other with affordable housing.

To help in that effort, one of her new board members set up a phone conversation between her and Barbara DiPietro, who directs policy and advocacy for the National Health Care for the Homeless Council.

"I think the biggest takeaway from our conversation was that both the housing and health care sectors are close to making this marriage work, but we just need to speak the same language," Serviss says.

Of course, health care records are guarded by HIPAA laws and service providers for the homeless protect the client records entered into the Homeless Management Information Service, or HMIS. But Serviss isn't sure it's fair to point to the same old suspects.

Serviss finds money-related areas to be more challenging. For instance, for Permanent Supportive Housing clients, she always hears the same advice: "Bill Medicaid." In some places, Medicaid does pay for the services that a formerly homeless person receives once they're housed.

The process is not as simple as it sounds, Serviss says. "Anything around funding is complex." But overall, it's not so much about translating specific terms or even integrating funding streams, she says. Instead, it's about breaking away from

Residents come together to identify challenges in their community and brainstorm sustainable solutions to help increase quality of life in Houston's Northline neighborhood.



the longtime assumption that housing and health care issues should be dealt with in different conversations.

Other housing and health providers are similarly in need of guidance about how these new partnerships should proceed. Or so the Urban Institute found in its report *Emerging Strategies for Integrating Health and Housing*, which examined the increasing number of interventions that integrate health services and affordable housing.

“Despite the growing interest in collaboration, there has been little evidence to inform how to build and sustain meaningful cross-sector partnerships,” the authors wrote.

The Urban Institute researchers found that, historically, motivations to pair health and housing were spurred by a few specific missions and events, including the landmark U.S. Supreme Court’s *Olmstead* decision in 1999, which pushed providers to focus on the intersection of health and housing as it related to the housing of disabled people who were trying to live on their own in non-institutional settings.

More recently, the Affordable Care Act’s requirement has again highlighted the intersection. Beyond its coverage of many low-income adults who may also experience housing instability, ACA requires that nonprofit hospitals include social needs when creating community needs assessments. In conjunction, the Internal Revenue Service included some housing investments in guidance issued for nonprofit hospitals that are trying to fulfill their “community benefits” requirements. As a result, hospitals are now able to fulfill their community benefits requirements by investing in lead abatement, neighborhood revitalization, senior housing, parks and playgrounds that improve physical activity, and post-discharge housing for vulnerable people.

Today, the result is a rich set of partnerships, spurred and encouraged at both the board and staff level, in housing agencies across the nation.

Trying to Elevate the Connection

People who work in nursing have always felt the need to broaden partnerships and, in recent years, there’s an increasing interest in housing agencies, says Sofia Aragon, the executive director of the Washington Center for Nursing.

The Urban Institute study recognized the same trend, which it characterized as “an awakening within the health care sector that housing status is a key indicator of health.”

So, two years ago, Aragon was pleased to become part of the board for the Washington Low Income Housing Alliance, a statewide nonprofit. “I’m just happy that they were welcoming to me, because I had a lot to learn about their work,” she says.

Recently, as part of a Washington state grant from the federal Center for Medicare and Medicaid Innovation, Aragon was asked to serve on a committee that

helps get homeless people into housing. That work involves the alliance. “It’s a work in progress,” says Aragon, who is figuring out how best to “elevate the connection” between her work with the alliance and her work on the grant.

Though collaborations between the two sectors are still “new-ish,” she says, most nurses begin dealing with housing-related issues as soon as they get their degrees.

Aragon started her career at Providence Health & Services, now part of Swedish Medical Center, where the mission was to serve the community. In last year’s report, Urban Institute researchers found that the earliest health care leaders interested in housing needs came from mission-driven community health systems, which were focused on finding answers to patients’ ailments in a way that transcended organizational boundaries.

“In a community setting like that, if you want your care to work, you need to consider what else is going on in patients’ lives,” she says. “Did they have transportation? Did they have housing?”

But once she knew her patients’ situations, she often had to go the extra step to seek out affordable-housing and social-services providers because connections between the two worlds were often spotty and the now-prevalent concept of housing chronically homeless people with medical supports hadn’t yet been developed.

Aragon’s devotion to these connections helps to inform her work on the alliance’s board, she says. She and her colleagues are now working to develop an interviewing tool for nurses to use, to screen patients for so-called social determinants that needed to be addressed. Nurses in the Seattle area are already familiar with the short video and handout that Aragon and her colleagues use to teach others about social determinants.

The two-page handout, which Aragon helped write, outlines the basics of the concept. A big blocky headline reads: “Why is Mrs. Smith in the hospital? *She has chronic bronchitis.*”

The text takes it several steps further:

But how did she get chronic bronchitis? *Her cough persisted for a year and she didn’t seek treatment.*

But why didn’t she seek treatment? *She is homeless and doesn’t trust providers because of how she has been treated in the past.*

But why is she homeless? *Because she and her husband became unemployed a while ago. They couldn’t keep up with their bills and lost their home.*

But why are they unemployed? *Because neither of them has much education and they couldn’t find jobs.*

If a senior is always falling, [the hospital will] check to see if there are loose tiles or steep stairs and then work with those organizations to fix that.

But why?

The handout encourages each nurse to “Look beyond your patient. ... Are there agencies working to tackle broad social issues? Do they need board members or committee members? Lend your expertise!”

Because of her work on the alliance board, Aragon feels like she is always on the lookout for ways to match her health care experience with the board’s work. “I try to find opportunities,” she says.

Supportive Partners

North of St. Louis, where Angela Pinex heads up the Spanish Lake Community Development Corporation, Christian Hospital is the natural partner for anything the CDC does to improve the neighborhood. “If there’s a health component, Christian will support us or be a co-applicant on the grant,” she says.

So it makes perfect sense that the board includes two members of the hospital staff.

Christian Hospital also helps to stabilize Spanish Lake housing by providing assistance to employees who want to buy a house near the hospital and live closer to work. It also provides the CDC with office and meeting space within the hospital campus.

In turn, the Spanish Lake CDC and its partners work with the hospital if there’s a patient whose condition may have a housing component. The hospital’s Emergency Medical Technicians make home visits first, then ask for help to remedy each situation.

“So if someone is always having asthma attacks and they think that’s because of conditions in her home, they’ll work with other organizations to make repairs,” Pinex said. “Or if a senior is always falling, they’ll check to see if there are loose tiles or steep stairs and then work with those organizations to fix that.”

A few years ago, researchers from Washington and St. Louis universities outlined what is known as “the Delmar Divide” in a long report that highlights the inequities that divide St. Louis. The disparities

are evident to anyone who lives along Delmar Boulevard, which runs east and west and is seen as a dividing line for the city.

As Pinex drives along Delmar, she sees how the neighborhoods south of Delmar are affluent and white, while the neighborhoods north of Delmar, like Spanish Lake, are Black and poor. Tidy lawns and large homes sit on one side of her while rows of substandard houses sit on the other side.

The only hope to revitalize that degree of dilapidation comes when strong anchor institutions like Christian Hospital focus on common goals with housing agencies like hers, Pinex said.

Integrating Health

Five years ago, when the board of Foundation Communities in Austin, Texas, hired Andrea Albalawi as director of health initiatives, few other nonprofit developers had adopted that focus. “At that point, health was not on the radar of the other housing organizations that I saw,” she says.

But now, it’s happening everywhere she turns. “There’s an explosion in health.”

Though the Foundation Communities board only includes one person from the health sector, the remainder of the board has also been adamant about integrating health and housing as the “third pillar” of its work, along with education and financial stability. And while many housing and health practitioners now throw around the phrase “housing is health care,” Foundation Communities takes it a step further, asserting that a roof over someone’s head improves health, but it’s not enough.

“Health is being integrated into where they live,” Albalawi says, noting that each of the developer’s 22 communities in Austin and North Texas provides a variety of offerings, including health clinics, exercise classes, childcare, adult education, tutoring, community gardens, food pantries with fresh produce, and classes for smoking cessation, food management, and control of chronic conditions such as diabetes, high blood pressure, heart disease, and obesity.

All of Foundation Communities’ properties are smoke-free. Before they build features to keep residents active, they sit down with residents to hear what they want. The result varies from community to community. Some want soccer fields or basketball and volleyball courts, others push for walking paths.

Every class offered in Foundation Communities’ developments is free not only to residents but to anyone in the surrounding neighborhood.

And while Albalawi tracks the number of people who attend classes in an attempt to build health metrics, she also sees mental-health benefits for many residents who create strong social networks through the classes they take together. For instance, there’s the single mother, a domestic-violence victim trying to rebuild her life, who lost more than 100 pounds and formed a sense of community with the women in her Zumba class. “She had cut all ties with her past for her own safety, but now she can be healthier for her daughter,” Albalawi said. “She now has huge support and it’s been life-changing.”

Seeing Health Differently

After the Versailles and Village de l’Est areas of eastern New Orleans were hard-hit by the flooding that followed Hurricane Katrina and the federal levee breaks in 2005, a home-grown CDC was integral to its rebuilding.

Daesy Behrhorst, an administrator at the school of public health at the Louisiana State University Health

RESOURCES

Emerging Strategies for Integrating Health and Housing: Innovations to Sustain, Expand, and Replicate, by Corianne Scally, Elaine Waxman, Ruth Gourevitch, and sade adeeyo. Urban Institute, July 20, 2017

urbn.is/2o0zcGp

“Approaching Partnerships Between Health Care Institutions and Community Development Organizations,” by Amanda Abrams. *Shelterforce*, Feb. 13, 2018

bit.ly/SF189Abrams

“Aligning Health Systems With Community Development,” by Kevin Barnett. *Shelterforce*, Feb. 13, 2018

bit.ly/SF189Barnett

Sciences Center, is one of three people from health-related sectors who is on the board of the MQVN CDC in New Orleans, a CDC that is closely associated with the work of Mary Queen of Vietnam Church. The massive Catholic church has long been the center of the neighborhood's large Vietnamese community and now, because of the growing Latino community, the church is holding Masses in Spanish.

Behrhorst has helped to guide the board's work in placing housing in close proximity to its community clinic and to everyday activities such as community gardens.

In turn, her work is guided by the CDC's overarching philosophy that health is more than an institution or a building, that it must include housing and green space and healthy activities. It's been integrated like that from its start. But when Behrhorst attends conferences, health administrators often ask her how they can engage people from their own local housing agencies. "And people from housing ask the same thing: how do they connect to health?"

Behrhorst credits the residents who make up the majority of the CDC's board for driving that integrated philosophy. "This is important to people who live in this community," she said. "They see health differently. They don't see health as doctor-hospital-institution. They see it as the environment in which they live. So it's not just me pushing it."

In 2011, in the wake of the BP oil spill, which devastated neighborhood residents who relied on fishing and shrimping to survive, the CDC helped to form a co-op called VEGGI to help residents sell organic garden produce and pond-grown fish, nurtured through aquaponics systems.

Today, the community offers housing, a community clinic, opportunities for physical activity, financial stability and healthy foods—all within a small, walkable area of the community. "In my mind, I have not seen any other project like this. In small towns, maybe, but not in urban areas like this," says Behrhorst, who advised housing agencies to consider people from public health, not just medical health, when looking at board members. "It gives you a wider sense of what can happen in your community," she said.

Better Able to Respond

When Hurricane Harvey hit Houston last year, Avenue CDC found itself able to react quickly because of the integrated community work it had already been doing, says Jennifer Wagley, the CDC's deputy director. "We realized that, because of our comprehensive work, we were more able to do housing recovery," she says. "We began mucking and gutting houses right away. But we opened a whole new recovery office and we had it staffed and open within a month."



Because of the national model it had created, Avenue recently received a federal Build Health Challenge grant, a joint effort with Memorial Hermann Health System and the Houston Health Department. Avenue CDC has worked with neighbors on the Near Northside to create a safer environment by building sidewalks and reclaiming parks, finding ways for neighbors to become physically active and eat better. "Tying it together is what helped us win the award," Wagley says.

Like the MQVN board, Avenue's board has some people connected to health but is populated more by residents. "So health is just one lens that they look at the neighborhood," Wagley says, describing how Avenue staff first identified a key health concern—a high population of stray animals—during a neighborhood quality-of-life survey nine years ago.

Many of those concerns now turned out to have health effects, Wagley says. "For instance, we now know that, because of those stray animals, people wouldn't walk in their neighborhoods." At the top of residents' concerns was the neighborhoods' lack of playgrounds and green space, which also had health-related effects, but was acted upon first because of neighbor-driven priorities. "So we didn't say, 'People have diabetes, we need more parks.' We just heard about parks," Wagley says.

Integrating health and housing is at the heart of Avenue's mission of 26 years, which has been "building affordable housing and strengthening communities." Wagley sees the new shared health-housing focus as a way to fulfill deep missions that are more able to transform lives. "We know that housing is the foundation of health," she says. "But then you look around the neighborhood and see other things that need to be taken care of so that the people in the neighborhood can thrive." 🏠

To comment on this article, go to bit.ly/SF190Reckdahl or write to letters@shelterforce.org.

In Houston, Texas, Avenue CDC volunteers provide home repair assistance like scraping wood siding, painting, and landscaping to help residents maintain their homes.

KATY RECKDAHL is a New Orleans-based news reporter who has written for The Times-Picayune, The New York Times, The Daily Beast, and the Christian Science Monitor.

THE REAL LIMITS OF IMAGINARY LINES

By Ryan J. Petteway

My daily “place”
was actually daily
places, and they
weren’t defined
or bounded
by imaginary
lines, but by real
experiences.

I REMEMBER SITTING ON the backs of project benches, sipping my orange drink, while listening to Mobb Deep ask “where ya from?” and discuss dropping a “gem on ’em.” I was curious. Deep thoughts ensued . . . Huh. A gem, you say? What does this gem entail, exactly? Is it expensive? Can it be sold at the pawnshop? Will it multiply if I get it wet? Is it a metaphysical, theoretical gem—perhaps something RZA would wear to a cocktail reception at the World Congress of Philosophy? Are we dealing with conceptual jewelry here? Also, what and/or where exactly is this “where” they seem to be so fascinated with? Is it a geographic where, or a cartographic where? Rectangle or square? Or perhaps a sociologic where, where people *know* where? And what does it mean to be “from” this “where”? So many questions, so little orange drink to answer them all.

Unbeknownst to me at the time, someone had already answered these questions. And it turns out that my personal “where” was actually a *wheres!* I had a census tract where, a ZIP code where, a city council district where, and a congressional district where, amongst other wheres. Everybody and their great-grandma’s niece’s neighbor’s cousin’s barber’s cat knows their ZIP code (the number at least—I bet nobody could draw it, city and urban planners aside). I vaguely remember my congressional and council districts, but drinking a pint of Ponce de León’s blood couldn’t help me reproduce those lines on a map.

I had no idea what the demographic, geographic, or topographic details of my teenage political districts were—I never saw those lines. And even though my mom earned some extra money by working for the U.S. Census Bureau on occasion, I was well into college before I knew what a census tract was. And as it turned out, census tracts were, and still are, apparently considered the Gucci briefs in a drawer full of Hanes. Let me explain.

I’m a public health researcher who focuses on the intersections of housing, community development, and health. I examine the ways in which peoples’ daily place-based experiences and exposures affect their health, and I explore the larger social, economic, and

political factors that determine the spatial distribution and patterns of healthy and unhealthy exposures and opportunities. This work is commonly referred to as “neighborhood” and health research, or, as I prefer, “place” and health research. Prior to becoming a credentialed and dissertation committee-vetted “researcher,” I served as chief epidemiologist for a major mid-Atlantic city health department. A core part of my daily work entailed gathering, analyzing, and mapping data to inform and guide programmatic and policy priorities. A key requirement for producing consistent, reliable, and comparable health data across communities is having consistent and reliable population demographic denominators (i.e., how many people of which racial or ethnic background, sex, income, age, etc.) within a defined community. And the more geographically specific the data, generally the better for planning how to use limited resources to address community health concerns. ZIP codes (despite the hype and buzz around the whole “your ZIP code is more important than your genetic code” thing within public health circles) are too large, often containing completely disparate communities, which tends to mask the existence of health inequities and analytically skew indicators. Additionally, nobody is politically or jurisdictionally responsible or accountable for ZIP codes because they often span multiple cities, counties, and even states, so data produced based on them is birdseed. And many jurisdictions don’t track or report population and housing characteristics based on city council districts. So in the city where I worked, for example, I couldn’t produce a map comparing life expectancies (not precisely, anyway) between council districts. (Note: This should alarm you because health is political.)

What I was left with then was the census tract—those little polygons created by the U.S. Census Bureau to routinely count and describe us. The city planning and health department, in collaboration with leaders from neighborhood associations, worked to spatially define each city neighborhood as a cluster of about two or three census tracts. This wasn’t something unique in this particular health department, but indeed was, and is, standard practice at many health departments. Moreover, it’s standard practice in most research on place and health—defining, measuring,

and operationalizing “place” based on an imaginary line that 99 percent of people don’t even know exists. So, I mapped death rates, life expectancies, tobacco and alcohol retail densities, rodent and insect complaint rates, water and electric cut-off rates, vacant lot and building densities, and about 18.36 million other indicators at the “neighborhood” level based on these census tracts. And I thought I was killing it . . . until I remembered that prior to being a social epidemiologist, I listened to Mobb Deep and drank orange drink while conducting observational studies of project life.

If I recall correctly, between middle school and high school, my housing portfolio included Section 8, Low- Income Housing Tax Credit, and HOPE VI housing. And in walking to and from school, I now know, I walked to and through no fewer than three different census tracts. On any given day between

to approximate the important health exposures and opportunities I encountered?

So I resigned. I took these particular questions into my doctorate training and returned to my former public housing community in a small, urban Rust Belt city just outside of Pittsburgh, to try and answer them through a community-based participatory research project with current residents—the People’s Social Epidemiology Project, or PSEP. The PSEP was developed and designed to democratize the place-health research and knowledge-creation process—to counter standard practices that define “place” using arbitrary and imaginary administrative bounds like census tracts. PSEP was thus envisioned as a way for residents to represent and re-present important community spaces and experiences—and to resist efforts to, in the words of one resident, “wipe us off the map.” I worked with both

We can’t truly understand how a person’s health is affected by where they live if we look only at data within arbitrary boundaries like census tracts and ignore the places people actually go and don’t go every day.

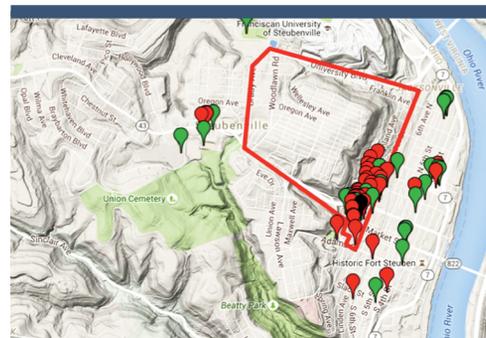
home, school, ball practice, visiting friends, going to the mall, etc., I might have been in six or seven or eight census tracts. And the funny thing is, not once do I remember walking to the end of a block and hitting my forehead on a census tract perimeter (or maybe I did and I forgot). But I do remember walking on certain blocks and being hit with racial slurs and having police pull a DJ Jazzy Jeff and Fresh Prince “Summertime” re-enactment alongside me and my boys (you know, “two miles an hour so everybody sees you . . .”). And I do remember cherry blunts and cherry sours being sold across the street at the corner store (literally across the street, but in a different census tract), but having to go “up on the hill” a mile and a half away (in yet another census tract) to see real cherries at the supermarket. My daily “place” was actually daily *places*, and they weren’t defined or bounded by imaginary lines, but by real experiences and exposures that were shaped by social and economic policies, practices, and processes. Practices that “police” certain communities differently—leading to a federal consent decree to manage the local police department. Policies that limit investment in low-income communities, turning swaths of the city into so-called food deserts with little to no public transportation. And processes that displace public housing residents to refashion their homes as college dorms and exclude them from city “comprehensive plan” discussions.

So what would it have even meant for my local health department to have mapped data based on my residential census tract? How could that possibly represent my actual lived experience of place, or even begin

youth and adults, recruited as parent-child dyads, to explore how “place” shaped health opportunities and exposures within the community. “Place” for this work was based on residents’ daily mobility patterns, so as to more accurately and completely account for their entire range of place-based health experiences and exposures.

In this spirit, participants used exclusively participatory methods to map out the specific locations of their daily health experiences/exposures—that is, their place-health experiences. Residents first photo-documented, via smartphones, the important places they went to daily, like school, work, a friend’s house, or a shopping locale. Then, they used large printed maps and color-coded stickers to locate the photo-places, adding additional non-photographed places as they deemed fit. Lastly, they used a web-based community-mapping platform to integrate their data, indicating for each location whether it had a positive or negative effect on their health.

Overall, 55 percent of adult places and 51 percent of youth places were located spatially outside of their residential census tract. For youth, 80 percent of their positive, healthy, and good places were outside of their census tract, including, for example, a youth development center, a major park, and a library. In contrast,



THE YOUTH VIEW

The polygon outline is the residential census tract for the participants’ housing project community, represented by the single black marker. Green markers represent places participants identified as positive, healthy, and good, while red markers represent places identified as negative, unhealthy, and bad.

67 percent of their negative, unhealthy, and bad places were inside, including numerous vacant lots, vacant buildings, and aspects of their own housing community (e.g. hallways, greenspaces). Among adults, 62 percent of positive, healthy, and good places were outside of their census tract (e.g. a supermarket), while negative, unhealthy, and bad places were fairly evenly distributed inside and outside.

The participatory and nonarbitrary, nonspatially bound approach of this project allowed residents to freely document the important daily places they visited. Here, residents' mobility, and the manner in which they repeatedly cross various imaginary lines of "place" was acknowledged and duly accounted for. This not only facilitated a revelation of what could be considered some of the residents' basic daily necessities (e.g. education, retail access, social and recreation spaces), but also where these necessities were spatially located in relation to home and how residents perceived they influenced health. Moreover, the intergenerational design of this project meant that both adult and youth perspectives were engaged. This allowed for an exploration of not only potential spatial differences between adult and youth places, but also their perceptual differences of place and its effects on health.

We learned that residents moved to and through at least six or seven different census tracts on a regular basis, routinely travelling as far as 4.3 miles to access important community resources and opportunities. Overall, it seemed clear that for positive places, there was nothing else closer to them (e.g. a supermarket or library). They go where they go because they have to. And their maps make it clear that, spatially speaking, the overwhelming majority of their home census tract has no bearing on their actual place experiences, as almost all of their daily activities and mobility patterns were concentrated in only a small portion of the census tract or were outside of it entirely. Most importantly, most of their positive place-health experiences and exposures were spatially located outside of their home census tract, while most of the negative ones were located within. Thus the "Gucci" standard of using census tracts to define and measure a community's "place" would have completely misrepresented and mischaracterized their

place-health contexts, and from a place-health research perspective, incorrectly specified place-health effects within the community.

I doubt these findings are unique to this particular community, and indeed there is a growing body of work within public health and geography fields that suggests that accounting for the routine "breaching" of imaginary lines is in fact the real Gucci way to define and assess place. If we want to truly

understand how place affects health—especially within the context of public housing and community development—we cannot simply sit at a desk and produce data that ignores the lived reality of the people

whose lives we're pretending to capture within said data. And we certainly cannot ignore the myriad ways in which place is actively made, unmade, and remade over time through deliberate and often calculated policy decisions and practice norms that determine the spatial distribution of health opportunities and risks.

Based on this work, understanding how public housing fits into the larger spatial, social, economic, and political landscape of residents' lived place beyond the housing community boundaries is critical to evaluating and improving place-based strategies involving public housing. And a requisite for understanding residents' lived experience with place, and consequent health effects, is explicating the mechanisms that either facilitate or limit their ability and power to participate in and influence placemaking processes. Without these commitments, it appears the increasing focus on place-based strategies within housing, community development, and public health fields will inevitably be . . . misplaced.

Consider the gem dropped. 📌

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RESOURCES

"Your ZIP Code Might be as Important to Health as Your Genetic Code," by Kristian Foden-Vencil. All Things Considered, NPR, Aug. 4, 2017
[n.pr/2GYUpUB](https://www.npr.org/2017/08/04/451111111)

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