Interview with

Cristal Thomas

It isn't often that we come across political figures or policy makers that have a background in science. Cristal Thomas, the former Deputy Governor of Illinois, provides exactly what is missing in a lot of policy decisions—a background and foundation in science. She has spent the last 10 years working in government, the last 4 of which were for the state of Illinois. Here, we get a sneak peek into the inner workings of how our government influences public health and what we can do to help.

By Nelly Papalambros

Nelly Papalambros (NP): Going back, what kind of central policy issue first drew you into government and how was it relevant to your scientific background?

Cristal Thomas (CT): Sure, well if I can remember back that back far. When I was in undergrad studying genetics it was at [a] time when there was a lot of conversation around stem cell research, human cloning, and the human genome project. All of that was really just at the beginning stages of the public debate. In particular, I realized that because government funded certain types of research it really drove the research agenda—at least in the university setting where I was — in a real way. That was the first policy issue that made me aware of this whole field of public policy and how important it was. Right after graduation when I was trying to figure out what I wanted to do, what graduate programs I wanted to apply to, I decided that I did not for variety of reasons want to go on the PhD track in genetics. I decided instead to switch over and get a master's degree in public policy and start a career in government.

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NP: Do you feel like that's sort of a typical path with people that you work with?

CT: Well, in my experience there is no typical path into policy, although I'm not sure that there is a typical career path for anybody anymore to be perfectly honest. I found that my background is fairly rare. I run into a few, but there aren't that many people with scientific backgrounds. It's more common for someone to have a degree in political science, economics, or a law degree and also people who are very involved in politics. The other thing I think that's different about me is that I did not start off as a political animal. Many people start off in politics, they volunteer for political campaigns and they get connected to a candidate, and then when that candidate wins they get into the actual policy side of things. That wasn't the case for me. I really started off interested in policy, got a degree in public policy, and went into policy. It wasn't until more recently in my career that I got more involved in the political side.

NP: You have spent a majority of your career working in government, what has been your experience? What are the biggest challenges in working in government?

CT: [One] challenge is the politics. Yes, politics exist everywhere but within government is just so much more. There is always this very reactive nature whenever a public health crisis occurs or it is perceived to have occurred. Public officials are scrambling to try to show that they are being proactive, responsive, and putting people's minds at rest, which results in driving where the resources go without actual evidence or data to suggest doing so. The result is these very uneven expenditures and priorities reflected. The greatest need and where public health efforts might have the greatest benefits might be in one area, but the money ends up somewhere else. For example, it might end up pouring in for a cause due to a powerful legislator who may have a family member with a specific condition. In government the priorities might change depending on where public sentiment is at the moment.

NP: Do you think government can drive public health behavior given the constraints they work within? What can government do for public health and the people?

CT: I actually think there's a lot that government can do and has done; you can look at past public health successes around anti-smoking initiatives and immunizations, which right now are kind of backsliding, but we can get control over that from a public health perspective. Those are real examples of how government playing a major role has influenced behavior or significantly changed and improved public health outcomes. People, I think, always forget now how difficult such campaigns were at the time; how prevalent smoking was in the culture.

Now people are looking at obesity and eating habits and they are saying how can you change people's behavior? You can. People have to realize these are cultural changes that don't happen overnight. Changing behavior takes time and you have to continue to be committed to the policies to see improvement. For example, some recent public health efforts that have occurred are in working with the fast food industry to get rid of trans fats and to provide the calorie count on menus.

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I am on the regulatory side and I think [that is] where the struggle is; things that I would like to see happen, haven't. People could benefit from comparative research looking at one intervention versus the other to find out what might work better for different groups of people. That is more difficult and that's where I have been wishing to see more action. We are learning more about personalized medicine and people's biochemical makeup and it is clear that there is no one size fits all. It was exciting to see that President Obama announced the federal government was going to significantly invest into research for personalized medicine. I think personalized medicine is the future because while it is very difficult and complicated, it is the next step in what needs to be understood.

NP: Over the last couple of years working in government, were there any particular projects that you found interesting or rewarding?

CT: As deputy governor I have worked in a lot of different policy areas, both directly [and] indirectly related to public health. On the medical side, over the last four years, we have actually done a lot within the Medicaid program. A person's experience within the health care system is very different depending on their circumstances. People on Medicaid, who tend to be overall lower income, often have poor health status and more complex needs. Low income and less education makes it harder to navigate the system, yet these are the people who are often left to do that on their own. What we have done in the Medicaid program is create accountable care and a care coordination program that is very specialized in managing people within this population. I think a big part of that revolves around understanding that there are these social determinants of health in addition to typical medical issues. It was empowering to put funding towards care coordinators

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who help people to navigate their own social determinants of health.These social determinants may be happening in their environments, in their communities, in their homes, and present a barrier to successfully managing their conditions.

Another project I worked on was a social impact bond, which they are now calling "pay for success contract". The pay for success contract is an effort in the area of child welfare for improving outcomes for children in the juvenile justice system. Ideally the goal is to be more successful in getting children out of correctional facilities and into community placement and on to better lives. The idea behind the pay for success contract is a public-private partnership where government partners woo a private investor to provide the upfront funding for an intervention. The government contracts with a social service provider that would then administer the program. There's an evaluation component and, assuming that the intervention is successful and the savings that were expected and agreed upon are actually reached, then the government will pay the investor back out of those savings. The reason why I was excited about this initiative is because it is an innovative model. It recognizes that the state of Illinois would like such programs, yet just doesn't have the money to invest in them right now. This is something that we just launched and I am hoping that the new administration continues on with it.

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NP: Now that you are leaving government, what are you looking forward to at your new position of Vice President for Community Health Engagement at University of Chicago Medical Center?

CT: I am looking forward to the opportunity to continue working in health policy and health reform, but to do it outside of government, and in a way that is a little closer to the ground. I am happy that at UC, in the position of community health engagement, their vision is not only to focus on their patient population but also to really focus on the population of people in the communities that surround UC. To really engage and develop strategies for how an academic medical center can positively influence and catalyze communities, in an effort to improve the health of the people within them, is something that I really see as a great opportunity.

NP: The last question is more on a personal note for the students or academics that read the article. What are the ways in which people with a science or public health background could get involved in either local or national policy making? Are there opportunities you think are overlooked for people who don't have necessarily experience in policy but kind of looking for that transition?

CT: Absolutely. There are a few ways people can get involved. The Dunn fellowship is for recent graduates at any level who are interested in doing a year of fellowship within the government. Often people who come in as DUNN fellows are then hired on within the agency where they were working. That is always a good way to get your foot in the door.

Another option is getting involved in public-private partnerships. There is a company called MATTER, which is an inter-health technology incubator that was recently launched in downtown Chicago. The group is looking to create opportunities and tables for people who are interested in the health care field who have a variety of different skills. They want to get different people together who are researchers, PhDs, MDs, IT, or entrepreneurial oriented. They want to create seminars, webinars, and to have round tables for discussion. I think they need to pull some policy people and have them join these conversations as well. I think that in the very near future health policy really needs to recognize and try to actively support the health care innovation and health care technology that is occurring because they can drive and influence each other. MATTER recognized the need for the kind of discussion space and how it is difficult to get everyone in the same room. This is one of the reasons why MATTER was created. I am very hopeful knowing that there is this vision and a group of people who are focusing on it full time.

Nelly Papalambros is a PhD/MPH student in Northwestern's Interdepartmental Neuroscience Program. She is interested in using science to advocate for evidence-based health policy.