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AHDC Email Network – Data, News, Articles and Policies Related to Health Disparities
August 05 – 11, 2010

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1) *Healthy Food, Healthy Communities: Promising Strategies to Improve Access to Fresh, Healthy Food and Transform Communities*

The report describes how low-income communities of color and low-income rural areas are most affected by limited access to healthy food and what can be done to improve this disparity.

http://www.policylink.org/atf/cf/%7B97c6d565-bb43-406d-a6d5-eca3bbf35af0%7D/HFHC_SHORT_FINAL.PDF

2) *Arizona's Pre-Existing Condition Insurance Plan Goes Live*

Part of the health reform legislation is the newly created "Pre-Existing Condition Insurance Plan (PCIP)," which is designed to help people with pre-existing conditions find health insurance. In Arizona, the Pre-Existing Condition Insurance Plan (administered by U.S. Department of Health and Human Services - HHS) went live last week. In order to qualify for the program, people need to have been uninsured for at least six months, have been denied health coverage because of a health condition, and be a US citizen (or living here legally). The monthly premiums for the Arizona PCIP range from \$323/month for people 0-34 years old to \$688/month for people over 55. There's a \$2,500 annual deductible and a \$25 copayment for doctor visits after that. There are also some medicine co-pay costs. The person's out-of-pocket costs are capped at \$5,950 per year.

<https://www.pcip.gov/StatePlans.html>

<https://www.pcip.gov/Apply.html>

3) Data on adults who are overweight or obesity available

The latest CDC data from the BRFSS on adults who are overweight or obese have been added for all states and the nation for 2009. Data are also available by gender and race/ethnicity. Except that in District of Columbia 49.8% of adults are overweight or obese, more than 50% of adults are overweight or obese in all other states. Adults in Mississippi have the highest percentage of overweight or obese with 67.8%. In Arizona, the percentage of overweight or obese for adults is 61.3%.

<http://www.statehealthfacts.org/comparemaptable.jsp?ind=89&cat=2>

4) Study Examines Discrimination, Posttraumatic Stress and Risk Behaviors among Mexican-American Adolescents

"The findings of this study support our theoretical model that perceived racial/ethnic discrimination is related to the development of posttraumatic stress symptoms among Mexican American adolescents, and, in turn, to higher levels of health risk behaviors," write the authors of an article published in the July 2010 issue of the *Journal of Counseling Psychology*. National survey data indicate that Mexican-American adolescents engage in many health risk behaviors at higher rates than African-American and white adolescents. Increasing attention has been given to contextual stressors in the social environment in which adolescents live. One important aspect of the social environment for Mexican-American adolescents is experiences of racial/ethnic discrimination owing to their ethnic minority status. Mexican-American adolescents report high levels of perceived racial/ethnic discrimination, which is the subjective experience of being treated unfairly, disrespected, disliked, stereotyped, and rejected relative to others in everyday experience on the basis of race or ethnicity. The study described in this article examined perceived racial/ethnic discrimination as a source of traumatic stress related to health risk behaviors among Mexican-American adolescents. The authors found that adolescents who perceived more racial/ethnic discrimination reported worse posttraumatic stress symptoms; adolescents who experienced heightened posttraumatic stress symptoms reported more alcohol use, more other drug use, more involvement in fights, and more sexual partners; even when posttraumatic stress was included as a mediator, perceived racial/ethnic discrimination was related to fights; adolescents who perceived more discrimination were involved in more fights; and the mediated effects of perceived racial/ethnic discrimination on health risk behaviors were significant for alcohol use, other drug use, involvement in fights, and number of sexual partners. Thus, posttraumatic stress symptoms mediated the effects of perceived racial/ethnic discrimination on alcohol use, other drug use, and number of sexual partners and partially mediated the relationship between perceived racial/ethnic discrimination and involvement in fights. The authors conclude that "this study has important implications for training counseling psychologists and mental health counselors working with Mexican-American adolescents in school and community settings."

<http://psycnet.apa.org/journals/cou/57/3/264>

5) Brief Looks at State Options for Covering Pregnant Women in CHIP

Covering Pregnant Women: CHIPRA Offers a New Option describes provisions in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), explains what states must do to comply with the law, and discusses the options that states have to expand access to comprehensive health care for women with low incomes through pregnancy, delivery, and 60 days postpartum. The brief, published as part of the CHIPRA Implementation Series by Families USA, examines the ways that states provided coverage to pregnant women before the enactment of CHIPRA and current options and guidance for providing comprehensive benefits to pregnant women in CHIP. Information on services covered and state eligibility levels is included. Links to additional resources for states are also provided, including a letter from the Center for Medicaid and State Operations to state health officials on the new option to cover pregnant women, frequently asked questions, and a sample state plan amendment for coverage of pregnant women.

<http://www.familiesusa.org/issues/childrens-health/chipra-implementation-series.html>

6) Study Shows That Foreign-Trained, U.S.-Trained Physicians Provide Same Quality of Care

Some in the U.S. medical community have questioned the competence of physicians trained abroad. But a new study in the newly released *Health Affairs'* August issue indicates that the quality of care provided by these physicians is no different from that provided by physicians trained at U.S. medical schools. In fact, the study--based on data from Pennsylvania, and the first to compare patient outcomes of care by both groups of physicians--found no significant difference in the death rates of patients treated by international medical school graduates versus those treated by graduates of U.S. medical schools. The study, however, raises important questions about U.S. citizens who seek training abroad. This group accounts for approximately one-fifth of all foreign-trained doctors certified to practice in the United States. The study found that the patients of U.S.-born doctors who graduate from non-U.S. medical schools had higher rates of in-hospital deaths than the patients of foreign-born international medical graduates. One-quarter of all doctors practicing in the United States are educated abroad. Since international medical graduates are clearly filling many gaps in care, the findings are encouraging, say John Norcini, president and chief executive officer of the Foundation for Advancement of International Medical Education and Research, and coauthors.

<http://content.healthaffairs.org/cgi/content/abstract/29/8/1461>

<http://content.healthaffairs.org/content/vol29/issue8/>

7) 2007 NSCH Child Health and System Performance Profile

New state snapshot reports allow data users and child health advocates to demonstrate state variations and disparities in health and health system performance. The data snapshots include an overview of how children in your state compare to the nation on 21 key health status and system performance measures related to: chronic conditions, complexity of health service needs, health insurance, access to

care, preventive care and medical home. Key disparities findings include: 1) children with special health care needs are less likely to meet all medical home criteria for care, have easy access to obtaining needed referrals, and have adequate insurance to meet their health care needs; 2) children with public insurance are more likely to experience gaps or inconsistency in insurance coverage, be obese or overweight, have problems getting needed specialist care, and not meet all medical home criteria; and 3) children with private insurance are less likely to have adequate coverage, have had a preventive medical care visit during the past 12 months, and receive standardized developmental screening.

http://nschdata.org/indicators/Indicator_Report.aspx?rid=4&gid=0

8) Ethnicity testing for adoption

The leading article in the current issue of *Archives of Disease in Childhood* discusses the increasing use of commercial “DNA ancestry or ethnicity testing kits” that use blood or saliva to “provide a breakdown of racial origins” for social care workers when looking to place a child in fostering or adoption. As well as disregarding the cultural, religious and linguistic characteristics of ethnicity, this testing has contributed to an “excessive emphasis” on the ethnic needs of a child’s placement over other relevant factors such as the child’s “health and development needs.” The authors conclude that these tests can reach incorrect conclusions, and even when correct only give vague hints about culture, religion and language and so “their use for determination of ethnicity should be strongly discouraged.”

<http://adc.bmj.com/content/95/6/404.extract>

9) Ethnic differences in blood pressure begin in adolescence

A recent study published in *Hypertension* has discovered that divergences in blood pressure between white and ethnic minority groups begin in adolescence and are “particularly striking” for boys. The study also found that socioeconomic disadvantage had a “disproportionate effect” on blood pressure for ethnic minority girls. The results signal the need for the early prevention of cardiovascular diseases that could have adverse effects in later life, especially for young people of minority ethnic origin.

<http://www.library.nhs.uk/Ethnicity/ViewResource.aspx?resID=375078&tabID=289&catID=11551>

10) Indian Immigrants are the third largest immigrant groups in the US

The United States is home to about 1.6 million Indian immigrants, making them the third-largest immigrant group in the United States after Mexican and Filipino immigrants. Between 2007 and 2008, the number of Indian immigrants surpassed the number of Chinese and Hong Kong-born immigrants for the first time since at least 1960.

<http://www.migrationinformation.org/USfocus/display.cfm?id=767>

<http://www.migrationinformation.org/USfocus/display.cfm?id=777>

<http://www.migrationinformation.org/USfocus/display.cfm?id=785>