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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

CHILDREN

The Last Piece of the Puzzle: Providing High-Quality, Affordable Health Coverage To All Children Through National Health Reform. By Jocelyn Guyer and Dawn Horner, Center for Children and Families. (The Center, Washington, DC) May 2009. 32 p.

Full text at: <http://ccf.georgetown.edu/index/cms-filessystem-action?file=ccf%20publications/uninsured/pieceofpuzzle.pdf>

["The nation has made significant progress in covering children, but nine million children still lack insurance and many more are at risk of not receiving the health care services that they need to develop and grow properly. To address these issues, children will need to be an integral part of the much larger health reform debate now underway. Based on the research and the experience gained over decades of efforts to cover children, this report provides a blueprint of what children and families need from health reform, including an overview of where the remaining gaps are for children's coverage and recommendations on the key challenges that must be addressed in order to complete the puzzle."]

[Request #S09-19-3818]

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Health Care Reform for Children with Public Coverage: How Can Policymakers Maximize Gains and Prevent Harm? By Genevieve Kenney and Stan Dorn, Urban Institute Health Policy Research Center. (The Institute, Washington, DC) June 2009. 9 p.

Full text at:

http://www.urban.org/UploadedPDF/411899_children_healthcare_reform.pdf

["This brief examines the potential effects of health care reform on the more than 25 million children who currently have coverage under Medicaid or the Children's Health Insurance Program (CHIP). Increased parental coverage will help these children since many have uninsured parents with unmet health needs. However, proposals to move these children into a new health insurance exchange could make them worse off through the potential loss of benefits and legal protections and possible exposure to higher cost-sharing; alternatively, if reimbursement rates are higher in the exchange than paid under Medicaid and CHIP, children's access to providers could improve."]

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HEALTH CARE

Health Coverage in the Safety Net: How California's Coverage Initiative Is Providing A Medical Home to Low-Income Uninsured Adults in Ten Counties, Interim Findings. By Nadereh Pourat and others, UCLA Center for Health Policy Research. (The Center, Los Angeles, California) June 2009. 12 p.

Full text at:

http://www.healthpolicy.ucla.edu/pubs/files/Medical_Home_PB_0609.pdf

["Only 27 percent of non-elderly adults in the United States have a 'medical home' - a place where they regularly receive medical care and advice. Shifting from more costly emergency care to a medical home impacts costs, access, quality of care and the overall health status of low-income uninsured individuals. This brief presents interim findings on the efforts of ten California counties to explore the medical home model as part of the state's Health Care Coverage Initiative, a three-year program to expand health care coverage for eligible low-income, uninsured individuals not otherwise covered by Medi-Cal. Among the innovations described are efforts to create electronic health and medical records, modify e-referrals to two-way communication between primary care physicians and other providers and standardize chronic disease registries."]

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Specialty Care in the Safety Net: Efforts to Expand Timely Access. By Lisa Canin and Bobby Wunsch, Pacific Health Consulting Group. (California HealthCare Foundation, Oakland, California) May 2009. 24 p.

Full text at: <http://www.chcf.org/documents/policy/SpecialtyCareOverview.pdf>

["Californians who depend on safety-net institutions for their health care often have difficulty accessing the specialty services they need. The hospitals and community clinics and health centers face a number of barriers in providing access to many specialty services, particularly orthopedics, gastroenterology, neurology, and dermatology.... This report identifies five types of improvement activities: 1) Development and implementation of referral and/or clinical care guidelines; 2) Training for primary care providers, including expanding the scope of practice to incorporate specialty care activities; 3) Expanded specialist networks; 4) Web-based referral or consult systems; and 5) Referral coordination improvements. The goal of these efforts is to enable systemwide change and advance the larger goal of integrated community care in the safety net."]
[Request #S09-19-3720]

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Comparative Effectiveness Research and Evidence-Based Health Policy: Experience from Four Countries. By Kalipso Chalkidou and others. IN: The Milbank Quarterly, vol. 87, no. 2 (June 2009) pp. 339-367.

Full text at: http://www.milbank.org/quarterly/milq_87_2-final-chalkidou.pdf

["A part of the recent discussions about U.S. health system reform has focused on the need for better evidence on the comparative effectiveness of various clinical treatments. Other countries' experiences in creating and operating comparative effectiveness research agencies may provide useful lessons to inform these discussions. In each of the four countries studied, the agencies have a clear mandate to produce information that will inform clinical and health policy decisions. By contrast, comparative effectiveness legislation under consideration in the U.S. Senate explicitly separates the generation of knowledge from health care decision-making.... Over time, the international agencies have begun to consider cost-effectiveness, as well as clinical effectiveness."]
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A First Look at the Volume and Cost of Comparative Effectiveness Research in the United States. By Erin Holve and Patricia Pittman, AcademyHealth. (AcademyHealth, Washington, DC) June 2009. 20 p.

Full text at:

http://www.academyhealth.org/files/FileDownloads/AH_Monograph_09FINAL7.pdf

["While the health policy community debates the potential contributions of comparative effectiveness research to health care quality and costs, there is limited understanding of the current capacity for conducting comparative effectiveness research in the United States. This report is intended to help fill this gap by providing an environmental scan of the volume and the range of cost of recent comparative effectiveness research.... The general range of cost for head-to-head randomized trials was reported to be extremely broad, from \$400,000 to \$125 million. Within this range, many smaller trials have a range of cost on the order of \$2.5 million to \$5 million, while the the cost of larger-scale trials clustered around \$15 million to \$20 million."]

[Request #S09-19-3810]

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"Should Health Care Come With A Warranty?" By Francois de Brantes and others. IN: Health Affairs, vol. 28, no. 4 (June 16, 2009) pp. 678-687.

Full text at: <http://content.healthaffairs.org/cgi/reprint/hlthaff.28.4.w678v1>

["How health care providers get paid has implications for the delivery of care and cost control; the topic is especially important during an economic downturn with persistent growth in health spending. Adding 'warranties' to care is an innovation that transfers risk to providers, because payment includes allowances for defects. How do such warranties affect patient care and bottom lines? We examine a proposed payment model to illustrate the role of warranties in health care and their potential impact on providers' behavior and profitability. We conclude that warranties could motivate providers to improve quality and could increase their profit margins."]

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HEALTH CARE REFORM

Realigning U.S. Health Care Incentives to Better Serve Patients and Taxpayers.
By Scott Armstrong and others, Health CEOs for Health Reform. (New America Foundation, Washington, DC) June 12, 2009. 12 p.

Full text at: <http://www.newamerica.net/files/DeliverySystemWhitePaper.pdf>

["As health care leaders who operate in our current system, we firmly believe that upwards of 30 percent of the resources spent on health care in the United States are a result of too few efforts to coordinate care and not enough attention to quality. We must achieve higher value for our health care dollar to make affordable coverage and high-quality care available for all, including our most vulnerable, for years to come. We will not control health care costs until we create clear incentives for providers -- the people who deliver care -- to focus on quality and efficiency. The Medicare program must convey the seriousness with which it will approach payment reforms that move away from fee-for-service and toward accountable payments. Medicare must articulate clearly its long-term goals to allow providers to prepare for future payment incentives."]

[Request #S09-19-3809]

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HEALTH INSURANCE

“What Does It Cost Physician Practices To Interact With Health Insurance Plans?” By Lawrence P. Casalino and others. IN: *Health Affairs*, vol. 28, no. 4 (May 14, 2009) pp.533-543

Full text at: <http://content.healthaffairs.org/cgi/reprint/hlthaff.28.4.w533v1>

["Physicians have long expressed dissatisfaction with the time they and their staffs spend interacting with health plans. However, little information exists about the extent of these interactions. We conducted a national survey on this subject of physicians and practice administrators. Physicians reported spending three hours weekly interacting with plans; nursing and clerical staff spent much larger amounts of time. When time is converted to dollars, we estimate that the national time cost to practices of interactions with plans is at least \$23 billion to \$31 billion each year."]

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“Peering Into The Black Box: Billing And Insurance Activities In A Medical Group.” By Julie Ann Sakowski and others. IN: **Health Affairs**, vol. 28, no. 4 (May 14, 2009) pp. 544-554.

Full text at: <http://content.healthaffairs.org/cgi/content/full/hlthaff.28.4.w544/DC1>

["Billing and insurance-related functions have been reported to consume 14 percent of medical group revenue, but little is known about the costs associated with performing specific activities. This study expands understanding of billing and insurance-related costs by describing and quantifying activities performed at a multispecialty medical group. Key findings in this report include: 1) Thirty-eight percent of nonclinical personnel performed tasks related to collecting payment; 2) Physicians spent an average of 35 minutes per day on billing and insurance activities; other clinical staff spent 38 minutes per day on such activities; and 3) The cost of billing and insurance amounted to \$85,276 per FTE physician. Standardizing benefit plans and billing procedures could reduce the complexity and costs of billing and insurance tasks for medical groups."]

[Request #S09-19-3718]

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More Bang for the Health Care Buck: How an Efficiency Standard for Health Insurers Can Reduce Overhead and Deliver More Patient Care. By Siena Kaplan, Frontier Group, and Michael Russo, CALPIRG Education Fund. (The Fund, Sacramento, California) May 2009. 25 p.

Full text at: <http://www.calpirg.org/uploads/Ci/Vf/CiVfq6kB7GPEzaNKIvO-GQ/More-Bang-for-the-Health-Care-Buck.pdf>

["The money that insurance companies spend on inefficient administration, billing and marketing -- instead of medical care for their enrollees -- contributes to the high health care costs Californians must endure. To encourage efficiency and get costs under control, California should require health plans and insurers to spend at least 85 percent of revenue on health care. The majority of California health plans, including small, large, non-profit and for-profit HMOs, already meet this efficiency standard, as do a large percentage of health plans and insurers across the country."]

[Request #S09-19-3821]

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Limiting the Tax Exclusion for Employer Sponsored Insurance Can Help Pay for Health Reform: Universal Coverage May Be Out of Reach Otherwise. By Paul N. Van de Water, Center on Budget and Policy Priorities (The Center, Washington, DC) 2009. 10 p.

Full text at: <http://www.cbpp.org/files/6-2-09health.pdf>

["Limiting the tax exclusion for employer-sponsored health insurance could provide significant revenues for health reform.... Limiting the tax exclusion deserves serious consideration for several reasons. First, the exclusion is poorly designed, providing the greatest benefit to those with the highest income. Second, the exclusion makes the problem of high and rising health care costs somewhat worse, encouraging employers and individuals to purchase costlier coverage than they otherwise would. Third, and perhaps most important, the White House has announced that it will insist that health reform legislation be fully paid for. Congress will likely find it difficult to meet this objective unless the bill includes a cap on the exclusion as a significant source of financing."]
[Request #S09-19-3815]

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Capping the Health Insurance Tax Exclusion: The Consequences Vary Greatly across States and Regions. By Elise Gould, Economic Policy Institute. (The Institute, Washington, DC) June 11, 2009. 10 p.

Full text at: http://epi.3cdn.net/6ebf892f25e8ff210a_4nm6bnzfd.pdf

["Under current law, employer contributions to health insurance premiums are excluded, without limit, from workers' taxable income. Capping the tax exclusion would alter the market for employer-sponsored health insurance.... Previous research finds that taxing expensive health coverage heavily burdens two groups: workers in small firms, and workers in employer pools with higher health risks, such as firms with a high share of older workers. What has yet to be examined is how cross-state variations in health costs change the likelihood of being directly affected by a tax cap. While some research has looked at regional variation in health insurance premiums and health care costs, even less research has examined regional variation in the share of the enrollee population likely to be affected by a cap in the employer exclusion."]
[Request #S09-19-3811]

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**Fork in the Road: Alternative Paths to a High Performance U.S. Health System.
By Cathy Schoen and others, The Commonwealth Fund. (The Fund, New York,
New York) June 2009. 58 p.**

Full text at: [Fork in the Road](#)

["This report analyzes alternative paths to reform and presents estimates of impacts on health spending. The approaches include: 1) a public health plan paying providers at Medicare rates, offered alongside private plans in a national health insurance exchange; 2) a public plan paying providers at rates set midway between Medicare and private plan rates, offered alongside private plans in an insurance exchange; and 3) no public plan, with only private plans offered to employers and individuals through an insurance exchange. All three approaches, if combined with Medicare payment and system reform, would produce substantial savings over time, but option 1 would yield the most -- \$3.0 trillion in cumulative health system savings over 2010 to 2020, compared with \$2.0 trillion (option 2) and \$1.2 trillion (option 3)."]

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**Finding Resources for Health Reform and Bending the Health Care Cost Curve.
By Rachel Nuzum and others, The Commonwealth Fund. (The Fund, New York,
New York) June 2009. 44 p.**

Full text at: [Finding Resources for Health Reform](#)

["Comprehensive reform will likely require an investment of \$1 trillion or more over the 2010–19 period to achieve coverage for all and implement critical system reforms. This report examines policy options that could slow growth in health spending, improve health outcomes, and provide additional revenues to finance comprehensive reform. It also illustrates how widely estimates of policy options can vary based on underlying assumptions. The rich menu of options presented here, along with impact estimates, should help policy leaders identify the resources required to make health coverage for all and improved health system performance a reality."]

[Request #S09-19-3827]

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Health Reform: Delivering for Those Who Deliver Health Care. By Robert A. Berenson, Urban Institute, and Ellen-Marie Whelan, Center for American Progress. (The Center, Washington, DC) April 2009. 13 p.

Full text at:

http://www.americanprogressaction.org/issues/2009/04/pdf/health_reform_providers.pdf

["In recent rounds of efforts to achieve substantial health care reforms, health professionals have been largely relegated to commenting on important but ultimately peripheral issues, while lawmakers, insurance and pharmaceutical companies, and patients' groups took center stage in proposing and opposing insurance coverage expansion and restructuring of health care delivery. This time it is clear that the interests of clinicians to best serve their patients are aligned with the American public's desire for a health care system that works, and that both of these goals can only be met through health reform that no longer accepts the unacceptable status quo. Today's evolving consensus on health reform targets precisely the issues that have frustrated clinicians and hampered their ability to do their jobs."]

[Request #S09-19-3710]

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Crossing Our Lines: Working Together to Reform the U.S. Health System. By Howard Baker, Tom Daschle and Bob Dole, The Leadership Project. (Bipartisan Policy Center, Washington, DC) June 2009. 68 p.

Full text at: <http://www.bpcleadersproject.org/>

["Former Senate majority leaders are promoting a healthcare overhaul plan aimed at bridging differences between the two political parties and overcoming objections by doctors, hospitals, and insurers.... The plan would tax some employer-provided health insurance premiums, require individuals and large employers to buy health insurance, and create public insurance pools run by states instead of the federal government.... In a bid to blunt Republican opposition to setting up a government-run insurance plan for those without coverage, Dole, Baker, and Daschle suggest giving states, instead of the federal government, the option of establishing insurance-purchasing pools. These pools would extend coverage to everyone regardless of their health status or ability to pay, Daschle said." Boston Globe (June 18, 2009) 1.]

[Request #S09-19-3808]

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**When Coverage Fails: Causes and Remedies for Inadequate Health Insurance.
By Katherine Howitt, Community Catalyst. (Community Catalyst, Boston,
Massachusetts) April 2009. 16 p.**

Full text at: <http://www.communitycatalyst.org/assets/pdfs/WhenCoverageFails.pdf>

["Government must guarantee that people who buy insurance can access and afford the health care they need.... Government must also avoid 'cheap' plans with hidden costs, such as permitting 'limited-benefit plans' or providing incentives to purchase high deductible plans. If limited-benefit plans are the only politically feasible option for expanding coverage, government should guarantee strong consumer protections, such as limits on out-of-pocket spending. Only by taking such a conscious and deliberate approach can we begin to control the parallel trends of uninsurance and underinsurance.]

[Request #S09-19-3714]

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**Health Reform: The Cost of Failure. By John Holahan and others, Urban
Institute Health Policy Research Center. (The Institute, Washington, DC) May
21, 2009. 28 p.**

Full text at: http://www.urban.org/UploadedPDF/411887_cost_of_failure.pdf

["A key question that many have been asking in recent weeks is whether the nation can afford health reform given the very large economic problems that the U.S. currently faces. But we argue that we should also be asking whether we can afford not to enact comprehensive health reform.... Under a range of economic scenarios, the analysis shows an increasing strain on business owners and their employees over the next decade if reform is not enacted. There would be a dramatic decline in numbers of people insured through their employers, and millions more would become uninsured. There would be large growth in enrollment in public programs, major increases in health care spending and growing levels of uncompensated care. While all income levels would be affected, middle-class working families would be hardest hit."]

[Request #S09-19-3778]

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What Matters Most: Californians' Priorities for Healthcare Coverage. By the Center for Healthcare Decisions. (The Center, Rancho Cordova, California) May 2009. 32 p.

Full text at: http://www.chcd.org/whatmattersmost/docs/wmm_report.pdf

["When it comes to healthcare benefits, Californians do not expect insurance to pay for everything. But they are very clear about the medical problems that matter most for coverage.... There is strong agreement among Californians that insurance coverage is most important for saving lives, preventing illness and restoring or maintaining basic activities of living.... Certain situations -- such as those regarding obesity and substance abuse -- elicit intense debate, reflecting differing views about illness and the obligations of health insurance.... Self-esteem, happiness, good mental health and individual achievement are goals that some view as high priority for coverage. Others regard them as intangible, without boundaries and not the purpose of health insurance. This topic divides discussion group members more than any other."]

[Request #S09-19-3816]

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Front and Center: Ensuring that Health Reform Puts People First. By Karen Davis and others, The Commonwealth Fund. (The Fund, New York, New York) June 2009. 40 p.

Full text at: <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Jun/Front-and-Center.aspx>

["This report focuses on those who would benefit from health reforms, including the estimated 116 million working-age adults -- two-thirds of all adults -- who report that they are uninsured or underinsured, have medical bill or debt problems, or experience difficulties obtaining needed care. A national health insurance exchange with competing private plans and a new public plan has the potential to provide greater choices, better benefits, and more affordable premiums. If coupled with broad system reforms, the average family could save \$2,314 a year by 2020, as the annual increase in health costs slowed from 6.7 percent to 5.5 percent. Cumulative national savings over the period 2010 to 2020 would be \$3 trillion, compared with projected trends."]

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INFORMATION TECHNOLOGY

"Clinical Information Technologies and Inpatient Outcomes: A Multiple Hospital Study." By Ruben Amarasingham and others. IN: Archives of Internal Medicine, vol. 169, no. 2 (January 26, 2009) pp. 108-114.

Full text at: <http://archinte.ama-assn.org/cgi/content/abstract/169/2/108>

["Health information technology is a viable solution to improve health care quality, enhance communication, and reduce costs and waste in the system. Research has shown such benefits, but few studies have examined multiple hospitals to gauge the effect of clinical information systems in inpatient settings. Focusing on a diverse group of Texas hospitals, this study examined the association between a hospital's use of automation -- specifically notes and records, test results, order entry, and decision support -- and inpatient mortality, complications, costs, and length of stay for four medical conditions."]

[Request #S09-19-3424]

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The Social Life of Health Information. By Susannah Fox and Sydney Jones, Digital Strategy. (Pew Internet and American Life Project, Washington, DC) June 2009. 72 p.

Full text at:

http://www.pewinternet.org/~media/Files/Reports/2009/PIP_Health_2009.pdf

["Now, 74% of American adults go online, 57% of American households have broadband connections, and 61% of adults look online for health information. We use the term 'e-patient' to describe this group. American adults continue to turn to traditional sources of health information, even as many of them deepen their engagement with the online world.... Online health inquiries have an impact on decisions or actions and there are clearly more positive experiences than negative ones.... Internet users report a surge of interest in information about exercise and fitness.... Change is coming, whether through the spread of wireless devices or generational shifts."]

[Request #S09-19-3817]

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MENTAL HEALTH

"Beyond Parity: Primary Care Physicians' Perspectives on Access to Mental Health Care." By Peter J. Cunningham. IN: *Health Affairs*, vol. 28, no. 3 (April 14, 2009) pp. 490-501.

Full text at: <http://content.healthaffairs.org/cgi/reprint/28/3/w490>

["About two-thirds of primary care physicians (PCPs) reported in 2004–05 that they could not get outpatient mental health services for patients --a rate that was twice as high as that for other services. Shortages of mental health care providers, health plan barriers, and lack of coverage or inadequate coverage were all cited by PCPs as important barriers to mental health care access. The probability of having mental health access problems for patients varied by physician practice, health system, and policy factors. The results suggest that implementing mental health parity nationally will reduce some but not all of the barriers to mental health care."]

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OBESITY

"Complex Systems Modeling for Obesity Research." By Ross A. Hammond. IN: *Preventing Chronic Disease*, vol. 6, no. 3 (July 2009) pp. 1-10.

Full text at: http://www.cdc.gov/pcd/issues/2009/jul/pdf/09_0017.pdf

["The scope and scale of the obesity epidemic motivate an urgent need for well-crafted policy interventions to prevent further spread and (potentially) to reverse the epidemic. Yet several attributes of the epidemic make it an especially challenging problem both to study and to combat. This article shows that these attributes -- the great breadth in levels of scale involved, the substantial diversity of relevant actors, and the multiplicity of mechanisms implicated -- are characteristic of a complex adaptive system. It argues that the obesity epidemic is driven by such a system and that lessons and techniques from the field of complexity science can help inform both scientific study of obesity and effective policies to combat obesity. The article gives an overview of modeling techniques especially well suited to study the rich and complex dynamics of obesity and to inform policy design."]

[Request #S09-19-3825]

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VETERANS

"Dual Use of Veterans Health Administration and Indian Health Service: Healthcare Provider and Patient Perspectives." By Josea Kramer and others. IN: Journal of General Internal Medicine, vol. 24, no. 6 (April 2009) pp. 758-764.

Full text at: <http://www.springerlink.com/content/1608n6351jt686q3/fulltext.pdf>

["Many American Indian and Alaska Native veterans are eligible for healthcare from the Veterans Health Administration (VHA) and from the Indian Health Service (IHS). These organizations executed a Memorandum of Understanding in 2003 to share resources but little was known about how they collaborated to deliver healthcare. The researchers sought to describe dual use from the stakeholders' perspectives, including incentives that encourage cross-use, which organization's primary care is 'primary,' and the potential problems and opportunities for care coordination across VHA and IHS. The authors of this study learned that fostering closer alignment between VHA and IHS would reduce care fragmentation and improve accountability for patient care."]

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WOMEN

Putting Women's Health Care Disparities On The Map: Examining Racial and Ethnic Disparities at the State Level. By Cara V. James, Henry J. Kaiser Family Foundation, and others. (The Foundation, Menlo Park, California) June 2009.

["Nationally, one-third of women self-identify as a member of a racial or ethnic minority group and it is estimated that this share will increase to more than half by 2045. The distribution of the population of women of color varies substantially by state.... Women of color fared worse than White women across a broad range of measures in almost every state, and in some states these disparities were quite stark. Some of the largest disparities were in the rates of new AIDS cases, late or no prenatal care, no insurance coverage, and lack of a high school diploma. Each racial and ethnic group faced its own particular set of health and health care challenges.... In much of the West, including Utah, Washington, Hawaii, Oregon, Colorado, Arizona, and California, disparities were lower than the national average."]

[Request #S09-19-3820]

Report. 112 p.

<http://www.kff.org/minorityhealth/7886.cfm>

Executive Summary. 8 p.

<http://www.kff.org/minorityhealth/upload/7886ES.pdf>

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