



**COALITION for
HEALTH FUNDING**

**Congressional Briefing and National Webinar:
Beyond Emergency Funding: Sustaining Public Health Funding in the Post-COVID
Landscape
Trust for America's Health and Coalition for Health Funding
June 22, 2022
1:30 – 2:30 PM Eastern**

Live Captioning by Ai-Media

MILA BECKER:

Good afternoon! And thank you for joining us for Beyond Emergency Funding: Sustaining Public Health Funding in the Post-COVID Landscape. I am Mila Becker, the chief officer at the Endocrine Society and I also served as the president for the Coalition for Health Funding.

The Coalition for Health Funding is the oldest nonprofit alliance working to strengthen health funding alliance in the best interest of all Americans will stop say Jeff is pleased today to be cohosting this event alongside the Trust for America's Health.

Before we begin, I would like to go over if you important housekeeping items. -- A few. Real-time captioning is provided today by Serena for Ai-Media captioning services will stopped to view real-time captioning, click on more at the bottom of your screen with the three dots. Then click on closed caption.

All audience members are muted to the discussion, but we do want to hear from you! And we will be taking questions at the end of our panelists discussion. To ask a question please use the Q&A function at the bottom of your screen, not the chat, Q&A!

Please check -- type your question, you can begin submitting them now and throughout the presentation. When you submit a question please be sure to include your name and the organization you are representing the

Now to business. Since the beginning of the COVID-19 pandemic, we have seen Congress appropriate a significant amount of emergency funding to respond to the pandemic.

This emergency funding was critical, due to our countries underfunded public health system. In today's briefing, you will learn why emergency funding along is not enough to build a strong sustainable public health ecosystem that will be resilient in the face of the next public health emergency or pandemic. And importantly, why robust and sustainable federal funding is necessary to protect the health of Americans during all times.

I would like to introduce today's speakers will share what public health is, what funding is used for public health, and why sustainable routine funding is so important. First, Doctor Michael

Fraser serves as the CEO for the Association of State and Territorial Health Officials the nonprofit organization representing public health organizations in the US, state territories, and the District of Columbia. As the chief health officials of these jurisdictions are dedicated to the moment lighting and influencing sound public health policy -- dedicated to formulating and influencing.

Under his leadership, he has received several awards from the American Society of Association directors for their outstanding performance and contributions – her team has made to advance the work of its members. --ASTHO.

Lisa Macon Harrison is our second speaker. The health director of Granville Vance health department in North Carolina, and has worked in the health practice in North Carolina since 1995. Ms. Harrison previously worked with the North Carolina Centre for Public health quality. The North Carolina division of Public health, and the Centers for Disease Control and Prevention on a public health infrastructure grant for performance improvement. She served as the president for the North Carolina Public health Association in 2015 and was elected to absent five southern states on the Board of Directors of the National Association of County and city health officials NACCHO from 2018 to 2020 – right twice why want. Where she now serves as president -- 2021.

Dr J Nadine Gracia is the president and CEO for Trust for America's Health. Doctor Garcia is a national health equity leader with extensive leadership and management expense in federal government, the nonprofit sector, academia, and professional associations. As president and CEO, she leads TFAH's work to advance sound public health policy, advance health equity, and make health promotion and disease prevention and national priority.

All three of these speakers are going to make everyone feel quite adequate. We appreciate your time today. And with that, Doctor Fraser I will turn it over to you to kick us.

MICHAEL FRASER:

Will thank you so much! I hope no one feels inadequate, we all have gifts to bring to this conversation – Maxwell, but thank you to TFAH and the coalition for the invitation to participate. As Mila mentioned, I work with the national organization who works with all of our national health officials and their teams, we advocate on behalf of health infrastructure and building our health system, and we work both with TFAH and NACCHO very closely, so I am pleased to share a panel with friends and colleagues all as dedicated as we are to develop a public health system this country deserves.

The message of this conversation is really that we cannot do it on emergency funding, and we want to talk a little bit about why, and offer some ways forward to build a public health system that works for all of America.

On the next slide, I want to start by a very pressing quote by Tom call, the representative from Oklahoma. In a testimony presented earlier this year at House appropriations he said, "As I have told our own side, and, I think the last year has illustrated to all of us, sometimes you need to spend billions to save trillions. And just look at the cost of what this pandemic has been..."

A cost in lives, over a million lives lost to COVID in our country alone! Not to mention the global toll, and an estimated US\$16 trillion in overall global response and recovery efforts to COVID. And had we had a public health, had we had public health system investments well prior to this pandemic, both of those numbers would be far lower. I am 100% convinced that that is the case.

In the United States only spend \$4.6 trillion in emergency assistance to people, businesses, state and local governments and healthcare systems. What if we used just a fraction of that? Three, five, 10 years ago, to build the capacity of our public health system and its partners to respond to disease outbreaks? That we know are coming and that we have experienced in years past.

On this next slide, I want to share this vision of how different what our public health response had been if public health agencies were fully resourced to carry out a complete range of monitoring that included global signals and trends, something that we have been talking about for years. Having outposts globally to signal potential threats to our nation.

Or having data systems that were fully integrated between healthcare and public health organizations at the local, state, and federal levels. That is not the state today. Or if we had the capacity needed to quickly scale/surge disease investigation and healthcare medications workforce. These continue to be areas that need improvement when we look at, had to be scalloped when we have disease threats?

And how do we communicate to a public that needs information so quickly? No help the parent had to commune acacia capacity needed! One of the infrastructure to quickly develop needed tests and supplies to support our laboratories in doing that testing, and what if we had adequate investments in community-based public health work focusing on achieving health equity and optimal health for all? Not as a pilot project, but as a core premise in local state and territorial health agencies for

All of these things we have called for for years, and we have seen interest in, but unfortunately as it comes to the appropriations of the passives as we have been left out, or we have not fully realized what is needed to build the public health system we need, and instead we spent \$4.6 trillion to respond to a pandemic over this last two years -- these last. (Laughs) That investment.

On this next slide, I want to point out, this is a tale of woe that a lot of public advocates have shared over many decades, that we are on a public health funding roller coaster. We see feast or famine, some call it panic and neglect, or boom and bust. In every single public health disaster, this country has rallied to support its public health system but it has been episodic... It has been time-limited, it has been disease specific, so competencies for H1N1, Ebola, SARS, and now COVID... When does run-out, the funding is gone.

If people to respond are gone for the system and the systems maintenance are gone, and that is what we have to stop doing if we do not want to spend another 4.3 trillion next infectious disease outbreak that affects us all! -- In the next.

IN the next like, you will see what we are talking about, is sustained funding for government health agencies that truly build the capacity of state and local governments, tribal governments to provide the foundational public health services to their communities. In some states those are offered directly by a State Department, in other states those are offered by local health agencies that work in partnership with the public department will stop in tribal agencies, it is run by the tribal departments and agencies was up and in territories, all work together to provide these public health services.

But what we have now in public health -- governmental public health is an amount of grant programs that nationwide, unevenly addresses these foundational systems. Not every state has every public health program that it needs to assure the conditions for everyone to express optimal health.

And foundational capabilities, things that keep the foundation running, and crosscut in program areas instead of the health agency to build the capacity to do its business, shares data and to work in partnership with communities, all of these things that we know are important to a functional high-performing health department.

Of course, all of this is rooted in equity, something that we will talk about hopefully more in this webinar and certainly well into the future.

But on this next slide, this situation that we have with data modernization is actually a really good example. We rallied interest with partners, this work has been led by many of our astho affiliates, the Association of public health laboratories, the health information management systems Society, many partners prior to COVID sat down and said, "We really need to address our systems. Need to improve our data systems and plan for modernization, and we have to ask to find it."

Over the last few years, this is of course else's right as COVID started, we received congressional appropriations for \$50 million in 2021 -- 2020, we received an additional 50 million for 2021, in FY 2020 200 million, and \$1.2 billion has been appropriate thus far, this is to build data infrastructure, a problem with data sharing and this is our responsible to you will see on the next leg, that while \$1.2 billion used to feel like a lot the actual asked, what is really going to take to bring us together... Tim I'm not sure if you can forward to it?

Is \$37 billion for a 10 year investment. \$37 billion, so we are talking big numbers here to establish the infrastructure we need to share data, to read those signals, all that it takes to build a functional data system for public health agencies.

These are big numbers. But they are certainly important if we are going to realize the public health system that we want in our country. On the next side, we are heading towards a very difficult time for public health agencies has the end of this quote unquote boom cycle. Many COVID funding fines have been spent and they will create a nap or a cliff. We will again find ourselves, potentially even as early as the fall, in a situation where when we need to respond it will potentially not be available to states, because we have focused on emergency funding as a

response rather than a sustainable infrastructure.

We are really thinking about the future, and this is a long game. We are so pleased to see the creation of the public health infrastructure fund with an initial investment of 200 million this year. We are asking again for that to be sustained into the future.

In the Build Back Better Bill, we had a \$7 billion ask over seven years to create that fund and to invest in that fund, we still think that we have to grow and maintain our public health infrastructure fund for the future.

Sustained, flexible funding is just as important as sustained programmatic funding. We do not want to grow one area of the health department and not others that share and exchange information and staff, so this is very important that as we think about future investments in public health infrastructure, that they remain as flexible as possible to support a wide range of needs and very diverse communities, and across the states.

We are hoping to see for FY 23 and beyond, our ask is an additional \$1 billion into the public health infrastructure fund which goes to states, locals and CDC to provide those foundational capabilities.

The total investment of \$7 billion over the next seven years in the Alta infrastructure fund. There is a lot of work to do. We're looking forward to work with our partners, all of US advocates! To tell the public health story about why sustained funding is needed. Even when we look back on the COVID-19 response, we can point out where things could have been better if we invested earlier, and let's not do that again. But build a public health system -- let's build the public health system we need.

LISA MACON HARRISON:

Thank you Mike. I am currently serving as a present for NACCHO, the National Association of County and city health officials as me – mentioned. I'm going to go over some of the things Mike has just talked about, from where I sit in a row to County Public health District North Carolina, I serve about 100 population and to have approximately 90 what a full public health workforce during the hard work of public liberty. -- Wonderful.

I want to make sure that we stress public health is very different from healthcare. The way that we are able to provide environmental, health, and sustainable change work with the things that you have been familiar with the pandemic. One of the things that is, when I advocate for and when I talk about future funding for public health, is this picture of smiling faces of my health promotional and wellness team. I think the workforce made by community is definitely our most significant public health asset, and without them we cannot wear so much about modernizing data structures or making sure that we are offering enough vaccines for the community, or a enough testing opportunity when it comes to new diseases and emerging issues. We need these folks! On the ground, in community with relationships and build trust to make the work happen no matter what the modernization of work ends up being.

I also like to point out this is my health promotion and wellness team my two District, and every

single one of these 11 individuals are grant funded. I have a job as a health officer in a two County district, I've a second job as a grant writer and grants manager. We have to manage about a million plus dollars per year to support people like the use doing the work that we know needs to be done that is not otherwise funded at the local, state, or federal level in a rural state.

NACCHO is here to make sure that those working across all local health departments in the United States, nearly 3000 of them are supported. We offer skill building programs, and resources focusing on health equity, and making sure that our practices and systems are needed. That is why we are here today, to talk but the funding needed to get there. -- Talking about.

There is a lot of diversity in how public health is organized, and in who we serve across the nation and how this work is executed. This is true in school systems as well as public health systems, where we have a sort of unique answer to what is needed community by community, county by county.

As you can see in the sort of dark tale, the majority of our health apartments across the united states are in a decentralized system. Also, the majority is serving a small to medium-sized population, whereas the larger health apartments, only 6% of those local health departments who serve a population of 500,000 or more are serving a lot of Americans.

So when we talk about infrastructure, and when we talk about supporting our workforce, we are talking about doing it in a similar way across the US. But know that we depend on county governments to be our partners in this makes it a low bit more complex sometimes. -- Little bit.

So what is the work that we should be doing and 2022 and beyond? And what are the structures, investments and policies needed to get there? That is what we are asking ourselves. That is what we are having a lot of exciting conversations about.

And I'm really excited that we get to think through this today with you all, to make sure that we are moving in the right direction. We talk in public health often about essential services core functions, and now the additional capabilities as Mike said, we certainly need more in the way of medications. After the pandemic, -- of communications, after the pandemic, we saw we need to definitely best in this, and we are good at partnering at the local level. So there are things on this list that we need to improve on, there are things we are already experts in, and there are things we could just find differently to be more effective across the board. -- Just fund.

The matter where you find a local health department, they do not do the work that they do alone. -- No matter. I think we are having really exciting conversations about new ways and nontraditional partnerships that we can forge. It is a little harder to do this in larger communities, but you also have more people to do more partnering with.

In rural communities, these are absolutely the foundation of the work that we do and the connectivity that we have with partners and local community makes our response to emergency situations much more effective.

A lot of people have realized that we are here to give immunizations, we are here to distribute

vaccines, we are here to provide testing and information, and that we have discussed that around epidemiology. The people do off – people do not often realize the amount of work that we do across the public health barman, that spans across lots of different specialties and expertise levels and lots of different kinds of work. -- the public health department. These different areas of work that we do, in fact it causes us to manage a lot of different ways of reporting back how we are spending funding on these different types of work that we are in charge up.

It is exciting work, it is good work, and it is a lot of different work! I think often we hear when we orient a new employee, they are astounded by all of the things that they did not realize we did in public health.

Many states are similar. There are a few nuances to this, but in general, along on the left-hand side are the mandated services. We'll provide their mental health, medical disease control, vital records registration, health education and promotion, and we conduct community health assessment regularly to make sure that the committee gets have a voice in the priorities or refocus a lot of our energies. -- The community.

I would like to point out on the left side, although these are general in law and state to take state, they are often not funded by state governments, so often times especially for communicable disease, vital records, and health education and promotion none of which are fee generating or revenue building, those have to be sponsored at the local level by county commissioners or grants are usually for those if states do not have the funding for the kind of work.

On the right, we provide, share, contract, or certified depending. Some of us to jail health, some of us partners with those that do that work, care management, dental public health, adult health etc.

Over time I think it is important to note that we have lost a lot of our workforce, and just as we were turning into the pandemic response, we realized we were 20% less on FTEs to do the work of public health from the downturn economically in 2008 to 2019, this graph shows that 20% decline and full-time equivalents -- in full-time equivalents per 10,000 people across the nation.

The revenue source picture is just complex. There are a lot of different sources, and this again varies community by community, just as you would see in a school so simple stopped some poor rural areas have less county or local funding, some systems the local people that have more ad valorem tax or property tax have more money to put into their public health system. But, it is suffice to say that there are a lot of different sources that you have to meld together and make work, and these different sources have requirements. -- Different requirements.

Take ways to know about public health funding. Funding sources vary tremendously, these can include Medicaid and fees and other sources typically grants find the remaining balance of a local health department budget and staff. As I have said our workforce is our most significant asset, and it is also where the revenue goes. To make sure we do the work our biggest cost is our workforce. Approximately 25% of our local health apartment budgets come from state federal combined on average, lots of room to make up the difference counted by Oedipus topped this shows to see what difference there is in the role continuum. -- Urban continuum. We see a lot of

audits. I do not go a month in my role as a local health director without seeing an audit from some funding source or some health program.

So I think it is important when we talk about new funding flex ability, that we understand governmental entities are highly accountable to the dollars that were given. For my health apartment alone, we have more than 80 different banks of revenue and related reporting requirements that are for each of those sources that looked different. -- Look.

Over time, what we have funded and public health is parts, and resilient public health system is more than just the sum of its parts. The current financing system in the United states is misaligned because we put money into the treatment of disease rather than prevention, and prevention has all of this complexity related to it.

I like in our budget and the local how the permit level to a game of --Jenga actually. I think today this conversation has helped us to be thoughtful about how to -- how we can build stronger public health system and be more prepared for emerging diseases in public of judges. There are so many important parts to consider.

When we pull a --Jenga piece out, it can cause the others to fall. So we need to make sure to pay attention to all the pieces, because each is designed to get the best results that they can, and those who really do this work understand you really have to look at each part of the system closely in order to really change the system.

I just want to share a few pictures again, of the people who are doing this work and people who are motivating me on how we can make changes and make the system easier for these dedicated hard-working skilled professionals. To make it a tear, these last two years have been tough, and we want to create a system that is easier for them to work in.

I just want to show a sharp -- a few more pictures of our vaccine clinics, and the people that -- truly shows how important public health funding is for our community. We need to give them a system that works better. Thank you and I will pass not to Doctor Grassi. -- Pass it off.

DR J. NADINE GRACIA:

Thank you. Greetings everyone! I'm the president and CEO for Trust for America's Health, and as such an honour to be a panelist, and thank you, I am glad to join with friends and colleagues. Long-standing partners of NACCHO --.

Trust for America's Health (TFAH), we are an independent, nonpartisan, public health, prevention and equity focused organization. We advocate for evidence-based policy changes that will help to protect the public's health, on issues that raise from substance use to chronic diseases in public other emergencies.

We have released a report that examines the impact of the chronic underfunding on America's public health system post we will release this report later on this month, -- system. We will release this report later on this month, and as you have heard from Michael and Lisa today, the importance of funding for a stronger public health system not just in emergency situations, but

for everyday.

In the work of public health, one of public health challenges is that often the successes of the field are invisible. They are not known to the public, and this can make it easier for policymakers and other decision-makers to overlook when it comes time to this critical but often unseen work that is critical to help community -- Fund. In our 2021 public health funding report, we analysed the Centers for Medicare and Medicaid Services national health expenditures for 2019, and we found that the total spending on public health are presented about 2.6%. That is less than 3% of the total \$3.8 trillion in expenditures. That was the lowest level since at least the year 2000

In comparison we just analysed the 2020 numbers, and the share of national health expenditures increased to \$4.1 trillion, largely because of the significant emergency health funding spent on the COVID-19 response. This is the largest share we have seen in decades. However Abby had -- as you have been hearing, short-term funding is not for sustainable public health. And as Michael has said, rather than investing in prevention of illness and in people who work, we spent trillions on the public health and medical response to the pandemic.

What we are seeing by the nation, is that prices are rising. And yet when we look at funding for public health nationally it is not keeping up with what we are seeing for the rising public health threats. We can look example at the centre for disease and prevention control, and CDC's budget has not grown accordingly to meet these challenges. They flat funding, what this has done is it has made it difficult to keep local and government health systems to be fully staffed with a workforce. This has led to burnout among staff, and harassment and attacks on public how the visuals we have seen during COVID-19.

In addition, CDC has not been able to make vital improvements to their infrastructure, especially as it relates to laboratory capacity and data modernization as we have been hearing, so we need to put investments in to ensure that it will be brought to the 21st century.

Another challenge facing public health funding is that it is often siloed. It is important that we make sure we have funding for crosscutting approaches, because the funding lines are inflexible and they are often underfunded in the first place was another challenge we often see with inadequate funding is that many of the evidence-based public health programs that do exist cannot be funded in all 50 states and territories.

Just to give you a couple of examples, the state nutrition and activity program, which addresses the root causes of overweight and obesity, this is only funded in 16 states. Or if you look at the (indiscernible) outreach program, which is to provide culturally tailored programs for committees of colour to reduce health inequities for committees that have a higher burden of disease was up while the CDC received over 200 applications in toy 14, it can only find 40 of these applicants. If we look at climate change with the states and cities ready initiative, that helps to address equities and social determinants of health and adoption, this can only be funded in 11 states. -- Adaption.

And lastly, around suicide a -- substance use and suicide prevention, only being funded on 11 sites nationwide. When we look at this issue around emergencies, a key problem that has also

made our nation more vulnerable to health threats has been cutting to Emergency Preparedness programs. When adjusted for inflation, the CDC's Emergency Preparedness funding shown here in orange sports emergency capacity for states and localities, it has decreased by 25% over the last two decades! Or over 50% if you count for inflation. The (unknown name) program shown here blue, shows the same, over the same time.. The challenge here is that his programs are our first line of defence! -- these programs, because of these cuts, we are not able to respond appropriately when for example COVID-19 or a natural disaster happens.

Michael referred to this as the "Boom and bust" Cycle of public health. Our responses are often dependent on supplemental funding. Multiple mental funding is important, and public health emergencies especially given the magnitude of emergencies, in most cases this funding is only temporary and it will not create vital sustainable improvements for public health that we are here to talk about today.

We cannot build solutions overnight. It takes time not only for the funding to be approved, but how best to get those resources out. In a public health emergency every second counts, and delays give threats a greater chance to take hold. It also means difficulty maintaining a workforce, it workforce is depleted and people cannot be rapidly rehired and retrained. Once supplemental funding expires, what happens is that we see the public health system is left unarmed for the next crisis and the cycle repeats itself.

It is only through sustained increased funding over time, that we will be able to put -- respond to these crises in an adequate manner.

As an organization, we are certainly advocating for specific recommendations to the federal government to be able to address this as it relates to our public health system. We need to increase the CDC's topline for agency to invest in crosscutting initiatives and strengthen our public health system. We also, as we have been describing, we know it is truly important we bring the public health system to the 21st century ensuring that we have diverse, qualified professionals of the expertise and resources to be able to deploy modern techniques to meet these rising public health rats, and so Congress should be investing in public health structure, authorization and the -- public health workforce.

We have a much better alternative to what has been the boom and bust cycle to supplemental funding. We certainly have all seen how the COVID-19 pandemic has exposed and exasperated health inequities in our nation. Long-standing social, economic, and health inequities, and so we must invest in addressing health disparities and ensuring that we have tailored interventions that will reach communities that have far too long suffered through these disparities. We need to increase the presence budget for fiscal year 2023, to request \$153 million to expand the CDC's social determinants of work, which would support the multi-sectoral drivers for high rates to disease. -- Of disease. CDC has many evidence-based programs that are only in certain states due to budget constraints, if we have more robust funding we can expand that type of critical work to more committees across the nation. -- Communities.

The pandemic must serve as a call for action for our nation to finally, truthfully invest in our public health system.

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MILA BECKER:

Thank you very much to all of our panelists. We will now segue to the Q&A part of our briefing. I will remind all attendees, you have a question, please type it into the Q&A section at the bottom of the zoom screen, and please identify yourself with the organization you are representing.

First we have a question about communications. I think there is a lot of content since -- consensus, right? How important communicating health messages is, we saw this during a pandemic when there was a lot of confusion.

The question is about any funding that is currently allocated specifically for public health communications, particularly funded -- funding that will support local and regional efforts? Maybe our NACCHO representative can take this question?

MICHAEL FRASER:

Sure I am happy to start, I think the issue we are trying to highlight here is that there are core capabilities like medication that currently -- like communication that the public health apartment has to potentially have cross programs, or uses as indirect, or to not use it at all. I think we have seen this in many smaller agencies they just do not have this core capability.

I think at the state level, lots more can be done in terms of funding public health medications. If you lit of hours, the national public information coalition, has public and state officials, they may track more closely? I'm not aware of any specifics for that, but it is what we would call foundational capabilities and it would be fundable through some of these and for structured dollars if they were flexible and allowed for which I believe they will.

LISA MACON HARRISON:

Yeah. And I will just add, that can indication is a crosscutting need in public health. -- That communication. We often have trained officers fork mitigation and response my but often as the funding dwindles for response and funding for emergencies, often there is not enough money at the local level for that FTE to be present, so you have to divvy up those responsible these cross people who have those -- that skill, rather than hiring specific lifework medications. And -- specifically for medications was

And now with social media, and to keep up with the ways to mitigate most effectively in this world of misinformation to boot, it is just a new skill set we need to hone in and make sure that we are funding.

MILA BECKER:

Yeah! It is so important, so that way people do not only hear about public health when it is a problem, right?

The next question is a three partner. -- Parter. What was funding for public health like before the pandemic? What has emergency funding allowed you to do? And why -- is sustainable funding

so critical?

LISA MACON HARRISON:

I will jump in here and reference managing the game --Jenga game, with all of the bullets I had only one slide, when I find how we work with different programs. For example \$10,000 for one program, 3004 another, twice a thousand for another and so on. What happens in poor and rural areas -- 26,000, is that you need a rural nurse being specialized to report to and to work on four or five different programs to help cover that FTE salary and benefits.

There is a lot of wearing of many hats as we say to be able to get the work accomplished. This is how programs have been funded in public health, in large part you hear resting by disease specifically -- you hear us say.

We certainly do not disagree with, there is a lot of response ability for these disease specific areas to get their work done was up so the money does not match the amount of time spent. Emergency money can help us do, is to help focus on the cost for sample, testing and vaccination are two buckets of funding that we have at local health departments.

We want to provide testing when that is needed. The challenges by a gets that night by the time it gets to the local level, after goes through the processes through the state levels, there is sometimes less time on the timeline for us to spend it and we get it sometimes after the surge or demand has happened.

And there are restrictions in place where we can only spend the money for that particular thing. So I think the requirement that are so stringent, and reporting that is not flexible is part of the challenge.

Whether it is regular funding as the is Mike as the person asked, or emergency funding and as the timeline gets shorter and shorter as he goes to the local level. Mike have something to add? Especially with centralized states that can do some interesting things through contracting that has been interesting to see.

MICHAEL FRASER:

I will echo what you said. For funding, there was funding for specific things like school testing that allowed us to scale up. There was more flexible funding for things like contracting, that allowed us to bring on public health experts or nurses, it was very, the funding I think was really used to scale and provide surge to meet the demand.

But also to find some core capabilities like munication, like information technology, like some of the HR crosscutting issues. -- Like munication. When those who go away, it becomes a pretty significant problem for the -- communication.

MILA BECKER:

In terms of responding to the ongoing COVID-19 pandemic, because we are still in it, and preparing for future health emergencies, can you be a little more specific in what areas of our public health system need the most attention?

MICHAEL FRASER:

I can start if you want. I think we have highlighted the data system, the data needs, and I think those are incredible (Laughs) Given that we do not need last year's data, we need real-time data for decision-making.

I think the workforce challenges in terms of expanding the workforce, and the staffing up project from -- that fancy and fab presented a couple months ago, it may have been longer than that, suggest that we need more health professionals just to maintain the current work, that is a lot of people to be hard. There is a new grant that the CDC announced, for state and -- for states and locals to recruit, and that is huge I think in terms of dollars but also in terms of impact when you divide it by 59. Workaround equity, or ground community engagement, the work of office how do you support and sustain work with committees that are most impacted by COVID? How does the department deploy resources?

If it is centralized, how does it work with communities and local groups when they are decentralized? That infrastructure cannot be based on philanthropic dollars, or pilot projects, this needs to be a core capability of healthy varmint, and this is one as Lisa mentioned, she's on a team that I'm sure could use for folks -- could use more folks, because there is lots of work to do! The last time I have checked, there are plenty of sick people and plenty of work to do in terms of managing chronic disease, and overall you know health literacy work.

We can certainly deploy people when there is not a pandemic, that we need to start doing more generally full sets of these three years data modernization, the workforce and equity we need to start.

LISA MACON HARRISON:

I agree with that completely. I do not have much to add, so I will turn it over to Doctor Garcia, but I think modernization for our government assistance is really needed! Make sure that we can cut through some of the time that it takes to hire and put people in place, that is also a barrier when we have limited funding for emergency response.

DR J. NADINE GRACIA:

I agree with Michael and Lisa. To underscore some of their points, one is that we are talking about lessons learned from the pandemic, and certainly we are continuing to learn these lessons as we navigate through the pandemic, as we have seen in past public health emergencies swell.

So with that centre, I will go with what Michael was saying about the privatizing of equity. There were partnerships, some that existed prior to the pandemic, that existed in existing communities that got enhanced because of the pandemic, and there were from -- and there were some that were formed -- formed a new. We want to maintain these relationships, to ensure that we are actually talk about health and well-being, because the pandemic has exasperated these inequities!

So if we do not have intentionality to the workforce, to the resources that are particularly going to committees that are disproportionately affected by this pandemic, all of the games that we

have seen over the years, the trust that needs to be earned in communities or built in communities will be lost, and we really have to -- have to have sent drink. Everything about data, and the workforce, and when we think about community partnerships and community engagement and actually decision-making and planning for committees, centrality of equity is going to be very important for us to learn the key lessons from this pandemic.

MILA BECKER:

looks like there is another question, at that I think touches on equity as well more of a clarification question. It is about states relying on the federal funding as their sole funding. Can you clarify that it is a combination of funding sources, and why federal funding is so important as a component?

DR J. NADINE GRACIA:

Yeah! Absolutely, my goodness I know that we have comments on this as well, we know that federal funds are a critical source for tribes and territories with and understanding there is a governmental responsibility to protect and promote residence health, to ensure conditions which everyone can be healthy.

So there truly is a responsibility of the government to do this! This is not just in times of emergency, but in times of nonemergency to ensure that we have access to clean water, clean air, safe and healthy foods. To ensure that there is access to services that really promote health and well-being, that is one source of it.

And what you can say, is patchwork that has been used in terms of the implementation of the dollars that come from federal sources to states and localities. I think a key message that we certainly Champion is the importance that there has just been in underinvestment!

As a nation, we are not seeing the health outcomes based on the spending that we have as a nation, we are not seeing the health outcomes that we should be seeing as nation waste on the amount of spending on health we have done. And looking at how to actually transform that to then ensure that we can actually have healthy and resilient communities.

Because the current funding model is not attaining and reaching those goals specifically.

MICHAEL FRASER:

We get that question a lot! "Why can't states just put up the money if they need it so bad?" I think the reality of the situation is, gated of his but -- is, located, but simply put, states have to moderate their budgets but the federal government does not. States have to make other decisions like making sure their Medicaid program is insolvent, or education and transportation, so I think it is unrealistic and probably a nonstarter to put it back on stage. -- States Many states do put funds on particular issues, like adding screening tests to panels. They may have environmental issues, special mandates and funds that they use, and locals put in a lot more.

I think Lisa cited that toy 5% of local budgets are federally funded -- 25%. We know in some states in the union, up to 25% of their local budgets are federally funded for public health budgets. There is a state contribution but it cannot meet the need!

I think over and show this pretty clearly. COVID has driven the public health system because of privilege funds all about. (Laughs)

LISA MACON HARRISON:

If we really believe in health equity, and if we know we are only as healthy as our neighbour in accounting -- in the county next over, we need equity, otherwise we will have a lot of more need for response that could be better coordinated if we had a more substantial federal level of connectivity to the work being done on the ground.

MILA BECKER:

Excellent! I love to hear from each of the panel members -- I would, and that is where do see the grass opportunities to collaborate with public health partners. Are there uses when it comes to data sharing and public health partners?--Uses in mind

LISA MACON HARRISON:

Necessity is the mother of invention, and in rural areas, what we have needed to do to be high-performance is to manage and write grants for we have an active health model, so I think to answer your question and the question in a chat at the same time, forging partnerships with academic centres when it comes to grant writing, grant management, data management and data sharing is essential.

We are lucky. I'm in North Carolina, am in a rural district, but I'm not too far away from Duke and UNC state universities who provide opportunities to partner and to have expertise that would -- that I would either be able to afford or employ -- in a local health department, but who I can certainly forge partnerships with.

I would highly encourage us to all think about how -- how we partner with our academic institutions as well.

DR J. NADINE GRACIA:

Just quickly I will say, is that when Lisa highlighted is what we are advocating for, why so -- social determinants are so important, this is also where investing in and building up CDC's social determinants of health program would provide greater resources and funding to local state health departments, to engage in these multi-sectoral partnerships, this is again where we do not have adequate funding for these partnerships that could create partnerships with education, and other sectors like transportation, food safety etc. that are critical to addressing the structural drivers of health, and promoting community conditions that promote health and well-being.

MICHAEL FRASER:

Just to add to that, some of the use cases that we have seen that I think are important and need to be expended on our health connections lay to COVID-19, will lead to infectious disease, like to overdose and behavioural health. -- Related to. So I think taking what folks have done and spreading that is our goal with the stylus, because like it has been mentioned, not every state has the same portfolio.

MILA BECKER:

Last question will it will be a lightning ran to the panelists. I like you to share what you think the biggest take away is for the audience from today's conversation? -- I would

DR J. NADINE GRACIA:

I think it was the message that we have, the theme of this. Emergency funding is not sufficient for our public health system and we need to truly invest and increase funding public health, to ensure that this funding is flexible and meets the capable dates required for public health.

MICHAEL FRASER:

I think sometimes, you have to spend billions to say trillions. -- Save trillions. We have proven this, we need to stop the cycle and spend Williams because I think there is lots that we can do.

LISA MACON HARRISON:

I will rounded out by saying local and public health entities are trusted governmental entities accountable to every public dollar that we received. We must do a better -- receive, we must do a better job with the streamline of these dollars to honour the workforce that that's the hard work! Community by community to keep us safe. -- That does the hard work.

MILA BECKER:

Thank you! Thank you to our panelists and thank you to our attendees, we have recorded this presentation. A copy of this recording will be available and you can share with your communities. Thank you everybody and have a great day.

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