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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 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

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 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

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 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

10 https://www.commonwealthfund.org/blog/2016/closing-equity-gap-health-care-black-americans
11 https://ehe.amfar.org/inequity?_ga=2.51214761.1618924293.1588715818-1730120696.1588715818

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 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

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/

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 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

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

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 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

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

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 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

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.

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/

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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

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

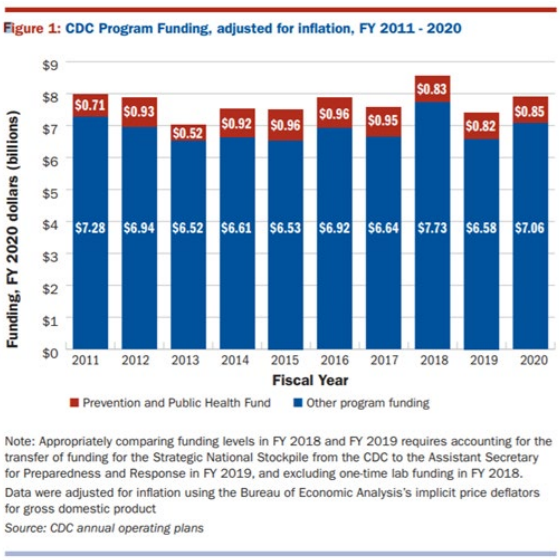
3 Merrick MT, Ford DC, Ports KA, et al. Vital Signs: Estimated Proportion of Adult Health Problems Attributable to Adverse Childhood Experiences and Implications for Prevention — 25 States, 2015–2017. MMWR Morb Mortal Wkly Rep 2019;68:999-1005. DOI: http://dx.doi.org/10.15585/mmwr.mm6844e1

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.

development sectors. More and more health agencies have re-focused their attention on the promotion of equity and the multi-sectoral and systemic factors that limit opportunities for certain populations to achieve good health.



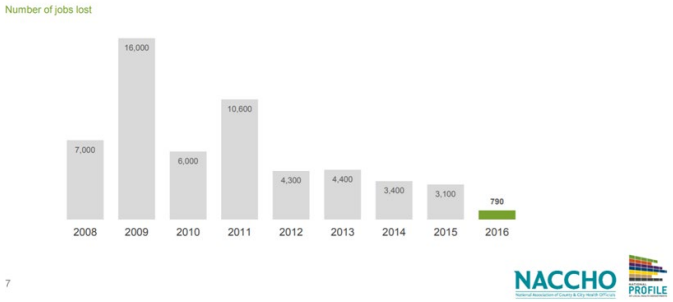
The Centers for Disease Control and Prevention (CDC) has developed innovative initiatives that address social and emotional health in the Centers of Injury Prevention and Control and the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, among other locations. Yet, such funding has 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	106,459	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.

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

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

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

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

with elevated exposure to COVID-19. They are exposed to more environmental health risks including air pollution and lead.[15,16] And they are more likely to live in overcrowded, 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

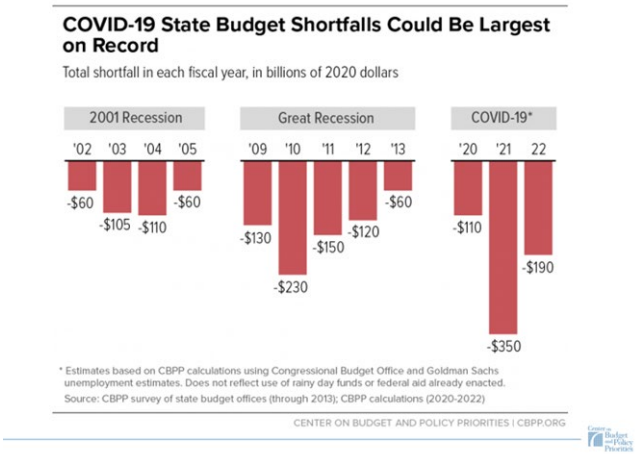
16 American Lung Association. Urban air pollution and health inequities: A workshop report. Environ Health Perspect. 2001; 109 (suppl 3): 357-374

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

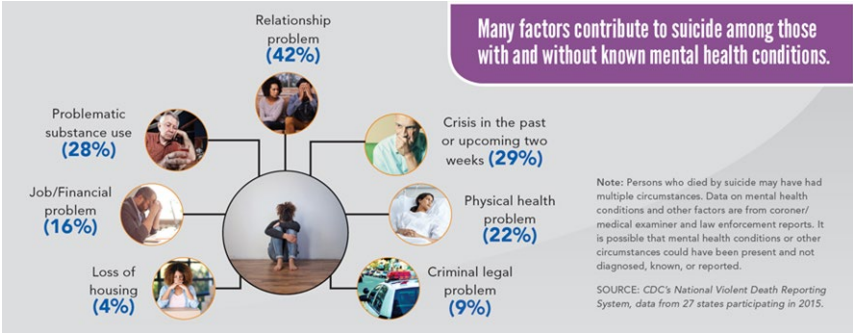
19 Department of Labor. https://www.dol.gov/ui/data.pdf

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



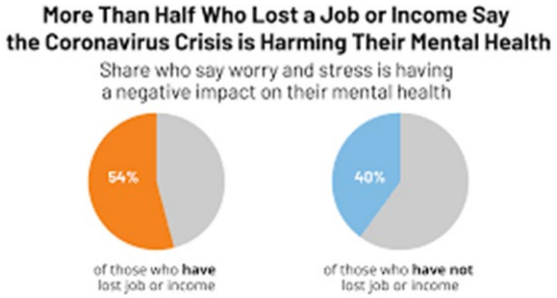
Increased deaths of despair

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

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

workforce in health departments. Such support would have resulted 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

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

any aspect of behavioral health or on policies with a significant impact on behavioral health (such as HUD, 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

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

health. This requires close partnerships with those in other sectors such as health, housing, transportation, education, 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.

BASIC NEEDS: HEALTH CARE

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

1 Tikkanen R. Multinational Comparisons of Health Systems Data, 2019. The Commonwealth Fund. January 30, 2020. https://www.commonwealthfund.org/publications/other-publication/2020/jan/multinational-comparisons-health-systems-data-2019

2 Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths. Centers for Disease Control and Prevention website. https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html. Published September 5, 2019. Accessed June 4, 2020

3 Wyatt R. Age and race are social determinants of health. Aging Today. 2016 Jan/Feb:15

4 Williams D. "Race, Racism, and Racial Inequalities in Health." Presentation to Harvard Kennedy School Multidisciplinary Program in Inequality and Social Policy. February 8, 2016. http://inequality.hks.harvard.edu/files/inequality/files/williams16slides.pptx?m=1455915158

5 Signorello LB, Cohen SS, Williams DR, Munro HM, Hargreaves MK, Blot WJ. Socioeconomic status, race, and mortality: A prospective cohort study. American Journal of Public Health. 2014;104(12):e98-e107.

6 Deaths by place of death, age, race, and sex: United States, 2005. National Center for Health Statistics, Centers for Disease Control. https://www.cdc.gov/nchs/data/dvs/Mortfinal2005_worktable_309.pdf

7 A population-based study of sexual orientation identity and gender differences in adult health. Conron KJ, Mimiaga MJ, Landers SJ. Am J Public Health. 2010;100:1953–1960.

8 Gay and lesbian homeless/street youth: special issues and concerns. Kruks G. J Adolesc Health. 1991;12:515–518.

9 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.

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

preventable 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-

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.

level impacts on society as a whole. A common thread that runs through them all is the notion of uncertainty; it is a 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

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.

contribute to this inequity —economic barriers, impact of quarantine, lack of testing, and structural inequities within 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

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

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.

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

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.
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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.

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.

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

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

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

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 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

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.

partnerships to 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

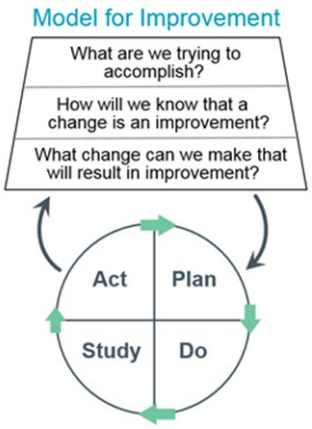
77 Lived Experience Advisory Council. Nothing About Us Without Us: Seven Principles for Leadership and Inclusion of People with Lived Experience of Homelessness. Toronto, Canada: The Homeless Hub Press; 2016.
78 Batalden M, Batalden P, Margolis P, et al. Coproduction of healthcare service. BMJ Qual Saf. 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.

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 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]

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

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

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

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

comprehensive housing navigation 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

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)

medical debt for those in the community through an 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,

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.

anti-racist effort to improve the wellbeing of marginalized 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

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

structural racism and injustice.

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

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/0d60c6de567e/covid-19-unique-opportunity-for-health-data
118 Robeznieks A. National COVID-19 patient data vital to fixing inequity. American Medical Association. April 24, 2020. https://www.ama-assn.org/delivering-care/health-equity/national-covid-19-patient-data-vital-fixing-inequity. Accessed June 4, 2020.
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
120 How to Address Equity as Part of COVID-19 Incident Command. Institute for Healthcare Improvement. May 6, 2020. http://www.ihi.org/communities/blogs/how-to-address-equity-as-part-of-covid-19-incident-command. Accessed June 5, 2020
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.

decision making power and to consider equity-creating processes—new ways of working and being that can get us 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.

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
125
126

Eliminate racism and other forms of oppression

Health care organizations must look at their systems, 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

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

care (equitable, patient centered, safe, effective, timely, efficient), and lower costs (more equitable, effective and intentional 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]

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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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- Immediate actions: Health care leaders can pause, 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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140

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

- 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

Center. J Midwifery Womens Health. 2019;64(5):592-597. doi:10.1111/jmwh.13018.

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.

collaboration is rewarded.

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

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/

149 Manchanda R. Three Workforce Strategies To Help COVID Affected Communities | Health Affairs. Health Affairs Blog. Published May 9, 2020. https://www.healthaffairs.org/do/10.1377/hblog20200507.525599/full/. Accessed June 5, 2020.

150 American Diabetes Association, American Public Health Association, Community Health Action Partnership, et al. Letter to Congress. Published online May 11, 2020. https://chw.upenn.edu/2020/04/17/callstoaction/. Accessed June 5, 2020.

151 ASTHO. Contact Tracing Memo to Congress. Published online April 10, 2020. Accessed June 5, 2020. https://www.astho.org/Federal-Government-Relations/Correspondence/ASTHO-Issues-Contact-Tracing-Memo-to-Congress/

152 Kangovi S. Letter to CMS. Published online May 11, 2020. Accessed June 5, 2020. https://chw.upenn.edu/2020/04/17/callstoaction/

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.

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

153 Emergency Task Force on Coronavirus and Equity. Massachusetts Public Health Association. Accessed June 5, 2020. https://mapublichealth.org/covid19equity/
154 Sivashanker K, Rossman J, Resnick A, and Berwick D. Covid-19 and decarceration. BMJ 2020; 369 :m1865
155 Norris T, Howard T. Can Hospitals Heal America's Communities? Democracy Collaborative; 2015.
156 Stout S, Loehrer S, Cleary-Fishman M, et al. Pathways to Population Health | An Invitation to Health Care Change Agents. http://www.ihi.org/Topics/Population-Health/Documents/PathwaystoPopulationHealth_Framework.pdf
157 IHI Leadership Alliance Health Equity Call to Action. http://www.ihi.org/Engage/collaboratives/LeadershipAlliance/Documents/Achieving%20Health%20Equity%20Call%20to%20Action_IHI%20Leadership%20Alliance_120517.pdf. Accessed June 4, 2020.
158 #123forEquity Campaign to Eliminate Health Care Disparities. Equity of Care, American Hospital Association. http://www.equityofcare.org. Accessed on June 5, 2020
159 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.
160 Making the Case for Hospitals to Invest in Housing. American Hospital Association. 2019. https://www.aha.org/system/files/media/file/2019/05/AIHC_issue_brief_final.pdf
161 A comprehensive package of urgent policy solutions. Campaign Zero. https://www.joincampaignzero.org/solutions#solutionsoverview.

health care institution as it relates to racism and inequity

- Be courageous

SOURCES AND DOCUMENTS

TRAININGS:

Racial Equity Institute

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

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

Accessed June 5, 2020

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 corporate consolidation, federal subsidies supporting

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

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,

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

individual donors and investors, and more" working together to amplify "the impact of philanthropic and investment communities in support of just and sustainable food 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

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-pro-

United Nations (FAO), and IFOAM Organics International.

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

gram/. Accessed 17 June 2020.

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.

a better supply chain are amplified across institutions and regions."[32] The incremental shifts created by the 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

32 Reinhardt, Sarah, and Kranti Mulik. Purchasing Power: How Institutional "Good Food" Procurement Policies Can Shape a Food System That's 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

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, 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.

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.

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/#719dfc0665oc. 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-idUSKBN22NoIN. 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.

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 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

50 The Common Market in the News. The Common Market, https://www.thecommonmarket.org/about/press. Accessed 17 June 2020.
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.

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 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,

53 The Good Food Cities Declaration. C40 Cities, https://www.c40.org/other/good-food-cities. Accessed 17 June 2020.
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.

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 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

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.
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.

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 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

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.
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.

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:

> *"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

70 Impact Report: Food Insecurity Nutrition Incentive (FINI) Grant and California's Market Match. The Ecology Center, 2018, https://market-match.org/wp-content/uploads/2018/09/Market-Match-Impact-Report-2018_web.pdf. Accessed 17 June 2020.
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.

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).

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

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.

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.

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