National Public Health Week Webinar: Ready, Set, Action: Bridging Public Health and Policy in a Shifting Landscape
National Webinar
Trust for America's Health
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TIM HUGHES:

Good afternoon, and welcome to our national webinar and recognition of national public health week, Ready, Set, Action: Bridging Public Health and Policy in a Shifting Landscape. Hosted by Trust for America's Health commonly known as TFAH my name is Tim Hughes. We would like to thank our speakers and audience for being here today.

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We encourage you all to share your thoughts and questions about today's presentation by typing them in the Q&A box. We will try to answer as many as we can as time permits. To open the Q&A box, click the Q&A icon at the bottom of your screen. From there, select enter when you are ready to submit your question.

And now, it is my pleasure to introduce the moderator of this event, Doctor Tekisha Dawn Everette who is executive vice president. She works to chart and implement the organization's strategic direction and priorities, provides counsel on current and emerging policy issues, and engages with key organizations, policymakers and other partners to advance policy priorities to improve public health. Welcome, Doctor Everette.

DR. TEKISHA DWAN EVERETTE:

Thank you, Tim and thank you to everyone for joining us. I'm the Executive Vice President for Trust for America's Health and I would like to welcome you all and thank our esteemed panelists for taking the time to attend this event today. We are honored that you are all here.

Our agenda for today is on the slide. After the discussion, our panelists will have time for your questions that are coming from the audience. We are proud to celebrate our 25th year and as part of that we are kicking off a series of webinars this year that will focus on what public health currently is and where we are heading. Specifically, it is important for all of us to weigh how the field has been doing and how we can evolve in this rapidly changing time. We will continue to highlight throughout the year the recent past, thinking about how the public health system has worked and how it has supported communities prior and soon after federal changes, the present

including navigating the initial wake of those policy decisions and how they affect communities, and thinking forward to the future reflecting on our field of practices can learn to enhance how we support prevention. This is part of what we are thinking about over the course of these year but is also the framework for what we are discussing today.

My hope for the webinar today is you will all leave with a better understanding of how public health systems are navigating this evolving landscape as we examine the status of key federal agencies in the broader network of public health programs.

As a reminder, we will have time for your questions at the end. And we want to ensure that we get to all of your questions so please be sure to use the Q&A box, not the chat, and that is where we will look for all of your questions after we go through our panelist presentations.

I'm pleased to welcome our amazing panel. First I would like to introduce Darlene Huang Briggs, who is the Deputy Director of Special Projects at the network for public health law. Where she leaves trust building and research efforts to bring traditional and nontraditional partners together to modernize systems.

She joined the network for public health law in 2023, she has been working to translate her over 15 years of commercial tobacco control policy experience to broader public health systems improvement work.

This experience was gained at a local Colorado health department, the FDA, Campaign for Tobacco-Free Kids, the O'Neill Institute for National and Global Health Law at Georgetown University Law Center and the Public Health Law Center at Mitchell Hamline School of Law.

I'm also pleased to have with us today Doctor Simbo Ige, the Commissioner of the Chicago Department of Public Health. Doctor Ige's public health career spans nearly 2 decades and prior to her current role, she served as a Managing Director of Programs at the Robert Wood Johnson Foundation.

Doctor Ige oversaw partnerships with health organizations nationwide, working together making public health and healthcare systems accountable and equitable. Really important work. Continuing that important work, she is doing every day, dealing with everyday challenges and opportunities of addressing public health at the Chicago Cooperative public health.

An experience she is extending her experience previously as the assistant commissioner of the New York City Department of Public Health and melt -- dental hygiene. She provided -- mental health.... Food security programs and health initiatives, mental health programs, violence prevention and the Public Health Corps initiative.

Last but certainly not least we are certainly excited to have Scott for joining us today. He is the Executive Director and founder of the Southern Alliance for Public Health Leadership which partners with state and local public health efforts in the southeastern US and strategies and advocacy for immunizations, access to care and infant and maternal mortality.

Scott has held senior leadership roles with the Georgia Department of Public health, partners in health and the South Carolina Department of Health and environmental control.

He is an expert in public health infrastructure, having directed major COVID-19 response teams, manage global health departments and spearheaded health equity initiatives centered on Community Health Workers, and Electronic Health Record modernization.

Darlene, Doctor Ige and Scott, I'm so thankful you are joining us today and am so excited to get us into our discussion. To guide our questions we have a few things, we have a few, divider discussions we have a few questions to reflect on the past year, what is happening right now in the present and thinking ahead to the future of public health. I'm going to start this conversation with, what has happened over the past year.

And I'm going to direct my questions, I will direct the question first to Darlene and then ask Doctor Ige to answer and then moved to Scott.

Reflecting over the past year, I want to hear from you, what federal administrative or policy decision have the greatest effect on your community and or the type of work you are currently doing?

DARLENE HUANG BRIGGS:

Thank you, Doctor Everette and the rest of the team for having me here today. I'm with the network for public health WA. just to get straight to your question, Doctor Everette, President Trump issued a record-setting 200+ executive orders or EOs in 2025 and over half were handed down in the first 100 days of his administration and almost immediately we are public health while partners were being asked what various anti-DEI, DIA and immigration related EOs and other federal actions meant for public facing materials. And an array of public health services, programs and their funding so I would view that big, broad category of anti-DEA -- DEI, DIA, diversity equity and inclusion, DIA, diversity equity inclusion and accessibility.

Based on those core constitutional tenants including the documents opening affirmation of a democracy established by and for "We the people" as well as separation of powers among the three branches of government, a limited federal government, federalism or shared power between the federal and state governments and fundamental rights such as free speech, due process and equal protection, we and our partners reminded folks that there are limits to federal executive orders and an array of various other sources of law including grants and contracts, statutes and regulations, the laws of jurisdictions, state and local, tribal/territorial and court decisions that also shape the impact of any particular directive at a particular point in time.

I think the last thing I will just say is that what was clear from the actions of the current administration, right, was, and it is still clear, quite frankly to this day, the intent is to strong-arm people to comply with their views of how the world should exist.

Including a narrow type of public health field and work that we all do, as well as harmful ideals that there are less deserving people that then translates into policies where health improvements continue to be unevenly distributed with those experiencing degrading health inequities -- greater health inequities bearing the brunt of that burden. At a high level I will also say that the network recently released executive order watch which collects in one place many of the 2025 federal EOs that impacted both the work of public health as a field and of course the public's health as well.

We did a webinar just two weeks ago to introduce that resource to the field, it included 69 EOs that have largely harmed public health both in the traditional sense and through a broader health policy lens.

That webinar could not cover all EOs topics but our team focused on equity, public health more generally, immigration and voting rights. I can share that link in the chat for folks to access that if they want more details.

DR. TEKISHA DWAN EVERETTE:

Amazing, thank you. There is no real way to summarize everything that you said but I will say that through point of what I hear is that you were hyper activated from the legal standpoint as a network to really go into action to help people understand as we were navigating the complex nature of a record-breaking number of executive orders coming out that was affecting the field writ large.

So it sounds like a lot of energy and effort to really understand and help others understand what actual the force of executive, what actual rather than perceived force of law or lack of the executive orders have. And what that actually means for each individual actor in the field.

Doctor Ige, how has your work been impacted? How is your community, the things you are seeing in Chicago been impacted by federal administrative or policy decisions over the last year?

DR. SIMBO IGE:

Thank you very much. To set the context, I am a Commissioner of a big city, the third-largest city in the country, more than 10 million people in Metro Chicago, 50, 60 million tourists every year so it is a big deal.

Let's zoom out a little. Public health, by definition, is about the public so the reason public health is a little different for medicine is that medicine is about individuals, public health is about communities. And population groups.

And in looking at the impact, it's when you think about 69 executive orders, it is the collective impact of the policy orientation and how all of that has impacted who we serve and what we are able to provide.

So, the who, immigrant communities, people experience homelessness, people with substance use disorders, LGBTQ communities, people of color, all of the policy changes and attempts to roll back funding have all been tailored at limiting who we can serve and what we can provide. So if this shift has touched coverage, who gets insurance coverage, it has touched access, who can have certain services, it has impacted trust because now folks don't believe the government is looking out for them.

It has touched equity. These were all the lessons we learn the hard way during COVID when the United States was impacted more than other developed countries. Where outcomes and life expectancy impact was worse than pure countries --peer.

And now we have been stifled. We have been constrained in terms of who we can serve and how

resources can be deployed to serve our communities. So it is frightening that the lessons that we learned over COVID and how can we emerge from the pandemic so battered and bruised, that we are in a situation where the policies and laws are even worse. Than that period.

I will give an example of what that means. During COVID, we saw that communities that are under resourced, underserved, the most impacted.

And since COVID, we have seen outbreaks of measles and outbreaks of M pox and other disease across the country. Normally, the way we would respond to that is which communities are most impacted. Before M pox the federal funds to support LGBTQ communities or communities of color and we cannot tailor the funding that way, how can we respond to communities that are most impacted? Which means it is simmering and then we have to stretch local resources that are already not sufficient, big city, 10 million people, tourists all over the world coming here.

This is what the federal government is designed to do. And this is now been left to local municipalities to solve on their own. Not effective, not equitable, not accessible.

DR. TEKISHA DWAN EVERETTE:

You will make it so hard to moderate the panel because I just want to dive in deeper into each one of the responses that you have. But what I really am taking away from your response is thinking through the fact that the third-largest city in the United States and what is really fascinating in terms of how our country is set up is do not have borders, really.

Our borders, we have states and cities and towns, are artificial. And when you think of that, the importance of having strong federal support at the local level to attend to the infrastructure necessary and needed to provide the coverage access and attuned to the population's health in a large city that does have a huge influx of visitors as well as residents who are permanent, has been really harmed in the last year you have really been impacted by that. We will dig a little bit into that more but I will transition to Scott and say Scott, what are you seeing in the southeast? What has happened for you?

What has been the most important or impactful administrator or federal policy decision that has impacted the work you are doing in the southeast?

SCOTT THORPE:

Yeah. Thank you for having me here today. I think for us, the shifts impacting policy at the federal level have more than anything else, created a lot of chaos at the state and local level around how to respond.

We have a system that is really built on the idea that everybody generally agrees that vaccines are a good thing and everyone who wants to get vaccinated should have easy access to it. And when one part of that system suddenly starts to break down and disagree and generate policies that conflict with everybody else, if so is chaos in the system. And so a good example is some of the changes around the COVID vaccine has sort of downstream impacts on how state and local health departments and other vaccine providers can readily access the vaccine and who can provide it. And it just kind of left a lot of state and local public health in the south kind of twisting in the wind

trying to figure out what the policy is on any given day. And for consumers trying to navigate these situations, that is nearly impossible. So trying to understand if you are just a normal person interacting with our Public Health Corps healthcare system, what is recommended on any given day, right now the answer is, it depends on what is going on with any given federal lawsuit and that is not really good for public health.

And so, those vaccine policy shifts of which there have been more than we can probably count, has really made it hard for the work that we do and the work that state and local public health do all in the midst of massive measles outbreaks. When we really need to be reaching as many people with vaccines and education around vaccines as possible.

DR. TEKISHA DWAN EVERETTE:

Yes. Scott, and what I hear from you is the tumultuous nature of what is happening with vaccine policy is really having us move from a space where we are really relying on the evidence and science in terms of how vaccines help the collective manager health and the impact of that, to one in which I'm going to use this all the time, any given lawsuit. Where are we in the process of any given lawsuit at any given time which is not an effective way to promote public health and to advance health and safety among the population.

I'm going to shift to one more question around the present because one of the things I think we want to highlight today is the impact that federal action is having on state and local but also how advocacy can help in the context of what is going on.

So we have seen some effective advocacy, actually, help to stall or pause or eliminate some of the detrimental administrative actions or decisions that we have seen.

One example I can think of is thinking about congressional funding and ensuring that what Congress is supporting in terms of funding and public health and healthcare programs are actually still going on. I would love to hear from each of you.

How has advocacy played a role in your work over the last year? And think of this federal, state, local, whatever example comes to your mind around effective advocacy and its impact it has had in the work that you do. I will start with Darlene.

DARLENE HUANG BRIGGS:

Sure. You both already touched on it, advocacy through the courts. Public health specific app is the -- advocacy and advocacy for social justice, and of the data advocacy rights has been instrumental in installing complete disruption of public health.

All of the public health lawsuits to help protect federal public health staff, try to protect public health staff, all of the lawsuits around research grant cuts, and the clawback of public health infrastructure grant funds.

Maybe Scott will talk about the vaccine win that was huge. We know we are not out of the woods yet but the AAP decision is a big one. American Academy for pediatrics. Sort of undoing most of what the federal administration had done related to the advisory committee for immunizations.

And I think one thing I will note, I think it was in January, democracy forward, one of the organizations that has been bringing a lot of the lawsuits, they noted that the current administration has actually largely losing in court. Their loss rate fluctuates at any given time, but it is generally between 70 to 80%.

And so the courts really have served as an important fact stopped to protecting public health. Not necessarily entirely rolling back things yet, that will take some time and obviously we will be reeling from this experience for the next decade, maybe even longer.

But the courts have been important. I will also say that I have been really excited to see a much needed and renewed effort to prioritize legislative and regulatory advocacy in the executive branch among the public health field as well.

It's great to have a better balance of efforts across three different policymaking branches of government and I feel like our field has seen the light that advocacy is so important and part of everybody's jobs, knowing there are legal constraints for certain government employees and others as well.

But I think there's a real sense of we are all in this together and advocacy has to be part of everybody's job.

DR. TEKISHA DWAN EVERETTE:

Love that. Thank you. Doctor Ige?

DR. SIMBO IGE:

Yes. I will give the example of HIV. City pH, the big city gets about $40 million across, from federal funding for different HIV-related from CDC and HRSA and beyond for HIV related work. We support 10 counties over the City of Chicago and (indiscernible) counties and we have about 20,000 people living with HIV that depend on this funding for housing and for wraparound services including HIV treatment.

So, there has been several attempts to clawback that funding. And advocacy efforts, you know, HIV organizations, people living with HIV, elected official, congressional leaders, everybody coming together, I had an op-ed in the news with the director of the state and the county, everybody elevating how important it is that 40 years of progress cannot be jeopardized.

For every HIV case that we prevent it is about $40,000 in lifetime healthcare expenses. These are some wins that we are very happy about. You may also know that Chicago was one of four cities that is part of four states that were targeted in an attempt to claw back the public health infrastructure grant.

Again, this is about over $20 million in funding the supports critical infrastructure and data and staffing and disease response activities and mobile services, etc.

Large city, many different opportunities to support our communities. In Chicago. And these 4

states were targeted for clawing back that became a legal battle and we are pleased that we got a temporary restraining order and temporary injunction. This has been the cycle, the state of Illinois has more than maybe 30 different lawsuits because literally every day, every week there is a new attempt to clawback public health protections, etc.

And I will just share why these things are important. In Chicago, life expectancy for people of color was trailing behind other cities. We have been doing a lot of work and steadily, that has been increasing. To a point where we have begun to close the racial life expectancy gaps.

These are some of the reasons why we need to protect the work that we are doing, showing that when we invest in communities, when we invest in an equitable, culturally competent way, we can change some of these outcomes for HIV, for Mpox opioid overdose is, for violence reduction. Overdoses in Chicago were reduced by 37% in one year. Violence reduced by 22%, mortality related to these things, this is what public health does. This is why we need to protect this infrastructure but we are spending all that time now, writing letters, making noise, saying "Let us protect the good work that we have started!" These are some of the real-time impacts in big-city life.

DR. TEKISHA DWAN EVERETTE:

Thank you! Scott, bring us in. What is happening with you?

SCOTT THORPE:

A lot of our advocacy focuses in the state legislatures, most of them are wrapping up for this year which I'm very thankful for.

I think a lot of times when we talk about state and local government they honestly get overlooked. And there is a lot of policy action that has a lot of impact on what is going on and frankly, we spend a lot of time sharing data and educating lawmakers with what these issues look like in their communities.

I cannot tell you how many legislators I have talked to on both sides of the aisle who will say, all of the people who live in my community are vaccinated.

And I can share the data that that is definitely not true. And so I think helping them understand what the risks are of negative changes to vaccine requirements for schools and for day cares, doing things that limit access to care in various ways, doing things that hinder healthcare in rural communities or pull back support from rural communities.

Those are all things that have a real, tangible, calculator will impact. And especially for state and locals folks, I don't think they hear from advocates enough and so we spent a lot of time facilitating that in doing more to connect them to folks who work in public health who are seeing this stuff day today.

It is obviously really tangible in a state like South Carolina where we work where we have this really large measles outbreak. But I always like to remind people that if you look at the vaccination rate for the county as a whole for the NMR, it is actually pretty normal for the southeast. --MMR.

Definitely not an outlier. And so we are lucky we have not seen more of that yet. And that is something we really try to emphasize as we are talking to legislators about some of the bills that are popping up right now.

DR. TEKISHA DWAN EVERETTE:

Thank you to each of you for your responses. I hear a very common thread between what you are saying and it is whether we are thinking about advocacy from a legal advocacy perspective, federal legislative or a state and local legislative one.

The key notion is if we are not speaking up about what is happening and providing the data and information to those who are able to make policy decisions because policy is an intervention in public health, then we are risking the continuation of negative and poor outcomes, not just for certain populations. We know from an equity lens, there are certain populations who are facing inequities, structural inequities related to some of the healthcare outcomes were looking for but I want to go back to over each of you keep saying we went to the question, "The collective."

If we are not actually doing things well for the collective, this is an individual problem, it's a population problem. Thank you so much for your reflections. I want to move us into proximal times. Let's look at 2026 and what is going on for us right now. What resources are needed to ensure the public health challenges you are looking at, whether it's from a legal perspective or local public health or vaccines, what can we, what is needed to ensure that the public health challenges we are facing can be addressed in the communities?

And I'm going to start with Doctor Ige then go to Scott and then Darlene.

DR. SIMBO IGE:

I will give you a couple examples. Public health, we are interested in people living long and healthy lives.

So, if we start with, what is it that is leading to premature mortality in our communities that we can do something about? I would start with chronic diseases, especially heart related diseases.

In the city of Chicago, mortality from chronic diseases is the number one reason why people do not live to the age of 65.Heart disease. And part of that is access to healthy food and nutrition. Part of that is exercise opportunity available in communities. Part of that is auditory marketing of the tobacco industry and menthol tobacco, etc. Every single one of these have been targeted. Tobacco (indiscernible), food, access. So what we are saying is that increasingly, the workforce of the United States continues to be at risk of developing chronic diseases, so the burden on the healthcare system continues to increase and the economic impact of that continues to be felt.

We are spending more on healthcare than any other country, because we refuse to invest in preventative measures and the safety net that helps people who are struggling to access the protective factors that they need to stay healthy, they are unraveling.

And these are real-time impacts, so that is mortality. What keeps people going to the hospital and

taking away resources from even more severe illnesses, I will give an example. In Chicago alone, in one year, 21,000 hospitalizations for mental health related admissions.

Many of these admissions are repeated admissions. Which means if your emergency department beds are occupied by people with mental illness than those who have cancer and other diseases come you do not have space to accommodate those people and serve them and many of the issues are driven by economic pressures and other uncertainties in communities and lack of resources, so you have seen attempts to unravel mental health services, to unravel substance use disorder services, etc.

So these are real, real. For us, we are on the front lines, we deal with this every day. And we see the impact on the healthcare system, we see the impact on organizations and people wanting their staff to be productive and contribute to the economy. We see the impact of this on our schools.

So public health is really tangible. I will give a last example. Again, Chicago is a big city we have 17,000 food establishments. Imagine how many people you need to inspect those food establishments to prevent outbreaks of disease? If there is an outbreak of disease in Chicago, the tourist industry, the hospitality industry, all of those folks who are dependent on the success, like NASCAR and taste of Chicago where millions of people come in, all of them will be negatively impacted.

If we don't have the disease investigation specialists and the epidemiologists and the public health inspectors who ensure that infrastructure is secure and safe, it makes consequences for everybody, including the airport and all of those who relate on tourism. It is not just vaccines, it is that the very fabric of most economies come most cities, most municipalities, most civilizations depends on having a protective infrastructure that enables people to leave work, live, work and play a healthy environment and that is what we do. How do we make that visible? How do we make policymakers appreciate that and why is it important that laws are funding resources continue to protect that so we can all thrive?

So I think that is the task for us in 2026. How do we make our work livable, visible so that everybody understands that it is necessary for all of our collective you know, lives?

DR. TEKISHA DWAN EVERETTE:

Thank you. Scott?

SCOTT THORPE:

I think this feels particularly present in the South. Across a swath of states where we have not expended Medicaid but access to care is front and in particular rural access to care needs more money.

The number of hospitals we see closing, the number of labor and delivery units we see closing, the number of primary care providers you are retiring, it is not going to get better anytime soon.

And it needs more money across all of these states. That drives a lot of what we expect to be focused on this year. Both in terms of what is happening in the rural health transformation funds

and all of the states that we were again, -- work in, but there is also room for policy change within the agencies in all of these states as well so we have these sort of instances of administrative friction that we see with for example people struggling to enroll and stay on the Medicaid program.

And that is insurance and eventually payment for all of these healthcare providers who are struggling and sound there are also, I think, opportunities for us to work on certain agency level improvements do not necessarily need a bill to run through a state legislature. But the access is priority number one across so many areas in the South right now, as we see healthcare infrastructure just on the verge of collapse in a lot of places.

DR. TEKISHA DWAN EVERETTE:

OK, thank you. Darlene?

DARLENE HUANG BRIGGS:

Maybe not repeat what has already been said but thinking about resources that help get us to what you've all talked about. To get more funding and community impact, community power needs to be built.

That is what changes who is in office. And our ability to flex that advocacy skill and build better advocacy coalition across Doctor partnerships obviously with the reduction in funding, we will all have to be cognizant of meeting to work together and use limited resources more efficiently and more coordinated.

Getting to some of the administrative friction and figuring out how to do that work better. And I think that the center of all of that really is trust and how that resource is either built up or depleted based on how we interact with people, quite frankly.

I think about the golden rule of I brought up with, treat others how I would like to be treated. But I think there's also a really important piece of treating others how they want to be treated.

Which kind of requires people to pause and think about what are other people's needs and preferences and what am I doing that furthers that ordination is that? -- Or diminish is that? Those basic interactions impact levels of trust and ability to build community power and the advocacy that we need and to be efficient in delivering services and effective that then allows us to have the advocacy wins that we are looking for.

DR. TEKISHA DWAN EVERETTE:

That is awesome. A few things I'm hearing from you all. You have mentioned kind of access is key, you've mentioned partnerships are important, you mentioned the notions that trust is important, some going to pull on some of those themes and ask you first and foremost, how are you engaging community partners and or groups in your work that you're doing now? And particularly thinking about community partners or groups from a different sector, from a nontraditional public health sector to actually advance the public's health? I will start with Scott on this question and then go to Darlene and then Doctor Ige.

SCOTT THORPE:
I think for us, we rely rely heavily on local engagement around public health issues to drive how we approach either sort of traditional public health coordination work or advocacy work because I think when we talk about say statewide vaccination rates or countywide vaccination rates, on its face I do not think the data is all that useful to legislators.

But what I do think matters is when you can provide texture and a story that goes along with that data and really describe with your community partners, what is happening. And a good example of that is we do some work in (indiscernible) County Georgia which for folks who don't know is also where the CDC is headquartered.

And there are particularly low vaccination rates in sort of the south side. And if you sort of dig into what is going on there and start talking to community partners, this is not a political (indiscernible) it is not driven by the political moment, it is being written by a serious access issue. Families are struggling to find access to care, they are struggling to find pediatricians to see their kids, all of the social drivers that keep people from accessing the healthcare system are very much present. Issues around housing, transportation, issues around anything, you name it.

And we work with community partners to understand what is really going on there so that we can be better at our jobs and be better informed when we are explaining the situation to legislators because the situation is not about religious exemptions, it is not about what is happening politically around vaccines, it is completely separate issue and requires a completely separate solution.

And so, we have to keep those community partners really centered in our work because they know better than we do, almost always, what is happening at a really hyper local level. And so that drives a lot of how we even talk about this stuff.

DR. TEKISHA DWAN EVERETTE:

I could continue the conversation for an entire hour just on your response but I know I don't have the time. But I really want to lift up and applaud the point you made that what is proximal and important to community members is not tied to a specific administration, specific moment, a specific now, that there are systemic and historic issues they have been lifting up and have seen and that our job in public health is to actively work with them to build that narrative and find the response to those issues in tumultuous times but also in common and what we would call study times.

Sorry, Darlene, that I had to pop in there and say that but Darlene come up to you now.

DARLENE HUANG BRIGGS:

That was great because I want to refund that. -- riff on that. Engaging with Public Health Services, that is all of us and for different types of resources and issue areas, we have a harm reduction team who serves individuals, people who use drugs, organizations who are serving people who use drugs, institutions that support people who use drugs.

We are engaging with all of those folks and taking all of the lessons and conversations and lenses and threads we are hearing and putting them into our resources. They are forming the types of

resources we deliver to the field. And to users of public health services. I think one of the newer areas that we are really excited about is to work with more groups who are serving immigrant populations and families, mixed status families as well.

Trying to understand what concerns they have and how resources that we might create that are geared toward that particular audience are helpful to them as well as the public health field and for advocacy purposes as well.

DR. TEKISHA DWAN EVERETTE:

Right. Doctor Ige, before I turn to you for this question, I do want to remind our participants who are in the audience that your questions, we are looking forward to hearing and seeing your questions, you can offer your questions in the Q&A box, not the chat box. If you are having difficulty finding that, just hit the three dots to the lower right of your screen, you will see Q&A there, provide your questions. I can selfishly take all the time and ask all of my questions but we do want to make sure we are making this useful and impactful to the work that you do.

Doctor Ige, let's hear from you. How are you using and involving and engaging community partners and groups in the work that you're doing in Chicago?

DR. SIMBO IGE:

Thank you. We are using an all of community approach, especially the voices of those who, beyond those who have lived experiences. So it is important to elevate the voices of those with lived expenses and say, this is my impact. We are at a time where we are in a zero-sum mindset where people feel like if I am giving resources you are taking something away from you so engaging those who feel like something will be taken away from them if health coverage increases for instance, and making it visible and getting their voices and buying in and demonstrating how this is collective impact, that having services for those who need it the most also makes it easier for you to access the services that you need.

If emergency departments are overrun by measles, then your waiting time and all the other services that you need will be harder. And so when we have that collective outcry, it is more impactful and those are some of the strategies that we are elevating. This is not just a problem of communities of color, this is an all of Chicago problem. And when we are trying to engage elected officials, again, it is not just those who are blue. It is how to be eliminated these issues across party lines so people see everybody benefits from this?

So community organizations, faith-based organizations across the board bringing in other sectors, sometimes we are talking about public health or even the education sector and even the Health and Human Services sector because housing for us in big cities, people expensing homelessness are a priority population for us and that is the Health and Human Services sector writ large.

So just broadening the coalitions to more than just health based, broadening the voices to include those who have misgivings or are concerned that something will be taken away from them by supporting other communities, some of the strategies that we are using to elevate the need for investment in public health.

DR. TEKISHA DWAN EVERETTE:
Love that! Thank you. Before I ask my final frontier question about the future, I'm going to turn to Doctor Breanca Merritt who is our Director of policy to see if we have any questions in the Q&A to lift up to the panelists.

DR. BREANCA MERRITT:

Thank you Doctor Everette and thank you to our wonderful panelists for your participation and interesting insights about the past year. One question we have is a future facing question of let's say we have a new administration that wants to restore some of the programs and efforts that have been lost and they are wondering how look at my take to recover -- how long it might take to recover some of the programs and functions that are gone for that might be a very analytical question so if you cannot answer it in an numerical way maybe alternatively if you can give an example of a function in your work that has been lost and maybe what it might take to restore that in the future.

DR. SIMBO IGE:

I can start because we are doing that exercise. So I did mention we have been working on improving life expectancy in Chicago and that work started in 2010.

And we saw the life expectancy gap among Black Chicagoans and the rest of the country continued to widen over time from 9.4 years to 12.7 years. Before the pandemic. But if we start to look at it from the pandemic and the impact the pandemic had on premature mortality, it has taken since 2026, it has taken us six years to get back to pre-pandemic levels.

Six years of hard work trying to gain the lost ground during the pandemic. The pandemic not just impacted COVID related outcomes, it impacted prenatal care. We started as a result of the pandemic to see congenital syphilis to 500 times increase in congenital syphilis because people who were missing prenatal care because there was interruption in care.

It's five years now of trying to correct that. We are down by 50% but there is still work to do. We saw a doubling of sexually transmitted infections because people's access to prep was interrupted and gaining the last grounds and regaining all of that and getting people back to care has taken five years and we are still not where we were pre-pandemic.

Chronic disease and engagement in care and annual medical examinations, a number of people showing up for their appointment, these are the real-time impacts when we interrupt care.

So we rollback Medicaid rollback healthcare insurance, we start to see all kinds of things pop up in emergency rooms that are ambulatory care sensitive conditions. (audio issues) primary care level if people had health insurance but now they are showing up in emergency departments.

It takes at least five years to correct those things so it's not just that we have an administration and this is a temporary thing, it is that the impact of these policies and actions are far-reaching and takes a long time to correct.

I will give one last example of when we impact vaccination coverage and we have measles outbreak, we had a measles outbreak in Chicago in 2024. It was 54 cases.

The estimate of the cost of time that was necessary to address that was about $8 million. For every day that we were not able to mount a vaccination campaign, it would have increased the duration of the outbreak by a couple of weeks and for every day of delay.

So when we stifle vaccination and we cause confusion and it's not that people who were willing to get vaccinated before now say they are not going to get vaccinated. What happens is that they wait. They say "I'm going to wait and see what happens."

And that waiting builds a pool of susceptible people and the impact of that is not just monetary, it is in staff time and it's the last economic impact, especially in schools and the time lost there.

So these are not trivial things. These are real-time impacts, not just in lives impacted, in monetary terms, and the time it takes to correct these things. The expertise lost it CDC and NIH, it takes years to regain lost ground.

So we need everybody working together to address these things that advocate and elevate for policies that keep our country and our city safe.

SCOTT THORPE:

I have what I think is a fairly short and sweet answer to this which is I really, firmly believe that health departments deserve a lot more unrestricted funds.

We have, I think public health has a little bit of a poverty mindset around how we approach a lot of the problems that we have which is, how are we going to sort of cobble together the resources to solve whatever issues we have?

And that is not always particularly effective, sometimes counterproductive, and it is because we have all of these giant block grants that we are dependent on to make public health work. And if health departments have more flexibility to respond to the actual local needs that they have, they would make a lot of this a lot easier.

DR. BREANCA MERRITT:

We will wrap up with one about lessons learned from the challenges you will discuss. A vegan share anything adding to where you talking about Scott where existing policy fell short it be useful to see how we can use those lessons learned.

SCOTT THORPE:

Yeah, I think one of the important things for us all to remember is the issues around funding for public health did not start just in this administration. And certainly, predated at least in the states that we working in the South, really most of our states saw huge cuts during the great recession and the mid to late 2000's and never got those funds back.

And so I think restoring that funding and support has to be part of our path forward for effective public health in the future.

And that does not just come from the federal government, that is something we can advocate for the state governments. Your county governments are also likely putting funding into, even in systems that are centralized or putting funding into your local health departments, they can put more.

And frankly, county commissioners or county counselors probably have not heard much from folks about how much money they are putting into public health.

So it is certainly something to start pestering them about.

DR. TEKISHA DWAN EVERETTE:

Thank you, Scott. I'm going to ask Darlene, do you have one final word to add to the conversation before I close us out? Because we asked two questions and I think you might have something more to say on one or the other.

DARLENE HUANG BRIGGS:

It is just building on this point of de-siloing the funding and that is the work. Government and public health and particularly is piecing together a lot of different things and is really restricted on delivering in certain areas.

And there was so much progress made from the covert funds and public health and the structure grant funds and still being made with those funds.

There's also frameworks that the public health system adheres to, 10 essential of public health services, government services for public health, those are really great frameworks to help folks prioritize what types of infrastructure and services need to be funded to help demonstrate a particular use for unrestricted funds as well.

And I think there's really great examples from states that have been working really intentionally over the last decade plus to shift the way that the public health system is funded from largely federal to state and county funds.

And I think we can really learn from all of those states with what they are doing and how they are measuring how much funding a state public health system actually needs. And demonstrating progress over years or stalled progress that helps decision-makers just understand the impact of their decisions.

DR. TEKISHA DWAN EVERETTE:

Thank you so much! Darlene, Doctor Ige and Scott, for being an amazing panel today. Thank you to all of our attendees for your questions. We stated that our progress over the course of this year as well as what we are doing on this webinar is thinking about the past, impact on the present and thinking about our future ahead.

And when I listen to all of the panelists today what I hear about the future of public health is that we

need to be able to have a more resilient, durable public health system that is responsive to the needs of the people working in conjunction with the community to create changes and opportunities we want to see for our collective health and making sure that advocacy, diverse and necessary and unrestricted funding and enough funding and infrastructure support is what the public health field needs in order to rebuild and continue to build trust with the community and to serve it in its best capacity.

I want to appreciate and thank you all for the work that you do every day, it is difficult, tough and enduring work. But I hope that you get all of the support you need from people in your community that you look to us as a partner for your work.

As we are nearing the end of our panel today, I want to thank our panelists again, thank a AI-Media caption services, Keystone interpreting and are behind-the-scenes staff at each of you who participated today. We clearly did not have enough time, we could have gone on for hours and hours, we hope that you found this informative and impactful and understanding how the federal changes that are happening actually have a real impact at the state and local level and of course, in our everyday legal advocacy and system.

Please join us as we continue these conversations in our next webinar, happening on May 12 at 2 PM entitled Building Bridges: Not Barriers, Advancing Health Equity in a Shifting Landscape. Thank you again. When this concludes we will have the recording available on TFAH.org as well as our slides. Things again for joining us, and have an amazing rest of your day and week ahead.