Public Health Society

PHAT: Refocused

Natanya Trazenfeld ’17

Community health students may be asking where Public Health at Tufts (PHAT) has gone. More likely, though, you haven’t noticed it’s missing. Every four years, clubs on campus have entirely new membership and leadership, which can make continuity difficult. When there is no one around to remind club leaders of the popularity of a certain lecture series or how helpful a certain faculty contact was, an executive board can be left grappling for guidance and vision.

PHAT, recently renamed Tufts Public Health Society, knows this all too well. During the 2014-2015 school year we planned and executed what we thought to be quality programming. Events included a community service trip to the Greater Boston Food Bank, an Oxfam Hunger Banquet, a community health abroad panel, a panel discussion on the immunization debate, and spearheaded the annual Healthy Week. However, time and again, attendance was poor. Most students’ response to the mentioning of PHAT was, “What’s that?” As an executive board, and, more importantly, as students who are passionate about public health, we were determined to make some big changes to increase the reach and recognition of the club. If only we could do a better job of refocusing on what our purpose has been, if only we could do a better job of making our presence and programming known to interested students. As a result, we set out to give new life to the club by renaming, revamping, and refocusing on what our purpose has been.

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The Open Data Revolution:

What It Means For Health Care In America

Lucy Fell ’17

In the technological age that we live in, we are under constant surveillance. Whether it is Gmail, Facebook, or Fitbit, every email we send and every step that we take can be tracked and recorded. The same goes for our health care - our doctors, hospitals, and government are constantly keeping track of our every diagnosis, sickness, and medical decision. As a result of this surveillance, there is a massive amount of health data out there. In the past, the majority of this data was closed off to the public, viewed and analyzed by the government and the private sector before streamlined results were published. In 2014, due to changing state policies, industry practices, and the Affordable Care Act, a huge amount of this data was made public, opening the door to new possibilities and questions on how best to use the unprecedented amount of health data now available: how can we use this data to better America’s health care system? How can we use it to inform policies that will make a difference?

The Experimental College at Tufts offers a course designed to delve deep into these questions. In the fall semester of 2014, I took Health Policy and the Open Data Revolution with Brent Cohn. At the time Brent worked for GNS Healthcare, having previously worked on the evaluations of several large Affordable Care Act-Created programs at RTI International. As the course description describes, the new wave of public data

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Community Health has much to celebrate this year. Students were able to declare Community Health as a primary (stand-alone) major for this first time this fall. In addition, Community Health is now a Department (previously a program) within the School of Arts and Sciences. This change will undoubtedly bring increased resources, autonomy, and recognition for the role that Community Health plays at the University. Moreover, we now have the ability to hire faculty into tenure-track lines, which will expand our capacity for research, teaching, and service. And, all of these changes are taking place during this, our 40th anniversary at Tufts. We will commemorate this event on April 4th, 2016 and hope that you will all join us (details forthcoming).

Since the mid-1970’s, Tufts has offered a program in Community Health within the School of Arts and Sciences. Students have had the opportunity to pursue an interdisciplinary course of study focused on the health of communities and populations. At its inception, Community Health offered a certificate program for students who completed seven courses and a semester-long internship experience. In 2002, Community Health began offering a program of study as a ‘second’ major. In 2006, 63 students graduated with Community Health as a second major from the University. Since 1976 (the earliest date for which data are available), more than 1375 students have graduated from Community Health at Tufts.

Growth within Community Health at Tufts is in line with national trends. For example, the number of degrees awarded within the field of community/public health at the undergraduate level in the U.S. increased 750% over the past two decades, growing from 759 degrees conferred in 1992 to 6,464 awarded in 2012. The number of universities and colleges offering undergraduate degrees in community/public health soared from 45 in 1992, to 270 in 2013. Community/public health has been ranked among the top 10 fastest growing majors as of 2012.

This surge of interest comes at a time when the American Association for Schools of Public Health and the Institutes of Medicine project a need for approximately 250,000 additional community/public health workers in the next five years. The Bureau of Labor Statistics projects a 21% increase in demand for community/public health workers in the next five years. To fill this gap, existing schools will have to educate three times the current number of students that are currently being served in U.S. undergraduate programs.

The Community Health Department stands ready to help fulfill these needs. With our long, rich history and exciting new growth, the Department of Community Health is uniquely positioned to take a lead role in preparing the next generation of leaders in our field. Dedicated to social justice and prepared with the requisite knowledge and skills to address the health needs of communities in an increasingly global world, we celebrate Community Health students of past, present, and future.

Jennifer Allen
Director of the Community Health Department

OPEN DATA CONTINUED FROM PAGE 1

ing home data to change practices. Dr. Lippitt discussed how Berwick was able to use CMS data to crack down on the number of nursing home patients being unnecessarily sedated. Berwick used the data on a CMS agency level to better Medicare practices in nursing homes. Dr. Lippitt asserts that this data management strategy would be even more effective in the context of a single-payer health care system, in which one entity can analyze and efficiently use data analysis, like Berwick was able to do at the CMS. As both Dr. Lippitt and Brent Cohn assert, this data can contribute to making great strides in improving health care quality and outcomes in America, but there is often a barrier to access all of this information. Although data is now public, it is not always used to its greatest potential - and that is where Tufts students come in. Health Policy and the Open Data revolution, Brent Cohn, and the Experimental College allow students the opportunity to try it themselves, using public data to unlock the secrets to improving health policy.

3 Personal communication, interview.

October 12th, 2015
Chloe Green ‘06

One cannot help but notice Chloe Green’s influence on Dimock Community Health Center, especially in the way it reflects in those who cross her path. On my first day as an intern, Chloe introduces herself as my new boss and a former Tufts Community Health student, reminding me that she can both guide and sympathize with me. As we begin our tour, no one wants to miss Chloe as she comes by. She addresses each person by name, recognizes patients and asks about their lives, all while teaching me the subtle ins-and-outs of work at Dimock. Looking back, these are things I have seen no other staffer do in my time as an intern, and none with as much grace as Chloe.

I have already learned endless lessons from Chloe as an advocate. I have seen her come up with innovative solutions for seemingly impossible questions and work tirelessly to reach a solution for someone she has never met. Recently, we had a client make the trip to the clinic simply to shake Chloe’s hand. The two had never met in person, but had worked for hours over the phone to help find the client safe and stable housing. Rather than shake her hand, Chloe gave her a hug.

Chloe recently took the time to answer a few of my questions about her history, view of public health, and perspective on social justice.

Jojo Emerson ‘16

Chloe:

I’m a white lady who grew up in Maine in relative wealth and comfort, in a queer-friendly, secular Jewish/Unitarian, musical community. I’m a lover of nature, an agnostic, a tomboy, and a musician. I moved to Boston to go to Tufts, and have lived a lot of my adult life in Boston, with the exception of 2 years in Los Angeles for Graduate School.

I’ve had a million jobs, including my share of landscaping, restaurant work, temp agencies and teaching gigs. My public health career started after graduating, when I worked at Boston Medical Center in the adolescent clinic as an HIV case manager and outreach/service coordinator for Boston HAPPENS. I then got connected with the Youth Workers Alliance of South End Lower Roxbury, where I started with ACE (Alternatives for Community and Environment), an environmental justice organization. The more I hung out at ACE, the more my understanding of and curiosity about environmental health and justice for young people grew. I spent two years training as a permaculture farmer and working at Mass General Hospital on a study of adolescent health and the built environment.

I decided I wanted to go ahead and get a masters in Urban and Regional Planning. I moved to Los Angeles in 2011 to attend UCLA, focusing on environmental justice and critical race studies. There I really fell in with the workforce health, rights and safety folks at the Labor Center. I worked with clinics and worker centers in South LA to address unique occupational health and safety needs of low-wage workers. I also helped develop an online mapping tool/database for garment worker organizing. I moved back to Boston from LA and took a job as a program manager for Health Leads! I’ve been working here over two years, and recently started splitting my time between the Dimock Center and our Health Leads National Office to facilitate a cohort of clinics who are in the “plan and build” stage of their programs.

What do you see for yourself in the future?

I’ve really enjoyed my work with students, so will always find ways to be a teacher, but my days of being paid to “help”, in the non-profit case management sense, are numbered. I’d like to get back to volunteering to support social movements for racial and economic justice rather than getting paid to “manage cases.”

What was your experience with Tufts’ CH program?

Generally, [undergrad was] the beginning of a long process of figuring out why I was drawn both to science and people and how I could find the happy medium place.

I remember in Edith Balbach’s class [Intro to CH] talking about the “upstream” way of viewing health, and I guess I’ve spent the last 9 years going farther and farther upstream. Well, guess what’s at the very source- the “Social Determinants of Equity”- a.k.a. racism, and other isms. Now my view of public health is that it needs to be about changing the power dynamics and institutional biases at the root of all our social and political systems.

What do you still have to learn?

Everything! So MUCH! I will always be learning, always be reading and listening, and trying to understand the world more. I want to know more about anatomy and physiology.

What kinds of opportunities would you suggest undergrads seek out while still in school or just after graduating?

I’d say do whatever you honestly have time to really do well and learn from. Between classes and work, it’s hard to get into still more things, so I say choose carefully and honestly. Pick one or two things instead of 10!”
Interning at the Boston Children’s Hospital was truly an experience that helped me on my career path. As a rising senior following the pre-med track, I wanted an internship experience that could give me insight into the medical field. I wanted to gain clinical research experience, and to increase my interactions with patients. I also felt the need to be in a hospital setting to surround myself with the kinds of professionals I wanted to emulate. Lastly, I wanted to conduct research pertaining to pediatric patients, due to my strong interest in general pediatrics.

After searching throughout the Community Health Internship Database as well as meeting with Pamela Schoenberg Reider, the Internship Coordinator, I came across the Critical Care Research Department at Boston Children’s Hospital.

When I started my internship, I was a very different person professionally. This was my first internship experience and I was very focused on not making mistakes and doing assigned tasks to the best of my ability. Initially, I went through the required medical records training which was completely new to me, and took a considerable amount of time to get comfortable with it. It was a completely new environment but I made sure to get the most out of it. My preliminary tasks were to conduct double data entry of case report forms for participants, using the medical record system to look for correct values of multiple clinical variables, and entering them in the database. In the beginning, my motivation was to finish them as fast as possible to show my proficiency as an intern. As my workload increased in this area, I saw my speed stall, and my enthusiasm diminish. I had become so concerned with doing everything right, that I forgot about the whole purpose of an internship. But then I quickly remembered the purpose was to learn!

After reading the protocol of the study, the clinical data I was sorting through began to be attached to so much meaning. I lost my apprehension to ask questions, and made Post-it notes of every word I didn’t know. And naturally my productivity increased but most importantly my growth as a student did as well. Difficult medical terminology became an opportunity to increase my knowledge; clinical procedures turned into conceptual discovery; and physician methodology for diagnosing patients taught me a different way of thinking. I began conducting many literature reviews beyond the papers assigned to fully understand the depth of what I was working with along with satisfying my curiosity of the clinical science surrounding me.

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I then was able to take on more responsibilities, pertaining to the research study. The main project overall aimed to analyze the innate immune response in pediatric patients suffering from life-threatening influenza-like illnesses via the analysis of various cytokines. Cytokines are proteins that mediate inflammatory cellular responses in the body. Under severe infection, we can study these biomarkers to help us better understand how to treat such patients. The knowledge I gained from reading and asking questions during my literature reviews enabled me to do more than I thought I could, and this was when I started to see my personal growth. Everything I was assigned to do, whether it was correcting Excel data sets, looking for possible clinical explanations for observed trends, or learning new programs, helped synthesize the medical information I learned and subsequently helped me appreciate the need and value of research. I started to attend medical talks held at Harvard Medical School, and attended ICU rounds with my principal investigator which helped clinically observe what I learned in the department. I was even invited to see two open-heart surgeries!

One afternoon, the research coordinator asked me what I was interested in researching, giving me an opportunity to answer my own research questions. At this point, I had so many ideas, because after understanding so many things, I began to question more and more. After learning that steroids called glucocorticoids mediate stress response in the body naturally and are related to cytokine mediation, I was given the opportunity to research the influence of steroids on innate immune response by analyzing its influence on certain cytokines. My hypothesis was that if steroids were...
As I enter my senior year at Tufts, I can’t help but look back on the past four years and wonder where the time has gone. While my time has been far from simple and easy, one thing has stayed consistent - I’ve stuck with “premed.” Carrying around the title of a “premed student” has been a scary and challenging experience so far, as I’ve fought my way through the notoriously difficult premed courses at Tufts. During those long hours in the library studying for exams, I’ve often wondered to myself, “Is this what I really want to do? How is this lab report going to help my future?” When I received my first poor grade, I started thinking: “Why do I even want to go to medical school?”

My internship this summer at Boston Health Care for the Homeless’ (BHCHP) Pine Street Inn helped me come a little closer to answering all of those questions. After many hours of research in labs with rats, I knew it was time to finally gain some clinical experience. I didn’t know what to expect from BHCHP, and I was nervous that I would discover I wasn’t “cut out” for medicine, or was scared I would decide I didn’t actually enjoy being with patients, or even that I was afraid of blood. The first day I walked into Pine Street Inn, I knew that I had made the right decision all along.

Pine Street Inn is a homeless shelter, although the name would suggest otherwise. It is a different kind of shelter than I was expecting; the staff treat people like guests, as equals. Up until this point, I hadn’t experienced what it might be like to not have access to adequate health care. I didn’t know what it might be like to not know when and where my next meal was coming from. Likewise, I hadn’t imagined what it might be like to be a health care provider to have patients who had problems much bigger than their health concerns, such as housing, food, and safety. The staff at PSI are not just doctors, but rather they are psychiatrists, case managers, primary care providers, and friends.

During my internship with BHCHP at Pine Street Inn, I had many opportunities to shadow the providers and I got to see what their work was really like, and it was hard. Many times patients didn’t show up for appointments, or they would show up severely intoxicated, and often times had to go to the emergency room. Patients are not always able to adhere to medications that need to be taken with food, as they don’t always know when their next meal is going to be. These barriers to proper health care that seemed quite fixable to me in the classroom all of a sudden didn’t seem so solvable.

Overall, this internship gave me great insight as to what I want to do with my future, and what kind of doctor I want to become. The doctors at PSI referred to everyone by first name and no hierarchy existed within the clinic; there were no white lab coats or fancy offices. Every health care provider really knew and cared about every patient that came through the door. PSI is a patient-centered medical home, and it really is a place that many call home. PSI connects all guests to health care, provides them with opportunities to see psychiatrists, case managers, and connects them with specialists. Additionally, providers make sure patients can get their medications, sometimes even going to the pharmacy to pick up and deliver prescriptions themselves. PSI is not your ordinary clinic, but rather it is a home filled with reliable people who care about their patients and their work. My internship experience this summer opened the door to a new world of health care I hadn’t known existed, and uncovered new passions for pursuing medicine. Overall, Boston Health Care for the Homeless is definitely an organization I can see myself staying connected with as I move forward in my academic and professional career.
According to the U.S. surgeon general’s report on oral health in 2000, oral health is defined as much more than maintaining healthy teeth and preventing disease (1). Oral health involves examinations and routine cleanings by a dental professional to ensure that inaccessible bacteria are removed and are not harming the body. Many of us with full access to adequate dental care may be unaware of the vast number of Americans who do not have the privilege of biannual dental visits and, by default, also lack the means of having good oral health. Oral health connects to overall health and well being; a clean and healthy mouth can reduce the risk of developing chronic conditions, enhance an individual’s nutritional and dietary behavior and produce a feeling of comfort and self-confidence.

A common ailment resulting from poor or neglected oral health is periodontal disease, an accelerated form of gingivitis. Periodontal disease originates from excessive and untreated plaque build-up on the tooth surface and in the gums. It can, in some cases, be prevented by brushing and flossing but many cases of periodontal disease are due to genetic predisposition (2). Treatment of periodontal disease requires adequate and immediate professional attention. Studies have investigated the role of periodontal disease on chronic and systemic diseases, such as cardiovascular disease and various forms of cancer, due to the inflammatory response associated with periodontal disease (3,4).

In 2013, nearly 40% of adults in the US, 18 years or older, had not visited the dentist within the past year (5). Many of the individuals who are able to visit dental clinics have only recently gained this access through coverage by Medicaid or Medicare or, unfortunately, pay for dental fees out-of-pocket, if they are still ineligible. These individuals are more often than not seeking dental care due to emergencies rather than routine treatment.

This past summer, I spent 3 weeks shadowing a dentist who had recently opened her private practice for general and family dentistry in a rural part of Texas, near Houston. Due to needs of the community and the dentist’s desire to begin building an extensive patient pool, the clinic accepted Medicaid, Medicare and out-of-pocket patients. This dentist in Texas faces patients with different dental complications and outcomes compared to those in a private practice. For example, if a patient with tooth pain requiring a root canal were to be paying out-of-pocket at the clinic in Texas, it is more likely that he or she would decide to have the tooth extracted. However, if that same patient was privately insured and came to my dentist’s clinic in Florida, he or she would be more likely to consider having the root canal treatment in order to save that tooth. The hypothetical patient’s reasoning diverges in that in one clinic, the patient could afford the necessary care to save the tooth while in the other, he or she could not.

The issue of health care working as a market versus being guaranteed as a fundamental right arises directly from this dilemma. This issue does not only concern access to oral health care but also access to quality oral health care. The care that one patient receives based on his/her income or socioeconomic status withholds the delivery of the best health care. The consequences of poor oral health involve physical pain, discomfort, lack of confidence, and worse. In the Texas dental clinic, despite the advice and ability of the dentist, patients found themselves deciding to remove teeth that were essential for chewing before choosing a plan for restorative care (i.e. dentures, partials, implants). There is a direct link between oral health and overall health because an individual with excessive tooth loss or even just the loss of molars would have difficulty eating and might consequently become malnourished (6). Other links to overall well being that may be compromised by impaired oral health and tooth loss involve complications in speech, self-esteem, social interaction and various other non-biological factors (1).

Why do we need to talk about oral health? We need to provide individuals with an equal chance to access dental healthcare services. We need to open more community health centers that provide dental services. We need to make more efforts to meet the dental needs of the underserved population. We need to treat oral health as we do overall health by equating the benefits of dental health insurance to general health insurance. With the understanding of oral health’s indisputable influence on overall health, our aims for improving healthcare and the actual health of America should be holistic.
been all along-- to serve as both a pre-professional group and general interest group for all students interested in public health.

My co-president, Judy Hess, and I met over the summer with key faculty members. With the help of Professor Allen, Community Health Department Director, Dean Baffi-Dugan, Director of Health Professions Advising, and Ian Wong, Director of the Department of Health Promotion and Prevention, Judy and I were able to understand the past role and successes of the club and develop a plan for moving forward. The ongoing support of these faculty mentors has been indispensable.

Now, after an intensive period of recruitment that included a GIM, lunch and learn, activities fairs, speaking to classes, and adding five new members to our executive board, we are ready to hit the ground running, new and improved. Our focus is on providing a space for all students interested in public health to connect concepts learned in class to real world issues through discussion and practice, to keep members updated on public health events and opportunities on and around campus, and to provide resources for students planning to pursue public health as a career. We also hope to serve as a student-led link between the community health, professional advising, and health promotion departments.

To this end, we will be holding bi-monthly general meetings. All are welcome at these meetings, which will include a variety of programming including teach-ins, news discussions, career prep workshops, and more. Additionally, we are planning a field trip to the graduate public health campus downtown and hope to have a community service event on the books for later in the semester. We are excited to keep striving for quality programming and look forward to engaging with more students, community health majors or otherwise.

Any questions or suggestions can be sent to tuftspublichealthsociety@gmail.com.

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statistically significant for influencing cytokine levels, treatments for pediatric patients in the ICU with influenza-like illnesses should take into account steroid affect. The results were insignificant, which meant that steroids used in treatment for patients were still up to standard clinical judgment.

At the conclusion of my research project, I felt a strong sense of fulfillment. I was afforded the opportunity to work in a leading pediatric hospital and was able to work with extraordinarily intelligent people in their respective fields. I talked to professionals I never thought I would come into contact with, and will be walking away with skills required in the next phase of my career. I was pushed to my intellectual limits but was rewarded with autonomy over my own project. With many valuable lessons learned, I strongly encourage students to never be afraid to ask questions! It enables growth and is the fastest way to better yourself. I learned that combining passion with intellectual curiosity is the professional recipe for success.

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