

Children's Health Issue

CaliforniaHealth

REPORT

Summer 2013

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Poor Kids
Shut Out of
Costly Care

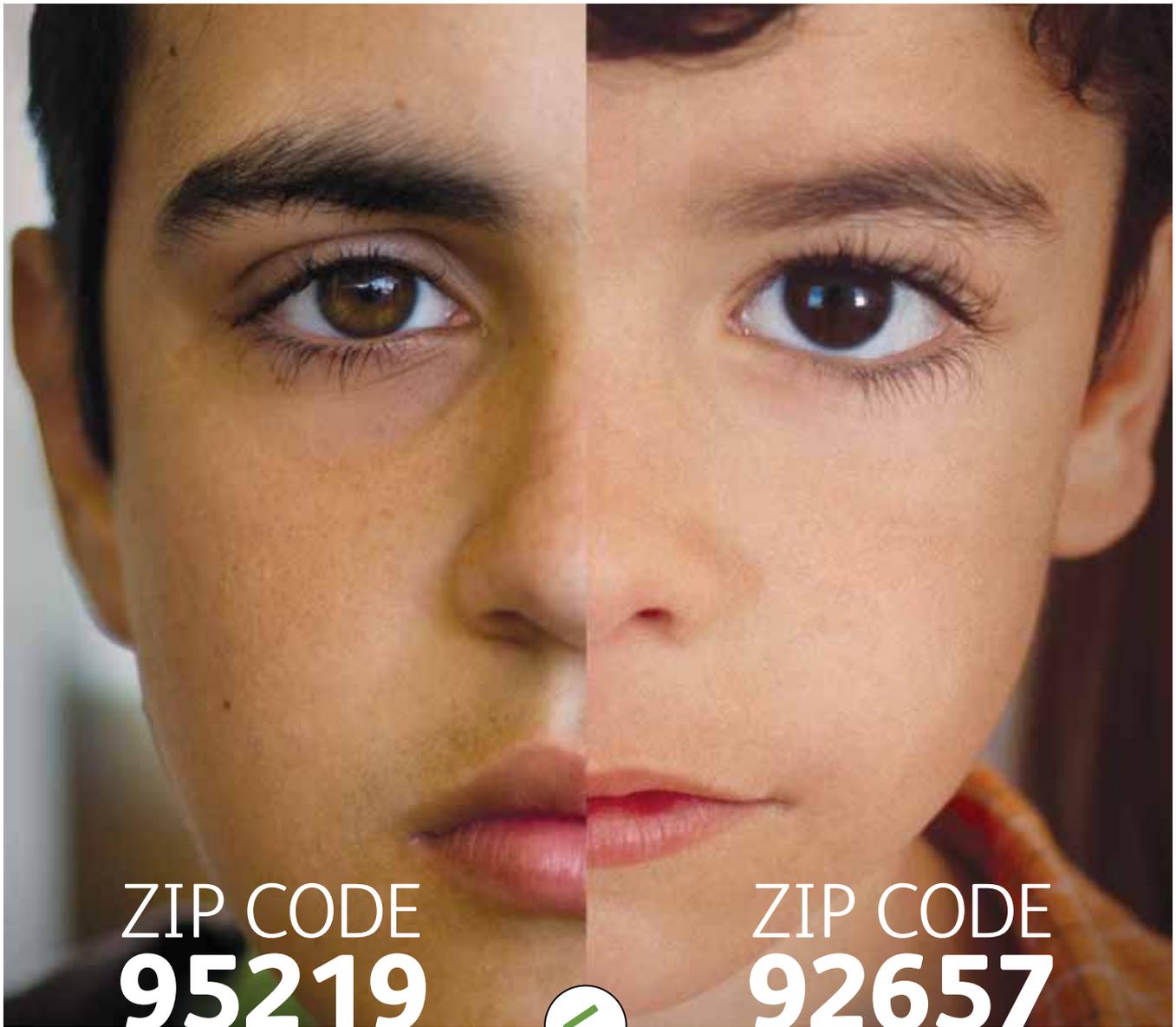
Latino
Diversity &
Public Health

Are Schools
Failing
Disabled
Students?



COMMUNITY HEALER

Jennifer Rodriguez



ZIP CODE
95219

Life Expectancy

73

ZIP CODE
92657

Life Expectancy

88



Your **ZIP code** shouldn't predict how long you'll live – but it does. Staying healthy requires much more than doctors and diets. Every day, our surroundings and activities affect how long – and how well – we'll live.



6

INEQUALITY

Poor Houses

Farmworkers come to the U.S. for a better life. Many don't find what they expected.

BY ROSA RAMIREZ

12

REFORM

The Invincibles

Health care reform depends on a pool of healthy people signing up for insurance. Will young adults buy into the system?

BY CALLIE SHANAFELT

30

VIOLENCE

Dangerous Complications

Battered women may face heightened abuse during pregnancy. New screenings required by the ACA aim to end the violence.

BY HANNAH GUZIK

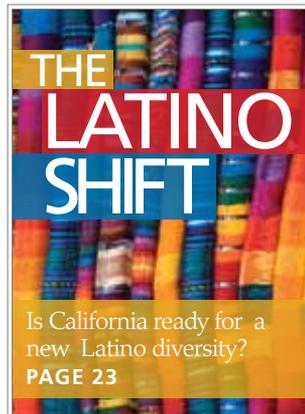
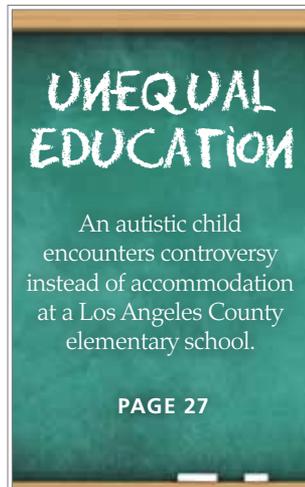
35

Q & A

Ted Lempert

Our editor in chief talks to the president of Children Now about the state of California's children.

BY DANIEL WEINTRAUB



DEPARTMENTS

- 4 **FOOD** • School district aims to fill the summer nutrition gap by bringing healthy choices to kids.
- 4 **REFORM** • Churches help boost enrollment in state-funded health insurance program.
- 5 **HEALTH CARE** • Pediatric specialists are hard to come by in California.
- 6 **POVERTY** • The state's farmworkers face deplorable housing and living conditions.
- 7 **CLINICS** • Women's clinics want to attract a new group of patients — those newly insured under ACA.
- 8 **PARKS** • The city of Coachella, which sprawled during the housing boom, aims for better land use.
- 9 **VIOLENCE** • After Steubenville, athletic coaches train their teams in respect.
- 10 **AGING** • The American Psychiatric Association expands the diagnosis of depression in the newly bereaved.
- 14 **COMMUNITY HEALER** • Jennifer Rodriguez of the Youth Law Center wants a better life for foster kids.
- 32 **DISPARITIES** • Bringing down hypertension risk with a program tailored to African Americans.
- 36 **SACRAMENTO FOCUS** • California is a state of extremes, especially when it comes to income equality.

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LETTER FROM THE EDITOR

California's Children

PUBLIC POLICY AFFECTS ALL of our daily lives, but vulnerable populations feel the consequences of policy most acutely. In this issue of the *California Health Report*, focused on children's health, we take a look at how policy is affecting the most vulnerable people in our community—children who live with economic disadvantages and special educational or medical needs and children without parents who live in the foster care system.



Federal law requires that mental health be covered no differently than treatment for physical ailments. But fulfilling that requirement is being left to the states, and California has taken a contradictory position on what constitutes equal care for some children. The state mandates that private insurance companies provide an intensive and expensive therapy, called applied behavior analysis, which can dramatically improve the functioning of some children with autism. But the state also exempted itself from the requirement to pay for the expensive treatment for children on Medi-Cal. We examine the painful consequences of that decision for low income-

children with autism who depend on the state for medical coverage.

Also in this issue, Robin Urevich looks at how children with special needs are accommodated at public schools. She investigates an incident at a Los Angeles County school, where accommodations for an autistic boy fueled a controversy among parents, who saw him as a danger to their children. And Hannah Guzik examines how the increasing diversity among Latinos will impact public health in California, where half of the child population is Latino. Is the state ready for the next generation of Latino children – a growing number of whom are indigenous and don't speak English or Spanish?

Jennifer Rodriguez, an advocate for foster children, is this issue's community healer. Rodriguez, who grew up in the foster care system, became a lawyer in order to help children who have to grow up with the state as a parent. She's advancing her cause and changing lives as the executive director of the Youth Law Center, an organization that advocates for young people in the foster care and juvenile justice systems. The state can build better facilities for youth, Rodriguez says, but cannot provide the one thing children need the most—love.

You'll also find stories about young people and the Affordable Care Act, a women's clinic and health-care reform, dangerous housing conditions for farmworkers and more.

Like what you see inside? Come over to our website at HealthyCal.org for many more thoughtful articles connecting the Capitol, the community and the places in between.

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Managing Editor, *California Health Report*

CaliforniaHealth

REPORT

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HealthyCal.org is an independent, non-profit journalism project covering health and health policy in California, led by veteran journalist Daniel Weintraub.



CALIFORNIA HEALTH REPORT

Filling the Summer Nutrition Gap

BY LILY DAYTON

FOR SOME KIDS, THE end of the school year means summer camp, family vacations and backyard barbecues. For others, the end of the school year means hunger.

"Many parents don't have enough money for healthy food, or they leave for work very early in the morning so it's difficult to feed their kids," says Gloria Arizaga, who has been serving meals to children in the North Monterey County Unified School District (NMCUSD) for 30 years.

More than half of the kids in California receive free or reduced-cost lunch at school—yet the majority of these low-income kids don't receive federally funded meals during the summer.



To find summer meal sites, call 1-866-3-Hungry or 1-877-8-Hambre.

More than 84 percent of those who benefited from school lunch programs in 2011—more than 2 million children—did not use summer lunch programs.

Now schools and community organizations are coming together to make sure summer lunch reaches kids in need, even if they aren't in summer school.

Last summer was the first time NMCUSD partnered with local parks and recreation centers to help feed the community's children.



The rec center lies within blocks of Castroville Elementary School, where over 80 percent of students

qualify for free or reduced-cost lunch.

"We figured if we're going to do summer school,

why not take on more?" says Kathleen Cleary, child nutrition supervisor for NMCUSD.

Arizaga is one of the servers on the catering truck used to deliver food to local parks and low-income housing areas. At first, she wasn't sure what the community's response would be. But once word got out, neighborhood kids came running to meet the truck.

"They love that we offer them fruits and vegetables, and healthy food they don't normally eat," says Arizaga. "The part of my job I value most is *la sonrisa de mis niños*—the smile on my kids' faces." **CHR**

Churches Connect the Needy to Care

By the time national health-care reform takes effect next year, Los Angeles County health officials expect to enroll 300,000 people in an expanded Medi-Cal program called Healthy Way LA.

But some estimates put the number of people eligible for the low-income insurance coverage countywide at more than half a million.

To help increase enrollment, a coalition of churches, synagogues and nonprofits has launched an enrollment drive that invites people to sign up at the neighborhood church.

Healthy Way LA provides free primary and specialty care, mental

health services, chronic disease management, medication and emergency treatment.

Enrollment is open to citizens or permanent legal residents between the ages of 19 and 64 who earn less than 133 percent of the federal poverty benchmark. That's about \$15,200 for an individ-

ual and \$31,300 for a family of four.

Lambreni Waddell, who organizes OneLA's church recruitment events, says that working through relationships in a congregation makes it easier to educate the public about the program.

"Our strategy is actually going to the people who are

not yet at the point of needing health-care coverage," she said. "It's meeting them when they're healthy, when they're bringing their kids to confirmation class, and saying, 'Hey, why not begin now learning what your options are? Let's get you connected now.'"

— By Chris Richard



Peds Subspecialists Scarce in California

BY ROSA RAMIREZ

CALIFORNIA HAS JUST ONE subspecialty pediatrician for every 5,464 children, making it difficult for children with special needs to see an endocrinologist, cardiologist or other medical specialist.

California's ratio is strikingly low in comparison to other states—in fact, it rates last in the country. California's kids experience more problems obtaining subspecialized pediatric care than children in any other state, a new UCLA Center for Health Policy Research study has found.

The study, "Assuring Children's Access to Pediatric Subspecialty Care in California,"* found persistent disparities to pediatric subspecialty care by type of insurance coverage, geographic location, language spoken at home and race and ethnicity.



SOME KEY FINDINGS:

- Children with Medi-Cal coverage often are subjected to longer waiting times to see a subspecialist because of the unwillingness of providers to participate in such programs due to low payments, excessive paperwork and payment delays.
- Uninsured children with special care needs in the state are four times more likely to have unmet health-care needs.
- Most pediatric subspecialty care is provided at large academic centers typically found in metropolitan areas, leaving many children residing outside such geographic regions with access hurdles.
- Lack of diversity in the pediatric subspecialty workforce, including those who can communicate with limited-English patients and their families, can also decrease access to

subspecialty pediatric care. The majority (64 percent) of children with special care needs are youngsters of color.

For some of these children, the consequences of such barriers can result in delayed medical care, which ultimately translates to less healthy children and higher medical costs.

The costs of training as a pediatric subspecialist can be daunting and may prevent people from entering the field.

"It has become very difficult to get the training, stay in school for so long, then come out making less money than other specialties," says Daphna Gans, lead author of the study. "That will continue to jeopardize children's access to the critical health-care services."

*The study was funded by the Lucile Packard Foundation, which is also a funder of the California Health Report. **CHR**

CURES for Abuse

In October of 2003, Jimena Barreto lost control of her Mercedes and killed Bob Pack's 10-year-old son, Troy, and 7-year-old daughter, Alana. Barreto was under the influence of alcohol and prescription painkillers. She had been "doctor shopping," going from one physician to another to get multiple prescriptions for the drugs she craved.

Pack wondered why there was no system in place to monitor such actions. He later learned that the state of California does have a Prescription

Drug Monitoring Program, the Controlled Substance Utilization Review and Evaluation System (CURES). Pack also learned that CURES is both technologically inadequate and critically underfunded.

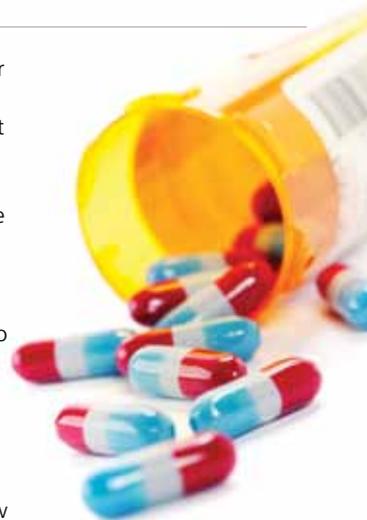
However, those shortcomings may soon be a thing of the past. State Senator Mark DeSaulnier (D-Concord) has introduced Senate Bill 809, which proposes funding measures to upgrade, operate and enforce the CURES program.

The way CURES is supposed to operate is straightforward.

Pharmacists are required to enter into the CURES database the Schedule II through IV drugs that they've dispensed. Pharmacists, physicians who prescribe these drugs and law enforcement have access to the database. The purpose is two-fold: keep an eye out for patients who are doctor shopping, as well as doctors who are over-prescribing potentially addictive pills.

DeSaulnier's proposed law promises to upgrade, fund and enforce the CURES program.

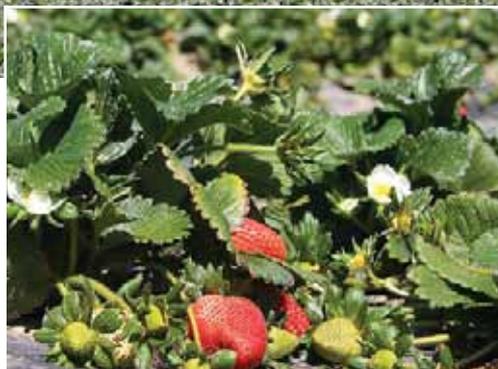
Pack is optimistic that the law will pass and allow CURES to more effectively track patients who doctor shop and physicians running pill mills.



"They're equally bad," Pack says. "They really go hand in hand." — *By Robert Fulton*

Farmworkers Face Deplorable Housing

Searching for a better life, but poverty hard to escape



BY ROSA RAMIREZ

THE ENTICING STORIES THAT Dario Gutierrez, a native of Mexico City, would hear before arriving in Oxnard two years ago prompted him to make the dangerous trek to the United States illegally. People here, he recalls hearing, earn enough to live comfortably.

“Dicen que aquí se barre el dinero en la calle.” (They say here, people can sweep money off the streets.)

For generations, the saying has prompted flows of people from Mexico and other parts of Latin America to migrate north for work in California’s bountiful agriculture industry.

They hope for upward mobility. But the reality for many toiling in the \$44.3 billion industry is different. Poor

pay, which characterizes the farmworker labor force, has left many struggling to find adequate and safe housing.

“A lot of the families and farmworkers who come into the valley live in deplorable housing conditions,” says Nadia Villagran, director of operations and communications with the Coachella Valley Housing Coalition.

So far, Gutierrez has found that the nearly \$8 per hour he earns picking strawberries hardly provides him enough for the room he rents, which he shares with another farmworker.

The Central Valley, a 450-mile stretch of incredibly fertile and agriculturally rich land, is home to the largest number of the state’s farmworkers, of which the great majority are Hispanic immigrants. Their housing needs are vast.

In poorer rural parts of Riverside County, illegal mobile parks without running water, sewage systems or electricity have become permanent and temporary homes for other farm laborers and their families.

In Ventura County, one of the leading citrus-producing

areas, farmworkers must often pool their resources to rent an apartment. The average apartment is more than \$18,000 per year, but the median annual household income for farmworkers is \$22,000.

While farmworkers in general experience poor housing arrangements, seasonal workers are more prone to dangerous conditions.

In Mecca, a small farming community 140 miles east of Los Angeles, farmworkers flood the area each spring to pick table grapes, bell peppers, watermelons and dates.

Years ago, two large empty

lots near Mecca's largest food stores became a campground. Lacking affordable housing options, seasonal agricultural laborers slept inside their cars or under trees. Teenagers and men would bathe with dirty canal water.

Recently, Mecca began addressing the situation.



DID YOU KNOW?

23% of U.S. farmworkers have total family incomes below the poverty line.

SOURCE: NCFH

Maria Machuca, a member of the Mecca Community Council, says housing initiatives, including a mobile home park and several apartments with a designated number of units set aside for farmworkers, have alleviated the housing needs for some, especially those who have families and can prove they are in the country legally.

Other regions are making strides too.

Marin County, one of the state's most expensive housing markets, recently partnered with a local foundation to provide housing for low-income farmworkers in the west part of the county, says Dan Schurman, director of business development with Ag Innovations Network. And some regions of Napa and Sonoma counties have created private or county-run housing for seasonal migrant workers.

"Is it enough?" asks Machuca, a daughter of farmworkers. She answers her own question: "No, it's not enough." **CHR**

Women's Clinics Eye Reforms

ACA could mean more insured patients

BY LEAH BARTOS

AS MILLIONS OF CALIFORNIANS are projected to gain health coverage over the next several years, the independent clinics that have traditionally served the uninsured will be facing new challenges. Soon, many more low-income patients are expected to have private insurance, following the rollout of the Affordable Care Act's signature reforms in 2014.

That's putting some clinics, like those in the Women's Health Specialists network, in a quandary. They want to be a part of the system that's creating a boon of paying patients—but in a way that allows them to hold on to their guiding principles.

In 1975, the first of the clinics, then called the Feminist Women's Health Center, opened in Chico. It was only a couple of years after the landmark *Roe v. Wade* decision, and abortion services were hard to come by. The health center filled the void.

Women's Health Specialists now operates half a dozen clinics across Northern California—and for four decades, they've done so essentially off the insurance grid, offering services ranging from sexually transmitted disease screenings to mammograms to abortions on a sliding fee scale.

While the clinics have always accepted private insurance, by and large they've been surviving on Medi-Cal and other public funding programs. Now, with changes



coming under the Affordable Care Act, independent clinics across California have the opportunity to join the third-party payer system.

Shauna Heckert, executive director of Women's Health Specialists, is fighting for the clinics to be integrated into the new health insurance scheme, as potential subcontractors in existing managed care networks.

Ideally, Heckert said, abortion and birth control would operate as a carve-out service—one where patients would not need pre-authorization from their primary-care physician.

Julie Rabinovitz, president and CEO of the California Family Health Council—an organization dedicated to promoting access to sexual and reproductive health care—says that for clinics like Women's Health Specialists, collaborating with private insurance companies will become imperative.

"For health centers to

remain viable and succeed in the future, they're going to have to," says Rabinovitz. She says the clinics can expect to see many of their currently uninsured patients become covered in the near future, which may mean that they can get their services from other providers.

Challenges for the potential collaboration with insurance companies will be more ideological than logistical in nature—in particular, navigating the politics of abortion.

Rabinovitz worries that the stigma of abortion may mean that clinics providing the procedure will be excluded from networked care after reform.

But Heckert isn't discouraged by challenges. To her, this only proves the need for the specialists to continue to specialize, and to continue to provide women with the services they need that primary-care doctors may not offer. **CHR**

Coachella Plans for Parks

For city residents, a place to play



Coachella's mayor, Eduardo Garcia, wants more parks for the city.

BY SUZANNE POTTER

NINETEEN-YEAR-OLD MARK GUERRERO OF Coachella is practicing soccer with his friends at 3 p.m. on a blustery Tuesday afternoon—because on nights and weekends the fields are overflowing with school-age players and their families. There simply aren't enough parks in Coachella. But Guerrero has been playing soccer for years and credits it with keeping him on the right track. "Without a place like this to play, I probably would have been out in the streets with the gang-bangers," he says. Instead, Guerrero finished high

school and now works at a pet store.

Stories like that warm the heart of Coachella's mayor, Eduardo Garcia, who fought to build the brand-new Rancho Las Flores Soccer Park, the first park to be built in the city since 1974.

Coachella added about 4,000 new homes over the past 20 years, but failed to require developers to set aside green space or make sure the gated communities have connectivity between the neighborhoods and local parks and schools. "The economy was moving fast—it was kind of build, build, build," Garcia explains. "No one took a step back to try to think forward, to say what

amenities are the people who live in these communities going to need?"

This summer, Coachella stands to become the first city in the Coachella Valley to adopt a new general plan that has been rewritten with health issues in mind. It's a preventative approach primarily designed to encourage more physical activity. That translates into more parks, sidewalks, hiking trails and bike lanes that are well lit and safe.

"We are programming the DNA of the city," says Garcia, "to actually motivate people to live healthier because of the way the city is planned and the things that are available." **CHR**

Seniors Trade Time

Asking for help is often hard for seniors, but it's getting easier thanks to an innovative web-based program under way in Santa Cruz. Members of the program, called TimeBank Santa Cruz, trade time and skills with other seniors.

While sharing their talents, members knit together a community, building support networks and friendships.

TimeBank Santa Cruz has 95 members who have exchanged more than 2,250 hours, says Bonnie Linden, strategic director of the organization, which debuted in February 2012. There are lots of seniors involved, probably because many of them have the time, she adds.

Every hour of help, from acupuncture sessions to gardening, is valued equally and recorded. Each time-bank hour can be redeemed for an hour of service from any other member. A member can prepare a meal for someone and get computer help in return, or give a music lesson and get a ride to the airport.

"I think it has tremendous potential for seniors," says TimeBank Santa Cruz member Jim Walt. "I like the idea of leveling the economic playing field with time."

— By Lynn Graebner



Stopping Another Steubenville

Coaches give lessons in respect

BY GENEVIEVE
BOOKWALTER

THE STORY MADE NATIONAL headlines: Two star athletes at Steubenville High (Ohio) were convicted of raping a 16-year-old classmate while she was drunk. One was found guilty of sending photos of her, nude, to friends with his cell phone. Some saw the crime and wrote about it on Twitter. No one stopped it.

But one football program took action. The football players at Mesa Verde High in Citrus Heights are participants in Coaching Boys into Men, a program that encourages high school athletes to develop healthy relationships and better respect themselves, their friends, girls and women. So after news of the horrific rape



DID YOU KNOW?

Half of women who have been raped were victimized before age 18.

SOURCE: NISVS 2013

broke, coach Ron Barney challenged his players. Their coach wanted to know: What did they think of the case?

"What if something like that were to happen at our school? How would that make you feel? What kind of steps are we taking to make sure this doesn't happen?" asked Barney, the high school's head football coach and athletic director for San Juan Unified School District.



The conversation quickly steered toward ways the students could monitor themselves and each other to prevent a similar situation from happening in Citrus Heights. "That right there is a really good indicator," Barney says. "I like the way they responded."

Coaching Boys into Men began in 2001 as a part of Futures Without Violence, a San Francisco nonprofit that aims to prevent the abuse of women and children around the world. The program works with athletic coaches nationwide who talk with their players—on the bus, in the weight room or during practice, among other places—about respect and healthy relationships, especially with the opposite sex.

The organization works actively with about 60 high

schools nationwide on Coaching Boys into Men, and the program continues to grow. Program leaders hope to move into three high schools in San Francisco Unified School District this fall.

Coaching Boys into Men consists of weekly lessons. Barney says he introduces the lessons on Mondays, after players watch film of the

Friday night games.

Barney sees the program's influence spilling into players' personal lives, especially when they use their lessons to motivate better behavior in their peers. "It's as simple as someone stepping up and saying, 'No, Boys to Men, remember?' It happens right on our campus. At lunchtime it happens," he says. **CHR**





Life After Grief

Moving past bereavement

BY KATE MOSER

WHEN BETTY JOHNSON WAS widowed for the second time in her life, after her husband's three-year battle with a rare form of leukemia, she was wracked with grief for a year.

"I knew that feelings can fester," says Johnson, 92, recalling that period in her life. "I knew that I had to get rid of the choking, suffocating feeling, the sickening feeling."

She cried every week that first year during her sessions with a counselor. Throughout her mourning, she says, it was a great help to bare her soul to a trained expert.

A change in the way depression is diagnosed in the bereaved, implemented in May by the American Psychiatric

Association, could have a particular impact on older people.

After a long review process, the APA published its revamped "Diagnostic and Statistical Manual of Mental Disorders," the first major revision in almost 20 years of the guide to psychiatric diagnoses.

Among the controversial changes to the DSM-5, as it is called, is the expansion of the diagnosis of depression in people who are newly bereaved. The new manual removes an exception in earlier editions for patients who lost a loved one in the last two months. Doctors were advised against diagnosing major depression in bereaved patients unless that person's symptoms are severe—if the patient is suicidal, for example.

As Johnson and many others can attest, the grief and depression they experience

after the death of a loved one are real—and treatment can help.

"What I find is that most older adults I see are dealing with bereavement," says Martin Skerritt, a licensed clinical social worker at the Community Hospital of the Monterey Peninsula. Skerritt has specialized in care of older people in his 19 years at CHOMP.

Whether it's the loss of a spouse, a friend or a pet, or of something as fundamental as eyesight, older people tend to battle bereavement more frequently than younger people. Because bereavement historically has been more narrowly defined, underdiagnosis of depression among older people has been a problem.

Depression affects more than 6 million of the more than 40 million Americans over the age of 65, according to the

Geriatric Mental Health Foundation, and experts are making a concerted effort to teach the public that it isn't a normal part of growing old—and that it can be treated.

"Many people, particularly younger but also as we age, see being depressed as a part of aging," Skerritt explains. "It's not."

That misconception sometimes can be worsened at the doctor's office when a patient complains of lack of energy and vague symptoms. Contributing to the problem, the clinician might say, "Well, you're 87 years old."

Not all experts agree that the change to the DSM is good. Although the DSM-5 could help address the problem of underdiagnosis of depression among older people, critics worry that it also could lead to overdiagnosis.



DID YOU KNOW?

Life expectancy in the U.S. is 81 years for women and 76.2 years for men.

SOURCE: NATIONAL VITAL STATISTICS REPORT 2013

"I personally see bereavement as a very normal part of living, and I don't like the idea of making it a medical item, especially for seniors, because they probably are

faced with bereavement more than any other age group," says Sheryl Zika, director of wellness and mental health services at Monterey County's Alliance on Aging.

The biggest problem, Zika adds, would be if the change to the DSM made it more likely an older person being treated for depression in a physician's office would be offered anti-depressant medication, without expanding access to counseling or psychotherapy.

In her 14 years directing the senior peer counseling program at the Alliance on Aging, Zika has seen seniors struggling with both depression and a host of bereavement issues.

"It's not just that their mood is depressed, but that they have all sorts of life issues they have to work out around that. For example, they have lost a spouse of many years—say it's a woman

The Vibrant Brain: A User's Guide

IN AN EYE-OPENING March report, the Alzheimer's Association claimed that one in three adults over 65 will die while suffering from dementia—and Alzheimer's disease is its most common form.

While the answer to reducing the incidence of Alzheimer's and dementia doesn't come in a pill, it's still quite simple.

Keep moving.

Not just physically, but in every part of your life: socially, intellectually and emotionally. Study French. Take a yoga class. Read a self-improvement book. Spend time with your friends. Learn an instrument. Push yourself. Change directions. Grow.

But moving your body is critical. As a single unit, the body and brain function together, so keeping the body in tip-top condition is crucial to brain health, experts say.



Fine-tuning the blood vessels to minimize disorders related to vascular health—diabetes, high cholesterol and high blood pressure—is critical to brain health, says Margaret Gatz, who chairs the department of psychology at the University of Southern California.

Injuries due to falls, especially head trauma, should particularly be avoided, says Dr. George Martin, former head of the University of Washington Alzheimer's Disease Research Center.

"Physical exercise is by far the most important risk-lowering activity, for many reasons," adds Judith Horstman, author of last year's "The Scientific American Healthy Aging Brain." Chief among these reasons, she says, is that heart health is "tightly connected to brain health. What's good for the heart is good for the brain."

— Matt Perry

who hasn't been doing the driving, or hasn't been balancing the checkbook," Zika says. "In peer counseling, we're working with the mood, but we're also working with what gaps are now in the person's life—because just giving them medication might help with the mood, but it's not going to help fill these other gaps in their lives."

Johnson was terribly depressed for about a year, though she was never diagnosed with depression or prescribed anti-depressants. She found a social worker to counsel her, and his support and advice helped her return to life without her husband.

In addition, peer support played a big role in her recovery. She signed up for a

six-week class for widows. The group invited speakers to talk about auto repair, traveling alone, health care and finance—any area with life decisions they'd have to face alone without their spouses. After Johnson graduated from the class, she helped to found a Monterey chapter of the support group Widowed Persons Service. Meeting with other widows was instrumental to her healing process.

The group helped Johnson jump-start her life, enabling her to take risks and live fully, from traveling around the world to falling in love again.

"Starting the group was my biggest accomplishment," she says, "aside from raising my children." **CHR**

The Invincibles

Will the young and healthy buy insurance?

BY CALLIE SHANAFELT

MOST YOUNG PEOPLE HAVE years of good health in their futures—and the optimism of youth. Common wisdom suggests that hopefulness is why they are so unlikely to buy health-care insurance.

The decision to forgo insurance, however, may be motivated by calculated risk-taking rather than blind optimism. “We’re not invincible—no one’s invincible,” says Tamika Butler. It’s not that people of her generation don’t want insurance, Butler explains—it’s that they can’t afford it.

Butler is the California director for the Young Invincibles, an organization created in 2009 by two millennials who advocate for health coverage for their generation.

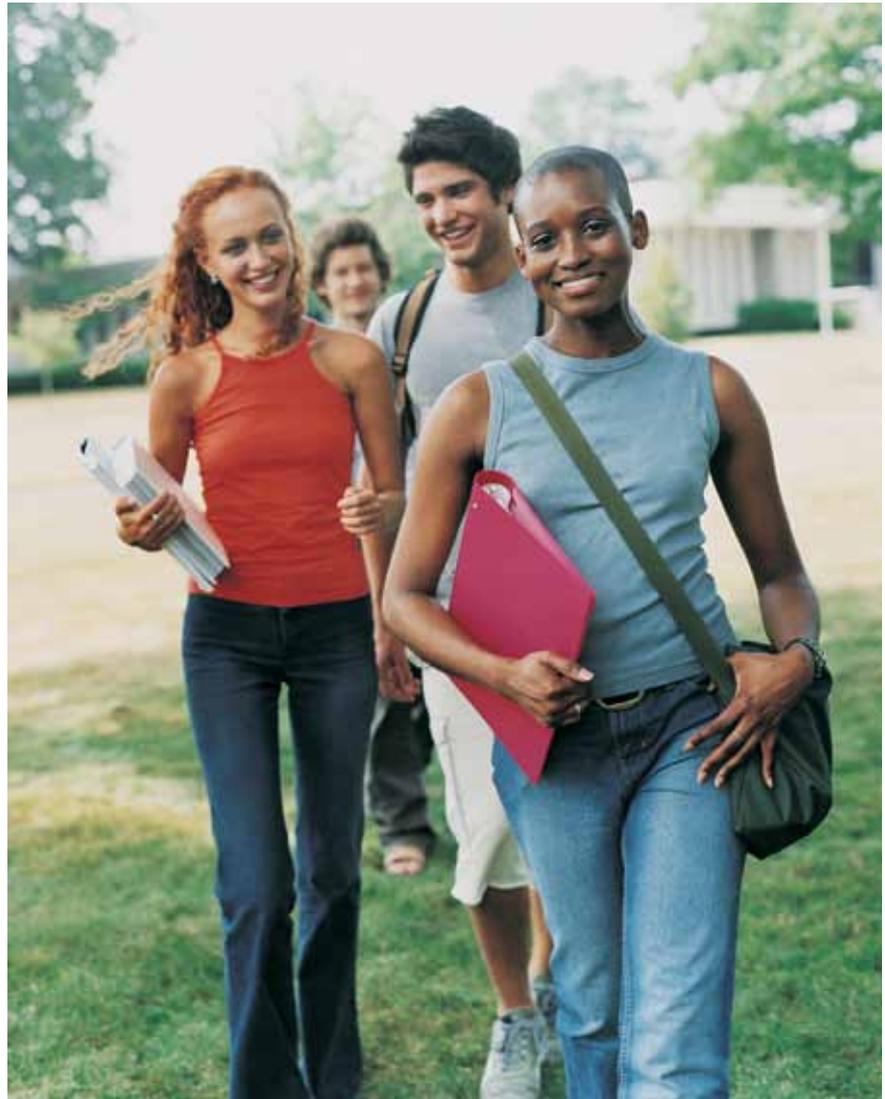
Many advocates and experts wonder if the Affordable Care Act will actually make care more affordable for young people, or if they will simply end up paying the price of lowering costs for everyone else.

The “age-rating” provision of the ACA prevents insurers from charging an older client more than three times the amount they charge a younger client. In most states, the rate stands at 5 to 1. To make up for charging older people less, insurers are expected to start charging younger people more once the provision goes into effect in 2014.

Right now, young people are generally benefiting from changes ushered in by the Affordable Care Act.

Possibly the most popular provision of the ACA—and not just among youth—was the expansion of dependent coverage so young people can stay on their parents’ insurance until age 26. Even those seeking to repeal the legislation want to keep that provision intact. As one of the first changes enacted, it’s also one of the first indicators to be evaluated.

The data suggests the change was successful in increasing the number of



Americans with insurance, says Benjamin Sommers, a Harvard professor and advisor to the U.S. Department of Health and Human Services.

More than 3 million young people gained insurance between September 2010 and December 2011 because of the change, Sommers found. He also notes that young adults of all socioeconomic and racial backgrounds benefited from the provision.

This provision can be an important

safety net for recent graduates. For example, the ACA allowed 23-year-old Kurt Henlin to stay on his parents’ insurance after he graduated from Temple University last May.

Three months later, Henlin moved to Los Angeles to follow his dream of becoming a talent agent. He is now temping at a talent agency that doesn’t offer insurance and is glad he has three more years to get on his feet before he has to worry about finding his own health plan.

“My parents agreed to pay until I’m a fully functioning adult,” Henlin says.

Next year, he could possibly qualify for a subsidy toward an individual plan through the state exchange, or for coverage through Medi-Cal once more of the Affordable Care Act provisions go into effect.

That’s when some experts worry the honeymoon between young people and the Affordable Care Act will end. Over the past few months, insurers and opponents of the legislation have said that young adults should fear “rate shock,” because premiums will go up once the remaining provisions take effect.

While testifying before a subcommittee of the House Energy and Commerce Committee on March 15, Christopher Carlson, an analyst for a management consulting firm, encouraged legislators to look closer at the Affordable Care Act’s effect on certain groups, including the young.

“Understanding these issues requires analyses that go beyond consideration of broadly stated averages, which can mask the effects on important subpopulations,” Carlson told members the congressional committee.

Other experts challenge the assertion that there will be huge rate hikes. An Urban Institute study, for instance, found that rate increases should be minimal once subsidies and the Medi-Cal expansion are taken into account.

More than 1 million uninsured young adults will qualify for Medi-Cal, and 1.5 million will qualify for a subsidy, notes Jen Mishory, deputy director of the Young Invincibles. The Affordable Care Act, she adds, also outlines a catastrophic plan for people under age 30, which satisfies the individual mandate if young people don’t want to pay the higher premiums.

The benefits of finally having coverage are worth the price even if premiums are slightly higher than they are now. “We looked at it,” she says, “as generational compromise.” **CHR**

Recent college grad calls ACA a lifesaver

KALWIS LO, 24, SAYS THE Affordable Care Act saved his life. Lo, who grew up in Southern California in San Gabriel, is the son of a low-wage cook and a waitress, who couldn’t afford health insurance.

Unlike his parents, Lo went to college. By the time he graduated from UC Santa Cruz in 2011, he was always tired. “I would sleep for weeks and weeks,” Lo recalls.

He lost his student health insurance when he graduated, so he went to a family friend who was a doctor. She noticed that his neck was swollen and asked if he had insurance.

Lo looked for coverage and found short-term insurance available to recent UC Santa Cruz graduates. After a month of expensive tests, doctors diagnosed Lo with stage three Hodgkin’s lymphoma. “That was a really scary time,” Lo says.

The insurance company ruled that his cancer was a pre-existing condition since he was so far into the disease. They refused to cover any of his care.

Once the Affordable Care Act health-care mandate goes into effect in January 2014, no insurance plan will be able to deny coverage to people like Lo based on pre-existing conditions. But the provision comes too late to help Lo.

He went through eight months of



chemotherapy, worried about financial ruin the entire time.

Then one day, while listening to news reports on efforts to repeal the Affordable Care Act, he decided to do some research. He found out that the ACA also created a Pre-Existing Condition Insurance Plan as a temporary option until 2014.

Lo joined and was able to finish his treatment and final tests with his plan. He’s been in remission since June 2012. Shortly thereafter, in July, he was hired as legislative director for an organization he volunteered for in college and moved to Washington, D.C.—where he has full health-care coverage.

— Callie Shanafelt

ONCE THE ACA HEALTH-CARE MANDATE BEGINS, NO INSURANCE PLAN WILL BE ABLE TO DENY COVERAGE FOR PREEXISTING CONDITIONS.



Every Single Day Matters

Foster child turned lawyer helps kids in the system

BY ALEXIA UNDERWOOD

JENNIFER RODRIGUEZ GREW UP hearing that she was a delinquent, a loser and a troublemaker. Her father was in prison, her mother was diagnosed as a paranoid schizophrenic, and the adults in her life didn't have

high hopes for her future. "They were like, I hope you don't get pregnant too early," Rodriguez recalls. "I hope you don't get incarcerated. I hope you don't end up homeless."

Rodriguez bounced between her mother's home and foster care facilities for the first decade of her life. She first

ran away at age 10. By the time she was 12, her expectations for her life had diminished. She no longer hoped to find a loving guardian. She just didn't want to end up in a group home, even if it meant living on the streets.

She wasn't so lucky.

"I was on the street for a couple of

PHOTOGRAPHS BY ED CALDWELL



income youth, she enrolled at Delta College in Stockton. Three weeks into the semester, Rodriguez realized that her education while in foster care had been woefully inadequate. “I had spent all of high school in special education, bouncing around between trailers for severely emotionally disturbed students, continuing education schools, schools that were part of hospitals,” she says. “I had never had a regular math or science or English class.”

Rodriguez, struggling with the course material, decided to drop her biology class. She went to see her teacher in person to tell her, because she didn’t want to hurt her feelings. “I didn’t understand how community college worked. I agonized over it for a long time,” she says.

The intervention from her biology teacher was a turning point in Rodriguez’s life. When the professor asked her why she was dropping the class, Rodriguez spilled out her whole story of past abuse, arrests and group homes. Rodriguez had come to see her teacher to drop out, but she left with a deal. If she stayed in the class and still failed, her teacher would give Rodriguez a withdrawal letter, so it wouldn’t affect her GPA. But she was betting that Rodriguez could pass the class if she tried.

Before she knew it, Rodriguez was spending all of her time on campus or at her professor’s house, helping her grade papers, tutoring other students and completely immersed in biology and her other course work. “By the time the semester was through,” she says, “I had an A in her class, and an A in all the rest of my classes.”

That was a defining moment for Rodriguez. “All of a sudden I could see that there was a different life possible. All of these people were studying and it was peaceful and everybody had goals and aspirations and was thinking about what they wanted to do with their life, the exact opposite of my experience in foster care. At that moment, when I thought about what I wanted to do, I just wanted to make sure that everybody had the chance to experience that.”

Now, as an attorney and the executive

director of the Youth Law Center (YLC) in San Francisco, Rodriguez is drawing on her experiences to help other children in foster care and the juvenile justice system find their own way to a better future. The YLC, a public interest law firm in San Francisco, was established in 1978 to keep children out of public systems and to protect the rights and improve the future chances of children in foster care and juvenile justice facilities.

“Our goal is that every child be treated in the way that we want our child or grandchild to be treated. All of our work is based on that,” explains Carole Shauffer, the former YLC executive director, who now serves as senior director of strategic initiatives.

Rodriguez knew firsthand what foster kids had to overcome to succeed. Changing their odds motivated her ascent. After she completed two years of community college, she transferred to UC Davis and started studying for the LSAT. She wanted to be an advocate. “I didn’t know anything about law school,” she says, “but I thought, I probably have to be pretty close to perfect. Perfect GPA, perfect LSAT score.”

Rodriguez also joined an advocacy organization called California Youth Connection (CYC), which shows foster youth how to become advocates for improving the system. “For the first time, I was exposed to all of these other people who had been in foster care,” she recalls. She felt newly empowered as she developed solutions to problems she had experienced firsthand as a foster child. She helped develop the first foster bill of rights, as well as other bills that required more stringent standards for educators at foster facilities.

Most state child welfare systems are underfunded, which leads to a lack of monitoring of group homes and family placements, and a slow response to reports of neglect or abuse. The number of children in foster care in California exceeds 55,000. Almost 50 percent of foster children in the United States suffer from chronic medical conditions, and more than two-thirds have serious emotional problems, according to Children’s

years, and then I went into the foster care system and never came out,” Rodriguez says. Even now, at 36, she has no idea how many group homes she lived in during this tumultuous period. But she recalls distinctly the abuse she suffered and the trouble she often found herself in, including being arrested.

It was only later—many years later—that Rodriguez could glimpse a future unfolding in front of her, one without prison, abuse or homelessness.

After she earned her GED through Job Corps, a free program for low-



“I WENT TO LAW SCHOOL FOR ONE REASON ONLY: TO HELP PEOPLE GROWING UP WITH THE STATE AS THEIR PARENT.”

Rights, a national advocacy organization.

One issue that comes up time and again is the bureaucratic, impersonal nature of a program that deals with so many human lives and futures. Shauffer says she was originally drawn to advocacy work because of her interest in human development. She wanted to understand how a system, or a facility, could serve as a parent. The answer she eventually came to is that it can't. "For the most part, it's the nature of the bureaucracy not to be able to personalize."

Rodriguez's evaluation is more blunt. "People have developed these very nice-looking facilities that lack the one thing that babies really need, which is, you know...somebody who is going to love them and going to be there for them," she says.

Instead of being loved as unique individuals, children are molded by a system—one that doesn't encourage the traits that kids need to become successful adults. "Some of the same traits I had that were really problematic when I was growing up in the foster care system were actually really assets in other contexts," Rodriguez says. "For example, I

was called manipulative or an instigator in all the facilities where I lived. But manipulative is being an advocate, being able to figure out how to get the outcome you want. I'd always been an instigator in situations where I felt like injustice was happening to other kids I lived with. It's what makes me a good lawyer."

After finishing her BA at UC Davis, Rodriguez earned a full scholarship to law school at the same university. Though the American Bar Association prohibit students from working full time while in law school, Rodriguez kept her job at the CYC. "I went to law school for one reason only: I wanted to help other young people who were growing up with the state as their parent," she says. She wasn't willing to give up work on their behalf in the meantime.

Rodriguez remembers walking through the halls of her law school and seeing press releases and announcements posted about foster care legislation that she was working on, with her name prominently displayed. Her friends would try to help by ripping them down. "They were like, you're going to get

busted! They're going to know why you weren't in class," she says.

During her last year of law school, Rodriguez had another distraction to contend with: She was pregnant with her first child. "He was born six weeks after the bar exam," she says, smiling. "I like to tell him that's the reason I passed the bar, because I had two brains. He's really smart."

Shauffer hired Rodriguez as a fellow in 2007, and Rodriguez took over Shauffer's position as executive director last year. "Jennifer knows. She's less removed, she's one degree closer to the system than we are," Shauffer says. "I can imagine, what if this were my child? She can say, what if this were me?"

Most of the staff at the center are lawyers, but legislation is just one form of their advocacy work for youth. That drew her to the center's work, says Rodriguez. "Advocacy is about bringing about change, no matter what mechanism you use to achieve that." The staff engage in policy work, work collaboratively with nonprofits and spearhead projects that focus on education and training.

One such project is an education intervention for incarcerated teen parents, aimed at helping them develop a deeper connection with their children. The Youth Law Center developed this program with researchers at Georgetown University. The program is unique



Alice Bussiere, Staff Attorney, Youth Law Center



Jennifer Rodriguez talks to Piper Kamis from the Vera Institute of Justice



Jennifer Rodriguez, Piper Kamis, and Ben Richeda, Baby Elmo Program Manager, Youth Law Center

in its use of media: the curriculum uses Sesame Street episodes to teach teens how to improve their parenting. The project is focused particularly on boys and has a unique name. “We were calling it the Juvenile Justice Teen Parenting Project, and the boys called it the Baby Elmo project,” Shauffer says. The name stuck. In a letter to the program founders, an incarcerated teen named Alfonso writes that if it were not for the Baby Elmo program, “I would be a stranger to my daughter. She wouldn’t even know that I exist.”

Much of the center’s work focuses on these two vital points: improving parenting skills and improving conditions for youth. “The most important thing for young people to have, no matter what system they’re in, is parenting—loving, supporting parenting,” Rodriguez says. “The reality is that institutions can’t provide that. People sort of forget, they think that habilitation happens by putting you in a facility and locking you up, but the truth is that it happens when you have a parent who loves you and sees your potential and connects you to opportunities to reach that potential.”

“Parenting is the basis of health,

really,” she continues. When her own daughter (now 5) was a baby, she brought her into work at the law center every day, and wore her strapped to her chest while she did public speaking engagements and trainings. “Parents drive everything related to health. Without having that person there, the stable loving committed adult in life, it’s really hard to tackle any of those other issues,” she says. Even though she didn’t have this experience growing up, Rodriguez understood how to give it to her children. “As a mother, it hasn’t been all that hard to figure out how to do it without a map,” she says. “It’s part of the reason I feel a sense of hope that we actually can reform the system.”

Shauffer and most of the other employees are in their 50s and 60s, and sometimes they worry about who will continue their work when they retire. “With Jennifer in leadership, we know that the center’s work is going to go forward,” Shauffer says.

Rodriguez remains focused on the kids in the system now. “When I hear stories about children who are living in a group care facility, there’s a certain level of outrage and urgency that I feel.

I can imagine that if my kids were put in a home where they didn’t have somebody who really loved them, every single day would matter. It wouldn’t be a matter of let’s get together and develop a working group and talk about this and make recommendations. I’d want them out tomorrow, or tonight, if possible.”

Rodriguez says that one predominant viewpoint today among social workers and others in the child welfare system is that family settings are only appropriate for certain types of children, and not others. “You’ll hear that, that they need to complete a program before we can move them into [a family setting], and it’s like, who is that? What child is that, that doesn’t need a family?”

Another issue that remains is recruiting enough families to foster these children, families that have the skills and resources to be good parents. Unfortunately, foster care is not seen in the same light as other altruistic undertakings, like the Peace Corps, she says. “If you really want to change the world and make a difference, becoming a foster parent is one of the best ways to do that.” **CHR**

THE PRICE OF PARITY

WHY LOW-INCOME CHILDREN WITH AUTISM DON'T GET COSTLY CARE



BY HEATHER TIRADO GILLIGAN AND CALLIE SHANAFELT

Cherie has autism—but it’s not easy to see signs of the disorder in the exuberant 4-year-old. She only needs a gentle prompt from her mother, Jenny, before she says hello to the strangers in her living room. After the nudge, Cherie is a whirl of activity: She spins around in her purple and pink dress, brings her mother a tiny bouquet of yellow daisies she picked herself and calls upstairs for her older sister to come and play with her.

The difference between today and the day Cherie was diagnosed with autism at 27 months is stunning, Jenny says. At the age of 2, her daughter had changed from a chatty toddler to a withdrawn and silent child. Jenny holds out a picture of her daughter around the time of her autism diagnosis—she’s sitting perfectly still in her high chair, a blank stare on her cherubic face.

Cherie started a therapy called applied behavior analysis (ABA) a few weeks after her diagnosis of mild to moderate autism. The change in her daughter was swift, Jenny says. “She just came back from the very deep fog she was in.”

Earlier this year, Jenny found out that she might lose coverage for the therapy that she says brought her daughter back from the fog—all because she cannot afford private insurance.

Starting this year, California requires children like Cherie, who receive private insurance subsidized by the state through a program called Healthy Families, to switch to Medi-Cal, the state’s version of Medicaid, the publicly funded health insurance for low-income children and adults. Jenny was reassured by the state, as were all other families who had to make the change, that autistic children would receive all of the same benefits under Medi-Cal that they had under private insurance.

That turned out not to be the case. Families who switched coverage slowly realized that despite these assurances, their children’s applied behavior analysis would not be covered by Medi-Cal. Some had their treatment halted abruptly. Par-

ents fear their children will lose access to ABA for good.

Federal laws require that mental health—including developmental disorders like autism—and physical ailments be covered equally by insurance. These rules are referred to as parity in health care. Federal rules were further extended by the Affordable Care Act, which will soon require coverage of behavioral therapies as part of mental health parity.

States, however, will determine precisely what parity in behavioral therapy means. Some have decided to mandate coverage of ABA, a treatment accepted over the past five years as a standard intervention for autism, to fulfill parity laws. Other states don’t see an ABA mandate as essential to maintaining parity.

California has approached the question of whether or not to mandate coverage of the intensive, expensive therapy in an especially curious way. The state mandates that all private insurance policies cover evidence-based autism treatment, including ABA. But California exempts Medi-Cal from that requirement. As a result, families with private coverage get ABA for their autistic children. But most of those who are low-income and covered by public insurance do not.

A SEA CHANGE IN TREATMENT

Cherie bounces with anticipation in the minutes before her therapy session starts and hurries to the door when she hears a car in the driveway. “This is my Camille,” Cherie croons by way of introduction when her autism therapist arrives. Camille

sits cross-legged on the floor in front of her, opens a bag of toys and pulls out a paper-bag puppet with the face of an elephant. She puts it on her hand and makes it talk to Cherie: “I’m saaad,” the elephant says. “Don’t be sad,” Cherie says encouragingly to the elephant.

What seems like play is actually designed to teach a series of social skills, all part of a personalized plan where her progress is carefully documented. Camille arrived with a goal sheet several pages long. “Cherie will engage in a reciprocal conversation on a neutral topic,” one goal read, “that will include making at least five appropriate comments with social partner while using eye contact and waiting appropriately.” There are boxes for her therapist to note how well Cherie did on each task. Camille guides Cherie through the tasks with a combination of firm disapproval and warm encouragement.

ABA is a form of behavior analysis, an approach that uses rewards to encourage helpful behaviors and discourage harmful habits. The therapy is intensive and conducted several times a week, sometimes even every day, in as many as 40 hours a week. Because of the intense, one-on-one nature of the therapy, ABA is expensive—costing as much as \$60,000 a year.

Advocates say that ABA is worth the cost because it works, and they cite studies to back up their point. “Some studies have shown that as many as 40 percent of these children do not need special ed by the age of 6,”

says Karen Fessel, executive director of the Autism Health Insurance Project, an advocacy group that helps parents get treatment for their autistic children covered by insurance.

While some parents say that the treatment comes close to a cure for their child’s autism, ABA does not help every child who receives the therapy. And ABA has not yet been subjected to a randomized trial to prove its effectiveness. Still, the therapy has prestigious endorsements as a

WEB CONNECT



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treatment for autism, from the Office of the Surgeon General to the American Academy of Pediatrics.

ABA has been a treatment for autism for decades, but insurance companies routinely denied coverage on the grounds that it was educational or experimental or that it was not medically necessary, until laws compelled them to pay, says Kristin Jacobson, co-founder and president of Autism Deserves Equal Coverage and California policy chair for Autism Speaks, an international advocacy group. "Health plans created a myth that it was not the standard of care," Jacobson says, "but over the last five years we have been able to dispel those myths." Autism Speaks says the last five years have brought a "sea change" in the understanding of ABA as a standard treatment for autism.

With this shift in perspective, some state laws guiding what insurance companies must cover have changed. Others have not. Thirty-four states have passed laws requiring that autism treatment be

covered by at least some types of insurance policies. Eighteen will require that insurance companies participating in their state insurance exchange pay for ABA.

Paradoxically, one of those states is California.

TIERS OF PARITY

The autism specialist who diagnosed Cherie in 2010 offered Jenny little hope that her daughter would regain her speech and ability to function. She advised Jenny to grieve. "I'll grieve later," Jenny responded, "I just want to know right now what to do." Jenny turned to the Internet and found a thriving community of parents of autistic children. They guided her toward treatment options that included applied behavior analysis.

Kaiser, her insurance provider, denied her first two requests for coverage of her daughter's ABA in 2010, Jenny says. She turned to the Internet again and, with the

help of advice from other parents, successfully appealed the decision.

As a private insurance company, Kaiser has not been allowed to deny coverage for applied behavior analysis for an autistic child since 2012, after California legislators passed a law requiring that private insurance companies cover the therapy.

That law was somewhat unusual. Many of the insurance mandates in California law require coverage of particular conditions, such as drug dependency or infertility. Others require that insurers help cover the cost of an ambulance and of screening children for lead in their blood. In the case of ABA, insurers were already required to provide the therapy if it was considered medically necessary. But many insurance companies, disputing the therapy's effectiveness, were refusing to cover it. So the legislature stepped in and ordered them to do so.

But the law requiring private insurance companies to pay for ABA still exempted

Healthy Families and CalPERS, the insurance plan for state employees. The state legislature passed an emergency measure to include those plans in the mandate for coverage last year.

Medi-Cal was exempted from these mandates without explanation, creating two different classes of autistic children: those who benefit from parity laws and those who do not.

The Affordable Care Act, which lists essential health benefits that insurance policies must provide starting in 2014, is unlikely to impose uniformity in covered treatments for autism. While “mental health and substance use disorder services, including behavioral health treatment,” are among the 10 essential benefits that insurance plans must offer according to rules issued early this year, the rules also left the specifics of what to include as a covered treatment to the states to define. Autism advocates who wanted applied behavior analysis named as an essential benefit for children throughout the United States were bitterly disappointed.

Advocates in California say that the lack of uniformity creates a system where coverage is not just varied, but unequal. The transition from subsidized private insurance to Medi-Cal is just one instance in which low-income autistic children suffer the most from lack of access to care. As families with private insurance continue to access their benefits for ABA, families on Medi-Cal must contact regional centers that provide services to all people with disabilities—from children to adults—and ask if their children are eligible for ABA there.

The California Department of Health Care Services, which declined to be interviewed for this article, provided a statement saying that ABA is covered by services offered to the disabled at regional centers. The centers are tasked with helping adults and children with disabilities.

Most autistic children, however, don’t qualify for ABA at regional centers, advocates say. “The problem with the regional center is that you have to have a certain level of disability to qualify,” Fessel says. That level of disability, she adds, is profound. “If you don’t qualify, you’re basically hosed.” She estimates that 500

low-income families have already had treatment for their autistic children disrupted since the switch from Healthy Families to Medi-Cal.

For families with autistic children, fighting for benefits is par for the course. Fessel, for instance, founded the Autism Health Insurance Project after her own difficulties getting her insurance policy to cover treatment for her son, who has Asperger’s syndrome.

She now guides families through the maze of accessing their benefits. How much help families need from her depends on how well they can advocate for themselves. “If they are very capable, a lot are just fine with advice,” she says, “but a lot of families don’t even speak English.” Not all parents, in other words, are like Jenny. People who do not speak English or otherwise lack the skills or time to advocate have the hardest time securing services for their children.

For instance, assistance for autistic children between 3 and 6 years old, the window for early intervention, varies widely by race, according to an analysis of 2010 data by the Los Angeles Times. The Times found that the state Department of Developmental Services spent significantly more on white and Asian children than on Latinos and African Americans, more than \$11,000 per child for whites and Asians, compared to about \$7,600 for Latinos and about \$6,600 for African Americans.

Fessel finds it difficult to understand the logic of a law requiring therapies for some autistic children but not others. The legislation that mandated coverage for ABA, Fessel notes, recognized the need for therapy as urgent while excluding a population of kids on Medi-Cal. “How can it be urgent for people with money,” she asks, “and not urgent for people without money?”

THE ULTIMATE PRICE

Jenny lives in San Mateo County, not far from San Francisco, at the end of a winding road fringed by olive trees and sun-bleached grass. She doesn’t look like someone who needs government assistance, but paying insurance premiums for an autistic child is not even a remote possibility for her, nor would it be for most

middle-class families.

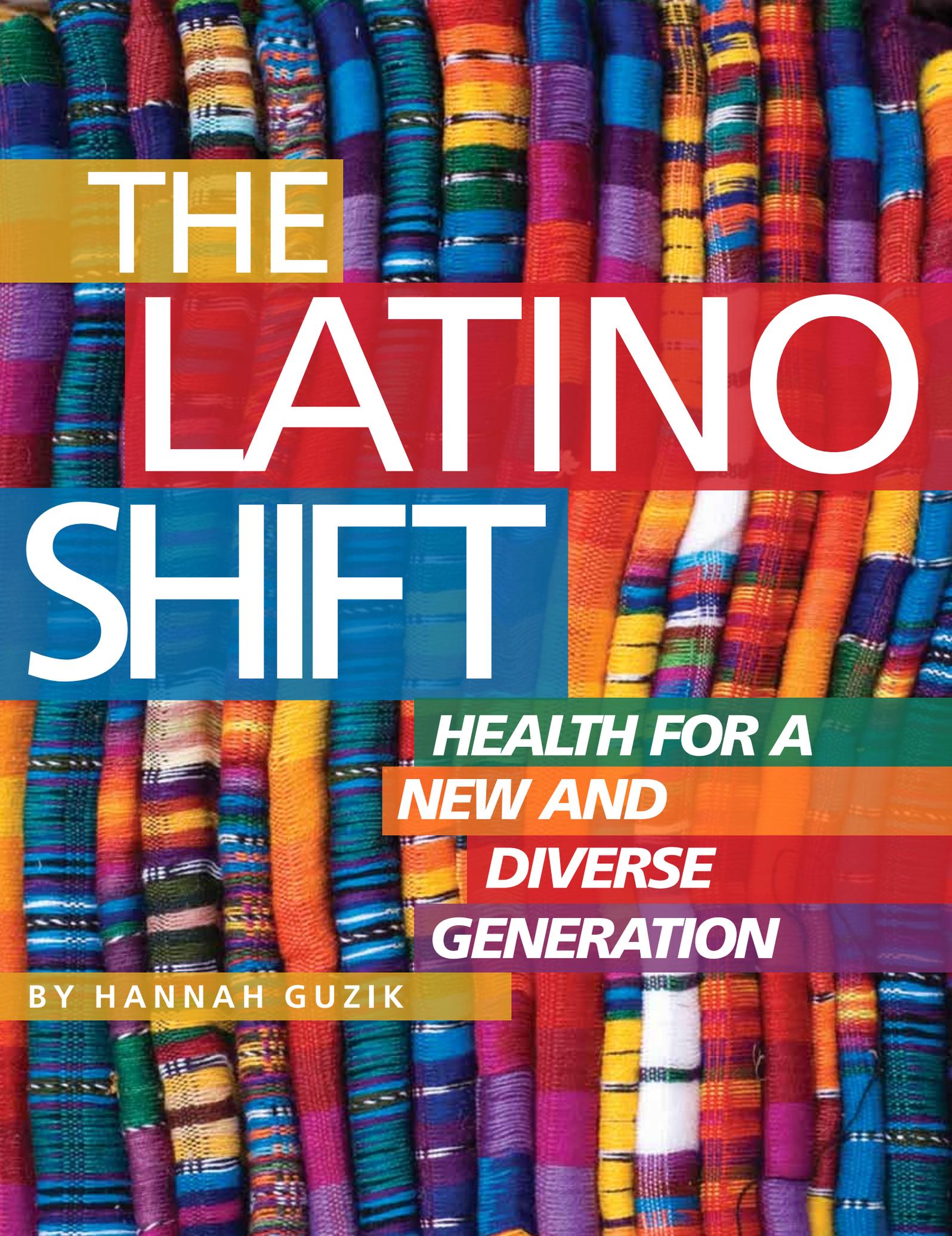
Despite her challenges, Jenny says that she is lucky. Her family helps as much as they can. They help pay for a nanny to watch Cherie while Jenny works as a property manager. They help pay for Cherie’s art and music therapy too. But there is no way they can afford to pay for Cherie’s applied behavior analysis.

The costs to Cherie’s health and future would be devastating if she lost her therapy, Jenny says. Thinking about what they would lose if Cherie’s therapy stopped, Jenny pauses as her eyes fill with tears. “Just being part of the family,” she says after wiping her eyes dry.

The costs to Cherie and her family will be incalculable. But the costs of autism to society have been measured in various ways over the years. One influential article published in *JAMA Pediatrics* in 2007 put the lifetime costs of autism for one person, both direct and indirect, at \$3.2 million. “Although autism is typically thought of as a disorder of childhood,” the researchers note, “its costs can be felt well into adulthood.” Much of the costs of adulthood come in indirect costs, such as housing and lost wages for people with autism and the family members who take care of them.

Though the costs of ABA therapy for autism are high in childhood, they pay off in savings in the relative short term, Fessel says, in three to five years, as children are more functional, and fewer need special education classes in youth and special care into adulthood.

Advocates and parents hoped that the state would enact a one-year stopgap budget measure that would cover ABA for children on Medi-Cal starting July 2013. That item, however, was deleted from the final state budget. Children on Medi-Cal will not be automatically eligible for the therapy in the foreseeable future. That includes children like Cherie who were already receiving ABA under Healthy Families. Jenny says she managed to get Cherie 15 hours of ABA through the school system, but only with the assistance of a lawyer. She knows her child is fortunate. Other families don’t have her resources. “Every autistic child should have ABA available to them,” she says, “regardless of income or class.” **CHR**



THE

LATINO

SHIFT

***HEALTH FOR A
NEW AND
DIVERSE
GENERATION***

BY HANNAH GUZIK



DEMETRIA MARTINEZ IS SITTING in a state-funded children's center in Oxnard, wrapping her baby daughter in a shawl, when worry invades her face. Her daughter is sick, she says. Something about her heart. The doctors told her, but she didn't understand.

Martinez is speaking Mixteco—an indigenous Mexican language full of clicks and tones not used in English or Spanish—but she conveys her emotion without words too. Twisting the ends of her rebozo, frayed from all the baby wearing and worrying, she says what she does understand is that she's still making payments on a \$1,700 hospital bill for the tests doctors did on her 5-month-old daughter.

"I can't afford it," she says, speaking through an interpreter. "I'm worried too much about it, and I don't know what to do. They said her heart isn't working right. They said her heart is not OK."

Martinez is among the more than 165,000 indigenous Latino farmworkers who have immigrated to California in the last two decades, driven largely by extreme poverty and drought in their native villages. Indigenous people trace their ancestry to people who lived in what is now Mexico before the arrival of the Spanish in the 1500s. Their arrival in the United States represents the latest demographic shift among the state's Latino population.

Public health officials and policy-makers often see Latinos as a homogenous group, but they're far from that. And the indigenous immigrants, with their varying cultures and languages, are already creating new needs for health services in California—needs that providers have yet to fully understand.

LATINO DIVERSITY

Bernardina Estrada came to the United States in 2000 from her native village of Paredon, a rural community in the Mexican state of Oaxaca, to look for work. "It was a necessity of our family that we come," she says. At home, "there was only work when it was time to do the harvest, but because there was no rain, there was no food to harvest." Estrada has two children she left behind in Mexico after she decided she could not risk their lives in a dangerous and illegal border crossing. She has since had three children born in the States, who are now part of a booming population of young Latinos in California.

More than half of all California children are Latinos, according to U.S. Census data. The number of children statewide grew just 1 percent, or by 45,211 kids, between 2000 and 2010, according to federal data. But the number of Latino children in California increased by 705,395 kids over the same decade, the second-highest increase in the country, behind Texas.

Exactly how many of those children are indigenous is unknown. It's difficult to make an official count, because they are

often lumped into the larger category of "Latino or Hispanic." But the indigenous population is growing most rapidly among children ages 5 to 12, according to Gaspar Rivera-Salgado, project director for the UCLA Center for Labor Research and Education.

About 30 percent of the state's farmworkers are indigenous, and that number is higher in the agricultural belt that runs between Salinas, Santa Maria and Oxnard. More than 60 percent of the state's strawberry harvesters are indigenous, and about 60 percent of those don't speak English or Spanish, instead relying on their native languages to communicate.

Estrada, as well as the other Mixtec women interviewed for this story, said they and their husbands have found work in the strawberry fields in the Oxnard Plain, where some of the nation's most fertile earth is used to grow acres of strawberries between January and June. Estrada's husband is at work in the fields right now, she says that morning at the Oxnard children's center. There's not enough money to pay rent, and she needs to go back to work too. "I was going to start today, but my son got sick," she says, holding her 1-year-old, "so I didn't want to leave him." She might start again tomorrow, she says.

Indigenous immigrants like Estrada and her young children face a set of issues that are distinct in accessing health care, and different from other Spanish-speaking Latinos in the United States. The first is a steep language barrier. There are 62 indigenous groups in Mexico, each with its own language.

"Traditionally, people think you need to just speak Spanish if you're a physician in this state, but actually it's more complicated than that, and there are a lot of different languages," says Carlos O'Bryan, a family-practice doctor who works at a south Oxnard Las Islas clinic, where about 20 percent of his patients are Mixtec. "Some people assume that if you speak one indigenous language, you're able to understand others, and it doesn't work that way."

Estrada says she understands enough Spanish to feel comfortable taking her children to the local emergency room when they're sick. But Martinez and another Mixtec woman sitting across from her, Librada Cruz, say they only can make out a handful of words in Spanish. The three women add that they cannot read or write in any language. It is common, health officials say, for Mixtec patients to simply sign all medical and consent forms with an "X."

The survival of the languages is a testament to the strength of the people themselves, who have been seen as "second-class citizens" in Mexico since the arrival of the Spanish, Rivera-Salgado says.

That discriminatory attitude has, to varying degrees, been carried over into the United States. Indigenous children are frequently bullied in school and teased for their short stature and dark skin—and other Latinos are often the culprits, Rivera-Salgado says. Several commonly repeated Spanish-language

folk phrases are disparaging toward indigenous people, including “No seas Indio” (“Don’t be an Indian”) and “No casarse con un Indio” (“Don’t marry an Indian”). Both are used to mean, “Don’t be uncivilized, don’t be backward, don’t be ignorant,” he says. “This is a very racist way of interacting with each other.”

The bullying was so widespread in Oxnard schools that the district recently banned the use of the word “Oaxaquita” (“little Oaxacan”), a derogatory word for people who hail from the Mexican state of Oaxaca, as Mixtecs and many other indigenous groups do. Last year, the Oxnard-based Mixteco/Indigena Community Organizing Project launched a “No me llames Oaxaquita” (“Don’t call me little Oaxacan”) campaign.

“At the very minimum, I think that the challenge for local services providers and also advocates is to be more aware of the diversity within the local Latino and Mexican population,” says Rivera-Salgado. “The fact is that these indigenous communities are here, but they have remained largely invisible to local agencies.”

HEALTH CHALLENGES

Librada Cruz came to California from San Martín Peras, a city in Oaxaca, in 2007. “I was living with my mom and there wasn’t enough space,” she says, cradling her 9-month-old daughter, whom she nursed to sleep in her arms. Life is better here, Cruz says, but it’s still not easy. She lives in a garage in Oxnard’s El Rio neighborhood with her husband and four children. Her husband picks strawberries, and she plans to join him again when her youngest is 1.

Following the pattern of previous waves of new U.S. immi-

grants, both with and without visas, indigenous Mexican adults and teens often work the lowest-paid and least-desirable jobs—jobs that can carry their own health risks.

“I DON’T UNDERSTAND SPANISH,” SAYS MARTINEZ, “AND I DON’T KNOW WHAT THE DOCTORS WILL DO.”

grants, both with and without visas, indigenous Mexican adults and teens often work the lowest-paid and least-desirable jobs—jobs that can carry their own health risks.

At work, the indigenous laborers may be exposed to high levels of pesticides and herbicides, according to preliminary findings from a Cal Lutheran University study that’s testing the urine of Ventura County farmworkers for chemicals. Strawberries, according to the Environmental Working Group, are among the most pesticide-laden crops. Residue from the pesticide may cling to the clothes, hair or skin of farmworkers, exposing their children to the dangerous chemicals. “I worry about that,” Estrada says, “but I have to work.”

For Mixtecs and Triques, the two most recent groups of indigenous Mexicans to come to California, that largely means working in the strawberry fields that stretch from Salinas to Oxnard. The workers—and, consequently, their children—are frequently forced to migrate to other jobs elsewhere in the state after they’ve plucked the berries from their vines and placed them in the little plastic baskets sold on supermarket shelves.

Along the way, the migrant laborers face limited access to health care, due to language barriers, their transiency and, sometimes, their immigration status. Estrada and her husband used to migrate between Oxnard and Salinas throughout the

year, she says. Every time they showed up in a new town or neighborhood, drawn by the work in the fields, they once again had to find schools, clinics, hospitals and social-service offices. The undertaking would be daunting for any low-income resident without access to the Internet, but add on top of that the fact that they don’t speak English or Spanish and aren’t literate—and you start to see why it can take some indigenous migrants months to enroll their children in local schools or bring them in for routine vaccinations.

Although their U.S.-born children generally have access to Medi-Cal, Mixtec women interviewed for this story said there are still barriers to health care. Oxnard has a few clinics that employ Mixtec translators, for example, but many California communities do not.

At home, wherever home is that season or month, indigenous immigrants often live in cramped quarters—due to poverty and lack of access to farmworker housing if they’re undocumented—sometimes resulting in spikes in contagious illnesses. “We’ve seen a lot of cases of children who have been exposed to tuberculosis,” O’Byrne says.

In farming communities like Oxnard, rundown houses and apartments often become something like tenements—with entire families occupying a single room, resulting in a dozen or more people sharing a bathroom and kitchen. Sometimes, a family may live in a garage or shed in the backyard, with no access to the indoor toilet or shower, says Sandra Young, a family nurse practitioner at Las Islas clinic who founded the Mixteco/Indigena Community Organizing Project.

“You have more diarrheal illness in living conditions that don’t have hot water or don’t have access to bathrooms,” she says. “I’ve had patients tell me they’re only allowed to use the bathroom during certain times, or literally the only water they’re allowed to use is from the hose on the side of the house. The more people you put into a small space, the more hygiene issues you’re going to have.”

Estrada considers herself one of the luckier ones, because she doesn’t have to share a house. She rents a one-room studio for \$600 per month, shared by her husband and three U.S.-born children, ages 8, 5 and 1.

Health-care workers need increased training about the diversity and diverse needs of the state’s Latino population, O’Bryan says. They need to understand, for example, that many indigenous immigrants are also illiterate, unable to read hospital consent forms or follow written medication guidelines for themselves or their children.

Health-care providers also need to create an environment where indigenous patients feel comfortable “walking into an agency, going through the bureaucratic process we have for everything,” says Young, who primarily sees ob-gyn patients, about 40 percent of whom are Mixtec.

“We want to create an atmosphere where we value the strengths of this community, including their tight-knit culture, which has many protective factors, and have a sense that we are so fortunate that we have this community here, as opposed to seeing them as just, ‘Oh, these poor struggling farmworkers,’” she says.

SO MUCH WORRY

Martinez, the mother of four whose youngest has a heart condition, came to the United States in 2004 with her husband, because in her native village, they “didn’t have money to buy food,” she says. “Here is better because here I have lots of stuff to eat.”

Here, though, she still lives far below the federal poverty line. Her husband works in the strawberry fields to support their family of six, and she joins him when she’s not caring for a newborn. They rent a room for \$450 a month in El Rio, and other Mixtec families occupy other rooms in the house.

On Mondays, she walks down the block to a parent-child baby class at the Rio Neighborhood for Learning, a center funded by First 5 Ventura County. It was here that interpreters helped her understand her 6-year-old son’s autism diagnosis a few years ago, after doctors and school officials left her confused. It is here that she turns if the family needs extra food or if her children’s schools send home papers written in Spanish. It is here that she finds pieces of the community and support network she once had in her native village.

But there are still so many things, particularly health related, that Martinez worries about. Much of it has to do with being



unable to speak Spanish, or read or write in any language. She avoids taking her children to the local emergency room, for example, because Mixteco interpreters may not be available. Instead, she waits until Las Islas clinic opens, relying on folk medicine in the meantime.

“I get worried about what’s going to happen to them, but I don’t want to take them to the hospital emergency room, because I don’t understand Spanish and I don’t know what the doctors will do,” she says.

At one time, doctors told Martinez her youngest daughter’s heart condition should resolve on its own, but she remains concerned and confused by the diagnosis and tests. The doctors used an interpreter to explain the diagnosis, but the finer points didn’t translate, she says. They also told her Medi-Cal would cover the cost of the tests, but she had someone fill out the paperwork twice and never heard back.

She’s also desperately searching for another place for her family to live, because her landlord has threatened to evict them. She believes the threats are unlawful, but she has no recourse, because she fears the police due to her immigration status.

Her face clouded over with worry, Martinez gets up to leave. The parent-baby class is over, and her daughter is almost asleep in her shawl. She swings the rebozo behind her and gathers her 3-year-old son—but then turns back. The interview is over, but she has one question herself.

She wants to know if anyone in the room can help.

“She’s worried too much about it,” the interpreter, Obdulia Vasquez, says, shifting from first-person translation because the interview is over. “She doesn’t know what to do. She’s worried about the kids too.” **CHR**

PHOTO COURTESY OF ROSA RAMIREZ

UNEQUAL EDUCATION

PUBLIC SCHOOLS AREN'T ACCOMMODATING DISABLED STUDENTS

BY ROBIN UREVICH



TWO YEARS AGO, GABE,* a roly-poly boy with soft brown curls, now 10 years old, stood at the center of a dispute that pitted parent against parent at a suburban elementary school.

Other parents tried to push Gabe out of school because of his disability, his parents say, alleging that the boy was a threat to their children. Gabe is autistic and didn't do things the way the other second-graders at Sierra Madre Elementary School did. The teacher knew of his disability, but chose to treat Gabe as if he had behavior problems, says his mother, Mary Brandenburg. The more the teacher required him to conform, the more he'd act out—out of confusion or frustration, not defiance.

*Name changed to protect privacy



Sometimes his senses were simply overwhelmed. Sounds are louder to him, light is brighter, and movement and touch are more intense, sometimes frighteningly so. He would hide under his desk, and when adults tried to pull him out, he'd fight or resist out of fear. He might scream or throw pencils.

Gabe would come home from school complaining that the kids refused to play with him, and children began talking about him on the playground in ominous whispers. Parents were talking too, Brandenburg says. They put their political muscle behind a drive to remove her son from Sierra Madre, citing playground violence of which the Brandenburgs say they were never notified.

The situation was so volatile that, two years later, parents who wanted Gabe out of the school refuse to talk about why they wanted him gone. One parent who asked not to be named says her son reported that Gabe would be dragged out of the classroom after falling to the ground and kicking. Former Pasadena Unified School District board member Ed Honowitz says the parents were genuinely concerned for their children's safety. A Pasadena Unified School District spokesman refused comment, citing fear of litigation.

But Ramon Miramontes, also a former board school member, says that a mob mentality took over. "We were aware," he says, "that there was an orchestrated maneuver to put pressure on the district's staff to remove the student."

Set in the town of Sierra Madre, a community of 10,000 known for its volunteer fire department, its wisteria vines and its homogenous population (it is more than 80 percent white), Sierra Madre Elementary boasts top standardized test scores and an army of dedicated volunteers. But the school culture is problematic, says school board member Scott Phelps. "It's a culture intolerant of people who are different."

The law extends protections for students who are different. The federal Individuals with Disabilities Education Act (IDEA) guarantees every disabled child the right to a free public education in classrooms with nondisabled peers, to the extent possible. But dozens of parents across the state say that, in practice, school districts flout the law.

Sierra Madre is far from the only school in the state that has been accused of noncompliance with IDEA. A group called Concerned Parents Association of California says school districts routinely discriminate against kids with disabilities, while the state agency charged with enforcing the IDEA, the California Department of Education (CDE), looks the other way.

The Concerned Parents Association, along with the Morgan Hill Concerned Parents Association, is suing the California Department of Education in federal court, saying the state's special education system is in shambles and out of compliance with federal law in every way, beginning with its failure to stop segregation of disabled kids.



DID YOU KNOW?

About one in ten California students receives special education services.

SOURCE: LEGISLATIVE ANALYST OFFICE

LAWS WITHOUT ENFORCEMENT

The Brandenburgs aren't typical Sierra Madre parents. Their well-kept home is painted purple, and Gabe's dad, Tony Brandenburg, who sports long gray hair, was the front man for a seminal Orange County punk band, the Adolescents, and still plays and tours. Tony and Mary are also special education teachers (though Mary is not currently working) whose two older children are also autistic.

The tide turned against Gabe after a story-time incident when he turned suddenly and elbowed another child, bloodying his nose. School officials told the Brandenburgs that Gabe would have to leave Sierra Madre and attend a private school for the disabled at district expense.

THINKSTOCKPHOTOS

SCHOOL DISTRICTS FEEL FROM THE GET-GO ENORMOUSLY STRAINED BY THE COST. THEY SAY SPECIAL ED CONSTITUTES AN ENCROACHMENT ON THEIR LOCAL BUDGET.

Mary Brandenburg insisted the bloody nose was an accident. For the family, Gabe's ouster was a civil rights issue, and they decided to fight back, arguing he could function in a general education classroom with proper support.

IDEA requires school districts to identify kids who have disabilities and determine what kind of help they need to learn. With that in mind, every year school personnel, parents and experts must sit down and hammer out an Individualized Education Plan (IEP), a road map for each special needs child's education, specifying the accommodations, like speech or behavior therapy, that must be made for each child.

But the Concerned Parents lawsuit alleges that school districts routinely fail to include parents in IEP meetings, and fail to provide the support services their children need to learn. Rony Sagy, the lead attorney for the plaintiffs, says general education teachers are overwhelmed and lack the training they need to educate disabled and typical kids in the same classroom. "As a result, they say we can't deal with it. Kids with various disabilities are just warehoused in classes or programs that do little to improve their education results."

A spokeswoman for the CDE declined to comment because of the pending litigation.

Complaints against school districts to the state Department of Education often go nowhere, Sagy argues, because the state doesn't actually investigate them. Instead, she contends, the department simply asks local districts to respond to allegations and accepts their responses. What's more, she says, the department's routine monitoring of school districts is flawed because it relies strictly on data, but doesn't check the accuracy of the data.

The CDE also fails to analyze the most telling information. For instance, it doesn't look at low graduation rates for disabled students, their declining proficiency in math and language arts, segregation of the disabled or the disproportionate number of African American and Latino students who are considered disabled.

"There is no enforcement," says Phelps, who notes that the state found his Pasadena district out of compliance in areas including providing assistive technology, and other areas, but took no action.

Money is tight too, one more reason school district administrators may put special education on the back burner, says Michael Gerber, a professor at the UC Santa Barbara Graduate School of Education. "School districts feel from the get-go enormously strained by the cost. They say special ed constitutes an encroachment on their local budget."

Another source of conflict is that schools are penalized under No Child Left Behind if special ed students' test scores don't show continuous improvement. "A lot of schools complain they were making good progress in the early days," Gerber says, "but were being thwarted because they couldn't improve the scores of kids with disabilities."

Whatever the reason for sub-par performance, the Concerned

Parents lawsuit calls for nothing less than court supervision of the state special education system until the court can ensure that the state enforces the law.

THE LIMITS OF LITIGATION

Only one state, Pennsylvania, has ever had its state education department overseen by a court as a result of a lawsuit based on the IDEA. But Perry Zirkel, a professor of education at Lehigh University in Pennsylvania who studies special ed law, says even if the plaintiffs prevail, he doubts their victory would bring meaningful change for special education in the state. "My overall sense is that the law is a limited mechanism for solving some deep-seated problems in our society, like segregation," Zirkel says. "Take a look since *Brown v. Board of Education*, where plaintiffs have won, and look how many schools are majority minority."

But Sagy points to the Ravenswood school district in East Palo Alto to show that court supervision can transform special education—at least in one relatively small school district.

Since 2003, when eight East Palo Alto students won a lawsuit against the district and the California Department of Education, Ravenswood district teachers have been trained to instruct both disabled and nondisabled kids in the same classrooms. The teachers—and school administrators—have changed their mind-set in the process, says Bill Koski, a Stanford University law professor who represented the plaintiffs.

"They really want to serve disabled kids," he says. No one knows what will happen once the court no longer oversees Ravenswood, he notes. But, he adds, "the culture in the district is completely different than it was 10 years ago. It's not frequently that litigation can change hearts and minds, but it really did."

In Sierra Madre, the Brandenburgs embarked on an ultimately successful battle to keep Gabe in Sierra Madre Elementary, and prove he was wronged, an ongoing effort they say has taken over their lives and drained their finances.

Now, Gabe is in fourth grade—in a general education classroom—and is considered a gifted student, with a teacher who cares about him, his mother says. The Brandenburgs say they're still pushing to get Gabe what he needs to learn—he doesn't have a current IEP or behavior plan.

Mary, who attends school with him in the morning, picks up the slack. She's coached him to tell his teachers how he feels when he's frustrated, and she's taught him a strategy to help him understand complicated instructions. Now when the 10-year-old needs time to process what he's heard, he turns to his teacher and asks, "Can I have a moment?"

Life is calmer for Gabe, but Tony Brandenburg says the ordeal has taken a toll. "We're not the same family we were in 2009. They've taken his childhood and he'll never get that back." **CHR**

A Dangerous Complication

Domestic Violence in Pregnancy

BY HANNAH GUZIK

WHEN MARGOT NEWMAN* WENT into labor, her boyfriend broke her cell phone and hog-tied her to the toilet in their cramped bathroom. If she left, or screamed, he said he'd kill her.

As her contractions grew stronger, she pleaded for him to let her go to the hospital. Finally, he allowed her to go to her sister's house nearby, and she took Newman to the Ojai Valley Community Hospital.

"I prayed and prayed and prayed that I could get through the day," Newman says.

"We finally got to the hospital, and my blood pressure was really high, and I had really high contractions, because he had put me into labor."

Her son, Landon, was born after 30 hours of labor and a number of medical interventions, due to Newman's high blood pressure and other complications, likely stemming from the abuse she'd experienced in the days before, her doctor said.

Her doctor didn't know about the severity of abuse beforehand, but had provisions of the Affordable Care Act been in place, he might have. Under the new federal law, health-care providers are required to offer domestic violence screening and counseling to all women, and health insurance companies are required to pay for those services.

"An estimated 25 percent of women in the United States report being targets of intimate partner violence during their lifetimes," reads a fact sheet on the coverage from the U.S. Department of Health and Human Services. "Screening is effective in the early detection and effectiveness of interventions to increase the safety of abused women."

* Names have been changed to protect the safety of the victims.



Health-care providers statewide have been working to implement the new requirements since they took effect in August 2012. Meanwhile, activists and those who work with domestic violence victims say the provisions are a good

start, but still not enough to solve the problem.

"I just think this is a really big problem, and I think we have to improve the ob-gyn comfort level with intervening and improve the skill sets to intervene,"

“ONE OUT OF FOUR WOMEN WILL EXPERIENCE INTIMATE PARTNER VIOLENCE IN THEIR LIFETIME.”

says Priya Batra, a women’s health psychologist who helps lead a domestic violence task force in Sacramento. “The most helpful intervention is saying, ‘This is not OK, you do not have to live this way, there is hope out there for you.’”

Most health-care providers have added a domestic violence screening aspect to their “well-woman exams,” or annual checkups. But, depending on the provider, the screening could range from simply asking women experiencing abuse to check a box on an intake form to the physician taking several minutes to ask each patient a series of questions.

“I encourage clinicians to ask, ‘How are things at home?’—something that’s a conversation,” says Brigid McCaw, an internal medicine doctor and the medical director of Kaiser Permanente’s Family Violence Prevention Program in Northern California. “I will often follow it up with, ‘Do you ever feel physically or emotionally threatened or hurt by your partner or spouse?’”

To help them comply with the new law, some doctors, nurses and therapists also receive special training on how to help women experiencing domestic violence. McCaw believes this should be standard.

“This is so common, unfortunately—one out of four women will experience intimate partner violence in their lifetime—and you can’t tell just by looking at age or social or economic status or education or religion or sexual preference,” McCaw says. “So screening every woman when she comes in for a well-woman visit or other conditions or concerns is absolutely warranted. There’s no way to know unless you ask.”

There’s also a lack of emergency shelters and transitional housing for victims, whose ability to escape the abuse often hinges on having another place to live, Batra says.

According to the 2012 National Census of Domestic Violence Services, a survey taken by all domestic violence agencies on Sept. 12, the agencies served 5,258 victims in California that day. On that same day, the groups were unable to meet 1,170 requests from victims for help. About 68 percent of those requests were for housing—both emergency and transitional.

Domestic violence often escalates during stressful life events, such as pregnancy, particularly if the pregnancy is unplanned or occurs in tangent with economic difficulties, according to the California Partnership to End Domestic Violence.

Women who have been pregnant within the last five years experience 12 percent higher rates of intimate partner violence, according to the 2005 California Women’s Health Survey cited by the nonprofit.

Of those experiencing physical intimate partner violence, 75 percent of the victims surveyed had children under the age of 18 at home.

Domestic violence and abuse—whether emotional or physical—can take a toll on both a pregnant woman and her developing fetus, McCaw says.

“We’re just beginning to understand in the last 10 to 15 years how important the maternal experience is for how babies do,” she explains. “The fear and stress related to intimate partner violence, even if there aren’t direct injuries, certainly have an impact on the developing baby, and

those risks can stay with the baby over time.”

Pregnant women living with abuse face higher chances of preterm delivery, as well as pregnancy complications, such as high blood pressure. They also have higher incidences of depression, post-traumatic stress disorder and anxiety disorders, McCaw said.

A pregnancy can make it more difficult for a woman to leave an abusive relationship, particularly if she’s reliant on her partner for health insurance, money or housing, says Krista Kotz, program director for Kaiser’s Northern California Family Violence Prevention Program. “In general, things that would make a woman more financially vulnerable make it more difficult for her to leave.”

Ventura mother Dena Lopez* experienced severe abuse when pregnant with all three of her children, giving birth twice with black eyes, bruises and broken ribs. Finally, after giving birth to a stillborn baby who she “felt sure was brain damaged because of the beatings,” she left her husband.

That was more than 30 years ago, and she’s now a grandmother. Lopez also volunteers at a local shelter for domestic violence victims.

“I talk to the women who are in the same state of mind that I was in, and I try to tell them, ‘You don’t try to stay together for the kids. In the end, the decision to leave, it’s a life or death choice,’” she says. “The biggest thing is just knowing you’ve got some outside support and that’s the one big reason that you stay or return.”

Newman, who was beaten multiple times while pregnant, left her son’s father a few days after he was born, with \$3 in her bank account. She wasn’t sure how they’d survive, but she found work as a waitress, got an apartment in Ojai and obtained full custody of her son.

Landon is now two and doesn’t remember his father.

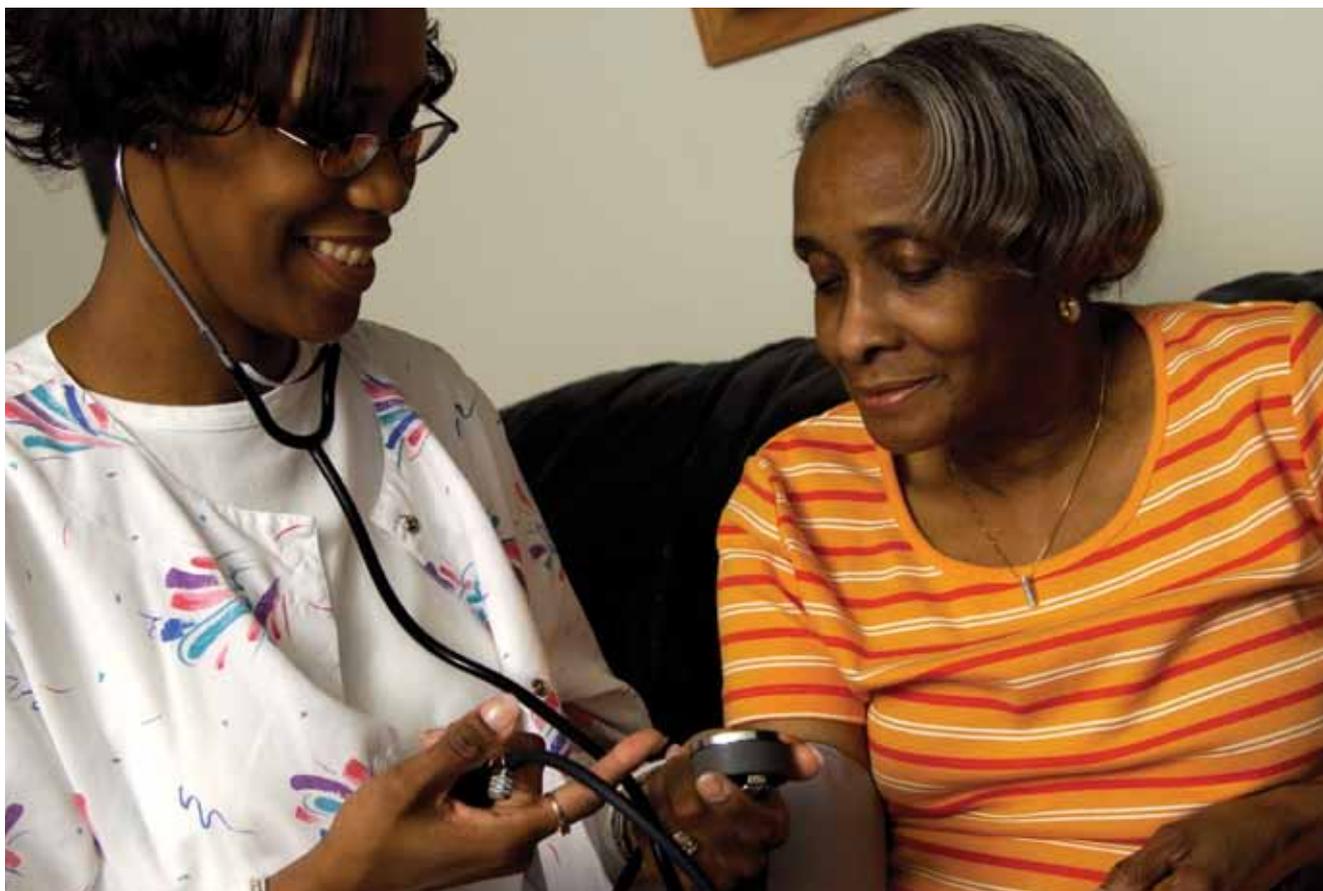
“I didn’t want Landon to grow up thinking that it’s OK to treat women that way,” Newman explains. “He’s such a sweet and loving boy. What happened before almost seems like a dream.” **CHR**



Are you a victim of domestic violence? Go to WomensLaw.org or call the National Domestic Violence Hotline: 800-799-7233.

Controlling the Silent Killer

Tailoring hypertension treatment for African Americans



BY HEATHER TIRADO GILLIGAN

WHEN CODY WALLACE HEARD that he had high blood pressure, he wasn't too worried about the diagnosis. His doctor prescribed a drug to help manage his hypertension, one that he would likely have to take for the rest of his life. But he didn't feel sick. "When I first started taking the medicine, I was still in denial," Wallace says, "and doing the regular things I would do every day." He didn't change his diet or start exercising.

Denial is not an uncommon reaction in patients newly diagnosed with hypertension, says Stephen Sidney, Associate

Director for Clinical Research at Kaiser Permanente Northern California Division of Research and doctor of internal medicine. High blood pressure does not come with physical symptoms and doesn't interfere with daily activity. "You don't feel it," Sidney explains. "It's just a number."

Because high blood pressure doesn't feel like a significant health problem, but can have grave consequences, the condition is often called the silent killer. Managing hypertension is crucial to good health and longevity. Uncontrolled high blood pressure is a significant risk factor for two leading causes of death in the United States: strokes and heart attacks. A blood pressure of 140/90 or

higher puts patients at risk "for all kinds of nasty illnesses," Sidney says, including kidney failure and peripheral vascular disease, a condition where blood flow to the legs and arms is restricted by narrowed arteries.

Sidney directs a new project at Kaiser Permanente's Division of Research that is designed to test the best way to treat hypertension patients like Wallace, who is African American and a Kaiser patient. Ultimately, the project aims to reduce the disparities in rates of hypertension between African Americans and whites.

One-third of all Americans suffer from hypertension, but many more African Americans suffer from hypertension than whites. Nationally, African Americans are

three times as likely as whites to suffer from strokes, despite efforts to increase awareness and blood pressure monitoring over the past decade. “The prevalence of hypertension in blacks in the United States is among the highest in the world,” wrote researchers from the American Heart Association in a 2012 analysis, “and it is increasing.” Not only are African Americans more likely to have high blood pressure, but they are less likely to have the condition under control.

Rates of uncontrolled high blood pressure have dropped dramatically among patients at Kaiser over the last decade, from 80 percent to 40 percent, Sidney says. But the disparity between African Americans and whites remains at 4 percent.

One project of the study, called Shake, Rattle and Roll, will try to erase hypertension disparities in the East Bay, where one-third of Kaiser patients are African American. The three steps of Shake, Rattle and Roll include helping patients to shake the salt habit, getting doctors to rattle the treatment protocol when treating African American patients and rolling out the results of the trial.

Though the exact reasons for the disparities in high blood pressure are unknown, some important differences have been noted in how African Americans react to risk factors and treatments for hypertension. African Americans appear to be especially sensitive to salt, Sidney notes. Some hypertension medications work better for African Americans than they do for people in other racial and ethnic groups. Diuretics are often used to treat high blood pressure, but they seem particularly crucial in treating African Americans with hypertension. Researchers hope that recommending lifestyle changes and treatment options tailored to African American patients will reduce their rates of hypertension.

**“YOU DON’T FEEL
HIGH BLOOD
PRESSURE,”
SIDNEY EXPLAINS.
“IT’S JUST A
NUMBER.”**

Researchers also hope to better understand what may be an emerging threat to improving hypertension-related health disparities. Recent evidence suggests that the prevalence of strokes is increasing in younger people, age 25 to 44. Younger African Americans are twice as likely to suffer strokes compared to younger whites.

Kirsten Bibbins-Domingo, an associate professor at UCSF and internist at San Francisco General Hospital, says that she has seen more strokes among her young patients. “We know that many things have changed over time,” Bibbins-Domingo says, pointing to rising rates of childhood obesity, young adults who weigh more, and higher blood pressure

and cholesterol. But little is known about exactly why such increases occurred.

Bibbins-Domingo is leading the efforts to analyze medical records to determine which factors young stroke patients have in common. “We know that will translate into lower rates of stroke over time,” she says.

Understanding what risk factors can be changed helped patient Cody Wallace. He decided to take his hypertension seriously after his sister died of cancer and his mother began to suffer from dementia that was likely brought on by a stroke. He knew what he had to do—modify his diet and exercise habits. Now he walks around Oakland’s Lake Merritt every morning and eats more healthfully—and his blood pressure is back to normal. “I feel a lot better,” Wallace says.

Sidney says that regular monitoring of blood pressure is also an important and relatively easy way to prevent strokes, as that is often the only way people know they have high blood pressure.

Wallace also has some advice for people newly diagnosed with high blood pressure: “You really need to listen to your hypertension signs. Even though you don’t feel sick, they actually mean something.” **CHR**





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The State of California's Children

A Q & A with Ted Lempert

BY DANIEL
WEINTRAUB

TED LEMPert IS PRESIDENT of Children Now, a nonprofit that tracks the condition of California children and advocates for policies the group thinks will benefit kids. Daniel Weintraub, editor in chief of the California Health Report, interviewed Lempert to get his take on how California kids are doing. These are edited excerpts of that interview.

Daniel Weintraub: How would you assess the state of California's children today?

Ted Lempert: Not very good. Not where it should be. We do a report, with the Annie E. Casey Foundation, where we look at all 50 states and how children are doing in education and health and on economic indicators. We ranked 41st out of the 50 states.

Weintraub: What are some of the indicators?

Lempert: There are 16, and they are more outputs than inputs, so we're not just measuring spending. We look at reading scores, math scores, percentage of kids who attend preschool, graduation rates, kids living in poverty, low-birth-weight babies. That's one study. But I think it's reflective of lots of other indicators we have seen.

California is a relatively high tax state, but we are in the bottom half in per capita spending on education, the bottom half in terms of kids' health. There is something completely out of whack in terms of kids not being a priority in this state.

Weintraub: How would you change that?



Lempert: We should invest based on our priorities. I think most elected officials and a lot of key groups would say kids and education need to be a priority. They should get first call. Not just kindergarten through 12th grades, but also early education and kids' health.

Weintraub: Are there any specific changes you support?

Lempert: We are strongly supporting the governor's local control funding formula. It would get dollars to the kids who need them most. Kids in poverty and English learners. It's clear these kids need some extra support, and this proposal is trying to do that in a more rational way. We also think it is good to start shifting the command and control from Sacramento to local districts. The state should have tough standards, yet then

the implementation needs to go back to the districts. This proposal really starts that in a responsible way.

Another big issue is early childhood education. If you look from 2008 and where the most egregious cuts were, child care and early education were slashed. But now that the economy is improving, the proposals say hold funding steady rather than reinvest. We need to do better.

Weintraub: Children Now also has raised questions about the state's transfer of low-income children from the Healthy Families insurance program to Medi-Cal. How do you think that is going?

Lempert: We opposed that transfer last year. We were told that kids' health care would not be interrupted. That it would be a seamless transition, and the state would make sure that the services remained intact and the

quality wouldn't suffer. That has not been the case. In terms of autism therapy and dental and specialty care, there has been a significant disruption of services.

Weintraub: Is there any good news?

Lempert: In a few areas we're making some progress. There's clearly more investment going into K-12 education this year. But if you compare us to other states, and when you look at how absolutely essential it is that we're making sure every kid has the education and health support to have a realistic shot to be successful in today's economy, we've got a long, long way to go. A lot of this is just prioritization. If the rhetoric behind kids was matched by the investment and a focus on quality, you could see some dramatic improvement. **CHR**

California is Richest, Poorest State

BY DANIEL WEINTRAUB

IT'S FAIR TO SAY that California is the richest state in the nation. We have more millionaires than any other state, and mansions dot our coastal bluffs and inland canyons.

But California is also, arguably, the poorest state in the nation. We have more people in poverty—6.1 million—and more children in poverty (one in five) than any other state. Even more ominously, a new measure of poverty shows that California has the highest percentage of its population living below the poverty line.

By the traditional measure, California's poverty rate is 16.6 percent, 20th in the nation. But the new, supplemental measure released last year by the Census Bureau puts California at the top of the list with a poverty rate of 23.5 percent. Unlike the official measure, the supplemental poverty measure reflects the cost of living—including housing—in a state and also takes into account transfer payments such as food and housing subsidies and tax credits.

By either measure, though, it is clear that California has a lot of poor people, far more than its glittering image would suggest.

Part of this is a reflection of our diversity and the character of our recent population growth. We are a state of immigrants, and the wave of immigration from Latin America that peaked in the 1990s brought millions of desperately poor people to California.

These immigrants were not just penniless; many also had little formal education. They had very little capacity to work in any job outside agriculture and menial labor. They were, largely, stuck at the bottom rung of the economic ladder. Their lives here might have been better than the conditions they left behind, but still they formed a large and intractable bubble in the state's poverty numbers.

Immigration also helps explain the regional differences in poverty in California. Immigrants tended to concentrate in counties where agriculture was dominant and the cost of living was low. A look at the poverty numbers by county shows the contrast.

The counties with the lowest poverty rates (using the traditional measure) are generally those near the coast, places like Marin, San Mateo and Santa Clara



counties. Some foothill counties are also on this list: Placer and El Dorado near Lake Tahoe, and Calaveras in Gold Country.

On the other extreme are, for the most part, counties in the Central Valley and other agricultural regions. In Merced County, more than one-quarter of the households have incomes below the poverty line. The situation is similar in Fresno, Kern, Tulare and Imperial counties. In fact, three of the five most impoverished metropolitan areas in the na-

tion are in the Central Valley.

The numbers also show the connection between poverty and family structure. Families headed by a single parent are much more likely to be living in poverty. In the 10 counties with the lowest poverty rates, 25 percent of families have a single parent. But in the 10 counties with the highest poverty rates, 36 percent of families are headed by one parent. And in those counties, more than half the families with a single mother are living in poverty.

Education is also correlated with poverty. The counties with the lowest high school dropout rates, like Placer, Calaveras, Marin and El Dorado, also tend to have the lowest poverty rates. And the same is true in reverse: Some of the poorest counties, like Kings, San Joaquin, Yuba and Fresno, also have some of the highest rates of high school dropouts. It's not clear whether failing to complete high school causes poverty or is caused by it, or both, but the two are definitely linked.

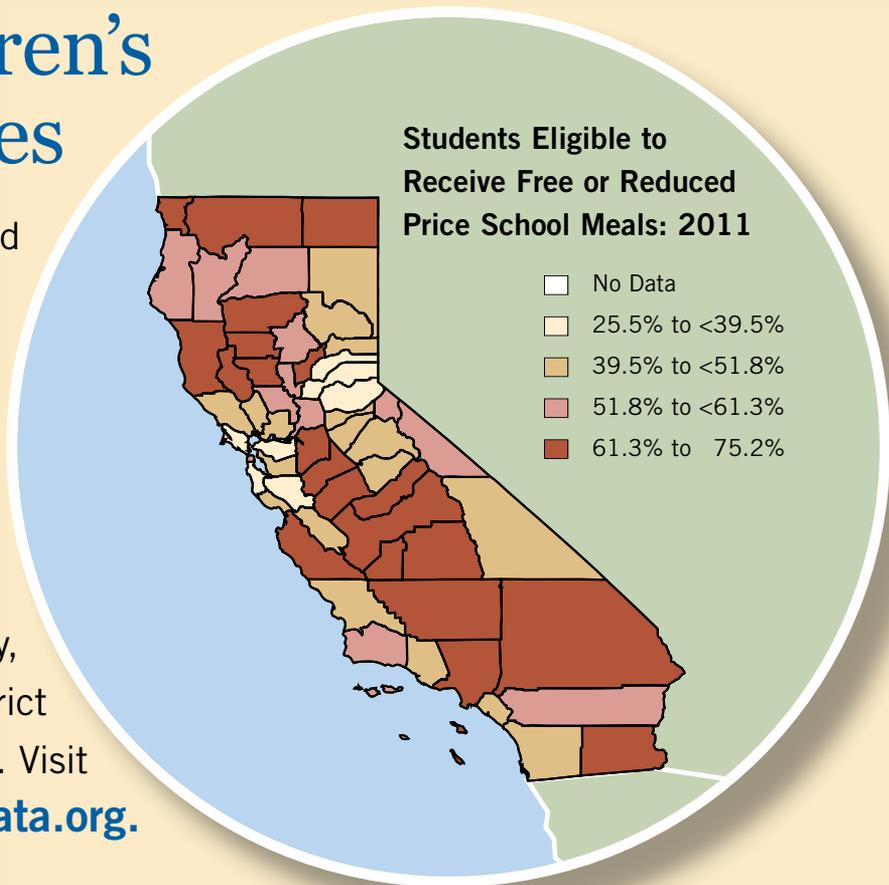
The good news for California is that second-generation immigrants tend to be better educated than their parents, have a better command of the English language and are less likely to be living in poverty. By the third generation, the gap between the grandchildren of immigrants and other Californians shrinks even further. So with immigration having peaked in the early 1990s, time will slowly make at least a dent in these numbers.

But California still has a long way to go. As the economy improves and the wealthy and middle-income people see their situations improve, the state needs to be careful not to sustain a forgotten underclass. We need a concerted, focused effort to change the things that are correlated with poverty—from high school dropouts to single parenthood. That won't eliminate poverty, but it would be a big start. **CHR**

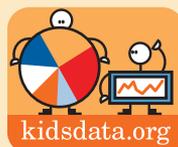


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10 THINGS YOU SHOULD KNOW

ABOUT AGING WITH DIGNITY AND INDEPENDENCE

Aging with dignity and independence is the ability to live life to its fullest in the place you call home, regardless of age, illness, or disability.



1

Most of us will need a little bit of help to get by as we get older.

2

Most of us are not prepared to pay for care.

3

Supportive services can be really expensive.

This free publication, **“Ten Things You Should Know About Aging with Dignity and Independence”** comes with five steps you can take to be ready in case you or someone you love needs help.

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