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BUSPH Public Health Conversation:
The Future of Public Health in Boston
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>> ADNAN HYDER: Greetings, everybody. Welcome. I'm so happy to welcome you all to this first public health conversation of 2026. My name is Adnan Hyder. I currently serve as the Dean of the Boston University School of Public Health and I am honored to initiate these series of public health conversations.

Let me begin first with an apology. We are deeply sorry for this delay of about 19 minutes or so. We had a technical glitch in the Boston University IT system based on the recent weather conditions and just got them sorted out. So, we are very sorry that we are beginning late. But we will ensure we still end on time. And we, of course, apologize not only to all of you as participants, but also our amazing panelists as well.

Now, this public health conversation, which is an annual tradition of the Boston University School of Public Health, is very special, because 2026 is our 50th anniversary. We are celebrating 50 years of our contributions to research, education, and service of public health.

And what better way to start than to think about the city where we are located, the city of Boston. And so today's public health conversation is framed as the future of public health in Boston. And I am so privileged and delighted to welcome the three panelists that we have for you today, amazing leaders who come from different perspectives and experiences and will inform this conversation.

I'm also delighted to welcome my colleague, Dr. Craig Andrade. Craig is the Associate Dean for Practice and also Director of our Activist Lab here at Boston University School of Public Health. He has many, many years under his belt, came to the academy and is leading our work in the policy and practice domain.

I am very honored both that Craig will moderate, and I want to thank in advance all our panelists for being here today. Thank you for joining us. And, Craig, I'm going to hand over to you right now.

>> CRAIG ANDRADE: Thank you, Dean Hyder, for that introduction and thanks to all of you for joining us here today. Now we will have the privilege of introducing today's speakers.

First we will hear from Bisola Ojikutu. Dr. Ojikutu is the Commissioner of Public Health and Executive Director of the Boston Public Health Commission. As the Commissioner of Public Health for the City of Boston and Executive Director of the Boston Public Health Commission, Dr. Ojikutu is a key advisor to Boston's Mayor on health issues and builds innovative partnerships across city departments and within Boston's communities to positively impact the health of all city residents. Among other public health priorities, she is committed to advancing health equity and addressing racism as a public health crisis.

Next we will turn to Carlene Pavlos. Carlene Pavlos is the Executive Director of the Massachusetts Public Health Alliance. As Executive Director, Carlene leads MPHA in achieving their mission to promote health equity and racial justice. The two primary commitments that guide their work include dismantling structural racism and listening to the voices of those most impacted by the health inequities in developing their priorities. MPHA is a catalyst for community-driven policy change that fosters conditions for people to achieve their full health potential where they live, work, and play.

And then, finally, we will hear from Elsie Taveras. Dr. Taveras is an Inaugural Chief Community Health and Health Equity Officer at Mass General Brigham and Executive Director of the Kraft Center for Community Health at Massachusetts General Hospital.

She leads systemwide strategies to improve health equity and the health of the communities served by Mass General Brigham. She is a pediatrician at Massachusetts General Hospital, the Conrad Taff Professor of Pediatrics in the field of nutrition at Harvard Medical School, and a professor in the Department of Nutrition at Harvard T.H. Chan School of Public Health.

As a reminder for our audience, following the individual presentations, we will turn to a moderated group discussion. When we have about 20 minutes left in the program, I will turn to audience questions. Please submit your questions using the Zoom's Q&A function located in the bottom middle of your screen.

And with that, Dr. Ojikutu, I will turn it over to you.

>> BISOLA OJIKUTU: Hey. Great. Good afternoon, everyone. And I'm truly honored to be here with you today. And thank you to the organizers of this event for that warm welcome. Thank you Dean Hyder and Craig for all that you have done in terms of public health here in Boston.

So, I'm going to share my slides, but what I am going to do is assure you that contrary to what you may expect me to say, given the current federal contacts, the future of public health in Boston is bright, and for those of you who are students or junior faculty, I want to emphasize that in the midst of all crises, there's always opportunity.

For some reason, I'm unable to -- hmm. Okay. Well, we are going to figure this out. Hmm.

Okay. Can everyone see my slides? Okay. All right.

So, what are we doing now at BPHC to ensure that the future of public health is bright in Boston? Well, here I just listed what I think is the path that we are following. We are certainly continuing to center health equity in all of our efforts. We are shifting power to communities, and by that I mean that, basically, we are focusing in on what authentic community engagement actually looks like, and we are collaborating and collectively investing with stakeholders because oftentimes people say even though we are research rich we don't collaborate here in Boston so we are focusing in on collaboration and working collectively and in partnership.

And we are becoming more efficient and more business oriented in terms of our work in public health. And our overarching goal is to close our life expectancy gap. Many of heard what has been happening in Boston and has been a persistent and pervasive gap that has been here in Boston for many years and I will tell you more about that. Our goal is to actually close that life expectancy gap.

So I mentioned what's happening on the federal level. I think everyone is aware of this. But I think it's also good to just say it and name the problem in the last 401 days and some people say who is counting? Well, I am. There has been a significant C change in regards to -- in regards to public health, and particularly federal public health, but really that's trickled down into what's happening at the state and local levels throughout our country.

And by that, I mean there's been profound transformation. There's been contracture with lots of job loss on multiple levels, there's been termination of funding, there's been uncertainty regarding future funding. Certainly we are all aware of the anti vacs sentiment and the antiscience approach to how decisions are being made. There's been withdrawal from the global health ecosystem which has fundamentally changed how the U.S. is viewed globally.

And certainly we are all holding our breath for what's happening in terms of federal cuts, in terms of particularly Medicaid.

I think it's important for us, particularly where I started in terms of health equity to think about how we are thinking about DEI as well as health equity and the ban on language and scrubbing of websites. We hear in Boston are not doing that. But it's important to say that that is part of what we are seeing on the federal landscape.

And, of course, I think we have all been dismayed about what we have seen in terms of violence and, you know, the harsh treatment of folks who are, you know, supporting our immigrant neighbors, and what we have seen both in Minneapolis as well as Maine has been very distressing.

And then I will also mention a lot of what we are seeing just right here in Boston, there's been a shift from what we would say our public health oriented models to really treatment first and public safety oriented models in regards to how we look at addiction as well as mental health disorder. So all of this has caused a lot of dismay.

But I think that what keeps us centered here in Boston is really equity, which is at the center of what we should be doing in terms of public health. So, many of you probably remember the 10 essential public health services. This was a diagram that I think really started to guide public health back in 2020. It was established by the Beaumont Foundation and what we now call FAB, or the Public Health Accreditation Board, but it's still in the CDC's website. It's still there. It hasn't been removed. And you see equity is at the center of everything that we do in public health whether it be the governmental level or in academia or other sectors.

And so here in Boston, how we are looking at advancing health equity is really focusing in on what I would say is our north star. And our north star is life expectancy. It's lowering had prematurity mortality, increasing life expectancy and ensuring everyone has the best opportunity at overall health throughout our city.

Life expectancy as many of you all know is one of the most highly cited measures used to assess and compare overall health

at the city, county, state and country level and not only says a lot about what we care about but it also says a lot of what we don't and what we don't care about. Most of you all know probably in 2012 there was a 33-year life expectancy gap that was noted between Roxbury and Back Bay here in our city. I think a lot of people saw this and were very much dismayed about this and there was a lot of activity and interventions that were implemented following the announcement of this particular gap, life expectancy gap.

Most of that involved the healthcare system, and I think that probably is part of the problem. But it really didn't necessarily create structural change. And it didn't look beyond what was happening within the four walls of the healthcare system. It really focused in on what was happening at clinics and in hospitals as opposed to what's happening in the community.

What we know now from updated data released by the Boston public health commission is we still have a stark gap. 23 years between that same small area in Roxbury and Back Bay. Interestingly we have gaps around our city, areas of relative disadvantage. So, it's not just Roxbury. We have a 20-year gap between small area Dorchester and Back Bay and we have an 18-year gap between Mattapan and Back Bay, so this is not just about Roxbury. This is about the challenges, the issues that we face, chronic disinvestments, chronic structural racism, chronic issues of systemic inequalities that have occurred throughout time and this is certainly not just Boston. This is across our country.

What do we see what we look at race? What we see is this data which I'm going to run through for you. This data was embargoed, we are having a press conference on Friday where we are going to be talking about what we are going to do about this. But we talked about places, now we are talking about race. So, who has the highest life expectancy, that's the general Asian population, certainly there are disparities within that population but generally we are talking about Asians. Next Latinx individuals and next white individuals. And then black individuals actually have the lowest life expectancy of all people by race and ethnicity in Boston.

When you look amongst black individuals what you see is black women have a life expectancy that's also low, it's lower than other women so 81 years of age. But black men actually have the lowest life expectancy of all individuals in Boston. And interestingly, as you probably know, we aren't able to capture indigenous populations because if you look nationally indigenous populations do have the lowest life expectancy.

So, this is certainly concerning but what's also concerning is when you look at the gap between black residents and other Boston residents, meaning all the other races and ethnicities and you see over time and we have been looking very intensely at this work, what we see is that that gap has actually doubled over time. So it was 3.3 years in 2013, 2014, and now it's about seven years. And seven years is significant. And it's actually larger gap than we have seen, and when I talk to my colleagues and we have been sharing data in New York City and Chicago.

So, very concerning. When we think about the future, because that's what the title of this program is about, what happens if we don't do anything differently? What will happen in terms of this gap? What will happen in terms of health equity? And what we see is very little will happen. We will continue to have some steady improvements and it's not to say that things haven't improved here in Boston but we are not going to see a closure of that gap unless we think creatively, innovatively about how it is that we address health and wellness throughout our city.

So, what we will continue to see 10 years from now is a seven-year gap.

So, I think your next question would be, so what are black people, particularly dying of? So, if you look at premature morality across our city, the top three causes, unintentional drug overdose, screenable cancers, and cardio metabolic disease and if you think about black men, number four is homicide and that's even in the setting of decreased rates of homicides across our city. This is what's on the death certificate and these are our immediate issues and immediate areas of concern and intervention.

But I think as public health practitioners, we always have to ask ourselves, what's the root cause here? It's not these issues. What are the real drivers of health inequities? What are the real drivers of premature mortality in our city? And it's the same as anywhere else. Deficits in social and structural determinants of health. So, you see them here. I think we are all familiar with graphics such as this.

And I think we all know that this is the nature of our country, it's the nature of differences between populations in our country, and if you take it further, you really can't make changes in these Sommer determinants of health unless you recognize that these deficits don't just manifest randomly. They are born of systems and institutions and structures of power that produce and reproduce what we say are intergenerational inequities and people's opportunities and people's opportunities are that's what really leads you to

having a high quality of life and a long life expectancy because that is the ability to realize safe, security, prosperous and in a healthy life and those include structural violence and structural racism.

I don't necessarily think that I'm saying anything that anyone doesn't know but I think it's important for us to understand exactly what we are looking at and what the problem is because that's where we start to design solutions.

So, in 2024, we issued a report called Live Long and Well. This is our city's population health equity agenda. I believe it was signed on by the other -- our other two panelists who I am happy to be here with. This is more than just an agenda. It's really our city's commitment to closing the life expectancy gap and we hope to close that by 2035.

How do you do that? You lead with data. I know I went through that very quickly because we don't have that much time this afternoon. But we start there because that's going to lead us to where the problem is.

We establish and strengthen our partnerships. As I said, lots of resources, we don't always work together. So, we need to strengthen our partnerships.

We need to share decision-making power, at least share decision-making power with communities, really shift, but share as a starting place and I think that's part of what we do already. We have to authentically do that. Focusing in on upstream and social determinants of health, yes, that's what I just said, with he have to think about root causes, we have to think about filling those deficits.

Supporting place-based strategies. If we know where the problems are, go where the problems are. We don't have to spread out all over the place. Let's go to where the problems are and target our efforts and we need to invest collaboratively.

In our city, we have I think some very progressive ways of thinking about things. We have a reparations task force and I'm mentioning this because part of this addressing these root cause issues is understanding our history and whether you agree with reparations or not, it's about understanding hard truths. It's about realizing as our country marks our 250 years we need to confront those truths and there are things to celebrate but there are also things that haven't been resolved and I think that's the purpose of this reparations task force. There will be a report, hopefully, it will be issued this year.

We also have a transformational community engagement plan and we, actually, have a policy at the Boston public health commission. We engage with people in a certain way and that is for it to be transformational, not transactional. It is to be

sort of a situation whereas I said we are shifting power not necessarily, you know, leading. We are getting out of the way in many cases that I oftentimes point to myself. I don't need to be the person leading people with true lived experience in Boston in the neighborhoods of concern need to be leading the way.

So, that's our toolkit. It is available online.

And I think we always come back to this. In July or excuse me June of 2020, the city declared racism a public health crisis. And at the time this logo was made it says racism is a public health crisis. Racism remains a public health crisis and we haven't gotten past that irrespective of what we don't talk about from a federal level, irrespective of what we don't fund anymore from a federal level. It remains a public health crisis and we have to do things like Live Long and Well, like the reparations task force, like the transactional community plan if we ever want to heal, close gaps, if he ever want to be the city that we really do want to be.

Lastly because I know there are a number of students out there and I get a lot of questions about, so what can I do? I think that there are a number of things that you can do. Number one, preparing for future roles in public health. What you are doing right now as students or as junior faculty is incredibly important. I particularly want to advocate for continuing to prepare for governmental public health roles. If you think about where the issues are, when you think about what's happening from this sort of threat to public health, the policies, making the infrastructure, funding the infrastructure, that's governmental public health and that's not to say that other aspects of public health are not important. I'm certainly in those other aspects and have spent most of my career in those other areas, those other sectors but think about what it is that you could do in governmental public health. Be an advocate, mobilize, be civically active. That's of course important. Increasing your own structural compensate, understanding people's lives, partnering with communities. These are key aspects, key things that you can do now.

And I have interacted with some students and there has been a sense of, well, maybe I don't need to go into public health or stay in public health. I think in the midst as I said in the midst of crisis, there's also opportunity. You need to stay and fight for the future of public health.

So, I'm going to end there. And I know I went through that very quickly. But I do, you know, hope that you got something out of that and I'm hoping that we can have a good discussion.

>> CRAIG ANDRADE: Thank you, Dr. Ojikutu. Fascinating. We could go on forever with that and I look forward to the questions coming with that.

Next we move on to Carlene Pavlos.

>> CARLENE PAVLOS: Hi, everyone. It's so great to be here with Dr. Ojikutu and Dr. Taveras, who you will be hearing from in a minute and, of course, the incomparable Craig Andrade, Dean. It's really wonderful to be with you all here today.

And I am going to start sharing my slides very quickly. I am hoping that folks can see those now. Let me check the chat and see. Great. It looks like you can.

I am again, Carlene Pavlos, from the Massachusetts Public Health Alliance and I am going to be talking largely from the work that we do at a statewide level but I should acknowledge at the beginning that I live in Boston. And so the future of public health in Boston really is my future. So I think about this with all due seriousness. I won't be around in 50 years. That would be pretty unlikely. Given how old I am now. But I see that event horizon and sessional people that I love, young people that I love are going to be here in Boston. So, this is the future that matters a lot to me.

These are the two questions that presenters were asked to reflect on: What do you hope public health in Boston will look like 50 years from now and what actions we can take, real action that we can take in local communities to achieve that vision. And I love these two questions. Hope and action are two things that I frame a lot of my public health work around. And I very first have to think about the vision that MPHA has and you are by the way, you are going to hear a lot of similar themes to what Dr. Ojikutu talked about and there's a lot of shared vision amongst people in Boston who people in public health so it's probably not surprising that the vision that the Massachusetts public health alliance holds is a Massachusetts or Boston that is healthy, equitable and just where communities thrive and where racism, poverty and zip code don't determine our health or lifespan. Where all that data that Dr. Ojikutu was just presenting is not the data that drives those health outcomes.

And to do that, the tacks that the mass public health alliance takes is to be a catalyst for community-driven policy change. Dr. Ojikutu talked about the importance of systems, institutions and structures. That's the level at which MPHA works, but we do that in community where community drives those policy change that foster conditions for people to really achieve their full health potential. And we very explicitly in our mission talk about the need to dismantle structural racism and other forms of health inequities because those are the root causes of the inequitable social determinants of health.

So, I think a lot of us are familiar with and they love this quote from Dr. King, the arc of history is long but it bends towards justice. So 50 years is a long way out. But the arc is bending towards justice. And if that is the case, it does give us hope that that vision, that that MPHA vision of health equitable just, that's going to come to be. But let's get real. We face enormous challenges. These are my top enormous challenges, but Dr. Ojikutu had others as well. Did other people just lose my slides? There. They are back.

Climate collapse. I think calling it climate change at this moment is a little bit like a code. It's really climate collapse and we are feeling already quite alarmingly the impacts of that on our health. We have a housing crisis that may be -- may shape differently over the next 50 years but it is certainly impacting health outcomes for people here now and forms of springboard for what it's going to look like over the next 50 years. Food access, spiraling healthcare costs, a number one concern when people with asked about their economic insecurity, the healthcare costs is the number one concern people raise.

There's a loss of public trust in public health or in some cases there is a continued lack of trust in public health. And some of that is manufactured right now by misinformation, of course. But there is also an undeniable history of public health being untrustworthy, it's a both/and. And at MPHA we really try to think about that reality.

We have a federal administration that is bent on intentionally deepening inequities, sewing fear and chaos, attacking ourselves, if we are immigrants, certainly our friends and families, neighbors, it is antiscience, it goes on and on. They are reducing funding for basic public goods, whether that's health, education, transportation, food, of course, public health as we already heard. The list goes on about the public goods that are being defunded.

At the same time this administration is clearly intent on accumulating their own power. And wealth as a proxy of that power and as an instrument of that power.

So, yes, the future, there is a possible future for justice. But it's possible, it is not inevitable. And the space between what we hope for and those challenges can only be filled by action.

What's more, that action is only going to be effective if it's collective, if it's done in partnership, if it builds community power. Because power is a social determinant of health, right? Certainly housing is a social determinant. Violence is Dr. Ojikutu was talking about, all social determinants of health, certainly so is power, both political

power, community power, social power. These are social determinants of health and we need to build those.

At MPHA, we do this in order to work again at the policy systems and environment change level so we work on state legislation, the state budget, state and local agency regulation practice. But we do this -- I want to focus on the how we do that work. So, these are the mechanisms that we work on, but I want to talk a little bit about the how. Because over the course of the next 50 years, issues will change. But the critical way in which we go about working on those issues and building community power is fundamental if we are to really create transformative change.

So, at MPHA we begin with humility, listening to the voices of those who are most impacted by inequity and being led by their priorities, not coming with a preestablished set of things that need to change, because the experts say this is a problem. But really listening to what communities are telling us. And acknowledging and overcoming that legacy of mistrust that I mentioned before that public health has earned and instead acting with integrity and being accountable to community partners so that we rebuild or build in the first place trust. And that includes counteracting this information certainly that's being promulgated by the federal government and others.

But it also really is about digging out of a hole that we ourselves helped to shovel.

And these build on humility, and trustworthiness and shifting power. Partnering with communities that have been historically completely excluded from policymaking and systems building processes in order to win the kind of structural change that we need to see for transformation, for a world that is where structural racism is not conditioning everything that we swim in and walk through, the water we breathe -- the air we breathe and the water we swim in or drink. And really transformation that systems change that we seek we can feel the difference. We -- there really is a difference that's lived by the people who have been demanding that change.

So, we work in partnership, as I said, these are the three ways we work in partnership. Sometimes we are convening coalitions, that sometimes we are getting in back of coalitions that already exist of community-based organizations or even better community residents that are building their own priorities and agenda and MPHA can help by aligning with that agenda and bringing our expertise in systems change, in campaigns, in how to testify before the state legislature to that work and organizing in solidarity with those coalitions. And then we can also work to build capacity and skills of people

who may not be working on issues that we are focused on, but are still -- need to know how to build power to change systems.

This is our policy agenda. We work in the housing space. We work in the environmental justice space. We work in the food space, all critical social determinants of health, as well as healthcare, a critical social determinant of health.

So, we have a policy agenda. But, again, over the next 50 years, the look and shape of that policy agenda is very likely to change, the whats, the hows will hold constant.

I'm going to skip through what we are doing at this political moment, although I'm happy to go back to that if anybody cares when the Q&A starts. But if you take anything from these few minutes I have had with you, power as a social determinant of health is critical.

And in terms of action, MPHA is a statewide alliance. You can join MPHA or, or and, you can sign up for our newsletter, including a weekly resistance and action newsletter that we do which shares actions you can take at the state and federal level to build public health and health equity and it's easy to do. Just scan that QR code and join our newsletter, which is franchisee, our you can join MPHA and become a student member.

And with that, I am going to stop my slides. Stop my share. And I think I hand it off to Dr. Taveras.

>> CRAIG ANDRADE: Thank you, Carlene. Dr. Taveras, it's on to you.

>> ELSIE TAVERAS: Hello, everyone. Give me one minute. Let me see if I can smoothly share my slides. Can everyone see my slides now?

>> CRAIG ANDRADE: Yes.

>> ELSIE TAVERAS: So, I knew that I was following Dr. Ojikutu and Carlene, and so that actually saves me a little bit of context and background that I need to give, because it's no surprise, as Carlene mentioned, that there's a lot of redundancy in the same messages that you are going to hear from all three of us.

So, it will allow me to shorten a bit what my remarks are today.

I want to start by thanking Dean Hyder for the invitation to present and the opportunity to present along with Dr. Andrade and Dr. Ojikutu and Carlene. I wear a number of different hats, as you heard in my intro. I'm the Chief Community Health and Health Equity Officer for our largest health system across Massachusetts. I lead community health innovation for Mass General Brigham, and I am also the chair of the Boston board of health so I'm very familiar with the work that is happening in public health led by Dr. Ojikutu.

But today I want to present as a lifelong student and practitioner with public health and a lifelong student of history. I think before we look forward, it's important that we actually think about our history and where we have gone or where we have been that actually then informs what the future holds for us.

Over the past half century, public health initiatives have fundamentally transformed American lives, delivering measurable improvements in health outcomes, extending life expectancy across generations. We over the last 50 years have made incredible progress in tobacco controls that have saved lives, childhood immunizations in the city of Boston and across the nation, we faced an HIV/AIDS epidemic and have finally with the help of so many leaders gotten to a place where once fatal diagnosis has been transformed into a manageable chronic condition and we have made huge strides in environmental health. But as you heard Carlene mention, so much more work to do and things that are at risk now with our federal administration that we need to develop some resilience around.

But I'm also incredibly proud of the fact that Boston and Massachusetts have helped define modern public health for decades. Boston has stood at the forefront of Public Health Innovation, demonstrating really what bold policy and leadership combined with strategic partnerships can achieve at scale. And, again, we are the epicenter of the amazing community health center organization and community health center movement across the state. We have 52 federally qualified community health centers that really the birth of that community health center movement was here in Massachusetts by Massachusetts leaders.

We pioneered the community health center model that became a national footprint. I mentioned already Boston and Massachusetts, not that there's any competition, but we led the nation in tobacco control leadership, implementing groundbreaking tobacco control policies that were then adopted nationwide. We are lucky to be in Massachusetts where we have led access reforms like the Medicaid 1115 waiver and those reforms that expand coverage to vulnerable populations and as I mentioned already, established treatment and prevention programs that have saved countless lives for people with HIV and AIDS.

So, we have a history of being pioneers in public health and that is a really firm ground to stand on as we think about the next 50 years.

But as you heard from Dr. Ojikutu, despite all of these advances in the last 50 years, progress has not been equal. Some drivers of premature morality remain stubborn and vexing and there's a deep inequity in some communities and I will show you a little bit of the data that Dr. Ojikutu also showed.

But public health's success has not translated into equitable life expectancy for all Boston residents. Thankfully in the last 15 years and in particular the last 25 years, there's a deeper understanding that health is shaped outside of healthcare and that it is shaped by nonmedical but health critical issues that we are more and more paying attention to to equal the playing field and try to improve life expectancy and inequities in premature mortality.

You heard already from Dr. Ojikutu, Boston is one of the healthiest U.S. cities across the nation but disparities exist. You saw already Dr. Ojikutu talk about a 22.8 year difference in life expectancy by two census tracks in the city of Boston, one being in Roxbury and the other being in Back Bay and we see persistent inequities in life expectancy in this Blue Hill avenue corridor, and that kind of corridor, that Blue Hill avenue corridor, we also see heightened and higher rates of hypertension prevalence, hospitalizations and morality that are higher in that Blue Hill avenue corridor than the rest of Boston.

So, it's a very troubling trend that not all communities are experiencing the advances that we have seen across Massachusetts, across Boston in an equitable way.

And I would say the other thing that Dr. Ojikutu and Carlene have mentioned is that despite years and years and years of efforts to really try to think about and tackle the gaps specifically in cardio metabolic disease, we have not closed those gaps, and it calls for really bold new approaches to community health. We have to think about doing public health and community health differently if we want to achieve different outcomes. This is a graph that shows cardio metabolic disease morality for black residents of Suffolk County and white residents for Suffolk County and you will see that not only have we made almost zero improvement for anyone, whether they are black or white residents across Suffolk County, but especially since the COVID pandemic, those gaps have increased among our black and white had residents across the city and all the more important why the agenda that Dr. Ojikutu mentioned about Live Long and Well and thinking very specifically about bringing precision to tackling data-driven challenges like these and vexing inequities like this is even more important.

So, what are other trends that we are facing as we look ahead to the future? Our public health systems were designed for disease patterns that primarily affect older adults. Disease partners are shifting younger. Risk is shifting earlier in life and it really demands a different thinking, a fundamental rethinking of prevention strategies. We are seeing early onset cancer, colorectal cancer rates that are rising

dramatically in adults under 50 years of age. We are seeing earlier onset of diabetes and heart disease among younger populations, and we are seeing obesity, vexing obesity prevalences that are concentrated in communities that are facing structural disadvantage and limited resources.

So, that's the history. That's the where we were, where we are, and now a little bit of where we are going, which I think we should be really excited about. And as Dr. Ojikutu said, I meet with students all the time to learn from our students, our public health students, our staff, our community health workers, to hear what are some of the challenges that they are experiencing so that it informs where we go next.

And I am really excited about what the future holds. I think the future clearly has to really quickly accelerate the pace with which what we know works is translated to what we do. And what we know works and where public health is heading is becoming much more predictive.

So, the next 50 years is going to see a fundamental transformation from reactive intervention to anticipatory prevention. I hope it does, actually. Public health is going to increasingly harness technology to detect risk before disease manifests. Today in the Boston Globe there's an article about the prediction of breast cancer tumors before they are even manifested in some imagines that we get in radiology. The future is in front of us now and it really takes preparing for how to approach this new way of delivering care. I think the future is going to mean using technology to assist in care delivery and using technology to support care management.

So, what does that look like? It looks like AI enabled prediction, I talked about and would urge you all to look at that article in the Boston Globe today about prediction of breast cancer. The future is in integrated data systems and I will come back to this at the end and realtime surveillance.

It means and what the future looks like and that is right in front of us, is that care delivery will decentralize and extend beyond hospital walls. And I'm really proud of the work that we are doing across Mass General Brigham, recognizing that health happens in neighborhoods and that the future really brings prevention and care to people's doorsteps and does not always live behind our brick and motor facilities. We have gotten so much better at having the hospital no longer serve as a center of gravity for health and healthcare delivery.

We are getting much better at remote monitoring, at fielding community health workers and specialists, at using apps and app Bad platforms to deliver personalized prevention to coordinate better the care that patients need and community members need. We are so excited about the mobile care that we

are delivering across Mass General Brigham, and point of care technologies that are helping us better deliver care delivery and support, care management for our patients in the communities that we serve.

So, let me end with my last slide by saying, how do we prepare for the next 50 years with all of these amazing students that are probably on the Zoom today? I really think that to achieve a truly healthier and more equitable future, Boston must commit to a fundamental transformation across five critical domains. I think and all of you would probably agree, first and foremost, we need data. We need realtime, interoperational data systems. In 50 years delayed data is going to feel as outdated as paper charts, for those of us that work with an electronic medical record, we have never looked back at paper charts. And the idea that we do not have realtime data for surveillance and to track our performance is really outdated. The future looks like having realtime data available for fails and tracking.

We have to invest and trust in partnership. You heard Carlene mention the threats to public health trust. And there's a lot of work that we need to do to regain that trust. We need to deepen relationships with communities most affected by health inequities through authentic engagement and partnership.

We need to train a workforce that sees themselves as system changers, professionals that are fluent in the newest technologies, and that are fluent in equity science implementation and methodologies. We need to align cross-sector policies that integrate considerations, as you heard Carlene mention, food, housing, climate action, education, and we need to continue to use and innovate in redesigning financial models so that we reward prevention and equity rather than volume of services.

So, I will end by saying, that if the last 50 years were about discovery and expanding access, my hope is that the next 50 will be integrated, equitable, and trusted in order to improve life expectancy and reduce premature morality.

I will stop there. Looking forward to hearing some of the questions from the group. And really also, again, grateful to be included with my fellow panelists and grateful for the invitation. Thank you, everyone.

>> CRAIG ANDRADE: Thank you, Dr. Taveras, and thank you all, speakers, for your presentations.

We will now move over to that moderated part of the discussion. And as a reminder, as we move towards an audience Q&A, we ask you to submit your questions in the Q&A function at the middle bottom of the screen. There's so much to touch on. One question I would start with, and Dr. Ojikutu, we will start with you. Recognizing that across the country, crossing our

state, and even within Boston, we have populations divided in terms of what we think are the ways that we care for our community, we care for ourselves, what we need to do and what we have to do in terms of making a better public health. I wonder what you do to help influence those that don't necessarily think that the traditional public health and healthcare models work for them or their family or others.

>> BISOLA OJIKUTU: Okay. So you are asking about people who may be feel as though public health hasn't worked for them or people who --

>> CRAIG ANDRADE: Or they may resist the issues around vaccines or masking and all kinds of other things that now are being framed as woke kind of activity.

>> BISOLA OJIKUTU: Sure. So I think there's been a lot of discussion about how to reframe our public health messaging so that it reaches more people, and particularly the people that you are talking about, Craig, this idea of folks who may not believe that, you know, they don't -- they feel like it's on the left or it's woke as opposed to it being for all people and for the good of all individuals.

And so there are a number of people who have been thinking about this and have done some training sessions with a number of us in public health. This is across the country, thinking about -- and this I think is also one of the things that I would like to see strengthened at the public health -- the School of Public Health level in terms of what we are teaching our future public health leaders. Personalizing our responses, you know, making it real for individuals. This is not about necessarily the community at large because that doesn't resonate with everybody. It's not about population-level health per se because that doesn't resonate with everybody. It is about you and your individual self, your family, how do you protect yourself, what does this have to do with you.

I think that's one of the things that came up in regards to masking, particularly because you used that as an example. This idea of vaccination, because there's a lot of antivax sentiment. Really explaining to people what it is that vaccines do and not, you know, catastrophizing, if you will, what may happen if people not vaccinated because people tend to turn off. Again, making it sound reasonable for your child to be vaccinated and to have some protection when they do -- you know, are vaccinated and what does that really mean to them.

I think it really is about health communication, and I do think that we haven't done a great job of teaching ourselves as health leaders or even, you know, in our schools and focusing in on how we should frame and reframe so that we are reaching the

masses and not just the few who may already be part of the choir, if you will.

>> CRAIG ANDRADE: Thank you.

Carlene, could you answer the same question?

>> CARLENE PAVLOS: I would, as I usually do, echo a lot of what Bisola says. I would add a little bit about how it happens at the MPHA level. Dr. Ojikutu is leading our Public Health Commission, our governmental public health response here in Boston. And I have this flexible flexibility in working with a nongovernmental organization. I get to say, I am very free to, and staff at MPHA are very free to say and to act in different ways. So, right, as a community organization.

So, one of the things that I think about is, we don't start our conversation with community residents around vaccine, around masking. We start our conversation with community residents around what are the issues that you see where you are experiencing, where there's an issue that's impacting your health, and what are some of the solutions that you have for addressing that.

And we join and drive, help to organize, solidify campaigns, move something forward. And so when we then are in a time of crisis, COVID or the current vaccine, what I think of as a nightmare of undermining vaccine infrastructure and trust in vaccines that have saved millions of lives worldwide, when we are in that time of crisis, we are already in relationship. We have a trusted voice. People ask us, we don't have to go to them. People ask us questions about what -- like, how do you all think about this and we have a trusting relationship where they have confidence in how we are framing and how -- that we will use -- that we will think about it in a perspective of truth and equity. So, that is, like that really helps.

And I want to add a sort of example of this, if I might. One of our priorities is housing justice. And I think we, like many other organizations, thought about the housing crisis in Boston and across the state as one of production, meaning we need to build more housing, make sure that there is more housing available to address the housing crisis. And people, tenants were organizing in the face of, like, statewide organizations saying that's what we needed to do. Tenants have been organizing to say, no, that doesn't help us. You build more housing and we just get priced out of the market. We are losing our communities that we have helped build for centuries, sometimes off -- always decades, sometimes centuries, and we are losing our communities, particularly as we get pushed out of Boston.

So, housing production is not the answer. Tenant protection needs to -- it's part of the answer. We need that.

But the first step is going to be tenant protection because we need to keep -- we need solutions that keep people in the communities that they have helped to build.

And so we then can join the homes for all coalition, which is grounded by many base-building organizations here in Boston, and follow their lead and develop relationships and trust. And so, then, again, when we come to the time of, like, of more traditional public health issues, like vaccines and masks and those kinds of things, we have -- we are on a footing where our allies are more interested in what we have to say.

>> CRAIG ANDRADE: Thank you.

Dr. Taveras, I'm going to ask a different question from the audience to bring the audience in as we move through our time. One of the audience members asks, how do we systematically listen to community? How do we listen to build a powerful community residents in a systematic way?

>> ELSIE TAVERAS: I love that question and I think I'm sure that all of us can answer with very similar themes. I think first and foremost, it is not by popping into communities every few years and solely doing and listening to those voices of community because we have a regulatory requirement to do triennial community health needs assessments. What it really means is continuous, embedded, authentic presence in the communities that we serve to learn about the biggest priorities, the biggest challenges so that we can be just as precise with our solutions as we are with understanding and diagnosing what some of the challenges are. We cannot be precise and we can't be responsive if we only do kind of the bare minimum every three year in an engagement of community members.

So, I think what you heard from all of us is this idea of authenticity, of making community voices and community members architects of what we build. You heard from Dr. Ojikutu all of the work to engage residents across Boston to understand what are the best solutions that work for them, where are the challenges, where are the barriers, how do we move forward with, again, community members as architects of the work that we are doing. And you heard Carlene mentioned about the work that, you know, MPHA is doing to really build that capacity for community members to be able to inform where we go next, what we build.

So, I think there's a very specific formula to doing it that is more than just, you know, superficial engagement. It's true, authentic, genuine embeddedness and listening to those voices and making sure that those voices are equal partners and architects in the solutions that we are building.

>> CRAIG ANDRADE: Thank you. Dr. Ojikutu, another guest asks, you referred to shifting power. What does that look like in practice? How does it include shared governance and

community decision-making alongside academics and other institutions?

>> BISOLA OJIKUTU: So, I think it's a great question and I think it's a term, a phrase that I use a lot, as do other people, this difference between sharing versus shifting. And I think that if you take a look and we can -- I can give you my slides. If you take a look at that transformational community engagement toolkit it does explain some of this.

One of the key components that differentiates between sharing and shifting is really about decision making. Who truly has decision-making power over whatever it is you are going to do. I think that it's about power dynamics. When community knows that, you know, we, actually, make the final decision in regards to where community -- where funding is invested and we make the decision as to what intervention is actually implemented, that is the point at which you have moved from sharing to shifting. Okay? And that's fundamentally what it is. It's not even about who holds the purse strings, per se. Okay. Because the purse strings, the money is going to be where the money is, unless our world completely changes.

But what changes things is when you actually say, look, we are going to be fully transparent. This is how much money we have. Let's work together, sure, we can go through a process of working together, but who is making the final decision?

And I also think that's just where the sticking points comes down to it, fundamentally. When you are dealing with institutions, large institutions, who, you know, sort of, have their own vision as to how change may occur.

Let me give you an example, because I want to be very clear about this. So, the City of Boston is going to get about a million -- $40 million, I want to be clear. $40 million over, say, 15 years from our opioid settlement dollars. This is the money that comes from the issues that we have had in terms of opioid addiction and the settlements that came from those judicial action and those settlements.

We were told by the state to do some sort of process to ensure that there was equity. It really wasn't mandated as to -- or dictated what it was we had to do but we had to show that we were engaging people in the process. So, we proceeded and this is, actually, documented also on our website, to engage communities both those with lived experience, the institutions caring for people with substance abuse disorder, other folks, lots of stakeholders, hundreds of people across Boston to figure out what it is they wanted that funding to go towards.

Now, we didn't say that, you know, this was going to be a shift in power, meaning that you are going to be the final decision maker because you got to be authentic, transparent,

honest. But my hope was at the end of the day, that that would occur, that there would be a clear understanding that what they said, how they ranked it was going to be how the money was going to be distributed.

And we came up with four, you know, four final goals, four things that the community wanted. One was housing. So I know Carlene has spoken a lot about housing. We talked about low threshold housing, so increase the housing, get the folks off the street. This is a lot of what we did in 2021, 2022 in terms of the encampments around Boston and you all are aware of that, that process.

Number two was give money to communities so they have boots on the ground. Particularly in Nubian Square other parts of the city. They also asked for overdose prevention sites which we knew we couldn't do because of the legal parameters, legal barriers. And then they said, okay, we have to lower these overdoses. We got to get naloxone out of the street. We, basically, went through each one of those and said all of this makes sense so we are going to say that we are going to do that. We are going to put all of the money there and we are going to make sure that community knows that this is how much money went to east, this is the percent of the money that went towards each and we see that as a step in the right direction. It's not full shift in power to be honest with you. But it was a step in the right direction. It's having that decision-making that I think is the biggest piece of shift in power. Not just governance because governance can be inauthentic. It really is about who is saying where the money is going to go.

So, I hope that's helpful.

>> CRAIG ANDRADE: Very helpful. Carlene I'm going to ask you a question and ask the same question to the other two panelists so we can get one more question in before we have to move forward and ending our session.

So, another guest has asked, what areas of public health do you see as the most in Boston and Massachusetts over the next few years that can -- can we best position ourself to contribute meaningfully to? What issues over the next several years are going to be really pressing and from your perspective and how do we best position ourself to be ready for it? Hopefully that's a good translation from the person's --

>> CARLENE PAVLOS: Yes, I think I, too, read that question, Craig and I think it's such an important one and I'm not saying this just because I am on a BU School of Public Health webinar. And congratulations, by the way, on the 50 years.

For those of you who are students at the BU School of Public Health, again, I think about this from a policy systems and environment change point of view. I am very -- we at MPHA

think upstream. We are less at the programmatic and clinical end so we are -- I'm really thinking about policy systems and environment change when I answer this. So, that's my disclosure.

And students at the BU School of Public Health from our experience are getting training in thinking about policy systems and environment change. And that is not true of all schools of public health. And so a shout-out to BU for that. Because I think that that is going to continue to be critical work.

We across Massachusetts MPHA convenes the coalition for local public health, which is a coalition that is thinking with governmental public health folks across Massachusetts about what is needed. And even people working now actively leaders in governmental public health are asking us as MPHA for tools and how to think about policy systems and environment change.

So, getting that training at BU, searching out those courses, talk to Dean Andrade, he will help you find them. I think that is critical work that no matter where you work in the spectrum of public health is invaluable, because it will help you think about those root causes that are impacting like when you see the data, it will add to your analytic framework about what is causing those inequities and then it has the added benefit of giving you strategies for how to address it that are populationwide, communitywide. So, that's one thing that I think about.

And I want to just add something to Dr. Ojikutu's last response, because I do -- I think that there are some ways of interacting in partnerships with community as a not a governmental person, but as a community-based organization, but I am a white woman leading an organization that has a deep commitment to dismantling structural racism so we have been very intentional at MPHA about how to think about doing some of this stuff and I'm going to put a chat -- a link in the chat of our health equity policy framework in case anybody out there would find that useful in both thinking about some skills and thinking about how to do community engagement.

>> CRAIG ANDRADE: Thank you. Dr. Taveras, you want to quickly answer that question?

>> ELSIE TAVERAS: Very quickly and it's interesting because I would say and put an exclamation point on everything that Carlene mentioned. But I also come from an orientation of being a physician. And I would say that the things that are killing people every single day is heart disease, it's unintentional overdoses, it's cancer. And I think that, and I feel very strongly that if the next 50 years don't think about how we improve disease, care, prevention, then it will be really challenging to look back and see those slides that I showed of

very little progress and very little movement and the things that are actually leaning to premature morality and shortened life expectancy that are influenced by the social risk factors that Carlene mentioned but we have to get better at improving, right, prevention and improving disease outcomes for the things that are leading to premature morality. The additional thing I would add to what Carlene mentioned is from a public health perspective and infrastructure, we have a lot of opportunity to work on all of those things that Carlene mentioned, housing, food, access, being climate ready, transportation and that is the work of a public health infrastructure.

But I would urge the public health students and practitioners in -- who are in training to think through how do you design programmatic work policy that really leads to prevention and leads to driving improvement in the health conditions that are killing members of our communities.

So, that's just a -- you know, an added perspective to some of the challenges and how to approach the challenges in the coming years.

>> CRAIG ANDRADE: Thank you. And Dr. Ojikutu?

>> BISOLA OJIKUTU: Craig, did you want me to answer the same --

>> CRAIG ANDRADE: Please. If you want to add something else, you are welcome to do that, too.

>> BISOLA OJIKUTU: No, but can you repeat exactly what the question was? I'm sorry. It was such an engaging answer --

>> CRAIG ANDRADE: Over the next several years, what do we anticipate as being to pressing and how do we position ourselves in a way that allows us to be ready for those kinds of issues?

>> BISOLA OJIKUTU: I think there was a good question that came up earlier that related to that. And I am looking -- I was actually looking at the chat and looking at the questions to see what folks were asking about.

And it brings me to a little bit of a shift in the question you are asking, because I think it's important because I know there are a lot of students listening and young people and people who are wanting to build careers in public health. And it's --

>> CRAIG ANDRADE: Faculty staff, too.

>> BISOLA OJIKUTU: 100%. And like I said, or thinking during my presentation, I do spend time mentoring and I enjoy that process. And I think that right now is a challenging time. Public health under threat on many different levels. In the midst of threat, though, there's opportunity, and the opportunity I think is based on your question -- is really embedded in your question.

What is it that we need to do to prepare for what public health should look like in the future? What is it? How should we be thinking about public health differently? How can we avoid threat like this from happening again? You know, how can we shore up and strengthen public health so that we don't enter this period of right now, which is, you know, it's chaotic, it's uninformed by science, it's very -- it's highly politicized. How do we prepare our workforce for that future?

So I think, and this relates to something that Dr. Taveras spoke quite a bit about, is really preparing our workforce, making us stronger. We need to understand and define public health in a way that makes it a clear sector. So, we know the tools that we need to be more effective and more efficient in public health.

When you talk about technology and AI, we need our students, our young people, our faculty, to be experts in this and how we use it best to harness the data that we have, the tools that we have to improve our messaging, to improve our delivery of services. How do we do that?

I have found and I will be very honest about this, is that sometimes, and I think Carlene mentioned this, we have folks leaving schools of public health who don't necessarily have the tools to function in these various sectors. And, again, I think it's important for us to be honest, you know. We need to think -- we need to have people who are at the cutting edge. They don't need to go to life sciences. They don't need to go to other places. What we need is to keep them in public health because public health is so fundamental. We need to be thinking about folks, how do we get our young folks to really think about data in different ways, folks who are committed to finding and thinking about different methodologies, realtime surveillance, really creative, innovative, and honestly, I think those of us who can sit and have been doing this for 10 or more years, we know that innovation hasn't necessarily sat within public health. So, we need to think about how do we ensure that that's what we embody. It's almost rebranding public health. I think we need a rebrand. We need a reboot. Okay? So, we can do a reboot, I think we will be more prepared for the future.

>> CRAIG ANDRADE: Thank you so much. We are nearly out of time. Dr. Hyder came in just at the nick of time. Thank you all for all that you have contributed. Dr. Hyder.

>> ADNAN HYDER: Yes, thank you very much. First of all, I want to thank our three panelists. What an engaging and exciting discussion we have had. And thank you for pushing us. And, Craig, thank you for your moderation and bringing your expertise to this discussion.

As all three of you have indicated, the Boston University School of Public Health is ready to be a partner in the reimagination of public health. That is why we are thinking about our 50 years that have gone by as a building block, but really interested in the next 50. And we welcome all of you, not only the three eminent panelists, but all of you in the audience right now to think about that, to think about the reimagination of public health.

Please join us for our continuing coverage, please visit our SPH 50 web page. We have got a bunch of events happening throughout this year. We will continue this discussion about the future of public health locally, nationally, and globally, and how that can inform the research, education service enterprise.

Thank you again to our panelists, thank you to Craig, and thank you all for joining today. Bye-bye. Thank you.