10 IDEAS
HEALTH CARE

POLICY OF THE YEAR NOMINEE:

Fighting Pain with Pills: Overprescribing and the Opioid Addiction Epidemic
FOR HEALTH CARE 2015

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Who We Are

The Roosevelt Institute | Campus Network, the nation’s largest student policy organization, engages young people in a unique form of civic participation that empowers them as leaders and promotes their ideas for change. Through coordination with political actors and community leaders, Network members design and implement solutions to the pressing issues facing their towns, counties, and states. Now boasting 120 chapters in 38 states with thousands of members, we’re building a network of young people who are filling the ideas gap in communities across the country. In doing so, we’re preparing a new generation of thinkers and policymakers to burst forth onto the nation’s political stage.

What You’re Holding

Now in its seventh year, the 10 Ideas series promotes the most promising student-generated ideas from across our network. This journal, which includes submissions from schools located from California to Georgia to New York, stands as a testament to the depth and breadth of our network of innovators.

Our 10 Ideas memos are selected for publication because they are smart, rigorously researched, and, most importantly, feasible. We want to see these ideas become a reality.

How You Can Join

As you explore these ideas, we encourage you to take special note of the “Next Steps” sections. Here, our authors have outlined how their ideas can move from the pages of this journal to implementation. We invite you to join our authors in the process. Contact us on our website or by tweeting with us @VivaRoosevelt using the hashtag #solve2015.

Thank you for reading and supporting student generated ideas. Together we will design the future of our communities, from towns to countries and all that lies in-between.
Dear Readers,

Young people on college campuses are often asked to make phone calls, knock on doors, and campaign for existing agendas, but they’re rarely asked about their own policy ideas. Since 2004, we have been working to change that norm. At its core, the Roosevelt Institute | Campus Network seeks to defy the public’s expectations of young people in politics today.

Over the past 10 years, we have built an engaged, community-driven network of students who are committed to using policy to transform their cities and states now and build the foundation for a sustainable future. We believe that broader participation in the policy process will not only improve representation but produce more creative ideas with the potential for real impact.

In this year’s 10 Ideas journal, we present some of most promising and innovative ideas from students in our network. With chapters on 120 campuses in 38 states, from Los Angeles, California, to Conway, Arkansas, to New York City, we have the potential to effect policy ideas that transcend the parameters of our current national debate. Our student authors push for practical, community-focused solutions, from using pavement to improve sanitation in Louisville, Kentucky, to creating community benefit agreements for
publicly funded stadiums in Lansing, Michigan, to building workforce development programs for agricultural literacy in Athens, Georgia.

Policy matters most when we take it beyond the page and bring it to the communities and institutions that can turn it into reality. Many of the students in this year’s publication have committed to pressing for impact. They’re connecting with decision-makers in city halls and state capitols, armed with the power of their own ideas.

The breadth and depth of our network is reflected in the diversity of the proposals featured in this journal. We hope you’ll enjoy reading them as much we did. The next generation of innovative minds and passionate advocates is here, and it’s changing this country one idea at a time.

Sincerely,

**Joelle Gamble**

*National Director*

Roosevelt Institute | Campus Network
CONGRATULATIONS TO

Erin Hollander

author of Fighting Pain with Pills: Overprescribing and the Opioid Addiction Epidemic

Nominee for Policy Of The Year

A jury of Roosevelt Institute | Campus Network members, staff, and alumni select one piece from each journal to nominate for the honor of Policy of the Year. We base our nominees off of the quality of idea, rigor of research and potential for implementation. The cover design of this journal portrays this year’s nominee in visual form.
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Preventing Discrepancies in Out-of-Network Billing: Reducing Consumer Costs and Increasing Transparency

Anbar Aizenman, University of Southern California

Out-of-network billing, specifically Usual Customary and Reasonable (UCR) calculations, suffers from a lack of transparency that places an undue financial burden on consumers. More stringent regulations, direct consumer access, and uniform calculations of UCR values can mitigate overcharging by health care providers and under-reimbursement for procedures by insurance providers.

Preferred Provider Organization (PPO) insurance plans currently allow individuals to receive care outside of their policies’ negotiated networks by requiring an external fee schedule. Usual Customary Reasonable (UCR) calculations are the primary parameter used to calculate consumer reimbursement amounts. UCR is calculated on the basis that a procedure is a “provider’s usual fee for a service that does not exceed the customary fee in that geographic area and is reasonable based on the circumstances.”

The widespread use of UCR is problematic, as UCR calculations are not standardized, and proprietary information prevents cost transparency. The lack of transparency affects the 151.6 million Americans enrolled in PPOs, comprising 57.8 percent of insured Americans. In 2011, Ingenix, the nationwide leader of “data benchmarking” products for

KEY FACTS

- A California Health Plan and Insurers survey found customer satisfaction in regards to getting plan information on what they pay was 6.25 percent less for PPO plan enrollees than for HMO enrollees.
- Out-of-pocket expenditures (which includes out-of-network care) comprise 13 percent of the $3,446 billion annual health care costs in the United States.
- All states (excluding Alaska) have consumer protection laws against balance billing (billing consumers the difference between procedures costs and insurance coverage) for HMOs, while only 27 states have similar laws for PPOs.
UCR calculations (owned by UnitedHealth Group), was found to have underestimated reimbursement values by up to 28 percent. This faulty database was used nationally for over a decade, impacting millions of Americans, including over two million federal employees and military service members.

This prompted the creation of a non-profit database, called the FAIR Health Database, which provides unbiased data for UCR calculations, allowing for uniformity and transparency.

California should pass legislation that mandates insurance providers to provide clear information regarding how they calculate prevailing rates for UCR, including a comprehensive database that allows both consumers and providers to estimate reimbursement amounts. As an alternative, insurance providers should be able to use the FAIR Health Database as their own fee schedule.

**ANALYSIS**

California has the potential to become a more competitive insurance market. Over five providers have over 5 percent market share each, and no provider has over 42 percent market share, making California a viable region for insurance market reform. Greater transparency will generate informed consumers and impose greater discipline on cost structures. This can mitigate overcharging by medical providers and discrepancies in UCR calculations by insurance providers. A 2009 AHIP (American’s Health Insurance Plan) survey found that in California, physicians’ claims for outpatient visits of moderate to high severity were 3,365 percent higher than the prevailing Medicare charges. Many insurance providers moved to Medicare-based reimbursements during the development phase of the FAIR database, decreasing reimbursements further. Requiring providers to utilize FAIR or comparable databases can reverse this.
development, and this practice is currently being incorporated into a New York health care bill. The FAIR Health database is updated biannually, and overseen by the Upstate Health Research Network (UHRN), an independent group of health care researchers, and reflects real, non-negotiated values for claims. The database is already published and accessible online, streamlining its potential and feasibility as either a benchmark tool or actual fee schedule for insurance providers.9

Next Steps

California should pass legislation that mandates the use of either the FAIR Health database for calculating reimbursement, or a publicized nonpartisan database that uses the same criteria and is equally accessible to consumers. Overall, providers should be required to make calculations for reimbursement based on UCR values as opposed to Medicare rates.10

ENDNOTES

Mandated Coverage for Diabetes Screening Through Medicaid in the District of Columbia

Derek Altema and Saumya Bollam, Georgetown University

Preventive diabetes screening as a mandated coverage benefit through Washington, DC Medicaid will minimize long-term costs associated with treatment of late-stage diabetes and related complications, and hinder the progression of diabetes to enhance patient welfare.

Type 2 diabetes is a preventable illness that has become increasingly prevalent in the United States. A 2014 National Diabetes Statistics Report released by the Centers for Disease Control and Prevention (CDC) shows that 9.3 percent of Americans have diabetes.\(^1\) The Community Health Needs Assessment released by the District of Columbia Department of Health (DOH) shows this has increased from 8.7 percent measured in 2010. In 2010, 8.3 percent of Washington, DC residents had diabetes,\(^2\) but in Wards 4, 5, 7, and 8, diabetes rates were well above the 2010 national average. Lower-income residents with higher morbidity risks inhabit these medically underserved wards.

Screening is utilized to detect early onset of diabetes. The U.S. Preventive Services Task Force recommends that people who are over age 45, have high blood pressure, or have high cholesterol get screened for diabetes.\(^3\) Although 85 percent of deaths attributable to diabetes occur in patients above age 55,\(^2\) diabetes is a progressive disease that worsens over time and is exacerbated by poor lifestyle habits.

Medicaid provides health coverage for low-income people from communities at greater

**KEY FACTS**

- 27.8 percent of the U.S. population remains undiagnosed with diabetes.\(^1\)
- Health care costs for diabetic patients increased by 40 percent in five years.\(^1\)
- Diabetes screening in high morbidity-risk populations decreases overall health care costs.\(^7\)
risk for developing diabetes. The National Conference of State Legislatures database shows that Medicaid in DC provides coverage for direct treatment and treatment supplies for those diagnosed with diabetes, but screening isn’t expressly covered.4

Blood sugar testing, a prevention strategy used for early detection and mediation of diabetes, is critical for minimizing long-term health costs. Expanding Medicaid coverage to include diabetes screening could hinder the progression of diabetes in higher-risk populations.

ANALYSIS

Mandatory coverage of diabetes screening through Medicaid in DC will help reduce health care costs resulting from diabetic complications. In 2007, estimated health care costs resulting from diabetes totaled $174 billion; the DC DOH estimated $346 million was spent on diabetes-related health care in the District in the same year.5 Medical expenditures for people diagnosed with diabetes increased 40 percent over a five-year period.1 Diabetes elevates risk for hypertension, heart disease, stroke, kidney failure, retinopathy, and lower-extremity amputation. Early diagnostic screening can curtail progression to prevent such severe side effects. While costly treatments and procedures are included in benefit coverage, preventive screening is not. In DC, where health care expenditures per capita exceed all 50 states according to the Kaiser Family Foundation,6 a reduction in health care costs is warranted.

A study from Chatterjee et. al. suggests diabetes screening exhibits cost-efficacy in populations with higher morbidity risk.7 Over a three-year period, health care costs decreased 7.3 percent for those with a body mass index (BMI) of 25 to 35 and 21.5 percent for those with a BMI over 35. Similarly, screening cut costs by 8.1 percent for adults age 40 to 55 and by 17.1 percent for adults over age 55. Because

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<td>• Health complications from diabetes are preventable with early detection.</td>
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<td>• A significant proportion of Washington, DC Medicaid enrollees reside in high morbidity-risk areas.</td>
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<td>• Diabetes treatment costs likely exceed the costs of instituting Medicaid-mandated diabetes screening in DC.</td>
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of cost and inefficiency, implementation and screening are likely deterrents for coverage expansion. Nonetheless, cost reduction can be observed in the short-term while diabetes becomes less burdensome on the health care system in the long-term.

Medicaid should expand benefit coverage to include diabetes screening. Out-of-pocket expenses for diabetes screening may discourage low-income Medicaid enrollees from getting screened. Medicare covers diabetes screening for enrollees, as older patients greatly contribute to health costs for diabetes treatment. Screening at earlier stages in higher risk populations can alleviate treatment costs by preventing complications in older patients altogether.

Next Steps

A proposal from the Centers for Medicare and Medicaid Services (CMS) to federal and DC governments is necessary for extending Medicaid coverage to include diabetes screening. The exclusion of screening from Medicaid coverage is not explicit in legislation, so discretion is left to CMS to expand benefit coverage. For this benefit to require minimal out-of-pocket input from enrollees, the program should wholly cover the costs of screening while financially incentivizing providers to perform blood sugar tests. This is important to promote diabetes screening in higher-risk communities.

ENDNOTES

Reducing Unintended Pregnancies: Promoting the Use of Long-Acting Contraception

Anna Grosshans, Cornell University

One in three women in the United States becomes pregnant before age 20. To reduce this rate, policy makers should create public programs to provide education about and access to the most effective forms of birth control: long-acting contraceptives.

Over half the pregnancies in the United States are unintended. Surprisingly, almost half of these unintended pregnancies occur among women who use birth control.¹ Since many birth control methods are difficult to use perfectly, many women experience birth control failure. Birth control pills, the most common form of birth control in the country, has a relatively high rate of failure. In clinical trials where women use the pill correctly and consistently, it’s over 99 percent effective at preventing pregnancy, yet about nine in every one hundred women experience an unintended pregnancy with the pill each year. To ensure maximum effectiveness, women must take the pill at the same time every day. Understandably, many women occasionally forget to take their pill on time or are unable to get to the pharmacy to pick up a new pack on time. These simple mistakes can lead to an unintended pregnancy.²

Unlike the Pill, several safe methods of contraception have extremely low rates of failure, even with typical use. These methods are referred to as Long Acting Reversible Contraceptives, or LARCs, and include the

**KEY FACTS**

- Almost half of all unintended pregnancies in the United States result from incorrect or inconsistent use of contraception.
- Long-acting contraception is the most effective form of birth control because it eliminates the risk of human error.
- Education and access substantially increase the proportion of women who choose long-acting contraception.
intrauterine device (IUD) and implants. They are effective because once they’re inserted, women don’t have to tend to them for several years, thereby virtually eliminating the chance of human error that causes almost half the unintended pregnancies in America.\(^1\)

Although LARC methods are the most effective forms of birth control, they’re used by only eight percent of American contraceptive users.\(^1\) The most significant barrier to LARC usage is that many women don’t know about them or receive incorrect information about them. Some physicians refuse to prescribe IUDs to young women based on false perceptions of safety. Even when women choose to use LARCs, they can be as expensive as $1000.

To promote the use of long-acting contraception among young women, policymakers should provide public funding for education and access. Education will help women understand their options and choose a method that best fits their lifestyles to minimize mistakes. Access will help women make these decisions based on effectiveness rather than cost.

**ANALYSIS**

A recent effort to decrease teen pregnancy in Colorado demonstrates the power of increasing education about and access to LARCs. Since 2009, when an anonymous donor contributed $23 million to a Colorado family planning initiative, Colorado has provided LARCs at little or no cost to over 30,000 women. At the 68 participating family planning clinics, the number of young women using LARCs increased fourfold. Between 2009 and 2013, Colorado’s teen birth rate dropped 40 percent. Colorado attributes three-quarters of this decline to the initiative to provide LARCs to young women. The decreased teen birth rate generated a ripple effect, leading to lower

**TALKING POINTS**

- Unintended pregnancies are part of a complex web of societal factors that magnify and perpetuate inequality.
- Education about and access to long-acting contraception drastically reduces unintended pregnancy rates.
- Policy makers should embrace long-acting contraception as basic, preventive, and highly effective health care.
abortion rates and a $42.5 million decrease in spending on health care related to teen births.³

Another project to provide young women with long-acting contraception produced similar results in St. Louis. The five-year project cut the teen pregnancy rate by 79 percent and the abortion rate by 77 percent.⁴ In both studies, almost 75 percent of the participants that received comprehensive information about birth control options chose LARCs. A nationwide policy to increase education about and access to LARCs would decrease unintended pregnancies and their social and economic costs.

**Next Steps**

The next step is to provide public funding for education and access to long-acting contraception. Education should begin with public outreach campaigns, school health programs, and local clinics. To increase access, policymakers should distribute public funds to clinics and health offices so that women can receive long-acting contraception at little to no cost. A sliding-fee scale is an effective way to maximize the use of public funds to help all women access high-quality contraception.

**ENDNOTES**

Community Health Centers should implement programs to target the specific health needs of the adolescent population.

Community Health Centers (CHCs) provide health care for high need populations where private practices can fall short. These centers fall under the “patchwork system of safety net providers” created to provide care for uninsured and low income patients. Although continuity of care is better, CHCs only manage to provide health services for about one in six people who do not have access to a primary care physician. With this imbalance in access, the adolescent population can easily fall by the proverbial “health care wayside.”

Health care professionals in the United States report self-perceived limitations in the provision of health care geared specifically towards the adolescent population, particularly in the areas of greatest concern which include sex, depression, and obesity. Other studies show that there are deficits in adolescent medicine ambulatory care training in pediatric residencies across the United States. These shortcomings call for the implementation of guidelines that can supplement care where health care professionals fall short. CHCs are critical because they are an important source of preventive care for impoverished adolescents who are known to have greater psychosocial problems.

**KEY FACTS**

- Adolescents who use CHCs have greater psychosocial problems although they seek preventive care as often as those using private practices.
- One in five adolescents experiences significant emotional distress, and one in ten faces more serious impairments.
- Uninsured adolescents are five times more likely to lack a usual source of care and four times more likely to have unmet health needs.
problems than adolescents seeking care at private practices.6

Adolescent medicine should be included in the federally required health services that New York City CHCs must provide to the catchment area that fall under their responsibility. The proposed provision of health services should be done through the implementation of a health service program, like Guidelines for Adolescent Preventive Services (GAPS), a set of guidelines created by the American Medical Association that provide preventative service recommendations and systems for identifying patients who face socially-based health risks. If patients ages 12 to 18 are provided with treatment and management of current chronic and acute conditions and preventive care for future conditions, adolescent health services can facilitate care as patients enter adulthood and seniority.

ANALYSIS

CHCs are an important source of health care for underserved adolescents because this population is more likely to be underinsured compared to other age groups.7 Socioeconomic status (SES) has been shown to be inversely related to the prevalence of mental health disorders among the adolescent population.8 SES is also associated with obesity and depression, both of which are chronic illnesses predictive of adult disease.9

Today, CHCs have the opportunity to target, treat, and educate this population through special programs. GAPS can be implemented rather easily since it requires less specialized training and utilizes services that are already provided at most CHCs.10 GAPS has been shown to improve quality of care for adolescents through the provision of preventive services and more health education material.11

TALKING POINTS

- Regular and comprehensive visits may be an effective strategy for CHCs to provide preventive services to adolescents.7
- The immediate next pool of workers and citizens will be overtaken by those who are currently adolescents in a not-so-distant future, therefore their health has an impact on the economy and body politic.14
Next Steps

The Community Health Care Association of New York State (CHCANYS), as the premier organization for optimizing health care quality and access to CHCs in New York, should initiate the movement towards implementing adolescent health services, such as GAPS, in CHCs throughout the state. This can be done with local health centers, initially, then further expanded throughout the state depending on the level of success.

ENDNOTES

1 Michael K. Gusmano et al., “Exploring The Limits of The Safety Net: Community Health Centers and Care for the Uninsured,” Health Affairs 21, no. 6 (2002), http://content.healthaffairs.org/content/21/6/188.short
Fighting Pain with Pills: Overprescribing and the Opioid Addiction Epidemic

Erin Hollander, University of Georgia

In the last two decades, deaths related to opioid overdose have increased fourfold, and prescriptions of opioids per year have increased sixfold. To curb overprescribing of opioids, the Narcotics and Drug Agency of Georgia should mandate that all opioid prescribers maintain a working Prescription Drug Monitoring Program (PDMP) and that prescribers consult state PDMPs before prescribing opioids and report any prescriptions they provide.

Opioids are powerful painkillers prescribed for conditions ranging from injury to chronic pain.¹ Opioid overdose deaths have quadrupled since 1999, with almost 17,000 deaths per year attributed to opioid overdose in 2013. Georgia had 461 deaths in 2013 related to opioid overdose.² One cause of the high overdose rate is the overprescribing of opioid painkillers by doctors and emergency rooms, resulting in an easier diversion of opioids to non-prescription holders and continued consumption of opioids beyond chronic pain relief.³

Overall, the 259 million prescriptions for opioids in 2012 is a dramatic increase from the 40 million in 1991.³ Emergency rooms in the United States increased prescription of opioids by 10 percent for pain-related visits between 2001 and 2010, although the percentage of visits related to painful conditions only increased 4 percent.⁴

KEY FACTS

- Total societal costs of opioid addiction were estimated at $55.7 billion for 2007.¹⁰
- Opioid overdose deaths have quadrupled since 1999, with almost 17,000 deaths per year attributed to opioid overdose, while opioid prescriptions have increased from 40 million in 1991 to 259 million in 2012.³,¹¹
- One percent deterrence of opioid addiction results in $22.6 million in avoided health care costs, $11.8 million in avoided productivity losses, and $112,000 in avoided law enforcement costs.¹²
Overprescribing also allows opioid diversion from those with legitimate prescriptions to non-medical abusers; three out of four abusers of opioids received them from friends or family with a prescription.\(^5\)

Prescription Drug Monitoring Programs, or PDMPs, are electronic databases that collect information on prescriptions for a particular state. Authorized individuals can access the databases to determine if a patient should receive opioids or not.\(^6\) To decrease the rates of over prescription, enrollment and logging of patient prescription information should be mandatory for opioid prescribers in Georgia.

**ANALYSIS**

This policy idea originates from Florida’s success with a similar program. Between 2003 and 2009, Florida experienced a 61 percent increase in drug overdose deaths. In reaction to the staggering change, in 2010, Florida made changes to its policies on opioid regulation. Changes included new mandatory usage of the state PDMP. Previously, usage of the PDMP had been voluntary, but now prescribers of opioids are required to file a weekly report on patient, prescriber, and dispensing information for prescription drugs in schedules II, III, and IV of the Controlled Substances Act. Within two years, mortalities dropped by 23 percent in Florida because of this and other favorable changes.\(^7\)

The Congressional Research Service has estimated the cost of starting a PDMP at $450,000 to $1.5 million, with maintenance costs between $125,000 and $1 million a year.\(^8\) However, Georgia already has a functional and maintained PDMP, so the initial cost is not applicable, and PDMP maintenance is in the current budget. The greatest challenge for policy implementation would be...
be convincing the Narcotics and Drug Agency that mandatory
PDMP usage is a cost-effective solution to opioid overprescribing.
The successes of states such as Florida in decreasing opioid
prescriptions through PDMP usage would aid in overcoming this
challenge.9

**Next Steps**

Georgia has already set up and maintained a state PDMP, so
the first step would be to pass a bill through the state legislation
mandating PDMP usage as outlined in this paper and giving
the Drugs and Narcotics Agency the power to enforce usage.
The second step would be to set a time limit for all prescribers
of opioids to enroll in the program and begin updating their
patient prescription records. Finally, after a trial period to allow
prescribers to become familiar with the new system and fully
integrate their records, prescribers must log every time they
prescribe opioids to a patient.

**ENDNOTES**

Mind Net: Early Detection and Treatment of Mental Illness
Emily Lau, Georgetown University

California primary care providers should be mandated to provide mental health screenings at physical checkups to promote early detection and treatment of mental illnesses.

Undiagnosed and untreated mental illnesses can have a huge negative impact on physical health, job productivity, and overall health and social outcomes due to stigma, lack of access to mental health resources, or insufficient mental health education. One in ten people suffering from schizophrenia and nearly one in five people suffering from bipolar disorder will commit suicide.1 Four out of ten of the leading causes of disability in developed countries are mental disorders.2 Mental illnesses lead to as many lost work days as physical illnesses.3

While primary care providers (PCPs) are in a prime position to identify and address mental illness, screening and early intervention services tend to be lacking at the primary care level.4 A study showed that 90 percent of people who committed suicide suffered from mental illness, and of that 90 percent, 40 percent had seen their PCP within a month of their suicide, but their mental health statuses often went unaddressed.5 In order to better diagnose and treat people with mental illness, there needs to be a move towards a system of wellness and early intervention and away from crisis management through a program of early detection and treatment.

California PCPs should provide mental health screenings during or before physical checkups to facilitate early detection and treatment of mental illnesses. This approach can lead to better health outcomes and reduced costs associated with mental illness.

KEY FACTS

- The economic burden of depression, which can be primarily attributed to lost work days, is estimated to be in the tens of billions of dollars in the United States alone.12
- The median delay between the presentation of symptoms and the treatment of mental illness is 10 years.13
- Earlier interventions can prevent the cumulative effects of mental illness and can result in a greater capacity for recovery.14
checkups to identify possible symptoms of psychosocial ailments that patients might be experiencing. Using any of the recognized primary care mental health screening tests, PCPs can quickly evaluate the mental health of their patients and either perform appropriate psychosocial interventions such as problem-solving treatment with the patient or refer the patient to a mental health provider.

**ANALYSIS**

Instituting mental health screenings at the primary care level means that all people who go to a physical checkup are screened. The Patient Protection and Affordable Care Act of 2010 (ACA)\(^6\) combined with California’s Mental Health Services Act (MHSA) makes California a prime location to institute ground-level mental health intervention services.\(^7\)

Studies show that short mental health screening tests such as the five-item version of the Mental Health Inventory (MHI-5) are just as effective as longer tests, making mental health screening an easy addition to typical physical checkups.\(^8\) Many screening tests with evaluation instructions are available for free from the Substance Abuse and Mental Health Services Administration (SAMHSA).\(^9\) If symptoms are identified, the PCP can refer the patient to appropriate mental health services. Additionally, there is evidence that interventions by general practitioners are an effective mental health wellness practice.\(^10\) Early diagnosis and treatment of mental illness would cause a decrease in lost work days and result in increased economic productivity.\(^11\)
Next Steps

The mental health screening mandate would need to be introduced as a bill. Analysis of how California’s MHSA funds are being used for intervention and innovation should be done to establish what funds may be available to support the development of a new system of detection and intervention. Additionally, a study should be conducted to evaluate different screening tools and their efficacies by collecting data from PCPs that already conduct mental health screenings at checkups.

After the mandate is instituted, studies should be commissioned to evaluate the effect that screenings have on increasing early detection and intervention as well as whether screening done by a PCP leads to appropriate referrals and follow-up by mental health specialists. Continued evaluations of the policy’s outcomes should inform physicians on which screening tools to use and how to use the results to best serve their patients.

ENDNOTES

3 Ibid
5 Ibid, 60.
11 “Prevalence, Severity, And Unmet Need For Treatment Of Mental Disorders.”
13 “Prevalence, Severity, And Unmet Need For Treatment Of Mental Disorders.” (Olympia, WA, US: Department of Social and Health Services, Mental Health Division, 2002), 2.
14 The President’s New Freedom: Commission on Mental Health, 57.
15 Anderson, Nancy and Sharon Estee. “Medical Cost Offsets Associated with Mental Health Care: A Brief Review.”
Revolutionizing Primary Care Medical Education

Suvra Mostafa, Jonna Rautsola, Sarah Rudasill, and Rosalia Arnolda, Wake Forest University

To combat the growing deficit of primary care physicians, the North Carolina legislature should provide grants to establish three-year medical education models for students who commit to practicing primary care medicine.

In 1910, the Flexner Report transformed American medical education by establishing a four-year educational model. However, the lengthy, expensive process generates an average student debt of $185,000 and pressures students to enter lucrative specialty fields. A 50 percent rise in specialist salaries between 1995 and 2012 spurred exit from primary care, which observed salary growth of only 10 percent. Consequently, the number of specialty physicians increased 26 percent in that time despite a constant physician supply.

Meanwhile, an aging U.S. population is demanding greater primary care services for chronic conditions that constitute 75 percent of health expenditures. Eight million Americans wielding health insurance under the Affordable Care Act are also seeking primary care, yielding a shortage of 52,000 primary care physicians by 2025. However, the state’s call for a 30 percent increase in primary care physicians has failed to increase the proportion of medical students pursuing primary care.

State legislatures should provide grants to medical schools to establish three-year educational models for students who commit to pursuing primary care residencies. The policy change incentivizes

KEY FACTS

- The United States will face a shortage of 52,000 primary care physicians by 2025.
- The median debt for medical students is $185,000, and average primary care physicians earn 40 percent less than specialists.
- Investments in primary care save the nation an estimated $31.5 billion annually.

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medical students to pursue primary care by eliminating irrelevant medical rotations, which can expedite graduation and reduce debt loads.

ANALYSIS

Nearly 56 million Americans lack access to primary care services that address chronic health issues before they become emergency medical problems. Primary care physicians provide timely, preventative care to patients managing chronic diseases, thereby mitigating the risk of life-threatening complications. Primary care saves the United States an estimated $31.5 billion annually since long-term disease management is 41 percent less expensive than emergency treatment.

Critics of three-year primary care policies claim that a one-year training reduction compromises care, but the four-year structure persists solely out of tradition. Some research-oriented schools like the University of Pennsylvania substituted one year of education for one year of research and did not observe any reductions in the students’ clinical abilities. Another concern is higher burnout rates in the condensed model; this was a reason the federal government abandoned its three-year educational change initiated in the 1970s. Although 95 percent of students completed the federal programs, the policy was ineffective because students could choose any specialty, thereby reducing time for career exploration. In contrast, the new three-year policy will require commitment to primary care, eliminating indecision and burnout.
Next Steps

The North Carolina Institute of Medicine can be leveraged to lobby state representatives for funding, conceivably via a tax, to change policy by first piloting programs at the state’s public medical schools. Medical schools and the American Association of Family Physicians can also convince the state that earlier career starts and reduced educational expenses for primary care physicians are investments that save billions in health care expenditures while expanding health care access. Publicizing this opportunity to university premedical offices is critical to securing qualified applicants.

ENDNOTES

4 Statistics from “Field Listing: Public Debt”
Promoting End-of-Life Planning with Physician Orders for Life Sustaining Treatment

Sarah Rudasill, Wake Forest University

To address the deficiencies of advance directives, North Carolina should pass legislation enabling physicians to issue and implement Physician Orders for Life Sustaining Treatment (POLST).

Advance directives are legal documents specifying desired medical treatment in the event of incapacitation. Under the Patient Self-Determination Act of 1990, patients gained the right to choose a desired treatment from a variety of medical care options. Each state then developed unique legislation, with North Carolina mandating only that physicians follow advance directives.

However, advance directives are limited in both participation and scope. Only half of adults over 60 dictate advance directives, and the legal focus on specific clinical conditions ignores the broader issue of patient-doctor communication. Since only 12 percent of patients discuss end-of-life plans with physicians, even the requests of patients with directives often go unfulfilled. Over 65 percent of physicians were unaware of an advance directive and thus provided undesired treatment. Oregon developed POLST, a unique form that consists of medical orders completed under physician guidance. POLST incorporates a brightly colored, one-page form displayed prominently on medical records that addresses patient desires regarding resuscitation, comfort measures, and artificial nutrition. POLST forms are approved by physicians and easily implemented by all health care entities.

KEY FACTS

- Only 50 percent of Americans over 60 have an advance directive.
- 65 percent of physicians were unaware of a patient’s advance directive.
- End-of-life planning saved Medicare $5,585 per decedent in high spending regions.
North Carolina should develop legislation to enable physicians to issue and implement POLST forms. POLST will transform attitudes toward death by fostering communication between medical professionals, patients, and families, ultimately fulfilling a patient’s end-of-life desires while reducing the decision-making burden on grieving families.

**ANALYSIS**

Physicians are significantly more likely to recognize patients’ wishes during emergencies with POLST. Resuscitation was withheld as desired in 94 percent of POLST cases but only 50 percent of non-POLST cases. The chief concern with POLST is that patients are less likely to receive full medical care if incapacitated. However, POLST patients are more likely to receive field resuscitation (84 percent POLST to 60 percent non-POLST) and hospital admission (38 percent POLST to 17 percent non-POLST) if desired because the medical orders permit no hesitation in treatment.

POLST also possesses cost-saving potential because 93 percent of POLST patients choose to avoid full treatment for a serious illness. Medicare spent 28 percent of its total budget – $170 billion in 2011 – on treatment in patients’ last six months of life. POLST creates an opportunity to fulfill patient wishes while avoiding the expense of unwanted end-of-life hospitalizations. Even after accounting for hospice usage, advance directives saved $5,585 per decedent in high spending regions.

**TALKING POINTS**

- Advance directives are legal documents whereas POLST forms are medical orders issued by physicians.
- POLST is more effective in fulfilling patient wishes for both withheld treatment and full care measures.
- Most POLST participants select limited treatment options, providing an opportunity to reduce Medicare expenditures.
Next Steps

With health care costs surpassing 17 percent of GDP, the state can approve a trial program at public hospitals to demonstrate cost efficiency. The North Carolina Medical Board must develop seminars and integrate POLST into physician licensing renewal requirements since physicians will devote more time to patient education and discussion of end-of-life values. A sweeping federal law approving physicians’ ability to issue and implement POLST could eliminate state discrepancies.

ENDNOTES

Safe Injection Facilities: Rethinking the American War on Drugs

Joe Russell, George Mason University

To combat drug usage and reduce drug related deaths, the Virginia Department of Health should create Safe Injection Facilities (SIFs) where limited amounts of Schedule I & II narcotics can be used under medical supervision and without fear of arrest.

In 1971, the U.S. government declared a War on Drugs, which sought to reduce and ultimately eliminate drug usage by punishing drug sellers and users.\(^1\) Forty years later, illegal narcotics are cheaper and more readily available\(^2\) despite a 96.4 percent increase in the number of federal inmates charged with drug related offenses.\(^4\) In 2012, 800 Virginians died of a drug overdose,\(^5\) which is a leading cause of death nationally.\(^6\) That same year 36,900 Virginians were incarcerated for drug use or possession.\(^7\) 65 percent of prisoners charged with drug-related offenses meet the medical criteria for substance abuse and addiction, yet only 11 percent received any addiction treatment – an oversight that causes higher recidivism rates.\(^8\) Clearly, a new approach is needed.

In the 1980s and 90s, European nations sought to treat rather than punish drug addicts by creating Safe Injection Facilities (SIFs).\(^9\) At SIFs, users can self-administer pre-obtained drugs under medical supervision. Users are given access to clean needles and syringe disposal facilities, along with information about vein treatment, overdose prevention, safe sex, and addiction treatment programs.\(^10\) SIFs currently exist in eight countries, and each country has seen a dramatic reduction in overdoses, HIV infection rates, incarcerations, and drug related deaths (see Key Facts).\(^11\)

**KEY FACTS**

- SIF users in Canada saw a 35 percent drop in overdoses.\(^24\)
- SIFs in Spain reduced HIV among patients from 20 percent to 8 percent in 17 years.\(^10\)
- SIF clients in Sydney were 44 percent more likely to start drug treatment than non-clients.\(^10\)
- America’s drug incarceration rate is 86.6 percent higher than that of Europe.\(^25\)
The Virginia General Assembly should allocate $15 million from the Virginia Department of Corrections (VADOC) budget to the Virginia Department of Health to create five SIFs. The General Assembly should also pass legislation that allows defendants charged with drug use or possession to be sentenced to attend SIFs instead of prisons. However, any Virginia resident who needs assistance may attend SIFs, free of charge. Patients may use Schedule I or II narcotics, obtained elsewhere, on the premises. Licensed medical personnel will staff each of the SIFs but may not handle any narcotics, unless there is a case of clear medical need.

ANALYSIS

Insite, a Vancouver SIF, serves as a good model for estimating the cost of similar facilities in Virginia. In 2012, Insite’s budget was $2.8 million, and it served 9,259 individuals. Assuming similar costs, Virginia would spend $15 million per year for five facilities, which will come out of the $1.13 billion VADOC budget. Given that it costs $25,129 to house one prisoner per year and Insite costs $305 per patient per year, SIFs are 98.8 percent cheaper than prison. Since those who voluntarily visit SIFs are 25 percent less likely to be arrested, and those who are arrested may be diverted to SIFs instead of prisons, SIFs represent an opportunity for significant budget savings for Virginia.

Despite some controversy, SIFs are legal under the Controlled Substances Act (CSA). Section 856 outlaws programs that facilitate drug consumption. However, Section 903 exempts state drug treatment programs from §856, unless the two programs “cannot consistently stand together.” For §903 to apply, SIFs must accomplish the goals of the CSA and mitigate the harms of drug usage. Numerous studies show SIF patients are less likely to overdose or become infected with HIV and are more likely to enter into detoxification programs. Studies also prove SIFs prevent addicts from using drugs in public.
public drug use raises property values and reduces crime rates. SIFs also relieve the burdens placed on emergency rooms, health care facilities, and first responders.

**ENDNOTES**


Next Steps

The five SIFs should be distributed among Virginia’s three major metropolitan areas. SIFs will provide clean needles, information about overdose prevention, and detoxification programs. The SIF program could be modeled after the existing Assembly-approved syringe exchange program. Groups such as the Vera Institute of Justice and the Drug Policy Alliance should strongly endorse such legislation and lobby for its passage.
Solving California’s Shortage of Primary Care Doctors: Loan Repayment Programs for Medical Students
Shannon Zhang, University of Southern California

The state of California is facing a shortage of primary care doctors. California’s Office of Statewide Health Planning and Development should restructure its State Loan Repayment Program to incentivize medical students to select primary care, by assisting with their loans while they are still in medical school.

California is expected to suffer from a major shortage of primary care physicians soon, with over 8,000 general practitioners needed by 2030 to maintain current doctor-to-patient ratios (which themselves are currently inadequate).¹

The National Health Service Corps (NHSC) currently provides scholarships and assistance with medical student loans, as well as grants for states to carry out their own programs to incentivize work in primary care. California’s State Loan Repayment Program (SLRP), funded by the NHSC’s grant, provides loan repayment aid to licensed professionals, provided that they serve in a health professional shortage area (HPSA) for a certain number of years.²,³,⁴

However, this program ignores students who choose to specialize in the face of overwhelming student loan debt. California’s current SLRP is a band-aid

**KEY FACTS**
- Loan repayment recipients tend to stay longest at HPSAs out of the five different types of service-requiring programs across the country.⁷
- Kentucky, by aiding 22 doctors with their loans via the SLRP, generated another 8 jobs and $1.2 million dollars in economic impact.⁸
- The United States would save $67 billion every year if every American consistently visited a primary care doctor.⁹
program for those who have already chosen general practice and does not attempt to spur more interest in primary care before doctors obtain their licenses.

The SLRP in California should expand its program to be more in line with the National Health Service Corps’ Students to Service Program. California’s SLRP would assist students with their student loans, provided that they commit to primary care. Students who commit to primary care by their third year of medical school would receive a substantial sum of money to pay off their medical school debt, and students who commit to communities in more dire straits will receive more favorable aid. This proposal does not suggest eliminating the current loan repayment program for licensed professionals.

**ANALYSIS**

The NHSC also oversees a system of scholarships for first-year medical school students who are willing to commit to primary care. California’s SLRP does not have an equivalent program. The scholarship program theoretically could be another method of incentivizing medical students to select primary care. However, the scholarship program, in a limited study, has been shown to observe lower retention of primary care providers in their assigned HPSAs compared to loan repayment programs. Expanding loan repayment programs would provide a more permanent solution to primary care shortages.

The decision to specialize is correlated with a student’s predicted amount of debt. In a longitudinal study comparing medical students in Year 1 and Year 4, medical students who switched from primary care to a specialized field predicted that they would have higher amounts of debt than their peers who chose to stay with primary care from Year 1 to Year 4. With 31 percent of those who originally chose primary care switching to specialized vocations, attrition...
Next Steps

Further research would be needed to fully understand which HPSAs to prioritize and how best to publicize this new program to students. In the meantime, California should petition the NHSC for more funding. In addition to California’s usual grant for its current SLRP from the NHSC, the state could request a smaller amount of money (i.e beginning with an additional grant of $200,000) in order to test the waters for a program similar to the Students to Service Program.6

ENDNOTES

2 A HPSA is defined by a deficiency in primary care physicians, when considering an area’s total geographic spread, its population group and any particular health vulnerabilities, and its facilities (whether it is a state or federal prison, or a public and/or nonprofit medical facility).