Improved Health Care Through Text Messaging

Policy of the Year Nominee

10 IDEAS for Health Care
10 Ideas for Health Care
2013

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The Roosevelt Institute | Campus Network was established in 2004 in response to the deep and pervasive sense that young people were overlooked in the policymaking process – that we could put boots on the ground and donate what little money we had to support leaders that promoted our progressive values, but our ideas, opinions, and priorities were not represented in our public discourse or electoral system. It was this realization and subsequent rejection of the status quo that led to the founding of what is now the nation’s largest student policy organization.

That original purpose has endured as the Campus Network has grown to over 100 chapters. Yet at a recent gathering, one of our top leaders noted that the challenges we face in the wake of the 2012 election are similar to the ones that first brought us together. We are increasingly powerful actors in our public debates, but despite the bold ideas and ambitious agendas we’ve envisioned, designed, supported, and fought for, we are still beholden to a political process more focused on scoring partisan points than moving our country forward.

What emerged from that moment of collective reflection was the recognition of our unrealized potential as a movement. While our members’ student-generated ideas and solutions-oriented action have redefined youth participation in the political process, it will take constant renewal and commitment to fresh ideas, rigorous engagement, and long-term action to achieve what we know is possible.

The 2013 10 Ideas series represents that ongoing effort to build the infrastructure, communities, and platforms that will allow us to realize the vision that was first laid out in dorm rooms across the country eight years ago. This year, our premier journals represent unique ideas from 83 authors at 30 different schools. As they go to press, our members are already translating those ideas into action by initiating petitions, collaborating with local partners and stakeholders, and lobbying on Capitol Hill.

Last year, we proudly presented the 10 Ideas series as a powerful reminder that this generation is not only willing to build a better future, but has already begun. This year, we put these solutions forward to demonstrate that members of this generation are in it for the long haul as part of an initiative that is always growing, always evolving, and always looking toward the future in the pursuit of progress.

Taylor Jo Isenberg
National Director
Roosevelt Institute | Campus Network
We are pleased to share the fifth edition of the Roosevelt Institute | Campus Network’s flagship 10 Ideas series. These journals, encompassing the best student ideas from our six policy centers, are filled with game-changing public policy suggestions that we can and must implement now.

We are in desperate need of these ideas. Rising healthcare costs, increasing inequality, global climate change, and a government that often seems unable or unwilling to address the things that matter most are challenges that require the very best and the very brightest.

At the same time, we are told that Millennials are checked out, have lost interest, and are waiting for someone else to solve our problems. These journals are an answer to that narrative, making the clear case that we are engaged and active citizens, putting forward ideas to change the problems we see in the world around us. We believe in the power of people working together to solve problems.

Each year, the 10 Ideas journals provide a vision for change that addresses the needs of our neighborhoods, our cities, and our country. Working with community members, local nonprofits, professors, and lawmakers, these student authors have identified the policies that can make the most difference. Yet this journal represents just the tip of the iceberg, with many hours of organizing, researching, fundraising, and developing public campaigns hidden below the surface.

This year’s Healthcare journal focuses on how we receive and process healthcare information. Authors identify healthcare literacy as a key way to improve outcomes and reduce costs in a broken system of care: Improving the communication skills of doctors or the reach of medical information through text messaging fit into a larger narrative of giving patients more information. There was also an emphasis on preventative care, tackling issues like nutrition and obesity before they can cause large drains on the healthcare system. Meanwhile, fighting for youth representation in national healthcare legislation can help bring many of the common sense ideas in this journal to fruition.

Taken on its own, each idea is a simple solution. These journals and the 10 Ideas series taken together are a library of ideas that can help us build toward a more equal, accessible, and community-minded world.

Join us in seeing these ideas realized.

Alan Smith
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First Aid Training on Connecticut Roadways

Toby Amodeo, American University

Adding a first aid training requirement to new driver’s licenses and license renewals in Connecticut would help provide early treatment in both traffic- and non-traffic related injuries.

Over 26,000 driving-related injuries occur annually in Connecticut.\(^1\) Treatment is crucial in the minutes after an injury occurs, even if only basic first aid is applied. Accidents and injuries can occur at any time, and bystanders often act as first responders. Yet the number of people trained in even basic first aid in Connecticut is not known. Connecticut drivers should be trained to provide immediate first aid when accidents occur. A similar requirement is employed in other countries, including Germany.\(^2\) Courses that include first aid training for potential traffic related injuries and other common accidents must be approved by the government. By providing Connecticut drivers with first aid skills, bystanders at the scene of an accident can begin assisting anyone injured, helping to stabilize the situation until professional help arrives.

Analysis

First aid training is expensive, with the cost of a CPR course alone ranging from $70 to $110 if led by a Red Cross instructor\(^4\) and higher with the additional first aid component. Yet it is estimated that road accidents cost countries between 1 and 3 percent of their GNP,\(^4\) about $500 billion in the United States. Training citizens in first aid can substantially reduce the cost of medical treatment by reducing panic and providing stabilizing, immediate treatment at the scene of an accident. Since 50 percent of all traffic deaths occur within minutes of the crash,\(^5\) it is vital that immediate assistance be present.

State legislators can take advantage of a broad base of support for this legislation. Parents of new drivers (including Mothers Against Drunk Driving), healthcare professionals, car insurers, and current drivers could be important sources of support for this initiative, as each would like to see fewer accidents. More generally, every commuter, parent, and Connecticut resident could gain enormous benefits from this program due to the added security it will provide in everyday life. If an emergency occurs, someone will be ready.

Next Steps

All new drivers, regardless of their income, should be provided with free training by the Connecticut state government. To provide instruction for new drivers, the DMV should partner with the Connecticut chapter of the Red Cross to train current DMV employees as Red Cross instructors for the six locations offering road tests. By providing training through existing DMV employees instead of hiring additional instructors, Connecticut could lower the costs of implementing this policy. Once the instructors are trained, they will still be official DMV employees. License renewals should also require proof of completion of an approved first aid course, either with a DMV instructor or another Red

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Key Facts

- In 2008, Connecticut citizens experienced 26,066 driving-related injuries.\(^1\)
- The Red Cross estimates that for help to be within reach at all times, 30 percent of the population must be trained in first aid.\(^3\)
Cross instructor. Expenses incurred by the driver should be counted as tax-deductible up to the value of the course offered at the DMV. All drivers trained in first aid would be exempt from prosecution if the first aid they provide does not save the life of a victim or causes injury, following the example of the Good Samaritan laws.

The Connecticut legislature must show bipartisan support for this program in order to ease public discomfort. Connecticut has already proven that it is willing to change its driving laws to ensure its roads are safe, such as its establishment of a curfew for drivers under 18. Connecticut can continue this precedent of creating safer roadways by adopting the first aid program. New instructors should be in place and training new drivers by mid-2015. The first aid requirement for license renewal should be implemented for all renewals after January 1, 2017. This window provides enough time for the Connecticut state government to have new instructors trained and to evaluate current courses that license renewal candidates may employ. To measure the effect of this program, it will be necessary to administer a first aid practical examination at the end of each license renewal to ensure that information is being retained by drivers.

**Endnotes**
Reducing Fraud with Incentives for More Accurate Medicare Billing

Poorvi Chhabra, University of Georgia

The federal government should incentivize hospitals to reduce false Medicare Evaluation and Management coding in order to reduce fraudulent Medicare reimbursements.

The Office of the Inspector General (OIG) published a report in May 2012 concluding Medicare Evaluation and Management (E&M) billing had increased significantly between 2001-2010. E&M codes reimburse physicians for their intellectual efforts when taking a patient’s history and physical examination and making a diagnosis and treatment plan. All physicians must use Current Procedural Terminology (CPT) codes to receive Medicare reimbursements. CPT billing guidelines were designed for individual physicians in private practice. In 2000, the Centers for Medicare and Medicaid Services (CMS) mandated that hospitals and emergency departments must also use CPT codes but did not create guidelines designed specifically for hospital use. Hospitals constantly struggle to cover their operating costs, and since E&M coding is dependent upon the individual interpretation of services rendered, E&M coding is especially vulnerable to fraud. Hospitals and emergency departments have been criticized for fraudulent E&M billing, but without billing guidelines, it’s difficult for the CMS to conduct audits. The American Hospital Association (AHA) has requested hospital-specific guidelines; various guidelines have been proposed but never backed by the federal government.

Analysis

Instead of creating new guidelines for hospital E&M billing, the federal government should look to the root cause of hospitals’ struggles to cover operating costs. All physicians and hospitals that take Medicare patients are paid a capitation rate – a base payment for accepting Medicare patients. The report published by the OIG identified 1,669 physicians who consistently billed higher-level E&M codes. The federal government should offer an increase in capitation rates to these 1,669 providers in exchange for a reduction in E&M billing over the course of two years. Across the U.S., the 2010 average Medicare Part B capitation rate was $336 per “aged” enrollee. If the federal government increased this average capitation rate for the 1,669 physicians by 10 percent, it would cost $2,558,035 for the 76,132 beneficiaries served by these physicians. If these physicians lowered their average Medicare payment per E&M service from $131.24 to $88.25 (the average for all other physicians), Medicare would pay $73,128,009 rather than $108,751,501, saving $35,623,492. If these 1,669 physicians kept this lowered trend for two years, and Medicare then increased their capitation rates by 10 percent, the

Key Facts

- Of the $2.19 trillion spent on personal health care in the United States in 2010, Medicare accounted for 23 percent, or $525 billion.
- Health care fraud costs taxpayers an estimated $60 billion per year.
- “Between 2001 and 2010, Medicare payments for E/M services increased by 48 percent, from $22.7 billion to $33.5 billion.”
- Thousands of medical professionals have billed Medicare at progressively higher rates over a decade’s time, costing taxpayers at least $11 billion in inflated charges.
federal government will have saved $33,065,457 every year. If this incentive works, then the federal government should consider raising capitation rates to all their providers as an incentive for providers to bill E&M more accurately.

When the hospitals defraud the federal government, hospitals are defrauding taxpayers. Hospitals are also stakeholders, as they are faced with slim to none profit margins. Many defrauding hospitals are simply trying to cover their losses when they resort to upcoding.\(^1\) Offering increases in capitation rates to motivate them to make their E&M coding more accurate would reduce fraudulent Medicare spending. Finally, the 47 million people who are insured by Medicare are stakeholders in this policy.\(^2\) Their insurance premiums rise as Medicare reimbursements to hospitals rise.\(^4\) Reduce reimbursements, reduce premiums.

**Next Steps**

Since the OIG has a list of potentially fraudulent providers, it can approach these providers with this proposal. The providers can then begin reducing their E&M billing to more accurately reflect the services rendered. The OIG will monitor these providers’ E&M billing using already established software. If after a two-year fiscal period these providers have reduced their E&M billing, the federal government should offer them increased capitation rates. The federal government should then use this as evidence for a broader proposal that encompasses all Medicare providers.

**Endnotes**


Stricter Safety Regulations Needed in the Pharmaceutical Compounding Industry

Layla Hood, Cornell University

To increase patient safety, the FDA should implement stricter and more coherent regulations on the production and distribution of compounded pharmaceutical medications.

The meningitis outbreak that began in mid-September has resulted in the deaths of 45 people and the infection of hundreds more. Thousands are still waiting to see if they, too, will be affected.1 The Centers for Disease Control and Prevention (CDC) reports that the cause of this infection was a tainted drug synthesized by a New England area compounding pharmacy.1 Pharmaceutical compounding is the practice of making individualized medications for unique patients. Children often require medicine in liquid or flavored forms, requiring them to be compounded. Hospice patients use compounded pharmaceuticals tailored to specific dosages for their prescribed treatments. Other patients have allergies and other special needs that prevent them from taking traditional medications. The recent outbreak and resulting deaths have reignited concerns about government regulations for pharmaceutical compound production and distribution.

Key Facts
- Compounded drugs are not FDA-approved.8
- Studies have found that about one third of compounding pharmacists fail to produce satisfactory medications.5
- About 40 million prescriptions for compounded medications are written each year in order to provide specialized medications to pediatric patients, dialysis patients, and patients with allergies and other special needs.1

Analysis
The Pharmacy Compounding Accreditation Board (PCAB) reports that more than 40 million prescriptions need to be compounded each year.2 Both state and federal mandates exist to regulate the safety of the drugs, but these regulations are often unclear, according to many health care policy professionals.3 For example, the line between compounding individual drugs and small-scale manufacturing has never been drawn, allowing manufacturers to masquerade as compounders and producing drugs with minimal oversight from state governments or the FDA.4 State pharmaceutical boards have found that compounding pharmacists fail to produce satisfactory medicines a third of the time and frequently are under or over concentrate dosages due to errors in calculations and mistakes during the manufacturing process.5 Additionally, many compounding companies, such as the New England pharmacy responsible for the meningitis outbreak, have never applied for accreditation.4 The Compliance Policy Guide of May 2002 states that compounding may occur in only small amounts and after receiving valid prescriptions.6 It also states that compounded medications must be synthesized using components from a list of FDA-approved substances and using commercial scale manufacturing or testing equipment.6 These compounding regulations clarify somewhat the difference between compounding and manufacturing but place little emphasis on regulation. Several states have pharmaceutical boards dedicated to adherence, but even these efforts are not
enough. Furthermore, because these drugs are not mass-produced, they do not need to be approved by the FDA. Compounding represents a blind spot in drug safety.

Compounded pharmaceuticals are often cheaper to produce than mass-produced drugs due to relaxed oversight from state pharmaceutical boards and the FDA. The compound form of progesterone is 1.67 percent of the price of the FDA-approved version of progesterone. It was also reported in testimony during a hearing in the U.S. Senate Committee on Health, Education, Labor, and Pensions in October 2003 that compounded drugs could be manufactured at just 2.5 percent of the price of FDA-approved drugs. However, the same testimony acknowledged that compound pharmacists often use cheaper and potentially unsafe products to make higher profits.

**Next Steps**

It is necessary for the FDA to research and enact stricter regulations to ensure that compounded products being released to the public are just as safe as FDA-approved medications. Additionally, compounding pharmacies should be required to become accredited by the PCAB in order to ensure compliance with government mandates. Until these stricter regulations go into effect, the FDA should mandate proper labeling to warn patients of the increased risks of compounded medications. Adopting these changes will increase the safety of compounding pharmaceuticals for many patients.

**Endnotes**

Utilizing SNAP to Reduce the Prevalence of Obesity
Allison Hudgens, Hendrix College

To reduce the prevalence of obesity within high-risk populations, Congress should create an opt-in program within the federal Supplemental Nutrition Assistance Program (SNAP) that increases participants’ funding while requiring that their SNAP dollars be budgeted according to USDA dietary guidelines.

According to the Centers for Disease Control, obesity costs the U.S. over $147 billion in medical expenses each year and affects more than one-third of adults. Nearly 70 percent of U.S. adults are overweight or obese. While no group is “immune” to obesity, some are more at risk than others. There is a strong negative correlation between income and the likelihood of obesity. Since low-income groups are most likely to participate in the Supplemental Nutrition Assistance Program (SNAP), the purpose of which is to help end hunger and to improve nutrition and health, SNAP is a good platform from which to address the obesity epidemic. But SNAP may not be improving nutrition or health. Individuals participating in SNAP are often consuming more calories than those with similar incomes who do not participate in SNAP, so they are often more likely to be obese. This may be because SNAP’s monthly payout schedule effectively encourages binge eating followed by energy restriction, known as the “food stamp cycle.” Foods commonly purchased in the food stamp cycle are high in sugar and fat. SNAP participants also consume significantly more soda than non-participants; an estimated $4 billion in SNAP benefits are spent on soda each year. SNAP’s lack of restrictions makes purchasing unhealthy foods and beverages possible. However, SNAP certainly has the potential to improve health and nutrition, as it makes food more accessible.

Analysis
A study conducted by the Harvard School of Public Health found that the prevalence of obesity was 30 percent higher in SNAP participants than in non-participants, even after controlling for socio-demographic factors. According to a USDA commissioned report, increasing the SNAP benefits of participants did not result in an increase in their consumption of healthy foods. However, financial incentives can be used to encourage a healthy, well-balanced diet by specifically designating and increasing SNAP dollars for each food group. Likewise, this policy proportionally increases people’s SNAP dollars if they choose to participate.

Next Steps
The USDA ought to periodically appraise the costs associated with following MyPlate guidelines and fund the program accordingly. An additional premium could also be offered to further incentivize participation. Existing technologies can be harnessed to make this policy work. Most food purchases made by SNAP participants involve optical scanning devices that scan barcodes on food items that contain information about

Key Facts
- 36 percent of U.S. adults are obese
- Obesity costs the U.S. over $147 billion per year
- Low-income groups are at high risk for obesity
the type of food." The Electronic Benefits Transfer system provides participants with a card containing their SNAP dollars that are automatically deducted through purchases and is refilled every month. To implement this policy, the USDA would allocate extra funding to the cards of participants in the new program. As participants buy food products with a barcode indicating a certain food group (for example vegetables) the money spent will be deducted from the card’s vegetable budget. The infrastructure for this policy would be similar to that of WIC, run by the USDA, which classifies specific foods as eligible for participants to purchase. The USDA should implement this policy as a pilot program to evaluate its effectiveness. An existing USDA partnership with New York City has created a program to double the value of food stamps when spent in farmer’s markets. The proposed policy capitalizes on New York City’s openness to SNAP reform and takes the partnership one step further by allowing an increased healthy food budget that can be spent anywhere. The USDA should also consider piloting a program in the South, where both poverty and obesity rates are among the highest in the nation.\textsuperscript{11,12}

Regulating the food purchased with SNAP dollars while offering extra money to buy healthy groceries will increase the quality of food eaten by low-income Americans, a group prone to obesity.\textsuperscript{13} This will relieve the burden on public medical programs such as Medicaid, which uses 11 percent of its expenditures on obesity-related medical conditions.\textsuperscript{15}

**Talking Points**

- Simply increasing SNAP funding does not increase the likelihood of purchasing healthy food.
- SNAP has virtually no restrictions on what food can be purchased.
- Stricter requirements for food purchases coupled with increased SNAP dollars may incentivize healthy eating.

**Endnotes**

6. “Is participation in food and income assistance programmes associated with obesity in California adults?”
8. “Is participation in food and income assistance programmes associated with obesity in California adults?”
15. “FastStats: Obesity and Overweight.”
16. “Adult Obesity Facts.”
Reducing Unintended Teen Pregnancies: Reforming Texas State Code
Madeleine McNally, Mount Holyoke

The Texas Board of Education can reduce unintended teen pregnancies by permitting School-Based Health Centers and nurses to provide access to basic contraception in schools.

School-Based Health Centers (SBHCs) are established health clinics that provide basic care, catering mainly to students. Schools without an SBHC have a designated school nurse. Both SBHCs and school nurses are means by which other states dispense contraception. Yet both are strictly prohibited from doing so according to the Texas Education Code, which states, “A school district may not distribute condoms in connection with instruction relating to human sexuality.” Yet sexually active teenagers without access to contraception are 85 percent more likely to become pregnant within one year. Unintended teen pregnancy is especially prevalent in Texas, where the teen pregnancy rate ranks third highest in the nation. In addition, Texas leads the nation in repeat births among adolescents ages 15 to 19. The high number of unintended teenage pregnancies has a massive societal and financial impact: only 33 percent of teen mothers will graduate high school and 1.5 percent will continue on to pursue a college level degree by the age of 30. High school dropouts and non-college graduates experience significantly worse financial outcomes compared to their peers with degrees. Increasing the likelihood that mothers will be forced to raise their children in low-income households perpetuates a cycle of disenfranchisement and poverty.

By authorizing SBHCs and school nurses to dispense basic contraceptive devices, the Texas Board of Education can help reverse the massive social and economic repercussions resulting from teen pregnancies. In 1986, the Oregon school district of Multnomah County allowed SBHCs and school nurses to dispense contraception to great success. Since implementation of this policy, 96.2 percent of sexually active females who reported to school health facilities for contraception did not get pregnant. Also, teens of both sexes started using contraceptive methods earlier and more frequently. Baltimore, MD had similar outcomes of increased and prolonged birth control use when its school district began dispensing contraception in its SBHCs. While dissemination of contraception often raises concerns about levels of sexual activity, a study done in Los Angeles County High School revealed that students with access to contraception showed no increased rate of sexual activity compared to those without.

Analysis
SBHCs are funded by taxpayer dollars and third-party insurance groups. Thus services

Key Facts
- Texas ranks third highest in the nation for unintended teen pregnancies, at 63.4 pregnancies per 1000 teens ages 15 to 19.
- In 2008, publicly funded family planning services helped avoid 98,700 unintended pregnancies in Texas.
- An unintended pregnancy costs $9,000 on average from taxpayer funds.
such as birth control are free for students. Given that adolescent pregnancies cost the state of Texas $1 billion in taxpayer dollars each year, the cost of stocking SBHCs with contraception would be extremely small in comparison. In 2008, publicly funded family planning services helped to avoid 98,700 unintended pregnancies in Texas, which would have potentially resulted in 43,900 births, 41,200 abortions, and 13,600 complications.\(^9\)\(^9\) With an unintended pregnancy costing taxpayers $9,000 on average, births in the year 2008 alone would have cost approximately $395,100,100.\(^11\) This does not even take into consideration the annual inflation of yearly expenses to raise these children. Since many teenage mothers are forced to drop out of high school, their potential earnings are vastly decreased. An average high school dropout can be expected to make $973,000 in a lifetime, in comparison to those with a bachelor’s degrees who will earn $2,268,000.\(^12\) Because their potential educational achievements are curbed by motherhood, adolescent mothers have little opportunity for advancement, forcing many into difficult environments for raising children. By extending family planning services to Texas’s SBHCs, taxpayers will save millions of dollars while increasing the chances of success for thousands of young women.

**Next Steps**

Policymakers in Texas should revise the education code to permit the dissemination of basic contraceptive services in school district health facilities. In doing this, the Texas Board of Education will drastically decrease the numerous costs of unintended teen pregnancies while fostering safer habits among sexually active teens.

**Endnotes**

5. Ibid.
7. Ibid.
Improving Healthcare Through Text Messaging

Chukwuma Onyebeke, Teshika Jayewickreme, Yvette Odu, Feras Alajmi
Yale University

Patient compliance poses a major challenge for health practitioners. Despite the wealth of health information available, compliance is low across most demographics, with the lowest rate among low-income and minority groups. One major hurdle is that medical information is not effectively conveyed to patients. A University of Florida study shows that physicians frequently overestimate a patient’s ability to translate medical advice into practice.

Additionally, health departments currently disseminate health information broadly, making finding pertinent health information difficult for patients. Targeting health information to patients can solve these problems. High text message usage amongst minorities and low-income families makes it a powerful information delivery system. Health care professionals can reinforce important themes by sending patients specific information during critical periods through targeted text messages. Using an automated texting platform in conjunction with healthcare expert contact can expand preventative care to low-income individuals.

Analysis

A University of Southern California study found that educational literature on diabetes management delivered through a texting-based program promoted healthy behavior changes among low-income diabetes patients. While not intended to replace interactions with healthcare professionals, this mobile initiative would work to increase patient compliance.

The deployment of such an initiative is also cost effective. Partnering with hospitals ameliorates costs by utilizing existing infrastructure and personnel. Furthermore, since most at-risk patients own cell phones with texting, there is no additional cost to them. Through the use of online customizable platforms such as Twilio, each patient can be served for less than $2 a month. Several hospitals using patient education programs have reduced healthcare costs by up to 20 percent. Through patient education, mHealth initiatives will increase patient compliance and reduce healthcare costs.

This policy would provide local residents with tailored information for maintaining healthy lifestyles. Additionally, local hospitals would provide necessary infrastructure and personnel while government social programs such as the Supplemental Nutrition Program for Women and Children (WIC) and Medicaid would guide low-income residents to these mHealth programs. Local and state health departments would also be

Key Facts

- 83 percent of American adults own cell phones and 73 percent of them send and receive text messages.
- According to the Cellular Telephone Industries Association (CTIA), monthly text messaging has increased from 18.7 billion in 2006 to 193.1 billion texts in 2011.
- According to the “The Emerging mHealth: paths for growth” study, on average, “about half of patients say that mHealth will improve healthcare.”
valuable resources in funding and implementing the mHealth programs.

**Next Steps**

Strong partnerships must be made between local hospitals and the personnel implementing the mHealth programs in order to identify local health disparities. Additionally, support from local and state health departments must be garnered in order to have the proper resources to implement mHealth initiatives. The messages could be constructed using available public health literature along with expert opinions in the field. Local and national organizations, such as WIC, can be valuable resources, as they craft material specifically for public consumption. To further test the effectiveness of the material, focus group interviews using local individuals may be conducted. A mobile texting platform, such as Twilio, may be programmed to automate the information delivery system. Such platforms allow for the personalization of texts based on subscriber characteristics and data collection. Thus, healthcare providers will be able to both deliver targeted information and gauge compliance.

Deployment would first involve testing the efficacy and acceptance of a texting-based support system within the community through pilot studies and clinical trials. Based on these results, the platform may then be deployed to multiple locations and the patient base could be expanded. These programs could also be incorporated into health insurance plans so that insurance companies can cover some of the costs while widening the patient base.

**Endnotes**

Preventing Stigma and Shortage in the Nation’s Blood Supply

Matthew Quallen, Georgetown University

In order to secure the American blood supply during a shortage and prevent sexual stigma, the FDA should revise its current lifetime ban on blood donations from men who have had sexual relations with other men to a one-year deferral period.

Since 1983, the FDA has enforced a lifetime deferral on blood donations from men who have had sex with men (MSM) at any time since 1977. The stated goal of this policy is to reduce the risk of introducing HIV into the blood supply. Over the lifetime of this policy, however, HIV screening tests have become incredibly reliable.

In June 2012, the American Red Cross declared that blood supplies were at “emergency” lows, suggesting that emergency or elective procedures might have to go unperformed due to the shortage of blood products.

Analysis

The tremendous advances in testing technology and the dire need for donations to the blood supply call for the FDA to revisit its current policy, which is inconsistent with deferral periods for other high-risk sexual activities. For example, a one year deferral period is maintained for individuals who have had sexual contact with an HIV positive individual.

As early as 2006, the American Red Cross, the American Association of Blood Banks (AABB), and America’s Blood Centers (ABC) called for the policy to be revised, declaring it antiquated and unscientific. They were met with intransigence.

The Williams Institute has conducted research into the implications of revising the ban, finding that the Red Cross’s recommended one-year deferral period would increase the pool by over 1 million eligible donors, and that approximately 90,000 additional units (pints) of blood could be donated annually. This number does not account for the fact that an end to counter-productive forms of protest against this ban – boycotts of blood drives on some college campuses – would potentially also contribute to increased blood donation.

The Red Cross states that the increasingly computerized blood bank system reduces the risk of releasing untested blood to zero, leaving testing failure as the main source of risk to the blood supply. The FDA reports that the failure rate of its HIV testing is about one in 1.5 million, due principally to the so-called window period, which, at about nine days, falls well within the proposed deferral period of one year.
At current test failure rates, a change to a one-year deferral period would most likely introduce only one tainted unit of blood into the supply between now and 2030.\textsuperscript{8}

**Next Steps**

The risk of introducing HIV into the blood supply is negligible, especially when compared to the threat posed by “emergency low” levels of blood supplies in the United States.

The continued maintenance of a lifetime deferral policy is inconsistent with current understandings of risk, testing technology, and recommendations from organizations involved in the safety and collection of the American blood supply. This same policy perpetuates stigma and, held to a scientific standard of scrutiny, cannot be justified.

The FDA should revise its current lifetime ban on MSM blood donation to a one-year deferral period. This can be carried forward by regular FDA processes, legislative or executive action, APA (legal) challenge, or administrative constitutionalism, wherein the FDA would internally reach the conclusion that its policy is inconsistent with the constitution.\textsuperscript{9}

**Endnotes**

3. “Joint Statement Before ACBSA on Donor Deferral for Men Who Have Had Sex with Another Man (MSM) – 6/15/10.”
4. Ibid.
6. “Joint Statement Before ACBSA on Donor Deferral for Men Who Have Had Sex with Another Man (MSM) – 6/15/10.”
CREATE A YOUTH PIPELINE FOR HHS FEDERAL ADVISORY COMMITTEES OVERSEEING HEALTH CARE REFORM

RAHUL REKHI, RICE UNIVERSITY

The federal government should appoint youth representatives to key federal advisory committees overseeing health care reform.

In 1972, the passage of the Federal Advisory Committee Act (FACA) heralded a new era of citizen representation in American government. The legislation called for the creation of active advisory councils throughout the federal government to provide a forum for citizens – expert and otherwise – to share their perspectives, guidance, and recommendations across the spectrum of public policy. Today, over 1,000 such committees exist in 50 different federal agencies, with almost 300 in healthcare alone.

FACA was written into law with the mandate that these advisory councils must represent broad, diverse, and wide-ranging points of view, spanning different professions, ethnicities, genders, beliefs, and even ages. In practice, however, this representation omits one key demographic in particular: American youth. Though we lack quantitative studies documenting this systematic underrepresentation, a cursory glance of federal advisory council (FAC) rosters shows a distinct lack of young Americans or Millennials. The very group that stands to be principally affected by the implementation of health reform is also the one singularly underrepresented in the decision-making process.

ANALYSIS

In order to address this lack of representation, the Department of Health and Human Services (HHS) should ensure that Americans between the ages of 18 and 30 to have their voices heard in the health policymaking process. In particular, focus on three key areas is needed in health reform going forward: prevention, technology, and education. Accordingly, this proposal specifically targets appointing young Americans on the A) National Prevention Council’s Advisory Group on Prevention, Health Promotion, and Integrative and Public Health, B) Health IT Policy Committee, and C) Center for Medicare and Medicaid Services’ Advisory Panel on Outreach and Education.

Increasing youth representation on federal advisory committees within HHS has numerous legal, political, and ethical benefits. Legally, there is a strong case to be made for the need for youth representation on HHS FACs. By law, in fact, the council composition must encompass a diverse range of membership, leaving the issue of persistent youth underrepresentation open to a judicial line of attack. Politically, the creation of a youth pipeline could result in an overhaul of policy discourse and outcome. The youth representatives bring the voice of their generation into the health policy debate. A recent national survey of

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**Key Facts**

- There are 46 million Millennials in the 18 to 29 voter block, comprising 20 percent of the voting population, and it is projected to reach 44 percent by 2020.
- There are over 300 federal advisory committees on health policy, almost none of which have youth representation.
- Millennials believe in the government’s capacity for problem solving in healthcare at rates above the national average.
adults compiled by the Public Religion Research Institute suggests that today’s Millennials tend to favor policies that promote equity and egalitarian principles. A full 44 percent have faith in the federal government’s capacity for problem solving, such as by providing universal health coverage.⁶

This viewpoint would clearly benefit the policymaking process, as well as politics more broadly. As young adults who are disillusioned about their ability to influence policy see their interests tangibly represented in national health policy implementation, they will likely turn out at the polls in greater numbers. Political groups advocating for youth representation on FACs may enjoy a groundswell of support among this key demographic. The potential for youth voter gains, both in terms of turnout and behind candidates that support the pipeline proposal, is significant; Millennials turn out in the polls at rates that are 10 to 20 percent lower than the national average.⁷

Ethically, too, there is considerable motivation. After all, Millennials are the demographic most likely to be affected by healthcare reforms in the long run, particularly since A) they form a demographic with some of the highest rates of underinsurance and B) the effects of most proposals, including those in the Affordable Care Act, will be implemented over a period of several decades.

Next Steps
Potential partners include national nonprofit organizations dedicated to advancing health care for American youth, including Young Invincibles and Families USA. Aligning this initiative with the interests of existing NGOs and advocacy organizations will be critical to its success. Such partnerships must necessarily be paired with media outreach along with the support of public officials—including local members of Congress, who may benefit from the resulting increased youth voter support.

The challenge of deciding which young Americans to appoint to these advisory councils might prove a contentious issue. To address this concern, young adults should be considered for FAC placement in a manner analogous to existing appointments, including a rigorous application and referral process.

Endnotes
4. Ibid.
6. Ibid.
Effective Communication: Health Literacy and Continuing Medical Education

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State medical boards should require Continuing Medical Education (CME) courses that teach physicians how to effectively relay healthcare information to patients.

Although health literacy is necessary for patients to make informed decisions, problems arising from the widespread lack of patient health literacy are often overlooked. Health literacy is defined as “the degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions.” For example, Williams et al. showed that nearly half of patients with hypertension or diabetes illustrated inadequate health literacy concerning their diagnoses despite attending previously provided classes addressing their respective health conditions. Patients often lacked even basic health knowledge, including that exercise lowers blood pressure or that symptoms of shaking and weakness indicate low blood sugar.

Low health literacy has several effects on individuals and society. According to the American Medical Association (AMA), poor health literacy is a stronger predictor of a person’s health than age, race, income, employment status, or education level. Seniors over the age 65, immigrants, racial minorities, and low-income citizens are most vulnerable to health illiteracy for a variety of reasons, including fewer educational opportunities, learning disabilities, cognitive decline, and impaired reading ability. The financial costs of poor health literacy are staggering. Some reports estimate that problems with health literacy cost the U.S. between $50 to $73 billion per year. Other publications report U.S. economic losses between $106 billion and $238 billion annually due to medical problems stemming from low health literacy, reflecting up to 17 percent of total healthcare costs.

Analysis
The low health literacy problem often results from a lack of communication between healthcare providers and patients. The average American cannot comprehend medical terminology and diagnoses without training. Healthcare providers are often patients’ only source of health education, so teaching physicians to communicate more effectively with patients is crucial in improving national health literacy. If physicians learn to communicate health information clearly and effectively, patients will be able to utilize
pertinent health information to reduce the health risks associated with poor health literacy. The AMA offers CME programs in health literacy. However, these CMEs are not required for physician re-registration.7 Requiring physicians to complete CME classes addressing health literacy and communication improves the overall health of patients by teaching doctors strategies to effectively convey vital healthcare information. CME classes provide physicians with techniques to convey crucial health information to patients with low health literacy. The workshops would also provide doctors with tools such as posters, fliers, and online resources to help explain medical procedures to patients. They would offer questionnaires to determine patient health literacy and strategies to improve medical offices to accommodate patients with low health literacy. Mandating that physicians attend CMEs targeting patient health literacy will guarantee that physicians are adequately trained to communicate health information to patients.

**Next Steps**

A nationwide requirement for health literacy CMEs is both difficult to approve and to implement. However, federal grants to state boards to develop health literacy workshops could encourage states to adopt health literacy CMEs as a requirement for physician re-registration. As the Affordable Care Act states in Section 5301, awarding grants to encourage health literacy CMEs “provide[s] training in enhanced communication with patients, evidence-based practice, chronic disease management, preventive care, health information technology, or other competencies as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Care Workforce Commission.”8 Mandating CMEs does not only yield health benefits, but also compelling financial benefits. In comparison to the hundreds of billions of dollars lost due to preventable problems with health literacy every year, the federal expense for accredited CME provision in 2011 totaled $69 million.9 Funding health literacy workshops would play a crucial role in encouraging state boards to require a health literacy CME as part of physician re-registration and represents an attempt to address the problem of poor health literacy in America.

**Endnotes**


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Sickle Cell Disease Screening Programs in Urban Africa

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Establishing screening programs for sickle cell disease will streamline resource allocation, address the lack of current data, and reduce childhood mortality associated with the disease.

Sickle cell disease (SCD) is caused by abnormal hemoglobin structure, causing deformed, sickled red blood cells that can clot easily. Globally, 7 percent of humans carry an SCD variant. Africa has high estimates of SCD-related mortality, particularly in children, but lacks reliable data to address the issue. The most recent major studies tracking SCD found associated child mortality to be as high as 50-70 percent in Africa, but the studies were conducted in the 1970s. Without relevant epidemiological data, providing medical aid to areas of greatest need is impossible. Systematic data collection allows countries to intensify efforts in areas that need the most help and can successfully decrease the incidence of other African diseases, including HIV/AIDS.

Analysis

To address the current lack of data, SCD prevalence and mortality information need to be systematically recorded. Newborn screening is an important and effective step in such data collection. U.S. newborn screening resulted in a 68 percent reduction in SCD-related mortality in ages zero to three. Once diagnosed, caretakers can plan and raise their families accordingly with education from health care providers and genetic counselors. Paired with education, data is key to this process, as it allow states to allocate resources for preventive measures. Awareness and education have greatly reduced SCD childhood mortality rates because of the availability of treatments like prophylactic antibiotics and vaccinations. Recent tests of a new pneumococcal vaccine (PCV7) for children have been dramatic in reducing bacterial infections, which are the main cause of SCD-related infant mortality. Vaccines require no follow-up, an important factor where resources are scarce – parents simply bring their children to clinics. Newborn screening is more effective than other strategies because it helps decrease child mortality and can decrease SCD incidence. Additionally, it is cheaper and less invasive than alternatives.

Revolutionary testing methods, such as IEF testing and HPLC testing, will continue to push testing costs down. Both are inexpensive, ranging from $3 to $5 in some areas.

Key Facts

- SCD is the most neglected tropical disease.
- SCD is a global health problem, as 7 percent of the world carries some variant.
- Over 300,000 are born with the disease annually.
- Estimates for newborn screening costs for SCD range from $3 to $5.
- Newborn screening has led to a 68 percent reduction in SCD-related infant mortality.
- Like AIDS, a huge barrier to SCD treatment is stigmatization. Education is key to overcoming this problem.
Children with SCD and families in regions of Africa experience the disease firsthand. Sexually active persons may be unaware carriers, making awareness key to family planning. Parents of SCD patients should know how to get help to prevent complications. Also, governmental agencies and relief workers as local health departments and hospitals should implement newborn screening programs to decrease childhood mortality. They should allocate resources to sectors reporting the highest SCD incidence. Global Aid agencies (WHO, etc.) will be crucial in funding efforts once these critically afflicted areas are recognized.

**NEXT STEPS**

Hospitals in Africa should test blood samples at birth in order to diagnose SCD immediately and track its current distribution.\(^6,10\) Compiling relevant data must begin with accurate record keeping by health care providers. Given enough funding, this would translate to electronic systems capable of tracking the data. Newborn screening programs, clinics to treat sickle cell crises, educational centers, and prophylactic antibiotics and vaccines distribution would have to be established first. Several parallel educational programs exist for other prevalent diseases, including AIDS and malaria, so partnerships with these programs would more efficiently use resources, such as hospital space and genetic counselors.\(^5,10\) Eventually, a “disease toolkit” could be used to simultaneously screen for common endemic diseases, including malaria, AIDS and SCD.

**ENDNOTES**

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