

**CALIFORNIA RESEARCH BUREAU
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**Studies in the News:
Health Care Supplement**

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Introduction to Studies in the News

Studies in the News is a current compilation of items significant to the Legislature and Governor's Office. It is created weekly by the California State Library's [California Research Bureau](#) to supplement the public policy debate in California. To help share the latest information with state policymakers, these reading lists are now being made accessible through the California State Library's website. This week's list of current articles in various public policy areas is presented below. Prior lists can be viewed from the California State Library's Web site at www.library.ca.gov/sitn

- When available, the URL for the full text of each item is provided.
- California State Employees may contact the State Information & Reference Center (916-654-0261); csinfo@library.ca.gov) with the SITN issue number and the item number [S#].
- All other interested individuals should contact their local library - the items may be available there, or may be borrowed by your local library on your behalf.

The following studies are currently on hand:

HEALTH

ALZHEIMER'S DISEASE

"Electromagnetic Field Treatment Protects Against and Reverses Cognitive Impairment in Alzheimer's Disease Mice." By Gary W. Arendash and others. IN: Journal of Alzheimer's Disease, vol. 19, no. 1 (January 2010). Various pagings.

Full text at: <http://www.j-alz.com/press/2010/20100106.html>

["Cell phone use has long been suspected, but not proven, of causing diseases such as brain cancer. Now at last there's a scientific study that has found a correlation -- but it indicates the opposite effect: In mice, cell phone radiation can prevent Alzheimer's disease. Researchers tested 96 mice, most of them genetically altered to develop the rodent equivalent of Alzheimer's disease. Those exposed to the cell phone radiation did better on tasks requiring memory than those not exposed. Already impaired old mice regained memory after the treatment. Younger mice never developed the impairment. It appears that the radiation broke up plaques of beta amyloid protein in the mice's brain cells. According to a popular theory, these plaques, which are found in the brains of patients with the disease, cause the brain cells to degenerate." North County Times (January 9, 2010) 1.]
[Request #S10-8-4536]

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AUTISM

"Risk of Autism and Increasing Maternal and Paternal Age in a Large North American Population." By Judith K. Grether and others. IN: American Journal of Epidemiology, vol. 170, no. 9 (September 2009) pp. 1118-1126.

Full text at: <http://aje.oxfordjournals.org/cgi/content/abstract/170/9/1118>

["Previous studies are inconsistent regarding whether there are independent effects of maternal and paternal age on the risk of autism. Different biologic mechanisms are suggested by maternal and paternal age effects. The study population included all California singletons born in 1989–2002.... In adjusted models that included age of the other parent and demographic covariates, a 10-year increase in maternal age was associated with a 38% increase in the odds ratio for autism, and a 10-year increase in paternal age was associated with a 22% increase.... Further studies are needed to help clarify the biologic mechanisms involved in the independent association of autism risk with increasing maternal and paternal age."]
[Request #S10-8-4288]

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CANCER

"Mobile Phone Use and Risk of Tumors: A Meta-Analysis." By Seung-Kwon Myung and others. IN: Journal of Clinical Oncology. (October 13, 2009) Various pagings.

Full text at: <http://jco.ascopubs.org/cgi/content/abstract/JCO.2008.21.6366v1>

["An analysis of data from 23 epidemiological studies found no connection between cellphone use and the development of cancerous or benign tumors. But when eight of the studies that were conducted with the most scientific rigor were analyzed, cellphone users were shown to have a 10% to 30% increased risk of tumors compared with people who rarely or never used the phones. The risk was highest among those who had used cellphones for 10 years or more. The other group of 15 studies were not as high-quality. They either found no association or a negative association or a protective effect -- which no one would have predicted. The main message of the analysis is that studies should be conducted so that findings are harder to refute." Los Angeles Times (October 14, 2009) 1.]
[Request #S10-8-4287]

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CHILDREN

"Soda Taxes, Soft Drink Consumption, And Children's Body Mass Index." By Roland Sturm and others. IN: Health Affairs, vol. 29, no. 5 (May 2010) pp. 1-7.

Full text at: <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.2009.0061>

["The taxes made no real difference on overall soda consumption or on obesity for kids overall. They did have a small effect on certain children -- especially those from families with an annual income of \$25,000 or less. Those kids -- who drank about seven cans of soda a week, on average -- drank one less can because of the taxes. However, if the taxes were more like 18 cents on the dollar, it would make a significant difference. Most states exempt grocery food from sales taxes. But in recent years, candy and soft drinks have been increasingly targeted, either through a tax or removal of an existing sales tax exemption. More than 30 states have some form of soda tax today, averaging about 5 cents per dollar of soda." Associated Press (April 1, 2010) 1.]
[Request #S10-8-4743]

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Shaping a Healthier Generation: Healthy Kids, Healthy America State Profiles in Progress. By the National Governors Association Center for Best Practices. (The Center, Washington, DC) March 2010. 44 p.

Full text at: <http://www.nga.org/Files/pdf/1003HEALTHYKIDSPROFILES.PDF>

["To support gubernatorial action, the National Governors Association Center for Best Practices awarded grants up to \$110,000 to 15 states to help them develop policies to prevent childhood obesity.... This compendium of state actions demonstrates that many governors are elevating obesity prevention policies and programs by building wellness practices into child care settings and schools, as well as by establishing statewide policy planning and prioritization to coordinate public and private-sector efforts, thereby making the most of limited resources. The willingness of governors to proactively address childhood obesity through state-level policy innovations has accelerated national progress and will ultimately help today's children and youth grow into healthy and productive adults."]

[Request #S10-8-4742]

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Trouble in Toyland: The 24th Annual Survey of Toy Safety. By Elizabeth Hitchcock, CALPIRG Education Fund. (The Fund, Sacramento, California) November 2009. 34 p.

Full text at:

<http://cdn.publicinterestnetwork.org/assets/20cc62cb74418d324f03333a001f0c9b/CA-toy-report-2009a.pdf>

["The recall of 45 million toys and other children's products in 2007 and continued recalls in 2008 reminded Americans that no government agency tests toys before they are put on the shelves. Specifically, the wave of recalls focused attention on the fact that the agency charged with protecting Americans from unsafe products -- the Consumer Product Safety Commission -- is a little agency with a very big job to do.... Tough new bans on lead and phthalates are a good step in the right direction, but there are tens of thousands of toxic chemicals in our children's lives.... This year, we focused on three categories of toy hazards: toys that may pose choking hazards, toys that are excessively loud, and toys that contain the toxic chemicals lead and phthalates."]

[Request #S10-8-4427]

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DENTAL CARE

Unaffordable Dental Care Is Linked to Frequent School Absences. By Nadereh Pourat and Gina Nicholson, UCLA Center for Health Policy Research. (The Center, Los Angeles, California) November 2009. 6 p.

Full text at:

[http://www.healthpolicy.ucla.edu/pubs/files/Unaffordable Dental Care PB 1109.pdf](http://www.healthpolicy.ucla.edu/pubs/files/Unaffordable_Dental_Care_PB_1109.pdf)

["The authors found that of the 7,240,000 school age children ages 5-17 in California, an estimated 504,000 missed at least one day of school due to a dental problem in the past year. The majority of these children report one missed day of school due to a dental problem, while the remaining 40 percent report missing two or more days. In total, California children report missing an estimated 874,000 school days due to dental problems. The ability to afford needed dental care is the key difference between those children who miss school due to a dental problem and those who do not. The authors note that frequent absences may have significant negative societal and economic consequences and suggest that policymakers consider addressing gaps in coverage and access, as well as school-based dental care, among other recommendations."]

[Request #S10-8-4500]

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Retail Dental Clinics: A Viable Model for the Underserved? Mary Kate Scott, Scott & Company, Inc. (California HealthCare Foundation, Oakland, California) November 2009. 31 p.

Full text at: <http://www.chcf.org/~media/Files/PDF/R/RetailDentalClinics.pdf>

["Among Californians who do not receive regular dental care, one of the primary reasons is that oral health services come at too steep a price.... Much as retail health clinics now offer convenient care at an affordable cost, retail dental clinics -- located in drug, grocery, or mass merchandising stores -- could help to close the oral health gap.... This feasibility report, based on interviews with dentists and other experts, consumer surveys, and published reports, examines factors that would support or inhibit the emergence of retail dental clinics in California and elsewhere. While the model seems promising in today's economic climate, it remains unclear if retail dental clinics would substantially improve access to services and the oral health of the underserved, since an innovation of this kind could evolve in various directions."]

[Request #S10-8-4502]

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DISABILITIES

“Disability Trends Among Older Americans: National Health and Nutrition Examination Surveys, 1988–1994 and 1999–2004.” By Teresa E. Seeman and others. IN: American Journal of Public Health, vol. 100, no. 1 (January 2010) pp. 100-107.

Full text at: <http://ajph.aphapublications.org/cgi/content/short/100/1/100>

["Americans entering their 70s today are experiencing more disabilities in old age than did the previous generation. The shift in health fortunes comes as a surprise and predicts future high disability rates for the baby boomers as well. The study is the first to foretell the end of a two-decade trend in which people appeared to be functioning better in old age than those who came before." Los Angeles Times (November 13, 2009) 1.]

[Request #S10-8-4505]

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ELDERLY

American Indian Elder Health: Critical Information for Researchers and Policymakers. By Delight E. Satter, American Indian Research Program, and Steven P. Wallace, UCLA Center for Health Policy Research. (The Center, Los Angeles, California) January 2010. 2 p.

Full text at: www.healthpolicy.ucla.edu/pubs/files/AI_Elder_FS_012210.pdf

["As more American Indians and Alaska Natives (AIAN) live to adulthood and old age, the elderly population (age 55 and older) is projected to increase from 5.5% of the total U.S. AIAN population in 1990 to 12.6% in 2050. This shifting demographic profile of the population calls for focused attention on the health status of AIAN elders. More American Indian elders reside in California than any other state.... This project provides population-level health information on the American Indian elder population in California for the first time. We call on service providers, health advocates, and policymakers to set priorities and allocate resources that will benefit this vulnerable population. These programs should focus on culturally competent strategies that work for a multitude of Native tribal cultures.”]

[Request #S10-8-4718]

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EMERGENCY CARE

Emergency Department Utilization in Orange County. By David L. Riley and others, Orange County Health Care Agency. (The Agency, Santa Ana, California) February 2010. 16 p.

Full text at: www.ochealthinfo.com/docs/AgcyPubs/admin/ED_Utilization-Report_23Feb10.pdf

[“Nearly half of all hospital emergency room visits were unnecessary. People with private health insurance had the fewest unneeded visits, while patients covered by state Medi-Cal or those who lacked any insurance had the most. Out of all visits, nearly 11 percent were made by patients without any insurance. Federal law requires emergency rooms to see anyone regardless of ability to pay.... Avoidable visits were defined as trips that could have been prevented with ‘timely and effective primary care’ such as asthma attacks or ear infections, as well as non-urgent visits for sore throats and fever. Children’s Hospital of Orange County had the highest percentage of avoidable ER visits -- 58 percent -- while South Coast Medical Center, now Mission Hospital Laguna Beach, had the lowest with 37 percent.” Orange County Register (February 24, 2010) 1.]

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HEALTH CARE

The Economic Stimulus: Gauging the Early Effects of ARRA Funding on Health Centers and Medically Underserved Populations and Communities. By Peter Shin and others, George Washington University. (The University, Washington, DC) February 16, 2010. 25 p.

Full text at:

http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_C41AE130-5056-9D20-3D65728F2361CFAF.pdf

[“During times of economic crisis, community health centers and other health care safety net providers become even more vital to the communities they serve. The current downturn, with its high levels of unemployment and enormous impact on family incomes, carries major implications for health insurance coverage. The American Recovery and Reinvestment Act, signed into law on February 17, 2009, provided slightly more than two billion dollars to community health centers for capital improvements, expansion (or retention) of personnel and services, and adoption of health information technology. All of these uses not only support health centers’ mission to serve populations with limited access to health care, such as the uninsured, low-income populations, minorities, and the homeless, but also generate new economic activities in communities hit hardest by the recession.”]

[Request #S10-8-4756]

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Incremental Cost Estimates for the Patient-Centered Medical Home. By Stephen Zuckerman, Urban Institute, and others. (The Commonwealth Fund, New York, New York) October 2009. 36 p.

Full text at:

http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2009/Oct/1325_Zuckerman_Incremental_Cost_1019.pdf

["Over the past several years, there has been wide and growing interest in organizing primary care practices into 'medical homes' which provide care coordination, patient education, and related services in addition to primary medical care.... But despite the attention being paid to the medical home approach, little is known about the costs associated with this practice model; the focus of most available studies is in establishing payment rates or value, not in providing clear cost estimates. We do not find evidence of additional costs associated with higher levels of 'medical homeness,' with the exception of information technology costs, which show a modest but statistically significant increase with medical home intensity."]

[Request #S10-8-4285]

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“Funding Growth Drives Community Health Center Services.” By Anthony T. Lo Sasso and Gayle R. Byck. IN: Health Affairs, vol. 29, no. 2 (February 2010) pp. 289-296.

Full text at: <http://content.healthaffairs.org/cgi/content/abstract/29/2/289>

["Federally qualified health centers are community-based health centers that primarily serve medically underserved communities and vulnerable populations, and have a clear mission to serve the poor. The number of federally qualified health centers has increased from roughly 750 centers in 2001 to the recently reached milestone of 1,200 centers in December 2007.... Federally qualified health centers stand to gain additional funding under the health care reform proposals being considered by Congress. Moreover, they are likely to maintain their relevance in a post-health reform era because even under optimistic projections, as many as twenty million Americans will remain uninsured once reforms are fully in place."]

[Request #S10-8-4755]

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The Potential of Global Payment: Insights from the Field. By Ann Robinow, Robinow Health Care Consulting. (The Commonwealth Fund, New York, New York) February 2010. 71 p.

Full text at:

http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Feb/1373_Robinow_potential_global_payment.pdf

[“In the 80s and early 90s, health care providers in the managed care world were frequently paid via capitation -- that is, a flat fee per patient. Use of the practice has eroded significantly, but experienced provider and plan leaders believe moving to improved models of capitation, called global payment, would result in much better care for all types of patients at more reasonable cost.... These experts unanimously supported global payment and estimated that proper alignment of payment and quality incentives could generate a 20 percent to 30 percent cost reduction while greatly improving care quality. They believe it is now possible to resolve problems that plagued capitation in the past, such as avoidance of sicker patients and excessive risk assumption, but that environmental changes have also created new challenges.”]

[Request #S10-8-4744]

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“Unchecked Provider Clout In California Foreshadows Challenges To Health Reform.” By Robert A. Berenson and others. IN: *Health Affairs*, vol. 29, no. 4 (April 2010) pp. 699-705.

Full text at:

<http://content.healthaffairs.org/cgi/content/abstract/29/4/699?ijkey=p3Di/BAt8Oh0w&keytype=ref&siteid=healthaff>

[“Faced with declining payment rates, California providers have implemented various strategies that have strengthened their leverage in negotiating prices with private health plans. When negotiating together, hospitals and physicians enhance their already significant bargaining clout. California’s experience is a cautionary tale for national health reform: It suggests that proposals to promote integrated care through models such as accountable care organizations could lead to higher rates for private payers. Because antitrust policy has proved ineffective in curbing most provider strategies that capitalize on providers’ market power to win higher payments, policy makers need to consider approaches including price caps and all-payer rate setting.”]

[Request #S10-8-4741]

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HEALTH INFORMATION TECHNOLOGY

Electronic Release of Clinical Laboratory Results: A Review of State and Federal Policy. By Kitty Purington and others, The National Academy for State Health Policy. Prepared for California HealthCare Foundation. (The Foundation, Oakland, California) January 2010. 19 p.

Full text at:

<http://www.chcf.org/~media/Files/PDF/E/ElectronicLabResultsExchangePolicy.pdf>

[“Health information technologies (HIT) and electronic health information exchange (HIE) are increasingly recognized as necessary tools for a high-performing, effective health care system.... Laboratory test results are a critically important source of information for medical decisionmaking and an integral data component of Electronic Health Records and electronic HIE. Both state and nationally convened groups have recognized that laws governing electronic laboratory results use and exchange must be reviewed and made compatible in order to facilitate the benefits of HIT and HIE.”]

[Request #S10-8-4724]

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HEALTH INSURANCE

The Market Structure of the Health Insurance Industry. By D. Andrew Austin and Thomas L. Hungerford, Congressional Research Service, Library of Congress. (The Service, Washington, DC) November 17, 2009. 65 p.

Full text at: <http://www.fas.org/sgp/crs/misc/R40834.pdf>

["This report discusses how the current health insurance market structure affects the two policy goals of expanding health insurance coverage and containing health care costs. Concerns about concentration in health insurance markets are linked to wider concerns about the cost, quality, and availability of health care. The market structure of the health insurance and hospital industries may have played a role in rising health care costs and in limiting access to affordable health insurance and health care.... Health costs appear to have increased over time in large part because of complex interactions among health insurance, health care providers, employers, pharmaceutical manufacturers, tax policy, and the medical technology industry. Reducing the growth trajectory of health care costs may require policies that affect these interactions."]

[Request #S10-8-4499]

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Number of Uninsured Jumped to More Than Eight Million from 2007 to 2009.
By Shana Alex Lavarreda and others, UCLA Center for Health Policy Research.
(The Center, Los Angeles, California) March 2010. 6 p.

Full text at: www.healthpolicy.ucla.edu/pubs/files/Uninsured_8-Million_PB_0310.pdf

[“One in four Californians, or 8.2 million people, now lack coverage.... In 2007, there were an estimated 162,000 Sacramento County residents without health insurance -- about 13 percent of the population. By 2009, that number had jumped by 46,000 to 208,000. The region's concentration of government jobs cushioned Sacramento from some of the more dramatic losses found in Los Angeles and other parts of the Central Valley.... As people lost jobs, they also lost health insurance through their employers -- despite federal stimulus money that provided deep subsidies for COBRA payments to help them keep their employer-based health coverage. Many took the offer, but substantial numbers of the laid-off workers apparently did not.” Sacramento Bee (March 17, 2010) 1.]
[Request #S10-8-4691]

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HEALTH SURVEY

America's Health Rankings, A Call to Action for Individuals and Their Communities: 2009 Edition. By the United Health Foundation, the American Public Health Association and Partnership for Prevention. (The Foundation, Minnetonka, Minnesota) 2009. 116 p.

Full text at:
<http://www.americashealthrankings.org/2009/report/AHR2009%20Final%20Report.pdf>

["California is getting fatter, just not as quickly as the rest of the country. The state's good marks in obesity rates, smoking and infant mortality pushed us up a notch to 23rd. But two persistent problems -- air pollution and the high rate of uninsured citizens -- are keeping California stuck in the middle of the pack. California once ranked a dismal 28th, in 1994, before climbing to a high of 18th, at which it held steady from 2003-05. But since then our state has fallen into the 20s and stayed there.... Here are two areas where California performs well: smoking and infant mortality. And here are two areas in which it could improve: Infectious diseases and high school graduations (Seen as a future predictor of health).” Orange County Register (November 17, 2009) 1.]
[Request #S10-8-4443]

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INFORMATION TECHNOLOGY

Making a Connection: Clinics Collaborate on EHR Deployment. By SA Kushinka, Full Circle Projects, Inc. (California HealthCare Foundation, Oakland, California) December 2009. 7 p.

Full text at:

<http://www.chcf.org/~media/Files/PDF/C/ClinicsCollaborateEHRDeployment.pdf>

["Electronic health record (EHR) technology has significant potential to enhance care for the safety-net populations served by California's community clinics and health centers. But there are financial and other barriers to successful adoption. To overcome these obstacles and achieve economies of scale, some clinics have joined together in networks to collaborate on EHR implementation, training, and maintenance. The California Networks for Electronic Health Record Adoption initiative promotes networks by helping to develop centralized support hubs that provide technology, training, vendor management, and other services that community clinics require for EHR adoption."]

[Request #S10-8-4440]

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INNOVATIVE THERAPIES

"The California Stem Cell Initiative: Persuasion, Politics, and Public Science." By Joel W. Adelson and Joanna K. Weinberg. IN: American Journal of Public Health, vol. 100, no. 3 (March, 2010) pp. 446-451.

Full text at: <http://ajph.aphapublications.org/cgi/content/abstract/100/3/446>

["The California Institute for Regenerative Medicine (CIRM) was created by a California ballot initiative to make stem cell research a constitutional right, in response to Bush administration restrictions on stem cell research. The initiative created a taxpayer-funded, multibillion-dollar institution, intended to advance public health by developing cures and treatments for diabetes, cancer, paralysis, and other conditions. The initiative has been highly controversial among stakeholders and watchdog groups concerned with organizational transparency, accountability, and the ethics of stem cell research. We interviewed major stakeholders -- both supporters and opponents -- and analyzed documents and meeting notes. We found that the CIRM has overcome start-up challenges, been selectively influenced by criticism, and adhered to its core mission."]

[Request #S10-8-4501]

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Bending the Productivity Curve: Why America Leads the World in Medical Innovation. By Glen Whitman, California State University, Northridge, and Raymond Raad, New York Presbyterian Hospital. (The Cato Institute, Washington, DC) November 18, 2009. 24 p.

Full text at: <http://www.cato.org/pubs/pas/pa654.pdf>

["Americans tend to receive more new treatments and pay more for them -- a fact that is usually regarded as a fault of the American system. That interpretation, if not entirely wrong, is at least incomplete. Rapid adoption and extensive use of new treatments and technologies create an incentive to develop those techniques in the first place. When the United States subsidizes medical innovation, the whole world benefits. That is a virtue of the American system that is not reflected in comparative life expectancy and mortality statistics. Policymakers should consider the impact of reform proposals on innovation. For example, proposals that increase spending on diagnostics and therapeutics could encourage such innovation. Expanding price controls, government health care programs, and health insurance regulation, on the other hand, could hinder America's ability to innovate."]

[Request #S10-8-4490]

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LONG TERM CARE

California Budget Cuts Fray the Long-Term Safety Net. By Steven P. Wallace and others, UCLA Center for Health Policy Research. (The Center, Los Angeles, California) October 2009. 8 p.

Full text at:

<http://www.healthpolicy.ucla.edu/pubs/files/LTC%20Budget%20Cuts%20FINAL%2009-22-09.pdf>

["This policy brief examines the likely effects of the sweeping 2009 cuts to California's safety-net programs for low-income and disabled seniors. Specifically, it examines reductions in programs that help disabled seniors remain safely at home, including the Supplemental Security Income, In-Home Supportive Services, Adult Day Health Care and other programs. Among the findings: researchers found that up to half a million seniors will have their incomes reduced by the cuts and tens of thousands will lose some or all of their in-home supportive services. The research is based on program data, published research and interviews with key informants in the health and government services sectors."]

[Request #S10-8-4279]

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Long-term Care Financing Reform: Lessons from the U.S. and Abroad. By Howard Gleckman, the Urban Institute. (The Institute, Washington, DC) February 2010. 39 p.

Full text at:

[www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Feb/1368 Gleckman longterm care financing reform lessons US abroad.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Feb/1368_Gleckman_longterm_care_financing_reform_lessons_US_abroad.pdf)

[“As part of health care reform, Congress is considering the Community Living Assistance Services and Supports (CLASS) Act. The measure would mark the most significant change since 1965 in the way the U.S. finances long-term care, the personal assistance delivered both at home and in nursing facilities to the frail elderly and other adults with disabilities. As policymakers consider the CLASS Act, they may be able to learn from past experiments in the U.S. as well as from the experiences of other major industrialized countries, most of which have migrated to universal, government-run financing systems. Although those models vary markedly in their specifics, they appear to be both popular and more costly than expected. By contrast, the CLASS Act is a voluntary system that attempts to meld public insurance with private long-term care coverage and Medicaid.”]
[Request #S10-8-4721]

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MALPRACTICE

Health Hazard: Litigation Increases Medical Costs, but Lawyers Block Reform. By the Center for Legal Policy, Manhattan Institute for Policy Research. (The Institute, New York, New York) October 2009. 8 p.

Full text at: http://www.triallawyersinc.com/pdfs/tli_update_8.pdf

["Trial lawyer lobby groups argue that litigation is an insignificant contributor to health care cost escalation because it only accounts for a tiny fraction of health costs. The tiny fraction they point to takes the total \$2.2 trillion in U.S. health expenditures as its denominator and an absurdly narrow definition of health-care litigation as its numerator. Such groups use as a numerator medical-malpractice losses as reported by insurance companies -- numbers that ignore legal defense costs as well as the fact that most major health systems in the U.S. cover at least a portion of their medical malpractice losses without insurance. More comprehensive estimates place the total direct cost of medical-malpractice litigation at \$30.4 billion annually -- an expense that has grown almost twice as fast as overall tort litigation and over four times as fast as health-care inflation since 1975."]
[Request #S10-8-4286]

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MEDI-CAL

Financing Medi-Cal's Future: The Growing Role of Health Care-Related Provider Fees and Taxes. By Brenda Klutz and Stan Rosenstein, Health Management Associates. (California HealthCare Foundation, Oakland, California) November 2009. 16 p.

Full text at: <http://www.chcf.org/~media/Files/PDF/M/MediCalProviderFees.pdf>

["Recent California legislation imposed a health care-related provider fee on hospitals and extends to Medi-Cal managed care plans the state's existing gross premium tax on insurance.... Funds made available by these assessments include federal matching funds the state receives when it uses such fee or tax revenue as the non-federal share of Medi-Cal or Healthy Families expenditures; California receives approximately \$1.60 (until 2011) in federal matching funds for every dollar in non-federal Medi-Cal expenditures to health care providers. This issue brief reviews federal requirements for health care-related provider fees and taxes and examines California's experience with provider fees under Medi-Cal."]

[Request #S10-8-4492]

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MENTAL HEALTH

Mental Health Research Findings: Program Brief. By the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. (The Agency, Rockville, Maryland) September 2009. 24 p.

Full text at: <http://www.ahrq.gov/research/mentalth.pdf>

["About one in four adults in the United States suffers from a mental disorder in a given year, with about 6 percent suffering from a serious mental illness.... The Agency supports a diverse array of mental health research projects that examine these and other issues. Topics of recently funded projects range from mental comorbidity and chronic illness, feedback systems to improved evidence-based therapies for children with mental disorders, and the impact of atypical antipsychotic use on elderly health care use to electronic personal health records for mental health consumers and assessment and intervention for elder self-neglect. This program brief presents findings from a cross-section of AHRQ-supported extramural and intramural research projects on mental health, which were published between 2007 and 2009."]

[Request #S10-8-4496]

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MINORITIES

Modest and Uneven: Physician Efforts to Reduce Racial and Ethnic Disparities.
By James D. Reschovsky and Ellyn R. Boukus, Center for Studying Health System Change. (The Center, Washington, DC) February 2010. 6 p.

Full text at: www.hschange.org/CONTENT/1113/1113.pdf

[“Despite broad consensus among the medical community about how physicians can help to address and, ultimately, reduce disparities, physician adoption of several recommended practices to improve care for minority patients remains low. Cost and lack of reimbursement for these activities are likely among the largest obstacles to implementation in physician practices.... The challenges physicians face in providing quality health care to all of their patients will keep mounting as the U.S. population continues to diversify and the minority population grows. Although disparities can stem from factors beyond the physician-patient encounter, the ability of physicians to communicate effectively with patients and understand their cultural and social context is important in caring for a diverse patient population.”]
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NUTRITION

State Indicator Report on Fruits and Vegetables, 2009. By the Centers for Disease Control and Prevention. (The Center, Atlanta, Georgia) 2009. 8 p.

Full text at:

<http://www.fruitsandveggiesmatter.gov/downloads/StateIndicatorReport2009.pdf>

["This report provides for the first time information on fruit and vegetable (F&V) consumption and policy and environmental support within each state.... The behavioral indicators are derived from objectives for F&V consumption outlined in Healthy People 2010, a framework for the nation's health priorities, and data is from CDC supported health surveillance systems. The policy and environmental indicators measure three different types of F&V support: availability of healthier food retail in communities; availability of healthier foods and nutrition services in schools; and food system support."]
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OBESITY

“Childhood Obesity, Other Cardiovascular Risk Factors, and Premature Death.” By Paul W. Franks and others. IN: **The New England Journal of Medicine**, vol. 362, no. 6 (February 11, 2010) pp. 485–493.

Full text at: <http://content.nejm.org/cgi/reprint/362/6/485.pdf>

[“The heaviest youngsters were more than twice as likely as the thinnest to die prematurely, before age 55, of illness or a self-inflicted injury. Youngsters with a condition called pre-diabetes were at almost double the risk of dying before 55, and those with high blood pressure were at some increased risk. But obesity was the factor most closely associated with an early death.... ‘This suggests,’ said Helen C. Looker, senior author of the paper, ‘that obesity in children, even prepubescent children, may have very serious long-term health effects through midlife -- that there is something serious being set in motion by obesity at early ages.’” New York Times (February 10, 2010) 1.]

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PUBLIC HEALTH

The Grocery Gap: Who Has Access to Healthy Food and Why It Matters. By Sarah Treuhaft, PolicyLink and Allison Karpyn, The Food Trust. (PolicyLink, Oakland, California) 2010. 44 p.

Full text at: www.policylink.org/atf/cf/{97C6D565-BB43-406D-A6D5-ECA3BBF35AF0}/FINALGroceryGap.pdf

[“As concerns grow over healthcare and the country’s worsening obesity epidemic, ‘food deserts’ -- areas where there is little or no access to healthy and affordable food -- have catapulted to the forefront of public policy discussions. Policymakers at the local, state, and national level have begun recognizing the role that access to healthy food plays in promoting healthy local economies, healthy neighborhoods, and healthy people. The evidence is clear that many communities -- predominantly low-income, urban communities of color and rural areas -- lack adequate access to healthy food, and the lack of access negatively impacts the health of residents and neighborhoods. These findings indicate that policy interventions to increase access to healthy food in ‘food deserts’ will help people eat a healthy diet, while contributing to community economic development.”]

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Ready or Not? Protecting the Public's Health from Diseases, Disasters and Bioterrorism, 2009. By Jeffrey Levi and others, Trust for America's Health. (Trust for America's Health, Washington, DC) December 2009. 96 p.

Full text at:

<http://healthyamericans.org/reports/bioterror09/pdf/TFAHReadyorNot200906.pdf>

["An annual report that ranks each state's public health emergency preparedness capabilities has found underlying gaps in the nation's ability to respond to public health emergencies. The 2009 H1N1 outbreak is the latest in a series of reminders from Sept. 11 and the subsequent anthrax attacks to Hurricane Katrina, that the nation's public health systems need to always be ready to respond to a major health crisis.... None of the states received a perfect score, or met 10 out of 10 preparedness indicators, but eight tied with a score of nine: Arkansas, Delaware, New York, North Carolina, North Dakota, Oklahoma, Texas and Vermont. Two-thirds of states received a score of seven or less, and Montana came in last with a score of three." Government Technology (December 15, 2009) 1.]
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SMOKING

Taxpayer Subsidies for US Films with Tobacco Imagery. By Jonathan R. Polansky and Stanton A. Glantz, UC San Francisco, Center for Tobacco Control Research and Education. (The University, San Francisco, California) November 2009. 29 p.

Full text at: <http://escholarship.org/uc/item/8nc8422j>

["Forty-one US states and several countries compete for big-budget Hollywood film projects by offering valuable public subsidies. In 2008, states offered an estimated total of \$1.4 billion to motion picture producers. On average, individual states now cover 24 percent of production costs for commercial feature films. Because an estimated 1.3 million current adolescent smokers in the US were recruited to smoke by tobacco imagery in films about 400,000 of whom will ultimately die from tobacco-induced diseases, this report estimates the size of recent public subsidies for youth-rated films with tobacco imagery. It explores making tobacco imagery a determinant factor in eligibility for public film subsidies so that these awards no longer work in contradiction to public health."]
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WOMEN

Health Disparities Among California's Nearly Four Million Low-Income Nonelderly Adult Women. By Erin Peckham and Roberta Wyn, UCLA Center for Health Policy Research. (The Center, Los Angeles, California) November 2009. 12 p.

Full text at:

http://www.healthpolicy.ucla.edu/pubs/files/Disparities_4Mil_Women_PB_11-09.pdf

["The authors examine health status and functioning, health risks, gaps in access to health care and health services, insurance trends and other topics of concern. The research finds that even though they are a younger population than women with higher incomes, low-income women have worse general health status and functioning. And mid-life, low-income women have a higher prevalence of three of the four chronic health conditions examined -- diabetes, high blood pressure and heart disease. Prevention practices, the expansion of insurance coverage and the waiver of out-of-pocket expenses and premiums are among the policy recommendations."]

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