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## Go-Along Interview Assessment of Community Health Priorities for Neighborhood Renewal

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## ORIGINAL ARTICLE



# Go-along interview assessment of community health priorities for neighborhood renewal

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## Abstract

Healthcare systems are increasingly investing in approaches to address social determinants of health and health disparities. Such initiatives dovetail with certain approaches to neighborhood development, such as the EcoDistrict standard for community development, that prioritize both ecologically and socially sustainable neighborhoods. However, healthcare system and community development initiatives can be untethered from the preferences and lived realities of residents in the very neighborhoods upon which they focus. Utilizing the go-along approach to collecting qualitative data in situ, we interviewed 19 adults to delineate residents' community health perspectives and priorities. Findings reveal health priorities distinct from clinical outcomes, with residents emphasizing social connectedness, competing intra- and interneighborhood perceptions that potentially thwart social connectedness, and a neighborhood emplacement of agency, dignity, and self-worth. Priorities of healthcare systems and community members alike must be accounted for to optimize efforts that promote health and social well-being by being valid and meaningful to the community of focus.

## KEYWORDS

EcoDistricts, health care system, health experience, neighborhood looking glass, place, social care, urban redevelopment

## Highlights

- Health system investments in social determinants are often untethered from neighborhood preferences.
- Go-along interviews efficiently ascertain community priorities for neighborhood transformation.
- Neighborhood residents articulate social connectedness as a key meaning of health.
- Participants described neighborhood emplacement of self-worth from internalizing outsiders' views.
- Community development interventions should include resident voices in planning and evaluation.

## INTRODUCTION

Health disparities research in recent years has extensively documented how place-patterned structural determinants, such as deprivation or affluence, class inequality, structural

racism, or employment opportunities, are powerful drivers of health beyond medical care (Adie et al., 2020; Braveman & Gottlieb, 2014; Dalton et al., 2017). However, policy and healthcare system initiatives aimed at addressing such health disparities have traditionally focused on increasing access to

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and improving quality of medical care (Carroll, 2002; Williams et al., 2008). This focus implies that health inequalities are largely affected by individual experiences such as those within the healthcare system, but a robust body of evidence suggests that health inequalities are driven by broader, reciprocally enforcing social risks such as socioeconomic inequality and inaccessibility to health-promoting resources (e.g., knowledge, social connections, political resources; Chen & Miller, 2013; Lam et al., 2021; Phelan & Link, 2013). Important gaps remain in understanding community, as opposed to biomedical, priorities for closing health disparities gaps and addressing social circumstances of health.

Propelled by community-level health planning mandates of the Affordable Care Act, healthcare systems' investments in both clinical (e.g., screen-and-refer systems) and neighborhood programs (e.g., community development and housing investments) that address local social risks have grown in recent years (Chait & Glied, 2018; Fukuzawa & Karnas, 2015; Horwitz et al., 2020). Nevertheless, such initiatives have been fairly independent of the health priorities of residents living within those neighborhoods, including the social conditions that shape exposure to health risks and health-promoting resources (Cockerham, 2021).

## Community investments and health equity

Multiple layers of socioeconomic influence coalesce to initiate and/or reinforce health disadvantages and disparities. For example, the inaccessibility of high-quality education truncates access to employment opportunities, tangibly exacerbated by living carless in a neighborhood with inaccessible public transportation (Grengs, 2010). In turn, the erosion of a household's earning potential may increase its odds of living in substandard housing, affecting health through exposure to mold or lead (Hood, 2005). Impaired income may also limit access to nutritious foods and, combined with unsafe neighborhood built environments for recreation, may undermine cardiometabolic health (Paquet et al., 2014). Overall, these and other social determinants are considered root causes of health inequities because they reflect a complex interplay of structural and institutional factors that influence clinical outcomes (Gray et al., 2020).

Health clinics across the United States have begun to embrace a renewed focus on social and structural drivers of health inequity and this can be seen in efforts to screen for social needs (Buitron de la Vega et al., 2019; Eder et al., 2021; Purkey et al., 2019; Trinacty et al., 2019; Tung et al., 2021), partner with social services organizations (Buitron de la Vega et al., 2019; Palakshappa et al., 2020) and, less commonly, to address community-level causes of health disparities through large-scale investments in housing and neighborhood renewal (Chait & Glied 2018; Fukuzawa & Karnas, 2015; Horwitz et al., 2020; Sandberg et al., 2014). It is estimated that during 2018 and 2019, healthcare systems in

the United States committed at least \$2.5 billion toward improving community social determinants of health (Horwitz et al., 2020). Across 57 healthcare systems within 30 states, investments most commonly prioritized housing (e.g., building affordable housing and eviction prevention), employment (e.g., direct hiring or job coaching), food security (e.g., expanding access to produce), education (e.g., youth workforce development), social and community context (e.g., programmatic investment in family stability or social services), and transportation (e.g., partnership with rideshare services for free or subsidized transportation to medical appointments) (Horwitz et al., 2020).

Despite these many promising programs, an important challenge remains: investments in community-level solutions are increasingly initiated by healthcare system executives without evidence from community engagement efforts or community oversight. As such, investment efforts risk being untethered from the preferences and perspectives of local community members. This contrasts with key tenets of community-based research paradigms, which hold that community insight regarding health change and disease etiology is crucial for any type of health intervention (Wallerstein & Duran, 2006). For example, efforts that build children's playgrounds to increase leisure time physical activity could lead to new but abandoned playgrounds if families find them inaccessible because of concerns for child safety due to neighborhood violence not obvious to well-intentioned outsiders (Colabianchi et al., 2009; Haas et al., 2018).

## Place and health

With these considerations in mind, large-scale community-level investments should take into account both material and social space that fundamentally comprise "neighborhood" (Keller, 1968). Material and social place are interrelated, and in this article we focus on residents of one specific Cleveland neighborhood as defined both by long-standing cultural and US census-derived parameters (Roy, 2019). Prior research emphasizes the relevance of both material and social space to health. For example, features of the material or built environment, such as the presence of neighborhood green space and quality institutional resources (e.g., libraries, recreational centers), have been linked to children's better mental health (Tillmann et al., 2018) and cognitive, relational, and motor development (Christian et al., 2015). Among adults, neighborhood physical disorder (e.g., litter, poorly maintained streets) has been associated with opioid overdose events (Li et al., 2022), poorer sleep quality (Hunter & Hayden, 2018), and with other biomedical health outcomes such as the risk of asthma or diabetes (Cuesta et al., 2019) and cardiometabolic risk (Robinette et al., 2018).

Beyond considering the role of the material neighborhood on biomedical outcomes, research has additionally

examined neighborhood as social space with implications for social and relational health. Though individuals' daily lives extend beyond the geographic bounds of the physical neighborhood (see Cagney et al., 2020), local neighborhood social networks remain important contexts for health and well-being. For instance, caregivers have noted the presence of accessible parks and other neighborhood green space as important settings for facilitating relational health (e.g., social interaction and parenting social support) (Haas et al., 2018). Studies have additionally found that older adults who perceive greater neighborhood social cohesion are more likely to engage in physical activity which, in turn, bolsters mental health (Kim et al., 2020; Kowitt et al., 2020). Some research also evidences that neighborhood social capital (e.g., residents commonly working together to improve the neighborhood) predicts better self-rated health through improved self-esteem (Maass et al., 2016) and better cardiometabolic and cardiovascular outcomes (see Rodgers et al., 2019).

Holistic understanding of place-health relationships demand inquiry to why, exactly, characteristics of the neighborhood environment become psychologically and biologically incorporated, or embodied, across time in ways that express as health or disease. Ecosocial accounts of health and place critically assert that bodies “tell stories about—and cannot be divorced from—the conditions of our existence” (Krieger, 2005). In other words, individuals daily confront, perceive, and physiologically encode myriad social (e.g., exposure to neighborhood violence, microaggressions) and material (e.g., air pollution and lead exposure) environmental experiences that are consequential for health and functioning (Petteway et al., 2019). The importance of integrating individuals' own perspectives of health into neighborhood investment and renewal initiatives is thus self-evident. Yet, methodological norms of place-health research tend to discount participants' own knowledge and conceptions of health (Petteway, 2022). Given the neighborhood as a key backdrop of residents' everyday social and material exposures, planning efforts around investment and redevelopment that consider residents' holistic perspectives on neighborhood and both social and biomedical health are warranted.

## Current study

The present study aimed to source and reconcile community perspectives with healthcare system-based reinvestment priorities to most optimally address neighborhood social determinants of health. Specifically, this community-based, participatory investigation sought to determine the neighborhood health priorities of residents and community leaders of the Clark–Fulton neighborhood of Cleveland, Ohio to align the goals of a healthcare system-initiated community improvement effort (termed “The MetroHealth Transformation”) with the perspectives and needs of its community neighbors. Anchored in the Clark–Fulton neighborhood,

The MetroHealth System is Cleveland, Ohio's primary safety-net hospital and The MetroHealth Transformation has two inter-related core priorities: (1) a total physical reconstruction of the aging campus and (2) the renewal of the surrounding Clark-Fulton neighborhood (The MetroHealth System, 2020).

Linking these two core goals is the EcoDistricts model of neighborhood development, a protocol and framework for guiding decision-making of urban regeneration projects to prioritize both physical and social sustainability and the promotion of neighborhood cultural integrity (EcoDistricts, 2018). The EcoDistricts approach is perhaps best described as a community-engaged planning and accountability framework that guides project teams and provides oversight to investment decisions seeking excellence in urban redevelopment (see the first supplemental appendix). The protocol itself includes three imperatives: Equity, Resilience and Climate Protection; and six priorities: Place, Prosperity, Health and Well-Being, Connectivity, Living Infrastructure and Resource Restoration. The certification process includes registering an imperative commitment for a community and forming a local neighborhood coalition of residents and other stakeholders, which then creates a governance structure to guide the coalition through investment and planning decision-making. As required for EcoDistrict certification, the neighborhood coalition builds a roadmap for addressing the six EcoDistricts priorities and measuring performance every second anniversary of EcoDistrict certification.

Nearly two dozen EcoDistrict projects are pending certification nationally, and the framework's explicit prioritization of equity and health has helped it emerge as a pathway to community health improvement with collaborations in 60 countries and 704 cities. As the world's first hospital-anchored EcoDistrict, a core goal of The MetroHealth Transformation is to promote health via partnership with community-based organizations and investment priorities in, for example, housing, transportation, parks and green space, food access, and internet connectivity.

Given the aim of integrating community residents' health priorities, two overarching research questions guided the present study:

1. How do neighborhood residents prioritize community health?
2. What are the concepts and measures necessary for understanding the success of urban design and redevelopment efforts from the perspective of neighborhood residents?

## METHODS

The current study is undergirded by the philosophical assumption that place is an ontological structure and that individuals live emplaced existences across both

social and material spaces (Heidegger, 1962). Study methods were guided by a social constructivist interpretive framework, grounded in our belief that individuals construct their own unique realities by deriving meaning both from social interactions and engagement with their environments (Crotty, 1998). Guided by Pope and Mays (2020), we maintain an epistemological stance of subtle realism wherein external independent realities exist (e.g., biological processes of disease, neighborhood violence) but that individuals engage with, and thus make sense of, such phenomena in their own unique ways (Hammersley, 1991). Research questions were investigated using a hermeneutic or interpretive phenomenologically informed (Van Manen, 1990), participatory, prospective qualitative study design developed in collaboration with leaders of local neighborhood faith-based and non-profit organizations. To better integrate community residents' health priorities into transformation planning by the local EcoDistrict's architects and clinical system operations leaders, we conducted a series of resident interviews in the Clark–Fulton neighborhood. The study was approved by the research team's university Institutional Review Board.

## Study setting

The Clark–Fulton neighborhood (hereafter, Clark–Fulton) is situated on the near-West side of Cleveland, Ohio. During the EcoDistrict project, understandings of the boundaries of the neighborhood have continued to evolve and gain definition and include a balancing of geographic boundaries (e.g., large, dividing busy roads), political boundaries (e.g., a city council ward), census designations (e.g., 2010 census tracts) and community and resident perceptions. For our work, the neighborhood approximates three census tracts within the 44109 ZIP code, bordered by Clark Road, Fulton Road, and West 25th Street. Per 2013 to 2017 American Community Survey estimates (US Census Bureau, 2018a), 8067 individuals reside in the neighborhood with most residents (65%) between the ages of 18 and 64; over 25% are under age 18 and 9% ages 65 and above. Clark–Fulton contains significant socioeconomic disadvantage: approximately 72% of adults age 25 and older have a high school diploma or less, the median household income is \$23,814, and 52% of all households received benefits from the supplemental nutrition assistance program (US Census Bureau, 2018a). The neighborhood has the fastest-growing community of Latino residents in the State of Ohio, the majority of whom have Puerto Rican ethnic backgrounds. Most (60%) identify as white and just over 15% as Black, and nearly 50% also identify as Latino compared with 11.2% of the city's residents as a whole (US Census Bureau, 2018b). Ten percent of Clark–Fulton residents, compared to 7.7% of Cleveland as a whole, lack health insurance, and over a quarter of Clark–Fulton residents of all ages have a disability compared to 19% of

Cleveland. However, Clark–Fulton exhibits generally better birth outcomes (e.g., 12.5% vs. 14.4% of births being pre-term) compared to the greater city of Cleveland (Center for Community Solutions, 2021).

## Interview approach and study procedures

Because this study was concerned with the dynamic, everyday perceptions and lived experiences of how neighborhood place relates to health, we aimed to inquire beyond knowledge generated from more distant measures of local area (e.g., census variables and global measures of disadvantage). We employed the qualitative “go-along” interview method (Evans & Jones, 2011; Kusenbach, 2003) wherein researchers and participants navigate, together, an outing in the participant's neighborhood or other salient local context while carrying out the study interview. With methodological roots as “street phenomenology” (Kusenbach, 2003; p. 456) at the nexus of phenomenology and ethnography, the go-along interview method is particularly aligned with the current study's goals of interpreting and describing how Clark–Fulton neighborhood residents prioritize health and, contingently, how health-aimed neighborhood redevelopment efforts might be considered successful given residents' perspectives. By conducting the interview while walking or using other transport modes to physically maneuver through the area, the researcher works toward a phenomenological understanding of participants' lived experiences and interpretations of the physical, social, and cognitive dimensions of the space (Carpiano, 2009). Extending the traditional “sit down” interview in qualitative research, the go-along is argued to illuminate “aspects of human experience that tend to remain hidden to observers and participants alike” (Kusenbach, 2003; p. 478) by harmonizing, in our case, participants' reflections on links between health and place with physical navigation through place itself.

## Community input to study design, analysis, and findings

Per the participatory element of this study, selection of the go-along approach was informed by consulting with a panel of 20 community leader stakeholders, approximately half of whom were Spanish-speaking, convened several months before data collection. Our approach to reaching community leaders in Clark–Fulton was entwined with parallel processes of building the EcoDistrict commitment. This included direct conversations with community development officials, neighborhood residents, and a series of visits to neighborhood locations. These conversations occurred over a period of more than 12 months of planning before enrollment and data



collection. Community collaborators were able to nominate others for participation and no nominees were turned away.

Community leaders felt the method would be compatible with other local activities such as neighborhood prayer walks that had been recently organized by local churches. Multiple meetings with five leaders of local faith-based and non-profit organizations were convened with three goals to: (1) gauge these community members' potential involvement in the project as a whole; (2) gather their input on the interview guide based on their community expertise and familiarity with the Clark–Fulton neighborhood; and (3) nurture relations with community members to best initiate involvement of community participants. These meetings yielded critical insights to both the structure and content of the study's go-along interview. For example, one initial meeting was with a community leader who eventually disclosed that in recent years, they and their family had been diagnosed with lead poisoning after relocating to the city and moving into an older home. That community leader emphatically endorsed our plan to include go-along interview questions inquiring specifically about relationships between the built environment and health, and we heeded their advice. Such initial meetings were vital for us, as outsiders, to earn a degree of community trust, but also for our understanding of how the project could holistically fit with the priorities of neighborhood residents.

## Interview guide

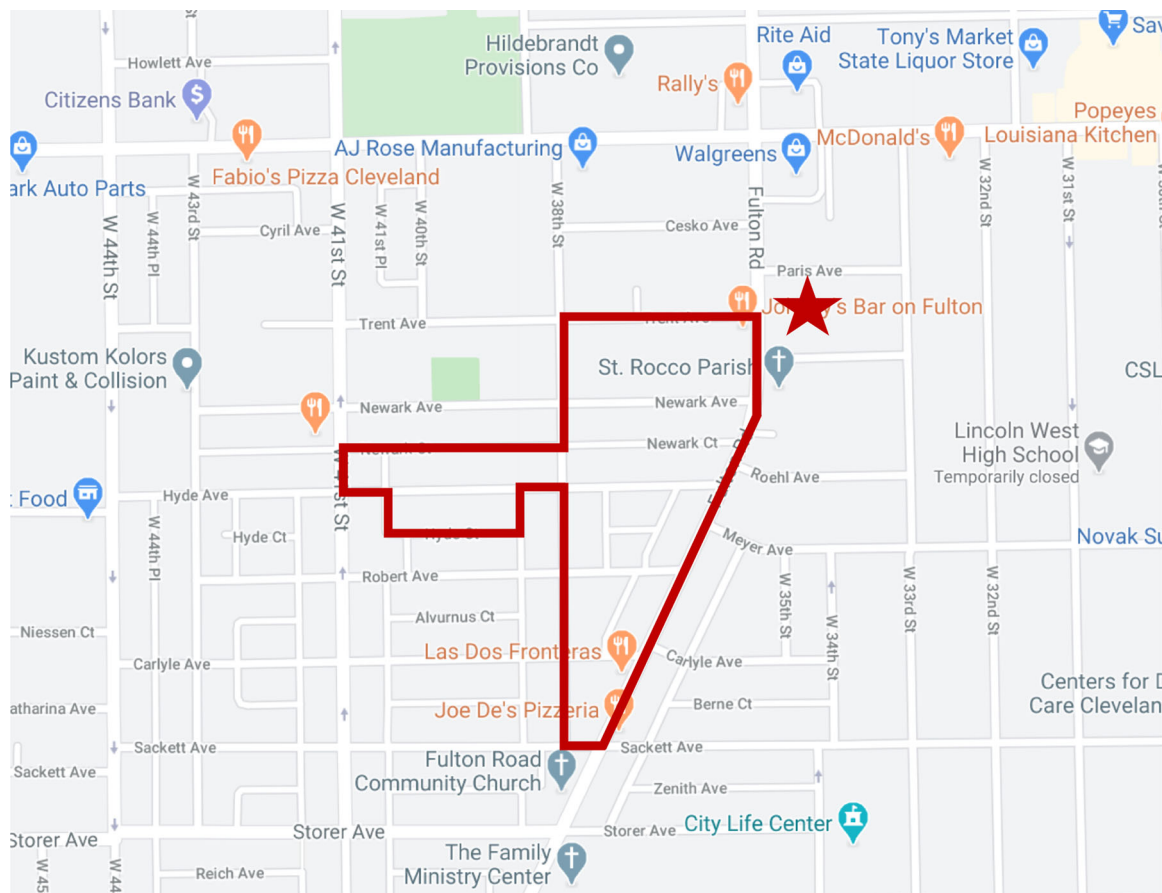
In the beginning of 2019, we formulated an interview guide in English through a collaborative, multistep process with community stakeholders as a potential series of questions to be asked during go-along interviews aimed at discerning how residents perceive neighborhood to affect health. At the beginning of the aforementioned series of community stakeholder meetings, the research team presented the broad interviewing goal of understanding what health meant to neighborhood residents. From there, we formulated specific questions based on topics that flowed from stakeholders' input. For instance, in addition to ensuring we inquired about the neighborhood built environment in the aftermath of the prior-mentioned community leader's lead exposure, other stakeholders emphasized the need to ask about community violence, safety, and the useability of neighborhood sidewalks. In addition to open-ended go-along interview questions, the final interview guide included a series of semi-structured questions focused on elucidating residents' perceptions of how and why certain neighborhood-based social circumstances were relevant to health. For example, two questions asked (1) *“Some people think that the neighborhood where you live matters to how healthy you can be, but other people think that it doesn't matter what*

*neighborhood you live in. What do you think?”*; and (2) *“Some people think that the house/apartment/building in which you live matters to how healthy you can be, but other people think that it doesn't matter what house/apartment/building you live in. What do you think?”* A bilingual native Spanish- and English-speaking collaborator then translated the interview guide into Spanish, and we pilot-tested that version of the interview guide with a community stakeholder to ensure the equivalence of question content across both versions.

In addition to demographic characteristics (i.e., age, race, gender, current employment, education, household size, and composition), participants were asked a series of abbreviated scale items from existing instruments created for the Project on Human Development in Chicago Neighborhoods (see Sampson et al., 1997; Sampson et al., 1999) to assess aspects of behavioral attachment (e.g., social ties—“How many friends/relatives of yours live in the neighborhood?”; neighbor familiarity—“How many adults/children do you know in this neighborhood or could you recognize by sight?”, possible range from *none* to *a great many*) and affective attachment to the neighborhood (e.g., evaluation of how they felt their neighborhood compared with others in Cleveland, *worse* to *better*); neighborhood sentiment—“On the whole, do you like or dislike this neighborhood as a place to live?”, *dislike it a lot* to *like it a lot*). The full interview guide is presented in the second supplemental appendix.

## Participant recruitment and data collection

The initial interviews were conducted with neighborhood residents who were directly referred by representatives of community-based organizations. The remaining participants were recruited through chain-referral sampling (Bailey, 1994). The referral chain included direct neighbor referrals from a participant to a neighbor and self-nominations from neighbors who were curious to participate after observing a go-along interview occurring on their street. Written consent to participate was obtained from all participants, and all interviews were conducted by graduate-level research assistants and began in various locations. We specified the project's focus on the Clark–Fulton neighborhood and while no geographical boundaries were set by the research team, all participants took us on routes within the census tracts comprising the Clark–Fulton neighborhood. Some started at MetroHealth hospital and others originated elsewhere in the neighborhood, but all were conducted on the route of the participant's choice. Routes were not confined to sidewalks, and included alley ways, parks, street crossings, yards, and even front porches. In the presence of physical mobility challenges, limitations, or concerns with weather, participants self-directed alternate forms (e.g., driving) or parameters for maneuvering the



**FIGURE 1** Example participant-guided walking route for a go-along interview in the Clark–Fulton neighborhood in Cleveland, Ohio.

neighborhood. An example route is presented in Figure 1. Interviews took place during the summer of 2019, and total interview time ranged from 22 to 63 min. Audio recordings in English were transcribed by a professional transcriptionist, and recordings from interviews conducted in Spanish were transcribed in Spanish and then translated to English by Author 2 who is bilingual. Most interviews were conducted by Author 2 (including all Spanish interviews), with some conducted by Authors 1 and 4.

## Data analysis

Framed by the go-along interview's phenomenological roots, we employed a phenomenologically informed approach (Smith & Fieldsend, 2021) to thematic analysis guided by Miles and Huberman's (1994) thematic analytic strategy. Nineteen interviews were completed, and transcripts were analyzed by a team of three master's and doctoral-level qualitative and mixed-methods researchers (Authors 1, 2, and 4). Data were analyzed using NVivo software version 12.0 (QSR International, 2018), and researchers utilized a pragmatic, inductive, and constant

comparative approach to thematic analysis with a focus on tracing and verifying the trustworthiness of thematic findings (Nowell et al., 2017). Working iteratively and independently, two researchers (Authors 1 and 2) first read through all interview transcripts multiple times to familiarize themselves with the whole body of data and then reduced the corpus by indexing significant interview quotations into a combination of semantic (e.g., similar words coded together) and latent (e.g., similar underlying concepts coded together) codes. The researchers independently cycled through revisiting interview transcripts and applying existing and new semantic and latent codes until no new concepts or ideas were identified in relation to the study's primary research questions (Weiss, 1994). Each coder then assembled their codes into broader conceptual categories common across all interviews to create preliminary coding schemes and, together with a third researcher (Author 4), coders compared their schemes. During comparison, data interpretations were scrutinized and reconciled whereby both schemes were harmonized into one cohesive framework of data-grounded findings. Data from the study's survey portion were analyzed with univariate frequencies and descriptive statistics using SPSS software version 25.

Our study employed several strategies to maintain rigor and data quality, check validity and enhance the trustworthiness of findings (Lincoln & Guba, 1985; Nowell et al., 2017). Researchers systematically debriefed on audio after each interview was completed, reflecting on the tenor of the interview, whether participants struggled in understanding any questions, and commented on emerging conceptual similarity or divergence across participant responses. Data were further triangulated with key community stakeholders during a half-day retreat to establish the credibility of thematic findings by assessing for misinterpretation or misunderstanding. This event was conducted near the midpoint of data collection to allow for any necessary recalibration of the interview guide and the analysis approach. To more systematically assess correspondence of emergent themes with community priorities and the EcoDistricts framework, retreat participants engaged in a community health measurement exercise during which specific measures were prioritized and reviewed during small-group roundtable discussions. The results of that exercise are presented in Table S1.

### Positionality statement

The first and senior authors are qualitative and mixed-methods researchers who have worked with and in the Clark–Fulton neighborhood for over 20 years. Though none of the authors are residents of Clark–Fulton, the current study is a product of rapport nourished during those years from authors' codesign, with neighborhood and civic leaders, of numerous health-focused studies. The first and second authors led the data collection and analysis; the second author's bilingualism in English and Spanish facilitated cultural trust and rapport with neighborhood participants requisite for sharing their experiences. The third author is an internationally recognized expert on this study's go-along method of eliciting qualitative data from individuals in their familiar environments, and the fourth author is an urban planner and registered architect and, with the senior author, an EcoDistricts accredited professional directly involved in the local EcoDistricts certification process (EcoDistricts, 2022).

Combined, the authors hold expertise, via avenues of both professional and lived experience, on the powerful role of community on health. To enhance the trustworthiness of analytic interpretations, the first and second authors continually bracketed, via memoing, preconceptions about the study neighborhood and population as they surfaced during data collection and analysis (Lincoln & Guba, 1985). Nonetheless, given our epistemological beliefs that reality is co-constructed between researchers and participants, we emphasize that our findings and their interpretation are also linked to our own experiences and longstanding ties to the

Clark-Fulton community. Moreover, despite our own constellation of varying social histories and identities, we are located as population health researchers working alongside residents of the neighborhood and leaders of neighborhood groups and organizations.

## FINDINGS

### Participants' characteristics, neighborhood connectedness, and sentiments

A total of 19 individuals between 18 and 77 years old (median age 39) completed interviews, with 37% identifying as Latino, 37% white, and 16% Black. Three individuals completed their interviews in Spanish. Approximately 60% ( $n = 12$ ) were female. By education, 37% ( $n = 7$ ) held a high school diploma or less, 42% ( $n = 8$ ) held a 4-year college degree, and three held another advanced degree. A total of nine (47%) were employed. Participants' households ranged in size from one to eight (with a median of three) individuals and included between zero and five children (with 1 child on average). The sample demonstrated a wide range of neighborhood connectedness and sentiment as well as family structure. For example, most expressed strong feelings of familiarity with their neighbors, with 80% reporting that they could recognize “a great many” neighborhood children and adults by sight. While 47% reported no relatives living in Clark–Fulton, 31% had six or more non-household relatives in the neighborhood. Participants reported positive overall sentiment for their neighborhood; nearly 80% indicated they “like it a lot” and all, when asked how much they would miss the neighborhood if they had to move, answered either “very much” (58%) or “somewhat” (42%).

### Go-Along interview findings

Qualitative findings from the analysis of go-along interviews reflected two primary themes articulated by the majority of study participants: (1) How neighborhood matters to health; and (2) Harmonizing health priorities and neighborhood beliefs. While the first theme concerns perspectives about the mechanism through which neighborhood context impacts the health of participants, the second centers on how notions of health encompass socioenvironmental factors beyond typical biomedical conceptions.

### How neighborhood matters to health

Participants described two general processes through which they saw neighborhood environments affecting health: first, living in homes or neighborhoods marked



by physical or social hazards (e.g., lead paint, abandoned housing, violence, relative deprivation) was thought to diminish health by either causing or exacerbating illness. Second, participants suggested that living in neighborhoods with features such as community service organizations, predictable access to healthful foods, and safe recreation spaces for families could foster individual and family health by offering practical assistance to households, enabling healthy eating patterns, and promoting stress-relieving recreation for youth.

### Physical or social neighborhood hazards

Comparing the risk of housing environments in Clark–Fulton to others nearby, one participant reflected:

*Things like lead paint are probably worse in Clark-Fulton than they are in some of the other surrounding neighborhoods, and I think that issues similar to that do have an impact on people's health outcomes. [509]*

Other participants alluded more specifically to both psychological stress processes activated by hazards like abandoned housing, and the associated risks to child and family safety:

*The only thing that really stresses me out is the abandoned housing, just walking by and just seeing a neighborhood with houses that are falling part. It's dangerous. It stresses me out. I think kids could just run around in there and get hurt sometimes. [511]*

From another's perspective, unequal opportunity to engage in health-promoting behaviors across more-versus less-advantaged neighborhoods were obvious. Alluding to the role of neighborhood safety in opportunities for exercise, and explicitly referencing neighborhood structural inequalities in urban metropolises like Cleveland, they stated:

*I think in different cultures, like more affluent cultures, it's "Oh, let's go do yoga or walk the dog somewhere." This neighborhood, it's not safe to do that at all hours of the day. [513]*

Of note, another participant articulated a process by which neighborhood residents might come to internalize or embody outsiders' projections of their neighborhood hazards in ways that might ultimately affect their own self-worth:

*I think definitely the neighborhood you live in, or grow up in, certainly plays some role in your overall health, whether it's actual*

*physical health, or even just kind of like mental health, psychological health, because if you grow up in a community where everyone you've ever met has told you that it's a bad neighborhood to live in, or it's a bad community, you're going to inherently feel like you're less of a person, or you're less of whatever because you come from a community or an area that has historically been looked down upon. [510]*

### Health-promoting neighborhood features

Findings centered around three subdomains: potential organizational and institutional opportunities; safe, predictable access to healthy foods; and safe spaces for child health, development, and play.

First, participants outlined *potential organizational and institutional opportunities* in their neighborhoods for improving the space in ways that might mitigate stress and promote health. For example, one resident suggested a process by which residents and neighborhood agencies could collaborate to coordinate local resources to build more usable areas for families and children to enjoy:

*The one thing I always thought was if you took all these community agencies we have around and you interviewed each person and said "What's your hidden talent?"...they would take everybody's little talent like woodworking, sewing and everything, and try to utilize them. I've lived in smaller communities where they do things like that—the bigger communities like Cleveland don't do that kind of stuff. They don't try to involve everybody. [505]*

Second, participants elaborated on having *safe and predictable access to healthful foods* as one powerful way through which neighborhoods could affect health, utilizing descriptive language such as “we're considered a food desert.”

*I think neighborhoods that don't have transportation and access to things that could help them, and in poor neighborhoods, people tend to eat ... my kids were part of eating that crap ... eating chips, because we didn't know. Little Debbie snack cakes, they're cheap. The kids have got high blood pressure, diabetes, depression. It's from the food. It's from the environment. [506]*

A participant from a youth-oriented community institution also emphasized the dearth of healthful foods in close neighborhood proximity but referenced the

potential food resource in their newly built community garden:

*There is only one grocery store, which is a good five or six blocks up the road, and I've learned we call those "food deserts." There's three corner stores down the street of each other where they serve the unhealthy snacks, the quick and easy stuff, but to actually get fresh produce and a good meal, that's all we have around here, and we have our garden here, which right now only has some things blossoming. [513]*

Third, residents overwhelmingly agreed that neighborhoods are critical environments responsible for fostering children's health, well-being, and facilitating space for their play:

*It's important to have some kind of a recreational outlet where they know their kid can go to play and be safe, so you're not stressed about that. The library is where a lot of the kids congregate, because that's the only place we have. We don't even have a rec center. [505]*

Recreation outlets were considered vital not just for children's well-being, but also for allowing caregivers to decompress:

*So instead of the kids being outside in the streets playing around where there's a lot of cars and violence and stuff, the parents can take their kids to the park and they could play on the playground, and the parents can watch them and relax. [512]*

## Harmonizing health priorities and neighborhood beliefs

The second core theme captures divergent perspectives on health between participants and traditional biomedical conceptions emphasized by health researchers, underscoring need for integrating community and clinical priorities. As reflected by participant responses, localized health beliefs and priorities emphasized social environmental factors, capturing more holistic conceptions of health beyond clinical concepts. However, enacting those socially focused health priorities was challenged by competing beliefs from those outside of the neighborhood.

### Localized health beliefs and priorities

Participants communicated priorities for health beyond the clinical conditions traditionally prioritized by health

researchers (e.g., hypertension, diabetes, obesity). One resident emphasized social conceptions of health, clarifying:

*It is "healthy" if you live in a neighborhood that has no violence, no shooting people, no drugs, nobody going out there and trying to hit someone with a car and stuff like that. [515]*

Residents repeatedly underscored social connectedness as a primary driver of health, with statements such as "The main thing that makes the community healthy is that people know each other," and contrasted closer bonds within Clark-Fulton with more distant relationships suspected in wealthier neighborhoods. In response to an interview question inquiring whether there were specific characteristics about some neighborhoods that made it easier or harder to be healthy, one participant stated:

*Well in our neighborhood, we all know each other. I think in different neighborhoods, you wouldn't know your neighbors that much because I think if you're more poor, you talk to each other and you help each other. [505]*

Other participants cautioned against prioritizing the opulence of more expensive homes in wealthier neighborhoods at the cost of social connectedness:

*I don't care if the house is made of diamonds or gold ... You don't want to move somewhere just 'cause it's nice and you think you're gonna be all happy. That doesn't make you happy. It's the neighborhood, the people around you. [506]*

This statement places a clear delineation between neighborhood as structures of wealth and neighborhood as social interactions. An additional participant, when asked whether the house or apartment mattered to health, extended this concept to the family ecology and emphasized connection between health and the fabric of family connectedness:

*Now, I just really don't see the house or the apartment making a big difference, because it depends on the family. If there's a sense of family at that apartment or house, that's what's gonna make it for them. [500]*

### Competing beliefs and priorities from outside of the neighborhood

Go-along interview participants were asked to describe features of the neighborhood and of neighborhood

health that they considered most important. Participants held varying beliefs and priorities about the neighborhood from those outside of the neighborhood. While participants discussed the significance of social fabric within the neighborhood to health, they also alluded to a neighborhood stigma that thwarted connectedness with friends and family outside of the neighborhood. For example, elaborating on why she thought her adult children would not live in her neighborhood, Participant 501 shared:

*Well they don't think it's safe, number one. They don't live there, so they don't know the people...Their perception of the whole neighborhood, you know Cleveland— I try to tell them it's not that bad. I go, "Well you go down to Tremont [a popular historic, gentrified neighborhood next to Clark-Fulton]; I don't live that far from Tremont," but they're like "Oh, no. We're not coming over there. You can come over here." I have a couple of friends that will come over, but the majority of them won't, and even the friends that do come over tell them, "It's not that bad. She lives in a nice neighborhood."*

Another participant offered corroborating insight as to how such stigma might develop and impede connections outside of the neighborhood:

*The worst part about the neighborhood is its negative perception because it's not necessarily based in reality. It's just based in what you see or hear on the news ... which, more often than not, if there is any media attention on our neighborhood, it's because of something negative. It's not because of something positive. Then people get a twisted view of what this neighborhood is when, in reality, it's just your everyday run-of-the-mill working-class neighborhood that you would find in any major city anywhere across the country. [510]*

In contrast to community flaws interpreted through the eyes of outsiders, participants described seeing a set of unrealized potentials as we walked the sidewalks with them. For example, when asked what was most important to them about the neighborhood, Participant 502 responded "The potential that it has. I can see it changing in the upcoming years. There's definitely potential here and there are people here who care." This view of neighborhood health as unrealized potential was also operationalized with articulated evidence of neighborhood assets and resident resilience:

*I do think that even though it is impoverished, technically, the people here— I mean, you hear*

*about how they have two or three jobs. They're very resilient as far as trying to just make ends meet, parents doing what they have to do for their kids, making sacrifices. [513]*

One young adult participant further reflected on some of the amenities in her neighborhood that differentiated it from others, highlighting community diversity as a specific asset:

*Living in the neighborhood as an adult is pretty cool, 'cause it's kind of a hidden gem. I'm by every major highway. I can get in and out of downtown in ten minutes. There's tons of ethnic food options that you don't really get anywhere else. There are a lot of amenities that are in this neighborhood that are culturally specific that you can't really find anywhere else...It's really cool being able to see such a diverse group of people, such a diverse community, both socioeconomically and ethnically, regularly interacting with each other. [510]*

Participants' reflections on competing intra- and extra-neighborhood perspectives underscore the value of integrating residents' own narratives in community-anchored redevelopment work.

## DISCUSSION

The current study examined Clark–Fulton neighborhood residents' community health priorities in the context of ongoing healthcare system-anchored urban design and neighborhood redevelopment efforts in Cleveland, Ohio. Movement within urban design and redevelopment initiatives to focus on both built and social components of the neighborhood space rendered the present study timely within the local context (EcoDistricts, 2018; US Green Building Council, 2018). Our study aimed to generate useful insights for other public health researchers, community groups, and planning and design professionals tasked with improving the health of communities. Though prior research has examined how characteristics of neighborhoods influence residents' ability to engage in healthy behaviors (e.g., Brenner et al., 2015; Cohen et al., 2017; Diez Roux & Mair, 2010; Dulin et al., 2018; Wallace et al., 2019), the current study examined how neighborhood shapes how individuals *think about* and *define* health, and we draw implications for urban design and redevelopment efforts. Overall, findings from the present study suggest four core takeaways that contribute to scholarship at the intersection of health inequities, place, and neighborhood development. We discuss each of these separately below.

## Residents' vocabulary and epistemology for how neighborhood matters to health

First, a core finding of our study centered on the only partial overlap of neighborhood residents' vocabulary and epistemology for health with that traditionally focused upon by healthcare systems and clinician researchers. Our findings that residents prioritize access to healthful food comport with a constellation of other data emphasizing, for example, the effect of neighborhood retail food environments on fresh food intake and clinical outcomes such as type 2 diabetes (Smalls et al., 2017) or obesity (Gorski Findling et al., 2018). We additionally find that neighborhood residents identify quality, accessible recreational spaces as essential to child and family health. This aligns with previous quantitative and qualitative findings that children's physical and behavioral health (Diez Roux & Mair, 2010; Evans, 2006), and healthful family dynamics (Haas et al., 2018), are critically shaped by the neighborhood built environment.

Our finding that neighborhood residents' health vocabulary differs from that of healthcare researchers and clinicians highlights that, in the context of evaluating the impact of urban renewal initiatives, data resources must be selected accordingly. In our project guided by the EcoDistricts framework for implementing community development, multiple indicators established within the EcoDistricts (2018) protocol broadly align with the expressed needs of the neighborhood participants we interviewed. For example, the metric "percentage of population within 0.25 mile walk of a public recreation space" is one measure by which the EcoDistricts priority of nurturing people's health and well-being through active living is assessed. This metric is congruent with the priority some of our participants voiced related to having "some kind of a recreational outlet where caregivers know their kid can go to play and be safe". However, other metrics (e.g., transit stops per square mile, number of bike and car share stations), meant to assess the EcoDistricts (2018) priority of safe and connected streets between people and places, measure a dimension of structural connectedness rather than the social dimension emphasized by participants in our study.

These findings suggest that renewal initiatives might find both relational and practical value in working more closely with neighborhood residents to better calibrate definitions of key redevelopment concepts to residents' own health priorities. In our project, such built-in accountability is a key programmatic feature of the EcoDistricts (2018) protocol; to maintain certified status as an EcoDistrict, districts are required to submit progress reports every two years to monitor concrete collaboration and decision-making with community stakeholders, and track performance and implementation milestones to measure impact over time.

## Embodiment of the neighborhood context

A core pillar of our study included gathering the insights of neighborhood residents and guiding the EcoDistricts effort to measure neighborhood health in a manner that would not perpetuate or amplify spatial stigma (Halliday et al., 2020). Our interviews with participants in Clark–Fulton extend evidence presented by other authors (Keene & Padilla, 2014; Graham et al., 2016); we find that neighborhood environments may become embodied through external perceptions that affect both intra- and interpersonal connections. Individuals may internalize or embody aspects of neighborhood environments in ways that, over time, shape their well-being and sense of self (Evans, 2003; Haas et al., 2018). Our research builds upon that work by excavating a neighborhood emplacement of self-worth and identity formed by refractions of ongoing commentary between community insiders and outsiders through the "neighborhood looking glass" (Sampson, 2012; p. 365). Charles Horton Cooley's (1972) theory of the looking-glass self posits that individuals learn, over time, how to make sense of themselves through their understanding of how others perceive them to be. This particular finding in our study exemplifies Cooley's work by illuminating a symbolic interactionism perspective of place, social position, and health. Cooley (1972) posited that communities would affect an individual's identity; our findings convey an effect on individuals' dignity and self-value, consonant with, for example, other work on territorial or spatial stigma (Graham et al., 2016; Kusenbach, 2020) and on experiences of community belonging and exclusion reported in go-along interviews with Canadian youth from stigmatized neighborhoods (van Ingen et al., 2018).

These findings additionally contribute knowledge to broader conceptual and empirical evidence of how individuals internalize social and physical strains of their neighborhood environments. As research on links between place and health has grown in recent decades, so, too, has research on place embodiment, or how social or physical aspects of neighborhood may "get under the skin" (Petteway et al., 2019). Expanded research examining how neighborhood stigma affects residents' health and social connectedness, and how those dynamics may shift throughout neighborhood redevelopment initiatives, is warranted.

## Social connectedness as health

Third, we find that the social fabric of a neighborhood is integral to resident-perceived health and that outsider perceptions of a neighborhood may impede insiders' capacity to maintain or foster social connectedness. Prior research has increasingly recognized the protective role of social support and connectedness in a variety of clinical health outcomes such as inflammation and



coronary heart disease (Heffner et al., 2011), health literacy and mortality risk (Smith et al., 2018), and longstanding evidence has linked social connectedness to behavioral health such as fewer depressive and anxiety symptoms (Cruwys et al., 2013; Paykel, 1994). Findings from our project dovetail with this research and build qualitative, shoes-on-the-sidewalk evidence that neighborhood social connection warrants attention as a potential source of resilience from physiological stress responses implied in myriad illnesses and diseases (Ozbay et al., 2007; Southwick et al., 2005). While early planning discussions of hospital leadership had focused on understanding how the urban redevelopment achievements might alleviate the burden of common chronic diseases like hypertension, asthma, and diabetes, our community members were sharply focused on social connectedness itself as a form of community health. For neighborhood residents in our study, health and social factors were entangled such that social well-being was bound to, rather than simply causative of, mental and physical well-being. Medical care and public health sectors are often focused on investments in neighborhood rejuvenation as pathways to improved outcomes and reduced costs but, for residents, the social flourishing of the community is, in and of itself, a salient *health outcome*.

Publicly available resources (e.g., US Census, city administrative data) and electronic health record data are convenient and expedient for assessing baseline status and changes in community and clinical health outcomes, respectively. However, findings from our study suggest that accompaniment by community-anchored survey and interview data is warranted to effectively evaluate more holistic health impacts. Moreover, our findings contribute to the notion that neighborhood redevelopment initiatives have the potential, and imperative, to act on individual health through both the built environment and social context (Barton et al., 2003).

### Utility of go-along interview for informing neighborhood redevelopment plans

Fourth, our study highlights the utility of the go-along interview for amplifying residents' voices throughout traditionally siloed approaches to neighborhood development. A key contribution of the go-along approach to redevelopment work done within the EcoDistricts framework is its capacity to build consensus around meanings of health as tied to EcoDistricts imperatives, priority areas, and measurement indicators in the planning framework. In our specific case, findings from this study directly informed the MetroHealth Transformation initiative's implementation and planned performance measurement process for evaluating future effects of the neighborhood redevelopment on community members' health. Go-along interviews thus appear to be a particularly effective mechanism for creating collaborative understanding of how to measure health when planning for

neighborhood improvement. Integrating *district-level* definitions of health and well-being may generate an implementation and evaluation plan more intuitive to neighborhood residents, promoting engagement and ownership in planning processes. Articulating the lived realities of residents on the sidewalk and in their own words serves to increase the understanding of root causes of health outcomes, and to articulate interdependencies that might not otherwise be foreseen by architects, executives and urban planners. In addition to the planning phase, our approach in this study can be extended in future work to examine progress toward satisfying EcoDistrict imperatives. For example, a 12-acre park is part of the plan for the Clark–Fulton EcoDistrict; follow-up go-along interviews could explore the extent to which the new park has fulfilled community expectations for promoting equity, resilience and climate protection.

### Limitations and strengths

Our research illuminates numerous considerations for researchers partnering with community members to measure the impacts of urban renewal efforts on health and offers useful lessons for the evaluation of current and future community renewal initiatives. However, some limitations of our study should be addressed in future research. First, resource constraints precluded our use of global positioning systems (GPS) technology to formally synchronize the spatial progression of each interview with participants' spoken words. Future research may, for instance, capitalize on the spatial video geo-narrative approach (Curtis et al., 2015) along with photovoice methods (Nykiforuk et al., 2011) to build more intricate knowledge of how the confluence of person and place affect health and well-being. While participants in our study did note meaningful places along their chosen go-along interview routes, we were not able to collect the depth and breadth of synchronized data that would permit reporting on specific location information. Second, it is possible that the nature of the go-along interview inadvertently limited what information participants disclosed. For instance, given the salience of neighborhood social networks, the presence of neighbors or other pedestrians on the street may have affected what information participants were willing to share. Relatedly, all interviews were done during traditional workday hours; the type and concentration of neighborhood social activity likely varies across time within days (Carpiano, 2009), and residents may have offered different environment-cued insight at other times of the day. Additionally, over half of the study's participants had a bachelor's degree or higher level of education, but the majority of Clark–Fulton residents have a high school diploma or less. Though participants with lower levels of education were included, unobserved differences between participants and non-participants may affect what we were able to learn about the neighborhood and thus the study's insights may not fully reflect those of the overall neighborhood.

Despite these limitations, the current study has numerous strengths. First, we employed the go-along interviewing method to enrich discussions of neighborhood relevance that traditional sedentary interviews inherently preclude. Our use of this interview approach to sociological inquiry of neighborhood-and-health concepts facilitated a more granular understanding of residents' attitudes about their health and environment, helping participants demonstrate, in vivo, the barriers to well-being inherent in structural features like broken sidewalks or blighted infrastructure. Other healthcare system-led, urban renewal, and community collaboration efforts might adapt our use of this method to distill neighborhood residents' own priorities for health. Second, study participants reflected the range of age, ethnicity, language, and race existing in the focal neighborhood itself, generating important insight to local health needs and priorities during an unprecedented healthcare system-anchored neighborhood transformation. Finally, we triangulated go-along interview content with community stakeholder data to explore the accuracy and validity of interview data as interviews progressed throughout the study. Such measures enhanced the trustworthiness of our data and nurtured community partnerships critical to the broader MetroHealth Transformation initiative's overall longevity.

## CONCLUSIONS

Growing evidence demonstrates the impact of health policy and clinical efforts in addressing social environmental factors to improve health. Our work sought to align the goals of a healthcare system-initiated community renewal effort with the perspectives and needs of community residents. Participants in our study clarified processes through which they perceived the neighborhood environment to affect health and underscored ambient exposure to lead paint or abandoned housing, access to health-promoting resources such as green space, and recreation areas as key processes. Findings also suggest that neighborhood residents may internalize outsiders' negative perceptions of their neighborhood in ways that assault dignity, alluding to a neighborhood emplacement of self-worth. In contrast with clinical outcomes traditionally prioritized by healthcare systems, neighborhood residents in our study articulated social connectedness as a key meaning of health. To optimize health and well-being in large-scale neighborhood investments, the priorities of healthcare systems and community members alike must be accounted for to design valid interventions that are meaningful and relevant to the community of focus.

## CONFLICTS OF INTEREST STATEMENT

Dr. Perzynski reports equity ownership in Global Health Metrics, LLC and book royalty agreements with Taylor Francis and Springer Nature, outside the current work. The authors declare no conflicts of interest.

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### SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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