ROOSEVELT INSTITUTE CAMPUS NETWORK

10 IDEAS
HEALTH CARE

Policy of the Year Nominee
HOW TO TACKLE THE BIKE SHARE HELMET PROBLEM
10 Ideas for Healthcare 2014

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**Who We Are**

Established in the wake of the 2004 election, the Roosevelt Institute | Campus Network was formed by college students across the country in order to engage our generation as powerful actors in the policy process. They envisioned a movement in which young people could fill the critical ideas gap in their communities, generating new solutions for the nation’s greatest challenges.

We believe in the value of a robust and active democracy, one in which all citizens have the opportunity to positively impact communities they love. By giving students a platform to elevate their ideas for local, regional, and national change, we contribute to that vision.

**What You’re Holding**

Now in its sixth year, the 10 Ideas series promotes the most promising student-generated ideas from across our network. This year’s journals, which include submissions from 20 different schools located from New York to Georgia to California, stand as a testament to the depth and breadth of these student ideas.

Entries in 10 Ideas are selected for publication on the basis that they are smart, rigorously researched, and feasible. Simply put, they’re darn good ideas.

**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 www.rooseveltcampusnetwork.org or by tweeting with us @Vivaroosevelt.

Thank you for reading and supporting student generated ideas.
Dear Readers,

December 2014 will mark ten years since a group of college students united behind a new model for engaging young people in the political process, a model that became the Roosevelt Institute | Campus Network. Deeply grounded in the belief that young people have more to offer than just showing up on Election Day, the Campus Network has continued to evolve and grow from its visionary beginning into the nation’s largest student policy organization, with a membership capable of shifting dialogue and effecting policy at the local, state, and national levels.

We believe that in the context of a stagnant public discourse and increasing disillusionment with a political system incapable of tackling our complex collective challenges, it is more important than ever to invest in a generation of leaders committed to active problem-solving and concrete change in the public sphere. As the Campus Network expands to more than 120 chapters in 38 states, we serve as a vehicle for fresh ideas, exciting talent, and real change.

In these pages you will find some of those ideas - from reforming western water rights to supporting green infrastructure through progressive toll taxes, students are envisioning and acting on better solutions. It’s indicative of our Network’s larger impact; in the past year, we’ve leveraged the effectiveness of our model to work with and inform dozens of other organizations on how to engage Millennials on critical issues, ranging from campaign finance to inequality to climate change. We’ve elevated a fresh, Millennial-driven vision for government in an otherwise stale public debate, and launched an initiative that taps into our generation’s unfettered thinking and ambition to reimagine the role of citizens in shaping fairer and more equitable local economies. Our members have continued to substantively engage in local processes to shape and shift the policy outcomes that directly impact their communities, from introducing new mapping systems to improve health outcomes in low-income neighborhoods to consulting local governments on flood prevention.

These ideas are just the starting place, because ideas are only powerful when acted upon. Yet this work is occurring in a dramatically shifting political and social context. The ways citizens engage their government,
participate locally, and advocate for their communities are changing every
day. As a vibrant, evolving network driven by our active members nation-
wide, we believe there is immense potential to capture these innovations
and ensure better and more progressive ideas take hold. We believe that:

• Millennials are turning away from traditional institutions and are
looking to build new ones as vehicles for social change. We be-
lieve there is an opportunity to channel this reform-mindedness
into building a healthier, more inclusive system that’s responsive
to citizen engagement and evidence-based solutions.

• To jump-start political engagement and combat disillusionment,
the focus needs to be on pragmatic problem-solving and inter-
sectional thinking across key issues. We can no longer tackle
economic mobility separately from climate change.

• There is immense potential (and need) for scalable policy inno-
vation at the local and state levels, and much of the most effec-
tive and important policy change in the coming decade will be
local.

• With the shift from top-down institutions to networked ap-
proaches and collective problem-solving, it is more important
than ever before to invest in the development of informed,
engaged community leaders capable of driving engagement and
action on ideas.

As you engage with the ideas, ambitions, and goals in these journals, I
encourage you to dig in and explore how our country’s future leaders are
taking the initiative to create the change they know we desperately need.
You won’t be disappointed.

Happy Reading,

Taylor Jo Isenberg,
National Director
Congratulations to

**Torre Lavelle**

author of How To Tackle The Bike Share Helmet Problem

Nominee for Policy Of The Year

A jury of Roosevelt Institute | Campus Network members, staff and alumni elevate one piece from each journal as a nominee for Policy Of The Year based off the quality of idea, rigor of research and ability to be implemented effectively. The cover design of this journal is themed to portray the above idea in visual form.
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Mental Health First Aid in Pennsylvania Public Schools
Emily Cerciello and Muad Hrezi, University of North Carolina at Chapel Hill

Public school teachers in Pennsylvania should receive Continuing Professional Education credit for completing the Mental Health First Aid program to promote early detection and treatment of mental illness.

Every day, children and adolescents living with mental illness struggle to access basic treatment resources. One in five youth meets criteria for a mental disorder,1 but only half of affected children received treatment in the last year.2 Common mental disorders, including anxiety, mood, behavioral, and substance use disorders, often emerge in childhood and adolescence.3 There exists an average 8 to 10 year gap between onset of symptoms and treatment interventions,4 which is costly for both taxpayers and the health care system.

Mental Health First Aid (MHFA) is an interactive 8-hour training program that aims to help the public identify, understand, and react to signs of mental illness, or reduce the harm that an individual may cause to themselves or others during a mental health crisis.5 MHFA strives to increase knowledge and confidence, reduce stigma, and improve the effectiveness of a community in connecting individuals with unmet mental health needs to treatment resources.6

MHFA shows great promise for educators. At a Canadian University, educator training in Mental Health First Aid resulted in a knowledge increase of between 18 and 32 percentage points in every category of mental illness, and a 30 percent increase in confidence to react to

**KEY FACTS**

- In Pennsylvania, 118,000 educators serve 1.8 million public school students daily.17,18

- One in five youth currently meets criteria for a mental disorder.19

- Half of mental illnesses in children remain untreated each year.20

- The economic cost of untreated mental illness is more than $100 billion annually.21
a mental health crisis. A course for high school teachers in Australia increased teachers’ knowledge, reduced stigma, and increased confidence in providing help to students.

ANALYSIS
Public school teachers in Pennsylvania should receive Continuing Professional Education (CPE) credit for completing the Mental Health First Aid program. Act 48 of 1999 requires all Pennsylvania educators with public school certification to complete 180 hours of CPE every 5 years to remain certified. Educators can meet these hours by pursuing collegiate study, completing approved CPE courses, or attending relevant trainings and conferences. Included are courses or noncredit activities in the areas of student health as well as safe and supportive schools, under which MHFA would qualify.

If MHFA training reaches just 5 percent of Pennsylvania educators, the program will affect 90,000 students. Approximately 360,000 Pennsylvania students experience some form of mental illness, with an estimated half of these cases remaining untreated. Currently, MHFA training is provided free of charge by several community organizations in southeastern Pennsylvania. MHFA is a practical and economical solution for Pennsylvania youth, as every $1 invested in mental health treatment saves $3 to $8 in reduced criminal activity and hospitalizations. Amid a $55 million cut to Pennsylvania’s mental health programs in 2012 and continued cost pressures in 2013, investing in early identification and treatment can save money for the state while improving outcomes for vulnerable public school students.

ENDNOTES

TALKING POINTS
• The US Surgeon General considers schools to be a major setting for the potential recognition of mental disorders in children and adolescents.
• Mental Health First Aid increases teachers’ ability to recognize signs of mental illness and provides strategies to connect students to treatment resources.
• Incentivizing teachers to complete MHFA by receiving CPE credit is a cost-effective solution for Pennsylvania’s struggling mental health system.
Next Steps

First, the Pennsylvania Department of Education must recognize MHFA as an approved CPE course to incentivize educator attendance. Second, the number of MHFA trainings and enrollment capacities for trainings must increase. To lay the foundation for sustainable success, implementation must begin at the grassroots level, with mental health advocates and educators contacting legislators and the Department of Education to recognize the Mental Health First Aid program as an approved CPE option.
Establishing a mentorship program that gives medical students interested in primary care the ability to experience the clinical aspects of the field along with the opportunity to be fostered by their mentors will increase the number of primary care physicians in New York State.

Primary care physicians (PCPs) are trained for and skilled in comprehensive first contact and continuity care. Primary Care is proven to provide better health outcomes and lower costs by reducing hospitalization, promoting disease prevention, and managing chronic diseases.¹

In 2011, New York State had about 18,000 primary care physicians that cared for 19.6 million New York State residents.² Currently, roughly 12 percent of medical school graduates are entering primary care, not enough to match the demand of PCPs in the US.³ By 2030, growth in demand for physicians in New York State will likely outpace growth in the supply of physicians. There is a forecasted shortage of up to 17,000 PCPs by 2030 because of the increase in insurance coverage enacted by the Affordable Care Act.⁴ There is significant gap between the number of available PCPs and the large medically underserved population. This primary care shortage is primarily due to medical school debts, underpayment, and a stressful work environment.

The Affordable Care Act also indicated the need to train more PCPs because of increasing health care coverage.⁵ Studies have shown

**KEY FACTS**

- In 2011, New York State had about 18,000 primary care physicians who care for the state’s 19.6 million residents.²
- Roughly 12 percent of graduating medical students enter the primary care specialty.³
- By 2030, growth in demand for physicians in New York State will likely outpace growth in the supply of physicians. There is a forecasted shortage of up to 17,000 PCPs by 2030 because of the increase in insurance coverage enacted by the Affordable Care Act.⁴

Confronting the Primary Care Physician Shortage through Mentorship

Kimberley Downer, Melissa Audige, and Angela Choi, City College of New York
that mentorship is an important part in the success of physicians. The Medical Student Home (MeSH) program and iLearn Mentor Program are two examples of effective mentoring programs.

**ANALYSIS**

Medical students who show interest in primary care are usually discouraged or lose interest halfway through medical school. Mentorship is a formal social support that includes emotional and informational support; it is important for medical professional development. The mentorship program is a cost-effective tool as compared to some of the other provisions in the Affordable Care Act created to encourage the increase of PCPs. Students enrolled in a mentoring program for the full course had a residency match rate of 87.5 percent in the first year and 78.9 percent in the second year compared to 55.8 percent and 35.9 percent of students that left the program. Overall, students who participated in mentorship had a higher match rate to primary care.

The iLearn Mentoring Program provides a forum for doctors to share their career experiences with students. However, the iLearn mentoring program lacks an interpersonal dimension and face-to-face meetings are not required. The MeSH program at Quinnipiac Medical School allows medical students to see patients in the office setting over an extended period of time. Under a supervising physician, the student works alongside the clinical care team. Our proposal aims to combine the strengths of these two programs.

**TALKING POINTS**

- The US has a shortage of primary care physicians.
- By 2030, in New York State, the demand for physicians will likely outpace growth in the supply of physicians.
- Students who had continuing participation in a mentoring program have a higher matching rate to primary care residencies.

**ENDNOTES**

Next Steps

New York State medical schools should seek partnership with primary care organizations such as the American Academy of Family Physicians (AAFP) for medical students. The AAFP currently provides mentorship for medical students throughout the country. This mentoring program will engage students in primary care before and during the rotations stage of medical school. Establishing a mentor prior to a medical students’ residency will help decrease the shortage gap of primary care physicians by increasing the number of students choosing primary care residencies. Students will be paired with practicing primary care physician and will be provided with opportunities to shadow doctors and clinic staff. Along with this component, mentors will stress the importance and value of the primary care field.

Working alongside a PCP can influence students to become practicing PCPs in New York State. Through the mentoring program, medical schools will be able to identify students that have an interest in becoming PCPs and guide them through the residency application process to assure that they will be able to become PCPs. Students who pursue primary care in New York’s medically underserved areas are eligible for loan forgiveness. This new mentoring program will allow students to gain experience and knowledge before choosing their careers, therefore sustaining and increasing the amount of students who become PCPs.
Mental Health in Fairfax, Virginia, High Schools
Serena Gobbi, Georgetown University

High schools can transform the attitudes stigmatizing mental illness by implementing the QPR suicide prevention program, which empowers students by giving them the tools necessary to act in mental health crises.

High schools currently design mental health programs around crisis intervention, intervening only once a problem has been identified, which limits the community’s involvement and knowledge of mental health problems and contributes to the stigma surrounding mental illness. Unfortunately, half of all Americans will suffer from mental illness at some point in their lives. One of the most devastating forms of mental illness is depression, which can lead to suicide, a rising problem among teens. Instead of stopping suicide through crisis intervention, high schools should move towards secondary prevention, focusing on teaching communities methods to diagnose depression in early stages. Concentrating on prevention will not only save lives, but also begin a needed dialogue on mental health, which will reduce the ignorance surrounding depression and other mental illnesses.

Analysis
The US Department of Health and Human Services calls the stigma associated with mental health the “most formidable obstacle to future progress in the arena of mental illness and health.” One successful evidence-based program that has brought de-stigmatization and secondary prevention to hundreds of college campuses is Question, Persuade, Refer (QPR), which is similar in concept to CPR training. QPR teaches students to recognize situations

Key Facts
- Half of all Americans suffer from mental illness at some point in their lives.
- QPR is a program designed to prevent suicides and empower students by teaching them how to be responders instead of bystanders during suicide crises.
- Implementation of QPR across the Fairfax County, Virginia, high schools would cost an estimated $3 per student.

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involving depression and potential suicide and intervene appropriately. Instead of remaining bystanders, students gain the confidence to ask someone if he or she has suicidal thoughts.

QPR has been taught to firefighters, policemen, and college students with great success. More recently, a QPR program geared toward youth has been developed in Northern Idaho.\(^6\) Crucially, QPR also includes three review sessions per year, which has been shown to significantly boost effectiveness.\(^7\)

Fairfax County, Virginia, is an ideal candidate to implement QPR across its public high schools. After the tragic Virginia Tech shooting of 2007, public support pushed for legislation that successfully altered Virginia’s mental health system.\(^8\) Any substantial change to school systems requires public support, and Virginia’s demonstrated commitment to mental health reform bodes well for implementing QPR in Fairfax County, which with the second highest median household income in the country, has the financial resources to support it.\(^9\)

Fairfax currently employs 140 psychologists and social workers. There are 25 high schools with approximately 49,000 students total.\(^10\) A QPR unlimited Level I license to train all students, staff, willing parents, and stakeholders of the school system costs $1 per enrolled student per year. Together with the costs of training roughly three instructors per school, an annual estimate based on this data would total $150,000, about $3 per student. Fairfax currently spends $13,472 on each student, so $3 would be 0.2 percent of per student expenditure.\(^11\)

**TALKING POINTS**

- Ending the stigma surrounding mental illness should be a basic goal of high school health systems.
- Through QPR, not only are high-risk students helped, all students are given the confidence to address mental health issues.

**ENDNOTES**

Fairfax has the necessary infrastructure for QPR in place already. Its Office of Intervention and Prevention Services provides close supervision over school mental health professionals. The directors of the QPR program, coordinating with the central office, could directly train instructors, probably school psychologists and social workers, and then provide the support material for those employees to teach staff, students, and willing parents QPR. Both in-person and online training options are available, allowing implementation across additional locations.

Once Fairfax commits to using QPR, the summer provides an ideal time for initial planning and instructor training. QPR could then be implemented during the school year in 90-minute sessions. The program in Fairfax county could serve as a guide to implementation across Virginia and, ultimately, across the US.
To provide SNAP participants with fresh produce and boost local farming economies, Congress must launch a Community Supported Agriculture (CSA) initiative with nutrition education based on successful existing infrastructure.

Low-income families face the highest obesity rates, and children living in these households have a 25 percent obesity rate. This is attributed to lack of nutritional education and inability to afford fresh produce. Adolescent dietary habits also persist into adulthood. A daily serving of fruits and vegetables costs $2.18, which some families cannot afford. While the Supplemental Nutrition Assistance Program (SNAP) provides participants with funds to buy food, a USDA study shows that participants buy more food composed of simple starches and sugars instead of healthier, more expensive food. In 2012, the average monthly per capita SNAP benefit was $133.41. Currently, the SNAP program is facing scrutiny due to concerns regarding effectiveness.

Community nutrition education along with SNAP participation has resulted in healthier decisions among participants. Cornell Cooperative Extension in Onondaga County has a six-week program that teaches SNAP participants nutrition and cooking education. A follow-up of 18,690 graduates found 87 percent improved diet quality, 79 percent improved food purchasing practices, 64 percent improved food handling practices and 41 percent increased frequency of exercise.

Community Supported Agriculture (CSA) is a shareholder-supported financial scheme in which subscribers pay a fee (or a share) to
farms in the beginning of a crop season to finance production costs and, in turn, receive boxes of produce on a weekly basis. The average cost per share is $400 a season for a family of 4 to 6 people. A season generally lasts 22 weeks, from May to October. Winter subscriptions are available for farms that operate year-round. CSA farms post higher profits than non-CSA farms.\textsuperscript{10} CSA’s are popular in both rural and urban areas—as of 2007, 12,549 CSA farms existed in the United States.\textsuperscript{11} Food boxes can be picked up at a central location or easily dropped off door-to-door.

**ANALYSIS**

A mutually beneficial relationship between food insecure, low-income families and a growing area of agriculture can flourish with government support. SNAP restrictions are insufficient in providing a nutritious, balanced diet.\textsuperscript{12} It costs $532 per month in SNAP funding to feed a 4 person family. The proposed $400 season-long share is a cost-effective way to provide families with fresh produce. In comparison, buying produce at supermarkets for the same season costs $1438. Balancing funds entails reducing funds per family to $459 per month. However, some farmers markets incentivize SNAP participants $2 in credit for every $5 spent.\textsuperscript{13} It is possible to reapply this credit so that each $400 CSA share yields $160 in general SNAP funds.

This program would be most effective if implemented with an educational component catered toward low-income families with young children developing eating habits. Encouraging families to establish healthier habits for their children is crucial, as poor food choices contribute to childhood obesity.\textsuperscript{14} A longitudinal study focusing on adolescent food choice behaviors recommends “interventions should begin prior to sixth grade, before behavioral patterns become more difficult to change.”\textsuperscript{15}

**TALKING POINTS**

- A study performed in Southwest Iowa found that a modest increase in fruit and vegetable production on farms could bring an additional $2.67 million in labor income and 45 farm-level jobs to the region.\textsuperscript{16}

- Obesity rates are highest in lower-income households, where financial access to healthier foods is often not an option.\textsuperscript{17}

- Purchasing a CSA subscription for a family of 4 to 6 would save $1000 in fresh produce purchases that would otherwise be purchased at a supermarket over a 22 week period.
ENDNOTES


Next Steps

SNAP participants will automatically be eligible to opt-in to the CSA program. CSA boxes are easily transported to rural residents, and can be quickly shipped into urban areas, where a large proportion of SNAP participants live. Weekly programs in urban areas will be modeled after the Cornell Co-Op Extension in Onondaga County and host nutrition and cooking programs at a central location at which CSA boxes will be distributed. Program graduates will receive a cookbook and remain eligible for the SNAP-CSA option. The rural program will be similar, involving educators, student interns and volunteers that are a part of the existing low-cost infrastructure to deliver the crates while teaching nutrition and cooking strategies within individual homes. Prior to implementation, individual sites should first be evaluated to ensure adaptability of the aforementioned Cornell Co-Op Extension program to account for differences of cross-regional contexts.
A Tax-Deferred Trust: Reducing the Financial Burden of Families with Special Needs Children

Mitra Kumareswaran, The University of Georgia

Congress should approve a tax-deferred special needs trust fund to alleviate the financial strains of parents with special needs children and to reduce the societal cost of taking care of special needs individuals.

More than 20 million families in the US have at least one family member with a special need.\(^1\) The Center for Disease Control’s Autism and Developmental Disabilities Monitoring Network states that 1 out of 88 children have been diagnosed with autism.\(^2\) The US Department of Agriculture estimates that a family spends an average of $241,080 (excluding college fees) raising a neurotypical child from birth to age seventeen.\(^3\) For parents of special needs children, this expense, much of which is out of pocket, can quadruple to enormous figures such as $964,320.\(^4\) Parents of children with autism will spend approximately $60,000 a year to cover their child’s therapy and medical bills. The costs and needs are similar for special needs individuals with conditions outside of the autism spectrum disorder. Depending on the IQ level of the disabled, lifetime expenses can vary from $1.4 to $2.3 million.

On top of current health expenses, parents with special needs children must plan how to financially support their children over the course of their lifetimes. A special needs trust is a fund primarily used to preserve the public assistance benefits for the beneficiary whose disability impairs the ability to engage in any substantial gainful activity.\(^5\) Public assistance includes

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**KEY FACTS**

- For many special needs families, one parent has to stop working in order to stay at home to take care of the child, thus reducing the money parents can use for therapy and trust funding.\(^8\)

- A disabled individual may receive up to $710 per month from Social Security Income, which is not enough with the current cost of living.\(^9\)

- Distribution of societal costs of autism estimates the total cost of care for all individuals with autism over a lifetime at $35 billion.\(^10\)
Social Security Income (SSI) and Medicaid eligibility.

**ANALYSIS**
Currently, the money that parents deposit into a special needs trust is not tax exempt. To improve upon the status quo, a new special needs trust should be created that combines the tax benefits of the 401(k) and Roth IRA retirement plans. For a 401(k), employees are able to deposit money from their earnings into their retirement funds, and this money is excluded from taxable income. The money in the 401(k) benefits from tax-deferred growth, so it compounds more quickly than it would if it were taxed annually. In a Roth IRA, the savings also grow tax-free although the money from the account comes from after-tax dollars. The money that the retiree withdraws from a Roth IRA is not taxed.

Parents who create a special needs trust fund are essentially creating a long-term care plan for their disabled children who will not be able to support themselves after their parents are deceased. In a tax-deferred special needs trust, the money that parents deposit will not be included in their taxable income. When the appointed trustee withdraws money for the beneficiary’s care, the money will also not be taxed. The money that can be deposited into the trust will be a set percentage of the parents’ income up to a certain maximum limit decided by the government. The children will then have more money from their parents, which will reduce their dependence on the state. The beneficiaries can use this money to live in their own homes and hire a caretaker (if needed) instead of relying on limited state group homes. These funds may also pay for medical expenses not covered by Medicaid. When parents have their taxable income reduced to some extent, they can use more of their own money on their children’s current health and therapy expenses, which may increase the children’s long-term

**TALKING POINTS**
- The cost of caring for a special needs child is exponentially higher than the cost of caring for a child without disabilities.
- The average income of a typical middle-class family is decreasing, yet the number of families with a special needs child is increasing. This will result in a financial strain on both parents and the state.
- Many individuals diagnosed with a disability as children face a decline in available social services after they age out of the school system.
independence and productivity. The cost of the implementation of this idea is negligible, because the government is not taxing only a small portion of the parents’ income, yet this untaxed portion will later reduce the amount of government funds needed for the disabled.

ENDNOTES


Next Steps

Special needs interest groups and organizations such as The National Down Syndrome Congress and Autism Speaks should bring the proposed special needs trust fund to the attention of Congress. Congress and the Social Security Administration should amend the current special needs trust guidelines to accommodate the proposed special needs trust. The financial organizations that currently cater to retirement plans can then reach out to families who may benefit from the modified special needs trust guidelines. A clause should be added to the amended special needs trust so that in the event that the fund is no longer needed by the disabled beneficiary, the remaining funds in the trust can be returned to the family and the federal government can decide how to reasonably tax the sum.

TALKING POINTS

• The proposed special needs trust will not only help parents retain more money to spend on their disabled children, but will also decrease the societal cost of providing for the child when he/she reaches adulthood.

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How to Tackle the Bike Share Helmet Problem
Torre Lavelle, The University of Georgia

The lack of onsite helmets provided by New York City’s Citi Bike bicycle share program contributes to low helmet use among bike share participants. Improving helmet vending machine pilot sites by bundling the bike and helmet rental fee would address this public health hazard.

The reinvention of city and campus transportation is demonstrated most clearly by the popular embrace of bike share programs, short-term bicycle rentals provided at unattended stations.1 However, the discrepancy in helmet use among bike share riders as compared to personal bike users is the one impediment to bike shares’ integration into communities.2,3 Helmets are not available at rental stations, so New York City’s Citi Bike bicycle share program currently recommends that its participants bring a helmet from home. In addition, the company offers $10 helmet coupons for annual members and encourages helmet rentals through a rental company.

Nevertheless, geographic inaccessibility is one of the most cited reasons why bike share participants do not wear helmets and any off-site attempts to obtain a helmet deters commuters, tourists, and quick trips.4 Helmet rental vending machines, currently undergoing local expansion at Boston bike share hubs, demonstrate a feasible onsite helmet accessibility. Integrating the $2 cost of this vending machine helmet rental into Citi Bike’s bike rental fee, instead making it an optional expense, will encourage helmet use. A bundled fee allows users the choice of whether or not to use the helmet, but doesn’t provide savings for unsafe bicycling practices.5

KEY FACTS
• There are currently 26 active bike share programs within the US, a number that is expected to double within the next two years.11
• About 80 percent of bike share riders fail to wear a helmet versus 48.6 percent of other riders.2
• Bikers who die of head injuries are three times as likely to be without a helmet.3
• The lifetime medical, educational, and social costs for one youth with a traumatic brain injury total approximately $7.65 million.12
ANALYSIS

Citi Bike greatly influences bicycle safety in New York City; 432,000 people have purchased Citi Bike access passes and approximately 35,000 people use Citi Bike daily.\(^6\)\(^7\) Direct, on-site availability of helmets at Citi Bike would decrease the total number of bicyclists seriously injured in crashes, of which there were 500,000 in 2012.\(^8\)

A key merit of this proposal is the flexibility of both funding and management of the helmet rental vending machines. For example, Boston’s vending machine helmet rental program is maintained by a separate company. Citi Bike’s bundled helmet fee offers the opportunity for similar collaboration between the bike share company and an external investor, potentially even a local bike rental store interested in benefiting from the unique platform of bike shares. This collaboration would impose no additional cost to Citi Bike as the vending machine maintenance fees, including helmet inspection and sanitization, would be undertaken by the collaborating company. A slight increase in the daily bike rental fee of $9.95 would be added to reflect the helmet rental, but the price advantage of using a bike share bicycle would still overwhelmingly win out over the annual cost to operate a car or to maintain a personal bicycle.\(^9\)\(^10\) Citi Bike’s size makes it an influential model for all US bike shares while its relative newness makes it receptive to helmet policy initiatives.

The use of helmets at every age is supported by two key stakeholders, the Department of Transportation and the American College of Emergency Physicians.\(^3\)\(^11\)\(^12\)\(^13\)

ENDNOTES

Citi Bike officials will meet with the creators of the helmet vending machine, who have voiced their desire to branch out to other cities, as well as Hubway, Boston’s bike share program, in order to confirm that the helmet system could translate from a Boston setting to a New York City setting. After gaining support for this initiative from the Department of Transportation, Citi Bike can discuss with the vending machine creators and potential outside companies the possibility of expanding the program to a bundled bike and helmet rental fee. There is a great likelihood for approval, as the integrated fee provides secured payment to the managing company of the vending machine with every bike rental.

Just as in Boston’s pilot sites, Citi Bike should begin with four or five vending machine sites on main bike share locations. User feedback should be collected on convenience and usage rates to gauge approval during a testing period. If successful, the program should be expanded citywide, and perhaps even nationwide.
Michigan’s public employee unions should use reference pricing to combat exorbitant health costs.

Two of the greatest problems in the US healthcare system are high costs and great variance in procedure costs across hospitals. High costs are especially problematic for state and local governments that provide health insurance to current and former employees. States’ per-employee healthcare costs nearly tripled from 1999 to 2009, with both state-paid premiums and employee contributions skyrocketing.

One possible solution to this problem is reference pricing. Reference pricing leverages an insurer’s size to encourage competition, thus lowering the price of certain procedures. A pilot program saved the California Public Employee Retirement System (CalPERS) nearly $2.8 million in 2011. CalPERS negotiated with 47 hospitals to cap prices for hip and knee replacements at $30,000, and informed employees that they would only cover costs up to $30,000 for those procedures. Consequently, hospitals charging more than $30,000 saw a 34 percent decline in patients, forcing them to substantially cut prices. As a result, prices for those procedures were reduced by 26.3 percent for all patients. While reference pricing is still a pilot program, its success in California has shown that it should be considered for implementation in other states.

**KEY FACTS**
- Healthcare spending in Michigan is equal to 18.8 percent of the gross state product, the 12th highest percentage in the nation. Costs increased annually at an average rate of 3.1 percent from 2000 to 2009.
- CalPERS lowered costs of knee and hip replacements more than 25 percent through reference pricing.
- Union workers make up 17.5 percent of Michigan’s workforce.

**ANALYSIS**
The key component to reference pricing is a group of employees so large that it has the buying power to convince clinics to agree to fixed lower costs for certain procedures. Once
provider partners are secured, an insurer informs their beneficiaries that the procedure cost will only be covered up to the agreed price, and beneficiaries are compelled to compare prices. This encourages other providers to lower their procedure costs to remain competitive, benefitting all patients.

Comprising 17.5 percent of the state’s workers, Michigan’s union workers are one such large employee group. Unions could be convinced to engage in an experimental practice with the ultimate benefit of extending beyond their membership because it is in their best interest. First, their employees stand to benefit from reduced procedure costs and greater clinic choice as a result of increased competition among clinics. Second, union members are in danger of being penalized by the “Cadillac tax” included in the Affordable Care Act. The tax applies to high cost insurance benefit packages, and is intended to spur employers to seek out cost-cutting measures. Reference pricing can reduce costs to avoid the tax without sacrificing coverage or quality of care.

STAKEHOLDERS
While unions and their members are obviously key players in the success of reference pricing, it is imperative that enough healthcare providers agree to fixed prices for procedures. If too few hospitals and clinics agree to a baseline price, providers across the state will not be compelled to lower their prices to remain competitive.

ENDNOTES

TALKING POINTS
• The United States pays far more for healthcare than other countries, without seeing better results.
• Reference pricing has been effective at reducing procedure costs in California.
• Unions have the scale necessary to help combat high costs for all consumers through reference pricing.
Centralized Prescription Drug Monitoring Program
Alexius Marcano, Emory University

Implement regional databases that track patient prescription history so that health professionals can prevent medication drug abuse and redistribution.

The US leads the world in the consumption of prescription drugs, a rapidly increasing trend demonstrated by the 70 percent of Americans who take prescription medications.1 Prescription drugs help patients treat or manage conditions such as chronic pain and depression. However, the continued prevalence of these medications has led to widespread abuse and the emergence of a pharmaceutical black market. The need for prescriptive oversight is particularly salient in Broward County, Florida. Addicts and traffickers throughout the American Southeast ride down Interstate 75, dubbed the “Oxy Express,” to purchase massive quantities of oxycodone in South Florida. Lax prescriptive oversight has fueled the region’s illicit

Next Steps
Reference pricing may eventually become a standard union practice, but there is currently little information available on the practice outside of the promising experience of CalPERS. Before wider adoption, more experimentation must occur. Unions should proactively seek out partnerships with medical providers to fix prices for certain procedures. Universities, which often have faculty unions and medical clinics, could both implement and evaluate reference pricing.

Additionally, more procedures must be identified as candidates for price fixing to achieve the full potential of referencing pricing. CalPERS identified knee and hip replacements as candidates for reference pricing because both are procedures with little variation in quality and great variation in cost. A panel of medical experts should be tasked with identifying more procedures with these features. Prescription drug prices in Europe are largely controlled by reference pricing, and the application of reference pricing to drug coverage should also be explored.
drug trade as “doctors in Florida prescribe 10 times more oxycodone pills than every other state in the country combined.”

There is clear legislative precedent in the documentation and prevention of drug diversion with the enactment of the National All Schedules Prescription Electronic Report (NASPER) Act of 2005. NASPER created a grant program to assist states in developing their own prescription drug monitoring program (PDMP). Additionally, in 2011 the Prescription Drug Information Exchange (PMIX) was established to provide critical assistance in the digital implementation of state-based PDMPs. The bipartisan endeavor to address the growing epidemic of prescription drug abuse is indicative of the issue’s political capital in Washington and throughout the states.

**ANALYSIS**

The abuse of controlled substances stems from two fronts—the abuser and the prescriber. Without a means of recording the outflow of prescription drugs, the tracking of patients’ prescription consumption and prescribers’ dispensing patterns become nearly impossible. To address this issue, regional prescription drug monitoring program (PDMP) databases should be implemented to prevent prescription drug abuse on individual and systemic levels. These databases would compile confidential patient prescription history derived from information reported by prescribing medical professionals.

Medical practitioners with prescription authority would be able to access patient medication history to flag and intervene with high-risk individuals, thus avoiding drug diversion by detecting suspicious activity. As well, regional PDMPs would collaborate with participating state medical boards to assess prescribers’ dispensing patterns. Deviations from medically acceptable practices would be recorded to identify excessive narcotic prescriptions dis-

**TALKING POINTS**

- An oversight program would be cost-effective since prescription drug abuse costs an estimated $72.5 billion per year to insurers in fraud and $53.4 billion to the US government in lost productivity, criminal justice costs, drug abuse treatment, and medical complications for opioid abuse alone.

- The ability to map prescriptions would yield more effective oversight and better inform policymakers on legislation concerning prescription drug diversion.

- Centralized databases also help non-abusing patients, as prescriber access to prescription history would help avoid deadly drug interactions arising from poly-pharmacy drug incompatibility.
tributed at pill mills. Records would prevent patients from taking advantage of non-coordination between physicians to request multiple prescriptions.

To protect patient privacy, personally identifiable information (PII) relating to patient prescription history would only be accessible to prescribing medical professionals abiding with Health Insurance Portability and Accountability Act (HIPAA) regulations. PII is protected from law enforcement because HIPAA federally preempts such action as, “no State law may either authorize or compel any disclosure.” State medical boards would have access to non-patient PII, however, and would be able to sanction doctors abusing their prescription privileges.

ENDNOTES


KEY FACTS

- The Centers for Disease Control and Prevention have classified prescription drug abuse as an epidemic, with deaths from prescription painkiller overdoses more than tripling in the past decade.
- Twenty-six million Americans between 26 and 50 have used prescriptive medication for non-intended or non-medical use. Opioids, depressants and stimulants are the most common categories of misused prescription drugs.
- The majority of drug overdose deaths (57.7 percent) in the US involve pharmaceuticals, claiming over 14,800 lives in 2008 alone.
Next Steps

1. Task US Department of Health & Human Services with program execution and maintenance.

2. Charge PDMPs with oversight of the five geographic regions used by the Substance Abuse and Mental Health Services Administration for its prevention technologies.6

2. Consolidate existing state and county prescription records into their respective regional databases while ensuring interregional communication to prevent interstate prescription drug trafficking.

3. Consult with state medical boards about program implementation and enforcing prescriber accountability through their authority to investigate and discipline those violating licensing laws.

4. Inform and educate the broader medical community by collaborating with medical professional associations such as the American Medical Association and the Federation of State Medical Boards.

Decreasing the Teen Pregnancy Rate in Athens, Georgia
MarQuenda Sanders, University of Georgia

The Carrera Program, which provides adolescents with a comprehensive life education program, should be adopted to lower the teen pregnancy rate in Athens-Clarke County, where the school system currently provides only a single sexual education course.

The teen pregnancy rate for Georgia is the 10th highest in the nation at 37.9 pregnancies each year per 1,000 girls age 15 to 19.2 Athens-Clarke County’s is a staggering 48 per 1,000, while the national rate is 31.3 per thousand.2,4 Though sex education and contraception use are encouraged as the most practical pregnancy avoidance measures, research suggests
that these measures must be coupled with others in order to maximize their effectiveness. \(^1\) Incorporating a more holistic approach would provide teens with numerous after school activities—such as daily academic tutoring, sports and art activities, and job skill preparation—in addition to sexual education. \(^1\)

The Family Life and Sexual Health curriculum (FLASH) in the Athens-Clarke County school district, adopted in 2009, educates students about STDs and contraceptive options, and is the county’s current chosen pregnancy prevention strategy. \(^3\) The FLASH curriculum, however, is only taught while students are in the classroom, and there are no mechanisms in place to ensure that this strategy is reinforced outside of the school environment. Community centers offering after-school tutoring and recreation time throughout inner city Athens only serve those in the 5th grade or younger.

Community leaders for Whatever It Takes (WIT), an organization centered on improving children’s welfare in Athens, agree that more needs to be done to significantly reduce the teen pregnancy rate. The Carrera Program should be adopted by WIT and established community centers to help lower teen pregnancy rates in the Athens community.

**ANALYSIS**

The Carrera Program has proven to be highly effective with 50 percent teen pregnancy reduction, as demonstrated through the large controlled trial among community centers in New York. \(^1\) The program’s success is attributed to the fact that it targets a variety of aspects of teens’ lives, including daily academic tutoring, arts activities, sports activities, job preparation, and family and sexual education. \(^1,5\) In addition, students who began the Carrera Program between ages 10 and 13 then continued throughout high school had an increase in their teen pregnancy rate. \(^1\)

**KEY FACTS**

- Athens-Clarke County’s teen pregnancy rate is 48 per 1,000 girls age 15 to 19 in a state that already holds the 10th highest rate in the nation. \(^2,4\)

- Teen pregnancies are costly for local and state governments, so any effective means to reduce the elevated rate is economically beneficial. \(^7\)

- The Carrera program has proved that it confers a 50 percent reduction in teen pregnancies and has been effective in the other states. \(^1\)
in high school graduation, college acceptance, and employment. This program provides those students who usually remain idle during the gap between school and home lives with a beneficial means to use their time.

If a more comprehensive and highly successful intervention program is not implemented, and only the FLASH curriculum is maintained, the economic costs of high teen pregnancy rates will continue to increase, in addition to the already well-documented social costs. Pregnancies and subsequent births are extremely expensive not only for the mother and child but also for taxpayers. In 2008, teen births cost the United States an estimated $10.9 billion, while Georgia taxpayers contributed $465 million dollars. Fifty-two percent of that sum was from state and local taxpayers; $75 million contributed to public health care and $89 million for childhood welfare. The economic burden on taxpayers in Georgia is enormous for the large number of teen births. The Carrera Program costs an average $4,750 per teen to implement, with the majority of the funding coming from private foundations and donors. However, the Office of Adolescent Health (OAH) awards $75 million in grant funding for Tier 1 teen pregnancy prevention programs and $25 million for Tier 2 prevention programs. Tier 1 programs are those labeled effective via thorough testing and evaluation, while Tier 2 programs are those still undergoing evaluation. Therefore, Whatever It Takes could potentially be awarded $75 million to implement the Tier 1 Carrera Program in Athens.

**STAKEHOLDERS**
The Carrera Program can be most effectively implemented through the WIT organization. If the OAH awards a grant to WIT, WIT can distribute the funds to implement and conduct trainings for the multifaceted components of the program in local high schools and clinics. For example, the Health and Wellness Team of WIT,

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**TALKING POINTS**

- Athens’ teen pregnancy rate is 48 per 1,000 teen girls and sexual education in school is not as effective at preventing teen pregnancy as it once was.

- The Carrera Program not only reduces teen pregnancy, it also provides teens with health education, job preparation skills, and daily academic tutoring, among a host of other services.

- Changing a teen’s perspective on her future, not just her knowledge about sex, will help to ensure a more significant reduction in teen pregnancies.
Next Steps

It is imperative WIT compiles a grant for OAH funding for FY 2015 to ensure the Carrera program be implemented as soon as possible. If awarded the grant, WIT must restructure the current after school curriculum to fully implement the Carrera Program and provide Athens-Clarke County teens with the services associated with the program. A health clinic will need to be established at the location of the after-school program to provide teens with access to contraception options. This will involve the assistance of the Public Health Department of Athens-Clarke County to provide the clinic with staff and medicine. Since a grant is funding all of the necessary changes, no financial burden is placed on the county to support the new program.

Rather than replace the current sexual education program taught in the county schools, the Carrera Program would be a supplemental after-school program to expand upon the effectiveness of the FLASH curriculum.

ENDNOTES


consisting of health centers in Athens, could receive part of the funding to provide free contraception and physical exams.
The Global Polio Eradication Initiative should augment its vaccine schedule to incorporate benefits from both vaccines available on the market.

Poliomyelitis is a devastating disease that attacks the central nervous system and often causes paralysis. The World Health Assembly sought to eradicate poliomyelitis in 1988, when the disease paralyzed more than 350,000 people each year. The most recent deadline for polio eradication was missed in 2012. Unfortunately, polio is still endemic in Pakistan, Afghanistan, and Nigeria, despite continual eradication efforts.

The current state of control is financially unsustainable and eradication is needed to save lives and money. A change in vaccine policy would be instrumental in eradicating polio. There are two main types of vaccines available: oral poliovirus (OPV) and inactivated poliovirus (IPV). OPV is still the vaccine of choice in most of the developing world because it is effective, easy to immunize, and inexpensive. Unfortunately, OPV is not perfect, and it causes vaccine-associated paralytic polio (VAPP) and circulating-vaccine derived poliovirus (c-VDPV), which makes eradication unattainable. IPV is used in most of the developed world. IPV is expensive and more technically demanding due to its intramuscular administration route. South Africa is the only country that has switched to a dual vaccine schedule, and it has experienced success already, even though it is still at beginning phase of the switch.

**KEY FACTS**
- Polio has still not been eliminated in Nigeria, Afghanistan, and Pakistan.
- The oral poliovirus vaccine (OPV) has problems, in rare cases causing vaccine associated paralytic paralysis (VAPP) and circulating-vaccine derived poliovirus (c-VDPV) that stands in the way of eradication.

**ANALYSIS**
Since OPV is a live-attenuated virus, it can...
still, in rare cases, cause VAPP.\(^7\) Also, after accumulated mutations in the genome, the live attenuated OPV viruses can replicate and revert to neurovirulence and become transmissible c-VDPVs.\(^8\) This is especially problematic in areas where poor supplementary immunization activities are completed.\(^2\) In Nigeria between January and November 2009, a large-scale outbreak of cVDPV type 2 occurred, amounting to 148 cases.\(^9\) Among individuals with immunodeficiency, the live-attenuated virus in OPV can cause individuals to be asymptomatic long-term excretors of immunodeficient vaccine-derived poliovirus (iVDPV).\(^9\) This is very dangerous to the eradication effort. Switching completely over to an IPV policy is important to the polio endgame, however, a dual policy would be better until IPV is financially feasible. The largest drawback for many of these countries is that IPV is 32 times more expensive than tOPV.\(^10\) Incorporating IPV into the current vaccination plan in the remaining polio-eliminated countries would help decrease the number of c-VDPVs and VAPP cases. This could be coupled with the diphtheria-pertussis-tetanus vaccine to bolster routine immunization as well, leaving an important legacy for the polio eradication initiative.

**STAKEHOLDERS**

Many organizations have come together as part of the Global Polio Eradication Initiative (GPEI). The GPEI incorporates both private NGOs and governmental agencies. The Bill and Melinda Gates Foundation and Rotary International have both been instrumental in polio eradication thus far. The Center for Disease Control and Prevention’s Emergency Communications Center was activated on December 2, 2011, by Director Thomas Frieden.\(^11\) Also, the World Health Organization has been instrumental in helping overcome many barriers to eradication. All of these partners make up the GPEI, but the largest benefits to this policy remain to the children under 5 who are at risk of paralysis or c-VDPV from OPV.

**TALKING POINTS**

- Introducing IPV into every vaccination schedule is an important step in polio eradication’s future.

- The challenges of this policy are that implementation is expensive and requires the intensive training of vaccination workers compared to OPV. However, this solution will increase demand for the vaccine, be more politically accepted, and prevent the most cases of polio, which all to drive towards eradication.
Next Steps

The GPEI and its partners should introduce IPV as first dose of polio vaccine into all vaccine schedules as soon as possible. The international health community has realized that the OPV paradox exists, so they are trying to push for a change in vaccination policies.

To overcome production troubles and introduce IPV to the developing world, the World Health Organization and their country offices have been working with manufacturers to purchase existing IPV products in volume (to lower the cost per dose) and develop alternative IPV options that can be priced at less than a dollar a dose. As production of IPV increases, the goal can be expanded to other countries until IPV is universally administered.

From here, OPV will start to be removed from vaccination campaigns. Polio eradication is possible with IPV introduction and carefully planned campaigns.