I SERVED MY COUNTRY.
I AM FULL OF FEAR.
I DRINK HEAVILY.
I HAVE NIGHTMARES.
I AM DEPRESSED.
I LEFT THE MILITARY,
BUT MY WAR ISN’T OVER.

THEY LOOK THE SAME.
THEY DON’T ACT THE SAME.
HELPING VETERANS
WITH INJURIES YOU CAN’T SEE.
Obamacare: The Devil Is in the Detail

Ready or not, the new health care law is here, and its biggest reforms have begun to kick in. SPH experts ponder its likely benefits—and potential pitfalls.

By Mike Saunder

Cover story

Helping Veterans

They’re proud heroes, but veterans are often also forgetful, suicidal, injured, and angry. New research is helping them access the care they need, where they need it.

By Sheryl Flatow

Features

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Fighting Fate

Getting a genetic test is easy; knowing what to do with the results is not. Catharine Wang wants to turn information about disease risk into positive action.

By Mike Saunders

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Frontline

The perils of office life; how oral contraceptives impact fertility; the connection between fish and ADHD; what teens are drinking.

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OP-ED

Juvenile courts have become the main thoroughfare for youth with substance abuse problems. Public health professionals should work harder to give them a better route.

By Dan McGinley
Dear Friends,

We have closed another very successful year at Boston University School of Public Health, and I am proud to report on our many accomplishments and advances during the past 12 months.

First, an update on The Campaign for Boston University. As part of this $81 million fundraising effort, SPH is committed to raising $40 million over five years; a little over a year into the campaign, we have already reached 60 percent of that goal, or $24 million. We proudly appreciate the generosity of the many individuals, foundations, and corporations that have already given. Your contributions go directly toward advancing our students, faculty, and teaching and research efforts.

SPH continues to produce an impressive breadth of research, as evidenced by this issue of SPHERE. I especially call your attention to our cover story on veterans (page 10) and the groundbreaking work of our faculty on Gulf War illness and post-traumatic stress disorder. We also have timely articles on genetic testing—Associate Professor Catharino Wang is helping turn information about genetic risks into positive action (page 20)—and the rollout of the Affordable Care Act. As the health care law enters its implementation phase, SPH faculty and alumni weigh in on the benefits and risks of this critical and still contentious legislation. At this fall’s 14th annual William J. Bicknell Lecture, keynote speaker Paul Campos, University of Colorado at Boulder law professor and author of The Obesity Myth: Why America’s Obsession With Weight Is Hazardous To Your Health, offered a provocative perspective on obesity. You can read his Q&A on page 8.

The past year also brought more recognition for our faculty and alumni. Recent award winners include Sara Bond (’14), who received the 2013 Boston University Young Alumni Award for her work in founding Circle of Life International, an organization that focuses on teaching and research efforts.

SPH’s president, Mark D. Pachter, M.D., M.P.H., MBA, was elected to the prestigious Institute of Medicine of the National Academy of Sciences for his contributions to public health education and research.

Sincerely,

Robert F. Moxman, MD, MPH, MBA

STAY CONNECTED

Comments or suggestions? Send all correspondence to: Editor, SPHERE, Communications & Marketing Office, Boston University School of Public Health, 715 Albany Street, 517E, Boston, MA 02118, or email at sphere@bu.edu facebook.com/BUSPH instagram.com/BUSPH twitter.com/BUSPH pinterest.com/BUSPH youtube.com/BUSPH

SPH in Numbers

150
FULL-TIME FACULTY

1027
DOCTOR’S STUDENTS

40+
PART-TIME AND ADJUNCT FACULTY

100

FEMALE STUDENTS

STUDENTS AGED 20-25

MALE STUDENTS

STUDENTS 40+

20-25

26-30

40+

RIGHT TO REFUSE

Should patients whose genes are analyzed for a particular medical condition be automatically tested for a host of other possible conditions—and told about those secondary results?

The American College of Medical Genetics and Genomics (ACMG) has said “yes” to these questions in a policy recommendation. But in a paper published in the journal, Science, Professor Georgia Annas and two other experts in law and medicine disagree with a definitive “no.” Annas is the William Fairfield Warren Distinguished Professor and is chair of the Department of Health Law, Bioethics & Human Rights. “Patients have an established right to refuse unwanted medical tests and the information they might disclose,” say Annas and his colleagues, Susan M. Wolf of the University of Minnesota and Sherman Elias of the Feinberg School of Medicine at Northwestern University.

“Starting down the path of unconsented testing and reporting in clinical genetics leads to grave difficulties, and should not be done without more careful analysis.”

—Georgia Annas et al.

"Starting down the path of unconsented testing and reporting in clinical genetics leads to grave difficulties, and should not be done without more careful analysis."

—Georgia Annas et al.
Black Women’s Health Study: Roundup

**Comparisons to Their White Peers, Black Women Have Higher Rates of Breast Cancer, Diabetes, Hypertension, and a Host of Other Conditions. They’re Also More Likely to Die Earlier.** Since 1995, researchers at Boston University’s Slone Epidemiology Center have tracked the health of 59,000 African American women through biennial questionnaires to find out why. Here’s a roundup of the latest findings.

**ABUSE LINK TO ASTHMA.** African American women who reported suffering abuse before age 11 have a greater likelihood of adult-onset asthma compared to women whose childhood and adolescence were free of abuse. Results indicate that the incidence of adult-onset asthma is more than 20 percent higher among women who had been abused during childhood.

**...AND TUMORS.** A study of 9150 premenopausal African American women found that childhood sexual or physical abuse raised the risk of uterine fibroids in adulthood. The incidence of the benign tumors was 16 percent higher among women who had been sexually abused. The risk of fibroids increased with the severity of abuse.

**OBESITY AND PREGNANCY.** Pregnancy obesity and excess weight gain during pregnancy in African American women are associated with an increased risk of giving birth to an abnormally large baby. Macrosomia, defined as when a newborn weighs more than 4,000 grams at birth (approximately 8.8 pounds), can cause delivery complications such as hemorrhage, infection, the need for a cesarean section, preeclampsia, and perinatal mortality.

**Black Women’s Health Study:** About $6.7 billion over the next 12 years—less than a quarter of the cost of the 2012 London Olympics—SFP is part of a consortium of research institutions promoting a strategy to end all preventable child deaths from pneumonia and diarrhea by 2025— a plan that researchers say is achievable with existing medical knowledge, modest international investment, and strong leadership. In a series of articles published in The Lancet, leading academics and public health professionals from the consortium recommended 15 interventions, from vaccinations to zinc supplementation to handwashing with soap, which they say could eliminate 95 percent of diarrhea and 67 percent of pneumonia deaths in children younger than five by 2025. In 2011, pneumonia and diarrhoea claimed the lives of two million children worldwide.

“Our failure to get any traction on this issue is entirely due to political will,” says one of the article authors, Associate Professor Christopher Gill. “It’s not that we don’t know how to do it or that we don’t have the tools. We hope the series will be a call to action.”

**MacArthur “Genius” Works to Improve the Human Condition**

**JULIE LIVINGTON, A MEDICAL HISTORIAN AND 1995 GRADUATE OF SPH, has been named a 2013 MacArthur Fellow. The honor—commonly called a “genius award”—is recognition of her work exploring the care and treatment of people suffering from chronic illnesses and debilitating ailments in Botswana.**

Livingston is the author of Improvising Medicine: An African Oncology Ward in an Emerging Cancer Epidemic, the culmination of tens of hours spent observing—and volunteering at—a cancer ward in Botswana. In the book, Livingston describes the struggles of patients, families, and hospital staff in the southern African country as they try to come to terms with cancer and its moral implications—all in an environment of limited resources.

A professor of history at Rutgers University, Livingston is one of 24 recipients of the MacArthur award, a five-year fellowship that comes with a $625,000 unrestricted stipend. The MacArthur Foundation awards fellowships to talented individuals in a variety of fields who have shows “extraordinary originality and dedication in their creative pursuits.”

“This year’s class of MacArthur Fellows is an extraordinary group of individuals who collectively reflect the breadth and depth of American creativity,” said Cecilia Conrad, vice president of the MacArthur Fellows Program, in a press release. “They are . . . working to improve the human condition and to preserve and sustain our natural and cultural heritage. Their stories should inspire each of us to consider our own potential to contribute our talents for the betterment of humankind.”

**MacArthur “Genius” Works to Improve the Human Condition**

**Saving Two Million Children**

What would it cost to prevent the majority of child pneumonia- and diarrhoea-related deaths? About $11.7 billion over the next 12 years—less than a quarter of the cost of the 2012 London Olympics. SFP is part of a consortium of research institutions promoting a strategy to end all preventable child deaths from pneumonia and diarrhoea by 2025—a plan that researchers say is achievable with existing medical knowledge, modest international investment, and strong leadership. In a series of articles published in The Lancet, leading academics and public health professionals from the consortium recommended 15 interventions, from vaccinations to zinc supplementation to handwashing with soap, which they say could eliminate 95 percent of diarrhoea and 67 percent of pneumonia deaths in children younger than five by 2025. In 2011, pneumonia and diarrhoea claimed the lives of two million children worldwide.

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**Hazardous Substance Research Gets $11M**

**RESEARCHER JENNIFER SCHLEZINGER has spent the past decade examining how environmental contaminants impact B cells, which form in bone marrow and play a vital role in the human immune system. Each step of her research has uncovered clues about the regulatory network that controls bone marrow physiology and also posed new questions about the impact of certain contaminants on immune cell development and overall quality.**

Schlezing’s research, and that of dozens of other public health and biomedical researchers, has been done under the auspices of BU’s Superfund Research Program, one of the University’s longest-running federally funded programs. In early 2013, the School of Public Health-based program, administered by the National Institute of Environmental Health Sciences, again secured a Superfund award—a five-year, $11 million grant.

The goal of all BU Superfund projects is to study the impact of exposure to hazardous substances on reproduction and development. Since 1995, researchers in the BU program have published more than 300 papers probing the toxic effects of chemicals on cancer, reproduction, and development in humans and animals. The latest award will allow studies to continue on the impact of chemicals on bone development, the perinatal health effects of contaminated drinking water, methods for mapping toxic exposures over time and distance, and the effects of contaminants on marine fish.

**The Dangers of Office Life**

A POTENTIALLY HARMFUL FLAME RETARDANT could be damaging the health of white-collar workers. Researchers testing the urine of office staff in the Boston area, as well as dust samples taken from study participants’ homes, workplaces, and vehicles, found widespread evidence of a chemical known as TDCPP—2,3,3,4-tetrachlorodiphenylchlorotrifluoroethane. The chemical, a possible neurotoxin that could negatively impact fertility and thyroid function in men, is commonly used in polyurethane foam.

During the study, published in Environmental Health, researchers discovered TDCPP in 99 percent of dust samples and concluded that the office environment was the strongest predictor of metabolized TDCPP in urine. There were significantly lower concentrations of the chemical among workers in a new office building than in older buildings.

“It is currently very difficult to avoid flame retardants. Hopefully, better options will become available in the near future,” says Courtney Carignan (’13), a doctoral candidate in environmental health and one of six SPH study coauthors. “The best advice we have for people is to wash your hands, especially before eating. Dust control, good ventilation, and air purifiers may also be useful for reducing personal exposure.”
Fish Connected to ADHD

SHOULD WOMEN EAT FISH DURING PREGNANCY?
The answer is complicated, according to a study that found links between pregnant women’s exposure to low-level mercury—primarily from eating fish—and an increased risk of their children exhibiting behaviors related to attention deficit/hyperactivity disorder (ADHD).

Co-authored by Sharon Sagiv, assistant professor of environmental health, the study also found that eating fish during pregnancy had a protective effect, reducing the risk of ADHD-related behaviors in children.

"Women need to know that nutrients in fish are really important for brain development, but they also need to be aware that high mercury levels in some fish pose a risk," says Sagiv. “The message is, eat fish—but don’t eat fish high in mercury,” such as swordfish, shark, fresh tuna, or king mackerel. Fish low in mercury include flounder, haddock, and salmon.

The study suggests there may be a “protective effect” from fish consumption over the recommended limit—government agencies recommend pregnant women limit their total fish intake to no more than two six-ounce servings per week. The researchers found a reduced risk of ADHD-related behaviors in children whose mothers reported eating more than two servings per week. The risk of childhood ADHD-related behaviors rose with increasing maternal hair mercury levels, which were lower than levels shown to be potentially harmful in most previous studies.

Fish Connected to ADHD

LONG-TERM USE OF ORAL CONTRACEPTIVES DOESN’T HURT A WOMAN’S CHANCES OF BECOMING PREGNANT, according to a study published in Human Reproduction. Researchers found that long-term users of oral contraceptives (OCs), like short-term users, experience a temporary delay in fertility, but that longer-term OC use is associated with a higher likelihood of pregnancy. They also noted a slight reduction in fecundability for women who used certain newer-generation oral contraceptives than for older ones, and for women who had first used OCs at an early age.

A collaboration between researchers at SPH and the University of Aarhus in Denmark, the study collected data via the Internet and included questions on sociodemographic background and reproductive and medical history, as well as follow-up questions on pregnancy status, frequency and timing of intercourse, and other lifestyle factors. More than 3,700 women aged 18 to 40 participated.

The Danish-based study found that women who had taken the medications for more than four or five years were more fertile than those who had used them for less than two years. Even women who used oral contraceptives for more than 12 years had higher rates of conception.

The team speculated that long-term use of OCs might increase fertility by inhibiting follicle depletion over a woman’s reproductive life. In a related study, women who reported drinking sodas regularly—especially sugar-sweetened ones—had lower fecundability, while women who drank tea had increased fertility. One possible explanation is that chemical additives or contaminants in some soft drinks, such as bisphenol A, may hinder fertility.

What Teens Are Drinking

JUST 25 BRANDS OUT OF A POSSIBLE 900 ACCOUNT FOR AROUND HALF OF ALL UNDERAGE DRINKING.

In the first study to pinpoint alcohol brands that appeal to youth, authors from SPH and the Johns Hopkins Bloomberg School of Public Health suggest “prevention programs and policies can now target specific brands, and advocacy efforts can focus on specific companies that manufacture the products most involved in problem drinking behavior among youth.”

MOST POPULAR BRANDS

<table>
<thead>
<tr>
<th>%</th>
<th>Brand</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>27.9</td>
<td>Bud Light</td>
<td>4c: Flavored Alcohol</td>
</tr>
<tr>
<td>17.0</td>
<td>Smirnoff Malt Beverages</td>
<td>9c: Beer</td>
</tr>
<tr>
<td>14.6</td>
<td>Budweiser</td>
<td></td>
</tr>
<tr>
<td>12.7</td>
<td>Coors Light</td>
<td></td>
</tr>
<tr>
<td>12.7</td>
<td>Smirnoff Vodka</td>
<td></td>
</tr>
<tr>
<td>11.4</td>
<td>Jack Daniel’s Bourbons</td>
<td></td>
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OF THE TOP 25 CONSUMED BRANDS:

<table>
<thead>
<tr>
<th>%</th>
<th>Brand</th>
<th>Type</th>
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<tbody>
<tr>
<td>4c: Flavored Alcohol</td>
<td>9c: Beer</td>
<td>12c: Spirits</td>
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“Women need to know that nutrients in fish are really important for brain development, but they also need to be aware that high mercury levels in some fish pose a risk.”

—Sharon Sagiv

Oral Contraceptives Don’t Harm Fertility—But Soda Might

Fall 2013
WAR ON WEIGHT IS “HAZARDOUS TO HEALTH”  
Controversial author and 2013 William J. Bicknell Lecturer Paul Campos on reframing the obesity debate.  
BY LISA CHEDEKER

During the summer of 2013, there was much rejoicing in the public health community when the Centers for Disease Control and Prevention (CDC) released data showing obesity rates among preschoolers were falling in many states.  
Heralding the news, CDC Director Thomas Frieden announced, “Although obesity remains epidemic, the kids has begun to turn for some kids in some states. While the changes are small, for the first time in a generation, they are going in the right direction.”  

According to Paul Campos, author of the controversial 2004 book, The Obesity Myth: Why America’s Obsession With Weight is Hazardous To Your Health, obesity concerns have been exaggerated for generations. The University of Colorado at Boulder law professor is a vocal critic of what he considers a self-defeating war against fat, claiming it has no basis in science and can have devastating consequences for women. In the fall of 2013, he continued his critique of America’s obsession with weight at SPHERE, where he delivered the 2013 William J. Bicknell Lecture.  
Campos argues that the health risks of obesity have been overblown by medical and public health professionals and the $50 billion a year weight-loss industry. Against a cacophony of voices calling attention to weight—from the CDC to First Lady Michelle Obama—he concludes that the health risks associated with body fat have been overestimated, save for a small minority of people who are at the extremes of body weight.  
Campos spoke with SPHERE about the hazards of the war on weight.  
SPHERE: WHAT REACTION DID YOU HAVE TO THE CDC’S CHILDHOOD OBESITY FINDINGS?  
CAMPOS: Like most of these reports that come out about weight, I think it’s important to contextualize. Obesity among preschoolers, as an indicator, was just invented a few years ago by the CDC—not based in science, but just an arbitrary definition. Basically, they took the 95th percentile of the height-weight chart from the 1960s and 1970s and treated that as a definition of childhood obesity. So it’s kind of a made-up definition. And I have trouble seeing a decline in a made-up definition as a big deal.  
In terms of context, rates of obesity and overweight have flattened out or declined all over the world. Much of the alarmism about obe-
sity is based on projections that people were just going to get fatter and fatter, and it appears from the data over the last 10 to 12 years that this has just stopped. The alarmism in many ways has never been based on a sound scientific analysis, but on classic moral panic, in the sociological sense.  
WHERE IS THAT “MORAL PANIC” COMING FROM?  
There are several factors. One is a very straightforward economic one—there’s an enormous weight-loss industry in the US. I don’t think most of this is really conscious at all—people’s economic interests just dovetail with beliefs. We have a very strong aesthetic preference for thinness in this society, and this gets medicalized. It becomes a sign of moral quality.  
Another factor is that we have, in many ways, an eating-disordered culture in this country. Anorexia nervosa is rampant. If you look at the normal representation of a female body, it’s in the second percentile. That just feeds into this tremendous anxiety about weight. There’s also a generalized anxiety about overconsumption, especially among the upper classes. Look at the popularity of the TV shows about hoarding—there’s a fascination with people consuming too much.  
SO THERE’S A SOCIAL CLASS ELEMENT TO THIS?  
Absolutely. Obesity in our culture has become a marker for lower-class status. This is something that makes people of higher economic status nervous. And since we have a culture with a lot of downward mobility at present, that anxiety gets fueled by weight. It’s tied up with a lot of discriminatory beliefs and actions.  
IF IT’S SO INGRAINED IN OUR THINKING, HOW DO WE FIX IT?  
Well, first we have to give up on this phony notion that somehow, somehow, we know how to make fat people thin. We don’t. Every discussion of this subject should start with an acknowledgment that we don’t know how to turn fat people into thin people.  
I’m all for encouraging people of all sizes to be active and avoid eating-disordered behavior. Physical activity and nutrition are good things. What I’m not for is stigmatizing people and haranguing them about their weight. It doesn’t make them thinner, and it doesn’t make them healthier. It’s like that old aphorism that defines insanity: Doing the same thing over and over again and expecting different results.  

Teens Online: What You Don’t Know Could Hurt Them  
BY THE TIME THEY REACH ADOLESCENCE, most children are familiar with the perils of driving a car—they’ve been squashed into car seats and strapped in with seat belts, perhaps witnessed near-collisions, and heard their parents harangue carless drivers.  
And yet when kids log on to the Internet for the first time, it’s rare that they have received anything close to that level of parental guidance.  
“We would never put a child in a driver’s seat and just say, ‘Ok, go’,” says adolescent health expert Sophie Godley. “We have constant conversations. We model behavior for them.”  
Not so with laptops and smartphones, which have become so ubiquitous among tweens and teens that parents and school offi-
cials are scrambling to keep up. Studies indicate that close to 80 percent of young people between 13 and 17 have cell phones, and 71 percent of 12- to 17-year-olds report using social networks. A recent study found that about one in five students between 15 and 18 say they have sent a nude or seminude picture or video—or a sexual text message—to another person.  
Godley (’93), a clinical assistant professor of community health sciences, has been issuing a call to action to campus, community, and parent groups: if parents and other caregivers don’t guide their children through cyberspace, with its vast trove of sexual content, they may find themselves in confusing—even potentially dangerous—situations.  
“If you don’t talk to your children about sex and sexuality and body image and behavior, other people will,” says Godley, winner of the SFSPH 2013 Educational Innovation Award. “We can’t compete with those messages in one 20-minute health class in ninth grade. It’s not going to happen.”
THEY’RE PROUD HEROES, BUT VETERANS ARE OFTEN ALSO FORGETFUL, SUICIDAL, INJURED, AND ANGRY. NEW RESEARCH IS HELPING THEM ACCESS THE CARE THEY NEED, WHERE THEY NEED IT.

By Sheryl Flatow

Lynn Santosuosso was an instructor in the Army Reserve when she volunteered to serve in the Gulf War. She was overseas for six months, and was exposed to nerve agents and...
chemicals while stationed near King Khalid Military City in Saudi Arabia. When she came home in June 1991, she was uncharacteristically anxious, and unable to sleep. Released from active duty, Santosuosso returned to her reserve unit and also went back to work at her full-time job. Her anger turned into rage, and she was so depressed that there were mornings when she couldn’t get out of bed. “I eventually quit my job, moved through a substantial amount of my savings, started drinking more, and sowed some wild oats,” says Santosuosso, who left the military in 1997 when her enlistment was up. “It was like an avalanche.”

New symptoms occurred, including difficulty breathing, memory lapses, gastrointestinal problems, and cognitive issues. “She had suicidal thoughts. Friends kept urging her to get herself checked out. In 1996, a psychologist at the US Department of Veterans Affairs (VA) in Manchester, New Hampshire, diagnosed Santosuosso with Gulf War illness, but told her “it cannot be documented as such in my records, because the VA would not take the term as a legitimate diagnosis.” It wasn’t until 2007 that Santosuosso learned she had post-traumatic stress disorder (PTSD), the diagnosis was long in coming because she had never disclosed her mental and emotional problems, nor the extent of her drinking. “I was afraid of the stigma,” says White. “I was afraid of looking weak; afraid of how it will affect my future job opportunities. Another problem is logistics. Veterans are unwilling or unable to give; often, they live in rural areas, they can’t get to certain places.”

LEGBITIZING COMPLAINTS

Of the 700,000 people deployed to the Gulf War, between 25 and 30 percent—or some 210,000 veterans—have had chronic health problems over the last 22 years. Their wide-ranging, seemingly disparate symptoms include fatigue, joint muscle pain, headaches, concentration and memory problems, gastrointestinal distress, and skin rashes. Much of what Santosuosso knows about the illness is the result of work done by Roberta White, professor of environmental health and associate dean, research, in one of many hospitals that take care of Gulf War veterans. In another series of studies, she used brain imaging to reveal that people in the Gulf who were exposed to the nerve gas sarin had evidence of brain damage. “The higher the concentration, the more severe the exposure, the more changes we see in the white matter of their brains,” says White. “So we know the cause of Gulf War illness exposure to mixed chemicals. The question is, what did those do to the body and how did that produce Gulf War illness? What have we done up to this point in our research at BU? We’ve been legitimizing these veterans’ complaints as a physical ailment. That has led to the illness being acknowledged as a reason for disability. We are now working on systematic research on treatment.” Kimberly Sullivan, a researcher and reservist trained with White, is currently leading an interdisciplinary team of researchers from a consortium of institutions in a four-year, $8 million study of 200 veterans, to learn whether chronic inflammation in the brain is the trigger for the illness. “This study is designed to assess whether the chemicals Gulf War veterans were exposed to have kicked off a process that causes damage to neurons that then continually activate the immune cells in the brain called microglia,” says Sullivan, who runs, along with White, the congressionally directed Research Advisory Committee on Gulf War Veterans’ Illnesses, which oversees research into illness in the VA. “This can lead to inflammation, muscle pain, headaches, fatigue, and concentration problems by causing a continuous activation loop between the brain and the immune system.”

FINDING A TREATMENT

Sullivan is able to design two additional studies— companion pieces, in a sense, to the larger one. All three are funded by the Department of Defense. The second four-year, $9 million study is titled Health Policy and Management. This will build the program to be totally outside that system, so we can reach as many people as possible and give them anonymity.” Six hundred veterans of Operations Iraqi Freedom volunteered to take part in the initial randomized, controlled trial for a new treatment for PTSD, which was funded by the American Recovery and Reinvestment Act. The program required a commitment of 20 minutes at the computer once a week for eight weeks. Participants were divided into two groups; the second group had to wait for the initial eight weeks to conclude before beginning. There was concern that people would drop out, but they didn’t—in fact, the results were as good as “regular” therapy, with a substantial number reporting a decline in drinking. “The waiting list group, or comparison group, was not only willing to wait, but they did every bit as well as the initial group,” says Sullivan. The third study, funded by the National Institute on Alcohol Abuse and Alcoholism, is a randomized, controlled, yearlong trial on alcohol and PTSD for the illness. “We built this program to be totally outside that justice issue.”

WHAT WE’RE TRYING TO DO WITH THESE NEW STUDIES IS GET THESE OBJECTIVE MARKERS SO THAT WE CAN SAY, YOU HAVE THIS MARKER, THEREFORE YOU HAVE GULF WAR ILLNESS. THEN WE CAN DEVELOP TREATMENTS.”

—Kimberly Sullivan

and focus on the things that we think actually helped the most, like feedback and goal setting. We’re also hoping to use handheld devices and mobile platforms, so people will be able to participate wherever and whenever they want to,” “The researchers have also been given $1.5 million in grants—from the Bristol-Myers Squibb Foundation and the VA’s National Center for PTSD—to launch free public versions of VetChange.”

Many of the researchers involved in veterans’ health issues have spent most, if not all, of their careers trying to help those who served in the military. Often, their commitment is as personal as it is professional. “When you work with a group that’s been maligned for so long, it makes you want to stick with them even more,” says Sullivan of Gulf War veterans. “They’ve waited 22 years for answers, and at this point it’s become a social justice issue.”

“WE KNOW THE CAUSE OF GULF WAR ILLNESS: EXPOSURE TO MIXED CHEMICALS. THE QUESTION IS, WHAT DID THESE DO TO THE BODY AND HOW DID THAT PRODUCE GULF WAR ILLNESS?”

—Roberta White
The devil is in the tail. Ready or not, the Affordable Care Act’s biggest reforms have begun to kick in. SPH experts ponder its likely benefits—and potential pitfalls.

By Mike Saunders  Illustrations by Angus Grieg

Whatever you think about the nation’s new health care law, it’s nothing if not resilient. The Patient Protection and Affordable Care Act—sometimes called Obamacare or the ACA—has emerged unscathed from a Supreme Court battle and survived around 40 attempts by the House of Representatives to shoot it down. (Even as SPHERE went to press, Republican lawmakers were making another effort to change, delay, or defund the ACA, leaving the federal government largely shut down.) But now comes its biggest test—the real world. Can it increase coverage, improve care, and reduce costs?

In January 2014, most of the 2010 law’s provisions will go into effect. Health insurance will be mandated for all, and private insurance plans will have to meet minimum coverage standards. There will be no annual coverage limits or exclusions for users with preexisting medical conditions. Reluctant state governors have already established state-run health insurance marketplaces—or decided to let the federal government do it for them. One change that won’t come into effect just
Yet is the employer mandate. In July 2013, the government announced it was postponing by one year the requirement for firms with more than fifty employees to provide insurance coverage to workers. For the law’s backers, however, January 1, 2014 remains a moment of great promise. “We are hoping that in a very short period of time, we will see better coverage, better care, quality of care, and then better prevention in public health for the entire country,” says Howard Koh (’95), assistant secretary for health at the US Department of Health & Human Services (HHS).

CARROT AND STICK

Behind its public face, the new law’s biggest benefit could be something most people will never see, according to Professor David Rosenbloom, interim chair of health policy & management. He says the law’s implementation of electronic medical records and the accompanying reduction of insurance paperwork will be one of the most positive changes over time. Streamlined record keeping may increase efficiency, while reductions in readmissions, inpatient infections, and other metrics may eventually increase quality by eliminating unhelpful and sometimes damaging interventions.

Rosenbloom notes these structural changes “may translate into higher profits for providers” rather than lower prices for patients, but the ACA was packaged with two major initiatives that aim to link Medicare reimbursement payments to improved performance. One of them, the Hospital Value-Based Purchasing Program, contains a financial motivation for hospitals to improve care and cut costs—as measured by factors such as better patient outcomes, fewer hospital readmissions, and reduced frequency of certain tests and procedures. If they score well against a range of metrics, hospitals are eligible for a share of millions in incentive payments paid for by a 5 percent reduction in Medicare reimbursement.

That’s the carrot. The stick comes in the form of penalties, for example, for hospitals with high readmission rates, says Carol VanDeusen Lukas, clinical associate professor of health policy & management. Hospital payments account for the largest share of Medicare spending, and Medicare is the largest single payer for hospital services. In 2009, hospital readmissions cost Medicare $26 billion.

“Say you come into the hospital because you have a heart attack,” says VanDeusen Lukas, “and the hospital cares for that and you’re released. If a week later, you get hit by a bus and come back to the same hospital, that is counted as a readmission.” She also says hospitals will be penalized if a patient admitted for specific procedures is discharged but then comes back to the hospital within a short time for a planned readmission as part of routine care.

One inherent challenge in applying these measurements to reimbursement is accurately measuring the behavior you’re trying to affect, says VanDeusen Lukas, who directs Boston University’s Safety Net ACTION Partnership IL, which aims to speed the transfer of research from bench to bedside.

“As we embark on meaningful consequences, there is some evidence that safety-net hospitals are disproportionately disadvantaged by readmission penalties because, for example, many of their patients have complex medical and socioeconomic issues that make them less compliant with their medications and more likely to bounce back.”

Many of these readmitted patients have chronic conditions being treated by multiple doctors, all making decisions about patient care independently of each other. The ACA aims to improve coordination by encouraging providers to combine into accountable care organizations (ACOs) to serve Medicare patients. While the government says ACOs could save Medicare close to $8 billion by reducing readmissions, Rosenbloom worries that the push for coordination might become one for consolidation, fueling an ongoing nationwide flurry of hospital mergers and practice acquisitions. In March 2013, McKinsey & Company reported that hospitals now own 54 percent of physician practices, compared to 22 percent in 2002. “It’s big and quite contrary to the public interest,” Rosenbloom says. “There is a lot of evidence that hospital consolidation — and particularly the elimination of competition as a result of hospital consolidation — can save Medicare patients. While the government says ACOs could save Medicare close to $8 billion by reducing readmissions, Rosenbloom worries that the push for coordination might become one for consolidation, fueling an ongoing nationwide flurry of hospital mergers and practice acquisitions. In March 2013, McKinsey & Company reported that hospitals now own 54 percent of physician practices, compared to 22 percent in 2002. “It’s big and quite contrary to the public interest,” Rosenbloom says. “There is a lot of evidence that hospital consolidation — and particularly the elimination of competition as a result of hospital consolidation — can save Medicare patients.”

And so we find ourselves, says Wendy Mariner, a professor of health law, with an entrenched private industry now subject to increasing levels of federal regulation to ensure the goals of a massive public program.

“I think what is particularly interesting about this is that by getting everybody in the system, we wanted to turn what is internationally known as a human right into a legal right in America. We also, for political and policy reasons, wanted to create the private insurance industry,” she says. “But it is far more difficult to construct and implement a law that requires private industry to conform to public goals than it is to simply have a public program with one set of rules.”

In 2012, Mariner co-organized an amicus curiae brief signed by 104 health law professors that supported the
Health care is now the world’s largest industry, according to McKinsey analysts, with a value three times greater than the global banking sector. After more than 20 years of steady increases, health care expenses now represent 17.6 percent of US gross domestic product—nearly $600 billion more than the expected benchmark for a nation of the United States’ size and wealth.

Removing incentives to order multiple tests should bring costs down, as should discouraging readmissions in favor of coordinated care. However, neither of these measures actually changes the way hospitals set prices for care delivered to private insurance patients.

Some aspects of health care are as mystifying to consumers—or regulators—as the way hospitals set prices for services. While Medicare reimbursements are kept tightly to actual costs plus a slim profit, pricing for procedures covered by private insurance is a high-stakes free-for-all. The same X-ray that Medicare economists say should cost $20 can be priced at $220 at the same hospital for non-Medicare patients, or $280 at a different hospital in the same city. Prices for a generic Tylenol tablet can be 100 times higher in a hospital than in a neighborhood drugstore; charges for the same knee replacement can be twice as much at one hospital than at a crosstown competitor.

"The problem really is that medical care in the US is ridiculously expensive—and unnecessarily so—at least for what we get in quality. We pay providers a lot more money in this country than they get paid anywhere else, and every other developed country seems to be doing just fine in terms of overall quality of care and patient outcomes."

—Wendy Mariner

Assistant Secretary for Health Howard K. Koh (’95) believes there are two lesser-known aspects of the ACA that will likely have an outsized impact on the lives of thousands of US residents—and to coverage limits and new minimum health benefit standards. “In the past, medical bankruptcy was a major concern for many people,” says Koh. “As a physician, I regularly saw patients who were struggling to deal with their illness, but also equally concerned about whether their coverage would be taken away from them because of annual limits on coverage or lifetime limits on coverage.” Beginning in 2014, says Koh, those limits will be banned, substantially reducing the risk of medical bankruptcy. “People can finally focus on getting better and have the security of insurance coverage that is strong and affordable for them.” All insurance coverage plans, both private and those offered by state-run insurance exchanges, will be required to meet minimum essential health benefit standards in ten categories, including inpatient services, outpatient care, emergency services, mental health, and social services. “This is a way of putting forward a comprehensive package of items and services—what we call essential health benefits for all people—on our insurance coverage starting next year,” Koh says.

For premiums to remain stable, the pool of new health insurance applicants needs to include the young and healthy, not just the elderly or infirm. To bring as many people as possible into the new exchanges, HHS has embarked on an intensive outreach program. “We now understand that health is much more than what happens to you at the doctor’s office,” says Koh. “Health starts where people live, labor, learn, play, and pray. And in public health, there is the theme of the social determinants of health. The Affordable Care Act recognizes that in order to really keep people healthy and keep communities healthy we need to use that approach.”

In 2006, Massachusetts became the first state in the nation to pass a law mandating health insurance; six years later, legislators were forced back to the drawing board to try to wrangle costs. In late 2012, the state’s Health Care Cost Containment Law went into effect with the goal of slashing an estimated $200 billion from state health care costs over 15 years. At the forefront are public health priorities with programs to reduce rates of preventable chronic diseases such as obesity, diabetes, and asthma. Those measures are backed up by hefty fines for hospitals whose costs rise faster than the growth rate of the state’s economy. To avoid penalties, most doctors and hospitals will need to cut their overall costs by half.

So it’s reasonable to assume, says Mariner, that the ACA will require its own second act to fulfill the "affordable" part of its name, despite the upcoming changes. What may have been unreasonable were predictions that the ACA would achieve the improbable trifecta of expanding coverage and improving quality while reducing costs. “It works according to theory. What doesn’t make sense is that it will bring prices down as much as we think, because people will normally charge whatever they can—particularly in an area in which people have very little understanding of what the service actually costs,” she says. “A provider can charge whatever they want because we don’t know what it takes to have a particular kind of operation or a particular diagnostic test. If we went into a grocery store or a deli and they charged us $160 for a sushi sandwich, you’d immediately know that makes no sense.”

OBAMACARE, TAKE TWO

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—Wendy Mariner
Getting a genetic test is easy. knowing what to do with the results is not. Catharine Wang wants to turn information about disease risk into positive action.

BY LISA CHEDEKEL PHOTOGRAPHY BY KELLY DAVIDSON
It was the genetic revelation that grabbed global headlines; actress Angelina Jolie’s public disclosure that she had undergone a double mastectomy after testing positive for a rare mutation of the BRCA1 gene put her at risk of developing breast cancer. As the media scrambled to cover all the angles—her mother’s death from ovarian cancer at 56, the impact on her family, her aunt’s subsequent death from breast cancer—Catharine Wang, associate professor of community health sciences, was quick to put Jolie first noticed the “deer in the headlights” look too many times.

Wang, a behavioral scientist and expert in public health genomics, has spent more than a decade watching the genetic-testing market explode, to the point where consumers now buy a $99 kit to find out if they or their offspring are at risk for a rare mutation for breast cancer. A 2012 study by UnitedHealth Group, Inc., estimated that spending on genetic testing could more than triple by 2021, from about $5 billion to $15 billion annually. And that was before the Supreme Court’s June 2013 decision that gene patents can’t be patented.

“I care about patient outcomes. I’m not so concerned with how scientists come up with the risk estimates—I’m more interested in what patients do with them,” says Wang. She’s not trying to halt the proliferation of genetic testing, but aims to improve the communication and understanding of risk for patients, with the goal of better health outcomes as a result.

Two decades later, that translation of information is even more complicated, because genetic testing is not just available only to people with a family history of disease, but—at a price from commercial companies—to a broad population. The emphasis in genetic counseling has been on high-risk patients, not those who have no family history, she says.

“If I were to give you two numbers—one based on behavioral risk factors, and one based on DNA—how do you weigh them?” asks Wang. The rise in genetic testing has increased the odds that people may get confused about the information.

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“If I were to give you two numbers—one based on behavioral risk factors, and one based on DNA—how do you weigh them?” asks Wang. The rise in genetic testing has increased the odds that people may get confused about the information.

Research has indicated that DNA risk information carries great weight for patients—an insight that raises questions about whether its disclosure will lead patients to try to alter their risk proactively, by making lifestyle changes, or instead will foster a kind of genetic fatalism. In reality, an individual’s concept of contacting any disease typically involves a complicated interplay of genetic and lifestyle choices, with a lot of unknowns.

Beliefs and Behaviors

Wang first noticed the “deer in the headlights” phenomenon 20 years ago, as a graduate student researching her master’s thesis at a clinic in Toronto; there, she watched women being tested for the variant called BRCA-1—whose her breast cancer, early onset—gene.

She saw “the gamut of reactions—from women who would fall apart, to women who would discount it completely. A lot of the time, they just didn’t know what to make of the information.”

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That is the muddle that Wang is trying to navigate, positioning herself in the middle of the doctor-patient conversation to figure out “how to get people to do what we want them to do” to be healthy.

Wang was also concerned about the links between beliefs and behaviors. One study she led found that many women were unaware of the medical benefits of healthy eating, exercising, and weight management.

Another study led by Wang suggested that emphasizing a genetic link to health concerns could even decrease a person’s motivation to engage in weight-management behaviors. In that study, participants were asked to indicate their self-perception that obesity is inherited was less likely to report engaging in exercise or healthy eating.

Wang is now spearheading research that tracks how participants respond to actual genetic information, not hypothetical scenarios. In a study funded by the National Human Genome Research Institute, she and other researchers are examining behavioral changes among patients who are told either their genetic risk is low, or that their obesity risk based on lifestyle factors. The study aims to further the understanding of how people might respond to genetic test results, as opposed to genetic versus non-genetic risk information.

Sharing Results—or Not

Wang is also examining whether people who undergo genetic testing share those results with others, especially their doctors.

Preliminary survey findings suggest that while consumers overwhelmingly talk about their results with family members, a relatively small percentage show them to health care providers. According to Wang, the usefulness of personal genetic information hinges, in part, on the extent to which consumers share the findings with medical professionals.

“The thought has been that the people who take these tests would be more involved in their medical care. But it’s more complex than that,” says Wang. “It’s a bit like figuring out what’s behind the decision to share or not share genetic information, and how we can support the people who need it.”

Wang is concerned about a lack of what she calls an “infrastructure” for recording information—for example, the absence of a standardized method for collecting family history information.

During the long-running Family Healthcare Impact Trial, for example, the researchers were trying to collect family history information from participants. That doesn’t worry Wang, who says the test is an important tool for women at high risk of breast and ovarian cancer.

But Wang does worry about the public perception of genetic testing, noting that the media tend to focus more on genetics than on lifestyle factors in discussions of some health risks.

“There are so many factors that may inform a person’s risk,” she says. “For some reason, whether it’s scientists or the media or both, DNA information comes across as so much more important. But if people think that doing X, Y, and Z isn’t going to matter because of their DNA information, I’m not sure where we’re looking at a major public health communication challenge.”

Wang advocates for more public education about genetics, especially as the science races ahead, with more researchers now striving to do whole-genome sequencing of newborns. While she applauds efforts to unravel and interpret DNA for disease prevention, she is concerned the public health system isn’t equipped to handle the information.

“Just because we can do it, doesn’t mean we should do it,” she says. “At this point, we don’t even have the tools to deal with all this information—our primary care doctors aren’t trained; we don’t even have the infrastructure to handle the information.”

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With head-spinning advances in genetic testing, Wang is anxious to help fill the void in knowledge about how to translate that information into positive health outcomes.

“In theory, I think the prognosis we’ve made is really exciting,” she says. “But if you came up and told me you wanted to sequence my kid’s genome, I’d be like, ‘You what?’ It’s one thing if my child was sick with a rare condition that doctors couldn’t diagnose. But the thought of everyone doing that for any condition that might not manifest until adulthood.

‘Until we have a better handle on how to interpret the meaning behind the genetic variation, the information alone is of little value.’
Substance use is particularly pervasive and frequently untreated among adolescents. Substance use disorders typically begin during adolescence and young adulthood. In fact, 90 percent of all substance use disorders start before the age of 18. The challenge of this problem is exacerbated by the fact that there are no national standards for identifying who are at risk for delivering the right treatment and the recovery services they need. Our current system is often ill-prepared to deal with substance-abusing youth and the problems they bring. The system delivers fragmented, uncoordinated, and publicly-supported programs are chronically short of funding. Our country’s juvenile courts have become the leading service delivery system for children and youth with substance abuse problems, not by choice but necessity.

RETHINKING JUVENILE JUSTICE

BY DAN MERRIGAN
ASSOCIATE PROFESSOR IN THE DEPARTMENT OF COMMUNITY HEALTH SCIENCES

Youth with substance abuse problems are often left in the hands of the courts—public health professionals should be doing more to help them.

A NEW APPROACH

Promising evaluation results indicate that a multisystemic continuum of care approach—combining prevention with evidence-based intervention and recovery supports, a system of graduated sanctions to set limits, incentives for behavior change, and community involvement—is better than traditional justice approaches. One such initiative is Reclaiming Futures, which since its founding in 2002 by the Robert Wood Johnson Foundation has expanded from a ten-site demonstration effort to cover 37 sites in eighteen states. Reclaiming Futures is not a program. Rather, it is an organizational and policy system that uses a six-step model (initiation, single assessment, service coordination, initiation, engagement, and transition) to interact with the community and improve outcomes for youth in the justice system. In each Reclaiming Futures community, judges work with local leaders to reinforce the law, engage law enforcement, courts, probation, detention facilities, treatment providers, families, schools, and the community cooperatively. Under judicial guidance, the initiative pulls together leaders and resources in a collaborative effort to mobilize the community and help troubled young people succeed. Reclaiming Futures is a tested model for this approach (you can find out more about it at www.reclaimingfutures.org).

THE ROLE FOR PUBLIC HEALTH

Many of the competencies that define public health–applied scholarship are at the heart of juvenile justice systems. Reform, policy implementation, and sustainability of Reclaiming Futures and other evidence-based innovations require dynamic, community-based participatory engagement strategies. In turn, they should be coupled with thoughtful consideration of empirically tested public health assessment, communication, advocacy, and policy intervention design frameworks. Descriptive and analytic epidemiology illuminates the magnitude of adolescent substance use and related activity and patterns of disparities among court-involved youth. Ecological assessment encourages the identification of social factors and other conditions that contribute to childhood trauma and put children at risk for delinquency. More practice-based public health leadership is needed to promote and translate research, and to advocate for effective policies that reduce delinquency, eliminate disproportional minority contact, and achieve better outcomes for court-involved children. A comprehensive strategy viewed through a public health lens and informed by systems and implementation science will lead to improved outcomes for these youth—and more cost-effective use of scarce resources—through a process of multidisciplinary collaborative decision making, better targeting of treatment and recovery needs in service provision, the adoption of evidence-based practices, and improved risk reduction.

Dear Friends,

Thank you for supporting Boston University and the School of Public Health. The SPH campaign, Investing for a Healthier World—part of the University-wide Campaign for BU—has increased philanthropic support from our alumni, students, parents, friends, faculty, and staff. Most importantly, the gifts listed on the following pages are helping to advance the School’s mission of outstanding public health education, applied research, and service.

We have raised more than half of the School’s $40 million goal, and many new contributors have joined in to support this effort. In May 2013, the graduating class participated in the campaign by designating their class gift toward a scholarship. Trus ted Kenneth J. Feld (MSGM’70) sponsored the “Battle of B.U.” challenge among all BU schools and colleges to increase participation in annual giving across the University. We are proud to say that our alumni participation increased by 14 percent, earning us second place in the challenge and a $25,000 bonus gift for the SPH Annual Fund. During the course of the year, over 500 alumni across the country turned out to attend events hosted by Dean Meeman and other faculty members in San Francisco, New York, Chicago, Washington, D.C., and Boston. Our top-campaign priority—supporting students and faculty—has inspired new leadership gifts. Here are a few examples:

• An endowed Community Scholar fund was established through the generosity of Blue Cross Blue Shield of Massachusetts. This is the fourth endowed scholarship gift we’ve received since the start of the campaign.
• Charles Donahue, a former adjunct professor and professor of a SPH alumn, made a gift to underwrite a speakers’ forum that will feature SPH faculty and stimulate networking opportunities among our students and alumni.
• Friends and family of Ted Colton, chair emeritus of epidemiology, launched a fellowship fund for doctoral education in the Department of Epidemiology to celebrate Ted’s eightieth birthday.
• Elizabeth A. Rivet’81, a fellow of the American College of Medical Genetics, and is a long-serving American Society for Human Genetics board member.

These gifts demonstrate the spirit of commitment and gratitude among our SPH community members and the growing momentum of the campaign. Every gift—from annual to endowment support—makes a difference as we work to improve the health and well-being of vulnerable populations at home and abroad. Thank you again for your generous support of Boston University and the School of Public Health.

Sincerely,

Jeaninne M. Rivet (’81)
Chair
Dean’s Advisory Board, Boston University School of Public Health
Executive Vice President, UnitedHealth Group

 Dean’s Advisory Board Appointments

ELIZABETH A. O’KLE (’82)
CUNBCN DRUG DEVELOPMENT CONSULTANT

When Elizabeth A. O’Kle studied for her Master’s in Public Health, she was doing something that might have been taught at many other institutions. “The School of Public Health allowed me the flexibility to apply for fellowships at many universities during a fellowship,” she says. “That is something that I would have not been able to do at many other schools.”

Now a member of the School’s advisory board, she sees other areas where her alma mater can distinguish itself. “The School has great opportunity for growth, particularly in the area of pharmaceutical licensing and other specializations, which will differentiate it from other schools.”

O’Kle was formerly chief medical officer and senior vice president of clinical development for Achillion Pharmaceuticals. Before joining Achillion, she held senior positions at Novartis, Inter throne Inc., and Genetics Institute/Wyeth Research. O’Kle is also a member of SPH’s Pharmaceuticals Program External Advisory Board.

PHILIP REILLY
PARTNER, THIRD ROCK VENTURES

Philip Reilly is exploring ways that the tools of molecular biology can be adapted to help lower diagnostic and treatment costs for infectious diseases.

“We live in a world that is both very big and very small,” says Reilly, a venture partner at Third Rock Ventures, where he focuses on nurturing transformational companies dedicated to breakthrough treatments for genetic disorders. “The public health community faces an enormous challenge to extend and implement technologies that are currently only available to the richest 10 percent of the world’s population. For the foreseeable future, there will be a vastly expanding role for public health schools, and I look forward to helping extend the reach and impact of the School of Public Health.”

A widely published author and board-certified clinician, Reilly, a trustee of Cornell University, has twice served as president of the American Society of Law, Medicine & Ethics, was a founding fellow of the American College of Medical Genetics, and is a long-serving American Society for Human Genetics board member.

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We are grateful to the following alumni and donors who have invested in Boston University and the School of Public Health to support faculty teaching and applied research endeavors, scholarships, and student financial aid. Donor support is critical to ensuring that the University maintains its rigorous standards of academic excellence, recruits and retains the best faculty, and educates the highest-caliber students. On behalf of the dean, faculty, staff, and students of SPH, we thank all alumni and friends who have invested in our mission.

This roster recognizes supporters who gave during fiscal year 2013, between July 1, 2012, and June 30, 2013. We strive to list donor contributions as accurately as possible. Should you have any questions, please contact the Development & Alumni Relations office at 617-388-4588.

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Duesased
Kate Jackson’s letter starts with a seemingly simple statement: “This scholarship has provided me with the invaluable opportunity to be a part of an amazing program as a full-time student. It has been a “gift,” write the student to do more than just study and attend classes. Thanks to the scholarship, Jackson (‘14) has been able to meet with distinguished guest speakers, volunteer at a poor student tutor and attend classes. As a member of the student-led Health and Human Rights Caucus, Jackson plans a career in health policy advocacy and writes, “The MPH program is preparing me for a career where I will make a real difference.”

Kate Jackson (‘14) received an award from the Outstanding Scholars Fund, which supports students in the top 10 percent of the incoming graduate students. The award is to whom Jackson asserts to remain anonymous.
Every year, students write donors to thank them for their generous gifts and describe how the support has changed lives.

DEAR DONOR

Anthony Akimbah (’13) trained as a doctor in Nigeria. It was at medical school, he tells the donor who supported him, that he began to realize that “a number of the leading causes of ill health and death in our communities were preventable.” He came to SPH to make a difference. His hope is that Aluminius is ready to go back to Nigeria to “contribute to the practice of rigorous research into the determination of prevalent diseases in that region, with an emphasis on HIV/AIDS.” In his letter, Akimbah reflects, “This journey that started about twenty-one months ago would not be possible without your generous contribution, and I am immensely grateful. I hope that I can utilize the wealth of knowledge and experience I have received here to SPH to positively impact the health, survival and coherence of a countless number of people, both back home and abroad.”

Anthony Akimbah (’13) received the Alumni Scholarsfoam Award in honor of the late SPH adjunct professor and international health expert. The annual scholarship supports students committed to international health. Aluminius wrote to Loyce for her support.
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