Post-Pandemic Recovery
From What, For Whom, and How?

A virtual symposium, October 4, 2022

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Welcome to today's webinar post pandemic recovery from what?

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For whom and how Dr. Monica Shakespeare will now begin.

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Hello, everyone! i'm Monica with the Johns Hopkins Center for Health Security and Webinar, co-organizer, with my colleague, Dr.

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Sanjayan Arabi today, and thursday we're going to engage a broad community of practitioners in discussions about how to operate a holistic process of post pandemic recovery, and at the outset

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I would like to thank our funder the open Philanthropy Project for making today's event possible.

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Just a quick review of today's Agenda We have a wonderful opening keynoteer, Dr.

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Lawrence T. Brown, followed by that participants in Round Table Number One are from very diverse sectors, housing, education, community development, health care, public health and rural health, well prescribed practical remedies for the pandemics

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urgent and ongoing harms to critical community systems.

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After a break we will move to Round Table number 2, and thought leaders from spiritual trauma, Recovery and restorative justice.

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Traditions will identify forms of relief and care that, taken to scale, can alleviate the inner damages.

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People have suffered during the pandemic Let me just share a few housekeeping notes in the interest of time.

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We're going to introduce speakers by name title and organization, and refer you to the more detailed bio sketches of our esteemed speakers available with the online agenda.

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There'll be a link in the Chat and you can also use the that earlier Qr.

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Code. We encourage you the audience to submit questions via the queue in a box.

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Please note, however, that there are hundreds of you. Thank you for coming, and also very limited time.

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So please forgive us if we can't get to your question Occasionally we're going to post to the Chat.

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Some recovery, related resources that both Round Table participants and the planning committee have singled out as valuable for attendees.

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And please know that a recording of proceedings for today and Thursday will become available online, and we'll share that link in the chat with you later on.

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I did want to take a few minutes to set the context for the webinar.

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I mean, What? Why are we here? apart from the obvious I did want to share some background information.

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So for a number of years prior to the pandemic Sancho, and I observed that an epidemics, readiness, and response phases tended to capture the disproportionate notice of decision makers

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practitioners, news services, and planners, and as the tail end of an epidemic curve trails off, it seemed to us that people assume that the concerning public health event is over.

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But the lived experiences of major outbreaks of infectious disease indicate otherwise.

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So way before the lingering effects of long, Covid, surfaced we knew epidemic recovery can be long and complex.

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In In the case of Zika you saw that geeon bare syndrome can diminish household budgets, that pregnancy loss can prompt, complicated grieving, and the need for moral support and that

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congenital Zika syndrome can mean ongoing medical and social service needs for affected children.

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Again way before the protracted Kovat. 19 pandemic beleaguered our public health and health care work forces.

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We knew that restoring the health sector post epidemic is a major challenge due to its rapid.

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No zochomial transmission. for instance, Sars sick and healthcare workers disproportionately get prompted Ptsd.

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Through their severe emotional distress, and it contributed to employee burnout and low productivity. and before COVID-19 widened social, fracturing and disrupted economies, we knew that major outbreaks could have totalizing

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the effects for communities. So during the West African Ebola operate in 2014 to 2,016.

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Fear led to stigma and to lost faith and health services, and also communities had to reconfigure social roles due to lost parents, wage earners, teachers, and local leaders and people had to work very hard to restore the

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rhythm of activity for schools, public services, markets, agriculture, and the health sector.

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So these are just 3 cases. but I think we can look at them and know that rebounding post event requires a much longer and a much broader view of outbreak management.

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Then a crisis response mindset permits So as a result of these observations, just prior to the start of COVID-19 the pandemic in late 2019.

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It just so happened that Sanjana and a colleague, Elena Martin and I decided to study this apparent blind spot or recovery.

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So we spoke with scholars, practitioners, and policymakers, who were actually in outbreaks disaster, recovery, community resilience, and or public health, emergency management.

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And we ask them, Why is post pandemic recovery?

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Not yet seen as a problem in need of a solution, and they gave us 4 explanations.

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The fuller studies available in in the chat. But the first observation was that urgent life inland matters take precedence, and recovery, takes the back.

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Seat. A poor response produces impacts that are very visible, more sickness, more death, more disruption.

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And constantly enumerated cases and deaths help elevate the problem and evoke sympathy and empathy.

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Secondly, the prolonged recoveries of marginalized, underserved communities generates generate less social attention.

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So the people most heavily affected by epidemics, whose recovery is likely to be protracted, are those to whom society routinely turns a blind eye.

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The thirdly, they pointed out largely a medicalized process.

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Response is seen to rest on the shoulders of a skilled public health and health care workforce.

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But epidemic recovery, which can touch many different sectors and affect many different community systems.

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Doesn't have a comparable dedicated resource, and skilled workforce. and, lastly, they pointed out that the definition of an epidemic and it's aftermath is subject to contestation, so

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What constitutes recovery is a political question. one of them underscored.

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A government can claim. Recovery has occurred once. the immediate crisis resolves, and yet still not address dysfunctions, amplifying a pathogens effects for human well-being.

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I think they're observations on the cusp of the beginning of COVID-19 are very precious about the pandemic.

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We don't have clarity or ownership around the job of recovery.

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The debate continues, Is recovery about returning to the status quo?

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Or is, Michael Marmot says, building back fairer? and a large proportion of the country, understandably is already looking at the pandemic from the rearview mirror.

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Yet hundreds of people are dying daily, and community systems haven't regained full functionality. So that is some context.

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For why we have organized this workshop, this webinar, and the purpose of discussions today and Thursday is to rough out for local leaders some kind of blueprint that includes an overriding vision and a

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set of specific actions for implementing a comprehensive pandemic recovery in which some people have been hit harder than others.

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So I want to thank you for making time in your very busy schedules for this event.

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I'd like now to introduce our opening keynote Speaker Dr.

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Lawrence T. Brown, a research scientist in the News Center for Urban Health Equity at Morgan, State University, and author of The Black Butterfly.

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The harmful politics of race and space in America. over to you, Dr.

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Brown. Thank you, Monica, and I really appreciate the invitation to deliver this keynote this morning, for everyone who who is not on the east coast were, of course, for us.

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It's just reached noon, so I want to get started, and before I dive into what I want to say today, I wanted to acknowledge that this is a nation that is going through a tremendous amount of issues.

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Certainly we have you know we're here to talk about the pandemic, but we're hopefully we're also very much in giving our thoughts and prayers to our friends in Florida who've been hit by a devastating

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hurricane. also in South Carolina. there have been some loss of life there, and also this year we're thinking about people from Eastern Kentucky a lot of flooding that happened there.

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Jackson, Mississippi, also experiencing tremendous issues with the water infrastructure.

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And then, of course, you know the mass shootings that took place in Buffalo.

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And you, Baldi, so so many of our communities are dealing, not just with the pandemic, but in reality ascendemic.

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This sort of synergy of pandemics and epidemics that are all converging impacting many communities at once. And so how do we emerge from all of the issues that we are facing?

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I think that's the question I want to raise for us this morning, and with that I want to start with the theme, and the thought that I have for you today, and that is basically that democracy is the recovered democracy is the

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recovery. But before that I want to dive into some data here from the County Health rankings and Robe Maps program.

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We see counties among the least healthy from their 2,020 key findings.

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Report. And so you see these counties here that are in purple.

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Those are some of the counties that had the lowest ranking among the outcome measures that they used.

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And if we look at this map as well, we see life expectancy.

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Some of the same counties. actually appear to have more issues, as you might expect.

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Certainly, if they're least healthy then there's going to be also a lower life expectancy in many of those counties.

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When I looked at this map back in 2,020, I was able to identify a certain pattern on what it became clear to be was that you had where the blue circle is oval. These The white appellation counties that

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are experiencing many issues. Then there's the southern black belt counties in many of our Southern States. And then to the west, you see a lot of the darker counties are actually counties with native tribal lands

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And so these are some of the counties that are dealing with many issues, even more so than many of our other areas around the nation.

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And then here's the map of children in poverty among us counties, and in some ways I like to think that this map is about telling us the future of the country.

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These are the children. And so, if there are issues today in these counties, then these are the counties that we're going to see issues in going forward, and we see some of the same counties that are being highlighted counties with native

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tribal lands. The white appellation counties Black Belt Counties in the South and then us.

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But on this map you actually see the orange cluster at the bottom, the oval.

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There you see the appearance of us Mexico border counties that are where children are dealing with high levels of poverty.

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So these are sort of the 4 geographic clusters where we can understand something about who's hurting the most in this nation who was the most vulnerable when the pandemic hit our shores back in 2,020 now

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when the pandemic first hit. I want you to go back to 2,020.

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There was 3 waves really that sort of characterized the way that the pandemic emerged in the United States.

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There's that initial wave where we first sort of found out what was, you know people were being, you know, first infections we were hearing about in the United States.

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They were in Seattle they were in California then nursing homes and cruise ships were beginning to get hit really hard, and it was still not yet apparent.

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We didn't have a lot of data the testing wasn't as strong as it should have been, and so it wasn't until March, when it became very apparent that the pandemic was really in full force and that's when

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we saw large numbers in urban areas like New York, New Orleans, and so by the first third, or by the certainly by the middle of the month there was a shutdown across the nation to Try to contain the spray of the

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pandemic. and then by the summer, even by April and May, the virus really had spread to rural areas the tribal lands and in counties that are more rural in the deep.

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South. And so looking at the data just a couple of weeks after the shutdown really hit.

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And this data comes from the United States Covid Atlas, at the University of Chicago.

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It became clear to me that these cities that were popping up, that were showing up as concentrated areas where Kovat was really impacting.

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Those many of these cities had legacies of hyper segregation.

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So we're talking about Either they are accurately segregated hypersectiongregated cities like Detroit, Chicago, Boston, New York City, or they had a history of hyper segregation.

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Even if statistically, they were no longer hyper segregated.

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The history of that seemed to auger some sort of rationale behind the spread of this virus.

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So you had Atlanta, Washington, Dc. Nashville, Albany, Georgia.

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And so these were the. This was a pattern that was very clear to me.

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Early on that, as this virus made it, it was not just.

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It was concentrated in urban areas in particular and in hyper.

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Segregated cities at that. So all of these cities here, as you see, either they're currently hyper segregated, or they were once hyper segregated.

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Now, what is it? How do we sort of understand hyper segregation?

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You may be asking that. So that was a measure of by 2 social scientists, sociologists, Nancy Denton and Douglas Massey.

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They co-wrote a book back in the ninetys called American Apartheid, And so they used these 5 different measures to understand racial segregation in urban metropolitan areas.

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And you can see those measures on the right side of the screen.

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An evenness, isolation, clustering concentration and system.

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And so they all range between 0 and 100, and if the city was over 60 to on just one of those managers, then that city was considered to have a low level of segregation.

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If they were overseas steel. On 2 of those measures they were considered to be moderately segregated.

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If they were over 60. On 3 of those measures they were considered highly segregated, and then, if they were over 60 on 4 or 5 of those measures, they were considered Hyper segregated, cities, and so interestingly I thought

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these are 5 different measures. So I made the analogy of a hurricane category, one through 5. And so the cities on the right side of my screen, I'm. going to go back to that slide in a moment the cities

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on the right side of that screen. These are cities that are over 60.

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On each of those 5 measures, so that I call them category.

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5 hyper segregated cities, and That's What We're, seeing right here those 8 cities Baltimore, Birmingham, Chicago, Cleveland, Detroit, Flint, Milwaukee, St.

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Louis. So these 8 cities are classified as being over 60 in all 5 measures, and just like a hurricane.

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These are cities that have the most damage when it comes, are most damaged, due to racial segregation.

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Now, what does that really lead to, especially when it relates to the pandemic?

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Well, we saw spatial inequity in covid testing rates and testing sites.

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So these 3 studies that you can see on your screen. This research has already been done to really reveal that cities that had that were highly segregated hyper segregated.

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They were found to have more despairity when it comes to testing rates for the Latino population in Chicago and New York.

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But then also there was also disparity. in testing Sites and that's in cities like Chicago, New York, Philadelphia, Los Angeles, Houston.

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These cities were found, many of them to have disparities, and, for instance, cities that were wealthier neighborhoods in these cities that were wealthier, they often had more testing science, wealthier and wider communities often had more testing sites and then more Latino

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more African-americans in a community they often had less testing sites.

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Now, of course, if you're going to track a pandemic you're going to track a virus the thing you're going to need in your community is robust testing and the people that needed the most did not have it in

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their community at the same level as wealthier and wider communities in our country.

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In these urban hyper segregated areas.

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And so the that's the damage of racial segregation.

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That's the damage of hyper segregation is that it results in the hyper deprivation of resources in Latino and black communities, and then it results in the hyper allocation of resources extra resources.

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Extra benefits, extra access for wealthier and wider neighborhoods.

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And so that's the harm of racial segregation, and we saw that play out the early phases of the pandemic.

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And then, like I said by April by May, as we see from this data from April, the 20 fourth, 2,020, many of our native American tribal lands were being hit very hard when it came to code and so this is

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data that We're, seeing here Mckinley, County, New Mexico, Novel County, Arizona, Apache County, Arizona.

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These counties were also being slammed by the virus, and that was also very much apparent, as though counties and those folks struggled with the initial impact of the virus.

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But then, like, I said, is spread to rural counties and So it's just this is sort of a demographic map of the country, and we can see here in the last row. that rural counties have the least amount of people 46

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1 million, but they constitute the most counties in the country and So that's that dark blue that you see so rural America doesn't have as many people as urban areas.

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But they're more spread out. They constitute a larger area in a larger number of counties across the nation going back to Monica's point at the top.

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You know, you see here that before the pandemic we know that there were issues.

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And so in rural areas we see here, as you see in the green circle, the yellow circle and the blue circle which represents in rural communities rural communities had less access.

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When it came to physicians or primary care, physicians and dentist.

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So much less access to medical and health professionals in rural counties.

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And then also we look at preventable hospitals days.

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We saw that even before the pandemic again, rural areas, folks living in rural areas had much higher rates of preventable hospitals, phase.

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And so rural areas are also facing these tremendous challenges.

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And so we want to make sure that we understand that.

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And similarly we see on this slide where there's adult obesity, rural counties in the country facing a higher level, nearly 32% of obesity compared to it's just under 26% for

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urban areas, so that's more of a challenge in rural areas.

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And then there's more unemployment more children living in poverty.

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These are issues that are being faced in rural counties and rural areas across the nation.

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Now, especially what what is also damaging is the lack are the challenges in the public health departments.

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So if you're going to have an epidemic you're gonna have a virus that's coming to the county in a rural area, they're facing more challenges in terms of their ability to respond to those to the

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emerging health issue. you can see on the right side. These are the things that public health departments do. they monitor the health? they evaluate folks who are maybe dealing with issues, health issues.

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They provide link to care. they enforce laws, they develop policies.

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But rural health departments often have fewer staff, as you see.

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In Point number 2. they lack specially staff with the exceptional nursing.

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So, for instance, the they are many of them, don't have epidemiologists who are trained professionals in terms of tracking where the virus is going, and if your Health Department doesn't have an

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epidemiologist that places that county at a severe disadvantage.

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These rural counties often rely on partnerships, but are limited in the number and types of local organizations.

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Just by the scale economies of skill, and then also, many of them are underfunded.

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And so they have limited access to technology. and I have to come off of the share screens.

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Just so I can make a point and say all of public health is underfunded in America.

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And that's another thing that really stey me and damage and hurt our ability to respond to the virus that hit our shores.

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We had health departments that in many ways, even if they went full force with Covid, the ball was dropped in other areas because they had to pull people from chronic disease.

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They had to pull people from infectious disease and so What we saw is that even though there is a full force effort to deal with Covid, you know, of course, when the shutdown first occurred, you know people put off elected

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surgeries, people, weren't getting tested for other diseases stis, the sexually transmitted infections.

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We started going up and we're dealing with that crisis now, so we often in our nation, and i'm speaking to my public health, or excuse me, our good my Government the folks right now, especially if you're in office this is

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for you. We don't think about what public health does until there's a crisis. it's hard to really understand and especially if your data person metrics you like metrics and outcomes.

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The best way to measure public health is what doesn't happen I mean that's the best measure she says.

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Did we prevent a rise and infections? Did we prevent, You know more?

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Hiv. did we prevent, you know, lead poisoning so It's hard to measure and really appreciate.

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Sometimes the value of public health, when the best measures of understanding public health is when something does not occur.

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Of course everybody understands when there's an issue when the epidemic takes place when the pandemic takes place.

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Then we all love a sudden understand why public health is so important.

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But unfortunately, by the time the pandemic comes if you haven't fully resources. if you haven't fully equipped your public health agency, if you have a major folks or training that you've hired folks that you've given

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them the tools they need they're not going to be equipped They're not going to be ready to deal with these monumental challenges.

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So public health overall is deeply underfunded.

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But rural counties that face that challenge even more. And so one way that we should really understand this is the way that many hospitals are closing in rural areas, and we see, since 2,005 to the left of this

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graphic produced by the chef center in Unc Chapel Hill.

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Over the past 15 years or so, the hospital closures have increased. So we're seeing more and more hospitals that are being closed.

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And then, if you look at the charter on the right, there was a decrease in 2,021, only 2 hospitals closed.

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But, as you might imagine, if you're following policy those recovery funds probably helped a lot of hospitals keep their doors open.

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But as that money up, we are likely to see more hospitals close going forward into the future, so that's the concern that we really have to look out for.

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Now again, what is it that hospitals do? We know?

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They provide services. We know that you know handled emergencies, with emergency rooms.

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And so when a hospital closes you know and you're in a rural area, where are you gonna go?

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You know. How far do you have to travel now to receive services to receive care that you need.

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And so this becomes a very critical issue when you're talking about something like the covid 19 pandemic, and indeed a host and variety of other issues even quote unquote regular issues like a heart attack you know that's an emergency

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you need immediate, urgent care, but with these hospitals closing folks in rural counties often don't have care. now.

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This is something that we really have to look at, in particular, in states that did not approve the Medicare extension or approve Medicaid, not Medicare, Medicaid during the Obama Administration.

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They were trying to expand medicaid. some States declined medicaid expansion, and those are the States that are seeing in witnessing more of these hospital closures.

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And so there's the policy element coming into play and here's a map of closures since 2,005 that we can see all across the nation.

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These kids are being truly impacted particularly when it's a closure, a permanent closure, and there's no conversion or a reopening like in my home county.

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The hospital closed my home county's crittton county Arkansas.

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It closed for 3 years. We didn't have a hospital and then it We had a new one come in and opened up, so we were very fortunate that our hospital, even though we lost it A few years later we were able to get

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another hospital in our county in arkansas so it's. very apparent that biology viruses attack social vulnerability under, you know, viruses they don't have know a mind of their own.

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They're not thinking you know organisms but they're just you know they're trying to find a host and they're trying to you know.

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Reproduce and affect, so that that virus can keep going, and unfortunately, is a truism that societies where there's deep inequality nations where there's social vulnerability that's what the virus

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is going to find this way to those communities. and it's going to start spreading and percolating the most in the areas where there's vulnerability.

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So I think we really have to understand this notion if we're going to recover. if we're going to be ready for the next pandemic then we have to understand.

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Where are we dealing with vulnerability in our nation and That's especially in the we're dealing with the people in places that have been red line subprime marginalized and demonized?

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These are the areas where we're seeing tremendous vulnerability in the nation, and these are the areas that are going to need.

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Now I want to get to the solution because I know That's what many of you are here for.

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How are we going to get out of the missed that we are in?

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And again i'm talking about not just even the covid pandemic.

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But i'm talking about the larger way in which the country is facing so many issues, we're talking about the hurricanes that I've mentioned earlier the infrastructure in Jackson Mississippi talking about

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infrastructure to go back to the Flint Water crisis in Flint Michigan folks, and we had an issue here in Baltimore, where in West Baltimore, E. Coli.

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Was found in some of the water, and folks there have been had to have it boil their water some days, receive bottle water, so infrastructure and segregated hyper segregated cities that have large black populations

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infrastructure that we're seeing is a critical issue we know that issues we saw in Kentucky the Eastern Kentucky.

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The flooding earlier this year, climate change producing these stronger storms, increase rainfall stronger hurricanes.

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So this is something that we know is going to keep happening unless we change the way we operate.

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Not only as a society, but as a global community. So what are we going to do to emerge from the syndic that we're facing it, which is spearheaded by the pandemic characterized by the covid

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19 bars. How are we going to deal with that i'm suggesting that democracy is the root democracy?

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Is the way we emerge from the pandemic is the way that we recover.

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But what kind of democracy is the question? What kind of democracy?

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And I submit to you that we have a democracy certain certainly, but it's imperil in America right now, and we know that if we go to the pledge of allegiance, we live in a republic and the republic that is characterized

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by a representative democracy. we elect folks who there represents.

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They go to Congress. You know that we serve on this at the State level.

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They're serving the State House State delegates Assembly, whatever you call it, in your state.

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So we have a representative democracy in America, and this democracy that is teetering on the edge.

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And I suggest that this representative democracy is all right.

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But we need to go further. We need to strengthen our democracy, and I want to point you to what what I consider who are considered to be the greatest social scientist of all time, and that is Dr. W. E. B.

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Du Bois, he wrote black reconstruction in America back in 1,935, and he talks about abolition democracy here on page 83 I'm.

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Going to read a portion of this, where he says: As the abolition democracy gained in prestige and power, they appeared as prophets, and led by statesmen, they began to guide the nation out of the morass into

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which it had fallen. They and their black friends there he's referring to white abolitionists and black abolitionists in the North. The new freedmen, the formerly enslaved people, black folks in the South became gradually

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the leaders of a reconstruction of democracy in the upper States while marching millions, saying the noblest war song of the ages. and that was the crisis of the time.

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The Civil War to the tune of John brown's body mine eyes have seen the glory of the coming of the Lord.

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He is trampling out the bench where the grapes of wrath are stored.

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He hath loosed the faithful lightning of his terrible slip sword.

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His truth is marching on, and so I just wanted to read their last part because I got excited.

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But this notion right here that you, weak, that, and had fallen into a morass, that we were syncing down, and we were in a heap of trouble that we needed to have that this nation needed to have a reconstruction of

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democracy and abolition democracy. One that said something is not right with our society.

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And if we're going to emerge from this crisis, if we're going to recover from this crisis, and this is back after the Civil War.

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If we're going to recover we're going to have to reconstruct democracy, there has to be reconstruction, because communities have been harmed, communities have been damaged, and I submit that we need the same kind

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of thinking today that we're dealing with this deeply devastating pandemic and the candemics that I've mentioned earlier crises and infrastructure crises of climate change crises of communities that are being impacted

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by mass shootings, and then the everyday, devastating gun violence.

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In so many countries, so many counties and cities across the nation that if we're going to make it out of this, we're gonna have to find a way to address the obstacles and barriers that communities are experiencing I know this is what

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you're going to talk about in the upcoming panels, and the upcoming discussions as a part of this great convening that's being held today, and on Thursday and so I want to leave you with a few thoughts

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around. what abolition democracy can can look like it would until so.

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Here. I want to start with the notion that the abolition democracy means that when you listen to people from all backgrounds, cultures, perspectives, and communities, you know, democracy means listening.

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That you have to have ways and forums and gatherings like bees and others where you're able to listen it.

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Sometimes the folks with the degrees like me, I got 3 flow degrees.

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We need to be listening. We need to be the ones listening and let folks in communities.

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The talking. So if you're the gut in Government sometimes you need to sit down, and I look I go to I've gone to several city council meetings here and back home in Arkansas, and the

testimony period the

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citizens of 2 min. You get 2 min to talk now. I know you don't want to be there all night, but sometimes 2 min is not enough.

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I think sometimes we want to have people give people a quick time to talk, and then we want to move on.

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Sometimes it takes we need to i'm not saying you need to let folks talk forever.

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But i'm just saying we need to have something where we are really listening to people, and that's just listening.

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But having conversation, so that you can really understand what are the issues? how is it that we're going to rebuild this nation going forward?

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We don't have both with degrees folks who are running governments We don't have our answers.

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We don't have all answers the only way We're going to rebuild this country is that we listen.

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We sit down we listen to folks from a variety of areas because we have what are called blind spots.

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We don't see, maybe because of our position of privilege and status.

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We don't see what folks are going through so the only way we're going to understand and be able to help develop a comprehensive approach is if we listen, Take a back seat sometimes and let communities speak and let folks articulate what it

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is that They're going through the next thing is we need to provide restorative resources to those 4 geographic clusters that I mentioned earlier.

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We had to help the least of these, and also provide those resources to red line neighborhoods and hypersegregated metropolitan areas.

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So you know the areas that I talked about earlier the counties with tribal lands. The Us.

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Makes the cold border counties. why Appalachian communities, Southern black built communities.

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And I have to mention, of course, these communities don't just have they're not all white or all black.

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They're there. Other people there, too, but this is how I think we can sort of generally think about which populations may be more dominant, or maybe more concentrated in those communities, even though they certainly have other people living in them and

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Then, thirdly, we need to remove the roadblocks to democratic participation.

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That's pretty much what I said earlier so i'm gonna move on to the last one.

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We, which is strengthened public health before the next disaster.

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Our pandemic strikes because y'all another one that's coming.

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It's going to be something some virus some something is going to be coming.

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Climate change. it's happening so we got stuff that we know the future is perilous.

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We know we live in a highly global society. Everybody is not really thinking about the impacts of what we're doing to our climate.

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We got wildfires out in the West water issues out in the West as well within Tata, and talked about the West without their issues out there as well.

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So what we're gonna have to do in this nation to recover truly is reconstruct democracy.

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And I think that is the way forward for us in the United States.

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Thank you. Thank you so much, Lawrence. Oftentimes we hear the words immunity and economy, as it relates to pandemic recovery and the introduction of democracy. and that is our endeavor and

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enterprise, I think, is a way to really open up this discussion, and very, very ways.

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So thank you very much for spending time with us today and setting the bar for for this discussion.

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I want to now welcome the participants for Round Table number one, and I would also like to introduce our moderator.

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Dr. Jennifer Horny Who's Professor of Epidemiology at the College of Health Sciences, with the University of Delaware.

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She's also on the core faculty of disaster research center over to you, Jen.

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Thank you all. Hopefully, Everyone can hear me, and somebody give me a thumbs up working. Thank you.

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Working in a shared space out here on a Pacific time.

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And so happy to be part of this really important

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And thoughtful discussion about what happens next i'm feeling constantly that we're falling into that trap that disaster.

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Scholars have told us about for years, which is that we just want to go back to the way that it was. so.

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We have a an incredible panel today. We We are missing Dr.

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Cassandra Davis, she's not able to be with us today.

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But we are going to hear from representatives from a lot of really important sectors representing the vital conditions and social determinants.

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And thinking about not only the urgency that we have with recovery, but the kinds of enduring harms that we're going to need to continue to address with that I will kick it off with our

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first prompting question to the panelists, and think about that more immediate harms of the pandemic, not only to public health, but to public health systems and other social infrastructure systems that we need during recovery more than

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ever So if i'll go first to to John if you could perhaps speak a bit about the harms to your sector in in terms of both the urgent or acute and short term, and then what you see more in the

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long term, and and also thinking about the kinds of solutions that leaders might be needing to look for. and we'll just go around and hear from from everyone on that.

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Thank you. thank you, jennifer i'm a housing advocate.

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I am a Texas perspective. I work statewide in the state. so I'm gonna talk a little bit about what we've seen in housing and been securely housing for the poor which is what I concentrate on as

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the co-director of Texas housing a nonprofit organization that has offices around the State.

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So the quote first question I was asked to address is how to measure If we've reached recovery and there's there.

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There was a long standing and affordable housing crisis, but for for the poor, before the pandemic and the pandemic broad millions of households to the edge of homelessness.

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So if by recovery we mean return to the pre-pandemic housing crisis, then recovery will be when rent to income ratios and affordable supply, return to pre-pandemic levels.

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But this understates the long-term economic harm suffered by people who face eviction and the emotional and mental health costs of households who are on the brink of homelessness.

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The pandemic showed us just how precarious housing is for the poor, or reminded us in non pandemic times.

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We needed to build a better economic cushion in low income housing markets, or we're going to chronically be repeating these hugely expensive, poorly administered and poorly targeted housing interventions as the next

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pandemic, and the next natural disaster roll out.

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So the second question has to do with what are the lingering arms, and how are we going to address them?

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Related to a affordable housing. I have 8 points here i'm going to try to get through.

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I've got 5 min. The The Federal and local eviction moratoria were important in preventing massive housing loss, and surprisingly both political parties used eviction moratorium to varying extense successfully many States and cities

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took action independent of those Federal efforts. Also eviction moratorium, are, were vital and are a vital proven tool that prevented much greater housing catastrophe.

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Number 2, given the effectiveness of the preemption of evictions.

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By these. By these declarations we need to be concerned about the future impact of the Supreme Court ruling that limits federally imposed eviction.

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Moratorium which is put in place at the end of the the biden administration's auditorium efforts the court's ruling will cripple our country's ability to effectively respond to future

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calamities. This is very serious stuff. We need to shore up legislation that makes clear the authority of chief executives at all levels of government.

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To exercise this emergency power. Number 3. We quickly built a generally workable natural national network for distributing emergency rental assistance that did great service in keeping people housed.

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However, geographic gaps occurred, as some jurisdictions did pretty good, and others failed or refused to administer emergency.

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Rent, assistance, local staff capacity, and experience by local cities and states seem to be determinative of the success levels along with attitudes toward racial tolerance and acceptance and racial discrimination.

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We believe that the emergency rental assistance is more effectively and more fairly administered.

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Therefore, as a Federal program, although many local cities and States did a great job.

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But a lot of people got left out for the reasons I just named Number 4, having demonstrated that the effectiveness of emergency red assistance and creating a distribution network in most places that kept poor families housed we

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shouldn't let emergency red assistants die. but we should instead institutionalize and fund an ongoing national rent assistance.

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Network their traditional strategy that we employ in the housing world where we focus on housing production can't be the sole approach for affordable housing. As many more people lose their homes through eviction on the back end that get new housing

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on the front end of the production. General block grants and this is the other thing we've observed that I think is important from public policy standpoint.

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General block grants like Arpa funds, they went to states and cities for pandemic release.

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Relief too often got hijacked and didn't end up being used for pandemic relief, and certainly didn't benefit out salts facing the housing crisis in my State our legislature set aside 2 billion

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dollars of Arpa funds in the bank, hoping to change the rules so that they can use it for tax relief.

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Dedicated funds like era are necessary if we're going to respond to pandemics number 5.

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Lots of people lost housing, both through self-eviction and judicial action and the right to council, which is in place in very few locales, can reduce or delay evictions by maybe around 20%.

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That's important eviction. Court watchers which we did a lot of during the eviction noted that the poor administration of justice on the part of many judges in lower courts was really problematic, and we need better oversight

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and training of judges and better presentedal law reforms to ensure that, the further lower these unjust evictions.

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Number 6. eviction record tracking and blacklisting of tenants who were evicted.

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Keep those tenants from being able to access housing in the future, and can play tenants for decades.

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These services need Federal and State guidelines like those that regulate credit reporting services, and most States don't add that number 7 media attention on the judicial evictions during the pandemic has improved the

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awareness of the way that our landlord tenant laws and eviction procedures unfairly favored landlords over tenants, and to address this States and cities need to better balance eviction and land more tenant laws and then

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finally Number 8. The shortage of affordable rental housing for the poor got massively worse, as the pandemic began to obey and to address this, we have to have better income targeted housing production at the poor and this

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is not when I want to emphasize this as many in the media are claiming these days simply a shortage of supply caused by housing development regulations.

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That's part of the problem. But public funding is not effectively targeted and subsidizing housing for the poorest people, and that is, producing the crisis in affordable housing, which is largely at the bottom that's

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what i've got as a general overview of those first questions, Jennifer, i'll get back to you.

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Thank you so much. And so I wanna although this was not the plan, because we had a someone who was asked.

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But I want to move sort of from that. I think micro housing to a lot larger community development perspective.

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So donna do you have a chance to address these first 2 questions.

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So. thank you so much, and it's a pleasure to be here this afternoon.

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I was so intrigued by Dr. brown's opening remarks I'm.

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Calling in from the Treasury Department this morning, where we are having a form related to Friedman Right.

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Friedman's bank was an institution perform shortly after the Civil War.

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That was focused primarily on inside, formerly enslaved.

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The bank unfortunately met I a a too early demise based on some very from being a portion.

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When I hear Dr. Brown talking about this need to really look at.

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How do we have this democracy? How do we keep that going?

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How do we build that up i'm reminded of just how much additional So I'm.

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President and Cdfi I'm. sorry President you know of a community development. financial. I'm.

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Struck like off the ground comments about making sure that We're, listening to various people from all back backgrounds because Appalachian community capital that I run it covers the entire State of West Virginia and then portions

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of 12 other States, with the bottom portion of what literally we follow.

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The spine of the Appalachian mountains all the way down to the top portion of the We are a small business lender.

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We are a community development window, which means that we along with the other 2 5 across the country, a single mission that is to serve on this market, and we know that, regardless of what pressure we're serving in this case, business, we also have

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Cdfi that are involved in housing communities, facility, and other sectors.

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We know that, for community supplies you can't sector all of those sectors with us.

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Is one that we have a particular because of the region that we're working in Appalachia is 420 counties that are designing part of Appalachia.

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Dr. Brown is correct in that predominantly white region, as it relates to the population. but it's also has 20% of its population that I of color.

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So we understand that diversity is everywhere throughout this nation.

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And clearly as we looked at the pen impact of the pandemic, we saw that in this region. Oh, that population continue!

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By the pandemic. Pretty movie enough the Appalachian region.

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4 years leading up to we're still recovering from the great recession of 2,007.

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To. So that's good 2,009 recession yeah. the region that much more to recover for a lot of reasons mostly due to on investment.

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But we were seeing some small household income, 2,011 and 2,01520, with 80. Yeah.

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The less accounting throughout the region. it the overall pop poverty in Appalachia,

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Which is 1413,015 and 2,020.

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We certainly did that. There were, you know, a lot of Jane for a number of.

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But there were also things that show that there was some remaining vulnerabilities that were exacerbated by cultural economic impact of Covid 19.

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So, though regional poverty late have declined overall right to stay the same or increased, and in 5 Appalachian talent, any app apple license population twins older than the nation as a whole with individual

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agents.

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Appleton accounting additionally, the 5 and over, with a disability with more than 3 for households or children under the age of is higher than the national rate.

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So clearly we are seeing the when they made impact related to health in this region.

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Not only again in both communities and population, but but also even more so in population.

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I'll call it. And so one of the things that I think, yeah, mindful of of working in conjunction with health, related organizations to identify and address some of the major priorities that are happening in this community so

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priorities have to come from the community. It requires a building of capacity of the Cdfi.

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It requires collaboration. The public and private sectors work help structure to identify.

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And I think we need to look not just the boot causes. it's awesome time to actually not only just food and security, environmental and .

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But also financial institute, and i'll talk a little bit more about that.

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I don't being the co-founder and board chair of a 6 7 member organization.

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Call. Yeah, we have been American aligned A. Pdf: I think you we, too, are very much focused on some of the health issues that we are seeing in those communities.

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Some of those might be still small, my minority and majority community, but others Pdf files that are blackware also.

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Supporting majority black wid majority minor people the color in in the a lot to talk about.

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I'll stop here because I know we've got a number of panelists as well, who have amount of information.

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Yeah, Well, thank you, General: Thank you. And I. I think that it is natural that we move on on.

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That idea of root causes and thinking about the partnership development and collaboration that's necessary to address these kinds of complex health issues.

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So we'll turn it over to our next panelists to address some of those issues.

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Anora. sorry. thank you sorry I wasn't sure if we were going in the order.

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Well, good morning, everyone, and thank you, John Hawkins, and the Center for real security for the invitation to join him.

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So inspired already by the a few speakers before me.

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So I want to reflect a little bit Dr. Brown thank you so much for your tremendous remarks this morning, and i'm actually gonna deviate a little bit from my pre-written remarks because i'd like to respond

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to a couple of themes that I think are paramount, not just in terms of the collaborative partnerships. But I do want to reflect a little bit on the impacts to health care, and some of the things that I think

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shape what we can do in terms of the healthcare partnerships, but also, I think, urgent issues that we need to address in order to think about the continuity and access to health care for everyone within our healthcare system So First.

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and foremost it I would be remiss if I didn't acknowledge the tremendous harm that's been done in terms of the healthcare workforce.

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And it really is just like public health and so many other sectors and industries, something that we really have to, I think, put urgent focus on both in terms of investment in solutions.

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But really taking a wholeistic approach and realize thinking about the health care workforce across the whole continuum.

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And I think i'm not sure if we get fully appreciate the interdependencies across the continuum of health care and the need to really drive towards holistic solutions that are going to address the immediate crisis in the psychological

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well-being of so many of our healthcare providers to address the traumatic injury that I think, in the moral distress that many of across our health care community, regardless of what sector they're from our

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experiencing right now to recognize the the rise, continued rise and violence against both public health and our health care workforce as a crisis that needs continuous and vocal kind of outcry and community solutions to try to mitigate

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but also just the the access around the the pipeline within our workforce.

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And I think about the context of our workforce availability also in terms of the impact that that is having near term and kind of in the context of the question about recovery.

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We are a long way from, I think, being able to replenish the healthcare workforce that we are going to need in order to address the access issues.

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And the ongoing public health and healthcare impacts that we have in our communities.

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So for the sake of time this morning, I when I think about the healthcare workforce, I actually there's been some very good thinking, and i'm not affiliated in this case with the national Academy of medicine.

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But very recently a good report that I would refer folks to in terms of the national plan that they just recently released.

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For healthcare workforce well-being, and you know they've outlined a nice set of points that I would have made.

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Otherwise, but I would encourage folks to reflect on some of their recommendations, as I think, a good guide in terms of the local experience.

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We have in seeing what the impacts are. to health care providers. I think there's a really strong set of recommendations that I would encourage folks to look at.

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I want to think about the impacts to health care workforce in the context of access.

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And Dr. Brown made some extraordinary connections in terms of the impacts to the rural communities and the the downstream effect of impacts on rural hospitals and rural health care providers on amplifying various levels of

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inequities, and I will underscore that.

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That is a critical gap, and we need to be looking at every aspect of our healthcare system from the perspective of what policies do we need to put in place?

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What solutions can we garner that increase access to care both in our rural, but also sustained care in our urban areas where there's a lot of interdependency for our rural partners, we've seen a

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number of solutions come out in terms of surge management come forth.

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So level loading strategies, moving patients from rural areas to urban areas to get access to tertiary care.

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But we also continue to see limitations in being able to really optimize those solutions that help enhance access Because we have limited numbers of providers.

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We have limited numbers of space and we have policies that sometimes don't actually streamline that kind of surge planning.

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And so, as we think about, where do we need to go from here?

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Both in the short term, looking forward towards the winter, which I fear is gonna bring forth another surge for us, and also the longer term, How do we look across the continuum of care at our policies, and really think are all of these policies

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working together, actually going to improve access to care. So How do we look at the long-term care, environment and think about whether it's at the Cms level, Or, you know, Medicaid, reimbursement levels that are decided at

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state levels or various regulatory environments. How do we really ask the question of, Are these policies going to improve access across the continuum?

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Are we going to? Can we enact policies that help streamline getting patients into long-term care which will improve the conditions within hospitals which remain very overcapacity for a wide variety?

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Of reasons, and we have so many impacts in getting patients out of hospitals and into appropriate settings, both in the rural and urban environments.

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We need to continue to look at policies that support good financial health and well-being for

our health care providers, but also again really making sure that we're looking across the continuum with our cms policies with our in-state regulatory policies and our reimbursement

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models to make sure we are putting in place policies that are going to streamline the discharge of patients from hospitals into appropriate levels of care that are going to keep patients near our top when possible, and so to do

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that we need to look at policies that actually support the reimbursement and equitable payment to hospitals.

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When patients need to move from rural to urban or tertiary care providers, and then getting those patients back, we need to record that we have reimbursement challenges for ems when they need to transport those

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patients between rural and urban and back so there's a number of different policies that we can look at, and improvement.

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I think that we need to address now in order to think about how we continue to deliver care in the most equitable, equitable way, but ensuring access in as many forums as possible.

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And lastly, I the question of community coalitions of public and private partnerships, healthcare coalitions like my own, that work across the continuum of care and with public health, and with private sector partners I think

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really are the crux of a lot of solutions.

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And so, not only do we need to build upon these partnerships and and create an infrastructure that really supports the engagement across the continuum of care, and with a wide variety of community in public public health and other

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public sector partners. We need both at the Federal level and also from private foundations and other community levels, the kind of advocacy for collective impact models that support preparedness and response and recovery work.

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We need to have investment and policy environments that really support the promotion of these kinds of public private partnerships and the kinds of solutions that we can generate.

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And I think we need to collectively see those as a part of the next step of preparedness is really about the building.

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More duplic, reducing the duplication of effort, streamlining our efforts, and building more partnerships that are really meant to work across the whole community and bring together the best practices and resources of public and private

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partners, and i'll pause there i'm really looking forward to the conversation.

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Thank you. Thank you so much. And I think that this you know.

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Actually, I guess all of us are working at so many intersections of all of these systems. But Dr.

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Matthews is going to speak next, and I think that communications and technology are 2 of your areas of expertise which kept coming to mind over the last speaker.

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So. thank you, we'll look forward to what you have to say here, thanks, Jennifer.

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Hi everyone, i'm Sarah and thanks for having me you know as a applied epidemiologist and governmental public health.

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My team, and I would always say there's Nothing like an outbreak to get your blood flowing, and certainly the covid 19 pandemic is a doozy of an outbreak.

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As we all know, the pandemic exposed all of our cracks, our vulnerabilities, and our incompetence.

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Structurally, no longer hidden was our societal lack of help, literacy, and our significant health inequities.

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Typically in the public health sector issues we've discussed free pandemic were brought to the forefront, such as or antiquated computer systems are lack of capacity in terms of workforce are disagreeable methods for

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recruitment and retention, and our inadequacy on our own focus on our own mental health.

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As an optimist, I say our covid 19 response and recovery gives us a chance to do it right, because we've all felt the effects of it in sufficient public health system.

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Public health is community health, community health involves all aspects, including those sectors.

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My round team colleague, brown table colleagues are speaking about today, and within the next few days. so short term and long-term terms include a cute chronic and mental health conditions.

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And we put our nation at risk we're becoming sicker so what do we do?

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I would like to invite everyone on this call to think systems approach and begin to integrate a help in all things I'd like to recommend a three-tiered approach that is, individual organizational and systems. level.

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The first. here is an in bad individuals we have some responsibility to become more help.

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Literate to prepare ourselves. Our communities are families to the best of our abilities, to know when to ask for help, and to participate in community.

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This can look like taking a Post Aid class volunteering at a food bank, participating in one of the numerous outreach events that your local public health department puts on including your community health assessment and community health

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improvement plans your chaws and your chips in power to build resilience.

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Our greatest tool and public health is our communication to educate.

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We collect and disseminate data to drive decisions we implement in for interface, to empower individuals to better health, and we help build a community or place unit communities in charge.

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You from the organizational level. We have to build a better public health system that's able to respond to the needs of the community with the power to communicate.

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This includes their pay schedules faster recruitment processes, a better career ladder screen and a change in mindset that we don't continually ask our workforce to do more with less it's also an operational

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process that I recommend to all sectors as we begin to integrate this help in all approach.

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In other words, Bill. Finally, since level, this is where our policy lawmakers and advocates have the biggest influence as structural barriers are identified.

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It. Book moves us to change, to ensure. our communities are not subjected to needless suffering.

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What are they? Nonbiased data shows that a brown or black community is disproportionately affected.

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Name it, and do something about it. don't just give the statistic, and leave communities to spend for themselves.

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When we see that our rural community is not getting appropriate funding, or they're being left out simply because they're small change.

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It help improve equitable funding algorithms, and personally invite and engage relationships with rural communities.

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In other words, collaborate local leaders can start to facilitate proper revenues to emergency response.

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They first ensuring their own help. Literacy, by knowing their community from a public health perspective, inclusive of the political and social determinants of health, develop a vocabulary that is inclusive and scientifically accurate

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practice 2 way and risk communication. that's by person to help build the 4 and 12 local leaders can support community partnerships and collaborations ensure recipients of funding

are taking a community centered approach with an

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evaluation arm, go to the people instead of always asking them to come to you.

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The people who most need your advocacy are too busy trying to live, support policies that ensure building a resilient community, including flexible work, schedules, volunteerism as well as access to home surfaces, Finally, invite

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public health to your table as a consistent contributor to your efforts, because, no matter what topic we choose, there's always impossible.

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Thank you. Thanks, Dr. Matthews. I think 1 one element that has been consistent across all the speakers, and that we have in this field often felt that there was sort of a unique resilience that rural communities have so when I

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hear now, specifically from an expert working in the rural setting I'm: thinking about how those kind of community systems might be unique.

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Thank you. I am Gayla Willen, and I am the CEO of a small critical access hospital in a rural county, and the Panhandle of Texas, and I really appreciate all the comments that everyone has offered about

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rural health care. Part of the challenges that we have are common with every healthcare system, with every hospital out there.

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But there are some that are unique to us. and Mr. Brown talked about staffing and some other people who talked about the workforce, and that is the thing that is a particular challenge for us.

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Our county has a population of less than 10,000, so as we look for those people who have special training nurses, positions, lab and radiology.

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Technologist, You know we don't have a large resource pool of people as they do in the urban areas, and we share the same potential employee pool with our neighboring counties who also have limited people So recruiting for

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us is a challenge. Every community needs in order to survive this schools, their churches and their hospitals, and the 2 things that hospitals need to survive our funding and staffing.

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So when the we work really hard to get our staff when the pandemic came along.

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Obviously the whole healthcare system is overwhelmed.

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Our hospital became. we don't have a icu normally when people need a higher level of care, we transfer them out to an urban area urban hospital.

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But there were no bits, so we became and I see you hospital, and we were taking care of our neighbors and our best friend's grandmother and our kids teachers and and people that we knew we want our nursing home as

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Mr. Brown mentioned it really tickets toll on the residents for a nursing home, and our staff

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As some of them became ill and had to be out you know There's long hours that you work there's the stress just of not knowing what this virus was, and this is a healthcare system. We were trying to figure it out and

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learn. You know. What is this virus, and how do we treat it?

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And how do we slow it down, and how do we stop it?

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And the the rules were kind of changing every day.

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It was very stressful, to say least i'm on the staff and so we were working short.

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Sometimes we try to get extra help in. people are working over time.

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The stress was just kind of beyond beyond bear tolerance.

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It sometimes. Then we had some agencies that would come along and say, Hey, we can help you, staff

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And then they would recruit our step out from under us pay them triple what we could pay them.

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And then. Now we've got another hole in in order to get more stab, you know.

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Do we pay this triple salary to this nursing agency, so that we're not short stacked.

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But then, that's demoralizing too our staff who stayed and become like, you know they were loyal to us because they, you know they like to have that kind of money as well.

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So. so it was kind of a cycle of you know.

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What do you do? we? We just want to survive and want to to do the right thing for our patient, so we want to do the right thing for our staff.

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The consequence of that was that many people in health care not just role, But many people in healthcare said, I don't want to do this anymore.

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And and so we have seen people leave health care as a career.

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Physicians, nurses, technicians I mean it's all across the board.

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Even people in Billing, you know. if another pandemic comes.

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I don't know that I want to live through that I'm not sure.

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I wanted to work through this one, but but here we are.

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So this urgent short term is is also a long term thing for us.

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It's already difficult to recruit people to the rural areas, because you know, we don't have the amenities that the urban areas have we don't have theaters you know big huge parks

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and we don't have you know a walmart and and Cbs.

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On every corner, and we don't have 24 7 things that are open, so that you all these activities and so that younger generation is really looking for that kind of excitement, and that's sort of not a lot.

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And we don't have that in general so this just compounded the fact that it's it's hard to get staff.

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So the question becomes, How do we convince people to come back into health care?

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Really good, strong clinicians. how do we convince them that it's okay to come back to healthcare.

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And the next part of that is, how do we convince people who are looking for a career to consider healthcare? You know how.

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How do we say, you know that pandemic is a one-time thing that won't happen again?

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Well, we don't know that how do we make healthcare attract again.

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So that's one thing that that really is a challenge for us the other thing is as the pandemic hit us in and grew and became more and more serious. Urgent part of our job at the hospital is to educate

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people and to tell them what is this what's going on how do we help you stay?

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Well, how do we treat you? If you do become ill and we're relying upon Cdc.

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And some other organizations to help us with that information.

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Is this one along? Our Our community was very confused because we were telling them one thing.

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The media took off the news every time you use to Had kind of a different story.

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No, don't do that Treat might get this treatment be sure and ask your doctor about this.

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Not do that. And then, of course, the Internet, which we all know is quite reliable.

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Everybody had a a Youtube. video and said no i'm The expert.

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Listen to me. we said we're mask wash your hands.

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This will help, and in many cases it did. but in other cases it did not.

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And some people just come to the virus, and and it was quite tragic for many, many people.

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So. our community, I think, lost confidence Not only in the healthcare system, but in our local hospitals and our local providers in our local clinics, because, you know, we're the ones that they look to and in this

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virus just took a life of its own and in them losing their confidence in us.

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They also, I think, began to not trust healthcare as a whole.

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You know who are these people and they're supposed to be the experts, and they have degrees, and and they're these.

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But they're telling us all these different things and we're hearing all these different things, and we don't know who to listen to.

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So I think long term one of the very large and and what difficult challenges that we're gonna have is regaining that confidence from our community and rebuilding that trust, so that they know that we they can count on

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us and and how do we do that and I think it's What other people have spoken to?

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We we partner with people We try to, you know. filter out the nonsense, and you know, kind of stand as a team.

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To give good information to them to be there when they need us. and to try to be as consistent as we can.

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And then in rule again, because we have small volumes, and you know he wants to move to rural community.

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But you want to come there if they have healthcare.

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But you need to trust that healthcare, so that I think that is gonna be a huge challenge for us as we go forward.

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Thank you so much I don't know if if Janet remembers she was one of the very first people that I met when I moved to Delaware, and I think that she works in a county that's been characterized as one of

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the most resilient in the country. So, looking forward to hearing your perspective from that that sort of community, health and social services wrap up.

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And then we have a second question that will let the panelists briefly respond to after we hear from Janet.

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So, thank you. thank you of course, of course, I Remember i'm actually a bit of an accidental tourist on your public health journey.

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And it's really funny that i'm now working for a hospital.

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So for the past decade I actually was spent my time primarily in emergency management. and, in fact, that's where I was when the pandemic started.

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I actually felt like I could do a lot more community good by moving over to the nonprofit

sector.

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So I work for our county wide food bank and Now i'm here, sitting across the street from a community hospital, and it's interesting.

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You're talking about the loss of rural hospitals unfortunately, in the county.

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I come from. We have shuddered. 2 hospitals within the past year. out of out of our hospital system. There's an adjoining county, also literally on the outskirts of Philadelphia is preparing to close 2

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more so in some cases they're being converted in some cases they're being there are question marks about what their future even is so.

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It's not just some ofural environment it's pervasive everywhere, and we are definitely considered about that health care loss.

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So, but that the original question is, Yeah, I think this conversation is absolutely imperative.

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Why? that? Because decisions are being made right now to ensure that the dollars and the best practices reach every community.

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And what I have seen time over time, and this really resonates with the keynote speaker.

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You know he was talking about those most at risk they're obvious I've been concerned about those for most at risk who are hidden. Why?

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Because these counties that I work in both currently and previously like to tap themselves as the healthiest as the wealthiest.

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That's great, if you're part of that subgroup, if you're not, it actually creates given a larger disconnect, because people are very quick to other things.

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So where a lot of these problems existed prep pandemic I think they're for a glimmer in time it really showed a light on them, and i'll take you through a few different examples of that.

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But I think now what we need to realize is we need to have a true understanding Of what did these communities look like in 2,019?

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What were the strategies, what were the successes? What can we build on out of what happened next?

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And how do we move forward collectively, But what we can't do? is simply have the expectation of we can take what was good in 2,019.

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Add what worked well through the pandemic use, less staff, fewer resources, and expect to do it all, because, as somebody alluded to, you could do more with more.

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You can do less with less where you can burn your staff out trying.

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And then really, what? what have you accomplished so I think that's really important.

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Actually come out of an education background. They had something called understanding by design and modeling their thoughts.

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Just a little bit for me is what recovery looks like it's Identify your desired results determine what your acceptable evidence is going to be.

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But now it comes to the point where you need to work with the community, not only to design it and implement it, but figure out ways.

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You can maintain it moving forward because it's great to come up with these great ideas.

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It's great to pilot them but if you don't leave the community with something that's sustainable and maintainable.

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You're simply going to be starting over the next time and at that point.

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There may be no resources, so I think that's I think that's important.

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Looking at it from through the food security lens this insecurity it's not necessarily lack of food.

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They're not the same things, although this for many people when they couldn't get their favorite foods with the grocery stores were shut down when there were supply chain issues.

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A wake up call that is not always the issue. things like.

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Why would people need prepared meals Well, people might need prepared meals?

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Because they don't have the dexterity to do it themselves.

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They don't have the cognitive ability to do that they may simply not have the desire or the time.

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Maybe they don't have electricity maybe you know giving somebody fresh produce is fantastic. but if they have no way to store it or prepare it, what have you actually accomplished? so I think it's really from a systems perspective, it's understanding

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that healthy eating is critical, but from an actual day to day implementation, what is it gonna take in order to do that?

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Is it access? And what does that mean? Is that access to the boot itself?

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Or is that access to human service programs within those human service programs?

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Again. You know how accessible are they really so i'm sitting here on the convergence of freedom counties, which means we have 3 different social networks that we're trying to work through.

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And then the services are found by county so we can't help them.

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So, whereas for some folks we're working within our 10 mile radius can get to the county

assistance office by walking and or by local transportation in the bus system, someone who lives next door is so either going to have to

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travel 18 miles in one direction or 22 miles in the other to reach their own county Assistance office.

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So that's not a challenge we're going to solve today.

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But looking at the true big picture, what does it mean when you could only receive services through your home county, even though the base of those services is much further away.

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When I was working in the other county. it actually Touches 2 other States which complicates things, including Jennifer's, which complicates things even further.

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So lack of affordable housing. I know our first presenter really touched on that.

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You know the cost of rentals have gone way up around here.

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So. not only was it lack of affordable housing which we knew about now.

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The cost of those rentals has gone way up, and that just continues to perpetuate the problem.

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So all the rental assistance. in the world all the housing vouchers in the world mean nothing if there's no one who's willing to accept them.

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We've seen this through an equitable school funding that's a huge problem in the state of Pennsylvania, and worth looking into our 10 mile radius alone.

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We have 7 autonomous school districts, all of whom have different resources to bear.

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When the world went virtual it became very apparent which schools were the house and the have nots.

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So even those who were able to get the technology out there was there a digital device in terms of who could receive those services. Play this out a little bit further.

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You certainly see, telemedicine was an absolute blessing, particularly with the shortage of mental health providers.

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But again, for whom? who had access, who continues to have access to that moving forward.

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So. so we think around the term of refilling. Thank you.

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I think you brought up every vital condition and social determinant in that.

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So we we have about 10 min left, and I was hoping that everyone in the audience and everyone in the panel would think a little bit about to them.

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What recovery means. We know the pace and the quality of recovery is different for different individuals, different communities, and different systems.

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So maybe speaking from your primary place for about 1 min each.

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You know, John, like what is what is a reasonable timeline for how housing recovery, and and what does it look like if we get there?

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And I know that's a lot for 1 min yeah as I said, You know we don't want to recover to where we were pre-pandemic in the affordable housing world because it's not a good place

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it's not a good place just from a housing standpoint.

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It's certainly not a good place from health outcomes but people who live in substandard housing people who are chronically moving from place to place, children who have no stability live in much invested environments and and problems like

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that So you know we've got a we have to Do we have to you leverage this some way to get something better out of it, and I've worked on disaster recovery for many years.

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Because we've had multiple hurricanes in texas and it is, there is a unique opportunity when the Federal government provides huge amounts of money and provides it as general grants to potentially to local governments.

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I mean, basically, if you are prepared to have a recovery plan in place, and if you are organized with A is a group of people who are advocates, and with the building from the community to make the case for the use of those

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funds. Then it's a unique opportunity, but you know the sad truth of the matter is, we go through multiple hurricanes, and we always start over from the very beginning.

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So, Donna, What is that look like for community financing?

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When when will we be recovered. Yes, Well, you know that's that's a $64,000 question.

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It's a great we all know that certainly with Covid.

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We had both a health crisis and an crisis for community development.

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Financial institutions. Both of those are really important. you know.

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I talked earlier about. Clearly the approach is that have been sought to individuals with food programs.

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Jennifer and transportation, utility, reimbursement.

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Extensive and good advantage. Individuals have core health outcomes and will occur financially stable and upwardly mobile.

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How do we address the economic vulnerability in in as well?

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And I'll just very quickly in 30 s talk about a pilot program that's underway in the Delta region of the United States and class. Still, Mississippi I sit on the board of put in bank or which is a community

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Development financial institution in Arkansas, and they have recently launched a 2 year pilot.

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That really has commitments like Kvin Vancouver on E.

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Henry Clinic, quite still Mississippi I said a 2 year pilot that really working to create a model to integrate Cdfi economic inclusion services at the standard of care and a federally qualified health

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center for low income clients and Clarksdale, Mississippi.

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Clearly, this is an area that's marked by deep integrate integer and intergenerational poverty racial inequality across sectors that have negatively affected the health health outcomes.

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And so what these 2 entities are hoping to do is to identify, identify the root causes of that financial vulnerability.

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To be more financially secure by dividing the kind of support services that are needed.

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For those individuals that have been chronically underserved by the financial sector, but also in doing so, identify ways in which economic elevation can also improve health.

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They were recently featured at a form for the Clinton Global Initiative, where they are thinking commitment from

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Both the public and on this pilot project and again. It's not necessarily something that's going to happen overnight.

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We know that community economic development takes a long time in the right direction.

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When we look at those very vulnerable communities and look at ways that between can not only support people's economic advances, but also tie that into how health can also be improved along the way.

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And what is what does recovery look like for you how long does it take?

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I'm not sure, I believe that there is a real end state of recovery.

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That's clearly definedable. So I think of these days post pandemic as recovery of kind of a process of continuous improvement.

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And I think some of the indicators, from a preparedness perspective that we can continue to look at.

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Are we actually improving upon the things that we saw as glaring bulnerabilities, and doing injury and harm to our community, to our providers, to our organizations?

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So are we making progress? Are we actively looking at the at the barriers, at the problems and trying to improve upon them?

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I would love to see legislators at all levels, holistically looking at the policy environment.

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So many of our solutions aren't gonna be tenable if we can't create a policy environment which we can really work across the continuum of health and actively and progressively ensure that people are getting the care they need at the

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right level of care, and that we are removing barriers to that, regardless of whether we're in a declared emergency or not.

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But that's really the philosophy we're driving towards you ask for a minute.

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I'll pass there but it's a continuous journey. so gala does that ring true for you in the rural setting?

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Have you talked a lot about your workforce pipeline that may reach a recovery point?

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Yes, and and I agree with the nora i'm not sure that there's a definable hi we've recovered now.

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Kind of period. But I, you know, in hospital we we show up every day and take your patients that come in, I think for us recovery is when we can figure out what did we learn, and how do we take that to approve what we do

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going forward. And how are we more prepared for whatever comes next?

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Because I agree with Mr. Brown, there will be a next something.

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And so for us, I think, for for recovery is just moving forward and and doing what we do.

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So, Janet, you talked about a lot of the inter woven issues in your communities.

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Any idea when we'll well recovery looks like there so I think I think it's not going to be linear it's not going to be one size fits all we need to figure out truly which communities weren't a part of the conversation

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and 2,019 may not have been a part of the conversation through the pandemic and start there.

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And that's where to put your dollars to put your resources to put your technical expertise and accept that resilience which is a term that we've been bantering around an awful lot you have to remember not everybody's starting from

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the same starting place. So resilience is really you know it's a you know it's a way of coping it's a mechanism, but it's not the solution that the solution is really setting setting things in place

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that are going to allow for a positive future, and sarah I didn't give you any heads up to do this, But i'm putting you on the spot for the last word, because I think you know maybe to to try in 1 min to explain what

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our systems, you know. level response to this is listen I agree with everyone on the pound.

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But i'm gonna put it to You and I think our timeline for recovery was yesterday.

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This is ridiculous. we're in the the most supported country in the world, and we should have better systems together.

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But instead, our public health system as monica said is in the in a stage of crisis management, we're trying to build this plane as we're flying it, and we need to be able to flexible nimble responsive and our ability to

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sustain whatever comes to us when if it's a another pandemic on another surge capacity events, you know we have lots of examples, and we have lots of models that we could follow.

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But yet we get things in our ways like like politics.

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And there's a way to use politics to to make sure our needs are met.

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But example, before this pandemic there was one before in 2,009 for H, one n one.

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We had system sometimes prepared, and people use those plans not only for H.

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One n one. But then, again, here in our pandemic for Covid 19, and that helped those businesses have some feeling of normalcy.

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When a public health expertise was scarce you know here in Florida.

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We're dealing with the aftermath of of hurricane?

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And what if we used a model like that? where we have our systems in place?

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We do this very well. There were working national in state local and communities coming together to help each other out.

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We can't just stay on the zoom calls hoping things are gonna be better.

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We have to be in person, hopefully masked, and doing all those wonderful things to protect

ourselves.

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But we have to be connecting, and we have to be involved.

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So doing those communications, and far more one more point I have to say we're all talking funding, but funding has to be lastable.

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It can't be a one-time size fits all as you said, Jennifer.

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Recovery is going to look different. No matter where we are in the country, and we've got to be able to make sure our our bucks are spent.

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Well for what our community needs. Thank you. So I think we had an important task to discuss some really big ideas in a really short amount of time.

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But I appreciate all the comments from the panel as we go into a break until 145 Eastern time.

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I want to remind everyone that is on the session that will be posting resources related to Long Covid, as it relates to a long-term issue for our community systems and a and a challenge to recovery which we

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didn't you know even have any time to address in in this particular panel.

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So we hope that you will take a brief break and

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Return in a few minutes to hear some of our panelists from the second session.

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Thank you so much.

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Welcome everyone. It is now 45 min after the hour whatever time zone you're in, and it's my pleasure to introduce the moderator for round table number 2 area to chicos in a word, of resilience

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Maven, and I want to hand this over to you area.

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Thank you. Thank you so much, Monica. I will. I would like to say thank you so much to our panel members and to everyone attending today.

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As we as we as we look at this very challenging issue of pandemic recovery, and explore together the the challenges we see with a spiritual and trauma subjecting that people have experienced at these

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last 2 years. So our our panel topic in general is, what do we need now to heal the collective wounds from the Covid?

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19 pandemic, and our speakers today are all thought leaders from spiritual trauma.

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Recovery and restorative justice traditions and they'll address How the pandemic recovery process can incorporate practical strategies embedded in our daily lives in our civil society and governments so that together we can

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address the existential wounds inflicted since the covid 19 virus has emerged.

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I want to share the prompting questions that we sent out to our speakers today, and then i'll introduce them.

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As they're posted on the agenda and we'll take our speakers in the order of the program itself.

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So the first topic that was sent out to our colleagues to discuss was, we asked them to speak today about their from their area of expertise, what forms of release, relief, and caretaking that we all need now to ease the inner

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damages inflicted by the pandemic, especially in hard hit communities.

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And so we will talk about what practical steps that local leaders can take going forward to schedule up, or even introduce healing modalities.

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And then look at how we can measure the success of these interventions as we go forward to see if we really are making a dent in the pandemic related, emotional and spiritual distress of our communities.

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And secondly, we ask people to consider these larger issues that so many of our speakers earlier today spoke about starting with Do Brown to look at the issues of racism, political strife, and social fragmentation that have amplified

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the collective trauma associated with the many and uneven numbers of Covid.

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19 cases, hospitalizations and deaths. What sources can our communities consider as they look to find common ground and develop and nurture?

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A sense of shared values as we go forward. And how can local community leaders use these sources to promote healing from the particulars of the pandemic, and then look forward to future disruptions?

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As we all discussed earlier, that are probably before us sooner than we might think so today. our panel is consists of renowned and respected leaders from around the country.

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We will open with Reverend Anthony Evans, who is the president of the National Black Church Initiative.

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He will be followed by Brian Flynn, his associate director of the Center for the study of traumatic stress in the Uniform Service University.

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From there. Deborah Pennell, who is the senior, medical and forensic advisor and editor-in-chief for the National Association of State Mental Health Program directors.

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She will. he she will be followed by Jennifer Llewell, who's the director at the Restorative Research Innovation and Education lab Ibu Patel will be up next who is president of

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interfaith America, and we will close with Rabbi Deborah Waxman, who is the president of reconstructing Judaism.

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So, Reverend Evans, will you lead the way in our discussion?

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Thank you. Sure it is an honor to be here, and certainly without distinguished panels as well as hosts.

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So thank you for this opportunity to reflect on what is consider a life-changing situation in our society dealing with Covid, and it's after effect.

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Well, let me just first of all lay the foundation of where I set, so that you would understand my perspective.

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I am the president of the National Black Church Initiative, which is a 150,000 African-american faith communities with 27 point, 7 million African American Church Gores, about half of the 42 million that African

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American people in this country, given that perspective, and haven't been involved with Covid since December of 2,019, and wrote a a paper outlining what are going to be the randomifications of covid given

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the fact that underlying communities were often overlooked.

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We saw that very clearly. We tried to contact the White House, and that was literally impossible.

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I will contacts. even within our structural organization, such as the National Medical Association, the and also the Naacp and other Civil Rights organization, really did not have the necessary relationships.

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At the time of this pandemic with the White House as they have now today under the Biden administration.

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So you can. So we were. a community was at a disadvantaged

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And in terms of our relationship, and that stem for

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Speak to what we have pointed out for years in our community.

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We cannot ever consider ourselves or democrats. rather we like it or not.

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But the White House looked at that and looked at that as a political statement.

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Therefore we were last to be served for political reasons. We were last to reserve for racial reasons, and we were last to be served because we were a a major voting block.

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That was not in tune. Politics had a central way entering into Kovat.

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If you can deny that all you want, and then you will get nowhere in America.

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If you, too, So, given that disadvantage, we we had no other choice but to force the White House to look at us, to look at our plans, to hear us.

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Well, what we found out was stunning. What we sound out is a healthcare system, not not only where they were that had ratio, structural and historic barriers.

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We found out a a healthcare system that was resistant to

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Any suggestion that we had any answer whatsoever about our own communities.

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And I point that out because we wrote a comprehensive plan for our country in terms of what my brother Dr.

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Brown spoke of in terms of a democracy, a reconstruction democracy.

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We wrote a comprehensive plan, outlining how to educate, vaccinate, and handle a 109 million Americans, which is about one third black and Latinos for all of the governors.

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And every State. we send it to the Governor.

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We send it to the Chief of Staff, so that the governor can get it.

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We send it to the head of the State Health Agency, whatever that constituted in that particular State, and we sent it to the Social Services director.

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We got some inquiries, and we held a few zoom call, but nothing really happens.

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So where are we now? Well, in the African American community, and especially in the religious community, we have 25,000 dead pastors.

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And those are numbers that we can glean from from our own data collection, and how we count

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That situation. Now, of course, those numbers and data is inaccurate, and they are inaccurate because we could not rely on the State dashboard because they didn't break the data down by race so it totally took us

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over a year to get to some sort of understanding of the impact.

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Cool. Covid will have on just the religious leadership of the African American community.

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I'm not talking Latino community, but only talking African American.

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We closed about 25, I think we could be a little bit more accurate in the churches.

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We closed about 25,000 churches. those those were still front churches that would not have survived, and any economy, especially in the covid economy.

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We also suffer disproportionately about the access to the vaccine.

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Once the vaccine was ready again by the state leaders and It has nothing to do with the Federal Government by the State leaders who was empowered, and a lot of people don't understand this.

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It was not Hhs who ran this particular covid experience it's not true.

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It's the State who ran the covid an issue and it?

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That's why it's very radically from state to state I remember very specifically.

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They deal that then President Trump made with those governors and I will try our interaction with the Governor's association was tragic to the fact that none of our national officeations will work with the governor's association going

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forward. That is not my perspective. That is our national denominational perspective.

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Over 37. We try to sit down with them to reason that we had a plan that they needed to make serious investment into the church structure.

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And if you notice about any of the situation that happened, the church came last.

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We came last to the rest of the State, all of us, all of a sudden the State recognize that the way to get to the people that they need the seniors, the homeless, and the disabled

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Those who were homebound was only through the State, and I blame that strictly on the State leadership.

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Because, remember, if you are the State Director of Health, you have a lot of power apparatus, and specially because the Governor of your State invested totally in you, and if we can that need to be an examination of all

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of our State leaders before and after Kovat, and in terms of our health care.

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I am not blaming them per se as individuals i'm i'm, hiding them as an agency that the agency itself did not have adequate plans and information for instant the agency did not know how

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many people were in this state, they only had it. They only go to the senses they go to when they went to the Us.

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Census, but they did not have command over that. They did not know where the poor were located.

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Even in their state brothers rule or urban. And this is what Dr.

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Brown pointed out earlier about the the Black Belt, the affiliation belt, the northeast belt, the tribal belt.

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They did not know those communities, because every health care worker agreed that those communities should be served first.

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And let me report to you right now, 2 and a half years later.

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Those communities are still not served today. We cannot account you cannot account for every single African, American and Latino senior has the vaccine that is, that cannot be counted, and that is a tragic point of our nation's history

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so, even when the Church was not upon the overall structural plan of the State cause, it was, it was a State ran situation.

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The the governors took full control, and I want to point out something that happened that the Governor should not be well respected for, and that they First they took the first Covid vaccine. that was given to their State, and they did not give It to

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the poor. they did not give it to the vulnerable.

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They gave it to their friends, and they give it to their neighbors, and they give it to the well connected.

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So as the Church leader. it is my moral authority to tell a nation that that is unacceptable move forward and dealing with any pandemic going forward, and that not only do we need a complete reconstruction dr brown

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call is a reconstruction of democracy i'm not going that broad, because I do not believe that this country is ready for any radical change.

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I have the stomach for any radical change i'm just simply asking for State leaders.

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State legislators and others to consider a reconstruction plan by those individuals, and not counting myself who serve on this panel and other panels, who clearly understand the science and the data that will move us to a point whereby

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we have an equitable plan and a democracy of health in this country.

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For the first time, excuse me i'm gonna thank you for that amazing opening.

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We're going to segue to our other panelists, and then we'll get back into our discussion.

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So our next speaker is Brian Flynn who's with the uniform Service University Brian.

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Thank you very much. I need to begin my conversation with you with a disclaimer that what you're going to hear me talk about today.

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Really reflects my own perspective on the topic, and not those of the uniform Services University.

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The Jackson Foundation of the Department of Defense. I think our previous presenters have done a good job in expressing the complexity of of Covid.

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I think we really have a quandary with Covid response and and recovery.

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And that is that it really occurs in the context of so many other stressors.

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We are in the middle of an economic crisis Questions about civil unrest and criminal justice, political upheaval, natural disasters.

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There's a number of things going on so we can't afford the luxury of just looking at Covid, as some of our presenters have have indicated.

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It's much more complicated than that. and one of the biggest complications, I believe, is that the interactive effects of all of these stressors has really caused us to challenge our values.

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What does it mean to care? What does equity look like?

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What does justice look like? What does connectedness look like and I think we know far too little about the interactive effects of all these issues and the duration, and I suspect that we'll be dealing this with this through generations

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rather than issues. So the the lens through which I approach.

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This. This topic is is a little bit unique. My academic training is in clinical psychology and mental health administration.

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My occupational history has a lot to do with disaster.

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Response of many different types. So that's the the lens through which I I speak, and I want to share some things that I think I've learned doing that kind of work over many years when we think about behavioral health our

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mental health disaster, mental health. our default setting is usually clinical, providing counseling services.

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Treatment for mental disorders etc. that is critically important, and it's a big issue in the recovery from call it.

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But I don't want to focus on that today because I think what I have to add.

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Probably is more relevant to the more public health aspects of behavioral health.

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And that is, thinking about this broadly, about how individuals and communities process information, how they make behavioral choices.

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We adapt to change, and how we individually and collectively grieve our losses and and and

changes.

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So i've had been in the field for a long time, and I've had a chance to look back, and I wanna share with you a few things that I think are consistent among virtually every disaster.

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I've been involved with There seem to be factors that either make or break the response, and recovery regardless of how much damage there is.

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How many resources there are from recovery. there's some common things that make or break that. And i'm going to lead those into some things that we might specifically do. One of those factors is leadership.

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I have seen response and recovery made or broken by good leadership, and I'm talking about general leadership organizational leadership, formal, informal, through a wide variety of of organizations the other is communications.

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If I had one tool in my belt it would probably be to be able to communicate effectively with people in a response in a recovery period, providing people with information that they understand.

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That's meaningful to them and that's presented in a way they can retain and can act. upon. There's a science.

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To this, and it is risk and crisis. Communication is different than general communication, and the third issue is culture. talk.

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We can talk about general culture. We can talk about occupational culture, organizational culture.

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Most of what I do these days is is organizational consultation.

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I talk frequently about the culture of an organization people know whether they're working for an organization that cares for them or not.

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And so thinking about the role of culture, and what the culture can do to help us, or might do to hinder us.

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So what can we do? One of the things we might do is go back to the foundation and of psychological first aid, and I've provided some resources for that, and those 5 elements that constitute that our sense of safety promoting

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calmness, sense of self efficacy, and that would include collective efficacy.

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I would I would promote, and also a sense of hope.

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So one of the things that I would recommend for people active in this field is to take a look at what you do as leaders.

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What we do as leaders, what our behavior is, what are the things that we write?

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Were the actions that we take? How do we communicate?

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What do we communicate? and measuring all of those against whether they help or hinder the promotion of those 5 foundations of of psychological first aid?

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Just a one comment about some other things that I don't want us to forget.

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I've also learned in my career that in a crisis situation.

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The the written and spoken word fails us very frequently.

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And I think we need them to turn to symbols and rituals in order to cross cultural lines, to promote our shared suffering and recovery.

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And I think the faith community in the military community probably know a lot more than behavioral health in that regard.

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I also, would like to just make a comment about moral discomfort, distress, and injury.

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It's been mentioned before, I think that is a factor that's getting more attention, but needs more attention, as we go forward, and considering what people have experienced, and what that means and my final statement in in a group of

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like-minded people like this is to never lose sight of the fact that there are those who don't share our values, that there are those who do not want healing to take place, who want fragmentation, promoted want

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conflict, societal discord promoted, and we have to be ever vigilant of that.

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So. with that I will stop and say, Thank you. Thank you so much, Brian.

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Next Our next speaker is Deborah Pennsylvania.

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Give us your wisdom, Debra. Thank you. Yeah, Well, thank you first of all, very much for inviting me to speak on behalf of Nashville.

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The National Association of State Mental Health Program Directors, and just by way of context, that organization represents 7.5 million people who are served by the public behavioral health system and all 50 States for Territories in the District of

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Columbia and The mental health leaders in in each State which have been referenced already, have really had much to learn from this covid pandemic, which I think we can take stock in and move forward as we

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look towards what they call pro traumatic growth Having recognized that we can't change what happened, and some of the very painful lessons that had that were learned.

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But we can learn from those lessons and move forward so I think leaders in behavioral health have a real opportunity to help make changes, so that if there were another pandemic or at any point where there's a disaster we

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can continue to improve upon the response. And one thing that was already mentioned is really focusing on building an infrastructure of support.

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The infrastructure of support was not ready for Covid.

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19. We know that in the behavioral health system we had done so much planning for other kinds of endemics.

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We had done planning for natural disasters of a sudden nature.

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Our system are required to have plans for continuity of operations.

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But yet, when the pandemic hit, there were many things that we were blindsided by.

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For example, we saw that our behavioral health system was not equipped with personal protective equipment proportionate to other systems and other entities.

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We know that the intersectionality of race poverty. now illness creates all sorts of multiple layers of disparities, and some of the disproportionate impact on our populations with getting covid 19 and succumbing to

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Covid 19 we saw fairly quickly. And so one of the things that we, I think, have an opportunity to do is learn through this disaster.

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Behavioral health experience how to ensure a better infrastructure.

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We worked with our provider community to help learn from them what their needs were, so that they could support people with incredible vulnerabilities in our communities. and I think we need to learn from that.

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I'd also like to say that we have a real opportunity to lift up the voices of people who have lived experience, who have suffered, but pursued and demonstrated resilience in that perseverance.

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The substance abuse of mental health services. Administration, for example, has elevated the voice of people with lived experience by highlighting a new office of recovery which, which really focuses on having people who in the peer community be able to

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have a real seat at the table on policy development and organizational change.

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At Nashville. We have many peer members in our staff as well, but give advice and technical assistance to the States, and I think by lifting up the voices with lived experience, with mental health issues substance use issues and other

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challenges. we can really help build that infrastructure in a way that will meet the needs of the populations that we're trying to serve.

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Behavioral health leaders also have an opportunity. We we found ourselves in a position to not only shore up the capabilities of our service providers and ourselves, but as as we were trying to ensure that the people, we serve those with serious mental

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illness and youth, with serious emotional disturbances, were also served well.

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So in terms of taking care of ourselves, so that we can take care of the vulnerable members of our society.

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I think we have opportunities for that we're also working hard building out a crisis.

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Care continuum the The initiation of 9, 8 8 in July of this year allows for a brand new opportunity for suicide, prevention, and crisis response to all people and all walks of life talking through phone or

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chatting by text, and through that 9, 8, 8 initiative.

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Our behavioral health leaders are working hard to make sure that when there is a crisis on an individual level or on a larger level, that there are people to respond, and that response is going to meet the needs of different populations.

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So the crisis continuum with 9, 8, 8, and then looking at building out mobile crisis services and other response systems, is going to be incredibly important.

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Again. From the pandemic we learned that Americans were able to articulate that they were suffering and suffering greatly from mental health conditions.

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People came out we had a household pulse survey that every 2 weeks provided data on the levels of depression and anxiety that people were reporting, and fully a third to 40% at different times.

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Sometimes more. we're experiencing real symptoms of anxiety and depression.

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So by having this 98 response and recognizing the importance of putting out in front mental health issues as part of public health, I think leaders have a real opportunity for growth and development of resources.

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It also allows a more frank conversation with hopefully reduced stigma.

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Unfortunately, the surveys show that the stigma pertaining to mental illness persists. despite being able to talk about mental well-being and mental health.

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It is still very difficult to talk about and acknowledge mental illness in a real and meaningful way, like we do with medical conditions.

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But through this covid 19 experience we may have opportunities you're on mute.

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But I think you may be telling me

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Those were illuminating comments, that we're going to move on, but we'll have chance we'll circle back together.

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We're done with our questions our next speaker is Jennifer Llewellen Jennifer Hi!

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It's a it's a pleasure to be with you it's such an incredibly rich and and inspiring opportunity to hear from our keynote and from panelists earlier and now my co-panelists i'm coming to you from from

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Canada, and and as as part of your North American contingent, deeply committed to thinking about these solutions in in the context in which I live, and in the communities in which I work internationally and and and in the us, so

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so humbling and and exciting to be able to to be with you.

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Today. I wanted to talk a little bit about in response to your question how it is that we understand the sort of needs for this build back fair and and more adjust from the perspective of the work that I do in restorative justice both sort of domestically where

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you all might be more familiar with restorative justice alongside, or as part of the criminal justice system as sort of these alternative justice processes or otherwise, within communities that sort of an individual level supporting interpersonal the recovery from

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interpersonal harms or those sort of inner inner terms that we that we do on when we cause harm to one another, and sort of raise the potential for the work that's being done in communities and in systems around

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restorative justice to support us in this time, as we try to think about what sorts of processes and and and opportunities do we need to tap into, as we try to understand and confront and respond to the harms that

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that and impacts of the pandemic as we've heard about on this mornings.

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I guess, boring for me. Maybe this afternoon for others. this morning's panel, and and also to think about How do we understand this idea of justice and the processes that might support this these kinds of justice responses for some of the

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proactive and prevented work that we need to do if we're going to be move towards a more just future.

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If we're going to learn some of the lessons that have been presented and revealed to us in this pandemic time.

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And so I kind of want to share our thinking about how we might look at those processes and and programs and folks in our various communities and systems that have worked on restorative justice to really see their potential as not just a set of

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practices that are useful in the legal system, or that are only responsive information to harm, although certainly they can be that.

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But that have the seeds for opening our eyes to the kind of idea of justice we need to support recovery.

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And so I approach restorative justice, and look to these various kinds of programs and and examples and experiments with restorative justice, as really telling us about what justice requires in a different way.

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This sort of idea of justice, as about just relations, and thinking about that, not only at a an interpersonal level, or at a at an individual level, but sort of all the way up or down, or out, depending on how you how you draw the

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the pictures of the ways in which we live, in context and systems and institutions and structures, and the way that they impact.

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How we feel about ourselves, how we interact with others and how we are.

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Then in relationship, at at group and community and societal way.

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And so if if that's the invitation that's seeing justice differently.

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If that's the invitation that restorative justice has for us to sort of look at the demands for justice.

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As about this relational work, then I think we can make sense of how restorative justice programs and processes and initiatives allow us to glimpse how we could do this work of justice differently, by calling people in rather than the

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more divisive work that justice sometimes does of calling people out, of being able to react and respond when harm has happened, but also to be able to think proactively about. How do we build sort of these just relations built on care and respect and

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mutual concern. How do we do that? In all of the places and spaces in which we we work, we live, we learn, we play, we pray, and faith communities, and and also in the places that we turn for help and care.

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And so I I wanted to suggest a sort of a concrete place that communities might look to begin to scale up our responses, to look at restorative justice in 2 ways.

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One is to really face this challenge that we're that this Panel and others are beginning to contribute to where we can sit and hear first voices and impacts where we can really deeply, as Dr.

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Brown suggested to us listen which is core to democracy and inclusion and participation, but also then understand one another's experiences and perspectives sort of look back, not to blame or to or to identify accountability in that

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backward-looking way, but to look back in order to be able to look forward and plan together and the way we do that really needs to be attentive to the kinds of relationships we need to be building through that process to be able to

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be different in future. So I think here of some of the initiatives around truth and reconciliation commissions we could learn from in South Africa, in Canada, and some of the movements in the Us.

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Around racial justice, and I think here about some of those review processes where harm has happened.

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But the other thing, and as I close i'll just say is look, I think we also need to think proactively about how to bring a restorative approach to the ways we do things that every day.

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There are great examples in the restorative communities movement that could be scaled up in Oakland, California, led by our joy. Restorative justice for Oakland Youth in Camera Australia, in my own home province of Nova

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Scotia, where they're at in leads the uk where we're really starting to think about who and how do we need to be as a community?

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And then I think about how that can show up in workplaces, in schools, in faith, communities, not only when harm happens, but to make sure that things go right more often.

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And so I I I kind of want to leave us with this idea that these sorts of processes, if we prioritize them in building relationships, can provide us the opportunity to build building.

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Now the relationships we wish and we know we need it in order to be safe.

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And well and healthy when the pandemic hit.

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And so I'll. leave it. there thank you so much Our next speaker is Ebu Patel, who's with interfaith America.

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Good afternoon, friends. My name is Eve Patel.

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I am the partner president of an organization called inter-paid America.

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It's the Nation's largest organization that positively engages religious diversity or kind of tagline is that they thought it would be a bridge of cooperation, and not a barrier of division so we

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ran a pretty large program over the course of the early months of the vaccine, which indicated the power of its engaging faith.

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Positively to improve help outcomes. i'll say that one more time, because that's kind of the the headline of what I want to to articulate here, which is the positive and proactive engagement of faith identity can very

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often lead to improved health outcomes. Now put this in colloquial terms.

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There are. there are segments of segments of our population, who, if told by a doctor, let's say, to change their dying for health, reasons, may not listen.

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But if told by a pastor to change their diet for spiritual reasons, the exact same tactics just articulated in the different framework. Let's do a Daniel fast, for example, they are much more liable to do we ought to take this.

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very seriously for health issues, and we saw this actually during the the early months of that of of the vaccine.

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So my organization interface America, along with a leading survey organization called the Public Religion Research Institute, did a series of large scale surveys to get a sense of how Americans, how Americans faith impacted how they viewed the vaccine specifically

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whether a faith intervention would encourage them to get the vaccine.

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It turns out that a third of a American said that they would be positively influenced by some sort of simple fake intervention.

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Their pastor, or mom, or Rabbi talking about this in their bait community.

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A town hall held in their church to discuss the Covid vaccine, and that vaccine clinic taking place in their mosque Bible versus or prayer, being said while they were getting the vaccine a third

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of Americans said that this would make a difference in them in what and whether they would consider getting the vaccine very important segments African, Americans and Latinos.

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Over 50% of black Protestants who got the vaccine said that a some kind of a fake intervention made a difference.

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Their pastor, saying it was important they're they're they're church hosting the vaccine clinic etc.

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This is not going to surprise Reverend Evans at all who spoke about this at the beginning.

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Over 40% of with Latino Catholics said that some kind of a fake intervention encourage them to get the next thing.

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So at my organization interfate America i'll put these links in the chat.

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We took this data, and we developed a program around it called the Faith and the Vaccine Ambassadors.

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I wanna spend a minute in this program, because not only do I think it is highly scalable, but I think that this kind of effort should be a permanent part of our health infrastructure a permanent part of our health

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infrastructure not just when there's a plate not just when there's a pandemic not just when they're we're rolling out of a vaccine but I we should have a layer

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of community health ambassadors in our country who are comfortable and fluent, engaging religious identity.

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This can be as simple as saying to somebody: Remember the Biblical belief that your body is a temple of the Holy Spirit.

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Remember the the Islamic concept of Moneylaha, of the common good protecting your neighbor.

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One of our ambassadors. pointed out that he got his Coptic Christian, Egyptian immigrant parents to get the vaccine.

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When he reminded them that the communion cup in Coptic churches is common.

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Everybody drinks from the same cup, and that unless everybody was vaccinated.

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They couldn't return to a common community It was a faith articulation that encouraged that kind of vaccination.

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So we, along with a set of sociologists, medical experts and theological, developed a curriculum called the Faith. In the vaccine curriculum we recruited ambassadors from 200 institutions 110

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campuses and 90 congregations and faith based institutions.

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We paid stipends to the lead recruiter in each of those institutions.

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A faculty member for the course of the summer, and for students and for congregants in the

in churches, and we mobilized over the course of the summer.

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In the fall these fate and that vaccine ambassadors to be advocates for the vaccine in ethnic, religious, and racial communities, to hold those town halls and churches, to speak to congregates

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and and and folks in communities about their bodies being the temple of the Holy Spirit.

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It was a highly successful intervention, the highly successful intervention so successful, in fact, that we're building an entire program at Interfate America called the Faith that health Program.

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To further explore and lift up and scale this kind of work.

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The positive engagement of faith can improve help outcomes I'll put a set of links in the chat for everybody to see.

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Thank you so much for that amazingly positive sharing and our final speaker is rabbi deborah waxman forever.

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It's so powerful to be here with everyone and this extraordinary panel, and i'm gonna I hope complement what what what the other panelists have said.

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I'm going to speak from a particular tradition i'm going to draw on Jewish wisdom, and practice with the aim of raising up some universal insights for this complex and challenging moment a Jewish response to

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the questions that were proposed sits at the intersection squarely of the theological and the sociological, of the transcendent and the supremely practical.

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See aologically, Judaism teaches that every so this is I.

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I hope, a good example of some of what what? what you boo.

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Patel was just talking about it. theologically, Judaism teaches that every individual is created

with Seleum Elohim in the image of God, and that all individuals, indeed all of creation, is deeply

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interconnected so sociologically. Jewish practice requires that we create social structures that bring to life, and that reinforce this theological vision of inherent human value.

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And of interdependence with special attention to the most vulnerable.

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Again and again we are commanded to provide for the stranger the orphan, the widow, the poor.

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There's a particularly powerful teaching from a classical medieval text, Safer Hussein, the book of the pious that teaches. if a community lacks a synagogue and a shelter for the poor it is first

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obligated to build the shelter for the poor.

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So this wisdom emerges out of a particular Jewish experience.

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For centuries up until the modern era. until just a couple 100 years ago, the Jewish people lived in South contained and semi-autonomous communities where the needs of the vulnerable could be mandated as

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a communal priority, and as this symposium demonstrates and is keenly aware of, this is a far cry from our current landscape, which is at once more integrated, and also far more polarized, and i'm

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so appreciative of the cross-disciplinary approach across the symposium and across this panel, even, and the wreckage that religious modalities of healing, they are necessary.

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You just heard how powerful and impactful they can be, and they are only partial solutions that to address the massive damages and inequities wrought by and exacerbated by the pandemic religious solutions, whatever

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their source. they can inspire, they can complement. they can be incredibly effective, but they but they can only work alongside, and as part of a robust and effective so social safety net

and not stand in totally for it.

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Judaism teaches the gorgeous paradox that for one's individuality to be most fully realized. for that image of the divine to really shine out.

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It must happen in community. COVID-19 shined a spotlight on the profound sense of isolation and alienation that is affecting so many people before, and perhaps even more, after, one positive outgrowth.

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I think of the pandemic is that it has re-emphasized the importance of community, and it has rehabilitated the power of networks of communities.

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You heard that Reverend Evans? the talk about the power of his network community, so incredibly, effectively synagogues and churches, denominations and multi faith organizations, mutual aid networks and support groups came together

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to meet urgent and essential needs, both physical and spiritual.

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So in terms of scaling up one path forward, I think, is to tap into these initiatives, like the ones that that have just been described, to strengthen and structure the extent of the structures and the experiences of community ideally I

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think that the the lines that Llewellen laid out of the rest of justice are such incredibly powerful ways.

02:48:07.000 --> 02:48:11.000
These structures of community can mitigate isolation.

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They can deepen connections on the individual level. They can address the question of values that that Dr.

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Flynn raised. They can be low side for the study of storage, Structural inequities and mechanisms for social chains change along the lines that Reverend Everett Evans charged us with Tonight and just

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very soon begins the holiest day of the Jewish year.

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Yom Kippur, the day of the Tongueman, and to throughout these last few weeks the high holiday season, Jews have been reflecting on our failures and our limitations and our sins.

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This process is called cashbone hanapesh the literally it means the accounting of the soul.

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And we do this exercise so that we can atone and seek forgiveness and resolve to do better.

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I'm not so sure how to measure interventions that might mitigate the pandemic related emotional and spiritual stress, but at a minimum, as all all the other speakers are reflected, we must we must reflect deeply on the

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lessons that have emerged from the pandemic.

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The Why were some communities that heightened risk? What added, told, did their vulnerability take what worked well?

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What didn't, what what should be in hand or or made permanent, that hi holiday season it demands accountability, but at core they are based on the belief that repentance and change are possible as reverend evans charged

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us, as Dr. Paul's lip pres described we must take the heart that we can learn, and that we can do better.

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Thank you so much for those moving words I think we've had a great deal of inspirational guidance from all of our speakers on this panel, and so I would love to just have everybody. have i'm sorry I I would

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love. If everyone could have 1 min to wrap up comments about this, and maybe talk about the recovery of the whole community, and how we can take very practical steps to move forward and then we'll i'll do a

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little wrap up for our morning session. So, Reverend Evans, will you start us off right now about for about a minute or so, to wrap up?

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Well my distinguished colleagues in the previous panels, and this panel clearly highlights the

the challenges that we face moving forward, and I think that we do have an rare opportunity here.

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Based on good intentions before. so what I mean is is that there has been any way between 50 to 70 billion dollars a fraudulent payment to people who utilize ppp loans and other programs What i'm asking

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for as a face step by our Federal friends State friends and our local friends is to use that money to begin to explore some concrete solutions strong actually about how to arrive at a just conclusion, and building a a plan for

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our our democracy to help. I think that that is be a great down payment.

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But I think the discussions just start at the community level.

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I think it will be very, very tragic to put these discussions back into the hands of our leaders right now.

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The leaders need to hear from from every segment of our society, and sincerely help to implement those. and they don't have to worry about where the money come from, because the money has already been outigated.

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They also need to be allocation money for long term. Covid.

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This is going to be a serious problem in the future, and of course there have been a commitment to mental health services.

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And the way we implement this mental health legislation that has come down as a result of the gun tragedy.

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And I agree with my friend brian we'll look at a broad-based support of how we do this cross sectors and do it in a way that it would have impact and build structure for times to come so

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that would be my concluding Remarks on the system I don't know.

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Thank you so much. I have to say that you really launched us, and just do a dynamic discussion this morning with this afternoon for those on the east coast.

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So thank you for that, Brian Flynn. Give us the last moment of your thinking.

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Here exactly. I would just recommit to continuing to look at those 5 elements.

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It's not just a good way of approaching crisis is a good way of approaching life.

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I think these these these elements are valuable even when there's not a crisis.

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So I I just can't emphasize enough the importance of that.

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I also think i'm reminded by by the Rabbis comments, that that we really need to to be very aware and attentive to loneliness and isolation of people, and do whatever we can in our

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occupational roles in our personal lives to reduce that.

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And the final thing, I would say is, I will be the first to admit there are times when I have not been optimistic.

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I felt helpless and trying to figure out what to do in the face of all this.

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And we One thing that I have decided that I can do, even if I fail at everything else is, I can be kind in my own life.

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I I can begin to model what I hope people will collectively experience, and maybe if I can't do anything else that may be enough.

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Thank you. Thank you for those very thoughtful comments, Brian Dr. Pennell.

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Some guidance on what we should do going forward. Yeah, I would say that what we should do I love what we what I heard before, and I would say, I I would echo the be kind the micro kindnesses when we have a

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society that is probably a little bit hard of hearing because of their own stresses and their own challenges.

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It's hard to hear. even the micro kindness and so it's if if we can amplify that voice, and it can be heard a little bit more.

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But I would also say that as leaders we have an opportunity to really try and have these kinds of conversations and through partnership, because no one system or person can do anything alone in this whole thing, that we've gone through collectively and

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individually, and so I would say, reaching across the aisle and listen and have dialogue with partnerships, with, for example, representative bodies of this panel really reflect different voices.

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So. partnerships with different voices, I think, is our only way forward to converse and take some lessons learned into action. Thank you.

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So much, Jennifer Llewell, and from the restorative justice perspective.

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What do you see ahead? I I think, if I leave this with one thing it's that we can't actually afford to rely on and draw down on relationships without structuring, as we heard from evo as we heard from the

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rabbi it without structuring support, of opportunities to build people's opportunities, and kept pass to to pay attention to who we are to want.

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Another how we are to want another. Those are skills, those are muscles.

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We need to exercise, and we need to create every chance we get whether it's in the classrooms in terms of how students encounter one another, and learn about one another, whether it's in the synagogue whether it's in

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the Temple, whether it's in the streets we need leaders to be facilitating opportunities for people to develop those skills.

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For how do we see one another? How do we understand one another?

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And how do we care for one another on the everyday if We're going to be prepared for the exceptional circumstances in which we need to draw down on those skills and capacities?

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They need to be our priority. Thank you so much, Mr.

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Patel from the Interfaith perspective. What do we build on going forward?

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So I think, with something works You do more of it, and you build it into a permanent infrastructure.

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And the faith in the dicing ambassador.

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And if there was something that worked, and I think to myself it this is an entirely doable thing.

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Every public health department can have a Cadra people who diverse people who are trained in how to engage diverse faith communities.

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How faith identities impact help outcomes. You can do this in colleges and universities.

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You can do this in faith communities, And I think to myself, what kind of a difference it would have made if you had that kind of a core already existing, and they worked with hospital administrators to for example, do do vaccination events

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for hospitals that included not just doctors, but nurses and custodial staff, in which diverse faith leaders were present to encourage people from all economic, racial and religious backgrounds to consider the vaccine I think It would have made

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a big difference in a diverse country. I think that this is something we can do, so we should do it.

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Thank you so much. I enjoyed that practical approach. Rabbi Waxman, will you wrap it up for

us this afternoon?

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Of course, one thing I really do appreciate the observation that even as we're looking ahead to like the next crisis, that that the long tail of long covid and one of the things that we're really I know that we're really grappling

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with in my community is the ways that shifting onto online created opened up accessibility for people with, whether it's for mental health or because of physical disabilities, and how to maintain that what the transformations are even from in the in

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the positive ways to make certain that as we move forward we don't leave people behind who who were brought forward.

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And then, I think, points to that point that that I made, that so pretty much.

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Everyone else made the the centrality the importance of relationship.

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I talked to a lot of friends and colleagues to prepare for this panel, and one of my dear friends and colleagues.

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She talked about that when we talked about all the all the different crises that that the Covid 19 is a part of, and she famed it as a crisis of humanity at core.

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That across all of these there's this question of how do we want to be treated.

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How do we want others to treat us? How do we see each other?

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And respond to each other to evoke the language I use.

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But, Salam, I want to thank the panel for this very, very illuminating discussion.

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This today, and our would like to also just touch on a few things.

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We covered this morning, starting with Dr. Brown, I think inspirational presentation on the

notion of abolition recovery, and and Donna Gambrell took it up and talked about empathetic democracy.

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As we move forward. So I I felt they really set the stage for this larger perspective on all the aspects of our community life, and the the way to integrate and coordinate going forward both at the very practical level from agencies and

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organizations to looking at what our speakers on this panel talked about the spiritual and healing notions that we have to embrace as we go forward.

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If we make a recovery that will be enduring and equitable, and that will last on Thursday morning.

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We will pick up this discussion with our panels.

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Sorry No Eastern time 9 Am. Western and Pacific and

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We will start to explore the larger issues of media and recovery, and how we can develop again a sense of the integration that's needed to go forward in a more enduring way.

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So thank you, everyone, for being in our day one of the symposium, and for your very helpful discussions and illuminating guidance.