



**Congressional Briefing and National Webinar:**

**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 20, 2023**

**3:00 – 4:00 PM Eastern**

**Live Captioning by Ai-Media**

ERIN WILL MORTON:

Good afternoon and thank you all for joining us today for shortchanged, The Impact of Chronic Underinvestment in Public Health. I'm Aaron Martin, executive director of the Coalition for Health Funding. CHF is the oldest and largest nonprofit alliance working to preserve and strengthen public health in the best interests of all Americans. CHF is cohosting this event alongside Trust for America's Health.

Before we begin, I want to go over a few housekeeping items. First please note that today's webinar is being recorded. Real-time captioning is being provided today by Lyah because we are using zooms webinar format, audience members will be muted throughout our discussion but do not worry we will be taking questions. The task questions use the Q&A function on your screen to ask questions. You can start the meeting questions now and continues to so throughout the presentation. Be sure to put your name and your full name of your organization.

The United States spent more in healthcare compared to other high income countries, however our nation still yields substantially worse outcomes, policymakers are asking why. What can be done to achieve better results? While we will not solve this problem today we aim to address the challenge with our experts in today's discussion. Our panelists today will share their unique perspectives on how to adjust the long-standing gaps in public health capacity resulting in chronic underfunding and the importance of targeting increased, sustainable and flexible funding to public health and prevention.

You can see our agenda today on the side, and after that we will have time for questions and comments from the audience. Now onto the panelists, I'm not going to read everyone's bios as you likely saw them on our register should page. I do want to take a moment to introduce you to our speakers. Doctor Tekisha Duan Everett is the executive vice president for trust for Marcus health. Were she collaborates to shape the organization's strategic direction and

implant parties. Krista Wasowski has 20 years of public health management experience. Currently serving as the health officer of Medina County Ohio.

Dr. Brian Castrucci is an award-winning epidemiologist with a decade of experience in various health departments. Where he is focused on something the public health system. Now does my honor to welcome Doctor Chee Keisha Everett from Trust for America's Health. Thank you Doctor Everett, I'm going to turn things over to you.

TEKISHA DAWN EVERETTE:

Thank you so much Erin, and thank you to our partners for cohosting this important event with us. My name is Tekisha Dawn Everett and as mentioned I'm the executive vice president for trust Americans health. TFA for short is a nonprofit, nonpartisan public Health Policy Research and advocate association dedicated to making disease prevention and health equity a national priority. Next slide.

Our organization uses data and research to analyze critical public health research issues and push for public policy changes and protect the public's health from issues ranging from substance misuse, chronic diseases and public all emergencies.

Released a report on the impact of chronic health Last week TFAH Released a report on the impact of chronic health, in the report it talks about consistent funding for public health efforts. Our reports are intended to inform policy makers, the public and media on the importance of a strong public health system. Every day, not just during emergencies. Next slide. One of public health's greatest challenges is that success is often invisible. This can make it easy for policymakers to overlook public health when it is time to find this critical work that is often unseen work. One striking comparison is the share of our national health expenditures the go to prevention of public health activities. In our report, we analyze national health expenditures and find that the total health spending on public prevention was about 4.4% of the total \$4.3 trillion in expenditure in United States.

That is that tiny blue sliver on the graph that you see right here. As we can see, that is not equated to living a healthier life. In fact, in the US we have a lower life expectancy, incomparable nations. But with much higher cost. Despite the return on investment from public health interventions, we continue to see the mismatch and funding. Next slide.

The Center for disease control and prevention, often called CDC has not grown accordingly to meet the budget. It has been difficult to keep state and local health apartments fully staffed with qualified professionals. A recent survey found that almost half of state and local health to permit employees have left between 2017 and 22 anyone

This is on top of provide basic health services in all communities. Another challenge that we faced with inadequate funding is that many evidence-based public health programs exist, but cannot be funded in all 50 states. So the states are not able to address some of the leading health crises. Eurocopter examples, the state physical activity and nutrition program. Which

addresses root causes of obesity is funded in only 16 states. Though we know there is a rise of obesity in the United States. But, principal suicide prevention program is only funded in 17 states, while CDC received 264 eligible applications for the racial and ethnic approaches to committee health program known as REACH in 2018, CDC can only find 40 recipients to reduce health disparities amongst racial populations. Next slide.

Another issue has been the cutting of emergency programs. CDC's public health emergency program which supports readiness capacity in state, territories and local areas has decreased by 25% over the last 2 decades. Or about 50% if you are accounting for (away from mic).

The ministrations for strategic impairments and responses hospital program which prepares health victims for emergencies expense a 59% cut over the same pair. Nearly 66% if you adjust for inflation. While these programs are much-needed funding increases in FY 23, funding numbers fell short. These programs are our first line of defense. Instead of upfront funding that would work to prevent and mitigate health crises, emergency responses often depend on emergency supplemental funding. Supplemental funding cannot build needed solutions overnight. It takes time for funding to not only be approved, but also to get resources out of the door. In a public health emergency, every 2nd counts.

These give threats, and even greater chance of taking hold. It also means that the workforce is depleted, and people cannot be rapidly hired and retained with short-term funding. Once the supplemental funding expires, the nation is left vulnerable in this cycle repeats itself over and over again. Only consistent funding over time can prepare the public health system to respond in an adequate manner. We are seeing this yet again, where we are seeing money that is been intended to support vaccination systems over time. We are hearing Congress discuss how funding cuts. Next slide.

Consistent underfunding of the health system and challenges that we see already are harming our already depleting public health workforce. Public health leaders must rely on data to a compass or mission. Our public health system is not able to react or respond to present health matters as quickly as it would like. To adjust health inequity and root causes of health issues in addition to emerging threat.

As a result, healthcare cost, and the resources necessary temperament necessary strategies and other forms of early intervention to prevent illness in the first place. Next slide. So our report includes recognition across a number of areas to make sure we are allocating appropriate funds for the nation's health. We seek increases to CDC's topline and those would enable the agency to invest cross initiatives that strengthen our public health system and ensure effective programs to reach all states.

It is important to bring public all into the 21st century by creating sustainable funding, to build modern, public health systems. Support state and local laboratory and recruit and retain qualified health workforce. Investment in health security will protect the nation from the next public health emergency, and are much better alternatives to the boom and bust cycle of

submental funding.

Investment in vaccine infrastructure, counter antimicrobial resistance, and climate adaptation are greatly needed. Some populations are an increased risk of expensing poor health outcomes due to societal condition. It is important to develop strategies to promote health equity and target the root causes of disease and illness by addressing the social determinants of health.

Increasing investment in chronic diseases, chronic disease intervention related to physical activity and nutrition are needed to lower rates of obesity across all age groups. In addition, public health should have a more active role when it comes to addressing the needs of our nation. Finally, primary prevention efforts are critical to reducing the rate of death. From suicide, drugs and alcohol. Strategies to address, conference of suicide prevention programs, preventing and mitigating adverse childhood experiences called aces and school-based services to reduce risk among youth. I want to thank the opportunity to thank staff for analyzing the data bringing forth these wonderful recommendations. They are very critical and important trust to advance the public's health. With that, I will turn it back to you Erin. Thank you for listening.

ERIN WILL MORTON:

Thanks Tekisha, next we are going to hear from Krista Wasowski, would be Medina County Health Department in Ohio. Just a reminder to be thinking about your questions if you have some for Tekisha, after the overview of the report. You can start to type them to the question and answer function. I will take one 2nd to let you know that the event is being recorded and will be made available later.

KRISTA R WASOWSKI:

Thank you Erin, I am health officer Krista Wasowski and I'm pleased to offer some context to how the funding situation described by Doctor Everett impacted local communities. I think all of you watching may be more familiar with the functioning of HHS or CDC or perhaps a state health department. But local work is very different, local public health makes a direct impact on the health of our communities. We are the ones ensuring the work is getting done to achieve the public health priorities laid out for our nation. Local health departments are both responsible for service provision and for strategy.

We are the ones out there collecting the data that rolls up into the systems that are in use by others and us to target programs and services. Local public health, we are the ones who are the ones discovering the first signs of emerging health issues in our communities. We are frontlines for the opioid crisis, or the rapid rise of invading amongst our teens and certainly for covid. In a moment, I will talk a little bit about those 3 particular situations. First, next slide. I would like to give you some background for you. Ohio is the 7th largest state by population in the nation. It is divided into 88 counties, whiht each county in some cities maintain a local health department this is the result of working together across the state to serve our 11.75 million residents. My district Medina County is an agency that covers one county. It is a bedroom community to both Cleveland of the north and Akron of the East. I have just over 185 residents. Next slide, this is life in the world population review shows you the growth I've expensed in my county began

before I came, from the 1960s and has continued until today.

The pressure today's on me is there health officer to serve more and more residents with solid funding. I'm doing this in a increasingly complex public health challenges. Next slide, this shows redefining mix of the Madonna County health apartment last year. 42% comes in in fees and contract, 33% is tax levy and 24% as grants. And less than 1% is a state subsidy provided by the Ohio legislature. So those are unrestricted ... restricted funds that I have, but by unrestricted funds are with my local tax levy. Unfortunately, not all health different tabs on restricted funds, because you cannot use current resources to bring us in. You have to raise outside donations, you have to have a community group of volunteers to pass in 5 to 10 years. In Ohio, less than half of help the perms have a kind of local, flexible funding.

I am fortunate, I have 2. One is collected the same base amount since 1992, and one since 2009. Yeah, the same base amount. So, living on that base amount over time, with the changes, and what you need to pay for at that time is challenging. The amount it's self though is not the only barrier. The timing and the restriction on that money also matters. For example, I have to set aside one third of that unrestricted levy money to front money for the grants that I do receive. For me, that price take in my agency is over \$1 million that have to type in order to bring grants into my agency. I have one federal direct, I have one from a state public safety organization and 7 that come to me from our state health department, those include emergency preparedness and the new workforce grant which are larger grants.

So I need to have money to receive money. But it is even more than that, at both federal and state decisions can directly impact my ability to serve my community. Every time a federal agency or my state makes a new funding party, they take a grant that we have had and they change the focus of it. I may or may not be eligible for that funding. I need to assess the program I've already had is still needed in my community, wanted in my committee and find ways to either find it or retrain staff that have been working on that grant if that funding goes away. For example for 22 years I've had maternal and child health money, but state parties no longer match what my community needs are in that area, so will not be funded in that grant next year.

I have to decide how to maintain that programming that I have, the needs that I have. I have right now of indicated axis but I've been told by the end of this year those are collapsing down into one smaller grant and one contract. So running a little help to permit his heart. You see the needs, you have a public demanding accident that Mike action either start summing or continue something you already been doing. But you have limited resources to take action with. Often those demands come in the form of new health issues. I mentioned 3 the beginning of my comment today. Was talk first about opiates.

In 2012 opiate related death was beginning to rise, in 2015, mine state made meloxicam, the medication to reverse they made that available. The catch was that you had to have the staff time to buy local training, blocks of management, distributing and reporting. I had a grant from a alcohol drug abuse board to help from that.

Larger counties were being funded to start opioid taskforces and 2017 Cuyahoga County, which is where Cleveland is located shared \$2000 with my County to allow me to start up a formal opioid task force. Then in 2020, federal funds came to made Missy by way of our state help the permit to fund this work.

So 8 years from recognizing a growing health issue in my community, to getting funds down directly to me at the local level in a meaningful way to do work to prevent that health issue. Just another exhibit, let us talk about beeping. The national youth tobacco survey showed the percentage of high school students in 2011, we read 4.5% of the students have ever tried e-cigarette's before. In one year that went up to 10%. I was seeing that same trend in my community, at the time I don't believe we knew that beeping cartridges had the vocal and of nicotine that is in a pack of cigarettes and we do not know the health effects.

We knew that heating up something, a liquid and putting it into the sensitive lungs of our teens was a really bad idea. So my staff, using my local levy money worked quickly with our juvenile courts, with our public schools to offer an education program that was in lieu of court sanctions. We broaden parents and students together and educated them about e-cigarette. About tobacco addiction, nicotine addiction. It was in lightning, and it changed the conversation that I was having in my community around Fabian, I receive now \$12,000 a year and it is part of a larger award that I get from a general tobacco control. I am grateful from the funding, I do not want to say that I'm not because I most deafly am. But have I not been fortunate enough to be in a county whose citizens put forward a levy, for me to have unrestricted funds I could not have addressed that issue as quickly as when I first recognized it.

The 3rd thing I mentioned was covid. This discussion sorely today is not about covid. I would be remiss if I did not mention how that long-term lap of investment in public health left us challenged to be able to provide what was needed in that crisis. One example I will give, there are many but this one really stands out to me. It was in the beginning of 2021, when cases were rising and the vaccine was available. It just started going out into the public.

My citizens, the media, my legislators they were all asking me to tell them the data on vaccination status of people hospitalized with covid. For covid, not with covid they were really specific about that. The problem for me was our state supplied disease reporting software system, which was created before the iPhone was developed didn't not connect with our state vaccination system. So my team had to sit by hand the reported County cases each day to find those that were hospitalized, and then look at their vaccine status in a different system, enter back into the first system in order to have a report. There was another limitation, this is actually a policy limitation to some extent. In my state, everyone is not required to report vaccinations administered into the state vaccine system.

So at times we had to wait for the hospital infection control team to find out from a family member or the person if they were able to tell them, even their health status. If they have been vaccinated or not. There was, I'm the County health Commissioner. I did tell the public and

legislature that I could not give them what they were asking for. I wanted to give it to them more than anything, heck I wanted information because we were trying to figure out and make policies as things were happening. But the truth was, I had the limitation of the system I was working with. That was embarrassing. It was embarrassing to admit, but I needed people to understand that it was not because I did not want to give them the answer. It was not because I was pushing a particular narrative about vaccines and covid. It is that I was working with an antiquated and limited system.

That is the case throughout our public health system, that lack of funding, that critical infrastructure to invest into people that are doing and for structure every day on the front lines, is infecting the health of our nation. We need adequate resources to serve our communities.-- Communities I think you for your time today and I look forward to your question.

ERIN WILL MORTON:

Thanks Krista, those really helpful to look at how funding is being used at the local level, how important federal funding is and the impact it has on the ground. So appreciate that context for all of us. Finally, we are going to your from Dr. Brian Castrucci from the de Beaumont Foundation. As a reminder similar questions, we have lots of good ones coming about funding and its impacts on the call. I will turn it over to you, Dr. Castrucci.

DR BRIAN CASTRUCCI:

I have to take myself off mute. He would've stopped 2 years we would have this all down. Good afternoon everybody, this is a pleasure to come speak here and share the stage with what wonderful speakers. The US is the 8th richest country in the world by GDP. What I've learned throughout my career is that the way that you understand the values of any organization is by looking at its budget.

I think that is what we have seen today, the budgeting that we've done around public health is simply inadequate. We have the results to show for. We are 41st in life expectancy, 50-50 and infant mortality, 32nd and infant mortality. We are still first in military spending. Spending 3 times more than the country spending the next most amount that is China. We spent more in healthcare but get less out of it than similar countries. We continue to medicalize and criminalize our health problems. Taking the response building and placing it solely on the individual, rather than looking at the tapestry of community and how we should be solving problems together.

Now we have 316 people on this call, and most of us are very fortunate. Our health is probably good, I am very fortunate that 2 years ago, I had a heart attack, I had an injection fraction of 34%. For those of you that are medical you know that is not so good. I can see Krista, and Krista is like "whoa" I was able to get really healthy really fast. I wondered why, was it my diet, did I change my diet? Was it my exercise, I started to exercise. No man, there was one reason I got healthy and that is privilege.

In this country health is a luxury item. That is what we are trying to undo with better public

health funding. If we do not really think and invest in public health, the bill will come due. We've already lost a million American lives to covid. We have lost people to opioids, diabetes, we have lost people and continue to lose people and the funding does not come. This is a decision. This is not something we don't understand not someone we don't know. This is an absolute decision and our political leaders are making one of the worst public health crises in our nation with public health being more politicized than it was before. With public all be under a greater attack than it was before.

We are prioritizing medical freedom, over the public's health. And in doing so, we are risking our continued safety, security and economic prosperity. That is what we are gambling, so everything you have heard today... We can continue to say these numbers. TFAH has done an amazing job opening a report out annually. Those of us who believe it have bought it, and those of us who do not care ignore it. We need to find a way to engage those who are cabling with the future of our nation by not investing in a public health and help them understand that this is a critical time.

We already have the next pandemic on the way, we all know that. We have warned for decades that this was coming. Imagine just for one 2nd, leaving a military conflict, we lost 1 million American lives on American soil, and the response was to cut military budget. So if I told you that half of the military had left their job and our response being crickets, there would be national outrage.

But here we are, but health practitioners, fewer of us than there were before. The money, even if all the money came the money is not enough. We need to understand how we rebuild a public health system that is responsive at the local, state and federal level. CBC has done an amazing job putting \$3.2 million in our public health info structure. Of course that is in 5 years and more to 100 different grantees but it is something. In 5 years, that money runs out. The most important person for our health going forward are our governors. They will make the decisions as to how that money is spent. We'll make decisions about how we rebuild public health. We need to find national unity around the cult and find it fast.

Make sure that public health isn't a decision whether we have it or not. If we continue to think that way, and we have political candidates who would advance their own ideologies by attacking public all. We must realize that this place is all of us in jeopardy. None of us are an island, yet we continue to believe that we can make individual choices and that is the whole kind of summation of our health. This has to stop. This cannot be seen today is a set of data that are intriguing and interesting. It must be seen as the call of action that it is.

You are determined, your values are most clearly communicated by your budget. Congress is telling us both Republican and Democrat, everyone are telling us about their values and their values are not in the public's best interest. They are not in public health. If we do not rectify this, covid will look like a good day at the park for the next time around. As we already have fewer public health practitioners than we did at the start of covid. We are already in worst shape now to prevent the next pandemic that we were at the start of covid.



So if I'm around for the next pandemic, I guess we will sit there again and say "which will do so, we warned you." We must be full throated in our advocacy to ensure that it does not happen again. We must quickly state clearly what they are. At this price is a public health funding is as critical as any in our country. One that should not be politicized or trivialize because we are taking a jackhammer to the foundation of our own house. When the house breaks, we will not have enough people to fix it. I appreciate your time and attention. I hope you take this call to action fiercely. I know you will because I know I will and my fellow panelists will. We have to get to work and ensure that the future of the country is both equitable and it continues.

The only way we are going to do that is by investing in public health.

ERIN WILL MORTON:

Thanks Dr. Castrucci, that was a great final presentation. That concludes our panel presentation. We are now going to open things up to questions and answers. As a mention, we've already got some good ones in the chat. Some key themes popping up here. I think Brian, I'm going to go back to you for this first one.

We've heard a little bit from a couple of you about workforce. We heard that a lot of the public health workforce has retired since covid. One of the most pressing public all issues is workforce recruitment and retention of our current workforce. You comment a little bit about how the public health student loan forgiveness and salaries as well as ongoing public-health force training are to Congress and federal agencies in terms of addressing the underfunding of public health. Happy for others to comment on this as well.

DR BRIAN CASTRUCCI:

Let's be thoughtful about what levers we can pull to improve our workforce. When you think about the workforce, you are talking about 3500 different systems leaving about the state and local. There is no magic want to say "we need to increase public health salaries." You have to do that 3500 times in 3500 different systems, with 3500 different ways to get that accomplished. That is not an easy solution. There are no easy solutions there are levers we can pull with loan and payment. I love our schools of public health but we all know they are not cheap. If we are going to go to a School of Public Health and you're going to occur 70, \$80,000 worth of debt on top of your undergraduate loans then going to work for that health department becomes really challenging.

Loan repayment is a singular level, that Congress can pull in making it easily accessible and something that everyone is eligible for. We can make governmental public health more attractive as a destination workplace. That is why it is important because it is a single thing we can do. By one action, impact everyone.

Most any other action in workforce it will take doing it 3500 separate times. This we can do once, we can impact the workforce and have a measurable effect on the future of our country.

KRISTA R WASOWSKI:

Brian, really to piggyback onto that. The skills that we need even with in public health have changed vastly over the past 20 years. We are recruiting people not from just our public health schools, but really people like social workers and statisticians, math, a lot of different skills. Students from all across the educational field. That is what we need, if we want to keep an edge on ongoing prevention and having a workforce that can truly do the work that we need to do in public health today at the local level, state level and at the federal level.

ERIN WILL MORTON:

Tekisha, anything to add on that before you move on?

DR TEKISHA DAWN EVERETTE:

I think it is well said, I will go to the next question.

ERIN WILL MORTON:

OK, so Krista we have got a question specifically about the local level, I'm wondering if you could comment a little bit about what strategies employees of local health departments can employ to advocate for increased state and federal funding. Realizing that both of those are important for to get to the local level.

KRISTA R WASOWSKI:

Sure Erin, I think the local level I know there is a struggle in understanding the difference between advocacy and going beyond what you are allowed to do as a governmental employee. We always say education is the key, working through our local leaders, our local legislators, state legislators just to help them understand. I would really encourage people to have folks come in and visit the local health department. I think when they walk in and see the vast work that we do in so many different areas they are always amazed the one little department touches so many facets of life in a community.

I would start there really about educating what it is we do, I think I would go from there.

ERIN WILL MORTON:

Tekisha, I want to go back to the TFAH report the you talked about, wondering if there is anything you can highlight in the report process you that is maybe an improvement from last year. Or specific things you want to highlight that stood out as different from where we were last time.

DR TEKISHA DAWN EVERETTE:

I want to posit for 2nd and supreme question and then answer that question if you don't mind. I just want to echo what Krista said and add to it. Telling your story is really critical, as I mentioned in the beginning of my remarks. Often when public health is done right and done well it goes unseen and unnoticed. I think it is really, really critical that those were on the front line, workforce individuals are sharing stories of what is happening in local communities and doing so in a way that is accessible and can be acknowledged by the folks were making policy

decisions. I think that is really critical. To your question about what have we seen in terms of the last one I would say since our previous funding report we have seen some increases in key areas. Most notably in emergency preparedness. That being said, funding is still not a recommended levels to be adequately prepared. If we continue to see the underfunding of key programs is going to be an issue. Especially when it comes to chronic disease in the United States.

This is again the boom and bust cycle that we are talking about. If we're looking at inflation accounting for inflation we are actually cutting public health funding. So, it is the most pressing issue since the previous report. I think it is really important that we focus on ending or ending the rescission in the boom and bust that is happening around pandemic response for our emergency funding. That is really, really critical and something I think we should just reinforce or talk about.

ERIN WILL MORTON:

So we are getting a number of questions about advocacy and what organizations can do. We talked little bit about what individuals can do at the local level. Brian, we had a question coming about what specifically be de Beaumont Foundation is doing. I'm also happy to weigh in on the Coalition for Health Funding perspective since advocacy is of course near and dear to our heart. Maybe we can spend a little bit of time here and tap all these questions that we are getting.

DR BRIAN CASTRUCCI:

For de Beaumont we take advocacy in a couple different ways. We are not directly at Congress advocating for policy change. Will redo work is at the local level tried to pass policies that really advance health for all. I would encourage you to look@cityhealth.org. We give the 75 rankings we give you the gold, silver and bronze as to whether or not you have policies in place to have a healthy population. It is not always what we would think about as health forward policies. It is policies that include things like clean air, but paid sick leave and green space that impact people's health. Even though we would not necessarily think of them as a public health policy. The city health.org. We also do a fair bit of research, so the needs surveys and then we've done since 2014 to help understand where the public health workforce is in time and space. It is backdated that allows us to quantify the departures in the workforce between 2017 and 2021. Half the workforce left and 75% of the workforce under 35 left. We've also conducted a a fair bit of research, and we encountered that we need 80,000 more FTEs in the public workforce not to do surge, not to do response but just to do the basics of public health. That was before these departures. So now there are places in this country where there are more vacancies than there are public health workers. We are actively trying to think through how we help convince legislators and elected officials not just at the federal level but at the state and local level of the value of public health, right? We have watched concepts like medical freedom come to the forefront. We need and someone said in the chat. What is a way that we can quickly communicate to politicians. There are some tools out there, there is phrases.org. I encourage everyone to check out the public health communications collaborative, it is something we work on with the CDC foundation and TFAH, there's going to be a lot coming in the future to help us do this better. Help us to negate better and build better partnerships with businesses. City

Council is going to listen to a business a lot sooner than they are going to listen to a public health practitioner. We need to start to mobilize our friends and identify our friends. I think that is what we are doing to try and support the public health workforce. But we also have ideas of the practitioner community think we need to advance these ideas.

ERIN WILL MORTON:

Tekisha, do you want to talk a little better about TFAH?

DR TEKISHA DAWN EVERETTE:

In general we are looking at.. All of our things work together. We synthesize and disseminate the data, use that to create recommendations and to support those augmentations to our Congress people as well as individuals in the White House and mensuration. Because we have such robust state-level data, those reports can also elevate until the story using rigorous evidence to tell the stories in a state and local level. We also look at social determinants of health, chronic disease, other aspects in order to ensure that we are looking at all aspects of the public health and the public health infrastructure that is necessary to respond to those critical public health needs through our government relations team.

Now I want to for a 2nd and say not just our government relations team. It is an old friend effort at Trust for America's Health because we are all focused on ensuring we have the best evidence to produce the best story that we can tell to convince the folks are making decisions as well as the public on how they can use that information to make those changes.

And we work with our partners so Brian mentioned it already in terms of how we work with public health communications collaborative but I also want to uplift the with other partners that we work with as well in terms of getting information out. And of course the Coalition for Health Funding.

ERIN WILL MORTON:

Thanks Tekisha, to pick up on that thread, TFAH, and others are members, we have over 85 members across the public healthcare spectrum and we collectively work together from an advocacy perspective, looking at that top line funding level for every program under the US Department of Health and Human Services. Really advocating for increased funding across the board. We like to use the phrase rising tide lifts all boats. For all our members talking about top line number, not just focused on one specific line or another or how one-liners would impact a program that is important to you or your members. We really need those voices within the collation lifted up that overall funding line. So as you guys talk today about the importance of sustained funding, right? Annual funding, federal funding that is reliable that we are not relying on emergency funding constantly like we did during covid. That is what the coalition prioritizes.

We do congressional visits of our numbers, we sent information and letters to the hill. We rely on materials that are created by our partners like those Beaumont Foundation NT FAH to make advocacy points. Partnerships-- TFAH partnership the debt today are super and porta. Anything

else on advocacy before we talk a little bit about sustained funding?

KRISTA R WASOWSKI:

I think you guys covered it well, thanks.

ERIN WILL MORTON:

So want to highlight this issue of sort of the cycle of funding for public health by emergencies. This is something that is highlighted in the TFAH report, this is something we know now from covid is a real challenge for help to perms at the local and state level. I'm wondering maybe we will start with you Krista, but others too if we can comment on this need for sustained funding. Worded emergency funding work during covid? Where was it successful, but where did it fall short and were we now as we are looking to this potential cliff of emergency funding moving away from covid.

We've heard about potential recessions, money that will be removed and money that will not exist going forward. What is the impact of all that as we think about how to talk to policymakers about the needs for sustained funding?

KRISTA R WASOWSKI:

So emergency funding surged into was not at the very beginning, but a little bit ways to covid. In our state, it came... I felt like death by a thousand cuts. We had 8 different grants at one time one was focused on one aspect and another aspect the mouse because of our state system limitations or how they could push out money to us. Everyone wanted a different way, then most of all. That funding in the emergency help to cover some of the polio staff from all the other projects they worked on but normally would've funded them. So that emergency funding in the moment certainly is not a replacement for our day-to-day public health needs. It was never meant to be, that is why I said this conversation was never about covid. That was long before covid. We are talking about funding, I am not talking about replacing emergency money, I am talking about making that investment long-term in public health so that we can be ready for emergencies. I will tell you what has changed, the levy that I talked about the clicks that 1992 base value. It took me 3 tries after covid to get that replaced from my local voters. That was the politicalization of public health the Brian spoke about. Those are the realities, and that is the reality of what we are dealing with now we are talking about what we need within our system. It is kind of overlaid with some of that. That is why it is so important for all the partners, and people coming in from outside of traditional public health really talk about and advocate for a system that contributes to needs in this nation.

ERIN WILL MORTON:

Brian, Tekisha anything on ...?

DR BRIAN CASTRUCCI:

I absolutely believe that we need consistent funding and public health. Asking for it is not going to get it done. We are going to need to understand, we are going to need to make public health something that people value. Listen, legislators are not always going to listen to the do-gooder

public health person but they are going to listen to the business community. Remember during the pandemic one of the times when Trump relented was when there was a New York Times article signed by 100 business leaders and he relented. Now that is powerful.

We need to start building coalitions advance public health and doing it for a reason that businesses can understand how we help them. This is something I think we have talked about for a long time in public all. We've talked about how the business community will benefit from better public health. We've never been able to realize it. I think we have the opportunity out of covid to make relationships that were not there before. I would drag people to the health action alliance which related an amazing job of translating some of our public health science and jargon into actual stop for businesses, right?

Folks like Krista need to be at the chamber of commerce routinely. We need to be making relationships. The worst thing I saw in the aftermath of covid, I saw people say "as a disease Facebook lives, Instagram lives anymore." You need to do the more, do them every day. Not running a health apartment but be out at the Rotary club. Out of the kawas club, I don't care what it is be out there. We're not just going to ask for funding and get it. We need to create a demand for better public health of the people are willing to fund it. How we do that, we do it together I watch the chat asking about all these different funds. We need to break through our silos.

I spent a lot of my time as a practitioner, as the MCH, and I will admit this to you as long as the block grant was held harmless the rest of it could all burn. Because that is what occurred but, I could about MCH. I've matured beyond that belief and understand now that it is the whole system. It is not HIV, immunization, it is all a bit. We need to start talking to people everyday about the importance of public health so that Tekisha can never say get "hey, sometimes in public health does its job no one really knows that it happens." We need to stop that.

I'll tell you when I do something in the house I tell my wife. I don't waiver to find out. "I did this today, I did that today." So that I have valued her, we do the same thing in public health.

DR TEKISHA DAWN EVERETTE:

I could not state any better Brian. I think we have to focus not only on value of public health emergencies but remembering that emergencies or were to happen. That is a given. Public health is every day. We need to be funded that way, respected that way, we need the workforce outweigh and build infrastructure consistently. That is a story we have to consistently tell over and over again. We are garnering support across sectors to focus on what we need to do to advance the public's health.

I wanted to state someone's in the chat earlier about taking away from the left-hand to the right hand. They said it a little bit differently but that is how I'm going to say. What we are talking about with the underfunding of public health is not about saying one thing is better than the other. It is the collective understanding that what we are doing is not working. If we continue to do it, we are going to continue Failures in our public also some daily and in

emergencies. That is the point.

We need to come together, value public health, build a strong respected public health infrastructure that can address the challenges today, and in the future unseen ones that we do not even know to advance our public's health.

DR BRIAN CASTRUCCI:

We are talking about funding today because funding is critically important. There is a beautiful chat going on about "what about this, what about that?" It is all of it, it is about the business community. Yes, there are people in the business community who are anointed us and you know what they are right. We did harm. I think we did the right thing, I support the fact that we didn't lock down, but we did harm. Some those businesses people work their whole lives for those businesses may never open again. We got to own that. We did not have was the trust with those businesses. You cannot have the health Commissioner meet the president of the chain of commerce the first time, introduce themselves and the health Commissioner say by the way I am shutting you down. That is a bad first date. Nobody is swiping right on public health then and nor should they.

We have to look at all this, how do we work with the community. In every health department we need an assistant commissioner for community engagement. That person should be of the community, at the table every decision that is made. That is something that we can do but we need to work altogether to build a national workforce. To build and I'll do a health department is, we need the funding to make it so. We need to find a group identity that we have never had before. Right now, remember Horton hears a who I don't know we'd escape the oil because we're not on the same page. We need to have a national plan to move public health forward. That will help build our public all in for structure and ultimately we can even sit back someday and say we saved the nation.

ERIN WILL MORTON:

This is great, and I was going to turn it to each of you to give some closing remarks but Tekisha and Brian those were great closing marauders. Krista, I want to make sure you have one minute to say anything else on follow-up to what the 2 of them outlined here but it looks like you are shaking your head.

KRISTA R WASOWSKI:

I just love, I love that we have organizations of people who get it. Who Karen I could not agree more with the comments that were made to close.

ERIN WILL MORTON:

I will just say I've been sitting here my job as moderator to ask questions and to figure out what is coming in both from a chat and the Q&A. The chat is just impressive. People have ideas, they have feelings. I hear people are getting excited and energized again. I feel like these kinds of conversations is to find like-minded individuals that we can hear from, partner with in addition to sharing our thoughts and ideas with policymakers and Congress. I think it is been usually

successful, I am enjoying the conversation with all of you today. I think this is important for us to continue to discuss and to work and to try and solve as we modernize our public health system. As I promised, we were going to discuss it today but probably not solve it today.

I think ongoing conversations like this are important. I really want to thank our panelist, I want to thank AI media captioning services and all of the by the scenes staff and all of you for joining and a vibrant conversation in the chat. Of course, we could not get all of the questions because there were so many good ones that came in. We did record today's events, so a recording along with the slides and some additional resources will be made available on the TFAH website [tfah.org](http://tfah.org). On behalf of TFAH and the Coalition for Health Funding I want to thank you for doing this today, thank our panelists and enjoy the rest of your afternoon!