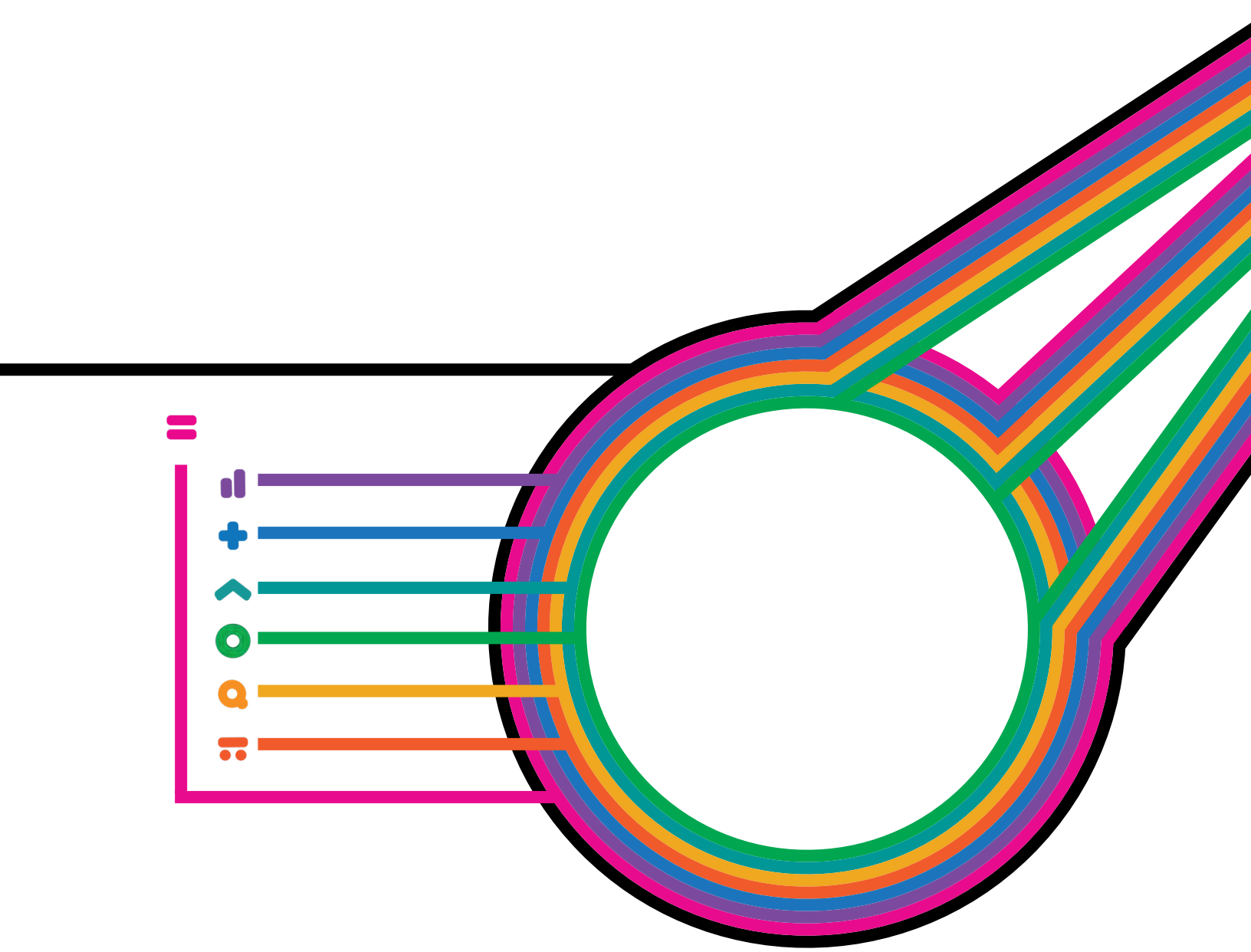

DEEP DIVES

ORIGINAL CONTENT FROM CONTRIBUTORS

DEEP DIVE

THRIVING NATURAL WORLD

JUNE 2020

CONTRIBUTION 1 OF 2

THRIVING NATURAL ENVIRONMENT

Sarah Milligan-Toffler
Children & Nature Network

CONTRIBUTION 2 OF 2

THRIVING NATURAL WORLD: ENVIRONMENTAL CLEAN-UP

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THRIVING NATURAL ENVIRONMENT

DEEP DIVE 1 OF 2

The Children & Nature Network (C&NN) believes that everyone deserves a meaningful connection with a healthy natural world. We have a responsibility to ensure that all people—especially those with the greatest barriers—have access to the many benefits of spending regular time in nature.

Our vision is a world in which everyone has access to the many benefits of a meaningful connection with a healthy natural world everywhere they live, learn and play. Our mission is to increase equitable access to nature so that children, communities and the natural world can thrive.

We drive equitable access to nature through three core strategies:

- Foster the belief that a connection to nature is critical for healthy physical and cognitive development and well-being.
- Drive systems change efforts to increase equitable access to nature.
- Grow and support the movement to connect all children, families and communities to the many benefits of time in nature.

C&NN is able to achieve this big vision through strategic partnerships and by influencing the big systems that affect children's daily connection to nature—including youth development, municipal and state government, education, early childhood, parent education, public health and others—that allow us to make an outsized impact for our size.

The most significant accomplishments of the past five years include growing a grassroots movement. In 2019 alone, we saw more than 435,000 unique sessions on our website, where practitioners, educators, and parents can access tools, research and practical information on how to increase equitable access to nature. More than 257,000 fans follow us on our social media platforms and more than 900 people participated in our monthly webinars. In 2019, more than 600 individuals and organizations from around the world joined or renewed their C&NN memberships. The support of these leaders builds the constituency for children and nature and helps make possible the work we do to curate research and develop tools, resources and training for the field.

More than 800 leaders from 15 nations joined us in Oakland, California in May 2019 for our biennial Increasing Impact of Inside-Out International Conference. Through inspiring speakers and hands-on workshops, participants learned about best practices for increasing equitable access to nature and networked with peers from around the world. The conference wrapped up our two-year residency in Oakland. Mayor Libby Schaaf helped kick off the event by announcing *Oakland Goes Outdoors*, a school district partnership that will provide every Oakland middle school student with regular, outdoor learning experiences. We are now actively working on our two-year residency in Atlanta.

C&NN's online Research Library now has more than 1,000 curated studies about the benefits of nature for people's health and well-being, with about 20 studies being added each month. C&NN has been building this collection since 2005, when there were approximately 60 studies available on this topic. Given the centrality of human and nature connection, it remains a surprisingly underdeveloped area of scientific exploration, however, the increase over the past 15 years in both the quantity and quality of research is notable. An accomplishment in itself, this milestone also represents the growth and momentum of the children and nature movement.

When we launched the Cities Connecting Children to Nature program six years ago with the National League of Cities, nature connection wasn't even on the radar for most municipal leaders. Today, a growing number of mayors and policymakers recognize that increasing nature access can support a city's top priorities, from reducing academic opportunity gaps and health disparities, to improving climate resilience. School districts, from Oakland, California, to Grand Rapids, Michigan, to Providence, Rhode Island, launched efforts to provide students with regular outdoor experiences and to create nature-filled schoolyards for learning and play. This short video provides a good overview of accomplishments to date.

C&NN joined with other national organizations to launch the Youth Outdoor Engagement Policy Playbook to provide education and information on how states are ensuring equitable access to nature. C&NN has a

diverse network of stakeholders made up of the following worldwide audience:

- Outdoor education, recreation and nature-based program service providers
- Health care and public health professionals
- Educators
- Conservation professionals
- Federal, state and local government officials
- Environmental justice and Indigenous-led organizations
- Landscape architects and urban planners
- Journalists and thought leaders
- Policymakers and funders
- Grassroots activists, parents, youth and children

THE STATE OF THE CHILDREN & NATURE MOVEMENT PRIOR TO COVID-19

The children and nature movement was growing and thriving pre-COVID-19. That said, most people not already part of the movement—and likely some inside the movement—tended to think about nature connection as a "nice to have" but not an essential part of what is needed to support healthy thriving communities and reduce health disparities. While there were significant efforts underway to address the lack of diversity across the field, leading organizations and government agencies were predominately white—staff and especially executive positions and boards of directors.

There is a considerable and growing body of scientific evidence that shows a direct link between positive outcomes for youth and regular connection to a healthy natural world. While there is a growing understanding that this is true, the systems and structures we have in place in most communities don't support regular connection to nature, especially in communities that could benefit most.

The environmental movement has a long and complicated history in the United States. While there have always been Black, Indigenous, Latinx and other People of Color who have advocated for environmental protection, the vast majority of widely recognized organizations and thinkers in the environmental movement have been white, affluent, and until recent decades, primarily men.

The operative framework saw nature as something pristine, needing protection from human encroachment, and certainly didn't recognize people as part of nature. This framework led to organizations and strategies that focused on ecosystem protection, without consideration for the human-nature connection. As a result, many of these organizations were considered elitist and not relevant to communities dealing with issues of safety, access to food, education, jobs, etc.

In 2006, the founder of the C&NN, Richard Louv, published his groundbreaking book, *Last Child in the Woods: Saving our Children from Nature Deficit Disorder*. Louv documented the world-wide disconnect from nature that has transpired in just the past 30 years. There are many reasons for this, but the impacts on both people and the planet raised dire concerns. Louv called for a New Nature Movement, one that recognizes the interconnection of all life on earth including plants, humans, and other animals. There is a growing international movement supported, in part, by C&NN. There are some systemic changes being made in communities across the country—this short video provides some examples—but much more needs to be done to ensure equitable access to the benefits of nature in every community.

EQUITY & ACCESS TO GREEN SPACE DURING COVID-19

Over the past few months, we have seen people around the world turn to nature for reprieve and respite from the stress and uncertainty caused by the COVID-19 pandemic. A new report from Google that analyzes cell phone location data to see how people's activities are changing during COVID-19 shows a marked rise in park usage. While some states are showing decline in park usage—New York is down 47 percent, Texas 27 percent, and Nevada 38 percent—others show a rise in park usage: North Dakota park activity was up 73 percent, Utah saw a rise of 26 percent, and park activity in South Dakota and Ohio more than doubled, increasing by 126 percent and 117 percent, respectively.

With each passing day of the crisis, however, it is becoming clear that too many children and families lack equitable access to the benefits of nature at a time when they need it most. Just as systemic racism impacted the design and distribution of parks and greenspaces, Black, Indigenous, and Latinx people in the United States are disproportionately dying from COVID-19 in yet another tangible reflection of the true cost of inequitable systems.

Mounting research suggests that improving equity in access to greenspace may help combat health inequities. Access to safe, nearby nature must be prioritized as critical public health infrastructure and not just an amenity for a few.

As we think about how to help communities emerge from this crisis, will we repeat the mistakes of the past, or will we think holistically about what truly supports health and well-being? Let's not make false binary choices between things like food, shelter, and transportation or access to education, jobs, health care, and nearby nature. People need all of these things to thrive. While somewhat beyond the scope of these recommendations, it bears mentioning that the loss of ecosystems and habitat, climate change, and other factors are part of the reason for this and future pandemics (Rich, F, 2020). Biodiversity in and outside of cities can create buffers to zoonotic-disease and therefore pandemics.

The C&NN's Research Library has more than a 1,000 peer-reviewed articles that help us understand how, why and under what circumstances connection to nature supports health and well-being

PIVOTAL MOVES FOR NEAR-TERM ACTION TO IMPROVE EQUITY IN ACCESS TO NATURE

Green schoolyards

The recent closing of school buildings and the move to online learning has been a tremendously difficult challenge for many families to navigate. While there are many benefits to online learning, especially for older students, teaching and learning happen best in relationship with others and the rest of the natural world. How can we leverage the momentum of this time of massive disruption to shift to a more mindful, sustainable, and equitable model of public education that addresses new and deeply embedded threats and injustice?

COVID-19 has taught us we are capable of rapid change. It is time to turn education inside-out. Green schoolyards, forest preschools, and outdoor early childhood programs have been around for decades, but now their practices seem prescient: they call for ample outside time, natural play, and exploration, all of which support the physical distancing measures that will be needed moving forward. These programs also employ enthusiastic educators who enjoy helping children learn in and from nature, a critical skill as we become more keenly aware of our interconnectedness with nature and the need for thinking ecologically—to understand how nature supports our health, and how we can support the health of the natural world.

Early studies are showing that COVID-19 is much more likely to spread indoors, where it can stick to surfaces and live for days. Outdoors, there's a dilution factor that reduces exposure. A recent article in the New York Times, *What We Know About The Chances of Catching the Virus Outdoors*, reported that there is "growing consensus among experts that, if Americans are going to leave their homes, it's safer to be outside than in the office or the mall. With fresh air and more space between people, the risk goes down." Setting up outdoor classrooms allows students to spread out, with the recommended six feet or more of distance.

We have the land we need. Public schools are one of the top three land holders in most communities, as stated in Green Schoolyards America, 2015. This points to a great and often underutilized resource that can be reimagined to support student achievement and community well-being, and to mitigate the effects of climate change. School grounds and the natural infrastructure that exists in every community can be activated for effective learning, dovetailing with professional development for teachers and school staff on how to move learning effectively and safely outside.

Now is the time to call on school districts and community leaders to invest in green schoolyards and other nature-based learning environments as we continue to adjust to the presence of COVID-19 in our lives. Let's create a new normal of equity, peace and health. We need schoolyards packed with trees, native plants and grasses, and gardens where children can explore and learn in spaces that encourage creativity and solution-oriented thinking. Imagine how a foundation like that can shape the life-long learning of engaged citizens working to make the world we live in the best it can be.

What would green schoolyards achieve?

Green schoolyards foster resiliency and equity which translate to better test scores

Studies show that exploring, playing and learning in nature improve academic achievement more than indoor

classroom instruction. An integrative review of the research (Kuo, Barnes, and Jordan, 2019) found positive shifts in perseverance, problem-solving, critical thinking, leadership, teamwork and resilience—skills that are essential in overcoming the unprecedented challenges we face today.

Researchers have also found that outdoor learning can improve standardized test scores and graduation rates. Current longitudinal studies offer encouraging data. A six-year study of 905 public elementary schools in Massachusetts found that third-graders who attended schools that were closer to natural areas got higher scores on standardized testing in English and math (Leung, et al., 2014). Likewise, preliminary findings of a 10-year University of Illinois study of more than 500 Chicago schools, comparing green schools with more typical schools, indicate similar results, especially for the most challenged learners (Kuo, et al., 2018). While all students benefit from outdoor learning, the outcomes are relatively greater for those who are negatively impacted by economic disadvantage, systemic racism, trauma and other challenges, suggesting that green schoolyards are a smart strategy for addressing education gaps (Kuo, et al., 2019).

Outdoor learning also supports the health and well-being of educators. One study (Paddle and Gilliland, 2016) suggests that educators who have the opportunity to take students outdoors to learn are less likely to burn out. Improving teacher retention and the quality of educators attracted to the profession can have profound effects on the success of students. One of the best choices we can make as we prepare to go back to school is to equip a new generation of teachers with the knowledge and confidence to take students outdoors to learn.

Green schoolyards reduce stress and support well-being

The stress and the social isolation resulting from the COVID-19 pandemic is taking a toll on our collective mental health. Teachers are going to need strategies to support themselves and their students once school is back in session.

When children, or adults for that matter, are overloaded with stress hormones, their stress response systems kick into high gear. Cortisol is dumped into the bloodstream, negatively impacting sleep, metabolism, and other physical systems. This dramatically impacts a child's ability to learn and develop healthy, trusting relationships with adults and peers (Felitti, et al., 1998).

We know that outdoor learning helps reduce stress. In an experimental study, views of green landscapes from classroom windows helped high school students recover more quickly from stressful events (Li and Sullivan, 2016). In another study, 11-year old students in Germany were either taught indoors or spent a day a week over the course of a year learning outside in forest school programs. The forest school students showed a normal, healthy decline of cortisol levels over the course of the morning. This decline in cortisol was not found in the indoor control group, suggesting a more chronic level of stress in students taught indoors (Dettweiler, et al., 2017). A 2020 report of peer-reviewed studies found that as little as 10–20 minutes in nature daily may serve as a preventative measure for stress and mental health strain for people between the ages of 18–22 (Meredith, et al., 2020).

Physiological health markers of stress associated with time in nature included decreased heart rate and blood pressure (Twohig-Bennett and Jones 2018). Psychological indicators of reduced stress associated with time in nature included less depression, anxiety and fatigue and increased vigor, positive affect and feelings of calm (Meredith, et al., 2020). The natural world is abundant in healing qualities that we can make more accessible to teachers and students by implementing green schoolyards and outdoor education programs.

Green schoolyards promote environmental stewardship and climate action

The typical public schoolyard includes turf grass, impervious surfaces, and aging playground equipment and athletic facilities, which provide little to no benefit to the natural environment. Current schoolyard conditions unintentionally contribute to flooding, loss of pollinator habitat, and heat island impacts. A lack of nearby natural amenities limits the ability of schools to: better integrate environmental education; use the outdoors as a classroom; and foster next generation environmental stewards.

Green schoolyards are a solution to this problem. By reimagining how we use public land around schools in every community, we can reduce the risk of flooding, keep communities cooler, and create places where birds and pollinators find refuge. With outdoor classrooms, students can learn about the natural world all year long,

which encourages pro-conservation behaviors (Hughes, Richardson, and Lumber, 2018) .

There are numerous examples from across the country of successful implementation of district-wide green schoolyards. This short video provides an overview.

Green schoolyards offer access to nature for students and communities out-of-school time

Green schoolyards are an exceptional use of public space, creating equitable access to green space, providing places to play and learn during school time, and offering community access out-of-school time. Given the inequities in access to parks and green space, partners in numerous sectors—from education, to health care, to landscape design—are advocating for using that public land to support community health and well-being by opening school grounds for the public when not used by the school. With play structures being closed due to COVID-19, the public access of green schoolyard features has become even more critical. Formal community schoolyard access is imperative to ensure that schoolyards—whether school is in session or not—are able to provide public access benefits to ensure that all communities have safe, quality green space within a 10-minute walk of their homes.

C&NN worked with dozens of national partners to develop an action agenda for ensuring that every public school ground in the U.S. has a green schoolyard by 2050. This action agenda outlines the conditions that would allow for this vision to become a reality. Specific actions that federal partners can take include:

- Include green schoolyards in the next federal assessment of school facilities.
- Add green schoolyards to the Collaborative for High Performing Schools, U.S. Department of Education Green Ribbon Schools, U.S. Green Building Council Green Schools, and LEED for Schools criteria.
- Create a menu of green schoolyard elements that can aid municipalities in meeting Clean Water Act permitting requirements for stormwater and combined sewer systems run by the states and U.S. Environmental Protection Agency.
- Expand use of Community Development Block Grant funds to include green schoolyards for green space development.
- Include quality and quantity of green schoolyards in the Office of Civil Rights (Department of Education) school report card in order to collect accurate data on inequities in green schoolyard distribution.
- Align green schoolyards with Centers for Disease Control and Prevention (CDC) and Association for Supervision and Curriculum Development (ASDC) "Whole School, Whole Community, Whole Child" model.
- Broaden definition at Internal Revenue Service of "community benefit" for addressing Community Health Needs Assessments to include green schoolyards.
- Pilot a Health Impact Project where green schoolyards have been identified as an intervention and included in a Health Impact Assessment.
- Advocate for new language for technical specifications that address ADA compliance in outdoor learning and play environments on school grounds.

Elevate the outdoors as a platform for youth leadership and employment

As we rebuild communities after COVID-19, we recommend a national program to employ young people to help bring more parks and greenspaces into communities where they don't exist, support the creation of green schoolyards, plant community gardens, native healing gardens and trees to help with urban heat island effects, and provide outdoor programming, at a safe distance.

Our country's demographics are rapidly evolving. According to a 2015 Pew Research Center report, Millennials are the most racially diverse generation in American history, a trend driven by the large wave of Hispanic and Asian immigrants who immigrated to the United States over the past half century, and whose US-born children are now aging into adulthood. The US Census Bureau projects that Latinix, African Americans, American Indians, Asian American/Pacific Islanders are the emerging majority in the United States and will comprise more than half of the American population sometime around 2040. Additionally, 29 percent of the emerging majority are Millennials between the ages of 18-29 and a

staggering 59 percent of all Millennial-age citizens identify as non-white.

There is a growing gap between people and nature, particularly among youth living in urban communities (Louv 2005). Kids spend less time engaged in meaningful outdoor activities, opting instead for video games, television and other indoor activities. And now that, according to the US Census Bureau, 80 percent of Americans live in cities, whole communities lack critical access to natural areas, and fewer people understand how their own well-being is inextricably linked to the health of our natural world.

When kids spend more time outside, everyone benefits. Some of the outcomes associated with engaging youth in regular outdoor activities outdoors include:

- Public Health and Wellness—When kids and their families spend more time outdoors, using the natural infrastructure that exists in every community, communities see meaningful, documented improvements to health and well-being.
- Education and Workforce Development—Integrating outdoor education and environmental literacy into education and workforce development training creates new job opportunities and improves education and learning outcomes.
- Youth Development—High quality nature-based programs support positive youth development and social-emotional outcomes.
- Economic Development and Conservation—Outdoor recreation and conservation provide direct economic benefits to local communities, as outlined in the Outdoor Industry Report on the Outdoor Recreation Economy, and also in more intangible benefits such a violence reduction (Kuo and Sullivan, 2001).

Young People of Color are, therefore, at the epicenter of our planet's future and their access to nature and participation in nature-based experiences is disproportionately low. In its 2014 report, the Outdoor Industry Foundation found that Caucasians have the highest outdoor participation rate at 70 percent, while the emerging majority accounts for less than 25 percent, with African Americans representing the lowest participation. Today also marks a pivotal moment in conservation, outdoor recreation and public lands policy in the United States. The outdoor industry has grown dramatically over the past decade and currently represents 6.1 million American jobs, $646 billion in outdoor recreation spending each year, and $39.9 billion in federal tax revenue (Outdoor Industry Report on the Outdoor Recreation Economy). Engaging the emerging majority in the outdoors has never been more critica—but there is much work to be done.

All of us who care about the future of conservation have a role and a stake in engaging the next generation of diverse leaders in the movement to connect children and families to nature and taking action to protect our shared natural heritage. We must also elevate the existing nature connections and competencies that exist within every culture and collaborative efforts to engage the emerging majority in critical conversations and decisions concerning our shared natural resources, in order to welcome a new era in America's conservation legacy.

Engaging youth in outdoor and nature-based infrastructure development would achieve several things:

- It would provide needed jobs and skills training for young people during an economic downturn.
- It would provide needed natural infrastructure to support the health and well-being of communities that have been underinvested in.
- It would provide ample opportunities for young people to spend time outdoors and be part of the recovery effort.

The infrastructure for this kind of effort exists (e.g. national and local organizations, park districts, etc.), but they need funding to ramp up these efforts. Also, there would need to be guidelines in place to ensure that investments are made equitably, focusing first on those communities with the greatest needs and largest health disparities. Federal partners could help with funding, through leveraging job training and employment dollars.

Park-library partnerships

Communities need new and innovative approaches to reduce growing health and academic disparities. Current solutions are often sporadic, singularly focused and "provided for" communities. There are many programs designed to engage kids and families in nature, creating meaningful experiences and important social connections.

But low-income communities have been historically underserved and not involved in planning and leading such programs. There is also a limit to the impact these programs can have on their own. Systemic change needs to come from within underrepresented communities.

To address nature access disparities, collaborative, community-driven "Nature-Smart Libraries," are a feasible and replicable model. The primary goal of Nature-Smart Libraries is to use the trusted, but underutilized, platform of public libraries that exist in every community to develop informed and knowledgeable school-aged children and their parents who can identify local needs and engage in healthy nature-based activities. The effort would focus on building the capacity of libraries to integrate Nature-Smart strategies into their city's library departments and regular operations.

Initial need for Nature-Smart Libraries was identified through a 2017 survey conducted by the Minnesota Library Association of 75 of its member libraries across Minnesota. 82 percent of libraries indicated that it is a priority to develop nature-based programming based on community interest. Additionally, the City of St. Paul, Minnesota has identified park-library partnerships as a priority, building on a successful model piloted at one of their sites, the Sun Ray Library. While libraries are beginning to recognize their potential for engaging families in hands-on, nature-based activities, they report they are not currently equipped to provide these programs. Eighty percent identified lack of know-how, capacity, and funding as primary barriers for implementing nature-based programs.

We recommend that a national effort be piloted in 10 to 20 cities across the country to equip libraries with training and tools to engage parents and school-aged children in hands-on, nature-based learning and conservation activities, with an emphasis on libraries that serve low-income families and neighborhoods where access to safe green space is sparse. Because we are building the capacity of libraries to integrate Nature-Smart strategies into their city's library departments and regular operations, this effort could have lasting impact.

Evaluation of the pilot could provide critical data to help inform if and how library services might help address disparities and leverage opportunities. It would explore how new ways of engaging families in nature-based programming might enhance the health and well-being of families and communities. Using libraries as key community conveners, the process should place the voice of children, youth, and parents at the center of needs-identification, planning, and decision-making and use regular community checkpoints to refine and redirect project activities.

Major outcomes of the Nature-Smart Libraries pilot could include:

- The design, development and implementation of a new, replicable model for equipping libraries to deliver "nature-smart" programming, and position libraries as a significant community resource for equitable access to nature.
- Creation of Nature Action Backpacks that include hands-on lesson plans and resources, activity cards and community-based stewardship planning tools.
- Training, support and engagement of youth in nature-facing internships and job training.
- An online suite of Nature-Smart Library resources and tools that librarians can access for replicating Nature-Smart Libraries at their library.

The infrastructure for Nature-Smart Libraries already exists. Federal funding through the Institute of Museum and Library Services could support a pilot that could be scaled over time.

Policy framework for long-term transformation to ensure equitable access to nature

The three ideas presented above present opportunities for both immediate action and long-term transformation.

We also recommend the adoption of a policy framework developed by a national coalition of organizations that supports youth outdoor engagement. The policy framework is informed by key principles that define and inform our approach to policy focused on youth outdoor engagement. High-quality policy should adhere to the following principles:

- Child-centered and focused on the whole child
- Family focused and multigenerational
- Equitable access for all
- Leverage multiple approaches

- Locally supported
- Culturally relevant
- Research based
- Systemic

What this looks like in action is linking municipal, state, and national decision makers with community-led grassroots groups to design and implement local solutions that respond to community needs.

There are many national partners that are critical to these efforts. For green schoolyards, there are 100+ organizations that have signed onto the Green Schoolyards Action Agenda. There is a national cohort of organizations working to increase green schoolyards including, Trust for Public Land, The Nature Conservancy, National Recreation and Park Association, City Parks Alliance, National League of Cities, Children & Nature Network and others. There is already good momentum moving on these efforts, so with minimal effort, there could be some significant movement towards implementing a green schoolyard agenda.

There are also many partners at the national and local level working on engaging youth in the outdoors to improve health and well-being outcomes. The Aspen Institute Forum for Community Solutions, Native Americans in Philanthropy, Casey Family Programs, the National League of Cities and the Children & Nature Network are working to advance integration of nature-based interventions into youth development efforts.

Likewise for Nature-Smart Libraries, the Urban Library Council as well as a growing network of libraries around the country are starting to think about how to use libraries as a jumping off point for nature connection.

Each of the actions taken should be prioritized through an equity lens and informed by understanding of who does and doesn't have access to safe outdoor spaces. Everyone—especially those with the greatest barriers—deserves access to the many benefits of a meaningful connection with a healthy natural world.

We will know if these interventions made a difference by understanding and evaluating:

- What explicit structural change is happening across communities to increase equitable access to nature: Policies, Practices, Resource Flows.
- What semi-explicit structural change: Relationships & Connections, Power Dynamics.
- What transformative change has impacted mental models constraining ways of thinking that hold inequities in access to nature in place.

The National League of Cities, in partnership with many other national organizations including the Children & Nature Network, has developed a set of metrics that could be employed to track impact.

SOURCES AND DOCUMENTS

Multimedia Sources

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References from key scientific literature on the health and well-being benefits of nature

The Children & Nature Network has collected more than 1,000 peer reviewed articles that speak to the health and well-being benefits of spending regular time in the outdoors and nature-filled areas. While it is difficult to point to one "definitive" article, the sheer volume of research that point to similar outcomes in physical and mental health outcomes and pro-social behaviors add up to a compelling case for including access to nature in youth development, community development and planning, public health planning, school policy and infrastructure investment. Below is a summary of the key data culled from the research.

Physical health benefits

Youth in nature tend to be more active.

- Time in nature promotes physical activity—Kondo, et al. 2018 (review)
- Daily physical activity improves brain function in children—Hillman, et al. 2014
- Play in natural environments promotes locomotor skills—Lim, et al. 2017

Greener neighborhoods boost immune functioning.

- While there are many physical and psychological benefits of spending time in nature, a central pathway for these impacts has emerged from the literature: enhanced immune functioning – Kuo, 2010

Time outdoors protects eyesight.

- Time outdoors in bright sunlight reduces risk of myopia – French, et al. 2013 (review); He, et al. 2015 (experimental study involving over 1800 children)

Newborns tend to be healthier if mothers live in greener neighborhoods.

- Residential greenness may benefit maternal health and fetal growth – Fong, et al. 2018
- Increased exposure to green space may be a

positive influence on gestational age of newborns for women with a low level of education – Nichani, et al. 2017

- Surrounding greenness is associated with increased birth weight and head circumference – Dadvand, et al. 2012

Nature can serve as a protective factor and reduce violence.

- Branas, et. al. 2018 – found that urban green space exposure is linked to improved human health and decreased community violence
- Shepley, et. al. 2019 – Based on the 45 quantitative and qualitative papers summarized as part of this review, researchers felt there was ample evidence to support the idea that the presence of parks and other green space reduces urban crime
- Younan, et. al. 2016 - Overall the results of this study indicate a consistent pattern of decreased aggression associated with increasing residential greenspace

Mental health and well-being benefits

People of all ages living in greener environments tend to have more positive moods, higher self-esteem and greater resiliency.

- Kondo, et al. 2018 found a positive association between time in nature and more positive moods, suggesting that adding greenspace to a neighborhood can improve mental health of residents (review, primarily experimental studies; excluded were qualitative studies and case studies)
- Farmer, et al. 2017 found that adding more natural elements to the school playground and encouraging more risky play through engagement with nature led to more reports of "being happy" at school and of playing with more children)
- Tillman, et al. 2018 found that time in nature was associated with resilience in children (systematic review of quantitative studies)
- McCormick 2017 found access to green space was positively associated with different aspects of well-being (systematic review)
- Bang, et al. 2018 found significant improvement in self-esteem and significant decrease in depressive symptoms after participation in a forest therapy program
- Twohig-Bennett and Jones (2018) - Meta-analysis of the data showed that greenspace exposure was linked to statistically significant reductions in diastolic blood pressure, salivary cortisol (a physiological marker of stress), heart rate, and incidence of diabetes. Findings also indicated that exposure to greenspace reduces the risk of preterm birth, premature death, and high blood pressure. Kids who spend time in nature on a daily basis tend to be happier.
- Engagement with nature is associated with more positive moods – Kondo, et al. 2018 (review)
- Forest Therapy show significant decreases in depression – Bang, et al. 2018
- Engagement with nature led to more reports of "being happy" at school and of playing with more children – Farmer, et al. 2017
- Daily exposure to nature can have a positive impact on adolescents' mood – Li, et al, 2016

Time in nature promotes self-esteem and reduces risk for mental illness.

- Time in nature reduces children's risk factors for mental illness – Bratman, et al. 2015
- Interactions with nature may positively influence the mental health of children and teenagers and Time in nature can promote resilience – Tillman, et al. 2018

Time in nature reduces stress and anxiety.

- Nature can reduce stress levels – Lee, et al. 2018, Dettweiler, et al. 2017, Wells and Evans 2003
- Nearby nature helps children cope with adversity – Corraliza, et al 2012
- Nature can promote resilience – Tillman, et al. 2018, Holland, et al. 2018, Chawla, et al 2014
- Nearby nature is associated with decreased depressive symptoms – Bezold, et al. 2018 (correlational study involving 11,000 children)
- Engagement with nature can decrease anxiety – Tillman, et al. 2018

Nearby nature can help children cope with adversity.

- Corraliza, et al 2012 correlational study involving 172 children from 4 schools; data based on multiple assessment measures showed that nearby nature was linked to improved children's ability to cope with adversity.
- Youth who spend time in nature demonstrate more positive and fewer negative social behaviors.
- Time in nature promotes enhanced social skills and pro-social behaviors – Müller, et al. 2017
- Time in nature promotes empathy – Holland, et al. 2018 (review)
- Children demonstrate fewer behavior problems in natural settings – Tracey, et al. 2018, Holland, et al. 2018 (review)
- Less bullying occurs in natural vs. built environments – Farmer, et al. 2017
- Natural playscapes foster more sustained, constructive, and cooperative play – Kuh, et al. 2013
- Decreased risky behaviors, such as substance abuse, etc. – Tesler, et al. 2018

Educational achievement benefits

- Kids with nearby nature at school do better academically
- School garden activities increased students' knowledge of nutrition and science Wells, et al. 2015
- Green schoolyards were associated with attention restoration – Li and Sullivan 2016
- Student engagement with nature may be especially helpful for children from disadvantaged backgrounds and may help close the achievement gap – Jagannathan, et al. 2018, Ray et al. 2016
- Garden and green space improve educational outcomes – Williams and Dixon 2013
- Green space learning experiences promote self-regulated learning – Dettweiler, et al. 2017
- Green space learning promotes engagement with learning – Ohly, et al. 2016
- Increased greenness around schools was associated with decreased absenteeism – MacNaughton, et al, 2017
- Connecting children with nature can promote brain functioning
- Exposure to greenspace early in life results in beneficial structural changes in the brain – Dadvand, et al. 2018
- Children living in greener urban neighborhoods have better spatial working memory Flouri, et al. 2018
- Long-term exposure to green space is positively associated with cognitive functioning – de Keijzer, et al. 2016 (review)
- Engagement with nature is associated with improved executive function – Carr, et al. 2017, Torquati, et al. 2017
- Nature-based risky play promotes problem-solving, socialization, creativity, focus, and self-regulation and reductions in stress, boredom, and injury. – Brussoni, et al. 2017
- Children with ADHD who regularly play in green settings have milder symptoms than those who play in built outdoor and indoor settings, Faber Taylor and Kuo, 2011

THRIVING NATURAL WORLD: ENVIRONMENTAL CLEAN UP

DEEP DIVE 2 OF 2

INTRODUCTION

Natural Resources Defense Council (NRDC) combines the power of more than three million members and online activists with the expertise of some 700 scientists, lawyers, and policy advocates across the globe to ensure the rights of all people to the air, the water, and the wild.

Our purpose is to solve humanity's most pressing environmental challenges. NRDC advocacy is firmly grounded in meticulous research and sound scientific principles. Our experts, drawing on their knowledge and experience in disciplines ranging from molecular biology to nuclear physics, examine critical environmental challenges and identify the most effective solutions. NRDC helped pass our nation's bedrock environmental laws, and our seasoned attorneys have argued all the way to the Supreme Court to ensure those laws are enforced and polluters are held accountable. We take on the world's most powerful corporations and win, delivering justice and standing with those who fight for their right to clean air, clean water, and healthy communities.

Creating Springboards for lasting environmental change isn't enough. We have to persuade decision makers to adopt those innovative solutions, so NRDC's advocates work at every level, from mayors' offices to the halls of Congress to international negotiating tables. Our successful track record means those decision makers listen to our advice, and when they need an extra push, we mobilize strategic coalitions and the grassroots power of millions of citizen activists to urge elected officials to put the public interest ahead of polluting industries. We also have some of the smartest minds in the business world put their economic expertise to work on ways to spur global prosperity while improving our environment and communities. We pioneer strategies to make buildings more efficient, improve green infrastructure, and encourage manufacturers to clean up the fashion industry.

No organization, no matter how motivated, can change the world alone. To help shield communities from pollution and build political strength, NRDC joins forces with a diverse network of allies: leaders of low-income communities and Communities of Color concerned about air pollution, mayors seeking to institute innovative policies to address climate, religious groups calling for climate action, ranchers committed to living peacefully with wolves and grizzlies, and brewers whose success depends on clean water, and many more.

Our work is intended to benefit all demographic groups across the country. NRDC believes community sustainability is best achieved when all races, income levels, ages, and abilities are beneficiaries of each initiative. We have a particular interest in strategies that bring equity to People of Color and low-income families. Our work spans different scales from international to the community level.

THE ENVIRONMENT PRIOR TO COVID-19

Across the country, low income communities and Communities of Color have experienced disproportionate burdens from environmental hazards, unhealthy land uses, historical traumas, and other sociodemographic stressors. The wealth of evidence shows that Communities of Color are already highly vulnerable to and disproportionately live near sources of toxic air and water pollution, exposing them to a higher risk of serious health problems. That some of these very health conditions—asthma and cardiovascular disease, for example—have now been linked to worse COVID-19 outcomes underscores the cumulative nature of vulnerability that is experienced daily by low-income communities and Communities of Color.

Private industry has a legacy of locating facilities and exploiting business for profit at the expense of low-income and Communities of Color. The current Administration is dismantling the safeguards to project the most vulnerable communities. When it comes to protecting the victims of environmental injustice, the U.S. Environmental Protection Agency has been close to worthless. Flint, Michigan has the unfortunate role of being a poster child from the problem. Environmental justice, in practice, has brought

little in the way of environmental benefits or legal justice to communities that continue to suffer from the toxic and other health impacts of deliberate policies that have created a swath of destruction through poor and minority populations.

THE IMPACT OF COVID-19 ON THE ENVIRONMENT

As the global COVID-19 pandemic rages, the spread of the virus is exposing deep and persistent fault lines of vulnerability along race and economic status, and a stark absence of social safety nets in this country. Historically, the environmental movement has largely failed to prioritize in its work the creation of strong social safety nets. Now, more than ever, we must assume this responsibility if we hope to build a just, equitable and livable future for all.

Our most vulnerable communities face multiple and compounding threats in a crisis like this one. As the virus itself ravages Black, Indigenous, and Latinx communities, many of these people lack the luxury of working from home and have to continue placing themselves in harm's way carrying out low-wage, consumer-facing service jobs. Previously seen as unskilled and replaceable, service industry workers are now essential to maintaining the basic functioning of our society.

The multiple catastrophic disasters of recent years and the predicted increases in disaster damages due to climate change—as well as the sudden rise of COVID-19 itself—highlight the shortcomings of our current approaches. Clearly, we could be planning and preparing better, but existing gaps in hazard mitigation will be further strained by COVID-19 and vice versa, as responding to the health crisis necessarily diverts resources from other work.

Even absent a global health crisis, disasters exacerbate existing inequities in our society. Without urgent action, the dual threat of COVID-19 and climate-driven disasters will only further burden Communities of Color, low-income communities, and other marginalized and at-risk populations.

Safe running water for household cleaning and personal hygiene is a paramount necessity, especially during this public health crisis. Energy is needed to heat and cool homes, prepare meals and keep food and medicine secure. Yet, one in three households in the US face extreme hardships in paying energy bills and rural, low-income and Communities of Color, especially Indigenous communities, have the least access to clean water in the United States, exacerbating risks to COVID-19.

Clean water should be a right of all people, at all times. Congress should institute a national moratorium on shutoffs of water, electricity and gas for occupied residential buildings; require and provide resources for utilities to safely reconnect water and electricity; and increase funding to support affordable water and energy programs for low-income families. The legislation should ensure that families get plenty of time after the crisis to use long-term repayment plans, and utilities that receive federal grants or loan forgiveness should forgive their residential customers past arrangements.

AN ACTION AGENDA TO RECOVER FROM COVID-19

A just response and recovery to COVID-19 means understanding the interconnectedness of this global pandemic with issues of income inequality, access to health care, environmental degradation, and racism. It means supporting those who have historically been made socially and economically vulnerable, as well as rethinking the way we provide care and create opportunity in our society. And it means standing with and supporting communities and advocates who are demanding a response to this crisis that ensures social justice and centers on equity.

Provide tools and resources that communities can use to develop their own response

These tools should support communities and local stakeholders to analyze climate and future catastrophic events to support an equitable and just path to build resiliency.

Rapid Climate Vulnerability Assessment (RCVA)

The RCVA is a 3-step process that brings community members together around local goals and priorities. This can be for the update of a local planning effort, or responding to future natural disasters or events, or even projects such as developing a new grocery store or soccer field. Using readily available climate data and local knowledge, RCVA participants consider how those decisions might be affected by future climate change projections such as rising heat or sea level.

The assessment prompts them to consider both existing stresses relating to health, equity, or any other community priorities, and the effects of climate change. They can see where these variables intersect—an exercise that helps them see the ways people connect to nature and the environment, understanding that climate change directly affects their lives in ways both small and large. Once those initial links are made, community leaders can engage in a strategic session to address vulnerabilities and solve for what the community cares about. That leads to decisions about investment and revitalization that means the community can better withstand the effects of climate change.

Illustration: Elevated Chicago

An RCVA workshop in Chicago led by Elevated Chicago focused on promoting racial equity, prosperity, and resilience in Chicago communities by using equitable transit-oriented development as the catalyst for change. One focus of its work is centered on displacement, and it's RCVA prioritized ways to "ensure residents can remain and want to remain in their communities." The workshop focused on climate change interactions with health and community equity, which was defined as the sharing of community assets and other development resources and investment in neighborhoods in a fair and equitable way. The RCVA explored connections including, for example:

- Health: The Chicago region will face annual temperatures 5-9° F higher by the end of the 21st century and changing precipitation patterns resulting in both higher risks of flash floods and extended dry periods. These changes would be expected to increase heat-related illnesses and deaths, worsen air quality and aggravate respiratory illness and asthma, exacerbate crime, cause the release of contaminants from soils, and disrupt the food supply chain.
- Equity: Concentrated flood damage from heavy rainfall would hit low-income families especially hard. The Center for Neighborhood Technology's urban flood risk data show the lowest income ZIP codes are disproportionately impacted by urban flooding. In areas of Chicago, such as those near the California Pink Line, residents have the highest percentage of impervious surface area, leading to greater flood risk and air quality concerns.
- Climate: The impacts of ground-level ozone and other air pollutants, for example, are exacerbated by high temperatures, which increases the frequency of red-air days (restricting the use of outdoor space, and limiting outdoor activity), damages trees and vegetation, threatens crops, and keeps tourists away, affecting jobs and businesses.

The RCVA in Chicago revealed the need to explore potential air quality hotspots, including generating improved and more localized data, especially those related to poor air quality in residential neighborhoods with already significant rates for asthma, especially childhood asthma. When you add the simultaneous challenge of heat vulnerability from climate change, this makes for an even bigger health concern. Proposed solutions included advocating for requiring clean freight transportation best practices, planting hedges around perimeters of new developments to improve air quality, requiring clean air stipulations for new developments, advocating for community benefits, and encouraging people to check the air quality before going outside for extended periods of time.

Environmental Justice and Cumulative Impact Tools

Provide mapping tools such as EJSCREEN and the Environmental Justice Screening Method to analyze the high cumulative vulnerabilities to environmental pollution borne by environmental justice communities. Utilize data and methodologies in partnership with community groups and state agencies to map industrial corridors, polluting hot spots, and other sources of contaminations that harm already vulnerable communities. Communities can use the analysis to advocate for land use and public health reforms to address these zones filled with diesel trucks, dusty materials, noxious odors, and other environmental hazards located immediately adjacent to parks and dense residential neighborhoods.

Cumulative impacts analysis seeks to look at both environmental and sociodemographic factors because research has shown that the same environmental exposure is more likely to harm health or result in greater harm when it occurs in populations with certain sociodemographic indicators of vulnerability. For instance, young children experience greater personal exposure than adults despite the same level of ambient pollution, as they take in more air relative to their body volume. Seniors are more likely to have pre-existing heart, lung, and other health conditions, making their systems particularly vulnerable to pollution. Low-income communities and Communities of Color also may be more likely to have

been burdened by other environmental exposures in the past and to experience higher rates of psychosocial stress than other communities. Looking at environmental and socio-demographic factors together provides a more complete picture than assessing environmental information alone.

Illustration: Chicago mapping analysis

A mapping analysis with Chicago community organizations reinforced what advocates and residents have been calling out for years: the high cumulative vulnerabilities to environmental pollution borne by environmental justice communities in Chicago. The analysis mapped against Chicago's industrial corridors, calling attention to the cumulative vulnerabilities in Little Village, Pilsen, McKinley/Brighton Park and other nearby Southwest Chicago communities, as well as on the Southeast Side near the Calumet River and Lake Calumet. Communities adjacent to rail yards also show up as highly vulnerable. Unsurprisingly, these communities are largely low-income and Communities of Color, which research shows compounds their vulnerability to environmental threats.

The cumulative impacts map of Chicago took a combined look at environmental conditions along with sociodemographic characteristics that are associated with increased vulnerability to such environmental pollution, comparing the resulting cumulative burden across census block groups. It is a screening tool that brings out disparities and highlights areas in the City that should be targeted for increased environmental monitoring, enhanced enforcement, and land use and public health reform.

Ensure Equitable Access to Parks and Open Space

Through COVID-19, we've seen the need for access to adequate public and open space that allows for people to access fresh air, sunlight, and exercise while maintaining proper distancing. Lower-income and Communities of Color are least likely to have access to park and open space areas. A focus on equitable development of parks and urban open spaces is a focus on people's right to live in and have access to safer and less polluted environments, ensure that environmental projects provide the intended benefits for Communities of Color, and help provide natural and safe respites for families and cultural activities. Such an approach takes into account the daily struggles of low-income and People of Color, some of whom experience open space not as a freeing and restorative experience, but as potentially threatening and unsafe.

The positive aspects of parks and open space can only be created if their development is just, equitable, and inclusive in both process and outcome—so that people can stay in place if they so choose. Use the Principles of Park Equity when planning for new space and addressing deficits in existing parks and open spaces, particularly in low-income and Communities of Color.

Illustration: The 11th Street Bridge Park

The 11th Street Bridge Park in Washington, D.C. took an approach to focus work on workforce development, housing, small business and wealth building, and social equity while planning for future park space. Since the vision began, 71 full time jobs have been created in historically lower income Wards 7 and 8, more than 2,500 residents have become engaged in tenants' rights initiatives, cultural works such as the Black Love Experience featuring music and art have been supported, and more than 7,500 pounds of fresh produce have been harvested through community-driven strategies. One lesson that the 11th Street Bridge Park has for others is to start the work of equitable development early, countering the practice to build the infrastructure and then deal with the consequences.

This model illustrates that green spaces can be a positive anchor for community and equitable community development, while ensuring that their wide range of social, economic, environmental, health, and cultural benefits can be captured by all members of a community. Benefits that range from free spaces for arts, to healthier air, and to improved psychological well-being. By centering green space development on racial equity and spatial justice, it also ensures that these spaces don't drive up the cost of living so much that residents are displaced from their homes and unable to benefit from the improvements.

Ensure universal access to clean water and energy throughout the crisis and beyond.

Institute a national moratorium on shutoffs of water, electricity, and gas for residential buildings and provide $100 million to water utilities to compensate for reconnecting all residential water services nationwide.

Extend the moratorium on shutoffs to at least 120 days after the crisis to enable people to regain financial footing and prohibit draconian collection practices such as liens. Require lenient payback periods. Such provisions were included in section 103 of the House COVID-19 legislation.

Require safe reconnections for water and provision of safe municipal watering stations where immediate safe reconnection is not possible. Safe reconnections are critical because water that has remained stagnant after a shutoff loses chlorine disinfectant and can allow high levels of bacteria and pathogens to grow in pipes and can also have a buildup of lead and structural problems may occur due to corrosion. Crews and plumbers may not be immediately available so mobile safe municipal water stations, such as water buffalos, should be temporarily installed.

Transforming Communities

Invest in equitable community infrastructure so that we can rebuild stronger than before the crisis

Lawmakers must look towards reinforcing the long-term strength of communities. At a minimum, significantly more federal resources are needed to ensure all communities have access to basic infrastructure that is safe, climate-ready and healthy. Basic infrastructure includes healthy housing, water, food, energy, mobility, transit, parks, health care, hazard mitigation, quality child care, and more. Frontline infrastructure such as community health centers are especially in need of support during this time. It is imperative to require an inclusive recovery implementation process that engages residents and nonprofits from vulnerable communities in the design, construction, operations, and maintenance of these infrastructure systems.

Increase funding for the Drinking Water State Revolving Fund (DWSRF) by at least $10 billion a year and the Clean Water State Revolving Fund (CWSRF) by at least $10 billion a year for at least the next five years and permanently extend Buy America provisions for both programs. As part of this legislation:

Establish a federal interagency partnership between key departments and agencies

Focus on partnerships between the EPA, DOE, HUD, DOI, DHS, DOT, SBA, etc. with the goal of ensuring that the agencies' policies, programs, and funding consider and support the interconnectedness of climate, health, and equity.

Modeled after the Partnership for Sustainable communities, a new administration should establish cross-agencies programs, funding, and policies that support healthy and affordable housing, equitable transportation, green buildings, clean energy, safe and affordable drinking water, access to open space and environmental protection, all together. Founded on the idea that how and where we invest in our communities affects our economy, our environment, and our everyday lives, this new cross-programmatic partnership would align investments and policies to support communities that want to give Americans more housing choices, make transportation systems more efficient and reliable, and support vibrant neighborhoods that attract businesses, run with clean energy, and have healthy, green infrastructure. Coordinating federal investments in infrastructure, facilities, and services meets multiple economic, environmental, and community objectives with each dollar spent.

SOURCES AND DOCUMENTS

- Rapid Climate Vulnerability Assessment
- EPA EJ Screen
- Environmental Justice Screening Method
- Principles of Park Equity
- Partnership for Sustainable Communities

DEEP DIVE

BASIC NEEDS: FREEDOM FROM TRAUMA, VIOLENCE, AND ADDICTION

JUNE 2020

BASIC NEEDS: FREEDOM FROM TRAUMA, VIOLENCE, AND ADDICTION

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BASIC NEEDS: FREEDOM FROM TRAUMA, VIOLENCE, AND ADDICTION

Well Being Trust is a national foundation dedicated to advancing the mental, social, and spiritual health of the nation. Launched by the Providence health system in 2016 as an independent 501(c)(3) public charity, Well Being Trust was created to advance clinical, community, and cultural change, and invests in approaches that have the potential to model the way forward. Well Being Trust (WBT) strives to transform the health of the nation and improve well-being for everyone.

With the recognition that success in transforming health and well-being is a huge effort that will require the wisdom of people, organizations, and communities, WBT partners with the purpose of supporting and encouraging a powerful movement that benefits everyone.

With an initial seed endowment along with funding for California-specific programs, WBT has Invested over $50 million to increase access to mental health care; improve quality of services, research, measurement, and surveillance; work upstream to improve vital community conditions; advance policy; and impact social factors influencing health outcomes.

In addition, Well Being Trust continues its investment in its national portfolio—one that has helped stand up major work in the area of mental health and well-being. WBT collaborates with a diverse group of stakeholders to promote data, information, and policy solutions to improve mental health and well-being.

To inform efforts and ensure alignment, WBT convenes leaders, advocacy organizations, community-based programs, provider groups, and academia and researchers focused on mental health, well-being, and substance abuse across the country to establish and advance common goals.

PRIOR TO COVID-19, THE MENTAL HEALTH SYSTEM WAS FRAGMENTED, OVERBURDENED, UNDERFUNDED

A history of stigma, both social and structural, related to mental health issues has contributed to an unwillingness amongst many in need to recognize or seek the care that they need, as well as led to a lack of resources devoted for this purpose. Simply put, mental health care has been too hard to get access to, too expensive to afford, and uncoordinated, making it all the more frustrating for families everywhere.

Health care fragmentation as well as the disconnect between clinical systems and the community has perpetuated difficulties in obtaining appropriate care. Access to care is a significant barrier, as evidenced by the following:

- 33 percent of those seeking care wait more than a week to access a mental health clinician
- 50 percent drive more than one-hour round trip to mental health treatment locations
- 50 percent of counties in the US have no psychiatrist
- Only 10 percent with an identified substance use disorder (SUD) received care
- A mental health office visit with a therapist is five times as likely to be out-of-network when compared to a non-mental health office visit.[1]

These barriers are often more significant in Communities of Color, particularly the Black community, and often result in more severe mental health concerns due to unmet needs. High rates of serious psychological distress reported among African Americans and increasing suicide rates[2] are among the growing disparities that are systemic and can be attributed to centuries of racism,[3] and will require significant devoted effort to begin to appropriately address.

Limited health care funding in an environment where

1 Healing the Nation
2 https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=24
3 https://www.washingtonpost.com/outlook/2019/07/29/how-bigotry-created-black-mental-health-crisis/

there are always competing priorities has been a significant factor in shaping mental health and addiction services. There's a historical precedent for mental health being on the sideline and marginalized—most of this is because it was created as a separate system and subsequent policies, payment methodologies, and programs have reinforced this. Mental health is often its own budgetary line item on a funding chart, which has created a culture where mental health services often have to justify their own expense and offset these costs.

Current investment and health care spending structure has forced a prioritization of more expensive emergent care and crisis response, as opposed to investing in prevention (upstream investment that will result in future savings by averting more expensive tertiary care). To address mental health beyond just another program to manage the crisis response, there must be a more consistent way to identify and treat individuals earlier in the process.

Available resources often dictate limitations and shifting funds within the same pool, as opposed to comprehensive investments to address both existing needs and prevention. Without prioritizing prevention, we are caught in a cycle of continuing to spend more on care with worse results.

While monumental for mental health policy, the Mental Health Parity and Addiction Equity Act (MHPAEA), which passed in 2008, is still not well understood or enforced, leaving families in a position where they are stuck with large insurance bills. Many of these problems are due to lack of transparency by health insurers and the government, both federal and state, and holding them accountable for fulfilling the law.

Stigma related to mental illness and addiction has resulted in a lack of emphasis on the critical importance of strategies and funding to address mental health needs. The stigma present at every level—individual, community, and societal—has artificially separated mental health from physical health. Since the manifestation of physical health indicators have traditionally been more tangible than those related to mental health, the limited funding available through our health care system has been prioritized for the more visible physical health concerns.

Not recognizing how mental health and physical health are inextricably intertwined has done a disservice to our collective health and well-being on both an individual and population level. In addition to impact on health outcomes and increases in health care spending, the lack of recognition of the importance of mental health has stymied policy and research efforts that could mitigate many of the significant health and social problems we face.

Mental illness is the largest contributor to disability, with effects that include deteriorating physical health and premature mortality; escalating interpersonal violence; interfering with sustained employment, parenting, social life; and unraveling the social cohesion of our neighborhoods, to name a few. COVID-19 has underscored the fragility of the system we have come to rely upon, and now more than ever it is incumbent upon us to assume the formidable task of bolstering foundations for emotional health and resilience across our communities.

THE ADDITIONAL IMPACT OF COVID-19

COVID-19 has had a profound impact on the functioning of society and individuals. The shift in the way we operate has been sudden and seismic, leaving no one unimpacted, and not all communities have been impacted in the same way. Longstanding structural inequalities show profound health disparities across this country.

Though the physical impacts of COVID-19 have been wide ranging for individuals, we all have experienced significant change, reaching into every facet of daily life. Disruption in work, school, transportation, and food supply, paired with concerns related to meeting basic needs and fear of contracting a novel virus whose impact on a given individual and society as a whole is largely unpredictable, and all impact mental health.

With unemployment at its highest rate since the Great Depression, millions contending with housing insecurity, and close to 50 million children separated from school and their usual social networks, the potential mental health effects will endure for some time. We are at risk of having multi-generational trauma, and in some cases, death due to despair. Even prior to COVID-19, underserved communities experienced greater barriers in accessing necessary mental health care,[4,5] and evidence indicates this is even more of a significant concern following traumatic

4 Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. The National Academies Press; Washington, DC: 2002.

5 US Department of Health and Human Services, Office of the Surgeon General. Mental Health: Culture, Race and Ethnicity. A Supplement to

events.[6,7]

Factors that impact mental health concerns, such as unemployment, isolation, and uncertainty, have been exacerbated by COVID-19 and further exposed vulnerabilities that exist within both our health care system and social structure.

Exposed vulnerabilities

Lack of coverage

The high rate of insured or underinsured prior to COVID-19 means that many in need had no previous connection to care, and may have already been experiencing existing undiagnosed and unaddressed mental illness. With increasing rates of unemployment, the number of those who are uninsured is rising. People will continue to go without necessary care, and those who have lost coverage will no longer have affordable access to the treatment they need. The new concerns created by COVID-19 create a compound impact when added on top of the existing access and coverage barriers.

Widening of the racial disparity gap

Health outcomes prior to COVID-19 across many indicators have historically been worse for People of Color, particularly for the Black population. The impact of COVID-19 has exposed the cumulative impact of these inequities, as outcomes related to the virus have also been far worse. Lack of access to preventive services and adequate health care, social and environmental factors, and unaddressed underlying conditions have resulted in greater severity of illness and mortality that has disproportionately impacted People of Color. The new challenges that COVID-19 presents for mental health and well-being will also be borne disproportionately by this population without dedicated investment and effort in meeting both the longstanding and emerging needs.

Workforce shortages

Inadequate numbers of mental health professionals to meet needs existed prior to COVID-19, and there is no surge capacity to meet growing demand. Recent survey data indicates that the pandemic has impacted services through community-based mental health centers, with many being forced to reduce operations and furlough staff because of financial concerns. Despite the influx of need created by COVID-19 for treatment of underlying serious mental illness and addiction, lost revenue and unanticipated costs to deliver care under the current circumstances may result in clinic closures.[8] Without viable community treatment options available, those in need will go without care or be forced into more expensive emergency services.

The mental health impact of COVID-19 has the potential to reverberate through the US long after the virus itself is contained. A recent analysis[9] released by Well Being Trust and the Robert Graham Center estimates that COVID-19 will likely result in 27,644 to 154,037 additional deaths of despair—deaths due to drug, alcohol, and suicide. Deaths of despair have been on the rise for the last decade, and as a result of factors impacted by COVID-19, deaths of despair will likely be an epidemic within the pandemic. Preventing these deaths will require taking meaningful and comprehensive action as a nation.

What are the significant immediate impacts?

- Psychological distress and increased anxiety related to the physical and economic impact of the virus as well as from isolation has had a disproportionate impact on People of Color. In the U.S., people of color face barriers to quality and affordable health care. Black Americans are more likely to be uninsured or underinsured,[10] and have no source of care they need for prevention and treatment of illness. Additionally, lack of culturally and linguistically appropriate care creates barriers for Latinx and other immigrant communities. According to a recent study, Black communities

Mental Health: A Report of the Surgeon General. USDHHS; Rockville, Md: 2001.
6 Kessler RC, Galea S, Jones RT, Parker HA. Mental illness and suicidality after Hurricane Katrina. World Health Organ. 2006; 84:930–939.
7 Wang PS, Gruber MJ, Powers RE, et al. Mental health service use among hurricane Katrina survivors in the eight months after the disaster. Psychiat Serv. 2007; 58:1403.
8 https://www.thenationalcouncil.org/press-releases/behavioral-health-crisis-in-america-getting-worse-as-covid-19-forces-community-behavioral-health-care-organizations-to-cut-back/
9 Petterson, Steve et al. "Projected Deaths of Despair During the Coronavirus Recession," Well Being Trust. May 8, 2020. WellBeingTrust.org
10 https://www.commonwealthfund.org/blog/2016/closing-equity-gap-health-care-black-americans

account for nearly 60 percent of all COVID-19 deaths in the country.[11] Unemployment has also disproportionately impacted Communities of Color, as rates have skyrocketed as a result of COVID-19, reaching historic highs, with 16.7 percent of African Americans and 18.9 percent of Latinos out of work.

- Lack of access to necessary care is pushing people into crisis, which leads to more expensive care situations or can result in death.
- High levels of stress can lead to more domestic abuse and violence. Our sense of loss and grief as well as increased stressors for and about essential workers all have a cost to our collective mental health.

What are the significant long-term impacts?

- A rise in deaths of despair related to drug and alcohol abuse and suicide.
- Unaddressed trauma and adverse childhood experiences (ACEs). These can lead to life-long impact, poor health outcomes, and a need for more intensive and expensive care.
- Long-term economic impacts may lead to future cuts and jeopardize funding for critical services, particularly for underserved populations.
- Limited access to care and services may contribute to an increase in the current disparity gaps.

PIVOTAL MOVES FOR ACTION

There is critical need for policies and actions that maintain infection control while addressing mental health and addiction needs, to respond to those in crisis and provide support to prevent a future surge of substantial need.

The next years must have two specific policies pursued at once: a structure to accommodate new models of care that bring mental health forward into primary community settings; and a workforce that can deliver that care in a culturally competent and evidence-based way.

As outlined below, there are specific approaches and policies that can facilitate better addressing a community's mental health needs. We've outlined three categories for change: immediate investment to continue to facilitate access, an integrated approach to assure connection, and building resilience throughout our communities.

Immediate need: address funding shortfalls for services

We must begin to first address the problem of front-line mental health clinicians not having the revenue to keep their doors open. In one national survey, and one state survey (Ohio), it is clear that COVID-19 has impacted our mental health clinicians' ability to maintain their service array at the level they did before COVID-19. In the national survey, nearly all (92.6 percent) of those surveyed report that they have had to reduce their operations and 62.1 percent of mental health and addiction providers project they can only survive for three months or less based on current in pocket resources.

While we build the next system to address our workforce challenges, to retain our current workforce and prevent further provider shortage and access issues, Congress should appropriate at least $38.5 billion in emergency funding to organizations that primarily treat individuals with mental health and substance use disorders and use evidence-based practices, with a significant portion of these emergency funds set aside for organizations enrolled in Medicaid. As previously mentioned, many of these organizations are at risk of closing their doors at a time when the need for their services is expected to increase.

Foundational need: make access to care easier

COVID-19 has highlighted vulnerabilities within our current delivery system, underscoring that care in the clinical or hospital setting is not always feasible or the most effective approach. Policies that support creative opportunities for care delivered at home—virtually or in-person—will provide comfort and safety. The artificial walls we have created around who can be seen where, by whom, and for what, have not been proven to work effectively for mental health. The work of mental health needs a presence beyond the four walls of specialist offices, that operationally mirrors its impact and reliance on all of the vital conditions.

Our plan for recovery and resilience pivots at the corner of traditional delivery in an attempt to better democratize knowledge that can be used more broadly by all throughout the community and creates economic

11 https://ehe.amfar.org/inequity?_ga=2.51214761.1618924293.1588715818-1730120696.1588715818

opportunity alongside conditions that foster service. The ability to enhance access for mental health services is predicated, in part, on three mechanisms for strengthening our workforce and in turn strengthening our communities.

Stabilize existing services and our mental health and addiction workforce

To prevent services from shutting down, we must ensure there is funding available to pay existing providers and invest in our infrastructure to meet the growing needs our communities will have. Financial support is necessary for mental-health and addiction clinicians to provide meaningful, timely, and convenient care. Supplemental emergency funding is critical and must include a significant allocation earmarked specifically for mental health and substance use disorder care. Any enhanced funding to Medicaid programs or hospitals should explicitly include an allocation for mental-health resources, including prioritization for programs that integrate mental-health resources in emergency rooms and other hospital wards.

Ensure the current workforce is able to provide care

We must also ensure that the current workforce is distributed such that they are able to meet the need in places people present. This includes integrating mental health staff into primary care, outreach into community settings and schools, and given the current number of people who are primarily in the home environment to reduce possible exposure to COVID-19, ensuring online and digital care is available. This includes the continued and expanded use of telemedicine.[12] These services, while not new, have made it easier for people throughout our communities to get timely access to mental health services. Easing privacy restrictions has made it easier for people everywhere to use their phones, computers, and other devices to connect with their provider. These services should be continued beyond the expiration of the emergency order for at least the period of a year, during which Congress can study the impact of these changes to decide if they should be retained and codified into law. Similarly, policies and funding that support employers in providing mental health services through the implementation of Employee Assistance Programs would maximize existing channels to reach people where they are.

However, we must recognize that our traditional mental health workforce does not have the capacity, on their own, to meet the demand for services. As these needs are rooted in, and deeply impact, their communities, now is the time to turn to proven methods to shift this work into the community. Mental health and wellbeing cannot be adequately realized without a fundamental shift in the way care is delivered. "Task-sharing", which involves taking both clinical and cultural knowledge and methods that heal and prevent and packaging them for optimal use in the hands of more people and places, is necessary to meet the growing need.

Build out of the community workforce

We propose restructuring and strengthening our current mental health ecosystem, as well as the communities they are in, through the development and scaling of solutions that leverage community resources to best meet local needs. To meet the multiple needs for renewal within communities, this workforce expansion is best accomplished through the creation of the Community Health Service Corps.

The goal of the Community Health Service Corps is multi-pronged, and modeled after the National Service Corps model, which at its core aimed to get more primary care clinicians into communities where there was little to no access. Both models foundationally provide incentives as well as training for a new generation of the workforce to operate within settings that needed the services the most.

There are two main functions of the Community Health Service corps:

- Training: Working within communities, the goal here would be to provide training on basic mental health and addiction issues—think mental health first aid but less dependent on a lengthy course. There is a curriculum and the corps member is able to lead community wide training sessions on the topic. In addition, there may be sites where the corps member spends time working in more detail developing more tailored plans for the community's needs (e.g. workplace sites, houses of worship, barbershops, hair salons). The end goal is that a community is better prepared to know how to talk to each other about issues that are often not discussed due to stigma and cultural norms.
- Education: The educational arm is much more about taking information and tailoring it to the

12 https://wellbeingtrust.org/news/telepsychiatry-bridges-gaps-in-access-to-mental-health-care-how-providence-st-joseph-health-and-well-being-trust-are-bringing-care-to-communities/

unique needs of that Community. For example, creating flyers or brochures on the importance of addressing mental health and addiction. This arm of the corps would be about directly engaging local leaders with educational materials in ways that address the mental health and addiction crisis head on and allow for an enhanced understanding of the issues each community will face.

This approach can work to ease immediate and long-term capacity barriers in overwhelmed clinics, hospitals, and healthcare institutions for mental illness treatment and support. A large body of research on what has been described as "task-sharing" demonstrates how many of the tasks of treating mental illness, such as screening and tracking improvement, providing aspects of supportive counseling, coaching skills in self-care, and promoting mental health through increasing emotional resilience, enhancing attachment, and mitigating toxic stress can be done, often with greater acceptance, by trusted non-mental health professionals that meet people literally where they are. Leveraging community resources such clergy, teachers, community health workers, peers, and parents markedly expands the breadth, depth, and reach of the "system."

The Community Health Service Corps will need to establish a nationwide infrastructure

They will need to train, coach, and help coordinate a diverse set of community members who can take on these roles in the context of community led planning and aims. Doing that at scale will rest on mechanisms for broadly aligned and evidenced, responsive localized ways to:

- Establish and facilitate the work of community coalitions to lead and identify aims and priorities for the adoption and spread of task-shared skills by local resident Corps members.
- Make available training in task-shared skills for community members/organizations.
- Enable health/behavioral health systems and providers to coach, partner, and support such community-led work.[13]

There are models for this, including the cooperative extension program and the unfunded primary care extension program.[14]

To realize success in addressing mental health needs, and particularly the trauma, violence, and addiction issues occurring in the wake of COVID-19, we must achieve systemic change that moves toward comprehensive, multi-sector, community-based capacity, and capability solidly anchored in promoting mental health and emotional resilience across the population. Planning processes and distribution of funding for this effort must be designed to:

- Close disparities and advance equity.
- Work through participatory and co-created processes that incorporate local knowledge and culture.
- Bolster and strengthen trusted anchor institutions and existing social and community networks.

Fidelity to these objectives will require engaging residents from neighborhoods facing such disparities, or from trusted institutions or grassroots networks with a history of operating within and supporting a community. As only 6.2 percent of psychologists, 5.6 percent of advanced-practice psychiatric nurses, 12.6 percent of social workers, and 21.3 percent of psychiatrists are members of minority groups,[15] Corps members who reflect the demographic of the community they are serving is key to addressing gaps in linguistic and culturally-competent care. In addition, Corps members who have lived experience with mental health or addiction will also need to be included.

Work through the Corps should impart substantive experience and skill as an entry to further employment paths in health, social services, or community development. In this way the Corps can amplify and further secure the role of these institutions and networks as resources for social cohesion and emotional well-being in their communities moving forward.

There are existing models which promote the benefits of situating mental, social, and spiritual support services within the community setting.

Community Health Workers/Promotoras as members of the communities they serve

CHWs/Promotoras have a unique vantage point, enabling them to better recognize and understand community needs and reach those in need. Because they often live in the community, share culture and language, they are often

13
14 https://www.annfammed.org/content/11/2/173.full
15 https://www.blackmentalhealth.com/

trusted and able to deliver culturally-competent care. Evidence is mounting that these positions can positively impact the health of a community.[16]

Peer support services, especially for youth

A growing body of evidence demonstrates the great benefits of peer support. There is an important element to both arms of this corps where the "peer to peer" aspects of the work will be most impactful. For example, recent high school graduates working with current high school students about the importance of mental health has a very different look and feel than more traditional routes for help. This does not mean to minimize the role of professional clinical services, when needed, but more outlines the unique ways we can leverage the "peer" role around sensitive topics. This is particularly beneficial to youth, who will have unique needs in the wake of COVID-19. In addition to the impact shutting down schools may have had on milestone events typically shared with friends and peer (graduation, prom, etc.) and the impact of social distancing on relationships, there is still much uncertainty on how things will look going back to school in the fall—and navigating all these feelings and new ways of life will be difficult. "Post-vention" for youth that include recognition of these differences and struggles will be necessary, and peer support models will be important for meeting this specific need.

Though these models have not been expanded to the degree necessary to realize widespread benefits of community driven mental health support, they would serve as a critical component within the Community Health Service Corps. There are a variety of programs that speak to the efficacy of this approach, and can be used to inform best-practices, development, and widespread dissemination of a Community Health Services Corps.

Creation of a Community Health Service Corps to address mental health and substance abuse needs should be seen as complementary to, and an extension of, existing clinical and specialty care. In many cases community workers may be sufficient in meeting needs for support, and in others can serve as a bridge to other resources or more intensive services. The key to success is ensuring that communities have adequate points of entry along the spectrum of services, that the network is coordinated and integrated to ensure there is "no wrong door" – and needs can be addressed by the appropriate provider in the ideal setting.

Foundational need: build resilience

Central to many of the problems in our communities will be the need to find work. Unemployment is an undeniable risk factor for suicide and drug misuse as well as decrease in overall health status. To this end, policy solutions must focus on providing meaningful work to those who are unemployed. Service can be a powerful antidote to isolation and despair, and COVID-19 offers new and unique opportunities to employ a new workforce.

Employment opportunities focused on providing mental health support serve a dual purpose by supporting those feeling isolated while providing meaningful work and financial security to those who may have otherwise been out of work. Increasing capacity to address needs by employing community-based mental health service providers has the potential to create jobs and new career pathways, promoting economic development within the community as well as for the individuals being employed.

Foundational need: get people connected

A key aspect of developing a Community Health Service Corps is to solve multiple problems at once—enhance our communities' ability to help one another with issues of mental health while also giving communities an opportunity for service, a proven technique to address issues of isolation. In addition to increasing access to necessary care, creating jobs and building capacity and economic strength at the local level, the Community Health Service Corps connects people within a community, providing outreach and information necessary to navigate local resources and programs to mitigate fear and uncertainty.

Policies and funding to support small non-profit organizations, faith communities, and community solutions to get people connected to their neighbors have proven successful,[17] and should be amplified to produce a more profound impact across the nation.

Big ideas for transformation in the next 10 years

As we have outlined in this document, there are two

16 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4816154/

17 Felzien, Maret, Jack M. Westfall, and Linda Zittleman. 2018. "Building a Mental, Emotional, and Behavioral Health 'Community of Solution' in Rural Colorado." Community Development Investment Review, no. 1: 81–90.

big ideas that permeate our approach to addressing issues of mental health and addiction. The first is our democratization of mental health knowledge and skills into the community. The second is that we bring much needed services into the community, integrating them in key places people present with need.

For us to be truly practicing prevention, comprehensive treatment, and establishing a firm foundation for resilience, we must be creative in our response. Addressing mental health and preparing each of our communities for a response requires a new structure for care and a new vision for how we can deliver mental health everywhere.

Our approach to the Community Health Service Corps solves three critical problems at once. First, it encourages social interaction through a range of community interaction, including addressing mental health; second, it spurs economic development as these positions offer jobs that provide livable wages for corps members; and, third, it provides an opportunity for service, which can have a positive impact on the corps members mental health as well as those they are serving.

Barriers to mental health and substance use care did not begin with the global pandemic. Though addressing immediate needs exacerbated by the impact of COVID-19 is critical, a long-term strategy must be implemented to transform mental health and well-being. The following framework (Graphic 1) can be used to guide the work necessary.

Mental health services must be available in all the places people have need. Investment must be made in community supports and an integrated network of services, providing a continuum of care that reaches into settings as varied as primary care, our schools, our prisons, our workplaces, and our homes to improve outcomes and ultimately reduce spending—not just in health care dollars, but across all of these sectors.

Vital Community Conditions

In addition to expanding the workforce available to address mental health and well-being through the use of community extenders like CHWs and peer support specialists, upstream factors that impact mental health, such as intergenerational poverty, racism, and discrimination, must be addressed to truly build resilience across communities. Funding, programs, and policies

must be intentionally designed to counteract inequities that have emerged and address issues that have plagued society. Basic needs like food security, meaningful employment opportunities that provide a living wage, safe and affordable housing, reliable transportation, and education are at the core of mental health and well-being and are drivers for the disparities that we see in outcomes based on race, socio-economic status, and geography. As many have noted before us, a nation's greatness can be measured by the treatment of its most vulnerable members, and taking steps to improve vital conditions for those most impacted by historic inequities is crucial to advancing as a nation.

Investment in prevention is key to achieving improved outcomes related to morbidity and mortality, academic and employment productivity, and savings across sectors by reducing the need for more expensive health care services and costs associated with the criminal justice system.

Coverage for care

Ensuring affordable access to timely and comprehensive care is critical not just to improving health outcomes, but in the case of mental health and addiction care, necessary to saving lives. Creating the conditions and financing structure in which every American has a connection to care that meets their specific needs is foundational to our collective health as a nation. Simply put, coverage cannot be a barrier for anyone getting access to services.

Integration

In addition to expanding workforce capacity to meet the need, more work is needed to integrate care across existing, and any new, points of service within the delivery system. Policies and a payment structure that support and incentivize integrated care is necessary to

ensure optimization of system resources, and provision of comprehensive care.

Advancing efforts to operationalize a National Health Service Corps has the potential to impact each of the areas within this framework, ultimately improving outcomes. Though this calls for creative thinking and mobilizing at the community level, it holds the potential to truly transform our current system of "sick" care into a model that values health and well-being.

KEY CONSIDERATIONS

The potential for additional deaths caused by diseases of despair in the wake of COVID-19 surpasses the number of lives already lost in the US from the virus. Deaths of despair are preventable, but changing this trajectory will require a swift and well-coordinated national response.

Addressing the root causes of morbidity and mortality will not be possible unless data is available to identify the factors driving the disparities in health outcomes. In addition to the presence of underlying conditions, data collection and analysis must include racial and socio-economic demographics to inform where efforts to promote resilience are most effectively focused.

As we look forward as a nation to the development and achievement of Healthy People 2030 goals, it is important to note that not only did we not achieve targets related to mental health and well-being set forth in Healthy People 2020, outcomes actually deteriorated in many of these measures. Meeting future objectives will require a coordinated strategy, and investment of adequate resources to fully operationalize a plan for mental health improvement.

Resources and guidance from the federal level are necessary to assist states and local communities in recovery efforts. There must be some level of flexibility with funds distributed to allow those delivering care at the local level guide decision making to ensure resources are used to meet existing community needs.

Positioning for pivotal moves

Upfront investment in prevention within communities improves individual health outcomes, averts spending on serious conditions, and saves health care dollars. Consequences to a lack of prevention spans more than just personal health outcomes. There is an impact on families, communities, workplaces, the criminal justice system, as well as strain put on the health care system in terms of availability of services and cost. In addition, good health contributes to a more productive and economically stable society—conditions to which we all aspire.

By ensuring appropriate mental health services and supports are in place, and leveraging our community resources to deliver necessary care, we have the opportunity to reduce suffering while mitigating long-term social and economic impacts.

While we work to reimagine a structure for care that better brings mental health into our communities, it is important to assure that the reimagined structure extends beyond traditional clinical settings into other community-based services like public safety. For example, unbundling certain services from public safety may allow first responders, such as police officers, to be saved for criminal encounters. Why should we ask police to serve as social workers when we can have an entirely complementary workforce who can co-produce better community health? This visioning requires a foundation of a community health service corps to be deployed to address the larger, often time consuming, social and emotional issues typically faced by police.

Creating a new structure for how we approach mental health in our communities begins with a recognition that the responsibility of mental health is not just in the hands of the clinical delivery system. As has been documented in this Springboard, factors that far extend past the reach of a clinic hold power over our mental health. This means that we should consider which structures are supportive of a more community and integrated approach to mental health and those that stand as an impediment or further fragment health.

We posit that by creating a robust Community Health Service Corps, it will provide the foundation for a structural redesign. Without this base, however, structural reform will be more difficult because many of the pieces needed to offset the downstream services will not be in place. Better integrating mental health into places outside the clinic, places like schools and prisons, will require a workforce that may not exist. The Community Health Service Corps allows for many of these more clinical tasks to be shifted to the corps. Through robust training, standards, and accountability, the corps becomes a new

foundation for mental health reform.

This Springboard provides the opportunity to improve the infrastructure that supports mental health and well-being, advance policy, and create guidance, resources, and tools for communities through strategic investment and coordinated leadership. Through a Community Health Service Corps, we can impact each area of renewal—enhancing civic life through commitment and investment in community solutions; strengthening the economy by providing meaningful jobs that in turn provide mental health support that will result in improved educational attainment, greater productivity, and cost savings in health care and criminal justice; and in social/emotional well-being by creating accessible and culturally competent support services within the community that create connection and a sense of belonging.

ADDITIONAL RESOURCES

Healing the Nation

Projected Deaths of Despair from COVID-19

https://wellbeingtrust.org/wp-content/uploads/2020/05/WBT_Deaths-of-Despair_COVID-19-FINAL-FINAL.pdf

https://healingthenation.wellbeingtrust.org/

https://www.theatlantic.com/ideas/archive/2020/05/coming-mental-health-crisis/611635/

https://www.un.org/sites/un2.un.org/files/un_policy_brief-covid_and_mental_health_final.pdf

https://www.beam.community/

https://thementalhealthcoalition.org/wp-content/uploads/2020/06/Black-Mental-Health-Resources-MHC-2.pdf

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Petterson, Steve et al. "Projected Deaths of Despair During the Coronavirus Recession," Well Being Trust. May 8, 2020. WellBeingTrust.org.

USAFacts. 45% of Americans are feeling down, depressed, or hopeless during the COVID-19 pandemic. https://usafacts.org/articles/45-americans-are-feeling-down-depressed-or-hopeless-during-covid-19-pandemic/.

World Health Organization. Depression. https://www.who.int/news-room/fact-sheets/detail/depression.

Additional data, references, and analysis related to trauma, violence, and addiction are included in Deep Dive: Basic Needs, Public Health.

DEEP DIVE

BASIC NEEDS: PUBLIC HEALTH

JUNE 2020

BASIC NEEDS: TRUST FOR AMERICA'S HEALTH

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BASIC NEEDS: TRUST FOR AMERICA'S HEALTH

Trust for America's Health is a non-partisan, non-profit organization that envisions and strives for a nation that values the health and well-being of all, and where prevention and health equity are foundational to policymaking at all levels of society. To achieve these goals we produce groundbreaking reports, utilize strategic communication approaches, identify and promote evidence-based policy, and engage in effective advocacy.

Our primary networks include key organizations and individuals in the public health sector; federal policy makers in both the Executive and Legislative branches; a wide array of non-profit organizations and governmental agencies focused on policies, practices and programs that address or affect physical health, behavioral health, and equity; and policymakers at the state, local, tribal, and territorial levels

THE CURRENT STATE OF PUBLIC HEALTH

The governmental public health sector has agencies at the federal, state, local, tribal and territorial levels. Each is focused on the protection and promotion of good health among all the members within its jurisdictions, with special attention to those at elevated risk of poor health. All such agencies are engaged in certain core activities such as data collection and analysis, disease and injury prevention, and control and the promotion and implementation of health-oriented policies and practices. However, the size and resources of these agencies vary significantly.

Public health spending in 2018 amounted to approximately $286 per person—just 3 percent of all health care spending in the country.[1] On the federal level the Prevention and Public Health Fund, which was designed to expand and sustain the nation's investment in public health and prevention, remains at half of where it should have been funded in FY 2020 due to the re-appropriation of monies to other programs.[2] This lack of investment is made more challenging because policymakers, not public health professionals, determine the specific diseases, injuries, or conditions on which to focus by passing budgets with multiple condition-specific line items, limiting the ability of the agencies to address unfunded or cross-cutting issues.

Historically, there have been few instances of targeted resources to address our emotional, psychological, and social well-being and its impact on health. Yet in recent years the public health sector has increasingly recognized the importance of addressing such health concerns. Federal, state, and local funding has been allocated to the sector to combat the epidemic-level drug, alcohol, and suicide deaths. In addition, research has demonstrated the impact of Adverse Childhood Experiences (ACEs), childhood and adult trauma, and structural social, economic, and environmental factors, such as racism and poverty on a wide range of health risks including obesity, chronic disease, and violence.[3,4,5,6] As resources allow, public health agencies have developed partnerships with other sectors that have an impact on the health and well-being of the public, such as the health care, educational, criminal justice, housing, transportation and economic development sectors. More and more health agencies have re-focused their attention on the promotion of

1 The Nation's Healthcare Dollar, Calendar Year 2018: Where it Came From. In Centers for Medicare and Medicaid Services, Office of Actuary, National Health Statistics Group, 2018. https://www.cms.gov/files/ document/nations-health-dollar-where-it- came-where-it-went.pdf (accessed March 14, 2020)

2 Trust for America's Health, The Impact of Chronic Underfunding on the Public Health System, 2020

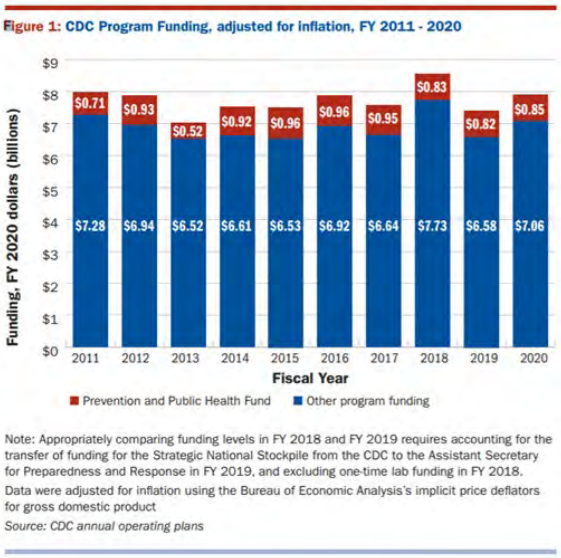
3 Merrick MT, Ford DC, Ports KA, et al. Vital Signs: Estimated Proportion of Adult Health Problems Attributable to Adverse Childhood Experiences and Implications for Prevention — 25 States, 2015–2017. MMWR Morb Mortal Wkly Rep 2019;68:999-1005. DOI: http://dx.doi.org/10.15585/mmwr.mm6844e1

4 Nardone, A et al. Associations between historical residential redlining and current age-adjusted rates of emergency department visits due to asthma across eight cities in California: an ecological study. The Lancet Planetary Health, Vol. 4, Issue 1, E24-E31, Jan 1, 2020. https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(19)30241-4/fulltext

5 Bower, Kelly M et al. "Racial Residential Segregation and Disparities in Obesity among Women." Journal of Urban Health: Bulletin of the New York Academy of Medicine vol. 92,5 (2015): 843- 52. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4608933/

6 Goodman MS and KL Gilbert. "Segregation: Divided Cities Lead to Differences In Health". Washington University in St. Louis and Saint Louis University. Nov. 2013.

equity and the multi-sectoral and systemic factors that limit opportunities for certain populations to achieve good health.



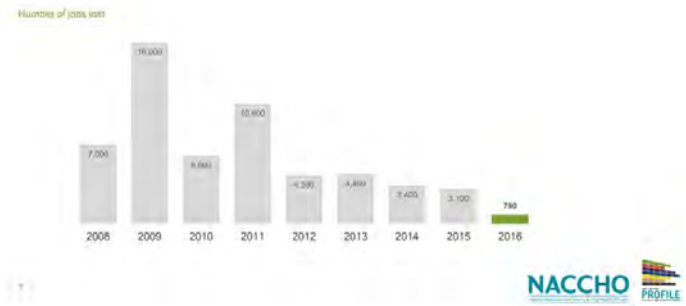
The Centers for Disease Control and Prevention (CDC) has developed innovative initiatives that address social and emotional health in the Centers of Injury Prevention and Control and the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, among other locations. Yet, such funding has been limited and, consequently, the public health sector has done relatively little in this arena. Furthermore, most public health agencies lack personnel trained in social and emotional health.

The state of public health funding

Core federal public health funding has declined following the recession of 2008. During the last ten years, the CDC budget has decreased when inflation is factored in Figure 1 – TFAH, The Impact of Chronic Underfunding on the Public Health System, 2020.

Over the last 10 years, more than 30,000 local jobs have been lost and close to 10,000 state public health jobs have been lost.[7] About half of the local jobs lost occurred during the 2008-2009 recession.

Job Loss in Local Health Departments – 2008 – 2016 (Source – NACCHO – profile 2016)



Job loss in state public health departments 2010 - 2016 (source – ASTHO – State Profile 2016)

	2010			2012			2016		
	MEAN	MEDIAN	TOTAL	MEAN	MEDIAN	TOTAL	MEAN	MEDIAN	TOTAL
Number of FTEs (N=50)	2,129	1,210	106,458	2,010	1,152	100,468	1,945	1,090	97,230

While core funding has been flat or declining, during emergencies—from H1N1 to Ebola to COVID-19—one-time only funds have been made available to public health departments, often with delays that impeded prevention efforts. Following the emergencies, such funds are eliminated, making it difficult to maintain the workforce and programs funded with supplemental appropriations.

During the last several years, health departments have been called upon to address a variety of new issues. Sometimes there is new funding to address these issues but often there is not. Among the new issues has been the opioid epidemic, the dramatic rise in suicides, widespread vaping and vaping-related lung injuries, weather-related emergencies, and the reemergence of vaccine-preventable infectious diseases (such as measles). Another indication of the new challenges facing public health has been the increase in federally declared public health emergencies.

Number of public health emergency declarations by year from 2010 – 2019[8]

7 National Association of County and City Health Officials. (2020). NACCHO's Profile Study: Changes in Local Health Department Workforce and Finance Capacity Since 2008. Retrieved from: http://nacchoprofilestudy.org/wp-content/uploads/2020/05/2019-Profile-Workforce-and-Finance-Capacity.pdf

8 https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx

2010 – 2
2011 – 6
2012 – 3
2013 – 1
2016 – 2
2017 – 18
2018 – 15
2019 – 12

As the issues and emergencies have increased, the public health sector has lost experienced personnel. A disproportionate number of public health employees have reached or are nearing retirement age.[9] The lack of competitive salaries and benefits have made it challenging to fill these positions when they become vacant.

Recent notable public health issues

Increased deaths of despair

More than 1 million Americans have died in the past decade from drug overdoses, alcohol and suicides.[10] Life expectancy in the country has decreased for the first time in two decades, and these three public health crises have been major contributing factors to this shift.[11] In 2018 more than 150,000 Americans died from drug- or alcohol-induced causes or suicide.[12] That equates to more than 350 deaths per day, 14 per hour and one person dying every four minutes. These trends are a wake-up call that there is a serious well-being crisis in this country. In stark terms, they are signals of serious underlying concerns facing too many Americans—about pain, despair, disconnection, and lack of economic opportunity—and the urgent need to address them.

Social determinants of health

Despite advances in health care, too many Americans will continue to needlessly fall ill due to social, economic, and environmental conditions that contribute to poor health. In contrast, adopting policies that improve access to quality education, safe housing, jobs, and more can have lasting effects on individual health. The circumstances that Americans encounter in their everyday lives shape their health. Whether it's where they live, how they eat, where they go to school, their workplaces, who they care for, or what opportunities they have (or don't have) to succeed, it all has a profound effect on long-term health—regardless of what type of medical care they receive. For many Americans, poverty, discrimination, access to education, the immediate environment, and other systemic barriers make it difficult to prioritize a healthy lifestyle and even more difficult to lead one. The adoption of certain policies can prevent the onset of disease, help residents lead healthier lives, lower health care costs, and increase productivity by removing obstacles and expanding opportunities.

Impact of racism, bigotry, homophobia, sexism

The root causes of racial and ethnic health and health care disparities are complex and interconnected, and these inequities existed long before COVID-19. The National Academies of Sciences, Engineering, and Medicine affirmed this with its comments that health inequities are "...the result of the historic and ongoing interplay of inequitable structures, policies, and norms that shape lives."[13] Indeed, these inequities result from ingrained poverty, structural racism and ethnic discrimination, and disinvestment in Communities of Color.

These conditions have led to higher rates of many underlying medical conditions such as diabetes, heart disease, and stroke that lead to vulnerability for severe illness from COVID-19.[14] Furthermore, systemic inequities have created obstacles for many Communities of Color to have optimal health on a daily basis. They are less likely to have health insurance and access to high quality health care, including skilled nursing facilities. They are more likely to work in jobs that are unsafe, including at those with elevated exposure to COVID-19. They are exposed to

9 de Beaumont Foundation and Association of State and Territorial Health Officials (ASTHO), Public Health Workforce Interests and Needs Survey: 2017. Online. Phwins.org/most-recent-findings/
10 Trust for America's Health (2020), Pain in the Nation Update: Alcohol, Drug, and Suicide Deaths in 2018. Online. https://www.tfah.org/report-details/paininthenationupdate2020/
11 Kochanek KD, Anderson RN, Arias E. Changes in life expectancy at birth, 2010–2018. NCHS Health E-Stat. 2020.
12 "CDC WONDER." In: Centers for Disease Control and Prevention, April 29, 2020. https://wonder.cdc.gov/ (accessed April 30, 2020)
13 Communities in Action, National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Population Health and Public Health Practice, Committee on Community-Based Solutions to Promote Health Equity in the United States, National Academies Press, Mar 27, 2017
14 Warren, M et al. *State of Obesity: Better Policies for a Healthier America.* Washington, DC: Trust for America's Health, Sept 2019.

more environmental health risks including air pollution and lead.[15,16] And they are more likely to live in over-crowded, sub-par, segregated housing where population density has increased the risk of disease transmission.

In addition, the economic impact of the COVID-19 response has disproportionately affected People of Color. They are more likely to have lost their jobs due to layoffs or extended furloughs. As a result, they have found it difficult to have the necessary resources to feed their families and pay rent. Because of the higher death rates and the greater economic impact, People of Color are more likely to need support for their social and emotional well- being.

Emerging understanding of trauma and Adverse Childhood Experiences (ACEs) to health

Living with prolonged stress and adverse experiences can significantly increase a child's risk for a range of physical, mental, and behavioral problems—increasing the likelihood for hypertension, diabetes, heart disease, stroke, cognitive and developmental disorders, depression, anxiety, and a range of other concerns.[17,18]

Currently, approximately one-quarter of children ages 5 and younger live in poverty and more than half of all children experience at least one ACE. According to research from the Centers for Disease Control and Prevention (CDC), more than one-quarter of children experience physical abuse and substance abuse in the household while sexual abuse and parent divorce or separation are also prevalent.

The effect of COVID-19 on the public health

Increased poverty and unemployment, especially for those already marginalized

The economic impact of the COVID-19 pandemic has led to economic insecurity for millions of people. More than 40 million Americans have filed for unemployment.[19] Without the ability to pay for such basic needs as healthy food, secure housing, medical care, and education, physical as well as social and emotional health suffers. COVID-19 highlighted long-standing socioeconomic contradictions which not only led to elevated levels of chronic disease among People of Color and low-income people, but also made it easier for a virus to spread. Those who worked in low-wage jobs to which they were unable to telecommute or who lacked health insurance or ready access to treatment were more likely to become infected, develop more serious illness or die.

Increased budget shortfalls

It is likely there will be significant state budget cuts in the coming years as a result of the economic impact of the pandemic. The Center for Budget and Policy Priorities has estimated a state budget shortfall of $765 billion over three years, based on projections from the Congressional Budget Office and Goldman Sachs. The Center highlights that during the 2008 recession, almost half of the budget shortfalls in states resulted in spending cuts, many of them layoffs. Given the loss of almost 30,000 local public health jobs since the 2008-2009 recession, many additional public health jobs will likely be in jeopardy in the coming years.[20]

15 Institute of Medicine. Toward Environmental Justice: Research, Education, and Health Policy Needs. Washington, DC: National Academy Press, 1999; O'Neill MS, , et al. Health, wealth, and air pollution: Advancing theory and methods. Environ Health Perspect. 2003; 111: 1861-1870; Finkelstein et al. Relation between income, air pollution and mortality: A cohort study. CMAJ. 2003; 169: 397-402; Zeka A, Zanobetti A, Schwartz J. Short term effects of particulate matter on cause specific mortality: effects of lags and modification by city characteristics. Occup Environ Med. 2006; 62: 718-725

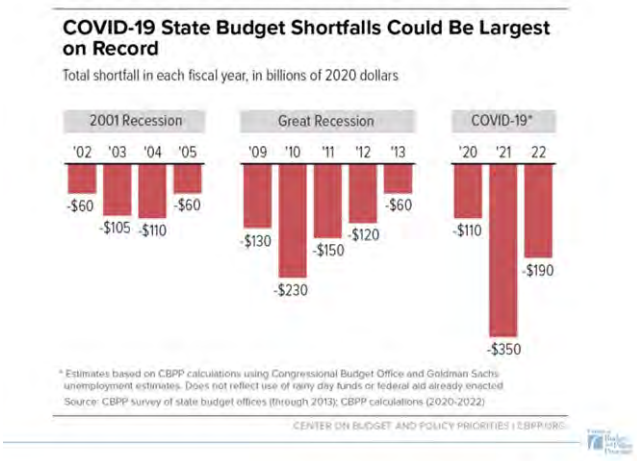
16 American Lung Association. Urban air pollution and health inequities: A workshop report. Environ Health Perspect. 2001; 109 (suppl 3): 357-374

17 Moore K, Sacks V, Bandy T, and Murphey D. "Fact Sheet: Adverse Childhood Experiences and the Well-Being of Adolescents." Child Trends, July 2014. https://www.childtrends.org/wp-content/ uploads/2014/07/Fact-sheet-adverse- childhood-experiences_FINAL.pdf

18 Merrick MT, Ford DC, Ports KA, et al. Vital Signs: Estimated Proportion of Adult Health Problems Attributable to Adverse Childhood Experiences and Implications for Prevention — 25 States, 2015–2017. MMWR Morb Mortal Wkly Rep 2019;68:999-1005. DOI: http://dx.doi.org/10.15585/mmwr.mm6844e1

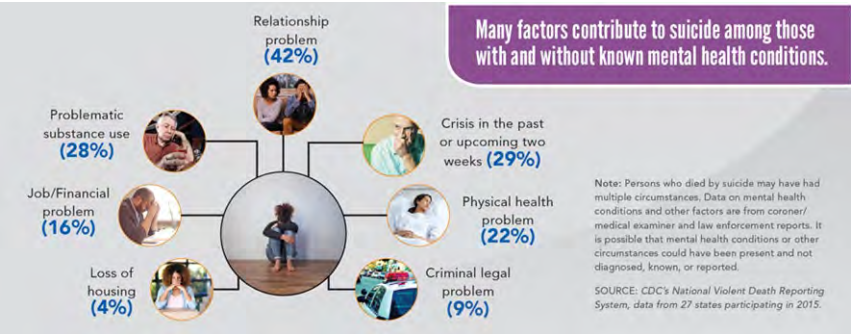
19 Department of Labor. https://www.dol.gov/ui/data.pdf

20 https://www.cbpp.org/blog/projected-state-shortfalls-grow-as-economic-forecasts-worsen



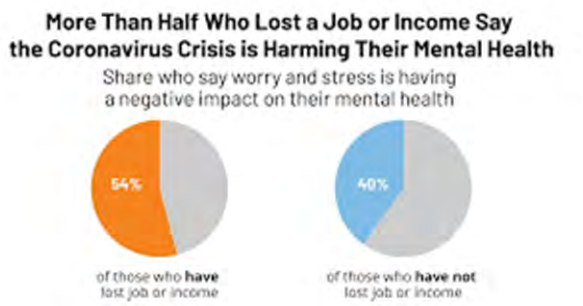
Increased deaths of despair

Based on previously established relationships between unemployment, pandemics, suicide, and substance use, there has been increased attention for behavioral health services. CDC data indicates many suicides are preceded by social, economic, and environmental crises. Early evidence has warranted this concern. A May report by the Office of National Drug Control Policy found that two states have had a statistically significant increase in overdoses since the pandemic began. As of June 1st, over 40 million Americans have filed for unemployment. All of this is compounded by recent data by the Census Bureau showing a third of Americans showing signs of clinical depression.



Increased trauma

Based on the experience from previous outbreaks, there is a high level of trauma associated with novel viruses.[21] In this pandemic, the trauma is due to illness and death (and fear of such) as well as economic fallout. A Kaiser Family Foundation brief in April 2020 found that nearly half of adults across the country say that worry and stress related to COVID-19 is hurting their mental health.



There is early evidence of such trauma in the roughly 1000 percent increase in text messages to the federal Disaster Distress Hotline in April 2020, when compared to the previous year. In addition, calls to the National Domestic Abuse Hotline were up 12 percent in April 2020, highlighting another possible impact of the sheltering in place, economic distress, and stress associated with the pandemic. Given that ACEs are often precipitated by such matters as family instability and insecurity, there is a danger of long-term impacts from the conditions resulting from the pandemic.[22]

Changing course from current to future state

We are primarily focused on increasing funding for upstream efforts, the promotion of equity, addressing the social determinants of health, and strengthening and leveraging existing public health infrastructure to compliment clinical behavioral health services by developing connections to care and timely data.

Infrastructure funding for public health

The chronic underfunding of public health has limited health departments' ability to modernize labs, surveillance systems, and informatics;to hire and retain workforce; and to address the underlying health conditions that put communities at heightened risk from COVID-19. The nation's response to COVID-19 would have been stronger with sufficient infrastructure and workforce in health departments. Such support would have resulted

21 Anna L.D. Lau, Iris Chi, Robert A. Cummins, Tatia M.C. Lee, Kee-L. Chou & Lawrence W.M. Chung (2008) The SARS (Severe Acute Respiratory Syndrome) pandemic in Hong Kong: Effects on the subjective well being of elderly and younger people, Aging & Mental Health, 12:6, 746-760, DOI: 10.1080/13607860802380607

22 Reger MA, Stanley IH, Joiner TE. Suicide Mortality and Coronavirus Disease 2019—A Perfect Storm? JAMA Psychiatry. Published online April 10, 2020. doi:10.1001/jamapsychiatry.2020.1060

in greater capacity to identify cases, locate those who had been exposed, and quickly put policies in place that would reduce the need to shut down schools and workplaces. Public health experts estimate only 51 percent of Americans are served by a comprehensive public health system,[23] and an investment of $4.5 billion per year is needed to modernize the foundational capabilities of state, local, tribal and territorial health departments.[24]

Recommendation

To address this shortfall, Congress could consider establishing a core public health infrastructure program at the CDC, awarding grants to state, local, tribal and territorial health departments to ensure they have the tools, highly trained workforce and systems in place to address existing and emerging health threats. More than 160 groups have already signed onto a request for $4.5 billion a year in such public health infrastructure funding.

Redouble equity efforts

While everyone is at risk for COVID-19 infection, Blacks, Latinos, American Indians/Alaska Natives, Asian Americans, Native Hawaiians, and Pacific Islanders are at elevated risk due to a variety of factors. The root causes of racial and ethnic health and health care disparities are complex and interconnected, and these inequities existed long before COVID-19. Indeed, much of the inequity that spans generations results from poverty, structural racism, discrimination, and disinvestment in many Communities of Color. For example, residential segregation creates concentrated poverty, isolates Communities of Color, and decreases opportunity and resources in those communities. These realities manifest themselves as poorer quality schools, substandard housing, greater exposure to pollution, less healthy food grocers, less availability of health care services, lack of good jobs, and an inability for upward economic mobility—all of which negatively impact health and well-being.

This systemic disadvantage not only creates obstacles for many Communities of Color to achieve optimal health, it also limits the community's ability to be prepared against and recover from public health emergencies, such as COVID-19.

Additional risks are from the types of jobs that are disproportionately held by People of Color. Many work in frontline, essential jobs, such as in grocery stores, transportation systems, and delivery operations during this pandemic. More than half of Latinos and 38 percent of Blacks do not earn paid sick days through their jobs, making it more likely they will work when sick or exposed to others who are. Finally, People of Color are also more likely to live in densely populated metro areas and depend on public transportation, making physical distancing guidelines more challenging.

Recommendation

More efforts are needed to collect and publicly report data by race, ethnicity, sex, age, primary language, socioeconomic status, disability status, and other demographic information of COVID-19 cases, including hospitalizations and deaths. This disaggregated data is vital to identifying impacted areas and partnering with communities on outreach, prevention, and access to care. Investments to modernize public health data surveillance, including enabling electronic case reporting between clinical providers and public health, would help improve data collection and reporting.

Additional resources are also needed for the communities at greatest risk and with disproportionate burden of disease and death to reduce disparities and ensure access to testing, care, and treatment. This could take the form of tailored, culturally and linguistically appropriate public health campaigns, partnering with trusted messengers to effectively reach Communities of Color and immigrant communities; and opening satellite testing and treatment facilities in communities where health care access is an issue. More than 250 groups have proposed strengthening the collection of racial and other demographic information of COVID-19 related data and directing resources to those communities at elevated risk.

Specialized CDC division in social and emotional health

Currently, there is no specialized unit at the CDC that focuses on social and emotional health. This makes it challenging for the agency to build on existing work throughout the agency as well as at the local, state, tribal, and territorial levels.

23 National Longitudinal Survey of Public Health Systems. Accessed: http://systemsforaction.org/national-longitudinal-survey-public-health-systems

24 Public Health Leadership Forum. Developing a Financing System to Support Public Health Infrastructure. Accessed: https://www.resolve.ngo/docs/phlf_developingafinancingsystemtosupportpublichealth636869439688663025.pdf

Recommendation

In order to ensure that social and emotional health are considered as core public health issues, there should be a specialized unit at the CDC. Such a unit would be led by experts in the field and would provide a variety of resources to the field including training, technical assistance, grant funding, and research. The unit should strive for internal cross division integration of components into other work—collaborating with other federal agencies both within and outside of the Department of Health and Human Services to ensure alignment and non-duplication.

Data on social and emotional health

There is insufficient data gathered on the social and emotional health of people in America. The information that is gathered on drug and alcohol deaths and suicides shows significant variation from state to state. Some states have relatively low drug-related death rates and relatively high alcohol-related death rates. Some have unusually high or unusually low suicide rates. The sub-populations differ also by race, ethnicity, age, density of population, sexual orientation, and gender identity.[25] Can we determine the correlates of risk? Of protective factors? To fully understand the sub-populations that are relatively small (such as American Indians and people who are transgender) it may require over-sampling. That, too, is crucial.

Recommendation

The CDC's surveys (including BRFSS, DASH and NCHS) should add questions to gather additional information regarding the impact on social and emotional health. Such questions could seek to answer if some populations are more vulnerable, and for what conditions they are more vulnerable. CDC, SAMHSA and other federal agencies should supplement such quantitative data collection with qualitative data collection. Initially, the addition of these questions to the existing surveys—and the oversampling of sub-populations—and detailed analysis should be done to examine the impact of COVID-19. Such research is time-sensitive and of enormous importance in planning for the likely impact. However, such data collection should become routine and ongoing with annual reports on the findings and their implications for policies and programs.

Educational and technical assistant resources

Because social and emotional health has traditionally not been a core component of public health work at the federal, state or local levels, it will require concentrated and continual training to elevate the understanding of those within the field.

Recommendation

Congress should fund the CDC to develop educational and skill-building programs for state, territorial, tribal, and local health agencies to promote the incorporation of social and emotional health content into core public health activities. Such programs should highlight best practices and lessons. In addition to education resources, public health agencies will require direct assistance or make it possible to fully integrate social and emotional health prevention and promotion into ongoing work. This will likely require the assistance of specialists and experts via contracts with non-profit agencies. Such assistance should incorporate a mechanism for peer assistance from those in the field and a prioritization of support for equity in the planning and implementation phases.

Increased research

Insufficient research exists regarding the ways to prevent and control the impact of trauma and to promote social and emotional health.

Recommendation

Additional resources are needed to evaluate community interventions to prevent or mitigate behavioral health conditions, with attention to the involvement of community members and grass roots organizations in the determination of need and the optimal ways to address them.

Cross sector and integrative work should be routine

Historically social and emotional prevention, health screening, and treatment services have been siloed in specialized agencies such as SAMHSA at the federal level, and drug and alcohol or mental health agencies at the state levels. Often such agencies have focused their limited resources on those with acute needs and relatively few resources have been devoted to prevention or to assisting those with less than urgent needs.

Recommendation

A transformative approach is needed that would be integrative, where all federal agencies focused on any aspect of behavioral health or on policies with a significant impact on behavioral health (such as HUD,

25 TFAH's Pain in the Nation update – 2020.

the Department of Education, USDA) would work collaboratively to become more aware of, and take action to, address the needs in an aligned manner. This might be facilitated by an administration-wide task force or coordinating committee.

Age-friendly public health

COVID-19 has exposed the need for a specialized public health focus on the needs of the growing older adult population. Eight out of ten COVID-19 related deaths in the US have been among those 65 years old and older.[26] These elevated deaths stem, in part, from the higher percentage of older adults with underlying serious health conditions and from their concentration in skilled nursing facilities where infection control procedures were lax. Current US recommendations for older adults to stay home can have unintended consequences that could worsen their health due to the consequences of social isolation. In addition, older adults who contract COVID-19 and have mild to moderate symptoms are generally encouraged to stay home and avoid going to a health care provider's office or the emergency room. Such self-care for this population—especially for those living alone—can be difficult and dangerous. Public health interventions can play a valuable role in optimizing the health and well-being of older adults during this time by supporting independence and fostering cross-sector collaboration with the aging sector. Yet the public health sector currently has few if any specialized funding for programmatic efforts among older adults.

Recommendation

Public health agencies at the federal, state, and local levels need specialized funding to address the range of issues facing older adults during the COVID-19 response and afterwards. These include protection from COVID-19 infection as well as the range of consequences from social isolation and from interruptions of care for chronic disease and mental health. Authorizing language has been introduced to fund the CDC to create a grant program for state and local health departments that promotes age-friendly public health. The state of Florida is piloting what such age-friendly public health would look like. In addition, due to the disproportionate impact, there is a need for a National COVID-19 Resource Center for Older Adults that would bring multiple federal agencies to the table to identify and meet the COVID-19 specific challenges to the health of older adults, such as the need to ensure that nursing homes are safe.

Social Determinants of Health

Social and economic conditions such as housing, employment, food security, and education have a major influence on individual and community health.[27] These conditions—often referred to as the Social Determinants of Health (SDOH)—are receiving increased attention from insurance companies, hospitals, health care systems, and governmental agencies interested in improving health outcomes and controlling costs. In 2018, U.S. Secretary of Health and Human Services (HHS) Alex Azar, highlighted the necessity of addressing social determinants of health in HHS's work, including at the Centers for Medicare & Medicaid Services (CMS). For example, the CMS Innovation Center's Accountable Health Communities (AHC) pilot program funds 31 health systems to identify unmet health-related social needs of their patients and create referral mechanisms to address them. Its goal is "testing whether systematically identifying and addressing the health-related social needs of CMS beneficiaries will impact health care costs and reduce health care utilization."

However, while clinicians can identify non-medical social needs and make referrals to other organizations, they cannot ensure that there are adequate resources and policies in place to meet the needs of the referred. In addition, many of the social needs that are being supported by health care systems are short term—temporary housing, nutrition, or transportation—and do not necessarily address the underlying economic and social factors in communities beyond the individual patient. AHCs and other payer-supported models need support from public health and other sectors to create the communication mechanism, collaborations, programs, and policies to assure that patients' social needs are met. Public health departments are uniquely situated to build these collaborations across sectors, identify SDOH priorities in communities, and help address policies that inhibit health.

Recommendation

There is a need for federal funding, training and technical assistance within the public health sector to address the social, economic, and environmental factors that affect health. This requires close partnerships with those in other sectors such as health, housing, transportation, education,

26 https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html
27 https://www.rwjf.org/content/rwjf/en/how-we-work/grants-explorer/featured-programs/county-health-ranking-roadmap.html

public safety, and economic development. A bill has been introduced to fund the CDC to give grants to states, locals, tribes, and territories to expand their work on the social determinants through cross-sector collaboration, policy change and creating community-clinical linkages.

Policy changes can also enable the economic conditions to address the social determinants of health. Two policies of relevance to the COVID-19 pandemic are:

- Paid sick leave: The lack of sick leave benefits may result in workers coming to work when they should be in quarantine or isolation. COVID-19 has highlighted how easily diseases can spread from simple interactions. If employees stay home when they are sick, they reduce the chance that they may infect their coworkers or customers. The United States is only one of two developed countries without a national paid sick day (PSD) policy and almost two out of every five Americans don't have access to this important benefit. Low-income workers are much less likely to receive paid sick leave even though these workers are often less able to miss work when they are sick because they rely on their full pay.[28]
- Earned income tax credits: Given the economic devastation caused by the pandemic, an increasing number of Americans need tax relief in order to cover the cost of essential needs such as rent and food. The EITC helps eligible low- to moderate-income working people keep more of the money they earn by reducing the taxes they owe. It's important to note that the EITC's impact extends beyond just its fiscal impact and has been shown to improve infant and maternal health and has shown indirect benefits including increased graduation rates, college enrollment, and later impacts on future employment and income.

Preparedness for the next major threat

We have seen with COVID-19 the importance in investing in preparedness and prevention. We never want to go through this difficult public health emergency again. Yet we know that public health emergencies are inevitable and are of a wide variety of types (not just pandemics). In addition, we have learned that there is a societal price to be paid for underlying health conditions like obesity, diabetes and health disease that can be avoided with a commitment to these approaches.

Recommendation

Increase federal funding for the Public Health Emergency Preparedness Program and the Hospital Preparedness Program to build preparedness capabilities in all states and territories.

28 TFAH, Promoting Health and Cost Controls in States – 2019.

DEEP DIVE

BASIC NEEDS: HEALTH CARE

JUNE 2020

THE ROLE OF HEALTH CARE IN EQUITABLE RECOVERY & RESILIENCE IN COMMUNITIES ACROSS AMERICA

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THE ROLE OF HEALTH CARE IN EQUITABLE RECOVERY & RESILIENCE IN COMMUNITIES ACROSS AMERICA

INTRODUCTION

The Institute for Healthcare Improvement (IHI) is an independent not-for-profit organization based in Boston, Massachusetts, USA. For more than 25 years, IHI has used improvement science to advance and sustain better outcomes in health and health systems across the world. IHI brings awareness of safety and quality to millions, catalyzes learning and the systematic improvement of care, develops solutions to previously intractable challenges, and mobilizes health systems, communities, regions, and nations to reduce harm and deaths. IHI collaborates with a growing community to spark bold, inventive ways to improve the health of individuals and populations. IHI generates optimism, harvests fresh ideas, and supports anyone, anywhere who wants to profoundly change health and health care for the better.

IHI's values include:

- Courage: we stay true to our values, even in the face of risk or loss. We speak up. We do this all in the service of personal and organizational integrity.
- Love: we build relationships grounded in patience, kindness, gratitude, and respect. In our teams and in our work, we bring our whole selves in an authentic and caring spirit and encourage others to do the same.
- Equity: we work to prevent and undo unfair systems, policies, and forms of racism and discrimination that drive gaps in our organization and in our work. We tell the truth about inequities and value all voices. We believe that we are interconnected and that inequities lead us all to lose. We want everyone to thrive and none of us can truly thrive until we all do.
- Trust: we recognize the unique experience that each of us brings and believe in each other's strengths. We ensure that people feel empowered and supported. We engage in genuine dialogue and encourage feedback with one another and our customers.

From origins in performance improvement of hospital microsystems, we have broadened our focus in the past decade to work on population health and health equity. As improvers of health care quality, the Institute for Healthcare Improvement (IHI) believes that health care organizations, in partnership with the communities and partners they serve, can learn and innovate together to drive measurable change in inequities in a relatively short period of time—years, rather than decades or generations.

IHI has continued to support communities and multi-stakeholder coalitions from sectors within and outside of health care and public health, on myriad topics, and has an evidence-based approach to scale-up that we have applied globally to achieve results at the local and country level. IHI has learned a great deal about developing learning networks that build improvement skills and accelerate improvement across communities and health care systems. Our approach is rooted in partnerships and focused on supporting systems transformation. Relevant work includes: the Pursuing Perfection Initiative, 100,000 Lives Campaign and 5 Million Lives Campaign; the Triple Aim, Pursuing Equity, and the 100 Million Healthier Lives initiative, which includes SCALE, Pathways to Population Health, and the equity work of the IHI Leadership Alliance.

CURRENT STATE

Even prior to this global pandemic, health care in the United States has held a tension. There are incredible contributions, breakthroughs, and improvements that the health care delivery system can proudly claim, as well as systems problems that chronically plague the industry. Despite the pockets of excellence and innovation and the tireless commitment of health care providers, the US health care system continues to experience inefficiencies, challenges, and poor outcomes for populations in relation to the investment made.

THE HEALTH OF POPULATIONS

The US has health outcomes ranked among the lowest when compared to other high-income countries.[1] Our scorecard on inequitable outcomes is bleak.

- By race, Black, Indigenous and People of Color (BIPOC) fare worse across nearly every key measure of morbidity and mortality.[2,3,4,5]
- Compared to households with annual incomes greater than $115,000, households with lower incomes have a higher relative risk of mortality, which increases with decreasing income.[6]
- Lesbian, gay, bisexual, and transgender (LGBT) youth represent up to 40 percent of all young people experiencing homelessness and are also at an increased risk of physical or sexual abuse, sexually transmitted infections (STIs), and mental health issues.[7,8]

While these are just a few examples, health inequities are observed across many intersecting demographics. The primary drivers of inequitable health care outcomes are institutional racism, implicit bias, and other forms of oppression.[9] These play out across all societal systems, and health care delivery is no exception. Structural inequities and interpersonal bias are visible in adverse patient experiences of care[10] and contribute to unjust disparities in outcomes.

COST OF CARE

It is widely accepted that our current health care delivery system is unaffordable and unsustainable. The burden of health care cost falls on individuals, in the worst cases leading to personal financial devastation, and on the system as a whole in terms of proportion of GDP. In the US, some estimates suggest that upwards of 20 percent of an individual's paycheck is spent on health insurance,[11] over 60 percent of bankruptcies are due to medical expenses,[12] and 18 percent of our GDP is spent on health care. Perverse financial incentives and the associated overdiagnosis and overuse of services are a significant contributor to the problem of affordability.[13]

SYSTEMS OF CARE

Our current health care system has ongoing issues around safety, reliability, and right-sizing care for the right purpose. A 2015 study suggested there may be as many as 400,000 preventable deaths per year from hospital-associated patient harm.[14] And in 2016, a study published in the BMJ estimated the number at more than 250,000, which, the authors asserted, would make preventable

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10 Institute of Medicine; Smedley BD, Stith AY, Nelson AR (eds). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academies Press; 2003.

11 The Real Cost of Health Care: Interactive Calculator Estimates Both Direct and Hidden Household Spending. KFF. February 21, 2019. https://www.kff.org/health-costs/press-release/interactive-calculator-estimates-both-direct-and-hidden-household-spending/. Accessed June 5, 2020.

12 Himmelstein DU, Lawless RM, Thorne D, Foohey P, Woolhandler S. Medical Bankruptcy: Still Common Despite the Affordable Care Act. Am J Public Health. 2019;109(3):431433. doi:10.2105/AJPH.2018.304901

13 National Health Expenditure Data. Centers for Medicare & Medicaid Services website. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical. Updated December 17, 2019. Accessed June 4, 2020.

14 James, John T. PhD A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care, Journal of Patient Safety: September 2013 - Volume 9 - Issue 3 - p 122-128 doi: 10.1097/PTS.0b013e3182948a69

patient harm the third leading cause of death in the US.[15] Our system continues to function primarily as designed for acute, episodic, fee-for-service care. This has resulted in fragmented, inadequate, and at times, inappropriate service delivery for many chronic physical and mental health conditions.[16,17] For example, operational capacity of US health systems has significantly decreased, with inpatient psychiatric beds dwindling to less than 50,000 nationally, while differing insurance and other legal and regulatory requirements add complexity to the system.[18] Reduced supply of beds and psychiatric resources, coupled with the increased likelihood of an inpatient admission, means that patients with a behavioral health condition may spend three times as long in the emergency department as those without a behavioral health condition. This increases their overall length of stay (LOS) and likelihood of being transferred to another facility.[19] In addition, our health care delivery system has medicalized both birth[20,21] and death,[22] often in misalignment with the wishes and care preferences of patients. For example, surveys show that around 70 percent of people want to die at home, but in reality, 70 percent of people die in health care facilities. The adverse and inequitable experiences, costs, and outcomes due to this type of fragmented, unreliable care are tremendous.[23,24,25]

THE HEALTH CARE WORKFORCE

In addition, the unnecessary complexities and inefficiencies in the health care system—even prior to the added stresses of the COVID-19 pandemic—have negatively impacted the safety, burnout rates, and mental health and wellbeing of the health care workforce. Long before the country was captivated by the issue of lack of sufficient personal protective equipment (PPE) for those treating COVID-19, the Bureau of Labor Statistics reported the health care workforce as having one of the highest rates of injury of any private industry in the United States.[26] Between 35 and 54 percent of US nurses and physicians have substantial symptoms of burnout; similarly, the prevalence of burnout ranges between 45 and 60 percent for medical students and residents.[27] Thirty-three percent of new registered nurses seek another job within a year, according to another 2013 report.[28,29]

All of these challenges represent a significant opportunity to leverage this pivotal moment in time to drive whole-system redesign in service of better, more equitable health outcomes.

IMPACT OF COVID-19 ON HEALTH CARE

The impacts of the COVID-19 pandemic on health care are significant, including direct effects on patients, impacts on the health care delivery system, and macro-level impacts on society as a whole. A common thread that runs through them all is the notion of uncertainty; it is a

15 Makary Martin A, Daniel Michael. Medical error—the third leading cause of death in the US BMJ 2016; 353 :i2139
16 Stange KC. The problem of fragmentation and the need for integrative solutions. Ann Fam Med. 2009;7(2):100 103. doi:10.1370/afm.971
17 Stange KC. The paradox of the parts and the whole in understanding and improving general practice. Int J Qual Health Care. 2002;14(4):267–268.
18 ACEP Emergency Medicine Practice Committee. Care of the Psychiatric Patient in the Emergency Department: A Review of the Literature. American College of Emergency Physicians; 2014.
19 Zhu JM, Singhal A, Hsia RY. Emergency department length-of-stay for psychiatric visits was significantly longer than for nonpsychiatric visits, 2002–11. Health Affairs. 2016;35(9):1698-1706.
20 New ROOTS, Beyond Medicalization: Midwives and Maternity Care in America. Jewish Healthcare Foundation. April 30, 2020. https://www.jhf.org/news-blog-menu/entry/new-roots-beyond-medicalization-midwives-and-maternity-care-in-america. Accessed June 4, 2020.
21 http://blackmamasmatter.org/wp-content/uploads/2018/04/BMMA_BlackPaper_April-2018.pdf
22 Clark D. Between hope and acceptance: the medicalisation of dying [published correction appears in BMJ 2992 Jun 8;324(7350):1391]. BMJ. 2002;324(7342):905.907. doi:10.1136/bmj.324.7342.905
23 S.K. Bell, et al. A multi-stakeholder consensus-driven research agenda for better understanding and supporting the emotional impact of harmful events on patients and families Jt Comm J Qual Patient Saf, 44 (2018), pp. 424-435 ,
24 Delivering Quality Health Services: A Global Imperative for Universal Health Coverage. World Health Organization; Organisation for Economic Co-operation and Development; OECD; World Bank. ,
25 Frandsen BR, Joynt KE, Rebitzer JB, Jha AK. Care fragmentation, quality, and costs among chronically ill patients. *Am J Manag Care*. 2015;21(5):355.362
26 Bureau of Labor Statistics, US Department of Labor. Employer-Reported Workplace Injuries and Illnesses-2018. https://www.bls.gov/news.release/archives/osh_11072019.pdf. Published November 7, 2019. Accessed June 4, 2020.
27 National Academies of Sciences, Engineering, and Medicine. 2019. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being. Washington, DC: The National Academies Press. https://doi.org/10.17226/25521.
28 Lucian Leape Institute. Through the Eyes of the Workforce: Creating Joy, Meaning, and Safer Health Care. Boston, MA: National Patient Safety Foundation; 2013.
29 Perlo J, Balik B, Swensen S, Kabcenell A, Landsman J, Feeley D. IHI Framework for Improving Joy in Work. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017.

challenge to predict the full spectrum of consequences in the near, intermediate, or long term. Though studies are beginning to emerge on the clinical course of the disease,[30] utilization patterns,[31] and the characteristics and outcomes of COVID-19 patients,[32] at the time of the creation of this report, the nature of this novel virus has meant that expert clinicians are still relatively unfamiliar with the full nature of the disease. Because this virus came to us as an unknown entity, every treatment and approach is new and untested. Everyone has been doing their best to learn quickly, yet there is no standard for best practice and no standard way to learn and share quickly across settings and around the world. Amid these challenges, we are also seeing unprecedented levels of innovation and change.[33] The work of the unfolding months and years will be identifying and spreading positive innovations and mitigating the negative consequences of the pandemic on the various aspects of health care.

IMPACTS ON PATIENTS

The magnitude of impact of this epidemic on the experience of patients and families is hard to comprehend. There is a broad ripple effect even beyond the many sick and the hundreds of thousands who have died from the disease in the United States. An institution that is trusted to provide care, safety, and relief has done so for many, and at the same time has been forced to turn away families from their loved ones. In order to reduce risk of exposure to patients, families, and staff, many hospitals have essentially eliminated visitors.[34,35,36] This means that the sickest patients and the dying patients suffer and die away from loved ones.[37] For many, the hospital has become a place to fear. This means that a healthy woman giving birth in a hospital during this time of COVID-19 either gives birth in an environment of fear and isolation, or chooses to give birth at home to reduce risk of exposure.[38] Patients have been forced to defer care for chronic conditions like diabetes, asthma, or depression due to loss of employer-based health insurance [39] or suspended appointments.[40]

Most of all, this pandemic has focused attention on underlying defects in our system that negatively impact patient outcomes, especially among Communities of Color. Black people in US communities are contracting and dying from the virus at alarmingly disproportionate rates. A study of more than 3,100 counties by amfAR, The Foundation for AIDS Research, found that counties with higher Black populations account for more than half of all COVID-19 cases and almost 60 percent of deaths.[41] In places such as Chicago and Louisiana, African Americans account for 67 and 70 percent of COVID-19-related deaths, respectively, while representing only 32 percent of the population of each city. Multi-faceted factors contribute to this inequity —economic barriers, impact of quarantine, lack of testing, and structural inequities within

30 Zhou F, Yu T, Du R, et al. Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study [published correction appears in Lancet. 2020 Mar 28;395(10229):1038] [published correction appears in Lancet. 2020 Mar 28;395(10229):1038]. Lancet. 2020;395(10229):1054- 1062. doi:10.1016/S0140-6736(20)30566-3

31 Spriha G, Newton-Dame R, Boudourakis L, et al. Covid-19 X-Curves: Illness Hidden, Illness Deferred. NEJM Catalyst. https://catalyst.nejm.org/doi/abs/10.1056/cat.20.0231. Published May 29, 2020. Accessed June 4, 2020.

32 Marcello RK, Dolle J, Grami S, et al. Characteristics and Outcomes of COVID-19 Patients in New York City's Public Hospital System. medRxiv. Published online June 2, 2020:2020.05.29.20086645. doi:10.1101/2020.05.29.20086645.

33 Berwick DM. Choices for the "New Normal". JAMA. 2020;323(21):2125–2126. doi:10.1001/jama.2020.6949

34 COVID-19 Visitor Guidelines. UCLA Health website. https://www.uclahealth.org/covid-19-visitor-restrictions. Updated May 29, 2020. Accessed June 4, 2020.

35 Visitor Restrictions at UCSF Due to Coronavirus (COVID-19). UCSF Health. https://www.ucsfhealth.org/for-visitors/visitor-restrictions-due-to-coronavirus. Accessed June 4, 2020

36 Shapiro J. Hospital Visitor Bans Under Scrutiny After Disability Groups Raise Concerns Over Care. NPR.org. May 17, 2020. https://www.npr.org/2020/05/17/857531789/federal-government-asked-to-tell-hospitals-modify-visit-bans. Accessed June 4, 2020.

37 Schairer M. Coronavirus Patients Are Dying Alone, Leaving Loved Ones with Grief and Guilt. WGBH. May 14, 2020. https://www.wgbh.org/news/local-news/2020/05/14/coronavirus-patients-are-dying-alone-leaving-loved-ones-with-grief-and-guilt. Accessed June 4, 2020.

38 Holohan M. Home births: What to know about midwives, cost and safety. TODAY. August 28, 2018. https://www.today.com/health/home-birth-advice-women-about-labor-delivery-t135859. Accessed June 4, 2020

39 Zipperer B, Bivens J. 3.5 million workers likely lost their employer-provided health insurance in the past two weeks. Economic Policy Institute. https://www.epi.org/blog/3-5-million-workers-likely-lost-their-employer-provided-health-insurance-in-the-past-two-weeks/. Published April 2, 2020. Accessed June 4, 2020.

40 Kowalczyk L. Hospitals cancel hundreds of non-urgent procedures, surgeries, and medical appointments. The Boston Globe. March 17, 2020. https://www.bostonglobe.com/2020/03/17/metro/hospitals-cancel-hundreds-non-urgent-procedures-surgeries-medical-appointments/. Accessed June 4, 2020.

41 COVID-19 Racial Disparities in U.S. Counties. amfAR Making AIDS History. https://ehe.amfar.org/inequity?_a=2.70766672.1552216761.1591248840-1270368916.1591248840. Accessed June 4, 2020.

health care.[42] A retrospective cohort analysis of COVID-19 patients at Sutter Health, a large integrated health care system in northern California, found that, compared with non-Hispanic White patients, African Americans had 2.7 times the odds of hospitalization, after adjusting for age, sex, comorbidities, and income.[43]

The health care delivery system, in partnership with other sectors and communities, has a responsibility to dramatically change the trajectory of patient experience and outcomes in the midst of COVID-19. There is no quality without equity.

IMPACTS ON THE HEALTH CARE DELIVERY SYSTEM

In addition to the direct impacts on patients, COVID-19 has had a substantial impact on our health care delivery system, including the capacity for care delivery; supply chain planning, coordination, and distribution; and the safety and wellbeing of the health care workforce.

Capacity for care delivery

One of the most evident impacts has been the surge of patients in need of hospital-level care[44] and the associated need for hospital beds, ICU beds, ventilators, and staff, particularly in the communities that have been the hardest hit. Most, if not all hospitals, have disaster plans, yet in many cases, those have been pushed to the limit to manage this crisis. Mark Jarrett, MD, MBA, Senior Vice President and Chief Quality Officer of Northwell Health, a major health care system at an epicenter of the US crisis north, south, and east of New York City, shared his experience:

> *"We started meeting [around mid-February] to plan for COVID-19 surge preparedness and opened our formal emergency operations center [in late February]. At [the beginning of March], we had one case in one of our hospitals. [Very quickly], we had over 3,000 COVID-positive patients in our hospitals, with more than 600 on ventilators. Over 40 years of my professional career, this has been the hardest thing I've ever dealt with."*

To prepare for a COVID-19 surge, building bed capacity and building space has become necessary nationwide. By mid-April, Northwell had prepared 1,600 additional beds. Northwell, like its colleagues across New York, is providing little non-COVID-19 care in the hospital; extra capacity in hospitals and alternate locations are necessary for patients with non-COVID-19 issues.[45] Northwell isn't an outlier; these unprecedented circumstances have been met with ingenuity and innovation: other examples from around the US include opening and converting floors to increase surge capacity, and setting up short-term triage stands outside emergency departments to deal with the steadily increasing number of patients needing care.[46]

And across the health system, many surgeries, procedures, and services have been put on hold so as to reduce exposure to all involved and shift staff to attend to acute needs. From a business perspective, these service reductions are not offset by the influx of COVID-19 cases. A benchmark analysis of over 1,100 hospitals in 45 states showed that increases in COVID-19 cases have not offset the steep declines in patient volumes in other parts of the health system: inpatient admissions in April 2020 ran over 30 percent compared to January 2020, while emergency department visits and observation services were down 40 and 47 percent, respectively, and outpatient ancillary services declined 62 percent and outpatient surgery volume decreased 71 percent.[47] In addition to the impact this service reduction has on patient outcomes for those with non-COVID-19-related illnesses and those forced to defer preventative care, this drastic service reduction is a significant loss of revenue for many health care delivery systems, which has rippling effects on furloughed or laid off staff as a result, as well as the health system's stability in a community.

42 Thebault R, Tran AB, Williams V. The coronavirus is infecting and killing black Americans at an alarmingly high rate. Washington Post. April 7, 2020. https://www.washingtonpost.com/nation/2020/04/07/coronavirus-is-infecting-killing-black-americans-an-alarmingly-high-rate-post-analysis-shows/. Accessed June 4, 2020.
43 Azar KMJ, Shen Z, Romanelli RJ, et al. Disparities In Outcomes Among COVID-19 Patients In A Large Health Care System In California. Health Aff (Millwood)2020;f202000598.pmid:32437224
44 Public Health Preparedness Capabilities: National Standards for State and Local Planning. US Department of Health and Human Services, Centers for Disease Control and Prevention. https://www.cdc.gov/cpr/readiness/00_docs/capability10.pdf
45 8 Lessons from a COVID-19 Surge Hotspot. Institute for Healthcare Improvement. April 22, 2020. http://www.ihi.org/communities/blogs/8-lessons-from-a-covid-19-surge-hotspot. Accessed June 4, 2020.
46 COVID-19: Early Learning from One of the Epicenters. Institute for Healthcare Improvement. March 23, 2020. http://www.ihi.org/communities/blogs/covid-19-a-view-from-one-of-the-epicenters. Accessed June 4, 2020.
47 Crowe RCA Benchmarking Analysis | Hospital volumes hit unprecedented lows. Crowe website. https://www.crowe.com/insights/asset/h/hospital-volumes-hit-unprecedented-lows. Published May 2020. Accessed June 4, 2020

Possibly the most positive impact of this pandemic on the health care delivery system is the rapid shift of ambulatory care services to telemedicine to diagnose, monitor, and triage patients when traditional office visits pose a real or perceived risk to patients. Almost overnight, primary care and other providers began offering telephone and telemedicine consults for all kinds of issues that normally would have required an appointment and office visit,[48,49,50] or, as in the case of Bergen New Bridge Medical Center in New Jersey, expanded telehealth services to include COVID-19 screening and virtual infectious disease consultations.[51] NYU Langone Health reported that non-urgent telehealth visits increased by more than 4,000 percent from March 2 to April 14; urgent care visits increased 135 percent during that same six-week stretch.[52] In many cases, this has resulted in improved access and experience of care.[53] One US health system's telehealth department used an online retailer to get an oxygen saturation monitor and a thermometer to the homes of high-risk patients. Self-monitoring was complemented by frequent and regular check-ins from telehealth nurses. Clinicians can monitor patients at home, and the patients feel well-supported. These successes and innovations have been important and impactful and we must bring an equity lens to the expansion of telehealth to ensure access for low-income, uninsured, those with limited broadband access, and undocumented patients and families.

Supply chain, planning, coordination, and distribution

The widely reported shortage and maldistribution of PPE in the midst of COVID-19 has put many people's lives at risk.[54] This speaks to challenges in planning, coordination, and distribution. Similar challenges have been experienced relative to testing for the virus. The availability of testing early on and continuing today has been markedly insufficient. When supply shortages exist, decisions are made on how to distribute scarce resources. Without an equitable system, the outcome is that those scarce resources are often distributed in ways that reinforce existing inequities. That pattern plays out unjustly and predictably.

In California, for example, testing varies widely hospital to hospital, city to city, county to county. An overwhelmed supply chain and a disjointed public health system have created "testing deserts," especially in the state's rural northern communities and in lower-income urban neighborhoods where access to quality care was already an issue for residents. Lake County, California, has had so few testing supplies for its 65,000 residents that officials have resorted to buying swabs on Amazon and pilfering chlamydia testing kits for swabs and the liquid used to transport specimens to labs.[55]

As of June 2020, many American Indian/Alaskan Native tribal nations have not received promised federal health care funding included in COVID-19 relief legislation,[56] and some health centers that serve American Indian/Alaskan Native populations have received the wrong testing and treatment supplies.[57] Even as we celebrate the innovation and ingenuity of individual players in the system have demonstrated to overcome challenges, the system issues around coordination are pervasive.

48 COVID-19 and the rise of Telemedicine. The Medical Futurist. March 31, 2020. https://medicalfuturist.com/covid-19-was-needed-for-telemedicine-to-finally-go-mainstream. Accessed June 4, 2020.
49 Rashid Bashshur, Charles R. Doarn, Julio M. Frenk, Joseph C. Kvedar, and James O. Woolliscroft.Telemedicine and e-Health.May 2020.571-573. http://doi.org/10.1089/tmj.2020.29040.rb
50 Landi H. Half of physicians now using telehealth as COVID-19 changes practice operations. FierceHealthcare. April 23, 2020. https://www.fiercehealthcare.com/practices/half-physicians-now-using-telehealth-as-covid-changes-practice-operations. Accessed June 4, 2020.
51 Bergen New Bridge Medical Center Expand Telehealth Service for COVID-19. GlobeNewswire News Room. March 3, 2020. http://www.globenewswire.com/news-release/2020/03/03/1994551/0/en/Bergen-New-Bridge-Medical-Center-Expand-Telehealth-Service-for-COVID-19.html. Accessed June 4, 2020
52 Telehealth: Problems and Possibilities Beyond COVID-19. Institute for Healthcare Improvement. May 4, 2020. http://www.ihi.org/communities/blogs/telehealth-problems-and-possibilities-beyond-covid-19. Accessed June 4, 2020.
53 Peters AL, Garg SK. The Silver Lining to COVID-19: Avoiding Diabetic Ketoacidosis Admissions with Telehealth. Diabetes Technol Ther. 2020;22(6):449.453. doi:10.1089/dia.2020.0187
54 Ranney ML, Griffeth V, Jha AK. Critical supply shortages — the need for ventilators and personal protective equipment during the Covid-19 pandemic. N Engl J Med. 2020;382:e41
55 Barry-Jester AM, Hart A, Bluth R. California's Coronavirus Testing Still A Frustrating Patchwork of Haves and Have-Nots. NPR. May 3, 2020. https://www.npr.org/sections/health-shots/2020/05/03/849243723/californias-coronavirus-testing-still-a-frustrating-patchwork-of-haves-and-have. Accessed June 4, 2020.
56 Robeznieks A. AMA urges HHS to address funding for Navajo COVID-19 hot spot. American Medical Association. May 28, 2020. https://www.ama-assn.org/delivering-care/population-care/ama-urges-hhs-address-funding-navajo-covid-19-hot-spot. Accessed June 4, 2020.
57 Ortiz E. A Native health center asked for COVID-19 medical supplies. It got body bags instead. NBC News. May 5, 2020. https://www.nbcnews.com/news/us-news/native-american-health-center-asked-covid-19-supplies-they-got-n1200246. Accessed June 4, 2020

Safety and well-being of the health care workforce

The rapid impact and unknown nature of this crisis and the lack of PPE have all combined to create threats to the health care workforce. For those working on the front lines, including health care providers, environmental services staff, and food services staff, that includes risk of exposure for them and their families,[58] psychological trauma[59] associated with witnessing death after death, and moral injury from feeling like they are never doing enough and/or doing too much.[60] There is exhaustion, isolation, doubt, guilt, and fear. Health care workers are being revered as heroes even as they watch their patients and some colleagues die.

The pandemic only serves to exacerbate concerns about the burnout and well-being of the workforce, with a predicted "second curve" of mental health problems among both health care workers and the public due to unmitigated residual social, economic, and behavioral health impacts of the virus.[61] Studies are already emerging documenting the negative impact of the pandemic on health care worker mental health,[62] with a significant proportion of point-of-care clinicians experiencing extraordinarily high rates of depression, anxiety, insomnia, and distress.[63,64]

The most significant immediate impact of this pandemic is an urgency to drive improvement. We need to learn and respond quickly. The urgency is felt by the people who serve. Our health care workforce needs a better plan, safe available equipment, quick and transparent ways to share and learn, and a respite. The urgency is felt by the people we serve.

Our communities need a partner they can rely on to provide equitable, safe care that meets their needs. The urgency is felt by those who administer the services. The resources are stretched thin and decisions need to be made as to how to allocate those resources in service of better outcomes for all. And the urgency is felt in the communities we serve. For many communities, the hospital is among the largest employers. With layoffs and furloughs, that swells the growing ranks of the unemployed and potentially uninsured, which in turn negatively impacts community wellbeing.

The pandemic has upended numerous policies, practices, behaviors, and norms as health systems and frontline workers have moved with agility to respond to the influx of patients into the health care system. Over time, some changes will prove to be for the better, and some will not.

Undoubtedly, this crisis allows us the opportunity to examine the way care is delivered, coordinated, and paid for, and use this urgency as a disruptive moment to drive radical redesign toward better, more equitable outcomes. In the words of Dr. Don Berwick, "Fate will not create the new normal; choices will."[65]

CHANGING COURSE FROM CURRENT TO FUTURE STATE

HOW WE IMPROVE

If we commit to using this moment to redesign our broken health care system, how we approach that process matters. There are several considerations for how the suggestions we outline can be implemented and spread in a way that it is equitable and sustainable. A grounding set of design principles, a methodology for how to improve, and new ways of partnering and new ways of leading are proposed to guide how we approach the efforts in recovery and in reimagining a new normal.

First, it is important to establish clear definitions of the

58 Farmer B. At Least 9,000 U.S. Health Care Workers Sickened With COVID-19, CDC Data Shows. NPR. April 15, 2020. https://www.npr.org/sections/health-shots/2020/04/15/834920016/at-least-9-000-u-s-health-care-workers-sickened-with-covid-19-cdc-data-shows. Accessed June 4, 2020

59 Mock J. Psychological Trauma Is the Next Crisis for Coronavirus Health Workers. Scientific American. June 1, 2020. doi:10.1038/scientificamericano620-36

60 Williams RD, Brundage JA, Williams EB. Moral Injury in Times of COVID-19 [published online ahead of print, 2020 May 2]. J Health Serv Psychol. 2020;1.5. doi:10.1007/s42843-020-00011-4

61 Perez Ortega R. Health care workers seek to flatten COVID-19's 'second curve'—their rising mental anguish. Science | AAAS. April 22, 2020. https://www.sciencemag.org/news/2020/04/health-care-workers-seek-flatten-covid-19-s-second-curve-their-rising-mental-anguish. Accessed June 4, 2020.

62 Spoorthy MS, Pratapa SK, Mahant S. Mental health problems faced by healthcare workers due to the COVID-19 pandemic-A review [published online ahead of print, 2020 Apr 22]. Asian J Psychiatr. 2020;51:102119. doi:10.1016/j.ajp.2020.102119

63 Lai J, Ma S, Wang Y, et al. Factors Associated With Mental Health Outcomes Among Health Care Workers Exposed to Coronavirus Disease 2019. JAMA Netw Open. 2020;3(3):e203976. doi:10.1001/jamanetworkopen.2020.3976

64 Tan BYQ, Chew NWS, Lee GKH, et al. Psychological Impact of the COVID-19 Pandemic on Health Care Workers in Singapore [published online ahead of print, 2020 Apr 6]. Ann Intern Med. 2020;M20-1083. doi:10.7326/M20-1083

65 Berwick DM. Choices for the "New Normal". JAMA. 2020;323(21):2125–2126. doi:10.1001/jama.2020.6949

terms we use:

- Health equity: IHI uses the US Centers for Disease Control and Prevention definition for health equity: "Health equity is achieved when every person has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances."[66]
- Health inequity: Differences in health outcomes that are systematic, avoidable, and unjust.[67]
- Health disparity: The difference in health outcomes between groups within a population. Health disparity simply denotes differences, whether unjust or not. We often look for disparities in health outcomes or health care experience data as a sign of health inequity.[68]
- Institutional (or institutionalized) racism: The differential access to the goods, services, and opportunities of a society by race.[69]
- Multiple determinants of health: The health care services, social factors, physical environment, and healthy behaviors that directly or indirectly determine health, as well as the policy and advocacy activities that health care organizations can conduct to achieve health equity.[70]

Furthermore, in presenting the approaches below, we align with the World Health Organization, Healthy People 2030, and other national and international bodies in affirming the following:

- That assuring health includes and extends beyond physical health and disease prevention to encompass mental health and multiple types of wellbeing (evaluative, eudaimonic, hedonic)[71,72] for both individuals and communities.[73,74]
- That attaining health equity benefits all people and communities, and the social and economic thriving of our nation.[75]
- That health is a human right. As stated by the Constitution of the World Health Organization: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[76]

DESIGN PRINCIPLES

To facilitate transformational and lasting improvements, we recommend the following guiding design principles for health care, as it works in partnership with other sectors:

- Create a system that puts the people most affected at the center. Build and sustain partnerships to

66 NCHHSTP Social Determinants of Health: Definitions. Centers for Disease Control and Prevention. https://www.cdc.gov/nchhstp/socialdeterminants/definitions.html

67

68 Improving Health Equity: Build Infrastructure to Support Health Equity. Guidance for Health Care Organizations. Boston, Massachusetts: Institute for Healthcare Improvement; 2019. (Available at www.ihi.org)

69 Jones CP. Levels of racism: A theoretic framework and a gardener's tale. American Journal of Public Health. 2000 Aug;90(8):1212-1215. https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.90.8.1212

70 Improving Health Equity: Address the Multiple Determinants of Health. Guidance for Health Care Organizations. Boston, Massachusetts: Institute for Healthcare Improvement; 2019. (Available at www.ihi.org)

71 OECD Guidelines on Measuring Subjective Well-being, OECD Publishing, Paris (2013).

72 U.S. Department of Health and Human Services. (2020). Development of the National Health Promotion and Disease Prevention Objectives for 2030. https://www.healthypeople.gov/2020/About-Healthy-People/Development-Healthy-People-2030.

73 Stiefel MC, Gordon NP, Arsen EL. Sociodemographic Determinants of Health and Well-Being Among Adults Residing in the Combined Kaiser Permanente Regions. The Permanente Journal - Kaiser Permanente -. 2019;23:18-091. doi:https://doi.org/10.7812/TPP/18-09

74 Roy B, Riley C, Sears L, Rula EY. Collective Well-Being to Improve Population Health Outcomes: An Actionable Conceptual Model and Review of the Literature. Am J Health Promot. Published online August 5, 2018:0890117118791993. doi:10.1177/0890117118791993

75 U.S. Department of Health and Human Services. (2020). Development of the National Health Promotion and Disease Prevention Objectives for 2030. https://www.healthypeople.gov/2020/About-Healthy-People/Development-Healthy-People-2030.

76 Constitution of the World Health Organization. 1946. Bull World Health Organ. 2002;80(12):983-984.

co-design solutions with those in the system most affected by inequity (e.g., clients, patients, families, community members). [77,78,79,80,81]

- Prioritize equity as foundational and drive action at multiple levels. Recognize that equity is foundational to improving outcomes and act on this recognition. We can center our work around equity by continually asking "Who isn't thriving?" and "What would it take to change that together?" Learn about, understand, and seek to shift historical and current inequities—what they are, why they are in place, how they are sustained at multiple levels (institutional, cultural, interpersonal, individual)—so the new systems will be designed for equity.
- Call out and then address racial inequity specifically. This work includes:
    - Recognizing that our systems have been designed to achieve worse outcomes for Communities of Color.
    - Shifting language from "persons of color do worse..." to "our system(s) produce poorer outcomes for People of Color."
    - Combining continuous improvement and an equity lens to systematically identify and improve until racial inequities no longer exist.
- Let data, both quantitative and qualitative, drive decision making. This work includes:
    - Creating and using data systems and measures that support learning and inform action
    - Using data for improvement instead of judgement
    - Using measures that matter to people most affected by inequity
    - Integrating data into existing workflows and learning systems
    - Including both qualitative and quantitative data as a part of learning systems, as stories are one way to best help illuminate both the problems and potential solutions
- Build and rely on trusting relationships to create sustainable systems. Relationships, trust, collaboration, and transparency are essential for sustainable solutions, so actively work to develop and nurture trusting relationships.
- Eliminate silos and advance cross-sector collaboration. Rebuilding health care to be more equitable and effective will require that a full range of sectors and community residents work together, based on all the assets they hold, to advance common goals.
- Cultivate mindsets and approaches for adaptive, complex challenges. Equitable recovery is an adaptive challenge, rather than a technical one. To succeed, all stakeholders will need to adopt adaptive mindsets and approaches (e.g., failing forward and growth mindsets).
- Build capacity and capability for transformation at the community level so that the community as a whole, each sector, and community residents are better equipped to address equity and become better overall problem solvers. This includes both quality improvement and change management methods, as well as individual and group work to understand systems of oppression and structural racism.
- All teach, all learn, all lead. We all teach, we all learn, and we all lead together. For the system to be meaningfully different, we will not solve problems alone. We commit to learning together and sharing widely what we learn and discover, including our experiences of learning from failure along the way.

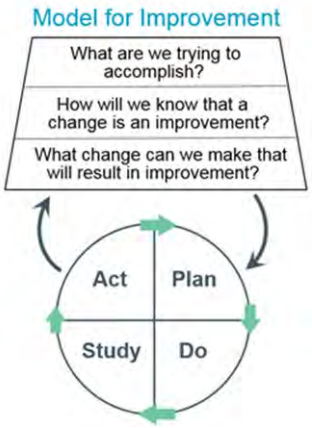
A METHODOLOGY FOR HOW TO IMPROVE

The path to recovery, resilience, and transformed systems requires working in ways that anchor in the above design

77 Lived Experience Advisory Council. Nothing About Us Without Us: Seven Principles for Leadership and Inclusion of People with Lived Experience of Homelessness. Toronto, Canada: The Homeless Hub Press; 2016.
78 Batalden M, Batalden P, Margolis P, et al. Coproduction of healthcare service. BMJ Qual Saf. Published online September 16, 2015:bmjqs-2015-004315. doi:10.1136/bmjqs-2015-004315
79 Elwyn G, Nelson E, Hager A, Price A. Coproduction: when users define quality. BMJ Qual Saf. Published online September 5, 2019. doi:10.1136/bmjqs-2019-009830
80 Homer A. Engaging People with Lived/Living Experience: A Guide for Including People in Poverty Reduction. Tamarack Institute; 2019. https://www.tamarackcommunity.ca/hubfs/Resources/Publications/10-Engaging%20People%20With%20LivedLiving%20Experience%20of%20Poverty.pdf
81 Coleman S, Byrd K, Scaccia J, Stout S, Schall M, Callender S, Anderson J, Behrman N, Budnik A, Smith D, Brown L, Douglas W, Bussey R, McDermott E, Munene E, Mullin F, Hatchett L, Pohorelsky J, VanLanen T, Pairolero B, Mann Z. Engaging Community Members with Lived Experience. SCALE 1.0 Synthesis Reports. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017.

principles; put continuous learning and improvement at the center; help us see and transform systems rather than blame individuals; help us use data to inform action; make visible vulnerabilities and inequities and provide tools that allow us to meaningfully work to eliminate inequities; and facilitate co-design with others, unleashing everyone's agency and power (ability to achieve shared purpose).[82]

We recommend the following approach to guide how we improve—across topics, across communities and systems, towards transformation in a way that snowballs learning, resilience, and equity. This approach is grounded in Improvement Science, specifically the Model for Improvement,[83] in methods for advancing equity and resilience, and in methods and approaches for achieving the Triple Aim[84] (improved health for populations, improved experience of care, at lower per capita costs). The Model for Improvement is a simple, yet powerful tool for accelerating improvement, detailed below.



To achieve equitable results at scale for populations, we must first identify a population of focus for improving health, wellbeing, and equity. We recommend focusing on populations or population segments that have been disproportionately affected by inequities and in which health status has considerable room for improvement.

After selecting the population of focus, the next step is to deepen our understanding of the needs and assets of the population, utilizing segmentation; stratified data analysis by race, ethnicity, gender; and engagement of individuals within the population to understand the lived experience of inequity. This understanding of the population will lead to a decision on concrete aims and goals for improving equitable outcomes. Without shared purpose and concrete aims, efforts to improve equity may serve narrow purposes and perhaps build trust, but do not move an entire organization, community, region, or nation toward outcomes.

The identification of a population of focus will also drive the creation and/or alignment of leadership and governance structures to champion and drive the work over time. Pursuing health equity requires change in a system's culture and infrastructure, as well as specific changes in aspects affecting the community-wide issues that are to be addressed. A number of different individuals and groups are required to effectively adapt and implement these changes, including individuals with lived experience of the inequities you wish to improve.

We also believe and recommend that there is an opportunity and a responsibility for health care to set some bold aims to drive us towards a transformed system. We have not proposed such aims within this document, because that is work that must be done in co-design with a full range of stakeholders, including those most affected by inequity.

How will we know if the changes we make are creating the improvements and system transformation we seek? How will we know if equity is improving?

Identifying a cogent set of system-level measures for population health, wellbeing, and equity is necessary to help organizations and coalitions evaluate their progress. These measures must be aligned with the identified population and aims and will help guide priority areas of improvement. The Well-being in the Nation Measures provide one place to start in identifying measures.[85]

What changes can we make that will result in lasting improvements and elimination of inequities at multiple levels?

82 Hilton K, Anderson A. IHI Psychology of Change Framework to Advance and Sustain Improvement. Boston, Massachusetts: Institute for Healthcare Improvement; 2018.
83 Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.
84 Whittington JW, Nolan K, Lewis N, Torres T. Pursuing the Triple Aim: The first seven years. Milbank Quarterly. 2015;93(2):263-300.
85 Well-being in the Nation (WIN) Measurement Framework: Measures for Improving Health, Well-being, and Equity Across Sectors. Facilitated by 100 Million Healthier Lives with the National Committee on Vital and Health Statistics; 2019. Available at www.winnetwork.org

A guiding purpose, concrete aims, and system-level measures are long-term guideposts—three to five years or longer. To accomplish this long-term purpose requires a portfolio of interventions and initiatives, and associated projects and investments that can be addressed in a shorter term, which will together achieve population health and equity. Projects and investments selected may center on an entirely new care or service design and/or care coordination model. Another option is to pull an existing project within the organization or region into the portfolio and build on it, where appropriate. The portfolio of interventions should tie to an explicit theory or rationale for system changes for the population of focus and align with identified population level measures.

To drive the outcomes over time toward spread and scale, a comprehensive learning system is needed that fosters intentional testing and learning, provides feedback loops to compare performance with specific aims and measures for the designated population, and integrates the assets of leaders and organizations. This includes learning by iterative testing (e.g., Plan-Do-Study-Act [PDSA] cycles, sequential testing of changes, Shewhart time series charts), using informative cases to "act with the individual, and learn for the population"84, and selecting leaders to manage and oversee the learning system with particular focus on rebalancing the portfolio of work overtime. This approach of how to improve comes to life in four overarching components, each with a set of guiding questions that include prompts related to advancing equity, that build on one another. This approach embeds learning and improvement skills within and across systems and communities, at both the individual and group level, as a means to support sustainability.

COMPONENTS	GUIDING QUESTIONS	KEY ELEMENTS OF THE APPROACH
Understand the population, align leadership and governance, and co-develop aims	• What are we aiming to accomplish—for and with whom? • Who is not thriving, and what would it take for that to change? • In what ways are those most affected by inequity partnering in governance, leadership, and initiatives we undertake?	• Identify population of focus (in partnership with those in the population most affected by inequity) • Understand the population's assets and needs through quantitative data review as well as client and provider interviews • Establish and/or align leadership and governance structures based on needs of assets and population • Co-design leadership structures with people most affected by inequity • Co-design clear and concrete aims
Identify cogent set of population level measures that matter for the chosen population	• How will we know if the changes we make are creating the improvements and system transformation we seek? • How will we know if equity is improving?	• Identify and use measures that matter—both subjective and objective, inclusive of topic-specific and overall well-being of people, communities, and the system
Identify and assemble a portfolio of projects and investments that together will achieve outcomes	• What changes can we make will result in lasting improvements and elimination of inequities at multiple levels (individual, interpersonal, organizational, cultural)? • Who is missing from our shared tables, in leadership and in participation?	• With people most affected by inequity, establish and implement a portfolio of strategic initiatives • Choose a collection of existing and new work to redesign the system (including care or service delivery and coordination, data integration, etc.) • Rebalance the portfolio over time as you learn
Create and continuously improve a learning system that will facilitate scale and spread equity	• What are we learning that we can share, scale up, and spread to others? • What do we still need to learn?	• Engage in overall testing and learning, in iterative cycles that align with the aims and advance scale up and spread • Have a bias towards sharing—both successes and "fail forward"

NEW WAYS OF PARTNERING AND NEW WAYS OF LEADING

Bringing about transformative change will require health care system stakeholders to use a new set of "hows"—new ways of partnering, of leading, and of being in our role. These new ways of being will invite health care to lean into humble leadership and partnership, to hold more responsible global citizenship, and to take seriously its responsibility for "the moral determinants of health."[86]

Through the 100 Million Healthier Lives movement (convened by IHI in partnership with communities, leaders, people most affected by inequities, and health care organizations globally), partners identified of a set of key skills, strategies, and tools drawn from multiple disciplines and designed to change mindsets and behaviors to improve health, wellbeing, and equity. The new ways of being can be thought of as muscles we are building, individually and as part of organizations, systems, and communities. This set of skills is organized around five dimensions of leadership, known collectively as the Community of Solutions Framework:[87]

Leading from within

Leading from within involves one's inner journey as a leader, including the ability to know oneself and what brings one to leadership, reflect, fail forward, and change as needed.[88,89] In addition, these skills involve seeing and committing oneself to unlocking the leadership of others, especially those with lived experience of inequity.[90] The concept of failing forward not only accepts that mistakes will be made in any transformative work but embraces them as a critical part of learning. This mindset is key for health care leaders for the longitudinal journey toward building and championing more equitable systems.

Embracing this form of leadership requires practicing "slowing down to speed up" and getting comfortable being uncomfortable. Recognize that leading and learning through complex, adaptive systems change and undoing systems of racism and oppression often requires us to take a pause before accelerating work.[91,92] Some of these ways of being may at first feel counter-cultural or unnatural. Practice these skills and exhibit these ways of being even and especially when they feel uncomfortable.

Leading together

Leading together is grounded in the perception of the community as a dynamic

network of interacting people, organizations, structures, and systems. Leading Together offers practical skills, strategies, and tools to create effective change within people, organizations, complex systems, and communities. Embracing a Leading Together approach requires health care organizations and systems to explore and map the current organizational and individual partnerships to address health equity as well as the other assets within the community to do this work. This will help the health care organization understand where new relationships are needed or where they should join existing efforts versus creating new interventions of their own.[93,94,95,96] For example, community stakeholders in Bergen County, NJ, have established a collaborative Housing First model that was recognized by the Department of Housing and Urban Development (HUD) as the first community in the country to end, or reach "functional zero" for, chronic homelessness in 2017. In a community like Bergen County it is most fruitful for the local health systems to join this multi-stakeholder coordinated entry system for housing rather than create a comprehensive housing navigation

86 Commins J. Berwick Outlines Sweeping 7-Step Campaign for the Quality Movement. HealthLeaders Media. December 12, 2019. https://www.healthleadersmedia.com/innovation/berwick-outlines-sweeping-7-step-campaign-quality-movement. Accessed June 4, 2020.
87 Stout S. Overview of SCALE and a Community of Solutions. SCALE 1.0 Synthesis Reports. Cambridge, Massachusetts: Institute for Healthcare Improvement, 2017. Available at www.ihi.org/100mlives.
88 Palmer, P. (2009). Let Your Life Speak: Listening for the Voice of Vocation (1 edition). Jossey-Bass.
89 Palmer PJ. Healing the Heart of Democracy: The Courage to Create a Politics Worthy of the Human Spirit. John Wiley & Sons; 2014
90 Coleman S, Byrd K, Scaccia J, Stout S, Schall M, Callender S, Anderson J, Behrman N, Budnik A, Smith D, Brown L, Douglas W, Bussey R, McDermott E, Munene E, Mullin F, Hatchett L, Pohorelsky J, VanLanen T, Pairolero B, Mann Z. Engaging Community Members with Lived Experience. SCALE 1.0 Synthesis Reports. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017
91 Heifetz RA, Linsky M, Grashow A. The Practice of Adaptive Leadership: Tools and Tactics for Changing Your Organization and the World. Harvard Business Press; 2009.
92 Hassan Z. The Social Labs Revolution: A New Approach to Solving Our Most Complex Challenges. Berrett-Koehler Publishers; 2014.
93 Heath C, Heath D. Switch: How to Change Things When Change Is Hard. 1 edition. Crown Business; 2010.
94 Improving Health Equity: Partner with the Community. Guidance for Health Care Organizations. Boston, Massachusetts: Institute for Healthcare Improvement; 2019. (Available at www.ihi.org)
95 Heifetz RA, Linsky M, Grashow A. The Practice of Adaptive Leadership: Tools and Tactics for Changing Your Organization and the World. Harvard Business Press; 2009.
96 Hassan Z. The Social Labs Revolution: A New Approach to Solving Our Most Complex Challenges. Berrett-Koehler Publishers; 2014

program of its own.

Leading for outcomes

Leading for outcomes supports organizations and communities in making change easier, co-creating a theory of change, identifying measures, testing the theory, getting feedback from end-users, refining, and planning for implementation and scale-up. With the rigor it brings to its quality improvement efforts such as preventing infections or decreasing wait times, health care can and should also bring a focus on outcomes to its pursuit of equity for patients, employees, and communities.[97,98,99,100,101]

Leading for equity

Leading for equity integrates with and applies Leading from Within, Leading Together, Leading for Outcomes, and Leading for Sustainability to address equity at a population and structural level. Leading for Equity skills provide practical strategies for addressing racism, identifying inequities, and working to eliminate inequities in partnership with those most affected by them.[102,103] These skills provide actionable ways to make real the recognition that, "it is not possible to achieve the health outcomes we seek without addressing equity ... of the tremendous waste in human potential that results from inequity... a belief in our interconnectedness, common opportunity and destiny."[104]

Leading for sustainability

Leading for sustainability facilitates an ongoing process of transformation in a community (generative sustainability) as opposed to maintaining programs. These skills consider dimensions of sustainability including the people making change, resources required, environmental factors, and considerations of sustaining the process of change and transformation.

Below are two case examples of this type of leadership in action.

Leading together & leading for outcomes in practice: Bellin Health Systems & the NE Wisconsin Poverty Outcomes and Improvement Network Team (POINT)

Bellin Health Systems participated alongside 100 other local community-based organizations and social service agencies in the NE Wisconsin Poverty Outcomes and Improvement Network Team (POINT) initiative.[105] The POINT was an 18-month improvement collaborative launched in 2016 as part of a multi-year regional effort that seeks to reduce poverty and meet the basic needs of individuals and families through the use of quality improvement methods and tools to improve the services provided to those in the community living in poverty.

The initiative drew upon the IHI Breakthrough Series Collaborative model,[106] in which partnering stakeholders co-created a theory of change for what interventions, services, and redesign efforts would lead to positive outcomes and launched multi-stakeholder improvement initiatives in a variety of areas such as: housing placement and stability, mental health service delivery, job creation and placement, domestic violence prevention and recovery, early childhood development, recidivism reduction, and the creation of positive post-high school pathways. Bellin Health Systems decided to take on medical debt for those in the community through an

97 Schall M, Howard P, Lewis N, Archer K, Blanton S, Byrd K, Chen S, Douglas W, Ebersole K, Fairley K, Fritsch S, Kendrick C, Klysa E, Munene E, Platson L, VanLanen T, Scaccia J. SCALE: Using Improvement Methods and Design Thinking to Guide Action. SCALE 1.0 Synthesis Reports. Cambridge, Massachusetts: Institute for Healthcare Improvement, 2017.
98 Langley GJ, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. 2nd ed. Jossey-Bass; 2009.
99 Moen R. A Guide to Idealized Design. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2002.
100 Brown T, Wyatt J. Design Thinking for Social Innovation. Stanford Social Innovation Review. Published online Winter 2010. Accessed May 12, 2017. https://ssir.org/articles/entry/design_thinking_for_social_innovation.
101 Barker PM, Reid A, Schall MW. A framework for scaling up health interventions: lessons from large-scale improvement initiatives in Africa. Implementation Science. 2016;11(1):12. doi:10.1186/s13012-016-0374-x
102 Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at ihi.org)
103 Institute for Healthcare Improvement. Improving Health Equity: Guidance for Health Care Organizations. Published 2019. Accessed June 4, 2020. http://www.ihi.org:80/resources/Pages/Publications/Improving-Health-Equity-Guidance-for-Health-Care-Organizations.aspx
104 Stout, S, Polan, S, Hatchett, L, Martin, D, Smith F, Peck, J, Ayers, J and Tucker E. 100 Million Healthier Lives Program Brief on Equity. Institute for Healthcare Improvement. April 2017. Available at www.ihi.org/100mlives.
105 Hostetter M, Klein S. Using Quality Improvement Methods to Combat Poverty: Northeast Wisconsin POINT Initiative. Boston, MA: Institute for Healthcare Improvement; 2018.
106 The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available on www.IHI.org)

improvement initiative to reduce the ratio of bad debt (patient debt that is considered unrecoverable) to community care (Bellin's financial assistance program) from 2.63 to 1.32 by December 31, 2018.[107]

By interviewing patients and employees sent to bad debt, the Bellin interdepartmental improvement team designed and tested a series of PDSA cycles to increase patients' and employees' awareness of and connections to financial health resources offered by the health system.

The work of this rigorous improvement effort has led to multiple improvements within the health system, including: steady improvements in the ratio of bad debt to community care which continue today; financial health being measured at a strategic system level; the use of a simplified financial assistance application, redesigned bills, and a host of user-informed materials that help patients and employees navigate financial resources; and the evolution of the work started within the POINT into a health-system-wide campaign to end medical debt.

Leading together & leading for equity in practice: Rush University Medical Center and West Side United

In January 2017, Rush University Medical Center, Cook County Health, and University of Illinois Hospital & Health Sciences System convened 130 individuals from 50 community organizations in Chicago's West Side to discuss how they could come together to equitably improve the health and wellbeing of their community.[108] The impetus for this first meeting was the "death gap" that residents of the West Side experienced. While the residents in the downtown Loop area have a life expectancy of 85 years, those living in West Garfield Park in Chicago's West Side, a 15- minute train ride away, have a life expectancy of 69 years.[109]

The group understood that life expectancy gaps are caused by factors that stretched beyond what a health care system could address on its own, including structural racism and economic and educational deprivation. With this understanding and a growing number of partners, in early 2018, six hospital systems—AMITA Health, Ann & Robert H. Lurie Children's Hospital of Chicago, Cook County Health, Rush University Medical Center, Sinai Health System, and the University of Illinois Health System—with support from dozens of community partners and stakeholders officially launched West Side United (WSU).[110]

From its inception, WSU has demonstrated Leading Together by seeing community residents as experts and holding a series of listening sessions with them to find out what was most important to them. Based on what they heard from residents, WSU decided to focus on four priority areas: health and health care, neighborhood and physical environment, economic vitality, and education. WSU then demonstrated its commitment to authentically leading with community residents by ensuring that half of the seats on its Executive Leadership Council would be filled by community residents and that all of WSU's working committees had substantial community representation. WSU has since shown its commitment to Leading for Equity by naming the root causes of inequities in their four priority areas, including structural racism, committing to tackling these root causes, developing transparent metrics with community residents to track their progress, and stratifying this data based on race, ethnicity, and other socio-demographic factors. This has resulted in a publicly accessible dashboard on the WSU website showing progress on 14 indicators for their four priority areas.

These new ways of partnering and leading are critical ingredients that when present, will enable success of equitable, sustainable transformation. When absent, we risk undertaking efforts that waste resources, erode trust, and build upon existing systems and years of physical, emotional, and intergenerational harm to patients, the workforce, and communities.

OPPORTUNITIES FOR STRATEGIC ACTION AND BIG IDEAS FOR TRANSFORMATION

An equitable recovery will not happen on its own—it will require intention. If we design for recovery in health care without the explicit use of an equity lens, we will maintain or exacerbate inequities and injustices. We have an opportunity to create a new future together by centering equity-creating processes and a broad-based, anti-racist effort to improve the wellbeing of marginalized

107 Bellin Health Systems Presentation at 2018 IHI National Forum on Quality Improvement in Health Care
108
109 Mapping Life Expectancy. Virginia Commonwealth University Center on Society and Health. https://societyhealth.vcu.edu/work/the-projects/mapping-life-expectancy.html
110 West Side United COVID-19 Resources. West Side United website. https://westsideunited.org/. Accessed June 5, 2020.

communities, and, because we are all interconnected, to improve wellbeing for all. The approach of Targeted Universalism demonstrates this.[111]

The status quo has produced predictable inequities in our systems time and time again. In order to get different, equitable, results, we will have to challenge the status quo. As Ibram X. Kendi notes, there is no space for neutrality. We either support (actively or passively) the status quo or we actively work against it to transform our systems and communities. Kendi shares, "Racist policies yield racial inequity; antiracist policies yield racial equity. A racist or antiracist is not who we are, but what we are doing in the moment."[112] Rebuilding health care equitably will require us to actively, intentionally choose equity at each step, in each decision, and in every process. How do we do that?

First, we present a set of "we must" statements and actions for health care to undertake if we are to keep equity as the foundation of our rebuilding efforts. In the final section, to leverage and support health care's contribution to equitable recovery and resilience, we propose areas to strengthen, to disrupt, and to grow, offering a set of both 24-month strategic actions and longer-term changes for health care to undertake, both within the health care system and in partnership with others, that will contribute to a more just society.

"WE MUST"

We must ensure that all in health care have a clear picture of persistent inequities and a shared narrative of the underlying why: the root causes of inequities

To address inequities, health care must acknowledge that racism exists. It is from a shared foundation of understanding the context, history, and root causes of racism and oppression that health care practitioners and organizations can begin to improve health equity. We need agreement on a shared narrative explaining *why* inequities exist by race, ethnicity, language, housing status, immigration status, and geography in incidence, testing, treatment, and deaths related to COVID-19 and across all diseases. Moreover, it is critical that we understand why it was entirely predictable that such inequities would manifest. That narrative is critical because it shapes public opinion, supports transparency and accountability, and provides information that can inform more equitable policies and resource allocation.

Noting the disproportionate impact on Native Hawaiian and Pacific Islanders, Dr. Keaweʻaimoku Kaholokula and Dr. Robin E. S. Miyamoto, from the Department of Native Hawaiian Health at the John A. Burns School of Medicine at the University of Hawaii at Manoa, outline the reasons for the inequities, including lower wages and poorer economic and living conditions as well as poor access to quality health care.[113] They note that the pandemic has "brought clarity to the structural racism that has created these inequities and we need to engage in the critical conversations while we have the opportunity."[114] Additionally, Dr. Braithwaite and Dr. Warren explain that the inequities in the impact of COVID-19 in Communities of Color are due to structural factors and "the country's history of dehumanizing racial inequities" and conclude, "The war against the coronavirus for People of Color is part and parcel of the war to eliminate historic inequities and to level the socioeconomic playing field."[115]

If we understand these inequities as tied to larger structural injustice that was present before COVID-19 and will be present after unless we take action urgently, that allows us to work together from an aligned perspective. If we do not have the why right, we cannot hope to get the solutions right. Once in agreement on the root causes, we will be required to think and act in new ways together. Furthermore, we must agree that it is the role, responsibility, and opportunity of health care to address structural racism and injustice.

111 powell, john, Stephen Menendian and Wendy Ake, "Targeted universalism: Policy & Practice."
Haas Institute for a Fair and Inclusive Society, University of California, Berkeley, 2019. haasinstitute.berkeley.edu/targeteduniversalism. (note: john powell does not capitalize his name)
112 Kendi IX. This is what an antiracist America would look like. How do we get there? The Guardian. https://www.theguardian.com/commentisfree/2018/dec/06/antiracism-and-america-white-nationalism. Published December 6, 2018. Accessed June 4, 2020
113 Kaholokula JK, Samoa RA, Miyamoto RES, Palafox N, Daniels SA. COVID-19 Special Column: COVID-19 Hits Native Hawaiian and Pacific Islander Communities the Hardest. Hawaii J Health Soc Welf. 2020;79(5):144.146.
114 COVID-19 Hits Native Hawaiian and Pacific Islander Communities the Hardest. John. A Burns School of Medicine, University of Hawai'i at Mānoa. April 30, 2020. http://www2.jabsom.hawaii.edu/native/docs/news/NHPI-Data-re-COVID-19-Keawe-Kaholokua-Google-Docs_4-30-20.pdf
115 Braithwaite R, Warren R. The African American Petri Dish. Journal of Health Care for the Poor and Underserved. Published online April 28, 2020. doi:10.1353/hpu.0.0026

We must stratify data by race, ethnicity, language, sexual orientation, gender identity, payer status, and other relevant socio-demographic factors

We cannot improve what we don't measure. Stratified data allow us to take stock of the current state, and track and be accountable for closing equity gaps. These data must be collected as a regular practice and reported transparently. The COVID-19 racial data tracker[116] has begun this work in our current context, and we must collect, share transparently, and act on these stratified data for COVID-19 and other diseases. Health care systems have to be supported in the collection, analysis, and leveraging for action of these data with training and best practices. The Disparities Solutions Center and the American Hospital Association's Equity of Care Pledge have moved these efforts forward, as have urgent calls by the American Medical Association, American Nurses Association, National Council of Asian Pacific Islander Physicians and many others to demand the collection and reporting of COVID-19 testing and cases by race, ethnicity, and language.[117,118] In addition to quantitative data, stories from those most impacted by inequities help to build an understanding of the problem and ideas for solutions. For example, conversations with women of color regarding their experience in the health care system helped shape the approach for IHI's work on better maternal outcomes. The Well Being in the Nation Measures provide a set of core measures (e.g., well-being of people, well-being of places, and equity), leading indicators by key topic area (e.g., health care, housing, environment and infrastructure), and an expanded set of measures for consideration and adoption.[119]

Brigham and Women's Hospital has used data dashboards to review COVID-19 data stratified by race, ethnicity, and language with key leaders and decision makers to inform their community outreach efforts.[120] They name racism and structural inequities as the underlying cause of inequities. This naming implores us to examine our systems that produce these results. In Chicago, informed by stratified data demonstrating the disproportionate impact of COVID-19 on Black communities, Mayor Lightfoot has launched a Racial Equity Rapid Response team with health care institutions as key partners, to engage in community-led efforts to close equity gaps.[121]

Dr. Aletha Maybank, Chief Health Equity Officer at the American Medical Association (AMA), penned an essay noting: "Our call for the reporting of racial and ethnic data is not based on a poisonous argument that some races are more susceptible to the coronavirus. Our call, instead, is based on widely known history that American health institutions were designed to discriminate against blacks, whether poor or not."[122] Again, the understanding of why we see the present inequities leads us to a particular set of conversations, decisions, truth telling, and system redesign. The field of health care must name structural racism and injustices as the root cause of inequities and make them visible with data and stories so we can get to work on these root causes.

We must use a racial equity framework for all decisions to understand who benefits and who is left behind

Immediate decisions in the current crisis include where to place testing sites, how to approach contact tracing, and how we decide who receives life-saving treatment, and in the future, vaccines. For decisions, policies, and practices, as a standard part of our process, we can pause to ask the question, "Who benefits and who is left behind?" and be prepared to amend our plans to promote equity and justice. By making intentional space for this question, we bring our awareness to this issue and design for equity from the beginning. This requires us to share decision making power and to consider equity-creating processes—new ways of working and being that can get us

116 The COVID Racial Data Tracker. The COVID Tracking Project. https://covidtracking.com/race. Accessed June 5, 2020.
117 NCAPIP Recommendations on CDC / Health Department Data Collection for COVID-19. National Council of Asian Pacific Islander Physicians. https://mailchi.mp/od60c6de567e/covid-19-unique-opportunity-for-health-data
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119 Well-being in the Nation (WIN) Measurement Framework: Measures for Improving Health, Well-being, and Equity Across Sectors. Facilitated by 100 Million Healthier Lives with the National Committee on Vital and Health Statistics; 2019
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121 Mayor's Press Office (Press Release). Mayor Lightfoot and the Racial Equity Rapid Response Team Announce Latest Efforts to Address Racial and Health Disparities Among Minority Communities. Published April 20, 2020. Accessed June 4, 2020. https://www.chicago.gov/content/city/en/depts/mayor/press_room/press_releases/2020/april/RERRTUpdate.html
122 Maybank A. Opinion | The Pandemic's Missing Data. The New York Times. https://www.nytimes.com/2020/04/07/opinion/coronavirus-blacks.html. Published April 7, 2020. Accessed June 5, 2020.

to new outcomes. This also requires there to be space in decision making, in meetings, to raise this question and to challenge the status quo. It has to feel acceptable to raise this question, and leaders have to model and thank those who do. Racial Equity Impact Assessments[123] help to guide a stepwise process of asking critical questions at key points to mitigate inequities in process and outcomes.

Without adopting a racial equity framework from the start, we risk crafting policies that perpetuate inequities. For example, the Crisis Standards of Care (CSCs) as originally written lead to increased deaths among marginalized populations. Dr. Manchanda and colleagues note: "CSCs that deprioritize people with coexisting conditions or with a higher likelihood of death within 5 years penalize people for having conditions rooted in historical and current inequities and sustained by identity-blind policies. In the US, Black, poor, disabled, and other disadvantaged people have shorter life expectancies than White and able-bodied Americans. If maximizing life-years is the prime directive, their lives will be consistently deprioritized as compared with already-advantaged groups."[124] The policy perpetuates inequity.

When we pause to ask who benefits and who is burdened, we have the opportunity to name gaps, identify harms, and make a plan to mitigate and eliminate them.

Health care has an incredible opportunity to live into a more equitable future, addressing structural inequities head on and taking a proactive role to pursue equity and justice. IHI, together with multiple health systems, has described and begun to test a framework for pursuing equity in health care and has produced guidance documents to share case examples and learning.[125] There are five components to the theory:

Make health equity a strategic priority

Organizational leaders commit to improving health equity by including equity in the organization's strategy and goals. Equity is viewed as mission critical—that is, the mission, vision, and business cannot thrive without a focus on equity. There are three strategies for this: build will to address health equity, include equity as a priority in the organization's strategic plan and department-level goals, demonstrate senior leader ownership for and commitment to improving health equity.

> *HealthPartners in Bloomington, Minnesota, has a longstanding strategic focus on health equity and diversity and inclusion, with a strong commitment from its consumer-governed board of directors and senior leaders. Since 2005, the organization has included equity and the elimination of racial and financial class disparities in five-year stretch goals called Partners for Better Health Goals to improve the health and wellbeing of each member and patient and the entire community.[126] To advance this priority, HealthPartners' leaders focused on equipping employees with the knowledge and resources needed to provide appropriate care and services, engaging communities to learn how to best support them, and improving care through data-driven quality improvement.*

Build infrastructure to support health equity

Operationalizing a health equity strategy requires dedicated resources, including human resources and data resources, as well as organizational infrastructure and capacity building efforts. Quality and equity in health care are inextricably linked; we cannot have quality, or fully achieve the other five aims, without equity. A health care organization's quality department and equity department or team (or equity leaders, if a separate department or team does not exist) need to work in partnership to create an infrastructure that brings together their unique assets for the benefit of the patients and populations served. Quality department staff also need to view equity as a part of their job.

Address the multiple determinants of health

Health care organizations must develop strategies to address the multiple determinants of health, including health care services, organizational policies, the organization's physical environment, the community's socioeconomic status, and healthy behaviors.

Eliminate racism and other forms of oppression

Health care organizations must look at their systems,

123 Keleher T. Racial Equity Impact Assessment Toolkit. Race Forward. https://www.raceforward.org/practice/tools/racial-equity-impact-assessment-toolkit. Accessed June 5, 2020.

124 Cleveland Manchanda E, Couillard C, Sivashanker K. Inequity in Crisis Standards of Care. New England Journal of Medicine. 2020;0(0):null. doi:10.1056/NEJMp2011359

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practices, and policies to assess where inequities are produced and where equity can be proactively created. We identified five strategies for eliminating racism and other forms of oppression in health care organizations: understand the historical context for racism and other forms of oppression, address institutional racism and its impact on health equity through culture and communication, establish policies and practices to promote workforce diversity and racial equity, implement business practices that support and promote racial equity, and improve clinical processes and outcomes to narrow equity gaps and improve equity for all.

> *Boston's Southern Jamaica Plain Health Center (SJPHC) invites elders and senior organizers from their community to staff meetings to provide historical context. Many SJPHC staff also have historical knowledge of Jamaica Plain and the surrounding communities. SJPHC Directors of Racial Justice and Equity provide training on using different types of narrative to discuss the historical, cultural, and institutional patterns that have perpetuated race-based advantage. SJPHC uses the Storytelling Project Curriculum as a framework to discuss racism with staff, focused on four types of stories and how to go beyond the stock stories narrative, the first of four types of stories: 1) Stock stories: Public, mainstream stories told by the dominant group and documented; 2) Concealed stories: Not public, hidden from the dominant group, and circulated by marginalized groups; 3) Resistance stories: Current and historical stories challenging stock stories and describing how racism has been resisted; and 4) Counter stories: New stories that build on resistance stories and are constructed to disrupt the status quo and deliberately challenge stock stories.*[127]

Partner with the community

To support communities to reach their full health potential, health care organizations must work in partnership with community members and community-based organizations that are highly engaged with community members.

> *In October 2018, Main Line Health and 25 other health systems, academic institutions, and community organizations officially launched Together for West Philadelphia (TfWP), a collaborative nonprofit organization aiming to dissipate inequities in access to health care, education, food access, and opportunity. TfWP's mission is to facilitate collaboration within West Philadelphia among community, public, and private sector stakeholders to foster shared projects that maximize impact in six areas: education, employment, food justice, health equity, housing, and senior wellbeing. The power of TfWP is in the collaboration of its partner organizations. In order to break down silos and work better together, TfWP's partners share their time, ideas, and resources as part of this cohesive organization dedicated to addressing the physical, mental, and social health needs of the residents living in the five zip codes of West Philadelphia.*

The immediate actions and long-term strategies we suggest in redefining and redesigning health care's role connect to this broader, five-component theory.

Redefine and redesign health care's role: strategic actions for the short and long term

In order for the health care sector to fully contribute to equitable recovery, we need to use this moment for system redesign, both to address chronic issues and to ameliorate immediate stressors. In every step, we must leverage the design principles and approaches described above to assure we drive change that centers Black, Indigenous and People of Color.

One pitfall health care must avoid is a temptation to lead with solving the health care sector's financial challenges. This will not lead to equitable outcomes, and based on history, will likely worsen inequities. Health care is already and will likely continue to experience economic downturn. This may be experienced as a financial threat to individuals and organizations, who then may seek to maintain prior levels of revenue or income, often referred to as "keeping us whole." Yet, more is not better.[128] The Triple Aim invites us to seek balance across three sets of outcomes, striving for: better health (equitable health and wellbeing outcomes across populations); better care (equitable, patient centered, safe, effective, timely, efficient), and lower costs (more equitable, effective and intentional

127 Bell L, Roberts R, Irani K, Murphy B. The Storytelling Project Curriculum. The Storytelling Project, Barnard College;February 2008. https://www.racialequitytools.org/resourcefiles/stp_curriculum.pdf

128

distribution of limited resources).[129]

Helpful framing borrowed and adapted from social movements is to think about what in our system we want to strengthen, what we need to disrupt, and what we want to grow. Below we will explore key *strengthen, disrupt*, and grow actions—both immediate steps and long-term commitments—the health care sector, together with people with lived experiences of inequity, community, and federal partners, can take.

Strengthen, build upon, and improve

Strengthen acute care's emergency response and readiness. Our health care system is anchored in our acute care service delivery. Equitably providing necessary acute medical treatment can be health care's unique contribution in times of crisis and beyond. There are many things about the acute care response that went right during this pandemic. Let's formally learn from what worked and what did not to be ready for the next surge. At the national, regional, and facility level, we can intentionally design for acute care surges of infectious disease or other disasters. This includes planning for rapid shifts and redeployment of facilities, supplies, workforce, and protocols, and intentionally bringing an equity lens to our emergency response planning.

- Immediate actions: Establish transparent learning systems at the local, regional and national level to broadly share, learn from and build upon successes, failures, opportunities, and exemplars.
- Long-term strategies: Commit to leveraging these learnings to improve national, regional, and local coordination and response and assure care is equitable, patient centered, safe, effective, timely, and efficient.

Build upon the stability of chronic care services. Even as the number of new cases of COVID-19 patients increased, the number of patients with chronic medical needs did not necessarily decrease.[130] Patients with serious chronic conditions such as heart disease, cancer, and mental illness still need access to acute and chronic care services. We know that People of Color carry a disproportionate burden of chronic disease due to structural inequity, and if ignored, that burden will increase.[131] Simultaneously, patients with chronic disease appear to be amongst those at the highest risk of severe disease from COVID-19 if infected.[132] In addition, in the U.S. self-reported levels of thriving are at a 12-year low, and the need for mental health services is likely to grow.[133] There is an opportunity to improve the continuity of chronic care services even as resources shift to the emergency response. This will likely require innovation.

- Immediate actions: Use data and stories to understand how needs for chronic care services, with particular emphasis on mental health, shift during crisis. Identify success stories of delivery systems who creatively met needs during this unique time.
- Long-term strategies: Partner with people with lived experience to test, improve and scale new approaches to chronic and serious illness care during crises.

Improve care for the caregivers. Through this pandemic, our health care workforce has experienced significant trauma, reaching from the doctors and nurses to all health care facility workers. The workforce includes providers, food service staff, environmental services staff, and all who contribute their skills to ensure a functioning health system. Many leaders of health institutions have made caring for their workforce their highest priority. And there is a need to continue to increase our emphasis on supporting the workforce. This will require healing spaces and system level changes. Many challenges that the workforce is facing are not unique to the pandemic. Ongoing efforts should include addressing meaning and purpose, choice and autonomy, wellness and resilience, and other factors as described in the IHI Joy in Work Framework.[134]

- Immediate actions: Health care leaders can pause,

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130 Krumholz HM, M.D. Where Have All the Heart Attacks Gone? The New York Times. https://www.nytimes.com/2020/04/06/well/live/coronavirus-doctors-hospitals-emergency-care-heart-attack-stroke.html. Published April 6, 2020. Accessed June 5, 2020.

131 Abrams EM, Szefler SJ. COVID-19 and the impact of social determinants of health. The Lancet Respiratory Medicine. 2020;0(0). doi:10.1016/S2213-2600(20)30234-4

132 People Who are at Higher Risk for Severe Illness. Centers for Disease Control and Prevention website. Updated May 14, 2020. Accessed June 5, 2020. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html

133 Witters D, Harter J. In U.S., Life Ratings Plummet to 12-Year Low. Gallup. Published April 14, 2020. Accessed June 5, 2020. https://news.gallup.com/poll/308276/life-ratings-plummet-year-low.aspx

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ask, and listen to what matters to their staff with particular attention to staff of color during all the phases of this stressful time. We should provide proactive support to manage fear and anxiety in daily work; ensure psychological safety and provide opt-out mental health and wellbeing support; and create opportunities for staff to reconnect to meaning and purpose in their work.[135]

- Long-term strategies: Support efforts to create conditions for thriving for all workers within our health care setting.

Disrupt to fundamentally redesign

Disrupt the office visit as we know it. Thousands of health care providers shifted their delivery mode from in-person office visits to virtual visits (telehealth) almost overnight. Overall this has been a huge success and represents an even bigger opportunity. What if the virtual visit became the default and we only invited people into an office when absolutely necessary (even when viral exposure is less of a worry)? A large proportion of primary care, chronic care maintenance, and mental health services can be effectively delivered virtually.[136] We must resist the temptation to return to the old normal and embrace this opportunity for change.

- Immediate actions: Intentionally partner with patients to design and improve the virtual care experience.[137] Attend to differential access to technology supports in the design (such as lack of internet access for some patients). Assure ongoing appropriate payment for virtual services, language access, and access for undocumented people.
- Long-term strategies: Leverage rapid and shared learning approaches to assure virtual care is equitable, patient centered, safe, effective, timely, and efficient.

Disrupt the current pattern of overuse. We must use this time of financial challenge to eliminate overuse.[138] Some will try to tell us that we have insufficient resources, but that is only true if we attempt to go back to our prior model of overuse of care. The limited access created by fear of exposure and a shift of resources toward the crisis has slowed the delivery of many services. The delay in critical services could cause harm. We may also find some delayed services were not necessary.

- Immediate actions: Use data and stories from this acute time of delay and avoidance to better define necessary and unnecessary services through a lens of equitable health outcomes.
- Long-term strategies: Set new standards of care and align financial incentives and disincentives appropriately.

Disrupt the medicalization of childbirth. Giving birth in a hospital has likely never been so scary. The medicalization of childbirth has led to a deeply held belief in this country that the only safe births are hospital births.[139,140] This is our opportunity to move healthy birth outside of the hospital, apply a critical race lens to the care we provide,[141] expand community-based support services, and assure strong linkages to advanced emergency obstetric care when needed.

- Immediate actions: Support and expand prototypes of asset-based community co-design centering Black, Indigenous and Women of Color alongside community partners and maternal and infant health providers to re-design care for better, equitable maternal and infant health outcomes.[142,143] Shift resources to better support doulas and midwives.

135 Laderman M, Perlo J. Three Actions to Support Healthcare Workforce Mental Health and Wellbeing During COVID-19. Fierce Healthcare. https://www.fiercehealthcare.com/hospitals-health-systems/industry-voices-3-actions-to-support-healthcare-workers-well-being-during

136 Bashshur RL, Howell JD, Krupinski EA, Harms KM, Bashshur N, Doarn CR. The Empirical Foundations of Telemedicine Interventions in Primary Care. Telemed J E Health. 2016;22(5):342.375. doi:10.1089/tmj.2016.0045

137 Torres T. Ways to Prevent Telemedicine from Becoming Lesser Medicine. Institute for Healthcare Improvement. May 14, 2020. http://www.ihi.org/communities/blogs/ways-to-prevent-telemedicine-from-becoming-lesser-medicine. Accessed June 4, 2020

138 Nassery N, Segal JB, Chang E, Bridges JF. Systematic overuse of healthcare services: a conceptual model. Appl Health Econ Health Policy. 2015;13(1):1.6. doi:10.1007/s40258-014-0126-5

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141 Hardeman RR, Karbeah J, Kozhimannil KB. Applying a critical race lens to relationship-centered care in pregnancy and childbirth: An antidote to structural racism. Birth. 2020;47(1):3-7. doi:10.1111/birt.12462

142 Welch S. Testing Virtual Ways to Support New Mothers. Institute for Healthcare Improvement. May 18, 2020. http://www.ihi.org/communities/blogs/testing-virtual-ways-to-support-new-mothers. Accessed June 4, 2020.

143 Karbeah J, Hardeman R, Almanza J, Kozhimannil KB. Identifying the Key Elements of Racially Concordant Care in a Freestanding Birth Center. J Midwifery Womens Health. 2019;64(5):592-597. doi:10.1111/jmwh.13018.

- Long-term strategies: Create a new narrative for healthy birth. Set new standards for the integration of advanced emergency obstetric care in support of community centered care. Align financial incentives and disincentives appropriately, including advocating for new payment models.[144]

Disrupt and discontinue practices and investments that accelerate the destruction of the planet to be a better global citizen. Divest from infrastructure that hastens the pace of climate change and invest in climate resilient practices.[145]

- Immediate actions: Learn more (at the local, regional, and national levels; know your carbon footprint, contribution to waste production, etc.). Critically review all new building projects. Learn about exemplars and opportunities to improve.
- Long-term strategies: Create standards of practice and align financial incentives to support this approach broadly.

Grow to invest in building, partnering, and leveraging

Leverage all assets. One thing we have learned from this epidemic is the power of social action—social distancing, safer at home advisories, and using masks in public all significantly impacted the course of this epidemic by actively bending the curve and helping assure the availability of acute services for the sickest people. These efforts rely on community and individual engagement. Similarly, community and individual engagement impact a multitude of health outcomes. Strengthening community and individual supports can be protective for a range of needs, including mental health and substance use disorders, elder care, maternal and infant health, heart disease and diabetes, and violence and trauma. We have the opportunity to build a network of actors that are connected and communicating to help strengthen the community and social bonds that are needed to act rapidly in times of emergency and support one another at all times. Where effective, this should be viewed as first-line care—the foundation of our care system (not a bonus feature).

- Immediate actions: At a local level, build relationships and invest resources in trusted community supports, including People of Color in their communities, who can activate and engage residents. Move toward shared power and decision making regarding community approaches to protecting and improving the health and building thriving communities.
- Long-term strategies: Promote, invest in, support, and grow self-care, family, peer, and community support in all appropriate instances.

Grow and strengthen public health and prevention. Availability and equitable distribution of testing and contact tracing are critical elements in slowing the pandemic and managing any resurgence. These efforts are anchored in the strength of our public health system. However, public health and preventive efforts have historically been hindered.

- Immediate actions: Invest in public health infrastructure to support equitable testing, contact tracing, mitigation of infections, and other crisis management efforts.
- Long-term strategies: Elevate the investment in public health infrastructure to prevent chronic disease. Strengthen innovation and research in prevention and primary care. Shift health care resources and locus of control toward public health and social services.

Partner to assure strong linkages and appropriate integration and handoffs between primary care, prevention, public health, social services, community-based supports, and acute care services.[146] Fragmentation leads to poor and inequitable health outcomes.

- Immediate actions: At the local level, choose an organizational or agency partner. Focus on an urgent local issue related to the pandemic or other priority. Solve a problem together. Build trust. Repeat.
- Long-term strategies: Identify and dismantle political and financial barriers to collaboration and integration. Co-create an environment where collaboration is rewarded.

144 Kozhimannil KB, Zimmerman M. Keeping Moms Alive: Medicaid Policy Changes And Ideas For Systems Transformation. Health Affairs Blog. Accessed June 5, 2020. https://www.healthaffairs.org/do/10.1377/hblog20200228.150620/full/

145 Chen A, Murthy V. How Health Systems Are Meeting the Challenge of Climate Change. Harvard Business Review. Published online September 18, 2019. https://hbr.org/2019/09/how-health-systems-are-meeting-the-challenge-of-climate-change

146 Hostetter M, Klein S. Improving Population Health Through Communitywide Partnerships. Commonwealth Fund. 2012. Accessed June 5, 2020. https://www.commonwealthfund.org/publications/newsletter-article/improving-population-health-through-communitywide-partnerships.

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Unleash the power and potential of, and integrate with, the community-based workforce, both in the immediate response and recovery from COVID-19 and to help prevent, mitigate, and respond to potential future public health crises. While public health, health care, and governments can and are doing so much, a comprehensive and ultimately effective and equitable response will draw upon the resources, evidence base, creativity, and collaborative knowledge that is already present in our communities. We need an operational, policy, and financing approach to ramping up a ground-level health workforce that can address this pandemic and its impacts, as well as prepare to be mobilized and ready for potential future crises. These efforts will be most effective if they draw on the skills and abilities of contact tracers, community health workers, and the broader workforce of peer navigators, promotoras, certified peer counselors, recovery coaches, community health advocates, community connectors, and other community workers helping members of their community navigate health care and social services, or access other important services. For communities facing some of the biggest impacts of COVID-19—including racial and ethnic minorities and lower-income populations—community health workers can conduct contact tracing and provide holistic support. In other communities, a surge army of volunteer tracers or even technology-based solutions may suffice.[147,148]

- Immediate actions: Partner with states to launch a Community Health Service Corps that can scale up enhanced contact tracing.149 Before building new community workforce for response efforts such as contact tracing, explore and partner with ground-level already trained and deployed within the community.
- Long-term strategies: Support short- and long-term financing for the community-based workforce. Such funding should be tied to evidence-based delivery systems and national standards for hiring, training, and deploying the workforce. Potential sources:
  - Community benefit dollars invested in state and local "wellness trusts"
  - Emergency Congressional supplemental funding (as part of broader contact tracing packages) as well as sustainable funding sources.[150,151]
  - Payment through CMS.[152]

Grow and strengthen health care's policy advocacy role. Leverage our voice and influence to improve the living and working conditions for those our systems have marginalized. We can increase linkage between health care, community, and business and leverage our collective voices in service of shared aims. It is time to be bold alongside our communities, not only to make better decisions, but to advocate for the future and the investment that is needed to improve outcomes of our citizens.

- Immediate actions: Learn more from patients, providers, staff, and community, with particular emphasis on People of Color, to understand what policy issues are most pressing and meaningful. Many community organizations are already working to support critical areas of need, and health care can lend its voice and resources. Some areas that need our advocacy: pause evictions and foreclosures, end sharing information with immigration and law enforcement, support the expansion of Medicaid, expand transportation access; ensure a living wage, and advocate for decarceration and an end to police brutality.[153,154]
- Long-term strategies: Co-create an integrated strategic approach to drive change that matters in our communities.

147 Kangovi S. Why States May Fall Short on Contact Tracing. IHI Blog. Published May 20, 2020. Accessed June 5, 2020. http://www.ihi.org/communities/blogs/why-states-may-fall-short-on-contact-tracing
148 Kangovi S, O'Kane M. Community Health Workers: Developing Standards to Support These Frontline Workers During the Pandemic and Beyond. Milbank Memorial Fund. Published May 15, 2020. Accessed June 5, 2020. https://www.milbank.org/2020/05/community-health-workers-developing-standards-support/
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It Starts with Us

To have a chance at successful transformation requires that we start with ourselves, holding up a mirror to our organizations to make our health care institutions more equitable. Health care has an opportunity to embrace a multitude of levers to impact health and equity. Health care organizations manage investment portfolios and purchase billions of dollars of food and goods each year to run hospitals and clinics. By aligning institutional needs such as hiring, purchasing, and investment with community needs and available suppliers, health care can have a massive impact on long-term economic security, population health, and equity.

This "anchor institution" approach, developed by the Democracy Collaborative, has great potential to substantially increase health care's impact on local economies and social drivers of health and wellbeing.[155] There are a host of system wide efforts to engage in—today, tomorrow, and in the long term—and there are immediate actions health care can take within its walls to show what is possible and be a model for equitable institutions.

The Pathways to Population Health framework, co-designed by the American Hospital Association (AHA) / Health Research & Educational Trust (HRET), IHI, Network for Regional Healthcare Improvement (NRHI), Stakeholder Health, and Public Health Institute (PHI), and supported by the Robert Wood Johnson Foundation, provides a starting point.[156] In addition, IHI's Leadership Alliance has undertaken many efforts, collected from across 40+ health system members, and crafted a call to action.[157]

Immediate actions health care can take include:

- Improve equity in hiring, promotion, and pay
- Pay a living wage
- Ensure a diverse board and leadership representative of the community served[158]
- Collect sociodemographic data, including race, ethnicity, language, sexual orientation, gender identity, and other factors
- Collect and contribute to individual- and community-level measures of equity[159]
- Review and act on stratified quality, safety, and patient experience process and outcomes data
- Design a system to surface and address inequities in different parts of the organization
- Accept Medicaid
- Hire and purchase with local, women, and POC-owned businesses
- Invest in housing[160]
- Reduce medical debt and decrease the percentage of people sent to collections
- Examine patient terminations by sociodemographic factors to determine the extent of the equity gap and work to address it
- Eliminate over-policing and review the calls to security and police on patients and families for inequity[161]
- Understand and acknowledge the history of the health care institution as it relates to racism and inequity
- Be courageous

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Undoing Racism by the People's Institute for Survival and Beyond

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Building Racial Equity Trainings by Race Forward

Advancing Racial Justice in Organizations by Interaction Institute for Social Change

WHITE PAPERS, FRAMEWORKS AND GUIDES:

IHI Psychology of Change White Paper

Community of Solutions Framework and Tools

Improving Health Equity: Guidance for Health Care Organizations

WIN Measurement Framework

Liberation in the Exam Room: Racial Justice and Equity in Health Care. Southern Jamaica Plain Health Center

PATHWAYS TO POPULATION HEALTH CASE STUDIES:

New Hampshire Foundation for Healthy Communities

Providence St. Joseph Health

University of Arkansas for Medical Sciences

DEEP DIVE

BASIC NEEDS: FOOD

JUNE 2020

THE CRISIS AND THE OPPORTUNITY: OUR FOOD SYSTEM IN 2020

Paula Daniels
Center for Good Food Purchasing

BASIC NEEDS: THE CRISIS AND THE OPPORTUNITY—OUR FOOD SYSTEM IN 2020

The Center for Good Food Purchasing was founded to expand the Good Food Purchasing Program nationally through a coordinated, multi-sector coalition of public, private and civil society organizations. The Center builds support for adoption of the Program by institutions in cities around the U.S., and provides intensive technical support to institutions to translate assessment findings into a roadmap to identify purchasing targets in each of five value categories, combined with short- and long-term strategies to achieve institution goals.

The Center partners in this work with local and national leaders and public institutions that provide food to low-income and at-risk communities and works with them to direct their purchasing power to improve human and environmental health, particularly for Communities of Color; to support fair labor practices, health, and well-being for farm and food-systems workers; to create opportunities for mid-sized regional food producers and producers of color; and to support high welfare standards for farm animals. The pre-COVID-19 state of the US food system: in need of a 21st century renovation. The mid-20th Century was a turning point in the American food system, ushering in a precipitous decline in farm populations ("a 'free fall' situation leading us to 'trauma'" stated former USDA demographer Calvin Beale[1]) as farms consolidated toward large scale operations. With this shift toward highly consolidated, vertically integrated and industrially efficient agriculture came a rise in obesity,[2] a loss of agricultural biodiversity, and a rise in nitrate pollution and greenhouse gas emissions due to concentrated methods of farming and animal rearing.[3]

Before the midpoint of the twentieth century, the lowest income Americans had the healthiest diets, with a national obesity rate of around 12 percent.[4] There was more diversification of farm ownership and type: around 40 percent of the US workforce was in agriculture, and there were over six million farms.[5]

In the second half of the twentieth century, the obesity rate climbed to 60 percent, and agriculture became consolidated: now less than 2 percent of the workforce is in agriculture, and less than two million farms, while average farm size increased over 60 percent and agricultural output tripled and became increasingly specialized.[6] In the meat sector, over that same time frame, meat supply consolidated into just four companies.[7]

Much of it is causally attributed to the Cold War era of American economic expansion, a political layer built on the post World War II use of military chemicals for farmland fertilizer, ushering in the age of agricultural industrialization.[8] Other factors often cited include

1 United States Department of Agriculture. A Time to Choose: Summary Report on the Structure of Agriculture. U.S. Dept. of Agriculture, 1981, https://archive.org/stream/timetochoosesummoounit/timetochoosesummoounit_djvu.txt. Accessed 17 June 2020.
2 Centers for Disease Control and Prevention. "Adult Obesity Facts". Overweight & Obesity. Centers for Disease Control and Prevention, 27 February 2020, https://www.cdc.gov/obesity/data/adult.html. Accessed 17 June 2020.
3 Ben Lilliston, Latest agriculture emissions data show rise of factory farms (Institute for Agriculture and Trade Policy, March 26, 2019, https://www.iatp.org/blog/201904/latest-agriculture-emissions-data-show-rise-factory-farms. Accessed 17 June 2020.
4 Ogden, Cynthia L., et al. Prevalence of Overweight, Obesity, and Extreme Obesity Among Adults: United States, Trends 1960–1962 Through 2007–200. Centers for Disease Control and Prevention, June 2010, https://www.cdc.gov/nchs/data/hestat/obesity_adult_07_08/obesity_adult_07_08.pdf. Accessed 17 June 2020.
5 Dimitri, Carolyn, et al. "The 20th Century Transformation of U.S. Agriculture and Farm Policy." Economic Information Bulletin, Number 3, United States Department of Agriculture, Economic Research Service, June 2005, https://www.ers.usda.gov/webdocs/publications/44197/13566_eib3_1_.pdf?v=7007. Accessed 17, June 2020
6 *Ibid*
7 Ostland, Emilene. "The Big Four Meat Packers." High Country News, 21 March 2011, https://www.hcn.org/issues/43.5/cattlemen-struggle-against-giant-meatpackers-and-economic-squeezes/the-big-four-meatpackers-1. Accessed 13 June 2020.
8 Pollan, Michael, What's Eating America (Smithsonian, June 15, 2006). Accessed at https://michaelpollan.com/articles-archive/whats-eating-america/; retrieved. June13, 2020

corporate consolidation, federal subsidies supporting commodity marketing,[9] as well as aggressive food marketing.[10]

Our food system is an economic system managed mostly by a handful of large companies driven by a shareholder obligation to produce profit. Ten multinational companies now control most of the global food system.[11] While some of them are now recognizing the need to evolve their business practices consistent with United Nations Sustainable Development Goals, there remains little room in the prevailing economic imperative for the complexity of fair economic relationships. Food that isn't "standard" to support the efficiencies of scale, marketing and logistics, often gets wasted.[12] Cheapness" depends on low wage and often exploited labor,[13] and highly processed, manufactured food is a known contributor to chronic health problems.[14] And, with climate change creating extremes in weather as well as pest and disease proliferation, agriculture based on monoculture cropping is at risk.[15]

Olivier De Schutter, United Nations Special Rapporteur on the Right to Food, serving from 2008-2014, wrote in his January 2014 final report to the United Nations:[16]

> *"Most stakeholders agree, in general terms, on the urgent need for reform. Measured against the requirement that they should contribute to the realization of the right to food, the food systems we have inherited from the twentieth century have failed. Of course, significant progress has been achieved in boosting agricultural production over the past fifty years. But this has hardly reduced the number of hungry people, and the nutritional outcomes remain poor."*

In other words, according to many, the food system is in need of a redesign and the pre-COVID-19 status quo of the global food system was "deeply inequitable."[17]

It has been propped up on a bubble of growth and global export that is unsustainable from the standpoint of human and planetary well-being.

FOOD SYSTEM REDESIGN EFFORTS

Recognizing the urgent need for re-designing the food system, over 200 cities around the world have signed the Milan Urban Food Policy Pact since its launch in early 2014. The Pact acknowledges that:

> *"...current food systems are being challenged to provide permanent and reliable access to adequate, safe, local, diversified, fair, healthy and nutrient rich food for all; and that the task of feeding cities will face multiple constraints posed by inter alia, unbalanced distribution and access, environmental degradation, resource scarcity and climate change, unsustainable production and consumption patterns, and food loss and waste."*

The signatory cities to the Pact commit to, among many other things:

- Develop sustainable food systems that are inclusive, resilient, safe and diverse, that provide healthy and affordable food to all people in a human rights-based framework, that minimise waste and conserve biodiversity while adapting to and mitigating impacts of climate change.
- Encourage interdepartmental and cross-sector coordination at municipal and community

9 *Op. cit*., Dimitri. *The 20th Century Transformation of U.S. Agriculture and Farm Policy*
10 Chandon, Pierre, and Brian Wansink. Does food marketing need to make us fat? A review and solutions. Nutrition Reviews, 4 October 2012, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3495296/. Accessed 17 June 2020
11 Taylor, Kate. "These Ten Companies Control Everything You Buy." Business Insider, 28 September 2016, https://www.businessinsider.com/10-companies-control-the-food-industry-2016-9?op=1. Accessed 13 June 2020.
12 *An Economic Analysis of Food Waste Solutions.* ReFED, https://www.refed.com/analysis?sort=economic-value-per-ton. Accessed 17 June 2020.
13 Food Chain Workers Alliance. The Hands That Feed Us: Challenges and Opportunities For Workers Along the Food Chain. Food Chain Workers Alliance, 6 June 2012, https://foodchainworkers.org/wp-content/uploads/2012/06/Hands-That-Feed-Us-Report.pdf. Accessed 17 June 2020.
14 Bahadoran, Zahra, et al. Fast Food Pattern and Cardiometabolic Disorders: A Review of Current Studies. Health Promot Perspect., 30 January 2016, https://pubmed.ncbi.nlm.nih.gov/26933642/. Accessed 17 June 202
15 Climate Change and Land: An IPCC Special Report on climate change, desertification, land degradation, sustainable land management, food security, and greenhouse gas fluxes in terrestrial ecosystems. Intergovernmental Panel on Climate Change, 2020, https://www.ipcc.ch/srccl/. Accessed 17 June 2020.
16 De Schutter, Olivier. "Final report: The transformative potential of the right to food," Report of the Special Rapporteur on the right to food. United Nations General Assembly, 24 January 2014, http://www.srfood.org/images/stories/pdf/officialreports/20140310_finalreport_en.pdf. Accessed 17 June 2020.
17 Fraser, Evan, and Elizabeth Fraser. "10 Things You Need to Know About the Global Food System." The Guardian, 1 May 2014, https://www.theguardian.com/sustainable-business/food-blog/10-things-need-to-know-global-food-system. Accessed 17 June 2020.

> levels, working to integrate urban food policy considerations into social, economic and environment policies, programmes and initiatives, such as, inter alia, food supply and distribution, social protection, nutrition, equity, food production, education, food safety and waste reduction.

Of the 210 signatories to the Pact, only nine are US cities.

Last year, the EAT-Lancet Commission issued a report called Healthy Diets from Sustainable Food Systems. In the summary, they note: "A radical transformation of the global food system is urgently needed." The report sets out key goals, targets, and five strategies, which include:

- Seek international and national commitment to shift toward healthy diets.
- Reorient agricultural priorities from producing high quantities of food to producing healthy food.
- Sustainably intensify food production to increase high-quality output.
- Strong and coordinated governance of land and oceans.
- At least halve food losses and waste, in line with UN Sustainable Development Goals.[18]

In 2017 the Barilla Center for Food and Nutrition, in partnership with the Economist Intelligence Unit, published the Food Sustainability Index, a global study on nutrition, sustainable agriculture and food waste. They collected data from 67 countries across the world to "highlight best practices and key areas for improvement in relation to the food paradoxes and the main Sustainable Development Goals" of the United Nations. The overall best, globally, was France; other countries in the top quartile were Japan, Germany, Spain, Sweden, Portugal, Italy, South Korea and Hungary. The rank of the United States was in the bottom half.

There are many organizations in the United States dedicated to improving the food system, and in this it is important to draw a distinction between those working on systems change, by contrast to those working specifically on an aspect of the system, such as agriculture or public health.

Borrowing a definition from the Oxford Martin Programme on the Future of Food, a food system is "a complex web of activities involving the production, processing, transport, and consumption. Issues concerning the food system include the governance and economics of food production, its sustainability, the degree to which we waste food, how food production affects the natural environment and the impact of food on individual and population health."[19]

As pointed out by the Oxford Martin Programme on the Future of Food, a more holistic framework is needed to address the myriad interconnected issues pointed out above, and "a food systems approach" has become increasingly valued "to identify, analyse and assess the impact and feedback of the systems different actors, activities and outcomes to help identify intervention points for enhancing food security."[20]

More recently, an impressive level of coordination has emerged in the United States, with the recognition of the need to more formally align into coalitions or collaborations to amplify and synchronize the work as collective action toward systems change.

> Among the more recent systems oriented academically affiliated centers or programs in the United States are: CUNY Urban Food Policy Institute (a center at the CUNY Graduate School of Public Health and Health Policy); Johns Hopkins Center for a Livable Future (within the Bloomberg School of Public Health); the Center for Regional Food Systems at Michigan State University;the Berkeley Food Institute; the Tufts University Food and Nutrition Innovation Council; the Center for Environmental Farming Systems at North Carolina State University; and the Food Systems project at Colorado State University.
>
> In philanthropy, the Sustainable Agriculture and Food Systems Funders is an affinity group of "community and corporate foundations, private foundations, government agencies, health conversion foundations, investment organizations, individual donors and investors, and more" working together to amplify "the impact of philanthropic and investment communities in support of just and sustainable food

18 *Healthy Diets from Sustainable Food Systems: Food Planet Health*. Summary Report of the EAT-Lancet Commission, EAT, https://eatforum.org/content/uploads/2019/07/EAT-Lancet_Commission_Summary_Report.pdf. Accessed 17 June 2020.
19 *The Future of Food*. Oxford Martin School, https://www.oxfordmartin.ox.ac.uk/food/. Accessed 17 June 2020
20 *What is the Food System?*. Oxford Martin Programme on the Future of Food, https://www.futureoffood.ox.ac.uk/what-food-system. Accessed 17 June 2020

and agriculture systems."

Institutional affinity groups have also taken up food systems work, such as the Urban Sustainability Directors Network and their Sustainable Consumption Toolkit for food. The nation's largest School districts have formed the Urban School Food Alliance, which was particularly effective in advocating for rule waivers that would allow school districts to offer emergency meals during the first months of business interruption due to COVID-19 public health orders.[21] The Urban School Food Alliance is a collaboration started in 2012 among the largest food service divisions of the largest school districts in the country. This "alliance of alliances" now represents 12 districts, serving 3.6 million students, over 635,000,000 school meals per year, for a combined $800 million in food service. When they turned their attention to antibiotic free chicken, the poultry supply chain was compelled to meet that demand.

In the civil society, or nonprofit, sector—sometimes called NGO or non-profit; referred to here as Civil Society Organizations, or CSO's—a significant number of collaboratively based organizations are forming or growing, from local food policy councils to national collaborations and coalitions.

THE SCALE OF ENGAGEMENT: LOCAL ACTION, NATIONAL NETWORK

The worldwide growth of food policy councils in the last decade has, in turn, given rise to a dedicated project of the Johns Hopkins Center for a Livable Future, which describes food policy councils as "networks that represent multiple stakeholders and that are either sanctioned by a government body or exist independently of government, and address food-related issues and needs within a city, county, state, tribal, multi-county or other designated region."[22] In committing to this project area, The Center for a Livable Future recognizes that "... collaboration amongst diverse sectors—community, government, nonprofit and private— has emerged as a long-term strategy to create systemic and meaningful improvements in the food system."[23] Their database of food policy councils shows them at over 300 in North America.[24]

Among the more notable food policy councils is the Los Angeles Food Policy Council, launched in 2011 as an initiative of Mayor Villaraigosa of Los Angeles. It was launched with a mandate developed by a task force, to advance 55 action steps in six priority areas, directed toward the goal of building a more sustainable and equitable regional food system in the LA region of southern California.[25]

The well staffed, local government supported council gave rise to the Good Food Purchasing Program (the Program), adopted by the City of Los Angeles and Los Angeles Unified School District in 2012. The Program is now widely considered a powerful tool for leveraging market power to create a fulcrum for food system change; it harnesses the purchasing power of large institutions—particularly governmental institutions—to drive supply chain changes that increase the production and distribution of food that supports local economies, fair labor, environmental sustainability, animal welfare and public health. The Program provides a metric based, flexible framework that is the basis for a feedback and rating tool for the enrolled institutions.

It was designed through an extensive multi-sector, interdisciplinary, multi-stakeholder collaboration and review process within the LA Food Policy Council (LAFPC). Due to the immediate success of the Program at LA Unified School District, interest in adoption by other cities was piqued. In 2015 the Program was spun off from the LAFPC and became the program of the Center for Good Food Purchasing, established to advance the national expansion of the Program. It is now in 20 cities and over 45 municipal institutions across the country. The systemically holistic Good Food Purchasing Program was favorably recognized in 2018[26] by the World Future Council, the Food and Agriculture Organization of the United Nations (FAO), and IFOAM Organics International.

21 Green, Erica L., and Lola Fadulu. "Schools Transform into 'Relief' Kitchens, but Federal Aid Fails to Keep Up." The New York Times, 19 April 2020, https://www.nytimes.com/2020/04/19/us/politics/coronavirus-school-meals-relief.html. Accessed 18 June 2020.
22 *About Us.* Food Policy Networks, http://www.foodpolicynetworks.org/about/. Accessed 17 June 2020.
23 *Ibid.*
24 Food Policy Council Map. Food Policy Networks, http://www.foodpolicynetworks.org/councils/fpc-map/. Accessed 17 June 2020.
25 Good Food For All Agenda. Los Angeles Food Policy Task Force, July 2010, https://goodfoodlosangeles.files.wordpress.com/2010/07/good-food-full_report_single_072010.pdf. Accessed 17 June 2020.
26 Good Food Purchasing Program. FuturePolicy.org, https://www.futurepolicy.org/healthy-ecosystems/los-angeles-good-food-purchasing-program/. Accessed 17 June 2020.

Integral to the work of the Center for Good Food Purchasing is its collaborative approach, organizing a network of cross-sector national and local partners[27] committed to food system change.

FOOD SYSTEM REDESIGN: COMMUNITY BASED, REGIONAL FOOD SYSTEMS

Among the national partners of the Center for Good Food Purchasing is the HEAL (Health, Environment, Agriculture, Labor) Food Alliance, a "multi-sector, multi-racial" 50 member coalition working toward transformation of food and farming systems. The membership includes "rural and urban farmers, fisherfolk, farm and food chain workers, rural and urban communities, scientists, public health advocates, environmentalists, and indigenous groups."

The 10 point platform of the HEAL Food Alliance, published in 2018, is thematically inclusive and representative of the range of strategies that have cohered in the last several years around the needed direction for food system reform. Their platform is organized into four categories, with specific action steps detailed for each of the 10 points below:[28]

- Economy
  - Dignity for Food Workers
  - Opportunity for All Producers
  - Fair and Competitive Markets
  - Resilient Regional Economies
- Health
  - Dump the Junk: Curb Junk Food Marketing
  - Increase Food Literacy and Transparency: Increase knowledge of, connection to, and transparency around food sources
  - Real Food in Every Hood: Making affordable, fair, sustainable, and culturally appropriate food the norm in every neighborhood
- Environment
  - Phase Out Factory Farming
  - Promote Sustainable Farming, Fish and Ranching
  - Close the Loop on Waste, Runoff, and Energy

Similarly, the six categories for action[29] in the Milan Urban Food Policy Pact are: (1) governance, (2) sustainable diets and nutrition, (3) social and economic equity, (4) food production, (5) food supply and distribution, and (6) food waste.

FROM THE GRASS ROOTS TO THE SO CALLED GRASS TOPS, THE GOALS HAVE BEEN CONSISTENT AND EVIDENT

Incremental progress has been made in recent years toward the ideas which these pacts and platforms embrace, with many finding common ground in changing governmental purchasing practices. In his Briefing Note 8 (May 2014) *The Power of Procurement: Public Purchasing in Realizing the Right to Food*,[30] UN Special Rapporteur De Schutter recognized that "Governments have few sources of leverage over increasingly globalized food systems—but public procurement is one of them. When sourcing food for schools, hospitals and public administrations, governments have a rare opportunity to support more nutritious diets and more sustainable food systems in one fell swoop."

Procurement is also one of the recommended actions of category five of the Milan Urban Food Policy Pact, which calls for a review of "public procurement and trade policy aimed at facilitating food supply from short chains linking cities to secure a supply of healthy food, while also facilitating job access, fair production conditions and sustainable production for the most vulnerable producers and consumers, thereby using the potential of public procurement to help realize the right to food for all."[31]

As pointed out by the Union of Concerned Scientists in their 2017 report on the impacts of the Good Food Purchasing Program in Los Angeles, the "benefits of a better supply chain are amplified across institutions and regions."[32] The incremental shifts created by the

27 National Partners. Center for Good Food Purchasing, https://goodfoodpurchasing.org/about-the-center/#national-partners. Accessed 17 June 2020.
28 HEAL Platform for Real Food. HEAL Food Alliance, https://healfoodalliance.org/platformforrealfood/. Accessed 17 June 2020.
29 Milan Urban Food Policy Pact. Milan Urban Food Policy Pact, 15 October 2015, http://www.milanurbanfoodpolicypact.org/text/. Accessed 17 June 2020.
30 De Schutter, Olivier. "The Power of Procurement: Public Purchasing in the Service of Realizing the Right to Food." Briefing Note 08. United Nations, April 2014.
31 "Food supply and distribution." MUFPP Recommended actions. Milan Urban Food Policy Pact, http://www.milanurbanfoodpolicypact.org/mufpp_food-supply-and-distribution/. Accessed 17 June 2020.
32 Reinhardt, Sarah, and Kranti Mulik. Purchasing Power: How Institutional "Good Food" Procurement Policies Can Shape a Food System That's

institutions enrolled in the Program show combined totals across institutions of over $56 million in supporting local economies, over $32 million in supporting fair labor, over $20 million toward meat raised without routine use of antibiotics, and an additional $10 million supporting environmental sustainability.

A key complementary strategy is the mission driven food distributor, such as The Common Market[33] a non-profit CSO which is an aggregator and distributor of regional farm products. The mission of the nonprofit is to "connect communities with good food from sustainable family farms. We strive to improve food security, farm viability, and community and ecological health," in support of a vision of "a nation composed of vibrant regional food systems—where interdependent urban and rural communities thrive through relationships that build the health and wealth of all people."

Common Market and similar nonprofit, mission driven aggregation and distribution businesses are often informally called food hubs. They were characterized and identified in a comprehensive 2017 report by the Federal Reserve Bank of St. Louis as "being at the heart of the values-based supply chains,...that link agriculture producers with markets, while still maintaining core values and missions of equitable incomes for farmers and food systems workers, ecological and environmental sustainability, and access to healthy food.[34]

These mission driven food hubs have been an engine of food systems change, particularly effective when linked with a procurement strategy such as the Good Food Purchasing Program. And they proved particularly valuable toward addressing the urgent community needs which suddenly arose during the COVID-19 crisis.

WHAT COVID-19 HAS REVEALED

With the $900 billion food service sector[35] shut down, and our on-demand food culture ground to a halt, the COVID-19 pandemic experience starkly revealed, in almost daily headlines, the issues which the food system reform organizations had been working to address for so long.

It highlighted that farmers and small businesses have precarious livelihoods that are threatened by even a short-term loss of revenue. The shutdown of the food service pipelines they had built their business models on left many farmers and food processors dangling, with an estimated $1.32 billion loss of food,[36] imperiling their livelihoods.[37]

And yet, while the farmers and food processors were desperate to find markets for their supply, food banks were stretched beyond capacity, with not enough food to meet the dramatically sudden increase in demand.[38]

Although school districts nimbly met the challenge by diverting their cafeteria food programs to emergency meal delivery at pick up locations, they did so at great sacrifice to their budgets. The Urban School Food Alliance estimates that many school districts lost millions of dollars per day in this heroic effort.[39]

The most vulnerable in our food system were rendered even more so. Our food system workers, who are around one sixth of the nation's workforce, are essential, but the lack of safe working conditions and low pay leaves them vulnerable to contracting COVID-19 and their illness rate is rising.[40]

It was, unfortunately, not a surprise that the social determinants of health were a factor in COVID-19 illness and death, with higher rates of infection and mortality among those living in poverty, experiencing homelessness,

Better for People and Planet. Union of Concerned Scientists, June 2018.
33 Mission. The Common Market, https://www.thecommonmarket.org/about/mission. Accessed 17 June 2020.
34 Harvesting Opportunity: The Power of Regional Food Systems Investments to Transform Community (Federal Reserve Bank of St. Louis, et.al., 2017), at page 178. Accessed at https://www.stlouisfed.org/community-development/publications/harvesting-opportunity , retrieved June 15, 2020
35 https://www.ers.usda.gov/topics/food-markets-prices/food-service-industry/market-segments/
36 Tropp, Debra, et al. Harvesting Opportunity: The Power of Regional Food Systems Investments to Transform Community. Federal Reserve Bank of St. Louis and Board of Governors of the Federal Reserve System, 2017, pp. 178, https://www.stlouisfed.org/community-development/publications/harvesting-opportunity. Accessed 17 June 2020.
37 Thilmany, Dawn, et al. "COVID-19 Economic Impact on Local Food Markets." National Sustainable Agriculture Coalition, 23 March 2020, https://sustainableagriculture.net/blog/covid-economic-impact-local-food/. Accessed 17 June 2020.
38 Rector, Kevin. "Rotting food. Hungry masses. Chaotic supply chains. Coronavirus upends the U.S. food system." Los Angeles Times, 6 May 2020.
39 Urban School Food Alliance. Personal communication, 21 April 2020
40 Held, Lisa. "OSHA Faulted for Not Doing More to Protect Workers from COVID-19." Civil Eats, 16 June 2020, https://civileats.com/2020/06/16/osha-faulted-for-not-doing-more-to-protect-workers-from-covid-19/?utm_source=Verified%20CE%20list&utm_campaign=8c73dfe1d5-EMAIL_CAMPAIGN_7_3_2018_8_13_COPY_01&utm_medium=email&utm_term=0_aae5e4a315-8c73dfe1d5-294305685. Accessed 17 June 2020.; Food Chain Workers Alliance. The Hands That Feed Us.

and among ethnic minorities.[41] It is well known in public health that American racial minorities—particularly African American and Native Americans and Hawai'ians—suffer greater chronic diseases such as diabetes, obesity and hypertension, and it is now shown that these comorbidities lead to worse health outcomes in the case of COVID-19.[42] These underlying health conditions have long been attributed to the poor quality of nutrition in oppressed communities.[43] The inequitable availability of healthy food is apparent in low income communities which have limited access to affordable, nutritious food and instead are reliant on cheap, over processed food which is high in calories but low in nutrient density.[44]

The challenge to the nation's meat supply due to processing plant shutdowns was also problematic. The centralized efficiencies and economies of scale proved big enough to fail,[45] as shown by the health threat to workers[46] and the disruption to commodity meat supply due to virus outbreaks in the small number of packing plants in the hands of only a few highly consolidated and vertically integrated meat companies. Ninety-Eight percent of US meat is processed in 50 plants; six multinational companies[47] now control the world's meat supply. The supply chain is efficient, but it is not resilient. Further, the pursuit of production at the risk of the health of processing plant workers, was reported to benefit the profit driven export model of the large American meat businesses, not American consumers.[48]

THE SYSTEM THAT PUT PROFITS OVER PEOPLE SIMPLY DID NOT WORK

What did work? The more regionalized, localized aspects of the food system, particularly as supported by coordinated, community based networks.

The less centralized and more localized management of meat from ranch to retail was more nimble in a crisis; it is also found in the ranching systems that prioritize humane practices and ecological well-being, such as Blue Nest Beef, First Hand Foods, Belcampo, and Mary's Chicken, to name just a few. Most of these ranchers built their businesses by selling to high end restaurants; during this first phase of our COVID-19 experience, they were able to sell direct to consumers or deliver to food banks,[49] and meet the needs of the times. Not so with the consolidated meat conglomerates, who were locked into the rigid systems of scale they have created.

Those areas that had such mission aligned food hubs were able to pivot quickly toward redirecting their supply chains to areas of need, such as the example of The Common Market providing intermediary support for local farmers and emergency food relief in New York, Georgia, and Texas. Due to the relationships it developed in building its community-centered model, it was quickly able to pivot and connect the dots of supply and demand, operating within its existing networks.[50]

Local governments also learned to connect these dots

41 Abrams, Elissa M. and Stanley J. Szefler. COVID-19 and the impact of social determinants of health. The Lancet, 18 May 2020, https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30234-4/fulltext. Accessed 17 June 2020.
42 Kirby, Tony. "Evidence mounts on the disproportionate effect of COVID-19 on ethnic minorities." The Lancet, vol 8. The Lancet News, June 2020, https://www.thelancet.com/pdfs/journals/lanres/PIIS2213-2600(20)30228-9.pdf. Accessed 17 June 2020; Petrilli, Christopher M., et al. Factors associated with hospitalization and critical illness among 4,103 patients with COVID-19 disease in New York City. medRxiv, 11 April 2020, https://www.medrxiv.org/content/10.1101/2020.04.08.20057794v1. Accessed 17 June 2020.
43 Popkin, Barry M.. Global nutrition dynamics: the world is shifting rapidly toward a diet linked with noncommunicable diseases. The American Journal of Clinical Nutrition, vol. 84, issue 2, August 2006, pp. 289-298, https://academic.oup.com/ajcn/article/84/2/289/4881816#sec-1. Accessed 17 June 2020.; Mau, Marjorie K., et al. Cardiometabolic Health Disparities in Native Hawaiians and Other Pacific Islanders. Epidemiologic Reviews, 16 June 2009, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2893232/. Accessed 17 June 2020.
44 Ver Ploeg, Michele. Access to Affordable, Nutritious Food Is Limited in "Food Deserts." United States Department of Agriculture, Economic Research Service, 1 March 2010, https://www.ers.usda.gov/amber-waves/2010/march/access-to-affordable-nutritious-food-is-limited-in-food-deserts/. Accessed 17 June 2020.
45 Grandin, Temple. "Temple Grandin: Big Meat Supply Chains Are Fragile." Forbes, 3 May 2020, https://www.forbes.com/sites/templegrandin/2020/05/03/temple-grandin-big-meat-supply-chains-are-fragile/#719dfc06650c. Accessed 17 June 2020.
46 Lakhani, Nina. "US coronavirus hotspots linked to meat processing plants." The Guardian, 15 May 2020, https://www.theguardian.com/world/2020/may/15/us-coronavirus-meat-packing-plants-food. Accessed 17 June 2020.
47 Corkery, Michael, and David Yaffe-Bellany. "The Food Chain's Weakest Link: Slaughterhouses." The New York Times, 18 April 2020, https://www.nytimes.com/2020/04/18/business/coronavirus-meat-slaughterhouses.html. Accessed 17 June 2020.
48 Polansek, Tom. "As U.S. meat workers fall sick and supplies dwindle, exports to China soar." Reuters, 10 May 2020, https://www.reuters.com/article/us-health-coronavirus-usa-meatpacking-an/as-u-s-meat-workers-fall-sick-and-supplies-dwindle-exports-to-china-soar-idUSKBN22N0IN. Accessed 17 June 2020.
49 Curtis, Jennifer. "Firsthand Foods Community Fund." Firsthand Foods, 26 March 2020, https://firsthandfoods.com/2020/03/26/first-hand-foods-community-fund/. Accessed 19 June 2020.
50 The Common Market in the News. The Common Market, https://www.thecommonmarket.org/about/press. Accessed 17 June 2020.

from their command centers of the frontline responses to the public health crisis and its economic fallout.[51] They learned to match unused restaurant capacity with the growing community need for meal support, as with the model of the World Central Kitchen, and provide other services to match supply and demand.

The nation realized how much food is a public good, and that governments have an important role in its equitable distribution.

This experience underscores the view that food system change works most effectively and comprehensively where there are a few key elements in place:

- A collaborative, multi-sector coalition (like a food policy council) focused on a localized food system with shared values of community, equity, economic and environmental health.
- Quantifiable goals to direct the purchasing power of large anchor institutions (such as schools and hospitals) toward increasing economic viability along a values based supply chain .
- Supply chain infrastructure that includes mission driven centers of aggregation and distribution (food hubs), dedicated to the same vision and goals of the collaborative.
- Deeply invested, community informed local government leadership to connect the necessary dots within and across the many city and county agencies that intersect with food—which should include the workforce and economic development teams, in recognition that the food system is an economic one that responds to financial incentives and investments.

A more regionally oriented food system should be high on any resilience agenda. A system that serves community health, workers, and local businesses along those supply chains, can be a more resilient system in times of crisis. Indeed, this recommendation is being made for all systems in addition to the one for food.[52]

CHANGING COURSE

Healthy food, and the ability to make a fair living producing, picking, packing, and processing it, are essential to the equitable well-being of everyone who participates in the food system. The food system is an essential service, and managing it in a way that is sustainable for the planet and people is a social, economic, and environmental imperative. This increasingly urgent call to action is heightened by imminent threats of climate change to our food production systems. Here are some principles and steps to which commitment should be renewed, and action accelerated.

CITIES CAN LEAD THE WAY

As the COVID-19 crisis has illustrated, cities have a better understanding of their residents' needs, and the programs and processes that can work best for their population. In our modern, global context with the fluidity and immediacy of exchange in communication and culture, cities have the ability to network in a way not previously available.

Cities are the scale of government at which a more regionally responsive food system should be created. With financial and policy support from their national and state governments, cities can lead the way toward a regionally resilient food system that supports local and neighboring rural economies, when actively engaged in and informed by community, and the CSO sector.

- More cities in the US should commit to the Milan Urban Food Policy Pact and participate in the C40, a network of world cities that meet regularly to address climate change. At their October 2019 meeting, C40 leaders issued a Good Food Cities Declaration,[53] now signed by 13 major cities, which pledges to align food procurement to planetary and dietary health, and reduce food waste.
- Affinity groups of cities are already available to share best practices and learn from each other in the United States, such as the US Conference of Mayors, and Living Cities.
- Municipal leaders can tap into those networks to help fulfill their goals through implementation steps

51 CBSNewYork. "Coronavirus Update: De Blasio Pledges 'We Will Not Allow Any New Yorker To Go Hungry' As City Launches $170 Million Initiative To Fight Food Insecurity." CBSNewYork, 15 April 2020, https://newyork.cbslocal.com/2020/04/15/coronavirus-update-de-blasio-pledges-we-will-not-allow-any-new-yorker-to-go-hungry-as-more-face-food-insecurity/. Accessed 17 June 2020.
52 Slaughter, Anne-Marie. America, Not Trump, Will Save America. New York Times, 22 March 2020.; Newitz, Annalee. "Why Cities Fail." The New York Times, 17 May 2020.
53 The Good Food Cities Declaration. C40 Cities, https://www.c40.org/other/good-food-cities. Accessed 17 June 2020.

and best practices such as the ones set forth below.

USE PUBLIC CONTRACTS TO EXPRESS PUBLIC VALUES AND SET REGIONAL TARGETS

The procurement process of large institutions allows them to obtain reasonable percentages of value-based food within their budgets, as conveyed to the food service or supply bidders through Requests for Proposals. The financial security of the long-term, high-volume contracts of schools and other large institutions is a lower risk opportunity for the supply chain.

If cities as centers of regional food change were to coordinate their public food procurement contracts with value based goals, the combined purchasing power could be the basis for a more equitable, community centered, mid-scale food supply chain, operating alongside the more globalized supply chain, much like the way renewable energy operates alongside the prevailing energy fuel system.

A mid-tier or community level system—one organized as a regional supply chain calibrated with value based purchasing policies with large scale commitments from public institutions—could support entrepreneurial responsiveness to the varied needs of a community.[54]

- Cities and counties should adopt purchasing targets for all their large food service institutions that direct a meaningful percent of purchases to the public values of local economic support, fair wages and working conditions, and people and planetary health.
- Goals supporting local economies, sustainable production practices, fair labor practices, and nutritional health should be targeted and implemented with equivalent priority.
- Equity goals should be front and center, as shown in the Good Food policy resolutions of Cook County, Illinois,[55] and should incorporate access to land and capital for historically dispossessed communities.[56]
- City and county leaders should aggregate the institutional targets into regional targets.
- They should extend their reach beyond municipal and school food to include hospitals, military bases, jails and other publicly funded food programs available in each city; the aggregate dollars available to nurture a good food system would be more than enough to make a difference in the regional food economy and in the well-being of their region.
- They should implement these targets by holding their public institutions accountable in bi-annual publicly presented progress reports.
- Those targets should be backed up with contractual commitments to producers and distributors.
- Nationally networked city procurement goals could be leveraged to influence the federal role in funding aspects of the food system.
- Develop and direct financial incentives to the anchor institutions to enable purchasing support for fair wage and climate friendly food production practices such as soil health and incentives should include an increase in school meal reimbursements for the procurement of local, sustainable, fair, and humanely produced foods to provide all students access to nutritious, high-quality, local food, building on the pioneering local food incentive models established in Michigan,[57] Oregon,[58] and New York.[59]

ADOPT, COORDINATE AND FUND AN INTEGRATED SUITE OF POLICIES AND PROGRAMS THAT SUPPORT THE REGIONAL TARGETS

US consumers spend an estimated $1 trillion a year on food, which is nearly 10 percent of the gross domestic product.[60] Upwards of 20 million people are employed in

54 Lyson, Thomas A., et al. Food and the Mid-level Farm: Renewing an Agriculture of the Middle. MIT Press, 23 May 2008.
55 Cook County Board of Commissions. To Adopt The Good Food Purchasing Policy. 14 May 2018, https://gfpp.app.box.com/v/Resolution-CookCountyIllinois. Accessed 17 June 2020.
56 Leveling the Fields: Creating Farming Opportunities for Black People, Indigenous People, and Other People of Color. Union of Concerned Scientists and Heal Food Alliance, 2020.
57 10 Cents a Meal for Michigan's Kids & Farms, https://www.tencentsmichigan.org/. Accessed 19 June 2020.
58 Kane, Deborah, et. al. The Impact of Seven Cents. Ecotrust, June 2011, https://ecotrust.org/media/7-Cents-Report_FINAL_110630.pdf. Accessed 19 June 2020.
59 Farm-to-School. New York State, https://agriculture.ny.gov/farming/farm-school. Accessed 19 June 2020.
60 Ag and Food Sectors and the Economy. United States Department of Agriculture Economic Research Service, https://www.ers.usda.gov/data-products/ag-and-food-statistics-charting-the-essentials/ag-and-food-sectors-and-the-economy/. Accessed 19 June 2020.

the food industry, inclusive of production, distribution, processing, retail service and waste management.[61] Nationally, the single largest percentage of manufacturing jobs has been in the food sector.[62] And, for every four workers employed directly by the food system, another job is created indirectly due to economic activity of food system industries.[63] In other words, it is a powerful economic engine.

Small businesses are the connective tissue in our economy, and also the people taking the risks to make new models work. Per the Small Business Administration, there are around 28 million of them—defined as 500 employees or less—in the United States.[64] Most of the new jobs in the country are created from small businesses. The survival rate, however, is generally less than 10 years.[65] Providing a supportive structure for our small business risk takers in a re-designed food system is paramount to our future success on many levels.

Most major cities across America have robust programs to help small neighborhood markets source and sell healthy produce. They could provide more consistent long term support for those enterprises.

Urban and peri-urban agriculture and aquaculture are examples of distributed, localized food production systems with job creation potential, that currently struggle through multiple barriers to entry with very little to no public funding support.

Each region can design its own blend of programs and policies, in the way each region set goals for renewable energy that have unique blends of solar, wind, geothermal, or biomass. We have learned enough in the 21st Century to know that in addition to offering "all of the above" approaches to our multiple-choice problems, there is no one size fits all.

- The economic development, workforce investment, sustainability offices, public health and urban planning departments should be fully committed and coordinated toward implementing the values based regional targets.
- The municipal entities should work in partnership with rural communities, civil society organizations (including nonprofit and philanthropic) in developing action steps and achieving the regional targets.
- Coordination and cooperation should also be sought with the state level departments of food and agriculture, business development, education and health.
- Dedicate a permanent stream of government funding for value-chain innovation among regional suppliers to create those shorter supply chains, such as the mission driven distribution infrastructure in food hubs dedicated to intermediary work between local small to mid-sized farmers and food businesses, and public institutions, neighborhood markets and community serving organizations—this mission driven distribution infrastructure is worthy of public investment for the public good that is realized through more equitable distribution of food.
- Capital projects such as the warehousing and logistics involved in distribution, as well as school kitchens and incubator style commercial kitchens, could be supported through public finance mechanisms such as local bond measures.[66]
- There should also be investment in localized and decentralized meat, grain, and produce processing facilities that support local ranchers, growers, fisherman and fish farmers to enable their operations to get to mid-scale.
- Invest in the people power to coordinate and integrate the complex ecosystem of cross-sector partnerships between the public, private, and

61 Food Chain Workers Alliance, and Solidarity Research Cooperative. No Piece of the Pie: U.S. Food Workers in 2016. Food Chain Workers Alliance, November 2016, http://foodchainworkers.org/wp-content/uploads/2011/05/FCWA_NoPieceOfThePie_P.pdf. Accessed 19 June 2020.
62 Torpey, Elka. "Got skills? Think manufacturing." U.S. Bureau of Labor Statistics, June 2014, https://www.bls.gov/careeroutlook/2014/article/manufacturing.htm. Accessed 19 June 2020.
63 Local Food Impact Calculator. USDA Agricultural Marketing Service and Colorado State University, https://calculator.localfoodeconomics.com. Accessed 17 June 2020.
64 Frequently Asked Questions. SBA Office of Advocacy, September 2012, https://www.sba.gov/sites/default/files/FAQ_Sept_2012.pdf. Accessed 19 June 2020.
65 Do economic or industry factors affect business survival?. SBA Officer of Advocacy, June 2012, https://www.sba.gov/sites/default/files/Business-Survival.pdf. Accessed 17 June 2020.
66 Food Systems Finance Resource Center. Council of Development Finance Agencies, https://www.cdfa.net/cdfa/cdfaweb.nsf/resourcecenters/foodsystems.html. Accessed 17 June 2020.

civic sectors critical for building, maintaining, and activating strong local and regional food systems, especially during times of crisis. Each region could also explore the cultivation of an additional funding stream to support those coordinated goals.

RECOGNIZE, ACCOUNT FOR, AND BALANCE, THE TRUE COSTS OF FOOD

The singular focus of the business model that made cheap food possible overlooks the cost to society of suffering with or cleaning up pollution, the cost of aiding large segments of the population that are not paid enough to buy the food they handle, and the public health costs from the cardio-metabolic disorders that are a direct consequence of industrially created highly processed cheap food. The challenge is the uninformed choices we are making that perpetuate the problem. For example, the presence of sugar in sodas marketed aggressively to children is causally linked by public health officials to the alarming increase in obesity and diabetes among the youth of the world. Yet the purveyors of the sodas do not bear the medical costs of addressing the health problems their products have created. Most often, the public does, through the subsidized health care system. The medical costs are external to the price of the soda paid by the teenager and received by the soda company, yet they are a significant consequence of the transaction.

Illuminating the cost to society of these negative externalities through a true cost accounting framework might be a way to rework this unintentionally reinforcing system, of re-ordering policy priorities and bringing the system back into balance. This work is supported as a strategic initiative by the Global Alliance for the Future of Food an international alliance of philanthropic foundations which has as a strategic focus the recognition of the true cost to society of the negative externalities of food. Their initiative is called True Cost Accounting in Food.

Several studies are underway to "account" for the externalities. In 2018, UN Environment launched a study called The Economics of Ecosystem & Biodiversity in Agriculture and Food (TEEBAgriFood). The study is grounded in a systems perspective, the "visible and invisible impacts and dependencies," and produced a framework which the study authors suggest should be used in business analysis, policy evaluation, and national accounting.[67] The framework integrates cost benefit analyses, life cycle assessments, and multi-criteria analyses to characterize four "capital flows" from a food product or practice, assessed against impacts to natural capital, produced capital, human capital, and social capital.[68]

This framework is one of the more well known of a number of similar efforts, including Nature & More, an initiative of Eosta, a Netherlands based organic food distributor which is putting true cost accounting principles into practice. They have implemented true cost practices in their bookkeeping, which means that they calculate the impacts on natural and social capital in monetary terms, in addition to financial flows.[69] In this, they create transparency in an otherwise opaque bottom line.

The result is that a higher priced organic product, such as a strawberry, could be valued as incorporating into its cost the true price of farming the strawberry without offloading the cost to society of the pesticides that would harm the environment and the field worker. The affordability of the organic strawberry could then be addressed by government policy, such as the highly successful Market Match[70] programs (known in some states as Veggie Voucher or Double Up Bucks) which match nutrition assistance benefits dollar for dollar when used to buy fruits or vegetables at a farmer's market.

- Information from true cost accounting studies should be incorporated into decision making and the framework applied in business accounting and policy making.

CONCLUSION

These actionable implementation steps would restore a balance of community relationship to food, and to each other, that is a reminder of our very nature as humans on a fragile planet.

If this food "system" conversation started with Francis Moore Lappe and others of the 1970's, we should look to the changes ahead with her words in mind:

67 Muller, Alexander, and Pavan Sukdhev. Measuring What Matters in Agriculture and Food Systems. The Economics of Ecosystems & Biodiversity, UN Environment, 2018, http://teebweb.org/agrifood/wp-content/uploads/2018/10/Layout_synthesis_sept.pdf. Accessed 17 June 2020.
68 *Ibid.*
69 What is True Cost Accounting?. Nature & More, EOSTA, https://www.natureandmore.com/en/true-cost-of-food/what-is-true-cost-accounting. Accessed 17 June 2020.
70 Impact Report: Food Insecurity Nutrition Incentive (FINI) Grant and California's Market Match. The Ecology Center, 2018, https://marketmatch.org/wp-content/uploads/2018/09/Market-Match-Impact-Report-2018_web.pdf. Accessed 17 June 2020.

> *"Can the 21st century be the era in which human beings finally come home, meeting our deep need for security and meaning not in ignoring or conquering, but in living within the community of nature? Now that the stakes are indisputably ultimate, we can break through the limits of the inherited mechanistic worldview and discover the real meaning of the era of ecology—that our very being is dependent upon healthy relationships. We can find in the focus on relationships—the key insight of ecology—the beginning of what we need to meet the multiple crises affecting us, from homelessness to the environmental crisis itself."*

Those words are from her preface to the 1991 reprint of *Diet for a Small Planet* (Ballantine Books, 1971). Now that we are well on our way to a new era in our food system, let's hope the answer to her question is "yes, we can."

ADDENDUM

Immediate Action Steps to Address the food security and local farm economy impacts of the COVID-19 crisis.

National Farm to School Network advocacy priorities

The National Farm to School Network was launched in 2007 as a coalition of 30 organizations working toward a "local, equitable food system that promotes the health of the population, the economy & the environment." It now has 20,000 network members in all 50 states, which they support with capacity building, and policy development and advocacy at all levels of government. With their support, over 450 bills and resolutions were introduced throughout the US in the last decade; a notable achievement was the successful passage of comprehensive farm to school legislation in 25 states, resulting in "funded grant programs, funded coordinator positions, or funded local procurement incentives."

The following recommendations from their May 2020 policy brief were condensed for inclusion in this document.

Waive the non-federal match requirement for local food and agriculture programs, including Farm to School grants, for the next two years

- Why NFSN is working on this: Local and state governments and nonprofits will be hard-pressed to come up with non-federal matching funds now and as they recover from the COVID-19 pandemic. Communities where charitable and state resources have been the hardest hit will now have an additional barrier to accessing federal Farm to School grants. The same will be true for many grant programs that serve beginning and socially disadvantaged farmers and producers and regional food systems. Matching requirements disadvantage areas with less local philanthropy on which to rely,[71] especially in Southern states.
- The HEROES Act waives the non-federal match requirement for Food Distribution Program on Indian Reservations (FDPIR) and emergency COVID-related Local Agriculture Marketing Program (LAMP) funding, but not for the regular LAMP grants or other matching grants. A cost-share waiver should be extended to the normal grant cycles for the next two years for Farm to School grants, Value-Added Producer Grants, Farmers Market and Local Food Promotion Program, and the Beginning Farmer and Rancher Development Program.
- NFSN is advocating in the Senate for the Farm to School match waiver, and ideally other match waivers, to be included in any future COVID-19 relief legislation. The requirement for a non-federal cost-share is written in statute and must be waived by Congress.

Cover operational and emergency costs of Child and Adult Care Food Program (CACFP) sites

- Why NFSN is working on this: Many daycare and early childhood education (ECE) sites are financially struggling due to closures and the emergency expenses associated with the pandemic. The food children receive in ECE is a critical source of nutrition and shapes their future palates. Faced with mounting costs, ECE sites may choose not to participate in CACFP, may curtail or end their farm to ECE activities, or may close entirely.
- A measure included in the HEROES Act provides CACFP sites with the administrative portion of what they would have received in their normal reimbursement (using 2019 numbers).

71 Winne, Mark, and Andy Fisher. "Op-ed: With Food Insecurity on the Rise, Nutrition Incentives Should Be More Equitable." Civil Eats, 14 May 2020, https://civileats.com/2020/05/14/op-ed-with-food-insecurity-on-the-rise-nutrition-incentives-should-be-more-equitable/. Accessed 17 June 2020.

Create a set-aside small business relief fund for producers of color

- Why NFSN is working on this: Communities of Color have been especially hard-hit by the COVID-19 pandemic. Producers of color, historically denied access to USDA resources, are the least likely to benefit from the agriculture assistance payments that have been passed so far. The largest farmers, and those with existing relationships with Farm Service Agency (FSA) offices, will have a much easier time accessing these new programs quickly. The bills passed in relation to the COVID-19 pandemic have not included specific set-asides for producers of color (or "socially disadvantaged," in USDA terms). There is language to direct funds to minority lenders (banks with a majority of "minority" owners), but that does not help individual producers.
- NFSN asked for a $300 million set-aside for producers of color in its federal policy platform.[72]

Authorize USDA to issue farm credit debt relief for small producers

- Why NFSN is working on this: The Intertribal Agriculture Council has advocated for immediate measures from USDA to reduce farmer debt, by combining loan deferral and extension of the repayment period for FSA loans (Farm Ownership loans in particular).
- This approach would provide immediate financial relief without requiring a new program to be created. To avoid use of this relief by larger corporate producers, it would require payment limits and/or limits placed on the Adjusted Gross Income.

Expand online Supplemental Nutrition Assistance Program (SNAP) authorization

- Why NFSN is working on this: Many farm to school producers are turning to direct market opportunities as their institutional outlets have closed or reduced volume. At the same time, the expansion of Pandemic EBT for school meal- and CACFP-eligible families has shifted more purchasing power into consumers' hands directly. Unfortunately, only a handful of the largest retailers are currently able to serve online SNAP purchasers. This reduces choice and access for the consumers while disadvantaging the local producers who are not able to accept online SNAP. It was an issue with the pilot program, but with the pandemic, making online purchase and pickup/delivery accessible has become exponentially more important.

An Assessment of Impacts to Local Farming Due to the Public Orders Halting Food Service During COVID19 Management; Recommendations

The following economic impact assessment and recommendations was compiled in March, 2020 for the National Sustainable Agriculture Coalition by Dawn Thilmany, Becca Jablonski, Debra Tropp, Blake Angelo, and Sarah Low. More information about the authors can be found at the end of the document. It has been edited for presentation in this section. Please see the original report for its data sources and author information.

Among the businesses facing losses as a result of COVID-19 are the farms and ranches that sell through local and regional food markets. Social distancing measures such as the closure of universities, schools, restaurants, and local food markets (e.g., farmers markets, farm stands) will result in significant shifts in where food is sold or acquired, and subsequently, markets for farms and ranches. The Congressional Research Service estimated local food sales at $11.8B in 2017, with nearly 8 percent of U.S. farms and ranches (159,000 operations) participating. The vast majority (85 percent) of participating farms and ranches are small. Further, about one in four beginning farmers and ranchers use local food markets to differentiate their product (and get prices above commodity pricing) . Census data from 2007 and 2012 show that beginning farmers that had local food sales had higher average survival rates across all sales classes, and that local food markets can support profitable operations, even at the lowest sales categories.

Across key local and regional markets (i.e., farmers markets, farm to school, food hubs serving other institutions, and restaurants) we estimate a $688.7 million decline in sales leading to a payroll decline of up to $103.3 million, and a total loss to the economy of *up to $1.32 billion from March to May 2020*. Without immediate mitigation, we may lose many small, socially disadvantaged, and beginning farms and the important markets they serve.

72 National Farm to School Network Federal Policy Response to COVID-19. National Farm to School Network, 6 May 2020, http://www.farmto-school.org/documents/NFSN-COVID-PolicyPlatform.pdf. Accessed 17 June 2020.

Projected impacts by selected market, based on March-May period of social distancing:

Farmers Markets

- With COVID-19 induced market losses of 10-25 percent, there is an estimated $240 million to $600 million decline in sales, leading to a $36 million to $90 million decline in payroll paid by farms marketing to local markets.
- The multiplier effect of a loss of $240-600 million in sales would lead to an estimated loss to the community economy of: $460 million- $1.15 billion.

Policy Recommendations

- Explicitly Include Local Food and Farm Businesses in Small Business Support Programs: Declare local farm and food assets as key community assets. Require emergency food assistance dollars flowing to communities to support local farm and food businesses. Explicitly integrate local farm and food business into all small business, workforce and emergency payments/loan programs.
- Expand Incentives for Small Food and Farm Businesses to Move Online: Aggressively encourage farmers to integrate online ordering/ sales platforms, as increasingly states (e.g., CT) are requiring practices that limit customer interaction.
- Accelerate Waivers and Expand Flexibility for Current USDA Programs: Leverage congressional and executive authority to waive limitations on the reach of feeding programs' ability to purchase food from local and regional suppliers. Relax expenditure limitations so that current USDA award recipients can innovate and rapidly respond to community needs, e.g., Michigan reported that due to lost sales at schools, their Michigan Farm to Freezer program is shifting to freeze items for other markets. Expand and add flexibility to the LAMP and Value-Added Producer Grant Programs so future awards incentivize innovations that enhance rapid responses to future supply disruptions.

Farm to School

- An estimated 10 percent loss in farm to school sales will result from COVID-19. Total farm to school purchases were $789 million during the 2013-2014 school year. A 10 percent loss of direct and intermediated sales means an estimated $613 million revenue loss.
- Given estimates of labor share of local farm market revenues, this would equate to $9.2 million in lost payroll.
- The multiplier effect of a loss of $61.3M in farm to school sales would lead to an estimated loss to the community economy of: $120.3 million.

ADDITIONAL RESOURCES

Feeding American and its Hunger Action Center, Map the Meal Gap http://map.feedingamerica.org; recent report in impacts https://www.feedingamerica.org/research/coronavirus-hunger-research?s_src=W206REFER&_ga=2.59180205.1240024909.1592151695-1725205861.1592151695

Share our Strength https://www.shareourstrength.org, parent org of No Kid Hungry, teamed up with the James Beard Foundation to support the Community Meals Fund pending https://www.nokidhungry.org/who-we-are/pressroom/available-comment-share-our-strength-james-beard-foundation-urge-congress

DEEP DIVE

HUMANE HOUSING

JUNE 2020

HUMANE HOUSING: PLACE-BASED RESILIENCY & EQUITABLE RECOVERY

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HUMANE HOUSING: PLACE-BASED RESILIENCY & EQUITABLE RECOVERY

Enterprise Community Partners (Enterprise) is a proven and powerful nonprofit that improves communities and people's lives by making well-designed homes affordable and connected to opportunity. As a social enterprise, we bring together the nationwide know-how, policy leadership, partners, donors and investors to multiply the impact of local affordable housing development. Over more than 35 years, Enterprise has created 662,000 homes, invested nearly $53 billion and touched millions of lives. Our vision is that one day, every person will have an affordable home in a vibrant community, filled with promise and the opportunity for a good life. Our mission is to create opportunity for low- and moderate-income people through affordable housing in diverse, thriving communities.

Enterprise is the only housing organization in the United States with the expertise to multiply the impact for people and communities. We deliver the capital, develop the programs, and advocate for the policies needed to create and preserve well-designed homes that people can afford in inclusive and connected communities. Our talented staff bring agility and expertise in both the public and private sectors across a range of critical areas, and we are dedicated to improving and innovating housing solutions around the country.

We developed the national standards for greener, healthier communities, and we're continuously researching and sharing key data and lessons learned with our partners so that affordable homes and resources are more effective and families succeed.

Guided by exemplary board members—leaders in the public, business and nonprofit sectors—we are headquartered in the Mid-Atlantic and have offices in eleven markets nationwide, from New York to Los Angeles, as well as local, state and national partnerships.

Our Building Resilient Futures initiative brings together three vital Enterprise programs that collectively work to help protect people, homes, and communities:

- One of Enterprise's newest programs, Culture & Creativity, promotes art, creative placemaking, and more to build vibrant communities where engaged residents thrive and local economies succeed.
- For over 15 years, Green Communities has continued to break new ground by offering a framework and technical resources for healthy, environmentally sound affordable homes and communities.
- Since the devastation of Hurricane Katrina, we have introduced Recovery & Rebuilding, an important risk-mitigation resource to help vulnerable communities prepare for, recover, and rebuild after natural disasters.
- Resilience is more than just being able to bounce back or rebuild after a disaster. It's about drawing from the inherent strength in communities and helping everyone prepare for and move forward in the face of our new climate future.

DEVELOPING NEW STANDARDS

We believe that every affordable home should be well-designed and able to withstand the effects of our changing climate. That's why we support policies that direct dollars quickly and effectively where they're needed most and incentivize developers to make affordable homes climate resilient.

Enterprise also provides equity, loans, and grants that prioritize climate-resilient homes and communities.

We're creating new ways to make environmentally sound homes be cost-effective. Together, we can make climate resilience the norm not the exception by using the 2020 Green Communities Criteria and Keep Safe: A Guide for Resilient Housing Design in Island Communities.

Elevating community voices

Recognizing a community's strength and understanding what it truly needs starts with listening. That's why community voices are central to our efforts, helping to inform smarter decisions that build the foundation for even greater resilience.

Helping communities be as prepared as they can be for

climate events means both building stronger homes and building stronger community connections. Resources for this include Investing in – and listening to – Culture & Creativity grantees and Advancing community-driven resilience planning in Northern California.

Collaborating with all partners

The challenges are bigger than any one of us can solve alone, we're partnering with policy experts, investors, community organizations, developers and more to build a better future for everyone. We do they by working with congressional leaders to promote climate resilience and bridging a new collaboration with the International WELL Building Institute.

No two communities are alike and challenges differ. Enterprise is working to ensure everyone has access to the resources, knowledge, and best practices needed to prepare for our new climate reality.

Health begins with home

In January 2019, Enterprise launched a new national initiative, Health Begins with Home. Working with a broad group of partners and guided by data-driven insights, Health Begins with Home will put $250 million to work over five years to promote health as a top priority in the development and preservation of affordable homes and to elevate homes as an essential tool for improving resident and community health.

For both children and adults, the quality, affordability, stability, and location of home are seen not just as important factors, but as foundational to health and well-being.

The Health Begins with Home initiative is built upon the strength of cross-sector partnerships among community members, health systems, health insurers, housing developers, policymakers, public health associations, community development organizations, social impact investors and foundations. A bold, focused initiative, Health Begins with Home draws on Enterprise's on-the-ground experience and its work in raising and investing capital to further connect health and housing.

Health Begins with Home is committed to advancing cross-sector solutions impacting health inequities experienced by low and moderate-income populations across the United States.

Our vision is to advance health equity and address racialized health disparities by:

- Making well-being a priority in the development and preservation of every affordable home.
- By stewarding intentional public and private partnerships with the health care and public health sectors, we are demonstrating examples of unlocking economic, social, and political capital of the health sector to contribute to our vision.
- These solutions are intended to impact people, place, and policy through four key pathways—stability & services, quality & safety, affordability, and thriving communities.
- At scale, a clear focus on healthy homes, healthy families and healthy communities will strengthen our collective fabric.

We do this by addressing housing as a vital and foundational determinant of health through:

- The creation of new resource and capital streams for the development of affordable, stable, quality housing in communities of opportunity.
- The aggregation and deployment of housing + services models responsive to community needs.
- Innovative partnership and collaboration models focused on sustainable collective impact.
- Influencing policy levers that impact housing as a vital condition for health and well-being.

We believe this approach to cross-sector health and housing work can make advancements toward eliminating racialized health disparities by prioritizing housing as a structural determinant of health.

Structural health inequities refers to the systemic disadvantage of one social group compared to other groups with whom they coexist, and the term encompasses policy, law, governance, and culture and refers to race, ethnicity, gender or gender identity, class, sexual orientation, and other domains.

The *social determinants of health* are the conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. In the context of Enterprise's Opportunity Pathways, the social determinants of health are: education; employment;

health systems and services; housing; income and wealth; the physical environment; public safety; the social environment; and transportation.

Housing, as a social determinant of health, refers to the availability or lack of availability of high-quality, safe, and affordable housing for residents at varying income levels. Housing also encompasses the density within a housing unit and within a geographic area, as well as the overall level of segregation and diversity in an area based on racial and ethnic classifications or socioeconomic status. Housing affects health because of the physical conditions within homes (e.g., lead, particulates, allergens), the conditions in a multi-residence structure (an apartment building or town home), the neighborhoods surrounding homes, and housing affordability, which affects financial stability and the overall ability of families to make healthy choices. Housing is a basic human need, and a vital condition for individual, familial, and community opportunity to thrive. In addition, the location of one's home is a major determinant of access to community resources, including safety and recreation, food and other material goods, and transportation, employment, and education which are themselves social determinants of health.

Our primary stakeholder and partnership networks include affordable housing developers, public housing authorities, community development corporations, hospitals and health care systems, public health organizations, foundations and philanthropic partners, and public and private investors. We engage the enabling environment by influencing affordable policy levers at the state and local level as well as the federal level.

CURRENT STATE OF HOUSING IN THE UNITED STATES

Our collective health and well-being depend on building opportunity for everyone. Yet, across and within regions there are stark differences in the opportunities to live in safe, affordable homes, especially for people with low incomes and People of Color. These differences emerge from discrimination and institutional racism in the form of long-standing, deep-rooted and unfair systems, policies, and practices such as redlining, restrictive zoning rules, and predatory bank lending practices that reinforce residential segregation and barriers to opportunity. As a result, we consistently see worse health outcomes for people with low incomes and People of Color. We cannot thrive as a nation when the factors that contribute to good health are available to some, but denied to others. Numerous studies have also shown how structural racism in the U.S. housing system has contributed to stark and persistent racial and health disparities for low-income and Communities of Color. Reducing inequities in health requires us to examine, target, and address the systems that initiate and sustain inequities in a broad range of societal institutions that are the drivers of these inequities.

A myriad of factors spanning health, employment, income and social services concerns, however, can all be traced back to a common root cause: long-standing disparities in housing and access to opportunity.

Systemic discrimination in housing policy has created persistent inequities with respect to homeownership, wealth and racial segregation. From the 1930s through the late 1960s, the federal government practice of "redlining" limited or denied mortgage insurance in neighborhoods with high rates of Black households and other households of color, exacerbating existing racial segregation in private home mortgage lending.

The legacy of this discrimination continues today, in exclusionary zoning practices that restrict where people can live by artificially constraining supply and keeping house prices and rents beyond the reach of many low-income households, who are disproportionately households of color.

As a result, access to homeownership, better schools, healthy food options and other positive externalities afforded to mostly non-Hispanic white communities are less available to households of color. For example, as we have described in our quarterly Housing Tenure Report, Black households today have lower homeownership rates than all other racial and ethnic groups. This not only limits opportunities for asset building, but also locks Black families out of owning homes in neighborhoods that generally have better outcomes with respect to education, health care, and employment.

Meanwhile, Black renter households are more burdened by their housing costs, with nearly 31 percent paying more than half of their income on rent, compared to 22 percent of non-Hispanic white renter households. This cost burden impacts Black families' ability to pay for other essential needs, including health care, food and transportation.

Housing quality and stability has also been a persistent

challenge for Black households. Eviction rates among Black renters are often many times that of non-Hispanic white renters. Partially as a consequence, HUD's latest Annual Homeless Assessment Report to Congress shows that nearly 40 percent of the people experiencing homelessness are Black, including nearly 27 percent of people experiencing unsheltered homelessness, despite representing only 13 percent of the population.

Black households, for example, are also three times as likely as non-Hispanic whites to live in older, crowded, or substandard homes. Housing instability, quality, and homelessness all increase families' exposure to COVID-19, as lacking access to stable, safe housing limits their ability to practice social distancing and to take required COVID-19 precautions.

Compounding these housing challenges are a range of negative conditions prevalent in many neighborhoods where low-income Black households live. For example, recent research has documented racial disparities in access to healthy food at the neighborhood level, with generally lower quality and higher prices relative to stores in predominantly non-Hispanic white neighborhoods. As a result, nearly 21 percent of Black families are food insecure—that is, they are either uncertain of having or unable to purchase adequate food for all their family members. Black families are also subjected to higher levels of air pollution and lead exposure than white families, regardless of income.

In addition, Black communities are more likely to lack important community services, such as quality, multimodal transit, broadband internet access and recreational spaces necessary for physical activity. Black communities also continue to face significant inequities in the U.S. education, employment and justice systems, which hinders upward mobility for Black workers and families. These not only lead to poorer health outcomes for low-income Black communities, but also more precarious economic conditions that will make weathering the coming recession that much more challenging.

CHANGING COURSE FROM CURRENT TO FUTURE STATE

COVID-19 has created interconnected crises across our health, economic, and fiscal landscapes. The health disaster is impacting communities in ways other natural disasters have—closing schools and businesses, swamping our medical system, and centering local and state government and their partners as necessary leaders in both emergency response and recovery. The economic and fiscal disasters already appear deeper and wider than the Great Recession and effects are rippling across our employment, housing, and service sectors. We know the recovery from the last recession was slow and uneven, particularly for people and communities that have been marginalized. As we learn the extent of the impacts and start transition to recovery we can support communities in centering equity as a foundation for recovery.

We have worked with,and learned from hundreds of communities recovering from natural disasters and economic crises. While the outcomes of our COVID-19 emergencies are still evolving, an equitable place-based recovery will be built on key principles:

- Equitable recovery places Black and Brown communities, seniors, and children at the center. It begins with respect, works to gain trust, and builds on community priorities and strengths. Many of these communities have been hardest hit—often deemed essential, yet economically vulnerable and relegated.
- Equitable recovery is built on cross-sector solutions. These crises impact multiple sectors— from housing and food security, to employment and local businesses, to mental health and city budgets. The challenges compound each other and effective solutions are integrated.
- Equitable recovery builds on successful emergency response activities and any equitable pre-COVID-19 practices, and these successes are integrated into standard practice moving forward.
- Equitable recovery addresses acute fiscal challenges in communities, as recovery requires solvency. Effective financial planning invests in equitable outcomes.
- Equitable recovery leverages and aligns funding so that each dollar has multiple impacts— supporting food secure households, better connectivity through improved wifi in healthy homes, more accessibility to good schools and jobs,and in thriving communities.

For place-based recovery, these are universal factors that determine whether the recovery effort is "equitable." In practice, equity is not a fixed destination or singular dimension, it is dependent on where a community is

starting from. It is directional and needs to be defined by the priorities and self-determination of the community, tied to their specific needs and opportunities.

While many recoveries have exacerbated inequality, recent recovery successes demonstrate this is possible. In Houston's plan for recovery from Hurricane Harvey, for example, the community defined its equitable recovery as one where those most impacted by the event would receive help first. Houston's community outreach and engagement have been heralded as a promising practice, while implementation challenges demonstrate the importance of capacity and competence across government, contractors, and the systems and processes for recovery. In Rockford, Illinois,, which was slow to recover from the last recession, the community prioritized efforts for neighborhood-based strategies. Rockford's equitable economic recovery balanced its fiscal needs through a successful multi year financial plan with its effort to address homelessness, becoming the first place in the country to end veteran and chronic homelessness.

Even as communities focus on response efforts, we can work across sectors to design a framework for supporting equitable recovery. We can work now to organize the right people and partners, with the experience and approach consistent with equitable recovery.

The interventions that will best support recovery will be targeted to place and the local impact of the fiscal and economic disruption. They will be a mix of policy, strategy, capital, and capacity support. Some places will take longer and need more help than others, and some will need encouragement to focus their efforts on equitable outcomes. Many places will have multiple efforts to help communities recover simultaneously.

We have a greater chance for success across these communities if our work and solutions are networked—when we share what's working and build on successes. As entities that have managed efforts collectively, and as individual organizations across 100s of communities impacted by economic and natural disasters, we have experience meeting communities where they are and targeting solutions to their needs. Some key learnings that define how we work in partnership with communities are:

- Short-term fixes do not address long-term problems. Even in communities with significant assets, few have been able to reverse population decline or move significant numbers of residents out of poverty without fully committing to a comprehensive turnaround strategy.
- Localities and Regions need a coach, not just a playbook. With few resources and little fiscal and operational capacity, many municipal leaders struggle to set realistic priorities and pick a recovery starting point. More than providing information and expertise, successful efforts support implementation.
- Determined local leadership is essential to recovery. As much as megatrends such as deindustrialization and suburbanization may have caused economic decline, recovery is impossible unless local leadership is ready and willing to take on tough challenges with strategies that can be arduous and sometimes politically unpopular to execute.
- Progress begins with a reality check. However difficult, leaders must be able to acknowledge the underlying problems of their city, such as those stemming from a history of racial segregation, corruption, or dysfunctional local government, often identified in an assessment.
- Federal and state governments must redefine their partnerships with cities. Urban policy and programs tend to focus on Washington's priorities rather than the realities of individual cities, which must also contend with barriers in state law and burdensome funding structures. A city's relationship with federal and state government should reflect an actual partnership, not one defined by funding and regulation.
- Economic competitiveness requires collaboration. While local government leadership is essential, this alone is usually insufficient. Partnerships with other local government agencies (e.g., school districts, regional authorities and county governments), the business community, anchor institutions, philanthropy, and nonprofit and civic organizations require hard work but may prove the most effective and efficient approach to taking on a city's most pressing problems.

These efforts require competent teams, tracking and measuring the impact of cross-sector efforts and processes. Working together, we can align activities so that multiple organizations appear seamless to the community and create synergies. We can identify ways in which successes across individual communities, layered together,

can address national challenges. We can work to make sure our communities are successful in both addressing this crisis and in handling their next opportunity or challenge.

The current crisis adds even more urgency to addressing these long-standing racial and ethnic inequities in housing. Perhaps more than any other intervention, access to safe, stable, and affordable housing is now recognized as vital to helping prevent the spread of the virus. While the public and private sectors are taking bold action to respond to this need, they should also take this opportunity to address some of the long-standing inequities that Black and other Communities of Color continue to experience. This includes:

- Developing responsive relief and recovery policies that do not exacerbate existing racial and income disparities in housing markets, by prioritizing vulnerable renters and Communities of Color in federal aid and offering direct rental assistance rather than channeling benefits through financial institutions that Communities of Color are less likely to use.
- Supporting access to affordable housing in all communities, especially high-opportunity neighborhoods from which low-income households of color have been traditionally excluded, through expanded federal support to vital affordable housing and community development programs.
- Boosting federal support to efforts that help address persisting inequities facing Communities of Color, including investments in infrastructure, environmental and health hazard mitigation, and local health care and educational facilities.
- Increasing access to other vital needs during this crisis, such as internet connectivity, food assistance, medical care, and recurring income supplements that are predicated on need and not prior tax filing status.
- Expanding funding and support for state and local programs that address specific needs within their poorest and most vulnerable communities, especially as tax revenues decline and threaten continued provision of these valuable programs.

RESILIENCE LESSONS DURING COVID-19 AND BEYOND

Resilience is built before, during, and after we are faced with a challenge. Communities that are able to recover from adverse events, shocks, or stressors are not only structurally sound, but also socially empowered and connected. Whether responding to storms or wildfires, facing a period of economic downturn, or addressing a public health challenge such as the COVID19 pandemic, resilience means *doubling down* on collaboration and prioritizing the needs of those most impacted.

Researchers on resilience, such as Daniel P. Aldrich of Northeastern University, have repeatedly demonstrated the importance of social infrastructure at the community level as a primary factor in resilience. What does that look like, especially in a time of social distancing? How can our actions now strengthen resilience for future challenges? Enterprise's Made to Last case studies share stories of cultural resilience, from which we offer three lessons for taking care of each other in this moment.

LESSON 1: NOW IS THE TIME TO KNOW NOT ONLY YOUR COMMUNITY'S VULNERABILITIES, BUT ALSO ITS STRENGTHS

Practitioners must be sensitive to local needs in both understanding a place and determining how to help the community. Diversity of ideas, culture, governance, and action enables strength, flexibility, and creativity in responding to stresses, both physical and socioeconomic. Reaching out and being inclusive toward people and ideas is fundamental to increasing resilience.

Though broad-based policy strategies such as halting evictions and assisting renters and landlords are essential, the responses we provide must be tailored to the specific needs of particular groups of people in a particular place. Knowing your community is essential to mobilizing the most relevant resources for the highest positive impact. Many organizations do asset mapping as part of their organizing or emergency preparedness efforts.

Now is the time to know your community's vulnerabilities, but also its strengths and assets. This makes it possible to act strategically with limited resources. "In a disaster, everyone moves toward response and gets chaotic," Jennifer Gilligan Cole of Arizona State University advises, "listen and collect and consolidate information, try to connect things vs. invent things, think about resources as limited and flexible, and one size does not fit all."

LESSON 2: FORGE PARTNERSHIPS THAT MEET MULTIPLE NEEDS

It is through a diversity of people, perspectives, and ideas that solutions come forward that can match the magnitude of the issues facing a community. It is important to both recognize historic traditions, organizations, and leaders, and engage with new members of the community, as a diversity of stakeholders can lead to new coalitions and alliances. Collaboration among residents, local community-based organizations, and public agencies is essential to move from ideas to proposals to implemented projects.

Models are emerging across the country. For example, to support our homeless neighbors and also bolster local businesses and workers, some cities are paying restaurants to prepare meals for homeless residents, or leasing hotels to house those who are willing to come inside, with the possibility of making some of it permanent housing in the long term.

LESSON 3: SHORT-TERM ACTIONS ARE PART OF LONG-TERM CHANGE

Trust takes time to build and needs ongoing reinforcement. Making and doing things together, even remotely, fosters relationships and enhances cohesion within the community and can build toward long-term change. The challenge is to align near-term actions with the goals and aspirations of the future, so that efforts are done in a strategic, rather than ad hoc fashion.

Just as the temporary housing solutions we are seeing could become permanent, the ways in which we communicate and respond in the current moment will matter to the long-term well-being of our communities.

Responding in a way that is caring and attentive will build trust, especially for people who have been systemically put at a disadvantage by the structures of our society and economy. This is an investment in readiness for our next challenge and is especially important during a time when we are required to distance ourselves from one another—though this is necessary for public health, we don't want to lose out on the health benefits of social connection.

- Homeowners should not face foreclosure during or as a result of the economic downturn associated with the COVID-19 outbreak.
- The end of forbearance periods and other postponements of payments should not require unaffordable balloon payments. Financial assistance needs to be designed to be sustainable for those who are in immediate need months and years down the line.
- Any response should address the disproportionate impact of the crisis on Black and Latinx communities, which have higher rates of infection and death. For too many families of color, COVID-19 is the latest threat to stable and affordable housing. The disparity in infections has been tied to the decades of segregation, redlining, and persistent discrimination faced by Black Americans. We must ensure that the responses to this crisis narrow the racial gap in household wealth and health, not widen it.
- The subprime crisis taught us that the government should not be allowed to bail out corporations and let families fail. We must invest in supporting homeowners and bring industry around to invest in communities over the long-term.
- Tenant stability is vital to both renters and landlords. We need to support both homeowners and their tenants, so that the financial instability from the crisis does not lead to displacement.
- We all need a champion when times are tough. Housing counseling and legal service advocates are best positioned—when fully funded and included in all programs—to help homeowners understand their rights, navigate their options for recovery, and apply for help.
- This is no time to forget the immense environmental and climate change challenges we were already facing in order to solve short-term problems. A COVID-19 response must consider the impact of environmental racism on Communities of Color.
- People recovering from this crisis will need grants and low- or no-interest capital that keeps their housing expenses affordable and leaves them with emergency savings.
- All housing expenses associated with homeownership should be frozen for families facing income loss associated with the outbreak, without damaging their credit. This includes mortgage payments, taxes, homeowner and flood insurance, and utility bills.
- We must respect the time and the dignity of

working families by lowering the barriers to entry into critical programs, cutting red tape for both homeowners and those who are trying to assist them, and by coordinating across agencies and the private sector.

PRIORITIES TO HELP HUMANE HOUSING ORGANIZATIONS BECOME BETTER STEWARDS

Now we are at the precipice of a new and unprecedented syndemic of interrelated crises. If our emergency relief efforts fail to hold together our neighborhoods and sufficiently provide support for our more vulnerable populations, then expect land banks to play an outsized role in the long-term recovery efforts. The disruptions and inequitable impacts in too many of our neighborhoods will be significant. Efforts that focus on the following priorities can help humane housing organizations become better situated to steward equitable community centered partnership efforts.

Organizational adaptivity

Strengthen the ability of organizations to address barriers to organizational functionality. This includes organizational technology and other infrastructure supports to enable continued work.

Programmatic adaptivity

Strengthen the ability of organizations to shift and/or expand existing work to support clients/participants, members, and stakeholders, such as digital engagement and organizing, online census outreach in hard–to-count communities, etc. Supporting organizations to be responsive to the urgent needs and survival essentials of communities in the midst of the pandemic, including but not limited to meal delivery, access to health care and housing, mental health supports, and economic supports for lost income.

Healing

Provide immediate opportunities for staff, volunteers, members, or clients to build resiliency, wellness, and safety, grounded in community and culture, including resources to provide the space and tools to address mental health and trauma, and to heal in this moment of crisis.

Culture and systems change

Begin immediate actions to advance economic security, justice, and safety policies that positively impact the most vulnerable and marginalized communities. Examples include, but not limited to, anti-xenophobia and racism campaigns; advocacy for paid leave for all, universal health care access, prevention of rollbacks on bail reform and other decarceration policy accountability efforts, affordable childcare, economic relief for small business owners, etc.

As we plan for and implement recovery, let us center equity, inclusion, and resiliency. Let us be collaborative, bold, and compassionate. Maybe, just maybe, we can rise from this crisis with a new normal that promises dignity, security, and opportunity for all in inclusive, healthy neighborhoods worth calling home.

BIG IDEAS FOR TRANSFORMATION OVER THE NEXT 10 YEARS

Prior to the current crisis, a tremendous wave of local organizing and activity was already taking place across the nation—around housing, racial equity, gender equality, minimum wage campaigns, climate justice, immigrants' rights, and more. We continue to be inspired by the hard-won experience and wisdom of these heroic community-based efforts, from which we have greatly benefited and learned valuable lessons for our own work. Yet even when these activists achieved important victories, they ran headlong—*every time*—into a system taking the nation on a downward trajectory toward greater inequality, rising environmental destruction, and the undermining of our democratic polity. In the face of this plutocratic system, the landscape of progressive organizing has thus far remained too fragmentary and disconnected, with inadequate larger-order systemic thinking and analysis, to challenge the dominance of medicalized social problems, piecemeal market-oriented solutions, and the hyper financialization of the vital conditions.

EXCERPT FROM POLICYLINK'S COVID-19 & RACE: COMMENTARY ON CENTERING RACIAL EQUITY IN HOUSING – BY MICHAEL MCAFEE AND CHRIS SCHILDT

Millions of people are facing another rent bill, with no income or relief from our inadequate safety net programs. COVID-19 didn't create America's housing mess. Market failures have been hurting low-income people and people of color for years. But the economic and health emergencies brought on by the pandemic have changed the equation. People already struggling to make ends meet now face a nearly impossible decision: either pay

their rent or buy the food and medicine needed to survive. Many refuse to accept these terms. Instead, people are protesting and demanding a better future. If the nation is to come out of this crisis stronger and more resilient, we need to enact a different reality.

That starts with reimagining housing not as a commodity that enriches investors, but as an essential public good.

Even before the pandemic, nearly 40 million US households were spending more than they could afford on housing, and half a million people were unhoused. Less than 1 percent of housing is both affordable and accessible to people living with disabilities. Women of color suffer the highest eviction rates and cost burden, and Black and Indigenous people experience the highest rates of homelessness.

Housing insecurity of this depth creates chronic health disparities, exacerbating hypertension, diabetes, and other medical conditions that contribute to the alarmingly high COVID-19 death rates in Communities of Color. The situation is made worse by pervasive economic fragility: 60 percent of Americans can't afford a $1,000 emergency.

This housing crisis did not happen by accident. It is a direct consequence of decisions made by policymakers and corporate interests determined to profit from housing rather than house people, and by a government that has failed to build affordable housing that meets demand.

The result of this system was made painfully clear in the 2008 foreclosure crisis, which wiped out trillions of dollars of generational wealth, particularly in Black and Latinx communities. Millions of people lost their homes, which private equity investors acquired en masse. Then these investors rented the homes back to families for exorbitant rents, failed to do necessary maintenance and repairs, and eventually evicted tenants and resold the homes for massive profits. This was not a new story, but another chapter in a long playbook of dispossession of land and wealth for people of color and Indigenous communities. We've had government-sanctioned theft through generations.

The housing crisis is again in the national spotlight. In April, over 30 percent of renters were late on rent; in May, we can expect that number to be higher. But now we can decide to act differently. We must center racial equity and in doing so, serve the people most in need.

Alleviate the immediate financial burden

That means halting evictions and foreclosures, and providing emergency housing for everyone who doesn't have a home, including people experiencing homelessness, being released from incarceration and detention, or facing domestic violence. Over 35 states and 150 local municipalities—as well as the federal government — have taken some action to limit evictions during this crisis. Some of the stronger protections have passed in Massachusetts and Alameda County, California. Comprehensive moratoriums should be expanded to cover all tenants across the country and paired with the right to counsel for the many tenants who are still facing eviction despite local and federal laws. While many of these measures protect some renters and homeowners from immediately losing their homes due to the inability to pay rent, there will be a flood of evictions once the moratoriums are lifted. The best way to stop this is for the government to take the unprecedented and necessary step to forgive unpaid rent and mortgages; it is the only way to reach the scope and scale that we need. Additionally, homeowners and mom-and-pop landlords who have used investing in real estate as a vehicle to financial security and wealth must be made whole, while prohibiting large corporate landlords from profiting from this crisis.

Change the rules of the game to protect our affordable housing stock

Large for-profit investors must not be allowed to buy distressed homes and buildings in neighborhoods where venture and speculative capital has always preyed—Communities of Color where frontline workers disproportionately live. The same corporations that scooped up millions of homes in the last recession are poised to swoop in again and profit off of our pain. This is the market doing what it will naturally do if left unchecked. We must protect the nonprofits, owners of deed-restricted affordable rental units, and the small landlords in our communities who are providing affordable housing to make sure they have the operating support they need, and that they can expand in this moment to meet the demand for housing that is affordable. Large for-profit investors should be prohibited from purchasing homes and apartment buildings. Instead, we can use policies that give tenants, nonprofits, and local governments the first opportunity to purchase the buildings, coupled with acquisition funds, to make these properties permanently affordable.

Reimagine housing as a public good and critical infrastructure, not a commodity

Racialized capitalism has designed our housing system, and a network of laws and regulations reinforces this system. We must change the legal and regulatory framework that undergirds our housing policy so that it centers racial equity. Our democracy is an unfinished experiment. We must continue the work to perfect it. This means we cannot be wedded to a housing system that hasn't served us well. To reimagine housing as a public good, we cannot leave it to the market to dictate where people can live, how much they'll pay, and if they can access opportunity. Instead, we must be willing to do the work to make safe, healthy, and affordable housing a human right.

Turning this vision into a reality requires a shift in the national mindset. We have always put the premium on property, but human value must have primacy. Our emergency response and recovery must take us toward our equity goals, not return us to a status quo that has been failing our people.

ADDITIONAL RESOURCES

Opportunity360

Piecing it Together: A Framing Playbook for Affordable Housing Advocates

Investing with Purpose: Preserving a Neighborhood Legacy - The 2019 Social Return on Investment Report

On the Path to Health Equity: Building Capacity to Measure Health Outcomes in Community Development

Democratizing Resilience & Disaster Recovery Initiative: A Roadmap for Community Resilience

Centering Racial Equity in Housing (PolicyLink)

Health Equity Principles for State and Local Leaders in Responding to, Reopening and Recovering from COVID-19 (RWJF)

Stewards of Affordable Housing for the Future, SAHF Mental and Behavioral Health Profiles

RESOURCES FOR HOUSING PROVIDERS & ORGANIZATIONS

When Home Becomes the Hub: A Resource for Housing Providers During the Covid-19 Pandemic

Pandemic Guide for Real Estate Managers from the Institute of Real Estate Management (IREM)

The Federal Housing Administration (FHA) Guidance for Multifamily Owners and Stakeholder

LeadingAge Resources for Affordable Housing Organization

Covid-19: An Update from Enterprise Green Communities

Covid-19 Resources: Rural & Native American Program

Nonprofit Quarterly: How Nonprofits Can Utilize the New Federal Laws Dealing with Covid-19

National Council of Nonprofits: Loans Available for Nonprofits in the CARES Act

RESOURCES FOR RENTERS

Support for Renters: Fannie Mae Disaster Recovery Network

Enterprise's Emergency Action for Resident and Partner Stability Program

RESOURCES FOR BUSINESSES

Small Business Owners Guide to the CARES Act

Maintaining Business Continuity During the Covid-19 Pandemic

The U.S. Small Business Administration Covid-19 Guidance and Loan Resources

Small Business Paycheck Protection Program

RESOURCES FOR HOMELESS SERVICE PROVIDERS

HUD Covid-19 Prevention and Response for Homeless Providers: Daily Resource Digest

National Health Care for the Homeless Council Homelessness Resources

Guidance from United States Interagency Council on Homelessness (USICH)

CDC Interim Guidance for homeless service providers

CDC Interim Guidance on responding to Covid-19 among people experiencing unsheltered homelessness

STATE & LOCAL RESOURCES

National Council of State Housing Agencies (NCSHA)

HUD's Infectious Disease Toolkit for Continuums of Care

National Conference of State Legislatures (NCSL) for state-level action on Covid-19

National Governors Association (NGA)

National League of Cities (NLC)

MORE RESOURCES

Federal Housing Finance Agency (FHFA) statement

Guidance from LeadingAge

National Housing Conference (NHC)

National Housing Trust's COVID-19 Response Principles

National Low Income Housing Coalition (NLIHC) for Covid-19 policy

Novogradac & Co Covid-19 Resources

U.S. Housing Committee on Financial Services Covid-19 Resource Center

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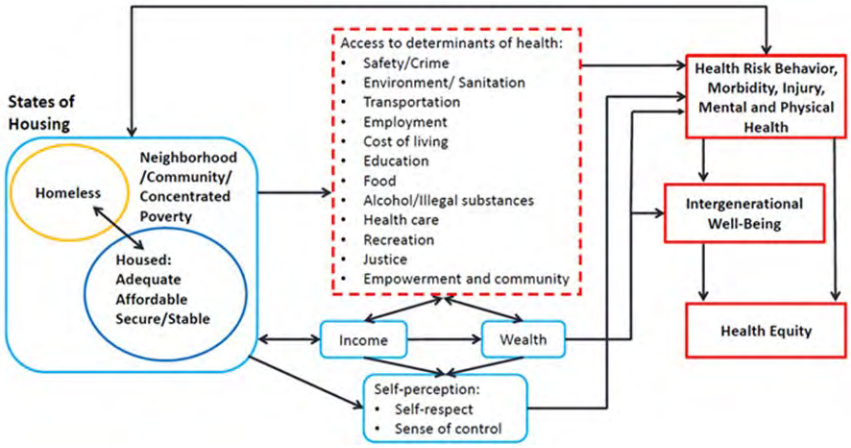

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Housing Element	Potential Health Impacts or Related Health Outcomes / When Housing Element Is Not Present
QUALITY	• Current living environment - sub-standard (poor quality, over-crowded, etc.) • Exposures to chemicals, household pests, allergens / mold • Structural / plumbing / insulation / heating & cooling issues in the home • *Asthma or other respiratory issues → unplanned medical visits to ER - at risk of nursing home admission / hospitalization* • *Lead poisoning / harm to brain development in children – other environmental health condition* • *Higher risk of infection or chronic conditions (COVID-19, other communicable diseases, etc.)* • *Risk of personal injury / fire / housing loss – due to substandard conditions*
STABILITY	• Current living environment – not adequate (doubled up, no lease, at risk / experiencing homelessness, etc.) • Transient, frequently move, disengaged from other attempts of care coordination / services • *Stress, depression and anxiety disorders → poor self-reported (and diagnosed) mental & physical health* • *Delayed access to medical care, few community supports, risk of losing Medicaid eligibility, children in household likely to miss school due to other stressors in home → minimal utilization of preventive care services*
AFFORDABILITY	• Severe Rent Burden or Lack Stable Income to Pay for Housing (at risk of eviction / homelessness, etc.) • Pay more than 50% of their income towards housing costs • *Stress – fewer resources to spend on healthy food, prescriptions, and other necessities* • *More likely to be disengaged from medical community, to lose Medicaid eligibility, children in household likely to miss school due to other stressors (food insecurity, job loss, etc.) → minimal utilization of preventive care services*
COMMUNITY CONTEXT	• Current living environment - not close to public transportation, work opportunities, social, public, and medical services • Lacks green / public recreation spaces, high presence of crime, and/or environmental pollutants / brownfields • *Stress, depression, trauma and anxiety disorders → poor self-reported (and diagnosed) mental & physical health* • *Asthma or other respiratory issues / High rate of gun violence or drug use → unplanned medical visits to ER* • *Disengaged from medical community and other support services → minimal utilization of preventive care services*

DEEP DIVE

MEANINGFUL WORK & WEALTH

JUNE 2020

SPRINGBOARD BRIEF FOR RECOVERY & RESILIENCE DOMAIN LEAD: WEALTH & WORK

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SPRINGBOARD BRIEF FOR RECOVERY & RESILIENCE DOMAIN LEAD: WEALTH & WORK

Since 1979, Prosperity Now has believed that everyone deserves a chance to prosper. Our mission is to ensure that everyone in our country has a clear path to financial stability, wealth, and prosperity, particularly people of color and low-wealth families. To advance our mission, we create and support programs and policies that foster an economy that offers opportunity to those who have not had it before. With a unique focus on assets, rather than purely income, and by applying a racial equity lens across our work, we help ensure families and communities not only get by but get ahead. Finally, through research, solutions, and policies, we fight for economic mobility for everyone in the United States.

The 24,000-member Prosperity Now Community consists of community-based organizations, coalition members, researchers, policymakers and advocates who support financial stability and wealth-building efforts across the country.

According to our Prosperity Now Scorecard, 37 percent of U.S. households and 58 percent of households of color lack a basic level of savings needed to survive at the poverty level for three months. In response to the significant financial insecurity facing families and Communities of Color, Prosperity Now launched the Racial Wealth Divide Initiative (RWDI) in 2015. We leverage our connection to national organizations, a growing network of state and local partners, and our core competencies–technical assistance, policy development, and advocacy, and applied research–to aggressively address racial economic inequality across the country.

THE STATE OF WEALTH AND WORK PRIOR TO COVID-19

The state of wealth and work prior to COVID-19 was shaped by many overlapping policies, institutions, and systems. Like health outcomes, which are determined in significant part by non-health social factors,[1] wealth and work status are shaped by conditions outside an individual's control: redistributive policies like the tax code, forces like the decline of unions that influence job quality, racism and discrimination embedded within policies and institutions, and a multitude of other factors. The resulting state is one of stark disparities in wealth and work, where far too many Americans are low wealth, lacking in economic opportunity, and subject to poor job quality.

In 2016, 37 percent of U.S. households (roughly 45 million households total) were liquid asset poor.[2] This includes 60 percent of households with a member with a disability, and nearly 60 percent of Black and Hispanic or Latino households. Among immigrants, non-citizens are considerably more likely to be liquid asset poor (58 percent) than are their citizen counterparts (35.7 percent). Non-citizens without permanent residency status have even higher liquid asset poverty rates (63.8 percent), as do non-citizens who are limited English speakers (82.7 percent). Unemployment among Black Americans and Native Americans is consistently double that of working-age White people.[3] In 2018, 27.6 million people nationwide were employed in low-wage occupations, comprising roughly 17 percent of the civilian labor force.[4]

In this section, we will explore this state in greater depth through the sub-domains of employment, entrepreneurship, financial stability and security, and health, all of which shape work and wealth and have

1 https://www.cdc.gov/socialdeterminants/index.htm

2 Prosperity Now analysis of Survey of Income and Program Participation, 2014 Panel, Wave 4 data. U.S. Census Bureau, 2019. Liquid Asset Poverty is defined here as the rate of households without enough cash on hand, in savings and checking accounts, or retirement savings to subsist for three months at the federal poverty line in the absence of income. Today, that threshold is $3,168 for an individual, and $6,550 for a family of four.

3 Bureau of Labor Statistics (May 2019). "Foreign-born workers: Labor force characteristics—2018". Available at https://www.bls.gov/news.release/pdf/forbrn.pdf.

4 Prosperity Now analysis of Occupational Employment Statistics, May 2018, Bureau of Labor Statistics. Low-wage occupations are here defined as occupations, within any industry, that offer a median annual wage at or below the federal poverty threshold for a family of four, which in 2018 was $25,100.

contributed to the disproportionate impact of COVID-19 on Communities of Color. We detail below how these subdomains have intersected to affect disparities in wealth and meaningful work in the past and present, with a historical look at the public and institutional policies that shaped these realities. These policies and sectors, among other factors, promote racial economic inequality and a growing racial wealth divide, which in turn further exacerbate disparities in employment and financial security for households of color.

RACIALIZED POLICIES

Before discussing these sub-domains, it is critical to focus on how systemic racism and discrimination have been embedded within public and institutional policies to boost the ability of White Americans and men to build long-term wealth and consolidate political power while blocking people and Communities of Color from doing the same.[5] These choices across multiple systems and institutions have deeply shaped outcomes in work and wealth, determined in no small part how economic benefits are distributed, and resulted in racial economic inequality and racial wealth disparities.

In particular, gaps between White Americans and people of color, and men and women, in income, wealth, health outcomes, employment outcomes, homeownership, access to routes to citizenship, educational access and attainment, access to banking and lending channels, and access to public benefits—and any number of other examples—are the result of discriminatory and exclusionary policies. These policies include, but are not limited to:[6]

- Naturalization and Exclusion Acts, and immigration quotas, enacted over centuries.
- Indian land theft, forced resettlement, Tribal "removal" and termination acts.
- Chattel slavery, Black Codes and Jim Crow laws, FHA redlining and other forms of codified residential segregation. Japanese internment (and, at the tail end of the Reagan Administration, reparations).
- The New Deal and G.I. Bills, both of which excluded—tacitly or explicitly—African Americans from accessing many of the benefits, including free education, unemployment insurance, Social Security, and low-cost mortgage loans.

In conjunction with these public policies, institutions and sectors have embedded racism within their policies, including financial services discriminating based on race in banking and lending, employers discriminating in hiring and workplace policies, and many others. These policies—past and current—are foundational to how wealth and work is distributed within this country, and in many ways, have dictated who benefits from the employment and financial systems.

EMPLOYMENT

The employment landscape has shifted significantly over the last several decades. The share of employees in unions, who have higher wages and levels of benefits on average than non-union employees, fell from 20 percent to 10 percent from 1983 to 2019.[7] In this period, jobs in food and beverage services have largely replaced lost manufacturing jobs, with the average food service worker earning 60 percent less than an average manufacturing worker. At the same time, employers have transferred the burden of many benefits to employees, such as through the transition from defined benefit to defined contribution retirement plans.[8] Moreover, these sorts of employer-supported financial wellness resources such as retirement/pension and health insurance are only available to a limited number of Americans, who typically have higher educational attainment and are disproportionately White.

Further, worker productivity from 1979-2018 grew by nearly 70 percent, with hourly pay only growing by almost 15 percent; these productivity gains have not trickled down to workers in the form of increased earnings.[9] Overall, these changes in the employment landscape have had an impact on overall job quality in America, where many employees face stagnating wages, decreased purchasing power, and fewer employer-provided benefits.

Wage amount and consistency is an enormous issue

5 Dedrick Asante-Muhammad, Chuck Collins, Josh Hoxie and Emanuel Nieves, The Road to Zero Wealth: How the Racial Wealth Divide is Hollowing Out America's Middle Class (Washington, DC: Prosperity Now, 2017). Accessed at https://prosperitynow.org/resources/road-zero-wealth.
6 United for a Fair Economy, "The Boosts and Blocks of Building Wealth: Infographic". Accessed at http://www.faireconomy.org/boosts_and_blocks_of_building_wealth_infographic.
7 https://www.bls.gov/news.release/union2.nro.htm.
8 https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/transitioningplans.aspx
9 https://www.epi.org/productivity-pay-gap/

for workers. As noted above, roughly 17 percent of the civilian labor force work in low-wage occupations. Low-wage work is associated with—and often the cause of—high rates of income volatility, an issue which is discussed in more detail in following sections. Workers in these positions also commonly suffer from inconsistent wages as a result of the rise of irregular and on-demand scheduling, which exacerbates income volatility and makes it hard for workers to meet expenses.[10] Twenty percent of households across the country experienced income volatility in 2019. Though work schedules and incomes might ebb and flow, bills don't—and that can lead to catastrophe for households who are unable to make up the difference from month to month.

Undergirding these challenges is a policy landscape that has not sufficiently addressed these issues, or in some cases, exacerbated them. The federal minimum wage has not kept up with inflation, and those working minimum wage jobs have lost 9.6 percent of their purchasing power against inflation since it was last raised in 2009.[11] Twenty-three states have passed or implemented laws preempting cities from passing legislation that would increase the minimum wage higher than the state's; as a result, local governments are not able to be responsive to the higher costs of living in some communities.[12] Moreover, several laws have been passed at the state level that limited the ability of unions to form and bargain workplaces, reducing the power of workers.

ENTREPRENEURSHIP

Entrepreneurship is a promising solution for individuals to build wealth, and also is critical to the state of work: new businesses (less than 5 years old) account for nearly all net new job creation.[13] However, entrepreneurs of color, who generally come from low-wealth communities, are not readily afforded the resources needed to start, scale and grow businesses. Families and friends aren't able to provide the initial capital needed to start businesses, and too often, traditional sources of capital are unavailable. Women, Black, and Latino entrepreneurs struggle to access financing for their businesses, with 63 percent of women reporting difficulty vs. 45 percent of men.[14]

Increases in business ownership can help people of color achieve greater social mobility. Numerous studies have shown that entrepreneurship (business ownership or self-employment) creates higher levels of asset creation. For example, it was found that at the end of a five-year period, families who owned a business were more likely to have moved into a higher income group than other families, and in fact, families who did not acquire or start a business in this period were more likely to stay in their income category or fall into a lower one.[15,16]

Focusing policies and resources to help entrepreneurs of color succeed will have the added benefit of significantly impacting the racial employment gap. Data collected from organizations that work with entrepreneurs of color have documented that minority businesses hire people of color at a substantially higher rate than white-owned businesses. For example, the Minority Business Development Agency data shows that these businesses have hired people of color for 40-50 percent of their workforce. In addition, supporting the success of new businesses is a proven way to increase the tax base, which helps all communities grow and thrive.

Even though they are challenged and disadvantaged by existing systems, structures and biases, people of color who independently own businesses are already making a big difference.

In a groundbreaking study, William Bradford successfully makes the case that African American entrepreneurs reduce the racial wealth gap. Bradford's analysis, based on his study of income data on family wealth between 1999 through 2009, shows that African American entrepreneurship significantly reduces wealth disparities between African American and White families in the United States. He also found that the upward wealth mobility of African American entrepreneurs is equivalent to that of White entrepreneurs. In fact, according to Bradford, self-employed entrepreneurs of any race have

10 https://www.epi.org/publication/irregular-work-scheduling-and-its-consequences/
11 https://www.pewresearch.org/fact-tank/2017/01/04/5-facts-about-the-minimum-wage/
12 https://prosperitynow.org/sites/default/files/resources/2018-Prosperity-Now-Scorecard-Main-Findings-Report_0.pdf
13 John Haltiwanger, Ron S. Jarmin, and Javier Miranda, "Who Creates Jobs? Small Versus Large Versus Young," The Review of Economics and Statistics 95, no. 2 (May 2013): 347-361
14 "America's Voice on Small Business" 2017. https://americassbdc.org/wp-content/uploads/2017/05/White-Paper-GenStudy-6-1-2017.pdf
15 http://www.hamiltonproject.org/assets/legacy/files/downloads_and_links/minority_women_entrepreneurs_building_skills_barr_final.pdf
16 Quadrini, Vincenzo. 2000. "Entrepreneurship, Saving, and Social Mobility." Review of Economic Dynamics 3 (1): 3.

higher wealth levels and more upward mobility than do those who are employed in the labor force.[17] Bradford's findings demonstrate that entrepreneurship is an effective way to address the racial economic opportunity gap.

FINANCIAL STABILITY AND SECURITY

Financial stability—the ability to meet day-to-day expenses and manage financial shocks—and financial security—the ability to build and protect assets and secure future financial goals—are both deeply influenced by the aforementioned employment system and policies designed for the betterment of White people and men. Job quality, particularly wages and benefits, have a deep impact on one's ability to meet day-to-day expenses, build a financial safety net, and grow wealth. Similarly, systemic racism built into policies and institutions, including employment, housing, and financial services, have created an ever-growing racial wealth divide.[18] These forces, along with others such as housing and costs of living, created a precarious situation for financial stability and security even in economic boom times, such as the pre-COVID-19 period.

Prior to COVID-19, millions of Americans each year suffered income shortfalls that had an adverse impact on their household finances and stability. For many, a financial emergency, such as a health care payment, very often and very easily cascaded into two or more additional crises, leading to adverse financial consequences like troublesome debt and material deprivation. Three of the key lenses to understand financial stability and security are as follows:

Savings

Savings is vital to achieving financial stability and building financial security, as it ensures that individuals can weather unexpected shocks, work toward their long-term goals and build assets. Even a modest amount of savings can help families move toward financial resilience. Savings is also linked to broad psychological, social, and physical health, by reducing stress and increasing access to needed medical care. However, Americans face a crisis of insufficient savings that extends to both short-term savings and long-term savings, such as retirement. Data shows that insufficient savings affects a broad swath of U.S. households:

- One-third of Americans report having no savings at all[19]
- If faced with an unexpected expense of $400, nearly four in ten adults would either not be able to cover it or would cover it by selling something or borrowing money.[20]
- One-fourth of Americans have no retirement savings or pension.[21]

Asset ownership

Asset ownership is critical to building and maintaining financial security. Asset ownership supports resilience; if there is a disruption in income, assets can help to cover the gap until paychecks resume. And, assets can be passed down to future generations to build their financial security from an even earlier age. However, as noted above, there are critical disparities across race and class in regard to asset ownership. Measures of net worth—which consist of a household's assets minus its liabilities—showcase this. Median net worth in the country is $92,110. However, broken down by race, White households own $141,825; Black households own $12,470; Latino households own $20,479; and Asian households own $212,511;[22] Moreover, in 2018, 25.4 percent of households of color had zero or negative net worth, compared with 13.1 percent of White households.

For most households, homeownership is the largest driver for building and maintaining wealth. The average net worth of a homeowner was $231,400, compared with just $5,200 for a renter, according to the Federal Reserve's 2016 Survey of Consumer Finances. In addition, 63.1 percent of occupied housing units are owner-occupied; however, homeownership rates fall dramatically for households of color, nationally averaging 45.0 percent vs. the 71.2 percent owner-occupied rate of White households. The role of

17 Bradford, William: The "Myth" That Black Entrepreneurship Can Reduce the Gap in Wealth Between Black and White Families. Accessed at: https://journals.sagepub.com/doi/abs/10.1177/0891242414535468

18 Dedrick Asante-Muhammad, Chuck Collins, Josh Hoxie and Emanuel Nieves, The Ever-Growing Gap: Without Change, African-American and Latino Families Won't Match White Wealth For Centuries (Washington, DC: Prosperity Now, 2016). Accessed at https://prosperitynow.org/resources/road-zero-wealth.

19 https://www.pewtrusts.org/en/research-and-analysis/articles/2019/07/29/many-americans-still-face-financial-instability-despite-economic-growth

20 https://www.federalreserve.gov/publications/2019-economic-well-being-of-us-households-in-2018-dealing-with-unexpected-expenses.htm

21 https://www.federalreserve.gov/publications/files/2018-report-economic-well-being-us-households-201905.pdf

22 Prosperity Now Scorecard: http://scorecard.prosperitynow.org/data-by-issue#finance/outcome/net-worth

homeownership in wealth building is especially central for lower-income households and people of color, who have more wealth concentrated in home equity than other populations. On average over the last 25 years, equity in homes represented half of the wealth in Black and Latino households, a third for Asians, and just a quarter for Whites.[23]

Beyond the legacy of discriminatory lending and real estate practices, households of color still struggle to purchase homes at the same rate as White families. As we state in our report "A Down Payment on the Divide," White families receive much more help from family to pay for the upfront costs that come with homeownership. Along with other savings and income advantages, White households have more years of equity in their homes than Black households. Black and Latino households are denied mortgages more often than Whites, and if they are extended a mortgage, it is usually on less favorable terms. While the denial rate for Blacks is more than 25 percent and for Hispanics is close to 20 percent, the rate for White households is just over 10 percent, meaning Blacks and Hispanics have a denial rate that is twice as high or higher than Whites.

Non-mortgage debt

Non-mortgage debt such as student loans, credit card debt, car loans, and lines of credit, can be an impediment to building financial security, particularly when individuals are carrying a high debt burden.[24] Non-mortgage debt, which is associated with financial vulnerability when it exceeds 40 percent of income,[25] increased from $3.84 trillion to $4.02 trillion from 2018 to 2019; however, in 2019, respondents were more optimistic about their ability to manage debt than in 2018.[26]

Once non-mortgage debt is incurred, it can have wide-ranging repercussions over time. Working to pay off costly debt, such as payday loans and other small-dollar credit products, can significantly reduce a household's ability to make ends meet, impacting both current and future financial outcomes.[27] Non-loan debt, such as out-of-pocket medical costs, state and local government fines and fees, and unpaid bills can have cascading negative effects on household financial stability and security.[28] Moreover, consumer debt is associated with both physical and mental health challenges.[29]

Overall debt, including mortgage, has tripled over the last three decades; as with other financial security factors, this is due to structural changes related to higher expenses, wage stagnation, underregulated predatory lending, increased income volatility and other issues. We have seen a tripling of debt, including mortgage, student and consumer, over the last three decades.

In summary, for households lacking savings and liquid assets in the short term, building assets and wealth over a lifetime is increasingly difficult. Families may struggle to maintain housing, save for retirement, or invest in ways that ensure long-term financial security. A lack of savings also leaves households vulnerable to economic shocks and may force them to take on troublesome debt to get by. Debt, in turn, becomes a barrier to further savings and wealth-building as climbing out of debt can be very challenging and working to pay off debt can result in cascading economic consequences.

THE INTERSECTIONS OF HEALTH AND WEALTH

Prior to COVID-19 and continuing today, wealth influenced our physical and mental health, and vice versa. Poverty and financial insecurity lead to toxic stress, chronic disease, and other poor mental and physical health outcomes.[30] Conversely, health care treatment can lead to devastating medical expenses and financial ruin,[31] especially (but not exclusively) for those of low-wealth. Moreover, discrimination throughout health care policies and institutions have led to the gaping disparities in health by race and ethnicity, just as they have for wealth.[32] Wealth impacts, and is impacted by, many of the social

23 https://www.stlouisfed.org/publications/housing-market-perspectives/2017/homeownership-racial-wealth-divide
24 http://www.aspenepic.org/wp-content/uploads/2018/03/Consumer-Debt-Primer.pdf
25 https://s3.amazonaws.com/cfsi-innovation-files/wp-content/uploads/2017/01/24183123/Understanding-and-Improving-Consumer-Financial-Health-in-America.pdf
26 https://s3.amazonaws.com/cfsi-innovation-files-2018/wp-content/uploads/2019/11/13204428/US-Financial-Health-Pulse-2019.pdf
27 Rob Levy and Joshua Sledge, A Complex Portrait
28 https://www.fdic.gov/news/conferences/consumersymposium/2012/a complex portrait.pdf
29 *Ibid.*
30 https://www.frbsf.org/community-development/files/choi.pdf
31 https://www.kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/
32 https://www.kff.org/disparities-policy/report/key-facts-on-health-and-health-care-by-race-and-ethnicity/

determinants of health, including housing, racism and discrimination, employment, education, food security and several others.[33]

EFFECTS OF COVID-19 ON WEALTH AND WORK

The health and financial crises caused by the COVID-19 pandemic are compounding to devastating effect in Communities of Color and other vulnerable populations. Incomes and job security have fallen for millions; available benefits (enhanced unemployment insurance, economic impact payments, local forms of aid, etc.) have increased to fill gaps in income during the crisis, but exclude many, including immigrant families, and are insufficient to stabilize families long-term. Some of the critical impacts are as follows:

- Economic insecurity, by nearly every conceivable metric, has risen—for individuals, households, businesses, and governments. Unemployment has ballooned (see below); food insecurity is more prevalent; housing stability, particularly among renters, is now more precarious.
- Unemployment rates ballooned in the month after the pandemic shutdown began, ranging from 7.9 percent in Connecticut to 28.2 percent in Nevada. Data collection issues likely resulted in an undercount, with the BLS estimating the national rate to be over 19 percent. Connecticut officials estimate that CT's state rate is closer to 17.5 percent. Through the end of May, an estimated 26 percent of the labor force had applied for unemployment insurance as a result of the pandemic response.[34]
- The disbursement of Paycheck Protection Program (PPP) funds prioritized larger and more capitalized firms, at the expense of Main Street businesses and microbusinesses. The Small Business Administration's internal analysis concluded that a lack of guidance during the program's rollout resulted in a loan distribution that skewed heavily toward larger businesses, and businesses owned by men or White people.[35]
- The number of active Black business owners has fallen by over 40 percent since the onset of the pandemic. Hispanic or Latino business owner counts dropped by 32 percent, and Asian business owner counts by 25 percent.[36]
- A high percentage of workers deemed "essential" are people of color, exposing them to increased health and related financial risks.
- Many immigrants and their families were written out of receiving the benefits of the COVID-19 relief bills. This is despite immigrants being less likely to use public benefit programs, and constituting a disproportionate amount of the "essential" economic sectors.[37]

As implied above, the relationship between health and wealth is manifesting with stark impacts on this crisis as well:

- The existing dynamic racial economic inequality influencing poor health outcomes is playing out tragically as Communities of Color are bearing an increased disease and death burden.[38] People of color are more likely to work in unsafe conditions, have less access to essential health supports like sick leave and health insurance, and face discrimination in care, all leading to adverse health outcomes.
- As noted above, the health crisis has led to financial vulnerability for a large portion of the population; this is having a cascading effect as this critical social determinant of health (income through employment and financial stability) is

33 https://prosperitynow.org/blog/shared-determinants-health-and-wealth#:~:text=Social%20determinants%20of%20health%20include,transportation%2C%20employment%20and%20economic%20stability.&text=Housing%20affordability%20and%20stability%3A%20Housing,financial%20well%2Dbeing%20and%20wealth

34 Source: BLS; U.S. Department of Labor; Connecticut Department of Labor)

35 U.S. Small Business Administration Office of the Inspector General (May 8, 2020). "Flash Report: Small Business Administration's Implementation of the Paycheck Protection Program's Requirements" Accessed May 12, 2020 at: https://www.oversight.gov/sites/default/files/oig-reports/SBA_OIG_Report_20-14_508.pdf.

36 Robert Fairlie, UC Santa Cruz

37 Jeffrey S. Passel and D'Vera Cohn (November 2016). "Size of U.S. Unauthorized Immigrant Workforce Stable After the Great Recession", Pew Research Center. Available at https://www.pewresearch.org/hispanic/2016/11/03/size-of-u-s-unauthorized-immigrant-workforce-stable-after-the-great-recession/; and Alex Nowrasteh and Robert Orr (May 10, 2018). "Immigration and the Welfare State: Immigrant and Native Use Rates and Benefit Levels for Means-Tested Welfare and Entitlement Programs", Cato Institute. Available at https://www.cato.org/publications/immigration-research-policy-brief/immigration-welfare-state-immigrant-native-use-rates.

38 https://prosperitynow.org/blog/how-COVID-19-deepening-inequalities-across-us-cities

removed for many, leading to effects on many other determinants, such as housing and food security.

These tragic dynamics are especially impacting Black Americans' health, as they are dying at over twice the rate of other races from COVID-19 (54.6 deaths per 100,000, compared to 24.9 for Latino Americans, 24.3 for Asian Americans, and 22.7 for White Americans).[39]

LIKELY LONG-TERM IMPACTS

In addition to the immediate impacts of the crisis, we anticipate many long-term impacts on employment and wealth. Unemployment will remain elevated for the foreseeable future. It took over 9 years (November 2016) for unemployment rates to fall to their October 2007 level (4.7 percent)—one month prior to the unemployment rise from the Great Recession.[40]

The nature of employment will change—and not necessarily for the better. Following the most recent recession, the gig economy exploded and state unemployment insurance requirements tightened, shifting the burden of risk, both economic and physical, onto workers and away from employers.[41] As a result, many employed workers who otherwise would have access to benefits like unemployment or health insurance do not.[42] In 2009 and 2010—the tail-end and immediate aftermath of the recession—the number of people earning at or below the federal minimum wage (4.36 million) nearly doubled from 2008's total (2.23 million). Totals didn't fall back down to their 2008 levels until 2016 (2.15 million)—six years after their peak.[43]

Small business closures and impact of the structural changes to human interaction on "normal" business operations will result in a protracted recession and recovery. Roughly 95 percent of Black-owned non-employer firms and 91 percent of Latino-owned nonemployer firms will not be able to receive a Paycheck Protection Program (PPP) loan through a mainstream bank or credit union.[44] The inability to access vital funding during a period with halted economic activity will result in a disproportionate number of small and microbusinesses closing permanently.

Consumer debt incurred during the crisis will have long-term repercussions. As families take on non-mortgage debt to make ends meet in this crisis, this debt will impact household financial security for years to come.

CHANGING COURSE FROM CURRENT TO FUTURE STATE

As policymakers seek to address this crisis, they must determine whether their solutions are merely patches over deep wounds or the hard medicine we need to begin treating the systemic economic syndrome that allowed these problems to fester long before the emergence of COVID-19. Whether due to a rise in gig work, a decline in union membership or some other fundamental shift in the American labor force, what lies at the heart of these issues is that the quality of work available to many in this country in terms of pay and benefits, as well as the economic mobility afforded by work, is a serious existing vulnerability that is now laid bare by attempts to correct it through temporary fixes and occasionally bolder calls for solutions to entrenched problems.

In some cases, the choices policymakers are making to address the income and financial needs of workers in an immediate, COVID-19 driven environment further highlight these serious flaws. The need to enact temporary paid leave measures so individuals can tend to their health in the midst of a pandemic without fear of losing their income, for example, suggests that too many individuals were already in a position of having to choose between their job and their health should they or a loved one become sick, and it underscores the need for permanent paid leave. In other cases, the growing number of jobless individuals who are soon to find themselves counted among the uninsured makes clear that all too often access to health insurance, and thus the ability to seek care, is dependent on finding (and maintaining) a high-quality

39 https://www.apmresearchlab.org/covid/deaths-by-race
40 Source: BLS; U.S. Department of Labor; Connecticut Department of Labor
41 Donovan, S. A., Bradley, D. H., & Shimabukuro. (2016). What does the gig economy mean for workers? (CRS Report R44365). Washington, DC: Congressional Research Service.
42 Rebecca Smith (March 24, 2020). "Independent Contractors and COVID-19: Working Without Protections." Washington, DC: National Employment Law Project. Available at https://www.nelp.org/publication/independent-contractors-COVID-19-working-without-protections/
43 Bureau of Labor Statistics (March 2019). "Characteristics of minimum wage workers, 2018". Available at https://www.bls.gov/opub/reports/minimum-wage/2018/pdf/home.pdf
44 Center for Responsible Lending. (April 6, 2020). "Small Business Support Must Extend to Businesses of Color." Accessed on April 30, 2020 at: https://www.responsiblelending.org/sites/default/files/nodes/files/research-publication/crl-cares-act2-smallbusiness-apr2020.pdf?mod=article_inline

job rather than a guaranteed right regardless of work or income status.

Similarly, the ability to make basic ends meet during a financial storm due to this crisis or the next can no longer be tethered to finding the right job at the right time. Certain guarantees must be in place to ensure all families have an opportunity to save for an uncertain future. The ability to earn a living wage that can afford financial security through savings—be it short-term savings to get through the next challenge around the corner or long-term savings to provide for a more stable retirement and the possibility to leave something behind for the next generation—cannot be based on the luck of the economic or racial draw. Policymakers should not focus only on policies that give a momentary boost in workers' wallets today. They must rebuild a broken minimum wage and social safety net system that long since fell behind the ability to guarantee an adequate or decent standard of living in this country—let alone create any chance for saving or being prepared for the next rainy day.

This crisis and the revelation that much of the pain felt now has existed for generations demands tough actions by policymakers to make real institutional shifts. This will require bold action to rethink how policies can ensure work, wages and the broader economy provide the opportunities for all individuals and families to thrive.

We should not only focus on efforts to replace lost income and stabilize families financially—we must aim to emerge stronger. Returning to the pre-COVID-19 status quo would further entrench racial disparities in health and well-being. Alongside policy solutions, we must consider programmatic and community-driven solutions to support meaningful work and wealth building. Policymakers, practitioners and philanthropists must address the root causes of economic hardship and disparities as we rebuild our economy. By taking a cradle-to-grave financial security lifecycle approach—at the household, community, and societal levels—and conducting a racial equity analysis on all proposed solutions, we can help ensure that wealth can be built to support multiple generations and a prosperous future for all.

PIVOTAL MOVES FOR ACTION IN THE NEXT 24 MONTHS

In the next 24 months, our efforts should focus on ensuring that everyone has the financial resources they need to make ends meet. Millions of people have lost jobs and these jobs are unlikely to return in the next year. There simply aren't enough existing opportunities for meaningful work with living wages. Our solutions aim to provide a living wage to everyone who can work, reduce debt, and support savings and investments in families.

HOUSEHOLD-LEVEL CONDITIONS AND SOLUTIONS

To ensure that everyone can make ends meet without suffering the chronic toxic stress and associated health problems that come with financial insecurity, our best options are to expand on what works at the federal and statewide level to boost income, reduce debt and help individuals launch new businesses, thereby creating new opportunities for themselves and economic development for their communities.

Earned income tax credit

To give all children a healthy start and provide opportunities for meaningful work and wealth to adults, we propose expansions of the Earned Income Tax Credit, increases in the minimum wage, child development accounts, debt relief and homeownership support.

The Earned Income Tax Credit (EITC) is our country's single most effective anti-poverty tool, lifting millions out of poverty every year. In 2018, it lifted 5.8 million people out of poverty, over half of whom were children.[45] Decades of research also shows that it is an effective public health tool, improving health and educational outcomes for mothers and children. The main lesson from the EITC and guaranteed income pilots in Stockton, CA, Jackson, MS, and elsewhere, is that unrestricted cash assistance is critical for financial stability and does not discourage people from working. Instead, it allows parents to dream of a better future for their children and invest in those dreams. In the next 24 months, we should seek to bolster the EITC, ensuring that everyone who is eligible for it can access it. We should expand eligibility, ensuring that more single filers can access it, and we should push all states to adopt or expand state earned income credits to at least 15 percent of the federal credit and make them fully refundable so that all low-income families, even those without a tax liability, can benefit from the credit. Currently, 14 states offer a refundable state EITC at 15 percent or more of the federal credit.[46]

45 https://www.cbpp.org/research/state-budget-and-tax/states-can-adopt-or-expand-earned-income-tax-credits-to-build-a
46 Prosperity Now Scorecard. https://scorecard.prosperitynow.org/

Minimum wage

While the once-a-year EITC provides significant support to families, increasing wages will be an important strategy to help families make ends meet day-to-day. The minimum wage has been insufficient to support households at the federal poverty level for decades. Each state and metropolitan statistical area should establish a minimum wage requirement that is tied to the local cost of living, with automatic annual increases built in. Such policies should be extended to caregivers, such as home health aides and childcare workers, as well as tip-based workers. At a minimum, we should implement these recommendations to increase income through the EITC and living wages over the next two years while we explore whether a universal basic income approach could replace the EITC and supplement increased minimum wages in the future.

Income that consistently exceeds expenses is necessary for financial stability and to enable people to save. Wealth, however—in the form of appreciating assets such as homes, businesses, and investment accounts, is a game changer for households in improving financial well-being and health outcomes long-term. As noted above, wealth inequality far exceeds income inequality in this country and has been increasing since the Great Recession. Entrepreneurship, which we address below, has been one of the only avenues to building income and wealth available to households of color.

Child development accounts

Child development accounts (CDAs), or universal investment accounts available to all children from as early as birth, can provide a nest egg to all children from which they can build greater wealth. CDAs can also free mental bandwidth for financially distressed parents so that they can focus on immediate and shorter-term needs without sacrificing long-term financial security for their children. Many local and statewide programs exist across the country that aim to provide an investment in children's education (children's savings accounts), such as Oakland's Brilliant Baby Program and St. Louis's College Kids Children's Savings Account Program, funded through parking tickets. Many such programs provide seed money, matching funds and financial coaching or education to parents to support the educational goals they have for their children. We can build on these programs to offer a wider set of opportunities to children through baby bonds,[47] which aims to provide an investment to all children that becomes available to them when they turn 18 and can be used to purchase a home, capitalize a business or attain postsecondary education. Local communities can explore different approaches to family investments, but all programs should include an initial universal deposit and direct larger investments on a sliding scale to families with lower income and net assets.

Both the EITC and CDAs have broad bipartisan approval and are supported by a majority of Americans.

First time homebuyer credits and matched savings initiatives

As noted above, homeownership accounts for the majority of family wealth, yet large disparities exist in homeownership rates; among other outcomes, White households start climbing the homeownership ladder 8 years earlier than Black households, almost a full decade of additional equity-building time. First time homebuyer credits and matched savings initiatives enacted at the local and federal levels and targeted to low-income families could provide much needed wealth-building support, as well as long-term financial security, to households of color and low-income communities. Such support should help ensure that people aren't cost-burdened through housing, keeping housing costs at or below 30 percent of monthly income. Additionally, alternative credit scoring models that take into account regular and on-time rent, cell phone and utility payments could expand access to favorable loan terms to more low-income people.

Debt bailout

Families without savings are more likely to incur debt, and high levels of unsecured debt impacts households' well-being and parenting practices.[48] Households often turn to unsecured high-cost debt when they are unable to pay for an emergency, such as a car repair; in the current crisis, we are facing previously unseen levels of consumer debt. Student loan debt levels have risen so high that homeownership is out of the range of possibility for years to come. Many people carry high student debt loads without a college degree. Additionally, medical debt stands in the way of households' ability to save. By discharging debt and providing asset-building support, we can greatly increase family financial security and health. The American

47 This term was coined by Darrick Hamilton and William Darrity, Jr. in Hamilton, Darrick, and William Darity, Jr. 2010. "Can 'Baby Bonds' Eliminate the Racial Wealth Gap in Putative Post-Racial America?" Review of Black Political Economy, 37(3,4):207-216.
48 https://assetfunders.org/wp-content/uploads/FINAL_AFN_2020_HEALTHWEALTH_CHILDREN_PROOF-8_SINGLE-5.26.20.pdf

people need a debt bail-out that matches that given to the banks in 2008. Debt relief funds could be established at the local or national levels to help relieve people of overly burdensome debts that prevent households from saving.

Consumer protections

To create equitable financial and labor systems, we need to ensure that public rules, consumer protections, and regulations on private, public and philanthropic sectors are appropriately enforced. For example, the CFPB's consumer complaint database offers a model for addressing consumer complaints. These consumer protection enforcement measures need to be transparent and public to ensure that entities are held accountable to communities for equitable treatment.

COMMUNITY-LEVEL CONDITIONS AND SOLUTIONS

Community reinvestment act

To more comprehensively address community-level needs, we need to strengthen the Community Reinvestment Act (CRA) and involve communities in assessing depository institutions' performance. A revamped CRA system that ensures funds flow from for-profit financial institutions to underserved communities to address the root causes of wealth and work disparities is one of the most impactful levers for change in the near-term. By requiring that these investments flow to Communities of Color and community-based organizations led by people of color, we can reallocate resources to effectively address racial economic and wealth inequality and other drivers of disparities in local communities.

Funds from the CRA should be, in greater part, allocated to build small and minority-owned businesses. Many regions of the country won't have enough jobs to meet worker demand in the next 24 months. For some people, the only opportunities might come in the form of self-employment. We should be ready to provide the support and access to capital that entrepreneurs need. Investments in entrepreneurship would go a long way toward bridging the racial wealth divide in communities across the country. The median net worth of Black business owners is 12 times higher than Black non business owners, and small business owners reinvest 68 percent of all revenues to build and sustain communities. Black-owned businesses hire people from the community at higher rates than other business owners and entrepreneurs of color throughout the country can help spur local economic development.

Community development financial institutions

Community development financial institutions (CDFIs) are a critical source of capital in economically distressed communities, often serving as lenders of last resort when entrepreneurs are turned away from banks in their communities. CDFIs need a large capital infusion from the federal government, as well as philanthropic and CRA investments from banks. Throughout our country, CDFIs work to build the capacity of entrepreneurs of color. These organizations are uniquely positioned to provide education, training, technical assistance and access to capital to help bridge the economic opportunity gap for entrepreneurs of color. CDFIs use market-based approaches to deliver measurable results. However, many CDFIs lack the support and infrastructure to bring these efforts to scale and alternative underwriting practices are needed to ensure that CDFIs' lending standards are not exclusionary toward entrepreneurs of color.

By strengthening CDFIs and creating public-private partnerships that grow and sustain the base of successful entrepreneurs of color, we would substantially increase investments in the capital resources, training and technical support that these entrepreneurs need to grow their businesses. These large-scale, strategic steps will move us from talk about the racial wealth divide to real action. Investments in CDFIs alone will not be sufficient to meet capital demands in this country, however. A strengthened Community Reinvestment Act is needed to encourage lending in underserved markets by banks at the scale we need, as well as invest in organizations that provide wraparound support to entrepreneurs of color.

Additionally, a strengthened CRA could provide the funds needed for community leaders to invest in community-driven solutions with a specific emphasis on racial equity and solutions led by and accountable to Black, Indigenous and people of color (BIPOC) communities. These efforts should include creating public, private, philanthropic and community-based organization collaboratives and partnerships led by and accountable to low- and moderate-income BIPOC communities, centered in an understanding of the institutional, systemic and structural causes and consequences driving disparate health, economic, social and political outcomes and committed to upstream interventions and solutions to remedy root causes of inequity. Such collaboratives could create cooperative and community wealth-building opportunities, like community development credit unions and food co-ops, community land trusts, and support employee

ownership of companies. Community stakeholders could also work with the health care industry to offer supportive services, like financial coaching and Volunteer Income Tax Assistance (VITA), and reimbursement for those services as a health intervention.

Matches to savings and removal of asset limits

Further, we need to support asset development for low-income families through matches to savings accounts and the removal of asset limits, or savings penalties, on safety net programs like SNAP. Without support for savings and boosts in income, families are only able to consider the short-term. Through these changes, coupled with community-driven solutions, we will support families across their life cycles in building meaningful work opportunities and building wealth at the household and community levels by addressing the root causes of wealth and work disparities.

BIG IDEAS FOR TRANSFORMATION FOR THE NEXT 10 YEARS

A NEW "NEW DEAL"

Our current moment calls for big transformations in the way we approach work and wealth. We need a new "New Deal" that not only closes the racial wealth divide in a generation, but also promotes broad-based financial security for all Americans. There simply aren't enough existing opportunities for meaningful work with living wages. Quality jobs with living wages through a federal jobs guarantee must be on the table to fill in gaps in the employment landscape.

Federal jobs guarantee

A federal jobs guarantee with a living wage has the potential to make an exponential difference to the financial security and health outcomes of millions of people, while enabling individuals to maintain and grow their skills during periods of economic downturns. Jobs made available through such a program could target growing sectors in need of workers, such as public health and infrastructure.

Paid sick and caregiver leave

A living wage is necessary but not sufficient to ensure financial security. To create a level playing field and increase financial security for all, paid sick and caregiver leave, health insurance, retirement benefits, and childcare assistance—supports traditionally available to a decreasing percentage of workers through employers—should be decoupled from employment and available to all workers. Only 14 percent of workers currently have access to paid leave. The COVID-19 pandemic makes clear that paid sick leave is critical to ensure that workers don't have to choose between caring for themselves or loved ones and paying rent, especially when public health is at risk. Paid caregiver leave is also necessary for the health and well-being of babies and mothers after childbirth, as well as people caring for dependent family members. Caregiving work has been significantly undervalued and traditionally falls to women, leading to ongoing disparities in lifetime pay and Social Security benefits. By decoupling benefits from specific employers, workers will have the freedom to change jobs without fear of losing critical supports.

Universal pre-K and childcare

Beyond paid sick and caregiver leave, universal pre-K and childcare can provide critical educational and socioemotional learning support to children while enabling parents and guardians to work. Longitudinal studies of children in HeadStart programs provide evidence for increased lifetime financial security, health and economic impacts far beyond the per-student cost of the program. Quality universal pre-K and childcare should be included in any new federal jobs program to ensure that parents and guardians can work with the confidence that their children are being cared for by licensed professionals. Critically, universal pre-K and childcare supports families when they are most economically vulnerable, as parents of young children have lower incomes than parents of older children. Providing these services universally therefore increases short-term financial stability and security for families.

Postal banking

A new New Deal could also focus on providing universal access to banking through postal banking. Consumers of color are more likely to be unbanked and underbanked, relying more on predatory alternative financial services, which each year strips tens of billions of dollars from low-income people through exorbitant fees and high interest rates. Lack of accessibility of affordable financial services and low trust in financial institutions are two of the factors that cause this reliance on alternative financial services. We must expand access to safe and affordable financial products, and postal banking is a promising way to do so. Given the reach of postal services—both in urban and rural

America—and the United States Postal Service's mission to serve the public, the foundation for achieving scale and impact is already in place. Senator Kirsten Gillibrand's (D-NY) bill would enable this expansion of service and create a lifeline for the USPS.

INVEST IN THE ENTREPRENEURIAL SPIRIT OF EVERYDAY AMERICANS

According to the paper "Start Us Up: America's New Business Plan," 40 percent of Americans would quit their job and start a business if they had the tools and resources to do so. Many feel locked into their positions due to workplace benefits, like health insurance and retirement support,[49] but even if these benefits are disconnected from work, as we recommend above, access to capital remains a significant challenge, particularly for women and people of color. In addition to our previous recommendations, changes are needed in valuations of creditworthiness. Our current credit rating system is unnecessarily excluding far too many people from accessing loans with favorable terms. CDFIs that are embedded in underserved communities are more knowledgeable about the creditworthiness of community members and can offer loans with lower barriers to entry. We need a large-scale overhaul of the credit rating system that centers the experiences of women and people of color in creditworthiness determinations.

Starting a business does not automatically confer wealth, however. We can help people of color and women build wealth more quickly by giving them a seat at the table of mergers and acquisitions. Twelve million Baby Boomers are expected to sell their businesses and retire in the coming years, creating an opening for employees to become owners of an established business or for acquisition by another business. Again, capital is critical to help ensure that women and people of color can acquire businesses at the same rate as White men. Additionally, business centers should provide assistance to women and people of color to find such opportunities and help broker the best terms.

Even large capital infusions into CDFIs will not meet the demand for business financing and wealth building opportunities through entrepreneurship, however. Increased access to equity products, venture capital, and state and local entrepreneurial catalyst grants targeted to women and people of color can fill gaps in capital in regions across the country.[50]

CREATE A RIGHT-SIDE UP TAX POLICY

To pay for the new New Deal, and invest in the creative capacity of entrepreneurs, we need to turn our tax policy right-side up. Our federal tax policy has consistently favored those with wealth and has aided the wealthy to increase their wealth through the mortgage interest tax deduction, low tax rates on capital gains, and other credits, deductions and loopholes designed to reduce the tax liabilities of higher-income, higher-wealth households.

We spend more than $700 billion a year in federal tax expenditures to help the wealthy maintain and grow their wealth. Policy experts of all political persuasions agree that tax programs are just government spending by another name. These tax expenditures—averaging $2200 annually for every man, woman and child in the country—currently reward the rich, miss the middle and penalize the poor. Americans making over $1 million a year—the wealthiest .1 percent—get an average annual benefit of $160,000 while working families get an average annual benefit of $226. We can restore the Estate Tax on wealth conferred by society and invest it into an endowment (baby bond) for every kid born in the country as Senator Cory Booker has proposed in the American Opportunity Accounts Act. Studies show that such an endowment could close the racial wealth divide in a generation.

Federal and state governments should turn these existing upside-down subsidies into an investment in the productive capacity of all people by providing first-time homebuyer support, matching funds for entrepreneurs, and child development accounts to help all Americans achieve financial security.

KEY CONSIDERATIONS

The COVID-19 pandemic has been particularly devastating to low-income Communities of Color. The disproportionate impact it has had in these communities is attributable to racial inequities in our health, employment, housing and financial systems—and many more—as well as centuries of oppression. The conditions that distressed and marginalized communities are facing extend beyond COVID-19 to police brutality and now boarded up, looted stores. The deaths of George Floyd, Breonna Taylor, Philando Castile, Tamir Rice, and countless others, have demonstrated that the lives of Black people are not valued at the same level as Whites. We cannot improve health

49 Start Us Up: America's New Business Plan
50 *Ibid.*

and well-being outcomes for Black, Indigenous and people of color unless we address the racism and discrimination built into our systems and policies.

Better data is needed on wealth and race. Most assessments of financial security and economic mobility use income as a proxy for wealth because we don't have a standard way to measure and track wealth. As noted in Ten Solutions to Bridge the Racial Wealth Divide, "It would be a significant benefit to have local data that includes information on household asset and debt disaggregated by respondent race, ethnicity, tribal affiliation and ancestral origin to provide better insight into the nation's racial and economic differences."[51] Having this data will allow us to better target interventions and design responsive policies to build wealth within all communities across the country.

Any new program or policy should be assessed for its potential impact on different racial and ethnic groups. Race Forward has developed a Racial Equity Impact Assessment tool to assist stakeholders in developing initiatives centered in equity. Additionally, the Government Alliance on Race and Equity has developed a toolkit, Race and Equity: Getting to Results, to assist local and regional governments to design services for racial equity.

The policies and programs recommended in this paper can close the racial wealth divide in 10-25 years, while lifting median wealth for people of all racial and ethnic backgrounds. All the policies suggested are investments that will yield returns greater than their costs in future years, and most can be funded by turning existing tax subsidies right-side up, as we state in From Upside Down to Right-Side Up. Trillions of dollars in new wealth will be created by millions of new entrepreneurs, jobs, homeowners, college students, skilled workers, hope, innovation.

As our founder, Bob Friedman, points out in his book A Few Thousand Dollars, we have proven that, given as little as a few thousand dollars—common people, even very poor people, will start businesses, create jobs, buy homes, go to college, work and build wealth. The greatest economic policies of our history—universal public education, the Homestead Acts, the 30-year Fixed Rate Mortgage, the GI Bill—created widespread, long term, significant increases in economic well-being mostly for White males. The GI Bill alone, which provided income support but more importantly low- or no-interest college, home and business loans, tripled the middle class in a decade and spurred decades of growth. We need a GI Bill for the 21st century—one that is designed to boost economic prosperity for everyone.

Through the solutions identified in this paper, we have an opportunity to help low-income households accumulate wealth at large-scale, which can be transferred to future generations and bring the possibility of prosperity within reach.

SOURCES AND DOCUMENTS

A Complex Portrait

A Downpayment on the Divide: Steps to Ease Racial Inequality in Homeownership

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DEEP DIVE

LIFELONG LEARNING: CRADLE TO CAREER

JUNE 2020

CONTRIBUTION 1 OF 2

AN OPPORTUNITY FOR PARADIGM SHIFTS TO ENABLE LIFELONG LEARNING

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AN OPPORTUNITY FOR PARADIGM SHIFTS TO ENABLE LIFELONG LEARNING

DEEP DIVE 1 OF 2

Large scale disruption such as we've suffered in recent weeks and months, presents both danger and opportunity. The dangers are obvious, life and death threats including economic catastrophe, job loss, housing instability and homelessness, lack of access to quality health care and personal safety threats. At the same time, dramatically raised public consciousness on matters of equity and social justice do present opportunities for change ranging from minor technical and symbolic tinkering to major paradigm shifts.

This is a complicated time in our nation's life. Not only are we coping with the losses and uncertainties of COVID-19, but national consciousness on matters of racism and police brutality has suddenly skyrocketed. Talk of change is in the air everywhere. Yet at the same time, people have been traumatized and are recovering from the loss, anger, frustration and anxiety brought about by COVID-19 and the recent murders of George Floyd of other innocent Black men and women. Some changes need to be immediate and are already happening, literally overnight. Others will take more time. The education sector, for example, has been traumatized by the school closings. It needs to recover its equilibrium before becoming open to embracing life-changing paradigm shifts. Nonetheless, now is the time for urgent, thoughtful contemplation of the ways in which this moment can be turned into a movement for major paradigm shifts. This is the time to call together all voices to envision changes which will, for example, eradicate childhood poverty, attack racism in all its forms, and improve the quality of our systems of child development and education to dramatically increase the well being and educational achievement and attainment of those who our education has least well served. The window for change will not be open forever and those who seek to take advantage of this moment for substantial system change must be prepared.

SEVEN MAJOR SHIFTS FOR CONSIDERATION

BUILD CRADLE-TO-CAREER SUPPORT SYSTEMS TO ENABLE LIFELONG LEARNING

If we are to prepare all of our children to fulfill their promise and be successful in work, citizenship, and family life, then we need to attack poverty and its insidious effects on families and children. Many other nations have long ago concluded that there is both a moral obligation and an economic imperative to have systems of universal health care, early childhood education, paid family leave, housing stability and access to nutritious food as minimum requirements for family stability and children's well being. Without addressing these challenges, it will be virtually impossible for schools, as we know them, no matter how significantly reformed, to be successful in doing what our leaders have appropriately asked schools to do: educate every child to high levels.

Given the rapidly and continuously changing requirements of 21st century work and democracy, nations will have to cultivate human talent as never before. To be successful in this century requires continuous learning through all stages of life. Continuous learning from the earliest stages of life to mature adulthood should be the norm if our citizens and society are to adapt to the changing economic environment and prosper in coming decades. Individual citizens and the entire society have a shared interest in lifelong learning. For individuals, the benefits are obvious starting with "the more you learn, the more you earn." There are clear ethical reasons to commit to having every child be given a fair chance to realize their full potential, but we have economic imperatives that necessitate educating our population to the maximum degree so that our nation can prosper and remain competitive in a 21st century, high-skill, high knowledge economy.

We also desperately need a highly educated, media literate

citizenry capable of discerning truth, recognizing evidence, and engaging in sophisticated analytical thinking. We need a much higher percentage of our citizenry to be motivated and prepared to actively participate in the civic life of our challenging democracy.

In coming years, human capital will be more important than ever to the prosperity of both our democracy and our economy. America has a long way to go in building a robust, nimble human capital development system to help our young people reach their full potential. Now is the time to redesign and rebuild.

As a starting point, we will need to reconceptualize society's simplistic idea of education. We must shatter the myth that our current K-12 education system is the great equalizer, single-handedly creating an equal opportunity society in spite of unprecedented inequality in income and wealth. It's a noble ideal, but the data over more than a century clearly prove that schools alone, even when substantially reformed, are too weak an intervention to deliver on the promise of giving all children a fair chance to succeed. It's a myth. Now, we must move from an old-fashioned, schoolhouse-bound model of child development and education to a system of robust, flexible learning opportunities coupled with basic supports available from birth through adulthood.

Our current K-12 school model consumes only 20 percent of a child's waking hours between the ages of 5 and 18. That's far too limited a strategy for schools to be expected to achieve world class standards and equalize achievement in a country with huge and widening gaps of income, wealth, and access to opportunity and social capital. Much more attention needs to be paid to equalizing children's access to the support and opportunities that pervade the 80 percent of affluent children's waking hours but are unavailable to their disadvantaged peers. Social mobility is steadily declining in the United States, and our systems of child development and education must be strengthened to reverse this insidious trend.

Our current, somewhat sentimental ideas about schooling have severely constrained our conception of education. We need to break down the barriers of time and space that lock us into the narrow confines of schools by preparing for an education system that provides learning opportunities literally anytime, anywhere. We now have the technological tools and internet availability to do this even if, in the education sector, we haven't yet learned to use those tools very effectively. As we develop ed-tech facilities and capacity, we can begin to consider how we alter the structure and strategies of in-person education to maximize the value of critical learning relationships by creating structural and incentive changes to deepen and extend learning opportunities. Schooling conducted face to face, in person, at least in part will always be with us, but it needn't be the entirety of what we consider education.

A place to start building a new conception of education is in our utilization of time. We could begin by acting on the strong research evidence showing that access to summer learning matters: those who get it surge forward, those who don't fall back and suffer learning loss. Access to summer learning is generally controlled by family wealth and social capital. Instead, we should be designing a system in which summer learning and enrichment are available to every child, not just to those fortunate enough to receive access through the accident of birth and family wealth.

The same applies to learning opportunities after school, weekends, and holidays. It's time to bury our agrarian school calendar and substitute flexible, year-round learning (see Chiefs for Change and the Texas Education Agency for recent proposals on this topic). It's time to have a school schedule that reflects the realities of American family life in the 21st century. A 19th century approach to the use of school time won't do it.

Schedule changes are a prerequisite but not a substitute for major shifts in curriculum and instruction to deepen and broaden access to high quality, engaging learning opportunities. To do all of this, we'll need to contemplate changes in teacher roles and schedules, new educational personnel, utilizing part-timers and community members while modularizing various elements of the curriculum and other learning opportunities.

We'll need to much more aggressively partner with individuals and organizations in our communities who care about, and have capacity and experience, in supporting and educating young people. Education and child development can no longer be seen as the exclusive responsibility of the school system. Entire communities need to become involved in addressing the needs of young people by providing the learning, support, and opportunities children require to become full, contributing adults. Our local communities are closest to the young

people and chock full of talented individuals, experienced youth, and community-serving organizations which can contribute to building, together with the school system, high-functioning cradle-to-career pipelines and lifelong learning systems that take full advantage of community assets.

Finally, we'll need to move beyond school boards to shape and govern a lifelong learning system. Our current systems of governance are too fragmented. Having separate boards for early childhood, K-12 and higher education to say nothing of health and employment means that our human development system is siloed, not integrated or comprehensive, not user-friendly and readily accessible to youth and families. Another problem is that these governance sub-systems are frequently so heavily influenced by various constituencies that children's interests take a back seat. Our governance systems need to be more representative, broader in scope, and more seriously engaged in matters of policy, accountability and connecting with the community.

New cross-agency governing bodies such as Children's Cabinets and "backbone" organizations should be created to design and implement cradle-to-career support systems, overseeing formal and informal systems of education, and systems of support and opportunity needed to assure that all children are prepared to succeed. Creating a "children's cabinet" and a robust coordinating organization offers a powerful solution to the challenge of educating all children to high levels. A children's cabinet is an action-focused, executive-level collaborative body that brings together agencies and organizations to create a coordinated agenda for children.

The children's cabinet is the lynchpin of the cross-sector collaboration, with responsibility for identifying top priorities and common goals, defining the role each entity can play in achieving them, developing strategies for carrying them out, tracking progress towards the goals, leveraging new resources, holding parties accountable for making progress, and communicating this progress to the public.

A variety of cabinet models exist. We favor cabinets led by a mayor, which include the superintendent and representatives from other entities with responsibility for or interest in children's education, opportunity, and support. Creating a children's cabinet has both practical and symbolic value. When agency heads, community leaders, philanthropy heads, and other executives join the cabinet, it signals the high priority the community's leaders are putting on the welfare of its children. Structurally and programmatically, cabinets reshape the way communities serve children by bringing together leaders across sectors to make children's success a community-wide responsibility rather than one that rests primarily with schools.

Many powerful organizations across the country have worked on designs to advance some version or various aspects of the lifelong, holistic, integrated support vision described above. A few examples are StriveTogether, Communities in Schools, the Coalition for Community Schools, Children's Aid Society, Harlem Children's Zone, Say Yes to Education, The Forum for Youth Investment, the Social Genome Project, and the Promise Neighborhoods Institute at PolicyLink. These, and many others, are pointing the way to the theory, practice, and evaluation of a "broader, bolder" conception of what needs to be done to guarantee that every childhood has sufficient education, support, and opportunity—in short, every child has ready access to a real pathway to success.

PROFESSIONALIZE FULL ACCESS, HIGH QUALITY, EARLY CHILDHOOD EDUCATION

Lifelong learning, as a right, should begin at birth. For years, brain science has shown that early childhood experiences significantly impact longer term health, educational, and economic outcomes. The evidence is still incontrovertible: the most highly leveraged investments in education come in early childhood when children's brains are growing, developing and vulnerable. Yet, the early childhood sector is the least adequately funded, least accessible, and least professionalized component of our education system. The closures of childcare centers due to the pandemic and the new safety requirements will mean many underfunded centers will close, making the already financially strapped sector even more fragile. The gaps in access and quality are well-known and seldom addressed. Early education teachers and personnel are woefully underpaid and, consequently, staff turnover in this field is unacceptably high while attracting talent to the field is extremely challenging. States struggle to promote quality improvement systems yet the lack of staffing continuity and general underfunding of the sector makes it difficult to enact high standards of quality.

Chronic, gross underfunding of this sector is the central

problem. To wit, the most influential paradigm shift in this sector would be to raise teacher salaries and place them on a par with those of K-12 teachers. However costly, salary parity would bring about a sea change in the field. Secondly, early childhood, because of the shaky state of its finances, is too often thought of as important for 3-5-year-olds, but as a luxury from ages 0-3. While 80 percent of childhood brain growth occurs before age 3 and approximately half of children living in poverty in the U.S. begin school unequipped with foundational knowledge and skills, we do not have policies and supports to create anything approximating full access to the necessary supports and development interventions in the earliest years.

These are also the years in which children's brains are highly susceptible to trauma. We know that the fewer adversities a child experiences, the more likely they are to develop into a healthy adult. Much more protection and prevention work needs to be done with this age group, not only for the children, but also for and with families of our youngest people. Trauma sensitive schools and other related organizations will be essential in the recovery from the COVID-19 crisis. Organizations like Turnaround for Children have provided strong leadership in the theory, science and practice of trauma sensitive practices and learning environments.

To advance this field overall, greater federal, state and local funding and policies are needed as are philanthropic investments. Community organizations, like Children's Cabinets, can provide leadership, coordination and advocacy for the appropriate policies and investments. The business community has been a powerful ally and champion for increased attention and funding to the early childhood sector.

Some promising examples of proven policies and programs include maternal health care, paid family leave, and home visiting programs.

- Maternal Health Care: Without access to health care, a mother is less likely to receive the prenatal health support that enables healthy births. Access to health care must be a universal right.
- Paid Family Leave: The United States is one of the only countries in the world—and the only OECD member—that does not require businesses to offer paid maternity leave to employees. Longer maternity leave is associated with a reduction in post neonatal and child mortality.
- Home Visitation: High quality home visiting programs have proven to be effective in improving positive health and educational outcomes for children and parents. As an example, one of the most effective early childhood support programs is the Nurse-Family Partnership, which helps young first-time moms-to-be starting in early pregnancy and continuing through the child's second birthday. Another program with an impressive track record can be found at HIPPY International. For thought leadership in this domain, the Center on the Developing Child (Harvard) has done extraordinary work. Forty years of research evidence shows that these kinds of programs yield significant reductions in child abuse and neglect, reduction in ER visits, and fewer behavioral and intellectual problems in children at age six.

INTEGRATED, PERSONALIZED EDUCATION AND SUPPORT

Perhaps the biggest shift of all would be to discard our factory system, "one size fits all", mass production approach to education, replacing it with one that meets each child where they are and gives them what they need to be successful inside and outside of school. Such a personalized, customized approach begins with each child being seen and understood by adults within the education system, with families and educators coming together to decide what that child needs both inside and outside of school in order to thrive, achieve well being, and be successful. This approach would require major restructuring of the existing systems, moving to a case management model, more like a medical system. It requires a mindset that distinguishes equity from equality and focuses on a fair system that is responsive to each child. Equality is giving every child the same, while equity is giving each child what they need to achieve success.

This kind of customized system requires great cultural sensitivity given the diversity of our country. This will be a major reach for the education system, but is a prerequisite for educating each child to his or her full potential.

A personalized system is not exclusively, or even primarily, focused on academics, but also takes into account social and emotional learning and children's widely varying circumstances outside of school. Such considerations, in themselves, are a major shift for our education systems. However, this is not the work for schools alone, because

schools generally do not have the scope or capacity to solve pressing, out of school challenges that impede student learning. In consequence, schools, operating on their own with a predominantly academic mission, have definitively proven not to have the capacity to equalize opportunity for young people in the United States. Mountains of data attest to this, not least of which are the data that persistently show the correlation between children's socio-economic status and their educational achievement and attainment. Our only hope of breaking this iron law correlation is an individualized strategy that customizes education, opportunity, and support to meet the unique needs of each child.

A paradigm shift to personalization, to individual success planning for each child, will require a community-wide, comprehensive system beginning with integrated student supports i.e. coordination between the education system and a wide array of child and youth-centered partners who deeply and regularly collaborate to meet young peoples' needs.

Integrated student supports (ISS), a concept that has been in use for decades, was further described in a book entitled "Broader, Bolder, Better: How Schools and Communities Help Students Overcome the Disadvantages of Poverty," which my colleague Elaine Weiss and I published in 2019. We describe how various communities are coming together to offer children the kinds of supports and opportunities that are always available to children born into privilege, but often denied to disadvantaged children. ISS envisions a system in which every child receives the nurturance, health care, support, and stability they need to come to school every day ready to learn. Further, ISS pushes to provide students the kind of out of school learning opportunities in summer and after school that are not equitably available. The basic theory of action is that until we do for all children, in the way of opportunity and support, what those of us who have privilege do for our own, then there is no hope of schools, by themselves, preparing all children for success.

Personalized Success Plans (Harvard's Education Redesign Lab) tailored to each and every young person are an especially promising strategy, and there is a growing body of research about their impact. These personalized plans are tools as well as processes for capturing the full range of strengths and needs of children and youth in order to connect them with tailored, seamless, and equitable services and opportunities. Conceptually, the plans represent our commitment to meet all children and youth where they are and give them what they need, inside of school and out, to be successful.

Practically, Success Plans are logical tools with which to build new systems focused on *individual* needs. The development of Success Plans for each student is a major undertaking with serious implications for staffing, data gathering, and privacy to name just some of the biggest challenges, but the benefits to students, teachers, and families are substantial. Strategically, the adoption of a student success planning approach signals the end of the factory model of education and the start of an era in which each child is seen and matters.

EQUITABLE ONLINE LEARNING

The COVID-19 crisis has catapulted a reluctant education sector into the 21st century world of educational technology. We've always been laggards when compared to the private sector or medicine. Now, it's time for catch up. Whether students physically return to school in the fall or not, we've now been forced to recognize the power and potential of online learning. We now have to transition from the early stages of emergency adaptations we have seen this spring, to effective, intentional best practices to be implemented in the fall.

In order to do this, we'll need to get everyone the equipment they need to participate online, then every student's home will need wifi/internet access. Districts will need to make informed decisions about platforms, applications, and curricula to be delivered online and teachers will need training. Families will need technical support to get hooked up and educational guidance in how to best support their learners. Finally, we'll need tutors, curators, and other new educational role players to support the operation of a 24/7, 365-day learning system. This is a heavy lift and will not be fully accomplished by the fall, but necessity has dictated progress, and the field is already making headway.

It's impossible to overstate the impact of the sudden, profound shift to online learning brought about by COVID-19. The genie is now out of the bottle in the world of education, and it's a safe prediction that things will never be the same. The advent of online learning will open up a vast array of opportunities, while at the same time presenting school systems, teachers, families, and students with an overwhelming number of choices about technical and substantive education matters—choices many

will not have the capacity, information, expertise, and experience to make. National organizations, federal and state governments, and entrepreneurs of all kinds can be helpful in curating the choices and supplying evidence to help key players make informed decisions. District leaders are going to have to commit to a substantial investment in professional development to help teachers, many of whom have limited experience in this area, to adapt to, and ultimately embrace, new tools and modalities.

This embrace of contemporary educational technology must be guided by relentless attention to all the dimensions of equity raised by greater reliance on technology. All of the dimensions of tech adoption, from equipment, to internet access, to training and support, to parental capacities and access, to technical assistance, have the potential to either close or widen the "digital divide." Great care must be taken to close that divide and use these new tools to create a better, fairer distribution of learning opportunities.

A sequenced acceptance of educational technology is a multi-year process and requires thoughtful staging. Demands will be high in the near term for school systems to shift from the emergency tech adaptations made in the face of a precipitous crisis, to a more intentional embrace of best practices and the development of a permanent, integrated system of educational technology. These changes won't happen overnight, but, in time, they will have a profound effect on learning possibilities and access to opportunity for children all across the country.

Not only will the delivery of education change, but the content will change (see section on Deeper Learning) while new challenges such as nurturing the relationships at the heart of education will be front and center. Thought leaders in this domain include Summit Learning, School of One, the Christiansen Institute, the Florida Virtual School, and Next Generation Learning.

DESIGN FOR NURTURING RELATIONSHIPS

The biggest casualty of COVID-19 school closings has been relationships between students and their peers and educators. Top priority must be given this fall, whether schooling is conducted in person or online, to designing our education systems to prioritize high quality, interpersonal relationships. Education, as reflected in the Mandarin language, is about teaching and nurturance. Our current education system is populated by teachers who care deeply about nurturance, but generally the structures and incentives of the system ignore the necessity of relationships. A paradigm shift in this area will require new roles for teachers and staff, new, more flexible personnel, changes in accountability measures to also prioritize students' well being and connectedness, as well as changes in structure, particularly in middle and secondary schools, where current structures often work against quality relationship formation. No student should go through a school year anonymously. Practices like 1:400 guidance counselor to student ratios, teachers seeing 150 students a week, students juggling six or seven classes at a time must be reconsidered and replaced.

Each child needs an educator advocate who follows that child for the duration of their experience in a particular school. Secondary school homerooms should all be converted to "advisories," periods of time when teachers and students interact for a few hours each week on respective journeys through the education system, their challenges, their families, their hopes and needs as they navigate through the turbulent waters of adolescence in a changing society. Teachers crave deeper relationships with their students and tools like success plans provide processes for permanently building those relationships.

Extracurricular activities are critical also. They are often the chief motivators drawing young people to school and should be prioritized, rather than cut the moment budget pressure increases. These activities from sports to music to community service are powerful means for building student confidence and motivation. They are also ideal venues for developing high quality, working relationships between students, their peers, and the adults in their communities. Through intensive, extended engagement, students will draw strength and resilience from their relationships with peers and educators.

This emphasis on nurturing high quality educational relationships, especially mentoring and advocacy for each individual student, is not just a response to this crisis but a necessary, permanent reform to our education system. This need will also increase in direct proportion to our utilization of remote learning tools and processes.

FAMILY ENGAGEMENT

For too long, the education system has, with some notable exceptions, given lip service to the importance of family engagement. In reality, most schools, most of the time, regard family engagement as a "nice to do" secondary or tertiary task. In the worst cases, schools sometimes

ignored family engagement altogether, trivialized it by over focusing on parents' attendance at meetings, or simply regarded family involvement as a nuisance. Suddenly, the COVID-19 crisis has irretrievably thrust families into the very center of the education equation. While educators have long recognized that families are the first and long-term teachers of the children, too little has been done to enlist the partnership of parents in the educational mission of the schools. With all children learning at home in the fourth quarter of this academic year, we've learned that if a "one size fits all" approach doesn't work very well for students, it works even less well for families because of the wide variability in family circumstances, home environments, parent/guardian availability due to job requirements, language barriers, technology familiarity, and general education background.

There is an urgent need now to establish mechanisms of communication, relationship-building, guidance, support, and technical assistance—all targeted toward helping parents to be effective supporters and nurturers of student learning. Family empowerment needs to be a top priority for leaders, school accountability systems, and educator training. Many challenges of language and culture exist in this field, and cross-cultural competency for educators will be of paramount importance and should be essential parts of pre-service and in-service training. Again, in this area, we are blessed by examples of many schools which already have fully engaged, parent partnership programs. There are also outstanding examples of individuals and organizations from the National PTA to Karen Mapp (Harvard) and her Dual Capacity Framework to 1647: Connecting Families & Schools, the KIPP Schools, and many more who have long track records in trying to build effective school-family partnerships. Now is the time for a breakthrough in this area. Now is the time for genuine, communicative, collaborative partnerships between educators and parents.

The kinds of changes being proposed here are generational in nature, just as the opportunities and interventions designed to achieve equity and excellence in education must be extended over generations. Those working on family centered, multi-generational support and development are leading the way in a broader concept, beyond a simple school-based strategy, for assuring the health and well being of students by recognizing and acting on the idea that in order for the child to flourish, the family must be healthy and stable. Interventions targeted at parents and guardians are critical. The work of the Northside Achievement Zone (Minneapolis) and EMPath is exemplary in this field.

DEEPER LEARNING

The core of the education portion of child development is, and should continue to be, teaching and learning. However, our current models of curriculum and instruction have proven, well before the current crisis, not to be effective with significant proportions of our students. The advent of large-scale online learning has only compounded the need for radically redesigned approaches to curriculum and instruction. There is no shortage of theory, research, and best practice examples to inform this shift, but a shift must happen. Students need to be engaged, to be connected, to experience rigor and relevance in their schoolwork. For too many children, that's not happening now.

It's time to enhance student agency in learning, to individually customize curriculum and instruction, to focus on real world applications of knowledge and skill, employing projects, simulations, and utilizing students' local environments. As mentioned above, it's time to be intentional about creating environments and incentives for building meaningful, ongoing student-teacher relationships and positive group and team-building dynamics among students. All the while, education needs to be substantially increasing the emphasis on the interpersonal and social emotional skills employers are now demanding. Organizations and models to lead the way in this kind of work are virtually unlimited: Jal Mehta's work on "Deeper Learning", Jobs for the Future's initiatives on career pathways, Year Up, The Campaign for Grade-Level Reading, CASEL's framework on social and emotional learning, Big Picture's experience in community-based and project based applied learning, High Tech High, mastery learning, Next Generation Learning, the Center for Curriculum Redesign, BELLexcel, Summit Learning, Teach to One and countless others can point the way.

Teaching will change dramatically with the advent of online tools and platforms. Teachers will need extensive professional development opportunities in order for them not only to transfer their curricula online, but, even if school is in-person, to learn how to use the tools of technology to enhance instruction and extend learning opportunities to students in non-school hours. Our schools are generally well behind the curve in adopting 21st century tools for instructional purposes. Now is the time to surge forward.

Professional development will also be required for teachers to develop new curricula, applied learning opportunities, parent engagement strategies, personalized student success plans, and strategies for nurturing student relationships. New approaches to staffing and scheduling, and more flexible, nimble professional structures must be developed. This kind of professional learning will take time, and must be teacher led, designed by and for teachers, but drawing on the expertise of early adopters, experts, and tech leaders from other sectors. These changes in teacher role and practice are essential for any of these paradigm shifts to work, but in order for changes in roles and practice to happen, schools must emphasize learning for the adults every bit as much as for the children.

It is time to envision significant shifts in how the delivery of education is organized. Once again, the current crisis creates a "necessity is the mother of invention" moment. With schools for the foreseeable future operating in limited and interrupted ways because of the COVID-19 threats, schools and entrepreneurs are already contemplating the modularization of education, offering new packages of content in new ways, contemplated by educators in different roles. Math education might come through one channel, while science education comes through another. One sub-contractor might specialize in arranging virtual internships while another might develop a set of online simulations. Organizations like City Year with national service corps members might supply talented young, aspiring educators to be the connective tissue between schools, teachers, and families, offering support on everything from internet connections to off-site tutoring. On the other hand, states might strengthen already promising efforts to offer state-wide classes by some of the top teachers to be curated and supported locally by resident teachers and aides. Building on the experience of innovative online providers like Southern University of New Hampshire, K-12 educators can begin to redesign a system for the future, one that will have value and endurance well beyond the current crisis.

LEADERSHIP

In order to take advantage of these opportunities, we will need leadership. We must have leaders with a special blend of traits and skills including courage, social justice values, persistence, interpersonal skills, empathy, listening, imagination yielding vision, trust, and political acuity to move an agenda of change.

Especially important will be:

Vision

Leaders will bring clarity to the challenge of system redesign, seeing that poverty, race, and disadvantage matter and must be addressed; that schools alone are not enough to provide children with equal opportunity; that a new social compact is needed between communities and families; that society has paramount moral and economic imperatives to educate all children, and all means all, to high levels; that our ideals of excellence and equity are not being realized, but could be if we created a system intentionally designed to achieve that equal opportunity society. Throughout the process of change, the vision must sustain our ideals of an excellent and equitable society that prepares all its children for work, citizenship, family life, lifelong learning, and personal fulfillment.

Strategy

To build an equal opportunity society which levels the playing field between those who enjoy the learning benefits of privilege, financial, and social capital, and those who don't is a monumental challenge and will require sweeping changes and highly effective strategy. Such a system resembles a cradle-to-career pipeline with highly functioning, core, component systems of early childhood, K-12 and post-secondary education. These subsystems must be full-access and high quality. Wrapped around the core pipeline are complementary systems of support and opportunity that make it possible for each child to have what they need to show up to school each day throughout the K-12 years "ready to learn" and to take full advantage of an optimized schooling system. Strategy selection will be key to making all this happen.

Timing

Leaders will need to know what to do and when to do it. Leaders will understand when the opportunities for change present themselves and when the people are too weary and traumatized to consider change. They will know that trust is essential to moving change, that change often means loss, shedding old ways, and that addressing the anxiety of embracing new ways and creating safety for those willing to do it is essential. This is especially true in a time of crisis such as the present.

CHALLENGES

To make any, let alone several of these changes, will require attention not only to the leadership characteristics mentioned earlier but also to an array of potential challenges and potential impediments. Among them:

Scarce, highly contested resources

Needs are urgent in all fields of government and human endeavor right now. The competition for scarce resources will be fierce and the economy is likely to be struggling for some years to come. Taxpayers and policymakers will have agonizing decisions to make about budgets. While some believe that significant change is best precipitated in times of recession, when organizations are forced to do more with less, others worry that the lack of financing for capacity building and program development will guarantee that recovery looks a lot like a restoration of the status quo. It will be impossible to generate the necessary resources to assure equitable systems for all children to succeed without changes in tax policy. Philanthropy should not be funding basic services and supports in our society.

Focused attention, urgency

Like financing, public attention is a scarce and valued commodity. Urgent needs for rebuilding the economy, bringing back jobs, attacking racism and police brutality, homelessness, food scarcity, criminal justice reform, and health care, to name a few, will compete for the public's attention with the redesign of our child development and education systems proposed in this paper. Furthermore, we cannot have an effective education system if the population's basic human needs are unmet. Education should not be competing for funds with children's and family's health care or nutrition. However, human capital development systems, which is what our outdated school systems are, urgently need attention. We must recognize that building human capital is an essential long-term investment for which today's leaders must make a compelling case in order to focus the public's near-term attention on these needs.

Adult interests

There is always some measure of both overlap and tension between the interests of children and the interests of adults when considering fundamental change in basic systems. The biggest enemy of reform is complacency and the inertia of the status quo, the tendency of reform to be modestly incremental and complement existing structures, interests and power relationships within existing systems. To overcome resistance from change that arises from virtually all constituencies in the education and human development sector, leaders must create a compelling value proposition for working differently and a safe environment that allows people on the front lines to embrace change. For example, the kinds of paradigm shifts described above will require unprecedented levels of flexibility, imagination and innovation from both management and labor unions in education.

Governance and accountability

Big shifts involving big changes in "business as usual" and significant investment of public resources will require oversight, reconsideration of governance mechanisms, and new tools for assessment and accountability. For example, it would be worth examining whether our existing structures for governing the work of educating and developing children are best suited to the kind of lifelong learning, holistic view of child development advanced in this paper. To take the schooling system alone, saying nothing about all the child welfare agencies, our governance mechanisms are generally fragmented into early childhood, elementary and secondary, and higher education silos. Wouldn't it make more sense to create an overarching governance system providing oversight and integration that is consistent and complementary across all levels? Or, wouldn't it be better, as suggested above, to have local children's cabinets, in every community or region to coordinate policy, resources and programs to optimize healthy child development and effective education?

At the level of service delivery, many of the proposed paradigm shifts would require new, different, more refined instruments of assessment and evaluation which would serve as the basis for a broader and deeper accountability system. In education, for example, there is a growing awareness of the need to nurture children's social and emotional development, to enhance their interpersonal skills which are essential to workplace success, to strengthen their relationships to teachers and mentors and their capacities to work in groups as they will in future jobs, yet we lack valid and reliable assessment tools to measure how schools are contributing to children's growth in these and other areas. To be sure, there is promising national work going on in organizations like CASEL and PEAR on these topics, but the state of the art is early stage and adoption of these tools is the exception rather than the rule. We continue to need ever more sophisticated tools for measuring students' academic progress, for both diagnostic and accountability purposes. However, to shift the paradigms, we'll need a much more robust system.

It will be especially challenging to develop evaluation tools to measure the "value-added" of our formal institutions of child development and education in terms beyond

relatively simple measures of academic achievement. For example, what kinds of tools and protocols would be necessary to measure how and to what degree a particular school effectively cultivates strong working relationships with parents, high levels of student engagement, and successful student teamwork on applied learning projects? How do we determine whether each child has an effective adult mentor/counselor or whether student advisories are adding value? Ultimately, how do we do a much better job of determining the degree to which our schools are preparing our young people to be successful in college and career, allowing them to attain at least middle-class status by middle age? Assistance in the area of evaluation can be found at the Center for Education Policy Research (Harvard).

POLICY, POLITICS, AND PUBLIC WILL

Many of the paradigm shifts proposed can be advanced in various ways by existing policies such as Medicaid or the Every Student Succeeds Act (ESSA). At the same time, changes in existing policies will also be required. For example, the return to school will necessitate significant shifts in ESSA policy about assessment and accountability. Some established policies make room, if thoroughly examined, for a number of the kinds of changes envisioned in this paper, as do various state and local policies. Leaders at all levels commonly under-utilize their own existing powers to make change because the resistance to change is often formidable and usually has political costs. At the same time, new policies will be required to enact many of the contemplated paradigm shifts, and in order to engineer such policy changes, leaders will have to be thoughtful and strategic in crafting language and building coalitions to support the kind of sea changes that will bring our education and human development systems into the 21st century.

The COVID-19 crisis coupled with the George Floyd murder and aftermath have revealed profound and disturbing realities to the general public, creating a moment of opportunity for change and advancing equity. True leaders will know how to seize this opportunity to make change, whether it's as simple as guaranteeing that every family has the education technology and internet access to make online learning an effective strategy for all, or whether it's as complex as assuring that all of our citizens, especially our children, have access to quality health care and nutrition.

All of these endeavors will require the building of public will. Organizing and listening to the public, the parents, students, and community members, the presumed beneficiaries of the proposed paradigm shifts, will be an essential departure point. Incorporating their perspective in final policy products is imperative. People support what they help create.

There are natural and deep constituencies for some of the proposed changes while others will be met with stiff opposition. Not everyone agrees, for example, that schools have any business in developing children's social and emotional capacities in spite of employers' insistence that these skills matter. Opponents will complain of government overreach. Others will fight for the interests of adults, of privilege, of race, of jobs, money, and other prerogatives. Skillful leadership and widespread public demand can overcome such resistance, but not without deep strategic thought and organizing. The kinds of changes proposed here will only be successfully implemented if they are made top priorities rather than incidental things to accomplish. Adopting measures like these will require visionary leadership, the kind we have seen in our work, and in communities all across this country.

There are numerous thought-leading organizations in the policy and finance space. To name just a few: the Learning Policy Institute, Education Resource Strategies, the Center on Reinventing Public Education (University of Washington), the National Center on Education and the Economy, the Children's Funding Project, and the Center for Educational Equity (Columbia). One state which has taken the lead with some exemplary legislation is Maryland and its Springboard for Maryland's Future. Indicative of the political challenges facing bold policy making, the bill has not been signed by the Governor, but it has substantial political support throughout the state.

CONCLUSION

Meeting these challenges is the stuff of leadership. We desperately need leaders to envision, embrace, and enact a bold new agenda for preparing our young people to be successful in work, citizenship and life.

Each of the potential paradigm shifts described in this paper will require monumental effort to enact. Any one of these changes would have a substantial impact on young people's prospects for success. Taken together, any combination of multiple shifts has the potential to

dramatically magnify the positive impact on children.

To conceive of learning as lifelong, to bolster a neglected system of early education, to approach our children as unique individuals and customize education to meet their particular needs, to deepen learning by making it more engaging, student and project centered, to intentionally cultivate and celebrate relationships between students and their teachers, to meaningfully engage families for the first time ever, and to embrace and capitalize on the tools of technology—all of these shifts, taken together, would revolutionize education and child development in the United States. These paradigm shifts would provide the foundation for migrating our outdated, outmoded system away from its early 20th century roots and into the bright light and new challenges of the 21st century.

Through it all, we must firmly fix our sights on building a system that is both excellent and, above all, equitable. We cannot do this without taking into account factors like poverty, racism, special needs, immigration, and the challenges of learning English. We can do far better than what we are doing now. This crisis gives us an unprecedented opportunity to seize the moment and create a movement to redesign our strategies and structures for developing and educating our children. Let's not miss the opportunity and revert by defaulting to the status quo ante. Let's move forward!

Paul Reville is a professor at the Harvard Graduate School of Education, where he leads the Education Redesign Lab. He is a former Massachusetts secretary of education.

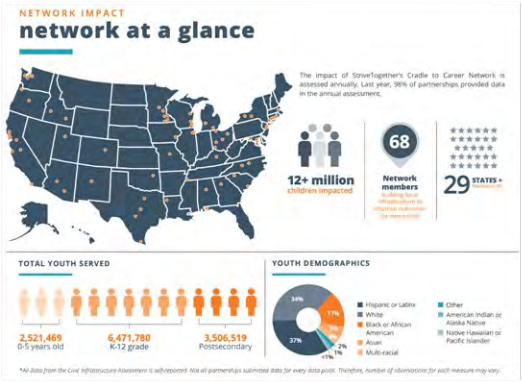
SPRINGBOARD FOR EQUITABLE RECOVERY & RESILIENCE IN COMMUNITIES ACROSS AMERICA: LIFELONG LEARNING FROM CRADLE TO CAREER

DEEP DIVE 2 OF 2

StriveTogether is building a world where a child's potential isn't dictated by race, ethnicity, zip code, or circumstance. We are a national movement that advances equity and justice for over 12 million young people, cradle to career. In partnership with nearly 70 communities across 29 states and Washington, DC, we work upstream to dismantle the cycle of inequitable outcomes by redesigning the systems that were not designed to support the success of Black, Indigenous, Latinx and Communities of Color across the country.[1] We are a network of community leaders, justice fighters and systems changers striving toward a shared vision of upward economic mobility. Partners include youth, families, residents and community leaders in government, philanthropy, business, education, early learning, employment, housing, health and human services. Our network members close disparity gaps and improve outcomes for young people.

The movement began with a group of local leaders in Cincinnati in 2006 who forged a communitywide partnership to build a new civic infrastructure to organize how they worked. They developed shared accountability for a vision that improved results for every child, cradle to career. StriveTogether was founded in 2011 to support a network of communities across the country that all want the best for every child.

Through the Cradle to Career Network, these communities use a common approach,[2] challenge each other, share their expertise and show what's possible when we work together.



CURRENT STATE

In a better world, the well-being of children would not be shaped by where they live or how they are racialized. Instead, youth and families would thrive in healthy, safe communities.[3]

We know racism is the root of many problems across the country. Communities are situated differently in relation to well-being and opportunity. Black, Indigenous, Latinx, and Asian communities each have their own experiences of racism.[4] Intersectionality is crucial to equity work.[5] The different identities we hold overlap and affect how we experience discrimination. Examples are race, ethnicity, class, gender identity and sexual orientation. We must take

1 For more information about StriveTogether and our impact, visit https://www.strivetogether.org

2 The common approach used by all members of the StriveTogether Cradle to Career Network is the Theory of Action™, available here: https://www.strivetogether.org/what-we-do/theory-of-action/. It was evaluated by a third-party evaluation firm, Equal Measure, which found clear and consistent patterns of civic infrastructure development across diverse partnerships in accordance with the Theory of Action: https://www.strivetogether.org/wp-content/uploads/2020/05/ST-Evaluation-Executive-Summary_Final-for-Discussion_14June19.pdf

3 Excerpted from the StriveTogether Racial Equity Statement: https://www.strivetogether.org/wp-content/uploads/2020/05/Racial-Equity-Statement_March2020.pdf

4 For more information about Opportunity Structures, review resources from the Othering & Belonging Institute, including the Othering & Belonging Framework: https://belonging.berkeley.edu/othering-belonging-framework-analysis-fair-and-inclusive-society-communities-creating-opportunity

5 For more information about intersectionality, review resources from Kimberlé Williams Crenshaw, including Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color: https://www.racialequitytools.org/resourcefiles/mapping-margins.pdf

into account their cumulative effect to understand the complexity of prejudices people face. Otherwise, efforts to remedy inequities in one group could perpetuate injustice toward another.

Research has consistently shown that where children live significantly impacts whether they prosper and thrive as adults. Data from Opportunity Insights reveals stark nationwide variation: children raised in neighborhoods experiencing extreme poverty in Memphis, Tennessee, go on to make just $16,000 a year as adults while children from families of similar means in Minneapolis suburbs made four times as much as adults.[6] Even within communities, disparities are vast. In the heart of Chicago, Illinois, residents of predominantly black West Garfield Park can expect to live to age 69 while residents of the Loop, just a 15-minute train ride away, can expect to live to age 85, according to Virginia Commonwealth University on mapping life expectancy.[7] In poverty-stricken pockets of rural America, children face higher infant mortality rates, have limited access to essential education and health resources, and experience adverse childhood experiences, as outlined by analysis by Save the Children.[8]

COVID-19 has unmasked long-standing inequities in our communities. Black, Indigenous, and people of color (BIPOC) communities and communities facing extreme poverty are suffering the brunt of the pandemic because of structural and institutional racism leading to inequities in systems like education, employment, health care, housing, environmental conditions, and food security. The need to transform systems and provide immediate relief to support youth and families and create a more equitable future for everyone has never felt more urgent.

In communities across the country, common factors are contributing to inequities. Across diverse contexts of partnerships within the StriveTogether Cradle to Career Network, common themes are emerging regarding the disruptions and anticipated long-term impacts of COVID-19 on the livelihoods of young people, cradle to career:[9]

- Digital divide: Many communities lack access to devices and broadband internet, leading to limited ability for children to navigate remote learning opportunities.
- Child care: Child care is only being provided for essential workers. Child care and early learning centers are at risk of not reopening, creating a gap in quality early learning.
- Health care: Black and Latinx families are at higher risk of fatal illnesses and many will not seek medical treatment because of historic inequities within the health care system.
- Food security: Many students depend on schools for two meals every day, but with schools closed, they risk going hungry.
- Housing and income: Unbanked and underbanked families are at risk, as are families with high levels of mobility.
- Language access: Non-English-speaking families have even more difficulty accessing support like internet access, educational resources, and mental health services.
- Undocumented status: Families that are undocumented are not receiving supports they need to stay safe and healthy, including stimulus checks.
- Learning loss: Due to the digital divide, competing commitments (like caring for siblings or working) and reduced teacher effectiveness, students of color and students experiencing poverty are falling further behind academically.

In response to these common factors contributing to inequities, cradle-to-career partnerships are serving as change agents in crisis:

TAKING UP THE ROLE OF CONVENER TO REDUCE DUPLICATION OF RELIEF EFFORTS AND ALIGN AND TARGET SUPPORTS TO POPULATIONS IN OUR CIRCLE OF HUMAN CONCERN.

In Tacoma, Washington, Graduate Tacoma quickly

6 This is just one of many data points from Opportunity Insights highlighted in the New York Times: https://www.nytimes.com/2018/10/01/upshot/maps-neighborhoods-shape-child-poverty.html
7 For more information on Virginia Commonwealth University's series of life expectancy maps, visit https://societyhealth.vcu.edu/work/the-projects/mapping-life-expectancy.html
8 For more details, read Save the Children's report, Growing Up in Rural America, the U.S. complement to the End of Childhood Report: https://www.savethechildren.org/content/dam/global/reports/2018-end-of-childhood-report-us.pdf
9 For some examples of how cradle-to-career partnerships are responding to the COVID-19 crisis, read https://www.strivetogether.org/insights/collective-impact-partnerships-in-the-time-of-covid-19/

partnered with the local Urban League to establish an online hub to share resources on everything from food and housing assistance to at-home activities with community residents. E3 Alliance, which serves Central Texas, is working to mobilize volunteer mentors and tutors to support graduating high school seniors as they prepare to transition to postsecondary opportunities.[10] This isn't just a recovery response—the region intends to grow and accelerate this practice in the future to ensure all young people have the guidance and resources they need when making a major life transition.

USING DATA AND STORIES TO AMPLIFY RACIAL INEQUITIES EXACERBATED BY THIS CRISIS

ImpactTulsa, in Tulsa, Oklahoma, leveraged their role as data experts and built on earlier work on a Child Equity Index to create internet access maps by census tracts. The team supports school districts in using this data to adapt their response to make education accessible to all students.

In collaboration with the local school district, Northfield Promise, in Northfield, Minnesota, used Tableau to create maps of students without internet access and maps of lower-income neighborhoods to guide food delivery route planning. With data at their fingertips, teachers and district staff can target outreach to students.

WORKING WITH YOUTH AND FAMILIES TO CREATE LASTING CHANGE

Engaging young people and co-developing strategies has stayed core to Baltimore's Promise's approach amidst the crisis. In Baltimore, Maryland, young adults connected to the Grads2Careers program have served as ambassadors to ongoing projects and provided input on evolving strategies, while getting support and mentoring. Baltimore's Promise compensates these young leaders for their time by using Cash App instead of gift cards.

In San Antonio, Texas, UP Partnership is actively engaging young people in its organizational structure to center their voice and experiences in policies and strategies. The partnership hired two youth interns who inform the decisions of Our Tomorrow, a network of young people across San Antonio building power and policy to shape the future they want to live in. These interns play a key role in infusing intergenerational leadership across the partnership by advising on matters of strategy, hiring and communications.

INFLUENCING INVESTORS TO ALIGN RESOURCES AND ADVOCATING FOR POLICY CHANGE

Partners for Education at Berea College, which serves 54 rural counties in Appalachian Kentucky, is advocating with partners for federal legislation, the Success for Rural Students and Communities Act of 2020. If successful, the legislation will increase enrollment and completion rates, advance rural economic development, promote economic growth and foster innovation.

Norwalk ACTS in Norwalk, Connecticut, has been building relationships across the community and with funders. Now, Norwalk ACTS is leveraging those relationships to connect funders with service providers who need support. They are using data collected through surveys and weekly calls to make strategic connections to sustain community organizations.

In addition to designing and implementing the state of Utah's emergency child care program, Promise Partnership of Salt Lake is leading a state task force to create a stabilization program for the child care sector so that there is a transformed and more resilient system in place for the long haul.[11]

To support the long-term sustainability of efforts like these, StriveTogether is working in solidarity with a broad coalition of partners[12] to advance an Equitable Recovery Pledge to Transform Systems and Advance Racial and Ethnic Equity. This broad, cross-sector coalition of local decision-makers and municipal leaders in government, philanthropy, business, education, health and human services advance this Equitable Recovery Pledge for the well-being of children, families and community members, centering people of color and creating solutions together, with particular attention to the Black, Indigenous, Latinx, and Asian communities that continue to be harmed by oppressive systems and wide inequities. We are dedicated

10 Learn more about the work of E3 Alliance through this case study: https://www.strivetogether.org/our-impact/case-studies/e3-alliance/

11 Learn more about the work of Promise Partnership of Salt Lake through this case study: https://www.strivetogether.org/our-impact/case-studies/promise-partnership-of-salt-lake-city/

12 As of June 1, the coalition of partners includes StriveTogether, The Center for the Study of Social Policy, Enterprise Community Partners, Institute for Healthcare Improvement, Ounce of Prevention Fund, The Educare Learning Network, Natural Resources Defense Council (NRDC), Strong Prosperous and Resilient Communities Challenge (SPARCC), Low Income Investment Fund (LIIF) and Results for America. More partners will be joining the coalition in the coming weeks.

to the principles outlined by PolicyLink's Principles for a Common-sense, Street-smart Recovery to build an inclusive economy and equitable nation that works for all by:

- Centering racial equity.
- Putting people first.
- Investing in community infrastructure.
- Building an equitable economy.
- Protecting and expanding community voice and power.

CHANGING COURSE FROM CURRENT TO FUTURE STATE

To support the development of more just and equitable systems and structures as we navigate a path out of this crisis, we must address and acknowledge the unique expertise, assets, and needs of each community. We must break down policies and power structures that fail youth and families of color. Racial and ethnic equity is necessary to help every child succeed in school and in life. This requires a commitment to anti-racist policies, practices, and behaviors.

It will take concerted, aligned efforts to improve at a national level. When leaders at all levels, across all sectors, align actions centered in community experience toward systems transformation, we can advance social, economic, health, and racial equity and achieve results at scale. We cannot settle for going back to normal. Normal for many people means living paycheck to paycheck. Normal means waiting to seek medical care because you cannot afford to get sick. Normal means worrying more about where you and your children will sleep tonight than helping them complete their schoolwork. Normal was never good for many of us and COVID-19 is only making conditions worse for people of color and those living in poverty.

Our ultimate vision is systems transformation and upward economic mobility: a fundamental and institutionalized shift away from policies, relationships, resources, and power structures that burden youth and families of color, as well as youth and families experiencing poverty, with the goal of achieving the result of equitable well-being at the population level for every child, cradle to career.

PIVOTAL MOVES FOR ACTION IN THE NEXT 24 MONTHS

To begin the work to accelerate a more equitable recovery, three pivotal moves are critical:

LISTEN to and work with youth, families and community members to center lived experiences in our recovery response to support equitable, healthy and resilient communities

Many express the desire to authentically work in partnership with the community from, "Nothing about us without us," to "We must do work with—not for... or to—the community." It's critical to enable youth, families, and other community members to create the vision of success and drive decisions and solutions that achieve it. But what will it take for families and young people to create the future they want to see, supported by institutions? What does it look like to create the structures and processes that enable systems leaders to work alongside the community? What does it take to shift and share power over resources, time, and funding?

For too long, youth and families have been left out of decision-making tables, despite the fact that the people most impacted by problems have some of the best solutions. The first step toward shifting power to community leadership is engaging the community and co-creating with the community. For example, the National Institute for Children's Health Quality's roadmap for authentic community engagement[13] requires authenticity; the prioritization of place, people, and practices; and willingness to give up power.

In Rochester, New York, ROC the Future created a Parent Engagement Collaborative Action network (PECAN) to build a coalition of parent advocates who identify priorities and co-design solutions. Parents serve as consultants and are compensated for their engagement. In late April, more than 80 parents, providers, and organizations attended an online session to discuss the support and resources needed as partners continue to adjust to the pandemic crisis. Parent leaders are reviewing data from a needs assessment completed by more than 100 parents to assess gaps in what families need.

In Central Oregon, Better Together focuses on supporting Latinx student success through the Latinx Success

13 Learn more about NICHQ's Roadmap for Authentic Community Engagement: https://www.nichq.org/insight/roadmap-authentic-community-engagement

Initiative,[14] a community group focused on solutions for Latinx students. The work is led by families, creating a space for families to say what they want. Leveraging the Student Success Act's $2 billion investment to Oregon schools to hold districts accountable for connecting that investment to community input, Better Together conducted 36 community listening sessions in affinity spaces and surveyed more than 2,000 parents and guardians, students, and their families to learn about their experiences in Central Oregon's school district. The team publicly shared results to drive action towards strengthening equity and inclusion in schools for underrepresented communities.

In Charleston, South Carolina, Tri-County Cradle to Career is working to bring diverse voices and experiences to work collaboratively in local outcome-based action networks. The partnership has worked to shift from "planning for" communities to "planning with communities to solve problems." This approach ensures that firsthand, lived experiences guide the development of solutions. Based on community perspectives, Tri-County Cradle to Career is developing a resource connector database to share information on the quality of community services to mitigate barriers to access, such as transportation and geographic isolation.

Across the country, Our Turn mobilizes, amplifies, and elevates the voices of students in the fight for education equity. Through organizing campaigns, leadership development, and national voice, young people channel their power to spark a new movement for justice.

To support bright spots like these, local, state and federal partners can play a role in creating the enabling conditions for communities to move from tokenistic community engagement to authentic collaboration and co-development of solutions. This could include:

- Creating the enabling conditions for authentic youth and family engagement
- Investing in local cradle-to-career intermediary organizations to convene spaces that center lived experiences of youth, families, and residents
- Supporting evidence-based strategies and interventions like universal home visiting, high-quality early learning programs and parent leadership institutes

NAME the systemic factors that produce racial inequities that have been exacerbated by COVID-19 and use data—disaggregated by race/ethnicity, gender and geography—and stories to influence system leaders to take action to address disparities

Today's systems are not broken. They are perfectly designed to perpetuate inequities in the lives of Black, Indigenous, and people of color and youth living in extreme poverty. The silos that continue to exist among sectors must be dismantled if we are to chart a course towards more equitable well-being for every child, cradle to career. The Annie E Casey Foundation's Results Count™ approach[15] encourages leaders to examine and attend to systemic factors that perpetuate uneven results, factoring in historic and structural inequity and bias.

The StriveTogether Theory of Action™ requires cradle-to-career partnerships to disaggregate data by key factors like race and ethnicity, to use data and community voice to understand the root causes of disparities, and to take action at the systems and the practice levels to advance more equitable outcomes. When leaders take data-driven actions grounded in the historical factors contributing to racial inequities, it is possible to advance equitable opportunities.

In Memphis, Tennessee, Seeding Success aligned community resources, data, and policy to get better results for children. They supported Memphis students by supporting organizations that work with students outside of school.[16] They established data collection processes that could be used by all these organizations and yielded more accurate data and then used that data to improve programming. Chronic absenteeism reduced by 27 percent across 15 schools and 59 percent more students were assessed at the end of summer reading programs.

In Multnomah County, Oregon, All Hands Raised regularly brings together school community teams—comprised of teachers, counselors, principals, social workers, youth/

14 Learn more about the Latino Success Initiative at http://bettertogethercentraloregon.org/find-your-role/latino_success/
15 Learn more about the Annie E. Casey Foundation's Results Count leadership approach with the Introduction to the Results CountTM Path to Equity: https://www.aecf.org/resources/introduction-to-the-results-count-path-to-equity/; to learn more about the application of Results Count, read this article on the Proof of the Power of Results Count: https://www.aecf.org/blog/strivetogether-proof-of-the-power-of-results-count/
16 Learn more about the use of data in Memphis through this case study about Seeding Success: https://www.strivetogether.org/our-impact/case-studies/seeding-success/

family advocates, culturally-specific organizations and industry representatives—to use data to identify, measure, and evaluate concrete practices and interventions that improve results for kids. Interventions that work are systematically communicated to the entire school community and across districts, partner organizations, and leadership bodies to inspire scale.

In Wisconsin, Milwaukee Succeeds and Higher Expectations for Racine County collaborated to increase post-secondary enrollment and completion rates for students of color. The partnerships brought together 18 higher education institutions into a regional alliance, collaborating to create a data dashboard that provides a first-ever regional picture of postsecondary completion, disaggregated by race, gender, age, and income.[17] As a result of this project, higher education institutions in Wisconsin are taking a deep look at their internal policies and adapting high impact practices from the Complete College America national network.

To support bright spots like these, local, state, and federal partners can play a role in creating the enabling conditions for communities to collect and connect real-time data, disaggregated by race, ethnicity, gender, and economic status, across sectors. This could include:

- Creating the enabling conditions to make data work for students, drawing from the Data Quality Campaign's four policy priorities:[18]
  - Measure what matters.
  - Make data use possible.
  - Be transparent and earn trust.
  - Guarantee access and protect privacy.
- Investing in local cradle-to-career intermediary organizations to publicly disaggregate data, galvanize cross-sector action, and build the capacity of local partners to use data for continuous improvement.
- Supporting evidence-based strategies and interventions that have evidence of improving outcomes and closing disparity gaps for children and families.

CATALYZE ACTION to mobilize cross-sector partners to shift resources, policies, relationships and power structures; implement targeted strategies to align resources to youth and families of color; and advance equitable outcomes from cradle to career

When we describe our work as giving every child every chance to succeed, people often default to the image of a classroom or a schoolhouse. We must think bolder and more creatively to ensure leaders align actions in ways that make a meaningful contribution to better results for every child, and we must work to address the barriers that contribute to racial inequities and block access to opportunity. This includes practicing targeted universalism,[19] directing supports to youth and families facing the greatest barriers because of the color of their skin, and acknowledging that a rising tide will not lift all boats.

Too often, people can feel paralyzed by the scale of the complex challenges we're up against—structural racism, misogyny, oppression, white supremacy culture, capitalism—you name it. The challenges our youth experience are bigger than any one sector to address. We know we can achieve more by working together than apart to end inequality. This is why we align to the same vision and agenda to ensure every child has every opportunity to succeed.

In Chicago, Illinois, Thrive Chicago used data to identify a priority population of opportunity youth—young people aged 16 to 24 who are not connected to education or employment. They brought key stakeholders together, including local city and county government officials. Prior to this effort, no funds were allotted for this population. Now, an estimated $15 million has been shifted in public funding to be directed towards opportunity youth, with over $1 million specifically allocated in the city's budget to Reconnection Hubs,[20] dedicated spaces for opportunity youth to access coaching and supports and to connect to community programs to address their specific needs around education and employment. As a result, over

17 Learn more about Wisconsin's Higher Education Regional Alliance and view their comprehensive data dashboard: https://www.herawisconsin.org/regional-data-dashboard/

18 Learn more about the Data Quality Campaign's four policy priorities to make data work for students: https://dataqualitycampaign.org/why-education-data/make-data-work-students/

19 Learn more about targeted universalism through this video and these primers from the Othering & Belonging Institute: https://belonging.berkeley.edu/targeted-universalism

20 Learn more about Thrive Chicago's Reconnection Hubs for Opportunity Youth via this case study: https://readymag.com/u18654686/1310194/

300 young people have been connected to education or employment.

In Bridgeport, Connecticut, Bridgeport Prospers and community partners are building an ecosystem of supports to increase the number of infants and toddlers on track for success in school and life by age 3 that is centered around care and support for parents. The Baby Bundle initiative[21] provides the tools needed to build a coordinated, systematic approach to supporting pregnant women, infants, toddlers, families, and other primary caregivers. Core to the Baby Bundle's approach is establishing connections between existing programs. With new linkages, partners can increase effectiveness and coordinate to pursue funding opportunities.

In Dallas, Texas, The Commit Partnership created a broad statewide coalition with other Texas-based cradle-to-career partnerships to advocate for a landmark school finance bill. House Bill 3[22] will ultimately invest as much as $6.5 billion in equitable funding to support Texas learners, including an increase in per-pupil funding for students experiencing poverty and English language learners, as well as investments in full-day pre-K, in college and career readiness, and investments in high-quality teachers.

To support bright spots like these, local, state and federal partners can play a role in creating the enabling conditions for equity-centered cross-sector collaboration. This could include:

- Creating the enabling conditions and incentives for cross-sector collaboration and the implementation of targeted strategies and anti-racist policies and practices that invest in children and families and build an economy that works for everyone.
- Investing in local cradle-to-career intermediary organizations to convene and catalyze action to mobilize cross-sector partners to shift resources, policies and practices.
- Supporting evidence-based strategies and interventions across sectors, including early learning, pre-K-12 education, postsecondary learning, child care, public health, housing, transportation, food security, small business development, public safety, and more.[23]

BIG IDEAS FOR TRANSFORMATION IN THE NEXT 10 YEARS

If we listen to and work with youth, families, and community members; name systemic factors and use disaggregated data; and catalyze action across sectors to shift resources, policies, relationships, and power structures, then we can start to truly transform systems: to shift power and increase the participation and leadership of Black, Indigenous, Latinx, and people of color to lead the pathway toward long-term resiliency and equitable well-being.

As shared by Bernadette Merikle, the executive director of the Road Map Project in South Seattle/South King County, Washington, "When we rebuild, we cannot go back to the way things were. We must resist the comfort of what was, and forge new paths to what can be—a society where young people can reach their full potential and be supported wholeheartedly, where community leadership paves the path towards a more equitable future, where race is a joy-filled experience instead of another traumatic storyline."

Walking the talk, the Road Map Project made a shift to having a community-led leadership team,[24] replacing the leadership table that historically included superintendents, funders, and education advocates. To support partnership strategy, the Road Map Project sought to intentionally engage those most impacted by practice and policy when developing a report called Start With Us: Black Youth in South King County and South Seattle report and the accompanying Forum for Black Student Success.[25] This initiative developed out of the partnership's disciplined

21 Learn more about Born Healthy and Ready at Three, Bridgeport's initiative to support infants, toddlers and their families, visit this innovation brief from the National Collaborative for Infants & Toddlers: https://www.thencit.org/see-whats-working/innovation-brief-creating-an-ecosystem-of-supports-for-infants-toddlers-and

22 Learn more about House Bill 3, which was made possible by advocacy led by Texas cradle-to-career partnerships: https://commitpartnership.org/advocacy/house-bill-3

23 Color of Change has outlined eight key components of policy change needed as The Black Response to COVID-19, including changes to government oversight, prison systems, work life, personal life, home life, small business, health care and democracy access. Learn more at https://theblackresponse.org/covid-19-resources/

24 Learn more about the Road Map Project's Community Leadership team: https://roadmapproject.org/action-teams/community-leadership-team/

25 Learn more about the Road Map Project's efforts to amplify the perspectives of young people, check out Start With Us: Black Youth in South King County and South Seattle and Let Us Succeed: Student College and Career Aspirations

disproportionality work. These efforts are early steps toward a sustained shift in power to Black, Indigenous, Latinx, and people of color across the region.

In San Francisco, California, the Mission Promise Neighborhood was formed as a response to the displacement pressures and academic achievement gap facing Latinx students in the historically Latinx community of the Mission District. The Mission Promise Neighborhood's Parent Council advocated for the Latinx Resolution for the San Francisco Board of Education,[26] requiring San Francisco Unified School District to hold itself accountable for working with the community and using data to close the achievement gap for Latinx students. Parents led this charge that resulted in structural change for Latinx students across San Francisco.

These early examples show what's possible when communities create the conditions for advancing racial equity, including authentic co-development of solutions with youth and families, and systemic and targeted strategies to achieve equitable well-being. The signals of progress and signs of success we seek include:

- Youth are at the center of all the systems that shape opportunity in their community.
- Black, Indigenous, Latinx and people of color are heard, valued and elevated for their power and authority.
- Youth voice, community wisdom and community assets are centered in decision-making processes.
- Our frameworks, approaches and shared outcomes are guided by our understanding of equity.
- Leaders have a deeper understanding of equity and their role in creating change.
- The racial and ethnic composition of staff—particularly leadership—represents their communities.
- Policies are adopted and/or amended to create better opportunities and outcomes for youth and families.
- Restorative practices are in place to repair harm and restore relationships.[27]

To support bright spots like these, local, state and federal partners can play a role in accelerating the shift in power required for systems transformation. This could include:

- Creating the enabling conditions for increased participation and leadership of Black, Indigenous, Latinx, and people of color in government agencies and boards
- Investing in local cradle-to-career intermediary organizations to shepherd local efforts toward systems transformation and galvanize cross-sector partners to shift resources, policies, and practices
- Supporting evidence-based strategies and interventions that have evidence of improving outcomes and closing disparity gaps for children and families

KEY CONSIDERATIONS

To ensure these pivotal moves and big ideas accelerate healing, recovery, and overall well-being for Black, Indigenous, Latinx, and Communities of Color, we must work to:

- Center people of color and create solutions together, with particular attention to the Black, Indigenous and Latinx communities that continue to be most harmed.
- Operationalize equity to get better results for those affected by oppressive systems.
- Increase participation and leadership of Black, Indigenous, Latinx and people of color.
- Understand the history and legacy of systemic racism, colonization and xenophobia, especially how racist institutions, policies, practices, ideas, and behaviors give an unjust amount of resources, rights, and power to white people while denying them to Black, Indigenous, Latinx, and people of color.
- Challenge policies that perpetuate oppressive systems and inequities.
- Foster learning and dialogue about key concepts including racial and ethnic equity, cultural, structural, and institutional racism, and white

26 Learn more about the Latinx Student Resolution, read this op-ed in the San Francisco Examiner: https://www.sfexaminer.com/opinion/latinx-resolution-commits-sfusd-to-closing-the-achievement-gap/

27 These results are drawn from StriveTogether's Racial Equity Statement: https://www.strivetogether.org/wp-content/uploads/2020/05/Racial-Equity-Statement_March2020.pdf

privilege.[28]

Every child—regardless of race, ethnicity, zip code or circumstance—should have the opportunity to reach their full potential. Every child. No exceptions. We have the opportunity to change what's possible for our kids by putting them on the path to economic mobility. Together, we must use our collective power for youth and families to end inequality and advance racial and ethnic equity to achieve economic mobility for every child, cradle to career.

Co-authored by Jennifer Blatz, Parvathi Santhosh-Kumar, Kelly Anchrum, Joslyn Davis, Bridget Jancarz and Colin Groth, StriveTogether

RESOURCES

StriveTogether Theory of Action

StriveTogether Racial Equity Statement

Equitable Recovery Pledge to Transform Systems and Advance Racial and Ethnic Equity

28 These results are drawn from StriveTogether's Racial Equity Statement: https://www.strivetogether.org/wp-content/uploads/2020/05/Racial-Equity-Statement_March2020.pdf

DEEP DIVE

LIFELONG LEARNING: HIGHER EDUCATION

JUNE 2020

SPRINGBOARD FOR EQUITABLE RECOVERY & RESILIENCE IN COMMUNITIES ACROSS AMERICA: RECOMMENDATIONS ON LIFELONG LEARNING

Sara Goldrick-Rab
Hope Center for College, Community, and Justice at
Temple University

SPRINGBOARD FOR EQUITABLE RECOVERY & RESILIENCE IN COMMUNITIES ACROSS AMERICA: RECOMMENDATIONS ON LIFELONG LEARNING

Sara Goldrick-Rab, Founding Director, Hope Center for College, Community, and Justice Professor of Sociology and Medicine, Temple University

The Hope Center for College, Community, and Justice is redefining what it means to be a student-ready college with a national movement centering #RealCollege students' basic needs. We believe that students are humans first. Their basic needs for food, affordable housing, transportation, and childcare, and their mental health are central conditions for learning. Over the last 20 years, we have led the five largest national studies of basic needs insecurity in higher education.

Our projects have a three-part life cycle. First, using rigorous research, we develop and evaluate creative approaches to solving challenges of practice, policy, and public perception. Second, our scientists work closely with thinkers and doers to ensure that effective implementations are enacted and scaled. Third, we spur systemic change by igniting a fire to engage others in taking advantage of what we have learned. Maximum impact is our ultimate goal.

We are responsible for more than a dozen pieces of state and federal legislation addressing students' basic needs, and have driven increased resources from both government and philanthropy to help institutions address students' basic needs. Finally, we have helped tens of thousands of students understand that they are not alone in facing these challenges, and engaged them in creating the necessary change.

The #RealCollege movement is composed of our primary stakeholders, who are committed to rendering visible the significant role that life, logistics, and finances play in students' chances for completing college. This includes about 500 public two-year and four-year colleges and universities nationwide, along with a handful of private institutions. It also includes community-based organizations in the food, housing, social work, and advocacy arenas, along with many policy intermediaries and NGOs. Most importantly, it includes those on the frontline of the fight—staff, faculty, and college students around the nation.

HIGHER EDUCATION BEFORE THE PANDEMIC

American higher education exhibited multiple signs of strain and stress prior to the pandemic. In particular, the sector was confronted with a potent combination of declining financial resources and complex demands, the likes of which it had never seen before. While the mid-20th century witnessed a great deal of public investment in the expansion of higher education, including major infusions of cash at the federal and state levels, a steady erosion of that support over 50 years has left most of public higher education (and some private colleges) struggling to survive in 2020. States began cutting their support in the mid 1970s, and the federal government began its cuts in the 1980s. Those cuts were in place, but not as drastic in the 1990s, and accelerated dramatically with the Great Recession. They included cuts to both institutional support, especially for the public broad- and open-access institutions educating three-quarters of all students. They also included cuts to financial aid, including a transfer of focus on grants to an emphasis on loans—a privatization of student financing. Before the pandemic hit, higher education had not yet recovered to pre-Recession levels of financial support, and even those levels were grossly inadequate.

As a result, the following major problems characterized the sector at the start of 2020:

- Rising yet persistently unequal rates of college-going, particularly by race/ethnicity, income, and urbanicity. Educational deserts were common.
- Relatively low and highly unequal rates of degree completion. About one in two students who enrolled in college did not finish, and those rates are much lower for students of color.
- An influx of students of color and low-income students into for-profit colleges and universities, which produce low rates of degree completion and subsequent low economic success.

- Substantial and growing evidence of food and housing insecurity affecting around 1 in 2 community college students and around 1 in 3 students at public four-year colleges and universities.
- Widespread anxiety and depression among students at both the undergraduate and graduate level.
- High rates of problematic student debt which could not be repaid by many, and which caused significant compromises in well being for others. This reinforced the racial wealth gap and included rising debt incurred at for-profit colleges.
- A workforce—particularly at the faculty and staff level—characterized by poor working conditions, including economic insecurity and exploitation. This contributed to under-resourcing of high-quality teaching and insufficient student supports.

Clearly, higher education was weakened and largely unprepared to deal with the additional challenges brought by COVID-19.

THE PANDEMIC'S IMPACTS ON HIGHER EDUCATION

The COVID-19 pandemic hit American higher education swiftly in March 2020. The most visible impacts occurred as campuses closed residence halls and rapidly shifted courses online. Many students were told to simply "go home," with little attention paid to their financial ability to do so. Those without homes were ignored. Faculty were told to "pivot" their courses to online learning without the professional development required to ensure that their online courses would be high-quality and equitably impactful. Students were required to attend those online classes with little attention paid to those without adequate computer or internet resources.

Institutional resources were rapidly shifted into emergency response—for example, staff had to be deployed to move students off-campus, shut cafeterias, close support services, and push courses online. Emergency aid funds were rapidly depleted and then efforts began (sometimes for the first time) to grow them, with insufficient attention paid to processes for equitable and impactful distribution processes.

While urban institutions and Predominately-White Institutions, and especially elite universities with wealthy alumni networks, benefitted from philanthropic support and community resources, Minority-Serving Institutions and rural colleges were left struggling. A focus on residential campuses and their students also directed both government and philanthropic focus to four-year colleges and universities rather than the nation's community colleges, which educate the vast majority of low-income, minority, and first-generation students. When the White House and Congress held calls and hearings about the pandemic's impact on higher education, not a single community college leader—representing 40 percent of all undergraduate students—was included.

Negative impacts on students are beginning to be quantified. Research studies and media reports document the following effects:

- There is widespread food and housing insecurity among students. For example, a Hope Center survey, released on June 15, of more than 38,000 students at 54 colleges and universities, fielded during weeks 4-8 of the pandemic, found:
  - Nearly three in five respondents were experiencing basic needs insecurity (food insecurity, housing insecurity, or homelessness).
  - African American students were experiencing basic needs insecurity at a rate nearly 20 percentage points higher than White students.
  - Food insecurity affected 44 percent of students at two-year institutions and 38 percent of students at four-year institutions.
  - Students living off campus before the pandemic were substantially more likely to be affected by housing insecurity, compared to students living on campus (43 percent vs. 27 percent).
  - More than 4,000 college students were experiencing homelessness due to the pandemic, including 15 percent of students at four-year institutions and 11 percent of students at two-year institutions.
- Students are evidencing high rates of anxiety. The Hope Center survey above found that 50 percent of respondents exhibited at least moderate anxiety.
- Completion rates of the Free Application for Student Financial Assistance (FAFSA) are down for both new and continuing students, suggesting that many do not plan to enroll in the fall as planned.

- Deposits securing fall enrollment at four-year colleges and universities are down.
- Students have lost critical jobs that allowed them to pay for school. The Hope Center survey found that nearly three in four students held jobs before the pandemic; among those one in three lost their job, and another one in three had their hours or pay cut.
- Students report difficulty concentrating on their courses and widespread dissatisfaction with online learning. The Hope Center survey found that half of respondents at two-year colleges and 63 percent of respondents at four-year colleges said that they could not concentrate on schooling during the pandemic.
- Many colleges and universities, especially smaller tuition-dependent private colleges, indicate that they are or will be closing.

These short-term impacts will be exacerbated as unemployment rates continue to rise, eviction moratoriums end, states' budget shortfalls lead to cuts in institutional appropriations and student financial aid, and the impacts of student debt accumulate. The following likely long-term impacts include:

- Heightened inequality in college attainment, as a result of declining enrollment and higher dropout rates among the bottom three-quarters of the income distribution.
- Increased rates of financial distress among those who ever attended college, as the wage premium declines and student debt becomes harder to repay.
- Lower rates of high school completion as opportunities beyond high school are blocked, leading to high rates of delinquency and teen pregnancy.
- Disruptions in family formation among individuals in their 20s and 30s, including more children born to single parents without sufficient incomes for economic stability;
- Increased food and housing insecurity.
- Diminished physical and mental health, especially among people with lower-incomes and people of color.

Higher education brings a host of economic, health, and social benefits when it is accessible and affordable. Unless the impacts of the pandemic are intentionally curbed with political and financial capital and rapid action, the aforementioned changes are likely inevitable.

RECOMMENDED SHORT-TERM PIVOTS

Over the next two years, the United States must use existing infrastructure to make major investments in innovation and public thriving for strong, healthy communities and, in turn, a strong workforce. We are faced with an unprecedented unemployment rate and were already facing a shortage of living wage jobs and workers in living wage jobs. We cannot expect an increased birth rate or greater female participation in the workforce nor immigration to solve our problems this time around. That leaves us with a necessary focus on increasing innovation and opportunity through educational expansion.

Here are key components to those short-term investments:

MODIFY AND PASS THE COLLEGE AFFORDABILITY ACT

It should focus on investments in community colleges and regional public universities. These institutions educate the vast majority of students, devote less money to advertising, recruiting, and exorbitant administrative salaries, are democratically governed, produce blue sky research, and are organized to promote the public good. We must focus on expanding capacity at accessible institutions rather than restoring the residential selective college campus experience.

- To drive an equitable recovery, this should be a federally funded, state-operated program with free tuition, strong maintenance of effort requirements for states and standards (e.g. transfer credit, cost ceilings), and student support (e.g. full-time faculty).
- Funding should be heavily weighted toward institutional headcount to ensure adequate funding for student support services. There should be an emphasis on next-generation infrastructures and professional development for faculty and staff to provide effective blends of learning.
- The Act should explicitly allow for the participation of a small number of private nonprofit institutions that should apply for inclusion, demonstrating their significant accessibility and value to local communities. Minority-Serving Institutions must be prioritized.

- All students attending these institutions should be eligible for support, with both recent high school graduates and older learning and returning students included.
- The Act should include a special emphasis on support for nursing programs. Each year more than 66,000 qualified nursing applicants are turned away, and the shortage will grow even more acute as the aging nursing workforce is disproportionately affected by COVID-19. There should be supplemental grants made available for funding to hospitals that add training slots for future RNs.

There are some important signs regarding the potential of these pivots. In April, Michigan Governor Whitmer announced "Futures for Frontliners," which would pay for college for frontline workers without a college degree. The effort echoes the Tennessee Reconnect program, which was launched with bipartisan support in 2019. Reconnect offers tuition-free access to community college for adults over the age of 25 without a college degree. Its built on the Tennessee Promise, which has offered tuition-free community college to recent high school graduates since 2015.

Integrating the approximately 430 public regional comprehensive universities along with the nearly 1,000 community colleges will help ensure access to the full career pathway, including for frontline workers, and will expand the economic impact of the program. Virtually every county in the country has either a community college or a regional comprehensive university. The latter were founded as teachers colleges, night schools, veterans' educational centers, and technical colleges. Two in five Historically Black Colleges and Universities are also regional comprehensive universities.

Congress will be essential to these pivots, and partnerships between the Departments of Education, Agriculture, Health and Human Services, Labor, and Housing will also be necessary. This is an innovation strategy that requires leadership from national economic agencies, not a narrowly conceived education-only agenda.

SUPPORT BASIC NEEDS TO PROMOTE ACTIVE ENGAGEMENT WITH OPPORTUNITY AND EDUCATION

This will require adjustment amendments to several existing policies and frameworks.

- Suspend work requirements in all means-tested public benefits programs. High unemployment rates render these especially cruel
- Revive the CARES Act emergency aid funding for college students, but make the following modifications to enhance its equitable distribution and maximize impact:
  - Distribute it to state systems of higher education (or state agencies) rather than institutions, and encourage centralized delivery mechanisms.
  - Ensure that any student may receive funding, irrespective of Title IV eligibility, including those who are returning to college.
  - Encourage the use of emergency funds for stabilizing maintenance payment for homeless students.
  - Ensure that the IRS treats the funds as hardship funds not income for tax purposes.
- Increase college-related opportunities for employment with an expansion of the Federal Work-Study program. This should include fixing the allocation formula and increasing opportunities for supporting community service.
- Pass the Food for Thought Act to address campus food insecurity, after amending it to include both community colleges and public regional comprehensive institutions. This will create a demonstration program to make grants available to colleges so they can provide free meals to food-insecure students.
- Remove barriers to housing affordability for undergraduate students. This should include removing full-time-student restrictions on Low-Income Housing Tax Credit (LIHTC) units and Section 8 housing vouchers. Build on the efforts of large public housing authorities such as Tacoma's by creating targeted housing vouchers for community college students.
- Increase access to online education by making broadband access universal.
- Improve access to health care by addressing problems with providing, reimbursing, and covering medical care across state lines (laws pertaining to licensure, prescriptions, universal NP practice authority, state telemedicine requirements, state

Medicaid plans). Right now a student covered by Medicaid in his home state cannot get critical mental health prescriptions at his college in another state. Students cannot receive essential life-saving therapy from their community provider (even over the phone) when they are out of state (at home, an internship, etc.) There are many organizations working on state telemedicine legislation, including Center for Connected Telehealth Policy and Federation of State Medical Boards.

FORGIVE STUDENT DEBT

Student debt currently weighs heavily on the lives of millions of Americans, and is especially burdensome to Black individuals, families, and communities. The economic stimulus created by striking the majority of that debt—the debt held by those with the least capacity to repay it—will be substantial.

Just 43 percent of public two-year college students, and 34 percent of for-profit college students who entered repayment on their loans in 2011 had paid even a dollar toward their loan principal after five years. Among four-year college students, a third of borrowers hadn't made any payment toward principal in the same time period. One-quarter of all student loan borrowers defaulted on their loans over a 20-year period: this includes half of Black borrowers and a third of Latinx borrowers.

Overall, individuals with the most debt are the least likely to default on their loans. But it is not sufficient to cancel debt based on how much debt is owed (as many plans do); there are too many Black borrowers with high levels of debt in a great deal of distress. Instead, support should be focused on those who are unable to establish a solid pattern of above-average earnings.

Therefore, the IRS should use tax records to identify individuals who have not earned an average of more than $100,000 per year over the last three years (including 2020—approximately the bottom 90 percent of earners), and automatically cancel all of their federal student loans.

PASS THE PANDEMIC RESPONSE AND OPPORTUNITY THROUGH NATIONAL SERVICE ACT

Dramatically expand the AmeriCorps program and integrate a prior learning assessment (PLA) component so that skills learned during national service can be awarded college credits, creating a more equitable "gap year."

PLA is the evaluation and assessment of an individual's life learning for college credit, certification, or advanced standing toward further education or training. The integration of PLA into the National Service program is critical so that individuals who engage in national service also benefit from an accelerated path to a college credential. PLA could be done using student portfolios, the College Level Examination Program, or other credit by exam programs.

AmeriCorps VISTAs trained and supervised by community-based organizations should be engaged to help current, future, and returning college students connect to public benefits and other supports (e.g. Seattle's Bridge to Finish program)

RECOMMENDED 10-YEAR TRANSFORMATIONS

Following the implementation of the aforementioned short-term pivots, the United States will need to continue to invest in building opportunities to buffer against *future* crises. This should include a Marshall Plan for higher education, Medicare for All, and the creation of new data and impact infrastructure.

MARSHALL PLAN FOR HIGHER EDUCATION

In the last century, American higher education dramatically expanded while keeping three core assumptions intact:

- Means-tested financial aid is the best way to break the link between family income and college attainment
- Academic potential for college work is most effectively assessed by standardized tests
- Only those individuals who excelled in high school stand to benefit from college.

A sizable body of empirical research now contradicts each of those assumptions and shows that they serve, independently and together, to exacerbate inequality. For example, the administrative burden and street-level bureaucracy associated with means-testing student financial aid substantially reduces the impact of the support. The SAT and similar tests are not the most effective mechanisms for determining who will do well in college. Academically "marginal" students seem to derive the most benefit from attending college.

Over the next ten years, the federal government should lead a Marshall Plan-style re-envisioning of higher

education that eliminates the economic rationale for reducing postsecondary education to solely job training.

This includes making public higher education at all levels tuition-free and supported by a robust set of programs (building on those described in the last section) to keep living expenses to a minimum during college. Standardized testing and grading should no longer be gates for entry and progression. The numerous alternatives, including the use of digital high school transcripts and portfolios, other forms of PLA, and hyflex 21st century instructional and assessment practices should be adequately resourced and prioritized. There is substantial precedent for such a move, including both the Morrill Acts of 1862 and 1892, the GI Bill, tuition-free models in California, and New York, and the nationwide growth of Promise programs.

MEDICARE FOR ALL

Medicare for All is a critical complement to the proposed major investment in postsecondary education. Comprehensive medical care would improve the health care received by teachers and students at all levels of education, while also reducing costs of that care. Indeed, the two are linked: teacher well being is strongly associated with improved student outcomes. One study estimates that a single-payer, universal health-care system is likely to lead to a 13 percent savings in national health-care expenditure, equivalent to more than $450 billion annually. Those savings could be redeployed to support education. There are likely other financial complementarities between universal higher education and universal health care.

NEW DATA AND IMPACT INFRASTRUCTURE

The impact of these two major investments should be monitored and assessed by a cross-agency center or institute bridging the Departments of Education, Health and Human Services, Agriculture, Housing, and Labor.

The purpose of the new entity (a revised National Center for Education Statistics/ Institute for Education Sciences) would be to assess and report on a far more extensive set of student metrics that align with a comprehensive vision of equitable well being. In addition to improved versions of current data on who is enrolled in education and where they attend, along with their progress and graduation, the government should also monitor student health and well being in multiple domains. This should involve scaling up existing surveys and assessment efforts, including those focused on basic needs and health. The entity should be required to disaggregate the data by race/ethnicity, gender, sexual orientation, generation-status, etc. The resulting broadened portrait of the impact of education at all levels should be used to make determinations about continuing investments.

SUMMARY

The pandemic brings enormous threats to the educational trajectories of many Americans, and particularly those already left behind before the current crisis. The 20th century was successful at improving overall national well being in large part due to the expansion of education. Further expansions in the 21st century, with an explicit focus on equitable investments, are now critical.

DEEP DIVE

RELIABLE TRANSPORTATION

JUNE 2020

TRANSPORTATION AND THE BUILT ENVIRONMENT

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TRANSPORTATION AND THE BUILT ENVIRONMENT

Transportation for America (T4America), the transportation arm of Smart Growth America, is a national nonprofit seeking a transportation system that safely, affordably and conveniently connects people of all means and ability to jobs, services, and opportunity through multiple modes of travel. We do this work through direct technical assistance, research and analysis of existing transportation programs, and advocacy. T4America works in partnership with a coalition of other national organizations and members, a cross-sector group of about fifty cities, counties, metropolitan planning organizations (MPOs), chambers of commerce, transit agencies, businesses and civic organizations.

Since the COVID-19 pandemic, Transportation for America has worked with Smart Growth America's other programs and organizations around the country in three main areas to address emerging needs.

FUNDING FOR PUBLIC TRANSIT IN THE CORONAVIRUS AID, RELIEF, AND ECONOMIC STABILITY (CARES) ACT

When Congress started deliberations on what would become the CARES Act in March 2020, the bill included zero dollars for public transit. Due in part to T4America's advocacy, the CARES Act ultimately included $25 billion for public transit to ensure that transit providers can continue safely moving essential workers each day, and be there to fuel recovery as more residents return to work. T4America has continued to push for additional transit operating funding and other support for transit.

CHRONICLING BEST PRACTICES FOR OPENING STREETS

Smart Growth America's National Complete Streets Coalition quickly worked to chronicle how cities are responding to the pandemic by opening streets to people and changing other policies. They also quickly pulled together city leaders and advocates to discuss how cities can and should respond.

SHARING LESSONS LEARNED FROM 2009 STIMULUS SPENDING

Smart Growth America produced data-based recommendations to help stabilize the economy in a way that creates the most jobs per dollar spent and ensures the investments are equitable and support access to jobs and opportunity for all people. It also shows how the investments from the infrastructure spending in the 2009 stimulus act did not accomplish those desired outcomes.

This work during the pandemic—and the challenges and successes we have heard about from local agencies, federal leaders, community organizations, and others around the country—has shaped our understanding of what actions must be taken in the near and long terms to foster equitable and sustainable recovery.

T4America would also like to acknowledge the many other advocacy and research groups, community-based organizations, and individuals who have rapidly developed resources for transit providers and cities, collected examples of places trying innovative practices, and provided thought-leadership on how the transportation and planning fields can best meet the needs of the most vulnerable Americans and foster equitable COVID-19 response and recovery. These groups and individuals have heavily informed our work. Many are referenced and cited throughout this chapter.

CURRENT STATE

Understanding transportation needs during the COVID-19 response and recovery requires understanding how the physical characteristics of our communities have shaped everything from economic mobility to community health and quality of life in the decades before the pandemic, and what policies have directed how our communities grow.

It is difficult and unsafe to reach daily needs outside a vehicle in much of the United States. Transportation has long acted as an economic barrier in the United States. Car ownership is a prerequisite for accessing jobs, food, health care, and other necessities in many regions because of how our communities are built.

Homes are located far from major job centers, services, and stores, requiring multiple car trips daily to reach essential needs. This spread-out development makes public transportation inefficient to operate, producing

infrequent, inconvenient, and unreliable service. Fewer than 10 percent of Americans currently live within walking distance of frequent transit.[1]

Even in areas where homes, stores, and medical care are geographically close, car-oriented infrastructure and development can make it difficult or impossible to travel between destinations without a vehicle. Wide, heavily trafficked roads with narrow or no sidewalks and few places to cross safely make walking or biking unpleasant at best and deadly at worst. For people with impaired vision or mobility, navigating these communities can be impossible. The design of development in these areas also typically prioritizes car travel—for example, with large surface parking lots standing between stores, restaurants, medical facilities, walking to those destinations would require crossing that parking. These conditions make any walking trip hazardous, long, polluted, and noisy. Those same conditions make it difficult or impossible to safely walk to transit stops.

CAR-ORIENTED COMMUNITIES LEAVE MILLIONS OF AMERICANS VULNERABLE

The characteristics of our transportation infrastructure and development in many areas across the country make it so driving is the only viable option for anyone able to do so—yet this leaves a substantial portion of our population vulnerable. Approximately 28 million Americans (about 9 percent of the population) do not have a car, and lower-income people and people of color are more likely to be car-less. Households with an annual income of less than $25,000 are almost nine times as likely not to have a car than households with incomes greater than $25,000.[2] In fact, some 20 percent of households in poverty don't have a car.[3] Just 6.5 percent of white households did not have access to a car in 2015 according to the National Equity Atlas, compared to 19.7 percent of Black households, 13.6 percent of Native American households, and 12 percent of Latinx households.[4]

People without access to a car do not just live in urban areas; more than one million households in primarily rural counties do not have a vehicle (6.2 percent of households in those rural counties).[5] In fact, the majority of counties in the U.S. with high rates of zero-car households are rural.[6] Carless residents in rural areas also face other challenges unique to rural America—for example, while many rural communities have transit service that plays a critical role in helping people reach healthcare and other needs, fewer communities have the type of scheduled, fixed-route transit that residents can use to get to work every day, making it especially hard for people without access to a car to access employment.

The design of our communities can also negatively impact other residents who cannot drive, including older adults and some people with disabilities. A 2018 survey from the National Aging and Disability Transportation Center found 40 percent of adults over age 65 cannot do the activities they need to do or enjoy doing because they cannot drive. Forty percent of the survey respondents cited access and availability of affordable transportation as a barrier, and respondents regularly described feeling dependent on others, frustrated, isolated, and trapped after giving up driving.[7] An estimated 25.5 million Americans have disabilities that make traveling outside the home difficult, according to the Bureau of Transportation Statistics, and people with travel-limiting disabilities are less likely to have jobs.[8]

OUR ROADS ARE DEADLY FOR PEOPLE WALKING, ESPECIALLY FOR ALREADY-DISADVANTAGED POPULATIONS

In many communities, traveling outside a car can be a matter of life and death. Between 2008 and 2017, drivers struck and killed 49,340 people walking on streets nationwide, the equivalent of a jumbo jet full of people crashing every single month. The number of people struck and killed while walking increased by 35 percent in the past decade, with little to no increase in walking nationwide over that time period, and a drop in traffic deaths among motor vehicle occupants over that time period. The U.S. saw the highest numbers of people killed while walking

1 http://t4america.org/wp-content/uploads/2020/03/20.03_GND-Transit_use_v4.pdf
2 https://www.bts.gov/archive/publications/highlights_of_the_2001_national_household_travel_survey/section_01
3 https://nationalequityatlas.org/indicators/Car_access
4 *Ibid.*
5 Calculated using data for all counties in the US from the American Community Survey five-year estimates for 2014-2018. Accessed at: https://data.census.gov/cedsci/table?q=dp&tid=ACSDP1Y2018.DP02.
6 http://t4america.org/2020/05/15/more-than-one-million-households-without-a-car-in-rural-america-need-better-transit/
7 https://www.prnewswire.com/news-releases/new-national-poll-inability-to-drive-lack-of-transportation-options-are-major-concerns-for-older-adults-people-with-disabilities-and-caregivers-300761774.html.
8 https://www.bts.gov/topics/passenger-travel/travel-patterns-american-adults-disabilities

since 1990 in 2016 and 2017.[9]

Older adults, people of color, and people walking in low-income communities are disproportionately represented in fatal crashes involving people walking. Even after controlling for differences in population size and walking rates, drivers strike and kill people over age 50, Black or African American people, American Indian or Alaska Native people, and people walking in communities with lower median household incomes at much higher rates.[10]

The design of our roads produces these dangerous conditions for people walking: wide lanes, large distances between traffic signals, and long unobstructed lines of site make it feel safe to drive fast—often significantly faster than the posted speed limit—and drivers unconsciously follow these visual cues. For people on foot, the likelihood of surviving a crash decreases rapidly as speeds increase past 30 mph.[11] Yet too often we rely primarily or exclusively rely on enforcement to manage speeding instead of addressing the causes of speeding like roadway design to change driveway behavior. This overreliance on enforcement disproportionately imperils Black motorists and other demographics subject to profiling and violence.

GROWING TRAFFIC, MORE POLLUTION, AND POOR HEALTH OUTCOMES

Car-oriented development has had other negative consequences for American communities: more driving means more transportation emissions, more traffic, and often poor health outcomes. Most of these impacts disproportionately harm people of color and lower-income communities.

Transportation can both positively and negatively impact our health, as research continues to show. Combustion in vehicle engines causes pollution, including fine particles 2.5 microns in diameter or smaller, known as PM-2.5. These particles are small enough to get deep inside the lungs and cause damage to the lungs, cardiovascular disease, asthma, diabetes and other health problems. Pollution from PM-2.5 is responsible for approximately 3.15 million annual premature deaths worldwide. In a recent study which mapped PM2.5 exposure from the vehicles, the Union of Concerned Scientists found that Communities of Color are exposed to significantly higher levels of PM2.5 than White Americans.[12]

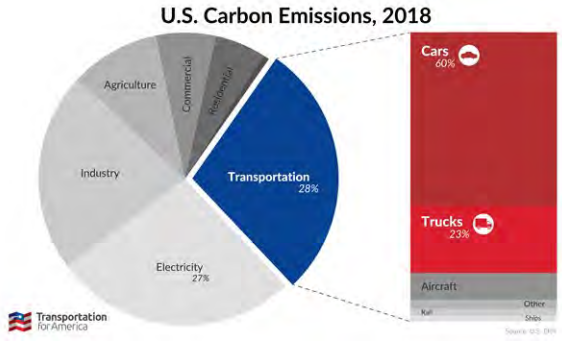
Further, most communities and roadways are designed to ensure cars can always drive quickly meaning less opportunity for physical activity, increased traffic crashes, increased exposure to air pollution, increased greenhouse gas emissions, and higher household transportation costs. Transportation is also a major barrier to accessing health care.[13] Before the pandemic, approximately 3.6 million people living in the U.S. missed or delayed essential, non-emergency medical care because of transportation barriers. A number of studies have shown chronically ill residents, non-white residents, women, the elderly, and low-income individuals facing the largest transportation burden.[14]

Communities built for driving means those who drive must drive more than they would otherwise. From 1980-2017, annual per capita vehicle miles traveled (VMT), a measure of how many miles each person drives every year, increased by 46 percent.[15] In absolute terms, VMT increased by 57 percent in the top 100 urbanized areas between 1993-2017, significantly faster than the 32 percent population growth in those areas. This exacerbates the health impacts listed above.

VMT growth is also contributing to climate change. Transportation accounts for the largest share of carbon emissions in the U.S., and those emissions are rising, even as emissions have decreased in other sectors. Emissions have risen despite increases in fuel economy standards and the beginning of electric vehicle deployment. The vast majority of those emissions—83 percent—come from the cars and trucks that people drive to the grocery store or school or that deliver our Amazon orders. Between 1990-2017, we saw an 18 percent increase in overall fleet fuel efficiency brought on by the implementation of CAFE standards.[16] But even as the fleet overall got far more efficient, emissions still rose 22 percent over the same time

9 https://smartgrowthamerica.org/dangerous-by-design/
10 *Ibid.*
11 https://www.ntsb.gov/safety/safety-studies/Documents/SS1701.pdf
12 https://blog.ucsusa.org/dave-reichmuth/air-pollution-from-cars-trucks-and-buses-in-the-u-s-everyone-is-exposed-but-the-burdens-are-not-equally-shared
13 Syed, S corresponding author Ben S. Gerber, and Lisa K. Sharp. (2013) Traveling Towards Disease: Transportation Barriers to Health Care Access. J Community Health. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215/
14 *Ibid.*
15 https://www.enotrans.org/eno-resources/u-s-vmt-per-capita-by-state-1981-2017/
16 https://www.bts.gov/content/average-fuel-efficiency-us-light-duty-vehicles

period. Our increased driving overwhelmed all of those improvements in fuel efficiency.[17,18]



Much of this design for fast moving vehicles has been in pursuit of reducing traffic congestion, but traffic has also increased over the past several decades. As Transportation for America found in our recent national report, *The Congestion Con*, billions of dollars invested in expanding highways have done little to solve congestion. In the 100 largest urbanized areas in the U.S., the number of freeway lane-miles grew by 30,511 between 1993 and 2017, an increase of 42 percent. That rate of expansion significantly outstripped the 32 percent growth in population in those regions over the same time period, yet annual hours of delay (a standard measure of congestion) grew by a staggering 144 percent.[19] In fact, congestion increased in every one of those 100 urbanized areas, including those with stagnant or declining populations.

GROWING DEMAND FOR WALKABLE, TRANSIT-RICH COMMUNITIES PRICES OUT THOSE WHO MOST NEED AFFORDABLE TRANSPORTATION OPTIONS

While many communities across the U.S. are primarily car-oriented, Americans pay a premium today for housing in walkable communities and accessible to transit. Six out of 10 people said they drive because of a lack of other options in a 2017 survey, 62 percent of Americans reported that nearby transit would be important in choosing where to live and 54 percent cited nearby bike lanes and paths.[20] Companies of all sizes are also relocating to or deciding to start up in walkable downtowns and communities with transit to ensure access to a high quality workforce.[21]

In spite of this demand, most local governments have zoning laws that make it illegal to build communities with amenities walking distance from home, and most transportation agencies have policies that make it against their standards to build roadways that make destinations close by walkable. As a result, the market has not been able to respond to the demand for walkable communities making them more expensive.

Due to the growing lack of affordable housing in cities and walkable places, low-income families and individuals have been pushed to the suburbs, where there are fewer options for traveling without a vehicle and people are disconnected from jobs and services. A study by the Brookings Institution found that residents in low-income suburban neighborhoods with access to transit can reach just 4 percent of metro area jobs with a 45-minute commute.[22] This means many people without access to a car can't get to jobs without a car, further trapping them in a cycle of poverty.

COVID-19 AND TRANSPORTATION

THE COVID-19 CRISIS HAS HIGHLIGHTED PROBLEMS AND INEQUITIES THAT ALREADY EXISTED

The coronavirus pandemic has upended many aspects of daily life and mobility that many Americans previously took for granted. It has also made the stark inequities perpetuated by our transportation systems more apparent. Low-income communities, people of color, and other disadvantaged populations have long experienced the most significant mobility challenges, as well the greatest harm caused by the negative impacts of our transportation infrastructure: exposure to pollution and noise, poor health outcomes, and more.

TRANSIT REVENUES HAVE PLUMMETED, BUT TRANSIT IS MORE ESSENTIAL THAN EVER

Transit agencies have been forced to drastically scale back service in the face of plummeting revenues. Early in the crisis, the public transportation foundation TransitCenter estimated that impacts from COVID-19 will cost U.S. transit agencies $26-$38 billion annually. This huge shortfall

17 https://cfpub.epa.gov/ghgdata/inventoryexplorer/#transportation/allgas/source/all
18 www.fhwa.dot.gov/policyinformation/travel_monitoring/tvt.cfm
19 Transportation for America. (2020). The Congestion Con: How more lanes and more money equals more
20 https://www.nar.realtor/on-common-ground/2017-community-preference-survey
21 https://smartgrowthamerica.org/resources/core-values-why-american-companies-are-moving-downtown/
22 https://www.brookings.edu/testimonies/the-changing-geography-of-us-poverty/

is a result of rapidly decreasing revenue from low ridership and reduced sales tax receipts and increased costs to combat the virus.[23] More recent analyses indicate these initial estimates were likely low.

Transit providers are working to adjust to rapidly changing circumstances to keep both drivers and riders safe and slow the spread of the virus, including canceling fare collection in order to keep operators safe. These necessary measures are further exacerbating budget shortfalls.

Yet while some Americans have been able to transition to long-term remote work and can run their periodic errands by car, millions of others do not have that choice. Transit continues to play a vital role in getting health care and other essential workers to their jobs and providing families with access to medical care, groceries, and other necessities. TransitCenter also found that 2.8 million transit riders before March 2020 were considered "essential workers," underscoring just how necessary it is to keep transit running.[24]

HOUSEHOLDS WITHOUT CARS ARE AT AN EVEN GREATER DISADVANTAGE DURING THE PANDEMIC

Individuals and families without access to a car find themselves unable to get tested for the virus or file for unemployment at drive-through only sites in some locations.[25] In New York, 45 percent of households have limited access to COVID-19 testing because they do not have a vehicle. In Florida, unemployment applications and testing have also been limited to drivers.

WITH FEWER CARS ON THE ROAD, SPEEDING IS ON THE RISE, AS ARE TRAFFIC FATALITIES IN MANY CITIES

Traffic volumes have plummeted since the pandemic. While that has led to fewer crashes overall in some states and cities, a growing number report large increases in speeding citations. In California, the number of tickets issued for driving above 100 miles per hour was 87 percent higher between mid March and mid April 2020 compared to the same time last year.[26] Similar reports have emerged in Missouri,[27] Minnesota,[28] Colorado,[29] New York City,[30] the Washington, DC[31] area, and more.

Some states are also seeing higher traffic fatality rates during the pandemic. In Massachusetts, traffic dropped by 50 percent on average, but the rate of fatalities on state roads doubled in April.[32] In Missouri, traffic fatality rates increased while crash rates have declined, indicating more serious collisions. Minnesota and Louisiana have reported higher numbers of traffic fatalities during the pandemic compared to the same period last year, despite fewer drivers on the road.[33]

EXPOSURE TO PARTICULATE POLLUTION IS INCREASING THE COVID-19 DEATH RATE

Research under review has found that exposure to pollution—including from motor vehicles—reduces the survival rate of individuals who have contracted COVID-19.[34]Those most at risk of death have underlying diseases which may be due to, or exacerbated by, long-term pollution exposure. Proximity to the source of pollution can play a role in increasing exposure. In urban areas, those living near high-volume roadways can have elevated exposure levels far beyond those living at a distance of 500 to 1,000 feet.[35] Long-term exposure to pollution can also contribute to many of the diseases that increase the risk of death from COVID-19.

People of color and people with low incomes are disproportionately facing these effects. As the Center for Disease Control and Prevention notes:[36]

> *"In the United States, it is widely accepted*

23 https://transitcenter.org/estimated-financial-impact-of-covid-19-on-u-s-transit-agencies-26-38-billion-annually/#_ftn6
24 https://transitcenter.org/2-8-million-u-s-essential-workers-ride-transit-to-their-jobs/
25 https://www.businessinsider.com/new-yorkers-without-a-car-are-turned-away-at-drive-thru-testing-sites-2020-4
26 https://abc7news.com/chp-coronavirus-california-shelter-in-place-speeding-tickets/6157264/
27 https://krcgtv.com/news/local/speeders-take-advantage-of-empty-highways-during-coronavirus-pandemic
28 https://www.mprnews.org/story/2020/05/06/pandemic-brings-fewer-drivers-more-speeding-to-minnesota-highways
29 https://www.westword.com/news/covid-19-colorado-major-speeding-tickets-up-despite-stay-at-home-order-11696614
30 https://www.nytimes.com/2020/04/16/nyregion/coronavirus-nyc-speeding.html
31 https://wtop.com/dc-transit/2020/05/this-must-stop-reckless-driving-soars-amid-covid-19-closures/
32 https://www.wbur.org/bostonomix/2020/05/04/massachusetts-roadway-deaths-coronavirus
33 https://www.wsj.com/articles/the-roads-are-quieter-due-to-coronavirus-but-there-are-more-fatal-car-crashes-11588152600
34 https://www.medrxiv.org/content/10.1101/2020.04.05.20054502v1?fbclid=IwAR3ZhanNrDMOmO7Sr3aHLAaXSSalTHbHo2mym1rCvrBx8q2Zqqf-WU_iAUos
35 https://www.cdc.gov/mmwr/preview/mmwrhtml/su6203a8.htm
36 https://www.cdc.gov/mmwr/preview/mmwrhtml/su6203a8.htm

that economically disadvantaged and minority populations share a disproportionate burden of air pollution exposure and risk. A growing body of evidence demonstrates that minority populations and persons of lower socioeconomic status experience higher residential exposure to traffic and traffic-related air pollution than nonminorities and persons of higher socioeconomic status. Two recent studies have confirmed that these racial/ethnic and socioeconomic disparities also exist on a national scale."

GETTING MEANINGFUL COMMUNITY INPUT IN DECISIONS HAS BECOME EVEN MORE CHALLENGING

Transportation decisions have often not addressed the needs of Communities of Color, those who cannot afford a car, or those who can or do not want to drive. Thanks to the work of community-based groups, some cities are moving towards incorporating more inclusive community engagement processes into their transportation projects. Yet COVID-19 is highlighting the challenges posed by the communities engagement practices used by many transportation agencies. In the era of social-distancing, decision-makers are struggling to develop processes to engage with households who may not have computer or broadband access, do not use English as a first language, or are overwhelmed with working and caring for their family.

COVID-19 HAS SPOTLIGHTED THESE PROBLEMS, NOT CREATED THEM

While the pandemic has highlighted these challenges, the problems—and their causes—already existed. Millions of Americans rely on infrequent, underfunded transit, but we are only now defining many of the workers who have always relied on transit as "essential." Roads have long been designed to encourage and prioritize high-speed car travel above the safety of people walking; reduced traffic from the pandemic has simply made this more apparent. More people are witnessing the consequences of these roadway design choices now while maintaining social distancing on narrow sidewalks next to wide roads with high speed traffic, yet the phenomenon is not new, and it has already disproportionately harmed people of color, older adults, and low-income communities. Exposure to pollutants has been found to reduce the survival rate among patients that contract COVID-19, disproportionately impacting the same disadvantaged communities that have long faced the most harmful impacts from transportation. Our communities will never recover while these inequities remain.

COVID-19 HAS ALSO SHOWN US THAT CHANGE IS POSSIBLE

At the same time, the pandemic has shown us that it is possible for communities to change the built environment and transportation services rapidly and responsively. Most people see transportation and development as essentially static and fixed. While they are not fixed (in fact, new construction or development can radically transform how a place feels) the decision-making processes that lead to those changes typically take years or decades with little public transparency or opportunities for community input.

During the pandemic, local communities have made changes rapidly, reforming transit practices and reallocating street and curb space to support essential businesses, provide access to those businesses, and create safer public spaces. These efforts have been imperfect in some cases, especially as cities are struggling to get meaningful community input in making these changes from people most vulnerable during the pandemic. Yet these changes show a glimpse of what real transformation could look like and what processes might be needed to make that transformation equitable.

HOW WE GOT HERE: THE ROLE OF POLICY

The physical built characteristics of our communities, including infrastructure and development patterns, are a result of decades-old transportation policies and funding systems at the federal, state, and local levels. These policies and funding systems encourage more and wider highways and sprawling development, pushing people to live further away from the things they need and the places they go, and causing most people to drive more every year to accomplish daily needs. These policies will need to change to support equitable and resilient communities as we recover.

TRANSPORTATION POLICY

Our current approach to transportation in the U.S.—modeled by our national surface transportation program and mirrored in state departments of transportation and other transportation agencies—prioritizes fast, freeflow vehicle travel and treats walking, biking and transit as afterthoughts. This focus on freeflow car travel is embedded in our policies, funding structures, performance measures, and it contributes to a feedback loop between our infrastructure and new development that pushes us to drive more every year.

Many of the standards and regulations used to make transportation decisions date back to the era when we were first building out the national interstate system and have not been substantively updated since. Those standards and regulations were developed for limited access highways, but get applied in some form to all roads today, including in contexts where an emphasis on free-flow traffic doesn't fit: commercial corridors with lots of development on either side of the road, local main streets, and residential neighborhood roads.

Designing roads primarily to keep cars moving as fast as possible creates unsafe and unpleasant conditions for people walking and drives our national reliance on car travel. By overwhelmingly supporting highway construction and incentivizing highway oriented development, development gets stretched out to the scale of a fast-moving car, not the person walking.

These conditions force people to drive even for short local trips, causing more congestion. Transportation agencies are primed by existing policies and political pressures to respond to congestion by widening and building new roads. Doing so does not solve congestion—in fact, there is a host of evidence indicating that expanding highways induces more driving and ultimately more congestion in a feedback loop referred to as "induced demand"[37]—it simply continues to make walking even less safe and enables more spread-out development and ultimately more congestion in a vicious cycle. This cycle comes with heavy costs. It leads to unsustainable increases in infrastructure spending from all levels of government and raises household expenses through increased transportation costs.

LAND USE AND HOUSING POLICY

The policies that govern local land development decisions also help drive this feedback loop, thus producing more spread out car-oriented development. Most local zoning ordinances follow the same basic formula, designating residential areas, commercial areas, industrial areas separately. This formula is based on an early 20th century model from the last time the federal government provided significant zoning guidance: the Standard Zoning Enabling Act of 1925. By separating these different types of development, traditional zoning codes increase the distance between daily needs, prompt more driving, and effectively ensure that new development will be car-oriented.

Today, government-mandated zoning requirements prevent the market from adding to the supply of walkable, transit-served communities to meet growing demand, driving up property values in these areas dramatically to levels that make these communities unaffordable to those who could benefit from them the most. Despite the demand for denser and more walkable neighborhoods, it is illegal to build anything except single-family detached houses on roughly 75 percent of land in most cities.[38] These laws have profound negative impacts. Artificially limiting the supply of urban housing directly leads to displacement of lower income residents, exacerbates inequality in the process, and drives sprawl, leading to longer car trips, more congestion, and more funds spent expanding roads to accommodate the additional traffic.

STRUCTURAL RACISM

Structural racism has guided many of the decisions made in the U.S. about transportation and housing for decades. The consequences of these decisions are still readily apparent in Communities of Color today. Federal policies and practices actively discouraged homeownership for people of color, particularly for Black people, by restricting mortgages outside of exclusively white neighborhoods. The construction of the National Highway System disproportionately carved through Communities of Color when building these new high-speed arterials.[39] These and other policies have been mirrored at the local level, with far-reaching impacts on economic opportunity and community health, contributing to the racial COVID-19 health disparities we see today.

PIVOTAL MOVES FOR ACTION IN THE NEXT 24 MONTHS

The United States needs to profoundly change how transportation and development decisions are made, and now is the time to make that change. Over the next 12 to 18 months, Congress will be passing multiple relief and recovery bills and a multi-year reauthorization of our national surface transportation program. With significant federal funding for transportation on the horizon, we have a window to either reorient the policies used to govern

37 www.citylab.com/transportation/2018/09/citylab-university-induced-demand/569455/
38 https://www.brookings.edu/research/gentle-density-can-save-our-neighborhoods/
39 Coughenour C, Clark S, Singh A, et al. (2017). Examining racial bias as a potential factor in pedestrian crashes. Accident Analysis & Prevention 98: 96-100. Available from https://www.sciencedirect.com/science/article/abs/pii/S000145751630361X.

our national surface transportation program toward better outcomes or more deeply entrench the current approach. Policy directly leads to new infrastructure in communities that can produce decades of lasting negative impacts. The longer we continue to preserve current policies, the further into the future we will see these impacts.

The federal government can and should aid this shift. However, states and localities do not need to wait for federal action. A growing number of cities have already stepped up with innovative transportation strategies, listed below, in response to the pandemic.

T4America believes the following strategies will be most critical to addressing immediate needs and making long-term change.

PROVIDE SUSTAINED OPERATING FUNDING TO PRESERVE AND EXPAND TRANSIT

Transit agencies around the country have been forced to cut back service substantially. It is critical to preserve transit as an affordable and lower-emissions alternative to driving as the economy reopens, particularly for the most vulnerable residents. This will require providing space on buses and rail transit to ride safely while maintaining the recommended social distance, meaning running more buses more frequently, not fewer buses less frequently.

The strategy

Congress provided $25 billion in emergency transit operating funding in the Coronavirus Aid, Relief, and Economic Security (CARES) Act of March 2020. This emergency federal support for operations was monumental and unprecedented. Yet more funding will be needed. TransitCenter initially estimated that COVID-19 will cost U.S. transit agencies $26-$38 billion annually.[40] New York MTA more recently led a coalition of transit providers in asking for an additional $35 billion in emergency assistance for transit operations, and we do not know yet how far-reaching the economic impacts for transit agencies will be.[41] Funding for rural transit providers was reduced in the final version of the CARES Act, with more support desperately needed. The federal government and localities both have a role in providing funding support for transit.

Transit is an essential public service and we must start treating it like one. Most transit agencies have never stood a chance at covering their costs through fare revenues (or even local taxes in many cases), and that will only be more true as we recover from the COVID-19 crisis. Yet we have allowed that false standard and expectation to guide federal transit policy and funding decisions for decades. Now is the time to change course.

MAKE TRANSIT SAFER FOR RIDERS AND DRIVERS AND MORE RESPONSIVE TO NEEDS IN THE "NEW NORMAL"

It will be crucial to make transit safer for those who operate it and continue to rely on it, especially as more people return to work. As advocates and transit providers have pointed out, transit operators are on the front line during the pandemic, getting health care professionals and other essential workers to and from their jobs. Bus and train operators, transit maintenance workers, and cleaning staff are risking their lives as they support essential travel for millions of Americans.

We also need to adjust service and evolve transit's role to respond to needs during and post-pandemic, particularly in supporting vulnerable riders.

The strategy

Some transit agencies around the country have already responded rapidly to emerging needs during the pandemic, making changes in an attempt to make conditions safer for riders and operators. According to interviews with transit agencies conducted by T4America, transit providers are already trying strategies like:

- Protecting transit vehicle operators with personal protective equipment and plexiglass shields.
- Changing ventilation systems.
- Closing seats.
- Requiring backdoor boarding.
- Going fare-free.
- Requiring riders to wear face-coverings.
- Running "trailer-buses" or "plug buses" on high ridership routes to reduce crowding (this is when a transit agency runs two buses in tandem to provide extra space).
- Partnering with app-based ride-hail companies to

40 https://transitcenter.org/estimated-financial-impact-of-covid-19-on-u-s-transit-agencies-26-38-billion-annually/#_ftn6
41 https://www.masstransitmag.com/management/press-release/21137639/mta-headquarters-new-york-mta-leads-coalition-of-15-us-public-transit-agencies-to-request-additional-emergency-federal-aid

provide rides for essential workers left stranded by cut routes.

The American Public Transportation Association has compiled other response strategies transit agencies around the country are using and other resources to support transit agencies during COVID-19.[42,43]

Transit service providers will also need to adapt service to meet the biggest needs during the pandemic, and some of the necessary short-term service changes should likely be permanent. For example, before the pandemic, many urban and suburban transit agencies ran their most frequent service to cater to the heavy demand during morning and evening rush hour peaks. This helped to mitigate traffic congestion. Yet running service this way also prioritized the needs of "nine-to-five" commuters, particularly those working white collar office jobs, a fact made more starkly apparent during the pandemic with many of those Americans now working from home.

Ridership trends around the world have been upended during the crisis, with growing speculation that these changes will be at least somewhat permanent as teleworking becomes more common. Some workers who do return to the office might switch from transit to other commute options like driving, biking, or walking if they have a choice. As leading transit thought leaders have pointed out, running more frequent transit service during rush hour is expensive for a number of reasons—maybe needlessly expensive as we adjust to new realities.[44]

Beyond responding to changing ridership demands, the pandemic has also provided renewed awareness that many riders are wholly dependent on transit despite the current risks of using it. A growing number of transportation advocates and policymakers are arguing that the needs of those riders should come first in a post-pandemic America. Some cities are already revamping their service with social equity as a priority. For example, Charleston, SC and San Francisco, CA have both updated transit routes during the crisis to ensure that people who rely on transit are prioritized and served appropriately.[45,46] It may be time for other cities to follow.

REDUCE SPEEDING THROUGH OPEN STREETS, OPERATIONAL CHANGES, AND TACTICAL URBANISM

Our poorly designed roads have paved the way for a dramatic increase in speeding during the pandemic, putting other drivers and people walking and biking at risk. When we don't address speeding through roadway design, we rely on enforcement.

At the same time, COVID-19 is demonstrating that people want or need to use public space for more than just driving—to exercise, and access jobs and other essential services.

The strategy

A number of cities across the country have rapidly made temporary adjustments to infrastructure to improve safe access to jobs and businesses and provide more outdoor space for exercise. These cities have used strategies like opening streets for physical distancing, extending sidewalks, and building temporary bike lanes.

The National Complete Streets Coalition and Smart Growth America have tracked trends in how cities across the country are adjusting their infrastructure to respond to COVID-19.[47] The National Association of City Transportation Officials (NACTO) has also released an evolving guide for managing and modifying street, sidewalk, and curb space during the pandemic, collecting examples from around the world.[48]

There are many cities who have taken initial steps to open streets and otherwise manage speeding using temporary changes to roadway design and traffic operations. For example:

- The City of Seattle, WA, which saw a 57 percent drop in vehicle traffic volumes accessing downtown Seattle,[49] adjusted its signal timing to give more time for pedestrians to cross streets and permanently closed 20 miles of its neighborhood

42 American Public Transportation Association. (2020, April 13). The COVID-19 Pandemic Public Transportation Responds: Safeguarding Riders and Employees. https://www.apta.com/wp-content/uploads/COVID-19_Transit_Guide_FINAL_04132020.pdf
43 https://www.apta.com/public-transit-response-to-coronavirus/
44 https://humantransit.org/2020/05/the-collapse-of-rush-hour-a-deep-dive.html
45 https://smartgrowthamerica.org/webinar-recap-complete-streets-responses-to-covid-19/
46 https://www.bloomberg.com/news/articles/2020-04-17/mass-transit-may-never-recover-from-the-coronavirus-pandemic?sref=fzXhlHko
47 https://smartgrowthamerica.org/our-vision/covid-19/
48 https://nacto.org/streets-for-pandemic-response-recovery/
49 https://www.cnn.com/travel/article/seattle-streets-closed-stay-healthy-trnd/index.html

streets to cars.

- Los Angeles, CA also adjusted the timing of its signals to slow down traffic.[50]
- Washington, D.C. temporarily widened some sidewalks around grocery stores and other businesses to provide safer access.[51]
- Oakland, CA closed 74 miles of road to cars to give pedestrians and bicyclists exercise room during the city's stay at home order.[52]
- In St. Louis, MO, advocacy group Trailnet launched a reporting tool to determine where overcrowding is occurring, and is continuing conversations with leaders about which street closures would prevent overcrowding.[53]

Temporarily opening streets to active transportation can fundamentally shift how people see roads as public spaces, paving the way for longer-term change. Cities can make quick changes using a tactical urbanism approach—which involves using the temporary design features to convey the purpose of the changes to the public, providing easy ways for members of the community to offer feedback, and making relatively rapid adjustments. These temporary changes can ultimately be transformative.

However, the movement to open streets during the pandemic has received uneven support from community-based organizations. While organizations are supportive of reclaiming space for people, many have raised concerns about whether cities are implementing open streets equitably, how cities are engaging with residents to plan and implement closures, and whether the streets closures are actually helping essential workers access their jobs and health care.

Therefore, not all Open Streets efforts are created equal. As Emiko Atherton, Director of the National Complete Streets Coalition noted in a recent article for the Institute of Transportation Engineers, "how cities implement Open Streets, slow streets, and other transportation adjustments will be critical for building support for active transportation now and in the future. For example, we should:

- Ensure the temporary projects help provide people who are walking, biking, rolling, and taking transit, with access to jobs, health care, and other essentials services especially in communities that have experienced historic disinvestments.
- Make sure that all projects, temporary and permanent, are helping front line workers access their jobs.
- Allocate transportation resources and infrastructure equitably, not just to communities who are speaking the loudest.
- Work with artists and designers to make improvements high quality and easy to understand (while considering budgets) so that people have a positive experience with the changes.
- Employ COVID-19 transportation demonstration projects as communication tools, where cities can explain what it means to bring more active transportation to their neighborhood.
- Use the projects as opportunities to pilot new processes to inclusively engage the community, especially those who have limited access to computers, broadband, do not use English as a first language, or are not able to attend virtual convenings because of time constraints or lack of capacity. Be open to changing or iterating the projects based on community feedback."[54]

CATALYZING TRANSFORMATION OVER THE NEXT DECADE

Federal funding levels for surface transportation are typically authorized every five to six years. In September 2020, the current federal transportation law—the FAST Act—expires, offering a rare opportunity to fundamentally shift the entire national transportation system. To make the necessary changes, the program needs to be shifted in three ways.

REORIENT OUR NATIONAL TRANSPORTATION PROGRAM AROUND ACCESS: CONNECT PEOPLE TO JOBS AND SERVICES

The point of transportation is to get people where they need to go. Since the dawn of the modern highway era, we have used vehicle speed as a poor proxy for access to jobs and important services like health care, education, public services, and grocery stores. The way we build roads

50 https://ladot.lacity.org/coronavirus/ladot-adjusts-signals-slow-excessive-speeding
51 https://ggwash.org/view/77199/dc-temporarily-widen-some-sidewalks-near-grocery-stores-businesses-coronavirus-open-streets
52 https://www.sfchronicle.com/bayarea/article/74-miles-of-Oakland-streets-will-close-to-cars-to-15191559.php
53 https://trailnet.org/2020/04/13/closing-streets-covid-19/
54 https://www.ite.org/publications/ite-journal/

and design communities to achieve high vehicle speed often requires longer trips and makes shorter walking or bicycling trips unsafe, unpleasant, or impossible.

Yet providing access has always been the purpose of our national transportation system. We must align how we invest in transportation infrastructure and services—and where we direct new development in communities—with that essential purpose. New technologies can now help us measure success by the primary thing that matters to real people: the ease of arriving at your destination. We can hold agencies accountable to deliver these connections.

The Strategy

We need to determine how well the transportation system connects people to jobs and services, and prioritize projects that will improve those connections. Congress should require USDOT to collect the data necessary to develop a national assessment of access to jobs and services and set national goals for improvement.

With these data, state departments of transportation and planning organizations can ensure federal investments are effectively connecting people to economic opportunity, particularly disadvantaged communities. Funding should go to projects that will improve these connections, regardless of mode: driving, transit, walking, or biking. State departments of transportation (DOTs) and metropolitan planning organizations (MPOs) should be held accountable by evaluating how well their investments help connect people to destinations and using the results to guide future funding decisions. Congress should require it.

DESIGN ROADS FOR SAFETY OVER SPEED

Access to safe, convenient transportation is a fundamental right. Today, most Americans are denied this right because their roads—not just highways—are designed to move vehicles at the highest speeds possible, and roads are not designed for people walking, biking, or taking transit as a priority.

Although people of all ages, races, ethnicities, and income levels suffer the consequences of dangerous street design, some neighborhoods and groups of people bear a larger share of the burden than others. We know older adults, people of color, and people walking in low-income communities are disproportionately represented in fatal crashes involving people walking.[55]

High speeds make sense on interstates and other highways, but fatalities occur when we design all streets for high speeds rather than to connect people and create value. Local and arterial roads must be designed to put safety first.

The strategy

A serious effort to reduce deaths on our roadways requires slower speeds on local and arterial roads. The federal program should require designs and approaches that slow traffic inside communities, provide safe places for those outside of an automobile and put safety first.

Roads surrounded by development should be designed to serve those areas with slower speeds because it dramatically decreases the likelihood of fatalities in a crash. Roadways through developed areas have lots of points of conflict (retail, services, driveways and intersections, not to mention bicyclists and pedestrians). Protecting the safety of all people who use the street must be a priority reflected in the decisions we make about how to fund, design, operate, maintain, and measure the success of our roads.

PRIORITIZE MAINTENANCE (AND JOB CREATION) OVER HIGHWAY EXPANSION

This keeps funding in existing communities and creates an opportunity to raise the state of local road repair. It allows a community to redesign the roadways for the needs of those in the community and not, as is often the case, those trying to get through that community.

We are not keeping up with road and bridge repair needs nationwide—between 2009 and 2017, the percentage of the roads nationwide in poor condition increased from 14 to 20 percent.[56] Yet states continue to spend billions expanding highways, adding to future maintenance liabilities and inducing more traffic. This sometimes means directing resources to build brand new communities instead of investing in the needs of existing (often underserved) communities.

This is not a sustainable path. In the age of COVID-19, transportation funds should be focused on retrofitting and equipping existing communities to handle the long term implications of this crisis rather than breaking ground on

55 https://smartgrowthamerica.org/dangerous-by-design/
56 http://t4america.org/maps-tools/repair-priorities/

something new.

Roadway repair projects also create more jobs per dollar—a needed investment in our upcoming economic recovery,—and spend money faster and create jobs more quickly than building new capacity. Maintenance jobs are open to more kinds of workers, spend less money on equipment and more on wages, and spend less time on plans and permits. New capacity projects also require more funding for buying costly property, which has little or no stimulative or reinvestment value.[57] Repairing our existing infrastructure is also a priority for the American electorate. A recent poll conducted for Transportation for America showed that fully 79 percent of voters agreed that the government should fix existing roads before building new ones.[58]

The strategy

At the federal level, the next reauthorization of our national surface transportation program should cut the maintenance backlog in half over the next six years by dedicating formula highway funds to maintenance. Changing how federal formula funds for roads are allocated would be transformative.

In addition, when building new road capacity, state agencies should be required to create a plan for maintaining both the new road and the rest of their system. This is common sense and is already required when building new transit projects. Roads should not be treated differently. On the highway side, it will be important to organize the program to better support repair. On the transit side, the program is organized well in terms of addressing maintenance needs but needs more resources.

States can make this change now without waiting for federal policy and guidance to help prompt this shift.

CONCLUSION AND KEY CONSIDERATIONS TO SUPPORT EQUITABLE RECOVERY

All across the United States, Black Americans are dying at much higher rates from COVID-19. Many of the factors that put Black Americans at increased risk are problems caused by the built environment—and the federal transportation and housing programs that created it.

It is a lot easier to be healthy when you don't breathe air polluted by highway traffic; when you have convenient access to grocery stores, doctor's offices, and pharmacies; when your daily commute doesn't involve crossing a deadly street. Communities of Color, majority Black neighborhoods in particular, have consistently been denied the public investments that make surviving COVID-19 more likely.

Federal transportation policy can be a powerful tool to remedy these massive health inequities if the success of transportation spending is measured by how it improves access and health outcomes for specific demographics. When we measure these transportation outcomes region-wide, we obscure whether our policies and investments are reducing inequities, perpetuating them, or making them worse.

Currently, the main metric for transportation success is vehicle speed, a measure that does not reveal how quickly people reached their destination, if they reached their destination at all, and who those people are. With speed as the metric for success, states, localities and the federal government spend precious transportation dollars on new road construction projects that are effectively guaranteed in many cases to reduce people's access to jobs and services over the long term—by creating more traffic and incentivizes sprawling land development where necessities are spread out and riding transit, walking and biking is incredibly inconvenient and oftentimes dangerous.[59]

Transportation infrastructure and the built environment overall—the buildings, streets, parks, and other features that compose the physical spaces where people work, live, and spend free time—are not broadly seen as upholders of systemic racism. Educating people on how the built environment contributes to inequities is essential because it can help them understand that our built environment is changeable. We do not need to accept dangerous roads, polluted air, and neighborhoods disconnected from jobs and services as the norm. We can no longer relinquish control of our built environments to the few people who work in the transportation and urban planning sector. It is critical to engage people on why the built environment matters so that everyone, no matter where they live or who they are, can enjoy living in a place that is healthy, prosperous, and resilient.

57 https://smartgrowthamerica.org/resources/recent-lessons-from-the-stimulus-transportation-funding-and-job-creation/
58 http://filesforprogress.org/memos/gnd-for-transit-polling.pdf
59 http://t4america.org/maps-tools/congestion-con/

FURTHER RESOURCES

Open Streets for Pandemic Recovery and Response (The National Association of City Transportation Officials, 2020)

Complete Streets and COVID-19 (The National Complete Streets Coalition, 2020)

Emergency Stabilization and Economic Recovery Recommendations (Smart Growth America, 2020)

Exposure to air pollution and COVID-19 mortality in the United States: A nationwide cross-sectional study (MedRxiv, 2020)

Transit Is Essential: 2.8 Million U.S. Essential Workers Ride Transit to Their Jobs (TransitCenter, 2020)

Estimated Financial Impact of COVID-19 on U.S. Transit Agencies: $26-$40 Billion Annually (TransitCenter, 2020)

The Green New Deal for Transportation (Data for Progress, TransitCenter, Transportation for America, other partners, 2020)

The Congestion Con (Transportation for America, 2020)

The State of Transportation and Health Equity (Smart Growth America, 2019)

Repair Priorities (Transportation for America, 2019)

Dangerous by Design (Smart Growth America, 2019)

DEEP DIVE

BELONGING & CIVIC MUSCLE

JUNE 2020

CONTRIBUTION 1 OF 3

CIVIC CAPACITY, RACE, AND COVID-19

David Chrislip
Skillful Means

CONTRIBUTION 2 OF 3

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CONTRIBUTION 3 OF 3

ADDITIONAL SOURCES

CIVIC CAPACITY, RACE, AND COVID-19

DEEP DIVE 1 OF 3

by David Chrislip, Skillful Means

INTRODUCTION

I am part of an eclectic network of colleagues devoted to building a just, equitable, and deeply democratic society. I want to thank each of them for helping to inform and inspire this work. Some of the central characters in this network include: David Chrislip, Skillful Means (author of this paper); Carl Larson, Ph.D., and Darrin Hicks, Ph.D., Communication Studies, University of Denver; Patti Schmitt, Family Leadership Training Institute, Colorado State University Extension; David MacPhee, Ph.D., Colorado School of Public Health, Colorado State University; Brandon Kliewer, Ph.D., Kerry Priest, Ph.D., and Mary Tolar, Ph.D., Staley School of Leadership Studies, Kansas State University; Victor Dukay, Ph.D., The Lundy Foundation; Ed O'Malley and Tim Steffensmeier, Ph.D., Kansas Leadership Center; Allan Wallis, Ph.D., School of Public Affairs, University of Colorado at Denver.

Collectively, we have conducted research and published numerous books and articles investigating civic collaboration, collective leadership, civic engagement, public deliberation, civic leadership, public participation, and other topics related to civic capacity. We have developed leadership frameworks and curricula for a wide-range of civic leadership development initiatives and taught thousands of participants through these offerings. We have designed and facilitated countless collaborative processes to help make progress on public challenges. We have created renowned organizations that build civic capacity.

We are active in a number of professional associations including: American Forensics Association, Association of Leadership Educators, Institute for Civic Discourse and Democracy, International Communication Association, International Leadership Association, International Society for the Study of Argumentation, The Kettering Foundation, National Clearinghouse of Leadership Programs, National Coalition for Dialogue and Deliberation, National Communication Association, National Council on Family Relations, National Epsilon Sigma Phi Extension Professionals' Organization, National Parent Leadership Institute, Network Leadership Training Academy, Society for Prevention Research, Society for Research in Child Development; and Truman Scholars Association.

We are connected to a number of local, state, and national collaborative networks and advisory groups in civic engagement, civic leadership development, collective leadership, public health, rural and urban development, social work, and university extensions.

THE CRISIS OF COVID-19

> *"Sometimes change is so vast and dislocating that it is hard to tell disaster from opportunity."*- The Economist, April 11, 2020

> *"The larger project, however, is to increase the resilience of American society."*- The New York Times, April 9, 2020

> *"We've never gotten to a place where racism is not a significant part of everyone's life in the United States."* - Rashawn Ray, The New York Times, May 31, 2020

As COVID-19 continues to devastate communities across the nation, planning for its aftermath is taking center stage. As horrendous as the initial shock has been, it is but the first of many cascading impacts that must be addressed. Economic decline (collapse, in some places), increases in inequality in health and wealth, inadequate capacity of institutions to respond, failing health and education systems, and so on, will follow, rending the social fabric of families, communities, states, and the nation. Trillions of dollars will be allocated and spent by federal, state, and local government agencies and foundations to address these challenges. Some communities will be able to put these resources to good use. Others will become more dependent on outside entities (like governments and foundations) for their survival and less resilient in the face of future challenges. The longer-term response to the effects of this pandemic will be as important as the initial response to its manifesting symptoms.

Given the immensity of the damage and the colossal investment needed to repair it, ensuring that subsequent responses enhance the capacity—the resilience—of communities and regions to respond to on-going and persistent challenges and disruptions becomes imperative. An emerging definition of community resilience goes beyond merely coping with an external shock like COVID-19 and returning to the status quo ante. Radical theories see resilience as a dynamic process, not of bouncing back, but of reinvention and transformation. A systemic response is more powerful than a symptomatic one.

This is adaptive work that involves power, politics, radical inclusion, authentic engagement, and mutual learning. The concept of civic capacity brings these elements together to make progress. Those who study how communities work know why some respond better than others to disruptions like COVID-19: they are more resilient because they have greater civic capacity. This disaster offers an opportunity to enhance the civic capacity of this country's communities and regions reclaiming the vital role of civic life in shaping this country's future.

THE CRUCIBLE OF CHANGE

Over the past two decades, there has been a distinct shift in thinking about where the impetus for adaptation and change should come from in neighborhoods, communities, and regions. Perhaps recognizing the limitations of top-down, externally-driven approaches, foundations, governments, and other civic actors now encourage and support community-driven responses to adaptive challenges such as health, education, housing, policing, and other public crises. Three premises inform this thinking about community-driven change:

- It is more effective in making lasting progress.
- It is more inclusive and egalitarian, therefore more democratic.
- Communities with the capacity for community-driven change are observably more resilient and responsive to disruptions and challenges.

At its heart, community-driven change can be defined in terms of shared power between decision makers and community members, multiple perspectives on issues, strong participation from diverse people, a focus on equitable outcomes, and decision-making processes that are equitable, authentic, and transparent.

	Top down, externally-driven (doing for)	**Community-driven** (doing from within)
Who does the work	organizations, foundations & public agencies	neighborhoods, communities & regions (residents, organizations & Governments)
The nature of the process	decide & announce	stakeholders set agendas, solve problems & build consensus
Who organizes and energizes the process	people with authority & influence	many people exercising leadership
Who informs the work	content experts	local knowledge & experience informed by content experts
Key leadership tasks	marshal expertise & influence	convene, catalyze, & facilitate

For many actors interested in the civic arena, community-driven change has become the preferred approach to transforming systems such as health care, education, and economic development. Over the past year, a panel of 34 experts from the U.S. and Canada, with conceptual and experiential expertise related to civic capacity, worked together to consolidate their knowledge and experience and create a broadly accepted definition of what community-driven change means and what it looks like in practice.

This work on community-driven change generated information about characteristics, qualities, and concerns of those communities capable of fostering constructive responses to disruptions and challenges. For example, these communities intentionally confront historic inequities and injustice. They couple an inclusive and engaging civic culture with institutions committed to community engagement. They keep a steady eye on the common good. Many people exercise leadership in different forms at different times, some with positions of authority, many without. The leadership focus is on purposeful collaboration and mutual learning to make progress on issues of shared concern.

This understanding of community-driven change led to the development of a Civic Capacity Index (CCI), a measure of a community's ability to make progress on complex, adaptive civic challenges. The CCI helps inform, shape, and evaluate intervention strategies from governments, foundations, and other civic actors. As a diagnostic tool, the CCI can help policy makers understand the capacity of a community or region to absorb and manage resources directed towards recovery from the impacts of a disruption like COVID-19. As a framework for community-driven change, the index can be used to design interventions that respond better to presenting challenges while enhancing the civic capacity—the resilience—of the community or region. Responses can be tailored to the civic capacity of a particular place. If, for instance, civic capacity is high, interventions may be able to leverage existing resources. If civic capacity is low, interventions may need to provide more guidance, technical assistance, and expertise. Communities can use the CCI as a place to start to assess and build their capacity for community-driven change. The index can track changes in civic capacity over time, tying them to current actions. With the help of the community-driven change framework, civic actors can take advantage of existing civic capacity, understand where it is lacking, and build resilience for the future.

THE OPPORTUNITY TO CREATE A MORE RESILIENT SOCIETY

Just as flattening the curve of COVID-19 in its initial stages took leadership and concerted action, so too does creating a more resilient society. COVID-19 has revealed, not for the first time, many of the staggering issues of inequality in our country. If we only mitigate the symptoms of the COVID-19 pandemic, we will have missed an opportunity to generate the ideas and political will to build a more just and equitable society. Realizing these aspirations takes civic capacity. Fulfilling them restores confidence in our collective capacity to respond to disruptions and challenges yet to come.

THE HISTORICAL CONTEXT OF COMMUNITY-DRIVEN CHANGE

The great social movements of the past half-century profoundly changed the civic landscape in manifestly different and clearly visible ways that carry deep implications for civic engagement and civic leadership. These provocative movements challenged traditional power structures, radicalized and mobilized unheard or disenfranchised voices and, at times, menaced the country with anarchy when institutions and policies failed to change quickly enough. The civil rights movement brought African-Americans and other minorities closer to full participation in civic life, eroding the power of one race to control the lives of another. Grassroots community organizers stymied the ability of traditionally dominant parts of society to act unilaterally, helping put issues of housing, income equality, and health care for the poor on the table.

Environmentalists helped ensure that influential industrialists or governments could no longer disconnect their interests from the broader interests of citizens and the country without protest or notice. Since the suffragist movement, women's rights have acquired new dimensions encompassing workplace rights, freedom from sexual harassment, and equal pay for equal work. LGBT activists have exposed a long history of abuse and discrimination based on sexual orientation and promoted laws and policies that protect the human dignity of all. These movements have irrevocably redefined for the better who should be included in American civic life.

Each of these movements has its own long, sometimes tragic, and still evolving history. They reflect the reality of community-driven change when other means do not suffice. By challenging the common, prevailing understanding through resistance and confrontation, they were able to provoke needed change, heightening expectations that hard earned progress should continue.

The present convergence of the COVID-19 pandemic, an onslaught of racial assaults, and a climate change crisis has brought us again to the perennial question: Is emotional-confrontational change the only way forward, or are there other rational-deliberative ways we can use to make progress on the issues we care about? Is it possible, for instance, to energize a conception of democracy that: makes significant decisions as accessible and inclusive as possible; avoids patterns of domination; and produces legitimate outcomes acceptable to all? Some of us believe so and have invested our lives in discovering how to do it.

THE EVOLUTION OF AN IDEA

The idea of civic capacity builds on a long history of related ideas, such as deliberative democracy, civic engagement, public participation, and collaborative problem-solving. Each of these ideas strives to make democracy come alive as a means of acting collectively in pursuit of a common good. This ideal contrasts

starkly with a narrower view of democracy where the public expresses its preferences through the popular vote and delegates responsibility for enacting policies reflecting these views to its representatives. This limited perspective places little or no expectation for leadership or engagement on citizens and residents of a place. The role of the public is simply to vote and get out of the way, allowing elected leaders to get on with the work.

More people engaging in the public sphere has been an ideal of deliberative democracy throughout the twentieth century. As long ago as the 1920s, Mary Parker Follett recognized the synergistic potential of collaborative action. She argued that working together in a deliberative way to bring out differences creates the possibility of a deeper, more integrated response that goes beyond the limitations of compromise and concession. Working with small groups in Boston, she had observed first-hand "people learning how to evolve collective ideas." She noted that when these initiatives worked, their efforts complemented the formal institutions of governance, mitigated conflicts between competing interests, engaged citizens deeply in addressing the local problems that concern them, helped legitimize public decisions, and built the capacity to negotiate future conflicts in ways that better reflect the common good.

Similarly, John Dewey, a near contemporary of Follett's, believed that democracy operates from the premise that human society exists because of community. Communication allows people to work cooperatively to discover what they have in common. When people help shape and evaluate public policy, a more legitimate democracy becomes possible. From 1936 to 1941, Dewey used the Federal Forum Project to organize and facilitate hundreds of public discussions. He and his partners believed "that a revived and enhanced democratic practice, by fostering intelligent deliberation, could lead to solved problems and a brighter future."

In the 1960s and 70s, John W. Gardner, one of America's great public philosophers, came to similar conclusions about the need for widespread civic engagement. He understood from his experience that if the nation were to make progress on its toughest problems, leadership would have to pervade all segments of society and that it would have to be a profoundly different kind of leadership than traditionally practiced. The challenges were too complex and the interests too diverse and conflicting for top-down leadership alone to be effective. The civic culture—the norms and practices of civic life—was too divisive and too reliant on government as the driving force. Few people acted across functional boundaries or spoke reliably about common interests. The key to civic progress, in Gardner's mind, was to transform the default civic culture from a "war of the parts against the whole" to an inclusive, engaging and collaborative one that could make communities better for all. To do this required building relationships, skills for working together, and a sense of responsibility for the future of the community or region.

Follett, Dewey, and Gardner all recognized that the civic arena differed fundamentally from other government, political, and organizational contexts and that a strong civil society was necessary for democracy to prosper. Civic work was collective work with and beyond government. Institutional approaches, by themselves, are inadequate to address shared problems. They understood the civic arena as a crossroads where interests converge and stories collide. As the notion suggests, and as the 2020 pandemic puts into stark relief, issues in the civic arena cross boundaries, some formal like jurisdictional borders, some less so but equally powerful like race and class. Everyone is part of the mess. The challenges are adaptive not technical, so require mutual learning and problem-solving to make progress. Expertise either doesn't exist or is distrusted. Values conflict. Ends, processes, and content in the civic arena are all subject to engagement in contrast to organizations with set missions, organizational structures, and disciplines. No one has absolute authority to impose top down solutions and community members don't necessarily follow.

The idea of civic capacity began to take shape in the 1980s and 90s when keen observers and chroniclers of American civic life noticed that some communities were making notably more progress on civic challenges than others. While not yet the norm, civic engagement was at the heart of these successes. Three aspects characterized these more successful communities. First, a few civic-minded people recognized that the default civic culture—the "war of the parts against the whole"—hindered progress. Second, they made conscious choices to do something different, convincing others that more progress could be made by engaging across factions rather than working against each other. As a practical matter, civic engagement provided the means for building support and legitimacy for public decisions. Third, they recognized that the institutions, relationships, norms, and the collective competencies to act that support an engaging civic culture must be cultivated. Investing in building these "civic

capacities" was essential for a strong civil society.

About the same time, scholars, also recognizing the variations in the way communities respond to challenges and disruptions, began to use the term civic capacity as a way of accounting for these differences. An emerging definition described civic capacity as the collective ability—efficacy—to solve public problems in an inclusive, egalitarian, and equitable way. With enough civic capacity, they argued, communities could collectively respond and adapt to public challenges and make visible progress. In this way, civic capacity became a normative idea, reflecting the hypothesis that communities and regions with more civic capacity respond more effectively to challenges and disruptions.

As this definition evolved, the connections with and distinctions from related ideas and domains became sharper. For example, many of the features of civic capacity are also characteristics of community resilience which is often defined in terms of a community's network of adaptive capacities. Similarly, social capital's emphasis on norms of reciprocity, shared information, and collective action complement some of the features of civic capacity. On the other hand, civic capacity is distinct from other factors such as geography, path dependency (historical events or choices that shape current conditions), and the social, political, and economic forces that also shape how communities and regions act. Civic capacity provides a means for communities and regions to gain more control over these contextual elements.

The idea of civic capacity, as it has come down to us from Follett, Dewey, Gardner, and others, reflects a conception of democracy that goes beyond voting, participation in public processes, volunteerism, or seeking public office. It puts civic engagement at its heart.

DISCOVERING THE DIMENSIONS OF CIVIC CAPACITY

This section describes two methods for discovering the dimensions of civic capacity. The first approach makes use of the knowledge and experience of an expert panel to define these dimensions. The second employs a series of case studies to define them. The insights from these two methods converge creating a broadly accepted understanding of what civic capacity means in practice.

HOW EXPERTS DEFINE CIVIC CAPACITY

In 2018, I was asked to help a statewide health foundation in the Midwest assess its strategies for improving health equity. Over the years, the foundation had shifted its interventions from foundation-driven initiatives to collaborative partnerships with local entities. Now, it was seeking to shift the impetus for adaptation and change as much as possible to counties and communities. The foundation staff had some ideas about how this might occur, but little agreement about what it meant in action or on what the foundation might do to support this transition.

My task, in a November session with the foundation's technical assistance team for its county health equity coalitions, was to help them understand the distinctions between foundation-driven approaches and community-driven initiatives. Using some descriptors I had developed for each approach, I asked them to outline what was happening in each site and place it on a spectrum running from foundation-driven at one end to community-driven at the other. Disappointingly, by their own assessment, these interventions were primarily driven by foundation staff or consultants along with a handful of influential partners from each county. This was not the community-driven response the foundation hoped for. I then asked them how the team's actions either supported or undermined the aspirations of the foundation. With this assessment, we were able to begin rethinking the nature of the foundation's support in ways that would move the sites closer to its aspirations.

As the group worked through this analysis, it became clear that some counties were observably better prepared to address health equity issues than others. Why was this so? What capacities did some counties have that others did not? At the time, we had no good way of assessing the civic capacity of each site other than our own judgments. Lacking this assessment, we were flying blind in our attempts to determine the right mix of technical assistance and foundation guidance.

Given this experience, I started looking into the literature on community-driven change and civic capacity. I wanted to understand: what community-driven change means; what civic capacities communities need to respond to challenges and disruptions; and how to assess these capacities. As is common with emerging conceptual ideas, I soon realized there was no broadly accepted understanding of what constitutes community-driven change and what it looks like in practice.

Coincidentally, my colleagues at Colorado State University, Patti Schmitt and David MacPhee, had received a grant to develop and pilot a leadership development program in two Colorado communities that would bring community members together with local policy makers to build their capacity to act together on shared concerns. In order to evaluate this dual-capacity approach to leadership development, they needed an assessment tool to measure the impact of the program on the community's civic capacity. My experience with the health foundation and their need for an assessment tool encouraged us to develop a Civic Capacity Index. Working together, we put together an initiative that would:

- Create a broader conceptual understanding by connecting multiple interpretations of community-driven change and civic capacity.
- Define the civic capacities communities need to respond to challenges and disruptions and what these capacities look like in practice.
- Develop a diagnostic tool—a civic capacity index—to help inform, shape, and evaluate interventions designed to build civic capacity, respond to challenges and disruptions, develop equitable and sustainable policies, and solve community problems.

To do this work, we convened a panel of 34 experts from the U.S. and Canada, with conceptual and experiential expertise related to civic capacity in terms of civic engagement, civic leadership development, and community building. In 2019 and 2020, we worked with the panel to connect and consolidate our knowledge and experience using a concept mapping process. We engaged the panel in brainstorming, sorting, clustering, analyzing, and mapping responses to queries related to the three tasks listed above. We began with the question: Based on your experience and knowledge, *what would you see if community-driven change is occurring?* Ultimately, the panel helped create a civic capacity index (CCI) with 52 items organized into 7 domains.

The resulting items represent more than simply identifiable characteristics that can be measured in terms of presence or not; they provide benchmarks—normative statements—about what you would see if community-driven change is occurring. This allows the CCI to be used to assess the relative presence of these characteristics, the crucial value of the instrument. We are now validating the CCI and piloting its use.

As a result of this work, we have a broadly shared conception of civic capacity, its domains, and what it entails in practice. Through this study, we began to understand civic capacity as the collective capacity of a social system—neighborhoods, communities, regions—to respond to challenges and disruptions. Progress emerges from the interplay of these domains in particular situations on specific challenges. Civic capacity ebbs and flows manifesting differently in different times, situations, places, and on different issues. Each dimension represents a necessary, but not sufficient, aspect of civic capacity. The whole is greater than the parts. No community can deploy all of these qualities in every situation, though some can do so better than others. With knowledge of this concept and data from the CCI, civic actors can take advantage of existing civic capacity to make more progress on shared concerns, understand where it is lacking, and build resilience for the future.

The expert panel and the concept mapping process helped us draw on the experience, knowledge, and insight gained from a lifetime of working with these ideas. This is what they told us about what community-driven change and civic capacity look like for each of the seven domains they identified:

COLLECTIVE LEADERSHIP

Local leadership provides the impetus for community-driven change. Diverse community members, including those who usually have less power and influence, have a meaningful and ongoing leadership role. Leadership is viewed as an activity, not a position, that anyone can engage in, so many people are exercising leadership, some with authority, many without. Those in key formal and informal leadership roles build bridges between groups and give roles to others leading the work. They act with fairness and humility, inspiring participation and creating an atmosphere where challenges can be addressed. Much of the activity of leadership is directed towards the process of working together. As a result, there is more consensus, action, and accountability.

CONFRONTING RACISM AND INJUSTICE

Diverse community members are committed to making amends for past injustices and work openly to address them. They honor the lived experiences of all and rely on this understanding to inform and shape decisions, actions, and policies. The community is sensitive to cultural barriers to participation and actively provides opportunities for

authentic engagement. Those with traditionally less power and influence are able to gain the knowledge and skills for working with others on community challenges.

INSTITUTIONAL SYNERGY

Institutions know that communities can and should be equal partners in creating policies and solving problems. Government agencies, on an ongoing basis, inform, consult with, involve, and collaborate with the public. These agencies are diverse and culturally competent. They look like the communities they serve. Community organizations, funders, and government agencies provide knowledge and resources to support collective action. They invest in community education and training to support shared leadership and working together. Institutions openly share expertise and know-how with community members. Public media (traditional and social) inform and highlight efforts to address local challenges.

ENGAGING CIVIC CULTURE

Lots of social networks are active across the community. They promote new and unusual partnerships and civic engagement. Initiatives in the community are backed by norms of trust, respectful engagement, and honoring commitments. Key players in the public and private sectors commit to working together. Social capital is being created: neighbors know and support each other facilitating partnerships and mobilizing action. There is an attitude of resilience and hopefulness based on common values, vision, or civic culture. Institutions and communities work across sectors to analyze problems and find solutions. Diverse community members work with coalitions and organizations to make decisions about planning and action. Community members challenge the status quo as they work together to make progress.

ORGANIC COALITIONS

From the outset, diverse community members are the ones identifying the problems or challenges they want to address. Coalitions learn from each other and from past efforts about what works and doesn't work. They proactively build relationships with those who are aligned as well as those who may be opposed. They find leverage points to exert influence on governments and other organizations who can influence change but are not fully capable of acting on their own. Coalitions attract the attention of the media and people with credibility and influence to promote their work. Key stakeholders share accountability for process and outcomes.

PURPOSEFUL COLLABORATION

Forums for dialogue, collective problem-solving, and civic action are popping up throughout the community as needed. Community members, including those most impacted, highlight or frame the problem, suggesting that it deserves more attention than it has received before. These groups take the time to understand the civic landscape—context, history, politics, interests, cultural assets, etc.—related to the problem they are working on. They create an intentional, concerted, strategic effort to do whatever it takes to address challenges and create equitable outcomes. Authentic processes create commitment and confidence, with people feeling that they are respected and valued.

A framework for how the group will work together is agreed to at the beginning: how agendas are set, problems are solved, actions are taken, successes celebrated. People rally around ideas and work that fills gaps, meets needs, and inspires hope for innovation. They try out solutions to see if they will work. If not, they try something else. These groups create a compelling story for why change is needed and why their strategies are well-suited to address challenges. Community members recognize that problems change over time and that solutions are rarely permanent. It's never over...

LEARNING TOGETHER

The ways in which the community is engaged are inclusive and flexible, meeting the needs of diverse audiences. Stakeholders have the knowledge and skills to constructively engage with each other and collectively move to action. They identify and work through tough choices and tradeoffs inherent to difficult issues. They perceive the process as fair and trustworthy so they invest in its goals. Group members have a shared focus on asking questions, learning, and experimentation. They rely on credible information from content experts and from context experts (those with lived experience related to the issue). There are clear ways to define, measure, share accountability for, and celebrate progress. Many forms of planned and open communication are occurring in the community.

LEARNING FROM CASE STUDIES

This section looks at what case studies have to tell us about community-driven change and civic capacity and compares it with the findings of the expert panel. As noted

earlier, the exploration of these ideas began only recently so the number of case studies focused on understanding civic capacity per se are limited. Two studies stand out:

- Briggs, Xavier de Souza (2008), *Democracy as Problem Solving: Civic Capacity in Communities Across the Globe*, Cambridge, MA: MIT Press.
- Pares, Marc, Sonia M. Ospina and Joan Subirats (2017), *Social Innovation and Democratic Leadership: Communities and Social Change from Below*, Cheltenham, UK: Edward Elgar.

These scholars use qualitative research to examine the nature of civic capacity. The central purpose of these studies is to discover how communities define, assess, and act on shared concerns and to identify the capacities that make this possible. The research conducted by Pares, et al. focused on simply observing and describing how or if progress occurred on certain public issues in eight sites and drawing lessons about civic capacity and leadership from these cases. Briggs looked at specific public concerns in six sites with "transparently observable processes" then extracted the major lessons about civic capacity.

The two studies present cases addressing a wide range of civic challenges in diverse contexts at the neighborhood, community, and regional levels. Several of the cases consider civic capacity through the lens of the response to the 2008 financial crisis and the recession that followed, a disruption not unlike the current COVID-19 crisis in scale and impact. The cases take place in quite distinct locations from Pittsburgh; San Francisco; Utah; and New York City in the United States to Mumbai, India; São Paolo, Brazil; Barcelona, Spain; and Cape Town, South Africa internationally. They address a range of public issues from economic and community development, youth employment, poverty, housing, and food access to managing urban growth, slum redevelopment, and regional governance.

The connections between the lessons learned in these studies and what our expert panel discovered are profound. Civic capacity is the crucial resource for responding to civic challenges and disruptions. Powerful social, economic, and demographic forces compel a striking shift toward "bottom-up" approaches to community change. Radical inclusion prevails. No one is systematically excluded or discriminated against. Enhancing the knowledge and skills of socially excluded groups promotes equality and shared responsibility for decisions and actions. Directly engaging the full diversity of the community taps new sources of leadership and the local knowledge of lived experience.

Making lasting progress in the civic arena requires moving the focus of leadership from the individual to the collective to learn, adapt, and innovate. Tight links between institutions and communities connect the "grassroots" with the "grasstops" leading to pragmatic, action-oriented coalitions. Civic intermediary organizations help build civic capacity and facilitate working together. Open, authentic, and structured processes help community members cross boundaries, bridge differences, learn together, solve problems, and get things done. Imagining new ways of making more progress challenges the established hierarchy and changes the dominant discourse.

THE MESSY REALITY OF CIVIC CAPACITY IN PRACTICE

Working with the expert panel and analyzing the case studies also provides a glimpse into the realities of civic capacity in practice. Civic work is messy and hard. Uncertainty and ambiguity are inherent in the work. The vagaries of an organically unfolding process make for more messiness than order. A few observations:

- One size doesn't fit all. Disparate elements come to the fore in different times and places.
- Nobody's perfect. Some communities function better than others.
- Civic work always involves conflict and consensus.
- Sometimes it's proactive, sometimes it's reactive.
- It progresses in fits and starts on its own time.
- Civic decisions always entail gains and losses.
- Civic initiative can start from the bottom, or the top, or anywhere in-between.
- The result will be what we make of it.
- Civic decisions are always tentative and progress fleeting.
- One thing leads to another. It's never over...

BUILDING CIVIC CAPACITY

GIVEN WHAT WE KNOW ABOUT CIVIC CAPACITY, WHY DON'T WE HAVE MORE OF IT?

Some communities will respond to challenges like the COVID-19 crisis better than others. Without a moment's thought, we instinctively know this to be true. David Brooks, in a recent New York Times column, observed a similar variance in two mostly Black and Latinx communities in the Los Angeles region, Watts and Compton. Both have similar demographics and share a history of persistent racism, decaying institutions, social distrust, and betrayal by outsiders. Yet Compton, for all the comparable circumstances, has noticeably higher social mobility and fewer incarcerated Black men than Watts. "Why," Brooks wondered, "are some neighborhoods able to give their kids better chances in life despite so many disadvantages?" The differences he found were partly structural—Compton has its own government while Watts was a part of Los Angeles—but mostly related to differences in civic capacity. In particular, he noted, Compton had more civic infrastructure, more civic reformers, and more faith in its capacity to cope.

Others have noticed similar patterns in the responses to Hurricane Katrina, Superstorm Sandy, and Hurricane Harvey. Downstate New York, New Jersey, and Houston were able to respond to these events more effectively than New Orleans or Puerto Rico. A deeper inquiry into more cases and places would undoubtedly uncover similar variations. Such an inquiry would highlight the general lack of civic capacity across the country and call attention to the persistent lack of it where it's most needed. Why is this? Here are three contributing factors:

PERVASIVE, PERSISTENT, SYSTEMIC RACISM

The insidious presence of "isms" or "phobias" always undermines civil society. Among the many of these in this country, the evil of racism is the most pernicious. The 400-year legacy of slavery and its aftermath continues to haunt our future prospects. We have yet to come to terms with this history and its consequences in any meaningful way. Not coincidentally, our expert panel explicitly recognized that neighborhoods, communities, and regions that make more progress than others work directly to right past injustices and systemic discrimination. It's a necessary element of building and sustaining civic capacity and making progress on shared concerns.

THE MYTH OF THE STRONG LEADER

The evidence of the myth of the strong leader is stupefying. Indeed, pick any media source at any time on any day and you will find leaders lauded or vilified. From the heroic to the egregious, we are inspired by fearless courage or deluded by charlatans. Implicitly, this is an exclusive realm for exceptional people—mostly White men—endowed with extraordinary traits—or not. We invest our hopes and dreams in these magical yet elusive qualities. We look to these people, these leaders, to guide us through life's travails. This conceit shapes how we see the world and our role in it. It frames how we expect challenges to be addressed: making progress is the domain of leaders not ordinary people. The strong leader is a "good thing." Illusions like this feed cultural conceptions of leadership, hindering the development of more productive views.

Our expert panelists and the case studies I cited recognize how this exclusive conception of leadership undermines democracy and civic capacity. The scale of our challenges is simply beyond the power of the few. In its place, they offer an alternative conception of leadership as something that is available to many people. Leadership, in this view, is collective, a shared property of groups. Individual agency is one element—rather than the central element—of the collective leadership capacity of a social system to respond to its context and its challenges. This emerging view of leadership and the competencies it implies must be intentionally and widely cultivated.

HAPHAZARD, MISGUIDED, AND INSUFFICIENT INVESTMENT IN BUILDING CIVIC CAPACITY

We can point to numerous examples of successful civic capacity building that address specific aspects with isolated and small cohorts in a particular time and place. In rare cases, these interventions produce lasting change and broad impact. In most instances, though, these effects are sporadic and scattered and tend to dissipate quickly, disappointing both providers and recipients and discrediting future efforts. In large measure, our attempts to build civic capacity have had only a marginal and fleeting effect on making real progress on civic challenges, improving the quality of civic engagement or civic leadership, or transforming the civic culture of our communities and regions. This failure to produce substantial results and systemic change reflects the haphazard, misguided, and insufficient nature of most investments in capacity building. Without intentional and

sustained large-scale investments in building civic capacity, the transformative power of the idea will remain elusive.

CIVIC CAPACITY EXEMPLARS

In his 1993 book, *Making Democracy Work: Civic Traditions in Modern Italy*, political scientist Robert Putnam described a "virtuous" circle connecting the elements that support democracy and good governance with civic action in the broader interests of the community. The elements of what he called the "civic community"—widespread civic engagement, political equality, norms of solidarity, trust, and tolerance, and associations or social structures of cooperation—combine to generate a steady focus on the broader good, solve problems, and build social capital. He wondered, at the time he was writing, whether the emergence of the "civic community" was entirely accidental or contingent upon historical circumstance and tradition or whether it could be consciously created. The deep historical roots of civic community found in Italy made him pessimistic about creating it in places where it does not now exist, "Where norms and networks are lacking, the outlook for collective action appears bleak." Recent experience confirms the opposite: the "civic community"—civic capacity—can, indeed, be built even when historical legacy works against it.

Civic capacity, as we learned through our expert panel and the two studies, is dynamic, not static or irreversible. It can be augmented through well-conceived initiatives aimed at enhancing the collective capacity of a community to address public challenges. The necessary spark for this work may come from a failure to respond well to a crisis or from imaginative leadership. The dimensions of civic capacity described earlier in this paper provide a range of possibilities for this work: developing civic leadership that can catalyze and facilitate concerted action; learning to confront and work with racism; constructing intermediary organizations that facilitate civic engagement; connecting the "grassroots" with the "grasstops;" strengthening community networks; and learning how to work together. Leadership development and confronting racism standout as the two most powerful leverage points for building civic capacity, the ripples fanning out from there into other domains. Here are some exemplars:

William Winter Institute for Racial Reconciliation. The daily drumbeat of the disproportionate deaths of African-Americans from COVID-19 and police killings serves as a stark reminder of the pernicious persistence of systemic racism. As a counter to Mississippi's long history of racism, former Governor William Winter founded his namesake institute in 1999 in the belief that "honest, purposeful talk (about race) works." It has a history of noteworthy accomplishments to back up the truth of this assertion. With the state's history of racial turmoil in the 1960s and 70s still palpable, the Winter Institute's programs recognized the need to talk directly about race and to learn how to intervene to confront it. Over the years, it has helped bring perpetrators of racial violence to trial, taught police officers how to avoid racial profiling, exposed the symbolic racism of Confederate monuments, created school curricula that tell the truth about the state's history altering the public narrative about race, orchestrated rituals of atonement, and advocated for institutional reforms to replace systems of oppression with equitable ones.

This is no ordinary organization doing mundane, touchy-feely tasks. The work is hard and sometimes dangerous, requiring skill, self-awareness, patience, and a willingness to put personal anger—rage—aside to help others work through the trauma of racism. It's the kind of deep, personally transforming work that must occur to get to its core. This powerful work relies much more on below-the-neck experiences than above-the-neck knowledge or technique. It's heart work, not head work. It goes far beyond cultural competency. These experiences, at their best, reshape how we talk and engage in ways that make it possible for a participant to change one's mind and behavior related to race, privilege, and power. Racism remains the central barrier to progress on every public issue in this country. Without confronting it directly, our responses can never fully succeed.

The Kansas Leadership Center (KLC) and The Kansas Health Foundation (KHF). The Kansas Health Foundation opened its doors in 1985 following the sale of a nonprofit hospital to a private corporation. Today, with a $500+ million endowment, KHF is the largest foundation in Kansas and one of the nation's largest of its type. Its mission is to improve the health of all Kansans by investing in four key program areas: access to care, healthy behaviors, civic and community engagement, and educational attainment.

In 1995, KHF established the Kansas Health Institute (KHI), its first foray into institution building in support of its mission. With an eye on effective policymaking, civic engagement at the state and community levels, and the

provision of nonpartisan data and information, KHI plays an essential intermediary role in the state's civic life.

Based on its experience with more traditional investments in improving health, KHF had learned that actively engaged communities and widespread civic leadership were critical to achieving its mission. Following the success of KHI in providing nonpartisan health policy data, KHF decided that the best way to continue its tradition of offering high-quality civic leadership programs was to start a new organization. To put this thinking into action, in 2007, the foundation invested an initial $30 million over 10 years to establish the Kansas Leadership Center (KLC), dedicated to developing civic leadership across the state. Today, KLC reaches more than 2,000 people a year redefining leadership and explicitly building civic capacity and resilience through its provocative programs and establishing a track record of helping others make progress on adaptive challenges. By shifting the focus of leadership from a few leaders in the heroic mold to pervasive leadership from all parts of society, KLC is transforming the civic culture of the state.

KLC has also taken on a prominent media role in the state. The precipitous decline of local media means that communities and regions no longer have a reliable source of news and information about the challenges they face. KHI (described above) provides part of the answer. KLC's award winning journal, *The Journal: Inspiration for the Common Good*, contributes another element, providing a host of stories and information about how communities and regions can come to grips with local challenges.

KHF's suite of investments evolved organically and strategically to address multiple dimensions of civic capacity—collective leadership, institutional synergy, engaging civic culture, organic coalitions, purposeful collaboration, and learning together. This remarkable series of interventions offers an extraordinary example of an intentional, sustained investment in building civic capacity at a scale that can make a difference.

Family Leadership Training Institute Dual Capacity Program (FLTI) at Colorado State University Extension
FLTI in Colorado reaches proportionally more African-Americans and Latinx along with low income Whites than most civic leadership development initiatives. This 20-week program provides powerful civic leadership development experiences in communities across the state. FLTI seeks to increase civic participation and promote greater collaboration between individuals, families, institutions, public administrators and elected officials to respond to local social, health, and economic challenges. The program provides Coloradans with the opportunities to build skills, form meaningful social connections, and develop partnerships necessary for collective impact. Since 2009, more than 1,400 family leaders have graduated from FLTI in 20 different Colorado communities. Through shared leadership, collaboration, and knowledge of how to get things done, these graduates are working together to empower marginalized groups, enhance social networks, and develop community services. Extending its reach, FLTI is piloting a "dual capacity" program in two sites that engages both community members and local policy makers to encourage deeper collaboration.

FLTI runs counter to the exclusive character of most civic leadership programs. Traditionally, these programs offer scant opportunity to people of color, rural communities, and grassroots activists where the cost of participation becomes a barrier. At FLTI, these groups are the primary audience. Its curriculum, too, differs from more common offerings with its focus on building both individual agency and the collective capacity of the community to respond to challenges.

Colorado Council on Leadership (CCOL). In 2018, the Colorado Health Foundation conducted a survey of the state's leadership landscape that found civic leadership development to be a hit-or-miss affair. Notable efforts have enhanced volunteerism, encouraged collaboration across sectors, built the capacity of nonprofit community organizations, and created support networks and peer-to-peer engagement in particular arenas. The survey also noted significant gaps. The exclusiveness of most programs limited opportunities for rural, grassroots organizers, and people of color to participate either for lack of access or prohibitive cost and time commitment. There was little space for those who do not feel the concept of leadership applies to them. Existing programs focused on an individual conception of leadership rather than the development of collective capacities to address challenges. No one knows much about the effectiveness of these programs.

The Colorado Council of Leadership, with some initial support from the Boettcher Foundation, set to work in the fall of 2019 with the intent of creating an organic coalition that would, hopefully, evolve into a "leadership ecosystem." The initiative brought together an unusual

mix of people: leadership development practitioners, funders, chambers of commerce, educators, civic organizations, advocacy groups, rural associations, and minority groups. Through a series of collaborative, now virtual, engagements, CCOL is beginning the work of creating a framework for a leadership ecosystem and a plan for how it might unfold. This experiment, in a short span of time, is already producing benefits: a growing network of practitioners sharing resources and teaching approaches; an effort to connect and engage alumni of existing programs; and some initial thinking about how to engage the network in convening collaborative efforts to address some of the state's major challenges. Promising experiments like this create the possibility of moving to scale and filling gaps where resources are scattered or scarce.

CHANGING COURSE FROM CURRENT TO FUTURE STATE

It will take a movement to transform America's civic culture. It begins with a widespread recognition that something in our country's civic culture has gone awry and that we can do better. Rather than fixating on a transcendental ideal of perfection, its central aspiration would acknowledge that perfection may be out of reach but that becoming better is not.

Harking back to the great social movements that led to such profound changes in this country's civic life offers a glimpse of what might be possible. Constructed from the bottom up, these movements implicitly recognized that a top-down approach could never inspire such a transformation. Small successes led to larger impacts over time. The movements connected and linked thousands of people with similar concerns. They informed and educated people whether supportive, in opposition, or even disengaged. Their actions—*interventions*—focused on a few themes but took many forms stirred by the imagination of participants.

A movement to transform this country's civic culture would embody such qualities but differ in subtle but distinct ways. Inspired by deeply charismatic leaders, these historical movements inspired a compelling sense of purpose and a deep commitment to a particular cause. Transforming the civic culture would rely, instead, on many people in many places to energize it. Rather than focusing on a particular issue, this movement would target the ways issues are addressed: bringing people together instead of driving them apart, making progress instead of engendering confrontation.

Such a movement would focus on relationships and how the deep wounds of racism preclude progress unless confronted. Without transforming how Americans understand and address racism, real progress on any public challenge will remain elusive.

It would focus on a conception of leadership that would open up the possibility of practical, pragmatic, and useful action by ordinary people in their own hometowns and regions. The competencies and strategies explicated in the other domains of civic capacity would become the curriculum for civic leadership development. Without a new conception of leadership that is available to all, trust in leadership will continue to decline exacerbating an already polarized society. These two domains of civic capacity—confronting racism and collective leadership—are the keys to unlocking the imagination and energy to accomplish this transformation.

BIG IDEAS

(Examples and early adopters in parentheses)

Promote civic capacity as a central component of this nation's well-being and health. Conduct a national benchmark survey of civic capacity:

- Create a benchmark for measuring the success of capacity building interventions and for directing resources to places with the most need (Saguaro Seminar on Social Capital).

Promote civic capacity as a measure of what a transformed civic culture would look like:

- Catalyze a series of local, state, and national conversations about the meaning of the results and how civic capacity can be strengthened (Saguaro Seminar on Social Capital).

Promote well-conceived, sustained, at scale investments in organizations and programs that directly confront racism and systemic injustice. Move to scale:

- Build on organizations that have a demonstrated track record of transformative race work (William Winter Institute).
- Repurpose existing initiatives that focus on diversity training to deliver well-conceived, transformative, and skillfully facilitated interventions that directly

confront racism going beyond cultural competency.

- Create new institutions as needed to do this work.

Promote a deeper, more powerful conception of what it takes to confront racism and systemic injustice. Create new curricula and faculty development programs to do this work based on the landscape survey of race-related interventions (William Winter Institute).

- Evaluate the impact of these interventions on civic capacity using the Civic Capacity Index and other relevant measures.

Promote well-conceived, sustained, at scale investments in civic leadership development. Move to scale:

- Build on existing programs where possible (KLC and chamber of commerce and university leadership development programs).
- Create new programs to fill gaps, e.g., rural, low income, minority (CCOL).
- Create new institutions at the state and regional level that can develop civic leadership at scale (KHF and KLC).

Promote a radically inclusive conception of leadership that responds to today's challenges and context:

- Focus on a conception of leadership that opens up the possibility of practical, pragmatic, and useful action by ordinary people in their own hometowns and regions (FLTI and KLC).
- Couple this radically inclusive conception of leadership with radically inclusive participation in leadership development programs (FLTI).
- Refocus leadership development on building the collective capacity of neighborhoods, communities, and regions to respond to challenges (FLTI and KLC).
- Create new curricula and faculty development programs that reflect the focus on collective capacity, radical inclusivity, and the lessons of the landscape survey of civic capacity building. (FLTI and KLC).
- Evaluate the impact of these interventions on civic capacity using the Civic Capacity Index and other relevant measures.

Create a national service program for young adults:

- Operate locally at the neighborhood, community, and regional level (Peace Corps and AmeriCorps).
- Focus work on building local civic capacity through collaborative partnerships with community, confronting racism and social injustice, and service learning.
- Create a program framework for providing transformational experiences for participants.
- Develop curricula and faculty development programs that reflect the best practices of service learning with a focus on building civic capacity.
- Evaluate the impact of this intervention on civic capacity using the Civic Capacity Index and other relevant measures.

PIVOTAL MOVES

Conduct a series of data gathering experiments to learn how best to use the Civic Capacity Index.

- The CCI as an indicator of leadership programs' impact. Use pre/post testing to compare impacts of traditional programs focused on developing top-down leadership vs. those focused on developing individual agency and collective capacity. Civic capacity should improve more in the programs focusing on individual agency and collective capacity.
- The CCI as a predictor of response to community adversity. Gather data on communities that are adapting well to COVID-19 and compare with the results of the CCI assessment. The CCI assessment should correlate with assessments of how well communities are adapting in the face of a crisis.
- The CCI as an indicator of communities' capacity to include marginalized voices in decision making processes. Higher civic capacity should correlate with other measures of openness to diversity when evaluating collaborative initiatives.

Survey the Landscape of Civic Capacity Building Interventions.

- Conduct a systematic survey of civic capacity interventions in terms of efficacy, approach, structure, and practice.

Design and implement innovative experiments in civic capacity building.

- Based on the survey of interventions, conduct a series of innovative experiments in civic capacity building.

Survey the landscape of race related interventions.

- Conduct a systematic survey of race-related interventions in terms of efficacy, approach, structure, and practice.

Design and implement innovative experiments in race related interventions.

- Based on the survey of interventions, conduct a series of innovative experiments in race related interventions.

ENABLING CONDITIONS

Build on the momentum towards community-driven change. The COVID-19 pandemic has sparked considerable interest in the research on civic capacity and in the civic capacity index. The recent racial unrest has accentuated this. As noted earlier, there is a distinct shift in thinking about where the impetus for adaptation and change should come from in neighborhoods, communities, and regions. Foundations, governments, and other civic actors now encourage and support community-driven responses to adaptive challenges.

- Promote these ideas with foundations, NGOs, community organizations, and federal, state, and local public agencies.
- Bring these ideas to the attention of the many essayists and columnists currently exploring complementary themes such as Roxane Gay, Anand Giridharadas, Tressie Cottam, David Brooks, James Fallows, Darryl Pinckney, Nicholas Kristof, among many others.

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CIVIC CAPACITY INDEX

The Civic Capacity Index (CCI) tells us about how well a community makes decisions, solves problems, and adapts to crises (resilience). The CCI can be used with different stakeholders, from neighborhood coalitions to people taking a leadership development program to a formal committee or task force. Stakeholders are those who are concerned about or affected by an issue, or who can influence decisions about an issue. If you're using this with others, come to a general agreement on the community you're talking about.

Community_____ Date_____

For each statement below, please circle the number that best describes your community. When answering, think about the full diversity of the community, not just those you know or usually engage.

	False 1	Mostly False 2	Mostly True 3	True 4
Collective Leadership				
1. Leadership is seen as an activity, not a position, that anyone can engage in.	1	2	3	4
2. Those in key formal and informal leadership roles build bridges between stakeholders and give roles to others in leading the work.	1	2	3	4
3. Community-driven change is led by local leadership.	1	2	3	4
4. Diverse community members have a meaningful and ongoing leadership role in community change.	1	2	3	4
5. People who usually have less power in our culture are actively involved in community leadership.	1	2	3	4
6. Community members giving leadership act with fairness and humility. This inspires participation and creates an atmosphere where challenges can be addressed.	1	2	3	4
7. There are many diverse people exercising leadership, some with positions of authority, many without.	1	2	3	4
8. Community members are providing process leadership. As a result, there is more consensus, action, and accountability.	1	2	3	4
Confronting Racism and Justice				
9. Community members are committed to making amends for past injustices.	1	2	3	4
10. The lived experiences of community members are understood, honored, and used to influence decisions and policies.	1	2	3	4
11. The community works openly to address past racial issues and injustice.	1	2	3	4
12. The community is sensitive to cultural barriers to involvement. For example, meals and childcare are provided, and meetings are scheduled at suitable times.	1	2	3	4
13. Community members with less power are able to use their cultural assets to work with others when dealing with community challenges.	1	2	3	4
Institutional Synergy				
14. Institutions know that communities can and should be equal partners in creating policies and solving problems.	1	2	3	4
15. Key players in the public and private sectors are committed to working together.	1	2	3	4
16. Government agencies engage with the public on an ongoing basis to inform, consult, involve, and collaborate.	1	2	3	4
17. Public agencies are diverse and culturally competent; they look like the communities they serve.	1	2	3	4

	False 1	Mostly False 2	Mostly True 3	True 4
18. Organizations in the community provide knowledge and resources to support collective action.	1	2	3	4
19. Funders and government agencies invest in community education and training to support working together.	1	2	3	4
20. Institutions openly share their expertise and know-how with community members.	1	2	3	4
21. Public media (social and traditional) informs and highlights efforts to address local challenges.	1	2	3	4

Engaging Civic Culture				
22. Initiatives in the community are backed by norms of trust, respectful engagement, and honoring commitments.	1	2	3	4
23. Lots of social networks are active across the community. They promote new and unusual partnerships and civic engagement.	1	2	3	4
24. There is a widespread attitude of resilience, prosperity, and hopefulness based on common values, vision, or civic culture.	1	2	3	4
25. Community members challenge the status quo.	1	2	3	4
26. Institutions and diverse communities work across sectors to analyze problems and find solutions.	1	2	3	4
27. Diverse community members work with coalitions and organizations to make decisions about planning and action.	1	2	3	4
28. Social capital is being built: Neighbors know and support each other, which facilitates partnerships and mobilizing action.	1	2	3	4

Organic Coalitions				
29. From the outset, community members are the ones identifying the problems or challenges they want to address.	1	2	3	4
30. Coalitions learn from each other and from past efforts about what works and doesn't work.	1	2	3	4
31. Coalitions proactively build relationships with those who are aligned as well as those who may be opposed.	1	2	3	4
32. Coalitions find leverage points through which to exert influence, e.g., governments or others who can influence change but are not fully capable of acting on their own.	1	2	3	4
33. Coalitions attract the attention of media and people with credibility and influence to gain attention for their work.	1	2	3	4
34. Coalitions of key stakeholders share accountability for process and outcomes.	1	2	3	4

Purposeful Collaboration				
35. Forums for dialogue, collective problem solving, and civic action are popping up throughout the community as needed.	1	2	3	4
36. Stakeholders take the time to understand the civic landscape – context, history, politics, interests, cultural assets, etc. – related to the problem they are working on.	1	2	3	4
37. There is an intentional, concerted, strategic effort to do whatever it takes to address challenges for fair and just results.	1	2	3	4
38. A framework for how stakeholders will work together is agreed to at the beginning: how agendas are set, problems are solved, actions are taken, successes celebrated.	1	2	3	4
39. Authentic processes are in place that create commitment and confidence, with people feeling that they are respected and valued.	1	2	3	4

	False 1	Mostly False 2	Mostly True 3	True 4
40. The stakeholders are able to create a compelling story for why change is needed and why their strategies are well-suited to address that challenge.	1	2	3	4
41.People rally around ideas and work that fills gaps, meets needs, and inspires hope for innovations.	1	2	3	4
42.Stakeholders try out solutions to see if they will work. If not, they try something else.	1	2	3	4
43. Community members—especially those most affected by the problem—highlight or frame the problem, suggesting that it deserves more attention than it has received before.	1	2	3	4
44. Community members recognize that problems change over time and that solutions are rarely permanent. It's never over...	1	2	3	4

Learning Together				
45. The ways in which the community is engaged are inclusive and flexible, meeting the needs of diverse audiences. There are lots of ways to engage.	1	2	3	4
46. Many forms of planned and open communication are occurring in the community.	1	2	3	4
47. The process relies on credible information from content experts and from context experts (those with lived experience related to the issue).	1	2	3	4
48. Stakeholders have the knowledge and skills to constructively engage with each other and collectively move to action.	1	2	3	4
49. There are clear ways to measure and reflect on progress—through data and stories—in order to hold each other accountable and celebrate progress.	1	2	3	4
50. Stakeholders see the process as fair and trustworthy so they invest in the group's goals.	1	2	3	4
51. Stakeholders identify and work through tough choices and tradeoffs inherent to difficult issues.	1	2	3	4
52. Stakeholders have a shared focus on asking questions, learning, and experimentation.	1	2	3	4

MEMORANDUM TO PARTNERS IN THE JUNE 30TH CONVENING ON THE ROLE OF THE ACCOUNTABLE COMMUNITIES FOR HEALTH MODEL IN PANDEMIC RESPONSE AND RECOVERY

DEEP DIVE 2 OF 3

June 23, 2020

MEMORANDUM

TO: Participants in the June 30th convening on The Role of the Accountable Communities for Health Model in Pandemic Response and Recovery

FROM: Funders Forum on Accountable Health

This paper is meant to provide background and context for our convening on June 30th. We hope it will stimulate creative thinking about how the ACH model might be adapted to the response to and recovery from the COVID-19 pandemic.

BACKGROUND

The COVID-19 pandemic continues to pose a tremendous challenge to our health care, public health, and social services systems, and has exposed community-wide vulnerabilities that relate to race and class. The pandemic has also highlighted our health system's insufficient attention to the social determinants of health that drive higher rates of population-level chronic disease, resulting in higher rates of serious disease and death from COVID-19 in certain populations. As the nation moves to reopen and as policy makers and communities contemplate what a rebuilt health system may look like, it is important to step back and think about both the objectives of the recovery as well as how decisions are made at the local level about what a more resilient community should be—one better able to take on and reduce the impact of other disasters.

We know that Accountable Communities for Health (ACHs) across the country are playing an important role in the response to the pandemic. This convening is premised on the view that the essential elements of an ACH—strong relationships and trust across organizations and sectors, authentic community engagement, shared vision and commitment to collaborative approaches, and a focus on health equity throughout all of the ACH activities—provide the foundation for marshalling and aligning community resources to more effectively respond to the pandemic and the vast needs of residents. Ultimately, ACHs operate from the belief that improving population health requires doing business differently in every community. It is critical that these elements be central to the recovery and rebuilding process that will follow the pandemic.

The ongoing response to COVID-19 is taking place during a simultaneous (and quite related) response to police killings across the country as expressed in the Black Lives Matter movement. Both the pandemic *and* police violence are underscoring the structural racism in American society. The confluence of these issues provides an opportunity to think more broadly about root causes – and to build a response that focuses around a broad vision for community health that encompasses community safety from violence and racism.

America's communities need to be supported in becoming more resilient to advance community health, safety and well-being so they can better address community threats (from pandemics and chronic diseases to racism and poverty) while building social cohesion. This can best be achieved by creating trusting relationships with communities and giving communities the power to allocate resources in a way that addresses each community's unique needs and challenges.

In short, we face multiple disasters that require a comprehensive recovery plan. This focus on building community-wide resilience and empowerment as the goal of recovery was a central theme in a 2015 Institute of Medicine (now National Academy of Medicine) consensus study, "Healthy, Resilient, and Sustainable Communities After Disasters: Strategies, Opportunities, and Planning for Recovery." The Committee noted that disasters, such as floods, fires, as well as disease outbreaks provide "opportunities for transformation to advance a vision of a

healthier and more resilient and sustainable community." Indeed, the committee's first recommendation was "that state and local elected and public officials incorporate a vision for a healthy community into community strategic planning and disaster recovery planning."

The committee concluded:

> Successful recovery and the post-disaster rebuilding of healthier and more resilient and sustainable communities require the coordinated efforts of a broad multidisciplinary group of stakeholders from health and non-health sectors (i.e., a whole-community approach)... [T]hose leading recovery planning need to be sensitized and trained on the importance of engaging all relevant stakeholder groups, including the health and human services sectors, through robust outreach efforts. Key stakeholders themselves similarly need to be educated on the importance of their participation and mechanisms by which they should engage proactively in the disaster recovery process.

This framework requires a new set of success metrics that go beyond the traditional measures of health that tend to be restricted to the health care sphere with narrow definitions focused on immediate outcomes and cost. Part of building healthier communities requires outcome measures that look beyond health – potentially measuring such outcomes as greater community resilience, overall equity (and reduced inequities in the health system), and community empowerment. Such metrics would ultimately result in healthier communities but may also take longer to achieve. It will be critical to have short-term goals and metrics that provide "early wins" that inspire continued efforts; but funders and policy makers must recognize the long-term nature of this effort and, particularly in the health arena, must move beyond a financial return-on-investment model and embrace a "social return on investment" approach.

RELEVANCE OF THE ACH AND SIMILAR MODELS

This broad perspective about what drives better health and more resilient communities must, therefore, be supported by a level of community engagement that defines and holds accountable the rebuilding process. This is where the ACH model can be of particular importance.

While the ACH model, as implemented across the country, is not identical, all ACHs have in common these key attributes that speak to how communities come together, which should also apply to pandemic response and recovery:

- Setting a multisector table to promote partnerships across functional lines including (but not limited to) health care, public health, social services, housing, education, and any other sectors relevant to advance the health of a community.
- Authentic community engagement, so that all efforts emanating from the ACH are reflective of the community's needs. This should ultimately result in true power-sharing among the sectors with the community.
- A shared vision for community health that drive the work of the different sectors engaged in the ACH. Each sector works within its own expectations and principles, but for a multisector approach that advances health to work, each sector must align its internal aims toward the shared vision.
- A trusted convener (sometimes called a backbone organization) that brings sectors together while also engendering the trust of the community. This role requires special skills and relationships and thus any collaborative function must have a convener that can move the sectors toward a common vision and shared responsibility for implementation of that vision.
- A focus on equity as driving the vision of community well-being and the decision-making process.
- A use of data/information that is granular to the community level to drive decision making and the ability to share data effectively across partnerships.

These attributes track closely with the elements that operationalize the vision articulated in the IOM report. The ACH model is just one example. We have also seen in response to an earlier pandemic, HIV, creation of a similar set of entities. As part of the Ryan White Program, metropolitan areas are required to establish planning councils that oversee (in total) more than a billion dollars that are distributed across the nation each year – starting with needs assessments and ending with allocation of resources to top priorities. The Ryan White councils also have an ongoing oversight role. The council's membership

must include a range of stakeholders, with one-third of the seats reserved for consumers of Ryan White services. A similar (and sometimes unified approach) is taken for HIV community prevention planning.

In short, this kind of multisector and community engagement is not new to our public health system. It should be embraced as foundational to the recovery process.

TRANSLATING PAST EXPERIENCE INTO RECOVERY AND RESILIENCE ACCOUNTABILITY COUNCILS

This convening, one of a series engaging people from across the country in various roles, is meant to test and develop the concept of Recovery and Resilience Accountability Councils as a mechanism for communities to design their pathway to resilience. This is, in a sense, a straw man that builds from the ACH model's principles and is meant to prompt discussion of how we can build community engagement and accountability into the next phase of the pandemic response. (It should be noted that while our focus is on recovery, we recognize that there may well be a second wave of the pandemic; this structure can help improve response as well as recovery.)

Our assumptions in developing this proposal and going into this dialogue process are:

- Recovery/rebuilding will be localized given the diverse nature of health systems across the country and will be more effective when inclusive of local context, racial equity and community conditions. (Definitions of "local" will vary. In some instances, leadership may be at the neighborhood level, in others it will be at the county or regional level. But ultimately interventions and programming must be localized.)
- New federal funds for recovery and rebuilding are likely to flow through state elected officials (and health departments) who in turn will provide funding to local (city or county) governments. It is possible that there will be a diverse set of funding streams ranging from health care and public health to economic development and education. Moving these investments along the lines of a common vision will be critical.
- There will be a tension between new funds for recovery and a very constrained fiscal environment at the state and local level. Keeping a focus on building resilient communities within this tension will be challenging but critical.
- There will be high levels of concern regarding accountability for how the money is spent. Accountability is more than the element of preventing fraud and abuse; it must also mean accountability to affected communities for creating health and resilience, with empowerment for actual decision making by community leaders.
- There will be strong pressure from those currently benefiting from the flow of government money to continue investments in a siloed fashion that would bake in the current structural inequities. This requires a countervailing force that will push for investments that support a community resilience and well-being frame.
- There will also be a strong effort to define recovery narrowly – with a focus on the existing health system. A broader vision will be essential if we are to address some of the structural underpinnings of the disparities we have seen in the pandemic.

The Recovery and Resilience Accountability Councils would ideally be mandated by the federal government as the principal funder of recovery, but they could also be mandated at the state level or created by local officials at their own initiative. They can also be catalyzed by investments from private philanthropy. The Councils could be responsible for ensuring recovery design is a collaborative process among all relevant sectors, not driven solely by the health care delivery system, and would use data and community-identified needs to develop recovery/rebuilding plans.

The Councils would be appointed by local officials and would have the following roles, building on the experiences of the ACH model:

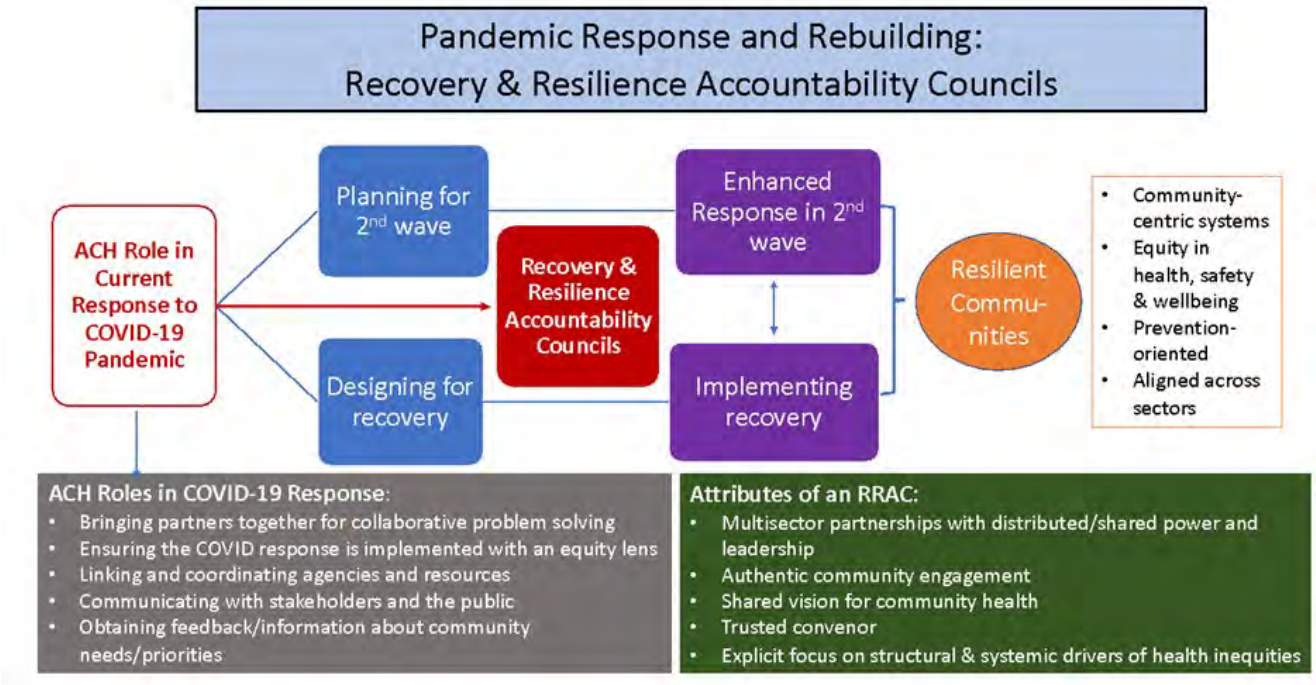
- Bringing diverse partners together for collaborative problem solving and ensuring the residents and community-based organizations are a majority of the voting participants.
- Obtaining feedback and information about community needs and priorities.
- Developing a shared vision and implementation plan for the community's recovery.
- Prioritizing allocation of resources based on the recovery plan. (This may start with new resources

that are recovery-specific; but ultimately a formal global budget approach would be more transformative and would enable more investments in prevention.)

- Making racial equity a conscious goal of the work and ensuring the pandemic response is implemented in an equitable manner.
- Aligning and coordinating public agencies and community-based organization resources.
- Communicating with stakeholders and the public.
- Overseeing implementation of recovery activities.
- Providing technical assistance and capacity building for all stakeholders, especially community members and consumers, to be able to participate equitably and effectively in shared decision making and shared resource allocation decisions.

TRUST BUILDING THROUGH POWER SHARING

We are in an unusual period in the United States where multiple crises have merged, and the nation is highly aware of cross-cutting legacies related to race, health, and power that undermine faith in government-led interventions at a time when trust to contain a public health epidemic is desperately needed. Recovery and Resilience Accountability Councils can lead to three outcomes that build trust. First, communities that are hardest hit by the pandemic and also have experienced historical racial and economic injustice will receive funding to support the priorities they most value to build resiliency and health in their respective communities. Second, Councils will bring together partners across sectors that will advance trust and create alignment among them. Third, the Councils will ensure that funds devoted to pandemic recovery (and possibly future response) efforts are distributed in an equitable fashion through this accountability mechanism. Establishing a new legacy of trust will be critical to ongoing efforts to improve health and to our ability to



successfully address future public health crises.

That said, this is not a simple undertaking and Council, or any recovery or rebuilding effort, will face key challenges. These include:

- Accepting community-led definitions of community health safety as the basis for recovery and resilience building.
- Power sharing in decision making and in resource allocation requires a culture shift among stakeholders, policy makers, and programmatic expectations.
- Identifying genuine community leaders and supporting them in their participation. This requires a different kind of "health literacy" – for both community/consumer leaders and those who traditionally hold levers of power. This can mean resetting the usual health policy tables and/or bringing health decision making to already-existing community-driven tables.
- If a broad definition of community health, safety and well-being is to drive recovery efforts, it will be essential for Councils to be able to leverage all resources in a community and thus have a broader definition of accountability beyond individual programmatic goals. This may require:
    - A functional, if not literal, global budget approach.
    - Creating accountability expectations and incentives for meeting community-defined goals that apply to the largest centers of financial power (e.g., managed care organizations and health systems).

KEY QUESTIONS FOR THE CONVENING

We look forward to a robust discussion of this concept. We are looking for your input in a variety of ways:

1. Are our working assumptions valid? Are there others?

2. Does the general principle of translating this notion of ACH-like accountability mechanism and structure into the recovery process resonate?

3. Is the vision of community health and safety one that resonates and can drive policy choices?

4. Are there additional key challenges? Are there solutions to those that have been identified?

5. Given that ACHs (and similar models) do not exist in every community, is this a scalable concept in the very near future? If so, what incentives and technical support would communities need to build these Councils?

6. What have been your experiences with ACHs or other types of power sharing that would be relevant to this framing?

Please come armed with your ideas and feedback; we seek critiques of this concept as well as any alternatives you might think are worth considering, building on our premise that rebuilding should be led by the very communities most dramatically affected by the pandemic and that as important policy choices are made there should be accountability *both* to the funding source and to the community.

ADDITIONAL SOURCES
DEEP DIVE 3 OF 3

ADDITIONAL SOURCES

ORGANIZATIONS

Braver Angels

Braver Angels brings together Red and Blue Americans in a working alliance to depolarize America. We welcome people with strong convictions and principles. We believe the best way to achieve a more perfect Union is by being forthright and transparent about our political leanings. In that spirit, we say to our fellow Americans, "Come with your convictions, your willingness to listen, and your readiness to talk with others who disagree with you."

Institute for Public Life and Work, Augsburg University

The Center for Democracy and Citizenship at the University of Minnesota's Humphrey Institute of Public Affairs created the Public Achievement organizing model. Public Achievement has been recognized as one of the best youth citizenship education efforts in the world.

Othering and Belonging Institute

The Othering & Belonging Institute at UC Berkeley brings together researchers, organizers, stakeholders, communicators, and policymakers to identify and eliminate the barriers to an inclusive, just, and sustainable society in order to create transformative change.

ReThink Health

At ReThink Health, a Rippel initiative, we work with national and regional stewards to discover what it takes to design and execute transformative change and produce better health and well-being for all.

ARTICLES

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DEEP DIVE

PLACE

JUNE 2020

SPRINGBOARD FOR EQUITABLE RECOVERY & RESILIENCE IN COMMUNITIES ACROSS AMERICA: RURAL AMERICA

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SPRINGBOARD FOR EQUITABLE RECOVERY & RESILIENCE IN COMMUNITIES ACROSS AMERICA: RURAL AMERICA

by Brian Dabson

"Place" is one of four cross-cutting themes of the Springboard. As noted in a 2002 report by the National Research Council,[1] a place is distinguished by its people, governance, and institutions as much as it is by its physical landscape, natural resources, buildings, and boundaries. The character of a place, its identity, and its people's sense of belonging are shaped by interaction within the place and with other places, and by its history and its culture. Every person lives in multiple places, both over a lifetime and at any given time—where they live, work, learn, shop, and play, and at different scales, home, neighborhood, city, state, nation, other countries. Quality of life is largely determined by the characteristics of places, for better or worse. Differences between places drive inequalities in economic opportunity, educational attainment, and health outcomes.

These differences are often expressed as "geography is destiny" or "geographic inequity." The idea that where you live determines your life chances strikes at the heart of the American Dream of opportunity for all—if you work hard, it doesn't matter where you come from or what you look like, you can achieve a stable and prosperous life. But, the groundbreaking research of Raj Chetty[2,3] on economic mobility has shown clearly that geography and race really do shape your destiny.

Rural America is a special place, or more accurately a mosaic of many special places, where connection to the land is the defining characteristic, reinforced by history, culture, and lived experiences. Equity in a rural context is complicated—in its relationship with urban and suburban America, in terms of who owns and controls the land and its resources, and the very present legacies of broken promises to Native peoples and of slavery and discrimination. Yet, it still is a place of both majestic and intimate landscapes, of resilient and resourceful people and communities, and a vital part of the United States, past, present and future.

This paper is a contribution to the *Springboard for Equitable Recovery and Resilience in Communities Across America* project. It begins by providing a baseline for understanding the current state of a geography that comprises 72 percent of the landmass of the United States and is home to 46 million people.[4] It continues with a discussion of the fault lines exposed and deepened by COVID-19 and some of the potential longer-term impacts and scenarios for rural places and people. Ideas are presented for short-term strategic actions to address some of these challenges and longer-term transformative proposals to seize the opportunities for change that the pandemic offers out of the wreckage it has wrought.

There is a fine line between focusing on the characteristics, needs, and opportunities of rural areas, and putting rural places in a box that is distinct and disconnected from the rest of the country. The intention of this paper is to embrace both rural America's distinctiveness and its interdependence with the rest of the nation as the basis for diagnosis, prognosis, and intervention.

1 National Research Council (2002). Community and Quality of Life: Data Needs for Informed Decision Making. Washington, DC: The National Academies Press. https://doi.org/10.17226/10262

2 Raj Chetty, Nathaniel Hendren, Patrick Kline, & Emmanuel Saez (2014), Where is the Land of Opportunity? The Geography of Intergenerational Mobility in the United States, The Quarterly Journal of Economics, Volume 129, Issue 4, Pages 1553–1623. https://doi.org.libproxy.lib.unc.edu/10.1093/qje/qju022

3 Raj Chetty, Nathaniel Hendren, Maggie R Jones, & Sonya R Porter (2020). Race and Economic Opportunity in the United States: An Intergenerational Perspective. The Quarterly Journal of Economics, Volume 135, Issue 2, Pages 711–783. https://doiorg.libproxy.lib.unc.edu/10.1093/qje/qjz042

4 Kenneth M. Johnson & Daniel T. Lichter (2019). Rural Depopulation in a Rapidly Urbanizing America. Carsey Research, National Issue Brief 139, University of New Hampshire.

THE CURRENT STATE OF RURAL AMERICA[5]

Policy and Perceptions. Rural America is not a homogenous and undifferentiated place. It is vast, complex, and diverse, and unfortunately its role, contributions, perspectives, and realities are often unrecognized or misunderstood. This is a matter of policy, politics, and inertia. Misconceptions abound, such as rurality and agriculture are synonymous and that farm subsidies represent rural development. True, agriculture is the primary economic driver in many parts, particularly on the Great Plains, but overall, fewer than 10 percent of the rural workforce are employed in agriculture, fishing, hunting, and mining.[6] Education, health care, and social assistance (22.3 percent) and manufacturing (12.1 percent) are the largest employment segments. Another misconception is that rural America is universally struggling, even though the data shows that economic growth and opportunity is unevenly spread across the rural-urban continuum—there are struggling urban areas and there are prospering rural places.[7]

Any discussion about rural America is usually accompanied by questions about what is meant by "rural." Multiple definitions are used by federal agencies; the way they define "rural" and "urban" has profound implications for policy, resource allocation, and program design. Despite obvious limitations and the availability of alternatives, most public policymakers and academic researchers use federal definitions that make hard and fast distinctions between urban and non-urban, metropolitan and non-metropolitan. Rural is treated as a residual category[8]—the distant parts beyond the city limits.

Economic, Demographic, and Spatial Dynamics. Most research rejects the notion of a simple rural-urban dichotomy and points to the shifting, crossing, and blurring of boundaries, reflecting the dynamic nature of rural-urban interactions. These interactions, and specifically locational patterns of economic activity, are products of comparative advantage, economies of aggregation, and costs of transportation and communications. The result is the economic dominance of cities as a strong and continuing centralizing force where rural-urban interactions primarily benefit urban centers, and where commuting is the most visible form of interaction. Recent demographic analyses[9] show widespread rural depopulation and divergent patterns of development across the United States. These have their roots in the 1950s as many rural counties reached their peak populations when agricultural employment was still robust and before mechanization and consolidation radically transformed rural landscapes. A combination of net out-migration and natural decrease have exacerbated the diminishing rate of population growth in the past decades and contributed to the downward spiral of population loss in some areas.

History and Inequities. History plays a large role in shaping a place and its development, not just in its physical form, but in the deeply embedded ideas, norms, and values that local people take for granted. These influence the way in which local structures, institutions, actors, and processes confront and respond to external economic, political, cultural, and environmental shocks. Seemingly benign policy changes can produce unexpectedly divisive reactions. History also shaped the policies, practices, and investment patterns that conferred benefits on some people while imposing burdens on others. Established systems reinforce entrenched poverty and racial inequalities that, generation after generation, worsen health outcomes and increase community vulnerability. These are particularly evident in the Delta and Appalachia areas. Often overlooked is the legacy of maltreatment and broken promises suffered by Native Americans. Some 2.9 million live in 574 sovereign tribal nations, many of whom are facing a range of health, poverty, employment, and educational disparities.[10]

Poverty is a feature of both rural and urban places, although rural places have suffered generations of relatively higher poverty and lower income rates, especially in more remote areas. These have been compounded by

5 Brian Dabson, Alan Okagaki, Deborah Markley, Travis Green, Katharine Ferguson, Christina Danis, & Timothy Lampkin. (2020), Regional Solutions for Rural and Urban Challenges. Richmond, VA: LOCUS Impact Investing, www.locusimpactinvesting.org .

6 Linda Laughlin (2016), Beyond the Farm: Rural Industry Workers in America. U.S. Census Bureau, Washington DC. https://www.census.gov/newsroom/blogs/random-samplings/2016/12/beyond_the_farm_rur.html

7 Richard Florida (2018, September-November). The Divides Within, and Between, Urban and Rural America. Retrieved from CityLab: www.citylab.com

8 Andrew M. Isserman (2005). In the national interest: Defining rural and urban correctly in research and public policy. International Regional Science Review. Vol. 4:465-499 https://doi:10.1177/0160017605279000

9 Kenneth M. Johnson, & Daniel T. Lichter (2019). Rural Depopulation Growth and Decline Processes over the Past Century. Rural Sociology, 84(1), 3-27. https://doi:10.1111/ruso.12266

10 National Congress of American Indians (2019). Tribal Nations and the United States. http://www.ncai.org/tribalnations/introduction/Indian_Country_101_Updated_February_2019.pdf

environmental injustice associated with location of land uses and functions not wanted in urban areas. Rural areas are becoming increasingly racially diverse, although social strains and fiscal challenges in meeting new community needs are apparent where this shift is recent.

Capacity and Inertia. Economic restructuring and loss of opportunity have led to population loss and a shrinking of tax bases in many rural counties. These have led to decisions to close rural hospitals, schools, and other essential services and to centralize them in distant urban centers. These impose cost and transportation challenges for all rural families and particularly for the elderly and infirm. Local governments with declining revenues lack the capacity to provide adequate levels of public services and to respond to external shocks, such as major weather events or pandemics.

There is well-documented evidence that some rural communities, blessed with strong and imaginative local leadership, can create positive futures for themselves despite these challenges. This is particularly so in rural areas near to urban centers and those in high-amenity regions. However, for other communities with fewer assets, inertia and hopelessness get in the way of action. For many rural areas, large private corporations own or control farm and forest production, mining, and energy extraction, while the federal government controls and manages vast tracts of public lands, particularly in the West. This often leaves little room for local economic opportunity and wealth creation and undermines community resilience.

Finally, there is the paradox of political power and voice. Rural constituencies have disproportionate sway in the U.S. Senate and in many state legislatures because of Constitutional arrangements that safeguard the interests of certain rural interests. This sets up conflicts with the large urban centers which have the economic power but constrained political influence. The current national political climate stokes the sense of rural versus urban interests and politicizes issues in ways that inhibit the search for common ground. That said, there is no coherent, unified voice for rural America beyond the special interests that control agriculture, forestry, ranching, mining, and water rights.

There are, however, people and organizations across the rural landscape who are active in trying to create new rural futures in their own communities and regions, and who are coming together in vibrant networks to shift state and federal policies to better serve rural interests. These include local civic organizations, nonprofits, regional and national foundations, and faith-based organizations, as well as public agencies and private associations. They represent multiple interests and issues including food, health, environment, entrepreneurship and economic development, workforce training, financial capital, equity and justice, housing, transportation, and many others. They are the hope for the future of rural America.

THE PANDEMIC'S FAULT LINES AND IMPACTS

Initially, rural areas saw a slower spread of COVID-19, with cases and deaths per capita fewer than urban areas. However, just as states are beginning to ease restrictions on movement and business activities, the data[11] shows higher rates of increase in non-metropolitan counties. These are causing concern for health officials because of a relative lack of hospital capacity, older average age, and higher shares of their populations with underlying health conditions. In some rural locations, hotspots of infections have emerged in meat-packing, food-processing, and other farm operations where social distancing on the job is difficult, as well as in congregate facilities such as prisons and nursing homes.

The economic impacts have been as severe as anywhere else in the country, as businesses of all sizes have been required to close, stay-at-home orders enforced, and supply chains weakened or broken. Regions dependent on recreation and tourism have been particularly hard hit.

The pandemic's health and economic consequences have acted as an accelerant exposing and deepening the fault lines in rural America. Here are some of the most evident.

RURAL HOSPITALS

The rural health care system in rural America was already in a fragile state before the pandemic. In the past decade, 120 rural hospitals have closed, 83 in the past five years.[12] A study published in February 2020[13] estimates

11 Kaiser Family Foundation (April 30/May 21, 2020). COVID-19 in Metropolitan and Non-Metropolitan Counties. https://www.kff.org/other/issue-brief/covid-19-in-rural-america-is-there-cause-for-concern

12 UNC Sheps Center for Health Services Research. https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

13 Chartis Center for Rural Health (February 2020). The Rural Health Safety Net Under Pressure: Rural Hospital Vulnerability. https://www.ivantageindex.com/wp-content/uploads/2020/02/CCRH_Vulnerability-Research_FiNAL-02.14.20.pdf

that 453 currently open rural hospitals are vulnerable to closure because of their precarious financial position. Population decline, changes in health care delivery through consolidations and mergers, state and federal policy particularly related to Medicaid expansion and Medicare payments, and shifts to shorter in-patient hospital stays all have had a significant impact on rural hospital revenues.[14] Not only are these facilities vital for access to health care for rural communities, they are major direct and indirect contributors to their local economies in terms of jobs, incomes, and purchasing.

Social distancing measures and stay-at-home orders have dramatically cut normal non-emergency hospital activities as patients have stayed away resulting in further financial woes. At the same time, the mortality rate is higher among people who live in rural areas than those who live in urban areas—known as the rural mortality penalty—and the disparity is growing.

RURAL BROADBAND

The pandemic has underscored the vital importance of reliable high-speed internet for business, governance, work, health care, education, shopping, and social connection. It has also highlighted the challenges faced by rural residents and businesses because of limited or no access to broadband. Although the Federal Communications Commission has in recent years ratcheted up investment in rural broadband, its 2019 Broadband Deployment Report[15] noted that 26 percent of rural households still lacked access to fixed broadband, and for those on tribal lands fewer than half have access. The digital divide has real world consequences for rural America, including limiting the options for recovery and resilience.

RACIAL INEQUITY

African-Americans bear a disproportionate burden from COVID-19 with 2.5 times more cases and three times more deaths per 100,000 people than white residents, with similar disparities for Latinx populations. One explanation is that these populations are vulnerable because of the prevalence of pre-existing conditions such as diabetes, cardiovascular disease, asthma, HIV, morbid obesity, liver disease, and kidney disease.[16] In a rural context, there are two other factors. The fractured system of rural health care in poor regions means shortages of health professionals and long distances to travel for medical care, creating real challenges for aging and minority populations, particularly in the South. The other factor is the number of pandemic hotspots in meat packing and food processing plants with disproportionate impacts on Latinx workers.

TRIBAL NATIONS

State-level responses to the pandemic, both in imposing and relaxing restrictions, is testing jurisdictional relations with tribes, particularly in South Dakota. There, the governor is disputing the right of tribes to restrict entry to tribal lands as a public health measure.

A note on racial diversity in rural America

While rural America overall is less racially and ethnically diverse than urban areas, there is significant variation across the country. African Americans constitute about 8 percent of the total rural population but are concentrated mainly in southern states—39 percent in nonmetro South Carolina and Mississippi, 31 percent in Louisiana, and 26 percent in Georgia. Similarly, Hispanic populations, 9 percent of the total overall, are concentrated in the southwest—47 percent in nonmetro New Mexico, 34 percent in Texas, and 25 percent in Arizona. Native Americans at 2 percent overall are more geographically dispersed—30 percent in Alaska, 34 percent in Arizona, and over 10 percent in South Dakota and Oklahoma. Population trends show losses in the White and Black populations while Hispanic and Native American populations are increasing.[17,18] This variation underscores the need to reject the idea of one-size-fits-all policies and programs for rural America and to acknowledge and embrace regional and racial diversity.

LOCAL GOVERNMENT

One third (35 percent) of rural counties totaling 676 are experiencing protracted and significant population loss, with just 6.2 million residents, a third fewer than who

14 UNC Sheps Center for Health Services Research. https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/rural-hospital-closures/

15 Federal Communications Commission. 2019 Broadband Deployment Report. FCC 19-44. Washington DC. https://docs.fcc.gov/public/attachments/FCC-19-44A1.pdf

16 Monica W. Hooper, Anna Maria Napoles, & Eliseo J. Perez-Stable (2020). COVID-19 and Racial/Ethnic Disparities. JAMA. Published online May 11, 2020. https://doi:10.1001/jama.2020.8598

17 USDA Economic Research Service, Rural America At A Glance, 2018

18 Rural Health Information Hub and America Community Survey 2018 5-Year Estimates. https://www.ruralhealthinfo.org/charts/topics

lived there in 1950.[19] This is due to chronic outmigration, mostly by younger adults, which contributes to fewer births, leaving a large older population aging in place and increasing mortality rates. Another third (31 percent), 599 counties with 14.6 million are also losing population but at a lower rate and have experienced mixed periods of growth and decline. These trends have profound effects on local government tax bases and their ability to provide adequate services to their residents and businesses. Estimates from the National Association of Counties of the impact of COVID-19[20] show that lost revenues and sales taxes plus increases in expenditures on health and human services, justice and public safety, and education will result in small counties seeing a 24 percent reduction in their budgets.

THE RURAL-URBAN DIVIDE

Political and cultural cleavages in recent years, often expressed as the rural-urban divide, have been even more evident during the pandemic. Universal public health measures to contain viral spread, especially in larger cities, have led to significant economic damage in rural areas even though they have seen (so far) far fewer COVID-19 cases. This has led to challenges to Governors' orders and further politicization of protection and relaxation measures.

LONGER-TERM IMPACTS

The pandemic has taken everybody into uncharted territory and, without any certainty on the availability of vaccines and treatments, longer-term impacts are hard to predict.

From the previous analysis, there are three broad scenarios for rural America:

RETURN TO THE OLD NORMAL

Even if it was possible, given the human and economic damage the pandemic has caused, returning to the status quo cannot be said to offer prospects of resilience and equity for many rural people and communities. Rural regions close to metropolitan centers and those in high amenity areas will continue to flourish, but the future for the rest of rural America is challenging, especially without any clear vision.

DOOM AND GLOOM

It is not hard to construct a scenario in which all the negative trends discussed earlier will accelerate post-COVID-19 with dire consequences for rural America. As essential health, education, financial, and governmental services collapse, large swaths of the country will experience steep population and business declines. The negative impacts on agriculture, forestry, ecosystem services, recreation, and other rural "products" will have repercussions across the rest of the country.

Underlying these two scenarios are three hard and unpalatable truths:

- Experience from the Great Recession indicates that economic recovery for most rural areas will take much longer than for the rest of the country, possibly resulting in loss of businesses, unemployment, and shrinking public resources for basic services. This will further push population decline in parts of rural America.
- The basic infrastructure to support community survival and development—housing, employment, health, education, social services—will be further weakened.
- The fault lines will be more difficult to bridge and will make sustained recovery harder.

SEIZE THE MOMENT

These stark and daunting realities should not, however, define rural America. They are the issues that must be addressed on the way to crafting a better future. By adopting Thrive Rural's vision,[21] the future can be one of dynamic, sustainable rural communities where all people can realize their full potential and live healthy lives.

The key is to articulate the contribution that rural America makes to the health and prosperity of the nation, emphasizing the interdependence of urban, suburban, and rural communities and places. The goal should be to ensure that geography is not destiny, that well-being and equity are core concepts for all, wherever they may live.

19 Kenneth M. Johnson & Daniel T. Lichter (2019). Rural Depopulation in a Rapidly Urbanizing America. Carsey Research, National Issue Brief 139, University of New Hampshire.
20 National Association of Counties (May 2020). Analysis of the Fiscal Impact of COVID-19 on Counties. https://www.naco.org/sites/default/files/documents/NACo_COVID-19_Fiscal_Impact_Analysis_1.pdf
21 https://www.aspeninstitute.org/programs/community-strategies-group/thrive-rural/

PIVOTAL MOVES FOR IMMEDIATE ACTION

Seizing the moment requires concerted and immediate action across multiple sectors and activities, as well as laying the groundwork for a major shift in federal policy and investment in rural America. It is, of course, a matter of funding and investment, but it also a matter of institutional innovation and reimagining a different future for people and communities across rural America.

For now, the focus must be on racial equity and the immediate public health crisis. Although the racial justice demonstrations are mainly taking place in our cities, it would be wrong to assume that this is an urban issue. Communities of Color across rural America experience discrimination, harassment, and violence too—it may be less visible, but no less real. The intersection of geographic and racial equity provides the north star for any efforts for recovery and resilience in rural America.

The CARES Act[22] provided injections of funds into critical access hospitals, rural health clinics, and community health centers to partially defray the costs of responding to the pandemic. Various legislative efforts[23] are being pursued to stem rural hospital closures, tackle health professional shortages, and shore up the rural safety net, but soon the process of developing long-term solutions will have to be found.

It is not too much of a stretch to argue that the future of large parts of rural America depends on being able to find long-term solutions to the multiple challenges facing rural health care. It is clear that there must be a funding model that either has the characteristics of a single-payer system or increases insurance coverage to include all Americans, provides adequate levels of Medicare reimbursements to ensure quality care for the elderly and sick, and supports new and effective ways of delivering health-related services across thinly-populated regions.

The latter the Affordable Care Act[24] set out to do. It sought to make affordable health insurance available to more people, expand the Medicaid program to cover all adults with income below 138 percent of the federal poverty level, and support innovative medical care delivery methods designed to lower the costs of health care generally. However, from the outset, the Affordable Care Act has demonstrated clearly the enormity and complexity of the challenge of reinventing health care, with myriad vested interests seeking to safeguard their turf, and strong political and philosophical differences about the appropriate level of government intervention in health care.

Nevertheless, the Affordable Care Act, despite multiple efforts to undermine and repeal its provisions, has transformed access to health care in the United States.[25] It has improved consumer protections by eliminating many of the worst practices of the health insurance industry, such as charging more or denying coverage because of a pre-existing health condition like asthma, diabetes, or cancer. Health plans are prohibited from putting annual or lifetime dollar limits on most benefits, and families can add or keep children on their health insurance policy until they turn 26 years old. The Act has helped shift the United States toward a health care delivery system based on primary care by increasing payment rates for primary care physicians who accept Medicaid or work in rural areas, and promoting better coordinated care.

Few would argue that the Affordable Care Act is perfect, but it does seem to be a good place to start a thoroughgoing review of what it will take to provide quality rural health care across the country. However, rural health care cannot be fixed in isolation from other matters that also need urgent attention—principally, broadband, economic development, and local government.

PIVOTAL MOVE: BROADBAND DEPLOYMENT AND ADOPTION

Reinforce enhanced federal investments in broadband infrastructure with measures to improve data and mapping, ensure digital inclusion, and remove barriers to local action.

If there was any doubt before the pandemic that access to affordable broadband was an essential service, akin to electricity supply, then this surely has been dispelled. There have been massive shifts in the way businesses, hospitals and clinics, schools, universities and colleges, and governments are staying in touch with employees, customers, patients, students, and constituents through digital communications. NTCA, the membership organization for rural broadband providers, has found that

22 Coronavirus Aid, Relief, and Economic Security Act of 2020
23 See National Rural Health Association, https://www.ruralhealthweb.org/advocate
24 Patient Protection and Affordable Care Act of 2010
25 American Academy of Family Physicians, https://www.aafp.org/advocacy/informed/coverage/aca.html

demand for bandwidth increased by almost a quarter in the first three weeks of the national emergency. This is against the background that access to broadband at the Federal Communications Commission's (FCC) minimum threshold download and upload speeds is unavailable to 21 million Americans, mainly in rural and Tribal areas. This number is widely believed to be a substantial underestimate, with estimates varying between 42 million to 162 million people unable to access reliable and affordable high-speed broadband. Without such access, the vision of dynamic, sustainable rural communities is unobtainable.

The FCC recently announced a Rural Digital Opportunity Fund Auction through which over $20 billion will be awarded over 10 years. The aim is to bring high speed fixed broadband service to an estimated six million rural homes and small businesses in eligible areas that lack it. This has been cautiously welcomed, but there are many issues that remain unaddressed which will inhibit deployment and adoption. Three issues are particularly important:

Broadband data and mapping

There has been widespread concern that the mapping of broadband deployment is flawed leading to overstated availability. Issues such as the use of census blocks as the basic unit of measurement, lack of independent data validation, and keeping the data updated have been raised.[26] This is important as broadband maps are the basis for the distribution of federal funds, including the Rural Digital Opportunity Fund. Responsibility for broadband mapping lies with the National Telecommunications and Information Administration (NTIA), the Federal Communications Commission (FCC), and the U.S. Department of Agriculture. Some of these data and mapping issues may be addressed as the FCC rolls out its proposed Digital Opportunity Data Collection program but this is not yet operational. An associated issue is the call for collection and reporting of demographic data, including race, ethnicity, gender, income and education-level to better gauge the extent of exclusion and discrimination.

Digital inclusion[27]

As important as providing access to broadband infrastructure are efforts to ensure that everyone, including the most disadvantaged, have access to and use of information and communication technologies. Digital inclusion requires "intentional strategies and investments to reduce and eliminate historical, institutional, and structural barriers to access and use technology."[28] It addresses the challenges of people and communities not being able to take advantage of digital opportunities because of the cost of access and devices, the lack of confidence, the skills required, or absence of local leadership that sees digital inclusion as a community priority. The FCC's Lifeline program makes online services more affordable for low-income consumers by providing a monthly discount. There is also a move in the U.S. Senate for a Digital Equity Act to provide funding to states for digital inclusion efforts, together with a competitive grant program for community projects.

Removing barriers for local action

There are many federal and state rules that constrain local efforts to provide broadband access. Some prohibit support for multiple providers (overbuilding) in an area to protect monopoly legacy carriers, some limit the ability of local governments to provide or support community broadband deployment, and others prevent flexibility or responsiveness to local conditions. Yet, there are multiple examples of innovation and creativity at the local level that need to be highlighted and, where appropriate, replicated.[29]

The pivotal move on rural broadband is to speed up the implementation of the Rural Digital Opportunity Fund with a target of applying the $20 billion investment in five years instead of ten, and to initiate with urgency actions across the country at the federal, state, and local level, in partnership with private sector, government, philanthropic, and nonprofit organizations, to improve broadband data and mapping, advance digital inclusion, and remove legislative and regulatory barriers that inhibit local innovation and creativity.

PIVOTAL MOVE: RURAL SMALL BUSINESS DEVELOPMENT

Stem the loss of and support small businesses in rural America through aggressive measures to retain existing

26 Congressional Research Service (October 16, 2019) Broadband Data and Mapping: Background and Issues for the 116th Congress. https://crsreports.congress.gov/product/pdf/R/R45962

27 See: Roberto Gallardo (2020). Bringing Communities into the Digital Age. State and Local Government Review I-9

28 National Digital Inclusion Alliance. https://www.digitalinclusion.org/definitions/

29 See: Harold Feld (2020). Solving the Rural Broadband Equation at the Local Level. State and Local Government Review I-8; Statement by Shirley Bloomfield, Chief Executive Officer, NTCA–The Rural Broadband Association before the United States Senate Committee on Commerce, Science, and Transportation. The State of Broadband Amid the COVID-19 Pandemic May 13, 2020.

enterprises, support start-up ventures, and increase capital flows.

The extraordinary impact of the pandemic on every sector of the U.S. economy is hard to overstate, with record numbers of people filing for unemployment benefits. The longer it takes to recover, the greater will be the damage to the economy in terms of business survival, employment, and entrepreneurship. An April 2020 survey[30] of the impact of COVID-19 on small businesses showed that 43 percent of 5,800 responding businesses had temporarily closed, mainly the result of reductions in demand and employee health concerns. Three-quarters of respondents had only enough cash on hand to cover two months of expenses or less, underscoring their fragility. If the crisis lasts through August, then fewer than half expect to be in business at the end of the year. Another survey of 8,000 small businesses in May 2020[31] showed that by the time the CARES Act was passed, 60 percent had already laid off one worker. Moreover, half (46 percent) did not expect to recover within two years. The specter of a repeat of the Great Recession effects of permanent business losses and slow recovery could be devastating for many parts of rural America.

Indeed, analyses of what happened to new business formation after the Great Recession show there is ample cause for concern. One study[32] shows that most rural communities lagged urban areas, experiencing meager growth in new business establishments, albeit with some bright spots in recreation and energy dependent communities. Unfortunately, these same communities are being particularly hard hit by the effects of the pandemic. Another study[33] shows that in the period 2010 to 2014, there was an unprecedented concentration of economic dynamism in a few urban centers, while three in five counties, including most of rural America, saw more business establishments close than open. Twenty counties, mostly in major metropolitan areas, generated half of the all new business establishments in the United States, and only one quarter of all counties performed at the national rate of business establishment growth.

Two ways to change the trajectory for rural economies are to focus on entrepreneurship and new business development and to increase the flow of capital to rural businesses through community financial institutions.

Entrepreneurship and new business development

Although some communities and their elected officials cling to the idea that recruiting new companies by offering tax and other incentives is the only way to achieve economic development, many now see taking care of their existing businesses and creating the conditions for entrepreneurship to be much more effective and sustainable.

Measures that will not only restore the economy, but "rebuild better by ensuring all Americans—especially female, minority, immigrant, and rural entrepreneurs who have been historically marginalized by investors and lenders—can turn their ideas into businesses"[34] are called for by the Start Us Up coalition of entrepreneurship organizations. The coalition's policy framework, "America's New Business Plan" proposes a series of actions both as an immediate crisis response and for the longer term across four ideas of need: funding, opportunity, knowledge and support. Here is a sample of the actions that are particularly relevant to rural entrepreneurs:

- Request that Congress make substantial funding available to states for strengthening the private financing of new businesses by expanding capital access through patient capital, innovative investment models and technologies, financing guarantees, and community banking.
- Establish clear goals for all federal capital access programs, including the number of new entrepreneurs who access capital (disaggregated by race, gender, socioeconomic class, and geography), revenues generated, new jobs created and sustained, and customer experience feedback.

30 Alexander Bartik, Marianne Bertrand, Zoe Cullen, Edward L. Glaeser, Michael Luca, & Christopher Stanton (May 2020). The Impact of COVID-19 on Small Business Outcomes and Expectations. Harvard Business School NOM Unit Working Paper No. 20-102 http://dx.doi.org/10.2139/ssrn.3570896

31 John E. Humphries, Christopher Neilson, & Gabriel Ulyssea (April 2020). The evolving impacts of COID-19 on small businesses since the CARES Act. Cowles Foundation Discussion Paper No. 2230, Cowls Foundation for Research in Economics, Yale University. http://cowles.yale.edu /

32 Olugbenga Ajilore (February 2020). Economic Recovery and Business Dynamism in Rural America. Center for American Progress. https://cdn.americanprogress.org/content/uploads/2020/02/20114441/DynamismRural-brief.pdf

33 Economic Innovation Group (May 2016). The New Map of Economic Growth and Recovery. https://eig.org/wp-content/uploads/2016/05/recoverygrowthreport.pdf

34 Start Us Up Coalition (2020). Rebuilding Better: Activating the Start Us Up Coalition in Response to COVID-19. America's New Business Plan. https://www.startusupnow.org/covid-19-response

- Create a single list of all requirements to start and run a business, and coordinate across agencies to simplify regulatory requirements and processes at the local, state, and federal levels.
- Include entrepreneurship and applicable information and tools in workforce training programs to help tens of thousands of young Americans start their own businesses.
- Facilitate the development of a system of portable benefits that follow workers as they move across jobs or out of the workforce to start a business.

There are many national, regional, and local support organizations across the country that are supporting entrepreneurs and entrepreneurship in different ways, some of which have a specific rural focus. RuralRISE,[35] a community of organizations that aims to increase opportunities and prosperity for small and rural communities across the United States, shares insights and ideas through conferences and webinars. Entrepreneurial Ecosystems (formerly the Center for Rural Entrepreneurship)[36] helps communities and regions connect, learn, and share best practices.

Capital for business development and growth

The pandemic intensifies the perilous financial position of many small businesses and shows the urgent need to move capital into low-income, low-wealth communities to stem the loss of these businesses so critical to their economies. It also underscores the importance of intermediaries that can reach into rural communities and serve rural businesses, given that major banks have largely withdrawn from these markets. Community Development Financial Institutions (CDFIs) have, for over 30 years, leveraged capital from banks, foundations, corporations, and government, to direct capital into rural, urban, and Native communities beyond the reach of mainstream financing. There are 1,100 CDFIs certified by the U.S. Department of the Treasury's CDFI Fund with a total of more than $222 billion in assets. In FY 2019, CDFIs had almost $25 billion of small business and microloans in their portfolios. Twenty-six percent of CDFI clients are rural.[37] The unique characteristic of CDFIs is that they are place-based organizations with deep and extensive connections in their communities, combining local knowledge with financial acumen, and as such are often anchor institutions for their regions. Many provide financing for housing, community facilities, and consumers as well as for businesses.

The Opportunity Finance Network, the national CDFI network, was active in ensuring that the second round of Paycheck Protection Program funding included a $30 billion set-aside for community finance institutions, small insured depository institutions, and small credit unions. This was a response to the fact that, in the first round, businesses with strong commercial lending relationships with larger banks and credit unions were favored recipients, shutting out businesses of color and smaller businesses from accessing the program.

An important part of funding for CDFIs is through the U.S. Treasury's CDFI Fund which in FY 2020 received an appropriation of $262 million. For FY 2021, OFN is advocating $304 million on the way to building support for an appropriation of $1 billion to expand the capacity of CDFIs to bring vital financing to businesses and communities in greatest need.

The pivotal moves on rural small business development are to increase federal, state, and philanthropic support for organizations and their networks that provide advice, technical assistance, facilities, and finance for businesses and entrepreneurs. Specifically, the America's New Business Plan provides a good starting point for advocating additional funds and regulatory changes, and legislative priority should be given to rapidly expanding the CDFI Fund to channel funds into CDFIs, particularly those serving rural and Native communities.

PIVOTAL MOVE: LOCAL GOVERNMENT

Safeguard essential local public services by strengthening regional fiscal and technical capacity.

Even though the pandemic has highlighted how counties fulfill a range of community health, human services, justice, public safety, and transportation services essential to community well-being, it now looks inevitable that some county and municipal governments, particularly in areas with persistent population loss, will be in serious financial jeopardy. This will not be overcome by increasing taxes and fees, and inevitably there will be cuts in services and staffing. The Federal government seems to have a diminishing appetite for channeling further emergency

35 https://costarters.co/wp-content/uploads/2018/07/RuralRISE-Insights-Report-2018.pdf
36 https://www.energizingentrepreneurs.org/
37 Opportunity Finance Network. Impact Performance. https://ofn.org/impact-performance

funding to local governments, and state governments, already financially stretched themselves, may not be in position to help.

One way forward is to provide incentives and encouragement for local governments to enter into sharing and collaborative agreements with their neighbors to reduce and spread costs, combine technical expertise, and develop joint plans. There is already a nationwide network of regional development organizations—variously known as councils of government, regional development commissions, or regional planning agencies—through which multiple counties and municipalities work together on common issues, such as planning, transportation, housing, water quality, and so on. They are chartered or sanctioned by the state and use a variety of state, federal, and other funds to support their programs. Most receive modest planning funds from the U.S. Economic Development Administration (EDA) to support their planning for the preparation of Comprehensive Economic Development Strategies, as well as programmatic dollars for specific functions performed on behalf of the constituent governments.

The pivotal move on local government is to strengthen the network of regional development organizations, particularly those serving low-capacity county and municipal governments. Each state could provide incentives, perhaps in conjunction with philanthropic organizations and matching federal dollars, for local governments to explore greater regional collaboration and to provide technical assistance and planning funds for design and implementation of collaborative efforts.

TRANSFORMATIONAL IDEAS

Transformation must be driven by rural communities themselves—local people must set the priorities and determine what constitutes success. Moreover, the processes that enable this to happen must be inclusive of all people and interests in those communities to achieve long-lasting equitable recovery and resilience. That said, rural communities cannot take this journey alone. Structures at the federal and regional levels are needed to provide an overarching vision, to coordinate and direct resources, and to encourage learning across rural America.

TRANSFORMATIONAL IDEA: ESTABLISH THE US INTERAGENCY COUNCIL ON RURAL AND REGIONAL DEVELOPMENT

Coordinate federal investment and engagement with rural America and Tribal nations through a national partnership to support dynamic and sustainable rural communities.

It is commonly assumed that the U.S. Department of Agriculture (USDA) represents the interests of rural America. In practice, however, the USDA does not have the jurisdiction, influence, or resources to integrate federal policies and programs into a coherent approach to rural development. Rural Development programs, which include housing, utilities, and business, represent less than three percent of the USDA's budget authority and outlays in FY 2021.[38] As noted by Ferguson and Pipa,

> *"With no real vision or true national rural strategy—and no one really "in-charge" of rural issues—all too often the unique needs of rural and tribal communities fall through the cracks. This shows up as eligibility criteria that lock-out rural applicants because the population is too low, the crime-rate not high enough, the geography not contiguous. It also shows up as funding formulas that don't account for the higher per-capita costs of providing services in a rural area, or that automatically provide cities with funds while small, comparatively low-capacity places must prepare proposals and compete against one another."*[39]

There is a need for system transformation at the federal government level that provides this vision and facilitates a national rural strategy truly reflective of the needs and aspirations of rural people and communities in their full complexity and diversity.

Last year, a new Council on Rural Community Innovation and Economic Development was established in the 2018 Farm Bill as a successor to the White House Rural Council and the subsequent Interagency Task Force on Agriculture and Rural Prosperity. This brings together the heads of 26 federal departments, agencies, and offices under

38 U.S. Department of Agriculture Budget Summary FY 2021. Note that 65 percent of the budget goes to nutrition assistance programs, 22 percent to farm, conservation, and commodities programs, and five percent to forestry. https://www.usda.gov/sites/default/files/documents/usda-fy2021-budget-summary.pdf

39 Katharine Ferguson & Tony Pipa (June 2020). Redesign Required: Four ideas for Reimagining Federal Rural Policy in the COVID-19 Era. Aspen Institute Community Strategies Group and the Brookings Institution. https://www.aspeninstitute.org/blog-posts/ and https://www.brookings.edu/blog/

the leadership of the Agriculture Secretary "to enhance federal efforts to address the needs of rural areas by creating working groups within the council to focus on job acceleration and integration of smart technologies in rural communities and making recommendations to the Secretary of Agriculture."[40] Unfortunately, with no additional funding or staff allocations, and a limited remit, this is unlikely to achieve anything close to transformation.

A way forward may be to create a new cabinet-level Department of Rural and Regional Development with the goal of catalyzing public and private investments at a regional scale to foster dynamic, sustainable rural communities. The model would be the Department of Homeland Security created in response to 9/11 to develop and coordinate the implementation of a comprehensive national strategy to secure the United States from terrorist threats or attacks. It consolidated 22 agencies concerned with anti-terrorism, border security, immigration and customs, cybersecurity, and disaster prevention and management.

It is possible to imagine a Department of Rural and Regional Development that would consolidate the Department of the Interior, the Rural Development and Economic Research Service functions of the Department of Agriculture, and the Economic Development Administration, as well as coordination of other rural-focused such as the Federal Office of Rural Health and the Federally-designated regional commissions. However, the navigation and negotiation of such a move in the face of Congressional Committee and departmental opposition would likely require more political capital, resources, and time than can be justified.

Instead, a potentially more feasible and effective approach could be the establishment of a *U.S. Interagency Council on Rural and Regional Developmen*t modeled on the U.S. Interagency Council on Homelessness. Its mission would be to coordinate Federal investment and engagement with rural America and Tribal nations through a national partnership at every level of government and with the private sector to create dynamic, sustainable rural communities where all people can realize their full potential and live healthy lives. Key elements of the organization's charter could include the following:

- The Council would be an independent entity within the executive branch, authorized by Congress.
- The Council's membership would be composed of departmental and agency heads with responsibilities and duties related to rural and regional development.
- The Council would elect a chair and vice chair from among its members, these positions rotating annually.
- The duties of the Council would include:
    - Submit to the President and Congress a National Strategic Plan for Rural and Regional America, which would be updated annually.
    - Review federal activities and programs that impact rural America to reduce duplication and monitor, evaluate and recommend improvements.
    - Provide professional and technical assistance to States, local governments, and other public and private nonprofit organizations in navigating Federal programs, receive recommendations for improvements, and organize regional workshops.
    - Conduct research and evaluation.
    - Develop joint federal agency and other initiatives to fulfill the Council's goals.
    - Require each member department and agency to prepare and submit annual reports to Congress and the Council on progress.
- The Council would appoint an executive director, and provide authority to the executive director to appoint additional personnel as required to fulfill the functions of the Council.

System transformation, however, must be more than a federal initiative. It will require ramped-up engagement from state and local governments, nonprofit organizations, philanthropy, and the private sector both to hold the Council accountable and to generate insights on gaps, priorities, and opportunities. There are many venues and arrangements that potentially could fulfill this role, such as state and local government associations (e.g. National Governors Association, National Association of Counties), philanthropic organizations (e.g. Council on Foundations, Independent Sector), nonprofits (e.g. Thrive Rural, Rural Assembly), and the private sector (e.g. Council on

40 Congressional Research Service (2019). The 2018 Farm Bill (P.L. 115-334): Summary and Side-by-Side Comparison. R45525. p. 23. https://crsreports.congress.gov/product/pdf/R/R45525

Competitiveness, U.S. Chamber of Commerce).

TRANSFORMATIONAL IDEA: PURSUE CONCERTED REGIONAL COLLABORATION

Organizing key services and functions to create regional ecosystems and new modes of collaborative governance.

Many, if not most, of the challenges facing rural communities and local governments are of a scale and complexity beyond the resources, capacity, and expertise of any single entity to tackle on its own. Only by working across jurisdictions, service territories, and sectors can there be possibilities for action and change. Urban and rural places are inherently interconnected and thus, collaboration that embraces both rural and urban interests is not only beneficial but essential for enhancing social and economic opportunity and health for all people and places within a region.

A first step in the process is to strengthen the network of regional development organizations as described in the *Pivotal Move: Local Government*, but concerted regional collaboration goes much further in terms of scope and ambition. Some important principles for effective regional collaboration derived from recent research[41,42,43] should shape the way this idea is implemented.

Effective regional collaboration reflects local and regional historical, geographic, social, and economic conditions

Many types of institutions may fill a regional leadership and convening role depending on their institutional capacity and acceptability within the region. It can be a council of governments or some similar form of regional development organization, a community development financial institution, a community foundation, a public-private partnership, a nonprofit agency, or institution of higher education. More important than the exact structure or composition of a collaboration is engaging the right actors and trusted institutions in an extensive and nuanced understanding of the region—past, present, and future.

Effective regional collaboration recognizes, celebrates, and leverages the many ways in which rural and urban people and economies interact

Supply chains, water quality management, commuting, urban expansion, and outdoor recreation, are just a few examples where rural and urban interests must be aligned for mutual benefit. If regional collaboration is to lead to improved opportunity and health for rural communities, then the contributions that they make to the regional economy and well-being, often "hidden in plain sight," must be recognized and rewarded. These contributions may include stewarding natural resources, providing ecosystem services, and managing high-amenity landscapes.

Effective regional collaboration welcomes voices to the table that were previously absent or ignored[44]

In any state or region, there are always concerns about inequities of power and influence that lead to imbalanced allocations of attention and resources. These concerns over power, voice, and belonging can be at the heart of rural-urban divide and other us-vs-them narratives. Inclusion in a sustained and meaningful way will inevitably alter the power dynamics within a region. Thus, regional approaches to problem solving will not come easy for people and communities uncomfortable with change or perceived loss of power. Nevertheless, rapid and fundamental demographic and economic changes are already impacting urban and rural communities, making regional collaboration even more necessary.

Effective regional collaboration recognizes that affordable housing, childcare, health care, workforce development, transportation, air quality, and broadband are all interdependent and essential to creating and sustaining healthy economies and communities

Each of these elements is the focus of distinct systems and networks of policy advocates, service delivery agencies, funding sources, research specialists, and political constituencies. At a regional level, the aim must be to connect these systems and networks together

41 Brian Dabson (2020). Regional Solutions for Rural and Urban Challenges. State and Local Government Review. https://doi.org/10.1177%2F0160323X20925132

42 See also Anne C. Kubisch, Janet Topolsky, Jason Gray, Peter Pennekamp, & Mario Gutierrez (2008). Our Shared Fate: Bridging the rural-urban divide creates new opportunities for prosperity and equity. The Aspen Institute Roundtable on Community Change

43 See also Community Strategies Group, Aspen Institute (2019). Rural Development Hubs: Strengthening America's Rural Innovation Infrastructure.

44 See Seema Shah & Lisa D. McGill (2020). A Foot in Both Worlds: Working with Regional Organizations to Advance Equity. New York: COMM|VEDA Consulting.

into regional ecosystems. Regional collaboration entails working across these interdependent elements, sectors, and political boundaries towards articulating common goals, building regional ecosystems through mapping the multiple systems in a region, understanding any gaps, and determining what it will take to improve outcomes.

Effective regional collaboration requires flexible and long-term funding

It needs funding that adapts to regional needs and priorities, and collaboration incentives to encourage regional solution-seeking that crosses jurisdictions, service territories, and sectors. Regional collaboration is hard, slow, and expensive, but the potential rewards can be significant. Whatever the form of the lead regional organization, resource and capacity constraints inhibit their ability to achieve impact. Transaction costs, both financial and personnel, associated with convening multiple organizations, engaging communities, and managing complex systems are high and difficult to fund, and especially so in low-wealth predominantly rural regions.

A few such concerted regional collaborations already exist in one form or another, but the process of more widespread adoption will likely be slow as local governments struggle to balance their fiscal realities with concerns over loss of local autonomy. The regional development organization is an attractive model in this regard as the organization is governed by the constituent county and municipal governments and is therefore not separate or unaccountable to local interests.

Whatever form the federal leadership entity takes, among its first tasks are to establish a series of pilots for testing models of high-performance service delivery systems in rural regions. These will combine in different ways health care, education, transportation, workforce development, entrepreneurship, housing, and emergency management in self-defined but coterminous regions. The aim is to encourage innovative approaches that break down organizational and functional silos to make best use of financial, personnel, buildings, and information resources, with the aim of enhancing social and economic opportunity and health for all people and places within the region. The lessons learned from each of these pilots will then be used for replication or adaptation in other regions across the country.

They will also need to commission the development of a social accounting system for measuring the contribution that regions in rural America make to the prosperity and well-being of the country. The aim is two-fold:

- Estimate the value of sustainable food and fiber production, water quality and availability, renewable energy, landscape and wildlife protection, and ecosystem services, so that rural communities and rural people can be appropriately compensated, trained, and recognized. Current urban-centered metrics based on economies of scale and per capita expenditures and returns significantly under-value rural contributions.
- Create a set of regional performance benchmarks for health care, education, transportation, workforce development, entrepreneurship, and other functions against which regions can measure progress over time and in comparison with their peers.

DISTINCTIVENESS AND INTERDEPENDENCE

Embracing both rural America's distinctiveness and its interdependence with the rest of the nation has been the intention of this paper from the outset. The assessment of rural America's current state and the effects of the pandemic clearly show the extent and depth of the challenges rural communities and rural economies face. But why should urban and suburban America care? What does it matter if large tracts of America continue to depopulate, if young people cannot see a future for themselves in rural communities, and if rural people struggle to earn a living and have access to the basic services that urban residents take for granted?

The simple answer is that urban and rural America in all their complexity and diversity need each other. Rural America grows the food, provides the energy, supplies the workers, stewards the natural resources, and offers places for recreation and renewal, without which urban America cannot survive; in return urban America provides the markets, jobs, specialized services, and the investment capital to sustain rural America.[45] A more complicated answer is that rural and urban people, communities, and economies are inextricably connected, with continual flows of people, goods, and capital back and forth across invisible boundaries. Pitting rural and urban America against each other makes no sense and is harmful to all.

45 Brian Dabson (2007). Rural-Urban Interdependence: Why Metropolitan and Rural America Need Each Other. Brookings Institution.

It follows that there are no easy solutions to the challenges that rural America faces. There must be widespread agreement and commitment to bring about change, but urban-facing solutions will not solve, and may even exacerbate, rural problems. To restate an important point made earlier, change and transformation must be driven by rural communities themselves—local people must set the priorities and determine what constitutes success, and to do so in ways that are inclusive to everyone in their communities.

The strategies and ideas presented in this paper are not new and indeed, many are being implemented to varying degrees in some locations. What is different is that the pandemic and the calls for racial justice have created a new environment where systemic change might be possible. Taking action on health care, broadband, business development, and local government *together and at scal*e, while creating different frameworks at the federal and regional levels to guide priorities and investments, offers hope that rural America can strive for dynamic, sustainable communities where all people can realize their full potential and live healthy lives.

THE AUTHOR

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Brian Dabson in this paper attempts to reflect the missions of the three organizations with which he is affiliated. The UNC School of Government seeks to improve the lives of North Carolinians by engaging in practical scholarship that helps public officials and citizens understand and improve state and local government. LOCUS Impact Investing guides and supports foundations as they move from exploring the tool of local impact investing to unlocking meaningful, mission-driven assets to deploying those assets for catalytic community impact. Thrive Rural is pursuing a shared vision and understanding about what it will take to create dynamic, sustainable rural communities where all people can realize their full potential and live healthy lives. However, the views expressed in the paper are those of the author and not necessarily those of these organizations.

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use. Others will become more dependent on outside entities (like governments and foundations) for their survival and less resilient in the face of future challenges. The longer-term response to the effects of this pandemic will be as important as the initial response to its manifesting symptoms.

DEEP DIVE

FAITH

JUNE 2020

FAITH DOMAIN AS SOCIAL IMMUNE SYSTEM: RECOMMENDATIONS FOR RESPONSE AND RECOVERY

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NOTE: Figures available at the end of the Springboard document

FAITH DOMAIN AS SOCIAL IMMUNE SYSTEM: RECOMMENDATIONS FOR RESPONSE AND RECOVERY

by Gary Gunderson and Teresa Cutts

THINKING LIKE A VIRUS

A pandemic forces us to look for our social immune system protecting life of the social body. A virus moves without emotion to exploit social weaknesses. Humans, in contrast, are emotional, guided as much by our webs of meaning as we are by cold logic. Some of the most lamentable infection hotspots have been churches. And Spirit makes us resilient, so some of the most creative community scale partnerships are animated by networks of faith.

There is a long history of research and practice linking public health and faith relevant to the recovery from COVID-19. We can see the opportunity through seven questions:

- What do we mean by "faith" as our social immune system?
- What are the strengths of the social unit of faith that pertain to public health?
- What are the "religious health assets," that have helped the Centers for Disease Control (CDC) as well as World Health Organization (WHO), USAID, Bill & Melinda Gates Foundation (Gates), and NAS-Roundtable imagine substantive, appropriate and sustained partnerships in diverse contexts across many presenting conditions?
- How has COVID-19 affected these faith assets?
- How might the CDC frame a comprehensive recovery strategy including faith-based assets in an appropriate and sustained manner to move us toward the Healthy People 2030 goals? (These recommendations focus on leadership capacity to weave from both sides.)
- What should we NOT do in a pandemic and recovery period?

FAITH AS IMMUNE SYSTEM

Long before the chaos of COVID-19, Joshua Cooper Ramo, a health economist from the Kissinger Associates, wrote a pre-sentient book, *The Age of the Unthinkable*.[1] Ramo outlined how entities as diverse as terrorist groups or public health practitioners in Durban, South Africa, were learning how to adapt to a chaotic, post-modern world in which all the traditional behaviors of the structures of economy, health, climate, church, business and more, were no longer adequate. Ramo suggested we think more like the immune system which swarms to the locus of pain to galvanize healing. Faith-based organizations are often involved in community efforts, but usually understood as free help or cheap delivery systems. What if faith communities are part of our immune system?

Once, immune cells were thought to be concentrated in the thymus, lymph nodes, and spleen, moving only when an injury or infection occurred.[2] Actually, immune system cells are in every organ system of the body, particularly the gastrointestinal tract and what is often disparagingly termed "vestigial organs" (e.g., the appendix and tonsils).[3] Faith appears vestigial, too; showing great value in crisis.

Faith communities are visible in natural disasters such as Hurricane Katrina or COVID-19 as well as unnatural ones such as mass shootings. In Katrina, faith communities (and Wal-Mart) cut through red tape, showed up with water and food within hours, swarming like immune cells to meet the basic needs of the body of New Orleans and the overlooked towns on the Gulf. They were ready for the

1 Ramo, Joshua Cooper. The Age of the Unthinkable: Why the New World Disorder Constantly Surprises Us and What We Can Do about It. New York: Little Brown and Company; 2009

2 Parkin, J, Cohen B. An overview of the immune system. Lancet. 2001; 357 (9270): 1777-1789.

3 oij IA, Sahami S, Meijer SL, Buskens CJ, Te Velde AA. The immunology of the vermiform appendix: a review of the literature. Clin Exp Immunol. 2016; 186(1):1.9. doi:10.1111/cei.12821.

unthinkable.

Often, we find that the smallest congregations are *already* where the pain is located, in places big structures aren't nimble enough to reach. In Winston Salem, NC, we found no response from big churches when a man (with no local family) was discharged from the hospital after surgery and needed meals. A 12-member church provided three meals a day to this stranger for weeks.

Faith assets, like an immune system, are interconnected in mysteriously effective ways that allow quick delivery of resources, information, and more. This is not always ideal medicine, but even a casserole keeps the social muscle connected to more specialized help.

WHAT IS THE FAITH DOMAIN?

What do we mean by the "faith domain?" Not everyone uses the terms "faith," "religion," or "spirituality" in the same way, which makes precise analysis of the role of faith frustrating, especially to scientists.[4] The literature and language of the major traditions predate democracy and germ theory. Each tradition has its distinctive differences and commonalities, all visible in the 21st century United States which remains particularly religious, as industrialized Western nations go.[5] In recent years we have seen a regression to the historic baseline of lower active participation, including the rise of "nones," who claim no religious affiliation, but sharp civic values.[6]

The faith "immune cell" is its own social structure—the faith-forming entity, usually called congregations. These 331,000 entities[7] are linked in a complex system of hundreds of formal and informal networks. Some share a common theology, as well as training and credentialing of leaders. These social nodes often create other structures pertinent to the social determinants of health as well as clinical assets. The largest portion of private health care was founded by faith entities, as were a large portion of the "human service" domain addressed elsewhere in this Springboard.

Whenever faith can thrive in concert with the best scientific evidence, the combination is powerful in the service of human flourishing. People of faith create institutions intended to harness science for good. These institutions often grow to dwarf the congregations as they become woven into the government and insurance systems.

Faith networks a century ago created the politics that made public health possible. They viewed public health science as a gift to serve the mission of mercy and compassion, albeit sometimes with paternalistic overtones. It would be the rare public health department whose initial founding meeting was not opened in prayer with clergy on the Board.

RELIGIOUS HEALTH ASSETS

The modern history of public health and faith traces to the CDC's 1984 "Closing the Gap" conference, which focused on how much of the burden of premature death could be prevented with existing knowledge in the hands of civil society.[8] This resulted in the creation of the Interfaith Health Program of The Carter Center, which initiated the concept of "religious health assets" at another CDC conference, Strong Partners in 1992.[9] The language was borrowed by the WHO in 2005 responding to the HIV/AIDS pandemic.[10] They contracted with researchers of The Carter Center and the University of Cape Town to form the Africa Religious Health Assets Program (ARHAP), eventually with other funding from the CDC, Gates, and the World Bank. Practices built on this foundation in Memphis are recognized by the Agency for Healthcare Research and Quality (ARHQ)[11] and CDC as validated

4 Koenig HG, King DE, Carson VB. Handbook of Religion and Health (Oxford Univ Press, Oxford), 2nd Ed.; 2012.
5 Eck D. A New Religious America: How a Christian Country Has Become the World's Most Religiously Diverse Nation. San Francisco: Harper San Francisco; 2001
6 Pew Research Center, Oct. 17, 2019, "In U.S., Decline of Christianity Continues at Rapid Pace." Retrieved June 4, 2020 from https://www.pewforum.org/2019/10/17/in-u-s-decline-of-christianity-continues-at-rapid-pace/
7 Hadaway CK, Marler PL. How many Americans attend worship each week? An alternative approach to measurement. Journal for the Scientific Study of Religion, Sept. 2005; 44(3): 307-322.
8 Foege W, Amler RW, White CC. Closing the Gap: Report of the Carter Center Health Policy Consultation. JAMA. 1985;254(10):1355-1358. doi:10.1001/jama.1985.03360100105023
9 Gunderson GR. Strong Partners: Realigning Religious Health Assets for Community Health. Atlanta: The Carter Center; 1997.
10 ARHAP. Appreciating assets: the contribution of religion to universal access in Africa.Report for the World Health Organization by the African Religious Health Assets Programme, Cape Town, 2006.
11 Agency for Healthcare Research and Quality. US Department of Health and Human Services. Church-health system partnership facilitates transi-

models for Community Benefit planning. Stakeholder Health is a group of health care systems (mostly faith-founded) focused on adapting this logic to many U.S. communities including, of course, North Carolina.[12] A broad professional literature has emerged.

STRENGTHS OF CONGREGATIONS

The social structures of faith have strengths on which cross-cutting public health programs can be built.[13] The strengths are of the social unit, not just the clergy leadership.

The first strength is to *Accompany*. Even six feet apart, congregations create roles and practices of relationship beyond bonds of blood, commerce, and politics. They *Convene* people around the urgent prevention opportunity, such as wearing a mask. They *Connect* not only by talking to clergy, but many lay people of influence in business and civic life beyond their own self-interest. They develop a community *Narrative* or *Story* for new knowledge that helps people find their role. They do not have any command power, but do have the strength to *Bless*. They reverse blaming in favor of sustained recovery, be it from dependency on substances or the long slow slog to reconstruct an economy. They create *Sanctuary* for song, tears and hard conversations, and programs such as testing. They do *Pray* and help create civic rituals tapping the roots of common purpose. Finally, they have a long view based on the strength to *Endure* and lend strength to the communities that need to rebuild their life.

These strengths function within public health strategy as community assets, not just inside the religious group. The Winston-Salem Masking the City movement created masks for the whole city. They were woven, distributed, and promoted with a seamless partnership of business, health, government and, at the very center, faith networks modeling all of the eight strengths.[14]

THE LEADING CAUSES OF LIFE

Faith groups commonly use an integrative framework for health as bio-psycho-social-spiritual. This term traces to a World Council of Churches consortium on Mental Health and Faith, held in Vellore, India in December 2007. [15] The participants focused on integrating mental health into the existing faith structures and ministries. Faith communities of the United States invented the first mental health facilities, just as they did hundreds of hospitals and social service organizations. The four-fold model integrated medical and mental health providers with community-based trainers, peer supporters, community health workers, and into the congregations practice.

The movement within faith communities toward a fully integrated model of health led to the development of the Leading Causes of Life (LCL).[16]

The ideas of LCL resonate with studies of the long-term nature of the social bruising that many have in early childhood known as Adverse Childhood Experiences (ACES).[17] Long term patterns of diseases and disability reflect the damage to our human capacities to nurture and care for each other, planting weakness at our greatest strength.

Like the concept of well-being, LCL cuts across disciplines and domains. In doing so, it helps us see the most important thing: what we have to work with. The causes are:

Connection

The ways people live "a thick weave of relationships" that can build and support trust. For children experiencing ACES, any stable relationship with a teacher, a neighbor or health provider who cares and understands the child's triggers for acting out when exposed to toxic stress can

tions from hospital to home for urban, low- income African Americans, reducing mortality, utilization, and costs. Agency for Healthcare and Research and Quality website. Available at: https://innovations.ahrq.gov/profiles/church-health-system-partnership-facilitates-transitions-hospital-home-urban-low-income. Accessed September 17, 2018.

12 Cutts T, Cochrane JR, eds. Stakeholder Health: Insights from New Systems of Health. Winston Salem, NC: FaithHealth Innovations; 2016.

13 Gunderson GR. Deeply Woven Roots: Improving the Quality of Life in Your Community. Minneapolis: Augsberg Fortress Press; 1997.

14 National Academies of Science Action Collaborative on Business Engagement in Building Healthy Communities. Webinar: A Conversation about Employer COVID-19 Issues and Emerging Opportunities, May 22, 2020. Available at https://www.nationalacademies.org/event/05-22-2020/collaborative-webinar-a-conversation-about-employer-covid19-issues-and-emerging-opportunities

15 World Council of Churches. Consultation on Mental Health Faith Communities. Vellore India: Christian Medical College. Available at www.arhap.uct.za.

16 Gunderson GR with Pray L. Leading Causes of Life: Five Fundamental Ways to Change the Way You Live Your Life. Nashville, Abingdon Press; 2009.

17 Burke Harris N. The Deepest Well: Healing the Long-Term Effects of Childhood Adversity. Boston: Mariner Books; 2018.

mitigate impacts of ACES in later life.[18]

Coherence

The meaning and purpose in life held narratives. Post-traumatic growth syndrome is a phenomenon in which persons grow stronger after trauma,[19] as they craft their own story of healing (coherence), claim their sense of control (agency) and embrace the challenge of illness or problems as an opportunity for growth.

Agency

The "human capacity to choose and to do." Self-efficacy is the belief that a person can make a difference in their circumstances, with a sense of control.[20] The root of resiliency, doing something, even in limits, improves depression and anxiety.

Inter-generativity or Blessing

How we sense our relationship to those who have come before, after, and those with whom we share our life journey. Psycho-neuro-immunology shows how our immune system function can be impacted by every encounter with others enhancing both physical and mental health.[21] In several studies,[22] visiting and caring for others decreased loneliness, depression and improved immune system functioning in the lonely person and the visitor.

Hope

The positive orientation toward the future, not just optimism about personal medical outcomes. Study after study shows better cancer, cardiac, and surgical treatment outcomes and improved anxiety and depression levels in those with higher levels of optimism and hope.[23] Hope enables us to continue our life, work, and relationships, even in adversity.

The Leading Causes of Life are most relevant in the context of those traumas we inappropriately call "mental" or "psychological." Like ACEs, the LCLs do not recognize the unhelpful distinction between mental and physical and social wounds. Very recent work links LCL with the toolbox of Positive Deviance to develop community-based programming perfectly tuned to the recovery phase.[24]

VITAL SIGNS OF THE FAITH DOMAIN

Faith communities in the United States make a large contribution to the well being of the communities. Many of the activities related to healthcare, education, and social services amount to $378 billion annually.[25] These include providing support groups, volunteers, food pantries, housing, health clinics, day care, after school tutoring, and more.

Many of these derivative health-related organizations manage even larger endowments and reserve funds. While the operating budgets are subject to Community Benefiting, the endowments are rarely seen as assets to be held accountable for community health. Many hospitals are just beginning to consider investing in housing voluntarily. The CDC recovery plan could bring these assets into view and thus potential alignment. Faith leadership (if not management) would welcome this.

Harder to quantify, but just as valuable, are the ways faith communities weave and maintain the relational webs within every community. Members worship, but also run businesses, teach in schools, work in the health and health care sector, serve in the civic service, and hold office. Faith communities are one of the few places left where community members spend significant time with people outside their families or their work mates. Congregations' still stratify along lines of race, geography, or economics, but they also provide a safe place for people to explore and extend the boundaries of relationships in their community.

The post-pandemic world will likely see fewer viable

18 Burke Harris N. The Deepest Well: Healing the Long-Term Effects of Childhood Adversity. Boston: Mariner Books; 2018.
19 Tedeschi RG, Shakespeare-Finch J, Taku K, Calhoun LG. Posttraumatic Growth: Theory, Research and Applications. New York, NY: Routledge; 2018.
20 Bandura A. Self-efficacy mechanism in human agency. American Psychologist. 1982; 37 (2): 122–147.
21 Kiecolt-Glaser JK. Psychoneuroimmunology: Psychology's Gateway to the Biomedical Future. Perspect Psychol Sci. 2009;4(4):367- 369. doi:10.1111/j.1745-6924.2009.01139.
22 Uchino BN, Cacioppo JT, Kiecolt-Glaser JK. The relationship between social support and physiological processes: A Review with Emphasis on Underlying Mechanisms and Implications for Health. Psychological Bulletin, 1996; 119(3): 488-531.
23 Schiavon CC, Marchetti E, Gurgel LG, Busnello FM, Reppold CT. Optimism and Hope in Chronic Disease: A Systematic Review. Front Psychol. 2017;7:2022. Published 2017 Jan 4. doi:10.3389/fpsyg.2016.02022
24 Leading Causes of Life Initiative and Positive Deviancy. Leading Causes of Life/Positive Deviance UnConference, Zoom meeting, April 16, 2020.
25 Grim BJ, Grim ME. The Socio-Economic Contribution of Religion to American Society: An Empirical Analysis. Interdisciplinary Journal of Research on Religion, 2016; Vol. 12, Article 3, p. 31.

congregations overall, sharply accelerating a 30-year decline that has seen gifts to religious charities, including churches and synagogues, decrease as much as 50 percent since 1990.[26] Many were already close to the financial brink for many reasons, and the reduction in revenue most congregations are experiencing will accelerate their demise. Church closures, previously taking place at 1 percent annually, are projected to increase to 5 percent annually.[27] While 30 percent of pastors and church leaders reported that giving was close to the same, over 60 percent have seen their giving go down.[28] This includes 25 percent saying that giving was down at least 10 percent, and another 24 percent saying giving was down at least 25 percent. Most concerning is the 11 percent of pastors and church leaders who replied that giving was down by at least 50 percent. Lastly, churches reporting a decline of at least 25 percent are 41 percent rural and 44 percent urban, notably higher than the 31 percent of suburban churches.[29]

Two groups may be more resilient: smaller congregations without the burdens of overhead, instead built on social relationships; and very large churches that have economic strength and a greater use of technology (essential during this pandemic) at the core of their ministries. Most vulnerable are the mid-range of churches (150-500 in regular attendance).[30] They often struggled with expensive aging facilities and declining attendance and giving before COVID-19.

Black churches were the only faith group in the US not suffering declining membership before COVID-19, their high relevance even more visible now. They are front-line as trusted liaisons, providing information and advocating to hospitals and government for services to protect their members and neighbors, and to lead people of color to earlier screening and interventions. A recent paper outlined how COVID-19 is "failing" yet another test of how America deals with health disparities.[31] These authors shined a light on the disproportionate COVID-19 mortality rate among people of color, citing a mortality rate of almost 81 percent for Black people in Milwaukee, when only 26 percent of the residents are Black.

RECOMMENDATIONS FOR ACTIVATING THE FAITH IMMUNE SYSTEM

Activating the "immune system" of faith is less about faith-based programs and more about linking the generative leaders in faith, public health, and health care. It is as important to train leaders of public organizations how to engage faith as it is to train faith leaders how to engage public health. Research in North Carolina tested the assumptions underneath the Memphis Model to find more generalizable principles for expanding FaithHealth at public scale.[32] Summarizing these for an NAS Roundtable, it found it critical to focus on:

- Community-scale networks and capacity building in a broader population health management strategy are necessary, not just individual care reflected in the traditional biomedical model.
- Trust building among community members must shape every program design decision.
- Raising up humble leaders who value community intelligence.
- An asset based focus, not gap or deficits focused. Use ARHAP model of mapping, aligning, and leveraging them.
- Community-based participatory research principles; co-creation of model design, transparency, and ongoing participatory analysis of data, program, and outcomes; shared risks and benefits.
- Person-centric, not hospital-centric focus needs, based on "a person's journey of health."
- Integrative strategy, which blends community caregiving with traditional clinical medical care.
- Shared data protocol across stakeholders to show proof of concept in a mixed model design, relying

26 IBID 6.
27 Alternet.org. "Why American Churches Are Struggling to Get by during the Pandemic." 29 Apr. 2020. www.alternet.org, https://www.alternet.org/2020/04/why-american-churches-are-struggling-to-get-by-during-the-pandemic/.
28 IBID 27.
29 IBID 27.
30 IBID 6.
31 Owen WF Jr, Carmona R, Pomeroy C. Failing Another National Stress Test on Health Disparities [published online ahead of print, 2020 Apr 15]. JAMA. 2020;10.1001/jama.2020.6547. doi:10.1001/jama.2020.6547.
32 Cutts T, Gunderson G. The North Carolina Way: Emerging healthcare system and faith community partnerships, Development in Practice. 2017; 27:5, 719-732.

on both qualitative data captured from community mapping and congregational caregiving, as well as quantitative metrics captured from hospitals.[33]

It is now much easier to act on these assumptions at large scale because of wide interdisciplinary and trans-partisan streams of work that bridge a number of federal administrations and a wide range of academic and research institutions with a long relationship to the CDC. The faith aspect has grown up with the healthy communities movement that, itself, is borrowed from the embrace of the social determinants and then the concepts of well being and vital conditions and Leading Causes of Life. We are finishing the alignment, not starting it.

SO MUCH ALREADY EXISTS

Much valuable structure and curricula noted above rests "on the shelves" and should be taken off, but we recommend the light spreadable model of FaithHealth Fellows as the quickest way to support COVID-19 recovery.

The long history of the CDC engaging interfaith, trans-partisan, and racially diverse faith networks has resulted in:

- The Interfaith Health Program (IHP) at The Carter Center
- The CDC Institute for Public Health and Faith
- The FaithHealth Consortium (pairing numerous schools of public health and seminaries)
- The Religious Health Assets Program (Emory/ University of Cape Town and Wake Forest)
- Stakeholder Health and the faith-based health care systems
- Community Health Assets Mapping Partnership and other community assessment tools
- The Strong Partners Cooperative Agreement, which created a web of local conversion foundations that matched federal funding and flows to FBO/CBO aided by technical assistance from IHP
- Two large implementation sites (Memphis and NC) and dozens of other smaller ones

One of the surprisingly durable assets is the HHS Office for Faith-based and Neighborhood Partnerships which was established by President Bush and continued through the administrations since. It has extensive experience navigating the sometimes challenging waters of religious conflict and politicization. For 20 years, the HHS Office of Faith and Community Partnerships has been a facilitating partner through this evolution and remains a point of collaboration to this day. We expect it will play a key role in continuing to gain collaboration across the broad faith networks in this crisis and recovery too. Given the always-present wariness of inappropriate entanglement, it is best for this office to not be positioned as the hub, but a point of coordination within government as a crucial catalyst.

FaithHealth Fellows

In North Carolina, we have found a very light touch of training with a focus on connecting several roles, including Connectors, Supporters of Health, and FaithHealth Fellows.[34] Fellows are individuals already working for organizations near the intersection of faith, public health, and health care. They work locally to build the web of trust among generous and generative relationships, and among the leaders that make all public health efforts thrive. The Fellows are not just trained as individuals, but given the funds to hire two part-time Connectors (described below) that invite the Fellow to learn the arts and crafts of institutional engagement and influence for the purpose of locally relevant conditions and needs ("social determinants"). The Fellows usually gain institutional support during the Fellowship, including the funding for the Connectors. Most Fellows stay involved in mentoring the next class of Fellows, which is crucial because they need each other more than they do a didactic curriculum.

The Fellows are identified as FaithHealth leaders working with healthcare or public health. Their local role is the same as the national vision of the Springboard: to make visible and align all the relevant assets of faith for the purpose of recovery and thriving. The Fellows develop cross-cutting competencies where health, public health, social factors, and faith find their powerful effect for well being. It adapts the model of transformational leadership competencies developed by a team of public health leaders led by Kate Wright[35] and augments the map with "transformational competencies" for engaging

33 National Research Council. Faith–Health collaboration to improve population health: Proceedings of a workshop—in brief. Washington, DC: The National Academies Press; 2018. https://doi.org/10.17226/25169

34 Cutts TF, Gunderson GR. Impact of Faith-Based and Community Partnerships on Costs in an Urban Academic Medical Center. Am J Med. 2020;133(4):409-411. doi:10.1016/j.amjmed.2019.08.041

35 Wright K, Rowitz L, Merkle A, et al. Competency development in public health leadership. Am J Public Health. 2000;90(8):1202-1207. doi:10.2105/

highly diverse faith networks and integrating their broad strengths for community well-being. See Figure 1 attached at the end of the Springboard document.

The Fellows are already leaders, but usually without all of the competencies and experience necessary for this task. The faculty provide some framing and tools when appropriate; the balance comes from their peer Fellows, including the alumni. There is nothing distinctive about it's pedagogy, except perhaps its humility. Their training highlights the more distinctive component of transformational leadership: the undergirding "spirit competencies." See Figure 2 attached at the end of the *Springboard* document.

This model could work at a national scale using distance tools for the faculty with local groups of Fellows organized by Stakeholder Health partners and other "mainsail" institutions aligned with Springboard values. Community leaders already mobilized by Well-being and Equity (WE) in the World, Well-being in the Nation (WIN) Network, and other Community Initiatives groups might resonate with the Faith framework of the fellowship added to their toolkit. The FaithHealth accent might draw in other elements of new communities not already involved in broad movements so far.

Connectors

Many varieties of community health workers have been adapted to the FaithHealth logic and are evolving this work. In North Carolina, dozens of part time Connectors are trusted liaisons who work 8-10 hours per week, embedded in a denominational network, housing complex, or neighborhood. They can provide capacity building through networking, train volunteers, or provide direct navigation to resources and, on occasion, provide direct caregiving in the community. Their work is designed for ameliorating the chronic conditions of poverty and exclusion. These skills are highly relevant for the social demands of COVID-19 and the very sensitive work of helping those that tested positive find their way. Connectors often train, nurture, and deploy their own volunteer teams in the community to meet needs.

Supporters of Health

The position of Supporters of Health, a full-time community health worker role, came about in 2012 when Wake Forest Health considered the outsourcing of jobs of 267 environmental service workers. Instead, leadership was told that, through training some of these staff as community health workers, it would recoup at least $1million of the "savings" that consultants predicted could be saved by outsourcing the jobs.[36] Supporters of Health are persons with lived experience, serving as hybrid community health workers and navigators as well as triage for community-based care. These roles require Certificates of different levels, not degrees. A new FaithHealth Consortium could provide a trellis for this work.

All three roles—Connectors, Supporters, and FaithHealth Fellows—focus on competencies that include familiarity with the local health systems, community based organizations, and safety net resources, as well as being trusted members of their social and faith networks. Their work leverages hospital, safety net, and health care resources to build capacity within congregations and social networks that serve the needs of clients referred to collaborating health institutions. This kind of cross-cutting thinking now pervades the training of traditional roles such as Chaplains and counselors.

It would take another whole paper of recommendations to explore all the new roles emerging in the complex web of organizations noted above. While faith networks are famous for their volunteer muscles, the large institutional ecology carrying the work includes daytime career jobs likely to evolve quickly in the recovery of COVID-19. These roles typically rest on some credentials from the faith network as well as from some other discipline, such as social work, psychotherapy, or health science. We are not suggesting starting new degree programs, but aligning and inviting those emerging into the broad work of the Springboard.

Many clergy will desire bi-vocational work and would be attracted to cross-training that aligned with their mission and values just as health and public health institutions are trying to move into the social spaces where health is built and recovered.

The Unpaid and Unpayable

Even in a time when most families have both parents working, faith networks are a dependable place to look for people willing to give their time and sweat for the health

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36 Barnett K, Cutts T, Moseley J. Financial Accounting that Produces Health. In Stakeholder Health: Insights from New Systems of Health, edited by Teresa Cutts and James R. Cochrane, 124-147. USA: Stakeholder Health; 2016.

of their community. It is rare for that energy to restrict itself to the members of their own congregation. Volunteer roles vary from site to site and reflect a wide spectrum of formality of training. However, frequent volunteer tasks include providing transportation (both medical and non-medical), food, support, helping complete paperwork, and helping secure other resources (e.g., furniture, clothing, household supplies, utility or rent assistance, housing.) In more rural settings, volunteers tend to provide more transportation and hands-on caregiving (e.g., helping with light housekeeping, putting medications in pill boxes for the elderly). Across the statewide version of FaithHealth, "The NC Way" we have trained and deployed 995 unique volunteers since March 2015.

Seminaries and Religious Schools of Higher Education

Hundreds of faith-based higher educational institutions train leaders and laypeople in the crafts of mission. Some of the best and least known schools are of faith, forming a very rich leadership training ecology. Less than half of the alumni serve in pulpits anymore, instead working in the broad array of social service. These institutions are familiar with federal scholarship protocols and thus the "church-state" issues. They should be invited to mediate structures to help their alumni build the civic muscle detailed in the Springboard. Their extensive alumni might trust their continuing education—now commonly converted to distance technology. The longer 2030 goals may benefit from curricula for new students or degree programs.

The FaithHealth Consortium

The CDC/Robert Wood Johnson Foundation collaboration created a network of schools of public health and seminaries called the FaithHealth Consortium. These schools offered interdisciplinary courses with field immersion in community health networks such as described here. With no small part of the robust literature from both Memphis and the North Carolina Way, the FaithHealth work has emerged from these consortiums and has continued for many years after the seed funding and as faculty have dispersed to other institutions. The recent books edited by Drs. Doug Oman[37] and Ellen Idler[38] are only the latest among many. This Consortia could stand back up to humbly undergird the faith aspect of the work of the Springboard in solid science and evaluation. Given the global nature of the pandemic and the social immune system of faith, it would be most valuable for a Consortia to be global.

WHAT NOT TO DO

The most important of the operational assumptions undergirding the spread of FaithHealth as a cross-cutting asset is humility. Faith networks do not need to be invited into the work of recovery, mercy, justice and well being. They are already present in the places of greatest pain and creativity. It is very important that the Springboard does no harm to the very assets that might help it succeed. A few specific recommendations about what not to do.

DON'T SEE LIKE A STATE

The Springboard is emerging from philanthropy linked to and for the CDC, our most noble of government institutions. A key insight of the work of AHRAP was an appreciation of all civic structure and the tendencies of governments and para-governmental organizations such as philanthropies to "see like States".[39] Civil recovery depends on activating the positive social determinants for a sustained response and recovery process. One must see them to do that and pause before their vitality and resilience. It is as important to not step on the flowers as it is to plant new ones. The Community Health Assets Mapping Partnership (CHAMP) approach is a systematic participatory model making visible networks of trust and resources for action as well as historical traumas so that programs are not naïve.[40]

DON'T MICROMANAGE FAITH BASED ENTITIES

When health care organizations first come into relationship with faith groups, they often think they could be run more efficiently. They can look ragged, but deserve some respect for having survived a number of millenia of pandemics before *they* invented medical science. There is no need for off-putting micro-design of congregational best practice for all houses of worship of every faith. The key assumption of the Memphis Model was that it did not prescribe specific program structure and priorities for the

37 Oman, D. (Ed.). Why Religion and Spirituality Matter for Public Health: Evidence, Implications, and Resources. Springer; 2018
38 Idler EL, Ed. Religion as a Social Determinant of Public Health (Oxford Univ Press, New York); 2014.
39 Scott JC. Seeing like a state: how certain schemes to improve the human condition have failed. New Haven & London: Yale University Press; 1998.
40 Cutts T, King R, Kersmarki M, Peachey K, Hodges J, Kramer S, Lazarus S. Community Asset Mapping: Integrating and Engaging Community and Health Systems. In Cutts, Teresa and James R. Cochrane (Eds.), Stakeholder Health: Insights from New Systems of Health (pp. 73-95). USA: Stakeholder Health; 2016.

hundreds of diverse partners. Collaboratively analyzing the data with faith partners, we came to understand what was working: the congregations were helping patients come a bit more likely to the *right door* (not so much ER) at the *right time* (depending on the condition) *ready for treatment* (mainly not expecting to be disrespected) and most important, *not alone*.[41] These are qualities the hospital cannot even know how to affect, entirely produced by those that love the patient: ideally their family, or often their congregation. This leads to the next thing to not to do.

INVITE, DON'T PRESCRIBE

Point faith based entities toward the science, but trust them to direct their activities. Faith networks play their role with greatest effect if the health experts lend expertise without trying to run their church or mosque, do their theology or design mercy and care. The key is the invitation preserves room for creative adaptation. This "limited domain" of collaboration[42] extends the invitation to more broad partnership of community scale. Make it all invitational, with care not to presume on the formality of relationship. In Memphis the partnership was named in broad outline with a "covenant"; in North Carolina the social/political context made explicit agreements less acceptable, so we found a less restrictive partnership based on almost pure invitation.

Avoid sinking millions of dollars of resources into creating new programs, training and infrastructure and send those funds directly to those in need as possible

Use what already exists and focus on funneling more funds, jobs, roles, and opportunities to the "boots and brains" on the ground already. Many of our most under-served persons of color could step into the roles outlined above, fulfilling the cries for justice that are resounding in the wake of both COVID-19 and the tragic death of George Floyd.

BE BOLD, NOT BOSSY

Lead with science because it illuminates opportunities for bold missions that may not have been possible at earlier stages of institutional development. After the last great pandemic a hundred years ago many faith groups took the best science of the time and created the hospitals that are now at the core of our trillion dollar health economy as well as the human service and educational complex. The Board members of all of those institutions would be open to a serious discussion about the best and highest role of all those faith-based health assets. What would science suggest faith leaders should invent—or reinvent—now?

41 IBID 34.
42 IBID 13.

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ATTACHMENTS

Figure 1: See the end of this document

Figure 2: See the end of this document

DEEP DIVE

INVESTMENT

JUNE 2020

FINANCING DELIVERY, RESILIENCE AND WELL-BEING

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FINANCING RECOVERY, RESILIENCE, AND WELL-BEING

INTRODUCTION

This document provides recommendations for pursuing financing strategies that will result in post COVID-19 recovery, greater resilience, and systemic transformation to well-being in low-income communities and so that residents have an equitable opportunity to thrive.

The purpose of the financing recommendations contained herein are to achieve:

- Recovery to a pre-COVID-19 level for low-income communities in the short term of less than 3 years. Recovery is an important first step, but completely insufficient for creating an equitable society. The pre-COVID-19 environment was far from fair and just.
- Resilient communities and families are defined as able to withstand economic shocks and maintain basic needs, economic stability, and the opportunity to thrive in the next 2 to 6 years. Resilience is a noble goal i.e. to enable those who live paycheck to paycheck to avoid being thrown into bankruptcy and economic or emotional disaster during a recession or health crisis, yet having so many live paycheck to paycheck is not our ultimate goal.
- Thriving and well-being for all in the long term of 10 years and beyond. Transformation to an equitable society where everyone thrives is the goal and is the moral imperative to aspire to. It may not be fully attainable in our lifetimes, but what can be achieved is an equal opportunity to thrive—which is a fundamental principle of a free and fair society.

A just and equitable society is not only a moral imperative, but as history has shown, it's also in the best interest of the whole. Creating equitable communities where we all have an equal and strong opportunity to thrive leads to an exponentially healthier more vibrant society. A nation that has a shared fate and shared interests has a strong social contract, resilience in the face of adversity, and creates significantly increased wealth, safety, health, and well-being for the vast majority of Americans.

We must pursue comprehensive, long term attitude and mindset shift initiatives to reframe Americans' mental models toward shared fate and equal opportunity.

As a nation, if we understand our shared fate, we will be much more motivated to create an equitable society, not only for the moral imperative, but because it is also in the self-interest of the population as a whole. This is the central argument for our transformational work.

PRE-COVID-19: FAILURE TO CREATE AN EQUITABLE ECONOMIC SYSTEM

Currently, wealthy and powerful interests benefit from our economic system while the vast majority of the population is vulnerable to economic shocks.

- 60 percent of Americans have $500 or less in the bank and are unable to withstand a crisis.
- Income and wealth disparities are the highest mark in a century.
- Net worth of African American families is $8 according to the Boston Federal Reserve.
- Life expectancy in low-income communities are 15+ years less than affluent ones.
- College enrollment rates for black students is 37 percent.
- 37 million Americans are food insecure.
- Housing crises exist across the country in low income communities.

COVID-19 has exacerbated the existing inequities with people of color disproportionately bearing the economic and health burden and twice as likely to die from COVID-19.

Interventions to date have largely failed to achieve population impact and a more equitable society in economic and thriving measures (Cantril's). This failure is a result of:

- Fragmented interventions implemented in silos and

not getting to scale.

- A lack of systemic approaches that shift core societal structures and behaviors.
- Programs that try to mitigate symptoms or try to "fix" communities. These programs miss the primary cause of inequities, which are the systems that disadvantage these groups.

Our systems writ large do not work for low-income Americans. In fact, they are oppressive by actively making it more difficult for them to thrive, particularly those of color who experience systemic racism. This is not an issue of individuals making bad decisions and ending up poor while others make good decisions and do well. This is the result of multiple systems that govern how opportunity is afforded in America that work against 50 percent of Americans and primarily benefit the top 10-25 percent.

Unfortunately, there are few comprehensive systemic approaches being pursued to shift underlying systems. Systemic approaches require financing which they currently lack. Without a change in underlying systems that address root causes, our society will continue to primarily benefit only a few at the top. We must change our systems if we are going to succeed in achieving resilience and transformation toward an equitable society with equal opportunity.

EXISTING FINANCING SYSTEMS

Financing systems for those with wealth were working well prior and during COVID-19. The stock market and lending markets backstopped by the Federal Reserve continue to function effectively and to disproportionately benefit those in the top 10 percent of wealth.

Meanwhile, the financing systems that fund well-being for all and support the conditions for everyone to thrive are woefully ineffective. The aggregate assets of the 1,100 or so CDFIs whose mission is to invest and make loans in low income communities is about $200 billion, which is about 1 percent of the $18.3 trillion in assets held by FDIC insured banks and credit unions—a totally inadequate level of investment needed. Half of Americans are not invested in the stock market. The wealthy can self-finance high-quality health care and education, while poor communities cannot do so.

THE INVESTORS

This section identifies major investors in financing well-being and previews required systemic changes in mindsets, roles, and industries of the various players. To date, most "investors" have been either consciously or unconsciously supporting the existing inequitable system through their investments or have ignored investing in equitable well-being. Major shifts in how each player operates in society are needed in order to finance and achieve an equitable society where everyone has an equal opportunity to thrive. These shifts are further elaborated on later in this document.

GOVERNMENT

City, state, and federal governments fund in fragmented ways with fragmented measures and agencies working in silos. These agencies need to significantly increase their coordination and integration based on a shared set of agency goals and outcomes metrics.

The current tax and spending priorities of governments do not reflect the creation of an equal playing field to succeed. Before COVID-19, the safety net had been eroded—except expansion of Medicaid—and stimulus bills have not permanently increased funding for basic needs. The government is not prioritizing investments in the seven vital conditions—e.g. transportation and infrastructure bills have languished, almost zero direct support for housing, food programs are inadequate with 37 million Americans food insecure—and there is almost no support by the government for systemic change.

The overarching government notion that the marketplace, if left to its own devices, will create an equitable society has been proven wrong many times, and certainly over the last decade. That philosophy helps prop up a wider economic system that accrues financial benefits to those with power and wealth that gain from markets that are designed to make them even more powerful and wealthy while preventing equitable opportunity for all. A mindset shift that changes the philosophy that free markets alone will remedy inequities and changes attitudes about the limited role of government is *essential* to enable financing and outcomes of resilience and well-being for low income populations.

A massive prioritization of government funding for the seven vital conditions that includes direct appropriations as well as incentives for private investment and co-

investment with the private sector is required. This type of shift is possible. We have seen trillions in spending due to COVID-19 with more to come. It is ultimately a matter of stimulating public will (through communications campaigns etc.) that translates into political will and elected officials who support financing an equitable vision of society and the integral role of government as part of the financing solution.

The democratization of power so that there is a shift to community and local governance models where government resources are provided to local communities who are responsible for making decisions about how to improve their conditions is a key element in successfully financing well-being. Community decision-making requires collaboration with city and state leaders on state policies and information and measurement systems to make ongoing course corrections.

This shift will invigorate our democracy and help enable financing of well-being goals. It will create a different social contract between citizens and government that engages citizens in improving their communities, versus the primacy of individualized pursuits of wealth and prosperity. Social contracts are rooted in reciprocity and mutually beneficial relationships that over time sew bonds and relationships of trust that transcend self-interest and are critical for achieving well-being and for surviving over the long term as a unified prosperous nation and human experiment in freedom and justice.

BUSINESS AND FINANCE

The business and financial sectors are not investing for sustainable well-being, they are investing for return-on-investment (ROI). They are not prioritizing investments in major, socially beneficial initiatives such as economic development in low income communities that share returns with residents, or profit sharing with employees, or in educating our future workforce through scholarships for students and employees, or in affordable housing in the communities they work and sell in.

The public good initiatives they have pursued are often a reaction to pressures to mitigate the damage they are doing to the environment or obvious exploitation of workers. Worse, entire industries have emerged to prey on low and middle-income consumers through predatory lending and bogus education degrees, as just two examples. These predatory industries have been allowed to operate relatively unfettered.

Even responsible businesses do not come close to equally weighting social value and ROI. This is the key mindset shift that must take hold in the public, business, and financial sectors—that social value is equally important to financial returns. Short-term profits need to take a backseat to sustainable profits and social value creation. This mindset needs to be reinforced by regulations and incentives (tax breaks), consumer behaviors that shun companies that don't live these values, corporate governance and laws (such as eliminating the primacy of maximizing shareholder value). This would create a different social contract between companies and employees and consumers that helps drive well-being. A contract that would also financially benefit companies because more citizens will have more resources to fuel economic growth.

PHILANTHROPY

While it has far less resources than government and business, philanthropy is an important player given its flexible capital and ability to fund organizing efforts. Philanthropy's good intentions have failed to achieve much progress in the major measures of well-being. For institutional philanthropy, this is due to fragmented efforts, a model where collaboration is not the norm, decisions made by elites versus community-led, and very little support for systemic change initiatives. The few attempts to pursue multi-sector efforts are grossly underfunded.

A mindset shift in philanthropy that embraces collaboration as the norm, accountability to population level impact, democratizing of grantmaking, and taking system level approaches are necessary transformations for the field to successfully finance well-being at a population level.

Incentives can be put in place to spur this transformation, including tax incentives, public pressure through impact rankings (e.g. US News & World Report Rankings) and other means. Trustees are insulated with no major internal pressure to change from their current ways of working, so outside pressures will likely be necessary.

A unique contribution philanthropy can make is to fund infrastructure for system change approaches to be implemented and to build the field of systems change in the social sector.. Recently, five foundations decided to borrow $1.7 billion to expand their giving during COVID-19. And yet, $1.7 billion is a fraction compared to government

or private potential spending. However, if the $1.7B were used to fund systems change infrastructure, or systems initiatives, or organizing public pressure on business and government to transform, it could leverage enormous change.

The majority of individual donors do not contribute a significant amount of their net worth to philanthropy. This could be remedied through tax levies, incentives, and public pressure campaigns. However, remedies will need to extend to the use of funds, since most major gifts are loyalty donations to universities, diseases, or hospitals. There is little focus on equity, infrastructure, power sharing, or creating a just society.

Mega donors (mostly white males) pursue their efforts in silos and elitist decision-making, thus perpetuating the ineffectiveness of the philanthropy to bring about equitable change. They have shown almost no appetite in supporting systemic change that would disrupt the status quo that they have benefited so much from. Public pressure and mindset shift campaigns (and peer-to-peer efforts) that promote community involvement in mega donor grantmaking decisions (see Raikes Foundation) is a critical part of the philanthropic transformation process that would enable financing of well-being.

BIG IDEAS FOR SYSTEM CHANGE

This section focuses on big ideas that can start now, but take longer to achieve. The "big ideas" cover systemic shifts to meta-systems, including capitalism and the field of financing, that would need to change in order to finance well-being in any significant way.

SYSTEMIC CHANGE OF META-SYSTEMS: CAPITALISM, DEMOCRACY, AND RACISM

Central to successful financing of well-being in low-income communities is systemic change to the system of capitalism. This is a meta-system that has a high degree of impact on so many other facets of financing and society. However, capitalism is integrally tied to our democratic system and to racism. These other two meta-systems need to be transformed along with capitalism in order to achieve our goal of all people having an equal opportunity to thrive and for recommendations in this paper to succeed.

CAPITALISM

Capitalism is the meta-system within which the field of financing sits, and which essentially governs how the field of financing operates—from human behaviors and attitudes, to investment flows and actual rules and laws. Our current form of capitalism is designed to benefit a few at the top who control the means of capital and political power. The disparities in wealth and the economic fragility of two-thirds of Americans makes it painfully obvious that the system is not working for the majority of Americans. The goal is to restructure capitalism so that it creates equal opportunity for economic success for all Americans and more equitably distributed prosperity.

DEMOCRACY

Our democratic system must enable communities to be deeply involved in making improvements that affect them. We must facilitate grass roots and grass-tops leaders across sectors, as well as along political, economic, and racial divides to work together. Sharing more power with communities of color and low-income citizens is a must so that all feel they can contribute to bettering our society and their own local conditions. Democracies function effectively with all citizens contributing to the whole and a service mentality. This document does not elaborate on recommended changes to our democracy, however, this report is a useful resource on the subject.

RACISM

Racism, prejudice, and unconscious bias are all part of a systemically racist society that has not worked for people of color. Without addressing these attitudes, we will not shift systems that oppress people of color, including unjust financing laws and practices such as redlining, inhibiting voting by blacks, and violently racist law enforcement practices. Policies and programs will not be enough to transform our systems. Systemic racism in America needs to be addressed and dismantled to ensure all people have equal opportunity to thrive and have a sense of well-being.

Attitudes can shift, as seen in the aftermath of George Floyd's killing, but transformation will require long term awareness efforts, training, desegregation, and a broad movement that encompasses major changes in individuals, organizations and systems.

RESTRUCTURING CAPITALISM AND CAPITAL MARKETS

Specific near-term recommendations can help build momentum for systemic shifts in capitalism and result in recovery and, in some cases, more resilience for low income communities. However, to achieve well-being for all Americans, deeper changes to capitalism will need to occur that focus on how the system works. They encompass shifts in mindset, beliefs, and values and can be seen as falling under the "Inclusive Capitalism" movement. They include the following ideas.

ROOTING OUT SYSTEMIC RACISM IN FINANCING

A comprehensive effort is needed specifically to change attitudes and beliefs related to race in the financial sector. Financial leaders in government, starting at federal level, and in the national banking system, need a full examination and a plan to address racist attitudes that are systemic to the profession. A change in racial attitudes and beliefs enables transformative progress in changing racially inequitable laws, hiring practices, access to capital, etc. This document does not lay out recommendations for such an effort, but without it, systemic and racially inequitable practices, laws, and outcomes will persist in financing and everything that financing touches in society.

MAKING SOCIAL VALUE EQUAL TO SHAREHOLDER VALUE IN BUSINESS AND FINANCE

If maximizing profit and shareholder value continues to be the "a priori" in business and finance, we will never effectively finance resilience and broad-based well-being in low income communities. While this entails a value shift and intentional campaigns to change mindsets (including prioritizing sustainable profits versus quarterly profits), it can also be advanced through incentives and regulations and through the creation of intermediaries that align the interests of the corporate sector and those pursuing social impact.

It will entail shifts in corporate and securities laws that equally weight shareholder value and social impact. Use of tax incentives is viable to change behaviors and cultures, some of which are detailed in subsequent sections. However, tax incentives should be capped to enable sustainable profits but not enrich corporations. Tax penalties can be used as a regulatory tool.

The promotion of B-Corps[1] and for-benefit enterprises through tax incentives, preferential financing terms, marketing support, and other means should be undertaken as a key strategy to advance social value creation. If these types of corporations become the dominant model, the purpose of capitalism will be transformed.

DEMOCRATIZING WHO MAKES THE SYSTEMS LEVEL RULES

Diverse, representative bodies that have full representation by low-income communities should be a part of the decision making. Governance structure needs to be overhauled, including fundamental questions such as "who decides the role of banking institutions and how markets operate and to what end?" Currently, the decisions are made by elites who are biased toward the existing system where powerful interests reap the benefits. Why should banks be allowed to maximize profits, while communities of color remain in grinding poverty for generations? An analysis of the current rule making bodies should occur and then a plan for changing their governance structures implemented. The United States should take the lead on international efforts. Without changing the rules and roles of the system and who gains from it, at a governing meta-level all other interventions will be incremental.

SHIFTING POWER STRUCTURES AT A COMMUNITY LEVEL

Democratizing local investment decisions is necessary so that communities most affected are making investment allocation decisions versus financiers or policymakers. Who makes the rules? Who receives the capital? Who owns the assets and receives the ROI? Local-level democratization coupled with national systems democratization enables the benefits of finance and capitalism to accrue fairly to all citizens.

Cities and states should establish policies that invest rulemaking in community governing bodies that create vetting criteria and resource allocation decisions. Governing bodies consist of an equal number of cross-sector grass roots and grass-top leaders.

GLOBAL BUDGETING—SOCIETY'S ALLOCATION OF RESOURCES

In order to create well-being, society must invest in it at scale. Only implementing pinpointed incentives for certain industries—such as value-based payments in health—creates fragmentation and winners and losers based on

1 Certified B-Corps are a new kind of business that balances purpose and profit. They are legally required to consider the impacts of their decisions on their workers, customers, suppliers, community and the environment. There are now over 3,300 in 71 countries, mostly in the U.S. and Canada. see https://bcorporation.net/about-b-lab

who has the resources to influence the incentive rules. Instead a state-level "global budgeting" framework that allocates public resources based on shared well-being goals is needed. (The city of Santa Monica has recently employed this type of budgeting).

This approach allows sufficient investment in the seven vital conditions of health. State government controls major resources and can see value creation across industries, e.g. investment in early childhood generates savings years later in lower incarceration rates. Budgeting should use direct funding and incentives. A portion of incentive revenues should be returned to a community fund for community members to decide how to re-invest. While it will take time to transform to this type of approach, specific recommendations of how to get started are spelled out in subsequent sections of this document. The following is a description of a global budgeting approach.

> *"A global integrated payment and budgeting system at state level is one that shares payments based on global outcomes and standards. It has shared accountability to well-being goals by government agencies and across society. This includes testing alternative payment models across sectors as well as to individuals.*
>
> *The aim is to incentivize cross-sector collaboration, as well as incentivize services, products, and programs across the spectrum of social interventions that improve well-being; and to enable communities to be recipients of operating support and incentive payments so that they have the ability to re-invest capital in further advancing community well-being. The approach includes coordination and the blending and braiding of government agencies so that services can be delivered in integrated and complementary ways to achieve well-being goals, instead of the current siloed and fragmented government agency response."*

MAJOR PIVOTAL SHIFT: BUILD SYSTEMS CHANGE INFRASTRUCTURE

Pivotal shift recommendations have two categories: infrastructure to enable financing of systemic change for resilience and well-being; and specific 0-3 year financing recommendations for different components of well-being that align with the seven vital conditions. These recommendations have a focus on individual well-being and community well-being, which are integrally tied.

NATIONAL INFRASTRUCTURE

Infrastructure is needed to enable widespread systemic-change approaches—combined with coordinated, cross-sector local approaches—that lead to resilience and transformation. Our society currently lacks the capacity and capabilities to broadly engage in systemic change. Building and sharing our knowledge and practices, deploying effective technical assistance providers, creating collaborative infrastructure to engage multiple stakeholders, financial support for systems initiatives, and more are all needed infrastructure elements.

CREATE A CROSS-SECTOR SYSTEM CHANGE MEMBERSHIP FORUM

This is where public and philanthropic leaders can work together to build the capacity to engage in systems transformation. It would be a central field-building entity that can collaboratively establish standards, communications vehicles, knowledge venues, practice improvements, and financing for the spread of high-quality systems change initiatives at local, state, and federal level. Such a field building entity is currently being designed by industry leaders facilitated by the Social impact exchange.

CREATE OF A FEDERAL SYSTEMS FUND

This will provide annual appropriations for systems change organizations and specific initiatives. The fund can be modeled after the CDFI Fund or the Social Innovation Fund. The current CDFI Fund budget is $390 million which would be a sufficient first year allocation. All government awards can be matched by private grants. Sustainability plans should be an application requirement. Training and technical support would be a prerequisite as part of the contributed funds.

IMMEDIATELY FUND A COVID-19 SYSTEMS ANALYSIS AND MAPPING PROJECT

This is to determine the main points of system intervention to enable recovery, resilience, and transformation. The 4-month project would cost approximately $250,000.

BUILD LOCAL AND REGIONAL INFRASTRUCTURE

Cities need the capacity to organize networks of cross-sector players to develop comprehensive, equitable transformation plans for the well-being of all residents.

This includes business, government, nonprofits, academia across issues of health, education, economic development, housing etc. The networks should include grassroots and grass-tops leaders working together to develop shared goals and plans for investing in the 7 vital conditions of health.

Attempts to build this type of collaborative network that pursues systemic changes have been underfunded and have consequently fallen short of their goals. Organizing these collaborative efforts is difficult, however, systemic transformation and resilience cannot occur without them. There are existing nascent efforts (e.g. ACOs in health) and successful precedents in economic revitalization plans, such as in Pittsburgh, that can be built upon. The central focus of these initiatives going forward should be on low-income communities. Without this type of targeted universalism for low-income communities of color, they will be left behind. A description of cross sector initiatives:

> *"Models that create deep and broad cross-sector collaboration through incentives and other means to systematically improve well-being; puts communities in the center of generating well-being with community organizations receiving payments and directing reinvestment to further advance community well-being; focuses on equity and closing well-being gaps; The aim is to enable collaboration across-sectors and across political, economic and racial groups, and enable systems change and broader implementation of policies, products, programs and services across the spectrum of interventions that improve well-being and empowers communities."*

CONDUCT A FEDERAL AWARD CONTEST

Offer a minimum of $500 million to each of ten states that put together the best plans for a comprehensive, cross-sector transformation initiative for resilience and well-being in at least three of the state's cities. This can be modeled based on the successful Race to the Top contest in education which emphasized application backed by an array of cross-sector leaders across the political, business, and nonprofit sectors. Race to the Top was a $4.35 billion appropriation with most states receiving $500 million or more. Even cities that did not win were so committed to their plans that they pursued them anyway. States that meet 3-year milestones should receive additional funding. Private capital should be required as a match. Communities must be the leading voices in determining the plans. Such a contest will spur the type of demonstrations that are comprehensive enough to succeed in transformation.

LOCAL AND REGIONAL ECONOMIC DEVELOPMENT PLANS THAT CENTER EQUITY

Local and regional economies have a major impact on recovery, resilience, and the financing of well-being. If local economies are sputtering, it is extremely difficult to generate well-being. Cities and regions should be supported by the state and federal government to develop and implement equitable local economic revitalization plans with a focus on low-income communities. Banks, financial institutions, business, academia, and community groups should all be involved by government spearheaded efforts. Without the specific focus on vulnerable communities, the plans will bypass the lowest income communities, often communities of color.

MAJOR PIVOTAL SHIFT: BUILD INDIVIDUAL AND COMMUNITY WEALTH

Family economic success is a critical driver of health and well-being. Community wealth is integrally tied to individual wealth and enables investments in many vital conditions that are so important to well-being. That is why this section's recommendations focus on building community and individual wealth and includes recommendations for specific issues that map to the seven vital conditions, such as housing and health.

OWNERSHIP

Alternative ownership models that share profits equitably among workers and residents builds both individual and community wealth. These models go beyond traditional ownership models. There must be a prioritization of investments by the government and the private sector in spreading shared ownership models. Financing includes start-up capital, low-interest loans, and other favorable tax and regulatory treatment. The following ownership models can be immediately scaled for enormous benefit to low income workers and residents.

COMMUNITY LAND TRUSTS

Community Land Trust (CLTs) are a vehicle in which the underlying land is owned by a mission-driven entity, usually a nonprofit, whereas the buildings on the land are owned or leased by residents. CLTs are used very

effectively to protect against displacement, especially where land values are rising quickly. CLTs have the explicit goal of promoting affordable housing and contain legal provisions governing ownership and transfer to keep units affordable in perpetuity.

This dual ownership model, which separates the cost of the land from the cost of the buildings, makes ownership more accessible to low- and moderate-income families. Homeownership through a CLT can also be more stable, because the strict formulas trusts use to calculate the permissible resale value of their houses effectively remove the properties from the speculative gyrations of the real estate market. There are currently about 225 of them in the US.

COOPERATIVE BUSINESSES

Worker and producer cooperatives can be scaled by providing start-up capital, technical assistance, convertible equity investments, and low interest loans through community banks, social purpose investment funds, and government entities.

Worker cooperatives are values-driven businesses that put worker and community benefit at the core of their purpose. In contrast to traditional companies, workers at worker cooperatives participate in the profits, oversight, and often management of the organization using democratic practices. Workers own the majority of the equity in the business and control the voting shares. There are 465 known workers cooperatives in the United States, employing approximately 6,500 people and generating over $505 million in annual revenues (2019 data). The majority are small businesses, (5-50 workers, with a few notable larger enterprises of 150 and 500 workers). Producer cooperatives, primarily farmers, is another successful type of business cooperative.

The model has proven to be an effective tool for creating and maintaining sustainable jobs; generating wealth; improving the quality of life of workers; and promoting community economic development, particularly for people who lack access to ownership and sustainable work options. According to United for a Fair Economy: "*One of the main barriers to business ownership for people of color is access to start-up capital…[Worker cooperatives make] business ownership more accessible.*" (Source: State of the Dream 2013).[2]

Unlike every other kind of business development in the United States, urban cooperatives have no funding and no home in American domestic policy. Neither the SBA, SBDCs, USDA nor Cooperative Extensions are funded to provide start-up resources for urban cooperatives. However, there is a bi-partisan *Congressional Cooperative Business Council* that helps advance a cooperative friendly legislative agenda at the federal level.

PUBLIC BANKS

Use federal appropriations to finance the proliferation of public banks. A public bank is owned by the government. Its profits go back to the government and can be used to invest in a variety of social services. Profits can also go into Community Funds, where communities determine how they are reinvested. There is currently one in the United States, the Bank of North Dakota (BND-$4B lending portfolio) which has demonstrated numerous social benefits of the public banking model.[3] California

2 By placing workers' needs before investors' profits, successful worker cooperatives democratize wealth rather than concentrating it. Through sharing risk, cooperatives make business ownership possible for entrepreneurs of all backgrounds. They build skills and participation in the workforce. Shared ownership can even be a means of preserving small businesses and saving good jobs when owners retire. At a worker cooperative, profits do not go to distant investors, but instead go directly to the workers. As a result, the money stays grounded in the local economy, building community wealth. Jobs at worker cooperatives tend to be longer-term, offer extensive skills training, and provide better wages than similar jobs in conventional companies. More than half of worker cooperatives in the U.S. were designed to improve low-wage jobs and build wealth in communities most directly affected by inequality, helping vulnerable workers build skills and earning potential, household income and assets.

3 Bank of North Dakota has generated almost $1 billion in profit. Nearly $400 million has been transferred into the state's general fund, to support education and other services. A public bank lends in partnership with community banks to strengthen them and increase their loans. Thanks in large part to BND, community banks are much more numerous in North Dakota than in other states. ND has nearly six times as many local financial institutions per person as the country overall. By helping to sustain a large number of local banks and credit unions, BND has strengthened North Dakota's economy, enabled small businesses and farms to grow, and spurred job creation in the state. BND also has direct access to the Federal Reserve, which provides liquidity at a low rate, enabling them to target geographic and service areas overlooked by existing markets. BND functions as a kind of mini Federal Reserve. It clears checks for both banks and credit unions, provides coin and currency, and maintains an Automated Clearing House. It assists local banks with short-term liquidity needs and has a daily volume of over $300 million. One of its explicit goals is to expand local ownership of banks and increase their capitalization. To this end, the bank has a bank stock loan program, which provides loans to finance the purchase of bank stock by North Dakota residents. BND also enables local banks to take deposits and manage funds for municipal and county governments. This gives local banks an additional source of deposits and benefits residents by ensuring that their city and county funds are held locally rather than turned over to Wall Street banks. Student loans are the only direct to consumer lending BND does. BND offers some of the

is exploring establishing them. In late 2019, California passed AB 857, the Public Banking Act, which allows local governments to start public banks. The East Bay region, San Francisco, the Central Coast, and Los Angeles are working to establish public banks, while the California Recovery Task Force is considering the conversion of the state's Infrastructure Bank from a revolving loan fund into a depository bank.

The Public Banking Institute and the newly formed National Public Banking Alliance are concentrating efforts on Congressional public banking legislation, and on other local efforts in 8 states and 16 cities. This legislation should be supported and passed.

COMMUNITY INVESTMENT TRUSTS (CIT)

Access to ownership in neighborhoods is a missing link in efforts to democratize strategies that foster inclusive wealth building. The Community Investment Trust (CIT) is a new approach to achieve this. The successful demonstration in Portland was designed to remove barriers to financial inclusion and provide a low-dollar investment opportunity in commercial property to local residents. The pilot in Portland's most diverse and high poverty neighborhood, enabled economically marginalized residents to invest and build long-term equity through shared ownership in a commercial retail strip mall for residents in four zip codes. Residents also receive training in goal setting, budgeting and investing.[4] CITs should be spread through grants and loans from foundations, federal state and local government, community banks and special low interest loans from the Federal Reserve.

COMMUNITY WEALTH

Low-income communities possess a wealth of assets that can be built on to create regenerative wealth capacity. To succeed in building wealth, it is critical to work collaboratively with community leaders and allow residents to lead the efforts. Three types of recommendations are offered to build community wealth that go hand-in-hand with infrastructure proposals earlier in the document.

- Increase the flow of affordable capital from the government (grants, loans, equity).
- Provide incentives for the private sector to invest in low income communities.
- Strengthen regulations to direct equitable investments by businesses & financial institutions.

INCREASE THE FLOW OF CAPITAL TO LOW INCOME COMMUNITIES

CDFIs should be considered "first responders" to address the need for capital in underserved communities, given their track record and the trust that these communities have in these institutions. They are highly underfunded compared to the need and require significant increase in funds by the federal government. Currently about 1,200 CDFIs total $200 billion in assets which is about 1 percent of total FDIC insured banks that total $18 trillion in assets. The CDFI Fund budget should triple in 2020 from $390 million in 2019 and CDFI assets should increase to $1 trillion over eight years.

FUND $1 BILLION ANNUALLY FOR EQUITY INVESTMENTS IN THE CDFI FUND

Make annual the $1 billion in emergency grant funding by the Department of Treasury's CDFI Fund included in the recently passed HEROES Act. Investments at this scale are needed to enable CDFIs to address the serious economic challenges facing our communities and fill the gaps left by the PPP.

GIVE ACCESS TO FEDERAL RESERVE LENDING FACILITIES

The minimum loan size and terms of the $600 billion Main Street Lending Facility is a poor fit for CDFIs and their portfolios. The Federal Reserve should create a CDFI lending facility to ease liquidity challenges preventing

lowest student loan rates in the country.

4 The Portland CIT was created using philanthropic capital as well as patient capital from an impact investor to create a novel financial product for community ownership. Residents invest as little as $10 to $100 per month buying shares in a C-Corporation and paying back the down payment on the property, which had been provided by Mercy Corps and the impact investors. The resident investors, who are mostly renters, women, people of color, and refugees and immigrants receive dividends annually, and long-term share price appreciation based on the mortgage reduction and change in the property's value. Their investment is protected from loss through a letter of credit from the bank that provided the mortgage, which also allows investors to exit any time without risk of losing the value of their shares. In 30 months since the launch, the CIT has delivered three rounds of dividends averaging 9.3 percent to over 160 families to-date (with 300-500 families anticipated), and a share price gain from $10/share to $15.86/share. For low-income investors that do not get access to traditional investment opportunities, this is significant: Investors renew their investment at a new share price annually at a 98 percent rate, and ownership activates their voice - 68 percent report that they are voting and becoming more active in their neighborhood because they are owners. The retail and non-profit tenants in the building report greater business and visibility from having their neighbors own the building.

CDFIs from doing more to meet the needs of low-wealth markets. There is a critical need to address the impact of the crisis on the balance sheets of CDFI microenterprise and small business lenders; if we don't do this, we will lose many of those CDFIs, with the greatest impacts on those serving and led by people of color. Having the Federal Reserve purchase restructured pre-COVID-19 loans is the most direct way to address this issue; it will have to take losses to do this and that's where the Treasury backstop comes in. It also provides debt relief to borrowers and can be positioned as saving businesses rather than taking losses.

In addition, the Federal Reserve can lend deeply subordinated, long-term debt to CDFIs by purchasing the equivalent of "Equity Equivalent Loans" to provide needed liquidity to all CDFIs and asset classes. It will help less-affected lenders weather the crisis and be able to deal with the economic consequences of the pandemic in LMI communities over the long term.

The Fed is taking many extraordinary measures to support the capital markets and corporations, including buying individual corporate bonds for the first time ever. It is unjust for them not to also take extraordinary measures to support lending and investment in low income communities. The Fed's new lending facility should extend to all nonprofits at highly preferential terms, not just CDFIs. Recent news articles suggest the Fed is exploring this option.

- ***Lift the moratorium on new Community Advantage lenders for CDFIs***
  Community Advantage is an SBA loan program designed explicitly to meet the credit, management, and technical assistance needs of small businesses in underserved markets. It offers unprecedented access to scale by enabling mission-based lenders to access to 7(a) loan guarantees as high as 85 percent for loans up to $250,000. Given the economic and financial uncertainties ahead, this guarantee authority will enable CDFIs to direct their services to low-income and communities of color—communities not well served by traditional financial institutions. SBA should lift the moratorium on new Community Advantage lenders to allow additional CDFI participation and expedite the approval process to onboard new lenders. There is an existing pipeline of lenders who can help these funds reach communities that need it most.

- ***Create funds of funds***
  This will enable CDFIs to sell their current loans to a secondary market and make new loans. The Fed can backstop the funds of funds and provide low interest loans, or directly buy loans from CDFIs. In both cases it will reduce risk and lower rates.

- ***Open the Federal Reserve window***
  Give CDFIs permanent access.

- ***Modernize CDFIs***
  Provide federal grants through the Treasury Department to modernize CDFIs through improved use of technology platforms.

ENGAGE LARGE PRIVATE SOURCES OF CAPITAL

It is imperative to involve large capital holders such as pension funds and insurers in investing in low-income communities. These entities' assets dwarf those of CDFIs. Tax incentives and CRA-type regulatory strategies can be used to catalyze their engagement. Additional recommendations include:

- Expand the field of Social Purpose Investment Funds. Support the increase the number of non-CDFI social purpose ("mission-first") investment funds and intermediaries that are able to invest more flexibly than CDFIs in low income communities. These funds can be given preferential loan rates by the Fed, and tax incentives for investors to invest.
- Create Federal Reserve supported funds of funds for social purpose funds, so that pension funds and insurers can make minimum investment of $50 million+.
- Support local governments with TA to market tax enhanced Opportunity Zones to secure investment from pensions funds and insurers and achieve high ROI for their communities.

USE THE TAX CODE TO FURTHER INVOLVE CORPORATIONS IN INVESTING IN LOW-INCOME COMMUNITIES

Higher baseline tax rates can be created for corporations while simultaneously offering tax breaks for community investment. Corporations can increase after tax net profits through investments in creating low income community wealth. Strict rules on community residents receiving a significant portion of the ROI are needed so that the

financial industry players or corporations do not reap the lion's share of the returns. Sellable tax credits can be used to create a secondary market such as used in affordable housing. However, there should be a limit on the returns available using tax breaks and tax credits so that companies cannot enrich themselves through community investments and are paying a fair share of taxes.

USE TECHNOLOGY PLATFORMS TO DEMOCRATIZE ACCESS TO PHILANTHROPIC FUNDING AT SCALE

Today's philanthropic marketplace operates in a way that mirrors the racial and wealth inequalities in our nation with few efficient distribution channels for grant capital that are not primarily relationship driven. Now that the use of technology has been proven in countless "crowd sourcing" efforts, it is time to deploy similar platforms dedicated to more sophisticated and long-term sources of capital. The design of a philanthropic platform will focus on reducing barriers to entry and democratize access to capital for impact organizations. It must offer value propositions to both sides—providing necessary due diligence to funders on grantees while also holding funders accountable for providing funds with flexible terms and timely payments.

DESIGN FINANCIAL TOOLS, SUCH AS GUARANTEES, TO ALIGN CORPORATE INVESTMENTS WITH IMPACT ORGANIZATIONS IN THEIR COMMUNITIES

The federal government has long used guarantees to create vibrant and productive financial markets for housing and small business. When well crafted, these guarantees have engaged the private sector and consumers in transactions that would have been impossible without the government's credit enhancement, producing highly positive economic returns.

More recently, foundations and donors are testing new ways to use guarantees to motivate both public and private entities to invest in ventures and initiatives that generate both financial and social returns. For example, the Kresge Foundation launched the Community Investment Guarantee Pool (CIGP) as a new, national financing tool for intermediaries participating in affordable housing, small business and climate lending with $33 million and plans to leverage $150 million in investments. In Dallas, Texas, the Good Returns' Cycle program uses capital to encourage private companies to invest in social impact by offering guarantees that lower risk and encourage repayment. The use of guarantees should be scaled up. For example, the Fed should guarantee a variety of lending vehicles in low income communities, which would reduce risk and interest rates.

EMERGENCY CHARITY STIMULUS PROPOSAL: CHANGE TAX LAW TO INCREASE THE DISTRIBUTION FROM PRIVATE FOUNDATIONS AND MANDATE MINIMUM PAYOUTS FROM DONOR ADVISED FUNDS (DAFS)

The tax system has enabled philanthropy to hoard charitable dollars in tax-advantaged foundations that remain under private control and are required to distribute just 5 percent of their assets annually— or, increasingly, in even more tax-advantaged Donor Advised Funds under no minimum distribution requirement whatsoever. A proposal for an Emergency Charity Stimulus is calling on Congress to require increasing the payout from 5 percent to 10 percent for three years, and to apply that to DAFs as well. This simple change would leverage some $200 billion for working charities, with the funds going directly into communities instead of staying on the sidelines. The proposal appeals to both progressive and conservative political leaders and new polling shows that it would have very strong public support.[5]

REFORM THE COMMUNITY REINVESTMENT ACT (CRA)

It is essential that this country supports an effective, well-enforced Community Reinvestment Act that recognizes and adapts its policies to a rapidly changing financial services industry. The fundamental purpose of CRA is to provide regulatory guidance and incentives to ensure that banks provide appropriate access to capital and credit to low- and moderate-income (LMI) people and places. It is also strongly encouraged that all three bank regulators—the OCC, FDIC and Federal Reserve—proceed together, so that the entire financial system is coordinated and aligned on the system, rather than fragmented, as currently is the case with OCC proceeding on its own. The CRA act needs to be significantly strengthened. Current proposals by the government do the opposite. Given the extraordinary impact of CRA on providing capital to low-income communities—an amount rivaled by no other source of capital—it is essential that all movement on changing CRA be postponed until we are truly in the recovery phase from the pandemic and all three regulators can pursue these changes together.

5 Scott Wallace, "How to trigger $200 billion in coronavirus aid at no cost to taxpayers: Tap foundations," USA Today, May 4, 2020. https://www.usatoday.com/story/opinion/2020/05/04/coronavirus-double-foundation-giving-requirement-for-3-years-column/3042968001/ Polling: https://inequality.org/great-divide/ipsos-emergency-charity-stimulus-poll/

INDIVIDUAL WEALTH

The definition of financial well-being (CFPB)—created by consumers. A person:

- Has control over day-to-day and month-to-month finances.
- Has the capacity to absorb a financial shock.
- Is on track to meet his or her financial goals.
- Has the financial freedom to make the choices that allow one to enjoy life.

To build individual wealth in low to middle-income populations, it is necessary to progress from basic needs to resilience to thriving. For the vast majority of low-income individuals to progress along this continuum requires establishing the civic infrastructure that provides a spectrum of support based on an individuals or family's needs. The progression may start with basic needs and then attachment to a livable wage job and then career development from which individuals can build income and then acquire assets with their savings. The infrastructure should adopt a human centered design and provide integrated supports because families have concurrent needs that require coordination. This includes state agencies coordinating and integrating their departments and local, cross-sector delivery networks in cities that are designed with strong community input.

INCREASE FUNDING FOR VITA COMMUNITY TAX PREP SITES

Community tax preparation centers, many of which are funded through the Volunteer Income Tax Assistance (VITA) program, deliver the highest quality tax preparation services in the nation to low- and moderate-income clients. VITA has generated a huge amount of Earned Income Tax Credit reimbursement to families. In many communities, these trusted organizations also provide valuable and complementary services ranging from access to bank accounts to voter registration. Provide an additional $12 million for VITA in 2020 and a much larger annual increase in subsequent years. This is a low cost, highly leveraged investment in building individual wealth.

FINANCE BASIC NEEDS

Below are recommendations for how to finance key aspects of the support that individuals need to build wealth along the progression of needs. A number of them require government appropriations. Many are also conducive to Pay-For-Success arrangements as an important financing approach. Success of PFS initiatives can then lead to larger government appropriations that not only result in positive impact outcomes but also financial returns to the government in savings or higher tax revenue. Currently federal support for PFS comes from SIPPRA. A recommendation is to triple SIPPRA funding in 2020 and convene a task force of industry and community leaders to recommend design improvements over the next 6 months.

FINANCING FOOD

Pre-COVID-19, about 35-40 million Americans were food insecure, 11 to 12 percent of the population.[6] 43 million Americans were receiving SNAP benefits, the main source of food aid. This is estimated to have risen by 40 percent during COVID-19 according to the USDA. SNAP and other food and nutrition programs have been unable to keep up with the food needs of low-income citizens, even pre-COVID-19

In 2020, it is recommended that there be a permanent increase in federal food appropriations through SNAP and a half dozen additional food and nutrition programs (such as school breakfast and lunch) by 50 percent from $100 billion to $150 billion to ensure no Americans are food insecure. The appropriations are done through The Farm Bill. For a list of food and nutrition programs that should be supported look here. TANF funding should also be significantly increased during the Pandemic.

FINANCING HOUSING

The gap between the supply of affordable housing and demand is 3.6 million units (National Low Income Housing Coalition). A commitment by local and state government and other leaders is necessary to adopt a set of shared goals that seeks to eradicate the shortage of safe, affordable (40 percent or less of income) housing. Specific financing recommendations include:

- The federal government should provide significant direct funding to build safe, affordable, enriched housing. Reliance primarily on tax credits to spur private sector home building has failed to meet the need. Tax credits as currently structured do not cover the cost of building housing. Affordable housing requires cobbling together other financing

6 Food insecure is defined as at times during the year, the food intake of household members is reduced and their normal eating patterns are disrupted because the household lacks money and other resources for food. – USDA).

streams which is in itself costly and complex and requires intermediaries.

- The mechanism for building housing with tax credits creates an industry where financiers and developers are demanding market rate returns e.g. 18 percent. Regulations are needed that cap return rates at 5-6 percent and require a certain number of units from developers and financiers (e.g. through tougher CRA provisions). The Federal Reserve can also provide low interest loans and guarantees to reduce risk and lower required rates of return
- Reduce cost of building affordable housing by having state and local government purchasing and holding land with federal assistance (land is a major cost driver), local zoning that prohibits single family units, and establishing universal housing codes.
- Regulatory recommendations:
  - Require a certain amount of affordable housing for each commercial rate unit.
  - Require mixed income housing so that higher rent units subsidize lower rent units
- Support renovation of aging home stock so it does not disappear. Foundation funded wrap around services can enhance the value enough to make the renovation viable financially.
- Triple government support for rental assistance (section 8 vouchers)
- Use Community Land Trusts and agreements with employers to prevent displacement
- Create renter's insurance through payroll taxes to have funds available for those who fall behind on rent and become at risk of eviction
- State and local governments can create Rent Resilience Funds to cover rent for those who require assistance during economic downturns.
- Mandate large corporations provide subsidized housing for employees below a certain income

FINANCING HEALTH

The financing system for health—including health care and upstream social determinants of health—is broken. Costs are spiraling and are the highest in the world, while population level outcomes are worse than other western countries.

The main systemic recommendation to transform health financing is to create the Global Budgeting model where the government allocates resources based on well-being. This emphasizes upstream social determinants of health and prevention over the life course. Other recommendations include:

- Significantly accelerate the transition to value-based payment for organizations and communities (ACOs). Create much stronger penalties and rewards to ensure comprehensive transition. Ensure community based social care orgs receive a portion of shared savings from VBP payments.
- Include a public option health plan in current ACA to reduce costs.
- Test the single payer model in 1-2 states.
- Spread Medicaid expansion to all 50 states.
- Increase taxes on tobacco and caloric drinks, and use revenues to subsidize healthy food.
- Hire tens of thousands of contact tracers to reduce the spread of COVID-19 and add needed jobs.
- Regulate profit maximizer players in the health industry such as pharmaceuticals.

FINANCING LIVABLE WAGE JOBS

Provide federal support to expand Family Success Center models and Student Success Centers as one stop shops for family services, job training, access to benefits and financial coaching. Focus a set of public and private interventions on improving and protecting credit scores of low- income individuals. Credit scores have a huge impact on employment and future ability to borrow and acquire assets. Revitalizing the Consumer Financial Protection Bureau (CFPB) is probably the most important strategy to protect credit scores. End "cliff effect" laws that stop government aid all at once when income reaches a certain level

FINANCING EDUCATION

A good education is key to generating sufficient income and economic stability. Black individuals who complete a four-year college education have a median income that is near parity with similarly educated white individuals. And yet, education financing is inherently inequitable in America because public education is primarily funded through property taxes.

The following are equitable education financing recommendations that support a strong opportunity to thrive in life for all Americans.

- Fund early childhood healthy development (0-3)—food, housing health care, including significant expansion of evidence-based intensive nurse visitation programs and ACEs screening.
- Establish universal pre-K and universal 3 year-old school/care nationally, including breakfast & lunch.
- Appropriate additional K-12 funding in each state for low-income students to level the playing field with more affluent districts that provide more funding through property tax.
    - Draw bigger district lines in order to aggregate more students in districts.
    - Give financial incentives to top teachers to teach in most difficult schools.
    - Close the digital divide for low-income youth with public schools/corporate collaboration.
- Offer free college tuition.
    - Government pays for community college or state college based on a means test (e.g. family of 4 income under $125K). Support ancillary costs as well e.g., food transport, etc.
    - Private colleges with large endowments pay for the scholarships
    - Corporate sector contributes significantly to state scholarship funds—perhaps 5 percent of the tax breaks they receive. Required contributions could be enacted in legislation modeled after the Community Reinvestment Act for banks.
- Reimburse tuition in return for a service year Americorps model.
- Reduce student loan debt by creating a limit of 2.5 percent for all student loans; refinance all of them at currently low rates. Package into bonds and have the Federal Reserve purchase the bonds.
- Dismantle predatory lenders and fraudulent online institutions with new laws and enforcement.
- Significantly expand Title 1 funding which was only 15.9 billion in 2019 amounting to about $500-$600 per child. Include in additional Title 1 appropriations funding for programs that address the school to prison pipeline phenomenon, an overt example of systemic racism.

MAJOR PIVOTAL SHIFT: ACQUIRING AND PROTECTING WEALTH

ACQUIRING WEALTH THROUGH INVESTMENTS

Create new products to broaden stock and other forms of equity ownership

The United States already has a market that has driven the greatest increase in wealth in human history along with the most profound levels of wealth inequality this nation has ever seen—the stock market. The basic tool is "share ownership"—which is a vehicle for companies to raise capital and for individuals to build wealth. Will Goetzmann, Professor of Finance and Management Studies at the Yale School of Management, offers two powerful ideas to achieve this:

- Create a government program that offers loans to people willing to make long-term investments into a diversified equity portfolio. This type of capital could be seen as a parallel to how the government provides the credit enhancement necessary to operate the long-term home mortgage marketplace. The government could lend 50 percent of the necessary investment to households willing to hold their investments for 10 years or more. Historical rates of return would make this a winning investment.
- Apply the lessons of behavioral economics to "nudge" people to invest part of their retirement savings in equity. The use of "opt-out" mechanisms to increase the rate of employees saving for retirement has been one of the great successes of household finance. We have not been as successful in providing the coaching or structures to encourage these savers to invest in ways that will produce the highest returns in the long-term. One powerful idea is to permit companies to replace cash, mileage or other loyalty rewards for purchases with "equity rewards" that automate the ability to purchase shares of stock. Not only would these purchases promote loyalty, but it is a direct way to demystify stock purchases and make this a "default investment."

Expand use of Employee Stock Option Plans and Profit sharing by corporations

HOME OWNERSHIP PROGRAMS TO BUILD WEALTH

Scale matched savings program to fund down payments and closing costs

Matched savings programs, formally known as Individual Development Account (IDA) programs, are special savings accounts that match the savings deposited by the account holder. Programs generally provide a dollar for dollar match, or more, depending on the program's guidelines and funding sources. IDAs are one of the most effective products to help low-income households save-up for one of the biggest barriers to homeownership: the down payment. IDA programs for homeownership combine two core elements—funding to match the savings of the aspiring homeowner ranging from 1:1 to 5:1, and customized financial coaching or training to prepare for and succeed at homeownership.[7]

Standardize "mortgage reserve accounts" to build emergency savings to make mortgage payments in a crisis

For most households in the United States, buying a home is the largest purchase in their lives. Given that most homeowners finance their home purchase with a mortgage, buying a home is also one of their largest sources of debt, presenting significant risk. Prosperity Now conducted a two-year pilot beginning in 2017 to incentivize saving for emergencies by providing $200 in matched savings through mortgage reserve accounts (MRA). They worked with two housing organizations to serve over 300 homeowners finding:

- Nearly 90 percent of the homeowners began or maintained savings.
- 40 percent of homeowners who accessed their savings used them pay their mortgage.

These findings show that low to moderate-income families who recently purchased a home are willing to save, and the importance of that savings to potentially stave off mortgage defaults and home foreclosure. We should work with national mortgage lenders to design and implement a standard mortgage reserve "opt-out" feature for all new homeowners.

INVEST AND LAUNCH UNIVERSAL CHILDREN'S SAVINGS ACCOUNTS

US Senator Cory Booker (D-NJ introduced a bill to create American Opportunity Accounts, or "baby bonds," as a powerful strategy for closing the racial wealth gap. This legislation builds on the twenty-year legacy of children's savings programs, now operating in over 40 states throughout the United States, starting at birth, kindergarten or other key time periods in the lives of children and young adults.

The Baby Bonds proposal is designed with an explicit focus on addressing the racial wealth divide to provide public funding to every newborn, with babies born into low-wealth families receiving significantly more than babies born into wealthier families. This bill would provide every newborn would receive an initial investment of $1,000. Each year following the family's annual income would be the basis for the sliding scale to determine the amount of each annual contribution to the child's endowment. The American Opportunity Accounts would be held by the US Treasury Department until the child becomes a young adult. At that point, the young adult could use the endowment to invest in an asset, such as education or a home. The goal would also be to integrate age-appropriate financial education throughout the child's education to build financial capability along with these assets in support of financial security and greater racial wealth equality.

PROTECTING WEALTH

Reinvigorating and updating the CFPB to its purpose

The Consumer Financial Protection Bureau is one of the greatest policy achievements of the Dodd-Frank Financial Reform Act of 2010. Between 2010-2017, the agency brought the regulatory, research, and consumer education activities of the federal government in line with the dramatic changes in the financial services industry over the past two decades. During this same time, the agency returned over $12 billion to consumers who were the victims of predatory and illegal financial practices. It served as the moral center for the rapidly growing "fintech" marketplace where the rules were few and the opportunities to exploit consumers high.

It is crucial to restore the CFPB to its original mission to

7 For example, program operators in Oregon report that homeowners who have purchased a home through their IDA savings programs experience a myriad of long-term benefits. A year after graduating from the IDA program, 71 percent of savers report that they are using a budget and are confident in balancing expenses with income. Homeowners are keeping up with their mortgages—98 percent report they have not missed a monthly payment. 59 percent report using automatic savings to continue the habit of saving to build assets. Given the homeownership is still the primary way that Americans build wealth, scaling a national homeownership IDA initiative would not only address wealth inequality, but help community members create financial resilience and build assets, even after purchasing their homes.

pursue the crucial work of making the financial markets a fair and safe place for Americans to operate their financial lives. Perhaps the most urgent task is to renew their effort to regulate payday lending, a task to which the CFPB devoted years of research before issuing rules to prevent borrowers from falling into the trap of spiraling debt, as four out of five payday loans are usually rolled over or re-borrowed. The rule brought to this industry the lending standard that has worked so well (when enforced) in the mortgage markets: lenders must document a reasonable ability to repay by the borrower before issuing a loan for it not to be classified as "an unfair and abusive practice." It is leadership like this that is even more urgent in our COVID-19 moment when financial insecurity is at an all-time high among the communities that need access to capital the most.

Regulate fines and fees

San Francisco was the first city and county in the nation to create a Financial Justice Project to assess and reform how fees and fines impact the city's low-income residents and communities of color. Fines, fees, and financial penalties can trap low-income residents in poverty and increase racial and financial inequality and mass incarceration. Recently, they launched "Cities & Counties for Fine and Fee Justice" with PolicyLink and The Fines and Fees Justice Center to expand this work to 10 additional communities who are testing new ways to reduce the use of fines and fees as a means to a more just and inclusive economy. This expansion to 10 cities should be funded by philanthropy and then scaled by the government throughout the country if proven effective.

DEEP DIVE

MEASUREMENT, LEARNING & EVALUATION

JUNE 2020

MEASUREMENT, LEARNING & EVALUATION

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MEASUREMENT, LEARNING & EVALUATION

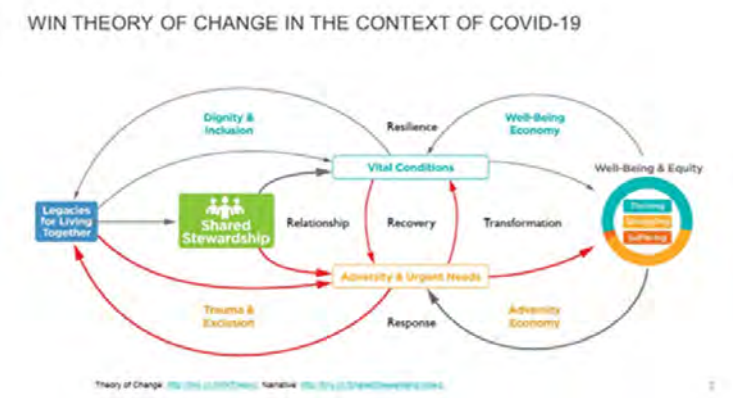
"Maybe stories are just data with a soul." —Brené Brown

INTRODUCTION

The COVID-19 pandemic has uncovered the societal fault lines of our nation's inequities. These fault lines, at the intersection of race, place, health, and wealth, have led to a pattern of surviving and thriving in some groups of people and of struggling, suffering, job loss, and premature death in many others. While these inequities have come into stark relief in the context of this pandemic, they reflect underlying conditions of interpersonal and structural racism and injustice which has contributed to a pernicious and perpetuated legacy of poor well-being for generations.

An equitable measurement approach to support a Springboard for Equitable Recovery and Resilience must therefore address both the COVID-19 pandemic today and build a path for equitable recovery and resilience in the future. Aligned with the overall theory of change, we propose a measurement system that answers the following questions:

- Was the COVID-19 response equitable in process and outcomes?
- Were the vital conditions needed for community resilience equitably advanced in the places that had the farthest to go?
- Did system transformation take place such that we:
  - Shifted inequitable legacies to reduce trauma and exclusion and advance dignity and inclusion in our processes of assessing, responding and planning?
  - Built relationships and shared stewardship between system stewards, community members and those affected by inequities?
  - Advanced civic infrastructure in measurement, data infrastructure and community process to create a more equitable and empowered response?
  - Changed policies, culture and systems to address the root causes of structural racism and other inequities?
- Did we create enabling systems to sustain these changes (changes in financing, data systems, etc) so that they become the new norm?
- Was there a difference in the percent of people surviving that bent the curve of inequities?
- Did the balance of people thriving, struggling, and suffering change in communities involved and in the nation over time?



This chapter of the Springboard outlines the key criteria of what such a measurement system could look like, informed by national organizations, communities and people with lived experience of inequities. It draws its measures from both community improvement efforts that equitably addressed community transformation, such as the 100 Million Healthier Lives SCALE initiative, and from several national measurement efforts that align efforts across sectors and chart a path toward an equitable learning measurement system to support a learning health system over the next decade, including the Well Being In the Nation measures and Healthy People 2030.

Finally, the authors offer a vision for what an equitable and connected data and measurement infrastructure could look like that allows community residents experiencing inequities, system change stewards, and policymakers to learn and create change together. A few building blocks for

these are detailed below.

AN EQUITABLE PROCESS TO ACHIEVE EQUITABLE OUTCOMES

A system can only achieve equitable outcomes if equity in process is part of its DNA. There are several key steps to achieving equity in process, based on our experience working with hundreds of communities around the nation. This adapts the 100 Million Healthier Lives Communities of Solutions frame to the WIN Theory of Change:

- **Leading from within.** An awareness and acknowledgment among a critical mass of stewards in a community of how past legacies have contributed to current outcomes.
- **Leading together.** The integration of system stewards, community facilitators and community residents with lived experience of inequities in co-design, co-implementation and co-evaluation of efforts.
- **Leading for outcomes.** The use of disaggregated data with a focus on understanding how people who experience inequities in particular are doing; a focus on measures and data that matter and are accessible to local communities as well as infrastructure to support community residents to ask and answer their own questions about their community's well-being and equity.
- **Leading for equity.** A targeted universalism approach which prioritizes populations experiencing inequities for programming and investments as part of assuring the vital conditions everyone needs to achieve well-being.
- **Leading for sustainable system change.** An examination of new and existing policies and systems that reproducibly perpetuate inequitable outcomes or are needed to achieve or sustain equitable outcomes.

AN EQUITABLE MEASUREMENT SELECTION

Our proposed approach to measurement offers a menu that was derived from the input of 100+ organizations and communities who collaborated together to develop the Well Being In the Nation (WIN) measures and tested these measures in communities. These communities also gave input into what measures matter to them in the context of COVID-19. However, we suggest that a few common measures be adopted across communities, while the rest of the measures—as well as additional measures that communities identify are relevant for them given their context—be used to guide improvement efforts. Communities vary widely in context, assets and focus. A common measure of thriving and surviving, with equity breakdown, can be complemented with the relevant measures by vital conditions, using WIN as a guide. Finally, we propose that communities be given tools to assess their own progress toward equitable system transformation.

AN EQUITABLE DATA INFRASTRUCTURE

Measures cannot be divorced from the systems that produce them, and equitable measures are difficult to create if those systems are siloed, inaccurate, or inherently biased. Therefore, attention must be paid to the ecosystem within which measures are created and the stages of their development: the idea of collecting data in the first place, defining what is to be collected, how it will be collected and by whom, responsibility for storage and security, how the data will be interpreted and disseminated, and any other element of data use and governance.

At each stage of data collection and management, those involved have the opportunity to reflect values of equity and the principle that community members and people with lived experience are able to exert stewardship and control over their own and their community's self-understanding and -description through data. This is especially important as the data systems created by community collaborations and institutions become more complex and sophisticated. This infrastructure—defined as the software, hardware, and systems that allow data to be shared over multiple organizations and uses—is expensive to create and maintain, and is not typically responsive to community definition and voice. For data to be sustainably equitable, the processes that generate it will need to be equitable as well.

IDENTIFYING MEASURES THAT MATTER TO UNDERSTAND THRIVING

The COVID-19 pandemic and associated physical distancing policies have elevated awareness of the broad array of factors that contribute to thriving, and have illuminated equity gaps in which people and places have access to these factors. The pandemic has highlighted the importance of financial stability and meaningful work,

social connectedness and support, trust in neighbors and in government, as well as physical, mental, and emotional health. Though inequities in these factors existed along racial and economic lines prior to the pandemic, it has both highlighted and exacerbated these inequities.

The United States has experienced higher rates of infections and deaths from COVID-19 among low-income and minority populations, as well as higher rates of unemployment and anxiety among these groups. As the United States and its communities prepare to emerge from the crisis set forth by the initial peak of the pandemic, it is paramount that we not only measure and track factors related to COVID-19 infection, but also the factors that contribute to equity and a high-quality life, as well as set up systems that promote better and more equitable outcomes in health and well-being in the future.

To develop a comprehensive measurement strategy that drives improvement in population health and well-being during both the response phase and the recovery phase—as well as the next 10 years as part of a larger equitable resilience phase—that leaves communities capable of responding to any pandemic, we must recognize that multiple factors and sectors affect the health and well-being of populations. As such, we must include holistic measures of health and well-being, such as thriving, in addition to measures of determinants or drivers of health and well-being, to guide recovery efforts and sustain equitable systems. Finally, all of these measures need to be evaluated using an equity lens that includes race, place, immigration status, and wealth. To drive collaborative improvement in population health and well-being, these measures must cross sectors; address economic and social determinants of health, well-being, and equity; and improve the health and well-being of people and of places.

EQUITABLY MEASURING THE HEALTH AND WELL-BEING OF PEOPLE AND PLACES

Measuring COVID-19

Measures that capture rates of new infections, severity of infections, and premature mortality from infections with SARS-CoV-2 are essential. In addition, measuring testing capacity is critical to monitoring and controlling spread. Also, tracking the economic and social effects of physical distancing policies is important to understanding fully tradeoffs being made between public health measures to manage disease spread and financial and social insecurity.

Measuring the well-being of people

The well-being of people captures and values how people think and feel about their own lives in a holistic, equitable way. We recommend using Cantril's Self-Anchoring Scale, a two-item measure of evaluative well-being that assess current life evaluation, future life optimism, and overall life evaluation, categorized into thriving, struggling, and suffering., This measure is well-validated and has been used to measure and track population well-being worldwide at the national level and within the United States at state and local levels for more than ten years. It is recommended by the OECD as a measure of population health and well-being. At the county level, thriving is associated with better population health outcomes.,,

We also recommend measuring other important domains of well-being, including perceived overall health, financial security, social connectedness, and sense of meaning and purpose in life. The 100 Million Healthier Lives Well-being Assessment is a brief tool composed of validated items to measure these different domains of well-being. These subjective measures of how a person is doing, in combination with an objective measure of health—life expectancy—provides a comprehensive picture of a population's health and well-being.

Measuring the well-being of places

Places (e.g., communities) provide the context within which the well-being of people may be achieved, and influences how easily well-being can be achieved. Understanding the well-being of places requires measuring the characteristics of places that contribute to placemaking and community life. These characteristics include the built and social environment. For example, walkability, perceived safety, and sense of belonging, as well as access to housing and reliable transportation, are several of the characteristics that describe a community and influence the health and well-being of the people who live there. To support communities in selecting measures of well-being of place, the National Committee on Vital and Health Statistics Framework for Community Health and Well-being adopted an index approach across the multiple domains of place.

Measuring equity

Eliminating differences in outcomes among different subpopulations is essential to achieving improvements in population health and well-being. Continually tracking key outcomes stratified by sociodemographic characteristics

that have historically been associated with poorer health and well-being outcomes is paramount. As described above, COVID-19 disproportionately affected communities of color, and it is essential to track outcomes in these subgroups if we are to know whether interventions are succeeding in reducing these inequities. We recommend stratifying all of the above measures by age group, gender identity, preferred language, race/ethnicity, and education level or income. In addition to tracking measures stratified by sociodemographics, it can also be helpful to measure the upstream structural, programmatic, or policy factors that create, sustain, and influence equity gaps.

DEVELOPING A MEASUREMENT STRATEGY

MEASURING FOR OUTCOMES, IMPROVEMENT, AND SYSTEMS TRANSFORMATION

We recommend using three complementary measurement strategies: measuring for outcomes, measuring for improvement, and measuring for systems transformation. Measuring for outcomes refers to using measurement to assess whether the intervention has resulted in an intended change (typically comparing the magnitude of an outcome measure before and after an intervention). Measuring for improvement refers to rapid-cycle measurement to assess whether processes are leading to desired outcomes and allows for adapting interventions as needed along the way. Measuring for systems transformation refers to a multi-level measurement strategy that includes a suite of process and outcome measures to assess whether all parts of a whole system are working together towards achieving the common goal(s).

Measuring for improvement is usually done using sequential, frequent, observable tests using small samples. The goal of measurement for improvement is to assess whether changes are actually leading to improvement. A measurement strategy for an improvement initiative involves tracking a parsimonious set or family of multiple measures (e.g., outcome, process, and balancing measures) with the data collection occurring frequently (e.g., monthly) to allow learning from rapid changes in support of improvement. Selecting a small, highly relevant set of measures that really matter to people is ideal, as is integrating data collection and tracking into usual workflow as best as possible. This measurement is best supported by the use of visual displays of data over time that inform and motivate improvement efforts (e.g., lead to adaptation of an activity).

In contrast, measuring for outcomes is performed less frequently and among a larger number of participants. The goal is to assess an outcome for an entire population. For this purpose, it is important to get information from all participants (whole cohort) or from a random sample of participants that can approximate results from all participants.

Measuring for whole systems transformation involves selecting and tracking measures that catalyze and sustain improvement in how community outcomes are produced. This involves choosing measures that drive collaboration across sectors and includes process and outcome measures as well as short- and long-term measures. Complementary measures are selected at multiple levels to assess each person's, site's, department's, and/or sector's contribution to the shared goal. In addition, variation in performance among sites can be identified and addressed.

Measure subjective and objective outcomes

To measure what matters, a measurement strategy will include not only objective measures (e.g., mortality rates from SARS-CoV-2 infection, income inequality) but also subjective measures (e.g., perceived safety, sense of belonging). Moreover, a holistic measurement strategy that supports "whole person, whole system, whole community" improvement will include measures of overall well-being (e.g., overall life evaluation) in addition to measures specific to a particular outcome or process (e.g., daily new COVID-19 diagnosis rate; social support)

Measure with passive versus active data collection

To design a measurement strategy that maximizes efficiency and reduces burden, we recommend using passive data collection when possible. Passive data collection utilizes data that are already being gathered for another purpose. Repurposing data that is already being collected is an efficient way to inform existing efforts.

It is important, however, to recognize that there may be limitations on how these data can be generalized and interpreted based on the mechanism by which they are collected for their originally intended purpose. We recommend performing a landscape analysis across sectors to understand what data are being collected that can also serve the current purpose, and then leveraging these data to contribute to the overall measurement strategy (e.g., using food purchase data). Then any available resources for

active data collection (e.g., surveying) can be allocated to collect complementary and highly important data, such as assessing subjective well-being.

Measure at multiple levels

Thriving for people and places is fostered or undermined by factors at multiple levels, from the community and systems levels to the interpersonal and individual levels. To understand the system of factors that are influencing thriving, and how improvement activities are changing them, it is essential to measure at multiple levels. Choosing measures that assess thriving at the individual level (i.e., residents' overall life evaluation), interpersonal level (i.e., levels of social support), community level (i.e., social capital, sense of belonging to community), and systems level (i.e., organizational collaboration) provides a mechanism to monitor that all of the interconnected parts of a community are being leveraged to collectively foster thriving.

When selecting measures, consider the below criteria adapted from National Quality Forum Measure Evaluation Criteria.

Category	Specific Criteria
Important	Potential to drive improvement in health Potential to drive improvement in social drivers of well-being Potential to drive improvement in equity Aligned with major national/global strategy Potential to develop new knowledge about what creates well-being
Objective & effective	Strong evidence that this improves health, well-being, and equity Valid Reliable Benchmarking available
Feasible	Data already collected, analyzed, and/or reported Cost of additional collection/availability of resources to support collection Burden of collection and reporting Groups ready to adopt
Usable & useful	Timeframe within which data changes Timeliness of data availability Usefulness to communities Usefulness to researchers/national stakeholders Meaningfulness to people with lived experience Level of data availability

MEASURING WHAT MATTERS IN THE CONTEXT OF COVID-19

Measures that matter in the context of the COVID-19 and associated physical distancing policies include measures that can drive improvement in the on-going response to the pandemic, improvement in inequities, and improvement in conditions that support community recovery, resilience, and transformation.

POTENTIAL TO DRIVE IMPROVEMENT IN RESPONSE TO COVID-19

To drive collaborative improvement in response to COVID-19, we recommend selecting measures that: include outcomes that matter across sectors, address economic and social determinants, and improve health, well-being, and equity of people and places. A measurement strategy that includes both health and well-being of people supports an integrative approach to monitoring outcomes such as mortality from COVID-19 and the economic and social implications of policies to limit spread of infection. Including well-being of place allows communities to understand how place-based factors both affect risk related to COVID-19 and are affected by COVID-19.

In selecting measures, consider those that assess the vital conditions for community health and well-being: basic needs for health and safety (e.g., COVID-19 testing, COVID-19 outcomes), humane housing (e.g., conditions, stability), reliable transportation (e.g., access, safety), thriving environment (e.g., drinking water safety, energy use), meaningful work and wealth (e.g., employment, small business closures), and lifelong learning (e.g., access to high quality childcare, equity in access to distance learning).

POTENTIAL TO DRIVE IMPROVEMENT IN INEQUITIES

Given the inequities that the COVID-19 crisis has not only illuminated, but also exacerbated, it is essential to include measures that assess equity over time and drive improvement in inequities. To assess equity, we recommend developing a measurement strategy in which process, outcome, and balancing measures are disaggregated or stratified across sociodemographic characteristics (e.g., race, ethnicity).

We also recommend measuring racism as well as upstream structural factors that create and maintain inequities. If communities do not pay close attention to inequities in health, well-being, and their determinants, their COVID-19

recovery efforts could maintain, or even worsen, existing inequities. Alternatively, if mindful, communities can use this crisis as an opportunity to improve systems to create and sustain gains in equity over time.

Potential to drive improvement in the vital conditions that support community recovery, resilience, and transformation

In striving for community recovery, resilience, and hopefully long-term transformation, communities may measure aspects of their community that support their efforts. The sense of belonging and civic muscle within a community can support recovery, resilience, and transformation. Measures to assess belonging and civic muscle might include measures of social connection, cohesion, and capital; loneliness and social isolation; financial stress and well-being; trust in community and government; discrimination, tolerance, and hate; and volunteerism and voting, among others.

In addition to belonging and civic muscle, other levers to create and strengthen community resilience have been described in the setting of recovery from natural disasters, and these levers can be adapted for recovery from the current pandemic as well as preparation for any future threats to population well-being. Physical resilience of people (i.e., physical health) and of places (i.e., infrastructure systems), psychological resilience (i.e., mental and emotional health), and organizational resilience (i.e., have built in redundancies and are capable of adapting quickly) have been described as key components of community resilience.

Other important levers for community resilience include measures aligned with the vital conditions, such as access to care, education (i.e., effectively informing the public of risks and preparedness), housing (including housing density), access to meaningful work and wealth, and civic infrastructure (i.e., promoting participatory decision-making). Using data to measure levels of resilience across each of these levers, and then tracking these data over time to drive improvement in each of these levers creates the vital conditions that support health and well-being of a community and that withstands threats to the health and well-being of that community.

BALANCING PROCESS AND OUTCOME MEASURES

To encourage community transformation, we recommend a measurement strategy that includes a balance of process and outcome measures. Process measures that support transformation include those that assess and track elements of community transformation frameworks such as Collective Impact and Community of Solutions., These include process measures such as development of stewardship, community engagement, and numbers of system changes implemented. Outcome measures that drive transformation include changes in percentage of population thriving, struggling, and suffering; years of potential life gained for populations at risk; mortality rates from COVID-19; and composite metrics such as health adjusted life expectancy or well-being adjusted life years (in development).

In selecting outcome measures, we recommend considering measuring outcomes related to COVID-19, well-being of people, well-being of places, and equity. We have highlighted measures that should be part of a core measure set below with an asterisk. Here is a table with selected measures to consider in each of these areas.

Area	Outcomes to Consider	Measures to Consider
COVID Outcomes	COVID-19 mortality*	Mortality rate from COVID-19
	Years of potential life lost due to COVID-19*	Years of potential life lost before age 75 attributed to COVID-19
	COVID-19 testing*	Rates of COVID-19 testing
	New COVID-19 cases	Daily rates of new COVID cases
	Excess unemployment *	Unemployment rate above expected based on historical trends

MEASUREMENT, LEARNING & EVALUATION

Area	Outcomes to Consider	Measures to Consider
Well-being of People	People's perception of their own well-being*	Cantril's ladder: • Mean current life satisfaction • Percent of people thriving, percent of people struggling, percent of people suffering
	Life expectancy*	Life expectancy at birth
	Hopefulness*	Cantril's ladder: Mean difference between future life optimism and current life satisfaction; percent of people with future life optimism greater than current life satisfaction
	Social support*	Percent of adults 18 years and over who report not receiving sufficient social-emotional support
	Social isolation*	Percent of adults reporting feeling lonely
	Racism*	Percent of adults who have felt emotionally upset, for example angry, sad, or frustrated, as a result of how they were treated based on their race in the past 30 days
	Mental Health*	Deaths of despair: Deaths due to drug overdose, alcohol, or suicide (# per 100,000 population)
	Substance use*	Rates of binge drinking or rates of ED visits and hospitalizations for alcohol intoxication and opioid overdose
Well-being of Places related to the Vital Conditions	**Basic Needs for Health & Safety:** Child poverty rate*	Percent of population under age 18 living under 100 percent of the federal poverty level
	Basic Needs for Health & Safety: Social/policy protections	Number of people receiving public benefits (e.g., unemployment, SNAP benefits, free/reduced lunch)
	Basic Needs for Health & Safety: Food insecurity	Percent of population who state that within the past 12 months were worried that food would run out before having money to buy more
	Lifelong Learning: High school graduation rate*	Percent of students who graduate high school within 4 years of entering 9th grade
	Lifelong Learning 3rd grade reading level	Percent of students entering 4th grade who are at age-appropriate reading level
	Lifelong Learning, Basic Needs for Health & Safety, Meaningful Work and Wealth Access to internet*	Percent of people with access to high-speed internet or smartphone
	Meaningful Work and Wealth: Unemployment rate	Unemployment rate: percent of civilian labor force, age 16 and older, that is unemployed but seeking work
	Meaningful Work and Wealth: Financial insecurity*	Percent of adults who would still be able to pay all of their current month's bills in full if faced with a $400 emergency expense
	Meaningful Work and Wealth: Childcare	Availability of childcare (measure in development)
	Humane Housing: Household size	Number of people residing in a household
	Humane Housing: Homelessness	One-day sheltered homeless rate (number per 10,000)
	Reliable Transportation: Access to transportation	Percent of people commuting by each: car, foot, bike, public transport, and working from home
	Belonging & Civic Muscle: Trust in government*	Percent of adults who trust and have confidence in the local governments in the area where they live when it comes to handling local problems
	Belonging & Civic Muscle: Trust in police*	Percent of adults who trust their local police department to make decisions that are good for everyone in their city
	Belonging & Civic Muscle: Voting rate	Percent of total voting- age citizens who cast votes in the most recent mid-term or presidential election
	Belonging & Civic Muscle: Community belonging*	Percent reporting strong sense of belonging to community

Area	Outcomes to Consider	Measures to Consider
Equity	Differences in COVID-19 mortality rates*	Mortality rate from COVID-19, stratified by differences in demographic factors
	Differences in premature death from COVID-19 and in general*	Years of potential life lost attributed to COVID-19 and in general before age 75, stratified by differences in demographic factors (per 100,000 population)
	Differences in rates of new COVID-19 cases	Daily rates of new COVID-19 cases, stratified by differences in demographic factors
	Differences in rates of COVID-19 testing	Rates of testing for COVID-19, stratified by differences in demographic factors
	Differences in excess unemployment*	Unemployment rate above expected based on historical trends, stratified by differences in demographic factors
	Area deprivation index or social vulnerability index*	Multidimensional evaluation of a region's socioeconomic conditions, which have been linked to health outcomes
	Differences in hopefulness	Hopefulness, stratified by differences in demographic factors
	Income inequality	County GINI coefficient for income inequality
	Differences by sociodemographic factors in other measures that matter*	Race/ethnicity, age, place (zip code), urban/rural, gender identity, primary language, educational attainment

To identify other measures to include in a measurement strategy to optimize community response to, recovery from, and transformation through COVID-19, we recommend using the Well-being in the Nation measure set as a resource, particularly for measures of vital conditions for well-being. Example measures include overall health (percent of adults self-reporting fair or poor general health), early education (percent of 4th-grade students reaching "proficient" or above in English Language Arts standardized test), built environment (Walkability Index), and public safety (percent of adults who feel safe walking on their street after dark), among many others.

MEASURING SYSTEM CHANGES

> *"Every system is perfectly designed to get the outcomes it gets." —Dr. Paul Batalden*

Current systems structure in the United States created the context within which SARS-CoV-2 was able to rapidly spread among a population with high levels of chronic disease, leading to massive rates of infection and death, as well as stark inequities along racial and economic lines in these rates of infection and death. To alter these trends, systems transformation is necessary not only in the near term to prevent spread of infection, but also to set up for successfully achieving the goal of better and more equitable population health and well-being outcomes over the next ten years.

Measurement should be used to constructively guide this transformation. Strategically choosing measures that catalyze cross-sector collaboration, such as thriving, increases likelihood of success over time.

Whether it is educating fourth graders, increasing access to green spaces for exercise and socialization, caring for the elderly, or providing access to safe, efficient, and reliable transportation—every sector understands what they can contribute to creating a thriving community, making it easier for us all to work together to achieve a shared goal. In addition, having more proximal measures relevant to each sector is also important in order to understand whether planned progress within each sector has intended effects both on the sector-specific measure(s) and on the shared goal of increasing percent thriving.

We recommend choosing, measuring, and tracking process and outcome measures over time that are inclusive of all collaborating sectors to create a "learning management system" that uses harmonized data shared transparently to work together to achieve a common goal of creating an equitable, thriving community.

This learning management system can inform the journey towards a thriving community, with guideposts designated by tools such as the community transformation map or the AACT tool. These self-assessment tools, which have been tested in 100+ communities each, offer a readiness-capability model for communities on the journey to equitable processes and outcomes. Rather than asking

communities to assess whether they are equitable on a Likert scale, they integrate an understanding of what improvement looks like into the tool itself, with links to resources for communities to advance their outcomes. For example:

- Are community residents with lived experiences of inequities integrated through surveys? Focus groups? Part of the improvement team? Co-leading work and helping to set priorities and identify solutions? Each of these might represent a different stage of development.
- Similarly, who has access to the data for the community? Is it understandable at a 5th grade level? Who helps to interpret it? Who helps to set priorities for data collection?

Most communities desire to be equitable, but have not mapped the processes they would need to follow or set goals around these. Tools like the CTM, which are useful to communities and can be leveraged for evaluation, help to bridge this gap.

Each community has different capacities and capabilities for measurement that range from minimal to robust. At minimum, we recommend selecting and tracking meaningful measures that are passively being collected across as many sectors as possible. Stratifying these measures by sociodemographic characteristics that have been historically associated with inequities is critical. If possible, we also recommend obtaining other relevant objective measures (e.g., COVID-19 testing rates) and subjective data (e.g., perceived well-being). These measures should be obtained as frequently as possible to be able to monitor trends over time. They should then be reviewed among a community-wide, multi-stakeholder, cross-sector collaborative to implement changes to improve selected measures.

An example worth noting comes from the Delaware Department of Substance Abuse and Mental Health, which used well-being measures in real time to identify who in their population might not be thriving, and in what domain. By assessing Cantril's ladder and additional questions related to financial insecurity, loneliness, and social support, they were able to identify a substantial increase in suffering in these areas. They rapidly mobilized to provide support—from unemployment benefits to housing, to legal aid, to peer supports—and have now watched the percentage of people suffering return to close to baseline.

BUILDING AN EQUITABLE AND CONNECTED DATA AND MEASUREMENT INFRASTRUCTURE

Much has, and should be made, of the need to create and use standardized measures of health, well-being, and equity. Less attention, however, has been paid to the source of those equitable measures. We outline below the principles of equitable and connected data and measurement infrastructure.

Equitable ownership and access

An equitable and connected data infrastructure is necessary to support the systems that address individual suffering and development as well as to support the policy and system change toward a society that prioritizes well-being. Equitable data systems are those that reflect the operational and measurement priorities of those who use them, including persons with lived experience, the organizations that work with them, their partners in program operations and data exchange, and their funders, public or private. The key to making equitable and connected data instratructure is to ground all aspects of the system development and use the experience and control of the people and communities whose experiences are documented in the systems.

The role of connected data systems is to support a variety of functions, such as assessment, service delivery, resource and referral management, reporting, advocac,y and measurement. Communities across the country are at all different stages of system development, from gathering and planning to full-fledged multi-sector data interchange. These data "systems" range from simple shared spreadsheets to sophisticated community information exchanges, and usually begin in response to a local expression of a need or opportunity felt by multiple people in a single community. Examples include community dashboards and engagement platforms, geographic hotspotting and targeting, platforms that support universal needs screening and community resource referrals, open data initiatives, integrated data systems, and health and community information exchanges.

For many community-based health and human service organizations, their first exposure to data management systems was primarily for funder metrics reporting. For organizations that have been able to piece together components of a "client information system," they are

often required to maintain multiple systems that require duplicate data entry, have limited internal reporting tools, and allow for no interconnection between them.

This tradition of providing community-based organizations with technology that benefits external partners to the exclusion of the CBO continues with the rash of information and referral platforms that enable health care entities to interact with social service providers. Typically, the value of those connections is realized by clinical providers that provide the system, because access to the software does not typically come with additional resources for the services provided or for the participants being referred. Equitable ownership and control over data is proposed as an equalizer. These points are addressed further under data sharing agreements and protections below.

Data infrastructure for coordinated response and resilience

An equitable data and measurement infrastructure should enable coordinated response across sectors to support individuals and families and tracking of data at a local level to see if areas with historically poorer outcomes are catching up. Unfortunately, there are serious limitations to existing data. The US Small-area Life Expectancy Estimates Project (USALEEP) data demonstrate dramatic differences in life expectancies across small distances. Similarly the COVID-19 pandemic has laid bare extreme inequities in vulnerability to exposure, morbidity, and death.

Sharing data across sectors for coordinated response is hampered by trends we have already seen in the sharing of health care data (data silos, lack of standards, lack of will to share with market competitors, top down approaches, inadequate legal framework) and made worse because leaders in different sectors lack a shared language and vision. Most importantly, there is little financial incentive to share data, which drives *trade-offs* between:

- Granularity and timeliness: Data collected at a local level is often averaged over multiple years, or not collected with sufficient frequency to measure change over time
- Granularity and precision: Small numbers lead to wide confidence intervals and inability to make inferences about differences in estimates over time and place.

Local data may not exist for rural areas or small towns: having a sufficient sample requires including a larger geographic area—averages thus do not represent localities

To address current weaknesses, we recommend maximizing the use of connected data systems composed of data collected in the course of providing services, and investment in systems to collect hyperlocal data directly from community members and people with lived experience.

Connected data systems

Frequently, measurement for improvement takes advantage of data generated as part of operations. Data are collected from individuals and families in the course of providing health, social, educational, or other services. Increasingly, health care, public health, community based organizations and others are connecting these data systems as they work to build systems of care across sectors that address the health and social needs of individuals and families in a coordinated manner. Such data allow service providers to screen for multi-faceted health and social needs, make referrals across sectoral boundaries, divert people from inappropriate settings (such as the criminal justice system or emergency departments) to address the underlying issue, among other benefits.

Where developed and integrated, these connected data systems have been applied to respond to the COVID-19 pandemic.

- LA County redirected their data hub to begin focusing on the response to the virus and related factors by: identifying homeless clients with a positive COVID-19 diagnosis to limit contact and promoting safe isolation practices, informing shelter workers of a positive COVID-19 diagnosis so that they can take appropriate precautions.
- Allegheny County has developed internal and public facing dashboards to monitor the impact of COVID-19 on the county's most vulnerable residents. Examples include a public facing dashboard that monitors calls to child welfare, calls for housing assistance, calls for involuntary commitments, calls for older adult protective services, etc.
- Children's Optimal Health in Austin is working with United Way to analyze the 211 data to understand the requests for assistance they are receiving. They

are creating a set of maps for a multi-county area looking at requests by ZIP related to housing, food, utility assistance, health care, unemployment, financial assistance, and possibly other areas. We are tracking need requests as they change over time.

While there are bright spots such as these described above, it is important to note that data systems supporting health and social service screening and referral also have significant limitations: the majority of initiatives do not have a sustainable funding source; and many efforts originated by health care entities do not prioritize equitable participation of community residents or community based service providers.

Importantly, these systems should not be used to create narrow networks, new data silos, or require community based organizations to participate in multiple platforms; they should facilitate measurement at the community (population) level, not only for a specific set of clients or patients.

Collecting Hyperlocal Data

Community dashboards that include visualization and mapping are an important component of a data ecosystem for measuring well-being and addressing the immediate and long-term needs of a resilient community. There are many examples of such dashboards being leveraged for responding to COVID-19 and documenting resilience for the future. Open data initiatives are important policy and infrastructure components enabling these dashboards.

Western Pennsylvania Regional Data Center maps assets available for COVID-19 response, using a dataset originally developed for Census 2020 outreach. The Data Center provides a technological and legal infrastructure for data sharing to support a growing ecosystem of data providers and data users; it maintains Allegheny County and the City of Pittsburgh's open data portal, provides a number of services to data publishers and users, and is managed by the University of Pittsburgh's Center for Social and Urban Research, a partnership of the University, Allegheny County and the City of Pittsburgh.

Data sharing and agreements

Effective and collaborative data sharing depends on the cultivation of authentic relationships with clearly defined use cases for sharing data. Self-determination is a collective human right that ensures personal freedom to make decisions about an individual's data. The design of equitable data agreements to protect the individual while enabling meaningful cross sector collaboration is critical. Data use and consent require substantial investments in the mindful creation of policy leveraging the existing legal and regulatory framework. This complicated process to identify the applicable laws for the persons involved, the data sharing partners, the data itself, and the particular use case is lengthy.

Data sought is often governed by consent to share. Privacy and data sharing policies and laws are constructed to protect individuals and individual health data. When equity and well-being are centered on a person and their data is utilized to support the ultimate goal of health and well-being, community organizations are better able to provide the supports needed to meet that individual where they are.

Community based organizations share a collective commitment to mission and vision that drives the need for person-granted access to data. For example,

> *"If the COVID-19 response is to be effective, it must be underpinned by robust science and quick access to data. Some of this data will constitute personal data and so be regulated by data protection rules. (It is important to note that data that is not personal may be shared freely, as far as privacy and data protection law are concerned, but must still be done in a way that is ethical, compliant with human rights, and public trust.)"*

Attention to the Social Determinants of Health (SDOH) have expanded the interest in non-medical personal data to identify key factors that contribute to access and availability of resources for health and well-being. Types of data sharing (i.e. individual level or population level) will identify data sharing platforms, existing agreements, and key governmental or non-governmental partners that can be helpful. Data sharing and agreements are critical to extend these protections in communication with partners. Cross sector organizations likely have unique data, systems, reporting and agreements that govern each.

> Advancing Data-Driven Partnerships: Accountable care organizations, accountable communities for health, and the federally-driven CMMI AHC model (mentioned above) are all emerging examples of data-driven partnerships

between health providers and CBOs. A July 2017 national request for information (RFI) survey, carried out by the Scripps Gerontology Center at Miami University, discovered that nearly half of the 593 responding CBOs already have or are pursuing partnerships with healthcare providers. Many of these partnerships have established some form of data sharing that enables the CBO to share data about client referrals with the health provider. For example, a Washington accountable care organization is receiving data through dashboards hosted as part of the state's Analytics, Research and Measurement (ARM) strategy.

In the context of well being and health equity the role of existing legal and policy constructs can serve as guideposts to determine what rules apply, how to be compliant and how these can be the foundation to build upon new community focused data sharing agreements.

THE VISION FOR DATA INTEROPERABILITY

A lack of interoperability hinders data sharing within health care and across human service sectors. Interoperability is "the ability of different information systems, devices and applications ('systems') to access, exchange, integrate and cooperatively use data in a coordinated manner, within and across organizational, regional and national boundaries, to provide timely and seamless portability of information and optimize the health of individuals and populations globally."

Achieving interoperability is a compelling vision but many barriers must be overcome for it to be realized. Data do not in fact flow seamlessly across sectors. Efforts are underway to develop standards where needed, promote adoption of standards and map concepts and data elements across domains. For instance, health care systems have not traditionally measured social factors such as housing status, transportation needs, or food insecurity. The Gravity Project seeks to standardize definitions and codes to store these data within health care data systems, and then produce implementation guides. Implementing the codes will require policy and funding. As new software systems expand explicitly to collect social determinants data for exchange between health and community services, it is important to ensure that those systems don't also create new data silos and barriers to interoperability.

Within human and other community services, efforts are being made at Federal and state levels to standardize around the National Information Exchange Model (NIEM). This work requires commitment and investment to update many legacy systems. As that proceeds, connecting across NIEM and health care standards will be a challenge. "As NIEM's adoption continues to expand, non-clinical NIEM domains that utilize health data elements for information exchange will require support to successfully navigate through the complexities of the health IT/health information exchange (HIE) environment. Furthermore, operational health IT/HIE safeguards must be in place to ensure the legal, secure and private exchange of health information." The National Interoperability Collaborative seeks to demonstrate further that it is possible to map data items between health care data standards and NIEM.

INDIVIDUAL AND COMMUNITY PROTECTIONS TO ENSURE RESILIENCY

While shared data systems have the capability to inform better interventions, they can also exacerbate inequities. Practitioners must go further to identify root causes to the inequities we see reproduced in data, and form interventions that address and protect. These interventions, which also include legal and data protections, are constantly evolving, with some emerging out of the COVID-19 epidemic. Though we may be well intentioned in our pursuit for equitable data, below are common examples of how inequities can be reproduced in a data system, and ways they can be addressed.

For multi-sector data sharing, the goal is to connect data that appears in siloes or that one sector would not have had access to without a partnership or data-sharing agreement in place. Because of the nature of one-dimensional data, sectors may have a hard time agreeing on what to report, what to collect, etc. The UK Department for Digital, Media, Culture & Sport recommends interrogating these questions at the onset of the data collection process by demonstrating clear intent and public benefit.

Protections challenge our notions of who needs access to what data and why. As digital technology and its use as a data collection tool become widespread, more and more communities ask about their privacy. Actionable Intelligence for Social Policy recommends looking at a data sharing initiative's benefit and risk along an axis grid, with those actions being considered a high-benefit to society and a low risk to vulnerable populations being most ideal (such as mapping initiatives that allocate resources to high-

need communities); and steering away from low-benefit, high-risk behaviors such as sharing social media activity to local law enforcements.

Even more so important during the COVID-19 pandemic, policy can enforce or push for certain reporting criteria. This is with the caveat that some data sharing endeavors can be low-risk, high-benefit, and others can have a high risk (which we want to avoid). An example of a low-risk and high-benefit data sharing move is the push by Data4BlackLives to record open data reported by race during the peak of COVID-19 cases in the United States. Explicit reporting by race lets practitioners and researchers alike understand disparate impact and potential reasons. Strategies such as these, in turn, allow public servants to see what short-term (i.e. providing PPE to essential workers) and long-term (increasing funding to hospitals, staffing capacity in a heavily impacted area) interventions are possible, feasible, and equitable.

Among all of these recommendations is the suggestion to continue to involve community members in the data sharing and collection process. Ensuring that the language and technology we use is accessible to all will increase the potential for vulnerable populations to be able to have power over their data and its impacts. Creating and maintaining equitable data systems is an active process. The data we use must measure how successful our policy and programmatic changes have been; as well as continue to develop baselines and progress points towards community goals. As such, data harm mitigation practices can offer an opportunity to rethink what community engagement and public access can look like.

THE PATH FORWARD

Recommendations for a learning measurement system to support a resilient and equitable health and well-being strategy

We have been learning at an unparalleled pace in the context of the COVID-19 pandemic, which has resulted in not only massive shifts in public health and health care, but also in the economy, modes of social connection, and mental health. The sections above outline specific recommended measures for thriving, struggling, and suffering, as well as for an equitable measurement process and equitable data infrastructure to support resilience. We recommend:

- A small set of common measures to assess overall outcomes, along with a menu of measures based on the vital conditions, with additional measures available in the WIN measures and other sources that relate to the vital conditions for well-being.
- A balance between people reported outcome measures to assess thriving, struggling, and suffering, using tools such as Cantril's ladder, and objective measures such as years of life lost or gained.
- An equitable process by which communities identify measures that matter among the vital conditions that relate to the context of their communities.
- A process for communities to assess their own journey in equitable transformation.
- The development of an equitable data infrastructure that is accessible to community residents, connected and interoperable across sectors, and equitably governed.

A Springboard for equitable recovery and resilience would be incomplete without an equitable learning and measurement system across sectors and that can help us learn quickly and adapt our systems rapidly. To support the development of such a system, we recommend that Congress invest in the development of an equitable data and measurement infrastructure across communities with a focus on communities that are most affected by inequitable outcomes from COVID-19 and underlying social vulnerability.

In addition, we recommend that the Federal Data Strategy and measurement approach be aligned to give communities the supports they need. In particular, we recommend that:

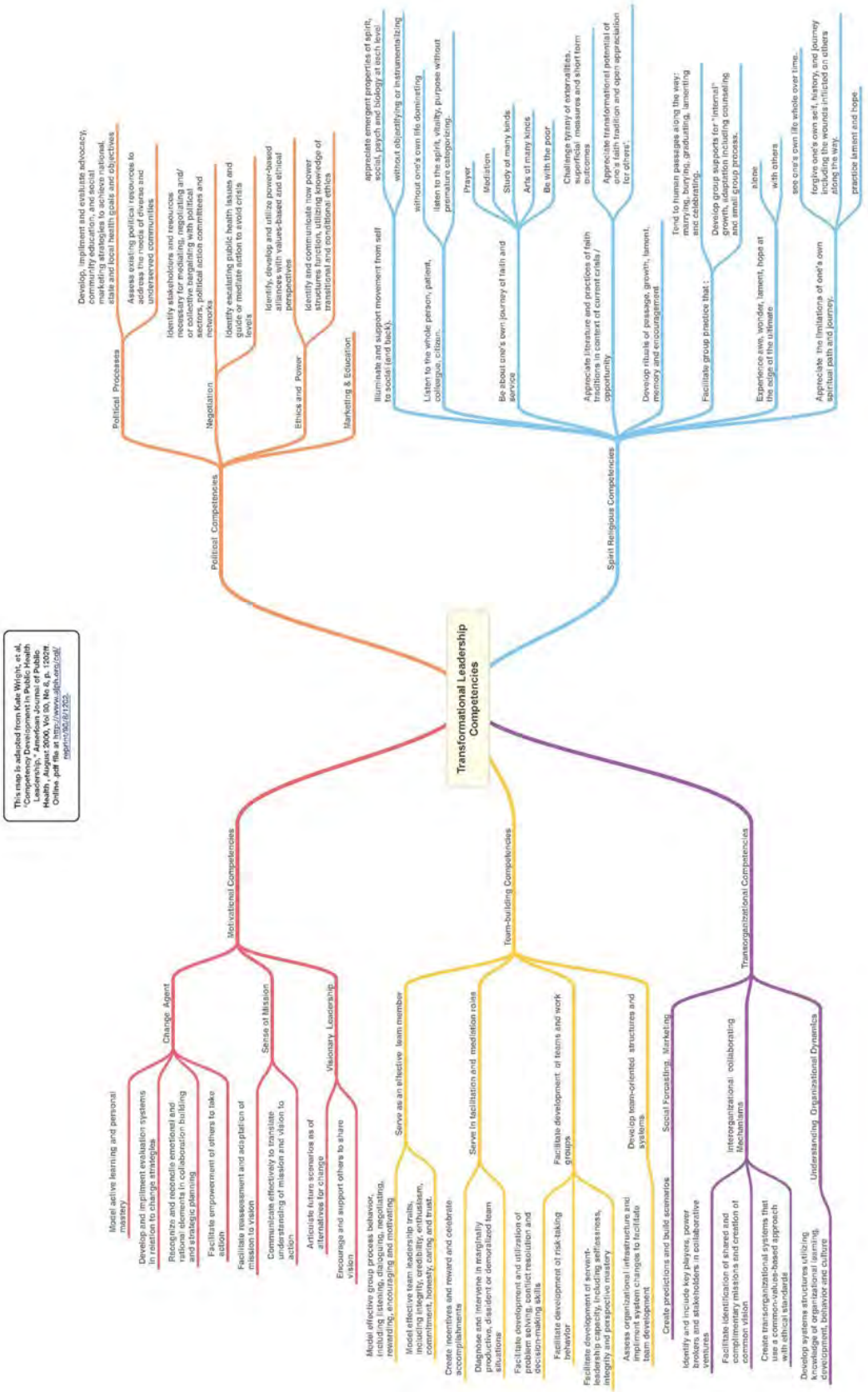
- Federal data, gathered at taxpayer expense, needs to be publicly available and accessible in an equitable way to local communities, meaning at the sub-county level or lower.
- The input of communities and other cross-sector stakeholders should drive national priorities in the federal data strategy, in addition to the input of federal agencies.
    - This includes what data is accessible to support measurement, based on a process that has received substantial input from communities and nonfederal stakeholders, such as Well-Being

In the Nation measurement framework (which includes data related to the County Health Rankings and Roadmaps and the US News and World Report Healthiest Community Rankings) and the measures included in this Springboard.

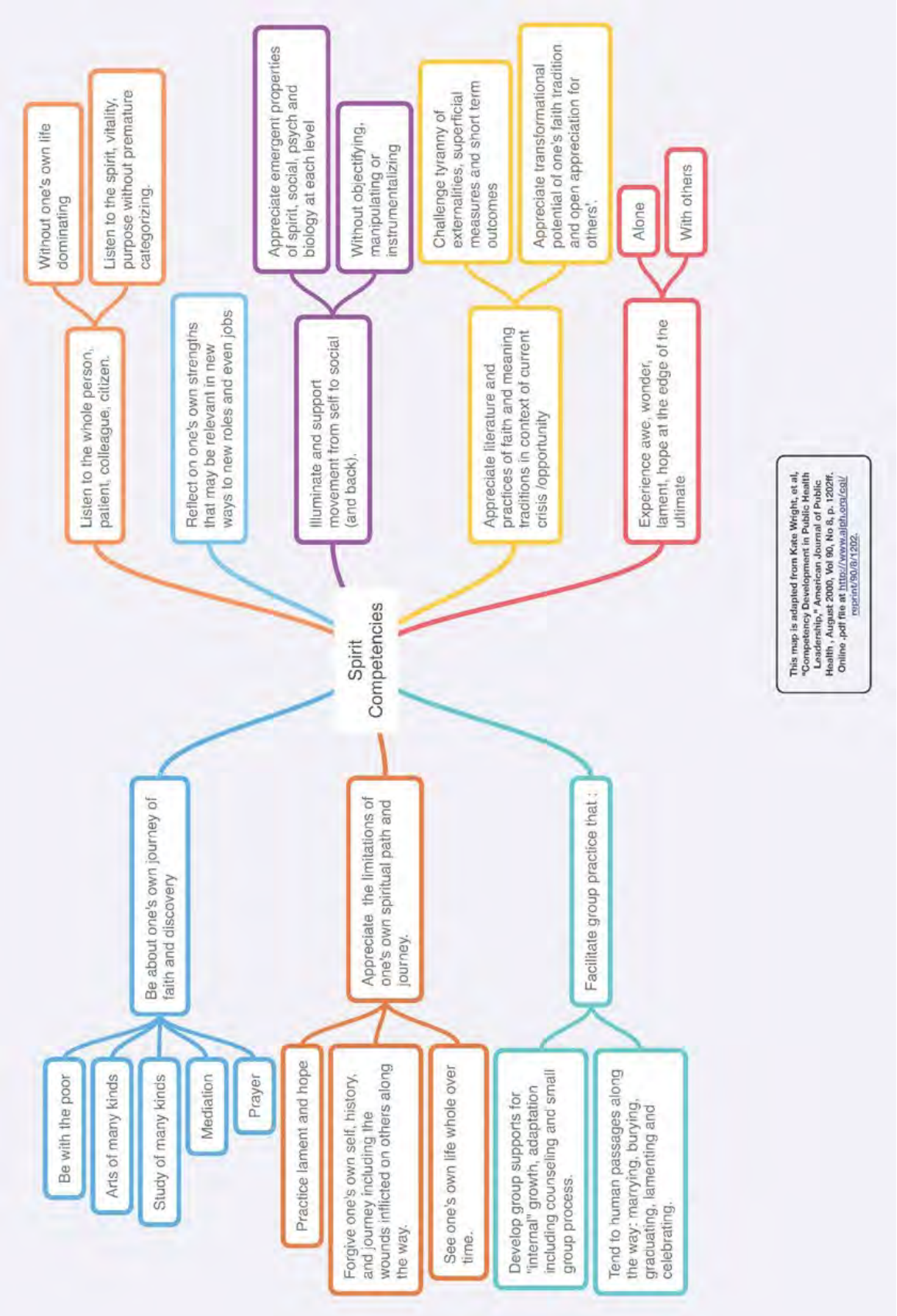
  - Where analytic capability is focused to collect and make data available at the local (sub-county) level.
  - How data are made available for sociodemographic subpopulations to assure that we can understand disproportionate harm as well as opportunities.
  - How data is available at the local level to support national objectives, such as those captured in Healthy People 2030.

- Identification of data priorities should be based on fair and equitable processes, and ideally a public-private partnership, such as the one conducted for the development of the Well Being In the Nation measures to identify these priorities.
- Data availability and capacity-building for local communities to use the data be achieved through public-private partnerships in collaboration with federal agencies.
- Protections be put into place to assure that data cannot be used to target a population or individuals in any way that would adversely impact their well-being.
- Passive data be utilized, with consent from people whose data it is and that such data be made publicly accessible in the commons.
- Use of algorithmic based data be approved by a data equity expert before being used or supported by federal or state dollars.

FAITH: FIGURE 1



FAITH: FIGURE 2



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