

Bolster Investments in Public Health Departments and Communities to Advance Health Equity

SUPPORTING COMMUNITIES AND LOCAL PUBLIC HEALTH
DEPARTMENTS DURING COVID-19 AND BEYOND —
A ROADMAP FOR EQUITABLE AND TRANSFORMATIVE CHANGE



Public Health Alliance[™]
OF SOUTHERN CALIFORNIA

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This document is one section of the [Supporting Communities and Local Public Health Departments During COVID-19 and Beyond - A Roadmap for Equitable and Transformative Change](#) report drafted by the Public Health Alliance of Southern California that includes policy, program, and resource recommendations to ensure that local public health departments are adequately prepared to support communities most vulnerable to the health and socioeconomic impacts of COVID-19 as well as future public health emergencies.



RECOMMENDATIONS

- ▶ Significantly Increase Funding for Local Public Health Departments
- ▶ Invest in Communities in Ways That Support Public Health and Addresses Health Inequities
- ▶ Infuse a Health and Equity In All Policies Approach with Investments from Other Sectors
- ▶ Promote Innovative Community Investment Strategies to Address Community Health and Equity
- ▶ Ensure Healthcare Funding Streams Include Investments in Public Health and Community Needs
- ▶ Develop a Statewide Equitable Public Health Resilience Plan

“The health emergencies of the past year—from flooding to wildfires, vaping-associated lung injuries to the novel coronavirus (COVID-19)—are a stark reminder of the critical importance of a standing-ready public health infrastructure and workforce. Such a public health system requires adequate and sustained funding”
Trust for America’s Health

OVERVIEW

Low-income and communities of color have endured centuries of historic disinvestment, a lack of resources, and structural racism. These factors led to the disproportionate impacts of these communities by COVID-19 as well as other public health and climate change-related emergencies. COVID-19 was the third leading cause of death in 2020, with [deaths among people of color being double those of the White population](#). At the time of this writing in 2020-2021, state data showed that Census tracts with the least opportunities for health as identified by the Public Health Alliance’s [Healthy Places Index® \(HPI\)](#) are home to 24% of Californians, but they have accounted for 40% of COVID-19 cases. Black, Latinx and Native Hawaiian and Pacific Islander Californians have disproportionately shouldered the burden of this pandemic. Black residents represent approximately 6% of California’s total population, but [close to 8% of all COVID-19 related deaths](#). While Latinx people represent approximately 39% of all Californians, [they represent 61% of the cases and over 48% of all the deaths](#). This is nearly half of all COVID-19 related deaths in California. Data also reveal inequitable health outcomes that are especially stark for [younger \(ages 18-34\) Black, Latinx, and Native Hawaiian and other Pacific Islander \(NHPI\) Californians](#).

These disparate COVID-19 outcomes are rooted in and exacerbated by structural inequities that have long existed in communities. In California, like the rest of the country, centuries of policies and practices have created barriers to stability and health. From Jim Crow, to redlining and predatory lending, Black, Latinx, Indigenous, and other communities of color were pushed into under-resourced, highly segregated neighborhoods, and locked out of wealth-building opportunities that were afforded to many White Americans. The effects of these policies are still felt today, as many of the same communities still disproportionately face worse economic, environmental, and health outcomes and injustices, including those associated with COVID-19 and climate change. Moreover, the community-based organizations that serve as trusted messengers within these communities are often small and resource-limited in normal times, let alone a pandemic where they are going above and beyond to get accurate information, services and resources to the hardest hit and hardest to reach communities in California.

The institutions meant to provide critical services to these communities, including local public health departments (LHDs), have also been decimated by budget cuts. Local public health departments provide critical services to their communities, especially those most impacted by inequities. When LHDs do not have adequate resources, the community is adversely impacted. California’s LHDs have been leaders in advancing health equity, but because of budget decisions by political leadership at all levels, this work has become

Public Health Infrastructure is defined in this report as the policies, systems and, resources that protect the health and safety of the entire population, especially those groups impacted by inequities. It encompasses resources and investments in communities, as well as the government (e.g. local public health departments) and private sector systems (e.g. healthcare providers) that ensure community health and well-being.

increasingly hard to do with diminishing resources and increasing public health and climate threats. Almost all funding sources for LHDs have been declining at the same time that public health threats are growing. LHDs are consistently underfunded and, even during the worst pandemic in most people's lifetimes, are facing further funding cuts. Under-resourced, dedicated public health workers have put in long hours to address the COVID-19 response, while departments are understaffed, and challenges are swelling. Our public health systems are woefully unprepared to address future challenges lurking around the corner, including wildfires and extreme heat threats, rising rates of chronic and communicable diseases, and persistent health inequities. This includes data surveillance systems and equipment, which in many cases have not been upgraded in years and were not built to handle the volume of cases a pandemic would bring.

Inadequate funding for public health departments is a grave threat at a time when the essential services they provide are absolutely critical. LHDs cannot turn these services on and off during times of emergency. COVID-19 demonstrates the real risks a pandemic has to public safety, the economy, and national security, and the serious impacts on the most impacted populations already experiencing the most significant health inequities. There is a need for a transformative "New Deal" type investment and sustainable model moving forward. Coming out of this pandemic, the United States has a unique opportunity to invest in building a robust, and resilient statewide public health system to support LHDs. It is important that LHDs are able to perform their core functions and provide essential services that protect the health and safety of the communities they serve at all times, not just during a pandemic. They need sufficient funding and resources to provide for everyday, ongoing public health needs, as well as to prepare for future public health emergencies related to infectious disease outbreaks, climate change, natural disasters and other events. There is currently an opportunity to create a national system that is prepared for the future and works daily to not just ameliorate threats, but work to eliminate health inequities and create healthy communities that allow everyone to live to their full potential.

It is also important that other sectors coordinate with local public health departments to align their investments toward improving health and equity. This includes government agencies, healthcare, community development, community-based organizations, and the business sector. Community investments can occur along a continuum of care and with collective impact in mind, with everyone coordinating, aligning and leveraging each other's resources to promote better health outcomes. The public health sector also needs to think more innovatively about how to finance its operations, as well as broader health equity-promoting community investments. Traditional models alone will not backfill the public health funding deficit. The public health system must be rebuilt in partnership between local and state public health departments, other sectors, and the community. It must be rebuilt with more innovation, and with equity front and center. The partnerships that have been established between LHDs, other sectors and community-based organizations during the pandemic need to be sustained, and new ones established, so that the most impacted communities are not left behind again.

To assist with laying out the roadmap for these investments, California needs a statewide resilience plan that identifies the magnitude of this need and identifies the universe of potential funding sources that could fund public health departments, communities and other sectors. Together, California's public health community can seize this opportunity and create a system that is prepared for the future and works daily to not just ameliorate threats, but work to eliminate health inequities and create healthy communities that allow everyone to live to their full potential.

CHALLENGES

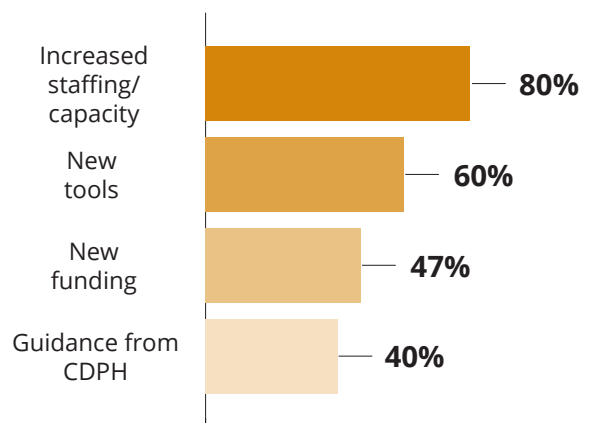
1. Public health departments have been chronically underfunded for decades, and the shift to pandemic response had major impacts on LHD capacity and funding to protect the health of communities most impacted by inequities
2. Lack of resources and investments for community-based organizations to address the response and recovery
3. Pandemic funding has focused on addressing short-term immediate needs, not long-term needs to build a more sustainable system, and to address root causes and the social determinants of health
4. Pandemic funding has had challenging requirements that have hindered an equitable response
5. Multi-sector partnerships between LHDs, CBOs and other sectors were stalled or slowed by the pandemic due to a lack of capacity

1. Public health departments have been chronically underfunded for decades, and the shift to pandemic response had major impacts on local public health department capacity and funding to protect the health of communities most impacted by inequities

When the pandemic unfolded in early 2020, LHDs were already underfunded for their core functions. When they quickly had to pivot to address the growing threat of COVID-19, **89% stated that funding was a barrier to addressing the response, with a quarter stating it was a major barrier.** In addition, the categorical nature of public health funding has made it difficult to shift existing funding to address COVID-19, and LHDs shared that the State and federal government did not provide much flexibility. Some categorical work had to stop because of redeployed staff, but the funding tied to it still required the work be done or LHDs risked losing funds. LHDs also described in this report's surveys and interviews that their existing

data surveillance systems and equipment were not set up to handle a pandemic of the magnitude of COVID-19, which affected their ability to collect data, do case investigation and contact tracing, and other core functions of tracking an infectious disease. **In this report's LHD data survey, these systems did not improve until additional resources were provided.**

FOR THOSE THINGS THAT IMPROVED, WHAT CONTRIBUTED TO THE IMPROVEMENT?



For close to 20 years, political leaders at all levels have cut almost all funding sources for LHDs, at the same time that threats to public health are increasingly growing. **Over the past decade alone, local and state health departments lost 20% of their workforce, and LHD budgets shrank by as much as 24%.** State and federal decisions have led to California's LHDs receiving \$177 million less in total funding in 2018-2019 versus 2007-2008. **Eleven local public health labs in California closed over the past 15 years** because of funding cuts, limiting the capacity during COVID-19 to scale up testing and staffing needed to adequately meet the State's phased reopening goals. County general funding remains flat and LHDs have to compete with other agencies for funding. For example, in **Riverside County**, the health department

has a budget of approximately \$100 million per year, and the Board of Supervisors allocates \$12 million from the County General Fund, but this amount has been flat for years amid competing priorities while public health threats are growing. As a result, Riverside has had to **cut its LHD staff by about 60%** over the past decade. For more statistics on LHD funding cuts, see the Public Health Alliance's *Investing in Our Local Public Health Departments Brief*.

Altogether, this chronic underinvestment had a significant effect on LHD operations during the pandemic and left them not as prepared as they could have been to protect the health and safety of their communities, especially groups most impacted by inequities.



“Over the past decade alone, local and state health departments lost 20% of their workforce, and LHD budgets shrank by as much as 24%”
LHD respondent

Best Practices

- Additional funding did become available to LHDs from the federal government through the Coronavirus Aid, Relief and Economic Security (CARES) Act, the Center for Disease Control and Prevention’s (CDC) Epidemiology and Laboratory Capacity (ELC) funding, National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved Communities, Including Racial and Ethnic Minority Populations and Rural Communities, American Rescue Plan Act (ARPA), and other sources. The State of California established several equity-focused metrics to guide investments in the most impacted communities. This includes the **Health Equity Metric** of California’s Blueprint for a Safer Economy (announced in October 2020), and the **Vaccine Equity Metric** (announced in March 2021). As part of the Health Equity Metric requirement, LHDs were required to develop **Targeted Investment Plans** that allocated resources to the lowest HPI quartile in each jurisdiction. Altogether, \$272 million in local public health department CARES and ELC funding was directed to the most impacted communities, defined as those in the lowest **Healthy Places Index®** quartile. The CDPH Office of Health Equity also directed \$5 million in funding for community-based organizations to implement **Health Equity Pilots** within these communities. The Vaccine Equity Metric allocates 40% of vaccine doses to communities most impacted by COVID-19, also utilizing a combination of the Healthy Places Index® and CDPH-derived scores. More details about both metrics are provided later in this report.
- Several funders pooled resources to boost local health department capacity to address the needs of communities most impacted by inequities, including the following two initiatives that the **Public Health Institute** is fiscally administering:
 - » **TRACING HEALTH:** In August 2020, Kaiser Permanente announced a \$63 million investment in **Tracing Health**, which provides contact tracing supports to LHDs within their network in California. Modeled off a successful contact tracing program in Washington and Oregon, the Tracing Health program has hired, trained, and deployed an estimated 500 full-time team members to provide culturally and linguistically competent contact tracing support to LHDs in California, with a focus on the most impacted communities. These contact tracing resources were flexible enough to be able to be used to support multiple communities. Collectively, Tracing Health has the capacity to contact up to 5,550 people per day.
 - » **TOGETHER TOWARD HEALTH:** A group of more than 18 funders invested over \$30 million in an initiative to connect community-based organizations with LHDs to support outreach, education, and communication activities to groups most impacted by inequities. The goal was to develop a culturally and linguistically competent workforce development pipeline for communities most impacted by COVID-19 and support LHDs in reducing spread of the virus. Together Toward Health (TTH) has funded more than 270 community-based organizations across the State. A full list of the funded CBOs and their focus is available on the **TTH website**. The funders include: the Ballmer Group, Blue Shield of California Foundation, the California Health Care Foundation, Crankstart Foundation, Genentech, the Gordon and Betty Moore Foundation, the Conrad N. Hilton Foundation, the Heising-Simons Foundation, the James Irvine Foundation, Medtronic Foundation, the David and Lucille Packard Foundation, the Sierra Health Foundation, Sunlight Giving, the California Endowment, the California Wellness Foundation, Tipping Point Community, the Chan Zuckerberg Initiative, and the Weingart Foundation.

2. Lack of resources and investments for community-based organizations to address the response and recovery

Community-based organizations serve as trusted messengers in communities most impacted by inequities. They have played a significant role in providing outreach, education, communication, and other essential services to these most impacted communities during the COVID-19 pandemic. This has been in addition to their everyday activities to support community members, which has put a financial strain on many of them. **In this report's CBO survey, conducted between October 2020 and January 2021, 85% indicated that they would most benefit from general operating support in order to make the greatest impact during COVID-19 and other public health and climate emergencies.** When asked about their top three supports during the COVID-19 public health crisis, 77% listed funding, grants, and other types of emergency aid as their top support.

Local public health departments were able to deploy more resources to CBOs in later stages of the pandemic, but the process was gradual and started slowly. **When we surveyed CBOs between October 2020 and January 2021, nearly three-quarters (70.4%) stated that they had not yet entered into any contracts with LHDs or other local government agencies** in order to support the communities they represent and/or serve. For those that had entered into agreements, LHDs were three times more likely to initiate contract conversations with community organizations with whom they had a previous non-COVID-19 related agreement or relationship. Approximately 68% of respondents indicated that they can navigate local governmental contracting processes without, or with very little, difficulty. Only one respondent replied that they cannot navigate government contracts at all. **But nearly half (48%) of respondents indicated that technical assistance (TA) around contracts**



and procurement would at least somewhat or strongly impact their ability to quickly apply for funding. While LHD resources and contracts with CBOs did improve over time, the slow start is an important challenge to consider for future pandemics and public health emergencies, so that the most disproportionately impacted communities receive resources and supports as early as possible.

Best Practices

- To facilitate the contracting process with CBOs, LHDs were able to utilize and coordinate with fiscal intermediaries such as local community foundations to allocate funds more quickly and to smaller, less traditional partners to assist with the response. For example, Riverside County utilized the Desert Community Foundation, and Sacramento County relied on the Sierra Health Foundation to contract with some CBOs. The **LA County COVID-19 Community Equity Fund** selects grassroots CBOs with some cultural and linguistic expertise in highly impacted communities.
- As an intermediary to **First 5 LA**, Prevention Institute worked closely with 7 high-capacity community-based organizations to address inequities in the built environment related to parks and open space, food access, and transportation with the aim of improving supports, resources, and opportunities for children 0-5. They learned from the grantees (via ongoing conversation and peer-learning sessions) that they were adapting their policy advocacy and community engagement strategies in response to COVID-19 in creative, yet resource-intensive, ways. They partnered with First 5 LA to allocate additional resources to these grantees to accommodate the additional needs to adapt their policy advocacy campaigns and resident engagement strategies during COVID-19.
- Philanthropy played a major role in supporting community-based organizations during the COVID-19 response. Many funders were able to make quick shifts in their grantmaking to support rapid response, as well as turn restricted grants meant for a particular project or purpose into more general and flexible core support grants, and/or augment support. Because the pandemic happened early in the year, many funders were still early in their grantmaking for the year. Many investments were rapid, and at the beginning, funders thought addressing COVID-19 would be a short-term response. As the pandemic wore on, funders had to increasingly pivot and figure out how to best support grantees. In this report's interviews with funders, they stated that they may make longer term shifts in their grantmaking based on how the process went, including more flexible application and reporting processes, and changes to their program priorities. They have also been able to build new partnerships with existing and new grantees, and recognize the importance of making investments in public health.
- Other funders pooled their resources into local rapid response funds to support a range of community needs. Examples are below (administering foundations in parentheses), and a full list is available at **Philanthropy CA**
 - » **LA County COVID-19 Response Fund** (California Community Foundation)
 - » **Northern CA COVID-19 Response Fund** (Sierra Health Foundation)
 - » **Central Valley** (Central Valley Community Foundation)
 - » **San Diego** (San Diego Foundation)
 - » **Silicon Valley** (Silicon Valley Community Foundation)
 - » **Just East Bay** (East Bay Community Foundation)

“We used \$45M in just a period of 4 months. Why did we have to wait for a pandemic to get this? Wish there would be a more long-term investment so we can rebuild our infrastructure and get ourselves ready so that when another crisis hits, we just pull out our plans and we are ready to go.” LHD respondent

“We are always playing catch up. And once the funding goes away we can no longer support the needed efforts.”
LHD respondent

3. Pandemic funding has focused on addressing short-term immediate needs, not long-term needs to build a more sustainable infrastructure and address root causes and the social determinants of health

At the time of our survey (October 2020 to January 2021), 40% of LHD survey respondents felt that the funding received throughout the pandemic was inadequate. Of the LHDs that found it was adequate, there were concerns about the fact that it was focused on immediate needs. This funding was helpful for short-term emergency response needs such as scaling up testing, contact tracing and vaccinations, but it was insufficient for addressing more long-term LHD needs and rebuilding a more sustainable public health infrastructure. Many LHD interview respondents stated that this always happens during a public health emergency – that they receive one-time temporary allocations that help with the immediate response, but leave them without the staffing and resources to prepare for the next emergency. LHDs need to recruit and retain a well-trained workforce, and one-time funding undermines that critical goal. The lack of sustained funding significantly limits the ability of LHDs to perform their essential core functions and build up their infrastructure to cover the foundational capabilities and core areas.

There was also uncertainty at many points during the pandemic about the longevity of emergency funding. The CARES Act expired in December 2020, and was renewed at the last minute, leaving many LHDs without resources to continue providing critical COVID-19 functions into 2021. Subsequent federal relief bills did address these needs, but the timing of votes and receipt of funds did not always coincide with when the money was actually needed, and put LHDs in the position of having to identify

other funding sources to continue essential programs in case federal funding did not come through.

In addition, while pandemic funding did address short-term community needs due to economic loss and other social determinants of health, it has not addressed the root causes of these issues and only serves as a temporary fix. LHDs have done their best to support and protect the health of their communities, but they expressed a need for greater investment to address these issues over a longer term.

How Does California Compare?

The Trust for America's Health publishes state-by-state comparisons of public health spending in its annual *Ready or Not* and *Impact of Chronic Underfunding on America's Public Health System: Trends, Risks, and Recommendations, 2020* reports. Both reports highlight that while overall public health funding has decreased over the past 20 years, it has started to stabilize in many states as a result of emergency funding for the pandemic. Though the reports also caution that emergency funds historically ebb and flow, and do not allow for building long-term infrastructure to protect against future emergencies. Some states appear to be making investments in long-term public health infrastructure as a result of COVID-19, but the future outlook remains uncertain in many states. California falls in the middle tier of state emergency readiness.

4. Pandemic funding has had challenging requirements that have hindered an equitable response

In this report’s interviews with LHDs and community-based organizations between October 2020 and January 2021, while everyone was grateful for the pandemic funding received, there were concerns raised about challenging requirements. These included the following:

- Certain activities not being eligible for FEMA reimbursement (e.g., community-based organization outreach and education)
- Work plan and spending plan requirements were not always coordinated
- Direct reporting requirements. One LHD reported having to hire an additional staff

person to oversee CARES and ELC funding administration and reporting

- Monthly compliance checks
- Funding was not always made available to use right away
- Pandemic funding was not consistently allocated within city/county governments, and funding for other sectors was not always aligned with public health (e.g., public health funding falling under the umbrella category of “public safety” along with law enforcement)
- Duplication of benefits requirements preventing the most impacted community members from accessing services. This was especially true with the Great Plates Delivered program:

The **Great Plates Delivered** program provided seniors with three home-delivered, restaurant-quality meals per day. However, the program excluded seniors already receiving other nutrition assistance like CalFresh/Supplemental Nutrition Assistance Program (SNAP) or Meals on Wheels. This essentially denied enhanced nutrition benefits to those who need them most. Seniors with higher incomes who are not currently accessing nutrition assistance programs were able to access \$66 per day, while their lower income counterparts were excluded from this program, receiving the maximum benefit of only \$6.26 per day under the CalFresh expansion and left to navigate a rapidly-evolving emergency food system:

NUTRITION ASSISTANCE BENEFIT COMPARISON

NUTRITION ASSISTANCE PROGRAMS	MAXIMUM DAILY BENEFIT AMOUNT PROVIDED	DAILY MEALS PROVIDED
Seniors on Existing CalFresh	\$6.26	1+ meal
Seniors on Proposed CA Great Plates Delivered Program	\$66.00	3 meals
Difference in Benefits Received	\$59.74 less benefits/day for seniors currently on CalFresh than seniors on the Great Plates Delivered Program	

The eligibility requirement essentially established a two-tiered benefits system, in which CalFresh recipients with the highest need were set-up to receive less than 10% of the benefits that new higher-income enrollees in the Great Plates Delivered Program were set to receive. This is a serious injustice that exacerbated structural disadvantages along socio-economic lines and failed to meet the fundamental needs of countless seniors across California. In the future, it is critical to ensure that all seniors and high-risk individuals are guaranteed access to expanded supportive services to address food insecurity and that they are not excluded from higher benefits, simply because they were accessing smaller benefits that they are eligible for, and entitled to, under current guidelines. Increased nutritional access will help mitigate seniors already heightened risk of morbidity and mortality due to COVID-19.

5. Multi-sector partnerships between LHDs, CBOs and other sectors were stalled or slowed by the pandemic due to a lack of capacity

Local public health departments are part of many multi-sector efforts with other government agencies, healthcare, community-based organizations, businesses, and other sectors to elevate health equity and an upstream prevention approach to decision-making. Due to COVID-19, LHDs had to step back from many of these efforts, which stalled and slowed their progress on important existing and ongoing work. In the interviews conducted as part of this report, LHDs reported being unable to continue their health equity, climate change, healthy communities, and other multi sector work because staff was redeployed to COVID-19 emergency response functions. Community-based organizations also reported having to shift to addressing COVID-19 and putting their core work on hold.

Best Practices

The **California Accountable Communities for Health Initiative** (CACHI) sites were able to quickly pivot to supporting the COVID-19 response because of their robust, established partnerships between public health, healthcare, and the community. Their **COVID-19 brief** outlines how they were able to convene partners, coordinate action and disseminate information, deploy staff and resources, and train key staff and volunteers to ensure an equitable response and recovery. These sites played an important role because they were trusted conveners and already exploring and implementing ways to fund community health needs. For example, the **East San Jose Wellness Fund** was already set up and able to give direct payments to people ineligible for federal stimulus payments (e.g., undocumented populations). They were able to raise \$600,000 and support 700 families.

“The impacts of COVID are so much greater than the narrow response efforts that the funding is targeted to support. Funding is too restrictive to infection control efforts and not broader public health and social impacts of COVID.”
LHD respondent

“Funding sent directly to public health departments has been helpful, but the reporting requirement for all funding (including CARES) has been extremely taxing.”
LHD respondent



RECOMMENDATIONS

Significantly increase funding for local public health departments

There is a significant need for more funding from local, regional, state and federal sources to be dedicated to local public health departments. It is important that this funding is flexible and allow for the hiring of critical staff, purchasing new and modernizing existing equipment and facilities, acquiring critical supplies, developing plans and strategies for addressing important public health challenges and emergencies, and partnering with other sectors and community-based organizations to advance health equity. In addition, COVID-19 has resulted in LHDs taking on and responding to the immediate needs necessary to respond to the pandemic, and funding needs to be provided for back funding and loan forgiveness for costs incurred while responding to this crisis. Finally, it is important that this funding maintain and enhance existing health equity supports, including enhanced funding for dedicated equity staff at the local level.

There are five important strategies for investing in our local public health departments:

1. **Increase Non-Categorical Funding:** LHDs need flexible funding to allow them to develop a cross-cutting workforce that can be trained in

multiple skills and functions. Less than 5% of current LHD funding is flexible, which limits ability to hire staff trained in multiple disciplines and pivot as public health emergencies arise. By providing more flexible funding for local public health departments, they will be more able to have the resources they need to respond to a range of issues and threats, including health equity and climate change, in a more sustainable way.

2. **Provide Greater Allowances Within Categorical Funding:** Loosening the requirements on many categorical funding streams will allow greater flexibility. In the absence of a significant infusion of new funding, this will allow LHDs to be more innovative in how they use their funding to address important public health issues. It provides an opportunity to shift the paradigm of emergency preparedness from “break the glass in case of an emergency” to an “always on” system that is proactively ready to respond. For instance, in times of emergency, there could be a state or federal policy that LHDs can shift a certain percentage of their categorical funding to address the emergency response.

3. **Enhance Categorical Funding for High-Need Positions:** There are high demand functions, such as epidemiologists and public

health nurses, that require sophisticated skill sets and certifications. It is important that enhanced funding be provided to LHDs to ensure adequate staffing, training and retention of workers with these technical capabilities.

4. **Establish Sustainable Funding:** LHDs need long-term funding to be able to build and strengthen their workforce and systems to address everyday public health threats and more proactively prepare themselves for future emergencies. It is common for LHDs to receive one-time infusions of funding for public health emergencies such as COVID-19, but these temporary solutions only address current needs. Longer-term, more sustainable funding is necessary to ensure LHDs have the staffing and resources they need for all situations.
5. **Enhance Data Platforms to Provide Real-Time Disease Surveillance and Facilitate Data Sharing:** LHDs need funding to modernize and upgrade their data collection and reporting systems. These are important to conduct real-time disease surveillance, detect the spread of COVID-19, collect various data points, and monitor public health threats. It is important that these systems are integrated within LHDs and across other agencies at the local, regional,

state and federal level to facilitate greater data sharing; and that these systems have the ability to collect and disaggregate demographic data, including race/ethnicity, income, geography, and the social determinants of health, to address health equity concerns. Staff also need support in understanding and being able to link the data to the historical and current contexts that lead to racial inequities. There are also many examples of LHDs unable to access data from divisions within their own department, such as being unable to obtain mortality data, as well as across other agencies at the local, state and federal level, such as barriers to accessing Section 8 housing data. To address this, it is important that investments are made in developing data sharing agreements and other legal documentation that addresses privacy and confidentiality issues while also providing the information LHDs need to make informed decisions.

There are various approaches that have been put forward at the state and federal levels to increase funding for local public health departments. The following were either enacted or under consideration in the time between October 2020 and July 2022:

- The U.S. Centers for Disease Control and Prevention (CDC)'s [National Initiative to](#)

“Sustainable funding is essential now to ensure that a robust public health safety-net is in place to contain and minimize not only the next outbreak or emergency. Additional sustainable funding will also ensure that we can confront the smaller, yet daily devastating waves of infectious and chronic diseases, which contribute to premature mortality and crippling morbidity in many regions and underserved communities.”
California Can't Wait Campaign \$200M general fund ask letter



Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved Communities, Including Racial and Ethnic Minority Populations and Rural Communities, which offered \$2.25 billion over two years to local and state health departments to reduce COVID-19 related health inequities.

- The [California Can't Wait Campaign](#), led by the California Health Executives Association of California (CHEAC), which has been working to secure an ongoing State of California General Fund investment for public health department and workforce needs as well as other asks from budget surplus funds, such as the Health Equity Readiness & Opportunity (HERO) initiative.
- The California Alliance for Prevention Funding's efforts to establish a [Health Equity and Racial Justice Fund](#).
- The federal [Public Health Funding Prevents Pandemics Act](#), which would restore funding for the federal Prevention and Public Health Fund to its originally authorized level of \$2 billion, starting in FY2021 and for each year thereafter.
- Trust for America's Health push for a federal public health funding bill as part of a comprehensive infrastructure package

- [Improving Social Determinants of Health Act of 2021](#) which would create a social determinants of health program at the CDC.
- [Health Force, Resilience Force, and Jobs to Fight COVID-19 Act of 2021](#), which would establish a national standing workforce to respond to the COVID-19 pandemic in their communities, provide capacity for ongoing and future public health needs, and build skills for new works to entire the public health and healthcare workforce.

THE MEDIA HIGHLIGHTS DISINVESTMENT IN PUBLIC HEALTH INFRASTRUCTURE

USA Today, March 2, 2020

'This is not sustainable': Public health departments, decimated by funding cuts, scramble against coronavirus

San Francisco Chronicle, March 16, 2020

Even before coronavirus, infectious disease was on rise in California — but spending got cut

LA Times, March 20, 2020

Officials long warned funding cuts would leave California vulnerable to pandemic. No one listened.

Detroit Free Press, April 4, 2020

Panic, then neglect: Prior pandemics gave us lessons to fight the coronavirus. But funding dried up.

NY Times, April 9, 2020

The U.S. Approach to Public Health: Neglect, Panic, Repeat

Los Angeles Times, June 15, 2020

Public health funds are needed more than ever but lack 'lobbying muscle' in California

Invest in Communities In Ways That Support Public Health and Addresses Health Inequities

There is a need for a new path forward for investing in the most impacted communities beyond the COVID-19 recovery. Sustainable investments need to be made in communities to address longstanding health inequities, community conditions, and structural racism, and in coordination with local public health departments. It is important that these investments are made more proactively and over a longer term, and not just in response to the COVID-19 pandemic or other future emergencies. Investing in communities goes hand in hand with investing in our public health departments. California will build a stronger, more equitable, and resilient public health system if structural barriers to optimal health are eliminated. It is important that any resources made available for COVID-19 recovery and rebuilding public health systems dedicate a portion of funding for investments in the communities most impacted by COVID-19, and those most at risk for impacts by future threats. For example, as part of the California Blueprint for a Safer Economy's Health Equity Metric requirement, LHDs developed Targeted Investment Plans that allocated resources to the lowest HPI quartile in each jurisdiction. Altogether, \$272 million in CARES Act and ELC funding was directed to the most impacted communities, defined as those in the lowest Healthy Places Index® quartile. The CDPH Office of Health Equity also directed \$5 million in funding for community-based organizations to implement Health Equity Pilots within these communities. Outside of COVID-19, the California Climate Investments initiative is a statewide model for how to set aside dedicated funding to the most impacted communities. This program has legislative requirements (SB 535 and AB 1550) to allocate at least 35% of all grant funding to projects within and benefitting disadvantaged and low-income communities. Another model is the Together Toward Health initiative, where community investments incentivize and encourage partnerships

between LHDs and community-based organizations that represent the most impacted communities, to work together on addressing health equity. These investments are necessary and complementary to investments made in public health departments.

Infuse a Health and Equity in All Policies approach with investments from other sectors

Beyond community and LHDs, it is important for other sectors to play an active role in supporting an equitable and just response and recovery. Social and economic factors such as access to safe and affordable housing, good-paying jobs, quality educational opportunities, healthy food, and convenient transportation options have a greater impact on health than genetics. It is important that investments by other sectors, including housing, economic development, employment, transportation, criminal justice, and more, are made with the social determinants of health and health equity in mind. This means taking a multi-sectoral Health and Equity in All Policies Approach. Non-health sectors can integrate health and equity principles into their planning and programming, and fund public health-supportive investments. They can also incorporate health equity metrics into their planning and investment, similar to the model the CDPH deployed for the Health Equity Metric and Vaccine Equity Metric. If not doing so already, these sectors could also explore partnering with CBOs to assist with their work, and providing set-asides within their funding to support investments in the most impacted communities, similar to the model used by many transportation and climate programs under the guise of “disadvantaged communities.” They can also expand eligibility for LHDs and community partners to apply for their funding, especially in partnership with each other. For example, LHDs can apply to the California Transportation Commission's Active Transportation Program grants to promote walking, bicycling, and Safe Routes to School, but there are many other grant programs, including most of the California

Climate Investment programs, where they are not eligible or are only identified as recommended partners in project implementation, without funding attached for their participation. When LHDs receive this kind of funding, they are often able to bridge silos, bring in multi-sector partners, and pass through the funding to community-based organizations that are led by those who are most negatively impacted by health inequities. Expanding eligibility to include LHDs and allowing funding to be used for their participation in multi-sector projects can encourage greater community and multi-sector collaboration, and a Health and Equity in All Policies Approach to government-funded investments.

Promote innovative community investment strategies to address community health and equity

Traditional funding sources alone will not provide sufficient funding to address health inequities for the most impacted communities, let alone in a public health emergency. There are innovative financing strategies being implemented across the United States that supplement the resources available to communities and LHDs. This includes strategies like blending funding with sources from other sectors like healthcare and community development, creating a Wellness Fund, developing an Accountable Communities for Health model, exploring anchor institution strategies, and partnering with community development financing institutions and other sectors to leverage funding sources. The Public Health Alliance has created a comprehensive [research report](#) outlining these innovative community investment strategies, which provides more information on best practices and recommendations for greater implementation and inclusion of LHDs in these investment efforts.

The California Governor's Office of Social Innovation has catalyzed these models through 27 [public-private partnerships](#) that have leveraged \$3.9 billion in corporate and philanthropic investments

before and during the COVID-19 pandemic. The [CACHI model](#) mentioned above is bringing together public health, healthcare, and community partners in 13 sites around California to work together and explore financing models including wellness trusts and blending and braiding of funding. There are also efforts to set up a [State Wellness Trust or Health Equity Fund](#) to support both LHD and community needs. The benefit of many of these models is their greater flexibility from traditional public health funding. They also can have a distributed leadership model where the backbone is not one single entity and everyone has a role to play in implementation. There are also community ownership models such as the Funders Forum concept of [Response and Resilience Accountability Councils](#) (also known as [Recovery and Equity Councils](#)) that could be explored to ensure greater accountability of government response to the community, as well as



efforts to put [safeguards](#) and “guardrails” in these mechanisms to ensure they meet the needs of those they are intended to serve and provide effective stewardship of public funds.

Ensure Healthcare Funding Streams Include Investments in Public Health and Community Needs

Given that an [estimated \\$3.6 trillion is spent annually on healthcare](#), but less than 3% of that is spent on public health and prevention infrastructure, there is a significant opportunity to leverage healthcare expenditures to improve public health infrastructure and support the community health needs of groups most impacted by inequities. This is especially important because LHDs provide many basic healthcare services covered by Medi-Cal and Medicare, often with little to no reimbursement. Many LHDs do not have the billing systems set up to properly account for and be reimbursed for all the services they provide under Medi-Cal. They also lack the capacity to track all the state and federal policy changes that impact their work, including the complex Medicaid waiver processes. There needs to be greater collaboration between the healthcare and public health sector, and incentive mechanisms need to be put in place to ensure this happens in a meaningful way. For example, California’s [CalAIM](#) proposal, if approved, will provide stronger incentives for Medi-Cal managed care plans to contract with LHDs to provide basic healthcare services and to advise on the development of population health management plans, enhanced care management and in lieu of services. Efforts are [cost containment](#) can also be leveraged to provide funding for public health departments and community investments.

Develop a statewide equitable public health infrastructure resilience plan

To address all of the above and put together a holistic, comprehensive roadmap to rebuilding California’s systems in a way that supports public health, other sectors and the communities they serve, there is a need for a statewide resilience plan that can guide investments and policy. The aim of this plan would be to identify where systems were overwhelmed in the COVID-19 response, with goal of strengthening the entire public health system to withstand and prevent the community impacts that resulted from a lack of preparedness. This plan would be similar to other statewide comprehensive plans in that it would have a public process and be used as a framework for guiding all investments. The community engagement process would need to ensure that those most impacted by COVID-19 were able to participate. Specific elements of this plan would include identifying funding needs and scale of need (including everything mentioned above in this Recommendations section), recommendations for meeting these needs, and potential funding opportunities, workforce needs (detailed more in the section below). Recent legislation, [AB 240](#) (2021), which would have created a LHD workforce assessment, is a good example of how to advance this approach, but there is a need for a large-scale comprehensive planning effort that also addresses community needs and a focus on equity.