NAVIGATING FEDERAL UNCERTAINTY FROM THE FRONT LINES
A CONVERSATION WITH MICHELLE TAYLOR, M.D., DR.P.H., M.P.A.

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Q: Could you start by describing the Baltimore City Health Department—its mission, priorities, and the degree to which federal funding supports your ability to carry out that work?

The Baltimore City Health Department is a larger local health department, with 700-plus employees across administration and four divisions: Youth Wellness and Community Health, Population Health, Public Behavioral Health, and Aging. The mission is to protect health, eliminate disparities, and enhance the well-being of everyone in our community through education, coordination, advocacy, and direct service delivery. Our vision is an equitable, just, and well Baltimore, where everyone has the opportunity to be healthy and to thrive.

We rely heavily on federal funding, with about 38 percent of our $200 million budget coming from federal grants or federal pass-through funding from the state health department. Much of this funding supports core services and public health infrastructure. Historically, the federal government has consistently funded bread-and-butter public health, as well as innovative new projects. That is the role of the federal government: to support essential services, as well as invest in projects that may not reap rewards for 10 to 15 years but will have significant benefits when they do.

The federal funding that the Baltimore City Health Department receives is concentrated in specific areas of work, and that's not uncommon for local health departments. For example, in FY 2026, $91.5 million was allocated to services for older adults in Baltimore City. Of that amount, a little over $86 million came from federal funds. Because federal funding isn't evenly distributed across areas in the health department, we are heavily dependent on it in some areas but less dependent in others.

Q: Before the changes that began in early 2025, how would you describe the Baltimore City Health Department's relationship with CDC and the broader federal public health infrastructure? What did that partnership make possible that Baltimore could not readily replicate on its own?

The Baltimore City Health Department's relationship with CDC in early 2025 and before was strong, as it was for many local health departments. We hosted CDC Masters Fellows and Prevention Health Fellows, which was invaluable. They did tremendous work in adolescent and reproductive health, preventing substance-exposed pregnancy, and improving health literacy. We've seen major successes here with Baltimore City's Ryan White program as a result of our partnerships with CDC. The program has always been a leader in innovation and practice across the state, and Baltimore was one of the early pioneers in harm reduction, mainly because of skyrocketing HIV rates decades ago. Baltimore now has a new HIV infection rate commensurate with the state of Maryland, and many of those living with HIV are older adults who have stayed connected to treatment. We continue to receive and utilize funds from the Public Health Infrastructure Grant to revitalize our workforce, expand educational opportunities, provide training, and update our systems. The funds have been

transformative, and that has been the case both here in Baltimore City and in my previous role in Shelby County, Tennessee.

Normally in public health, if we knew a cut was coming, we would have six months to a year to prepare for that cut. We would be informed super early. We would have time to cross-train our workforce. We would have time to find other positions for people and to prepare the community for cuts that were coming. In this new environment, we get notice to change our work plan, or else. The funding is cut, and you're scrambling to figure out: Can I keep the workforce on the payroll that was funded by this program? Can I keep these services going without these funds? It's chaotic, and it makes the work a lot harder. When we're not sure where our funding will come from in the next three to five years, it means we cannot plan for future expansion of services. It means that our attention is split. Instead of focusing solely on the health of our residents, we must also prepare for overnight losses of funding. We're having to become much more efficient in the way we do business while also holding our collective breath to see what the next shock to the system might be.

Q: Federal funding that supports Baltimore's public health work reaches your department both through direct federal grants and through the Maryland Department of Health. Much of your work also depends on partnerships with community-based organizations, health care providers, schools, shelters, and other local entities. When federal funding, guidance, technical support, or grant administration becomes uncertain upstream, how does that affect the Baltimore City Health Department and the partners who depend on it as a funder, convener, and source of public health expertise?

One thing about community partnerships that we rely on is the trust that we've built over the years. Community partnerships can be dicey at times because sometimes we go for the same funding. But in Baltimore City, I have been impressed by the level of partnership and the understanding that everybody's resources are required to do this work. Organizations ask the health department to help with applications or to be partners.

We are still working to act as a primary convener because the way that we get through this time is together. While we're looked at as a source of public health expertise, our ability to fund ongoing work is diminished. And our partners know that. Because of the loss of teen pregnancy prevention funding, city schools will not receive an education program that they thought they would have for another two years. The Baltimore City Health Department continues to convene local hospitals, opioid-associated disease prevention and outreach programs, and federally qualified health centers to ensure that we are working collaboratively to make the best use of our funding and improve the health of our public. We know that we continue to act as a convener, but it's not just us as a local health department. Everybody in the system is feeling this and realizing that we have to be honest brokers and partners with each other to get this work done.

Our residents have felt the impact of this changing funding landscape. They know that they may not continue to receive the types of services they've come to expect from the health department. They hear about it on the news. Ultimately, this makes it even more difficult to gain the trust of residents who may be in vulnerable situations or have historically struggled to access services. The last thing you want to do is start something in a community—or have something that's been in a community for years—and then have to abruptly cut it off.

Q: One theme we are exploring is that appropriated funding levels alone do not fully capture whether public health agencies have the capacity to function effectively. Does that resonate with your experience at the local level? What has changed for your department that may not be visible in the grant award amounts?

Public health has been consistently underfunded over the years. We are asked to accomplish more with less

and have been asked to do that for decades. The creation of Public Health Infrastructure Grant funds was one of the first times public health was given flexible dollars to do the type of work we needed to do, at a scale that allowed us to operate at the level we needed. Now, the question is whether we can function effectively with much less funding than we have traditionally had. Funding may appear in the budget line, but everybody who leads a local or state health department, along with all their staff, understands that in the current environment, just because it's on a line in a funding document doesn't mean it's going to stay there. We've had some very honest conversations with our staff about that.

We're trying to figure out how to effectively, safely, and responsibly use AI and data to automate certain activities that may not require as much funding but will help us continue to get the work done. We're learning from the lessons of COVID, including good and not-so-good examples of communication, to let people know that we're not perfect, but that the public health message and the advocates who carry that message are important. The messengers may change based on who the population is. We're also looking at aging populations and systems. What does it mean that our population in the United States is older than it's ever been? We have to know how to reach older adults to make sure that they have a good quality of life, and if we reach them intergenerationally, we're reaching those younger generations as well. Those are challenges that we are facing, but they also present unique opportunities to do things a bit differently, a bit more efficiently, and to really turn the chaos that we're seeing in the system on its head.

Q: Baltimore has made progress in reducing overdose deaths, even as overdose mortality remains a serious public health crisis for the city. You have also identified overdose prevention as a major priority. How does federal public health support help make that work possible, and what has this period of federal change and uncertainty meant for those efforts specifically?

Most of the Baltimore City Health Department's funding for the overdose crisis response is from the city's Opioid Restitution Fund under the mayor's office. This is a fund that was established using settlement dollars from litigation regarding the involvement of pharmaceutical companies in the opioid crisis. The mayor issued an executive order requiring a strategic plan and a two-year needs assessment. This funding from the mayor's office has been essential in supporting our work to address overdose mortality in Baltimore City, including a new division of public behavioral health within the health department. We ask ourselves what program sustainability looks like and how federal uncertainty may impact long-term planning. It's encouraging that, no matter what the uncertainty is on the federal side, Baltimore City has these settlement funds and has decided to use them responsibly and to respond to community voice, both in real time and over the long term. We have a Restitution Advisory Board of residents with lived experience with substance use disorder or who work in that space, and they are informing the rules for this next set of RFPs. That does not happen everywhere. I really do believe that we're going to continue to see significant reductions in overdose mortality and a healthier community in the long term because people are making smart fiscal decisions with community voice at the top of the list.

Q: Beyond the dollar amounts in grant awards, federal health agencies provide technical assistance, scientific guidance, laboratory support, data infrastructure, and subject matter expertise that local health departments rely on to do their work. Have you experienced changes in that dimension of the partnership? What does it look like when a familiar federal contact or source of expertise is no longer available?

We have traditionally depended on the federal government for lab support, for subject matter expertise, and for leadership on national public health issues, such as air quality emergencies, cyclosporiasis

messaging, and childhood vaccines. Recently, insufficient federal leadership has required state and local agencies to assume greater responsibility within their own jurisdictions. While we are capable of this, I can say from both a military and local perspective that the lack of leadership complicates coordinated responses, an area where federal leadership is most effective. Organizations such as the Northeastern Public Health Collaborative have strengthened connections among states and cities nationwide to address major public health issues and share information on changes in national funding.

When the federal government started layoffs, the CDC COVID disparities grant project officer changed several times. Our staff would email the project officer they thought they were working with, get no answer, and then eventually hear that someone else was the officer. It made it more challenging to close out our grants. Technical assistance and guidance on fulfilling requirements for federal grants may change mid-funding cycle. It's gotten to the point where, no matter which public health partner I'm talking to, if one entity gets an email that says we have five days to do something, we're all emailing one another, saying, "I got this. Did you get it? Check Grant Solutions, check your other websites, make sure that you didn't get the same letter." We're partnering to try to manage the chaos.

Q: Through your role as Board Chair of the Big Cities Health Coalition and your connections across the local public health community, are there patterns you are seeing in how this period has played out for urban health departments across the country? Are local agencies experiencing similar challenges even when the details differ from place to place?

A lot of local agencies have networks, and those networks existed before the type of chaos that we've seen for the last year and a half. We are really leaning on each other to make sure that everybody has the same information. A good example would be with hantavirus. Through our regional contacts, we were notified that there was a chance some passengers might have to come to this region because of where we sit geographically. Everybody in this region, from a public health or health system standpoint, was on calls together to make sure that if any passengers had to be brought here, everybody was aware and prepared to push out messages to the public. We were prepared regionally because we were communicating. Our federal partners have done as much as they can to help, while making sure that they can give us as much information as they're allowed to give.

These agencies—federal, state, and local—have been coordinating for years. When our federal partners aren't saying something that we would be accustomed to getting in their messaging, that's a message too. It tells us at the state and local level that since they're not answering this question in the way we would normally expect, let's get together and figure out what else we would normally do in this situation. It really is about filling in some of those coordination gaps. Is this something we should have to do? No. It puts everybody in danger from a health standpoint. But what I can tell you is that coordination is still happening because you have a lot of dedicated people who want to make sure that we are minimizing threats in the way we have been trained to do and in the way we have been accustomed to minimizing them throughout the years.

Q: The President's FY 2027 budget proposes significant reductions to CDC and other federal public health programs. What would those cuts mean in practice—for your department, for the communities you serve in Baltimore, and for local public health agencies across the country?

You may not see the changes right away, and everything will look the same at first. But we're already asking ourselves: Can we do the same amount of work with less? Will we have to cut positions or potentially leave vacancies unfilled? Will we hold back from applying for new projects because we're so focused on maintaining services? Based on the kind of cuts being proposed, we will have to be vigilant for increased rates of STDs and STIs, which we're already seeing.

We've seen a 246 percent increase in babies born with congenital syphilis because they were infected while they were being carried by their mothers. We will see an increased need for support among vulnerable pregnant people, higher rates of teen pregnancy, greater challenges in vaccination, increases in suicide or depression among LGBTQ+ community members, poor outbreak tracking in general, and more emergency room visits among those who are uninsured or underinsured, especially those who may be undocumented or no longer able to access insurance due to changes in Medicaid.

While public health agencies across the nation will try to stem the tide, changes at the federal level will undercut the public's health for decades to come. This is not hyperbole. The changes being proposed to Medicaid alone are going to be devastating to population health and to our health systems, which will be charged with dealing with more people showing up in emergency departments because they don't have adequate coverage or coverage at all. And some of those changes have already been passed. Starting October 1, H.R. 1 will restrict Medicaid coverage for some noncitizens, including many refugees and asylees. Then, starting January 1, new work-related requirements will take effect for some adults who rely on Medicaid. So yes, things are happening in the background to try to mitigate that, but we are going to feel the stress of that soon.

Q: What would you most want members of Congress—and the public—to understand about what federal public health investment makes possible at the local level, and what is genuinely at risk right now?

In 2009, Baltimore City had one of the worst rates of infant mortality in the country: 13.5 infant deaths per 1,000 live births. Black babies were five times more likely to die than white babies. The city came together and took a public health approach to address this issue. By 2021, Baltimore City had achieved the lowest infant mortality rate in the city's history: 7.5 infant deaths per 1,000 live births. Now, Baltimore City travels the nation educating other jurisdictions about how they can do the same. We host graduation parties for the babies and parents who complete our programs. These parents may not have been with us without public health intervention and public health funding. Better yet, think about the classrooms of kindergartners we would never have seen if infant mortality rates had remained at their 2009 levels.

In 2008, Baltimore City had a new HIV diagnosis rate more than three times higher than the state average. The Baltimore City Health Department introduced an innovative idea for the time—a syringe service program to reduce unintentional infection and increase education. And now Baltimore City's new HIV diagnosis rates are commensurate with the state. We've been able to watch a disease that killed thousands become a chronic illness for our residents living with HIV.

And that's what we stand to lose. Sometimes people say, "That's Baltimore City, but it's happening in other places." No. I led a local health department in a city where the investment levels were not the same. When I left Shelby County, Tennessee, the county and the surrounding area for our Grant Area were number two in the nation for new HIV infections in 2023. You can track, by jurisdiction, the level of investment—local, state, federal—and what these different jurisdictions have been able to do based on that investment. People will say, "Oh, it's choice, it's culture." Sure. But that investment in true evidence-based public health is palpable, and the evidence is there every single day.

Q: Is there anything else you'd like to add?

Public health has done hard things before. This is not new. I can imagine the folks in the 19th century dealing with yellow fever. Those public health professionals, whether they were calling themselves that or not at the time, were trying to figure out just how to keep so many people from dying from these epidemics. We figured it out. We will get through this challenging period. And I really do believe that we will be better on the other side because we will know what needs to be rebuilt and how to rebuild it better.

This interview was conducted in July 2026 and has been lightly edited for length and clarity.