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IMPACT AND FUTURE OF LATINO HEALTH: A Review of the 2007 Legislative Health Agenda



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Latino Health in California: *The Status of Latino Health*

Recent projections from the California Department of Finance provided an updated look at the future of Latinos in California. It was of little surprise that the data indicated what many of us already suspected – Latinos are due to become a majority of the state's population by 2042.¹

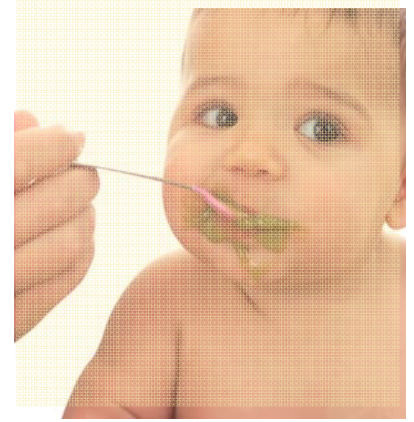
Not only significant in size, Latinos are generally younger than their counterparts, with a median age of 25 compared to 34 for our counterparts.² This is not surprising, considering that one out of every two children born today is Latino. As a young and growing population, Latinos are expected to make up the majority of those in our educational system by 2020.³

At the same time, California's entire population continues to climb. Already California is not only one of the largest states in terms of its geographic size, but also in terms of its population. Today, its population is nearly double that of the next largest state, the state of New York.⁴ According to the same Department of Finance report, it is expected that California's population will increase to 60 million residents, nearly twice the population size since the 2000 U.S. Census. The majority of the population growth projected to occur in California's Central Valley and the Inland Empire, largely due to increases in California's Latino population.⁵

Unfortunately, the future of Latinos remains unclear, as Latinos in California continue to struggle in educational attainment rates, often more likely to experience a working-poor status over their lifetime.⁶ In fact, working poor families are more likely to be Latino and more than half of Latino working households with children had incomes below 200 percent.⁷ Additionally, Latinos are less likely to receive health care coverage as a job-based benefit.⁸ The combination of working yet still poor makes many Latinos eligible for the Medi-Cal and Healthy Families program.

Given their sheer population size and working-yet-poor status, it is not surprising, that many Medi-Cal and Healthy Families enrollees are Latino. Medi-Cal in total covers more than 6 ½ million enrollees. The majority of these Medi-Cal enrollees, are in fact, Latino representing over 3 million Latinos, out of the state's 11 million Latino residents, that rely on Medi-Cal as their usual source of care.⁹ Healthy Families, created to provide health care coverage to children, provides coverage to an additional half a million Latino children, representing 60% of the program's total enrollee population, totaling more than 3 ½ million Latinos represented in both programs.¹⁰

Now more than ever, however, health care continues to be a critical issue for Latinos. With increasing rates of obesity, ongoing health disparities, and increasing rates of chronic illnesses such as diabetes and cardio-vascular



disease, this generation of Latinos may be the first generation whose life expectancy will be less than that of their parents.¹¹ Rising healthcare costs, little-to-no checks on profits gained by private entities, a complex patchwork of participants in a complex health care system all compound many of the issues Latinos face on a personal level. How can we begin to effectively address these issues?

History of LCHC – Celebration of our *quinceañera*

It was a group of advocates, health care providers, and consumers that recognized the strong need for the Latino voice to be represented at the statewide policy-making level, where often decisions are made that impact the day-to-day lives of many Californians. Unfortunately, not every decision is made from the perspective of California's consumer, much less Latinos, which have over last several decades become a significant portion of those consumers.

As a result, LCHC was formed in 1992 in order to provide advocacy that represented the specific health care needs of California's Latinos. The heart of LCHC has remained strongly committed to three major themes. First, to work towards ensuring that Latinos have access to quality, affordable healthcare. Second, that Latinos, given our propensity to be overrepresented in those with chronic conditions and who continue to face ongoing healthcare disparities, must have those disparities reduced or removed and third, to improve our overall community health.

Almost immediately, LCHC began to work with various state agencies and departments to ensure that culturally-appropriate care was provided, particularly in Medi-Cal, California's Medicaid program that today is the largest in the nation. LCHC also developed the Latina Health Policy Project in 1994, as a way to empower Latinas to advocate for their health care needs. Today, that commitment to community empowerment continues through the various regional networks held throughout the state.

As a way to address issues related to ensuring that Latinos were represented in the health care workforce, LCHC co-sponsored legislation with the California Medical

Association and the California Primary Care Association to develop the first-ever loan repayment program for doctors serving in medically-underserved areas, later named the Stephen L. Thompson Loan Repayment program.

Today, LCHC is committed to expanding those same opportunities to those wishing to pursue a health care profession beyond becoming a doctor. This year, LCHC sponsored SB 615 (Oropeza) that would have provided one of the first loan repayment programs for an allied health profession – pharmacy technicians representing the second-largest profession in allied health, which today is made up of more than 200 various professions. While the Governor has vetoed SB 615, LCHC will continue to strongly advocate for the development of an accessible health care system in designated medically-underserved areas in order to ensure that Latinos have access to the same level of services as all other Californians.

Additionally, LCHC's remains committed to developing a workforce that is reflective of the state's population. This year, LCHC co-chaired the Healthcare Workforce Diversity Advisory Committee through California's Office of Statewide Health Planning and Development Office in order to develop recommendation on policy solutions to address California's health professional shortages, particularly among California's underrepresented populations.

Since its inception, LCHC has worked to promote culturally appropriate medical service, primarily through ensuring cultural competency and linguistically-appropriate treatment and care. This is of particular interest for California's limited English proficient patients (LEPs), who today represent one in five Californians.¹ For Latinos, it is estimated that over two-thirds of California Latinos (78 percent) speak a language other than English at home.²

For this reason, LCHC sponsored legislation in 1994 to implement culturally and linguistically sensitive standards for health maintenance organizations participating in Medi-Cal and developed a cultural index that was later adopted by the state's then-named Department of Health Services. Similar efforts were undertaken for mental health as the state's Department of Mental Health followed suit and adopted the recommendations in 1998. Today, LCHC continues to work around cultural competency and linguistic access and currently co-chairs the Medi-Cal Language Access Services (MCLAS) Task Force with the Department of Health Care Services' Office of Multicultural Health, as follow-up to last year's legislation that would have created the task force, SB 1405 (Soto).

Today, the changing needs of our community point to a

new problem – obesity. Latino adolescents struggle with obesity at alarming rates above those of their counterparts. As a direct result, LCHC co-sponsored legislation, SB 965 (Escutia) and SB 12 (Escutia) in 2005, spearheaded by the California Center for Public Health Advocacy that removes soda and junk food from California's schools that began to take effect in July 2007. Despite serious efforts around preventing obesity, new research indicates that the problem continues to grow. As a result, LCHC sponsored legislation (AB 898) earlier this year that would have targeted the specific needs of conducting obesity prevention through nutrition and diet information in a culturally appropriate manner, utilizing *promotores de salud*, a tool that has proven effective for California's Latino communities. Beyond all of these issues, we continue to recognize,

however, that more needs to be done.

Building Regional Advocacy

Since its foundation, LCHC has worked to establish Regional Networks throughout the state to engage local community leaders in state and local issues affecting Latino health. These networks are located in the state's geographic hubs with high concentrations of Latino residents including Los Angeles (LARN), the Bay Area (BARN), San Diego (SDRN), and the Central Valley (CVaRN). LCHC works with regional partner organizations and coalitions to empower and activate local leaders to fully participate in government decision-making processes. These regional networks work to develop a socio-political infrastructure that addresses locally-defined needs and conditions, poses local solutions to the health problems Latinos face, and increases community knowledge. Additionally, the regional networks work to foster skills and capacity to participate in and contribute to policy-making decisions, and coordinate statewide responses to policies affecting Latino health.

This year, the Regional Networks prioritized the issue of health care reform and other Latino health legislation. As a result, Regional Network and Coalition members took action that included signing on to letters and principles statements, calls to legislators and the Governor, and going to visit with Latino Caucus members in their district offices. LCHC's Regional Networks will continue to convene activities that strengthen our regional members' relationships with elected officials and other stakeholders in the community as a means to bring decision-making, advocacy and agenda-setting back to the community through its local leaders.

2007: Still the Year of Healthcare Reform

As we work toward the end of the 2007 legislative year, health care reform continues to be the main topic, having been initiated by Governor Arnold Schwarzenegger who dubbed the 2007 legislative session as the year of healthcare reform. Speaker of the state Assembly Fabian Núñez and state Senate President Pro Tem Don Perata both introduced legislation to overhaul and reform California's healthcare system, closely followed by the release of Governor Schwarzenegger's own proposal earlier this year. Considering the major implications of health care reform and the hope consumers, advocates and legislators all shared, health care reform has proven to be a difficult problem to solve. Without a doubt, our complex health care system and, more importantly, finance of the system are critical to that resolution. All of the major proposals sought to increase coverage

for uninsured Californians, control of health insurance costs which continue to skyrocket, reform certain aspects of the health insurance market, and improve the general wellness of the state's population. Unfortunately, each of the initial plans identified a different manner of accomplishing their goals, which ultimately provided for a year of engaged and lively debate.

The uncertainty surrounding healthcare reform has spilled over into many pieces of legislation that LCHC either sponsored or worked on this year. Proposals on obesity prevention, such as AB 898, or healthcare access expansions through school health centers (SB 564) were held over because it remained unclear if these bills would be trumped by a larger healthcare reform proposal. As such, healthcare reform was a greater influence in all health-related legislation in 2007, and even raised questions about the future of the state budget.

Looking Back, Where Are We?

In discussions throughout the year, both sides remained optimistic about reaching a deal by the end of the regular legislative session in September, but discussions were to later be delayed by the state's unexpected budget stalemate. After much speculation, the Governor did ultimately call a special legislative session (referred to as the First Extraordinary Session) immediately after the state's regular session. Having started in mid-October, the special session is expected to last till late November.

The state Assembly has convened a working group to go over the Governor's proposal, which was released in early October, and on November 5, legislative leadership developed substantive language for a reform bill in this special session. The current proposal from Speaker Núñez

and Senator Perata shows some major strides towards a compromise between all sides of the debate, especially with the Governor. The new proposal includes a mandate for individuals to have insurance, but only if the coverage is affordable and does not create a hardship. It also drops the original employer contribution from a flat 7.5 percent to 6.5 percent and below for smaller employers. It includes a hospital tax, as well as vast public programs expansions. Another financing measure introduced is a \$2 per pack increase on cigarettes to fund healthcare reform.

Advocates have believed that the Legislature and the Governor could likely agree on the broad policy measures needed to move healthcare reform forward. However, financing these expansions through a legislative vote would be near-impossible. As such, financing for these proposals will likely appear on a ballot measure, giving the power to California voters to make healthcare reform happen. Regardless, there is work left to do, and the building blocks are in place to improve our broken healthcare system.

As of the print date of this publication, it remains unclear whether actual reform will be completed by the end of the year, with some speculation indicating that the issue will need to occur in January 2008. However, both the Governor and legislative leadership remain optimistic about attempting to reach an agreement in policy differences, but members of the Assembly working group continue to have concerns on insurance rate regulation, the scope of benefits available to consumers, and, most importantly, the affordability of health care insurance coverage particularly if California's consumer will be required to purchase it through an individual mandate. With the new language proposed by the Legislature making some concessions to the Governor's proposal, there remains a real possibility for change to come.

LCHC, as the leading voice for Latino health will continue to advocate for over half the state's uninsured population, which is Latino. The Latino Coalition for a Healthy California will keep you posted on developments to the special session, and ways for our members to get involved.

Understanding the Legislative Process

In the following pages, we review legislative issues, referred to as bills, that affected Latino health. In addition, here is brief review to provide you context for the legislative issues included in this report.

Background

California's state government is composed of three branches: the Judicial, Executive and Legislative branch. For policy purposes, only the Executive and Legislative branches are required. The Legislative branch generally oversees the entire legislative process; however, the Governor's signature (Executive branch) is required in order to move the legislative measure, otherwise referred to as a bill, into law, particularly since legislation generally impacts the work of the Executive branch and they will often be referred to in order to provide technical assistance and background.

The Legislature is divided between two houses: the state Assembly and state Senate. In total, there are 120 legislators – 80 Assemblymembers and 40 Senators. Each California resident is represented by one Assemblymember and one Senator based on your home address and where you reside. Currently, Assemblymembers serve in two-year terms and Senators serve in four-year terms. All members of the Legislature must be elected by a majority of voters in their home districts, also based on their residence.

Each member is subject to limits on the number of terms that they may serve, with Assemblymembers subject to a limit of serving 3 two-year terms for a total of six years that they may serve in the Assembly. Senators are subject to a limit of serving 2 four-year terms for a total of eight years that they may serve. Each of these limits is per lifetime and no individual may serve longer than the total time limit for either the state Assembly or Senate, despite ongoing political debate on extending these limits.

Once these terms are completed, members are allowed to run for office in the opposite house, however, the lifetime limits still remain. Once those terms have been completed, members are not allowed to continue serving in that respective house.

Legislative Process

All legislative ideas, or bills, must be introduced by either an Assemblymember or Senator, called authors of the bill. The bill generally begins as a proposal or idea that can be initiated through a variety of sources including the general public, advocacy organizations representing the public, lobbyists, state agencies, or local government. These entities are generally referred to as sponsors of the bill.

Once introduced, each bill is assigned to a Policy Committee in the house of origin, based on the content area of the bill that will review the bill for its actual content. Through public hearings, policy committee members discuss the merits of the bill and vote on whether to pass the bill or not. To move forward, a bill must receive a majority of the full committee's support. Bills that impact more than one policy area may be 'double-referred', that is, referred to more than one policy committee for content review. This may occur in instances where a bill impacts, for example, both health and education.

If a bill has a fiscal impact, basically any bill that will cost money to implement, then the bill is referred to the Appropriation Committee in addition to the policy committee. It is no secret that the state has been struggling to balance its budget, and as a result, for the last few years, has held a tight line on increasing funding in any area. This atmosphere has made it so that any bill with a significant spending amount come under strict scrutiny. Generally, bills that are estimated to cost over \$150,000 are sent to the 'suspense file' developed by the Appropriations Committee. Initially, the suspense file allowed the Appropriations Committee to review spending on a whole instead of bill-by-bill.

More recently, however, this suspense file has become a graveyard for bills deemed expensive. Since the bulk of the legislative process is driven by legislative statute, meeting deadlines embedded in the legislative process is critical. Bills not meeting these deadlines often cannot proceed and are therefore referred to as 'dead'. Holding bills in a committee is one method to prevent a bill from moving forward in the legislative process which passively kills a bill simply through inaction. This is a particularly popular method of preventing bills from moving forward since it is not proactive, and in fact, requires no action. This naturally brings down the number of bills initially introduced.

However, bills are provided with a second chance in the two-year legislative session. If an author foresees problems in passing the bill, he/she may choose to hold the bill allowing for negotiations and changes to the bill language, known as amendments. The author may then take up the legislation in the second year of the two-year legislative session, bypassing first year deadlines to face second year deadlines. Bills that undergo this process are called 'two-year bills'.

Each bill is reviewed by a minimum of two committees, a policy committee and appropriations committee, before the measure is reviewed by the full all members of the house, which is either

the state Assembly or Senate. Once passed by each committee, the bill must successfully go through a full vote of the house with at least a simple majority of votes, referred to as a 'floor vote'. All bills must be reviewed first by the house that introduces it. If the bill is introduced by an Assemblymember, the bill will first be reviewed by policy committees and the appropriations committees of the Assembly. This is then often referred to as the 'house of origin' for that bill.

Once a bill successfully navigates through the legislative process in its house of origin, it then begins the identical process through the opposite house. All Assembly bills are reviewed by the Senate and all Senate bills are reviewed by the Assembly. Bills can be amended several times during the process as the result of negotiations,

and the final bill can be dramatically different from the original language of the bill. Thus, after passing the second house, bills are often returned to their original house for concurrence before being forward to the Governor.

Accordingly, the Governor has three choices: sign the bill into law, allow the bill to become law without signature, or veto the bill. Historically, Governors have rarely allowed bills to become law without his/her signature since this is one of the powers of their position as Governor. Once a bill is signed, it automatically becomes law beginning January 1 of the following year unless otherwise noted in the bill language. For more information on the legislative process, please visit:

<http://www.assembly.ca.gov/clerk/BILLSLEGISLATURE/LEPROCESS.HTM>

Budget Process – How does it relate to the Legislative Process?

Hand in hand with the legislative process is the budget process, which outlines what programs the state will fund next year and to what extent. While the legislative process lays out policy and bill language, the budget process provides for the actual state funding, which is often the implementation, of legislation. Bills, regardless of their successful passage through the legislature, are meaningless without funding, with a significant number of bills relying on General Fund support for implementation.

Occurring somewhat simultaneously to the legislative process, California's budget is introduced by the Governor in January and must be passed by a 2/3rds vote of both the Assembly and Senate before it can be forwarded to the Governor for their final review (with possible deletions through line item vetos) and their signature for final

enactment. The 2/3rds vote has generally meant that some votes must be garnered from the minority party, which in California has recently been from Republicans, in order to pass the budget measure. Given the unusually high number of votes needed and overall tight state budget has resulted in austere funding of new programs, legislation, and state budgets that are not passed on time due to political difference in funding of programs and state spending priorities. LCHC publishes two in-depth analyses of the budget each year in January and July. For more information on these analyses, please visit: www.lchc.org/policy

Intended to be a participatory process, California's Legislature and legislative process employs a static calendar with various points in the legislative process for public input, particularly during committee hearings. As an advocacy organization, LCHC's core function continues to rely on advocating for California's Latino population by providing such input as method to influence decision-making at the state level.

We continue to look to you for your input on these and other issues and welcome your feedback. Please feel free to join us at one of our regional network meetings.

For up-to-date information, please visit our website at: www.lchc.org



2007 Policy Priorities

Access to Healthcare

A Latino community that is strong, vibrant and able to access care in a timely and appropriate manner and that, when care is needed, the care provided is high quality, culturally and linguistically appropriate and affordable.

Health Disparities

Build healthy community through collaborative, multi-sect approaches to prevent disease and injury and to address social, economic and environments in Latino communities.

Community Health

Eliminate the underlying root causes of health disparities in low-income, people of color, and under-served communities in California so that all persons have a fair chance at being healthy.

Tier 1

Assembly bills:

- AB 1 (Laird) CA Healthy Children Ins [S]
- AB 8 (Nunez) Health Care Reform [W]

Senate bills:

- SB 32 (Steinberg) CA Healthy Children Ins [S]
- SB 472 (Corbett) Rx Label Standardization [S]
- SB 564 (Ridley-Thomas) School Health Ctrs. [S]
- SB 840 (Kuehl) Single-Payer [S]

Assembly bills:

- AB 269 (Eng) Dental Data [S]

Senate bills:

- SB 139 (Scott) SNAPLE [W]
- SB 615 (Oropeza) Pharm Tech Loan [S]

Assembly bills:

- AB 898 (Saldana) Promotores & Obesity Prevention [S]

Senate bills:

- SB 48 (Alquist) Grocery Stores [S]
- SB 120 (Padilla) Nutrition Info [S]

Tier 2

Assembly bills:

- AB 343 (Solorio) Beneficiary Report [W]
- AB 363 (Berg) Community Clinic Reimb [S]

Senate bills:

- SB 260 (Steinberg) Same-Day Visit [S]
- SB 400 (Corbett) Community Clinics [S]
- SB 606 (Scott) Rx Trial Data [S]
- AB 1226 (Hayashi) Provider Enrollment [S]

Assembly bills:

- AB 330 (Hayashi) Health Disparities [S]
- AB 365 (Portantino) State Workforce [S]
- AB 428 (Carter) College Prep Notice [S]
- AB 834 (Hayashi) Dental Outreach [S]
- AB 1540 (Bass) Cash for College [W]
- AB 1559 (Berryhill) Nursing Program [O]

Senate bills:

- SB 1 (Cedillo) CA Dream Act [S]
- SB 405 (Steinberg) Coursework [S]
- SB 764 (Migden) Physician Shortage [W]

Assembly bills:

- AB 74 (Dymally) PODER [S]
- AB 967 (Nava) Farm Fresh [S]
- AB 1472 (Leno) Healthy Places Act [S]

Senate bills:

- SB 207 (Padilla) Outdoor Recreation [S]
- SB 601 (Torlakson) PE Teacher Dev [S]

Key: [S] – Support [W] – Watch [O] – Oppose

Without a doubt, California’s uninsured population looms larger than any other state, generally due to our sheer size in population, representing more than 6 million uninsured Californians, the majority of which are Latino.¹ More than half (57%) of California’s uninsured are Latinos.² Latinos are also more likely to be uninsured than any other ethnic group and, unfortunately, are about two and a half times more likely to be uninsured than their White counterparts.³

Much of this can be directly attributed to their work status and level of annual income, largely due to the fact that our health care system is dependent on an employer-based system where employees receive a benefit such as their health care coverage through their place of employment.⁴ Unfortunately, employer-based health care coverage is declining, with lower-wage employers and small businesses often not providing access to health care coverage simply due to the high cost.⁵ As a result, those employees, despite the fact that they are working, are often locked out of a system of receiving benefits and must purchase coverage privately or, in some instances, may be eligible for a public health program such as Medi-Cal or, for children, Healthy Families.

As a direct result of this, public health programs have become critical lifelines for many employed Latinos who depend on this coverage for themselves or their families and children. Unfortunately, our healthcare system, even with access to health care coverage, is incredibly complex – particularly for those patients that may speak a primary language other than English. California’s patchwork of health care coverage coupled with its maze of health care delivery in the form of managed care plans, varying providers and coverage that may or may not match services provided often leave California consumers stranded, with many citing California’s broken health care system. Some of these issues raised previously in this report were replicated in legislative efforts listed below. LCHC continues to support efforts to increase access to health care and health care coverage while supporting safety net providers who are often at the front lines of providing critically-needed primary care and other preventive services. Below are the issues impacting access to health care:



Health Care Reform

For more than a year, California had debated its broken health care system, creating the impetus for a real reform of that system. As one of the largest state’s in the U.S., California represents not only one of the largest states geographically, but more importantly, one of the largest states population-wise.⁶

Overshadowing all other states, California’s population is nearly double that of the next largest states. In fact, just the Latino population alone is larger than either the states of Michigan, Virginia or Oklahoma.⁷ With such a large population, the percentage of uninsured translates into millions of Californians who today go without a usual source of medical care. While the debate on health care reform has not yet ended (as of the print date of this publication), the following bills represent the legislative efforts undertaken during the last year on health care reform:

AB 8 (Núñez)
Health Care Reform

WATCH

After months of debate, the Legislature – including both the state Assembly and Senate consolidated their legislative efforts by collapsing both, SB 48 by Senator Pro Tem Don Perata and AB 8 by Assembly Speaker

Fabian Núñez into one bill, AB 8.

The move to put forward one bill represented the entire Legislature’s effort to negotiate and comprise on differences in health care reform proposals (mentioned previously in this report) that many argued allowed proper public review through the typical legislative process.

The author and supporters of AB 8 contend that AB 8 would provide comprehensive health reform to expand affordable health care coverage to the California’s currently uninsured. Both SB 48 and later the consolidated AB 8 largely built upon California’s existing health care infrastructure by expanding eligibility for existing public health insurance programs such as Medi-Cal and Healthy Families while creating a purchasing pool for those not eligible for existing programs. AB 8 focused its coverage primarily on working Californians and utilized our current system of employer-based coverage. The majority of its expanded coverage would have been financed through employer pay-ins for those employers opting not to directly cover employee insurance costs.

One of the largest issues surrounding each of the health care reform proposals has been the issue of who pays. Under AB 8, those covered by insurance would have had a 5% cap on the total amount they would have to pay,

based on their annual income. This is often cited as the ‘affordability’ component of the proposal. One other element often highlighted in the debate has been the issue of whether consumers, much like California’s current requirement for auto insurance coverage, would be mandated to purchase – and prove – health insurance coverage. AB 8 did not include such a requirement.

These two issues combined account for the largest difference between the Governor’s proposal and the Legislature’s proposal. During the months of negotiations, the Governor was generally clear that, despite his support of reforming California’s health care system, he was not supportive of AB 8 and would be vetoing the bill. The debate on health care reform continues to evolve. LCHC will keep you posted.



Status: Vetoed by the Governor
AB 8 was forwarded to the Governor on October 2nd and was recently vetoed by the Governor.

SB 840 (Kuehl) SUPPORT
California Healthcare System (Single-Payer Healthcare Coverage)

SB 840 (Kuehl) would create the California Healthcare System (CHS), a single payer health care system that would be overseen by the California Healthcare Agency. SB 840 would provide health care insurance coverage to every California resident, regardless of their work status.

Coverage under SB 840 would make it so that any eligible individual could receive services under CHS from any eligible professional health care provided for services already typically provided, such as inpatient and outpatient care, preventive care, dental care and vision. Additionally, SB 840 encourages use of preventive care by removing any co-payments or deductibles for preventive care. For California residents whose family income does not exceed 200% of the federal poverty level, or approximately \$41,000 thousand in annual income for a family of four, no-cost Medi-Cal coverage would be made available to them at more-than or equal-to the same level of benefits otherwise provided through CHS.

Arguably, SB 840 fundamentally aims to replace an otherwise fragmented health care system in California and leverages dollars already spent in healthcare. Introduction of SB 840 in the 2007 legislative year represents a multi-year attempt by the Senator to continue efforts around a single-payer system. SB 840 and its predecessor bills, including last year’s SB 840 and SB 921 in 2003 has continued to be vetoed. With other reform proposals being discussed, SB 840 has continued through the legislative process with advocates in Sacramento and others working on state policy remaining somewhat divided over health care

reform and whether single-payer should be the eventual goal for providing healthcare. It remains unclear whether SB 840 – or elements of it – will be part of the final reform package.

SB 840, by covering all those residing in California, regardless of employment or citizenship status, would work to greatly reduce uninsured Latinos in California.



Status: Now a two-year bill
SB 840 has been held by the Senator and has not been sent to the Governor. Instead, this bill will continue in the legislative process when regular session begins in January.

Child Coverage

Covering all of California’s children has continued to be an issue debated at the state level. Despite aggressive efforts to cover every last uninsured child, it is estimated that there are still over 700,000 children in California today who are uninsured and lack access to medical care.¹ Last year’s legislation – AB 772 (Chan) and SB 437 (Escutia), which would have created universal child care for California’s uninsured children, at times appeared to be an easy win and, at other times, appeared to be struggling. Nonetheless, covering all children in California has continued to elude us.

With talk of reforming California’s entire healthcare system looming at the close of last year’s legislative session, SB 437 ultimately became an enrollment streamlining and simplification bill in the hopes that universal coverage for children would be included as part of the state’s larger health care reform discussions. The bills below reflect efforts mounted this year to move this legislative issue:

AB 1 (Laird/Dymally) SUPPORT
California Healthy Children Insurance

In an effort to cover all uninsured children, AB 1 authored by Assemblymembers John Laird and Mervyn Dymally, would expand both the Medi-Cal and Healthy Families Program to cover all children with family incomes at or below 300% of the federal poverty level, or approximately \$61,000 a year for a family of four. For those families earning above that income threshold, AB 1 would allow them to purchase health insurance coverage through a buy-in option, where some amount of payment would need to be made by families. Coverage under AB 1 would include health, dental and vision benefits.

Similar to other proposals included in the larger health care reform, coverage for children under AB 1 would be maintained through California’s Managed Risk Medical Insurance Board, which currently operates the existing Healthy Families program, and the Department of Health Care Services, which currently operates the Medi-Cal program.

Today, more than 60% of those covered under California's Healthy Families program are Latino children, representing more than half a million Latino children.¹ This is not particularly surprising, given that one out of every two children born today is Latino – a trend that is only expected to grow.² Programs that aim to cover California's Latino children will prove critical to improving the next generation of Californians.

Sponsors of the bill: The 100% Campaign and PICO California



Status: Now a two-year bill

AB 1 has been held and was not forwarded to the Governor. Instead, this bill will continue in the legislative process when regular session begins in January.

SB 32 (Steinberg) SUPPORT
California Healthy Children Insurance

Like last year's previous twin efforts of AB 772 and SB 437, SB 32 authored by Senator Steinberg mirrors its Assembly counterpart, AB 1, described above.

Sponsors of the bill: The 100% Campaign and PICO California



Status: Now a two-year bill

Like AB 1, SB 32 has been held and was not forwarded to the Governor. Instead, this bill will continue in the legislative process when regular session begins in January.

Provider Reimbursement & Enrollment

Health care providers today are the backbone of our health care delivery system. Without a doctor or other healthcare provider, having access to health care coverage is generally rendered useless without someone to provide or administer the treatment or services.

Essentially, health care coverage must be mirrored by actual access to a provider that delivers the service. Below are those legislative issues that work to improve access, particularly for those that provide primary care for vulnerable populations:

SB 400 (Corbett) SUPPORT
Services Provided by FQHCs Off-Site (Four Walls)

Today, community clinics, many of which are identified as federally qualified health centers, provide critically needed care to many of California's vulnerable.³ SB 400 would allow federally qualified health centers (FQHCs) to provide and bill Medi-Cal for services provided to FQHC patients at non-clinic locations.

Since 1989, federal law has required states to

reimburse FQHCs.⁴ Based on federal guidance that outlines clarification of off-site locations includes the provision of services at locations and time in order to ensure that services are accessible to the community being served, with specifications that such services could be provided in locations other than the 'four walls' of the clinics. Despite those guidelines, the state of California has not specifically delineated reimbursement of these 'off-site' services, despite the specific requirement by the federal government for states to reimburse FQHCs.

SB 400 would mirror federal requirement and would authorize federally qualified community health centers to provide services to Medi-Cal patients in offsite locations by providing reimbursement for these services within limitations that include the initial and subsequent follow-up hospital visits, patient discharges, and obstetrical deliveries.

Given the various needs of many at-risk communities, community clinics have proven to be responsive to the community's needs, with many rural communities proving to be adaptable in the manner with which services are being provided. Today, these services may be provided through mobile units, employer sites, migrant or other types of group housing and even schools. SB 400 would provide critically-needed reimbursement for these services to ensure that they continue being provided where the community needs them most.

Sponsors of the bill: California Primary Care Association



Status: Now a two-year bill

SB 400 has now been converted into a two-year bill and is due to resume in the legislative process at the beginning of the 2008 legislative year in January.

AB 1226 (Hayashi) SUPPORT
Reducing Enrollment Time for Medi-Cal Providers

Today, all physicians desiring to serve Medi-Cal enrolled patients must submit an application that essentially qualifies these physicians for reimbursement. Much of the processes in the Medi-Cal program, and its parent department, the California Department of Health Care Services (DHCS) must abide guidelines provided for in state statute, including timeframes and application requirements for these physicians.⁵

AB 1226, authored by Assemblywoman Mary Hayashi, would impact state statute by streamlining the application process for those physicians already enrolled in the Medi-Cal program who may be changing practice locations within the same county. Physicians must currently complete a full Medi-Cal provider application when changing practice locations, even if the move is within the same county. AB 1226 would

help the state develop a more efficient process for bringing eligible, already-practicing doctors in good-standing, into the Medi-Cal system in instances where they may be changing the location of their primary practice, so long as the move of the primary practice would still be in the same county. In so doing, AB 1226 would remove an unnecessary barrier to increasing the number of providers within one the state's prominent health program – Medi-Cal, where a majority of those enrolled in the program are Latino, representing more than 3 million Latinos who rely on the Medi-Cal program for both their health insurance coverage and their treatment conducted through Medi-Cal enrolled providers.¹ Streamlining the process by which Medi-Cal providers are enrolled into the program and increasing the pool of providers in the program would work to ensure that Medi-Cal patients actually have access to a physician.

Sponsors of the bill: California Medical Association



Status: Signed by the Governor

AB 1226 received strong bipartisan support throughout the legislative process and was signed by the Governor on October 14th. This bill is due to take effect in January 2008 and impacts Sections 14043.1, 14043.26, and 14043.65 of the Welfare and Institutions Code.

AB 363 (Berg)

SUPPORT

Access to Specialty Care Services

Today, many federally qualified healthcare centers (FQHCs) are designed to serve federally designated medically underserved areas. Already struggling to provide even the most basic level of primary care and other essential services, access to specialty care may become impossible for many low-income patients, particularly for those in the Medi-Cal program, the majority of which are Latino.² In fact, it is estimated that 85% of low-income patients “often” or “almost always” have problems in accessing specialty care, including allergy/immunology, dermatology, orthopedics, physical and occupational therapy, psychiatric and specialty care for diabetes.³

AB 363 (Berg) would provide a critical mechanism for FQHCs to ensure that their low-income patients have access to medically necessary specialty care services by allowing FQHCs to enter into professional agreements with specialty providers in order to increase access to specialty care for eligible, low-income patients. Services provided under the agreement must be medically necessary health care services no otherwise offered at the FQHC.

Sponsors of the bill: California Primary Care Association



Status: Now a two-year bill

SB 400 has now been converted into a two-year bill and is due to resume in the legislative process

at the beginning of the 2008 legislative year in January.

SB 260 (Steinberg)

SUPPORT

Reimbursement for Same-Day Mental Health Visit

In order to best provide integrated behavioral health services to patients, many community clinics and health centers provide medical and mental health services on the same day, which is the hallmark of the Integrated Primary Behavioral Health Care model. However, Medi-Cal will not reimburse for a patient to see a primary care provider and a mental health provider/behavioral health specialist on the same day.

Numerous studies over the last 30 years have found high rates of physical health-related problems and death among individuals with serious mental illness.⁴ For both adults and youth, mental health services can provide the crucial intervention to avoid further physical, and potentially fatal, problems. However, few individuals needing mental health services access that care. At the same time, eighty percent of those suffering from mental illness have had a primary health care visit in the last six months.⁵

SB 260 (Steinberg) would work to remedy that by allowing federally qualified health centers to be reimbursed by Medi-Cal for multiple visits by a patient with a single or different health care professional on the same day at a single location, and specifically allows for billing for two visits when a patient has a medical visit and an additional visit with a mental health practitioner or a dental professional.

Sponsors of the bill: California Primary Care Association



Status: Vetoed by the Governor

SB 260 was sent to the Governor on September 12th and was vetoed on October 14th. The Governor cited the cost associated the program as the primary reason for his veto.

Prescription Medications

In California, prescription drug spending totaled over \$188 billion in 2004 and has continued to increase since then.⁶ In fact, costs association with prescription drug spending continues to be among the most significant cost factors in California's overall spending on health care and continues to be the fastest-growing segment of our overall health care spending.⁷ Unfortunately, little of the spending translates into a savings for the consumer. Below are the legislative issues that focus on ensuring access to prescription medications:

SB 472 (Corbett)

SUPPORT

Standardizing Prescription Drug Labels

For many Latinos facing a chronic illness in their

lifetime, such as diabetes or a cardiovascular disease, prescription medications may prove to be a critical lifeline in management of those illnesses.

Unfortunately, increased use of prescription medications also increases the likelihood of experiencing a medication error. In fact, according to the Institute of Medicine of the National Academies, medication errors are among the most common medical errors, harming at least 1.5 million people every year.¹ It is estimated that up to one-half of all medications are taken incorrectly and approximately 46% of American adults cannot understand the label on their prescription medication.² Limited English proficient (LEP) patients in California, defined as those that speak English less than “very well”, may face an additional risk, given their likely inability to read critical information contained on prescription drug labels.

SB 472 authored by Senator Ellen Corbett, would begin to reduce medication errors by authorizing the California Board of Pharmacy to develop statewide regulations that require a standardized, patient-centered, prescription drug label on all prescription medication dispensed to patient in California through public meetings to be held statewide on standardizing prescription drug labels. Throughout the process, SB 472 received significant bipartisan support. As a result of its passage, California will be the first state in the U.S. to begin moving towards prescription label standardization.

Sponsors of the bill: Gray Panthers California, Latino Coalition for a Healthy California, Senior Action Network



Status: Signed by the Governor

SB 472 was signed by the Governor and will take effect in January 2008, Section 4076.5 to the Business and Professions Code.

SB 606 (Scott) SUPPORT
Information on Clinical Drug Trials, Right-to-Know Act

In a third-year effort, Senator Jack Scott has again resumed introduction of SB 606 which would force pharmaceutical companies to publicly provide information about the safety and effectiveness of their products.

In the last several years, incidents such as those that previously occurred with medications such as Vioxx, little-to-no information was available to the general public about data on prescription medications or their testing, despite many tests that each pharmaceutical manufacturer has to undergo prior to making prescription drugs available to consumers, referred to as clinical trials.

SB 606 would require pharmaceutical companies to make available, on a free, publicly accessible website,

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the results of all clinical trials (with certain defined exemptions) on a specific prescription medication. This might include potentially negative evidence that might be beneficial for the public to know.

In disclosing this information, consumers would have the ability to decide on the risk associated with the specific medicine in order to make informed decisions about their medical treatment.

Not surprisingly, the pharmaceutical industry has been greatly opposed to SB 606 and its predecessors, SB 1683 (2006) and SB 163 (2005). With documented incidents such as Vioxx, where its manufacturers actually had substantive data that indicated that consumption of Vioxx significantly increased the risk of serious heart problems, LCHC supports consumers being provided the information they need to know to make informed decisions about their healthcare.

Sponsors of the bill: CalPIRG



Status: Now a two-year bill

SB 400 has now been converted into a two-year bill and is due to resume in the legislative process at the beginning of the 2008 legislative year in January.

Other Access Issues

SB 564 (Ridley-Thomas) SUPPORT
School Health Centers Expansion Act of 2007

School health centers in California respond to community needs and give families options for their children’s health care by providing primary medical care, mental health services, dental care, health education, nutrition services and/or youth programs. School health centers take health problems out of the classroom and put them where they belong – in the hands of doctors, nurses, counselors, nutritionists and dental professionals. Located generally on or near school grounds, there are currently more than 140 school health centers throughout the state.³

As a generally young population, is estimated that Latino children will be a majority of those in California’s K-12 system by 2020, a factor not surprising, considering that one out of every two children born today is Latino. Already, a majority of those served by school health centers in California are Latino, with 49% of those served in high school-based health centers and more than 60% of those served in elementary-based school health centers are Latino.^{4,5}

SB 564 is authored by Senator Mark Ridley-Thomas and serves as a follow up bill to last year’s bill, AB 2560, which established the framework for the establishment of school health centers, largely by calling for collection of baseline data still needed on school health centers. As a continuation of those efforts, SB 564 would develop a grants process needed

in order to expand the number of school health centers and would provide resources for technical assistance and evaluation to support the expansion.

Over the last year, Governor Schwarzenegger has indicated great interest in expanding the number of school health centers across the state, having announced his intent to add an additional 500 school health centers statewide. More recently, it appears that health care reform – including the method in which services are delivered – may impact the outcome of this bill.

Sponsors of the bill: California School Health Centers Association, California Primary Care Association and Latino Coalition for a Healthy California



Status: Now a two-year bill

Due to the evolving nature of health care reform, SB 564 has been converted into a two-year bill and will continue in the legislative process at the start of the next legislative year which is due to begin in January 2008.

AB 834 (Hayashi)

SUPPORT

Dental Disease Prevention Program

The Children’s Dental Disease Prevention Program (CDDPP) is a school-based dental disease prevention program that began in 1979 and was originally known as the SB 111 program. The program currently receives approximate annual funding by the state of over \$3 million and serves more than 300,000 low-income California preschool and elementary school children annually, providing classroom oral health education, fluoride treatments, plaque control, and dental sealants largely through local sponsors, such as a local county health department. Despite the services that it provides, it is estimated that another 1 million students are not provided these services due to funding limitations.¹

It is estimated that ninety-five percent of all children in California have dental disease in the form of dental caries and gingivitis, many of which are Latino.² AB 834 (Hayashi) would require dental disease prevention educational programs to be age appropriate, be provided by a licensed or registered dental health professional, and permit increases in reimbursement rates to local sponsors.

Oral health, like many other aspects of our overall health, is best when focused on prevention. AB 834 would have invested critical prevention dollars in a program that has already proven effective.

Sponsors of the bill: California Dental Association



Status: Vetoes by the Governor

AB 834 was forwarded to the Governor for his consideration in late September and it was

returned with a veto in the first half of October. In the veto message associated with the bill, the Governor appears to be supportive with the overall intent of the bill but specifies that his veto that funding and overall program cost is a primary issue, resulting in his veto.

AB 343 (Solorio)

WATCH

Employer Coverage Disclosure

California’s system today relies heavily on employer-provided health care coverage. In recent years, however, employer-based health care coverage has been declining.³ In fact, despite the national trend of eroding employer-based health care coverage, California continues to be among the worst for the rate of job-based health care coverage, ranking 45th out of 50 states, according to a recent study by the Economic Policy Institute.⁴

The percentage of Californians with employer-sponsored health care coverage declined from 56.4% in 2001 to 54.3% in 2005.⁵ Many of those formerly covered through employer-based coverage, particularly in low-wage sector employment, are eligible for public health programs such as Medi-Cal and Healthy Families, though little data exists on whether employees are utilizing these programs.

AB 343, the third attempt to compile such information (AB 1840 in 2006 and AB 89 in 2005) would have required the Department of Health Care Services and the Managed Risk Medical Insurance Board to collaborate in a report that identifies all employers who employ 25 or more persons who are beneficiaries in Medi-Cal, Healthy Families or the Access for Infants and Mothers (AIM) program.



Status: Vetoes by the Governor

AB 343 was forwarded to the Governor on September 12, 2007 and was returned with a veto on October 10th on the basis the information yielded would be incomplete, in addition to the cost it would incur the state.

Unfortunately, Latinos continue to be over represented in developing many chronic illnesses. In fact, nearly one out of every five Latino adults over the age of 50 (19.7%) report that they have diabetes – twice the rate for their White counterparts and among the highest for all racial and ethnic groups.¹ In estimating the lifetime risk, Latinos – both males and females – face the highest risk for developing diabetes, particularly between the ages of 45 and 53.² Even worse, individuals with diabetes are more likely to have multiple chronic diseases, often including heart disease, hypertension or asthma.³ Treatment and appropriate maintenance of illnesses such as Type II diabetes and heart disease is critical to care and cost containment over the long term. For Latinos, it is important that such a treatment is provided to them in a manner in which they can understand as culturally competent and linguistically appropriate care is the starting point for effective treatment of their illness.

Although California is becoming increasingly diverse, there is also a significant mismatch between patient and providers. Despite being over a third of California’s general population, Latinos represent less than 8% of all practicing physicians, 6% of nurses and 5% of dentists in California.⁴ According to the bi-partisan Sullivan Commission, the lack of diversity in health care professions is a more forceful indicator of health disparities than lack of health care coverage.⁵

Simultaneously, the state continues to experience, or is projected to experience, ongoing shortages in many of these fields.⁶ Given the growing numbers of Latinos in our educational system and the ongoing or projected shortages in many of these fields, there is a great opportunity to match the needs of economy with the capacity of California’s Latino population that would create an additional benefit of providing appropriate care ultimately leading to cost savings for the state.

LCHC has prioritized workforce diversity as a means to reduce health disparities, highlighting the issue. The Governor recently convened the Healthcare Workforce Diversity Advisory Council, administered by the Office of Statewide Health Planning and Development and chaired by LCHC to develop policy recommendations to address health profession shortages, especially among those underrepresented in the health profession. Following are those issues that would build on this opportunity while working to reduce ongoing health disparities:

Workforce Development & Health

Shortages are anticipated for various health professions, though little is known concerning the extent of shortages, the variety of professions that the health care industry encompasses, and steps to enter the health profession. Compounding these factors are California’s demographic shifts. Over the next several years, California is expected to become more diverse with Latinos currently constituting over one third of all Californians and one half of all children born in the state. California is at a crossroad where demographic shifts are already causing gaps between workforce supply and demand. Below are those legislative issues that would work to improve and promote workforce development within health professions:

AB 365 (Portantino) SUPPORT
Taskforce on State Workforce Needs

The state trains our workforce through numerous programs and institutions including those funded through the California Workforce Investment Board, the Employment Training Panel, CalWORKs, and other sources. Public investment in education and workforce development statewide totals well over \$12 billion

dollars invested in higher education alone.⁷ However, little connection or clarity is provided to the role of postsecondary education in workforce training, particularly the health workforce. A minimum of some postsecondary education is required to become a health professional highlight the need to coordinate the two.

AB 365 would require the California Postsecondary Education Commission (CPEC) in collaboration with the Labor Workforce Development Agency to convene a Task Force of various stakeholders on State Workforce needs and to report findings and recommendations to the Legislature and the Governor. Additionally, this bill would add professional development training and support for public employees, depending on additional funding sources.



Status: Vetoed by the Governor
Vetoed by Governor on October 5, 2007.

SB 615 (Oropeza) SUPPORT
Pharmacy Technician Scholarship & Loan Repayment Program

Not traditionally considered when thinking of the health industry, allied health includes over 200 different

professions, including pharmacy technicians, respiratory technicians, dental assistants in addition to many others. It is one of the state's fastest growing economies, representing nearly 60% of the nation's health professionals.¹ Like many sectors of the health care industry, allied health continues to struggle to meet the demand and often face difficulty in finding a trained workforce.

Authored by Senator Oropeza, SB 615 would have provided a scholarship and loan repayment program for pharmacy technicians, the second largest allied health profession and largest allied health profession without a specific scholarship and loan repayment program, agreeing to work in underserved communities. This would meet the increasing demand caused by a growing aging population and technological changes within the pharmaceutical industry while increasing access in underserved communities. Additionally, SB 615 would ensure that financial cost does not become a barrier to becoming a pharmacy technician and develop California's health workforce.

Sponsors of the bill: Latino Coalition for a Healthy California



Status: Vetoed by the Governor

SB 615 was vetoed on October 13, 2007 although, in his veto message, the Governor directs the California Department of Health and Human Services to review the potential shortages in the pharmacy technician workforce.

Higher Education & Technical Training

The Latino population, representing a third of California's overall population, is relatively young. As a result, this trend projects that, by 2020, Latino children in California will represent about 50 percent of children enrolled in school.² However, in California, Latinos are far less likely than any ethnic group to complete high school. More than 75 percent of the Latino population of California does not have any post-secondary education.³ A minimum of some postsecondary education is required to become a health professional. As a result, LCHC supports strengthening the educational pipeline and to remove barriers to higher education:

AB 428 (Carter)

SUPPORT

Notification regarding college preparatory courses

Despite the growing number of Latino students, the college attendance rates of Latinos remain dismally low. This is in part due to the poor development of college preparatory course of study in many high schools with high Latino student populations and the fact that 70% of schools with over 90% enrollment of African-American and Latino pupils do not offer enough college preparatory courses for all pupils to take the courses.⁴

Authored by Assemblymember Carter, AB 428 would require all high schools to inform students and parents about the A-G college preparatory requirements, which are the 15 courses required to be considered for admission into the University of California, as well as career technical education to ensure all parents and students are informed of the courses needed to pursue higher education.

Sponsor of the bill: Applied Research Center



Status: Signed by the Governor

Signed by the Governor on October 12, 2007, Section 48980 and to add Section 51229 to the Education Code.

AB 1540 (Bass)
Cash for College

WATCH

The cost of postsecondary and graduate education is one of the largest barriers against entering the healthcare workforce, especially for underrepresented students who are more likely to grow up in low-income areas. In California, Latino families are larger in size than other groups, have the lowest income levels, and are more likely to live below the federal poverty line.⁵ AB 1540 would create the Cash for College Fund in the State Treasury for contributions and donations to be placed.

The bill would require the Student Aid Commission to allocate funds to regional coordinating organizations to plan, coordinate, or conduct Cash for College workshop series so students with financial are aware of the financial aid opportunities afforded to them.



Status: Signed by the Governor

AB 1540 was signed on October 14, 2007, Article 3.5 to Chapter 2 of Part 42 of Division 5 of Title 3 of the Education Code.

AB 1559 (Berryhill)

OPPOSE

Community College Nursing Admission Program

For many students, nursing is the first entry point to entering the health profession. Denying students' access to community college nursing programs based on ill-defined criteria would negatively impact groups who have traditionally suffered from limited access to nursing and other health professions. In fact, a study conducted under a grant from the University of California Chancellor's Office demonstrates that applying a merit-based admission system resulted in certain groups particularly African-American, Latino, and Asian-American were impacted by a greater degree, in terms of a decrease in enrollment numbers.⁶

AB 1559 (Berryhill) changes the community college nursing admissions from a lottery-based to merit-based

system.

Additionally, community colleges were built on the philosophy of equal access to all students and AB 1559 runs contrary to this mission. Although the stated purpose of the bill is to address high attrition rates coupled with shortages in the nursing field, no consistent data has shown that higher GPAs result in lower attrition rates and/or more qualified nurses. Rather than severely limiting access to health professions, community colleges should be enforcing the equal access provisions so as to create a workforce that reflects the population's demographics. In fact, studies indicate that a diverse workforce improves the academic preparation of existing students and results in better patient outcomes.



Status: Signed by the Governor
 AB 1559 was signed on October 14, 2007, 78261.5 of the Education Code.

SB 1 (Cedillo)

SUPPORT

The California Dream Act

Authored by Senator Cedillo, SB 1 (originally SB 160) would provide a proactive response to the financial barriers to higher education access by requiring the California State University and California Community Colleges, and requesting the University of California, to establish procedures that would enable non-citizen residents to participate in student aid programs. This bill makes California high school graduates who meet the non-resident in-state tuition requirements eligible for a fee waiver at community colleges and able to participate in the Cal Grant program. Identical to a bill introduced last year by Senator Cedillo, SB 1 was vetoed again by the Governor with the Governor citing budgetary constraints in his veto message.



Status: Vetoed by the Governor
 SB 1 was vetoed on October 13, 2007.

SB 405 (Steinberg)

SUPPORT

Access to College

African American, Latino, and American Indian students are dramatically underrepresented at every point along the road to meeting University of California admission requirements. One of the roadblocks is the shortage of A-G college preparatory classes and advanced A-G classes which are more likely to occur in schools where African American and Latino students are the majority.¹

Authored by Senator Steinberg, SB 405 would help at-risk schools and require counselors at schools participating in the program to meet with every student to discuss college and career opportunities. Additionally, SB 405 provides support for students who are in danger of missing college entrance requirements or who may not be prepared to pass mandatory exit exams. SB 405 strengthens knowledge about and

access to meaningful college and career opportunities for high school students in California.

Sponsors of the bill: ACLU



Status: Signed by Governor
 SB 405 was signed on October 14, 2007, Section 52378 of the Education Code.

Data Collection & Planning

Despite being home to the largest health care workforce in the country, very little is known about California's health professionals with respect to demographics, geographic distribution, and language proficiency of California's health professionals. Compounding these issues is California's changing demographics – aging and more diverse – which is creating consumer demands for a health care workforce that reflects the state's demographics.

With health care reform on the horizon and the possibility of adding millions of newly-insured individuals, it is critical to act now to ensure that decision makers have accurate data to form future policy as it relates to developing a healthcare workforce that can treat them.

Disparities in information across the professions as well as the general lack of local practice data constrains policy making and contributes to the ongoing inequities in the supply of health care providers. Increased information can be used to inform health care workforce policy and improves access to care for all Californians. Below are those issues impacting this data collection:

AB 269 (Eng)

SUPPORT

Data Collection on Dental Workforce

Authored by Assemblymember Mike Eng, AB 269 would allow the state to begin assessment of the state health profession capacity by collecting data on the race and ethnicity, language proficiency by the zip code of primary practice for dentists, dental hygienists and dental assistants.

In order to secure a state license, dental providers are required to apply for and renew their state license every two years, based on their birth date. Utilizing the current license renewal process, AB 269 allows race/ethnicity and language spoken to be aggregated and publicly reported on the California Dental Board and Committee on Dental Auxiliaries' website every July 1st beginning in 2009.

A follow-up to last year's AB 2283 (Oropeza), a bill sponsored by LCHC to collect information on physicians, AB 269 will begin to provide information on California's existing capacity to treat, work and speak with the estimated 6 million Californians who are limited English proficient (LEP) and the 4 million

Californians living in communities with a shortage of dental providers.¹ AB 269 successfully passed both the Assembly and Senate with bi-partisan support before being forwarded to the Governor for his signature.

Sponsors of the bill: LCHC



STATUS: Signed by Governor
AB 269 was signed on October 5, 2007, Sec. 1715.5 of the Business & Professions Code.

AB 330 (Hayashi) SUPPORT
Health Disparities Report

Efforts to study disparities in health outcomes and care for communities of color have been hampered by the lack of available data on race, ethnicity and primary language. In fact, according to the 2006 National Healthcare Quality Report, while some aspects of care quality have improved for minority patients, disparities persist throughout the health care system. The report indicates that roughly 25 percent of care disparities experienced by minorities improved, while 33 percent deteriorated.²

AB 330 would require the Office of Statewide Health Planning and Development, with support from the California Health and Human Services Agency (CHHS), to develop a health disparity report to assess the levels of measurable health disparities in the state among minorities based on the inpatient hospital discharge data set, specifically regarding information on cardiovascular disease, breast cancer, cervical cancer, diabetes, HIV/AIDS, infant mortality, asthma, mental health, and trauma.



Status: Held in Assembly Appropriations. Failed passage.

SB 139 (Scott) WATCH
SNAPLE and Health Care Workforce Clearinghouse

As a follow-up to SB 1309 (Scott) chaptered last year, SB 139, among other things, makes changes to the terms of the State Nursing Assumption Program Loans for Education- State Facilities (SNAPLE-SF). More importantly, the bill requires the Office of Statewide Health Planning and Development (OSHPD) to collect and annually report health profession data. Specifically, this bill would establish a healthcare workforce clearinghouse, to be housed within OSHPD, to serve as the central source of health care workforce and educational pipeline data in the state.



Status: Signed by Governor on October 12, 2007, Sections 70101, 70106, 70120, 70124, 70125, 78261, 87482, 89267, and 92645 of, and to add Sections 66055.8, 66055.9, 70128.5, 78261.3, and 89267.3 to, the Education

Code, and to add Article 5 to Chapter 2 of Part 3 of Division 107 of the Health and Safety Code, relating to nursing education.)

SB 764 (Migden) WATCH
Primary Care Physicians

Primary care physicians are the backbone of our healthcare delivery system. Having an adequate supply and sufficient geographic distribution of primary care physicians is essential to ensure access to health care services for all Californians. Unfortunately, Latinos being the majority of the uninsured (59%) often do not have access to primary care providers, instead relying on emergency services as primary care.³

Authored by Senator Migden, SB 764 requires the California Medical Board and the Osteopathic Medical Board of California to provide physician information to the Office of Statewide Health Planning and Development (OSHPD), and requires OSHPD to prepare a report with projections concerning primary care physicians for the Legislature and the Department of Health Care Services. California's citizens and policymakers need to know the status of the state's primary care physician workforce in order to accurately plan for the future.

Sponsors of the bill: California Association of Physicians Groups



Status: Vetoes by Governor
SB 764 was vetoed by the Governor on October 10, 2007

In 2003, Surgeon General Richard Carmona identified obesity as a national crisis, due to its growing prevalence in all age groups, the lifelong conditions associated with it, and the ease with which it could be prevented.¹ In California, Latino adolescents demonstrate the highest risk of overweight or at risk for overweight, with one in three Latino teens in that category.² These teens are at risk for developing diabetes, high blood pressure, coronary heart disease and other chronic conditions at younger ages than their parents. Furthermore, 21 percent of Latinos between the ages of 50 and 64 have diabetes³. In 2000 alone, obesity and physical inactivity cost California an estimated \$20.7 billion.⁴

Sadly, these are preventable conditions. Over 75 percent of Latino teens drink soda daily, a rate much higher than other teens.⁵ High soda consumption is closely correlated with high fast food consumption, another area where Latino teens are, unfortunately, in the lead. More than half of Latino adolescent boys eat fast food at least once a day and as a result, are not eating the fresh fruits or vegetables that contribute to a healthier diet and lifestyle.⁶ Coupled with low physical activity, this becomes an easy equation for children and teens becoming overweight and obese. Teens who live in disadvantaged neighborhoods, those with low household incomes, high rates of local unemployment and crowded homes, have less access to safe parks closer to their homes, making it far more difficult for them to engage in regular physical activity.⁷

By pursuing legislation that takes a community-based approach, we can create ways to increase the availability of healthy foods in neighborhoods and schools and improve opportunities for physical activity. This will bring California a long way in fighting the disturbing trends our children and young adults are facing. Below are issues related to improving our community's health:



Nutrition and Healthy Foods

Latinos in California face disproportionate challenges when trying to buy or prepare healthy foods, due in part to the fact that much of the population lives in areas that are over-served by fast food and liquor stores and that supermarkets avoid. Currently, more than half of Latino adolescent males eat fast food daily.⁸ Creative and progressive legislation needs to be pursued to decrease these alarming trends.

AB 898 (Saldaña)
Obesity Prevention

SUPPORT

AB 898 creates pilot programs in 3 to 5 school health centers in California to apply for grants to create a nutrition education and obesity prevention program using *promotores de salud* to work with students and families. Schools with higher-than-average food stamp participation, uninsured students, and limited English proficient pupils would be eligible.

One out of three Latino children are overweight or at risk for being overweight,⁹ and Latinos need locally-based sources of medical information on maintaining

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healthy lifestyles. School health centers and community health educators would provide a culturally-appropriate, cost-effective means of reducing obesity and working with families and students to promote nutrition and diabetes education.

Sponsors of the bill: National Council of La Raza, California School Health Centers Association, Latino Coalition for a Healthy California



Status: Now a 2-year bill

This bill passed through the Assembly Health Committee, but was initially held in the Appropriations committee due to its potential cost. It is now a 2-year bill.

AB 967 (Nava)
Farm Fresh Schools Program

SUPPORT

AB 967 creates the Farm Fresh Schools Program, which establishes a grants program for schools to purchase fresh fruits and vegetables from farmers throughout the state. Not only would this improve school nutrition, but also help farmers who cannot otherwise provide their produce to schools. AB 967 would also provide assistance for school districts through the creation of a nutrition curriculum on healthy eating and cooking. For

many children in public schools, breakfast and lunch are the only nutritionally balanced meals they receive during the day. Schools are the place where children eat the bulk of their daily calories.¹

Although school lunches ensure a minimum standard of nutrition for meals served in schools, many children select à la carte items, which are currently not held to the same standards. In fact, 80 percent of school districts sell foods that compete with regulated school meal programs, and offer food that is lower in nutrients and higher in calories.²

Sponsors of the bill: Healthy Eating Lifestyle Principles, Community Alliance with Family Farmers



Status: Now a 2-year bill

This bill easily passed through both the Assembly Education and Agriculture Committees, but was held in Appropriations due to cost. This has also become a 2-year bill and will be back next year.

SB 48 (Alquist) SUPPORT
Access to Healthy Foods Act

SB 48 creates the Healthy Food Retail Innovation Fund to provide grants, loans and technical assistance to food retailers to increase the amount of healthy and fresh food they sell. Considering that many low-income Latino neighborhoods have little-to-no access to fresh and healthy foods, and that many of the food retailers in Latino communities operate mini-marts and liquor stores,³ this bill would have given much-needed assistance to community members who want to improve their merchandise but are financially unable to do so.

This bill was originally introduced as SB 107 (Alquist) and represents a second-year effort on the Senator's part to increase healthy foods in certain communities. Unfortunately, last year's version did not complete the legislative process, largely due to cost.

Sponsors of the bill: American Heart Association, California Center for Public Health Advocacy, PolicyLink



Status: Held in Assembly Appropriations Committee. SB 48 made it through the Senate Health and Appropriations Committees, as well as the Assembly Health Committee, but was held in the Assembly Appropriations Committee due to its projected cost.

SB 120 (Padilla) SUPPORT
Nutritional Information and Menu Boards

SB 120 would have required chain restaurants in California to provide nutrition information such as calories, saturated fat, trans fat, carbohydrates, and sodium content on their menus next to the menu item, or on menu billboards at fast food restaurants. Latino

adolescents eat more fast food on a daily basis than any other ethnic group.⁴ Many Latino families use fast food as a low-cost answer to providing meals as many supermarkets are not located in low-income communities.⁵

SB 120 authored by Senator Padilla would have given consumers critically-needed information in order to make informed choices about their food, including information on hidden calories and fat in many retail foods, as many salads offered in fast food chains can rival a double-cheeseburger in terms of calories, fat, cholesterol, and sodium.⁶

Over the last year, SB 120 faced enormous opposition from the fast food and restaurants industry. In the Governor's veto message, SB 120 was called "inflexible" and "impractical", though the Governor iterated the need for consumer education and indicated he would continue to work with advocates and restaurants on the issue.⁷ While we are disappointed that consumers still face barriers in accessing nutrition information at restaurants, we look forward to continuing to work with the Governor and the Legislature to promote better food choices for Latinos.

Sponsors of the bill: American Cancer Society, American Heart Association, California Center for Public Health Advocacy, California Optometric Association



Status: Vetoed by the Governor on October 14, 2007.

Physical Activity

According to research from UCLA, teens such as Latinos who live in underserved communities have far less access to physical activity and exercise.⁸ Less than one quarter of Latinos walk on a daily basis and have diminished access to park land and open spaces.⁹ This promotes the sedentary lifestyles that are associated with overweight and other health problems and calls for increased access to exercise and open space in Latino communities.

SB 601 (Torlakson) SUPPORT
Physical Education in California's Schools

SB 601 creates greater accountability for schools in providing their physical education curriculum. This bill requires that any data collected by schools indicate actual minutes that students spend in physical education classes and whether that time matches the state's requirements for physical education.

It also ensures that schools are executing their mandated physical fitness testing requirements. Schools in low-income neighborhoods tend to have poorer Physical Education (PE) facilities, more dependence on the sale of junk food to support athletics and other student programs, and less time

devoted to PE and health education, than schools in affluent areas¹⁰.

As it was originally introduced, SB 601 also provided for professional development incentive grants for physical education teachers to further and improve their teaching. That aspect had to be later removed from the bill, though the intent of school accountability for student fitness standards remained.



Status: Signed by the Governor
SB 601 was signed by the Governor, Sec. 33352 and 51241 of the Education Code.

SB 207 (Padilla) SUPPORT
Access to Parks and Recreation

SB 207 would make grants available to public and non-profit education programs to provide outdoor recreation and environmental education to at-risk and low-income youth. It includes provisions for education on healthy and active lifestyles, including nutrition and physical fitness. Many Latino adolescents from urban areas do not have access to healthy outdoor activities and as a result, are more sedentary than other ethnic groups, especially among females.¹

Sponsors of the bill: American Diabetes Association, Sierra Club



Status: Now a 2-year bill
This bill passed through the Senate Natural Resources and Water Committee, but was held in Senate Appropriations, where it became a 2-year bill and is due to resume in the legislative process.

Other Prevention & Community Health Issues

The Legislature and Governor have taken important steps to preventing obesity through nutrition and physical activity, but these measures cannot solve these issues alone. Other activities are needed, such as academic research and multi-disciplinary government and community approaches to reach a systems change.

AB 74 (Dymally) SUPPORT
University of California Obesity, Diabetes and related-illness research center (PODER)

AB 74 would create a research institute within the University of California at Irvine and Charles R. Drew University of Medicine and Science to study the phenomenon of obesity and diabetes and would promote experimental research in the field. This research center would also provide clearinghouse information and educate policy-makers on ways to reduce and prevent diabetes and obesity. The

prevalence of diabetes has increased nearly one percentage point in the last 4 years alone, and is much higher among Latinos and other communities of color.² Those with low incomes and lower educational attainment have a higher prevalence for diabetes,³ and should be of great concern to policy makers. Diabetes treatment will figure closely into escalating healthcare costs and those with lower access to disease management could be of great expense to the state.



Status: Now a 2-year bill
This bill has been a priority of the author for several years, and passed through the Assembly Health Committee, but failed to gain passage through Appropriations. This bill is now a 2-year bill.

AB 1472 (Leno) SUPPORT
California Healthy Places Act

AB 1472 would have created the California Healthy Places Act which would have established a working group of various stakeholders in state government to develop a standard for assessing planning and transportation decisions, called Health Impact Assessments (HIAs) at the local level and their impact on the health of the community.

The goal of HIAs is to promote planning efforts that support healthy childhood development, injury prevention, reduction of illness and chronic disease, ensure environmental health, and reduce health disparities. The wraparound nature of this bill creates a holistic view of health in the built environment. This practice is important for Latino communities, who tend to live in areas where environmental quality outcomes are far worse than other for ethnicities.⁴

The California Department of Public Health estimated they would need 8 additional staff positions to properly fund this program, totaling \$1.6 million for implementation.⁵

Sponsors of the bill: California Pan-Ethnic Health Network, Human Impact Partners, Latino Issues Forum



Status: Now a 2-year bill
This bill passed through its house of origin but faces some difficulty related to funding. AB 1472 is now a 2-year bill.

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About LCHC:

The Latino Coalition for a Healthy California (LCHC) – the only statewide organization with a specific emphasis on Latino health – was founded in 1992 by health care providers, consumers and advocates to impact Latino health through enhanced information, policy development and community involvement. Three major functions provide essential focus to the organization's work: *public policy and advocacy; community education and research.* These functions complement LCHC's work in three key strategic areas: access to health care, health disparities, and community health. Through its Rapid Response Network of 2,200 community-based organizations and its Regional Networks in San Diego, Los Angeles, the Bay Area and the Central Valley, LCHC affiliates stand ready to be mobilized to impact public policies, services and conditions that affect Latino health.

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