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IDEAS

ONLINE

KIDNEY TRANSPLANTS FOR ALL: ENSURING ACCESS TO LIFE-SAVING PROCEDURES FOR UNDOCUMENTED IMMIGRANTS

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Thesis

To improve health outcomes for undocumented immigrants, many of whom do not have health insurance, and reduce the taxpayer burden of sustained hemodialysis for end-stage renal disease, Texas should extend emergency medical coverage to include kidney transplants, regardless of insurance status.

Background Analysis

According to the American Immigration Council, Texas had an estimated 4.9 million foreign-born residents in 2018—17 percent of its total population—and 33 percent of its immigrant population was undocumented (American Immigration Council 2020). Many of these immigrants likely do not have insurance: Among the total non-elderly population in the United States, 45 percent of undocumented immigrants are uninsured, compared to 23 percent of lawfully present immigrants (Kaiser Family Foundation 2020). And while the difference in insurance rates between documented and undocumented immigrants is already incredibly large, both are much higher than the rate of US citizens who are uninsured—only 8 percent (Artiga and Diaz 2019). Without health insurance, many undocumented immigrants in Texas lack access to adequate health care, including to kidney transplants for end-stage renal disease (ESRD), which is a major public health threat nationally. This disease is particularly prevalent in Texas, where the incidence of ESRD exceeds the national rate (Addressing Chronic Kidney Disease in Texas 2009), and one study

estimated that there are between 2,050 and 3,270 undocumented immigrants living with ESRD in Texas (Rodriguez, Cervantes, and Raghavan 2019).

Lack of insurance makes it extremely difficult for undocumented patients to manage ESRD financially (Asnel et al. 2015). Under federal law, the structure of safety-net Medicaid coverage excludes kidney transplants following federal guidelines established under the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA). According to guidelines in EMTALA, federal funding can only be used to cover emergency conditions involving “acute symptoms of sufficient severity” (EMTALA n.d.). A kidney transplant is not considered an emergency treatment for ESRD, and is thus excluded from federal reimbursement (Linden et al. 2012). As a result, under state protocols, hospitals in Texas resort to implementing a less effective, federally subsidized treatment—emergency hemodialysis. Hemodialysis is only a short-term solution, and in many states including Texas, undocumented immigrants and uninsured individuals are forced to wait until life-threatening conditions like “metabolic acidosis, hyperkalemia, uremia, or volume overload” develop before even being able to receive emergency dialysis (Persaud 2019).

Although both hemodialysis and kidney transplants are costly medical procedures, access to kidney transplants is ultimately cheaper and would alleviate the financial burden of managing kidney disease over the long term. As such, there is a vital economic, medical, and humanitarian impetus for a policy solution ensuring access to kidney transplants for undocumented immigrants. In 2014, Illinois became the first state to address the gap in coverage via Senate Bill 741, which allowed the state government to reimburse hospitals for uncompensated kidney transplant costs (Ansell et al. 2015). Since then, 10 other states and the District of Columbia have included provisions to facilitate kidney transplants for undocumented immigrants (Ackah et al. 2019). A similar policy in Texas would have three

principal stakeholders: taxpayers, patients in the existing transplant pool, and undocumented immigrants.

The Policy Idea

Texas should extend emergency health services to undocumented immigrants and uninsured patients by allowing hospitals to cover outstanding costs of emergency kidney transplants under Medicaid. By applying the legal and legislative precedents set in Illinois and Washington, DC, and crafting a bill that expands Medicaid to cover emergency kidney transplants for undocumented immigrants receiving care at public Texas hospitals, public medical institutions can eliminate prolonged emergency hemodialysis, a much more costly procedure.

Policy Analysis

Undocumented immigrants combine two historically marginalized identities: They are predominantly people of color and are oftentimes uninsured. As such, they face barriers related to both immigration and insurance status.

In addition to aiding a vulnerable population, this policy would provide long-term economic benefits. Hemodialysis in Houston costs \$285,000 yearly per patient, and the procedure can last an indefinite amount of time—anywhere from 1–20 years (Raghavan 2017). In contrast, kidney transplants only cost \$20,000 annually, on top of a one-time \$300,000 to cover the cost of the operation (Bentley 2014). Based on these numbers, kidney transplants would start saving money after roughly 13 months, refuting the argument that expanding kidney transplants to undocumented immigrants forces more taxpayer dollars to be funneled into emergency care. Extrapolating from these figures, over five years, routine hemodialysis

would cost \$1,425,000 while transplants would cost only \$400,000 and would therefore save over \$1 million per patient in that short time.

Our policy solution would also drastically improve ESRD survivorship. After five years, sustained hemodialysis has a 35 percent survival rate, while transplantation has a 97 percent survival rate (USRDS 2018). In short, increasing access to kidney transplants reroutes money that is already being spent on a medical imperative toward a more promising medical and economic outcome. This policy would therefore allow for more effective health care for uninsured, undocumented patients and a more efficient use of taxpayer money for this particular health care issue, as well as ultimately saving the state of Texas money each year.

This policy would also benefit the health of the community at large—not just undocumented immigrants—by improving organ donation rates overall. A common concern associated with adding undocumented immigrants to an organ transplant list is that it forces them to compete for organs with insured American citizens. However, approximately 60 percent of undocumented immigrants have a family member willing to donate a kidney (Baru 2013). In addition, noncitizens have a track record of giving more than they take when it comes to organ donation, contributing at least three times as many organs to the deceased donor pool than they withdraw (Ackah et al. 2019). Allowing them to access a pool to which they already donate will only incentivize them to engage more with the system, thereby increasing overall organ donation rates.

Talking Points

1. Eleven states and Washington, DC have already implemented mechanisms to improve access to kidney transplants for undocumented immigrants and uninsured patients (Ansell et al. 2015; Ackah et al. 2019).

2. This policy proposal would be impactful for undocumented immigrants in Texas, allowing them to have more equal access to long-term kidney transplant treatment.
3. This policy would relieve the burden of access to certain health care procedures for uninsured minorities (Kuruville et al. 2014).

Key Facts

- Emergency dialysis in Houston costs \$285,000 per patient each year (Raghavan 2017). In comparison, kidney transplants have a \$300,000 upfront cost, and then cost only \$20,000 per year (for anti-rejection medication). Kidney transplant is therefore less expensive than emergency dialysis within 13 months (Bentley 2014).
- After five years of treatment, ESRD patients with transplants have a 97 percent survival rate, compared with the 35 percent survival rate of ESRD patients receiving hemodialysis (USRDS 2018).
- Noncitizens contribute at least three times as many organs to the deceased donor pool as they withdraw (Ackah et al. 2019).

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INSTITUTING FINANCIAL INCENTIVES TO INCREASE EMPLOYMENT FOR PEOPLE WITH DISABILITIES IN CALIFORNIA

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Thesis

To decrease unemployment rates for people with disabilities, California's Employment Development Department (EDD) should provide a fiscal incentive for hiring people with disabilities by expanding the Work Opportunity Tax Credit (WOTC) to include all individuals classified as having a disability by the Social Security Administration (SSA).

Background Analysis

In 1974, California passed the Fair Employment and Housing Act (FEHA)—the state's first law intended to ensure that people with disabilities were protected from discrimination in the workplace. Several decades later, in an effort to protect and employ people with disabilities in the workforce, California's 2002 Workforce Inclusion Act required the Employment Development Department (EDD) to create "a sustainable, comprehensive strategy to bring people with disabilities into state government employment" (Cunningham 2017). Today, the EDD works to ensure that all applicants with disabilities receive equal employment opportunities in California. However, while California has worked to provide equal treatment for people with disabilities once they have entered the workplace, historically the state has not been as effective at increasing their employment rates; in 2019, the employment rate of people aged 18–64 with a disability was a mere 38.2 percent, compared to 76.4 percent for the same age group without a disability (National Institute on Disability 2020).

According to an analysis published in the Journal of Occupational Rehabilitation, “the principal barriers to employing workers with disabilities are lack of awareness of disability and accommodation issues, concern over costs, and fear of legal liability.” Among other results, the report also found that 68.5 percent of the employers surveyed were “afraid the workers with disabilities won’t work up to the same standards as other employees” (Kaye et al. 2011). A 2007 report released by the International Disability Rights Monitor similarly found that “the biggest barriers to [disability] employment are prejudice and fear about potential additional costs” such as special transportation and pension costs (United Nations Enable 2007). However, a Cornell University report concludes that these fears are not rational; while a cost difference between employees with and without disabilities exists, it is marginal (Linkow and Barrington 2019). Moreover, a meta-analysis released by the Cerebral Palsy Research Foundation found that there is “no productivity difference between people with disabilities and people without disabilities” (Legnick-Hall and Gaunt 2014).

Current events have only worsened the situation—now more than ever, a lack of financial incentives for hiring people with disabilities perpetuates employers’ fears of costly adaptations and only serves to increase the staggering unemployment rate for people with disabilities in California. According to the US Bureau of Labor Statistics, since the beginning of the COVID-19 pandemic in March 2020, one in five workers with disabilities have been dismissed from employment, compared with one in seven workers in the general population (Smith 2020). To begin to address the lack of representation of people with disabilities in the workforce, states such as New York, Maryland, and Tennessee have included them as an eligible group of the Work Opportunity Tax Credit (WOTC).

The Policy Idea

To decrease California’s unemployment rate for people with disabilities, California’s EDD should provide employers with a financial incentive to hire people with disabilities by

expanding the “eligible target groups” under the WOTC to include “all individuals determined disabled according to criteria established by the Social Security Administration” (Burwell et al. 2017). Furthermore, the EDD should work closely with private sector employers—both large and small businesses—to generate awareness of this reformed WOTC and to combat the negative stereotypes that lead to underrepresentation of people with disabilities in California’s workforce.

Policy Analysis

An expansion of the WOTC to include all people with disabilities would be beneficial in three main ways. It would: (1) decrease unemployment (Rall 2016); (2) strengthen California’s economy by adding productive workers to the workforce (Kansas University Center for Research on Learning 2005); and (3) provide benefits in the workplace such as employee turnover, reduced absenteeism, and increased productivity (Kansas University Center for Research on Learning 2005).

While California has promoted the inclusion of people with disabilities in the workforce through “employment-first” policies, California’s EDD has not provided any fiscal incentives to encourage employers to hire people with disabilities. Recognizing that businesses face challenges while hiring underrepresented populations, Congress amended the WOTC in 2014 to provide businesses with incentives for employing certain economically disadvantaged individuals, including people with vocational rehabilitation referrals and Supplemental Security Income recipients (Center on Budget and Policy Priorities 2018). However, as the Center on Budget and Policy Priorities finds, these two WOTC-eligible categories of people with disabilities make up an extremely small subset of the total population of people with disabilities in California (ECVC 2021).

As a result of this narrow scope of eligibility, three states—New York, Maryland, and Tennessee—have implemented tax incentives aimed at increasing the employment rate for people with disabilities. While Maryland and Tennessee have tax credits for employees with disabilities, their frameworks are not based off of the WOTC which means they offer fewer benefits to eligible businesses and include a smaller subset of the disabled population. New York’s Workers with Disabilities Employment Tax Credit, which was introduced in May 2018, is modeled after the WOTC; unfortunately, since it has only been in place for a few years, its effect on the employment rate for people with disabilities has yet to be measured.

However, California’s unique legislative success with increasing employment for other groups—such as qualified veterans, ex-felons, Supplemental Nutrition Assistance Program (SNAP) recipients, Supplemental Security Income (SSI) recipients, qualified long-term unemployment recipients, and more—under the WOTC signals opportunities for a reformed WOTC to lessen the alienation of individuals with disabilities in the labor market. While some critics claim that encouraging employment of people with disabilities through a tax credit may make it so those hired are seen as less able to do the job, a 2018 article from the Indiana Law Journal finds that employment programs like the WOTC can be successful at overcoming the stigma associated with hiring eligible groups (English 2018). This solution, a reformation of the WOTC, also calls for an educated, informed cadre of employers who understand both the tax credit and obstacles people with disabilities may face when entering the workforce.

Moreover, research findings show that the benefits of hiring people with disabilities can include “improvements in profitability (e.g., profits and cost-effectiveness, turnover and retention, reliability and punctuality, employee loyalty, company image), competitive advantage (e.g., diverse customers, customer loyalty and satisfaction, innovation, productivity, work ethic, safety), inclusive work culture, and ability awareness” (Lindsay et al. 2018). A research report jointly produced by the American Association of People with

Disabilities and Disability:IN quantified these effects, finding that during the four year period analyzed in the study, companies that stood out for leadership in disability employment and inclusion had on average, “28 percent higher revenue, double the net income and 30 percent higher economic profit margins” than companies that did not (Accenture 2018).

Talking Points

1. Policies to promote equal employment for people with disabilities that do not address glaring gaps in the job application and hiring landscape have contributed to the staggeringly high levels of unemployment for people with disabilities (Hamersma and Heinrich 2007).
2. The biggest barrier to employment for people with disabilities is employers' fear of potential additional costs. However, a Cornell University report analyzing the engagement of people with disabilities in the workforce noted that the cost difference between people with disabilities and people without disabilities is marginal (Linkow and Barrington 2019).
3. A lack of representation of people with disabilities in “eligible groups” under the WOTC has prevented people with disabilities from gaining access to employment opportunities. Expansion of the WOTC to include more people with disabilities would help integrate them into the workforce.

Key Facts

- The employment rate of people with disabilities (ages 18-64) in 2019 in California was a mere 38.2 percent, while the employment rate of people without disabilities (ages 18-64) was 76.4 percent (Annual Disability Statistics Compendium 2020).
- Twenty-three percent of California's adult population has some type of disability (Centers for Disease Control and Prevention 2020).
- Only three states in the US—New York, Maryland, and Tennessee—provide tax incentives to employers who hire people with disabilities (Deloitte Economic Access 2011). These incentives differ by state. In New York, The Workers (with Disabilities) Employment Tax Credit (WETC) ensures that businesses can receive a “tax credit of \$2,100 for each individual” with a disability who is hired (NYS Education Department 2013). In Tennessee, eligible businesses are allowed to claim a “one-time \$2,000 credit against franchise and excise liability tax for each qualifying part-time job created and \$5,000 for each qualifying full-time job created for people with disabilities who are receiving state services directly related to their disability” (Tennessee Department of Labor and Workforce Development 2019). In Maryland, eligible businesses are allowed to claim a “credit against state income tax, insurance premium tax, financial institution franchise tax, and public service company franchise tax for wages paid and child care or transportation expenses incurred for employees with disabilities in the amounts of 30 percent of up to the first \$9000 in wages earned and up to \$900 for employer reimbursed expenses” (Cunningham 2017).

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BANNING NONCONSENSUAL PELVIC EXAMS IN MICHIGAN

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Thesis

Nonconsensual pelvic exams are violent and painful invasions of a patient's trust and bodily autonomy. The practice should be banned in the state of Michigan through a bill prohibiting doctors and medical students from performing pelvic exams on non-consenting patients in any scenario where the patient's life is not reliant on a pelvic exam.

Background Analysis

The practice of nonconsensual pelvic exams is embedded within the medical practices of many hospitals and teaching institutions as part of certain standard medical processes and procedures. Medical professionals often instruct medical students to perform pelvic exams on anesthetized patients so that the students can complete a requirement for their rotations (Tsai 2019). For example, a firsthand report by Shawn Barnes, who was a fourth-year medical student at the time it was released, revealed that Barnes was asked to perform pelvic exams on unconscious women four to five times a day for three weeks (Barnes 2012). Additionally, a 2005 study through the University of Oklahoma found that three-quarters of junior and senior medical students at the university who performed pelvic exams on anesthetized women reported not having consent before doing so (Schniederjan and Donovan 2005). Medical students often feel as though they don't have a choice about whether they perform or don't perform this procedure (Friesen 2018), and often follow through with these exams even if they feel it is wrong because they fear that failing to do so will jeopardize their careers (Bruce 2020).

Further, medical students and professionals performing pelvic exams do not always believe that consent is important. According to a troubling study in the *American Journal of Obstetrics and Gynecology* in 2003, medical students who have completed a clerkship in obstetrics or gynecology are more likely to believe that consent is significantly less important than students that have not completed a clerkship at all (Ubel, Jepson, and Silver-Isenstadt 2003). The common explanation for this phenomenon is that educational hospitals believe that pelvic exams are necessary for students' education—consensual or not. Medical practitioners also justify not asking for the patient's consent, or notifying them after, by asserting that it “adds an unnecessary stressor onto an already anxious patient” (Valencia 2019). Finally, many medical professionals argue that nonconsensual pelvic exams are an invaluable teaching tool for medical students who identify as men (Sullivan 2018). They argue that it helps to familiarize them with gynecological examinations—something with which they may not have any prior in-person experience. Each of these defenses of nonconsensual pelvic exams exemplify a disregard for the needs of the patient, and create an imbalance of power between the patient and medical institution.

A pelvic exam can be violating and traumatizing for patients who are unconscious, incapacitated, or otherwise unable to consent. Being unconscious during the procedure does not make a pelvic exam harmless for a patient. If a patient wakes up during the procedure, or finds out about it afterward, the feelings of invasion and violation can cause PTSD and medical trauma (Valencia 2019). Findings have also shown that there are racial and socioeconomic disparities in who is more likely to receive a nonconsensual pelvic exam. Ryan O'Keefe, a fourth-year medical student observing at the Ludmir Center for Women's Health in Pennsylvania, claimed that students at hospitals that treated patients with private insurance were more likely to simply observe these exams taking place. However, at hospitals treating higher numbers of uninsured and Medicaid-covered patients, medical students were

instructed to take a more hands-on approach—which included performing nonconsensual pelvic exams (Goldberg 2020).

This racial trend is not new—in general, Black women are more likely to face medical negligence or receive worse care than their white peers (Chalhoub and Rimar 2018), and Black people have historically been exploited and abused by medical institutions, which have taken advantage of them for research without their consent (Nuridden et al. 2020). Not receiving consent before pelvic exams exemplifies the idea that patients, especially those with vaginas, do not deserve bodily autonomy. Patients with vaginas are historically and disproportionately objectified in this way, making them particularly vulnerable to unjust medical practices (Kellie 2019), and nonconsensual pelvic exams perpetuate an acceptance of invasive and exploitative procedures being forced upon racially and economically marginalized communities.

The Policy Idea

Doctors and medical students should not be allowed to perform pelvic exams on non-consenting patients in any scenario where the patient's life is not reliant on a pelvic exam. This includes medical students performing pelvic exams on unconscious patients for educational purposes, doctors performing pelvic exams on incapacitated gynecological patients, and doctors performing pelvic exams on patients who are otherwise unable to advocate for themselves. The Michigan State Legislature should pass a bill banning this practice in all medical schools and hospitals in the state of Michigan.

Policy Analysis

Patient autonomy in medical law is protected through informed consent, which requires health care providers to receive full consent from patients before any treatment is given so long as the patient is able to do so (Coggon and Miola 2011). Explicit and informed consent

should be given before any form of examination, but especially for exams of sexual and reproductive organs since patients do not think of these areas in a “[scientifically] detached or neutral way,” and tend to believe these exams require more explicit consent than exams of other parts of the body (Bruce 2020).

Ten states have banned nonconsensual pelvic exams: [Hawaii](#), [Illinois](#), [Virginia](#), [Oregon](#), [California](#), [Iowa](#), [Washington](#), [Utah](#), [New York](#), and [Maryland](#). Other bills are pending in multiple states, including [Massachusetts](#) and [Minnesota](#). Some of these states only ban nonconsensual pelvic exams performed by medical students on anesthetized women for educational purposes, but some bills, such as those in [Maryland](#) and [Washington](#), expand their ban to state that pelvic exams should not be performed on any person with a vagina without their consent. This applies if they are anesthetized, incapacitated, or otherwise unable to give legal informed consent. Many bills only refer to “women,” but our policy, like these few others, expands this practice to include any person with a vagina. This inclusion is essential to ensuring the success of the policy, as trans and non-binary people are also affected by this issue, and they are not necessarily included under the term “women.” These policies, especially those that include more comprehensive terminology, are essential to the elimination of the practice of nonconsensual pelvic exams from the medical field, and Michigan’s adoption of this ban would prevent this harmful practice and benefit the patients in the state.

A policy banning the practice of performing pelvic exams without the explicit and informed consent of the patient would prevent those receiving care in Michigan’s hospitals from being violated. This policy would reinforce the value that a patient’s right to body autonomy needs to be at the center of medical practices.

Talking Points

- The practice of performing nonconsensual pelvic exams on anesthetized or incapacitated patients violates patients' rights to autonomy over their bodies.
- Performing intimate exams on patients without explicit consent can cause lasting physical and emotional trauma and pain (Friesen 2018).
- By implementing a ban on nonconsensual pelvic exams, Michigan can defend patient rights and ensure their safety, just as Hawaii, Illinois, Virginia, Oregon, California, Iowa, Utah, and other states have done.

Key Facts

- According to a 2005 study in Oklahoma, around 75 percent of medical students reported not getting consent before performing a pelvic exam (Schniederjan and Donovan 2005).
- In a 2010 study from the University of Calgary, 80 percent of women stated that they were unaware that a medical student might perform a pelvic exam on them in the operating room. Seventy-two percent expected to be asked for consent before a pelvic exam was performed (Stone 2015).
- Teaching hospitals, which are more likely to use this practice of nonconsensual pelvic exams, tend to be located in urban centers and to "serve more diverse populations in terms of race, ethnicity, and economic status than non-teaching hospitals," which suggests that these groups suffer disproportionately from this practice (Murtha 2020).

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IMPROVING HEALTH IN NEW YORK CITY COMMUNITIES: INVESTING IN SCHOOL NURSES

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Thesis

The New York City government should pass a bill establishing a grant program that pays the cost of education at City University of New York (CUNY) institutions for aspiring nurses in exchange for five years of service in the NYC public school system.

Background Analysis

New York City first began hiring school nurses in 1902 as a way to address growing concerns over inequity in health care (Jewish Women's Archive 2019). However, more than 50 NYC public schools do not have an on-site school nurse each day (Watkins 2020). The onset of the COVID-19 pandemic only exacerbated this issue, with public schools struggling to compete against large hospitals that offered nurses higher salaries to meet the influx of COVID-19 patients (Brody 2020). In September, 1400 school buildings had nurse positions that needed to be filled, and NYC scrambled to hire nurses under 10-month contracts to fill those positions before schools reopened. Many of the nurses travelled to NYC from out of state to temporarily help cover the shortage, yet the disorganization and risk of contracting COVID-19 has deterred many from taking up these positions. Evidently, this is not a long-term solution (Culliton 2020).

The shortage of school nurses has a particularly negative impact on the most vulnerable youth in the city. Forty percent of New York City public school students are Hispanic and 25.5 percent are Black, and a majority of these students attend a school where more than 75

percent of the student population experiences poverty (New York City Council Data Team 2020). Many of these minority students don't have access to high-quality health care, and so are hit particularly hard by the nurse shortage because nurses monitor students' symptoms and support children who may otherwise not have reliable access to health care (NYC Department of Education 2020). Moreover, 20 percent of New York City students have a disability, with the South Bronx suffering from some of the highest rates of childhood asthma in the country (New York City Council Data Team 2020; Division of Population Health 2019). In the absence of a school nurse, a serious injury, allergic reaction, or an asthma attack could have catastrophic consequences (Brody 2018).

The lack of school nurses also places a large economic burden on society due to lost productivity of teachers or parents forced to take on the role a school nurse should provide. A 2014 study found that teachers may lose up to 20 minutes a day of instruction time providing health care to students (Pittman 2014), and the shortage of school nurses also leads to avoidable school absences and unnecessary early dismissals (Ziminski 2016). Greater rates of absenteeism are linked to lower achievement (Healthy Schools Campaign 2015). Thus, the lack of school nurses only furthers the achievement gap between affluent, white students and low-income students of color who depend heavily on the resources provided by school nurses (NASN 2012).

The Policy Idea

To address this acute shortage of nurses, the New York City government should establish a grant program to provide four years of free nursing education at any CUNY institution in exchange for five years of service in the NYC public school system. The proposed program will have no income cut-off or location requirement for applicants, but preference will be given to NYC residents from lower socioeconomic backgrounds. This will both expand access to university education, and lead to hiring culturally competent school nurses; the nurses who

will take advantage of this program will likely come from areas that often lack school nurses (Watkins 2020). Most importantly, the program will ensure that NYC's children—many of whom suffer from chronic illnesses such as asthma—will have guaranteed access to health care.

Policy Analysis

New York City's school nurse shortage has the greatest effect on students from lower socioeconomic backgrounds who do not have access to quality health care outside of school. Many of these students will only continue to become more vulnerable, as the rates of chronic and acute illnesses among adolescents have increased across the board over the last decade (ACAAI 2017; Mojtabai et al. 2018; Ostermeyer 2019). Providing school nurses to these students has a ripple effect: Better management of students' physical health will lead to lower rates of preventable absenteeism, which improves academic performance. Additionally, school nurses spend 32 percent of their time providing mental health services, which benefit both school performance and the overall well-being of students (NASN 2012). By establishing a strict nurse pipeline from CUNY institutions to public schools, our proposed program ensures that at the bare minimum, the most vulnerable students have access to a consistent health care provider in school, which will have multifaceted positive impacts on their quality of life. In addition, there are economic benefits to investing in school nurses. For example, when the state of Massachusetts invested \$79 million in school nursing, they saved \$20 million in medical expenses and \$157.2 million in productivity costs for parents and teachers (Wang et al. 2014).

The state of New York has numerous full tuition scholarship programs, such as the Excelsior Program, but these programs have strict applicant income cutoffs (Chen 2017). Our program benefits those who don't qualify for programs like Excelsior but still need significant financial aid. Moreover, unlike many other New York scholarship programs, our program

guarantees employment after graduation in a position that develops transferable skills (NASN 2016).

Our program mirrors the Indian Health Service's (IHS) national medical school scholarships, offered in exchange for two years of service in Native American health facilities (IHS 2020). IHS has long suffered from a clinician shortage, and in 2008 only 0.5 percent of medical doctors in the US were Native Americans, contributing to the poor health outcomes in Native communities due to higher medical distrust (AAMC 2010; Heath 2019; Guadagnolo 2008). Since the recent implementation of a more robust scholarship program with the renewal of the Indian Health Care Improvement Act in 2010, IHS has graduated over 7,000 Native American physicians, many of whom have gone to work in their own Tribal communities. The IHS scholarship program exemplifies the attention to underserved communities, increased access to education, and culturally competent health care our program aims to promote (American Psychological Association 2019; IHS 2020).

The majority of nurses-in-training who would receive grants from our proposed program would be from a lower socioeconomic background. These nurses, working in underserved school communities where the shortage is most severe, would have a deeper understanding of the issues the students face. They could integrate into their work culturally specific attitudes toward health and an understanding of which treatments and resources are accessible to students. Since a majority of Black and Hispanic NYC public school students attend schools with high poverty rates, culturally competent health care is important. Cultural competence has been proven to advance health care outcomes: For example, peer educators known as *promotoras* in Latinx communities and bilingual mental health programs for Asian Americans have increased the quality of care for those groups (Ihara 2020). Studies have also shown that African American, Latinx, and Asian American patients

are more likely than white patients to believe that their care would have been better if they were a different ethnicity. Further, African American patients are most likely to report that they felt disrespected during a visit (Ihara 2020).

Talking Points

- A shortage of school nurses disproportionately affects students from lower socioeconomic backgrounds. These students often don't have access to high-quality health care, so they especially rely on resources provided by school nurses (NASN 2012).
- Giving these vulnerable students consistent access to school nurses will help close the wide disparities in health care within the New York City youth population.
- Nurses serving their own communities are able to more effectively advance health care outcomes (Ihara 2020).
- Programs which help resolve school nurse shortages confer many economic benefits to society (Pittman 2014).

Key Facts

- More than 50 NYC public school buildings do not have a school nurse in the building on any given day, meaning that many children with asthma and diabetes cannot count on support for their chronic illness (Watkins 2020).
- School nurses spend 32 percent of their time providing crucial mental health services, which is vital to student academic performance and well-being since the top five health problems for US children are related to mental health (NASN 2012).

- By investing \$79 million in school nurses, the Massachusetts government generated a net benefit of \$98.2 million by preventing medical bills and making up for lost parent and teacher productivity costs (Wang et al. 2014).

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BREAKING NUTRITION BARRIERS: IMPROVING ACCESS TO HEALTHY FOOD OPTIONS FROM URBAN GARDENS IN SOUTHERN DALLAS FOOD DESERTS

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Thesis

Although urban gardens can exist in residential districts in Dallas, sale of food products from them is prohibited in these districts. Chapter 51 of the Dallas Development Code should be amended to allow the sale of urban garden products on-site in residential districts to increase access to nutritious food choices in food deserts (Ernst 2015).

Background Analysis

There are many areas in southeast Dallas that qualify as food deserts (United States Department of Agriculture Economic Research Service 2019)—a classification for neighborhoods where the majority of households are low-income and the nearest grocery store is more than one mile away (Institute of Medicine and National Research Council 2009). The gap left by lack of access to grocery stores in food deserts is often filled by corner and liquor stores, which typically do not carry nutritious produce. Residents within food deserts therefore often have limited access to healthy foods, leading to negative health impacts and susceptibility to disease. For example, individuals who consume an unhealthy diet are more likely to suffer from obesity and related conditions like heart disease and diabetes (USDA 2015). These diseases negatively impact quality of life, and can lead to early mortality (Abdelaal 2017). In Dallas, food deserts disproportionately include neighborhoods with a majority of residents of color (Cable 2019) and/or of low socioeconomic status (Data USA 2019), compounding racial and socioeconomic health inequalities by limiting healthy food access for people of color and low-income households (IOM and NRC 2009).

The City of Dallas has attempted numerous initiatives aimed at providing healthier food options. In 2016, Dallas City Hall offered a \$3 million grant to incentivize grocery stores to move into food deserts, but no stores agreed to the plan because they did not know if there were enough customers in the area to justify the large expense of investing in a new store (Wilonsky 2019). The City of Dallas has attempted similar incentive strategies unsuccessfully at least four times over the past 20 years, indicating that large chain grocers may not be an answer to the city's plight (Stone 2019). Instead, smaller, more localized initiatives, like the urban garden Bonton Farms, have had greater success in providing fresh produce to food deserts in southern Dallas neighborhoods (Bonton Farms 2020). Bonton Farms grows organic food products and has helped provide healthy food to the Bonton community, where over 48 percent of the population lives in poverty (Bonton Farms 2016). The farm exports its products to local grocers and holds farm-to-table dinners to get fresh food to members of its community. Based on Bonton Farms' success, legislation targeted at making urban garden products more accessible to community members could ensure greater access to healthy food options in southern Dallas food deserts.

Access to good nutrition is an important part of an environment's social determinants of health—factors impacting health that are related to social wellbeing (Social Determinants of Health 2020). The presence of urban gardens can increase access to nutrition, as they provide fresh, clean produce that can be used to feed the people living in a community. For example, they were widely utilized in New York City in the 1970s to provide healthy food to those living in poverty—after the 1970 financial crisis in NYC, a nonprofit group called the Green Guerrillas began to convert vacant and abandoned lots into urban gardens. The movement picked up steam after neighborhood participation increased, and in total nearly 500 community gardens were created (Jungblut 2012).

The Policy Idea

Amending the Dallas Development Code to allow urban gardens located in residential districts classified as food deserts to sell their products on-site would increase access to fresh produce for the predominantly low-income (Data Usa 2019) and minority food desert residents of these areas (Cable 2019).

Policy Analysis

The proposed amendment would make progress toward ensuring that low-income and minority communities have access to sources of healthy food. In addition to the huge health benefits this would provide for members of these communities, this would also benefit society as a whole.

First, this policy change could reduce health care costs. For example, health care costs for obese individuals over their lifetimes are, on average, a staggering \$92,000 more than for healthy weight individuals (Hammond 2015). The proposed amendment would give many more people access to healthier food choices, over time lowering the risk of obesity for residents of food deserts as well as associated health care costs. Furthermore, suboptimal diets cost about \$300 per person per month and account for 18 percent of all heart disease, stroke, and type 2 diabetes costs in the country (Lagasse 2019). These costs could be lowered through the use of urban garden food products to provide healthier food options.

Expanding access to healthy foods would not only minimize health care costs, but also reduce productivity losses associated with nutrition-related illnesses. In 2012, Texas lost an estimated \$11 billion due to illness caused by poor nutrition, which includes type-2 diabetes, high cholesterol, osteoporosis, heart disease, stroke, and some cancers (O'Donnell 2017).

Healthy diets, which can come from urban garden products, help boost good cholesterol and lower unhealthy triglyceride levels, resulting in improved health outcomes (USDA 2015).

Improved health outcomes increase productivity, as fewer individuals must miss work due to health conditions (Lagasse 2019).

One possible argument against implementation of this policy could be the unforeseen consequences of changing zoning regulations. However, zoning regulations were created in part as a public health measure to prevent deaths from communicable and pollution-related diseases (Atlanta Regional Health Forum 2006). Consequently, as several nutrition-related diseases are now leading causes of death for Americans (Center for Disease Control 2017), changing zoning restrictions to prioritize prevention of these diseases is in keeping with the initial intention of zoning policies.

Additionally, some opponents of this policy argue that the increase in pedestrians and vehicles may impede traffic, parking, etc. (City of Dallas 2019). These concerns can be ameliorated by ensuring that adequate parking is available. Regulations for parking can follow the established rules for community gardens selling food in nonresidential areas, which require a minimum of two off-street parking spaces (Ernst 2015). Additionally, many residents of food deserts lack access to cars, so they would not contribute to an increase in vehicle traffic and would not impede parking (Snyder 2011).

Talking Points

- Food deserts disproportionately include neighborhoods with a majority of residents of color (Cable 2019) and/or of low socioeconomic status (Data USA 2019).
- Expanding access to healthy foods through urban gardens will provide benefits to society by lowering health care costs and productivity losses associated with obesity and other health conditions.

- Ensuring equal access to sources of healthy food will reduce existing health disparities for low-income and minority individuals.
- New York's communal gardens of the 1970's, which are still maintained to this very day, transformed unused or abandoned lots into a community resource for families often surviving on the margins (Jungblut 2012). They can be examined as an example of how urban agriculture has increased the health and well-being of local residents.

Key Facts

- Roughly 19 percent of Dallas residents face food insecurity (O'Donnell 2017).
- In 2017, 86,072 of the 274,501 family households in the city of Dallas were located in food deserts, and over one-third of children under 18 lived in food deserts (O'Donnell 2017).
- In 2015, Dallas areas identified as food deserts had an average per capita income of \$15,554, well below the average \$28,693 income for the city of Dallas as a whole (O'Donnell 2017). In Texas, the poverty line is \$12,760 per capita per household (Poverty Guidelines 2020).
- In 2012, the state of Texas lost an estimated \$11 billion in productivity and health care costs due to illness caused or worsened by poor nutrition (O'Donnell 2017).

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BANNING “SOURCE OF INCOME” DISCRIMINATION: INCREASING HOUSING ACCESS FOR LOW-INCOME VIRGINIANS

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Thesis

The Commonwealth of Virginia should pass legislation preventing “source of income” discrimination to ensure that landlords cannot discriminate against renters using federal housing assistance, and to help alleviate the state’s housing affordability crisis.

Background Analysis

Lack of affordable housing is an urgent problem in Virginia. Between 2001 and 2018 the price of monthly rent has skyrocketed in the state, increasing by 21 percent while household income rose only 6 percent (Center on Budget and Policy Priorities 2019). This rapid price increase has made it difficult for many Virginians to afford housing. Almost twice as many state residents now spend above 30 percent of their income on housing (the threshold for being “rent burdened,” according to the US Department of Housing and Urban Development [HUD]) as did during the peak of the housing bubble in the early 2000s (Lombard 2018).

Low-income Virginians can take advantage of several federal programs to help make housing more affordable. One of the most widely used and successful federal housing programs is the Section 8 Housing Choice Voucher (HCV) program. HCVs provide low-income families—the majority of whom have incomes 30 percent or below an area median income (AMI)—with subsidies that pay the difference between what they can afford and the cost of local private rent (McCarty 2005). Many of the beneficiaries of the HCV program are members of groups who have previously been unable to receive federal housing assistance due to redlining and

segregation. HUD estimated that in 2020, 70 percent of HCV recipient households in the US were from minority groups, including 48 percent who were non-Hispanic Black households, 18 percent Hispanic households, and 3 percent non-Hispanic Asian or Pacific Islander households. Additionally, 78 percent of HCV recipient households in the US were headed by a woman and 25 percent had household members with disabilities (HUD 2020).

However, though HCVs have helped many low-income families around the country afford housing, there are also several issues with the program. HCVs are in high demand: The average time on the waitlist to receive an HCV in the US is about 1.5 years, and 25 percent of HCV waitlists are three or more years long (Aurand et al. 2016). If a family is lucky enough to receive a voucher, they often only have 60 days to find appropriate housing before the benefit is revoked (Section 8 Apartments 2019). To make matters worse, false yet persistent stereotypes of Section 8 recipients have caused many landlords to discriminate against renters using the program; matched-pair testing has found that prospective tenants who disclose that they hope to use an HCV to rent an apartment are 15 percent less likely to receive a response from a landlord (Moore 2018).

Many low-income Virginians have benefited from the HCV program. In 2020, 77 percent of HCV recipients in Virginia were from minority groups: 71 percent were non-Hispanic Black households, 4 percent Hispanic households, and 2 percent being non-Hispanic Asian or Pacific Islander households. Additionally, 82 percent of HCV recipient households in the state had a female household head and 23 percent had household members with disabilities (HUD 2020). However, the HCV program could do much more. In 2018, Virginia assisted 47,100 households through HCVs, but there were 494,000 renters paying more than half their income for housing (Center on Budget and Policy Priorities 2019).

The Policy Idea

The Commonwealth of Virginia should pass legislation expanding its fair housing laws to make it illegal to discriminate against a tenant based on the tenant's source of income.

Virginia would join the District of Columbia and 11 other states that have passed "source of income" (SOI) legislation to prevent landlords from discriminating against renters using any type of federal housing assistance, including Section 8 Housing Choice Vouchers (Bell et al. 2018).

Policy Analysis

HCVs have proven highly effective at helping recipients manage cost burdens and access higher opportunity areas. SOI legislation improves the effectiveness of HCVs by lowering the overall number of landlord denials for HCV recipients. HUD data from a 2018 report showed that only 35 percent of HCV tenant applications were denied by landlords in areas with SOI legislation compared to a 77 percent denial rate in regions without such protections (Bell et al 2018). SOI legislation also increases the number of HCV recipients who are able to use housing vouchers; research published by HUD in 2011 found that HCV recipients in areas with SOI protections were 11 percent more likely to successfully be able to use their voucher (Freeman 2011).

Finally, SOI protections allow HCV recipients to secure housing in neighborhoods with lower poverty rates. Research has consistently shown that children exposed to higher income neighborhoods have higher earnings in adulthood (Chetty et al. 2018; Galster et al. 2007). Only 23 percent of the population in census tracts where HCV recipients reside are below the poverty level, compared to 32 percent of the population in census tracts for public housing residents (HUD 2020). For example, in Washington, DC and New Jersey, SOI legislation led more HCV recipients to live in areas with significantly lower poverty rates, suggesting that

SOI legislation allows HCV recipients to access areas with greater economic opportunity and to access a wider range of neighborhoods overall (Freeman 2011). Access to housing in areas with greater economic opportunity can have lifelong benefits, as research has found that growing up in a top versus a bottom quartile neighborhood leads to a \$910,000 lifetime earning difference (Rothwell and Massey 2015).

Passing SOI legislation in Virginia would lower landlord denials and allow HCV recipients in the state to secure housing in areas with greater economic opportunities, improving the program's effectiveness and benefiting a greater number of low-income Virginians.

Talking Points

- Many families wait years to get Section 8 HCVs but are unable to use them to secure housing due to discrimination by landlords against people using the program.
- Persistent, false, and harmful stereotypes about Section 8 HCV recipients hinder the program's success and prevent recipients from accessing housing markets, particularly in high-opportunity neighborhoods.
- Preventing landlords from discriminating based on an applicant's source of income would expand housing availability for HCV recipients in Virginia and allow more families to secure stable housing.

Key Facts

- Monthly rent in Virginia rose 15 percent faster than median household renter income from 2001 to 2018 (Center on Budget and Policy Priorities 2019).

- Eighty-five percent of Virginians who are extremely low-income (i.e., at or below the poverty line or below 30 percent AMI) are burdened by housing costs, and 71 percent of extremely low-income residents are severely cost burdened by their housing and rental payments (National Low Income Housing Coalition 2020).
- The housing affordability crisis in Virginia led to 217,800 residents, or about 8 percent of Virginia renters, needing to use some form of federal rent assistance for relief in 2018 (Center on Budget and Policy Priorities 2019).

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