10 IDEAS
HEALTH CARE

POLICY OF THE YEAR NOMINEE

Blocking D.C.’s
School-to-Prison
Pipeline Using Improved Mental Health Resources
Who We Are

The Roosevelt Institute, working to redefine the rules that guide our social and economic realities, is home to the nation’s largest network of emerging doers and thinkers committed to reimagining and re-writing the rules in their communities to create lasting change. Our members, organizing in 130 chapters in 40 states nationwide, partner with policy makers and communicators to provide them with clear, principled ideas and visionary, actionable plans. Our members are actively influencing policy on the local, state and national level – from introducing legislation on protections for LGBTQ youth to consulting with local governments on natural disaster flood prevention.

What You’re Holding

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

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

How You Can Join

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

Thank you for reading and supporting student generated ideas.

Together we will design the future of our communities, from towns to countries and all that lies in-between.
Dear Readers,

Young people are incredibly important to the American political process. Millennials and Generation Z now make up the same portion of eligible voters as the Baby Boomer generation. This emerging generation is also the most diverse in our nation’s history: Half of all eligible Latino voters in 2016 are between the ages of 18 and 35. We’re told we can make the difference every election, and candidates and elected officials ask for our votes, time, and money—but they don’t ask for our ideas.

Young Americans continue to transform our economy and culture. Now it’s time for us to disrupt our political system.

The 10 Ideas journals, one of our oldest and most competitive publications, elevate the top student-generated policy ideas from across the country. In this year’s journals, you will find solutions to problems in places ranging from South Dakota to North Carolina to Oregon to New York. Whether seeking to make Pittsburgh an immigrant-friendly city or to reduce recidivism in the state of Massachusetts, the following proposals take a creative and locally focused approach to building opportunity for all.

Roosevelters are also committed to turning their ideas into action. Whether that means meeting with decision-makers, writing opinion pieces in their local papers, or organizing actions in their communities, we intend to see the solutions we propose become reality.

Why? As the generation that will inherit the world shaped by today’s decisions, we have the most to lose or gain. Involving the emerging generation in the policy process will lead to outcomes that benefit everyone. We believe it matters who rewrites the rules, and we have ideas for how to change them.

I hope you enjoy reading the proposals in this journal as much as we did.

Onward,

Joelle Gamble
National Director, Network, Roosevelt Institute
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Blocking D.C.’s School-to-Prison Pipeline Using Improved Mental Health Resources

By Samantha Garzillo, American University

Thesis
D.C. Public Schools should replace their punitive responses to delinquency with referral to on-site mental health services, providing students the opportunity for behavioral and emotional development, with funding provided by the Substance Abuse and Mental Health Services Administration.

Background and Context
The School-to-Prison Pipeline, which disproportionately affects low-income urban minority youth, criminalizes students for small offenses and pushes them into the juvenile justice systems. Prioritizing punishment over constructive reform leads to increased incarceration rates, the acquisition of juvenile records, and removal from school. Schools are taking less responsibility for the actions of students, and instead passing responsibility off to law enforcement. Policies such as zero-tolerance, the use of school resource officers (SROs), the implementation of metal detectors, and barriers on returning to school after entering the juvenile justice system dehumanize students, disrupt education, and increase dropout rates. A lack of belief in the effectiveness of rehabilitation in the 1970s and the “hard on crime” mentality of the 1980s has extended the juvenile justice system to include more and more young people, but the penal system has not proven to be effective at deterring crime or benefitting students. New policies must work to move beyond punishment and towards reforming and helping students. Otherwise, the juvenile justice system will become increasingly overwhelmed, while the needs of students are ignored.

Policy Idea
The D.C. Public School system should refer delinquent students to on-site therapists, who can address issues concerning drug use, social and familial issues, abuse, and anger management through crisis intervention or long-term support. The referral system would exclude potentially lethal crimes, such as carrying a weapon. Therapists would then identify the causes of the student’s behavior, working towards positive behavioral, emotional, and social reform. Sessions would be integrated into students’ schedules to avoid competing with instructional time or be scheduled before or after school to accommodate for work and family obligations.

Talking Points
► Funneling students into the juvenile justice system prevents them from attending school, inhibiting their access to education
Punitive punishments respond to behavioral issues, without resolving the underlying factor(s) driving the behavior.

Currently there are no rehabilitative measures directly work against the School-to-Prison pipeline in DC

Policy Analysis
In a study of Chicago Public Schools, mental health treatment reduced violent crime by 44 percent and non-violent crime by 36 percent. A reduction in juvenile crime makes schools and communities safer. Punitive policies increase dropout rates, restrain future income, increase recidivism, and use tax revenue, amounting to $8 to $21 billion a year. Comparatively, a school-based treatment program in New York City costs $140,025 to $156,106 annually. However, existing programs are limited. Only 43 percent provide substance abuse counseling; the proposed policy is more responsive to student needs. Teachers, untrained in addressing mental health and overwhelmed with high teacher-to-student ratios, would no longer be responsible for student reform.

KEY FACTS
- Fifty percent of chronic mental illnesses begin by age fourteen.
- Those afflicted with mental illness often do not receive treatment until 8 to 10 years after symptoms first appear.
- Seventy-five to 80 percent of children with a mental illness do not receive care, among children of color this number rises to 87 percent.
- African-Americans are 7.3 times more likely to live in high-poverty neighborhoods with limited to no access to mental health services.

NEXT STEPS
This policy should first be piloted in Luke C. Moore and Washington Metropolitan High Schools, given their high dropout rates, high percentage of minorities, high percentage of impoverished students, and use of SROs. D.C. Public Schools should work with the D.C. School Mental Health Program and the D.C. Department of Mental Health to provide these strategic mental health services, given their investment in the wellbeing of youth. The Department of Education’s Office of Elementary and Secondary Education also has vested interest in the academic achievement of students, their ability to remain in school, and students’ health; they should be a key ally in enacting this policy. A coalition of the D.C. public schools should be formed, with information regarding students in the program being transferred as the student rises through grade levels or changes schools. Over time, the policy can be expanded to include family and parental resources and program availability post-graduation to provide on-going treatment.
Optimizing Obstetric Hemorrhage Protocols: Reducing Maternal Mortality in the State of Georgia

By Esther Osinaiya, Annie Ho, and Hannah Lumapas,
University of Georgia

Thesis
Georgia has one of the highest rates of maternal mortality in the U.S., with most deaths occurring due to obstetric hemorrhage. Georgia maternal health care providers should be mandated by the Georgia Department of Public Health to optimize protocols for treating postpartum hemorrhage (PPH).

Background and Context
Despite spending $60 billion on maternity care in 2012, maternal mortality remains a challenge in the U.S. Every year, an estimated 1,200 women in the U.S. experience fatal complications during pregnancy or childbirth.1 Georgia has one of the highest maternal mortality rates in the country. In 2011, Georgia’s maternal death estimate was 35 maternal deaths for every 100,000 births compared to the national average of 21 per 100,000 births.2 PPH is traditionally diagnosed in many Georgia hospitals when estimated blood loss surpasses 500 ml after vaginal birth or 1,000 ml after cesarean birth, which is standard across most states.3 Obstetric hemorrhage during the postpartum period remains a major factor in pregnancy-related deaths in Georgia.4 Though many women in Georgia deliver in hospitals with knowledgeable and trained staff, underperforming hospitals lack standard and efficient protocols in managing obstetric hemorrhage emergencies. Existing protocols are not always designed and approved by all maternal health care providers in the hospital. Unfortunately, this has led to a lack of quality assurance and teamwork precision needed to treat hemorrhages.5

Talking Points
● The high rate of maternal mortality in Georgia indicates that existing protocols for maternal hemorrhage are ineffective.
● Optimizing protocols across the state of Georgia, similar to the way other states have optimized protocols can be effective in treating hemorrhages in a timely manner.6
● Affordable programs and seminars about treating PPH—provided by organizations such as the Association of Women’s Health, Obstetric, and Neonatal Nurses (AWHONN)—are available to a limited number of member hospitals and nurses.
Policy Idea
Public health officials should devise a uniform policy on the protocol for maternal hemorrhage and post-delivery check-up and care for the mother and child. The updated protocol should include rapid emergency blood transfusion and a call extra attention to maternal blood loss, during the pregnancy and the early postpartum period. These protocols should be state-mandated and taught statewide through a public health education program. Trained maternal health care workers who can accurately identify early stages of PPH in addition to updated protocols would allow for timely and appropriate treatment.7

Policy Analysis
To decrease the number of obstetric hemorrhage cases, the California Maternal Quality Care Collaborative (CMQCC) and the California Department of Public Health prepared a similar policy in 2009 to update protocol for hemorrhage treatment methods.8 The California Department of Public Health Program general funding for Maternal, Child and Adolescent Health State Operations was $3,554,000 in 2009. Of all the live births in California, 2.4 percent were complicated by PPH, though some reviews have found this rate to be as high as 5 percent or more.9

CMQCC improved the quality of care within the accumulated surveys from California’s maternity services. Many of the problems that CMQCC found in their obstetric branches reflect Georgia’s current lack of protocol for massive transfusion and obstetric hemorrhage.10 CMQCC provided guidelines in the event of obstetric hemorrhage to identify at-risk patients and establish the stages of hemorrhage. Hospitals that execute periodic drills

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KEY FACTS

- Postpartum hemorrhage affects 2 percent of all women who give birth. It is associated with nearly 25 percent of all maternal deaths and is the leading cause of maternal mortality in the world.13
- According to the World Health Organization, skilled care before, during, and after childbirth can save the lives of women and newborn babies.14
- Out of the 116 hospitals in Georgia, only 25 are part of the Association of Women’s Health, Obstetric, and Neonatal Nurses’ Postpartum Hemorrhage Project, a dues-free program created to help medical professionals detect and treat PPH.
and examinations for PPH cases show behavioral change among staff, which improves the quality of care for all mothers.¹¹

From 2006 to 2008, the rate of maternal deaths in California was 14 per 100,000. After the updated protocols were put in place, the rate of maternal deaths declined to 6.9 per 100,000 between 2011 and 2013.¹²

Through statewide training programs and an optimized protocol, health care workers will acquire the skills to care for mothers. Investing in statewide programs to train healthcare workers to efficiently recognize PPH would also save money by reducing medical malpractice lawsuits.

**NEXT STEPS**

The next step is a pilot program in several hospitals in the state of Georgia to evaluate and detect flaws in existing protocols for maternal hemorrhage. In the pilot program, the Georgia Department of Public Health should mandate that hospitals optimize their protocols by addressing the detected flaws and training healthcare providers in more efficient and productive ways of treating PPH.

Data from the pilot program will determine the most effective protocol. A uniform statewide initiative should be launched based on the most effective protocol. Possible supporters and key targets for the policy idea include the Georgia Department of Public Health, Georgia Department of Community Health, and AWHONN. The Georgia Department of Public Health is the leading agency that works to promote public health and well-being. The Georgia Department of Community Health is one of the top Georgia health agencies and responsible for a $12 billion budget. AWHONN is a non-profit, application-based, membership-only organization that promotes women’s health.
Starting a Dialogue: Encouraging Responsible Firearm Ownership at the University of Oregon

By Madeleine McNally, University of Oregon

Thesis
To encourage responsible firearm ownership on the University of Oregon campus, the University Police Department should send letters to incoming students outlining the legal responsibilities of firearm owners.

Background and Context
The U.S. is currently experiencing a firearm violence epidemic. In 2013, there were 21,175 suicides involving firearms. In the same year, 11,208 homicides involved a firearm and 505 additional lives were lost due to “accidental discharge of firearms.” In the state of Oregon alone, there were 497 deaths by firearms in 2014. Lane County, home to the University of Oregon, had 62 firearm-related deaths.

Firearms account for an average of 30,000 deaths per year in the U.S. In 2010, the estimated societal cost of firearm violence was $164.6 billion. Firearm violence has significant social costs, but continues to rise due to government inaction.

The Federal Bureau of Investigation (FBI) reported an upward trend in active shooter incidents between 2000 and 2013. An active shooter is a person engaged in killing or attempted killing in a confined or populated space. Between 2000 and 2005, the FBI reported an average 6.4 incidents annually; however, between 2006 and 2013 annual incidents increased to 16.4. The U.S. cannot afford a continued rise in firearm violence. Firearm legislation is uncoordinated across the U.S. because states maintain autonomy over firearm policy.

Oregon does not require gun owners to obtain licenses or register their guns, allow local governments to regulate firearms, impose waiting periods on gun acquisition, or require license for firearm dealers. However, the state does require background checks prior to the transfer of a firearm between unlicensed parties. The state also allows universities to ban concealed carry at their own discretion, which the University of Oregon has chosen to do.
Talking Points

- A dialogue about active shooter incidents and firearm legal obligation does not exist on the University of Oregon campus between students, faculty and staff.
- Students from out of state may not be aware of their legal responsibilities as firearm owners in Oregon. Firearm legislation varies drastically between states.
- The University of Oregon Police Department can leverage their authority to meaningfully engage and educate students.

The Policy Idea

To start a dialogue about safe, responsible firearm ownership on college campuses, the University of Oregon and its Campus Police Department should work in tandem to inform students of their responsibility as firearm owners.

Upon committing to the University of Oregon, the University of Oregon Police Department will send letters to every student reminding them of their school and state-level legal responsibilities and firearm storage safety tips.

The letter will provide students with a foundational understanding of existing firearm policy. To further educate students, the school can host an awareness day and share its existing firearm safety protocol in case of an active shooter scenario. The school will maintain an open-door policy around the topic of firearm safety on campus. Based on their newly curated knowledge of firearm policy, students will be encouraged to share their ideas about safety on campus.

Policy Analysis

Between 2005 and 2009, the California Department of Justice worked in conjunction with the Los Angeles Police Department to distribute letters to people in the Los Angeles region who applied to purchase a handgun. The letter was signed by the Attorney General, City Attorney and Chief of Police and reminded the handgun purchaser of their responsibility to run transactions through a licensed gun store if they chose to transfer gun ownership to someone else.

The Los Angeles City Attorney’s Office stated that the letters were effective at reminding individuals of their legal obligations and had an impact on gun
purchasing behavior. Moreover, individuals who received a letter were over twice as likely to report a stolen gun than those who had not received a letter.

Both the objectives of the policy in L.A. and the demographic it targeted are quite different than the proposed policy. However, L.A. provides a provocative and innovative solution to a complicated issue. The goal of the proposed policy is to shift the narrative around gun safety.

Much of the current dialogue on college campuses exists around whether or not to ban concealed carry or ban police carry. The University of Oregon has a unique opportunity to be proactive and engage with students about firearm safety in a time when college campuses are looking for innovative solutions to reduce firearm violence. A letter allows the university to be transparent while providing knowledge to students and parents about legal expectations and responsibilities that may otherwise not be known. With this knowledge transfer, the university makes room for a deeper level of dialogue with diverse viewpoints. A well-crafted letter will increase accountability among students on the University of Oregon campus. Both firearm-owning and non-firearm-owning students will be empowered with knowledge to engage in conversation that will help develop additional, comprehensive firearm safety protocols.

**NEXT STEPS**

The University of Oregon is the institution in charge of facilitating and implementing change. Anne Mattson, nurse practitioner in the University of Oregon Health Center, is an ally because firearm violence is considered a public health problem in the medical sphere. Ginevra Ralph, University Board of Trustees, is a target because she is an active community member and has long worked with children and students in the community of Eugene. Ralph also has a large stake in the university and would provide good feedback about the policy proposal as a member of the Board of Trustees.

Associated Students of the University of Oregon (ASUO) holds a lot of clout with the school administration and have already raised concerns about firearm safety on campus. Carolyn McDermed, Chief of Police, is a potential ally because her department is a major stakeholder in this proposed policy. The police department has been holding talks about officer-carry on campus. These discussions would be a good place to introduce this policy idea.
Presumed Consent for Organ Donation: Combating the Increasing Organ Shortage in the U.S.

By Hayley Padden, University of Michigan

Thesis
To combat the increasing organ shortage, the U.S. should implement a presumed consent law, allowing organs to be considered for donation unless there is stated opposition, therefore increasing the number of organ transplants that could occur.

Background & Context
The number of people waiting for an organ is steadily rising in the U.S. In 1991, there were 23,198 people on the waiting list compared to 123,000 people in 2014. However, while the list of people on the transplant list increased fivefold, the number of available donors has not even increased twofold. Every day an average of 22 people die while waiting for a donation. Even with the implementation of many initiatives across the country to increase the number of available organ donors, it is simply not high enough to meet the increasing need.

Despite the fact that 90 percent of U.S. citizens support organ donation, only 42 percent are registered organ donors. One reason for this disparity is lack of trust of medical professionals. There is a myth that doctors are less likely to take all life-saving measures if a patient is an organ donor. This is not true, but public perception persists. Another contributing factor is death is a sensitive topic and many people feel uncomfortable making plans for after their deaths, therefore they fail to become organ donors.

Currently, the U.S. has an opt-in method of consent where citizens have to actively sign up to become an organ donor or families have to consent to donation after death.

Talking Points
► The need for organs for transplant far outstrips organ donation in the U.S.
► Currently, Americans must opt-in to become organ donors. A presumed consent law would increase organ donation. Under that law, only those opposed to donation would have to register their wishes.
► Organs would never be donated against the wishes of the individual or
their family.

**The Policy Idea**
The U.S. should adopt a presumed consent law where organs will be automatically considered for donation unless the individual has stated their refusal in an official form, or the immediate family objects to donation after the death of the potential donor. If neither of these applies, consent is implied and, if organs were suitable, organ donation would take place. In addition, all major hospitals should employ transplant coordinators who would have access to a national database of those who object to organ donation. These coordinators would be responsible for identifying potential donors and directing the entire donation process from the donor to the recipient.

**Policy Analysis**
Implementing a presumed consent law is the best way for all potential donors to be considered for organ donation unless the individual or the immediate family objects. An objection by the individual would be documented and, in the event of brain or circulatory death, a transplant coordinator would refer to a national database before making any decision regarding donation. If there is no document of objection on file, consent is implied.

If immediate family members were present at the time of death, the transplant coordinator would be required to inform them of the intended organ donation and they could disallow the donation. The ability of family to deny donation is another step to ensure that only people who do not oppose donation will have their organs donated.

Belgium uses a presumed consent system, which has resulted in organ donation more than doubling. Public support is extremely high in Belgium. In 1996, 10 years after presumed consent was implemented, fewer than 2 percent of the population had submitted an objection to organ donation. Spain’s system, another successful presumed consent system, relies heavily

### KEY FACTS
- An average of 22 people die a day in the U.S. waiting for an organ donation.
- Ninety percent of Americans support organ donation yet only 42 percent are registered organ donors.
- Ten years after Belgium implemented presumed consent their organ transplants more than doubled.
on transplant coordinators, funded by the government, to talk to families and make sure that they support the donation before it takes place, which builds trust between the general population and medical professionals.10

NEXT STEPS

This policy change should be made via federal legislation. Lawmakers should use as models the presumed consent policies successfully enacted in Belgium and Spain. This policy requires partnership between lawmakers, medical organizations, and key allies such as Gift of Life or Donate Life.

An education campaign to inform the public about the policy change is necessary. Citizens must understand how the policy works and how to opt-out of donation. Organ donation is a personal decision and must be discussed with sensitivity. Citizens who are unsure of the process or their rights may opt-out due to confusion or fear. The education campaign should explain the policy change and dispel myths about donation.
Eliminating Cultural and Linguistic Boundaries in Healthcare: Creating Standards and Funding for Medical Interpreters

By Vineet Raman, University of Georgia

Thesis
Weak regulation has allowed states to leave the use of appropriate language services up to individual hospitals. Congress should require states to implement a standard level of interpreter to all limited English proficiency (LEP) patients in all healthcare settings.

Background and Context
The U.S. has increasingly become more culturally and linguistically diverse with the influx of migrants from around the world. As a result, the number of Americans who speak a language besides English at home has increased by almost 50 percent in the last two decades.1 Additionally, the number of patients with LEP has increased by more than 50 percent over the last ten years.2

For LEP patients, healthcare providers use varying forms of language services. Ad hoc interpreters, such as family members, friends, or other untrained personnel, are the most readily available type of interpreter.3 However, generally more than half of physicians’ questions are miscommunicated by these interpreters, negatively affecting patients’ quality of care and their satisfaction.5 6 Additionally, LEP patients who do not receive language services are more likely to incur unnecessary charges by means of longer hospital stays and additional diagnostic tests.7 8

Funding for interpreters is available through Medicaid and State Children’s Insurance Programs in all fifty states.9 Only thirteen states reimburse through these programs for language services, despite findings that it would cost only $4.04 more per visit to provide proper language services to all U.S. LEP patients—only $4 more to provide safe, high quality medical care to 49.6 million Americans.10 Most of the remaining states opt out of providing language services on account of rising costs.11

No stringent regulation regarding ad hoc interpreters exists.12 In fact, physicians in regions with large LEP patient populations are less likely to
provide appropriate language services. Existing contradictory recommendations allow hospitals to implement language services at their discretion. Immediate action is necessary to properly meet the needs of an increasing LEP patient population.

**Talking Points**
Language should not be barrier to quality healthcare, but currently it can be. Ethnically and racially diverse states such as Texas, Florida, Hawaii, and Illinois have the greatest need of language services, yet they have failed to pass any legislation requiring standardized language services to every LEP patient. Funding for language services exists for patients covered by Medicaid and SCHIP. The number of LEP patients will only continue to grow and LEP patients will suffer if states remain inactive.

**The Policy Idea**
Congress should introduce a bill requiring states to fund more interpreter positions via a standard medium of their choice (telephone, professional interpreter, or bilingual provider) to serve LEP patients on Medicaid or State Children’s Health Insurance Programs using reimbursement schemes through the respective third-party program (Medicaid or SCHIP). The medium should be certified by The National Board of Certification for Medical Interpreters, ensuring a consistent standard of interpreting regardless of medium. These funds should be disbursed with the stipulation that the hospitals reduce use of ad hoc interpreters by 50 percent and increase certified interpreter use by 50 percent over the next ten years. Hospitals not meeting the aforementioned targets will not receive the maximum reimbursement for the language services they provide.

**Policy Analysis**
The policy’s funding is modeled after a bill proposed to tackle California’s shortfall of interpreters. The bill had the state spend $200,000 to gain access to $270 million in federal funds authorized under the Affordable Care Act.

**KEY FACTS**
- Untrained ad hoc interpreters misinterpret or do not interpret more than half of physicians’ questions.
- Funds set aside by a state’s Medicaid/SCHIP program can be matched by existing federal monies to fund trained interpreters.
- It would cost only $4.04 (or 0.5 percent more) per physician visit to provide all U.S. patients with suitable language services.
- Patients who encounter language barriers have longer and more costly hospital visits.
to fund a state-certified interpreter system. States are allowed to choose the standard of language services they wish to provide so long as they hold all hospitals to the same standard. All hospitals and individual providers are eligible for reimbursements from Medicaid or SCHIP as long as they used a certified service. Physicians have been shown to use professional language services more often when third-party reimbursement is available, because they do not have to bear the full cost themselves. After ten years of this policy, hospitals must show that they have reduced ad hoc interpreter use by 50 percent and increased certified interpreter use by 50 percent to retain the maximum reimbursement.

LEP patients will benefit from standardized language services and a reduction in the use of ad hoc interpreters. Professional language services avoid unnecessary diagnostic tests and prolonged hospital stays, saving up to $11 per LEP patient visit on average. The use of interpreters substantially increases patient-provider satisfaction with communication during visits. Implementing a similar policy of providing language services in most healthcare settings nationwide could save over $300 million in unnecessary charges incurred by LEP patients. Though the cost of these changes would be about $268 million, there would still be a net benefit of about $30 million nationwide.

NEXT STEPS
Congress must act to establish a standard of language services across the country and eliminate use of ad hoc interpreters. The Office of Minority Health would support the policy, because it enforces its published standards regarding appropriate language services in healthcare. Within a year of implementation, providers will be required to provide baseline data regarding their ad hoc interpreter use. This data must be tabulated by an unaffiliated third-party such as a local health department.

The LEP community overlaps significantly with the Hispanic community, making Latino advocacy groups such as The National Alliance for Hispanic Health and The National Council of La Raza key advocates. Both groups are dedicated to improving health outcomes, which would be the case as more Hispanics would be able to communicate with their providers and would spend less money and time on visits. Other minority rights advocacy groups, such as the Southeast Asia Resource Action Center, would also be important advocates.
REACHing for Safety: Restructuring the Chemical Regulation Process in the U.S.

By Grant Rosensteel, Georgetown University

Thesis
To safeguard public health and reduce chemical related healthcare costs, the U.S. Congress should adopt a “guilty until proven innocent” regulatory system that imposes mandatory health evaluations on chemical manufacturers.

Background and Context
In the U.S., chemical regulation is fragmented under multiple federal agencies, such as the Food and Drug Administration (FDA), Environmental Protection Agency (EPA), and the United States Department of Agriculture (USDA). The intended use of each chemical determines which agency has jurisdiction. Under the Toxic Substances Control Act of 1976, the agency that has jurisdiction over the chemical bears the burden of proving the safety of that chemical. Additionally, chemicals in cosmetics are not required to have FDA approval, and any substance that is “Generally Recognized as Safe” (GRAS) can be sold without testing. Under current legislation, manufacturers are not required to conduct health evaluations on chemicals before appealing to the government for approval. Many chemicals such as rBST, Nitrates, Potassium Bromate, and BPA are sold in the U.S. but banned internationally due to their negative health effects.

Allowing chemicals to be sold without extensive health and toxicological testing is costing the U.S. billions of dollars in healthcare-related costs. The inefficiency of the current system, described as an “innocent until proven guilty” approach, is demonstrated by the approval and subsequent ban of DDT after its detrimental effects on health and environment were discovered. The neurological effects of lead paint alone have cost the U.S. $53 billion in healthcare expenditures. By restructuring the way chemicals are regulated in the U.S., public health will be protected by ensuring that all chemicals used in food and consumer products pose minimal risk to individuals’ wellbeing.

Talking Points
Chemical regulation in the U.S. is divided between several federal agencies and fails to test all chemicals for potential health impacts.
American chemical regulation is less stringent than other nations. Chemicals in food and consumer products permitted under current regulation have the potential to harm the health of Americans.

Requiring manufacturers to prove that chemicals are not harmful before selling them, will reduce exposure to toxic chemicals and healthcare costs. Some chemicals currently permitted are known mutagens and have negative impacts on genetic code.

**Policy Idea**
The U.S. Congress should implement a “guilty until proven innocent” approach to chemical regulation, similar to that of the recently implemented Registration, Evaluation, Authorization, and Restriction of Chemicals (REACH) program in the European Union. Under such an approach, manufacturers would be mandated to test all chemicals for effects on human health and provide that research when seeking regulatory approval. Additionally, a single federal agency should be given sole authority to regulate all chemicals, and to conduct random audits. These audits would validate companies’ health documentation and ensure that manufacturers are submitting scientifically sound evidence. A three-tiered regulation process should also be implemented, in which all chemicals undergo tier one testing for absorptivity and general toxicity, and those that prove potentially harmful would move on to the second and third tiers for more intensive biochemical evaluations. All chemicals previously designated as “GRAS” should undergo the same toxicological screenings as new chemicals.

**Policy Analysis**
Chemical regulation in the U.S. has failed to match the rapid development of new and complex chemicals, resulting in increased rates of chemical-related diseases, especially cancer and endocrine system disorders. In the

**KEY FACTS**
- The U.S. government currently does not have safety data on chemicals that were in use before the introduction of the Toxic Substances Control Act of 1976.
- The FDA cannot conduct research on a chemical unless there is reasonable suspicion that it poses a threat to human health.
- Phthalates, which are often used in plastics, are known to cause cancer in the reproductive system of lab animals, but are still allowed in consumer products.
U.S., approximately 75 to 80 percent of all cancers are caused by exposure to toxic chemicals and other environmental factors, costing over $260 billion in medical bills and lost productivity. The healthcare costs of endocrine-disrupting chemicals, such as BPA, are estimated to be $175 billion since initial production.

Under the REACH program, thousands of chemicals have undergone safety testing. As a result, the impacts of chemicals on human biochemistry have been compiled and dozens of dangerous chemicals have been banned. Investing in the REACH program has a projected return on investment of $6.2:1 over the next 10 to 20 years. Based on the costs incurred by the European Union, the cost of implementing these regulations in the U.S. would be about $3.5 billion a year. However, these costs will be recouped from decreases in chemical-related healthcare expenditures and lost productivity in the long term. Annually investing a small amount towards a new federal agency to oversee all chemicals and requiring strict health and safety testing will pay for itself and allow for focus on preventative care. By banning certain chemicals in foods, the U.S. will then be able to export products such as dairy, farm-raised fish, and meat that were previously banned for import by certain countries due to the presence of harmful chemicals. The chemical industry conducted the largest lobbying effort in EU history in an attempt to defeat EU REACH, and similar industry lobbying is expected to occur with the introduction of a similar program in the U.S. Implementing more rigorous safety measures will prevent harmful cumulative health effects, decrease societal costs of chemical exposure, and positively impact the American economy.

NEXT STEPS
Publicizing the dangers of the current regulatory process is the first step in implementing a REACH program in the U.S. This could be done by creating websites and billboards dedicated to the issue as well as having individuals who have been negatively impacted by current chemical regulations appear on national television and other media outlets. Public hearings with experts in the fields of medicine, public health, toxicology, and biochemistry should be held so that these experts can testify about the impacts of chemicals on health.

The next step would be to establish a new federal agency to review all chemicals, determine their safety, and institute a program modeled after the EU’s REACH. Finally, after the legislative framework is established, manufacturers should be given a 5 to 10 year timeframe to comply with the new mandate of supplying health and toxicological studies on all new and existing chemicals.
Expanding Scope-of-Practice Laws to Meet the Primary Care Shortage

By Sarah Rudasill, Wake Forest University

Thesis
To meet the growing demand for primary care and preventative medical services, North Carolina must expand scope-of-practice laws for advanced practice registered nurses to authorize use of the full range of medical skills conferred by their advanced degrees.

Background and Context
Advanced practice registered nurses (APRN) are nurse practitioners and specialists who hold masters or doctoral degrees that permit direct patient care and population health management. Over 240,000 nurses qualify for advanced practice, providing family, pediatric, gerontology, psychiatric, and emergency care for patients. In addition, APRNs are responsible for 27 million anesthetic procedures and 10 percent of U.S. births annually. The role of APRNs is especially critical because the nation is facing a shortage of 29,800 primary care providers. North Carolina alone will need an additional 4,800 primary care physicians by 2020, with over half of its counties presently designated as full or partial health professional shortage areas. Rapidly rising chronic disease rates, accounting for 86 percent of all health care spending in 2010, are shifting focus to fill the gaps in preventative medicine for communities to combat the health and financial burdens posed by cardiovascular disease, diabetes, and cancer.

APRNs are critical in providing the primary care that Americans need, but there is variation among states in defining responsibilities and roles. Regulatory barriers in some states hinder this highly educated workforce by mandating physician supervision and restricting prescriptive authority, despite the fact that APRNs possess the training to practice more independently. Although the Veterans Health Administration and armed forces health services have already secured federal approval for APRNs to practice the full extent of their training, North Carolina is one of thirty-one states that have not authorized full scope-of-practice status. Reducing restrictions on APRNs will alleviate the immediate primary care shortage with quality medical services, reducing healthcare expenditure and improving population health.

Talking points
- APRN are specialists who have completed advanced training in
patient care and population health management.\(^8\)

- APRNs can alleviate the growing primary care need, but current scope-of-practice regulations must be changed to reflect the advanced training provided by their degrees.
- APRNs provide equal or superior primary care services for a lower cost relative to physicians.

### The Policy Idea

The North Carolina General Assembly should pass legislation authorizing APRNs to provide healthcare services within the full scope-of-practice permitted by their advanced degrees. By revising the state’s nurse practice act to reflect evidence-based standards, the state legislature will meet the growing primary care gap for communities while improving population health and reducing overall healthcare expenditure. This model can ultimately be expanded to other states.

### Policy Analysis

Expanded scope-of-practice laws would yield an estimated 24.4 percent more APRNs in the state by 2019, which will alleviate the primary care shortage by substituting APRNs for physicians, reducing supervision responsibilities to increase physician consultation time, and reducing hospitalizations associated with chronic disease through preventative disease management.\(^9\) North Carolina’s primary care gap would be reduced by 83 percent through the creation of 3,800 new APRN jobs, and the legislation would eliminate the state’s shortage of obstetricians and gynecologists while meeting 85 percent of its anesthesiologist gap.\(^10\)

Opponents raise concerns about whether APRNs provide adequate care quality, but research demonstrates that APRNs provide equal or superior primary care services relative to physicians. Patients are more satisfied with care provided by an APRN, with no differences in health outcomes or the number of return consultations as compared to physicians.\(^11\) APRNs are more likely to devote appointment time to disease prevention counseling,
and this greater focus on health education results in a reduced rate and length of re-hospitalization for patients treated by APRNs relative to primary care physicians.\textsuperscript{12}

The benefit of expanding scope-of-practice laws rather than training more physicians is that APRNs provide equal or superior care for significantly lower costs. Hospital costs were 27 percent lower for patients managed by an APRN, preventative care visits were between 25 percent and 53 percent the cost of physician appointments, and APRNs saw 10 percent more patients in an ambulatory setting relative to physicians.\textsuperscript{13} North Carolina could save an estimated $433 million to $4.3 billion annually in health costs by expanding scope-of-practice laws, while also generating increased economic output of at least $477 million.\textsuperscript{14}

**NEXT STEPS**

The key target is the North Carolina General Assembly, which is responsible for revising and updating the nurse practice act governing scope-of-practice laws in the state. Key allies include the North Carolina Board of Nursing, which makes recommendations for nursing practice, the American Association of Nurse Practitioners, which promotes the field, the North Carolina Nurses Association, which is the lobbying body for nurses in the state, and the Metrolina Coalition of Nurse Practitioners, which is the local promoter of the field. AARP and the Robert Wood Johnson Foundation will also be key allies because they have played a pivotal role in lobbying for scope-of-practice changes in seventeen other states across the country. These national organizations will be especially important in framing the policy change for the American Medical Association as a reduced regulatory burden on physicians, providing greater time for patient consultation and more assistance in operating clinical practices.
Maximizing the Value of Direct-to-Consumer Genetic Testing

By Sarah Rudasill, Wake Forest University

Thesis
To address medical concerns regarding inaccurate consumer interpretation of, and response to, genetic test results, North Carolina should require all direct-to-consumer (DTC) genetic testing companies to provide genetic results, interpretation, and guidance to clients through a licensed genetic counselor.

Background and Context
A DTC genetic test bypasses healthcare professionals to provide genetic information directly to consumers.1 Whereas a physician administers traditional genetic testing, DTC genetic testing consists of a cheek swab or saliva sample sent directly to a company that provides results online, via mail, or over the telephone.2 While some companies offer optional genetic counseling or recommend independent counselors to contextualize results, the majority do not integrate genetic counseling into their service models.3 This is problematic because the interpretation of genetic test results is medically complicated. Results may confirm a diagnosis, carrier status, or increased risk of disease, but tests may miss rare mutations or account for only a few genes of the 24,000 that influence phenotypes.4 Furthermore, genetics is just one factor influencing risk for complex illnesses such as heart disease or cancer. Environment, lifestyle, and medical history play critical roles in determining actual health outcomes.5 Consumers, who misinterpret results in 20 percent of cases, may risk their physical and mental health with medical decisions based upon inaccurate or exaggerated interpretations.6 Although the 1988 Clinical Laboratory Improvement Amendments set quality control standards for genetic testing laboratories, and the Food and Drug Administration (FDA) regulates test accuracy, there is no regulation governing consumer interpretation of complicated genetic results.7 Genetic counselors can fill this void and guide consumer understanding because they are trained to assess medical, familial, and psychosocial risk while providing culturally appropriate and non-coercive support.8 With a rapidly growing DTC market valued at $230 million by 2018, governments must act swiftly to protect consumer health with licensed genetic counselors.9

Talking Points
- DTC genetic testing is an emerging field that provides personalized genetic information to consumers without a healthcare intermediary.10
- DTC genetic testing empowers consumers to be proactive in their health,
improving long-term outcomes.\textsuperscript{11}

- Consumers lack the ability to contextualize complicated genetic effects on health conditions that are also influenced by a multitude of social and environmental factors.\textsuperscript{12}

- Genetic counselors are state-licensed professionals who are trained to support individuals in understanding the medical, psychological, and familial implications of their genetic results.\textsuperscript{13}

**Policy Idea**
Recognizing the value of DTC genetic testing for early diagnosis and consumer health empowerment, the North Carolina General Assembly should pass legislation requiring DTC genetic testing companies to provide consumer test results and interpretation directly through a licensed genetic counselor. This policy can be scaled to the federal level upon successful implementation in North Carolina.

**Policy Analysis**
In 2013, the FDA stopped DTC genetic testing company 23andMe from offering health reports that ignored the complexity of genetic interpretation.\textsuperscript{14}

When over 3,000 published research papers present contradictory evidence and differing severity estimates for the role of one Alzheimer’s gene, accurate consumer risk interpretation is challenging.\textsuperscript{15} In one study, only 80 percent of participants correctly identified their carrier status, with comprehension significantly lower for minorities, the elderly, and those with less education.\textsuperscript{16}

While interpretation is difficult, DTC genetic testing is valuable because confirmation of a diagnosis, carrier status, or increased risk empowers individuals to modify behaviors and improve long-term health. One study found that disclosing Alzheimer’s disease risk compelled 53 percent

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**KEY FACTS**

- The market for DTC genetic testing will skyrocket to an estimated value of $230 million by 2018.\textsuperscript{23}

- While 91 percent of consumers engage in DTC genetic testing to learn about potential future diseases, over 20 percent incorrectly interpret their genetic test results.\textsuperscript{24}

- Only 39 percent of primary care physicians report feeling comfortable interpreting their patients’ genetic test results,\textsuperscript{25} and only 10 percent report a comprehensive understanding of genetics.\textsuperscript{26}

- Knowledge of mutations in the gene for Alzheimer’s disease compelled 53 percent of study participants to positively change their health behaviors.\textsuperscript{27}
of participants to positively change their lifestyles. Knowledge of the BRCA1 mutation, which increases breast cancer risk to 55 to 65 percent and ovarian cancer risk to 39 percent by age 70, encourages early and intensive surveillance. Over 80 percent of consumers reported deriving empowerment from genetic knowledge, confirming the value of increased accessibility through DTC testing.

However, state governments should require licensed genetic counselors to provide and interpret complex results. Genetic counselors are certified to explain disease transmission, familial implications, and mechanisms to cope with increased risk. Genetic counselors will reduce the influx of consumers seeking genetic interpretation by physicians, who report feeling ill-equipped to explain implications. Since genetic counseling assures appropriate interpretation and action, marginalized populations may attain better outcomes through preventative measures that reduce health inequalities. Genetic counseling also has the potential to slow healthcare expenditure by fostering improvements in health behaviors and reducing consumer reliance upon physicians for genetic interpretation.

NEXT STEPS

The institution responsible for change is the North Carolina General Assembly, which must pass legislation mandating that a genetic counselor provides test results and interpretation as a part of the service provided by genetic testing companies. The state legislature may work in conjunction with the FDA, which only has the power to regulate the medical device’s accuracy, clinical sensitivity, and specificity but is interested in protecting consumer health. Allies for this policy include genetic testing companies seeking to reenter a market temporarily halted by the FDA; the National Society of Genetic Counselors (NSGC), which promotes the genetic counseling field; and the North Carolina Medical Genetics Association (NCMGA), which promotes access to genetic information for North Carolina residents.

Legal challenges to the requirement for an intermediary may be averted by formulating this policy in association with DTC genetic testing companies, which are eager to reenter and expand the genetic testing market. Furthermore, emphasis on genetic information protection laws such as the Genetic Information Nondiscrimination Act and Health Insurance Portability and Accountability Act may avert legitimate ethical concerns about the confidentiality of personal data. Key targets include the state legislature to pass legislation and the FDA, which must be convinced that this regulatory scheme ensures consumer safety. Thus the FDA will be confident that it can reinstate genetic testing companies who will provide accurate health information through licensed professionals.
Patients, Not Consumers: Limiting Drug Manufacturers’ Tax Deductions for Advertising and Promoting Research for Rare and Orphan Diseases

By Tracee Saunders, University of North Carolina, Chapel Hill

Thesis
To de-incentivize direct-to-consumer advertising (DTCA) for prescription drugs, decrease state and federal health expenditure on pharmaceutical products, and promote innovation in the pharmaceutical sector, the federal government should prohibit drug manufacturers from claiming a tax deduction for any advertising expenditure that exceeds their research and development (R&D) expenditure for medicines for rare and orphan diseases. Congress needs to shift from a corporation-driven focus in legislation to a patient-driven focus.

Background and Context
Health care is the single largest industry in the U.S., representing 17.3 percent of the gross domestic product (GDP) as of 2013. Costs and prices of prescription drugs in the U.S. are unnecessarily increased by large investments in marketing. The U.S. and New Zealand are the only two countries that allow DTCA for pharmaceutical products, and in these two countries, branded (non-generic) prescription drugs tend to be considerably more expensive than in other developed countries. The U.S. spends more per capita on prescription drugs than any other nation, but its citizens are not proportionately healthier. In fact, they are less healthy and have a slightly lower life expectancy. The life expectancy at birth in the U.S. is 79 years, whereas in Iceland and Japan, life expectancy is 83 years. Iceland’s and Japan’s health expenditures as a percentage of their GDP are 9.1 percent and 10.3 percent respectively. Similar patterns are evident in France, Sweden, Switzerland, and Germany (see Figure 1). Although the increased price of pharmaceuticals is by no means the sole reason for the U.S.’s health expenditure, it is a contributor. There are more effective way to spend healthcare dollars. To extend better health care to more citizens, the government claims to need more money. Ending DTCA tax deductions would mean billions of extra dollars in revenue.

In a comparison of U.S. drug prices with those in Norway, England, and Canada’s province of Ontario, U.S. prices were higher for 93 percent of 40 top branded drugs available in all four countries. With these prices, Americans fund a majority of the global drug industry’s profits. In 2013, Americans spent $271.1 billion on prescription drugs alone. The U.S. pays more because of practical and philosophical differences in the way the U.S. health system provides benefits, drug manufacturers’ lobbying power, and Americans’ need for personal choice in health care. Although other countries, such as the U.K., treat the pharmaceutical industry much like
other industries and deduct all marketing costs from their income taxes, they don’t allow DTCA, and their health systems are frequently able to negotiate more effectively with pharmaceutical companies. Their health expenditures are a fraction of U.S. expenditures. DTCA inflates demand for new, more expensive drugs, even though these drugs may not be more effective or chemically much different than their older, less expensive counterparts. Additionally, pharmaceutical companies currently have no monetary incentive to research medicines for rare and orphan diseases. Rare and orphan diseases are defined, in the U.S., as diseases that affect less than 20,000 people. Pharmaceutical companies have little motivation to invest in rare diseases because they do not offer much potential profit.

Talking Points
▶ DTCA raises demand and encourages costly, unnecessary drug switching.
▶ DTCA indirectly increases the price of pharmaceutical products because of its effect on consumer demand and increased advertising costs that trickle down to the consumer.
▶ The average number of prescriptions per person increased 44 percent from 2000 to 2009 without correlating increase in health.
▶ DTCA increases the risk of inappropriate and unnecessary prescriptions.

The Policy Idea
The policy idea is to amend the Internal Revenue Code (IRC) of 1986 to limit pharmaceutical manufacturers’ advertising deduction for prescription drugs to the amount that each company spends on R&D for rare and orphan disease. The IRC cites “ordinary and necessary” business expenses as tax deductible, and generally, advertising costs are included within these tax deductions. Pharmaceutical advertising is inherently different than other advertising. Prescription drugs have the ability to improve peoples’ lives and health, but also come with a wide range of risks and negative consequences. Limiting tax deductions would incentivize research for drugs with less profit potential and de-incentivize DTCA without regulating free speech. Pharmaceutical companies often defend pharmaceutical advertising as a form of free speech. Several court precedents establish that ads cannot be banned outright because they are a form of commercial free speech and reflect the right of a for-profit company to make a profit. These rights have been

KEY FACTS
▶ For every dollar spent on advertising, drug companies make four.
▶ Pharmaceutical companies’ spending on advertising has increased 30% since 2013.
▶ Last year, Pfizer spent $7.15 billion on R&D, making $44.51 billion. Merck and Co. spent $6.53 billion on R&D, making $36.61 billion. Similar data for advertising expenditures could not be found.
▶ Physicians are nine times more likely to prescribe an advertised drug than a non-advertised drug.
upheld as protected by the Constitution. However, revocation of tax deductions is constitutional. Eliminating tax deductions would not violate the corporations’ right to commercial speech, but it would de-incentivize DTCA and raise revenue for the federal government. Pharmaceutical companies are rewarded for innovation and discovery with extensive patents and full tax deductions for any R&D expenditure. Losing a portion of the tax deduction for advertising should not significantly hurt profit margin, especially if companies respond by downsizing or ceasing DTCA campaigns.

Policy Analysis
In May 2002, the Fair Advertising and Increased Research (FAIR) Act was introduced to Congress. Similar to this proposal, the bill called for limits in tax deductions for pharmaceutical companies’ advertising, but also appropriated the resulting tax revenue to the Hospital Insurance Trust Fund. The Hospital Insurance Trust Fund partially funds Medicaid. The bill was not made law. The political divisiveness of expanding Medicaid support and funding jeopardized support of the rest of the bill. Opponents of the 2002 proposal argued that a limit on tax deductions would decrease incentive for R&D. Since the proposal still allows for advertising deductions equal to the deductions claimed for R&D for rare and orphan diseases, R&D is actually further incentivized because increases in R&D expenditure for medicines with less profit potential will allow commensurate increases in marketing expenditures. Because marketing investments have proven to have a 300 percent return on investment, companies will want to take advantage of this economic opportunity. Pharmaceutical spending on advertising nearly doubled between 2001 and 2005, growing from $654 million to over $1.19 billion. Yet, no tax limiting legislation has been introduced in Congress since 2003. Pharmaceutical lobbying has made legislation that encroaches on the sector increasingly difficult. There is an absence of reliable data on the pharmaceutical industry’s cost structures. This allows partisans anywhere on the political spectrum to cite figures favorable to their own positions. A reliable estimate is key for policymaking. In many cases, data from the various pharmaceutical market intelligence firms do not agree with estimates based on the information in the annual reports of the pharmaceutical companies. It seems that the pharmaceutical companies themselves are skewing the data, or paying the market intelligence firms to skew the data to favor their position. In a 2008 study, Canadian researchers Marc-Andre Gagnon and Joel Lexchin concluded that U.S. pharmaceutical companies are spending almost twice as much on marketing as on R&D.

NEXT STEPS
Congress needs to enact a patient-driven focus in their legislation to reduce health care costs, while emphasizing more appropriate health care solutions for patients. A key ally for this policy could be the American Medical Association, which called for a ban on DTCA on Nov. 18, 2015.
The Study Drug Problem: Reducing the Abuse of Amphetamines on College Campuses

By Preston Simmons, University of Louisville

Thesis
To combat the abuse of amphetamines on college campuses, the Kentucky state legislature should pass a bill that creates a stricter set of qualifications to diagnose Attention Deficit Hyperactive Disorder (ADHD) and prescribe amphetamine-based drugs. This would decrease the number of amphetamine-based drugs prescriptions and their subsequent abuse by college students.

Background & Context
In response to increasing pressure for academic and social success in college, many students seek out amphetamine-based drugs such as Adderall, Ritalin, or Vyvanse to gain an advantage over their peers. These drugs, which are meant for the treatment of ADHD, mimic the effect of chemical epinephrine in the sympathetic nervous response, creating a rush of energy that focuses attention and combats hunger.¹

Fraudulently accessing these drugs violates the student code of conduct and creates academic disparities when some students can study longer due to drug use. As well, abuse of amphetamine-based drugs is detrimental to the health of young adults; they are highly addictive, and chronic abuse can result in weight loss, insomnia, irritability, and, in severe cases, psychosis.² Adderall, and most other amphetamines, are considered Schedule II substances—which means they have a large potential for abuse—and can result in psychological or physical dependence.

Between 2007 and 2012, the number of adults with prescriptions to treat ADHD tripled from 5.6 million to almost 16 million.³ This figure includes those who were given a legitimate prescription, but the inclusion of those who sought false diagnoses further inflates it. Emergency room visits resulting from the abuse of non-prescribed stimulants tripled from 2005 to 2011 among people between the ages of 18 and 34.⁴

Kentucky ranks among the top states in the nation for diagnosis of ADHD,⁵ and this is in large part due to the use of self-reported screenings to diagnose ADHD, which allows college students to easily create the illusion of having the disorder. A study conducted by Pennsylvania State University and Arizona State University found that 93 percent of students who wanted a diagnosis for ADHD were successful, thus gaining access to a prescription for
Adderall or similar amphetamines.\(^6\)

**Talking Points**
- The illegal use of amphetamines has increased rapidly over the past decade on college campuses, largely because of the method of diagnosis for ADHD via self-evaluation at hospitals, clinics, and university health centers.
- Students with prescriptions for amphetamines often sell the drugs to other students.
- A combination of psychological evaluations, continuous performance tests, and even further medical assessments prove to be much more effective in correctly diagnosing ADHD, reducing the possibility of a false diagnosis and the potential abuse of amphetamines.

**Policy Idea**
ADHD screening among college students is mainly self-reported and subjective. To decrease the abuse of amphetamine-based drugs on college campuses, a stricter screening process should be created and subsequently enforced for the diagnosis of ADHD. This screening process would include psychological evaluations, performance tests, and further medical assessments that create a multi-disciplinary approach to the diagnosis of ADHD. Better screening would decrease the number of false diagnoses, which would, in turn, reduce access to amphetamine-based drugs on college campuses.

**Policy Analysis**
Research studies have found that a majority of college students who express a desire to obtain prescriptions for ADHD drugs were able to do so.\(^7\) While it holds true that more rigorous screening for ADHD costs more than self-reported assessments ($600 to $1800 vs. $125)\(^8\), the cost is small compared to the cost of emergency room visits due to complications that accompany the abuse of ADHD drugs. In 2010, 8,148 emergency room visits were made by young adults ages 18-25 as a result of the abuse of ADHD drugs. With

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**KEY FACTS**
- Nationwide estimates of the percentage of college students that have illegally taken amphetamine stimulants range from 6.9 percent to 35.6 percent.\(^11\)
- Approximately 13 percent of American teens have abused Ritalin or Adderall at some point in their lives, adding up to 2.7 million young people taking powerful pharmaceuticals without a prescription.\(^12\)
- In 2009, 67 percent of people admitted to an emergency room for complications with prescription amphetamine stimulants had other drugs in their system.\(^13\)
an average cost of $7,600 per stay for patients who abuse drugs, hospital expenses total almost $62 million per year. In addition, up to 30 percent of hospital visits related to stimulant abuse also involved alcohol, adding yet another dangerous layer to this already harmful habit. While this problem could be addressed by limiting the number of pills dispensed to any person with a prescription to reduce the amount of “leftover” pills that could then be sold or given to someone without a prescription, this solution would be unethical because it could prevent students who do need the drugs to treat ADHD from obtaining enough medication.

Because this is currently an overlooked problem nationwide, there has been little research proving the effectiveness of creating a stricter screening process for ADHD. However, we can assume that with stricter diagnostic criteria, the percentage of students with access to these amphetamine-based drugs will decrease. This strategy has the potential to decrease the number of college students for whom prescription drugs are easy to obtain, which has been reported to be as high as 82 percent.

NEXT STEPS
The current form of diagnosis for ADHD through self-reporting is archaic and ineffective. The first step to correcting this system is to assemble a team of health experts from the state of Kentucky to create a new statewide, standardized screening for ADHD that incorporates a multi-disciplinary approach. Funding could come from various sources including the state government and private and public insurance companies. After new criteria have been established, the Campus Health Services at the University of Louisville, where most students who attend the university come for their medical needs, should run a pilot program. If the pilot program is a success, it could then be expanded to the University of Louisville Hospital and other local clinics in the area that specialize in the treatment of ADHD. Success at the local level would provide the impetus to take a new screening process for ADHD to the state legislature and lobby for statewide implementation. Ideally, after seeing the results in Louisville, the Kentucky Department of Public Health and its local partners—such as Campus Health Services at the University of Louisville—would advocate for this new, more effective screening process and move for statewide action, facilitating a smooth and efficient transition.
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