



Addressing the Social Determinants of Health

Taking Health Care Investments in Housing to the Next Level

By Amanda Abrams

MANY HEALTH CARE ORGANIZATIONS around the U.S. have woken up to the not-so-new concept that investing in housing and nutrition can significantly impact their patients' or customers' health. Not incidentally, these interventions can also lower the health care costs of a region's neediest—and most expensive—residents, subsequently boosting hospitals' and insurance companies' bottom lines.

Aside from a few major outliers, though, efforts by health care providers and payers to address social determinants of health in their respective communities have been piecemeal, often limited to nonprofit hospitals' federally mandated community benefit activities

organization as a true partner and leverages its employees' expertise, and that includes a real return on investment for a hospital or insurer. Initiatives can be standardized, replicable, and set up so that multiple voices are reflected.

The groups—the Center for Community Investment, the Nonprofit Finance Fund, the Healthcare Anchor Network, and Enterprise Community Partners—point out that the problem isn't simply that more capital is needed to have an impact on a local population. In many cases, the money is there, but it could be better

Efforts to address the social determinants of health have largely been piecemeal. But several organizations are working to coordinate these investments to truly boost community health.

or one-time initiatives resulting from serendipitous meetings between community development professionals and health care executives.

But because investing in social goods like affordable housing, economic development, or walkable communities can have a long-term financial impact, several organizations around the country are arguing that it's time to take these interactions to the next level. They're saying that an effort to boost a community's health doesn't have to be a one-off grant by a large health care institution. It can be developed as a contract that treats a community development

directed, coordinated, or absorbed. Together with key funders like the Robert Wood Johnson Foundation, the Kresge Foundation, and the Kellogg Foundation, these organizations are working with big health care players, and a variety of community development groups and other stakeholders, to build trust, grow capacity, and expand the idea of what it means to invest in the health of a community.

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Seeing the big Picture

“This isn’t just about one affordable housing deal,” says Robin Hacke, executive director of the Center for Community Investment (CCI). “We want them to be able to come into the system with their eyes open, thinking about the pipeline of transactions, and thinking about the enabling environment that’s necessary to move the pipeline.”

That’s one of the goals of the organization’s key programs, Accelerating Investments for Healthy Communities (AIHC), which is designed to increase health system investments in upstream determinants of health, with a particular emphasis on affordable housing. Hacke and her staff are engaged in a hands-on process to help hospitals better understand the communities they’re working in and their own potential contributions, and then translate that understanding to act on affordable housing investments. AIHC, which began in January 2018 with a group of executives from eight large health care systems, asked participants to stretch from the beginning: “We started by saying they had to nominate a cross-disciplinary team” in order to be able to take part in the initiative, says Hacke.

She and her staff urged leaders to think beyond the usual suspects and bring in hospital staff with other expertise: employees in finance, for example, or facility management. After all, a hospital has far more resources to potentially invest in a region than simply community benefit dollars; it may have an endowment, a capital budget, mandated or voluntary cash reserves, or significant real estate, all of which could potentially be put to work. And many other departments—like the one in charge of managing Medicaid benefits—stand to gain from improved community health.

Kensington Gardens, a 41-unit apartment building in the East Bay Area, was directly impacted by the Housing for Health Fund.



Over the course of five months, the diverse groups systematically examined their hospitals’ community investment initiatives and available resources in the context of the actual communities and their needs. That was the first phase of Accelerating Investments for Healthy Communities, and it was useful, says Hacke. “The key takeaway for us in phase one was that people were using grant resources in ways that were spending rather than financing.” If those dollars had earned a return, they could have gone much further.

Nonetheless, the early phase had impressive results. In San Bernardino, California, Dignity Health reached out to the state’s Strategic Growth Council to discuss an affordable housing project, and the council wound up committing \$20 million to the initiative. And in Toledo, Ohio, another participant, ProMedica, partnered with the Local Initiatives Support Corporation (LISC), providing the organization with \$20 million in grant funding and \$10 million for a loan fund.

The initiative’s second phase began in January with six health care systems. Participants will examine what it will take to close affordable housing deals: the range of players involved, the many sources of money required, and the changes to their own operating procedures or to the larger policy framework that might be needed for it all to come together. Lasting for two years, the second phase will include learning labs, monthly coaching calls, and strategy sessions.

The health care systems have been asked to put together teams that include stakeholders from outside the hospital: representatives of neighborhood groups, faith-based organizations, or affordable housing developers. “If you align stakeholders, there’ll be more for everybody,” says Hacke. “You’re getting the benefit of each other’s wisdom.”

Bon Secours Mercy Health has staff participating from both its Baltimore and Cincinnati locations. Dr. Samuel Ross, the institution’s chief community health officer, says his hospital joined the initiative to better understand all the parts that will have to come together to advance affordable housing in the system’s two communities. Bon Secours (the system merged with Mercy Health in September 2018) has been involved in CCI’s program since the beginning, and Ross says he’s appreciated the push to think more broadly about potential partners and allies. The institution has created some affordable housing, but most was done through low-income housing tax credits, which could be threatened due to the 2017 tax cut. “Robin’s challenge to us is, ‘can you be open to evaluating other ways to expand affordable housing?’” Ross and his team are learning how to do that. “If affordable

housing is embraced as a game changer and a transformational initiative, what we’ve all struggled with is the ‘how,’” says Ross. “One of the benefits of CCI and especially this two-year initiative is it takes us a long way to understanding the nuances of the how—the depth and breadth of expertise, commitments, and sheer willpower that’s going to be required in order for it to be accomplished.”

Helping Nonprofits up Their Game

On the other side of the equation is the Nonprofit Finance Fund (NFF). Just as CCI helps health care systems expand their thinking about community investments and connect with potential partners, NFF works directly with community-based organizations to help them work with health care organizations as equals and better absorb the capital that hospitals are considering utilizing.

NFF has been focused on partnerships between

nonprofit groups and health care systems for several years, and it launched the Healthy Outcomes Initiative in late 2016. The initiative aimed to address one of the main quandaries in the field: a health care institution's money is worthless if community development groups aren't in a position to absorb that funding and put it to good use. To some degree, it's an issue of underdeveloped skills and capacity on the part of the organizations. But it's also a matter of habit. "In the social sector in general, services aren't typically funded based on full costs," says Nima Krodel, NFF's vice president, who led the initiative. The result is a partnership between health care institutions and social service groups that's not particularly equal or durable. "There are a lot of pilots, demonstrations, and smaller-scale experiments about how community-based organizations can partner" with hospitals, says Krodel, "but on a large scale, getting to sustainable, equitable, contractual relationships is further off and where we need to head towards."

To begin creating those relationships, NFF staff spent two years working with organizations through convenings, workshops, and cross-sector dialogues with hospital executives. NFF heard their experiences of partnering with nonprofit groups, but perhaps more powerfully, it provided the organizations with one-on-one coaching to help them develop robust cost analyses that translated into sustainable pricing and build their capacity to better utilize funding coming in.

Among other things, says Krodel, the goal was to have "clear and equitable relationships; that's the holy grail. To do that, you'd develop contracts"—as opposed to receiving one-time grants—"price them appropriately, and develop new ways of funding and financing."

One of the beneficiaries of NFF's efforts was the Pittsburgh-based Community Human Services (CHS). CHS was negotiating a program with the University of Pittsburgh Medical Center in which the hospital would pay the community group for housing some of the institution's highest users, subsequently reducing its medical costs. Through a partnership with the Corporation for Supportive Housing, NFF helped CHS structure the deal.

Jeremy Carter, CHS's chief housing officer, says the consultations were invaluable. "The biggest impact from NFF was getting us to a better place on the true costs of the program. That's something that we have struggled to really identify," says Carter. NFF helped his organization establish a solid indirect rate for the organization and a responsible budget that didn't undersell their services. Together with the Corporation for Supportive Housing, NFF helped CHS add a pricing structure into the contract that rewards CHS with a bonus for every patient who remains in housing for over 10 months and a share of the savings when those patients' medical costs go down. "There isn't [another] model like this in the country right now," says Carter.

The Healthy Outcomes Initiative wrapped up in mid-2018, and now NFF is launching a follow-up program called Advancing Resilience and Community Health (ARCH). Rather than focusing on individual organizations, ARCH will work with existing networks of community-based groups, together with the providers or payers that they're aiming to partner with. Details of the program are still being worked out, but it is slated to include three networks that NFF will work with over the course of 30 months, with an ultimate goal of establishing standardized models that can be replicated by networks elsewhere.

"There's no shortage of pilots and waivers to test things out. But unless those move to the next stage and have broader replication, all you're really doing is having these little experiments," says Bill Pinakiewicz, NFF's chief strategic innovation officer. "These are groups

looking to build new payment models and contracts together. We'd like to help build that road map."

Thinking More Broadly

In 2017, representatives of 10 health systems came together to share their knowledge and questions about how to effectively address some of the upstream factors that were keeping their patients sick. Two years later, that group has swelled to 42, and it's still growing. The Healthcare Anchor Network (HAN), unlike CCI or NFF, isn't primarily concerned with strengthening interactions between community development organizations and hospitals or insurers. HAN is focused on health care groups learning from one another to best leverage *all* of their assets to boost the health of their communities.

"The core of what we're doing is three areas: hiring, purchasing, and investing," says Dave Zuckerman, director for healthcare engagement at HAN, which is supported by the Democracy Collaborative. Discussions might center on how to leverage new funds to make grants or loans to community groups. But they might also address how a hospital can boost an area's economic health by more strategically hiring from the community itself and increasing professional development opportunities. Or whether it can do a better job of keeping some of its procurement local.

"We're very focused on human resources, the supply chain, and core businesses practices that could more powerfully address the issues of poverty and other disparities," says Zuckerman. "These are systemic problems, and we're not going to address them by writing a few more checks. It's about aligning and leveraging resources differently."

Health care systems pay to be part of HAN, and a big part of the group's appeal is the peer-to-peer dialogue that occurs there. It's not unusual, says Zuckerman, for a health care executive to invite a colleague from another institution to visit and share their experience with senior leaders. It's also common for staff from across a hospital to be invited to participate—including folks in charge of, say, facilities or government relations—so that they too can become champions of impact spending.

With an eye toward making dollars and efforts go further,

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HAN members are also beginning to advocate more broadly for policy priorities. On Feb. 28, the group was expected to advocate on Capitol Hill in an effort to educate members of Congress about the relationship between housing and health, and perhaps nudge them to support beneficial policies. One of the speakers in Washington that day was Thea James, vice president of mission at Boston Medical Center. She and her colleagues at

'The resources currently in play are not having the impact that we want them to make. Capital is only good if it does something.'

Boston Medical are wholly on board with efforts to promote Boston's health by focusing on upstream factors. They've helped to organize a sub-network among HAN member hospitals in New England and are part of a committee within Boston Medical designed to disseminate knowledge among staff.

Thanks to ideas discussed among the full group, Boston Medical has begun examining how many of its vendors are minorities, women, or people with disabilities. "Those things impact the community and contribute to economic development there," says James. "It's good for us to see how other [health care systems] do it so we're not reinventing the wheel."

Moving Forward With a Big Idea

Enterprise Community Partners has long helped finance complex affordable housing deals around the country, so it's unsurprising that it has become a major player in addressing upstream determinants of health. Enterprise is collaborating with the Denver Housing Authority, for example, to find ways to partner with the health care sector. In Detroit, the organization is part of a public-private partnership led by Sinai-Grace Hospital to explore potential neighborhood revitalization projects. But in its work in the burgeoning field, Enterprise

has identified some limitations.

"In other [Western] countries, many of these classes of investment are seen as public goods, financed through different tax structures," says Brian Rahmer, vice president of health and housing at Enterprise. That is, because so many people and institutions benefit from a healthy population, investments in things like affordable housing, early childhood education, and a social safety net are paid for by taxes in most

developed countries. In this country, the private sector may be hesitant to fund programs that improve health because they might receive only partial returns. For instance, an insurance company that finances the construction of an affordable multifamily building won't recoup its full investment if only some of the residents are covered by its policies.

To address that, Enterprise has begun thinking about a new model. In August 2018, *Health Affairs*—a peer-reviewed journal of health policy thought and research—featured an article by Len Nichols and Lauren Taylor describing how health care institutions, working with community development groups, could provide some of those public goods and still earn a return on their investment. Nichols and Taylor suggest that a "trusted broker"—a financially neutral organization like a nonprofit or foundation—convene all of the potential players in such a deal. The broker would transparently select an intervention, project its return on investment, assign a portion of the cost to each of the stakeholders in proportion to their potential gains, and implement the intervention. So a hospital system that would gain the most for keeping someone out of the ER would pay a greater share for an affordable housing project than a homelessness service provider whose savings would be less.

The role of the broker could be filled by any skilled organization, including Enterprise. And an effective model doesn't have to look exactly like Nichols and Taylor's. "We want to be able to create an investment portfolio at the regional or local level allowing multiple stakeholders to have a very easy pathway to drive their money, with a floor in terms of the return," says Rahmer.

And that's happening now. In January, Enterprise announced several new initiatives. Partnering with Kaiser Permanente, the organization set up an equity fund that will grow to as much as \$85 million through matched investments for the greater Bay Area, and another \$100 million loan fund covering regions across the U.S. where Kaiser operates. And over the next five years, Enterprise is committing \$250 million to, among other things, bring together "capital from health care organizations, institutional investors, and social impact funds" to develop and preserve affordable homes. These funds are intentionally set up to drive health outcomes in the communities where they operate. Enterprise is guaranteeing a 4 to 5 percent return on investment to Kaiser; that's less than what it could earn on the private market, but for a mission-driven organization, it's significant.

The new initiatives aren't the final answer. "Are we there yet? No. But we're creating these pathways now to allow solutions to come to fruition," Rahmer says. "The resources currently in play are not having the impact that we want them to make. Capital is only good if it does something."

After all, in this country, government isn't able or willing to spend big on the upstream factors that significantly impact people's health. In response, Enterprise and many other groups are stepping in to find a new source of revenue that might do the trick. The big question is whether their efforts will be able to wring enough funding from the giant health care industry—and whether hospitals and insurers will find the work worth their own while. 📌

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RESOURCES

"Social Determinants As Public Goods: A New Approach To Financing Key Investments In Healthy Communities," by Len M. Nichols and Lauren A. Taylor. *Health Affairs*, August 2018
bit.ly/2UeLZQ5

"Hospital System Helps Housing Partners Unlock Capital," by Alyia Gaskins. *Shelterforce*, Jan. 11, 2019
bit.ly/2CpVNz3

Just Resilience

By Katy Reckdahl

IN NEW ORLEANS' 7TH Ward neighborhood, Jeraldine Galle, 81, is back in the house she's owned for more than 60 years. But in 2005, the house was flooded with 10 feet of water after a nearby canal ruptured as Hurricane Katrina approached the Gulf Coast. Afterward, fraudulent contractors delayed her return and threw her into a depression that often left her in tears whenever she talked about how she'd raised six children there with her late husband, Floyd, a truck driver for the local McKenzie's bakery.

But after six years, she'd made it home, with the help of a nonprofit rebuilding agency that came in to help her. "There's nothing like your own," Galle had said, as she turned the key in her front door.

At first, she was ecstatic about being inside her own house. She loved sitting on her front porch, listening to after-school practices by the nearby St. Augustine Marching 100, one of the city's foremost high school bands.

Still, her mind was not at ease. Before Katrina, Galle knew nearly everyone who passed her porch on Annette Street. Now, many were strangers. A good share of the houses on her block were still empty,

Orleans and its citizens can truly thrive, in a way that makes it more resilient to the next natural disaster. Or at least that's the thought behind the new municipal resilience strategies that are cropping up around the world, with the help of 100 Resilient Cities, a Rockefeller Foundation initiative.

In August 2015, as New Orleans somberly marked the 10th anniversary of Katrina, it became one of the first cities to finish the Resilient Cities process. Its city hall released a 90-page resilience strategy and created a new position, chief resilience officer, to integrate the city's resilience activities into a unified agenda.

At the same time, people across New Orleans had become weary of the word "resilience," which had become a buzzword around the storm's 10th anniversary, bandied about in

Cities cannot weather the effects of climate change without going beyond infrastructure to address institutional racism, historical inequities, and access to physical and mental health services.

because homeowners had died or experienced fraud or money shortages that stopped them from rebuilding. Without that neighborhood network, she didn't really understand which blocks were struggling with gun violence and why.

Then, a few years ago, a gunman who was chasing another man shot into a neighbor's house. Galle started avoiding her porch after sunset. The depression returned.

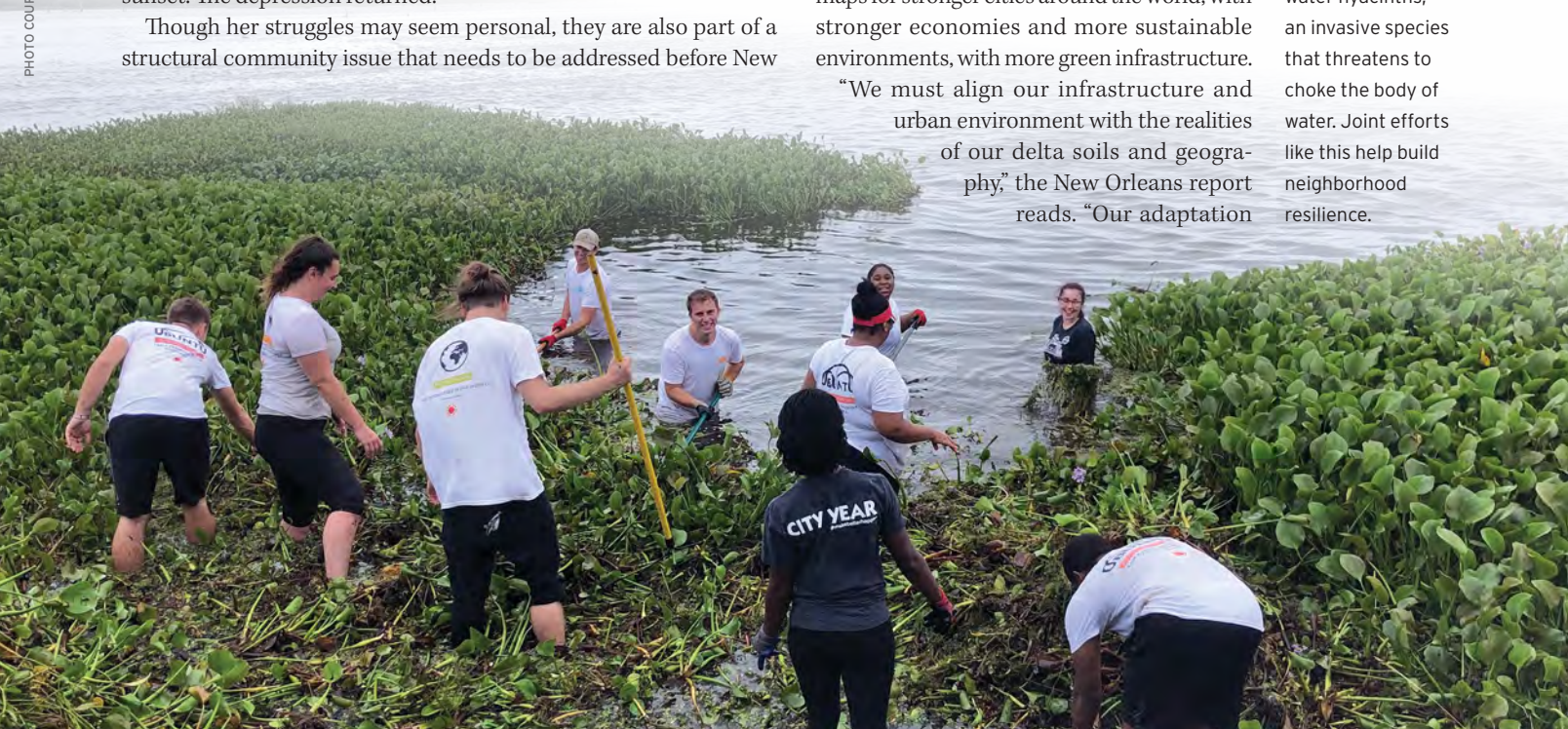
Though her struggles may seem personal, they are also part of a structural community issue that needs to be addressed before New

shallow mentions of people who had rebuilt and returned after Katrina, without acknowledging the toll the storm had taken.

Resilience strategies, as envisioned by 100 Resilient Cities, are meant to go far beyond that simplistic use of the word to create road maps for stronger cities around the world, with stronger economies and more sustainable environments, with more green infrastructure.

"We must align our infrastructure and urban environment with the realities of our delta soils and geography," the New Orleans report reads. "Our adaptation

A cleanup effort to rid Bayou Bienvenue of water hyacinths, an invasive species that threatens to choke the body of water. Joint efforts like this help build neighborhood resilience.



must be both physical and behavioral. Rather than resist water, we must learn to embrace it.” Infrastructure, especially related to water, is crucial to many other Resilient Cities plans. A high proportion of the cities identify a water issue—either too little or too much—as their top concern. In New Orleans, the prevailing threats are severe storms, hurricanes, and floods, along with the sea level rise driven by climate change.

Yet there’s a growing consensus that cities cannot weather the effects of climate change without going beyond infrastructure to address institutional racism, violence, and historical inequities in income, education, housing, and access to physical and mental health.

Sometimes this more holistic focus is called “just resilience,” because it builds stronger communities by acknowledging that unjust, historical frameworks placed more vulnerable people at risk in cities around the world.

“For decades, social-science researchers have clearly demonstrated that the majority of those who live in the most vulnerable places are the most vulnerable people,” says sociology professor Lori Peek, who directs the Natural Hazards Center at University of Colorado Boulder. “The poor, racial minorities, the elderly, children, and persons with disabilities are the ones who are more likely to reside in shoddily constructed homes located in low-lying areas. They are the ones without air conditioning on excruciatingly hot days. They are the ones less likely to own cars that would allow them to escape when ordered to evacuate.”

That rings true in New Orleans where, when compared with white homeowners, African-American homeowners were three times

as likely to live in neighborhoods that flooded. With higher devastation often came more depression and anxiety.

An ambitious study led by the Louisiana State University Health Sciences Center is building on a community mental-health project begun after Katrina to address community resilience beyond the four walls of a clinic. The study, called C-LEARN (Community Resilience Learning Collaborative and Research Network), includes collaborations with grassroots partners and is funded by the National Academy of Sciences Gulf Research Program.

“It’s not sufficient to provide doctors and psychiatrists and Prozac pills—we have to help communities realize the assets they have,” says Dr. Benjamin Springgate, chief of the section of Community and Population Medicine at LSU Health New Orleans School of Medicine. Springgate has worked with partners to provide mental health services in the wake of disasters in cities like Houston, New York City, and San Juan, Puerto Rico.

“If we can recognize that the national climate change report is pretty damning about survival for many parts of our country, including our community, but we feel this is worth fighting for, we have to push ourselves to see what more can we do,” Springgate says. “If we didn’t like that so many people were displaced after Katrina, if we didn’t like that entire social networks got wiped off the map and that so many people in Gentilly or New Orleans East or the Lower 9 didn’t come back, we have to be a stronger community in advance of the next threat.”

There’s a growing consensus that in a world that always has insufficient resources, networks make communities stronger. As seismologist Lucy Jones wrote in *The Big Ones: How Natural Disasters Have Shaped Us (And What We Can Do About Them)*, once the physical infrastructure is gone, the social infrastructure is all that’s left. “Although natural hazards are inevitable, human catastrophes are not,” she wrote.

“It takes more of a village to handle massive problems,” Springgate says. “As we look at the impact of climate change not just along the Gulf Coast but across the United States and around the world, we know that wildfires, sun-baking effects, deluges, floods, hurricanes, frigidly cold temperatures will be superimposed on social risk factors and have an effect on mental health.”

A bicycle chained to a lightpole in the Central Business District carries a message of resilience: residents are considered to be more resilient if they have a sense that their community matters and is worth standing up for.



Creating Emotional Well-Being Through a Neighborhood Hub

Though it sits near the grand mansions of Esplanade Avenue, St. Anna’s Episcopal Church has long been a gathering spot for diverse crowds because it’s located a few blocks from the French Quarter in an historically working-class area of the city. In 2005, after Katrina, its location had another advantage: because Esplanade sits on a land ridge, the church didn’t flood.

The church was a natural partner for the C-LEARN study, which will help church staffers learn how to build on the lessons that they learned on the fly after Katrina, says Diana Meyers, St. Anna’s director of mission and wellness.

In 2005, St. Anna’s became a key hub, along with a few other high-ground churches and community centers. Very early on, the church worked with partners to start a mobile health van, basically a clinic on

wheels, that helped neighbors get medicine and treatment for the “Katrina cough,” a respiratory condition common during the post-storm months, along with chronic conditions like high blood pressure and diabetes. But that wasn’t enough.

“We started realizing that people needed to talk: they had depression and post-traumatic stress disorder,” says Meyers. Luckily, the church had a parishioner whose daughter worked in the psychiatry department at Tulane University School of Medicine and was able to connect the church with a supply of Tulane psychiatry residents and students. “People felt comfortable talking in the van; it was a relaxed atmosphere, as opposed to hanging a shingle outside that says ‘psychiatry’ and feeling the stigma that comes with that.”

The ease of that Tulane linkage is at the heart of C-LEARN’s emphasis on connecting churches, government agencies, and nonprofits into networks that know and trust each other. That way, if disaster strikes, people at hubs like St. Anna’s know who else they can rely on.

The talking seemed to help people, Meyers remembers. So St. Anna’s hired New Orleans musicians to play weekly concerts in the church. It employed musicians who had no gigs and then staffed the concerts with mental-health professionals who neighbors could talk to and, if desired, make future appointments with. They found that when people gathered to hear music, it had therapeutic effects on its own. “It was the community atmosphere, the ‘I’m OK, you’re OK’ or ‘I’m not OK, but you’re not either,’” she says. They hosted art-therapy sessions and drum circles where they asked people to shout out what they were thinking as they played congas, bongos, and timbales.

Community-health workers, placed in hubs like St. Anna’s, also joined teams that went door to door in neighborhoods to screen and educate. “Depression is treatable,” they might say to someone who scored high on a screening tool. They would then follow with suggestions of how that person could address depression or give them a referral to get into care.

Those workers were part of the community-academic collaborative program REACH-NOLA, which laid the groundwork for C-LEARN during the year after Katrina, when so many people felt symptoms of PTSD, depression, or anxiety, but the metro New Orleans area had only 22 psychiatrists still practicing there. Tiers of others were part of the collaborative, such as therapists who were trained in cognitive behavioral therapy to address depression, and primary-care doctors, who were trained how to help their patients manage depression and anxiety.

The idea was that a collaborative model could best provide services in a resource-poor area.

St. Anna’s children’s program hosted group-therapy classes, where kids could talk about fears and anxieties. They could discuss why they were scared every time it rained after Katrina or how they didn’t know anyone in their new school.

Some people couldn’t talk until their lives were more stable.

“If you don’t address basic survival issues, you can’t address mental health,” Meyers says. “If someone is hungry or doesn’t have clothes, they don’t think about their depression. If they don’t have anywhere to live, you provide them with a list of a few legit people who are working to help. Only then can you begin to address Katrina anxieties.”

The learn-as-you-go approach had shortcomings, Meyers says, because it took a while to learn what other social-service providers or community agencies were doing: who was handing out food, who was providing physical or mental health care, or who had put

together a group of lawyers or advocates to help families get duplicates of documents lost in the flood, or complete grant applications for rebuilding homes.

As part of the C-LEARN process, every participant will receive technical assistance through webinars on four topics: financial assistance, disaster planning, housing, and mental health. Then half of the providers will be selected randomly to build coalitions with one another. The study results will show whether coalition-building has an additional effect.

Meyers has found the financial planning information to be helpful for households that regularly asked the church for help paying electricity bills or rent. “A lot of families live day to day, dollar to dollar,” she says. “They get their money, they spend their money.” Afterward, they’ve seen family members join job-training programs or get hired for a new job, based on information that St. Anna’s provided. “We feel like we’ve done something to build the resilience of those families,” she says.

It’s also a continuing priority at St. Anna’s to decrease the stigma surrounding the mental-health challenges and depression often faced at high levels after disasters. “As we found out after Katrina, we’ll all suffer from it,” Meyers says.

For Meyers, it makes sense that creating a trusted coalition now would be beneficial if/when another disaster strikes. “If we already have contact info for other organizations, we can call and say, ‘We’re up and running, what do you have?’ Or ‘I’m flooded, can you provide this?’”

Drawing on History to Keep a Neighborhood Healthy

Arthur Johnson has a community office, a restored house that serves as home base for the Center for Sustainable Engagement and Development (CSED) in the Lower 9th Ward. So people stop in. “We talk with them and get to hear their stories,” he says. Sometimes, those conversations end with a referral for further mental-health services elsewhere. Other times, he can steer people toward practical solutions to expedite their main struggles—by connecting them to rebuilding agencies, social services, or volunteer attorneys. But often,

‘It’s not sufficient to provide doctors and psychiatrists and Prozac pills—we have to help communities realize the assets they have.’

Shelterforce is a national publication for the housing and community development field. We've long recognized the connection between health, affordable housing, and community development, and are now exploring it more deeply in this regular health and community development supplement. For more on this topic, or on affordable housing and community development in general, visit us at shelterforce.org. You can also sign up for our weekly email summary of new stories at bit.ly/SFWeeklySignUp.

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after frustrating days, people just need to vent. “Even though it’s been 14 years since Katrina, people still have a lot inside,” he says. “What we do is listen and let people exhaust what they’re feeling inside.”

Despite the devastating flooding his neighborhood suffered in 2005, Johnson can see signs of resilience. Construction is slow, but ongoing. Thanks to work done by his nonprofit and others, the houses around him are dotted with solar roof panels: the Lower 9 rebuilt after Katrina with some of the highest per-capita rates of solar in the nation. A nonprofit called Groundwork New Orleans even partnered with the Small Center in the community arm of Tulane School of Architecture to build solar-powered bus-stop benches that could be used to charge cell phones after a disaster. Neighbors also worked to open an overlook on Bayou Bienvenue, at the edge of the neighborhood, and hold regular cleanups there to clear invasive plant species and trash. Then there’s plucky entrepreneur Burnell Cotlon, who opened up the area’s only grocery store as a service to his neighbors. “Burnell has a big dream there. It’s that mindset. Resilience is in this community,” Johnson says.

CSED is also a partner in the C-LEARN study. On his regular stops by the neighborhood’s active senior center, Johnson finds that seniors are glad to know about resilience planning and what’s being done to prepare for the next disaster. “They’ll tell me about their experiences during and after Katrina and say, ‘I can’t do that all over again.’” He educates his neighbors on four topic areas: disaster planning, housing, financial planning, and mental health. For those who suffer with depression, C-LEARN can provide a phone app called Chorus that can send them regular tips to improve their mood.

The crowd of gray-haired neighbors also fuel Johnson with their stories about the neighborhood’s history, when African-American families who were redlined from buying homes or getting loans elsewhere built their own homes at what was then the far end of the city. “Our grandparents were stubborn. They built here even though it was in the middle of nothing. They stood for something,” Johnson says. Residents also became very comfortable with water, living in a neighborhood that’s bounded on three sides by it: a canal, a bayou, and the Mississippi River became spots for fishing and crabbing. “Even though we have heard people say, ‘You shouldn’t live there,’ the water is part of who we are,” says Johnson.

Those narratives, about self-sufficiency and co-existing with the natural environment, are woven into the history of the Lower 9’s community and drive their determination to correct injustices in programs and plans that affect their everyday lives. “People in my community know that they have the right to demand that their heritage and history and their families be protected,” he says.

In some ways, that itself gives Johnson a head start on his work. “Because the concept of protecting your community is resilience,” he says. 🏠

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