

# FREEDOM OF EXPRESSION SYMPOSIUM POLICY PROPOSALS



GOLDFARB CENTER  
FOR PUBLIC AFFAIRS  
AT COLBY

2023

# Contents

---

Introduction .....	ii
Remove the Cap, Expand the Map: Increasing Residency Positions and Rural Healthcare Coverage Michelle Bechtel '25, Justin Kim '24, & Helen Wang '23 .....	1
Breaking the Cycle of Emergency Department Overuse: A Proposal for Continuous Access to Healthcare Saathvika Diviti '25 .....	4
The Malady is the Monopoly Anna doRosario '25 .....	8
Chipping in with CHIP: A Two-Pronged Approach to Increasing Healthcare Accessibility with the Children's Health Insurance Program Cliona Kenny '26 & Sonia Marnoto '26 .....	12
Doctoring in a Drought: How the Shortage of U.S. Healthcare Professionals is Leaving Patients Thirsty for Care Saia Patel '26 .....	15
Community Health Workers: Bridging the Divide between Patients and Providers by Eliminating Medical Mistrust Sophie Peterson '25 .....	19
Addressing Inequities in Harm Reduction: A Call for the Protected Expansion of Operations to Mitigate High-Risk Substance Abuse in Marginalized Communities Susie Swann '23 .....	23
About the Goldfarb Center for Public Affairs .....	27

# Introduction

---

Each Spring, the Goldfarb Center for Public Affairs sponsors a Freedom of Expression Symposium and prize competition on a current topic in public discourse. Students compete for up to \$2,000 in prize money by crafting innovative policy proposals and giving public presentations that respond to a topic selected by Goldfarb's Student Executive Board. For the 2022-2023 academic year, the Board selected "healthcare" as the theme for the Symposium, and competitors were challenged to develop the most compelling policy solution to the question of: "what is the biggest problem with access to health care?"

The Goldfarb Center extends its congratulations to all of this year's Symposium winners and participants. Michelle Bechtel, Justin Kim, and Helen Wang placed first in the competition for their proposal to address the shortage of rural physicians by removing barriers to and adding incentives for increasing residency positions in remote communities. Sophie Peterson placed second with a proposal to improve healthcare access for marginalized patients through the use of community health workers. Susie Swan placed third with a proposal to address the overwhelming number of opioid overdose deaths through the protected expansion of harm-reduction programs such as syringe distribution programs. Saathvika Diviti, Anna do Rosario, Cliona Kenney, Sonia Marnoto, and Saia Patel were also selected to compete in this year's competition based on the merits of the creative proposals you will find herein.

The Goldfarb Center also wishes to extend our thanks to Bill Goldfarb for his generous funding of this initiative and to Professors Nadia El-Shaarawi, Chirstel Kesler, and Jerzey Wiczorek for their work judging the competition.

The publication before you represents an inspiring feat of Colby student achievement. Within it you will find fresh, actionable ideas to address pressing issues in the healthcare sector that rival policy proposals being shaped in Maine's State House and the halls of Washington D.C. As a long-time practitioner in the policy-making field, I would not hesitate to bring each and every one of these ideas to the forums where elected officials are currently crafting the healthcare policies that will impact the lives of our communities for years to come. I hope that the depth of mind, heart, and vision that this year's Symposium participants poured into their proposals will move you in the same ways it has moved those of us who are part of the Goldfarb Center.

Congratulations!

Alison Beyea, Executive Director, Goldfarb Center for Public Affairs

# Remove the Cap, Expand the Map: Increasing Residency Positions and Rural Healthcare Coverage

*Michelle Bechtel '25, Justin Kim '24, & Helen Wang '23*

---

## Background:

According to the Association of American Medical Colleges, since 2002, medical school enrollment has grown by 33%. However, the number of available residency positions for medical school graduates has failed to match these increasing numbers. Despite this student body growth, the looming physician shortage will continue to worsen without additional residency positions<sup>1</sup>. By 2034, the United States is estimated to reach a shortage of between 37,800 and 124,000 physicians in both primary and specialty care<sup>2</sup>. But as of now, the cap for residency positions is not determined by the need for physicians, but by the amount paid by the Centers for Medicare & Medicaid Services allocated to match residents to hospitals.

These shortages prevent patients from accessing necessary treatment and resources from healthcare providers, a problem that is exacerbated in underpopulated communities. While 20% of the U.S. population lives in rural areas, only 9% of the physicians practice in rural communities<sup>3</sup>. With this lack of physicians comes longer wait times to schedule appointments, farther drives to receive care, and less personalized care from doctors who must treat dozens of patients a day. The reduced quality of care discourages patients from receiving care at all, limiting their overall access to resources and treatment options.

The gap between patients and their access to doctors must be bridged.

## Policy Proposal:

To ensure that the cap on residency positions will not depend on limited funding:

1. The United States Department of Health and Human Services should allocate the necessary funds to the Centers for Medicare & Medicaid Services (CMS) to match the cap on needed residency positions.
2. With this funding, the CMS should create and fund specialized programs that commit medical students to complete their studies and residencies in rural areas.

With an increase in residency positions proportional to the need for medical professionals, the physician shortage can effectively be eliminated in the coming years. Additionally, the new programs that would fully cover the cost of students' tuition would incentivize students to pursue medicine in rural communities. Thus, the number of providers in remote areas would increase and healthcare would become more accessible as a whole.

## Remove the Cap, Expand the Map · Bechtel, Kim & Wang

### Precedent:

On December 21, 2020, Congress passed the first increase to the Medicare graduate medical education (GME) program in nearly twenty-five years<sup>4</sup>. The passed legislation included one-thousand new GME residency positions, prioritized for rural and underserved communities. While the previous legislation is an enormous step in the right direction, it phases in only two-hundred slots per year over five years, which is simply not enough to compete with the growing medical school enrollment numbers. However, it does uphold the fact that similar programs have prior Congressional support, which would expedite the process of allocating future federal funding.

Implementing specialized programs for rural medicine also has strong backing. For example, the Tufts-Maine medical track is a program for students that are committed to pursuing a career in rural medicine<sup>5</sup>. This rural medicine program has shown success in bringing more physicians to rural Maine (forty Maine Track graduates are practicing rural medicine in Maine as of 2021). The policy would further expand on this success by implementing these programs across all rural areas in the United States.

### Feasibility:

This proposal is a comprehensive expansion of already existing policies that have seen success in providing greater access to healthcare, which provides a strong basis for this policy to be approved by Congress. As aforementioned, Congress has already passed legislation to increase the GME program. This policy would expand on this legislation to actualize a more meaningful impact on access to healthcare.

At present, numerous federally funded programs provide financial coverage for students interested in pursuing medicine. One such example is the U.S. Army Health Professions Scholarship Program (HPSP), which provides a financial stipend of up to around \$2,600 per month—in addition to no tuition fees—in exchange for mandatory service in the U.S. Army Reserve<sup>6</sup>. As such, proposing a similarly, federally funded program would commit more students to practice medicine in areas with limited physicians and enable students—who were once previously discouraged by insurmountable debt—to pursue medicine.

### Predicted Outcomes:

Currently, students who have graduated from medical schools are still at risk of not being matched into specialties. It is counterintuitive to create more barriers to qualified students when there exists a substantial shortage of physicians in America. By matching the cap on residency positions to the number of medical school graduates, students who have completed their degrees would be guaranteed a position to continue their careers in medicine. This policy would directly address the issue of physician shortages by increasing a physician's likelihood of moving on to residency; thus, evening out the physician-to-patient ratio.

Although there is a near-universal shortage of physicians across the U.S., the problem is intensified in rural areas. Creating specialized programs that compensate students who commit to rural medicine would increase overall interest and enrollment. Looking forward, if more students pursue this track, patients would have more access to physicians in rural areas, essentially bridging the gap between the two.

Conclusion:

If the current system is to remain in place, the United States will continue to spiral into an irreversible physician shortage. While the government has enacted legislation to improve these issues, further action must be taken to guarantee overall access to healthcare. By increasing funding and incentivizing students to study in remote areas, healthcare can become not only accessible, but guaranteed.

References:

1. Boyle, Patrick. "Medical School Enrollments Grow, but Residency Slots Haven't Kept Pace." AAMC, 3 Sept. 2020, <https://www.aamc.org/news-insights/medical-school-enrollments-grow-residency-slots-haven-t-kept-pace>.
2. "AAMC Report Reinforces Mounting Physician Shortage." AAMC, 11 June 2021, <https://www.aamc.org/news-insights/press-releases/aamc-report-reinforces-mounting-physician-shortage>.
3. Rosenblatt, R. A. "Physicians and Rural America." *Western Journal of Medicine*, vol. 173, no. 5, 2000, pp. 348–351., <https://doi.org/10.1136/ewjm.173.5.348>.
4. "Congress Passes Historic GME Expansion." AAMC, 23 Dec. 2020, <https://www.aamc.org/advocacy-policy/washington-highlights/congress-passes-historic-gme-expansion>.
5. "Maine Track MD." Maine Track MD | Tufts University School of Medicine, <https://medicine.tufts.edu/academics/medicine/maine-track-md#:~:text=Offered%20in%20partnership%20with%20Maine,at%20clinical%20sites%20throughout%20Maine>.
6. Lambert, Mindy. "Medical School Stipend Program." U.S. ARMY RECRUITING COMMAND, 17 Mar. 2022, <https://recruiting.army.mil/News/Article/2995500/medical-school-stipend-program/>.

# Breaking the Cycle of Emergency Department Overuse: A Proposal for Continuous Access to Healthcare

*Saathvika Diviti '25*

---

## Problem Statement

Access to healthcare is not limited to a single, isolated instance but instead refers to the equitable availability of preventive and primary care (PC) services. Studies show that many individuals, especially those from low-income or uninsured backgrounds, use emergency departments (EDs) for non-urgent medical issues that PC providers could treat (Chou et al., 2020). This practice can lead to inconsistent care for patients and strain the limited resources of EDs, causing longer wait times and potentially compromising the quality of care for those with true medical emergencies (Adams, 2013; Cheung et al., 2012).

While several factors contribute to ED overuse, lack of access to PC is one of the main contributors, especially for low-income patients who encounter significant obstacles in obtaining timely PC services. Consequently, low-income patients are more likely to rely on EDs for non-urgent medical problems (Cheung et al., 2012).

Patients with no consistent preventative care and guidance on their medical needs or navigation of the healthcare system have limited knowledge about when to seek emergency care, prompting them to visit the ED for non-urgent problems and fueling the continued overuse of EDs.

EDs are integral to the US healthcare system, providing a significant portion of hospital-related healthcare, thus highlighting the unsustainability of overuse and the need for increased access to preventive and PC services to prevent ED overuse, particularly for low-income patients. (Marcozzi et al., 2017).

## Proposed Solution

Currently, several policies aim to address the issue of ED overuse directly. The Affordable Care Act has provisions to expand access to PC and preventive services, which can help reduce the number of ED visits (McConville et al., 2018). Medicaid and Medicare have also implemented policies to reduce unnecessary ED use, including increasing reimbursement rates for non-emergency care provided in outpatient settings (Kim et al., 2017). Other government initiatives, such as the Community Health Access and Rural Transformation Model, aim to improve access to care in rural areas and reduce reliance on EDs (CMS, 2020). However, despite these policies, the lack of sufficient PC providers remains a significant gap, forcing patients to seek care at EDs.

## Breaking the Cycle of Emergency Department Overuse • Diviti

A reason for the shortage of healthcare professionals (HPs) in regions where access to PC is limited for the public is due to significant educational debt, which often deters HPs from taking positions that may not pay as well as those in more affluent regions or specialties (Chisholm-Burns et al., 2019). Therefore, to tackle the larger issue of ED overuse, the best solution would be to address this root cause by implementing a loan forgiveness program (LFP) for HPs to work in regions where access to PC is limited for the public, either due to geographic or economic circumstances.

However, current implementations of such programs are incredibly varied, and improvements are needed to establish a more effective model (McGurran, 2003). This proposal aims to enhance three key areas of focus for such programs: refining eligibility criteria, streamlining the application process, and optimizing funding mechanisms.

The current eligibility criteria for most LFPs are fairly limited, with many programs targeting only physicians (Friedman et al., 2016; Davis et al., 2023). Expanding the eligibility criteria to include other critical HPs, such as nurses, nurse practitioners, physician assistants, and mental health providers, could help address workforce shortages more effectively and ensure all communities have access to high-quality care.

However, the complexity of the current application process makes it challenging to broaden the eligibility criteria for LFPs, as each program boasts unique requirements. As such, HPs often find it challenging to navigate the system to find programs that match their qualifications and needs (Geletko et al., 2014; Bärnighausen et al., 2009). Consequently, many HPs opt out of pursuing LFPs altogether, which undermines the intended positive impact of LFPs and perpetuates the shortage of PC physicians.

A centralized LFP application system, similar to the residency match system, should be implemented to address this issue. Managed by a governing body such as the Health Resources and Services Administration (HRSA), the new system would employ a matching algorithm to connect HPs of different specialties and experience levels opting into the program with their most suitable LFP, increasing PC access by ensuring the equitable distribution of HPs across different regions. The system would also include provisions catering to established PC providers and early-career HPs aspiring to work in PC. For instance, the system may match seasoned PC providers with programs providing greater levels of loan forgiveness and early-career HPs with programs providing more training opportunities alongside a level of loan forgiveness.

Studies have shown that participating in LFPs can increase the likelihood of early-career HPs choosing PC as their permanent career path (Bärnighausen et al., 2009; Scheckel et al., 2019). Thus, by streamlining the application process, the new system would increase accessibility to and, subsequently, participation, particularly of young HPs, in LFPs, ultimately addressing the shortage of PC professionals in the long term.

Implementing this new system would require a different funding model than the current one, which primarily relies on federal and state governments, creating uncertainty and the po-



## Breaking the Cycle of Emergency Department Overuse • Diviti

tential for shortages and cancellations due to a lack of funding (Geletko et al., 2014). A more effective funding model is needed to minimize the risk of funding shortages and ensure the sustainability of LFPs. Specifically, one that disperses the financial burden across various collaborative sources, such as the government, private organizations, and hospitals/healthcare systems (Kruk et al., 2018).

Partnering with private organizations and healthcare systems can establish a more sustainable funding model. For instance, a relationship with hospitals or healthcare systems may result in funding for LFPs in exchange for recruiting HPs to work for their organization, furthering the program and providing participating HPs with the necessary support to provide high-quality care.

Upgrading a loan forgiveness incentive program in the three detailed areas effectively addresses limited access to PC services and ED overuse. It can benefit patients by providing affordable continuous care and reducing out-of-pocket costs, while healthcare systems can operate more efficiently and offer better patient care.

### References

1. Adams, J. G. (2013). Emergency department overuse. *JAMA*, 309(11), 1173. <https://doi.org/10.1001/jama.2013.2476>
2. Bärnighausen, T. & Bloom, D. E. (2009). Financial incentives for return of service in underserved areas: A systematic review. *BMC Health Services Research*, 9(1). <https://doi.org/10.1186/1472-6963-9-86>
3. Cheung, P. T., Wiler, J. L., Lowe, R. A., & Ginde, A. A. (2012). National Study of barriers to timely primary care and emergency department utilization among Medicaid beneficiaries. *Annals of Emergency Medicine*, 60(1). <https://doi.org/10.1016/j.annemergmed.2012.01.035>
4. Chisholm-Burns, M. A., Spivey, C. A., Stallworth, S., & Zivin, J. G. (2019). Analysis of Educational Debt and Income Among Pharmacists and Other Health Professionals. *American journal of pharmaceutical education*, 83(9), 7460. <https://doi.org/10.5688/ajpe7460>
5. Chou, S.-C., Gondi, S., Weiner, S. G., Schuur, J. D., & Sommers, B. D. (2020). Medicaid expansion reduced emergency department visits by low-income adults due to barriers to outpatient care. *Medical Care*, 58(6), 511–518. <https://doi.org/10.1097/mlr.0000000000001305>
6. CMS. (2020, August 11). Fact sheet community health access and rural transformation (chart) Model fact sheet. Centers for Medicare & Medicaid Services. Retrieved April 5, 2023, from <https://www.cms.gov/newsroom/fact-sheets/community-health-access-and-rural-transformation-chart-model-fact-sheet>
7. Davis, C., Peterson, L. & Bazemore, A. (2023). Healthcare workforce implications of physician student loan repayment funding. *Economic or Policy Analysis*. <https://doi.org/10.1370/afm.21.s1.4221>

## Breaking the Cycle of Emergency Department Overuse • Diviti

8. Friedman, A. B., Grischkan, J. A., Dorsey, E. R. & George, B. P. (2016). Forgiven but not relieved: US physician workforce consequences of changes to Public Service Loan Forgiveness. *Journal of General Internal Medicine*, 31(10), 1237–1241. <https://doi.org/10.1007/s11606-016-3767-2>
9. Geletko, K. W., Brooks, R. G., Hunt, A., & Beitsch, L. M. (2014). State Scholarship and Loan Forgiveness programs in the United States: Forgotten driver of access to health care in underserved areas. *Health Affairs*, 33(15), 1994–2003. <https://doi.org/10.4236/health.2014.615234>
10. Kim, H., McConnell, K. J., & Sun, B. C. (2017). Comparing Emergency Department Use Among Medicaid and Commercial Patients Using All-Payer All-Claims Data. *Population Health Management and Practice*, 20(4), 271–277. <https://doi.org/10.1089/pop.2016.0075>
11. Kruk, M. E., Gage, A. D., Arsenault, C., Jordan, K., Leslie, H. H., Roder-DeWan, S., Adeyi, O., Barker, P., Daelmans, B., Doubova, S. V., English, M., García-Elorrio, E., Guanais, F., Gureje, O., Hirschhorn, L. R., Jiang, L., Kelley, E., Lemango, E. T., Liljestrand, J., Malata, A., ... Pate, M. (2018). High-quality health systems in the Sustainable Development Goals era: time for a revolution. *The Lancet. Global Health*, 6(11), e1196–e1252. [https://doi.org/10.1016/S2214-109X\(18\)30386-3](https://doi.org/10.1016/S2214-109X(18)30386-3)
12. Marozzi, D., Carr, B., Liferidge, A., Baehr, N., & Browne, B. (2017). Trends in the contribution of emergency departments to the provision of hospital-associated health care in the USA. *International Journal of Health Services*, 48(2), 267–288. <https://doi.org/10.1177/0020731417734498>
13. McConville, S., Raven, M. C., Sabbagh, S. H., & Hsia, R. Y. (2018). Frequent Emergency Department users: A statewide comparison before and after Affordable Care Act Implementation. *Health Affairs*, 37(6), 881–889. <https://doi.org/10.1377/hlthaff.2017.0784>
14. McGurran, B. (2023, March 27). Student loan forgiveness for healthcare workers. *Forbes*. Retrieved April 5, 2023, from <https://www.forbes.com/advisor/student-loans/loan-forgiveness-healthcare-workers/>
15. Scheckel, C. J., Richards, J., Newman, J. R., Kunz, M., Fangman, B., Mi, L., & Poole, K. G., Jr (2019). Role of Debt and Loan Forgiveness/Repayment Programs in Osteopathic Medical Graduates' Plans to Enter Primary Care. *The Journal of the American Osteopathic Association*, 119(4), 227–235. <https://doi.org/10.7556/jaoa.2019.038>

# The Malady is the Monopoly

*Anna doRosario '25*

---

## Executive statement

When market leaders gain monopolistic control, they almost always become complacent. The result: innovation dies. Healthcare is a prime example. **We can mitigate this by leveraging existing economies of scale to create hubs of innovative medical care.**<sup>1</sup>

## Key messages and recommendations

- Problem: Monopolistic control exercised by a small number of hospitals and healthcare providers over large sectors of the American population
- Recommendation 1: Use consolidation as a force for innovation, not price-gouging
- Recommendation 2A: Adopt and improve upon the “Hospital at Home” model
- Recommendation 2B: Use assistive AI technologies to automate administrative tasks and cut costs for H@H model

## Introduction/Problem/Context

To outline the magnitude of the problem, consider the following: the US spends more on healthcare than the total GDP of every nation in the world besides China, Japan, and Germany.<sup>2</sup>

“It’s the prices, stupid” - [Uwe Reinhardt, 2003]<sup>3</sup>

## Medical outcomes do *not* justify the dollars spent

Despite spending twice as much as the other twelve most industrialized nations (2021), the US is last in healthcare outcomes.<sup>4</sup> The biggest difference between the US and other nations is that we *charge more* for the care we provide. Exorbitant prices stem from each of the sectors prioritizing monopolistic control over provision of essential medical services.<sup>5</sup>

Exorbitant pricing of American medical care is the *deliberate product* of a “conglomerate of monopolies”: hospitals and health systems, doctors backed by private equity, and drug and device manufacturers. Whenever there is market consolidation, the result is almost always limited competition, diminished choice, and higher prices without added value. Worst of all, innovation dies and brings affordable healthcare down with it. To illustrate this point, consider the following:<sup>6</sup>

- The 40 largest health systems own roughly  $\frac{1}{3}$  of all emergency and acute-care facilities in the U.S
- The top 10 health systems own  $\frac{1}{6}$  of all hospitals and combine for over \$320 billion in revenue.

Monopolization is becoming the driver of higher revenue and profit in American medicine. Chief example: mergers and acquisitions in the hospital industry that have raised prices,

lowered quality, and diminished choice. Although the Antitrust Division of the DOJ usually wields enormous power in destabilizing monopolies more broadly, this power is rendered useless, given the intense lobbying and legal loopholes.

As hospital prices rise, so too do premiums. There have been mostly stagnant wages for the past 20 years in the US, as majority of companies use additional revenue to fund higher premiums. Furthermore, employees shoulder most of the burden that is yearly medical costs, e.g., what might start as a 6% annual increase costs employees 3%, the government 1%, and businesses only 2%. Thus, there is little incentive for businesses like those in the Fortune 500, for example, which provide health insurance to more than half of the population, to expostulate these flawed systems.<sup>7</sup>

As Uwe Reinhardt averred, the heart of problem and that which we must attack is the prices, which stem from a so-called “conglomerate of monopolies”. In the war to be waged on medical monopoly, there are multiple fronts. The following policy proposal attacks the hospital consolidation front:

### Policy recommendations

Hospitals with monopolistic control need oversight. The following measures extract the benefits of hospital mergers by doing the following:

- Eliminating inefficiencies and appropriating economies of scale for cost savings
- Spurring competition and innovation with specialized centers
- Building upon the successes of the response to COVID in providing non-complex care
- Incorporating assistive AI technologies for user-friendly care

This policy will have two effects. First, it will reintroduce the concept of innovation that’s been all but killed by monopolistic control exercised by a few hospital groups. The specialized centers will be hubs of innovation and allow the theoretical benefits of consolidation to come to fruition. Second, it will address the changing nature of healthcare and prevent profit-driven motives to fill hospital beds.

### 1. Leverage economies of scale for good.

Size should equal cost savings. Instead, when hospitals merge, the inefficiencies of both hospitals persist. They chose to use consolidation as a force to raise prices rather than an opportunity to become more efficient. Case in point: following a merger, hospitals continue to schedule orthopedics, cardiac, and neurosurgical procedures across all low-volume locations. Instead, they can combine cases in each specialty into centers of excellence or three separate locations focusing on each of the specialties. Doing so would increase case volumes for operative teams and augment their experience and expertise. This allows them to provide improved care at a fraction of the cost rather than offering three duplicative services.

Case study of a successful hospital merger: The Allentown Hospital-Lehigh Valley Hospital Center Allentown, PA<sup>12</sup>

- Allentown Hospital specialized in obstetrical and gynecological services, psychiatric

## The Malady is the Monopoly • doRosario

services, pediatrics, and clinics while the Lehigh Valley Center specialized in secondary/tertiary care

- Lehigh Center operates with state-of-the-art equipment and techniques, and has developed a regional market for certain specialties, such as open-heart surgery.

### 2. Bring back the “Hospital at Home” model.

For patients who don’t require intense treatment around the clock, avoiding the risks of being an inpatient can be equally as lifesaving as highly attentive care. One in four patients will experience a medical error during a hospital admission. The longer a patient stays admitted, the greater the odds of hospital acquired infection, medical error, or complication from underlying disease.<sup>2</sup> The COVID-19 pandemic ushered in an era of better clinical outcomes and markedly less costs for patients who were sent home due to lack of beds. By avoiding the constant noise and light in hospitals, patients were better-rested and able to recover faster. It’s time to build on this, not regress.<sup>10</sup> Using readily available AI technologies to automate bureaucratic and administrative tasks, a team of clinicians—set up in a central location—could monitor hundreds of patients in their homes around the clock.<sup>15</sup> Despite its many advantages, use of this model is receding, for CEOs are paid to fill beds in their brick-and-mortar facilities.

The benefits aren’t simply theoretical, and the facts speak volumes:<sup>11</sup>

- Early pilots of the model, such as the Johns Hopkins model, have already achieved savings of 30% and more per admission. Early trials found that:
  - the total cost of at-home care was 32% less than traditional brick-and-mortar hospital care (\$5,081 vs. \$7,480),
  - the mean length of stay for patients was shorter by one-third (3.2 days vs. 4.9 days)
  - the incidence of delirium (among other complications) was dramatically lower (9% vs. 24%)
- Using a prospective quasi-experiment, Leff et. al, found the following:
  - 2 of 3 sites studied, 69% of patients who were offered hospital-at-home care chose it over acute hospital care
  - The mean cost was lower for hospital-at-home care than for acute hospital care (5081 dollars vs. 7480 dollars)

### Notes

1. It’s the Monopolies, Stupid!, <https://www.commonwealthfund.org/blog/2018/its-monopolies-stupid>

2. Fixing Healthcare Podcast, Episode #83

3. It’s The Prices, Stupid: Why The United States Is So Different From Other Countries, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.22.3.89>

4. U.S Healthcare from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes, <https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022#:~:text=In%202021%2C%20the%20U.S.%20spent,high->

er%20than%20in%20South%20Korea.

5. Understanding why healthcare costs in the U.S are so high,  
<https://www.hsph.harvard.edu/news/hsph-in-the-news/understanding-why-health-care-costs-in-the-u-s-are-so-high/>
6. U.S Healthcare: A Conglomerate of Monopolies,  
<https://www.forbes.com/sites/robertpearl/2023/01/16/us-healthcare-a-conglomerate-of-monopolies/?sh=736cf6b42e4d>
7. In Healthcare’s Game of Monopoly, One Player Will Control the Board,  
<https://www.forbes.com/sites/robertpearl/2023/03/27/in-healthcares-game-of-monopoly-one-player-will-control-the-board/>
8. US Healthcare System Overview, <https://www.ispor.org/heor-resources/more-heor-resources/us-healthcare-system-overview/us-healthcare-system-overview-background-page-1>
9. De Lew, N., Greenberg, G., & Kinchen, K. (1992). A layman’s guide to the U.S. health care system. Health care financing review, 14(1), 151–169. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193322/>
10. “Hospital at Home” Programs Improve Outcomes, Lower Costs But Face Resistance from Providers and Payers, <https://www.commonwealthfund.org/publications/newsletter-article/hospital-home-programs-improve-outcomes-lower-costs-face-resistance#3>
11. Hospital at home: feasibility and outcomes of a program to provide hospital-level care at home for acutely ill older patients, <https://pubmed.ncbi.nlm.nih.gov/16330791/>
12. The Effects of Hospital Mergers on the Availability of Services: A Case Study of Eight Hospital Mergers, <https://oig.hhs.gov/oei/reports/oei-04-91-00500.pdf>
13. Can AI solve healthcare administrative burdens?,  
<https://www.healthcareitnews.com/news/emea/can-ai-solve-healthcare-administrative-burdens>

# Chipping in with CHIP: A Two-Pronged Approach to Increasing Healthcare Accessibility with the Children's Health Insurance Program

*Cliona Kenny '26 & Sonia Marnoto '26*

---

Medicaid and the Children's Health Insurance Program (CHIP) are two healthcare programs jointly funded by the federal and state governments that aim to extend healthcare availability to low-income families and children. Created in 1997, the block grant program CHIP complemented Medicaid by providing coverage to children ineligible for Medicaid. In 2021, the two programs insured an impressive 35.9% of U.S. children. Despite the success of Medicaid and CHIP, in the same year, 4.165 million children remained uninsured, many of whom were eligible for either Medicaid or CHIP.<sup>1</sup> Our proposed policy aims to reduce this number of uninsured children by increasing access to CHIP and its associated benefits.

First, we identify the economic burden of cost-sharing and physically accessing healthcare as the driving factors behind CHIP inaccessibility. While few Medicaid programs charge premiums or cost-sharing for children, most CHIP programs do. These shared costs for doctor visits, prescriptions and emergency room visits lack income variability, which makes families pay the same copayment as families with significantly higher incomes. Furthermore, the program does not account for the time and money that it takes for caretakers to bring children to regular, preventative appointments. If children are unable to get to the doctor's office in the first place, CHIP is rendered obsolete.

To tackle the economic burdens of CHIP, we propose a two-pronged approach. (1) CHIP should implement income variability for premiums and copayments. (2) Congress should implement a block grant to CHIP programs for a firm fixed-price contract with the Children's Health Fund to increase physical healthcare accessibility via mobile healthcare buses.

## **(1) Lessening the economic burdens of copayments and premiums:**

Implementing income variability in premiums and copayments of CHIP will increase program accessibility. Currently, CHIP offers varying prices for monthly premiums based on the age of the child in need of coverage. Essentially, the younger the child is, the less the family must pay for the monthly premium. However, CHIP does not offer any income variability for the premiums or the copayments of doctor visits, brand name prescriptions, generic prescriptions, specialty visits, or emergency room visits. Instead, all copayment prices are constant regardless of the income of the child's family. The lack of income variability creates a finan-

## Chipping in with CHIP · Kenny & Marnoto

cial and mental block in families seeking healthcare for their children as the program is more expensive than it should be.

CHIP Income Guidelines Chart

**How to use this chart:**

Step 1: Locate the number of people in your household.

Step 2: Find the box that matches your household's annual gross income and age of your children.

Step 3: Look down the row to the COST BOX to see your appropriate, average monthly cost per child and the co-payments per child, per visit.

**Example:** A four-person household with an annual income of \$69,840 will have an average monthly premium of \$75 per child, plus any co-pays for services.

**INCOME\* (Effective March 1, 2021)**

HOUSEHOLD SIZE	Free		Low Cost				Full Cost ages 0-18
	ages 1-5	ages 6-18	ages 0-1	ages 1-18	ages 0-18	ages 0-18	
1	\$ 20,222 - \$ 26,791	\$ 17,131 - \$ 26,791	\$ 27,692 - \$ 33,746	\$ 26,791 - \$ 33,746	\$ 33,746 - \$ 37,095	\$ 37,095 - \$ 40,444	\$ 40,444 - No Limit
2	\$ 27,350 - \$ 36,234	\$ 23,169 - \$ 36,234	\$ 37,453 - \$ 45,641	\$ 36,234 - \$ 45,641	\$ 45,641 - \$ 50,170	\$ 50,170 - \$ 54,699	\$ 54,699 - No Limit
3	\$ 34,478 - \$ 45,677	\$ 29,207 - \$ 45,677	\$ 47,214 - \$ 57,536	\$ 45,677 - \$ 57,536	\$ 57,536 - \$ 63,245	\$ 63,245 - \$ 68,955	\$ 68,955 - No Limit
4	\$ 41,605 - \$ 55,120	\$ 35,245 - \$ 55,120	\$ 56,975 - \$ 69,430	\$ 55,120 - \$ 69,430	\$ 69,430 - \$ 76,320	\$ 76,320 - \$ 83,210	\$ 83,210 - No Limit
5	\$ 48,733 - \$ 64,564	\$ 41,284 - \$ 64,564	\$ 66,736 - \$ 81,325	\$ 64,564 - \$ 81,325	\$ 81,325 - \$ 89,396	\$ 89,396 - \$ 97,466	\$ 97,466 - No Limit
6	\$ 55,861 - \$ 74,007	\$ 47,322 - \$ 74,007	\$ 76,497 - \$ 93,220	\$ 74,007 - \$ 93,220	\$ 93,220 - \$ 102,471	\$ 102,471 - \$ 111,722	\$ 111,722 - No Limit
7	\$ 62,989 - \$ 83,450	\$ 53,360 - \$ 83,450	\$ 86,258 - \$ 105,115	\$ 83,450 - \$ 105,115	\$ 105,115 - \$ 115,546	\$ 115,546 - \$ 125,977	\$ 125,977 - No Limit
8	\$ 70,117 - \$ 92,893	\$ 59,398 - \$ 92,893	\$ 96,019 - \$ 117,010	\$ 92,893 - \$ 117,010	\$ 117,010 - \$ 128,621	\$ 128,621 - \$ 140,233	\$ 140,233 - No Limit
9	\$ 77,244 - \$ 102,336	\$ 65,436 - \$ 102,336	\$ 105,780 - \$ 128,904	\$ 103,336 - \$ 128,904	\$ 128,904 - \$ 141,696	\$ 141,696 - \$ 154,488	\$ 154,488 - No Limit
10	\$ 84,372 - \$ 111,780	\$ 71,475 - \$ 111,780	\$ 115,541 - \$ 140,799	\$ 111,780 - \$ 140,799	\$ 140,799 - \$ 154,772	\$ 154,772 - \$ 168,744	\$ 168,744 - No Limit

**COST**

Average monthly premium per child (Effective July 1, 2021)	Free		Low Cost				Full Cost
	\$0	\$0	\$53	\$53	\$75	\$86	
							\$239

**CO-PAYMENTS (PER CHILD, PER VISIT)**

	Free		Low Cost				Full Cost
	\$0	\$0	\$5	\$5	\$5	\$5	
Doctor visit	\$0	\$0	\$5	\$5	\$5	\$5	\$15
Brand name prescription	\$0	\$0	\$9	\$9	\$9	\$9	\$18
Generic prescription	\$0	\$0	\$6	\$6	\$6	\$6	\$10
Specialist visit	\$0	\$0	\$10	\$10	\$10	\$10	\$25
Emergency room visits**	\$0	\$0	\$25	\$25	\$25	\$25	\$50

\*If your income is below any amount listed, your family could be eligible for Medical Assistance. For more details, please call 1-800-986-KIDS.

\*\*Emergency room visit co-pay applies if the child is not admitted for a hospital stay.

(Updated 6/1/21)

**Figure 1:** CHIP Income Guidelines Chart. Red circles highlight the absence of income variability in average monthly premiums and copayments.<sup>2</sup>

In determining the cost of copayments and deductibles for individuals and families covered by Medicaid and CHIP, states should identify the range of qualifying incomes for each program and divide this range into four equal income brackets. Individuals and families in the highest income bracket will pay 75% of the original cost of any copayment or deductible. Individuals and families in the second highest income bracket will pay 50% of the original cost of any copayment or deductible. Individuals and families in the third highest income bracket will pay 25% of the original cost of any copayment or deductible. Finally, individuals and families in the lowest income bracket will pay 0% of the original cost of any copayment or deductible.

See below for a model of this system using the federal qualifying limits for a family of four under Medicaid and a \$100 copayment as an example:

Income Bracket	Income Range	Percent of copay/ premium	Amount Due
First (lowest)	\$0-\$9,974	0%	\$0
Second	\$9,975-\$19,950	25%	\$25
Third	\$19,951-\$29,925	50%	\$50
Fourth (highest)	\$29,926-\$39,900	75%	\$75



## Chipping in with CHIP · Kenny & Marnoto

### (2) Breaking access barriers and investing in America's children

An analysis of the state of children's healthcare in America reveals the reality that children of color, children from low-income families, and children living in rural communities disproportionately suffer from institutional barriers to healthcare that are far beyond their control. Establishing comprehensive access to healthcare in childhood ensures that barriers to success such as poor eyesight, dyslexia or ADHD are caught early. The adoption of a free mobile health clinic service for newborns to children under the age of eighteen who are uninsured or benefit from Medicaid or CHIP programs would significantly lessen barriers to healthcare access for children throughout the country.

Therefore, we propose a firm fixed price contract of one billion dollars per year for five calendar years to fund mobile healthcare units modeled after the buses operated by the Children's Health Fund. The Children's Health Fund, a 501(c)(3) grassroots non-profit, has successfully run mobile healthcare units throughout the country since 1987. Their buses provide subsidized services including, but not limited to vaccinations, physical examinations, dietary consultations, mental health services, social work, health education, and healthcare benefit consultations for children. The mobility of a bus accounts for barriers such as appointment availability, inaccessibility of specialty services, and transportation, making healthcare more accessible for working and busy families.

This proposal will require financial support from Congress. Currently, each healthcare visit provided by the Children's Health Fund costs roughly \$31.25.<sup>3</sup> Based on this price, by investing one billion dollars per year for five years, the mobile healthcare bus service would guarantee at least 32,000,000 free healthcare visits for U.S. children. Ideally, Congress would enable this proposal by offering a high firm fixed price contract with a company providing the healthcare mobile units. With this high FFP, we anticipate interest and competition from for-profit organizations that would be willing to invest in the building and transporting of the healthcare buses. This immediate investment would help to jumpstart the program and provide appointments to uninsured children. We believe that the initial five billion dollar investment for this policy would help remove the barriers that stand in the way between America's youngest generation and accessible healthcare.

#### Bibliography

(1) More Children Were Covered by Medicaid and CHIP in 2021. Last modified September 13, 2022. Accessed April 4, 2023.

<https://www.census.gov/library/stories/2022/09/uninsured-rate-of-children-declines.html>.

(2) "CHIP Income Guidelines Chart." Chart. June 1, 2021. Accessed April 4, 2023. <https://www.dhs.pa.gov/CHIP/Eligibility-and-Benefits/Documents/CHIP%20Income%20Guidelines%20Chart%202021%20%28Effective%207-1-2021%29.pdf>.

(3) Children's Health Fund. "Healthcare for Every Child." Children's Health Fund. Accessed April 4, 2023. <https://www.childrenshealthfund.org>.

# Doctoring in a Drought: How the Shortage of U.S. Healthcare Professionals is Leaving Patients Thirsty for Care

*Saia Patel '26*

---

## Introduction

“Three months!?”

As a Patient Care Coordinator in my mother’s dental office during school breaks, I often received this reaction from new patients calling to book their first appointment. I usually grimaced, although this was a daily occurrence, and verified this wait time before asking the caller if they would like to be added to the lengthy waitlist. My mother is never able to keep up with patient demand; there is always a need for more dentists, dental assistants, and hygienists, yet nobody seems to want to move to rural New England to provide care.

The limited availability of primary care providers (PCPs) is a nationwide issue affecting millions of Americans’ continued access to healthcare (Shi 2012). The Maine healthcare workforce shortage is uniquely exacerbated by the state’s existing demographics; Maine has the highest percentage of people older than 50, who require the most healthcare, while containing the lowest percentage of a qualified healthcare workforce. Additionally, Maine-Health is still dependent on out-of-state contract labor, which costs significantly more than hiring local staff. (Wight 2023). Indeed, this nationwide issue is especially noticeable in rural regions, which have the highest rates of premature death (Bergum 2016), and contain even fewer healthcare facilities and PCPs to serve the population, leading to delayed medical diagnoses, extended appointment wait times, and lack of access to healthcare services (Center for American Progress 2021). Seeing these symptoms play out first-hand at the family dental practice, as well as at Colby Health Services and Maine General Health as a frequently sick college student, I wanted to learn more about this issue and advance a cogent solution to increase access to PCPs.

## Definition of Healthcare

Access to healthcare includes the ability of individuals to obtain affordable, effective, and timely healthcare services and attain the highest level of health outcomes. Adequate healthcare encompasses the ability to access emergency services, healthcare providers, medical facilities, and medications, as well as primary, preventative, and specialty care (Starfield 2005), regardless of geographic location or socioeconomic status.

## Doctoring in a Drought · Patel

### Policy Recommendation

Executing a policy intervention to address the limited availability of PCPs in this way requires a multi-faceted approach, involving collaboration among federal, state, and local governments, as well as PCPs and a wide range of educational institutions and health centers. This aim would be best achieved by focusing on creating and expanding healthcare educational institutions and training programs. There are several existing initiatives aimed at increasing funding for healthcare education institutions and creating new programs in areas facing shortages of healthcare workers. The Maine Health Access Foundation provides grants to support the development and expansion of healthcare education programs (Anon 2023), while Kansas offers tax incentives to healthcare education institutions that establish new programs in rural areas, encouraging organizations to attract and retain PCPs (Heard 2023). The Health Resources and Services Administration (HRSA) offers grants to support the establishment and expansion of nursing programs in areas with nurse shortages, and the Rural Health Care Services Outreach Program provides funding to support the development of healthcare education programs (Ofori 2020). These initiatives demonstrate how increasing funding for healthcare education institutions in areas with shortages of healthcare workers can help address the shortage of PCPs.

There is no federal initiative that offers tax incentives to healthcare institutions to address the shortage of PCPs that currently exists. The HRSA's Rural Health Care Services Outreach Program housed in the Department of Health and Human Services (HHS) should be expanded and receive a significant increase in funding to achieve this goal. The HRSA is the federal agency responsible for improving the health of the nation's most vulnerable populations, including increasing the number of PCPs and expanding access to healthcare in rural areas (HRSA 2023). The Outreach Program only provides grants to expand healthcare education programs but faces a lack of funding, as well as restricted eligibility criteria. Although grants can be an effective tool, offering tax incentives would increase the efficacy of this program.

Tax incentives provide a compelling financial incentive for states to invest in healthcare institutions rather than relying on grants as one-time funding sources, which creates an impetus for private sector investors and states to support healthcare infrastructure. This leads to more sustainable development through the creation of long-term jobs and economic growth, while encouraging competition among healthcare institutions, leading to higher quality of care, more affordable prices, and technological innovation. It would reduce the financial burden on recruiting and retaining PCPs, making it easier for institutions to offer competitive benefits and salaries to PCPs, making the field more attractive. Additionally, tax incentives offer more flexibility, as states can choose the healthcare institutions that they want to support, which is particularly helpful in rural areas where healthcare needs vary widely. States can use these funds for a variety of purposes, such as training PCPs, expanding facilities, purchasing equipment, offering additional services, and enhancing outreach efforts. Grants also provide a predictable, valuable funding source, and allow for more targeted investments in certain populations. Therefore, a combination of tax incentives and grants could be an effective solution to address the PCP shortage in rural areas.

## Impact

By increasing funding for the expanded Outreach Program, more rural communities would benefit from its services. Patients would have increased access to care, leading to improved health outcomes and lower healthcare costs. Sustainably investing in training programs would help ensure that there are enough PCPs to replace retiring providers and meet the growing demand for healthcare services in the future (Steinwald 2022). In addition, expanding the number and range of health education programs would help diversify both the emerging and existing healthcare workforce, which is essential for critically addressing healthcare disparities and improving the quality of care for all patients (Jackson 2014). Overall, a federal initiative that offers tax incentives to healthcare institutions to address the PCP shortage would be a promising step towards improving access to primary care and addressing the healthcare needs of underserved communities, ensuring that all Americans have access to the high-quality healthcare that they both deserve and need.

## References

- Anon. (2021, November 2). The Truth on Wait Times in Universal Coverage Systems. Center for American Progress. <https://www.americanprogress.org/article/truth-wait-times-universal-coverage-systems/>.
- Anon. (2023, February). Efforts and Progress in Implementing the Recommendations of the Commission to Study Long-term Care Workforce Issues. Maine Legislature. <https://legislature.maine.gov/doc/9747>.
- Anon. n.d. Healthcare Access in Rural Communities Overview. Rural Health Information Hub. <https://www.ruralhealthinfo.org/topics/healthcare-access>.
- Bergum, A., Catlin, B., Willems Van Dijk, J., Timberlake, K. (2016, July). What Works? Strategies to Improve Rural Health. University of Wisconsin Population Health Institute. <https://www.countyhealthrankings.org/reports/what-works-strategies-improve-rural-health>.
- Deas, D. (2021, October). University of California, Riverside School of Medicine Strategic Plan. University of California, Riverside School of Medicine. <https://med-school.ucr.edu/strategic-plan>.
- Jackson, C. S., & Gracia, J. N. (2014). Addressing Health and Health-Care Disparities: The Role of a Diverse Workforce and the Social Determinants of Health. *Public Health Reports*, 129(1\_suppl2), 57–61. <https://doi.org/10.1177/00333549141291S211>.
- Heard, A. & Rood, S. (2023). Governors and States are Advancing Equitable Rural Economic Development and Healthcare. National Governors Association. <https://www.nga.org/news/commentary/governors-and-states-are-advancing-equitable-rural-economic-development-and-healthcare/>.
- Heiser, S. (2022, June 29). AAMC Report Reinforces Mounting Physician Shortage. AAMC. <https://www.aamc.org/news-insights/press-releases/aamc-report-reinforces-mounting-physician-shortage>.

## Doctoring in a Drought • Patel

HRSA. S. (2023, January 1). 2022 Agency Overview. Health Resources & Services Administration. <https://www.hrsa.gov/about/agency-overview>

Ofori, A. (2020). Rural Health Care Services Outreach Program. Health Resources & Services Administration. <https://www.hrsa.gov/grants/find-funding/HRSA-21-027>.

Shi L. (2012). The impact of primary care: a focused review. *Scientifica*, 2012, 432892. <https://doi.org/10.6064/2012/432892>.

Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of primary care to health systems and health. *The Milbank Quarterly*, 83(3), 457–502. <https://doi.org/10.1111/j.1468-0009.2005.00409.x>.

Steinwald, B., Ginsburg, P., Brandt, C., Lee, S., & Patel, K. (2022, March 9). We need more primary care physicians: Here's why and how. Brookings. <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/07/08/we-need-more-primary-care-physicians-heres-why-and-how/>.

Wight, P. (2023, April 14). Maine's health care workforce shortage is exacerbated by the state's demographics. *Maine Public*. <https://www.maine-public.org/health/2023-04-14/maines-health-care-workforce-shortage-is-exacerbated-by-the-states-demographics>.

# Community Health Workers: Bridging the Divide between Pa- tients and Providers by Eliminating Medical Mistrust

*Sophie Peterson '25*

---

The true root of all issues related to healthcare access is far too large to address in just one policy. Centuries of discrimination in fields entirely unrelated to medicine such as housing, employment, and education, have created an environment in which marginalized groups have limited access to healthcare via financial, social, and geographic barriers. This divide has made it easy for the medical system to take advantage of marginalized patients; there are many celebrated moments in medical history in which medicine has used patients of color as test subjects rather than treating them as patients. To this day, the medical system is furthering the divide between providers and patients from marginalized backgrounds by offering substandard care to these patients. Studies have shown that over half of medical students held false beliefs about biological differences between black and white patients as recently as 2015 (Hoffman et al., 2016). As a result, patients of marginalized gender, race, educational status, and social class are all more likely to report experiencing discrimination in healthcare than their more privileged counterparts (Nong et al., 2020). Access to quality healthcare includes emotional and social divides that are just as harmful as physical barriers.

It is entirely expected that marginalized patients would not put their full faith in a system that has continually let them down, and this can further their lack of access to healthcare. A 2010 study found that sentiments of medical mistrust in Black male patients resulted in the reduced likelihood that these patients scheduled and attended routine health examinations (Hammond et al., 2010). Medical mistrust is a completely reasonable response to a broken healthcare system that reinforces the divide between patients and providers and directly correlates to poorer health outcomes (Armstrong et al., 2006). A policy that puts the onus on providers to redevelop the patient trust that they have lost would decrease this lack of access and increase the partnership needed between patients and providers.

One policy cannot right the wrongs of centuries, but it can begin to bridge the gap that these wrongs have created where it really matters. Studies have shown that patients are able to have confidence in their providers even when they do not trust the system at large (Armstrong et al., 2006). Patients whose relationships with their providers are described as improving are also more likely to have improving functional health. Improvements in this relationship include factors such as interpersonal communication, ease of accessing care, and advocacy for the patient by the provider (Olaisen et al., 2020). A policy that strengthens these relationships would also strengthen healthcare accessibility and quality.

Community Healthcare Workers (CHWs) have become an increasingly vital and popular

## Community Health Workers • Peterson

method of increasing contact and trust between the healthcare system and patients around the world. CHWs are members of the patient care team who come from the same communities as patients. The shared lived experiences between CHWs and patients allows them to understand community risks and needs better than other providers. The responsibilities of CHWs can include conducting home visits to assist in following treatment plans, following up with patients who have sought medical care, and helping patients develop their connection with a provider through methods like personal narratives. CHWs meet patients where they are at with their relationship to the healthcare systems and ensure that there is an understanding of the care that is needed and a trust that the healthcare system is invested in a patient's success.

I propose a policy that enforces the employment of Community Health Workers in every hospital, in a proportional quantity given the size of community. A CHW can be defined as any employee with a background in public health who is from the community being served and who has been hired with the purpose of offering additional communication, advocacy, and support to patients in a manner that has been tailored to the needs of the community. Seed funding for this program will be provided by the federal government, but if these programs save hospitals additional money, they will be obligated to return those funds with what has been saved. The purpose of this policy is to alleviate medical mistrust and give patients the benefits that come with a strong patient-provider relationship.

Several hospitals in the United States have begun to add CHWs to their team, and the results are significant. A hospital in the Bronx, New York observed a reduction in visits to the Emergency Department by 5% and hospitalizations of patients with chronic illnesses by 12.6%. Although financial incentives should never be as valuable as the health of a community, the hospital also found they saved \$2 for every \$1 invested into the program as a result of the reduced hospital visits, and a study at the University of Pennsylvania found similar results (Kangovi et al., 2020). This is a strong example of how these programs can end up paying for themselves, but it is important for hospitals to be provided with seed money, as not all hospitals will be able to initiate a program without that. The Bronx program provides a clear outline of recommendations on implementation of the CHW program that could be adapted to meet national needs (Findley et al., 2017). Multiple studies have reflected the success of CHWs in instilling patient trust in health promoting behaviors, such as adherence to medication plans and healthy lifestyle choices in varying communities across the country (Brownstein et al., 2007; Balcazar et al., 2009). In an interview-based study, patients who received care from CHWs described feeling a renewed sense of self-worth, belonging, and trust that the support provided by the CHW would be integrated into their primary care (Capotescu et al., 2022).

Programs employing CHWs around the country have been effective in developing patient trust in healthcare providers and programs. These programs have successfully given patients the health benefits that patients with strong patient-provider relationships experience. Not only is a policy that brings this opportunity to Americans around the nation vital to the health of our country, it is economically practical to fund a program that prevents patients from needing further care. Community Healthcare Workers are an essential step in eliminating barriers to healthcare access.

References:

- Armstrong, K., Rose, A., Peters, N., Long, J. A., McMurphy, S., & Shea, J. A. (2006). Distrust of the health care system and self-reported health in the United States. *Journal of General Internal Medicine*, 21(4), 292–297. <https://doi.org/10.1111/j.1525-1497.2006.00396.x>
- Brownstein, J. N., Chowdhury, F. M., Norris, S. L., Horsley, T., Jack, L., Zhang, X., & Satterfield, D. (2007). Effectiveness of community health workers in the care of people with hypertension. *American Journal of Preventive Medicine*, 32(5), 435–447. <https://doi.org/10.1016/j.amepre.2007.01.011>
- Capotescu, C. C. (n.d.). Community Health Workers' critical role in Trust Building between the medical system and communities of color. AJMC. Retrieved April 2, 2023, from <https://www.ajmc.com/view/community-health-workers-critical-role-in-trust-building-between-the-medical-system-and-communities-of-color>
- Findley, S., Matos, S., Hicks, A., Chang, J., & Reich, D. (2014). Community health worker integration into the Health Care Team accomplishes the triple aim in a patient-centered medical home. *Journal of Ambulatory Care Management*, 37(1), 82–91. <https://doi.org/10.1097/jac.000000000000011>
- Hammond, W. P., Matthews, D., & Corbie-Smith, G. (2010). Psychosocial factors associated with routine health examination scheduling and receipt among African American men. *Journal of the National Medical Association*, 102(4), 276–289. [https://doi.org/10.1016/s0027-9684\(15\)30600-3](https://doi.org/10.1016/s0027-9684(15)30600-3)
- Hector G. Balcazar, Theresa L. Byrd, Melchor Ortiz, Sumanth R. Tondapu, & Monica Chavez. (2009). A randomized community intervention to improve hypertension control among Mexican Americans: Using the promotoras de salud community outreach model. *Journal of Health Care for the Poor and Underserved*, 20(4), 1079–1094. <https://doi.org/10.1353/hpu.0.0209>
- Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences*, 113(16), 4296–4301. <https://doi.org/10.1073/pnas.1516047113>
- Hostetter, M., & Klein, S. (2021, January 14). Understanding and ameliorating medical mistrust among Black Americans. Commonwealth Fund. Retrieved April 2, 2023, from <https://www.commonwealthfund.org/publications/newsletter-article/2021/jan/medical-mistrust-among-black-americans>
- Kangovi, S., Mitra, N., Grande, D., Long, J. A., & Asch, D. A. (2020). Evidence-based community health worker program addresses unmet social needs and generate positive return on investment. *Health Affairs*, 39(2), 207–213. <https://doi.org/10.1377/hlthaff.2019.00981>



## Community Health Workers • Peterson

Nong, P., Raj, M., Creary, M., Kardia, S. L., & Platt, J. E. (2020). Patient-reported experiences of discrimination in the US Health Care System. *JAMA Network Open*, 3(12). <https://doi.org/10.1001/jamanetworkopen.2020.29650>

Olaisen, R. H., Schluchter, M. D., Flocke, S. A., Smyth, K. A., Koroukian, S. M., & Stange, K. C. (2020). Assessing the longitudinal impact of physician-patient relationship on Functional Health. *The Annals of Family Medicine*, 18(5), 422–429. <https://doi.org/10.1370/afm.2554>

# Addressing Inequities in Harm Reduction: A Call for the Protected Expansion of Operations to Mitigate High-Risk Substance Abuse in Marginalized Communities

*Susie Swann '23*

---

## Executive summary:

With an additional 1.2 million opioid overdose deaths projected by 2029, the United States faces a multisystem failure of addiction medicine treatment and mitigation of high-risk substance use. The politics of harm reduction and stigma of addiction continue to halt the incorporation of evidence-based practices and instead magnify isolation at the fault of the “addict”. This myopic perception further results in inequities where those without financial means, technological access, or previous knowledge to navigate the system are burdened with limited social support to navigate their recovery. However, through the federally-protected expansion of harm reduction programs, increased medicines access in incarcerated populations, and bolstering of long-term rehabilitation services, the 46.3 million Americans impacted by substance-use disorder may be empowered with an accessible toolkit to sustainably navigate their recovery.

## Expansion of Syringe Distribution Policies and Mobile Clinics

The federally-protected expansion of harm reduction programs is required where local legislation often fails to recognize how environmental barriers (e.g. transportation access) and housing instability compound with the stigma of drug-use to result in inequities towards healthcare access. Unfortunately, the politicalization of harm reduction programs has resulted in gaps between evidence-practice based and legislation where current “One-for-One” syringe distribution policies fail to address the need for sterile supplies. Housing instability magnifies this need where individuals experiencing homelessness might not have safe storage space for the syringes used, and thus are limited in the number of syringes received under the “One-for-One” policy.

I propose increased federal funds and legislation for the nation-wide adoption of a “Needs-Based” syringe distribution policy that ensures people who inject drugs (PWID) have access to sterile syringes. With reduction in syringe reuse/share and other high-risk injection behavior, this new policy will increase syringe coverage and lower HIV and Hepatitis C Virus (HCV)

## Addressing Inequities · Swann

risk. For example, with 72% of HCV cases attributed to intravenous drug use in 2018, sterile syringe access remains a critical component in addressing public health burdens and inequities in healthcare access.

In addition to the adoption of a “Needs-Based” policy, I propose mobile syringe clinics that may begin to address current inequities in communities impacted by environmental barriers and limited transportation access. For example, homelessness and unstable housing are amplified as social determinants among PWID with a 64 times greater risk of HCV infection among unstably housed in contrast to stably housed PWID. In addition, previous research indicates a rise in unsafe injection practices among individuals who live 10 or more miles away from a syringe service program. A mobile syringe clinic would address these environmental barriers associated with homelessness and also adapt to those living in rural communities by not only providing increasing access to sterile syringes, but also HIV and HCV testing and referrals to community resources for increased holistic care access.

### Expanded Medications Access in the U.S. Prison System and Re-Entry Support

I propose the protected expansion of community-based rehabilitation services into the prison system and federally-mandated access to substance use disorder treatment throughout an individual’s incarceration. Despite an estimated 15% of 1.8 million incarcerated individuals to have an opioid-use disorder, only 14% of the correctional systems offer buprenorphine or methadone treatment access as of 2021. Past researchers have identified forced withdrawal due to incarceration to reduce the likelihood of PWID continuing methadone treatment post-release with subsequent increased risk in death from overdose or other high-risk behaviors. Ultimately, legislative efforts must expand beyond the confines of addiction medicine facilities to include stakeholders in prison systems to systematically address inequities in access and risk associated with substance use.

In addition, I propose the protected expansion of community-based rehabilitation services as incorporated into prison re-entry programs to reshape the foundation of “mandatory” rehab. This incorporation will focus on a less punitive approach that emphasizes relationship-building and community involvement. For example, Community Reinforcement and Family Therapy (CRAFT) and contingency management training emphasize social relationship development, skills, and safety training while also providing participants tangible rewards along the way (e.g. ticket vouchers to the movie theater). Likewise, past researchers identified individuals who completed the full CRAFT course to be 47% more likely to continue with addiction medicine treatment.

As previous US Surgeon General Dr. Jerome Adams notes, “stigma keeps people in the shadows” where underfunded harm reduction programs compound with environmental barriers to reflect systemic biases. My proposal is centered on the protected expansion of harm reduction programs through 1. adoption of Needs-Based syringe distribution policies and 2. establishment of mobile syringe clinics as dual attempts to address environmental barriers to care. Likewise, my proposed advancement of nationally-mandated medication access in prison facilities and incorporation of community-based rehabilitation services into prison re-entry programs seeks to offer holistic treatment with tremendous opportunity to improve long-term health outcomes in a humanistic, equitable manner.

## References

Arum, C., Fraser, H., Artenie, A. A., Bivegete, S., Trickey, A., Alary, M., Astemborski, J., Iversen, J., Lim, A. G., MacGregor, L., Morris, M., Ong, J. J., Platt, L., Sack-Davis, R., van Santen, D. K., Solomon, S. S., Sypsa, V., Valencia, J., Van Den Boom, W., ... Strathdee, S. A. (2021). Homelessness, unstable housing, and risk of HIV and hepatitis C virus acquisition among people who inject drugs: A systematic review and meta-analysis. *The Lancet Public Health*, 6(5). [https://doi.org/10.1016/s2468-2667\(21\)00013-x](https://doi.org/10.1016/s2468-2667(21)00013-x)

Baumgartner, A. (2022). Too Many Lives Lost: Comparing Overdose Mortality Rates and Policy Solutions Across High-Income Countries. The Commonwealth Fund. <https://www.commonwealthfund.org/blog/2022/too-many-lives-lost-comparing-overdose-mortality-rates-policy-solutions>

Bluthenthal, R. N., Ridgeway, G., Schell, T., Anderson, R., Flynn, N. M., and Kral, A. H. Examination of association between syringe exchange program (SEP) dispensation policy and SEP client-level syringe coverage among injection users. *Addiction* (2007); 102: 638-646

Chacon NC, Walia N, Allen A, Sciancalepore A, Tiong J, Quick R, Mada S, Diaz MA, Rodriguez I. Substance use during COVID-19 pandemic: impact on the underserved communities. *Discoveries (Craiova)*. 2021 Dec 31;9(4):e141. doi: 10.15190/d.2021.20. PMID: 35261922; PMCID: PMC8896880.

Community Reinforcement and Family Training (CRAFT). (2015). American Psychological Association. <https://www.apa.org/pi/about/publications/caregivers/practice-settings/intervention/community-reinforcement>

Dasgupta N, Beletsky L, Ciccarone D. Opioid Crisis: No Easy Fix to Its Social and Economic Determinants. *Am J Public Health*. 2018 Feb;108(2):182-186. doi: 10.2105/AJPH.2017.304187. Epub 2017 Dec 21. PMID: 29267060; PMCID: PMC5846593.

Feldscher. What Led to the Opioid Crisis-and How to Fix It. 2022. <https://www.hsph.harvard.edu/news/features/what-led-to-the-opioid-crisis-and-how-to-fix-it/>

Handanagic S, Finlayson T, Burnett JC, Broz D, Wejnert C. HIV Infection and HIV-Associated Behaviors Among Persons Who Inject Drugs — 23 Metropolitan Statistical Areas, United States, 2018. *MMWR Morb Mortal Wkly Rep* 2021;70:1459–1465. DOI: <http://dx.doi.org/10.15585/mmwr.mm7042a1>

HIV and People Who Use Drugs: Human rights fact sheet series 2021.UNAIDS. <https://www.unaids.org/en/resources/documents/2021/02-hiv-human-rights-factsheet-people-who-use-drug>

Marcus, R., Cha, S., Sionean, C., & Kanny, D. (2021). HIV injection risk behaviors among HIV-negative people who inject drugs experiencing homelessness, 23 U.S. cities. *Journal of Social Distress and Homelessness*, 1–9. <https://doi.org/10.1080/10530789.2021.1892931>

## Addressing Inequities • Swann

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. HIV and Injection Drug Use: Syringe Services Programs for HIV Prevention. Centers for Disease Control and Prevention (2016). Available at <http://www.cdc.gov/vitalsigns/hiv-drug-use>

Rich JD, McKenzie M, Larney S, Wong JB, Tran L, Clarke J, Noska A, Reddy M, Zaller N. Methadone continuation versus forced withdrawal on incarceration in a combined US prison and jail: a randomized, open-label trial. *Lancet*. 2015 Jul 25;386(9991):350-9. doi: 10.1016/S0140-6736(14)62338-2.

Ronan MV, Herzig SJ. Hospital Injections and infections: understanding syringe service program utilization in a rural state. *Harm Reduction Journal*. 2016;35(5):832-7. <https://doi.org/10.1377/hltha.2015.1424>

Szalavitz, M. Treating Addiction as a Crime Doesn't Work. What Oregon is Doing Just Might. (2022). <https://www.nytimes.com/2022/01/26/opinion/oregon-drug-decriminalization-addiction.html>

Thakarar, K., Sankar, N., Murray, K. et al. Injections and infections: understanding syringe service program utilization in a rural state. *Harm Reduct J* 18, 74 (2021). <https://doi.org/10.1186/s12954-021-00524-1>

Turner-Bicknell T. Implementing best-practice with a local syringe service program: Needs-based syringe distribution. *Public Health Nurs*. 2021 Jan;38(1):85-92. doi: 10.1111/phn.12823. Epub 2020 Oct 20. PMID: 33084122.

Westervelt, E. Oregon's Pioneering Drug Decriminalization Experiment Is Now Facing The Hard Test. (2022). <https://www.npr.org/2021/06/18/1007022652/oregons-pioneering-drug-decriminalization-experiment-is-now-facing-the-hard-test>

Williams AR, Samples H, Crystal S, Olfson M. Acute Care, Prescription Opioid Use, and Overdose Following Discontinuation of Long-Term Buprenorphine Treatment for Opioid Use Disorder. *Am J Psychiatry*. 2020 Feb 1;177(2):117-124. doi: 10.1176/appi.ajp.2019.19060612. Epub 2019 Dec 2. PMID: 31786933; PMCID: PMC7002204.

### **About the Goldfarb Center for Public Affairs**

Founded in 2003 with a generous gift from Colby Trustee Emeritus, William Goldfarb '68, P '00, the Goldfarb Center for Public Affairs connects the Colby community to the world of public policy, inspires active citizenship, and fosters discussion about creative, interdisciplinary approaches to complex societal challenges. We believe in a nonpartisan, inclusive approach that welcomes every opinion as part of a healthy discourse. Our events include world leaders, innovative thinkers, influential politicians, community activists, and cutting-edge academics. We engage students and faculty across disciplines to address both pressing and emerging topics in public affairs and policy, and also support student and faculty research in the field.



---

Goldfarb Center for Public  
Affairs at Colby