Many senior citizens are forced to give up independent living because they are unable to find services to meet their needs. Urban Partnership and Community Development Center (UPCDC) is a Saint Paul community-based organization with the mission “to enhance the soul of our community through connecting senior citizens to each other and to living assistance services.” UPCDC is dedicated to serving local seniors through multiple channels and is the only local organization in Minnesota to offer free transportation to the elderly and disabled for medical and other appointments.

The organization’s founder and executive director, Mrs. Frances Harris, is a local senior and 2004 Concordia University graduate. Opening of the center was driven by an individual struggle of Mrs. Harris as she managed caring for her late husband with a terminal illness. “I had to deal with the loss of my husband while trying to find answers to many complicated questions such as: how do you keep working while taking care of your spouse, what is hospice care and how do you find information about it, and why do I have to sell my home of 37 years to pay medical bills?” Harris states, “I want to do something for others facing similar situations.”

The feature program of UPCDC is Healthy Senior Living, a support group for seniors that offers nutritional consultations, personal safety, legal services, and monthly activities and seminars on various health issues including arthritis, diabetes, heart disease, mental illness, and stroke. Elizabeth Webster, UPCDC development director, embraces the knowledge and wisdom each senior brings to the organization. “As I sit and listen to their life stories of strife and struggles, the gleam in their eyes and the smiles on their faces do not reflect the miles they have walked or the tears they have shed.”

The organization’s second annual conference, Seniors Keeping the Beat, will be held October 9, 2009 at the Amherst Wilder Foundation Center in Saint Paul with a focus on cardiovascular disease, diabetes, mental health, and elder legal issues.

For more information about UPCDC or their October conference, please contact: urbanpartnershipcdc@yahoo.com or 651-228-1445.
Understanding the Transitioning Character of African Immigrant’s Health

by Sirad Osman, New Americans Community Services

Towards the end of last century and beginning of the 21st century, local communities in Minnesota began to see new faces arriving on a daily basis. These faces wore the expressions of fear, confusion, and loss, as they were immersed into a society that contained virtually nothing familiar to them. Their minds were plagued by the loss of loved ones, traumatic flashbacks of war, and the fear of what would become of them next. The opportunity to travel to the United States and seek new opportunities gave them a renewed sense of hope for their futures.

Minnesota has the sixth largest refugee population in the United States, the second largest Hmong community in the nation, and the largest population of Somali immigrants. Today, there are 127,224 African immigrants and refugees in Minnesota of which slightly over 24% are Somalis. A large African and Asian immigrant population, in addition to the significant growth among Latinos, make Minnesota an ideal setting to develop innovative interventions to improve the health of these diverse communities. Given this rich opportunity, difficulty for health researchers and practitioners to assess the health priorities of African immigrant and refugee communities in Minnesota is still a common occurrence.

Minnesota’s refugees arrive as a result of a number of social, political, and economic reasons—including the prospect of increased opportunity, fleeing civil war, and political unrest in their country of origin. Many arrive with ongoing health problems. Additionally, the majority of African immigrants and refugees experience difficulties adjusting to American culture that impact their health, including learning the English language, finding affordable housing, and obtaining employment and transportation.

As African immigrant and refugee populations in Minnesota continue to grow, it is especially important to gauge the communities’ perspective of threats to their health and develop interventions that target their concerns and consider their perspectives. It is likely that other factors like length of time in the US, English language skills, and other features of the acculturation process that impact the health of Somali refugees may be similar for other African immigrants and refugees. We must also examine the experiences of specific refugee communities from Africa whose experiences may be very different from one another, as well as different from general immigrant experience. <<<
The risk of obesity is not randomly distributed across the U.S.; certain segments of the population are more likely than others to be obese. One factor that may contribute to obesity risk is the environment. A large and growing amount of research suggests that residents of low-income, minority, and rural neighborhoods often have poor access to supermarkets and affordable healthy food, and a significantly higher availability of fast food restaurants and high calorie, low nutrient food sources.

Research published in the March 2007 *Preventive Medicine* found lower-income neighborhoods have significantly fewer chain supermarkets than middle-income areas, and after controlling for income and other covariates, the availability of chain supermarkets in predominantly black neighborhoods is approximately one-half of the offerings in predominantly white neighborhoods. Predominantly Latino neighborhoods have under one-third as many chain supermarkets compared to largely non-Latino neighborhoods. Larger and chain supermarkets have consistently been reported to offer foods at lower prices, and more likely to carry healthy and fresh foods than smaller food stores.

In the December 2008 *American Journal of Preventive Medicine*, investigators examined a sample of 159 Baltimore City and County neighborhoods and the 226 food stores within them and found important differences in healthy food availability by neighborhood racial and income composition. Forty-three percent of predominantly black neighborhoods, and forty-six percent of lower-income neighborhoods were in the lowest category of healthy food availability versus four percent and thirteen percent, respectively, in the comparison neighborhoods. While these differences where largely attributed to less supermarkets in predominantly black and lower-income neighborhoods, variation in healthy food availability was also found in similar types of stores located in different neighborhoods.

Access to quality and healthy foods is a baseline requirement for obesity prevention and recovery, and high calorie, low nutrient foods are the real-life competition exemplified by their high availability and low price. To ignore the inequality of food environments between specific locations will guarantee less than ideal results for obesity prevention today and going forward. <<

Knee Replacements, continued.

between Caucasian and African Americans persisted in the nation overall and increased in 19 states.

To compound this problem, a January 2008 article in the journal *Archives of Internal Medicine*, among others, reports that while overall outcomes of total knee replacement procedures are favorable, racial and ethnic minorities, the poor, elderly, and less well-educated are more likely than others to have worse perioperative (time from ward admittance to surgery recovery) and functional outcomes. These outcomes are found to be strongly associated with hospitals performing a low volume of these procedures. The previous study found that patients using “low volume hospitals” were more likely to be nonwhite, be eligible for Medicaid, and live in rural areas. These patients were also more likely to come from neighborhoods with higher concentration of poor citizens, and higher concentration of foreign-born citizens and ethnic and racial minorities.

The likelihood of undergoing total knee replacement procedures in underserved populations and the respective procedure-related outcomes are two separate and significant issues yet to be adequately addressed. Within the broader field of health care quality, these findings represent two important and achievable opportunities for improvement. <<
Director’s Report continued

on understanding the role of patient-provider communication in health disparities and quality of care. Our goal in bringing Dr. Cooper to Minnesota is to provide learning opportunities for health care providers, faculty, trainees and community members focused on evidence-based approaches to reducing barriers to equitable care and overcoming racial and ethnic disparities in health care. Among smaller community events, Dr. Cooper will speak at the University, jointly sponsored by the Departments of Family Medicine & Community Health, and Medicine, on Wed., Oct. 21 from 12:00 to 1:00 p.m.

I hope you’ll enjoy reading this issue of The Connection and we look forward to receiving any feedback or suggestions that you may have. Feel free to visit us on the Web or contact us at: healthdisparities@umn.edu.

Fairly Healthy

Occupational Health Disparities and Immigration

by Eduardo Medina, School of Public Health, Cardiovascular Division, Department of Medicine

Immigration continues to receive the attention of our nation’s political and media cycles. Immigrant labor is a vital part of the national economy. The food we eat, clothes we wear, spaces we occupy, and much of the convenience of our lives is owed to immigrant labor. Much has been made of the impact of immigration on our healthcare system, but this discussion is incomplete until we address what impact our healthcare and immigration systems are having on immigrants.

According to the Centers for Disease Control and Prevention’s National Institute for Occupational Safety and Health, immigrant laborers are at a disproportionate risk for workplace injury and illness, primarily because immigrants are overrepresented in the most hazardous occupations – namely agriculture, construction, food processing, and manual labor. Immigrant workers also endure workplace abuse at levels intolerable in other communities. For example, the Southern Poverty Law Center documented that wage theft, sexual harassment, discrimination, and violence were widespread for Latino workers in the South. Therefore, a significant proportion of the workforce operates without the safe, healthy, and fair workplace conditions to which they are entitled.

Immigrants, no different than native-born citizens, need access to healthcare. However it is well documented that immigrant communities are underserved by our healthcare system. First and foremost, immigrants are less likely to have access to health insurance. Immigrants are almost three times more likely to be uninsured than native-born citizens. This difference is attributable to the lack of insurance coverage offered by immigrants’ employers. Not surprisingly, the profile of the uninsured is consistent across immigrant and non-immigrant groups, meaning that younger, less educated, and lower skilled employees are less likely to have access to health insurance.

Immigrants experience significant health disparities in outcomes and access to care. Resolving health disparities in the United States will mean addressing the lack of provision of healthcare for immigrants and native-born citizens alike. Advocates for immigration reform and health equity can find common ground in this mission.