An Interview with Julia Ratti

Perspectives from the COVID-19 Pandemic: Leadership and Learning in Nevada

Produced by:

The University of Nevada Las Vegas
The Lincy Institute
2024

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The following interview was a part of the "Perspectives from the COVID-19 Pandemic: Leadership and Learning in Nevada" research project. The recorded interview and transcript were made possible through the generosity of The Lincy Institute at the University of Nevada, Las Vegas. The goal of the project was to understand and document how Nevada organizations and leaders responded to the myriad challenges that the pandemic engendered. The interviewees thank The Lincy Institute and their supporters for the opportunity to reflect on their roles throughout the COVID-19 pandemic. The researchers also acknowledge the following individuals who contributed to the conceptualization, data collection, and analysis of the project: Dr. John Hudak, Dr. Makada Henry-Nickie, Elia Del Carmen Solano-Patricio, Taylor Cummings, Peter Grema, Kristian Thymianos, Saha Salahi, Madison Frazee, and Katie Lim.

Each interviewee had the opportunity to review their transcript. All measures have been taken to preserve the style and language of the interviewee. This interview features Julia Ratti, former Nevada State Senator and Director of Programs and Projects for Washoe County Health District, and was conducted on 10/3/22 by Kelliann Beavers and Elia Del Carmen Solano-Patricio. This interview covers topics including reflections on leadership, organizational challenges, and opportunities for collaboration.

Interview with Julia Ratti

Date: 10-03-2022

SPEAKERS: Kelliann Beavers, Elia Del Carmen Solano-Patricio, Julia Ratti

Kelliann Beavers [00:05]
Okay. So, to confirm, we have chatted about the fact that we're going to be recording the interview, and if you're comfortable with that aspect, as well as we will provide you a copy of the transcript for you to review. And then, upon your return, we can use it and potentially, use your name if we were to quote you.

Julia Ratti [00:22]
Yes to both.

Kelliann Beavers [00:27]
All right. So, I think before we get into our general questions, I want to preface your interview specifically by saying that you have played more than one role throughout the course of the pandemic, as you know. And our questions are intended to speak to both the beginning and the height of the pandemic, and even since the pandemic has stabilized. So, I would like for you to answer from any of the perspectives of roles that you were in, and just feel free to speak toward what you feel like comes up for you. Because some of these questions are sort of tailored toward your specific role, and I know that may be different from when you started to now.

Julia Ratti [01:05]
Okay. Great.

Kelliann Beavers [01:05]
Okay. So the first question is, how did you see your role during the pandemic, and then I'll have you speak to sort of how that's changed over time.

Julia Ratti [01:18]
Sure. So, like most Nevada legislators – actually, many Nevada legislators, being a citizen legislature, I definitely was wearing two hats. So the first would be serving as the state senator representing Senate District 13, and the Assistant Majority Leader of the Nevada State Senate. And then in my day job, I started the pandemic in a role that was specific to doing work around behavioral health from a public health system's approach, specifically working on behavioral health. I was recruited to be part of the COVID response and asked to lead the initial response to homeless individuals in our community, as part of the Incident Command System, so like the emergency response structure. And it has since – I had a promotion, and I'm now the Director of Programs and Projects at the health district, where I oversee our community engagement, community assessment, and community planning work, along with our internal organizational work, so like strategic planning, workforce development, and those kinds of things. And then I also supervise a new health equity team at the health district, so health equity is specifically in my role.

So this definitely evolved, and as I'm sure you're aware, I resigned from my senate seat in November of last year. So, I've not been a senator for about a year now, so, the tail-end of the response. Certainly, my role, early on, like right in the shutdown was like – I started my job at the health district in mid-March, about four days before the governor decided to shut down the economy to respond to the pandemic.

Kelliann Beavers [03:08]
So, you were doing them at the same time, is what you're saying, correct? You started your job at the health district, and you were in your role as a senator. I don't know that I realized that. I sort of thought it was from one to the other.

Julia Ratti [03:18]
No, we have a part-time citizen legislature, of course, in the State of Nevada. We're in session, every other year, for four months. And so, the vast majority of people are either retired, or they have another job that is their professional duty. And they just take a leave of absence for the four months. I had chosen to have – they are big jobs. I had chosen to have a part-time job at the health district so that behavioral health role at the health district was a part-time job and a supervisor that was willing to support a leave of absence.

When the pandemic hit, it was interesting because it shut down some of our legislative activities temporarily because generally, what we do is convene lots of meetings. And my part-time role at the health district immediately became full-time-plus because everybody at the health district was asked to lean into the COVID response. And some of us were asked to be part of what we call the "ICS," or the Incident Command System. Which is a specific mechanism the local governments will use – well, local and state governments will use for the emergency response.

And it was recognized relatively early in the pandemic that the response to homeless individuals would require probably a different line of thinking than the general response, when you're asking people to isolate and quarantine. And one of the primary protections for being able to stay safe and stay healthy is to be able to isolate in your home, and if you are unhoused, that obviously makes things more difficult. And then if you take yourself back to the very beginning of the pandemic, the access to personal protective gear was limited. And then obviously, if you are in a situation where you're unhoused, that becomes challenging, and then, just spacing.

And so, for about the first 10 weeks or so of the pandemic, that was my primary role in Washoe County, was to think about and drive – collaborate with the coalition of folks who would need to be involved to try to address some of those challenges. We did things like stand up a new shelter. So, our existing shelter, particularly for homeless adults, we could not accommodate the six-foot distancing. Going back to the very beginning, right? Very basic recommendation: stay six feet apart, wear a mask. We couldn't get people sleeping six feet apart. And so, it was in the course of about 48-72 hours, we stood up an emergency shelter at one of the convention and visitor facilities that we have in town, where we could get that six-foot spacing. And then, of course, did whatever we could to get personal protective gear and things like hand sanitizer.

Kelliann Beavers [06:20]
Wow. That's really quick to be able to make something like that happen.

Julia Ratti [06:23]
It was fast. The other interesting thing was that access to restrooms had to be considered because so many of our unhoused individuals have identified a friendly business or a public restroom that they can use. And when we closed down all the casinos and all the restaurants, all those things, the number of restrooms that were available to folks dramatically declined.

Kelliann Beavers [06:47]
Oh, when you initially said that I thought you meant in the shelter. And now, I understand what you're saying. That's intense.

Julia Ratti [06:53]
So, in the community. We also then needed to deploy. We did an emergency rollout of temporary restroom facilities across the community, where there was a higher concentration of individuals who were unhoused.

So, like right from the very beginning of the pandemic, my full-time-plus job was to work with the community, to think at least about this one special health equity population, who was top of mind from day one. And there were things like just really having to think about meeting people where they are. And so, if you're unhoused, and we can't get distance, well, we need to get them housing where they can get distance. And if you don't have access to a restroom, how do you get access to a restroom? We tried to do sanitary, but the outdoor handwashing stations would freeze because it was still March. So we did roll out outdoor hand stations at one point, but we had to delay that to a point where they could be functional.

And then hand sanitizer was an interesting one. Because with the targeted population that we were working with within this particular area, substance use is a significant issue. And you may remember, there was a shortage of hand sanitizer, but hand sanitizer is almost 100 percent alcohol, and we did have distilleries that were producing – but we needed to be cautious about having significant amounts of hand sanitizer, just out and about, because it was potentially unhealthy if folks were consuming, and then folks were.

Elia Del Carmen Solano-Patricio [08:23]
You said something earlier about transitioning your role from behavioral health to physical health, and then the emergency response, and what you were doing before them. But it sounds to me like you said something like "it would require a different line of thinking, to move from this group to another, to work with collaborators, and one field to another." But do you think that the opportunity since then, or the creativity since then has been that *you* have a unique perspective as a senator, to look at all these things and say, "Actually, they all have to do with the other," right, like behavioral health and with the emergency response? You have to come up with an emergency sanitation plan, etc. Do you think more folks that surround you think that way now? That it doesn't require a different line of thinking, but in fact, the same line?

Julia Ratti [09:13]
So, I think that I was asked to lead that part of the response because of the professionals. So my day job happened to be behavioral health but remembered that I had started four days earlier. So I hadn't actually started any of my behavioral health roles at the health district, which is a kind of systems change around behavioral health issues. But I didn't get a chance to start that. That just got set aside for the initial response. But I do think that when the health district officer walked down the hall and said, "Hey, could you take on this?" It was with him full-well knowing my background, both in serving in the legislature and having ample opportunity as the Chair of Health and Human Services specifically, to think about vulnerable and unserved populations. And he knew that a lot of the work that I had done in the legislature was specific to underserved vulnerable populations and health equity. We had done a resolution in the senate around racism as a public health priority, so he knew I had that background when giving me this task. I think is – not to say that there weren't other health people at the health district who've also done good work around health equity. I just was the person who didn't have any duties on my plate at that point, and hopefully, had the appropriate background as well. Also to say, I didn't do it alone. So really – and I think this also comes from experience being a legislator. But it was my job to facilitate a coalition of people to get to these things. I couldn't have done any of those things without lots of other people being on board to roll them out, and extra money, honestly, that came in with the pandemic response.

So I don’t know. It's a "chicken and egg" thing, right? I mean, I had learnings coming into the pandemic and I had more learnings coming out of the pandemic. And both the day job and the public servant role certainly inform each other, but we can't help but bring our whole selves to the legislature when we arrive. I don’t know if that answers your question.

Elia Del Carmen Solano-Patricio [11:12]
I love it, actually. And what you just said last is a beautiful quote [??11:16] I'm going to make a note there. You can't help but bring your whole self into the legislature. Thank you.

Julia Ratti [11:22]
Yeah. And in prior roles, I had been the executive director of a gang prevention and intervention and intervention agency that was specifically targeting primarily kids of color who were being overwhelmingly overrepresented in youth gangs. One of the earlier things that I did in my career, I had been the CEO of the Girl Scouts, really working on raising the next generation of powerful young women, so I worked in spaces that gave me the opportunity to have experiences that would inform me. I had not done work specifically with homeless individuals, so I had a learning curve on – the hand sanitizer thing, for example. But I had other homeless advocates, who I was working with, who were people who were in direct service. Immediately, when we said, "Hand sanitizer," like "We cannot put big bottles of hand sanitizer out. Don't do it." And so then we worked on little bottles or supervised ability to get hand sanitizer because *they* had that experience.

So I do know – I don't want to leave anyone with the impression that it was all my experience. But I had good facilitation skills, and the ability to bring all of the experts in the room to get their input and move quickly.

Kelliann Beavers [12:28]
And I remember seeing that you chaired a committee that had to do with affordable housing. So, certainly, the housing crisis, more largely, is something that you had thought a lot about and played a leadership role, and which I recognize is different than homeless services, but there's a lot of knowledge there that obviously, you had.

Julia Ratti [12:43]
Right. Yeah. And certainly, we dabbled in emergency and transitional housing, and we were looking more at permanent housing, but yeah.

So that's a very long explanation for the first 10 weeks. But the first 10 weeks were, you know, 60 to 80-hour days, all hands on deck. How do we involve the rest of the health district – just really focus on the overall response? How do I carve off some space, to focus on the particular unique needs of the unhoused, which then grew into a much larger effort that was in collaboration with the Human Services Agency of Washoe County, to set up isolated housing for folks who didn't have access to isolated housing. Which may be because you were houseless, but there are a whole bunch of other reasons. Maybe you are just in a house with 10 people. So, again, using a health equity lens, some cultures, and some traditions, are more likely to have large families and multigenerational families in one household. Some communities are much more likely to be frontline workers, who are needing to go into work every day and bringing more risk into their households. All of those things. There was a need for isolated housing outside of people's homes for people who could not safely isolate within their homes.

Kelliann Beavers [14:00]
How did you make that happen? Or do you want to describe a bit about that program? That sounds very challenging.

Julia Ratti [14:04]
Yeah. So, well, in collaboration with the Human Services Agency, trying to figure out how much need did we have. Because I mean again, you've got to pick yourself up and think about the very first days. We didn't know how much there would be. And so, in Washoe County –collectively, not me – as a coalition. We ended up having two different tools: one was a relationship with a provider in town called Well Care, who had transitional housing already and had some beds that were underutilized. So they were able to set aside a couple of their units to be COVID-isolated housing units. And then, largescale, the Incident Command System leased basically what – our workcamp housing. So they're generally set up on large job sites when you have oil mining or big, big, big construction, where you have hundreds of workers come in. And so, those workers don't impact the local housing market, sometimes it's just very isolated.

And so there happened to be some of that workforce housing in town. And so, the Incident Command System leased that housing and set it up for a portion of the response using some of the federal response dollars. So then there was a whole system that had to be set up behind that around screening, who needs it, how do we get them to it? And so there was an extra team stood up in the human services agency – not my team – that did all of the screening. They were on call.

And so we had to do all this outreach primarily to hospital emergency rooms. Because generally, hospitals are required to discharge someone to a safe environment. And so, if they're discharged from the hospital, but can't safely quarantine at home. So we had to work with the social workers and the emergency departments of each of the hospitals to have them know that they could refer the homeless shelters, the substance use treatment shelters. There are a lot of different reasons at places why people might need that extra housing.

There was a model in place, prior to the pandemic, in which, as a health district, we worked with patients who have tuberculosis. Who generally – I mean health districts work on chronic or infectious disease, right? So we had very small systems for doing the very small number of folks that we usually need to help with housing when they are highly infectious. Obviously, COVID exploded that. And so, at the front end, we actually ended up building way more housing than we needed because you just didn't know at what pace. And then, once it tapered off, and once we all learned a whole lot more about the pandemic response, we scaled that back pretty dramatically. And I don't believe we even have – I don't think it's running at all anymore. It's happening more traditionally through the Health and Human Services agencies, meeting this large emergency response.

So, certainly, that experience – a significant health equity lens. Because who needs – isolated housing is based on a lot of social-structural-environmental determinants of health.

Elia Del Carmen Solano-Patricio [17:20]
I have a question about that. Because we are talking about Washoe County, I'm remembering a discussion we had about Reno's housing crisis as tech corporations moved in. So it wasn't a question of whether workers could afford where to live. It was a question of supply, right? So, you had tech workers camping out in their cars and tents, what-have-you. And this was prior to, and if not during, and after the pandemic.

So those social programs, did they affect everybody as a blanket? Or you were just talking about those structures, in terms of what social factors would qualify a person for workforce housing aid?

Julia Ratti [17:59]
So, it wasn't workforce. It was emergency isolation housing.

Elia Del Carmen Solano-Patricio [18:01]
Okay. And is it something that you translated as a workforce housing provider, to now, emergency – so they changed your scope?

Julia Ratti [18:08]
No. I was purely set up for emergency housing. And so – and it was purely set up as a response to the pandemic. So the housing – there was a small amount, up to about 30-plus units, that could be kind of pulled out of our transitional housing system, that was underutilized that could be used for that. And then I want to say, it was over 100 that were built in these trailers – but you could only live there as long as you were infectious. So, once your COVID quarantine protocol was over, or your isolation protocol was over, then you were no longer housed. Because it was never intended to be a long-term social program. It was an emergency response to slow the spread of disease.

Kelliann Beavers [18:56]
Well, and then if I am understanding – go ahead. Sorry. I didn't mean to interrupt you.

Julia Ratti [19:00]
Well, that said, what was super interesting about it is, particularly, the part that was managed by the social service provider that we were contracting with, to be able to house folks, they also provided transitional service in case management. And the number of people that came in homeless, but they placed in transitional housing coming out was actually in the 30-40% range. Which is significantly higher than our ongoing rate of being able to transition people off the street and into transitional housing.

And so that impact of being in this emergency – on peoples' willingness to work with a case manager and go into housing that was a little bit more stable was significant. So we did demonstrate that if you can catch people at the right time, you can actually get people into transitional housing. But that actually was not the stated intent of the program. That was just a wonderful side benefit.

Kelliann Beavers [19:53]
Right. Thanks for sharing that, though. That is very impactful, and it raises a lot of interesting questions.

Julia Ratti [19:58]
Yeah, it does. So, again, that's a whole bunch of detail around – the early part of the pandemic, for me was first, how do we get homeless people someplace safe? And then it was, oh, my God. There are all these people who need to isolate, but don't have the capacity to isolate at home; either in their existing home or they don't have a home. So, how do we solve for that? Again, all coalitions – not just me.

And then the third piece was when I transitioned back into my mental health role finally. So I was no longer needed in the ICS structure. I just went back to my job. But in my job, we partnered with the state to try to think about some of the behavioral health impacts of the pandemic. And so the state had the Resilience Project. In Washoe County, what we were able to do is take those Resilience Ambassadors, which was again, this wonderful extra COVID resource, and we were able to make it so that every person who got a COVID-19 diagnosis; would go through their normal contact tracing process with our disease investigators and that process. But that disease investigator would ask them if they were willing to have a follow-up call, kind of a wellness check call. And if they opted in – so, not everybody opted in. But if they opted in, then one of these Resilience Ambassadors would call and check on them, with a look to using psychological first aid techniques to see just how folks were doing. And then, basic needs: Do you have food? Do you have shelter? Do you have everything that you need to be comfortable?

And so, many of those conversations were very short, but about 30-35% of those conversations – don't quote me exactly on the numbers because I haven't looked at these reports in a while. But a good chunk of them had conversations that were 15 minutes or longer, which is how we dice the data to just say, okay. This was a meaningful interaction to check on both their mental health and their basic needs – their ability to meet their basic needs while they were having a COVID diagnosis.

And so that was, I think pretty extraordinary from an emergency response standpoint. That every person who's being impacted by this emergency was offered this behavioral health sort of basic needs support as well.

Kelliann Beavers [22:16]
And different from making it possible for someone to call in and express needs because it was more of a check-in, which shows that someone cares, they're interested, and they're not – that you have to take the initiative to say, "I need help."

Julia Ratti [22:32]
Yeah. So then of course, we had to have a special session in the legislature because the budget was so severely impacted by shutting down the economy. And so then, my role, I think as the chair of the Health and Human Services Committee, combined with my role being the assistant majority leader was to do the very best that I could to make sure that the budget cuts we were going to have to make, which were going to be devastating. And whenever you're talking about Health and Human Services, traditionally devastating to populations who were least able to withstand it. That we were doing everything that we could to prioritize the most vulnerable populations, and doing as little long-term damage as we could. So that special session was, I mean, I don't know how else to describe it – it was brutal looking at what we might have to cut. And we were able to do some decent work in the 12 days that we were together, to make sure that we were not cutting programs that were just absolutely essential to people.

Elia Del Carmen Solano-Patricio [23:34]
That's a really unique perspective to have. To have to decide, "This is where we have to cut. But I work here, so I've got to make sure that these people aren't impacted so much."

You talked about vulnerable populations, which is a key thing for our research study here. And of course, you're dealing with the unhoused more often than not. Do you find that there's a subgroup within the homeless population that was most impacted by the pandemic? And that's health-wise and economically.

Julia Ratti [24:05]
So, I know my life is super confusing – but I actually don't have that much impact on – or I don't work closely with the homeless population. So I did for that 10 weeks because somebody needed to take that role. But now, I work more – so I still lead some of the behavioral health programs. And so, certainly, from that perspective, it's clear that if you have a dual diagnosis of serious mental illness or substance use, you are among the most vulnerable population, and that is definitely feeding into our number of people who are unhoused. But I know that not necessarily because I work with a lot of homeless individuals, but more because I work on systems change for behavioral health and substance use disorder, or more broadly, behavioral health, more broadly, mental health, and substance use disorder.

And then, as we are working through this health equity effort, we have been doing things like a listening tour, specifically with populations that traditionally have not been at the decision- making table, or who have not been engaged. The wonderful thing coming out of COVID is, we got better, all of us collectively, over the course of the COVID response. And so there have been a number of relationships that have been

developed between the health district and populations that traditionally didn't have that level of engagement.

Elia Del Carmen Solano-Patricio [25:25]
What populations are those?

Julia Ratti [25:28]
All over the map. So we certainly have them working with Safe Space populations, specific targeted efforts at Black individuals, Latinx, and LGBTQ populations. You name it. Take a diversity lens and apply it. And we are trying to make sure – and we're actually doing a network mapping exercise, where we're mapping our relationships and seeing who's missing. We've had some great meetings with tribal representatives. We've had meetings with people who are living with a disability. Seniors. All the different ways that we represent diversity in our communities.

And so that listening tour is continuing. What's been interesting is our health district has completed a community health assessment, which is something that we do every three years. Where we look at the secondary data, so your validated long-term national studies that are – where you can get information at the county level, for us to be able to compare sort of "apples to apples," so like a youth behavioral risk study. So we did a review of the secondary data, and then also did primary data, so focus groups and a survey, to see what the top health needs were in our community. And it came out, including mental health access to healthcare and social determinants of health, and then preventative health behaviors.

And then we did the listening tour, which was a much more informal "getting-to-know-you," "you tell us about your work. We'll tell you about our work," community engagement process. So, less of a research-based process. More of a community engagement process.

But in that listening tour, we did ask them what their top health priorities were at each of those interviews. Talked to – it was like 29 meetings with about 60 individuals. And we did ask them what their top health priority was, and it was the same top four. Not in the same order, in terms of the number of messages, but the same top four. And then we just held a community forum with 115 to 120-ish people, where we invited the folks that we had done the listening tour with, and many of our traditional Health and Human Services partners, to all get in a room. So it was a pretty good mix of what I would call subject matter expert leaders and community leaders, and they ranked the same four to the top. So it's very consistent, no matter how you ask the question. And with the breadth of diverse participation, mental health, and access to healthcare. Social determinants of health like housing, employment, hunger, education, and preventative health behaviors came out strongly.

In the listening tour, we got additional feedback around what we're calling "health literacy" for lack of a better bucket to put it in at this point. But it's knowing what services are out there, knowing how to access them, and having information about those services available in culturally and linguistically appropriate ways so that they're able to get the information that they need. And then transportation is a significant barrier.

So that came out a little bit more strongly in the listening tour – so in the more informal conversations than in the more formal research space health assessment was an important nuance for us.

Elia Del Carmen Solano-Patricio [28:46]
Do you find that – I'm so sorry, Kelliann. I just had to follow up. Did you find that list of providers and their information was created by a third party or nonprofit? We have one in Las Vegas that just popped up recently, which is just a website of RNs, nurse practitioners, and doctors, and they have them in different

languages, and that's all it is. You can't make an appointment there. But it's what they consider health literacy. Does Washoe have something like that?

Julia Ratti [29:13]
So, at 30 years into this work at this point for me now, the thing that definitely makes me the most sad is that we just have never been able to really nail the information and resource referral work. So we've done really large-scale system things like 211, where you're supposed to have access to all the information that you might need. We've done very targeted ones. We've got a project in Washoe County where it's a very targeted app for homeless youth, specifically, to know what services are available for them. At the end of the day, keeping it current in a way that that information is still valid and useful for the end user just constantly turns out to be a problem.

I know that the – we worked with the managed care organizations. So now, pivoting back to my role as a senator, we worked with managed care organizations who were – we were pushing them, which of course, are the insurance providers who provide Medicaid. Pushing them to recognize the frustration and challenges that their members and the folks we were talking to had about access to healthcare, and particularly, accessing culturally-appropriate care.

And so, we are starting to see now more – and particularly in the behavioral health space – more of their providers on their list will say, "LGBTQ-Friendly," or talk about target populations that they're comfortable working with or feel qualified to work with. We're starting to see some of that on a more systems-wide – so, less a list that gets populated every once in a while, but more, trying to affect systems so that people can find the provider that's appropriate for them. But with the providers that we have in our community and the waitlist, finding any provider is a challenge, let alone finding a provider that is a good match for you culturally. So, still, a big, big area where we need to do more work. I don't know if that answers your question but –

Elia Del Carmen Solano-Patricio [31:13]
Nods (affirmative).

Kelliann Beavers [31:15]
Thank you for speaking to that. It is really helpful to hear your perspective about how challenging it is to make things happen, even when it is a really high priority to you and to many people, and just how challenging it is to keep data like that current. I'm not even sure "data" is the right word. But information about resources.

I'm wondering, based on some conversations that we've had with other leaders, and based on the intensity of everything that you're describing that you do. If you have anything that you'd like to share about how, especially during this kind of crisis, you managed your own mental health, and your own capacity to carry all of this. Which, obviously, you, I'm sure, have developed some skills in already, just doing what you do. But I think, thinking about it – I'm not even sure "mental health" is the right word. But the mental health of leaders in addition – sort of like the humanity of leaders is something we've been thinking about a lot.

Julia Ratti [32:17]
Yeah. I mean that's one that I've struggled with, just being completely honest and transparent, that I have struggled a little bit. I think that working at the level that I have been working on community-based challenges and trying to do it both from the perspective of a 40-hour-a-week job, and then from the perspective of a legislator simultaneously, honestly, it led to me resigning from my senate seat.

Kelliann Beavers [32:48]
Hmm.

Julia Ratti [32:51]
So I think that the experience of the pandemic gave everybody meaningful opportunities to reflect on what's important.

Kelliann Beavers [32:59]
Sure.

Julia Ratti [33:00]
And on how much capacity you have to take care of others while you are taking care of yourself. And so I definitely went through the thought process of, you know, you've got to put your own mask on first before you can help others.

Kelliann Beavers [33:18]
Absolutely. And wear your own "powers," which are many magic powers if you will, are the most impactful for others. Because even just listening to you share a lot of this, I feel like I could cry listening to you. So, I can't even imagine what your every day is like. I know that it's necessary to keep a clear head, but it's intense.

Julia Ratti [33:39]
Yeah. And you know, it was a lot. There's no question. But I would say, compared to, relatively small, what medical providers were going through at the height of the pandemic-

Kelliann Beavers [33:49]
Right.

Julia Ratti [33:50]
-my public health peers, right? People don't think much about public health. But they were the backbone of all the immunization efforts, all of the testing efforts, and getting all of the good information out to the public in a way that could compete with social media, and all the bad information that was out there. And you know, those folks who were doing that disease investigation, and they're talking to the families, and people are dying every single day. I think the weight on them was extraordinary. Mine is a little more behind-the-scenes. But I think there are a lot of folks like me who were leaning in lots of different ways trying to make a difference in whatever way. And my eventual learning was, I could be better at doing – I think you framed it as 'determining where I could make the most impact.' And I would like to believe that I did that unselfishly. But the truth of the matter is, that's not – my primary was like, I need to do one thing, not two.

Kelliann Beavers [34:50]
Yeah.

Julia Ratti [34:52]
And where can I do that – still have an impact – and also, still, have personal health?

Kelliann Beavers [34:59]
Yeah.

Julia Ratti [34:60]
Because there are some ways that I can have more impact in the legislature. There are some ways that I can have more impact in the health district. But the one that was more balanced and could be done in a way that I could also have some sense of personal well-being was to go back to having a proper job, as opposed to serving the legislature.

Kelliann Beavers [35:18]
Yeah. Thank you for sharing that, and for the work that you do. You've spoken a couple of times about – and I may be misstating the same of it – but the health equity plan that you're working on, a health equity program.

Julia Ratti [35:31]
Yep.

Kelliann Beavers [35:34]
And you've also shared plenty with us about the things that inform that, including the listening tour, and the work that you've been doing more recently. Would you like to share more about what that is, or what it's moving toward? I don't know if I completely understand if it's-

Julia Ratti [35:46]
Sure. So I mean, one of the – we just talked about how dark things got, but there were also all these silver linings, right? And so, one of the silver linings was increased funding to do certain things. And I think another silver lining was the very bright light that got shone on equity issues. Many of us who have been working in the field have known that there have been equity issues and have been working on that for many years. But it was just so apparent with COVID that the burden of the disease was carried with much greater weight in certain communities: tribal communities, communities of color, and elderly communities. But you just couldn't ignore the health disparities, right?

And so that has brought a whole lot more energy, momentum, interest, enthusiasm, and resources towards addressing health equity and health disparities. For the health district specifically, we are one of a number of agencies in the state who have received a health equity grant from the CDC, that flows through the – well, for us, it flows through the state. Las Vegas – or I should probably say Clark County – they're are larger population, so they got their own direct funding from the CDC. Us, we're one of several subgrantees for the state. And that has given us the resources to really take a step back and look at what we are doing, as a health district, to address health disparities.

And so, we're sort of tackling it on a couple of fronts. One is that we were able to double the size of our communications team, which means we went from one person to two people. And if you could imagine, one person doing all that comms work during the pandemic. So now, we have two, and one is specifically hired to be bicultural-bilingual. And that has dramatically increased our ability to do targeted communications to the Hispanic community specifically, but even more broadly.

Kelliann Beavers [37:38]
I'm just absorbing what you said. I really can't imagine that that was one person who was in their shoes.

Julia Ratti [37:42]
It was one person.

Kelliann Beavers [37:45]
I mean, I recognize that everyone has people around them, but I would have never known that in that, and that's really intense.

Julia Ratti [37:48]
Yeah. And he was able to tap into the comms team at the county more broadly. But it really was him doing – yeah – daily media briefings and all those press releases.

Kelliann Beavers [37:58]
And I'm sure the county was looking to him to an extent, right?

Julia Ratti [38:02]
Oh, yeah.

Kelliann Beavers [38:05]
As an information [overtalking??38:03]

Julia Ratti [38:06]
Absolutely, yeah. It was crazy. So we invested in capacity in comms. We hired three community health workers. And so the community health worker model, being one of the actual research-based models, where it's a little bit more tried and true, and a little bit more evidence-based. That we know, when we hire people of the community, by the community, to work within our structure and build a bridge to the community, that we are far more effective. And so we now have three community health workers that sit in our clinical and community health services division. And they are specifically building bridges with the community to make our services more effective at that level. And so that was a big lift.

And then, we hired a health equity coordinator, whose job it is to look more globally across the health district; how we are approaching health equity. And her two big projects have been to do – complete what is known as the BARHII. That's the Bay Area Regional Health Inequities Initiative. It's a vetted and well-utilized tool that started with The Bay Area Health District. It's a tool the health districts use to assess – it's an organizational assessment to assess your capacity to work on health equity issues as an organization and ends with a series of recommendations about how you could strengthen your capacity through health equity work.

Kelliann Beavers [39:25]
Wow. Really extensive.

Julia Ratti [39:29]
So we just completed that. And then that is rolling over into a health equity capacity building plan, which we just wrote – I just finished editing the first draft of, which will then inform our health district's strategic plans. So that's a real internal tool of looking at how are we going to address health equity.

And then I think we did something really unique, and less tried-and-true and tested, but I think it's going to pay great dividends. We hired two community organizers. And so, community organizers are traditionally more going to be in a nonprofit or political setting. But we are hiring them internally with the idea of the work that we need to do needs to be a win-win. We need to do things *with* the community, not *to* the community. And so their jobs are to build those relationships we talked about earlier. Make sure that we have standing relationships. That was a really interesting thing that's happening right now. Because there's so much enthusiasm to work around health equity if you are a community leader that represents a subsegment of our population.

So I'm just going to take, as an example, a pastor at a primarily Spanish-speaking church. Everybody in the world wants to talk to you right now. They want access to the folks that you are serving in your church. They want to know your opinion about how we can do things better. And at some point, we actually end up becoming more of a burden than actually doing things well. So we're trying to do some sort of network mapping, and really authentic relationship building with folks to figure out, what is the win-win relationship? How do we make sure that we're deciding what problems, to solve together, and that we're doing things with people and not to people?

And so, those two community organizers are really charged with that relationship building that is so essential on the front end of any kind of initiative that you might want to do that is designed to address the health disparity that is prevalent in an [??41:15] population. So, we're doing that work. And they were the ones who really headed up the listening tour and all of this outreach and building these relationships. And they did things like make sure that our community health assessment was more representative, by making sure that when we recruited folks to focus groups, or we recruited – or we thought our community survey out in hands, that we got it out to diverse members of our community, and not just middle-aged women who tend to like to fill out surveys for some reason. You've probably experienced this phenomenon directly.

Kelliann Beavers [41:49]
Yes, by filling out surveys (laughs).

Julia Ratti [41:51]
So this is the work that we're doing so far. That grant sort of culminates in May, but we have a long-term commitment to keep this infrastructure in place. And it is also coming – there's a big part of the grant that is training for our workforce on diversity-equity inclusion, social determinants of health, and cultural competency. We are building with the Larson Institute a training that aligns their cultural competency and health equity competencies that are now required.

So, one of the cool things is, our accreditation board in public health has now included health equity and cultural competency in the competencies that you are required to have as a health district to maintain accreditation. So we're building training to make sure that we're building those competencies within our workforce.

Kelliann Beavers [42:39]
What do you mean when you say, "within our workforce."

Julia Ratti [42:43]
I mean, our staff. We've got 180-

Kelliann Beavers [42:43]
Okay. Your organization, specifically, though. I just didn't know if you meant something more broadly.

Julia Ratti [42:46]
Yeah. And this is more our organizational capacity to do this work well. So it really is – whether you're a restaurant inspector, a nurse in the clinic, an epidemiologist, or you staff the vital statistics department, doing the birth or death certificates. Do you have a basic level of cultural competency? And then, for those that are doing more work directly in the community, do you know what community organizing principles are? Do you know anything about your community? Do you know anything about-

Kelliann Beavers [43:20]
This is a huge effort. And even just you describing the different roles that could be a part of your workforce helps clarify, for me, what you mean.

Julia Ratti [43:27]
Yeah. We just need to be more competent.

Kelliann Beavers [43:31]
Mm-hmm.

Julia Ratti [43:34]
And while we're building this capacity. And so, our CHA has been produced. Our community health assessment has been produced with that health equity lens. Our community health improvement plan is being produced with that health equity lens. We're building relationships with partners that will hopefully help us live those community organizing principles, of doing things with people and not to people.

And so, it's a capacity-building effort right now that will lead to – because in January, we will know what our focus areas are in our community health improvement plan, which are our priorities for where we're going to partner, and kind of what issues we're going to tackle. Which will likely be mental health, and social – like the ones that have been popping – we haven't gotten there yet. The Steering Committee meets on the 20th to determine that.

So then, come calendar year '23, we'll start actually building initiatives with some of our traditional partners, like the food banks and the federally-qualified healthcare centers, and some non-traditional partners, like Black Wall Street or Latino churches. So that's what we're doing.

Kelliann Beavers [44:46]
I can only imagine that all of this has the potential to create a much stronger foundation of trust for potential emergency response in the future, right, should another crisis arise, in addition to it being a necessity and beneficial immediately. It just sounds like really smart practice in terms of the possibility of another kind of crisis.

Julia Ratti [45:06]
Absolutely. And the sentiments that came from the listening tour – we have a slide in that deck that's really capturing the sentiments. And there were a lot of folks sharing the sentiment that are very grateful that they were brought to the table for that response. And then, that second thought being – and we hope this wasn't a one-time effort, and that this can be how we're approached.

There was a quote from a disability – or not a quote – a sentiment. Because we're not doing direct quotes. But a sentiment from a disability advocate that was like, "Please talk to me at the front-end of your initiative, and not just when you have a disability issue that needs to be addressed." So that some of that caring – the weight of those voices for to say, how do we really engage people in the work, and have them be equal partners with shared leadership to do initiatives that will have an impact in their communities. And then absolutely, if you have an emergency, and you already have those relationships, and you need to pivot or do something quickly, having that network map and those relationships in place will be huge.

Kelliann Beavers [46:12]
Yeah. The formalness of the way you're describing the network mapping is really exciting to me. It just sounds like such a wonderful thing, that someone's taking the time to think about it in that manner. It just really can't be easy, and it sounds really great.

Julia Ratti [46:23]
It's really easy if you're just talking about the six people in your department when you try to map the relationships of everybody in the health district. It gets far more complicated-

Kelliann Beavers [46:29]
Exactly (laughs).

Julia Ratti [46:32]
But what I'm hoping is that what we'll realize is like, "Oh, wow. The only person who has strong relationships in the LGBTQ community is *this* person. When she leaves, we're going to lose that."

Kelliann Beavers [46:43]
Uh-huh.

Julia Ratti [46:45]
So let's make it our – broaden and strengthen those relationships across multiple people, and they're not just owned by one person. That when they leave-

Kelliann Beavers [46:51]
Yeah. I wasn't even thinking about that. Your mind is two steps ahead, and that is really important. Be careful saying that out loud, or they're going to give you another role – another job – to keep an eye on that.

Julia Ratti [47:05]
I have more than I can do right now, so.

Kelliann Beavers [47:07]
We are so grateful to you for your time and everything that you shared. This was just incredibly meaningful. Carmen, if you have anything else that you want to add. The only thing I would like to be sure to ask you, before we depart, and you could think about it if you'd like; is if there's anyone else we should talk to that you know of.

Julia Ratti [47:29]
Well, I'm hoping that you're talking – I, at least in terms of COVID, I'm not a person who is being unduly burdened by health disparities. So, I guess the only sentiment would be, I hope that you're talking to plenty of folks who represent and can speak for communities that were.

Kelliann Beavers [47:52]
Thanks. We will definitely keep that in mind. I know we have, to some extent, thus far. But we're about halfway through the amount of interviews we want to do, which is 100. So, we've been meaning to take a collective look, and sort of do an assessment of who we're speaking to and what that reflects.

Julia Ratti [48:10]
Right.

Elia Del Carmen Solano-Patricio [48:14]
I was going to say, to answer your statement, your responding statement was, "we have a group of leaders, and then a group of what we call frontline workers, so, everybody else.

Julia Ratti [48:24]
Right.

Elia Del Carmen Solano-Patricio [48:27]
Yes. And I did want to add, we just put out a public health factsheet recently. That's a big part of what we do, and it's a regional look. So, I thought that, as a state leader, you would be interested to see like yes, this is everything that's been going on in Nevada. But how does Nevada rank compared to the rest of Mountain West? So I can pop that link into the chat here before we jump off, so you have it. I'm the co-author on that. I just thought that I should plug it (laughs).

And then second, you said something, that in your many years of working in the roles that you have, you've not seen a comprehensive list of healthcare information. And so, I just wanted to show you ours. A good friend of mine is actually the founder of this organization. His name is Diego Trujillo, and he founded *vegashealthcare.com*. So if you look at that and divide it up by practitioner type or service type, and then language distinctions, as well as behavioral distinctions or cultural ones, just as you were talking about. So, just something to look at for reference, or if you wanted to be connected to that person, that organization, to do something like that up north, then we'd be happy to facilitate.

Julia Ratti [49:42]
So now, I very much appreciate that. I should clarify my comment.

So, I'm really – I actually live less in healthcare than I do in health and human services.

Elia Del Carmen Solano-Patricio [49:51]
Yeah.

Julia Ratti [49:53]
And so that breadth of health and human services of "I need childcare," "I need respite care for my senior citizen," "I need – that is actually beyond and outside of healthcare.

Elia Del Carmen Solano-Patricio [50:02]
Yeah.

Julia Ratti [50:03]
I think in healthcare there's probably more infrastructure around because you do have hospital systems, insurance systems, and things like that that you can build from. But Health and Human Services, I've seen the list. I've just never seen anything that has stayed updated and useful for people over the long haul, and so, everybody's always creating a new resource list.

Elia Del Carmen Solano-Patricio [50:23]
Yeah. Great. Well, thank you.

Julia Ratti [50:25]
It looks like a very exciting project, and I will definitely check it out. Because, as I mentioned, access to healthcare services – so, specifically, healthcare, not just broader population health or public health, is popping into our needs assessment. And certainly, culturally-responsive healthcare is definitely something that we're interested in. So I will take a look.

Elia Del Carmen Solano-Patricio [50:45]
And you'll find that we view things with the same type of lenses. In our factsheet, we don't just talk about

access to a primary healthcare provider, but also environmental issues. Like whether that person is housed, whether they live in safe housing, or whether they have other behavioral traits such as smoking or childcare responsibilities, what-have-you. So, yeah. Definitely, a holistic view.

Julia Ratti [51:09]
Great.

Kelliann Beavers [51:13]
Thank you again so much for your time. And we will definitely be in touch back with the transcript, once we get it transcribed. And again, I'm just very appreciative of you for all that you do.

Julia Ratti [51:23]
Great. I will just say one other thing. I think the one topic that didn't get emphasized that probably needs to get emphasized is the long-term results of the eviction crisis. And so I think there were two really big things from my senate seat – more of my senator's seat – that happened during COVID that are going to be these long-term impacts.

Kelliann Beavers [51:41]
Mm-hmm.

Julia Ratti [51:42]
One was unemployment and the inability to get unemployment resources when you needed them. And you know, over time, it got better. But we just know that people got lost, right? That there are going to be dramatic, life-changing effects for people who were employed, are no longer employed and are struggling to get back into employment because of this disruption.

Kelliann Beavers [51:59]
Yeah.

Julia Ratti [52:01]
And then the eviction crisis on top of that. And so we did things as much as we could to stave off evictions, but we just know that – and I know you have the data, right? The eviction rate and the number of people who were becoming unhoused because of the dual pandemic – we already had the affordable housing crisis, and people's housing was tenuous. And then you overlay the pandemic, and that affected their livelihood. And then that, of course, affects their ability to stay housed. And so, I am very concerned about the two-year, five-year, ten-year, and twenty-year impact of those two things, particularly on folks who were vulnerable, to begin with. So I just want to make sure that was a part of the conversation.

Kelliann Beavers [52:42]
Yeah, thank you. And it definitely has been – and I may have not emphasized it as much in my questions to you. Because that's really where my interest lies and is strong, and it's why once anyone said your name, I was like, oh, I want to talk with her because she has so much – just boldness in your ability to insist upon conversations and dialogue happening around affordable housing and all of the things related to it, including what you just articulated. So I am very appreciative of that-

Julia Ratti [53:16]
And we did do some good work in Nevada in order to slow down that eviction. I think it could have been much worse. Because we had a governor who was willing to extend eviction moratoriums, and we had folks, like Barbara Buckley and her team at Washoe Legal Services, who were very creative about helping to build legislation that would put in some more safeguards for people getting evicted, at least during the

time that we were in the recognized pandemic. So, it could have been much worse, but it's still bad. And so I just think that's going to be – if the point of this is the long-term impact on coming out of the Great Recession, and then the pandemic, that housing piece, particularly for tenants, is – I have serious concerns about the impact that we're going to see on that long-term.

I was just reading an article about long COVID, too. I mean, even the people who were going to have long COVID and be living life more now as a person with a disability who's unable to maintain the income generation levels that they had before, and the competition for the very small number of affordable housing units is – if there's going to be something that keeps me awake at night, that's it.

Kelliann Beavers [54:27]
Yeah.

Julia Ratti [54:29]
Tenant rights impact us through affordable housing.

Kelliann Beavers [54:30]
Yeah. It's such a large scale crisis, that the moment that all of the announcements were made about the funding that was available for housing and what would happen with it. Of course, there was a certain degree of gratitude and excitement about the things that will happen. But then immediately, and to just what you were saying, is the problem is so grave, it is so big, and there is so much that is unmet. And I don't know what the answer is. Any recommendations that anyone like you has, I would like to scribble down and record in stone because you've seen so much.

Julia Ratti [55:01]
Well, and the way I keep describing it is, we are with housing where we were with healthcare before Medicaid and Medicare. So if you go back to a time in our history, before Medicaid and Medicare existed, healthcare was not kind of a foundational – [pause] It was not a foundational safety net that we had for certain individuals. And Medicare came along, and we took care of our senior population, and Medicaid came along, and we took care of our low-income population with significant large scale, federal-scale, lots of resources. And prior to that time, it was a purely for-profit, pay-for-a-service-and-get-a-service model with no safety net for folks who couldn't compete in a capitalist model.

That's where we are with housing today. There are these tiny, little bit of extra programs, like the low-income housing tax credit, that helped to build affordable units. But for the vast majority of folks, and particularly, our vulnerable seniors, low-income, it's the same thing. We don't have that level of program. And that is the level of the program, I believe, that it would take to meaningfully address affordable housing and housing as a right or a recognized ability. That if you've worked your whole life, or you are unable to work because you're vulnerable, you have a disability, or whatever, that we still would like to see you be housed – requires the same level of attention and investment that we've done with healthcare.

Kelliann Beavers [56:35]
Yeah.

Julia Ratti [56:34]
[audio drops out 56:35] away from that as a society. So, instead, we're doing things like what I did, which were – alright, we'll get a $40,000,000 low-income house credit. Which means that 600 people per year will be housed, more people per year. For those 600, life-changing. For the other tens of thousands that need it, it doesn't do anything. Even now, the 500 million, the same thing. We're going to help – for those

who get it, life-changing. For everybody else, still a big problem. So that's what I really believe about it now, that it requires that scale of change in thinking and intervention. And you know, depending on where you are in your political leanings or your thinking about, is our current healthcare system doing what it needs to do? We have not done universal healthcare in the way that other first-world countries have. Do you build a system that is – because our healthcare system, while we have Medicare and Medicaid, is still built on a mostly capitalist model with for-profit medical care and for-profit insurance companies?

Housing right now is the same way. Even our affordable housing is done in partnership with for-profit developers, right? So we've stayed in America as a very capitalist model – the question is, is that working for healthcare? And if you were going to build something from scratch for housing, do you want to do the same thing?

So that's my very big – like you want to talk 100,000-foot thinking, that's what we actually need.

Kelliann Beavers [57:55]
I love it though, and it's so accurate. And it really – part of the conversation that I want to deepen and move a particular deliverable from this research project toward is about housing and the housing crisis. And exactly what you just said: that there is a new language, like housing, as healthcare, and housing as a human right, and those kinds of things that are emerging as rhetoric. But what does that really mean, and how can we give roots to that? Is it effective rhetoric? And what you just said is – I'm glad you said it. Because I guess it's been in the back of my mind, but I didn't think about it as a possibility. But really, how else are we going to meet this challenge?

Julia Ratti [58:31]
We aren't. And it would be fascinating – if I could be transported back in time, I'd want to be transported into the rooms of the people who were talking about Medicare and Medicaid when they were started. Because I think that the way it was really done was like, who do we want to be? Who do we want to be as a nation? Do we want our seniors to be unable to access healthcare, even though they've worked a long, full life?

Kelliann Beavers [58:51]
Yeah.

Julia Ratti [58:54]
Do we want our lowest-income, or people with disability, individuals, to have access to healthcare? And I think it was really around who – all right – kind of our identity as a nation, but I don't know. Maybe it was much more black and white pure political negotiation, you know. Because certainly, with any major change like that, the will of the people kind of helps the will of the political get there. So, I don't know what it's going to take in housing to get the will of the people to help the will of the political get to a place where everybody needs a home.

Kelliann Beavers [59:23]
But maybe it is a conversation like exactly what you just said, which is, who do we want to be? What is our identity? And are we willing – if we don't do this, to let that be an acceptable part of the identity that we thus have? Which is-

Julia Ratti [59:34]
Right now, we are. We are all driving by lots of unhoused people every single day.

Elia Del Carmen Solano-Patricio [59:41]
Especially in a state like Nevada where government spending is so controversial.

Julia Ratti [59:44]
Yeah. So, that's a huge philosophical conversation. But that's what I think about it now. After having spent a couple of years of my life really trying to move the needle. And hopefully, doing some nice things for some – a small number of people.

Kelliann Beavers [59:59]
Most certainly, you have. And you've definitely also changed the direction of the dialogue, which is really powerful-

Julia Ratti [1:00:06]
And you've got the Housing Coalition that's continuing the work. Which-

Kelliann Beavers [1:00:08]
Yes, and I was so grateful when that first happened. I went to one of the early meetings. I was doing an internship at the time at the RTC and was able to sit in on one of the early conversations about creating the Housing Coalition. And yes, that has grown to be a wonderful creation.

Julia Ratti [1:00:24]
Yeah. And things like that were what made me comfortable, like okay; I can step back now. They're going to work with legislators to get to the same place that I already got. So-

Kelliann Beavers [1:00:34]
Yeah.

Julia Ratti [1:00:35]
[overtalking 1:00:36] for a while, so-

Kelliann Beavers [1:00:37]
Yeah.

Julia Ratti [1:00:38]
Sorry. All right.

Kelliann Beavers [1:00:39]
Thank you again so much for everything.

Julia Ratti [1:00:41]
You bet.

Kelliann Beavers [1:00:42]
I hope to cross paths with you again and learn more from you. We're really appreciative of this.

Julia Ratti [1:00:46]
Well, I appreciate being included and look forward to what you come up with.

Elia Del Carmen Solano-Patricio [1:00:48]
Thank you so much.

Julia Ratti [1:00:49]
Nice to meet you.

Kelliann Beavers [1:00:49]
(waves goodbye)

Julia Ratti [1:00:52]
All right. Bye.

End of audio: 1:00:58