NHMA

National Hispanic Medical Association

and the

CALIFORNIA LATINO LEGISLATIVE CAUCUS

PRESENT

HISPANIC HEALTH STATE LEGISLATIVE DAY

STATE CAPITOL, ROOM 115
SACRAMENTO, CALIFORNIA

TUESDAY, MAY 23, 2006
1:00 – 5:00P.M.

Agenda

NATIONAL HISPANIC MEDICAL ASSOCIATION
AND THE
CALIFORNIA LATINO LEGISLATIVE CAUCUS

"HISPANIC HEALTH STATE LEGISLATIVE DAY"
STATE CAPITOL, ROOM 115
SACRAMENTO, CALIFORNIA
TUESDAY, MAY 23, 2005
1:00 – 5:00 P.M.

AGENDA

I. Orientation to the Day (1:00 to 1:30)

Elena Rios, MD, MSPH
President and CEO, NHMA

Mark Diaz, MD and Dolores Leon, MD
Members, Board of Directors

II. Welcome from the California Latino Legislative Caucus (1:30 to 1:45)

Assemblymember Joe Coto
Vice Chair, Latino Legislative Caucus

III. Key Policy Issues for Latino Physicians, with Emphasis on Obesity and Diabetes (1:45 to 3:30)

Ignatius Bau (1:45 to 2:00)
Program Officer for Cultural Competence In Health
The California Endowment

Carmela Castellano-Garcia (2:00 to 2:15)
Chief Executive Officer
California Primary Care Association

Veronica Montoya (2:15 to 2:30)
Policy Director
Latino Coalition for a Healthy California

Harold Goldstein (2:30 to 2:45)
Director
California Center for Health Care Advocacy

Dr. Francisco Prieto, MD (2:45 to 3:00)
Representative
American Diabetes Association

Katrina Mendiola (3:00 to 3:15)
Policy Analyst
National Council of La Raza

Francisco Estrada (3:15 to 3:30)
Director of Public Policy
Mexican American Legal Defense and Educational Fund

Representatives (invited)
Office of the Governor and
Office of the First Lady

- Short Break, time permitting -

IV. Access to Care and Coverage Issues/Budget Issues (3:30 to 4:00)

Senator Denise Moreno Ducheny
Chair, Senate Budget Subcommittee No. 3 on Health and Human Services

Assemblymember Hector De La Torre
Chair, Assembly Budget Subcommittee No. 1 on Health and Human Services

V. Presentations by Other Invited Members of the Legislature (4:00 to 4:30)

Assemblymember Alberto Torrico (invited)
Chair, Asian Pacific Islander Legislative Caucus

Assemblymember Mervyn Dymally (invited)
Chair, Legislative Black Caucus

VI. Closing and Next Steps (4:30 to 5:00)

Senator Deborah V. Ortiz
Chair, Senate Health Committee

6:00 p.m. Reception at Aioli Restaurant, 18th and L Streets

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MAY 23, 2006

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Manuel Prado

NHMA Background

National Hispanic Medical Association (NHMA)
Summary of Health Advocacy Projects

I. **Diabetes & Obesity Project**

II. **Medicare Part D**

III. **National Coalition on Hispanic Health**

IV. **Title VII Funding for Health Professionals**

NHMA continues its advocacy efforts on health issues. This year, NHMA hired Esther Garcia, as Director of Government Affairs, and is in the process of developing the Government Affairs Unit. Below is a summary of a few of NHMA advocacy projects.

NHMA DIABETES & OBESITY EDUCATION PROJECT:

Background

Obesity is a significant public health threat to the quality of life in the United States. Two thirds of American adults are overweight and half of these are obese and childhood obesity is reaching epidemic proportions. In the past three decades, there has been a 300 percent increase in the rate of U.S. children who are either overweight or obese, according to the National Center for Health Statistics[1].

Since the 1970's, the prevalence of obesity has more than doubled for preschool children aged 2-5 years (5% to10.4%), and adolescents aged 12-19 years (6.1% to 15.5%), and it has more than tripled for children aged 6-11years (4% to 15.3%). In 2004, approximately nine million children over six years of age were obese.[2] Childhood obesity involves significant risk to physical and emotional health. In 2000, it was estimated that 30 percent of boys and 40 percent of girls born in the United States are at risk for being diagnosed with Type 2 diabetes at some point in their lives. Young people are also at risk of developing serious psychosocial burdens due to societal stigmatization associated with obesity. Obesity-associated annual hospital costs for children and youth more than tripled over two decades, rising from $35 million in 1979-1981 to $127 million in 1997-99.

Although no population group is immune from the current shift in energy balance, differential rates of overweight seem to exist among ethnic groups. National probability samples of African American, Hispanics in the United States provide clear evidence that White children are lower risk for childhood overweight than are African American or Hispanic children[3].

According to the Census, Hispanics now number 37.3 million, constituting 13.7% of the total population. The median age of Hispanics (26.6 years) is 10 younger than that of the general population and a disproportionate number of Hispanics (as many as 80% of those with type 2 diabetes and 50% of those at risk of diabetes) have a combination of health conditions, including hypertension, dyslipidemia, obesity, and renal diseases, which together are known as metabolic syndrome. It is estimated among Hispanic patients with diabetes, 505 of adults and 20% of adolescents had metabolic syndrome before diabetes

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[1] Childhood obesity fueled by marketing tactics, San Francisco Chronicle, Ted Lempert, April 27, 2005

[2] IOM Report "Preventing Childhood Obesity: Health in the Balance

[3] Ethnic Issues in the epidemiology of childhood obesity, Crawford PB, Story M., Wang MC, Ritchie LD, Sabry ZI, in Pediatr Clin North Am, 2001 August; 48(4): 855-78

developed[4]. The number of Hispanic children and adolescents with obesity and prediabetes is increasing, possibly because of the high rates of undetected hyperglycemia among pregnant Hispanic women. Asian Americans and Hispanic adolescents born in the U.S. are more than twice as likely to be obese as are first generation residents of the 50 states.[5]

The Centers for Disease Control and Prevention (CDC) has recognized obesity as the major risk factor of Americans, surpassing cigarette smoking, and other major chronic diseases – diabetes, cardiovascular disease and cancer. According to the Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity, the medical and related costs of obesity in the United States in 2000 was more than $117 billion. In fact, the U.S. Surgeon General has identified overweight and obesity as "the fastest growing cause of disease and death in America."

There a multitude of causes. The role of marketing in the childhood obesity problem is significant. A recent Stanford study found that children who spend the most time watching TV, videos and video games are more likely to be overweight[6]. A 1999 study in the Journal of the American Medical Association also shows that exposure to food commercials influences children's food commercials influences children's food preferences and requests. Urban Latin Americans are switching from calcium-rich corn tortillas to refined-flour tortillas, from whole grains to white flour and rice. And activity levels in the United States urban centers across Latina America have plummeted, and as traditional foods loose prestige. [7] Thus, interventions that educate key stakeholders on how to change policies and programs to impact childhood obesity could improve the quality of life for future generations of Americans.

Established in 1994 in Washington, DC, the **National Hispanic Medical Association (NHMA)** is a non-profit organization representing licensed Hispanic physicians in the United States. The mission of the Association is to improve the health of Hispanics and other underserved.

In 2005, NHMA was awarded a one year grant by the U.S. Department of Health and Human Services Office of Minority Health to develop its Hispanic Obesity Abatement Campaign. Through this initiative, the Association designed the portal www.hispanichealth.info as an Internet resource on the NHMA website to provide research knowledge and educational information in English and Spanish targeted to Hispanics through various links about obesity abatement. Many searches were undertaken by NHMA staff and consultants to identify resource

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[4] Postgraduate Medicine Online, December 2004/Vol 116, No.6

[5] Adolescent Obesity Increases Significantly in Second and Third Generation U.S. Immigrants: The National Longitudinal Study of Adolescent Health—Department of Nutrition, School of Public Health & Carolina Population Center, UNC at Chapel Hill NC

[6] San Francisco Chronicle, Childhood obesity fueled by marketing tactics, April 27, 2005

[7] Hispanic American Center for Economic Research; Latino Diet Changes Deemed Health Crisis, Theresa Baine

materials such as nutrition information, obesity research and news, and meetings and conferences related to obesity.

At our 2004 annual conference, NHMA established the National Hispanic Health Professional Leadership Network—composed of the major national organizations working in Hispanic health to assist with the development of the portal, by providing information about resources in their disciplines for their patients, about obesity education. The members include: the National Association of Hispanic Nurses, the Hispanic Dental Association, the Hispanic Behavioral Health Association, the Latino Caucus of the American Public Health Association, the Association of Hispanic Health Executives, the national director of Hablamos Juntos, the U.S. Department of Health and Human Services (HHS) Office of Minority Health regional coordinators and the HHS Hispanic Employee Organization.

In 2005, NHMA also established the NHMA Council of Medical Societies, consisting of 14 state and regional medical societies to formalize linkages with the local medical societies to work with NHMA.

NHMA staff unveiled its portal design in the cities of Galveston, Texas, Miami, Florida, New York, New York, San Mateo, California, El Paso, Texas in the Fall, 2005 and gained valuable feedback at regional meetings with groups of physicians. In January, 2006, NHMA redesigned the portal to include the feedback. NHMA announced its obesity efforts at a press conference on September 2005 in Galveston, Texas .

NHMA now proposes to continue its obesity activities and add diabetes education. The purpose of the proposed program is to decrease childhood obesity and diabetes among Hispanics in targeted states in the country.

NHMA proposes to develop a public health campaign to reduce childhood obesity that will focus on three areas: a) information exchange via the NHMA portal regarding strategies and resources for reducing obesity in local communities; and b) the development of an NHMA membership program, including a speaker's bureau program that includes lectures targeted to middle school students, teachers and parents, and for state-level advocacy efforts; a weekly information update on obesity and diabetes; and c) media component of the Partnership with a Press Conference at its launch and during Hispanic Heritage Month.

II. NHMA & Medicare Part D:

Congresswoman Hilda Solis' Press Conference on Medicare Part D,
May 9, 2006, Remarks by Elena Rios, MD, MSPH, President & CEO, NHMA

Good morning. It is an honor to be with you today. Congresswoman Solis just mentioned the Ramirez Pharmacy in East Los Angeles –it's owner, Mr. Ed Ramirez is a long-standing leader in East Los Angeles. I grew up in the same area as the Congresswoman and know the importance of the importance of Medicare Part D to our Latino families.
In our community, our families are having a hard time with understanding the Medicare program.

Currently, CMS has enrolled 8 million in Stand Alone Drug Prescription Programs and less than a million in Medicare Advantage Plans –which is a total of nearly 9 million people into Medicare Part D. We know there are a lot more eligible. The Agency for Health Care Research and Quality (AHRQ) Disparities Report, recently released, announced that Hispanics are the group with the worst record for all access indicators. I believe that Medicare Part D will show the same results –that Hispanics will have the smallest enrollment rates.

The National Hispanic Medical Association is a non-profit association representing Hispanic physicians across the country who are on the front lines caring for families of patients everyday. They are interested in increasing access for their patients and explaining about joining Medicare Part D. The Medicare Part D is a major breakthrough because our doctors can offer more medications to patients.

Let me give some examples of patients we have to care for:
Nursing home patients. We all have grandparents and parents in nursing homes and it is the families we need to focus on teaching about the program. Nursing home staff aren't going to provide information to the patient on a new program like Medicare Part D – so it is up to families to get the information for them.

There is a major problem for Hispanics because they are the Low Income ---and we now know that of all 6 million dual eligibles (and a third are Hispanic), and 62% of them are low-income. Indeed, the government has reported that for the Low Income Subsidy –4 million applied but only 1 million applications were able to be processed.

Let me discuss the enrollment issues and problems for Latinos –
Knowledge and Awareness – critical before any enrollment can happen, that our families have the awareness. Since many of our elderly are suffering from chronic diseases and with so many diseases are not focused on asking questions – we need to be more aggressive in teaching patients. Then of course we need more information in Spanish.

Counseling – needs to be again, a directed program, through, not just senior citizen centers, but through our hospital and clinic social workers, who understand the community –our Doctors, Nurses, Promotoras. And a 1-800 number or an Internet Site aren't enough to reach our community –due to lack of computers in our homes - we need more involvement of the health professionals and media and businesses and the CBOs in our community.

Application – needs to be simple and in the language of our patients

Mistakes and Follow-up – happen, so we need to be more aggressive again at letting people know to continue despite mistakes

So there is a lot to learn and enrollment into this program needs to be studied in order to improve the way we help our communities.

The National Hispanic Medical Association has been involved with Medicare and a partner with CMS – announcing information in our Newsletter and conducting a major mailing to our doctors. We understand the extremely important role of Medicare Part D; however, we also recognize the critical nature of the enrollment issues for the Latino community – that is why we are standing with Congresswoman Solis on calling for an extension of Medicare Part D beyond May 15th.

III. NHMA & National Coalition on Hispanic Health

The National Coalition for Hispanic Health (NCHH) is a nonpartisan collaboration of organizations working to advance the health of nearly 44 million U.S. Hispanics through policy development, advocacy, and information exchange. NCHH is particularly focused on developing federal policies to reduce health disparities, improve access to quality health care, advance linguistic and cultural competence in health care services, and increase diversity in the health professions.

NHMA continues to convene and facilitate the work of NCHH, and our Coalition currently includes approximately fourteen national Hispanic organizations, i.e. NPRC, NCLR, LULAC, HSHPS, NHCSL, NALEO, CNC, LCAT, HACU and others. Our coalition has recently been working diligently on recommendations to the ongoing Congressional health disparities legislation discussions. Attached is a copy of the Coalition's letter to Congress regarding health disparities.

IV. NHMA & Title VII Funding for Health Professions

NHMA is currently trying to save and/or restore the federal funding for diversity programs including Hispanic Centers of Excellence (COE), Health Careers Opportunities Program (HCOP), Area Health Education Centers (AHEC), and Health Education Training Centers (HETC). Given the budget cuts to these programs in FY '06, NHMA is seeking to restore the funding for the programs at the '05 level.

The National Coalition for Hispanic Health (NCHH) is a nonpartisan collaboration of organizations working to advance the health of nearly 44 million U.S. Hispanics through policy development, advocacy, and information exchange. NCHH is particularly focused on developing federal policies to reduce health disparities, improve access to quality health care, advance linguistic and cultural competence in health care services, and increase diversity in the health professions.

May 18, 2006

The Honorable Michael B. Enzi
Chairman
US Senate Committee on Health,
Education, Labor & Pensions
428 Dirksen Senate Office Bldg.
Washington, DC 20510

The Honorable Edward M. Kennedy
Ranking Minority Member
US Senate Committee on Health,
Education, Labor & Pensions
428 Dirksen Senate Office Bldg.
Washington, DC 20510

Dear Mr. Chairman and Ranking Member Kennedy,

According to the 2005 National Healthcare Disparities Report released by the Agency for Healthcare Research and Quality (AHRQ, 2006), the Hispanic population received poorer quality of care than the comparison group of non-Hispanic White population for over half of core report measures. Hispanics had worse access to care than non-Hispanic Whites for 88% (7/8) core measures. In regards to change in disparities in core report measures of quality over time for members of the Hispanic population, the data show disparities in quality are worsening by 59%. In regards to changes in disparities in core report measures of access over time, the disparities in access to health care are worsening by 83%.

The above data serve to illustrate the dire need for Congress to address health disparities issues pertinent to the Hispanic community. The National Coalition on Hispanic Health (NCHH) respectfully urges the US Senate Committee on Health, Education, Labor and Pensions (HELP) Committee, and other Members of Congress to ensure that the following essential provisions are included in any health disparities legislation. The provisions include: Data Collection; Enhanced Research; Title VII Funding; Culturally Competent Outreach/Enrollment & Health Literacy, Language Services in Health Care Settings, and the Office of Minority Health.

Data Collection

As the recent National Healthcare Disparities Report (AHRQ, 2006) emphasized, Latino/as suffer from the worst record on most quality and health disparities indicators. Moreover, data collection on Latino health disparities has been lacking. In short, Latino/as have been ignored; therefore the health disparities experienced by Latino/as have been grossly underestimated. Without documentation of the extent of the problem, it is impossible to determine solutions. For all of these reasons, NCHH supports the data collection provisions found in the Closing the Health Care Gap Act of 2004, which require disaggregated data collection on race, ethnicity and primary language, as well as

information on the various subgroups (Mexican American, Puerto Rican, etc.), age, and gender.

Enhanced Research

The role of clinical trials is a critical component to providing better care and effective treatment for Hispanics. Currently, the majority of clinical trials have included a narrow segment of the U.S. population.[8] Clinical trials provide opportunities for participating individuals who may have a positive response to a new medicine, or improvement in a disease or condition. In addition, clinical trials can help with identifying and developing safer medications. Adequate funding for enhanced research, effective outreach, recruitment and implementation of clinical trials serving Latino/as and by Latino/a researchers and physicians in private practice networks is essential to address health disparities in diverse communities.

Title VII Funding

$43.6 million FY '07 – COE
$41.6 million FY '07 – HCOP

The intent of the Title VII Funding for ***Centers of Excellence*** (COE) has been to strengthen the national capacity to train students from minority groups that are under-represented in the health professions and build a more diverse health care workforce. Numerous scientific studies have shown that increasing Hispanic participation in the health care workforce improves access to health for underserved communities. NCHH requests restoration of the the funding for Title VII Funding for COE(s) at the same funding levels of FY '05 of $33.6 million. NCHH requests an additional $10 million set aside for at least five regional Hispanic Centers of Excellence, from a competitive applicant pool located in a geographic area that has a large medically underserved Hispanic population, and using a regional approach (through partnerships with other health professions schools, the private sector, school districts and community-based organizations (CBOs).

The intent of the ***Health Careers Opportunity Program (HCOP)*** has been to increase the number of individuals from disadvantaged backgrounds in the health and allied health professions. Unfortunately, the latest budgetary cuts in FY '06 and the proposed cuts in FY '07 completely severed grants to the health professions schools that would reach the Hispanic student population. Therefore, NCHH requests restoration of Title VII Funding for HCOP at the same funding levels of FY '05 of $35.6 million. NCHH requests an additional 20% (or $6,000,000) set aside for CBOs that have a successful track record of promoting the academic success of young people for the purpose of promoting the health professions among youth early in the education pipeline. This would be accomplished through mentoring, tutoring, academic enrichment programs, and scholarships that serve students from middle school to college.

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[8] National Institutes of Health (NIH) recently conducted a study on the issue with the Centers for Disease Control and Prevention (CDC) and Yale University School of Public Health. The researchers found that African Americans and Hispanics are willing to participate in public health studies, and when given the opportunity, they participate at the same rate as non-Hispanic Whites. Yet public health research has failed to include minorities. NIH reported that, "the researchers found big differences when it came to who was asked to participate." NIH, *New Findings on the Willingness of Minorities to Participate in Health Research* (Dec. 6, 2005).

NCHH requests continued support for other Title VII and VIII programs that increase the diversity of the health care workforce, i.e. Area Health Education Centers (AHECS) and Health Education and Training Centers (HETCS).

Cultural Competence Training in Health Professions

Due to the extreme shortage of Hispanic physicians, dentists, nurses and other health professionals, in order to minimize medical error and to increase patient safety and compliance, it is critical to support training on how to provide preventive care and treatment to patients from a different cultural background than the health professional.

As noted in the Closing the Gap Act, NCHH recommends the inclusion of Cultural Competence training of health professional students and health professionals by educational institutions and health professional associations.

Culturally Competent Education, Outreach, and Enrollment
$10 million annually for three years

Outreach and enrollment are necessary steps to improve community health and connect Latino/as to quality health care. CBOs and health care promoters (promotoras) who are leaders of their communities should be at the forefront of outreach and enrollment activities. NCHH strongly supports outreach programs for CBOs and promotoras to serve the needs for culturally and linguistically competent health education, awareness, prevention and media campaigns in the Latino/a community, and requests a substantial allotment for CBOs and promotoras to provide health literacy education.

In addition, the role of CBO's in promoting the well-being of Latino/as across their lifespan (infancy, adolescence, young adulthood, and elderly) should be strengthened, i.e. grants available from the CDC Futures Project.

An October 2005 pedriatrics study, conducted by Dr. Glenn Flores, demonstrated that strategies emphasizing community engagement such as the use of community-based outreach workers, can also dramatically improve levels of insurance within the Latino/a community. Therefore, NCHH recommends the inclusion of grants programs allowing Hispanic-serving CBOs also to assist Latino/as and their families in obtaining health coverage, such as the language contained in S. 1049, the Covering Kids Act of 2005. The language of the Community Health Workers Act of 2005, which uses a promotoras-based model to address chronic disease and enroll Latino/as into health care coverage, should be included in any health disparities initiatives.

Language Services in Health Care Settings

One of the greatest impediments that deters a significant portion of Latino/as from obtaining health care or receiving adequate treatment is the deficiency of translation and interpretation services in health care settings. While most Latino/as speak English "well" or "very well," according to the most recent American Community Survey data, there are over eight million Latino/as who are Limited English Proficient (LEP). Fluid communication not only enhances an LEP patient's experience; it also contributes to the reduction of medical error, increases trust between patient and doctor, and ultimately

ensures that patients are more likely to follow prescribed regimes and improve health outcomes. Policies which carry out the mission of Executive Order 13166 should be included in any health disparities initiative/legislation. While health literacy education is vitally important, it cannot be a substitute for language services. In particular, the NCHH supports the expansion of the Patient Navigator Outreach and Chronic Disease Prevention Act of 2004 Act (P.L. 109-18), and the Community Health Workers Act of 2005 (H.R. 4469), which promote the use of linguistically appropriate outreach workers to help guide patients through the health care system. NCHH supports authorization of relevant patient navigator provisions at the levels necessary to ensure equal access to health.

U.S. Department of Health and Human Services Office of Minority Health
$60 million FY '07

The U.S. Department of Health and Human Services' Office of Minority Health (OMH) was established in 1986 to lead and coordinate the activities of the Department affecting American Indians and Alaska Natives, Asian Americans, Blacks/African Americans, Hispanics/Latinos, Native Hawaiians and other Pacific Islanders.

The mission of the OMH is to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities. OMH advises the Department on health policy issues affecting health status and access to care among minority populations. It coordinates programs to help HHS implement minority initiatives, including the HHS Disparities Initiative, the White House Initiative on Historically Black Colleges and Universities, the White House Initiative on Educational Excellence for Hispanic Americans, the White House Initiative on Tribal Colleges and Universities, and the HHS Minority HIV/AIDS Initiative.

OMH works with HHS operating divisions and other Federal departments to improve collection and analysis of data on the health of racial and ethnic minority populations. It also monitors efforts to achieve the Healthy People 2010 goals for minority health.

The NCHH strongly recommends the increase in support of OMH and the inclusion of $5 million to enhance the critical efforts of the Center for Cultural Competence within OMH.

While NCHH understands that the current discussions on the health disparities legislation do not include access to health care due to the HELP Committee's limited jurisdiction on entitlement programs, **the Coalition believes it is of utmost importance to point out to the Committee, the following:**

Improved Health Coverage for Latino Families – ***The pervasive lack of insurance in the Latino/a community continues to be the primary reason why Latino/as go without needed health care.*** Despite high rates of participation in the workforce, in 2004, nearly one in three (32.7%) Latinos went without health coverage. This is a higher rate than any other population in the United States. In order to eliminate health disparities, it is paramount to address the growing lack of health insurance in the Latino/a community. In particular, any health disparities bill that moves forward should alleviate barriers that prevent many Latino/as from accessing health coverage, such as harsh restrictions on legal immigrant families' access to federal health insurance. One

such proposal, the Immigrant Children's Health Improvement Act (S. 1104, H.R. 1233), which has long garnered bipartisan support, would take the first step in repealing the federal bars for legal immigrant children and women, and allow the states to provide federally-funded State Children's Health Insurance Program (SCHIP) and Medicaid services to these vulnerable populations. It is essential for the committee to continue to highlight the need for increased health coverage and pursue opportunities for equity in health coverage.

Puerto Rico Parity

US citizens living in Puerto Rico, the great majority of whom are Latino/a, suffer disproportionate rates of a number of illnesses including asthma, HIV/AIDS, diabetes, low birth rates, and infant mortality. Primarily due to federal funding inequities in Medicaid, SCHIP, and Medicare, Puerto Rico's government is ill equipped to address these health disparities. While Puerto Rico's government spends close to $1.5 billion ensuring access to care for the low-income population, the federal reimbursement is just over $200 million, making it difficult for the Island to sustain its health care system. Similarly, Puerto Rico receives only a minute fraction (0.23 %) of SCHIP, America's largest children's health insurance program despite the fact that 5% of all the nation's poor children live in Puerto Rico.

It is imperative to take steps toward correcting federal funding inequities in health programs to reduce health disparities in Puerto Rico. NCHH urges Congress to equitably include Puerto Rico in all major health initiatives and reimburse Puerto Rico for costs associated with the initiatives outside the federal Medicaid cap (Section 1108 of the Social Security Act, which effectively renders reimbursement for Puerto Rico at 20%, compared to 50-80% for the states).

Congress should count reimbursements for health care of all children born after 2006 outside the federal Medicaid cap. Receiving federal reimbursement for the Island's youngest population would help Puerto Rico meet health care costs and it would demonstrate the nation's commitment to covering all of its children. It would also put the Island in a better position to cover more children living in poor families, an important step in improving health outcomes for minority children.

SUMMARY

Our broad coalition of national, nonpartisan nonprofit organizations serving the Latino community is unified in urging you to include the above measures in any health disparities legislation. These provisions are essential in order to be effective in decreasing the most severe health disparities experienced by the Latino community.

Sincerely,

ASPIRA
Cuban American National Council (CNC)
Hispanic Association of Colleges and Universities (HACU)
Hispanic Serving Health Professions Schools (HSHPS)
League of United Latin American Citizens (LULAC)
National Council of La Raza (NCLR)
National Hispanic Caucus of State Legislators (NHCSL)
National Hispanic Medical Association (NHMA)
National Latino Council on Alcohol and Tobacco Prevention (LCAT)
National Puerto Rican Coalition (NPRC)

cc:
The Honorable Bill Frist
The Honorable Judd Gregg
The Honorable Hillary Clinton
The Honorable Lamar Alexander
The Honorable Tom Harkin
The Honorable Barbara Mikulski
The Honorable James Jeffords
The Honorable Patty Murray
The Honorable Jack Reed
The Honorable Pat Roberts
The Honorable Mel Martinez
The Honorable Nancy Pelosi
The Honorable Ralph Regula
The Honorable Mike Honda
The Honorable Grace Napolitano
The Honorable Luis Fortuño
The Honorable Raul Grijalva
The Honorable Jim Costa
The Honorable Linda Sanchez
The Honorable Loretta Sanchez
The Honorable Lincoln Diaz-Balart
The Honorable Luis Gutierrez
The Honorable Jose Serrano
The Honorable Silvestre Reyes
The Honorable Henry Bonilla
The Honorable Henry Cuellar
The Honorable Harry Reid
The Honorable Jeff Bingaman
The Honorable Christopher Dodd
The Honorable Barack Obama
The Honorable Richard Burr
The Honorable Johnny Isakson
The Honorable Mike DeWine
The Honorable Orrin Hatch
The Honorable Jeff Sessions
The Honorable Ken Salazar
The Honorable Robert Menendez
The Honorable Hilda Solis
The Honorable Lucille Roybal-Allard
The Honorable Donna Christensen
The Honorable Ileana Ros-Lehtinen
The Honorable Luis Pastor
The Honorable Dennis Cardoza
The Honorable Xavier Becerra
The Honorable Joe Baca
The Honorable John T. Salazar
The Honorable Mario Diaz-Balart
The Honorable Nydia Velasquez
The Honorable Ruben Hinojosa
The Honorable Charles Gonzalez
The Honorable Solomon Ortiz

Elena V. Rios, M.D., M.S.P.H.
President & CEO, National Hispanic Medical Association
President, National Hispanic Health Foundation

Dr. Rios serves as President & CEO of the National Hispanic Medical Association, (NHMA), representing Hispanic physicians in the United States. The mission of the organization is to improve the health of Hispanics. Dr. Rios also serves as President of NHMA's National Hispanic Health Foundation affiliated with the Robert F. Wagner Graduate School of Public Service, New York University, to direct educational and research activities.

Dr. Rios also serves on the National Hispanic Leadership Agenda and the Partnerships for Prevention Boards of Directors, the American Medical Association Commission to End Health Disparities, and is Co-Chair for the Hispanic Health Coalition. Dr. Rios has lectured and published articles and has received several awards on health policy, including awards from the U.S. Department of Health and Human Services, the Congressional Black, Hispanic, Asian and Native American Caucuses, American Public Health Association Latino Caucus, Association of Hispanic Health Executives, Minority Health Month, Inc., and Hispanic Magazine.

Prior to her current positions, Dr. Rios served as the Advisor for Regional and Minority Women's Health for the U.S. Department of Health and Human Services Office on Women's Health from November 1994 to October 1998. In 1992, Dr. Rios worked for the State of California Office of Statewide Health Planning and Development as a policy researcher. In 1993, Dr. Rios was appointed to the National Health Care Reform Task Force as the Coordinator of Outreach Groups for the White House. Dr. Rios has also served as President, Chicano/Latino Medical Association of California, Advisor to the National Network of Latin American Medical Students, member of the California Department of Health Services Cultural Competency Task Force, Stanford Alumni Association and Women's Policy Inc. Boards of Directors, and the AMA's Minority Affairs Consortium Steering Committee.

Dr. Rios earned her BA in Human Biology/Public Administration at Stanford University in 1977, MSPH at the University of California School of Public Health in 1980, her MD at the UCLA School of Medicine in 1987, and completed her Internal Medicine residency at the Santa Clara Valley Medical Center in San Jose and the White Memorial Medical Center in East Los Angeles in 1990, and her NRSA Primary Care Research Fellowship at UCLA in 1992.

National Hispanic Medical Association

Established in 1994, the National Hispanic Medical Association (NHMA) represents licensed Hispanic physicians in the United States. The mission of NHMA is to improve the health of Hispanics and other underserved. The Association's programs support physicians and advocate for quality health care at the national level.

Physician Support: In 1998, the NHMA Leadership Fellowship was developed in collaboration with the Robert F. Wagner Graduate School of Public Service, New York University with the support of the U.S. Department of Health and Human Services (HHS) to develop the leadership skills of member physicians selected from across the nation. NHMA also developed the NHMA Resident Leadership Program and the Medical Student Mentorship Program. NHMA developed media training, a media breakfast series with the Congressional Hispanic Caucus with support form the U.S. Department of Transportation and speakers' bureau for media interviews and conferences. NHMA developed its cultural competence project in NYC with focus groups of faculty, community organizations, and residents to determine future direction for community-based training in GME programs and the promotion of linkages to develop research in Hispanic communities, and a September 2004 meeting with HHS Office of Minority Health (OMH) with the USMLE, AAMC, JAHCO, NCQA, NQF on current evaluation of cultural competence training. NHMA also nominates our members to national committees in public and private sectors.

Advocacy: NHMA serves as a resource to the White House, HHS, Senator Frist and Senator Kennedy and the House minority caucuses. In 2002, NHMA, the CHC, HHS, Robert Wood Johnson Foundation convened the National Hispanic Health Leadership Summit with 175 participants nominated by HHS and Congress and partners. NHMA has been supported by the Commonwealth Fund for symposia with Congressmembers, State officials and health leaders to discuss strategies to increase insurance among Hispanics and by the California Endowment to convene "Hispanic Health Congressional Briefing Series" on cultural competence, health professions, community based research, US-Mexico binational insurance. NHMA also serves on the National Hispanic Leadership Agenda, with the largest 40 Hispanic organizations of the country and the AMA Disparities Commission.

NHMA's 9th Annual Conference will be Mar. 31 – Apr. 3, 2005 at the Millennium Biltmore Hotel, Los Angeles, California. Lastly, we are seeking articles for NHMA's Second Journal with the American Academy of Family Physicians, "Caring for the Hispanic Patient".

National Hispanic Health Foundation

NHMA established the National Hispanic Medical Foundation in 1994 to provide research and educational activities focused on Hispanic health. In 2000, the name was changed to the National Hispanic Health Foundation (NHHF), and, in 2004, NHHF was officially affiliated with the Robert F. Wagner Graduate School of Public Service, New York University. A Congressional Earmark was awarded to develop the Hispanic Health Professional Leadership Network and a new list serve system as well as the strategic planning for the Foundation. The future programs include Policy Research and Research Training targeting Hispanic health, the Hispanic Health Professional Student Scholarship Program and Leadership development. Currently we are developing research on diversity in the health workforce for HHS OMH – both at the entry level, the HCOP program, and looking at executive leadership for Hispanics in major health care organizations.

We hope you can help us develop by contributing to NHHF online at
WWW.NHMAMD.ORG
We also encourage you to join NHMA online at same website and help build our organizations.

National Hispanic Medical Association
March 2005

Established in 1994, in Washington, DC, the **National Hispanic Medical Association (NHMA)** represents licensed Hispanic physicians in the U.S. The mission of the organization is to improve the health of Hispanics.

NHMA Leadership Fellowship Program

The NHMA Leadership Fellowship Program is a collaborative project with the Robert F. Wagner Graduate School of Public Service. The purpose of the program is to promote the development of leadership potential among members of the National Hispanic Medical Association. The emphasis is on the knowledge and skills necessary to take a leadership role in health policy development and advocacy at local, state and national levels on issues of importance to the health of the Hispanic community. The Health Resources and Services Administration, U.S. Department of Health and Human Services supported the program during the first three years. Amgen, Ortho Biotech, Pfizer and Aetna Foundation have also supported the program.

The program began October 1, 1998 and trains 20 mid-career Hispanic physicians per year with a one-day Orientation at the NHMA Annual Conference, a week-long NYU Institute, and a week-long Washington, DC Institute. The lectures, panel discussions, and case study discussions are presented by health experts from the federal and state governments, foundations, media, managed care, think tanks, and non-profit advocacy organizations.

NHMA has commissioned case studies on Hispanic health policy issues and will be publishing the first volume as a textbook for graduate level health policy analysis courses.

NHMA Resident Leadership Program

Similar to the NHMA Leadership Fellowship Program, NHMA provides lectures about policy and academic leadership and career decision-making. Twenty Residents are selected each year for a one-day Orientation at the NHMA Annual Conference. Of the twenty Residents, ten gather in Sacramento, California and ten meet in Albany, New York for a three-day institute. The Health Resources and Services Administration and the U.S. Department of Health and Human Services has supported the first three years of the program.

NHMA Cultural Competence Project

The purpose of the NHMA Cultural Competence Project is to develop recommendations for medical education curriculum on cultural competence and Hispanics. The project calls for developing a bibliography and summary of definitions as well as plenary sessions at the NHMA Annual Conference.

NHMA convened two plenary sessions at the Annual Conferences in 2001 and 2002 and a panel of experts on April 6, 2002, in Washington, DC to assess the current knowledge base on cultural competence training for medical education especially related to Hispanic cultural competence. The results of the meeting will be disseminated. The Office of Minority Health, U.S. Department of Health and Human Services, supports the project.

NHMA Cultural Competence Curriculum for New York City Graduate Medical Education

NHMA convened three focus groups of community leaders from Mexican, Dominican and Puerto Rican neighborhoods, faculty from GME programs in NYC, and residents from GME programs in NYC to discuss the curriculum needs and research challenges in the area of Hispanic health. Meetings occurred at the Robert F. Wagner Graduate School of Public Service, New York University. Currently, NHMA is in its third year of a four-year project with a focus on Cultural Competence Curriculum Evaluation. A presentation was made by GME faculty at the NHMA 8th Annual Conference and a meeting of accreditation and board examiners will be convened in September. The Office of Minority Health, U.S. DHHS, is the supporter of the project.

NHMA –National Highway Traffic Safety Administration (NHTSA) Partnership

The purpose of this project is to develop the discussions about Hispanic health, including traffic safety, and to develop relationships with media executives. NHMA convenes a media breakfast series with executives from TV stations and local media; this is done in collaboration with the Congressional Hispanic Caucus and other elected officials. In addition, the NHMA provides media training to member physicians for television and radio interviews. NHMA maintains a speaker's bureau of Hispanic physicians for NHTSA Regional Offices and national partners. At the 2002

NHMA Annual Conference, television management and physician reporters from CBS, ABC, NBC and UNIVISION made presentations at a plenary session. The National Highway Traffic Safety Administration, Department of Transportation, supports this project. Congresswoman Roybal-Allard, Congressman Rodriguez, Congressman Gutierrez, Congresswoman Velazquez, and Assemblyman Gil Cedillo have served as Co-chairs of the Media Breakfasts held in their districts. This year we support the "Impaired Driving Campaign" and developed an Alcohol Screening Kit in Spanish for our speakers bureau and partner organizations.

NHMA Redes En Acción Project

NHMA serves as a partner on the Executive Committee (Dr. Rios is a co-PI) of this project, funded by the Baylor College of Medicine and sponsored by the National Cancer Institute, NIH. The purpose of Redes is to raise awareness of cancer research and to encourage training in cancer research, which NHMA does through advocacy, the Annual Conference workshop, student poster sessions, mailings of the Redes newsletter, and developing NHMA physician profiles and articles for the newsletter. NHMA also participates in two annual meetings – one for NCI projects and the other for Redes National Steering Committee meeting in San Antonio, TX. This program was recently awarded its second 5 year grant from NCI.

The Commonwealth Fund Project

NHMA has collaborated with The Commonwealth Fund and Congressional members to plan and implement three regional health policy media briefings. The briefings introduced new reports on the Uninsured and Quality of Health Care, with foci on the Hispanic population, to community business and government leaders. The meetings served as forums to promote discussion on the challenges of the findings and strategic directions for health policy. State and Federal elected officials and the U.S. Surgeon General joined as speakers. The meetings were held July 1, 2003 in Los Angeles, October 1, 2003 in Atlanta, and December 4, 2003 in Washington, DC.

NHMA 7th , 8th and 9th Annual Conferences

The 7th Annual Conference was entitled, "Hispanic Health Model Programs: Prevention, Treatment, Training, and Research," and was held at the Hyatt Regency Capitol Hill on March 20-23, 2003. Plenary sessions included White House, DHHS, Congressional and Senate Speakers as well as Model Hispanic Health Program Speakers, including the Redes en Acción Program (research), Hispanic Centers of Excellence (training) and others.

"Hispanic Health Strategies Across the Nation" was the theme for last year's annual conference, held March 19-21, 2004 at the Hyatt Regency Capitol Hill Hotel, Washington, DC. This year, the NHMA will convene the conference at the Biltmore Hotel in Los Angeles on March 31- April 3, 2005 and the theme is "Medical Practice for the 21st Century: Enhancing Quality and Health Literacy". For interested speakers or sponsors, see the NHMA website.

NHMA National Hispanic Health Leadership Summit

In collaboration with the Congressional Hispanic Caucus, other invited Congressmen, the U.S. Department of Health and Human Services, the Robert Wood Johnson Foundation, the California Endowment, the Hispanic-Serving Health Professions Schools, Inc., Aventis, Amgen, GlaxoSmithKline, PhRMA, and several national Hispanic organizations, NHMA convened community leaders to build consensus on strategies to improve Hispanic health programs and policies at the national level. The meeting was held August 15-17, 2002 in San Antonio, Texas at the University of Texas San Antonio and at the Radisson Hotel. The purpose of the summit was to 1) share the strengths and weaknesses of current health care programs that impact Hispanics; 2) discuss strategies needed for future health care programs; and 3) build consensus on the Federal programs and policies that can be developed or enhanced to improve the quality of health care delivery to Hispanic in the United States over the next five years. Of note, the U.S. Surgeon presented his vision for a healthy America in one of his first public appearances. A report was issued and distributed nationwide. A summary was presented to both the Congressional Black Caucus and Congressional Hispanic Caucus at their annual policy conferences.

OWH Lupus and Latinas Project

The Office on Women's Health, U.S. Department of Health and Human Services sponsored a meeting of Hispanic physicians to discuss the management and treatment of Latina patients with Lupus and issues for future policy and research. The meeting was held on January 30, 2003.

NHMA Advocacy Infrastructure Development Project

NHMA developed this arm of the organization to hold the NHMA Hispanic Health Congressional Briefing Series and regular Federal official meetings. NHMA has brought Board Members, Advisory Committee Members, Fellows, and others to discuss health issues that impact Hispanic physicians and their patients. The briefings have focused on Cultural Competence, Diversity in the Health Professions, and Community Based Research and Eliminating Racial/Ethnic Health Disparities. The California Endowment started funding the four-year project in 2003.

NHMA Training and Information Dissemination Project

NHMA will develop plans for Training Institutes for senior managers from national and local Hispanic health professions organizations and Federal Government that focuses on using Hispanic data and developing policy analysis research on Hispanic health issues. Information on Hispanic health will be disseminated through a new portal, a membership services unit, and a targeted list serve to Hispanic medical societies across the nation, the NHMA Advisory Committee, Hispanic health interest groups and policy committees, as well as the National Hispanic Health Professionals Leadership Network at the NHMA Annual Conferences, beginning in March 2004.

NHMA Obesity Abatement Project

NHMA will continue the Information and Dissemination effort and develop a national Hispanic Coalition, with a focus on Obesity Abatement this year and convene five regional meetings in Hispanic highly populated cities across the nation. This educational campaign is supported by the U.S. Department of Health and Human Services Office of Minority Health for 2 years.

NHMA and AAFP Journal

NHMA entered into an agreement with the American Academy of Family Physicians in July 2003 to develop its first peer reviewed medical journal, "Caring for the Hispanic Patient" which was published in August 2004 as a summer issue. The second issue will be published for September 2005.

NHMA Press

NHMA has started planning the publication unit and will publish the first Volume of the NHMA Leadership Fellowship Case Studies this year. Other publications planned include the History of NHMA, the 2nd Volume of the Fellowship Case Studies, and the Hispanic Curriculum Case Studies.

National Hispanic Health Foundation

The National Hispanic Health Foundation (501c3), established in 1994 in Washington, DC as the National Hispanic Medical Foundation, is the philanthropic arm of the National Hispanic Medical Association. The mission of the Foundation is to support educational and charitable activities to improve the health of Hispanics. In 2003, the NHMA was awarded a Congressional Earmark to develop the Foundation, through the National Hispanic Medical Association, with the support of the Congressional Hispanic Caucus, Senator Arlen Specter and Congressman Regula. This year, NHHF has become affiliated with the Robert F. Wagner Graduate School of Public Service, New York University and is currently located with NHMA in Washington, DC. The programs of the NHHF include:

- **The Hispanic Health Professional Student Scholarship Program** – the first national scholarship program targeted at Hispanic students who are committed to careers in health care – medicine, nursing, dentistry, public health, health management and policy analysis, health research, and allied health. The first NHHF Scholarship GALA Dinner was convened at the Marriott Marquis Hotel, New York City, December 2, 2004. and the second Dinner will be held on December 1, 2005. Scholarship applications will be available on the NHMA Website in May.

- **National Hispanic Medical Association Leadership Fellowship** - The NHMA Leadership Fellowship Program is a collaborative project with the Robert F. Wagner Graduate School of Public Service. The purpose of the program is to promote the development of leadership potential among members of the National

Hispanic Medical Association. The emphasis is on the knowledge and skills necessary to take a leadership role in health policy development and advocacy at local, state and national levels on issues of importance to the health of the Hispanic community. The Health Resources and Services Administration, U.S. Department of Health and Human Services supported the program during the first three years. Amgen, Ortho Biotech, Pfizer, and Aetna Foundation have also supported the program.

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NHMA has commissioned case studies on Hispanic health policy issues and will be publishing the first volume as a textbook for graduate level health policy analysis courses.

- **Portal for Hispanic Health:** www.HispanicHealth.info –information in English and Spanish through the Internet for physicians and health providers is being developed.

- **Hispanic Health Research Training Program** – a training program to increase the knowledge about the use of datasets and surveys for Hispanic populations. This program will begin in Fall, 2005.

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Reports on Obesity
and Diabetes

CALIFORNIA CENTER FOR PUBLIC HEALTH ADVOCACY

THE GROWING EPIDEMIC

POLICY BRIEF NO. 4 AUGUST 2005

CHILD OVERWEIGHT RATES ON THE RISE IN CALIFORNIA ASSEMBLY DISTRICTS

SUMMARY

In 2002, the California Center for Public Health Advocacy (CCPHA) released a study reporting that 26.5 out of every 100 children enrolled in grades 5, 7, and 9 in California in 2001 were overweight. In this updated study, CCPHA reports that in 2004 childhood overweight rates had increased by 6%, to 28.1 out of every 100 children. Between 2001 and 2004, the percentage of overweight children increased among all demographic groups: boys and girls, students in all grades studied, and children of all racial/ethnic backgrounds.

The growing levels of childhood overweight point to two of the most serious public health crises facing California today: unhealthy diets and low levels of physical activity among our children. Poor eating and inadequate physical activity put California children at risk for diabetes and other chronic diseases in their youth, can lead to expensive and preventable adult illnesses, and may reduce their life expectancy.

These crises reflect not only factors under the control of children and their parents, but also conditions in schools and communities that encourage children to eat and drink unhealthy foods and beverages and that limit their physical activity. Unfortunately, not enough has been done to address these problems. To address this growing epidemic, the California Center for Public Health Advocacy calls on policy makers to establish comprehensive policies that support parents in providing opportunities for their children to make healthy choices about eating and physical activity.

BACKGROUND

During the past three decades, the prevalence of overweight among young people in the United States more than tripled among children 6 to 11 years and more than doubled among adolescents aged 12 to 19 years.[1] These figures are particularly alarming because of the health problems associated with children being overweight. Children and adolescents who are overweight are at increased risk for type 2 diabetes mellitus, asthma, and orthopedic problems; they are more likely to have risk factors for cardiovascular disease (such as increased blood pressure and cholesterol); and they are more likely to have behavioral problems and depression.[2,3] In addition, children and adolescents who are overweight are more likely to remain so as adults,[4,5] with an estimated 75% of overweight adolescents being obese as young adults.[5]

Obese adults are at increased risk for heart disease, stroke, osteoarthritis, and several forms of cancer.[6-8] These health risks result in increased human suffering, reduced quality of life, and premature death.[9-11] In addition, costs for health care attributable to excess body weight account for up to 7% of annual U.S. healthcare expenditures among adults, at a cost of more than $90 billion per year.[12-13] In 2005, medical care, workers' compensation, and lost productivity attributable to overweight, obesity, and physical inactivity among adults will cost California an estimated $28 billion.[14]

The increasing prevalence of overweight is a reflection of critical and fundamental health problems that plague our children: poor diet and a lack of regular physical activity. These problems are the result of a variety of individual, social, and environmental factors. These factors include increased availability and consumption of soft drinks and high-fat, high-calorie foods; increasing amounts of time spent in sedentary activities, including television viewing; and limited access in many neighborhoods to healthy foods and safe places to be physically active. Since CCPHA released its 2002 report on overweight children in California, far too few significant statewide policies have been enacted to promote healthy eating and physical activity in California.

The Study

The California Center for Public Health Advocacy (CCPHA) analyzed data collected in the 2004 California Department of Education Physical Fitness Test from almost 1.4 million children to determine the number of children enrolled in grades 5, 7, and 9 who were overweight.[15] The California Physical Fitness Test evaluates children using the *FITNESS*GRAM assessment tool, which consists of six measures of physical fitness.[16] The Healthy Fitness Zone is the *FITNESS*GRAM term used to describe the minimum level of fitness (that is, the level thought to provide some protection from health risks imposed by a lack of fitness) in each component of the test. Each Healthy Fitness Zone is based on criterion-referenced standards that have been tested and shown to be valid and reliable.

CCPHA analyzed one of these measures, body composition, as an indicator of whether or not children were overweight. Each student's body composition was assessed based on either body mass index (BMI) calculated from measured height and weight, triceps skin fold thickness, or bioelectrical impedance.[17] Children who exceeded the Healthy Fitness Zone were considered to be overweight. In this study, overweight is generally equivalent to the 90th percentile of BMI-for-age, and is slightly lower than the commonly used Centers for Disease Control and Prevention (CDC) definition of overweight as a BMI-for-age at or above the 95th percentile.[18]

CCPHA used data from the California Senate Office of Demographics to assign children to the 80 Assembly districts in California based on their school zip codes.[19] The percentage of overweight children was determined for each Assembly district by gender, grade, and race/ethnicity. The percentage of children who were overweight in 2004 was compared to the percentage of children who were overweight in 2001 as determined by CCPHA's prior analysis.[20]

Results

Table 1. Overweight Children in Grades 5, 7, and 9—California, 2004

Category	Overweight (%)
All Children	28.1
Gender	
Boys	33.9
Girls	22.0
Grade	
5th	29.3
7th	29.1
9th	25.4
Race/Ethnicity	
African American	28.7
American Indian/ Alaskan Native	31.7
Asian	17.9
Filipino	24.7
Latino	35.4
Pacific Islander	35.9
White	20.6
Other	24.4

STATEWIDE PERCENTAGES OF OVERWEIGHT CHILDREN

Overall, more than one in four (28.1%) children enrolled in grades 5, 7, and 9 in California were overweight in 2004 (TABLE 1). Boys (33.9%) were more likely to be overweight than girls (22.0%). The percentage of children who were overweight decreased with increasing grade level, from almost one out of three in grades 5 and 7 to one out of four in grade 9.

The percentage of children who were overweight was highest among Pacific Islanders (35.9%), followed by Latino (35.4%), American Indian/Alaskan Native (31.7%), and African-American (28.7%) children. Lower percentages of overweight were found among non-Latino white children (20.6%) and Asian children (17.9%).

CHANGE IN PERCENTAGE OF OVERWEIGHT CHILDREN FROM 2001 TO 2004

Statewide, the percentage of children enrolled in grades 5, 7, and 9 who were overweight increased from 26.5% in 2001 to 28.1% in 2004 (FIGURE 1). The percentage of overweight children increased among both boys and girls, among children in all three grade levels, and among children of all racial/ethnic backgrounds.

The percentage of children who were overweight increased among all race/ethnicity categories from 2001 to 2004 (FIGURE 2). American Indian/Alaskan Native children experienced the largest increase in overweight, from 25.1% in 2001 to 31.7% in 2004.

FIGURE 1. PERCENTAGE OF CHILDREN IN GRADES 5, 7, AND 9 IN CALIFORNIA WHO WERE OVERWEIGHT IN 2001 COMPARED TO 2004, BY GENDER AND GRADE

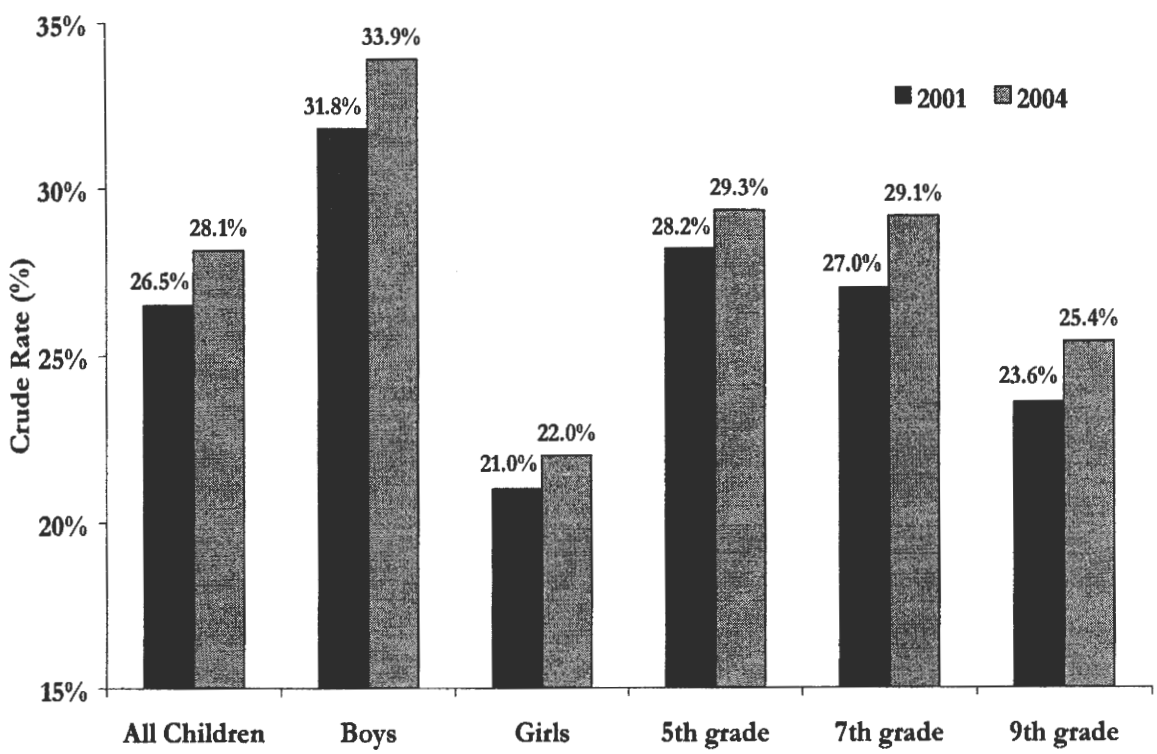
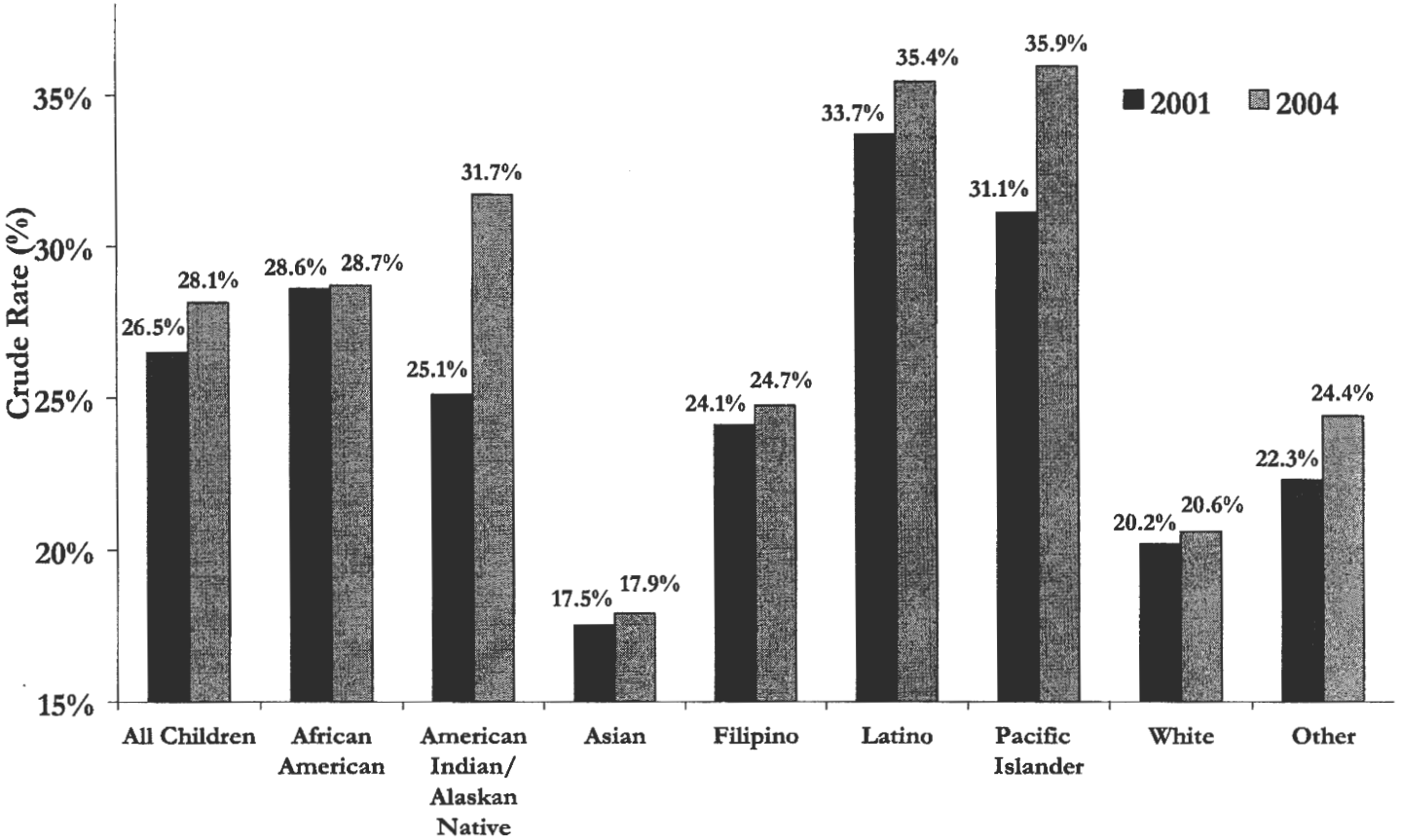


FIGURE 2. PERCENTAGE OF CHILDREN IN GRADES 5, 7, AND 9 IN CALIFORNIA WHO WERE OVERWEIGHT IN 2001 COMPARED TO 2004, BY RACE/ETHNICITY



PERCENTAGE OF OVERWEIGHT CHILDREN BY ASSEMBLY DISTRICT

Across all 80 Assembly districts, the percentage of children enrolled in grades 5, 7, and 9 who were overweight in 2004 ranged from 18.2% to 39.1% (SEE MAP). In 55 out of 80 (69%) Assembly districts, at least one out of four (25%) children was overweight.

Assembly districts in the Los Angeles area had particularly high percentages of children who were overweight. Eight out of ten (80%) Assembly districts with the highest percentages of overweight children were located in the Los Angeles area.

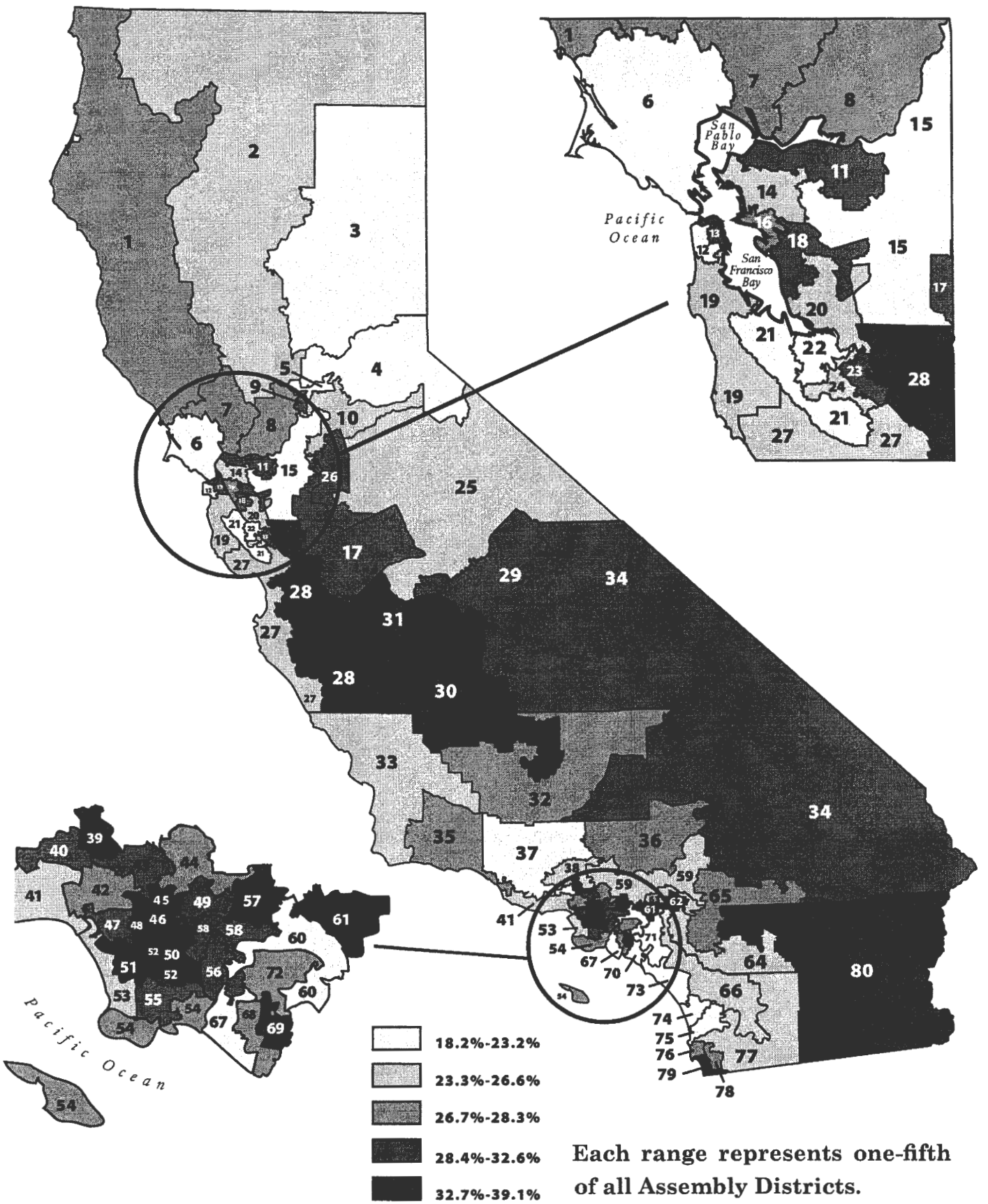
CHANGE IN PERCENTAGE OF OVERWEIGHT CHILDREN BY ASSEMBLY DISTRICT FROM 2001 TO 2004

Between 2001 and 2004, the percentage of children enrolled in grades 5, 7, and 9 who were overweight increased in 71 out of 80 (89%) Assembly districts. Of the 80 districts, 50 experienced a 5% or greater increase in the percentage of children who were overweight (TABLE 2). Only nine out of the 80 districts (11%) experienced a decrease in the percentage of children who were overweight.

TABLE 2. CHANGE IN PERCENTAGE OF OVERWEIGHT CHILDREN FROM 2001 TO 2004 — CALIFORNIA ASSEMBLY DISTRICTS

CHANGE IN PERCENTAGE OF OVERWEIGHT CHILDREN FROM 2001 TO 2004	NUMBER OF ASSEMBLY DISTRICTS
Increase of > 10%	27
Increase of 5% - 10%	23
Increase of 0% -5%	21
No Change	0
Decrease of 0% - 5%	6
Decrease of > 5%	3

Percentage of Children in Each Assembly District Who Were Overweight in 2004



Each range represents one-fifth of all Assembly Districts.

Conclusion

Across California, the percentage of children in grades 5, 7, and 9 who were overweight increased 6% in three years to 28.1 per 100 children in 2004, from 26.5 per 100 children in 2001. The increase occurred among both boys and girls and among children of all racial/ethnic backgrounds. An increase in the percentage of children who were overweight occurred in 71 out of 80 Assembly districts – almost 90% of all districts. The increase in the percentage of overweight children in California is a reflection of two of the most critical public health problems facing California children today: unhealthy diets and low levels of physical activity. In order to address these problems, statewide policies must be implemented to support parents in helping their children make healthy choices about eating and physical activity.

Policy Recommendations

The epidemic of childhood obesity will not be solved by calling for individual behavior change alone. To address this health crisis, state and local leaders must address the conditions in schools and communities that contribute to the epidemic and undermine parents' efforts to protect their children's health. The California Center for Public Health Advocacy (CCPHA) calls on policy makers throughout the state to take immediate action. The following recommendations are based on those made by a national Scientific Panel brought together by CCPHA and on recommendations recently developed by the Strategic Alliance for Healthy Food and Activity Environments.[21]

1. Institute healthy food and beverage standards for all items available in pre-school, school, and after-school programs. Standards should address levels of fat, sugar, and calories.
2. Ensure that all children receive physical education that meets minimum standards for quality, duration, and frequency. Students should be active, classes should be of appropriate size, and teachers should be credentialed and well-trained.
3. Establish grocery stores with produce and other fresh, healthy items in all underserved neighborhoods.
4. Eliminate advertising of unhealthy foods and beverages to children and youth.
5. Provide health plan benefits that cover age-appropriate nutrition counseling and education as well as physical activity programs.
6. Make school recreational facilities available for after-hours use by children and families, especially in neighborhoods that lack adequate, safe, and accessible park and recreational facilities.
7. Adopt and implement "complete streets" policies to provide safe and convenient roadway access for people who walk, bicycle, or use wheelchairs.
8. Provide financial incentives for establishing physical activity facilities, grocery stores, and farmers markets, and improving walkability, particularly in low-income communities.

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Acknowledgments

AUTHORSHIP

This policy brief and an accompanying background report were written by Margaret McCusker, MD, CCPHA's former Research Director. Editorial input came from Nancy Adess, consultant to CCPHA and CCPHA Staff. Graphic design was done by Brown Miller Communications, Inc. Bonnie Fisk-Hayden, consultant to CCPHA, designed the map.

DATA ANALYSIS

Karen Vasquez, MPH, analyzed the data for this study. Chi Kao, PhD, of the Institute for Health Policy Studies at the University of California, San Francisco, provided expert advice and supervision of the data analysis.

SCIENTIFIC PANEL

CCPHA convened a panel of experts to review the findings of the analysis and to provide insight on the policy recommendations. The Panel included Susan Babey, PhD (University of California, Los Angeles); Kelli McCormack Brown, PhD, CHES (University of South Florida); Patricia Crawford, DrPH, RD (University of California, Berkeley); George Flores, MD (The California Endowment); Betty Hennessy, PhD (Los Angeles County Office of Education); Gregory Welk, PhD (Iowa State University), and Antronette Yancey, MD, MPH (University of California, Los Angeles). Affiliations are listed for information only.

The views expressed in this report are those of CCPHA and do not necessarily reflect the views of the members of the Scientific Panel or their institutions.

Support for this project was provided by a grant from The California Vitamin Cases Consumer Settlement Fund. The 2001 analysis was funded by a grant from The Robert Wood Johnson Foundation.

Copies of this publication and a full report about this study can be accessed on-line at www.publichealthadvocacy.org.

ABOUT THE CALIFORNIA CENTER FOR PUBLIC HEALTH ADVOCACY

The California Center for Public Health Advocacy is an independent, nonpartisan, non-profit organization that raises awareness about public health issues and mobilizes communities to promote the establishment of effective health policies. The California Public Health Association-North and the Southern California Public Health Association founded the Center in 1999. The Center is currently supported by grants from The California Endowment, The California Vitamin Cases Consumer Settlement Fund, the California Nutrition *Network*, The California Wellness Foundation, Kaiser Permanente and contributions from other individuals and organizations.

The California Center for Public Health Advocacy provides updates on state legislation regarding physical activity, physical education and nutrition, and information about advocacy tools to a statewide network of advocates via email. Health and public professionals, community activists, teachers and parents interested in addressing the epidemics of childhood overweight and inactivity through policy reform are urged to join the network by going to our web site and clicking on "Join Advocacy Network." (www.publichealthadvocacy.org)

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IN MEMORIAM: RUTH ROEMER (1916-2005)

This study is dedicated to the loving memory of Ruth Roemer, JD, founding Board member of CCPHA, and colleague, mentor, good friend to so many of us.

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Diabetes Deaths in California Legislative Districts

LEGISLATIVE DISTRICT POLICY BRIEF Nº 3

California is in the midst of an unprecedented epidemic of diabetes. Far more adults and children have the disease than ever before. The increase in diabetes among adults and the emergence of Type 2 diabetes in children are associated with a dramatic rise in obesity and overweight in recent years. Projected future increases in both diabetes and overweight forecast staggering increases in chronic health conditions and overwhelming personal, social, and economic hardship in the years to come.

To understand the burden of diabetes in California communities, the California Center for Public Health Advocacy analyzed diabetes-related deaths in a unique way—by state legislative district. This analysis complements the Center's 2002 study on the prevalence of overweight and unfit children in California and provides additional insight into the relationship between diabetes and overweight in the state's legislative districts.

With strong and committed political leadership, much can be done to prevent, treat, and manage diabetes. Only by establishing policies that address the underlying social and environmental causes of both diabetes and overweight will Californians be spared a future of chronic health problems, decreased life expectancy, and unparalleled increases in long-term health care costs.

BACKGROUND

Diabetes: A National Epidemic

Diabetes rates have reached epidemic proportions in the U.S.[1] Diabetes affects as many as 18.2 million people in the U.S., or 6.3% of the population, including an estimated 5.2 million people that have undiagnosed diabetes.[2]

Diabetes prevalence is increasing dramatically among both adults and children. Among adults, the prevalence increased by 61% from 1990 to 2001.[3] At the same time, Type 2 diabetes—which until recently affected only adults—now affects a growing number of children, and accounts for almost 50% of new diabetes cases in some communities.[4] If current trends continue, an astonishing 32.8% of boys and 38.5% of girls born in 2000 will develop diabetes sometime in their lives.[5]

Diabetes prevalence is greater among certain racial/ethnic groups. Among individuals ages 20 years or older, American Indians and Alaska Natives are 2.3 times more likely than Whites to have diabetes, while African Americans are 1.6 times more likely and Latinos 1.5 times more likely to have diabetes than Whites.[6] Ninety-four percent of children and adolescents with Type 2 diabetes are from

What Is Diabetes?

Diabetes mellitus occurs when the body does not produce or properly use insulin, a hormone that regulates glucose levels in the blood. Improper glucose regulation can cause serious health complications, including heart disease, blindness, kidney disease, and death. Two main types account for nearly all cases of diabetes: Type 1 and Type 2.

TYPE 1 *(5-10% of diagnosed cases in the U.S.) occurs when the body cannot produce insulin. Type 1 diabetes, previously called "juvenile-onset diabetes," until recently was the most common form of diabetes diagnosed in children. There are no known ways to prevent Type 1 diabetes.*

TYPE 2 *(90-95% of diabetes cases) occurs when the body either does not produce enough insulin or cannot use insulin properly. Previously called "adult-onset diabetes," today large numbers of children are diagnosed with Type 2 diabetes, accounting for almost 50% of new diabetes cases in some communities.[§] Type 2 diabetes can be prevented or delayed with proper nutrition and physical activity.*

Projected future increases in both diabetes and overweight forecast staggering increases in chronic health conditions and overwhelming personal, social, and economic hardship in the years to come.

If current trends continue, an astonishing 32.8% of boys and 38.5% of girls born in 2000 will develop diabetes.

communities of color.[7] With these trends likely to continue or worsen, it is estimated that close to half of African American and Hispanic[8] children born in the year 2000 will develop diabetes sometime in their lives.[9]

California Diabetes Rates are Rising

From 1990 to 1998, there was a 67.4% increase in diabetes among California adults.[10] In 2001, more than 1.4 million California adults had been diagnosed with diabetes, representing 5.9% to 8.3% of the adult population, depending on data sampling and estimation techniques.[11] In addition, more than 12,000 adolescents in California have been diagnosed with the disease.[12]

Similar to national data, diabetes prevalence in California is greater among certain racial/ethnic groups, with 10.3% of African Americans having been diagnosed with diabetes, 9.3% of American Indians and Alaska Natives, and 6.0% of Latinos, compared to 5.6% of Whites and 4.7% of Asians and Pacific Islanders.[13]

Devastating Impact of Diabetes

Diabetes is the sixth-leading cause of death in the U.S.[14] It is also a leading cause of adult blindness, kidney failure, and non-traumatic amputation of the lower limbs. In 2002, diabetes caused 176,000 cases of permanent disability in the U.S.[15] Diabetes and its complications often have profound effects on the quality of a person's life, and often lead to depression and cognitive impairment.[16] Diabetes dramatically increases the risk for both heart disease and stroke. Adults with diabetes have death rates from heart disease that are two to four times higher than adults who do not have diabetes.[17]

Diabetes also has enormous economic costs. Annual per capita health care costs for people with diabetes are 2.4 times greater than for people without the disease.[18] The American Diabetes Association estimated that in 2002 the cost of diabetes in the U.S. was $132 billion, with $92 billion in direct medical costs and $40 billion in indirect costs, such as disability, loss of work days, and premature mortality.[19] In California, the total direct and indirect cost of diabetes has been estimated to be more than $17.9 billion per year.[20]

A Principal Risk Factor for Type 2 Diabetes: Excess Weight

Though there are several risk factors for Type 2 diabetes—including family history, older age, physical inactivity, and being of certain racial/ethnic groups—among the primary risk factors are overweight and obesity.[21]

Diabetes Linked to Obesity. The dramatic increase in the prevalence of diabetes among adults and the emergence of Type 2 diabetes in children are closely associated with rising rates of obesity and overweight. Over 80% of people with diabetes in the U.S. are overweight or obese.[22]

- **Adults.** From 1991 to 2001, obesity among adults rose by 74% nationally[23] and almost doubled in California.[24] In 2002, a shocking 64.5% of adults in the U.S. were overweight or obese,[25] including 59.4% of Californians in 2001.[26]
- **Youth.** Among adolescents 12–19 years old, the prevalence of overweight increased more than three-fold between 1976 and 2000.[27] Among fifth-, seventh-, and ninth-graders in California in 2001, 26.5% of children were already overweight.[28] Approximately 50% of overweight adolescents become obese adults.[29]

The risk of developing diabetes increases even with modest weight gain: a gain of 11 to 18 pounds, for example, doubles the risk.[30] As more people in the U.S. be-

come obese and overweight, the number of people diagnosed with diabetes and the resulting complications from the disease can be expected to increase as well.

Racial/Ethnic Prevalence of Overweight. In California, rates of adults who are obese or overweight are higher among certain racial/ethnic groups: African Americans, Latinos, Pacific Islanders, and American Indians and Alaska Natives have higher rates than Whites or Asians.[31] Among fifth-, seventh-, and ninth-graders in California in 2001, a greater percentage of Latinos, African Americans, American Indians/Alaska Natives, and Pacific Islanders were overweight than Whites or Asians.[32]

The Importance of Social, Economic, and Environmental Factors

A growing body of literature describes the impact of social, economic, and environmental factors on morbidity and mortality from chronic disease,[33] including a specific relationship of these factors to the prevalence of diabetes.[34] Though there is a genetic risk associated with diabetes, the recent dramatic increase in diabetes has occurred too quickly to be explained by genetics alone. Social, economic, and environmental conditions that may contribute to diabetes mortality and morbidity include factors such as lack of health insurance; limited access to high quality, culturally and linguistically appropriate health care; and factors that influence nutrition and physical activity.

Complex social and environmental factors that influence individual choices about eating and physical activity play a particularly important role in the growing epidemics of both diabetes and obesity/overweight. These factors include, but are not limited to, the trend to larger portions of low-cost, high-calorie foods and beverages; multi-billion-dollar advertising and marketing of unhealthful products; limited opportunities for physical activity in schools and communities; limited access to healthful foods in low-income neighborhoods; and increased television viewing.[35]

THE STUDY

The California Center for Public Health Advocacy analyzed deaths in California due to diabetes by state legislative district and used average annual death rate as the primary variable of analysis. In addition, the Center correlated the findings from this analysis with the findings from its previous reports on the prevalence of overweight and unfit children by state legislative district.[36] Finally, the Center analyzed average age of death due to diabetes.

Diabetes mortality data were derived from the California Multiple Cause of Death Files provided by the California Department of Health Services. Because of the relatively small population in legislative districts, data were aggregated for a five-year period (1996–2000) to ensure reliability of findings. Deaths for which diabetes was reported as either the underlying cause or as one of multiple causes were included in the analysis.

The Center convened a Scientific Panel of nationally recognized experts in diabetes to provide advice about how best to analyze the data and to recommend policies for addressing diabetes prevention and treatment.

In California, the total direct and indirect cost of diabetes has been estimated to be more than $17.9 billion per year.

Adjusted Data

Legislative district populations differ with respect to age and race/ethnicity. In order to make appropriate comparisons of diabetes-related death rates among legislative districts, death rates in this study were adjusted. Adjusting the rates for age and race/ethnicity ensures that differences in rates are not due solely to the demographics of the population in a particular location. The process of adjustment, whereby data for each district are applied to a "standard" population, removes this effect. Death rates in this study were adjusted for age and/or race/ethnicity to the U.S. population in 2000, as indicated.

4 KEY FINDINGS

1. **There is considerable variation in diabetes-related death rates among legislative districts, and districts that have higher diabetes-related death rates also tend to have a higher prevalence of overweight and unfit children.**
2. **Legislative districts in three regions—Los Angeles County, the Central Valley, and southwest San Bernardino County—have the highest diabetes-related death rates.**
3. **Three racial/ethnic groups—African Americans, Latinos and American Indians/ Alaska Natives—have the highest burden of diabetes-related deaths.**
4. **Diabetes-related death rates are increasing.**

FINDINGS

During the five-year period between 1996 and 2000, 115,423 people in California died from diabetes, an average of 23,085 deaths per year. Adjusting for age and race/ethnicity, the annual diabetes-related death rate for California for the five-year period was 82.2 deaths per 100,000 people. (For an explanation of adjusted data, see sidebar, page 3).

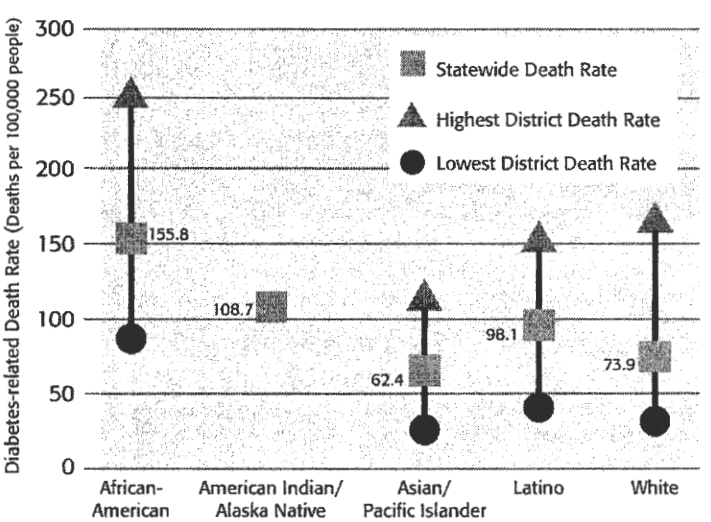
For the single year of 2000, the statewide diabetes-related death rate was 83.6 deaths per 100,000 people, which is 10.4% higher than the national rate of 75.7 deaths per 100,000 people.[37] The U.S. DHHS *Healthy People 2010* target is 45 deaths per 100,000 people.[38]

1. **There is considerable variation in diabetes-related death rates among legislative districts, and districts that have higher diabetes-related death rates also tend to have a higher prevalence of overweight and unfit children.**

◆ **There is considerable variation in diabetes-related death rates throughout California that cannot be attributed to age and racial/ethnic differences among legislative districts.**

- TOTAL POPULATION. Differences in diabetes-related death rates across legislative districts cannot be attributed to differences in age or racial/ethnic demographics. In Assembly Districts, diabetes-related death rates, adjusted for age and race/ethnicity, range from 40.6 per 100,000 people to 158.4 per 100,000—nearly a four-fold difference (see Map A). In Senate Districts, age- and race-adjusted diabetes-related death rates range from 52.5 per 100,000 to 140.2 per 100,000—nearly a three-fold difference (see Map B).
- RACIAL/ETHNIC POPULATIONS. Even for a given racial/ethnic group, there are differences in diabetes-related death rates across legislative districts that cannot be attributed to age differences (see Figure 1). When adjusted for age, diabetes-related death rates for African Americans, by Assembly District, range from 91.6 to 251.7 per 100,000 people; the highest death rate for a district is nearly three times that of the district with the lowest death rate. Rates for Latinos and Asians/Pacific Islanders also have at least a two-fold difference between the legislative district with the highest rate

Figure 1. DIABETES-RELATED DEATH RATES BY RACE/ETHNICITY, ASSEMBLY DISTRICTS*



*Average annual diabetes-related death rate, 1996–2000, adjusted by age. Data for American Indian/Alaska Native were not sufficient to compare by legislative district.

Within a given racial/ethnic group there is considerable variation in diabetes-related death rates across legislative districts and compared to the statewide rates for each race/ethnicity. African-Americans have the highest diabetes-related death rate of all racial/ethnic groups.

and the district with the lowest rate. However, the range for Whites—38.2 per 100,000 people in the Assembly District with the lowest death rate to 161.4 in the Assembly District with the highest death rate—shows more than a four-fold difference.

- **Diabetes-related death rates are strongly correlated with the prevalence of overweight and unfit children in legislative districts.**

  - CORRELATION WITH OVERWEIGHT CHILDREN. In both Assembly Districts ($r=0.75$, $p<0.0001$) and Senate Districts ($r=0.73$, $p<0.0001$) diabetes-related death rates and the prevalence of overweight children are strongly correlated (see Figure 2a for Assembly Districts). Across legislative districts, the higher the death rate from diabetes, the higher the percentage of overweight children in a district.[39]

  - CORRELATION WITH UNFIT CHILDREN. In both Assembly Districts ($r=0.68$, $p<0.0001$) and Senate Districts ($r=0.64$, $p<0.0001$) diabetes-related death rates and the prevalence of unfit children are strongly correlated (see Figure 2b for Assembly Districts). Across legislative districts, the higher the death rate from diabetes, the higher the percentage of unfit children in a district.[40]

Coupled with the scientific literature,[41] these findings strongly suggest that there are conditions in communities—societal, economic, and environmental conditions—that contribute to the variations in death rates related to diabetes. Because of the additional finding of a strong correlation in legislative districts between diabetes-related death rates and the prevalence of overweight and unfit children (an early risk factor for diabetes), it is likely that the nutrition and physical activity environment is simultaneously contributing to both diabetes-related death rates and childhood overweight and fitness levels.

2. **Legislative districts in three regions—Los Angeles County, the Central Valley, and southwest San Bernardino County—have the highest diabetes-related death rates.**

Legislative districts with the highest diabetes-related death rates are found in only these three regions. Map A shows this concentration by Assembly District; Map B shows it by Senate District. Rates are adjusted for age and race/ethnicity.

- LOS ANGELES COUNTY has 10 of the 16 Assembly Districts with the highest rates, and 3 of the 8 Senate Districts with the highest rates.
- THE CENTRAL VALLEY has 3 of the 16 Assembly Districts with the highest rates, and 3 of the 8 Senate Districts with the highest rates.
- SOUTHWEST SAN BERNARDINO COUNTY has 3 of the 16 Assembly Districts with the highest rates, and 2 of the 8 Senate Districts with the highest rates.

Figure 2a. DIABETES-RELATED DEATH RATES AND PERCENTAGES OF OVERWEIGHT CHILDREN, BY ASSEMBLY DISTRICTS*

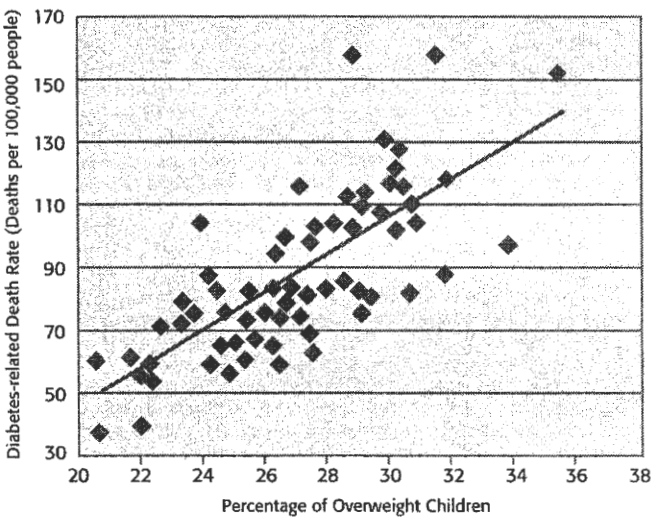
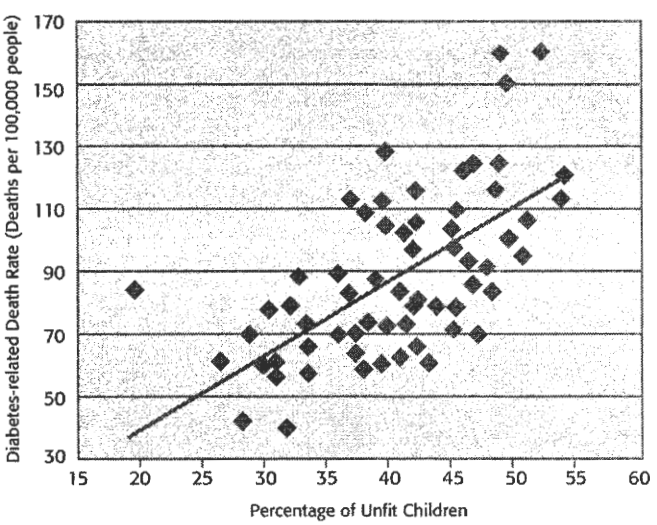


Figure 2b. DIABETES-RELATED DEATH RATES AND PERCENTAGES OF UNFIT CHILDREN, BY ASSEMBLY DISTRICTS*



KEY FOR FIGURES 2A AND 2B: ◆ = *One Assembly District. Each diamond displays both the District's diabetes-related death rate (vertical axis) and its percentage of overweight or unfit children (horizontal axis). There is some overlapping of individual districts.*

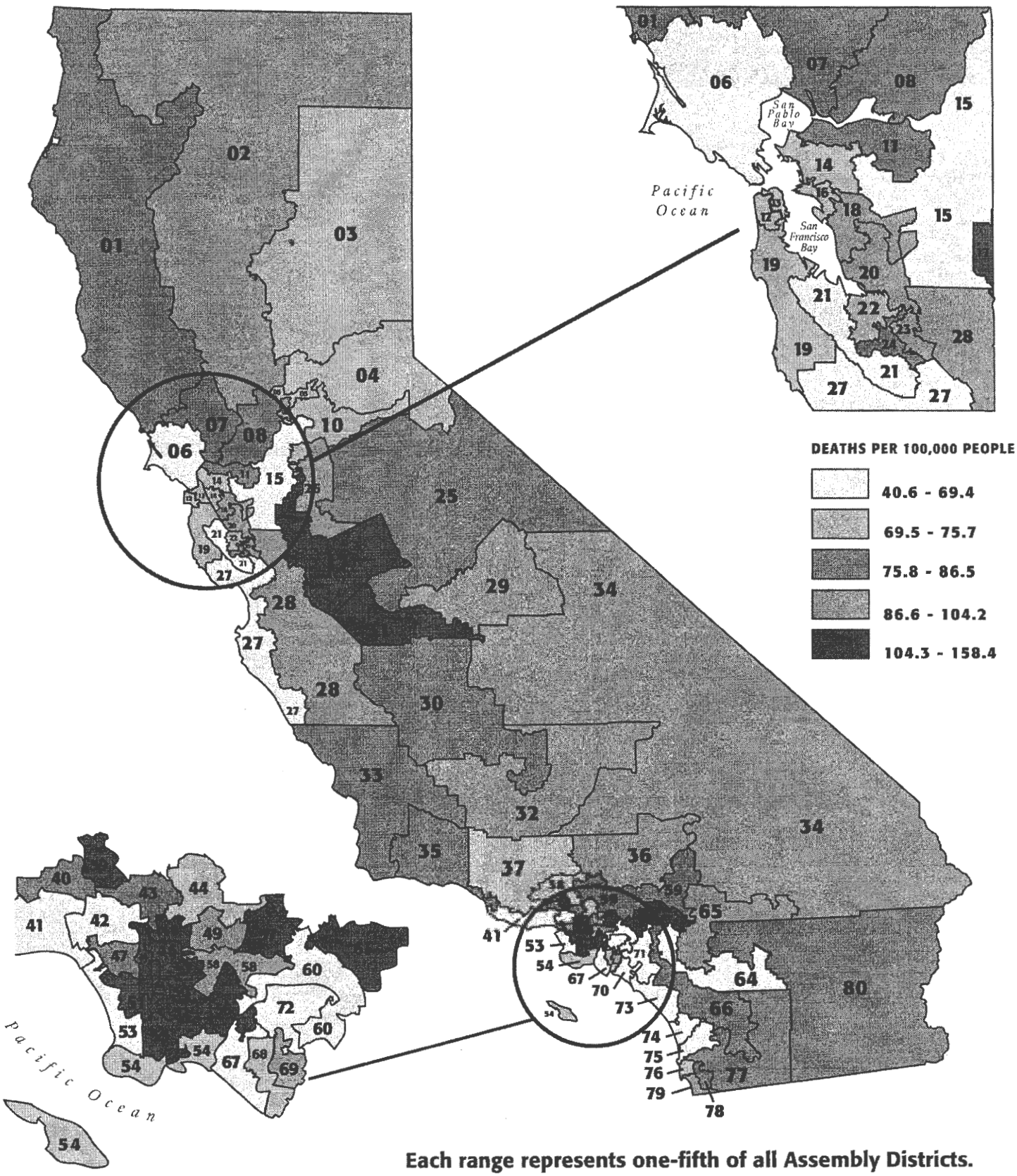
*Diabetes-related death rates are average annual rates for 1996–2000, adjusted by age and race/ethnicity. Percentages of overweight or unfit children are from 2001, adjusted by grade level and race/ethnicity.

Across legislative districts, the higher the diabetes-related death rate, the higher the percentage of overweight or unfit children in a district.

MAP A

Diabetes-Related Death Rates in Assembly Districts

Average annual diabetes-related death rate, 1996–2000, adjusted by age and race/ethnicity

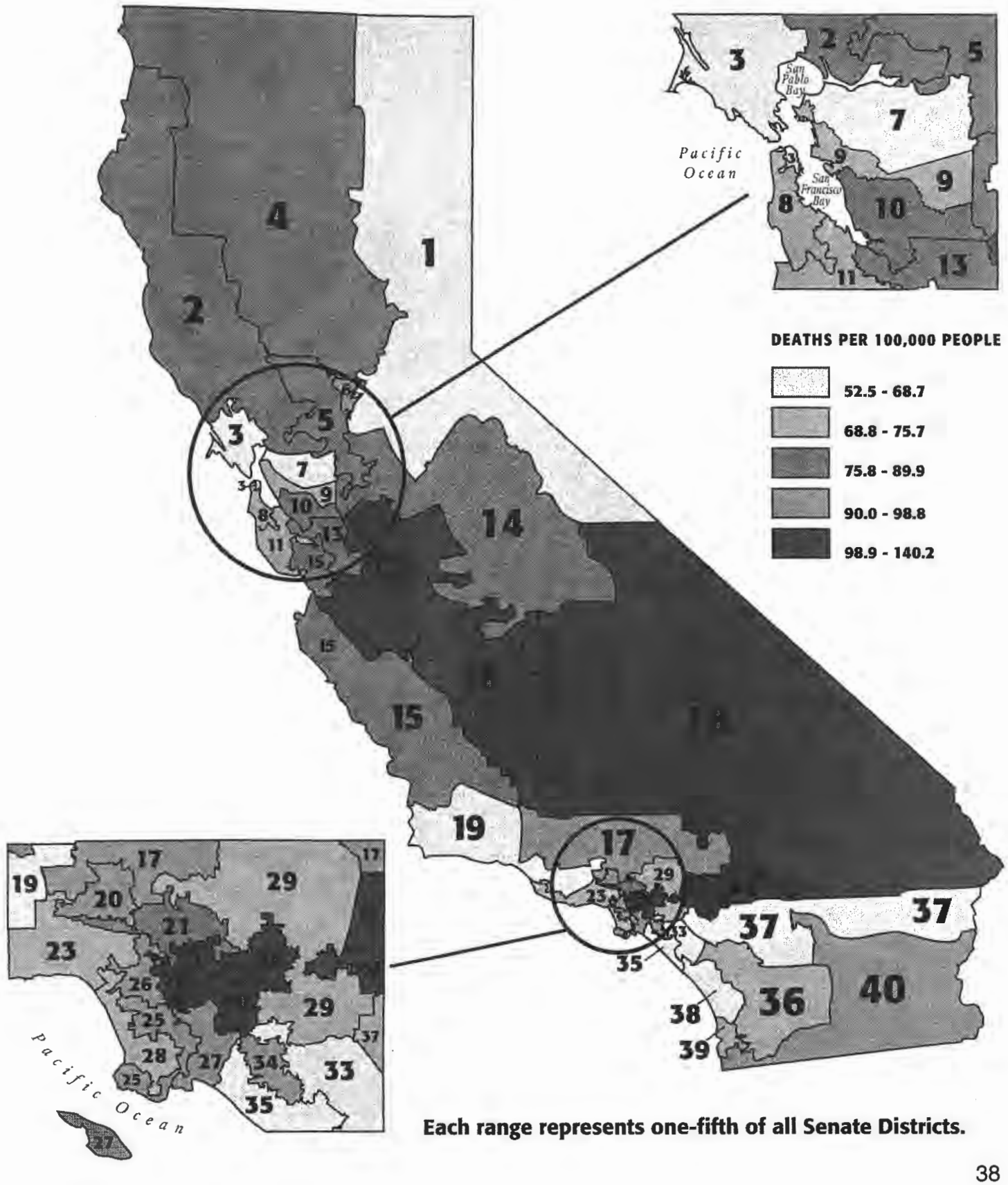


Each range represents one-fifth of all Assembly Districts.

MAP B

Diabetes-Related Death Rates in Senate Districts

Average annual diabetes-related death rate, 1996–2000, adjusted by age and race/ethnicity



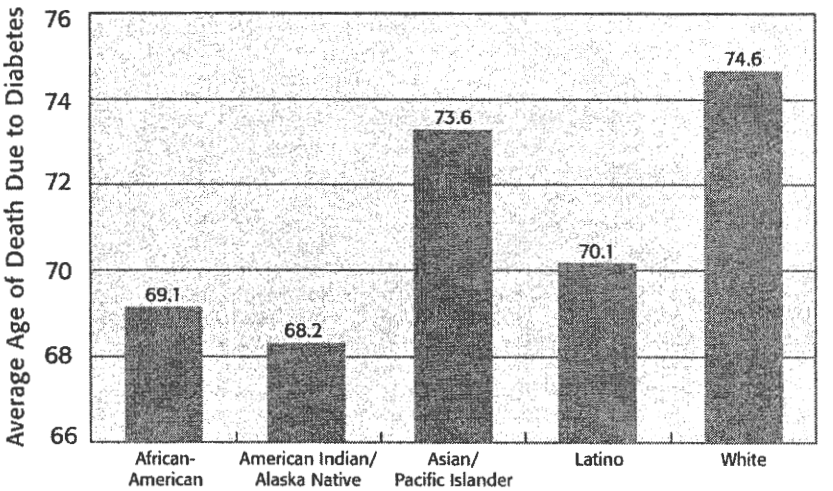
Each range represents one-fifth of all Senate Districts.

3. **Three racial/ethnic groups—African Americans, Latinos, and American Indians/Alaska Natives—have the highest burden of diabetes-related deaths.**

- **DEATH RATES.** Statewide, African Americans have the highest age-adjusted diabetes-related death rate of all racial/ethnic groups. For American Indians/Alaska Natives and Latinos, age-adjusted death rates are higher than for both Whites and Asians/Pacific Islanders (see Figure 1, page 4). In nearly every legislative district, African Americans have the highest age-adjusted diabetes-related death rates, followed by Latinos, Whites, and Asians/Pacific Islanders.[42]
  - **AFRICAN AMERICANS** have the highest diabetes-related death rate for all ethnic groups in 95% of Assembly Districts and 100% of Senate Districts.
  - **LATINOS** have a higher diabetes-related death rate than Whites in 69% of Assembly Districts and 75% of Senate Districts, and a higher rate than Asians/Pacific Islanders in 85% of Assembly Districts and 95% of Senate Districts.
- **AGE OF DEATH.** Statewide, American Indians/Alaska Natives, African Americans and Latinos also have the youngest average age of death due to diabetes. American Indians/Alaska Natives die from the disease an average of 6.4 years younger than Whites, while African Americans die an average of 5.5 years younger, and Latinos die an average of 4.5 years younger than Whites (see Figure 3). Across legislative districts, African Americans die from diabetes at the youngest average age, followed by Latinos, Asians/Pacific Islanders, and Whites.[43] In all legislative districts African Americans and Latinos have a younger average age of death related to diabetes than do Whites.[44]

The differences among racial/ethnic groups in both diabetes-related death rates and average age of death are consistent with findings from other studies that show a higher prevalence of diabetes and overweight among African Americans, Latinos, and American Indians/Alaska Natives.

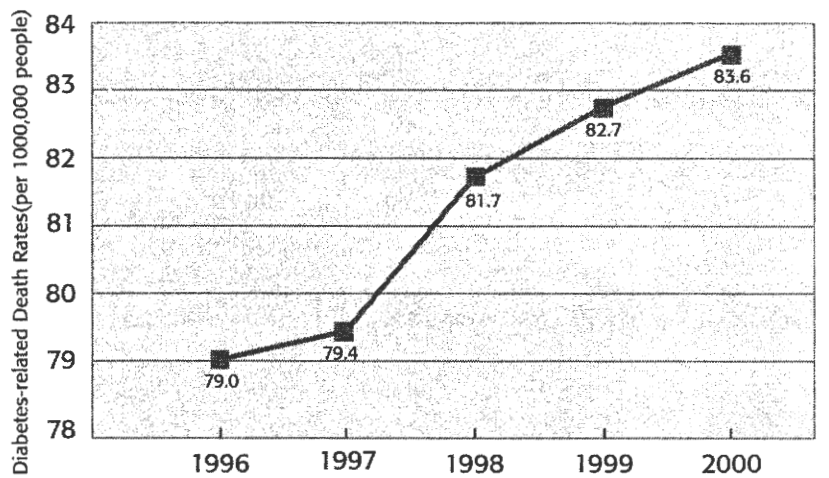
Figure 3. AVERAGE AGE OF DEATH DUE TO DIABETES,* BY RACE/ETHNICITY, CALIFORNIA



*Average for 1996–2000, unadjusted.

American Indians/Alaska Natives and African Americans have the youngest age of death due to diabetes.

Figure 4. DIABETES-RELATED DEATH RATES,* CALIFORNIA, 1996–2000



*Data were adjusted for age and race/ethnicity.

Diabetes-related death rates are increasing annually.

4. Diabetes-related death rates are increasing.

Over the five-year period under study, the statewide death rate due to diabetes, adjusted for age and race/ethnicity, rose annually, from 79.0 deaths per 100,000 people in 1996 to 83.6 deaths per 100,000 people in 2000, an increase of 5.8% (see Figure 4).

POLICY RECOMMENDATIONS

California communities and policy makers stand at a critical juncture. The prevalence of diabetes is increasing dramatically, and the state's diabetes-related death rate—already higher than that of the nation as a whole—is rising. The state's racial/ethnic diversity means a growing number of Californians will be at risk for developing diabetes. At the same time, increasing numbers of children and adults who are overweight or obese portend even greater increases in the prevalence of diabetes in the years to come. The frightening emergence of Type 2 diabetes among children is the unmistakable warning sign that generations of California children will suffer from preventable chronic health conditions at rates higher than ever before.

Unless action is taken, millions of Californians—both children and adults—will be sentenced to a future of chronic health problems and early death. In addition to the human suffering, California families and businesses will face unparalleled increases in long-term health care costs, and the public health care system is likely to be stretched beyond its capacity.

The epidemic will not be solved by calling for individual behavior change alone. Instead, policy makers must address the community and environmental factors that perpetuate the epidemic. Policies must be established that employ the following strategies to reduce diabetes-related deaths in California:

- Prevent and delay diabetes, and ensure access to health care to prevent, treat, and manage the disease.
- Create healthy nutrition and physical activity environments.
- Place special emphasis on racial/ethnic and geographic communities experiencing the greatest burden of disease.

The California Center for Public Health Advocacy calls on policy makers throughout the state to take immediate action. The Center's recommendations are based on those made by a national Scientific Panel.

Preventing Diabetes and Improving Physical Activity and Nutrition Environments

1. The Governor should declare the epidemics of diabetes, overweight, and obesity a top priority of his new administration and immediately convene a summit of government, business, health, education, nonprofit, and youth leaders to identify strategies to prevent and delay diabetes, improve the treatment and management of diabetes, and improve nutrition and physical activity environments.
2. Every legislator should convene a District forum of community leaders to address the epidemics locally. Legislators representing regions with the highest diabetes-related death rates should convene District forums early in 2004.
3. Hold legislative hearings to identify causes of and solutions to the diabetes and overweight/obesity epidemics.
4. Improve access to health care for individuals who are at risk for diabetes.
5. Expand public and private insurance to cover preventive care including but not limited to screening, education, obesity treatment, and counseling on the benefits of healthy eating and physical activity.
6. Reimburse diabetes educators, nutritionists, *promotores,* and team-based care for diabetes-related prevention services to individuals and their families.
7. Educate health care providers about diabetes-related primary prevention and

Unless action is taken, millions of Californians—both children and adults—will be sentenced to a future of chronic health problems and early death, and businesses will face unparalleled increases in long-term health care costs.

In 2000, the statewide diabetes-related death rate was 10.4% higher than the national rate.

Across legislative districts, the higher the death rate from diabetes, the higher the percentage of overweight children in a district.

clinical management practices proven to be successful with individuals at high risk for diabetes. Require that health care providers who receive state and federal funds implement these practices.

8. Develop and implement a coordinated statewide plan for simultaneously addressing the epidemics of diabetes and overweight/obesity. The plan should build on *California's Plan for Diabetes 2003-2007*[45] and other existing nutrition and physical activity initiatives.
9. Improve school environments:
   - Implement SB 19 nutrition standards in grades K-12.
   - Enforce state law mandating 200-400 minutes of physical education every 10 days in grades 1–12.
   - Use only healthful foods as rewards and as fundraisers.
   - Utilize in-service funds to train teachers in physical education.
   - Educate all children about the importance of healthy eating and physical activity and the role of school and community environments in influencing their eating and activity choices.
   - Establish Diabetes Education and Awareness Programs for students and their families.
10. Improve community environments:
   - Require chain restaurants to provide nutrition information on display boards and menus.
   - Establish zoning regulations prohibiting the sale of unhealthful food near schools.
   - Require hospitals and other health care facilities to sell only healthful foods.
   - Implement nutrition and physical activity standards in preschools, daycare centers, Head Start programs, after-school programs, and childcare programs.
   - Design communities in ways that promote healthy eating and physical activity.
11. Restrict marketing and advertising of unhealthful foods and beverages to children.
12. Conduct research to determine the specific conditions in communities that contribute to high diabetes-related death rates and high percentages of overweight and unfit children. Socioeconomic factors should be included in such research.

Over the five-year period under study, the death rate due to diabetes rose annually.

Improving the Management and Treatment of Diabetes

1. Retain the diabetes-related benefits currently provided by public and private health insurance plans.
2. Expand public and private insurance reimbursement for obesity-related care, diabetes self-management education, and other diabetes-related care provided using a team-based approach.
3. Ensure health insurance coverage for diabetes supplies and prescription medications for individuals with diabetes.
4. Improve access to health care for individuals with diabetes.
5. Ensure that Californians with diabetes receive "the standard of care" prescribed by the American Diabetes Association.
6. Develop a diabetes registry that guarantees the privacy of individuals with diabetes.
7. Require diabetes education as part of the training and continuing education of all health professionals.

Policy reform at the state and local level must address the fact that some racial/ethnic and geographic communities have higher diabetes-related death rates and are at higher risk for diabetes. To curb the devastating epidemic of diabetes, policy makers must pursue both statewide reform and policy initiatives that reduce the burden of diabetes in the racial/ethnic and geographic communities with the highest diabetes-related death rates.

Notes

[1] Tommy Thompson, quoted in Okie S., *The Washington Post,* March 28, 2002, p. A08.

[2] CDC, *National Diabetes Fact Sheet,* 2003. Atlanta, GA: November 2003.

[3] Mokdad, AH, et al., *JAMA.* 2003(1); 289: 76-79.

[4] American Diabetes Association (ADA), *Diabetes Care.* 2000; 23(3): 381-389.

[5] Narayan, KM, et al., *JAMA.* 2003; 290(14): 1884-1890.

[6] CDC, *National Diabetes Fact Sheet,* 2003.

[7] Fagot-Campagna, A, et al., *J of Pediatr.* 2000. 136(5): 664-672.

[8] The terms Hispanic and Latino are used interchangeably. When referring to a study, this report uses the term the study used.

[9] Narayan, *JAMA,* 2003.

[10] Mokdad, AH, et al., *Diabetes Care.* 2000; 23(9): 1278-1283.

[11] Mokad, *JAMA,* 2003; Diamant AL, et al., *Diabetes in California: Findings from the 2001 CHIS.* Los Angeles: UCLA Center for Health Policy Research, April 2003.

[12] Diamant, *Diabetes in California,* 2003.

[13] Ibid.

[14] National Vital Statistics System, US DHHS, *Deaths: Leading Causes for 2000.* September 16, 2002; Vol 50 No 16.

[15] ADA, *Diabetes Care.* 2003; 26: 917-32.

[16] Black, SA, *Am J Public Health.* 2002; 92(4): 543-548.

[17] CDC, *National Diabetes Fact Sheet,* 2003.

[18] ADA, *Diabetes Care.* 2003.

[19] Ibid.

[20] California DHS, *Fast Facts on Diabetes,* August 2003.

[21] The Centers for Disease Control and Prevention define obesity and overweight based on body mass index (BMI), a ratio of weight to height. For adults, obesity is defined as a BMI of 30 or more, and overweight is defined as a BMI between 25 and 30. The term *obesity* is not used for children. Instead, childhood overweight is defined as a BMI at or above the 95th percentile on age-based growth charts.

[22] USDHHS, *The Surgeon General's Call to Action To Prevent and Decrease Overweight and Obesity, Fact Sheet: Overweight and Obesity: Health Consequences.* Atlanta, GA, 2001.

[23] Mokdad, *JAMA,* 2003.

[24] CDC, *Physical Activity and Good Nutrition,* 2003.

[25] Flegal, KM, et al., *JAMA.* 2002; 288(14): 1723-1727.

[26] CDC, *MMWR.* August 22, 2003; Vol 52: No SS-8.

[27] Ogden CL, et al., *JAMA.* 2002; 288(14): 1728-1732.

[28] CCPHA, *An Epidemic: Overweight and Unfit Children in California Assembly Districts,* 2002; *An Epidemic: Overweight and Unfit Children in California Senate Districts* 2003. A child was considered overweight if body composition was above the California Physical Fitness Test (*FITNESSGRAM*) "healthy fitness zone," which designates age- and gender-specific ranges. This definition differs from the one employed by the CDC.

[29] Dietz WH, *J Nutr.* 1998; 128(2):411S-414S; see note 21.

[30] Ford, ES, et al., *Am J Epidemiol.* 1997; 146(3): 214-222.

[31] Diamant, *Diabetes in California,* 2003.

[32] See note 28.

[33] Bell, Judith, et al., *Reducing Health Disparities Through A Focus on Communities.* Policy Link, November 2002.

[34] Green, C, et al., *Soc Sci Med.* August 2003; 57(3):551-60.

[35] Brownell, KD and Horgen, KB, *Food Fight: The Inside Story of the Food Industry, America's Obesity Crisis, and What Can Be Done About It.* New York: McGraw-Hill/Contemporary Books, 2004; Nestle, M, *Food Politics: How the Food Industry Influences Nutrition and Health.* Berkeley: UC Press, 2002; Hill, JO, et al., *Science.* May 1998; 280:1371-1374; French, SA, et al., *Annu Rev Public Health.* 2001; 22 :309-35; Hu, FB, et al., *JAMA.* 2003; 289(14): 1785-1791; Robinson, TN, *JAMA.* 1999; 282(16): 1561-1567.

[36] Data presented in *An Epidemic of Overweight and Unfit Children in California Assembly Districts* (2002) and *An Epidemic of Overweight and Unfit Children in California Senate Districts* (2003) were not adjusted for race/ethnicity or age. In order to correlate the age- and race/ethnicity-adjusted diabetes-related death rates presented here, the percentages of overweight and unfit children from the previous reports have been adjusted for grade level and race/ethnicity.

[37] CCPHA calculated the national diabetes-related death rate for the year 2000 by dividing the total number of deaths among people with diabetes in 2000 reported in the CDC *National Diabetes Fact Sheet,* 2003 (see note 2) by the 2000 U.S. population reported by the U.S. Census Bureau.

[38] US Department of Health and Human Services (USDHHS). *Healthy People 2010: Understanding and Improving Health.* 2nd ed. Washington, DC: November 2000. Because of the relatively small population in legislative districts, diabetes-related death rates reported in this analysis have been adjusted for age to the 2000 U.S. population in a different manner from the age adjustment utilized to determine the target rate for deaths due to diabetes in the *Healthy People 2010* report. Employing the methods used by USDHSS to determine the *Healthy People 2010* target rate, CCPHA estimated that a comparable target for California is also 45 deaths per 100,000, and therefore the *Healthy People 2010* target rate for deaths due to diabetes provides a reasonable context for diabetes-related death rates reported in this analysis.

[39] The Pearson correlation coefficient was used to examine the associations between the adjusted percentage of overweight (or unfit) children and age- and race/ethnicity adjusted mortality rates across legislative districts. The *"r"* value is a quantitative measure of the degree of relationship between the two variables—for a positive correlation such as the one described here, the closer the *"r"* value gets to 1, the stronger the relationship. The *"p"* value is a description of the statistical significance of the relationship—the lower the *"p"* value, the more likely the relationship described is not occurring by chance.

[40] See note 39.

[41] See notes 33 through 35.

[42] Data for American Indians and Alaska Natives were not sufficient to compare by legislative district.

[43] See note 42.

[44] Average age of death data stratified by race/ethnicity were not adjusted. Differences in the average age of death between different legislative districts and the state may be largely due to differences in the age demographics for each race/ethnicity. Nevertheless, these data reflect the actual burden of diabetes deaths in a legislative district.

[45] Diabetes in California Task Force. *California's Plan for Diabetes 2003-2007.* For further information contact the Diabetes Prevention and Control Program, California Department of Health Services, www.caldiabetes.org.

[§] ADA, *Diabetes Care.* 2000

[§§] CDC, *National Diabetes Fact Sheet,* 2003.

LIMITATIONS OF THE STUDY

FOCUS ON MORTALITY. *This study focuses only on mortality related to diabetes—an important measure reflecting the end point of a disease that, in large part, can be prevented, delayed, and effectively managed. The study does not include analysis of any other diabetes measures, including prevalence or non-fatal complications of the disease.*

UNDERREPORTING OF DIABETES-RELATED DEATHS. *Only 35–40% of people who die with diabetes have diabetes listed on their death certificate.[§§] As a result, diabetes-related death rates reported in this analysis are likely to be underestimates.*

CORRELATION. *Although correlations are determined between diabetes-related death rates and the prevalence of overweight and/or unfit children in legislative districts, the data reflect two different cohorts: diabetes-related death data represent people of all ages for the years 1996 to 2000, while overweight and unfit data represent fifth-, seventh-, and ninth-graders tested in 2001. Consequently, the correlation is an indicator of characteristics in the same legislative district, not in the same group of people. Moreover, the correlation does not imply that high percentages of overweight and/or unfit children in a district are a cause of higher diabetes-related death rates in that district.*

SOCIOECONOMIC DIFFERENCES. *This analysis did not examine socioeconomic factors. Further study is needed to determine the degree to which socioeconomic factors contribute to variations in diabetes-related death rates among legislative districts and between racial/ethnic groups, and which specific underlying social determinants linked to socioeconomic factors are actually causing the variations.*

About this Brief

Data Source

The findings of this analysis were based on an analysis of the California Multiple Cause of Death Files provided by the California Department of Health Services. Chi Kao, PhD, of the Institute for Health Policy Studies at the University of California at San Francisco and Richard Cohen of the Public Health Institute conducted data management and analysis. Daniel Hackman and Stefan Harvey of CCPHA assisted in the data analysis.

Author Information

Nancy Adess, Harold Goldstein, Daniel Hackman and Stefan Harvey wrote this policy brief. Bonnie Fisk-Hayden provided graphic design. Karen Ertel, Lisa Craypo, Maria Boyle and Sarah Samuels of Samuels & Associates (contractors to the California Center for Public Health Advocacy), Dr. Chi Kao of UCSF, Daniel Hackman and Stefan Harvey of CCPHA wrote an accompanying background report.

Support for this Policy Brief was provided by a grant from The Robert Wood Johnson Foundation®, Princeton, New Jersey.

The report, *An Early Warning Sign: Diabetes Deaths in California Legislative Districts*, and fact sheets for each of the 80 Assembly Districts and 40 Senate Districts can be found at www.publichealthadvocacy.org.

Scientific Panel

The California Center for Public Health Advocacy convened a panel of diabetes experts composed of Ann Albright, PhD, RN (UCSF and the California Department of Health Services Diabetes Prevention and Control Program), Debra Cohen, MD (Kaiser Permanente Santa Theresa Medical Center), Guadalupe Heredia, RN, CDE (Clinica De Salud, Brawley), Alka Kanaya, MD (Division of General Medicine at UCSF), Francine Kaufman, MD (Keck School of Medicine), Bill Releford, Jr., MD (Diabetes Amputation Prevention Foundation), Phyllis Preciado, MD, RN (Latino Center for Medical Research, UCSF), Joe Solowiejczk, RN, MSW, CDE (Texas Diabetes Institute), Tress Stewart, RN (Southeast Health Center, San Francisco), and Chris Walker, MPH (Whittier Institute for Diabetes and Endocrinology). Affiliations are listed for information only.

The views expressed in the Policy Brief are those of the California Center for Public Health Advocacy and do not necessarily represent the viewpoints of members of the Scientific Panel and their institutions.

About the California Center for Public Health Advocacy

The California Center for Public Health Advocacy is an independent, nonpartisan, non-profit organization that raises awareness about public health issues and mobilizes communities to promote the establishment of effective health policies. The California Public Health Association-North and the Southern California Public Health Association founded the Center. The Center is supported by grants from The California Endowment, The Robert Wood Johnson Foundation®, The California Wellness Foundation, Kaiser Permanente and contributions from individuals and organizations.

The California Center for Public Health Advocacy provides updates on state legislation regarding physical activity, physical education and nutrition, and information about advocacy tools to a statewide network of advocates via email. Public health professionals, community activists, teachers and parents interested in addressing the epidemics of diabetes, childhood inactivity and overweight through policy reform are urged to join the network. To join, send your name, title, organization, address, phone and fax numbers via email to info@publichealthadvocacy.org.

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UCLA Health Policy Fact Sheet

April 2005

One out of Three Latino Adolescents Overweight or At Risk

Michael A. Rodríguez, Marlena Kane, Lupe Alonzo-Diaz, and George R. Flores

The number of overweight adolescents has reached epidemic proportions—both nationwide and in California. More than one out of three Latino adolescents in California are overweight or at risk for overweight. Overweight adolescents are at increased risk for becoming obese adults and for developing chronic, serious and costly medical problems, such as diabetes, heart disease and certain cancers. The annual cost of obesity in California is more than $6.4 billion.[1]

Latino Adolescents Demonstrate Highest Prevalence of Overweight

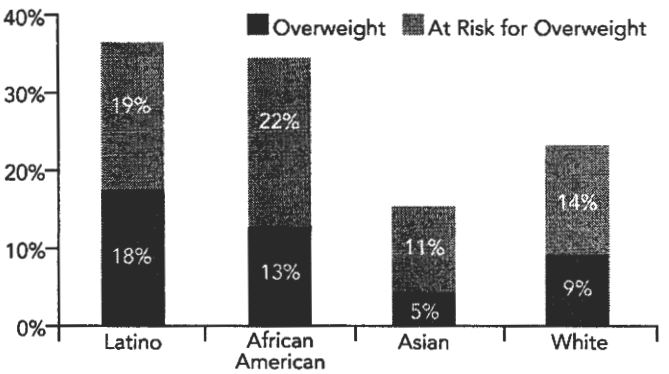
Among California adolescents, certain groups are more likely to be overweight or at risk for overweight. Latino adolescents were the most likely to be overweight and more likely to be at risk for overweight than Asian or white adolescents, leading to higher risks for overweight in adulthood (Exhibit 1).

Among Latino adolescents, the prevalence of overweight was twice as high in males as females (23% and 12% respectively; Exhibit 2). In addition, the prevalence of overweight among Latino adolescents who are U.S. born (20%) was nearly twice as high as among non U.S.-born Latino adolescents (11%). Other studies have shown that among U.S. immigrants, the number of years in this country is associated with an increase in overweight.[2]

Risk Factors for Overweight Among Latino Adolescents

Regular physical activity and a healthy diet are important to maintain healthy weight. An imbalance between these two factors contributes to overweight. Many Latino adolescents do not consume a healthy diet and do not get enough physical activity, which are behaviors that increase their risk for overweight and poor health.

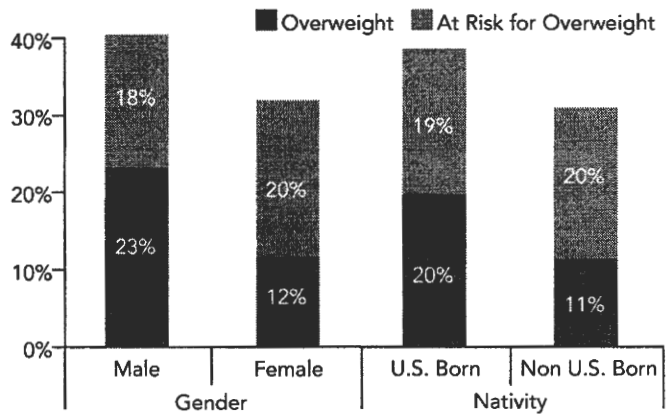
Exhibit 1: Prevalence of Overweight and At Risk for Overweight by Race/Ethnicity, Adolescents (Ages 12-17), California 2003



Note: Race/ethnicity is based on single race or the race/ethnicity with which the respondent most identifies. Body mass index (BMI) was calculated based on respondent reports of weight and height. A gender appropriate growth chart was used to compare reported BMI for age. Adolescents in the 85th-94th percentile are considered at risk for being overweight and adolescents in the 95th percentile and higher are considered overweight.

Source: 2003 California Health Interview Survey

Exhibit 2: Prevalence of Overweight and At Risk for Overweight by Gender and Nativity, Latino Adolescents (Ages 12-17), California 2003



Source: 2003 California Health Interview Survey

A joint publication of the UCLA Center for Health Policy Research and the Latino Coalition for a Healthy California

www.healthpolicy.ucla.edu

In California, three out of four Latino adolescents (76%) drank at least one soda every day, compared with just over half of white adolescents (57%). Sodas are one example of drinks popular among adolescents that are high in calories and low in nutritional value. Among Latino adolescents, 81% of males and 71% of females consumed at least one soda per day.

In addition, one in ten Latino adolescents (10%) reported engaging in no physical activity at all; with Latina girls (13%) being twice as likely to not participate in physical activity compared with Latino boys (6%).[3] Of even greater concern is the disparity in the proportion of Latino adolescents (10%) who get no physical activity at all, which was more than twice that of white adolescents (4%).

Discussion

Overweight disproportionately affects Latino adolescents, and is a serious threat to the health and well-being of Latino communities—and consequently to California. Unhealthy eating and inactivity are behaviors that are influenced by conditions in the home, school, neighborhood and in the media. Latino adolescents are not alone in the obesity epidemic. Families, schools, communities, health professionals and policymakers throughout California need to become engaged in efforts to change the conditions that foster unhealthy eating and inactivity. Latino adolescents especially need to be involved as peer educators, thought leaders and advocates for practices, programs and policies that promote healthy eating and regular physical activity.

Policy solutions to the obesity epidemic must be considerate of the unique social, cultural and environmental circumstances that face Latinos. More research is needed to uncover the impact of immigration, social and environmental inequities, and cultural experiences on behaviors contributing to obesity; as well as to uncover the most effective means to prevent overweight among Latino youth. Policymakers should consider the following recommendations to reverse these alarming trends:

1) **Educate** and **require** schools to provide healthier food choices for children and adolescents; for example, replacing sugary snacks and sodas available in vending machines with more nutritious snacks and healthier drinks.

2) **Ensure** that children are receiving physical education programs in all schools and after school programs.

3) **Encourage** the availability of affordable fresh fruits, vegetables and healthy food choices by locating grocery stores rather than liquor stores in all neighborhoods, and addressing the large presence of fast food restaurants in communities of color and low-income neighborhoods.

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The Latino Coalition for a Healthy California (LCHC) is forming strategic alliances to address issues related to overweight and obesity, and suggests supportive sites such as The Strategic Alliance (*www.eatbettermovemore.org*) and the California Latino 5 a Day Campaign (*www.dhs.ca.gov/ps/cdic/cpns/lat5aday/default.htm*).

Data Source

Based on data from the 2003 California Health Interview Survey (CHIS 2003), this fact sheet examines overweight among Latino adolescents. CHIS 2003 provides the most recent information available on overweight among Californians. For more information on the California Health Interview Survey, please visit *www.chis.ucla.edu.*

Funders

The Latino Coalition for a Healthy California, The California Endowment and The California Wellness Foundation funded the research and development of this fact sheet.

1 *The Economic Costs of Physical Inactivity, Obesity, and Overweight in California Adults.* California Department of Health Services, 2005.

2 Goel MS, McCarthy EP, Phillips RS, Wee CC. Obesity among U.S. immigrant subgroups by duration of residence. JAMA. 2004; 292: 2860-2867.

3 Engaging in "no physical activity" was defined as performing no vigorous activity (activity that made the respondent sweat or breathe hard) and no moderate activity (such as walking or bicycling) on any of the seven days prior to the survey.

FS2005-1

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UCLA Health Policy Research Brief

December 2005

Diabetes on the Rise in California

Allison L. Diamant, Susan H. Babey, E. Richard Brown and Theresa A. Hastert

Nearly 1.7 million California adults age 18 and over (6.6%) have been diagnosed with diabetes, up from 1.5 million (6.2%) in 2001.[1] The prevalence of diabetes nationally (6.6%) is similar to that in California.[2]

Diabetes mellitus, a chronic medical condition in which the body either makes too little insulin or does not use it effectively, is a significant and growing health problem in this country among both adults and children. The complications of diabetes include blindness, end-stage kidney disease, cardiovascular disease, amputation and even death.

Of the 1.7 million adults in California diagnosed with this condition, most—1.4 million (84.3%)—have Type 2 diabetes, and over 260,000 (15.7%) have Type 1 diabetes.[3] Type 1 diabetes, in which the body does not produce enough insulin, develops most commonly during childhood. Until recently, Type 2 diabetes, which is due to both insulin resistance and relative insulin deficiency, overwhelmingly affected older adults. Nationally, Type 2 diabetes has increased considerably in recent years among adults under the age of 50, both in the absolute number of cases and as a proportion of all adults with this condition.[4] Also alarming is the growing number of cases of Type 2 diabetes being diagnosed among adolescents and children. In California in 2001 nearly 15,000 teens ages 12-17 (0.5%) reported being diagnosed with either Type 1 or Type 2 diabetes, while in 2003 nearly 27,000 (0.8%) had been diagnosed; however the increase is not statistically significant.[5] The sample size of adolescents in California with diagnosed diabetes is too small to permit further analysis.

This policy brief examines the prevalence of diagnosed diabetes in California based on data from the 2003 California Health Interview Survey (CHIS 2003). It also describes how the prevalence has changed since 2001 based on data from CHIS 2001. The brief concludes with public policy recommendations intended to reduce the risk of diabetes and its related complications.

Disparities in Diabetes Prevalence by Race/Ethnicity and Socioeconomic Status

In California, the prevalence of diabetes increased significantly among men (from 6.4% to 7.1%), but remained constant among women (6%) from 2001 to 2003. Although the proportion of adults ages 18 to 64 with diabetes has remained relatively stable from 2001 to 2003, the prevalence of diabetes among California adults age 65 and over increased from 15.1% to 16.5%, paralleling an even greater increase nationally from 14.6% to 16.6%.[6]

The prevalence of diabetes varies by race/ethnicity. In California, American Indian/Alaska Natives (AI/ANs) and African Americans have the highest prevalence of diabetes, and whites have the lowest (Exhibit 1).

The California Endowment

The California Endowment funded the research and development of this policy brief.

Exhibit 1 **Diabetes Prevalence by Race/Ethnicity, Adults Age 18 and Over, California, 2003**

Race/Ethnicity	Diabetes Prevalence %	Percentage Point Change from 2001
White	5.6	0
Latino	7.5	+0.7
Asian	6.4	+1.4*
African American	9.3	-1.2
American Indian/Alaska Native	9.9	+0.9
All Adults	**6.6**	**+0.4***

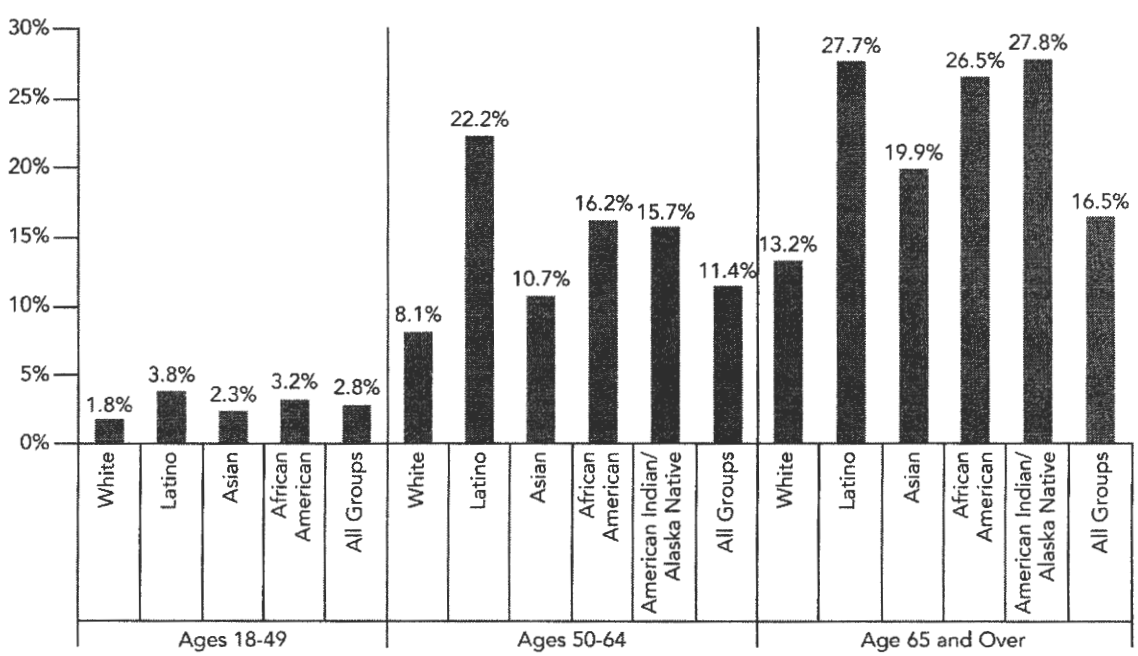
* Significant change from 2001

Source: 2001-R and 2003 California Health Interview Surveys

Diabetes prevalence is significantly higher among African Americans than Latinos, whites and Asians, and higher among AI/ANs and Latinos than whites. Although most racial/ethnic groups showed small changes in diabetes prevalence between 2001 and 2003, the only statistically significant increase was for Asians.

When diabetes prevalence is age adjusted, a somewhat different picture emerges. Although African Americans and AI/ANs have the highest prevalence overall, Latinos have the highest prevalence within each age group, in part because many Latinos are diagnosed with diabetes at younger ages than other groups. Among adults ages 18 to 49, diabetes prevalence is higher among Latinos than whites and Asians, and higher among African Americans than whites (Exhibit 2). For adults ages 50 to 64, Latinos have the highest prevalence of diabetes, followed by African Americans, AI/ANs, Asians and whites. Among adults 65 years of age and older, the prevalence of diabetes is higher among Latinos than whites and Asians, and higher among African Americans and Asians than whites. AI/ANs age 65 and over also have a rate of diabetes significantly higher than whites.

Exhibit 2 **Diabetes Prevalence by Age and Race/Ethnicity, Adults Age 18 and Over, California, 2003**



Note: Diabetes prevalence estimates for American Indian/Alaska Natives below age 50 are not statistically reliable and are not presented.

Source: 2003 California Health Interview Survey

Diabetes Prevalence by Education and Income, Adults Age 18 and Over, California, 2003 **Exhibit 3**

	Diabetes Prevalence %	Percentage Point Change from 2001
Education		
Eighth Grade or Less	12.0	+1.6
Some High School	9.5	+1.2
High School Diploma	6.1	+0.3
Some College	6.1	-0.2
College Graduate or Higher	4.5	+0.3
Family Income as Percent of Federal Poverty Level (FPL)		
Below 100%	8.8	+0.3
100-199%	8.8	+1.1*
200-299%	6.4	-0.7
300% and above	5.1	+0.5*
All Adults	**6.6**	**+0.4***

* Significant change from 2001

Note: The 2003 FPL was $12,384 for a family of two, $14,680 for a family of three, and $18,810 for a family of four, *http://www.census.gov/hhes/poverty/threshld/thresh03.html* (accessed November 7, 2005).

Source: 2001-R and 2003 California Health Interview Surveys

Latinos and Asians are heterogeneous populations and examining them as a whole might mask variations between ethnic groups. The prevalence of diabetes varies between Asian ethnic groups, with the highest prevalence among Japanese (13.2%) followed by Filipinos (8.2%), Vietnamese (6.7%), Chinese (4.8%), Koreans (4.4%) and South Asians (3.9%). Diabetes prevalence is higher among Japanese than among Vietnamese, Chinese and Koreans. Diabetes prevalence is also higher among Filipinos than Chinese and Koreans.

Diabetes prevalence varies minimally between the Latino ethnic groups ranging from a low of 6.8% among Salvadorans to a high of 9.3% among Latino Europeans, and the differences are not statistically significant. Diabetes prevalence among Mexican/Mexican-Americans is 7.5%. Diabetes estimates for Guatemalans, Other Central Americans, South Americans and Puerto Ricans were not statistically reliable and therefore are not presented.

Among non-U.S. born adults in California the prevalence of diabetes increases with the number of years they have lived in the United States. The prevalence of diabetes is more than three times as high among adults who have lived in the U.S. 15 years or more (8.9%) as among those who have lived here four years or less (2.4%). Approximately 4% of adults who have lived in the U.S. between five and 14 years have been diagnosed with diabetes.

Diabetes is strongly related to social and economic factors. It is more than twice as common among adults who either did not attend or did not graduate from high school, compared to college graduates (Exhibit 3). Similarly, diabetes is more common among adults living below 200% of the federal poverty level (FPL) than among those at or above 200% FPL. Although adults with household incomes of at least 300% FPL have the lowest rate of diabetes, this income group showed a statistically significant increase in diabetes prevalence from 2001 to 2003.

Diabetes Prevalence Varies by County of Residence

Even after adjusting for age, diabetes prevalence differs by county, ranging from 3.9% in Nevada, Plumas and Sierra counties to 10.9% in Imperial County (Exhibit 4). California counties vary in terms of

Exhibit 4

Diabetes Prevalence by Region and County or County Group, Adults Age 18 and Over, California, 2003

	2003 Diabetes Prevalence (95% CI)	2003 Age-Adjusted Diabetes Prevalence (95% CI)	Percentage Point Change in Age-Adjusted Prevalence from 2001
Northern and Sierra Counties	**6.5 (5.7, 7.4)**	**6.5 (5.7, 7.4)**	**-0.5**
Butte	4.3 (2.5, 6.1)	4.3 (2.6, 6.1)	-1.6*
Shasta	9.0 (6.2, 11.7)	9.0 (6.4, 11.6)	+2.4*
Humboldt, Del Norte	6.0 (3.8, 8.1)	6.0 (3.9, 8.0)	-2.4*
Siskiyou, Lassen, Trinity, Modoc	6.7 (4.1, 9.4)	6.7 (4.1, 9.4)	-0.8
Mendocino, Lake	6.4 (3.7, 8.9)	6.3 (3.7, 8.9)	-1.1
Tehama, Glenn, Colusa	7.6 (4.8, 10.4)	7.6 (4.9, 10.2)	+0.1
Sutter, Yuba	8.7 (5.8, 11.6)	8.7 (5.9, 11.4)	+0.1
Nevada, Plumas, Sierra	3.9 (1.9, 5.8)	3.9 (2.0, 5.7)	-1.6
Tuolumne, Calaveras, Amador, Inyo, Mariposa, Mono, Alpine	7.0 (4.0, 10.0)	7.0 (4.1, 10.0)	0
Greater Bay Area	**5.6 (4.9, 6.2)**	**5.6 (4.9, 6.2)**	**+0.1**
Santa Clara	5.5 (4.1, 7.0)	5.5 (4.2, 6.9)	-0.1
Alameda	5.1 (4.1, 6.1)	5.1 (4.1, 6.1)	-0.6
Contra Costa	5.8 (3.8, 7.9)	5.9 (3.9, 7.8)	0
San Francisco	6.5 (4.6, 8.3)	6.5 (4.6, 8.3)	+2.5*
San Mateo	5.4 (3.2, 7.6)	5.4 (3.3, 7.5)	+0.1
Sonoma	5.2 (3.2, 7.3)	5.3 (3.3, 7.2)	+0.5
Solano	6.5 (3.8, 9.3)	6.5 (4.0, 9.1)	-0.9
Marin	3.7 (1.5, 5.9)**	3.7 (1.7, 5.7)	+0.3
Napa	5.1 (2.9, 7.3)	5.1 (3.0, 7.2)	-2.6*
Sacramento	**7.3 (5.9, 8.6)**	**7.3 (6.0, 8.6)**	**+1.6***
Sacramento	8.2 (6.4, 10.1)	8.3 (6.5, 10.0)	+2.0*
Placer	5.5 (3.0, 8.0)	5.5 (3.2, 7.9)	+0.2
Yolo	6.2 (3.6, 8.8)	6.2 (3.7, 8.6)	+1.6
El Dorado	4.3 (2.2, 6.4)	4.3 (2.2, 6.3)	+0.6
San Joaquin Valley	**7.7 (6.6, 8.8)**	**7.7 (6.6, 8.7)**	**0**
Fresno	7.6 (4.9, 10.3)	7.6 (5.1, 10.1)	+0.5
Kern	7.3 (4.6, 10.0)	7.3 (4.7, 10.0)	-0.4
San Joaquin	7.6 (4.9, 10.4)	7.6 (4.9, 10.4)	-0.1
Stanislaus	5.9 (3.6, 8.3)	6.0 (3.7, 8.2)	-0.7
Tulare	8.7 (6.1, 11.4)	8.7 (6.2, 11.2)	-1.7
Merced	9.7 (6.7, 12.7)	9.7 (6.9, 12.5)	+2.5*
Kings	8.1 (5.2, 11.1)	8.1 (5.3, 10.9)	-0.1
Madera	9.8 (6.7, 13.0)	9.8 (6.8, 12.9)	+3.1*
Central Coast	**5.2 (4.2, 6.2)**	**5.2 (4.2, 6.2)**	**0**
Ventura	5.1 (3.1, 7.2)	5.1 (3.2, 7.1)	+0.5
Santa Barbara	5.4 (3.2, 7.6)	5.4 (3.3, 7.5)	-0.7
Santa Cruz	4.1 (2.1, 6.1)	4.1 (2.1, 6.1)	-0.1
San Luis Obispo	4.2 (2.3, 6.1)	4.2 (2.4, 6.0)	-1.9*
Monterey, San Benito	6.2 (3.9, 8.4)	6.2 (4.0, 8.3)	+0.8
Los Angeles	**6.9 (6.3, 7.5)**	**6.9 (6.3, 7.5)**	**+0.3**
Los Angeles	6.9 (6.3, 7.5)	6.9 (6.3, 7.5)	+0.3
Other Southern California Counties	**6.7 (6.0, 7.5)**	**6.7 (6.0, 7.4)**	**+0.6**
Orange	6.6 (5.3, 8.0)	6.6 (5.3, 7.9)	+2.0*
San Diego	6.0 (4.8, 7.2)	6.0 (4.8, 7.2)	+0.5
San Bernardino	8.5 (6.4, 10.5)	8.5 (6.7, 10.3)	+0.6
Riverside	6.1 (4.6, 7.6)	6.1 (4.6, 7.5)	-2.3*
Imperial	10.9 (7.2, 14.6)	10.9 (7.7, 14.1)	+0.9
California	**6.6 (6.2, 6.9)**	**6.6 (6.2, 6.9)**	**+0.4***

* Significant change from 2001

** Estimate is not statistically reliable

Source: 2001-R and 2003 California Health Interview Surveys

race/ethnicity, education, income, insurance status and obesity (data not shown), and these differences likely contribute to the variation in diabetes prevalence.

High Blood Pressure, Smoking and Overweight/Obesity Increase Risk of Complications Among Adults with Diabetes

High blood pressure (hypertension) among people with diabetes can contribute to the development of serious medical complications, such as end-stage kidney disease, cardiovascular disease and stroke. High blood pressure is much more common among people with diabetes (60.9%) than among those not diagnosed (20.6%).[7] Moreover, the prevalence of high blood pressure among adults with diabetes increased from 56.7% in 2001 to 60.9% in 2003, putting these adults at greater risk of developing serious complications.

Among people with diabetes there is considerable variation in the prevalence of hypertension by race and ethnicity (Exhibit 5). African Americans with diabetes have the highest prevalence of hypertension (74%) while Latinos have the lowest (50.2%). The prevalence of hypertension among adults with diabetes increased significantly among whites (from 59.8% to 64.4%), and Asians (from 52.8% to 67.2%) between 2001 and 2003.

For people with diabetes, smoking increases the risk of complications including cardiovascular disease, kidney disease and amputation. Although the prevalence of smoking decreased significantly from 2001 to 2003 among people not diagnosed with diabetes (17.2% to 16.6%), there was actually a slight increase among those with diabetes (14.5% to 15.0%) but the change was not statistically significant.[8] In addition, smoking prevalence among adults with diabetes varies by race and ethnicity, with the lowest rate among whites (12.2%) and the highest rate among AI/ANs (39.8%; Exhibit 5).

Obesity is a major risk factor for the development of diabetic complications, including cardiovascular disease and stroke. In California, three out of four adults with diabetes have an increased risk of developing complications because they are overweight or obese. Over one-third of adults with diabetes (34%) are overweight and over two-fifths (40.6%) are obese.[9] Obesity is also a major risk factor for developing diabetes. The prevalence of diabetes is more than twice as high among adults who are obese (13%) as it is among those who are overweight (6.3%), and three times as high as it is among those who are normal weight (3.7%) or underweight (4.4%).

Overweight and Obese Adults at Risk for Diabetes

Among adults not diagnosed with diabetes, over one-third (35.2%) are overweight and an additional one-fifth (18.8%) are obese. These 12.8 million adults who have not been diagnosed with diabetes are at risk for developing diabetes and some may already have the condition.[10]

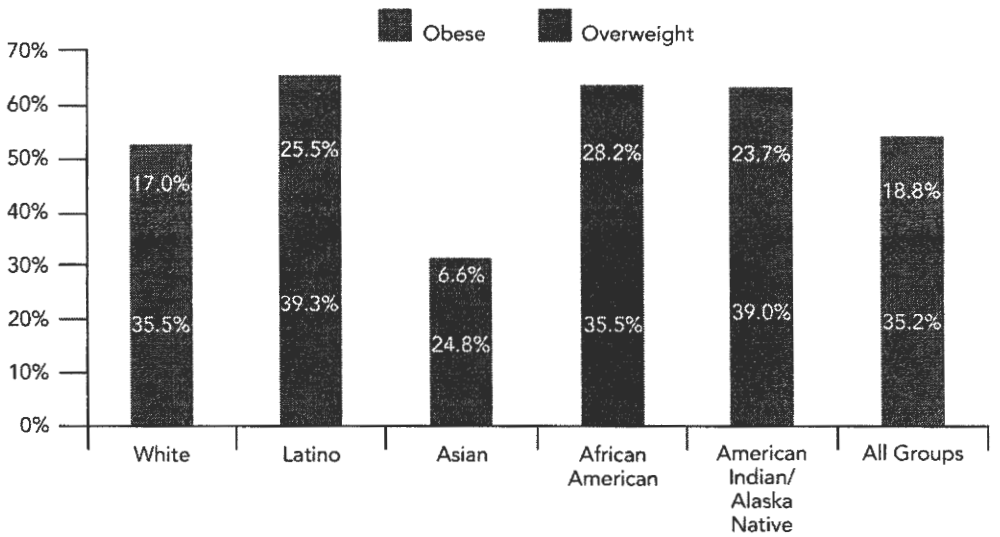
Prevalence of High Bood Pressure and Current Smoking by Race/Ethnicity, Adults Age 18 and Over Diagnosed with Diabetes, California, 2003 — Exhibit 5

Race/Ethnicity	High Blood Pressure %	Current Smoking %
White	64.4	12.2
Latino	50.2	15.2
Asian	67.2	16.1
African American	74.0	20.7
American Indian/Alaska Native	61.0	39.8
All Adults Diagnosed with Diabetes	**60.9**	**15.0**

Source: 2003 California Health Interview Survey

Exhibit 6

Prevalence of Overweight and Obesity by Race/Ethnicity, Adults Age 18 and Over Not Diagnosed with Diabetes, California, 2003



Source: 2003 California Health Interview Survey

There is considerable variation in the prevalence of overweight and obesity by race and ethnicity (Exhibit 6). Among adults not diagnosed with diabetes, approximately one in four African Americans, Latinos and AI/ANs, and more than one in six whites are obese, compared to one in sixteen Asians. As a result, some of the groups who currently have the highest prevalence of diabetes are also at the greatest risk of developing diabetes.

Conclusions and Policy Recommendations

Nearly 1.7 million California adults have been diagnosed with diabetes, and at least 12.8 million more (54%) are at significant risk for developing diabetes due to being overweight or obese. Based on national estimates, some of these at-risk individuals currently have diabetes but have not yet been diagnosed. In addition, nearly 27,000 adolescents ages 12 to 17 have been diagnosed with diabetes. In California, as obesity rates increase, the risk for diabetes increases among all populations, with some groups at elevated risk for developing the condition.

Preventing Diabetes

Obesity is a major risk factor for developing Type 2 diabetes. Therefore, obesity prevention among adolescents and adults should be a focus in the fight against diabetes. Regular physical activity in conjunction with a nutritionally balanced diet is the key to preventing obesity. Efforts to promote and encourage physical activity and healthful eating should take into account multiple factors—including cultural diversity, the environment and existing structures—to encourage healthy behaviors among individuals and families.

- ***Promote environments that encourage nutritious eating.*** Policies can be developed to encourage children and adults to eat culturally appropriate healthful diets, including more fruits and vegetables, and food with lower fat content.
- ***Promote environments that encourage regular physical activity.*** Lack of physical activity is a risk factor for obesity and should be addressed via policies to help

adults and children live more active lives, including access to safe parks, walking-friendly neighborhoods, and quality physical education in grades K-12. Physical activity should receive more emphasis in college curricula. Additionally, programs are necessary that focus on reducing sedentary behavior in the work place.

Reducing Complications of Diabetes

When diabetes is undiagnosed or poorly controlled, the risk of serious and preventable complications, such as blindness, kidney failure, heart disease and amputation, is greatly increased. Four strategies can help reduce the likelihood of developing these health-threatening complications:

- ***Promote early detection and appropriate management of diabetes.*** Policies are needed to guarantee access to health care to ensure that diabetes is diagnosed early and managed appropriately.
- ***Reduce the prevalence of overweight and obesity among people with diabetes.*** Among people with diabetes, there should be a focus on reducing rates of obesity in an attempt to better manage and control blood sugar, and limit diabetic complications. Partnerships between health care providers and insurers to provide weight loss options, as well as the development of culturally appropriate nutritional resources, should be emphasized.
- ***Reduce the prevalence of smoking among people with diabetes.*** Policies to provide help to people with diabetes for smoking cessation can be developed and should be strongly advised by health care providers.
- ***Reduce the prevalence of hypertension among people with diabetes.*** Health care providers should be further educated on the need for early diagnosis and the appropriate treatment and control of hypertension among patients with diabetes.

Data Source

All statements in this report that compare rates for one group with another group reflect statistically significant differences ($p<0.10$) unless otherwise noted. The findings in this brief are based on data from the 2001 and 2003 California Health Interview Surveys (CHIS 2001 and CHIS 2003). CHIS 2003 completed interviews with over 42,000 adults, drawn from every county in the state, in English, Spanish, Chinese (both Mandarin and Cantonese), Vietnamese and Korean. CHIS 2001 data were re-weighted to be consistent with the weighting methodology adopted for CHIS 2003. As a result, CHIS 2001 estimates may differ from previously published estimates. CHIS is a collaboration of the UCLA Center for Health Policy Research, the California Department of Health Services, and the Public Health Institute. Funding for CHIS 2003 was provided by the California Department of Health Services, The California Endowment, the National Cancer Institute, the Centers for Disease Control and Prevention (CDC), the Robert Wood Johnson Foundation, the California Office of the Patient Advocate, Kaiser Permanente, L.A. Care Health Plan, and the Alameda County Health Care Agency. For more information on CHIS, visit *www.chis.ucla.edu*.

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Acknowledgements

The authors wish to thank Lida Becerra, MS, Jenny Chia, PhD, Winnie Huang, Sungching Glenn, Hongian Yu, PhD, Garrison Frost and Celeste Maglan for their assistance. The authors would also like to thank the following individuals for their helpful comments: Francine R. Kaufman, MD, and Ann L. Albright, PhD.

The UCLA Center
for Health Policy Research
is based in the UCLA School of Public
Health and is also affiliated with
the UCLA School of Public Affairs.

PB2005-11

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Citation

Diamant AL, Babey SH, Brown ER and Hastert TA. *Diabetes on the Rise in California*. Los Angeles: UCLA Center for Health Policy Research, 2005.

Notes

1 Respondents were asked "Other than during pregnancy, has a doctor ever told you that you have diabetes or sugar diabetes?" As a result, estimates of diabetes prevalence do not include gestational diabetes.

2 Based on data from the 2003 National Health Interview Survey.

3 Respondents who indicated that a doctor told them they had diabetes were asked "Were you told that you had Type 1 or Type 2 diabetes?"

4 Centers for Disease Control and Prevention. National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2005. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2005.

5 Respondents were asked "Has a doctor ever told you or your parents that you have diabetes or sugar diabetes?"

6 Based on data from the 2003 National Health Interview Survey.

7 Respondents were asked "Has a doctor ever told you that you have high blood pressure?"

8 Respondents who indicated that they had smoked at least 100 cigarettes in their lifetime and that they currently smoked on some days or every day were considered current smokers.

9 Body Mass Index (BMI), a ratio of weight in kilograms (kg) divided by height in meters (m) squared, was calculated based on respondents' reported height and weight. BMIs below 18.5 kg/m^2 are considered underweight; BMIs of 18.5-24.9 kg/m^2 are considered normal weight; BMIs of 25.0–29.9 kg/m^2 are considered overweight, and BMIs of 30.0 kg/m^2 or greater are considered obese.

10 The Centers for Disease Control and Prevention estimate that nationally nearly 30% of adults who currently have diabetes are undiagnosed. See: Centers for Disease Control and Prevention. National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2005. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2005.

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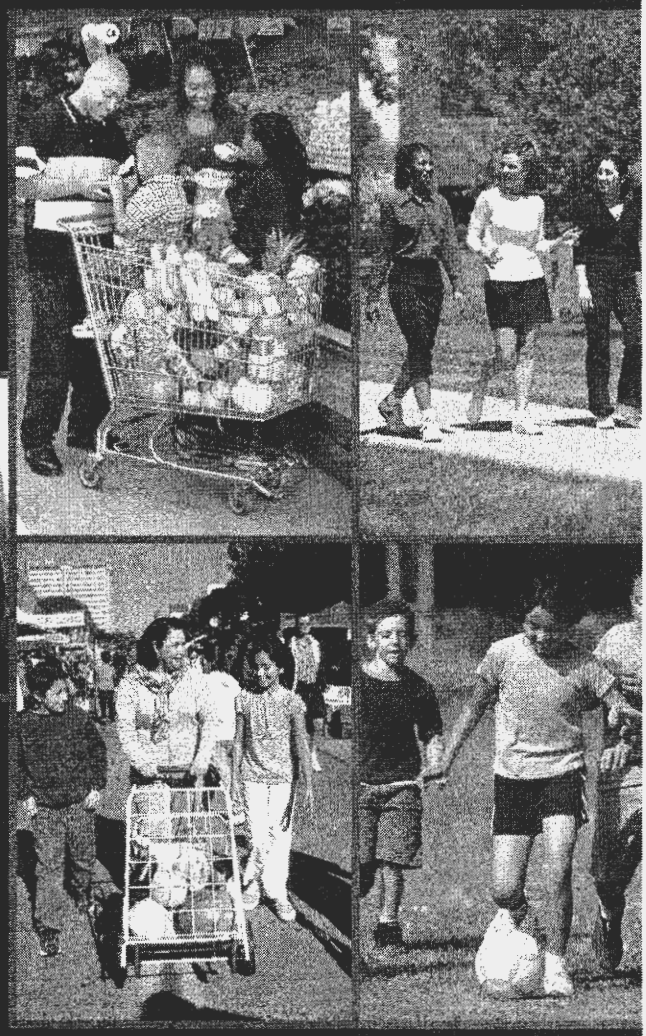
California Department of Health Services

POLICY STATEMENT TO REDUCE OBESITY AND OVERWEIGHT

November 2004

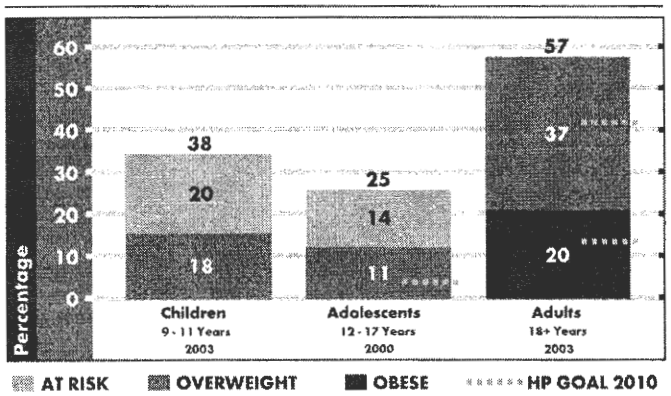


BACKGROUND

Urgency of the Problem

Over half of California adults are overweight or obese, and about one in three children and one in four teens is at risk or already overweight.[1-3] Available data indicate that overweight and obesity have risen dramatically in all age, income, educational, and ethnic groups.[1,4,5] Rates are highest among African Americans, Latinos, persons in poverty, and persons with the least education.[1-4] Such high rates contribute to other health disparities experienced by these groups. National and state surveys indicate that overweight and obesity rates began rising in the late 1980s and accelerated in the 1990s.

CALIFORNIA CHILDREN, TEENS AND ADULTS AT UNHEALTHY WEIGHT



Source: California Department of Health Services, Cancer Prevention and Nutrition Section

A decline among adults that occurred in 2002 was not sustained in 2003 (see graphic right). Of the nation's ten leading health indicators for Healthy People 2010, only overweight and obesity are moving strongly in the wrong direction.[6] The U.S. Surgeon General has called for national action to reverse the epidemic.[5]

Obesity and overweight are contributing to the rising rates of type 2 diabetes in adults and to a dangerous new phenomenon–type 2 diabetes in children. If left unchecked, type 2 diabetes may lead to complications such as kidney failure, blindness, heart attack, and amputations. It is feared that overweight and obesity may erase the last century's victories over heart disease and stroke and that the rates of breast, prostate, and colon cancer also will increase. Overweight, obesity, and physical inactivity were estimated to cost California over $21 billion in health care costs and lost productivity in 2000.[7]

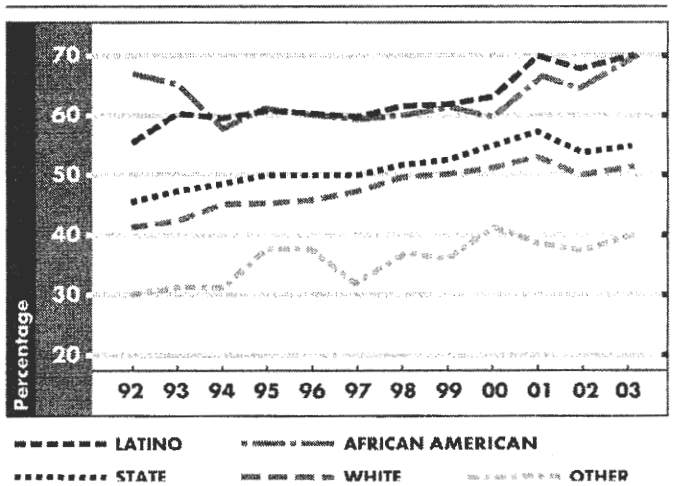
Root Causes

The worldwide spread of obesity is attributed to complex, powerful social forces that encourage eating too many high calorie foods, getting too little physical activity, and acquiring too much body weight over time. The pressure to eat too much has become increasingly pervasive. Large portions of high calorie foods with little nutritional value are mass produced, heavily advertised, and made widely available throughout the day, while the opposite is generally true for healthier foods like vegetables and fruit. Increased marketing of energy-dense, low nutrient foods to children; lack of access to healthier foods in workplaces, schools, and many lower-income communities; and food insecurity with or without hunger–in addition to a host of other barriers–make it harder for individuals to maintain a healthy diet.

Technology has decreased the amount of energy that must be expended in most workplaces, for daily living, for transportation, and at leisure. Pressure on the educational system has reduced the time and space available for active play as well as for physical education. Long workdays result in less time for physical activity and family meals, especially for single-parent households. Safety concerns, urban sprawl, and community design discourage walking, bicycling, and recreation in many neighborhoods.

Even factors occurring in the perinatal period may contribute to overweight and obesity later in life. These include uncontrolled maternal diabetes, abnormal birth weight, and lack of breastfeeding.[8-10]

RATES OF OVERWEIGHT BY RACE/ ETHNICITY CALIFORNIA ADULTS, 1992-2002



LEADERSHIP

It is critical for the California Department of Health Services (DHS) to establish a policy about the priorities and measures needed to prevent overweight and obesity, as well as their principal causes: poor diet and physical inactivity. DHS will place a high priority on promoting healthy eating and physical activity as critical factors to reduce the risk of illness and death from major chronic diseases such as heart disease, cancer, hypertension, and diabetes.

DHS will provide leadership by:

- Drawing more attention to the epidemic of obesity and overweight in adults and children; its detrimental effects on health, quality of life, and medical costs; and the urgency of enacting comprehensive corrective measures.
- Identifying and seeking the resources necessary to implement a long-term strategic plan to combat overweight and obesity that encompasses developing, implementing, and evaluating prevention programs using a broad spectrum of interventions benefiting all Californians.
- Partnering, collaborating, and coordinating with national, state, and local agencies, private organizations, and businesses to conduct large-scale interventions.
- Assuring that department programs mobilize their efforts and use comprehensive, multilevel, multicomponent, and culturally competent approaches.

DHS will use comprehensive, population-based and systems-oriented approaches to physical activity and nutrition to prevent both the immediate and the long-term health consequences of obesity and overweight. The following strategies will be used to focus on obesity and overweight-related outcomes. These combined measures will also help achieve goals in the DHS Strategic Plan, including those to optimize state and local public health capacity, prevent disease, eliminate health disparities, and contain health care costs.

STRATEGIC OUTCOMES

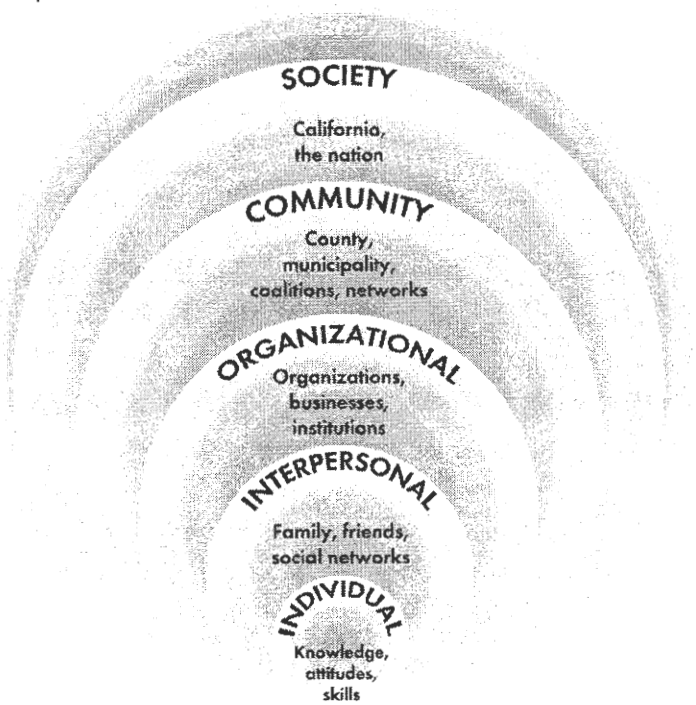
Population and Systems Change

Finding successful strategies to reduce the prevalence of obesity and overweight is complex. However, a growing consensus is emerging that several population and system changes comprise a promising set of strategies for reducing obesity and overweight, their co-morbidities, and related health disparities. These strategies are to:

- Build health-friendly communities by improving community design.
- Reduce TV viewing, especially among children and youth.
- Limit calorie intake by:
  - moderating portion size
  - limiting soft drinks and sweetened beverages
  - limiting foods with high amounts of sugar and fat.
- Choose healthy foods, especially:
  - fruits and vegetables
  - whole grains
  - beans, nuts, and seeds
  - low-fat dairy products.
- Increase regular everyday activity.
- Increase the initiation and prolong the duration of breastfeeding.
- Decrease rates of food insecurity and hunger.
- Improve access to prevention, early intervention, and treatment strategies for overweight and obesity in the health care system.

A COMPREH NSIVE APPROACH

International, national, and expert organizations have called for stronger, more specific preventive measures. Large-scale, multilevel, multicomponent prevention efforts that involve the public sector, nonprofit organizations, and business are considered the only effective public health options.



In 2001, the Centers for Disease Control and Prevention convened the nation's state health departments to discuss ways to organize large-scale efforts for healthy eating, physical activity, and obesity prevention. They endorsed using the newly developed *Guidelines for Comprehensive Programs to Promote Healthy Eating and Physical Activity* as the most promising means of mobilizing a nationwide response to the epidemic.[11] DHS also endorses these guidelines and will design implementation activities to include the following functions:

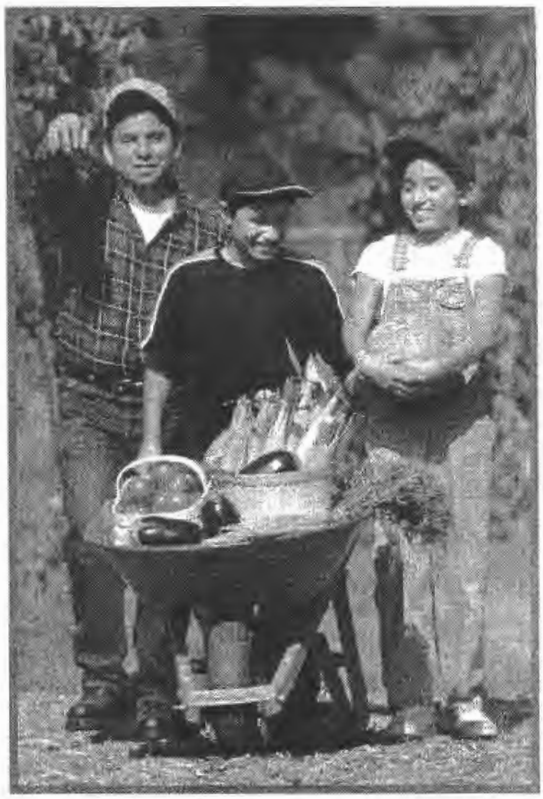
- **Leadership, planning/management, and coordination.** With key stakeholders, DHS will adopt the population and systems strategic outcomes identified above, set specific statewide targets, develop a comprehensive plan, and identify and utilize all possible resources for implementing the plan. In all activities, DHS will work with a wide range of partners, including other state agencies, local governments, nonprofit organizations, businesses, and private sector groups.
- **Environmental, systems, and policy change.** DHS will identify and advocate for new policies that create community, organizational, and household environments where healthy eating and physical activity become the easiest, most accessible choices.
- **Mass communications and media advocacy.** DHS will use current resources and identify potential new resources to develop and conduct vigorous communications campaigns to denormalize overeating and sedentary behavior and to promote healthy eating and physical activity. Such campaigns will work to improve the promotion of healthy foods outside the home, increase the use of federal nutrition assistance programs, and - especially to children and youth - encourage responsible food and beverage advertising.
- **Community programs and community development.** DHS will support counties and cities, including local health departments, to mobilize resources and empower residents to create more livable, healthy environments.
- **Programs for children and youth.** DHS will provide leadership to create environments for children and youth that promote active living and healthy eating, connect families in need with available federal food assistance and health care programs, and protect children from negative media and commercial influences. Strategies will encourage adults to model healthy eating and exercise behaviors to children.
- **Health care delivery.** DHS will continue its collaborative efforts with health care entities to promote clinical practices that address the full spectrum of primary, secondary, and tertiary obesity prevention services in health care settings.
- **Surveillance, epidemiology, and research.** DHS will sponsor, interpret, and make data widely available from a variety of surveys, surveillance, and reporting systems that track population trends and public opinion about eating, exercise, and weight. DHS will build on the *Healthy People 2010* objectives to identify a set of behavioral, policy, systems, and outcome indicators to assist all stakeholders in monitoring progress at the state and local levels.

CALL TO ACTION

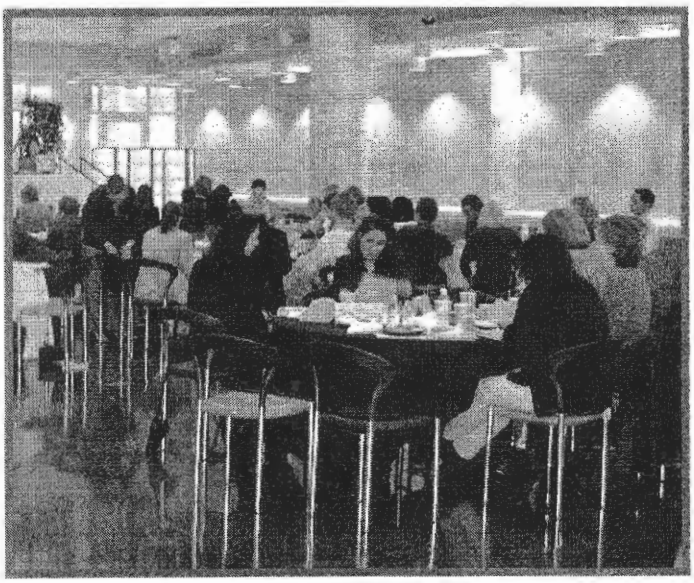
Reversing the obesity epidemic requires action now. DHS will continue to work on improving the coordination and operation of existing physical activity and nutrition programs. However, all DHS programs can play a role by promoting healthy eating and physical activity in the services they fund. Departmental programs are encouraged to work with their employees, partners, contractors, and other stakeholders to promote healthy eating and physical activity and to provide an environment in which the healthiest choices are also the easiest choices for people to make.

To implement these strategies, DHS will proceed in two phases. First, a more specific set of expectations for each of the seven comprehensive leadership functions will be developed. This process will include developing an inventory of assets, conducting an environmental assessment with stakeholders, and setting measurable objectives that can be achieved in the next four years.

Second, the DHS California Obesity Prevention Initiative led a statewide process to identify creative solutions. It produced *Reversing the Obesity Epidemic: California's Strategies for Action*, a compilation of recommendations for nutrition and physical activity goals, interventions, policies, and tools to help prevent obesity and related chronic diseases. This is an important start in encouraging the necessary change in California communities that will ultimately result in a healthier California.



DHS established a Physical Activity and Nutrition Coordinating Committee (PANCC), comprised of representatives from organizations within DHS that manage nutrition and physical activity programs. PANCC was formed to promote coordination, communication, and policy development across programs that address obesity, nutrition, and physical activity. PANCC assures leadership and action by DHS to reduce obesity and overweight in California. This policy statement was developed by PANCC.



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HEALTH POLICY fact sheet

Diabetes among Latinos in California: Disparities in Access and Management

Neetu Chawla, MPH; Michael A. Rodriguez, MD, MPH; Susan H. Babey, PhD; and E. Richard Brown, PhD

September 2003

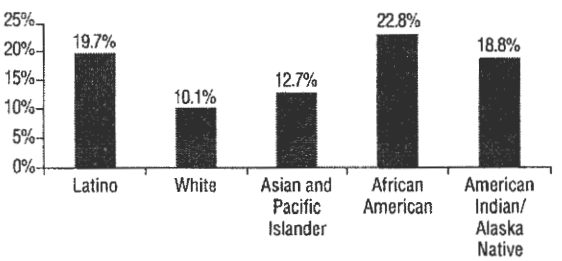
In California, over 339,000 Latino adults age 18 and over (6.0%) reported that they had diabetes in 2001. The prevalence of diabetes varies by age and is particularly high among older Latinos, with nearly one out of five Latino adults over the age of 50 (19.7%) reporting they have diabetes (Exhibit 1). This rate is nearly twice the rate for whites (10.1%) and among the highest for all racial/ethnic groups.

Diabetes is a chronic illness associated with acute and long-term complications, which can be reduced with appropriate medical care and self-management. Unfortunately, Latinos with diabetes face difficulties in managing their condition, such as limited use of diabetes medications and inadequate blood glucose monitoring. These limitations are associated with lack of insurance or usual source of care, and barriers to accessing health care related to language, high rates of non-citizen status, and low income. In this fact sheet, we examine diabetes among Latinos in California – with an emphasis on management of diabetes and barriers to accessing health care based on data from the 2001 California Health Interview Survey.

Management of Diabetes

Managing diabetes involves several components, including appropriate use of medications and regular home glucose monitoring. Although not all people with diabetes require medications, taking appropriate medications is a central part of managing diabetes for many adults. However, accessing medications and necessary materials for home glucose monitoring can be expensive and difficult. In California, only 67.5% of Latinos with diabetes report that they are taking medications for their condition, compared to 78.2% of whites. In addition, although self-monitoring of blood glucose is an essential aspect of managing diabetes in order to prevent serious complications, only one out of three Latinos with diabetes (35.6%) report that they check their glucose daily compared to more than half of whites (54.6%).

Having health insurance and an identified source of care are crucial factors for promoting optimal management of diabetes. However, nearly one out of five Latino adults with diabetes (19.9%) report being uninsured all year compared to less than one out of ten whites (6.4%). Among adults with diabetes, Latinos are also nearly four times more likely to have no usual source of care than whites (12.3% vs. 3.4%). In addition, having insurance and having a usual source of care greatly increases the likelihood of adequate management of diabetes among Latinos (Exhibit 2). Insured Latinos with diabetes are significantly more likely to report medication use (72.5% vs. 48.9%) and daily glucose monitoring (39.4% vs. 21.7%) compared to uninsured Latinos. Similarly, Latinos with a usual source of care had strikingly higher rates of medication use compared to those with no usual source of care.



Note: Race/ethnicity is based on single race or the race/ethnicity with which the respondent most identifies.

EXHIBIT 1:
Diabetes Prevalence by Race/Ethnicity, Adults Age 50 and Over, California, 2001.
Source: 2001 California Health Interview Survey

Barriers to Accessing Care

Having health insurance and a usual source of care – a medical "home" – are essential for people with diabetes to appropriately manage their condition. However, barriers such as language, non-citizen status,

	Percent Taking Any Diabetes Medications %	Percent Monitoring Glucose At Least Once a Day %
All Latino Adults with Diabetes	**67.5**	**35.6**
Insurance Status		
Insured	72.5	39.4
Uninsured	48.9	21.7
Usual Source of Care		
Has Usual Source of Care	71.4	38.2
No Usual Source of Care	39.7	*

* Estimate is not statistically reliable.

EXHIBIT 2:
Diabetes Management Indicators by Insurance Status and Usual Source of Care, Latinos with Diabetes, Age 18 and Older, California, 2001
Source: 2001 California Health Interview Survey

EXHIBIT 3:
Rates of Having a Usual Source of Care and Insurance by Language, Citizenship, and Federal Poverty Level, Latino Adults with Diabetes, Age 18 and Over, California, 2001
Source: 2001 California Health Interview Survey

	Have Usual Source of Care %	Insured %
All Latino Adults with Diabetes	**87.7**	**79.0**
Language Spoken at Home		
Spanish	85.4	66.0
Spanish and English	87.9	83.4
English	93.1	91.2
Citizenship Status		
Non-citizen without green card	74.6	54.6
Non-citizen with green card	83.0	69.0
Naturalized citizen	94.7	89.3
US-born citizen	92.3	90.2
Federal Poverty Level (FPL)		
0-99% FPL	82.7	75.0
100-199% FPL	85.3	71.6
200-299% FPL	94.3	90.1
300% FPL and above	97.5	91.7

and low income result in decreased access to health insurance and health care services for Latino adults. Among Latinos with diabetes, nearly one out of three is primarily a Spanish speaker (31.3%), more than one out of three are non-citizens (39.7%), and nearly three out of four (68.6%) have incomes below 200% of the Federal Poverty Level (FPL).

Among Latinos with diabetes, non-citizens are significantly less likely to report having either a usual source of care or having insurance than citizens (Exhibit 3). Latinos who have incomes less than 200% of the FPL are significantly less likely to have either a usual source of care or insurance compared to those with higher incomes. In addition, Latinos who speak primarily Spanish at home have significantly lower rates of insurance coverage compared to Latinos who speak either primarily English or English and Spanish at home. Latinos who primarily speak Spanish at home also have low rates of reporting that they have a usual source of care compared to those who speak primarily English at home, though this difference is not statistically significant.

Policy Recommendations

Latinos have high prevalence of diabetes and those with diabetes have low rates of medication use and regular home glucose monitoring. Lack of medication use and inadequate glucose monitoring are indicators of poorly managed diabetes that may result in increased complications, such as kidney, eye, and heart disease. These complications are associated with poorer health, higher rates of disability and death, and increased healthcare costs. Many of these added burdens are *preventable* with proper management and control of diabetes. Expansion of health care coverage, implementation of culturally and linguistically appropriate care, and additional programs covering medications and glucose monitoring materials can improve access to care and appropriate management of diabetes for California's Latinos with diabetes.

- Expand outreach and enrollment efforts to insure all eligible Latinos, particularly Spanish speakers, non-citizens, and adults with lower incomes
- Promote culturally and linguistically appropriate health care and health education materials
- Promote additional programs—for both the insured and uninsured—that cover costs of medications and materials for daily glucose monitoring

The California Endowment

The development and publication of this fact sheet were funded by a grant from The California Endowment.

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Data Source

This fact sheet is based on findings from the 2001 California Health Interview Survey (CHIS 2001). CHIS 2001, the largest health survey conducted in any state and one of the largest in the nation, covers a broad range of public health concerns including health status and condition, health-related behaviors, health insurance coverage, and access to health care services. CHIS 2001 completed interviews with 55,428 adults, 5,801 adolescents age 12-17, and 12,592 parents of young children age 0-11. The data for Latinos presented in this fact sheet are based on a sample of 9,458 adults who most identified with being of Latino or Hispanic origin. Within this group, 702 Latino adults reported having diabetes. The data were weighted based on the 2000 Census. The interviews, available in six languages, were conducted between November 2000 and September 2001.

***The California Health Interview Survey (CHIS)** is a collaboration of the UCLA Center for Health Policy Research, the California Department of Health Services, and the Public Health Institute. Funding for CHIS 2001 was provided by the California Department of Health Services, The California Endowment, the National Cancer Institute, the California Children and Families Commission, the Centers for Disease Control and Prevention (CDC), and the Indian Health Service. For more information on CHIS, visit* www.chis.ucla.edu.

Editor-in-Chief: E. Richard Brown, PhD; Communications Assistant: Celeste Maglan;
Editing/Production Services: Sheri Penney, Penney Layne Productions; Graphic Production: Donna Beilock, Ikkanda Design Group
The UCLA Center for Health Policy Research is based in the
UCLA School of Public Health and is also affiliated with the UCLA School of Public Policy and Social Research

FS2003-6

General latino Health

LCHC
Latino Coalition for a Healthy California

Latino Health

Quick Facts

Quick Facts

The health of the population is essential to a strong and vibrant civil society. "Healthy people living in healthy communities" is a national vision. Already comprising nearly one-third (32%) of the state population, Latinos are California's fastest growing population. One of every two children born in California is Latino, and it is estimated that half of the state's population will be Latino in 2040. The Latino population grew 43% between 1990 and 2000 and now totals 11 million, closing in on the state's majority of 16 million non-Latino whites. Given the significant demographic impact of Latino to the state, addressing their health needs contributes to improving California's overall health status and fulfilling the vision of a healthy California.

Background

- Over 11 million Latinos reside in California, comprising 1/3 of the state's population
- Half of the children born in California are Latino
- 45% of the Latino population is an immigrant
- More than one in three Latinos or 3.2 million live below the federal poverty level – a greater proportion than any of the major racial and ethnic groups in California
- Over half of Mexican Immigrants do not speak English well
- Half of Latino Adults have less than a High School Education
- By the year 2040, the Latino population is expected to be nearly half of the state's population

(Source: Reyes, B., California's Latino Population: Demographics and Policy Presentation, May 2004.)

Latinos Lack Access to Care

- Annual premium costs for employer-sponsored coverage in California rose from $7,432 in 2002 to $8,504 in 2003 for family coverage. California workers are shouldering an increasing share, rising from 26% of premium costs in 2002 to 30% in 2003.
- California workers are more likely to have a choice of health plans than the average worker in the U.S. Nearly four in ten (38%) workers nationwide were limited to one choice in 2003, while 26% of California workers were limited to only one plan.

(Source: http://www.kff.org/statepolicy/7086/sec4.cfm)

Latinos are Under and Uninsured

- California has approximately 6.3 million uninsured individuals or 20% of the statewide population.
- More than one in four Latinos ages 0-64 in California are uninsured (28% of Latinos compared to 9% of whites).
- Latinos high uninsured rate is largely due to the very low rate of health insurance provided by their employers, 43% compared with 76% for whites.
- Overall, Latinos are the most likely to report that their general health is fair or poor, compared with other ethnic groups.
- 54% of the uninsured are Latino while 25% of the insured are Latino.

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Quick Facts

- 67% of the uninsured have an income under 200% of the federal poverty level.
- Almost a third (64%) of the uninsured are employed adults while 85% of families with uninsured children have at least one parent that is working.
- Uninsured individuals rely on the safety net-community clinics, hospitals, and private physicians who deliver care without respect for ability to pay.
- 85% of the uninsured population, 41% of the Medi-Cal population, and 27% of the Healthy Families population often or almost always experience problems obtaining specialty care compared to 2% of those with private insurance.

(Sources: Insure the Uninsured Project, Who is Uninsured in California, June 2003. Aguayo, J. et. al, Important Health Care Issues for California Latinos: Health Insurance and Health Status, January 2003. Felt-Lisk, S. et. al, Examining Access to Specialty Care for California's Uninured, June 2004.)

Latino Children Remain Uninsured

- Overall, approximately 11.7% of adolescents (ages 12-17) lacked health insurance, while 8.6% children ages 0-11 lacked health insurance. However, children between the ages of 6 and 11 are most likely to be uninsured.
- Latino adolescents (ages 12-17)have the highest uninsured prevalence of all groups, 22.5% compared with 4.4% for Whites.
- Latino children (ages 0-11) have the highest uninsured prevalence of all groups, 15.5% compared with 4.3% for Whites.
- Almost two-thirds of the uninsured Latino children (ages 0-17) were eligible for one of the state's two public health insurance programs – Medi-Cal or Healthy Families.
- Legislative districts with the highest rates of children uninsured-and-eligible for public health insurance were primarily located in Los Angeles County and in the greater Southern California region.
- Latino children comprised the majority of all children in five Assembly and five Senate districts primarily in the Central Valley and Los Angeles counties with the highest uninsured-eligibility rates.
- Among children, with a non-citizen father, 21% had no health insurance, 12% did not visit at doctor in the last year, 12% had no usual place of care, and 45% of those with a usual place of care went to a clinic or a community hospital for care.
- Community and hospital clinics are the usual source of care for 50.1% of Latino children in households below 100% FPL and only 9.4% in households at 300% FPL and above.

(Sources: Holtby, S., et. al, Health of California's Adults, Adolescents, and Children: Findings from CHIS 2001, May 2004. Mendez-Luck, C., et. al, Many Uninsured Children Qualify for Medi-Cal or Healthy Families, June 2004. Reyes, B., California's Latino Population: Demographics and Policy Presentation, May 2004. UCLA Center for Healthy Children, Families, and Communities, et. al, The Health of Young Children in California, July 2003.)

The Immigrant Experience

- Mexican immigrants are less likely to have a usual source of care, 53.5% compared to 24.1% for U.S. born Mexican ancestry and 15.2% for U.S.-born Non-Latino White.
- Almost have of the children ages 0 to 17 in California – 4.4 million – are either immigrants themselves or live in families with at least one immigrant. Of these children, 1/3 are U.S.-born children of documented immigrant parents.
- About one in five children of undocumented parents are in fair or poor health.
- One in four undocumented children of undocumented parents are without a usual source of care.

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(Sources: Wallace, S., et. al, Mexican Immigrant are Generally Healthier, but Have Less Access to Needed Health Care, October 2003. Pourat, N., et. al, Demographics, Health and Access to Care of Immigrant Children in California: Identifying Barriers to Staying Healthy, March 2003.)

The Farmworker Experience

- 96% of farmworkers are Latino of which 34 to 42% are undocumented.
- 95% of California's migrant agricultural workers use Spanish as their primary language.
- In 1995, farmworkers averaged between 23 and 29 weeks of work.
- 61% of migrant families are impoverished; often they are not paid the minimum wage and the State lacks enough inspectors to enforce existing regulations.
- Approximately 70% of migrant agricultural workers lack public or private health insurance.
- 47% of migrant farmworkers had not visited a doctor in the last two years and 58% had not seen a dentist in the same time period.
- Low parental education, transportation problems, long wait times in community clinics, decreased preventive screening, language problems, cultural differences, and lack of a regular source of care impact access and care.
- Over 16% of farmworkers say their employer offers health insurance but a 1/3 of these workers did not participate due to high premiums or inability to afford the co-payments.
- 11% of farmworkers receive insurance through their employer, 7% participate in public insurance, and less than 5% purchase personal private insurance.
- A total of 26,148 certificates from 24 states during 1998 – 1993 were examined to show that farmworkers had higher proportionate mortality from injuries, tuberculosis, mental disorders, cerebrovascular disease, respiratory disease, ulcers, hypertension, and cirrhosis.
- 56% of migrant Latino children 6 and under experienced cavities.
- Approximately 40% of women farmworkers surveyed had had a medical visit in the prior 5 months, but 44% had never been to a dentist.
- In 1999, the California Agricultural Worker Health Survey found that nearly 1/3 of male agricultural workers had never been to a doctor or clinic in their lives; half had never been to a dentist, and 2/3 had never had an eye care visit.

(Source: Rodriguez, M., et. al, Health of Migrant Farmworkers in California, March 2003.)

Need Cultural and Language Competency

- Approximately one out of every five Californians – over six million persons – do not speak English very well and are considered "Limited English Proficient."
- In California, 40% of its population speaks a language other than English at home.
- In the U.S., 78% of Latinos speak a language other than English at home; 40% of Latinos speak English less than "very well"; and 24% of Latinos live in linguistically isolated households.
- Less than 4% of physicians in California are Latino and only 5% of the state's medical residents were Latino in 2000, even though Latinos comprise 31% of the population.
- While the population-to-physician ratio is 335:1, the Latino population-to-physician is almost 3000:1.
- Latino physicians are two to three times more likely to practice in underserved areas than their non-Latino white counterparts.
- Latinos are more likely to work as traditional providers in medically underserved areas, such as migrant health centers and free, county, and safety net clinics.

Quick Facts

- A study in the journal Pediatrics found an average of 31 errors per visit for Spanish-speaking patients using interpreters at pediatric clinics. Errors were most common when ad hoc interpreters such as family members or untrained bilingual nurses were involved. Almost 2/3 of the errors had clinical consequences which included wrong instructions on dose and duration of prescribed drugs and omission of important information about patient drug allergies or medical history.
- A poll by New California Media found that a majority of all California immigrants are unaware that they have a right to ask for an interpreter when seeking medical care; more than one out of three Hispanics say they have problems understanding a medical situation when it's not explained to them in their language; over half of Hispanics are confused by instructions when discharged from hospitals; and over half of Hispanics report problems over how to use their prescription medicine.

(Sources: The California Endowment, Improving Access to Health Care for Limited English Proficient Health Care Consumers, April 2003. Grantmakers in Health Issue Dialogue, Addressing Language and Culture in Providing Health Care, August 2003. Perkins, J., et. al, Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities, August 2003. Santa Cruz Sentinel, Health care for Spanish speakers lags due to slips of the tongue, January 10, 2003. New California Media Poll, www.ncmonline.com/polls/)

Race Bias

- Minorities are less likely than whites to receive health services, including clinically necessary procedures, even when controlling for insurance status, patient income, and other access-related factors. Cultural bias can affect clinical decision-making.
- Minorities are less likely to be given appropriate cardiac medications or to undergo bypass surgery, and are less likely to receive kidney dialysis or transplants. By contrast, they are more likely to receive certain less-desirable procedures, such as lower limb amputations for diabetes and other conditions.
- In a study of 139 patients at UCLA Medical Center's emergency room, 55% of Hispanic patients received no pain medication for bone fractures compared to 26% of White patients.

(Sources: Institute of Medicine of the National Academies, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, 2002. The California Endowment, Unequal Treatment – Unequal Health: What Data Tell Us About Health Gaps in California, 2002.)

Medi-Cal

- Medi-Cal serves one in six Californians or about six million residents.
- People eligible for Medi-Cal through cash assistance has been declining. They make up about 40.6% of all Medi-Cal eligibles.
- Medi-Cal or Healthy Families outreach could extend coverage to uninsured Latino children, more than 460,000 in all.
- More than half of all Medi-Cal recipients are in long term care and are aged, blind or disabled.
- Medi-Cal accounts for 15% of the state's General Fund and draws down more than $17 billion annually in federal funds.
- Medi-Cal enrollment rose nearly 10% from 2001 to 2002, largely in response to the economic downturn.
- California has 90,000 licensed physicians, but only about 26,000 physicians and physician groups are certified to care for Medi-Cal patients.
- At least 10,500 medical doctors statewide who want to treat the poor find their applications to do still being processed, sometimes a year or more after being submitted. If

Quick Facts

this backlog were alleviated, the state's poor would have about 40% more physicians from whom to choose.

- Outstationing eligibility workers in the community is associated with lower odds of Medi-Cal enrollment. For every additional outstation per 1,000 eligible children in the community, the odds of enrollment decreased by 2/3.
- Children who lived in counties with county-sponsored expansion program had three times the odds of being enrolled in Medi-Cal compared with children from a county without an expansion program.

(Sources: California HealthCare Foundation, MediCal Fact and Figures. January 2004. Governor's Budget, January 2004. Aguayo, J. et. al, Important Health Care Issues for California Latinos: Health Insurance and Health Status, January 2003. www.kff.org/statepolicy/7086/sec5.cfm. Orange County Register, Application Frustration, March 10, 2004. Kinchelow, J. & Brown, R., The Effect of County "Outreach Environments" on Family Participation in Medi-Cal and Healthy Families, August 2004.)

Healthy Families Program

- Of the 650,000 children enrolled in Healthy Families, 57.8% are Latino children.
- 61.2% of the total Healthy Families program enrollment are in Los Angeles, Orange, San Diego, San Bernardino, and Riverside Counties which have a high Latino population.
- Almost 40% of the Healthy Families application received were from Spanish-speaking applicants.
- Outreach money is associated with increased enrollment in both Healthy Families and Medi-Cal. Every additional dollar spent on outreach per eligible child in the county increases the odds of enrollment by 6% in Medi-Cal and 7% in Healthy Families.
- Outreach money spent on media is associated with decreased enrollment in Healthy Families. For every $1 increase in media per 1,000 eligible children the odds of enrollment decreased by 11%.

(Sources: MRMIB, Healthy Families Summary, Retrieved from www.mrmib.ca.gov September 2004. Kinchelow, J. & Brown, R., The Effect of County "Outreach Environments" on Family Participation in Medi-Cal and Healthy Families, August 2004.)

Diabetes

- Nearly one out of five Latino adults over the age of 50 (19.7%) report they have diabetes, which is twice the rate for Whites (10.1%) and among the highest for all racial/ethnic groups.
- In California, only 67.5% of Latinos with diabetes report that they are taking medications for their condition, compared to 78.2% of Whites.
- Only one out of three Latinos with diabetes (35.6%) report being uninsured all year compared to less than one out of ten Whites (6.4%).
- Among adults with diabetes, Latinos are nearly four times more likely to have no usual source of care than Whites (12.3% vs. 3.4%)
- Insured Latinos with diabetes are significantly more likely to report medication use (72.5% vs. 48.9%) and daily glucose monitoring (39.4% vs. 21.7%) compared to uninsured Latinos.
- Among Latinos with diabetes, nearly one out of three is primarily a Spanish speaker (31.3%), more than one out of three are non-citizens (39.7%), and nearly three out of four (68.6%) have incomes below 200% of the Federal Poverty Level.
- Latinos have a higher diabetes-related death rate than Whites in 69% of Assembly districts and 75% of Senate districts.

(Sources: Chawla, N., et. al, Diabetes among Latinos in California: Disparities in Access and Management, September 2003. California Center for Public Health Advocacy, Diabetes Deaths in California Legislative Districts, February 2004.)

Cancer

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- Latina women suffer the highest rate of invasive cervical cancer in California.
- Latina women are twice as likely as white women to develop cervical cancer and along with African American and Asian Pacific Islander women, are far more likely to die from cervical cancer than Whites.
- Latina women are far less likely to receive a pap smear than White women.
- Latinos report lower screening rates than Whites for breast cancer, colorectal cancer, and prostate cancer.
- The proportion of Latinas who have never had a Pap test, 10%, is more than double that of Whites.
- Only one in three (33%) Latina women report having a recent colorectal cancer screening test.
- More than 60% Latino men aged 50 and older have never been screened for prostrate cancer.
- Within family incomes below 200% FPL, only 67% Latina women older than the age of 40 have had a mammogram compared to Whites (72%).
- 92% among Latinas with Medi-Cal vs. 80% of uninsured Latinas received a PAP test within the last three years.

(Sources: The California Endowment, Unequal Treatment – Unequal Health: What Data Tell Us About Health Gaps in California, 2002. Babey, S., et. al, Cancer Screening in California: Racial and Ethnic Disparities Persist, September 2003.)

AIDS and HIV

- Latinos have the highest rates of new infection among California residents under the age of 30.
- As of April 2002, the cumulative number of reported AIDS cases by race/ethnicity and age showed that 40.5% of the adult/adolescent cases and 72% of the pediatric cases occurred in people of color.
- As of 2002, Latinos represented 31.9% of total AIDS cases.

(Source: The California Campaign to Eliminate Racial and Ethnic Disparities in Health, Health for All: California's Strategic Approach to Eliminating Racial and Ethnic Health Disparities, November 2003.)

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The Latino Coalition for a Healthy California – 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 1,700 community-based organizations and its Regional Networks in San Diego, Los Angeles and the Bay Area, LCHC affiliates stand ready to be mobilized to impact public policies, services and conditions that affect Latino health. To become a member, please visit our website at www.LCHC.org or call (916) 448-3234.






The California Latino




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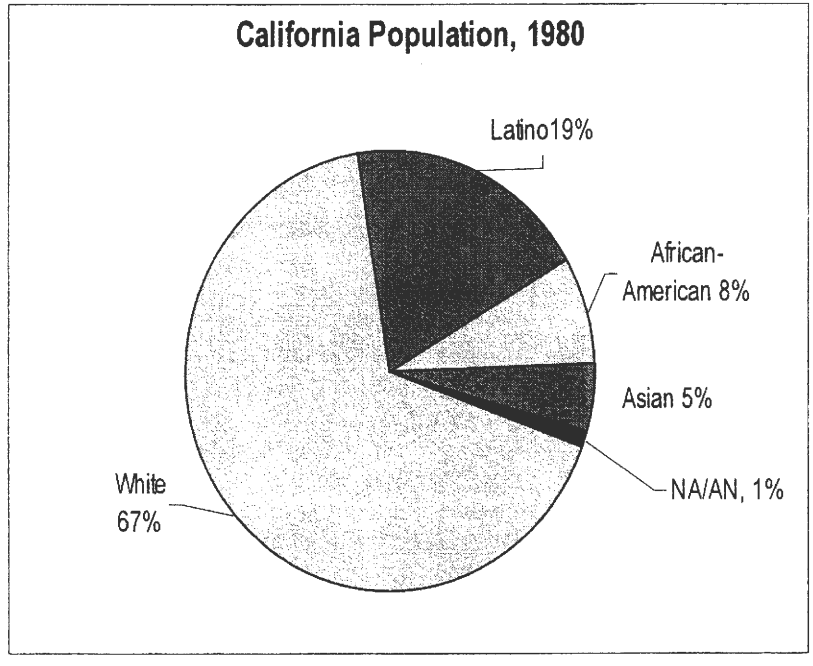
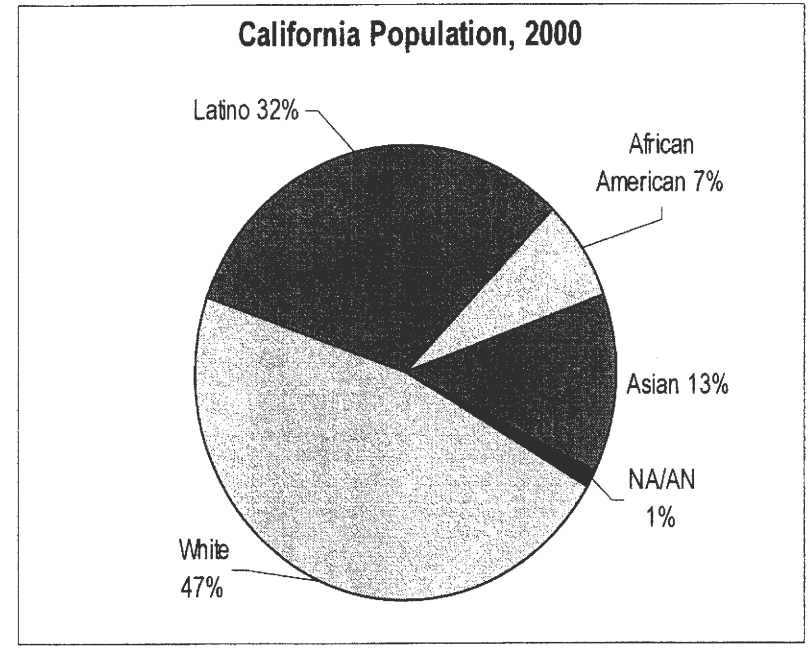
California Population, 1980 & 2000





Source: US. Census Bureau 2000; California Statistical Abstract, 1999

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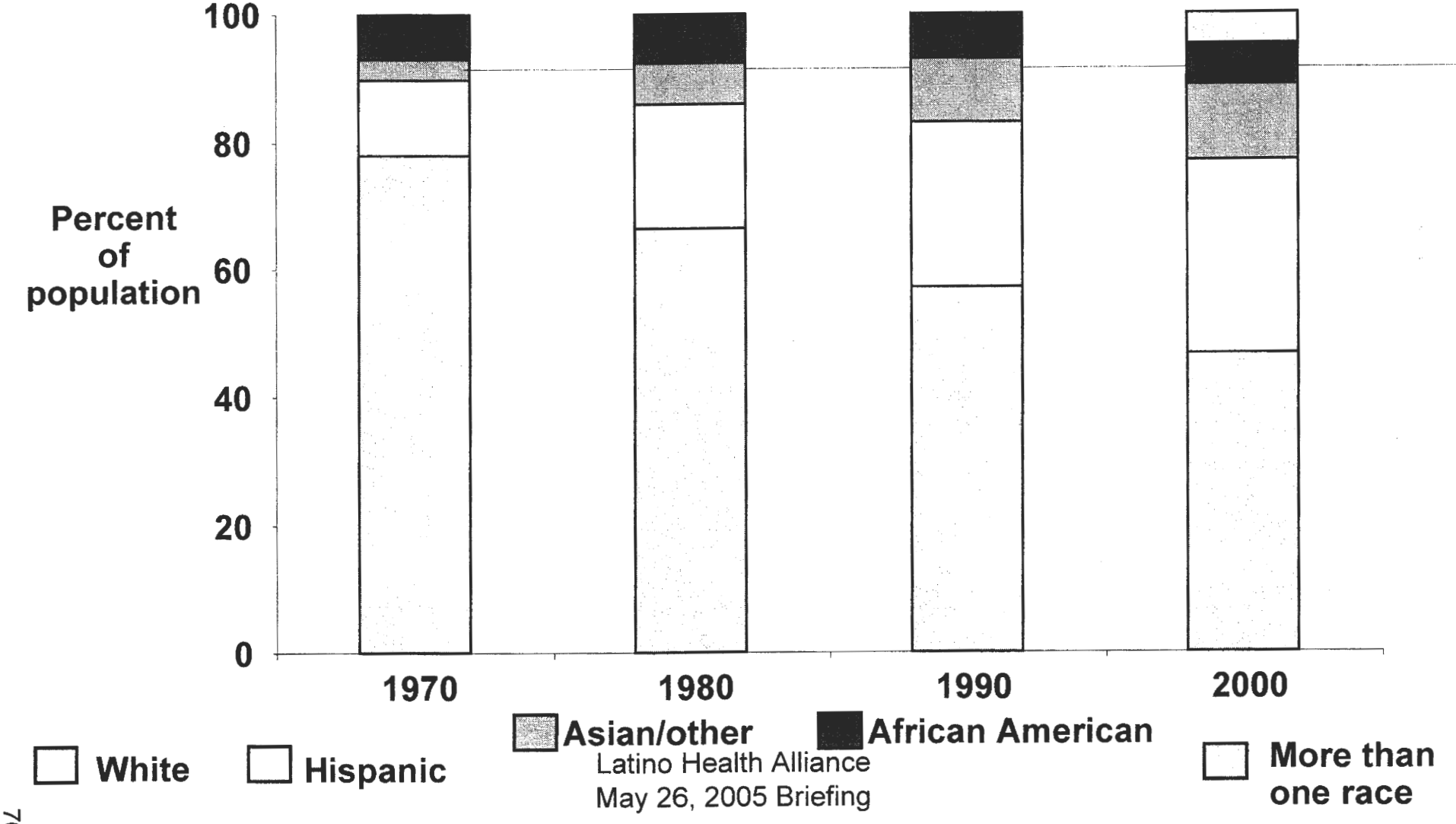
Whites No Longer Comprise Majority of Population in California



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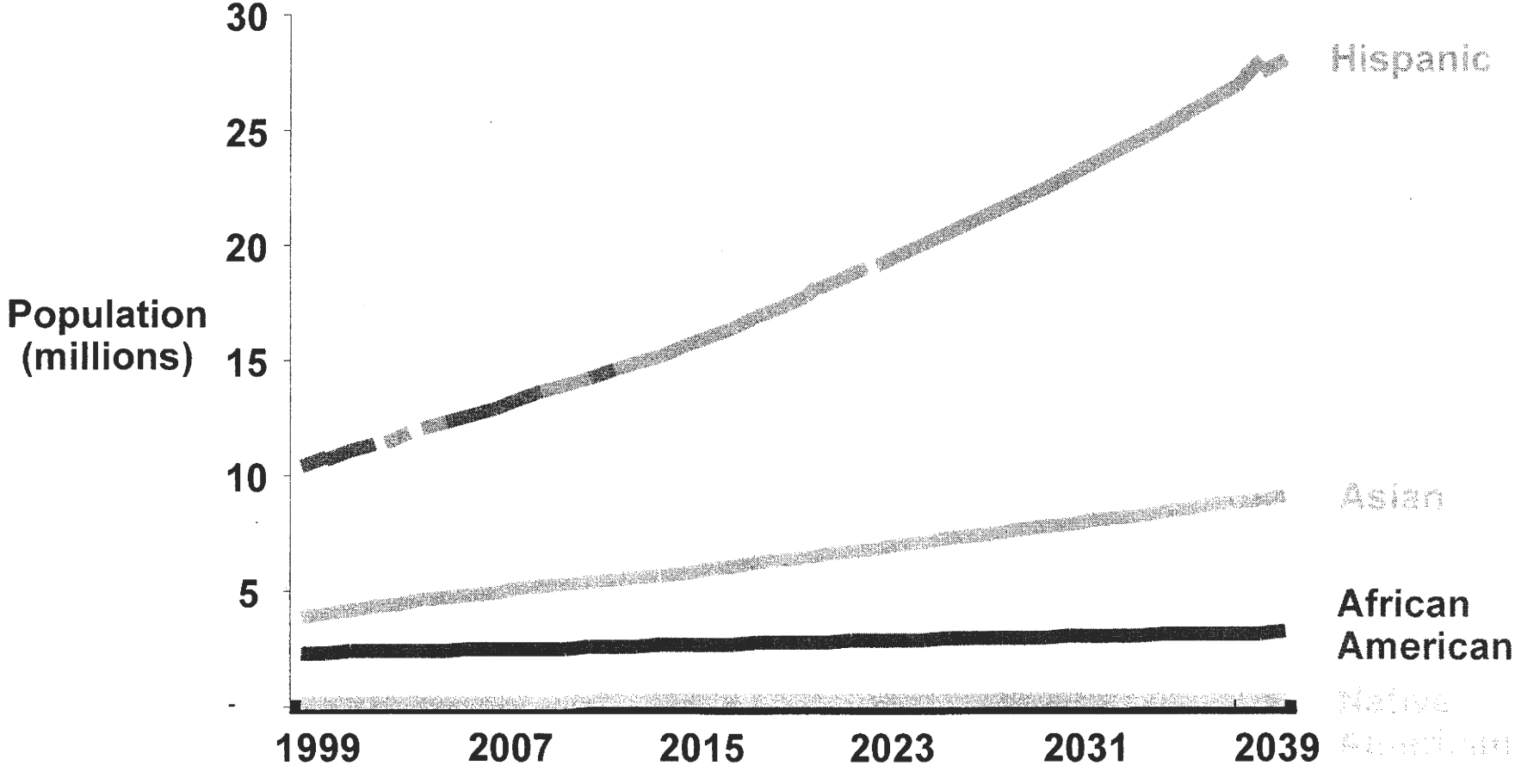
Latinos Projected To Be Largest Ethnic Group in State By 2021



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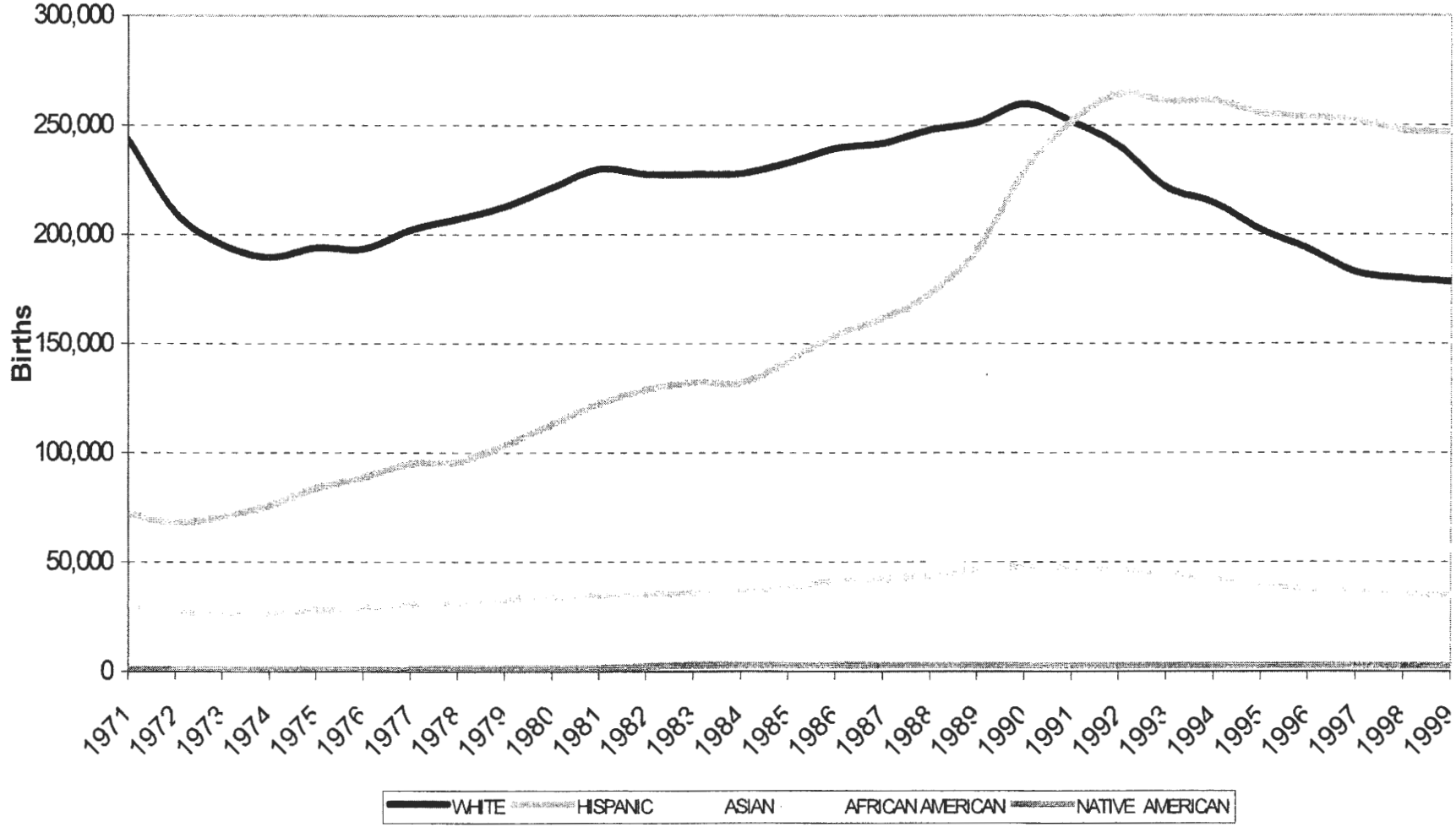
More Latino Children Born in California than White Children



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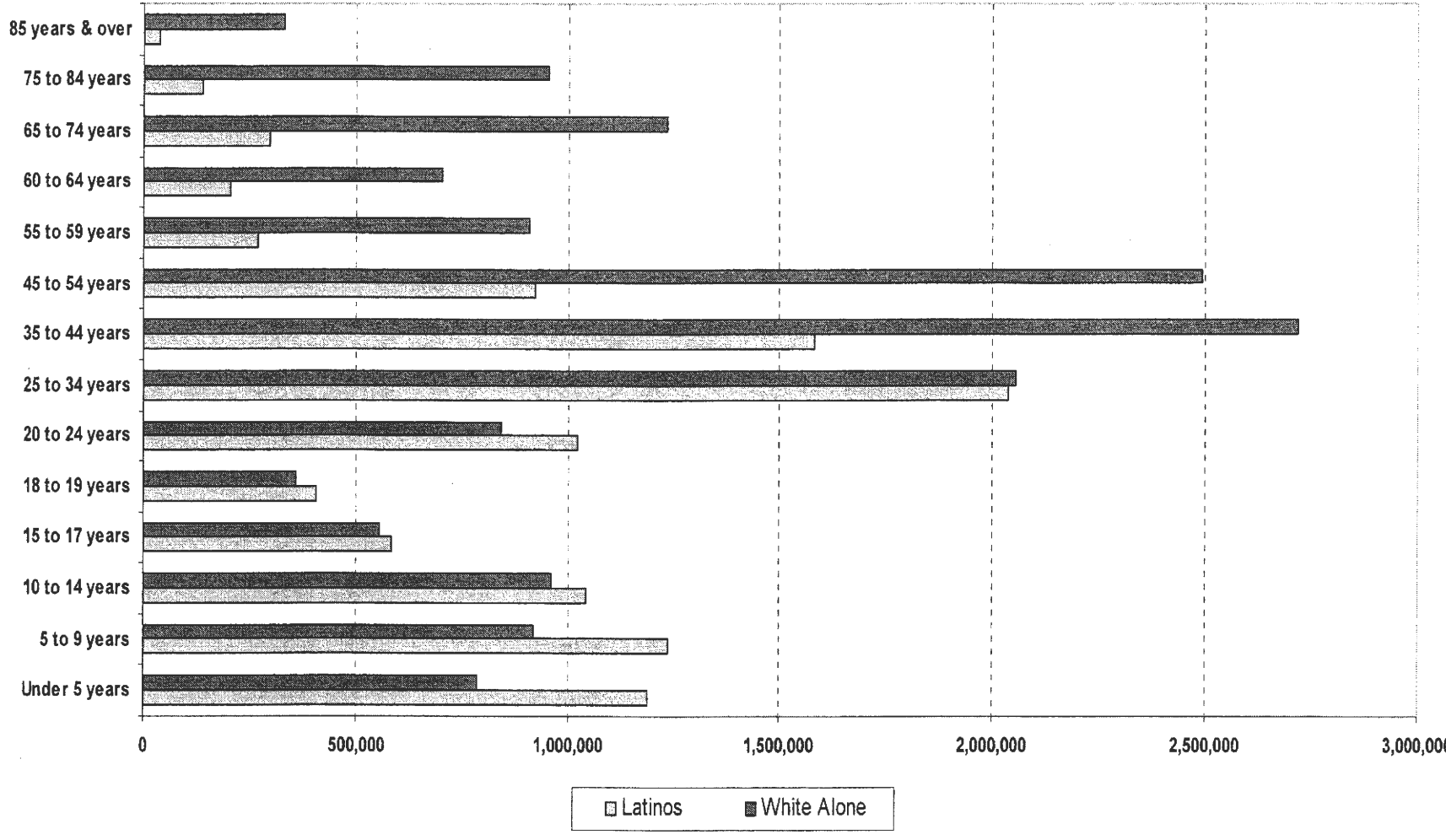
Latinos Outnumber Whites for People Younger than 25 Years Old



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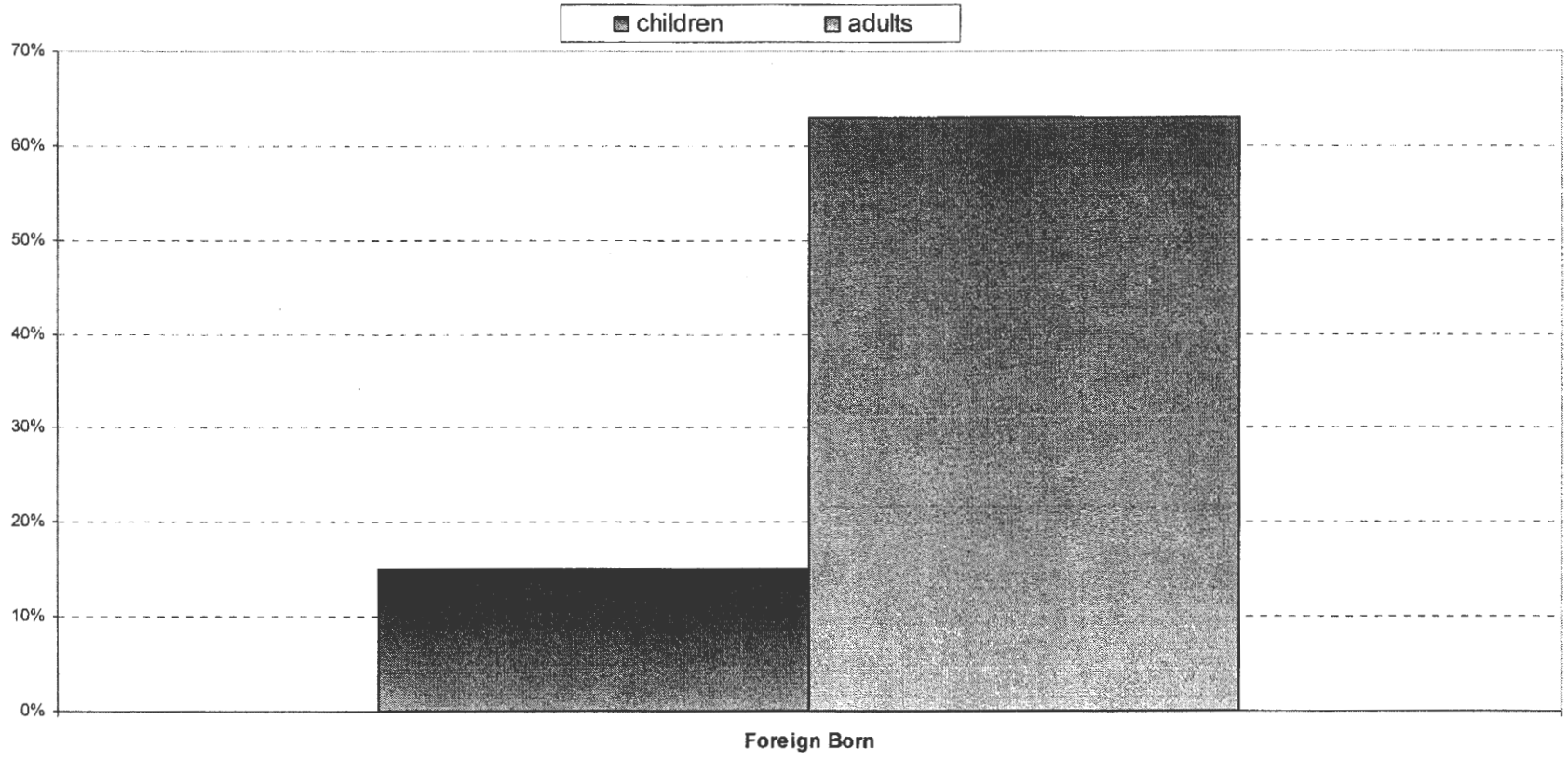
Most Children are Born in the U.S. and Most Adults are Foreign Born



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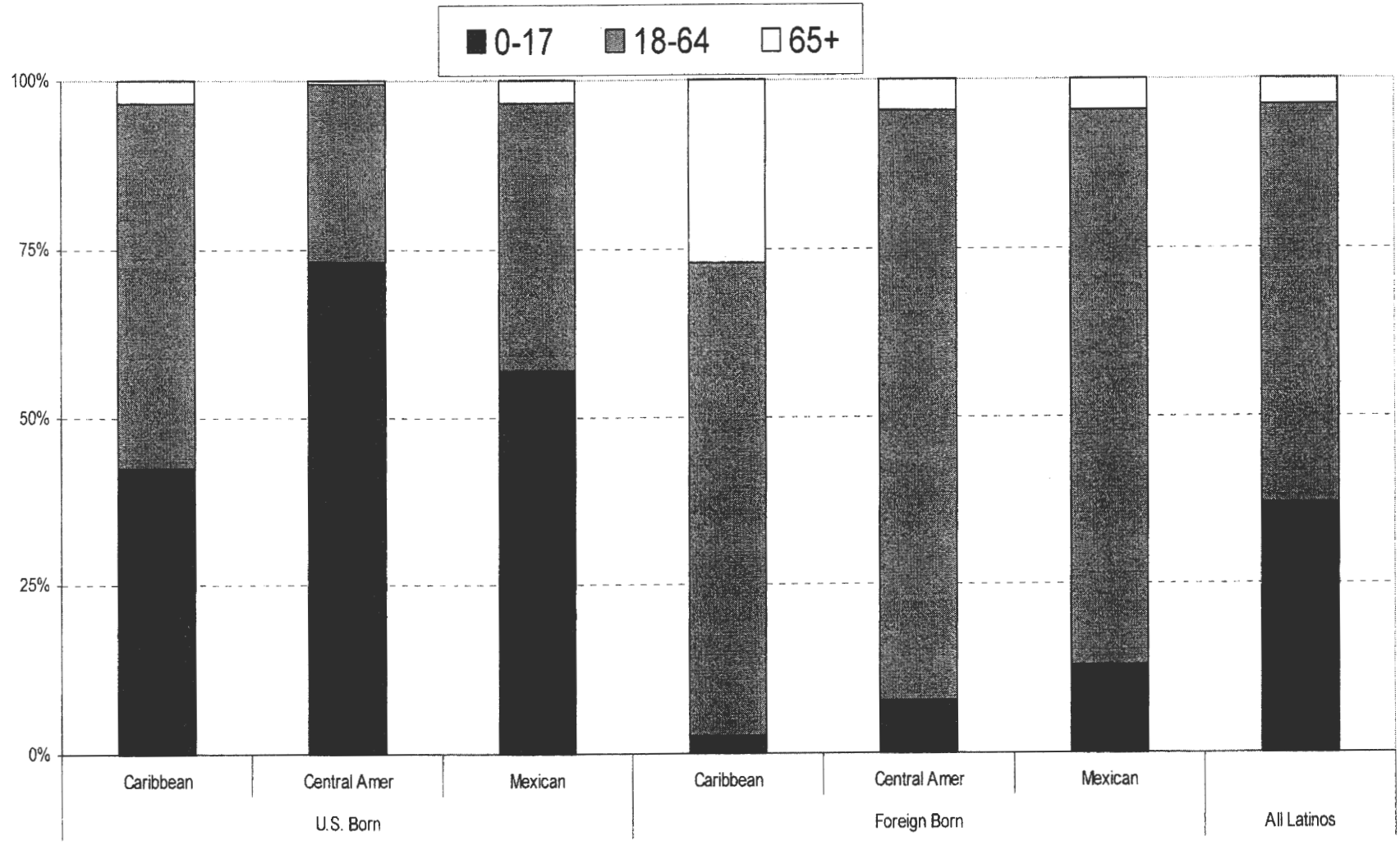
Latinos are a Young Population



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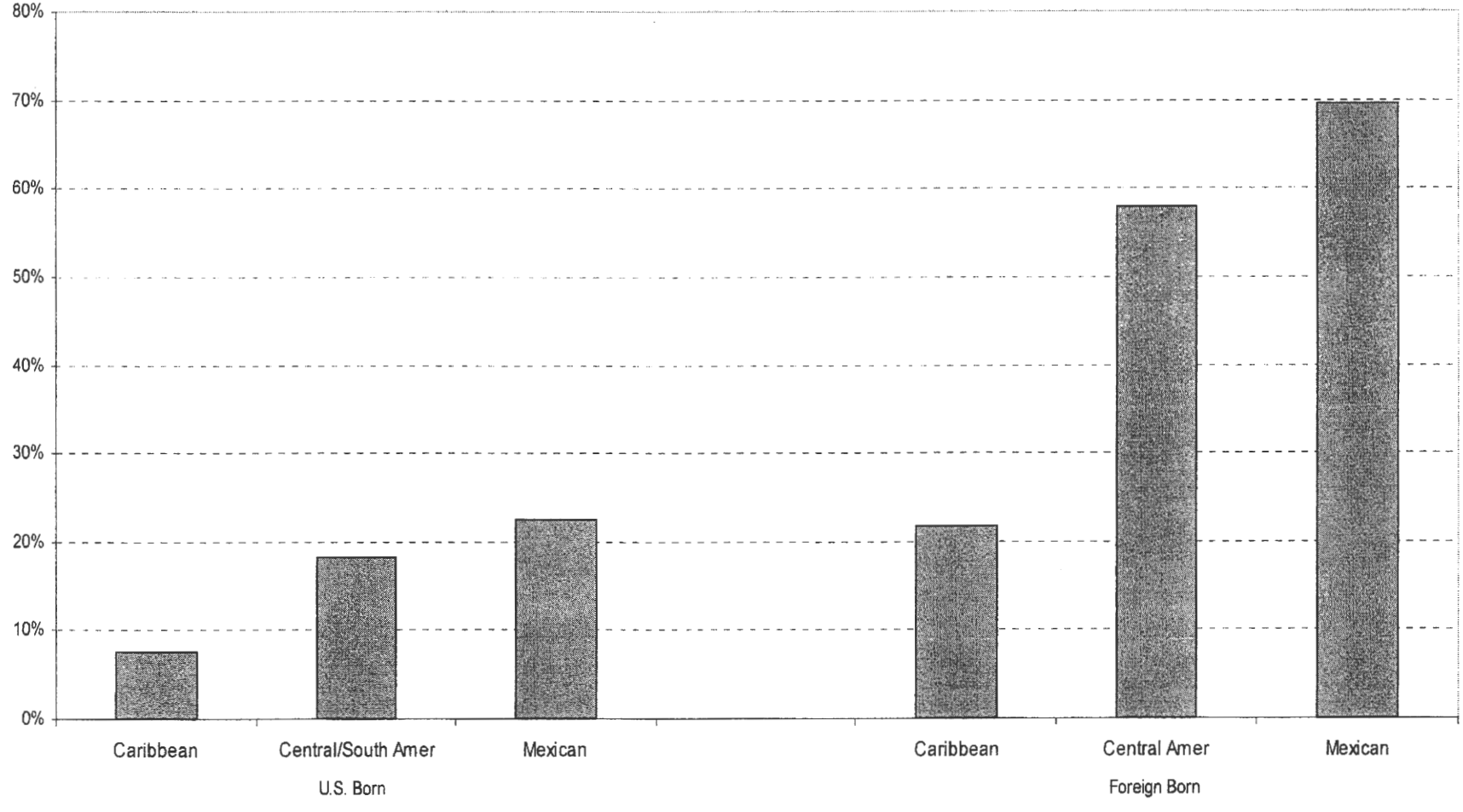
Half of Latino Adults had less than a High School Education



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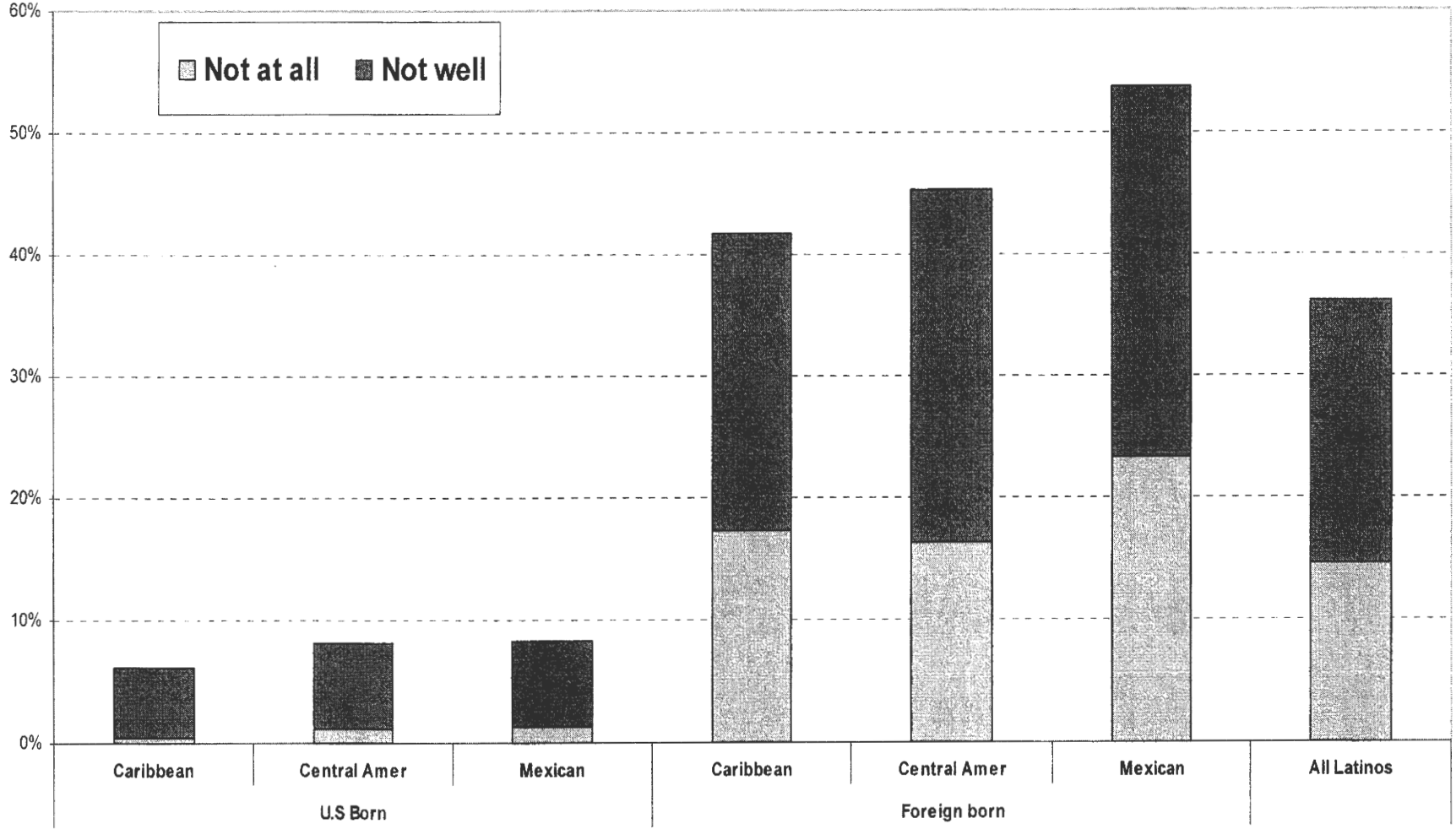
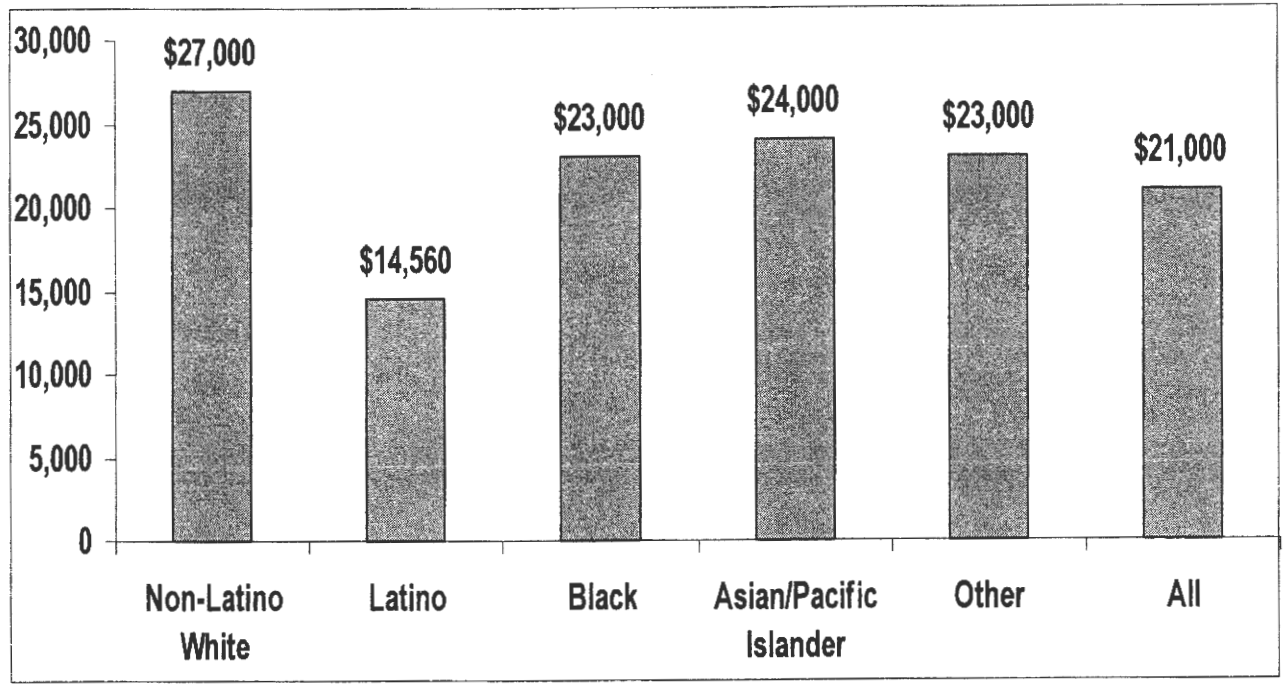
May 26, 2005 Briefing

Over Half of Mexican Immigrants do not Speak English well



Latino Health Alliance
May 26, 2005 Briefing

Median Wage: Latinos earn 54 cents tp the $1 of Non-Latino Whites



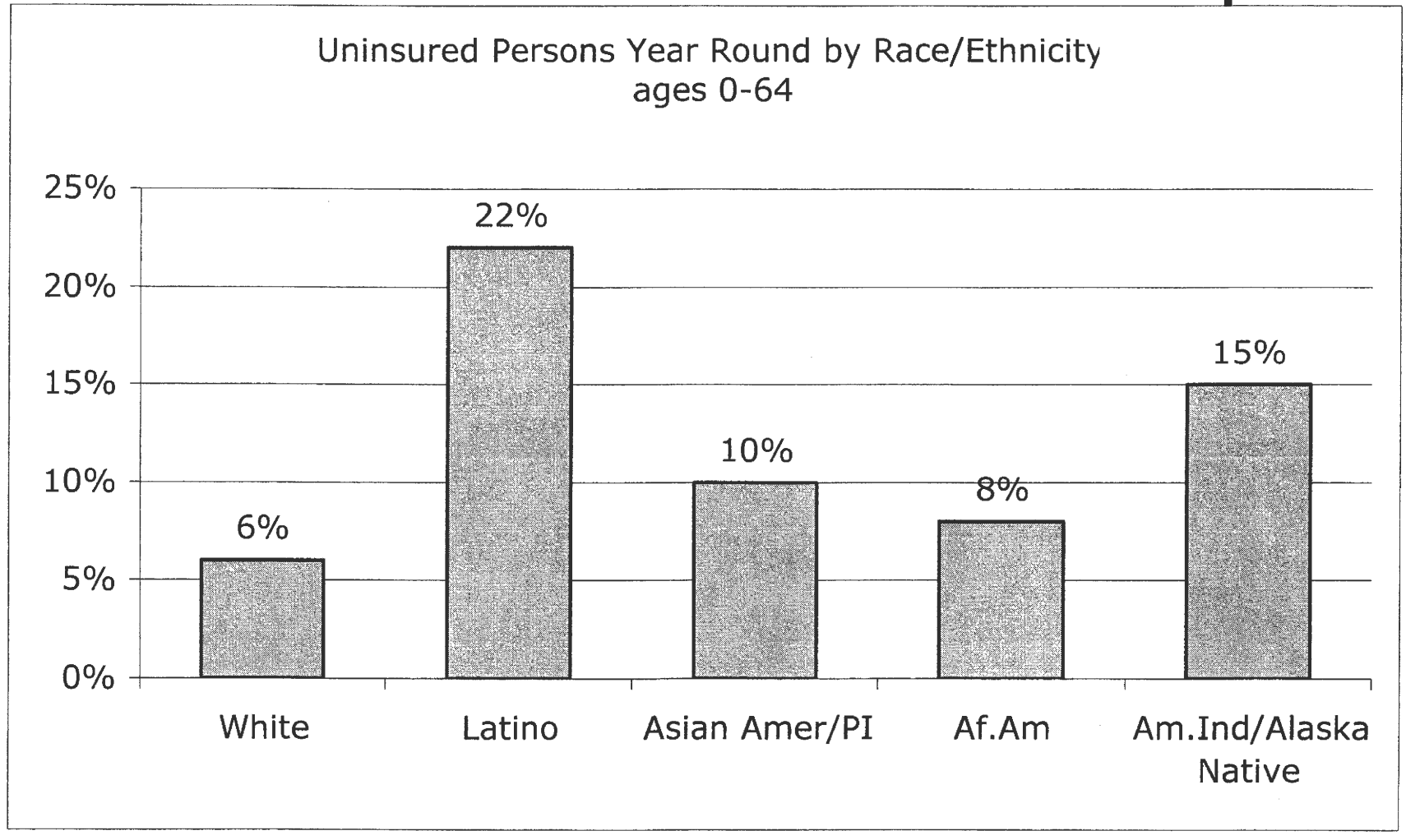
Source: California Research Bureau. 2000

Latino Health Alliance
May 26, 2005 Briefing

Many Latino Families are in Financial Difficulties

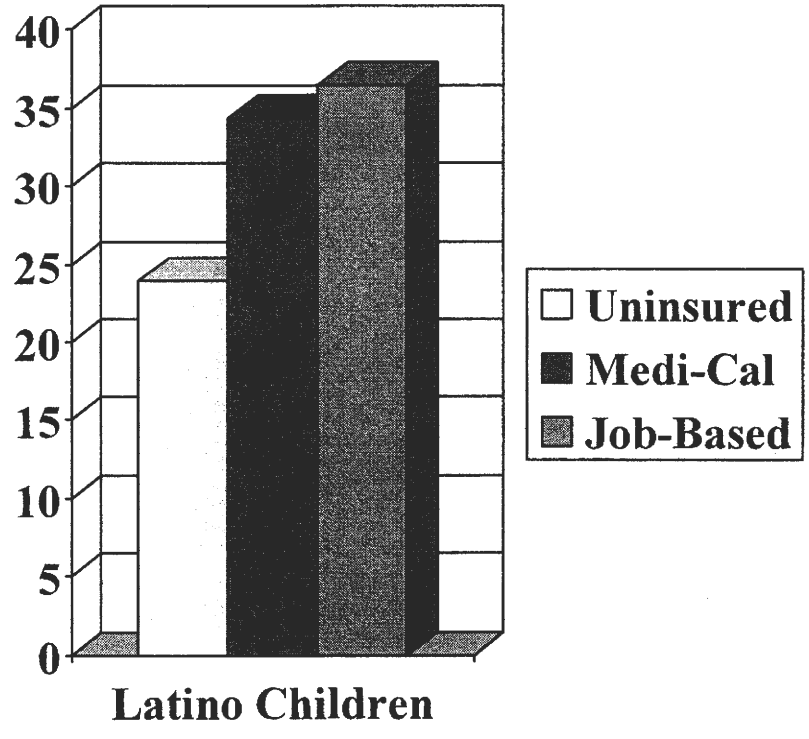
- One of every five Latinos in California were poor in 2000
- For Latino immigrants, one of every four were poor
- And for Latinos Children, one of every three Latino children was in a poor household
- A greater proportion of Latinos are poor than any of the major racial and ethnic group in California

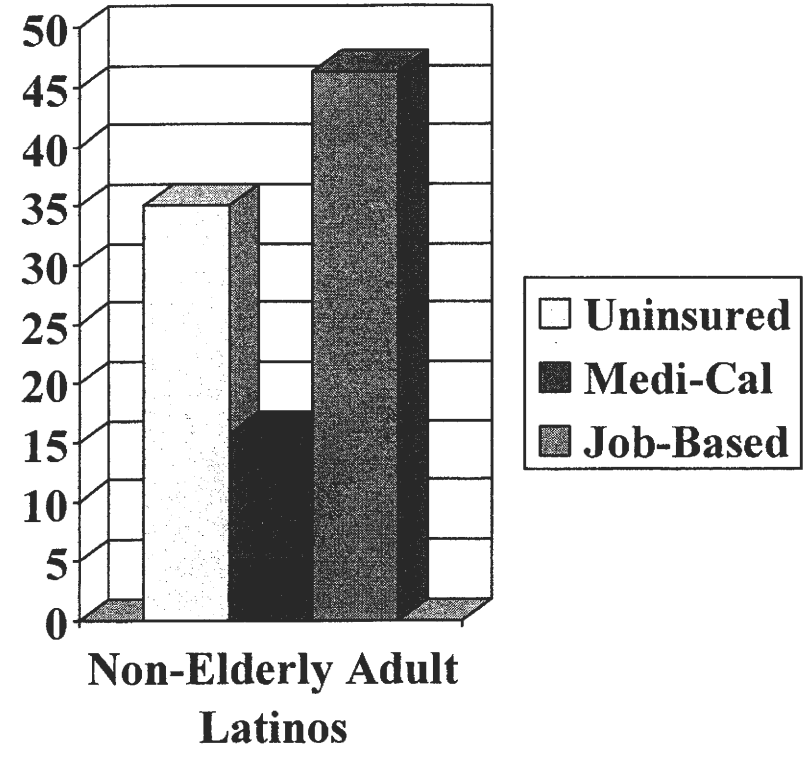
Latinos More Likely to Be Uninsured than other Racial/Ethnic Groups



Latino Health Alliance
May 26, 2005 Briefing

Many Latino Children and Adults do not have Health Coverage





Access to Health Care

- More than one in four Latinos ages 0-64 in California are uninsured (28% of Latinos compared to 9% of whites).
- Latinos high uninsured rate is largely due to the very low rate of health insurance provided by their employers, 43% compared with 76% for whites.
- Almost two-thirds of the uninsured Latino children (ages 0-17) were eligible for one of the state's two public health insurance programs – Medi-Cal or Healthy Families.
- Community and hospital clinics are the usual source of care for half of Latino children in households below 100% FPL.
- Less than 4% of physicians in California are Latino and only 5% of the state's medical residents were Latino in 2000.

In Conclusion

- Latinos are a critical population for the state of California
- They have specific characteristics:
  - Most Latinos children were born in the U.S., but most Latino adults were born abroad
  - Young population
  - Low Level of Education
  - Limited English Proficiency
- Important Policy Issues:
  - Health Care Access – healthy children are most likely to succeed in schools
  - Family Support and Poverty Reduction
  - Improvements on Educational Attainment

Sources

- Edwin Rivera, *The California Latino: A detailed Political and Financial Portrait,* Policy Director, LCHC, May 2003.
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- Latino Coalition for a Healthy California Health Fact Sheet, January 2005.

Prepared by the Latino Coalition for a Healthy California

Latino Health in California

Uninsured Rate

- California has approximately 6.3 million uninsured individuals or 20% of the statewide population.
- 54% of the uninsured are Latino.
- More than one in four Latinos ages 0-64 in California are uninsured (28% of Latinos compared to 9% of whites).
- Latinos high uninsured rate is largely due to the very low rate of health insurance provided by their employers, 43% compared with 76% for whites.
- Uninsured individuals rely on the safety net-community clinics, hospitals, and private physicians who deliver care without respect for ability to pay.
- 85% of the uninsured population, 41% of the Medi-Cal population, and 27% of the Healthy Families population often or almost always experience problems obtaining specialty care compared to 2% of those with private insurance.

Uninsured Children

- The uninsured rate for Latino children between the ages of 0 to 17 is 38%.
- Latino adolescents (ages 12-17) have the highest uninsured prevalence of all groups, 22.5% compared with 4.4% for Whites.
- Latino children (ages 0-11) have the highest uninsured prevalence of all groups, 15.5% compared with 4.3% for Whites.
- Almost two-thirds of the uninsured Latino children (ages 0-17) were eligible for one of the state's two public health insurance programs – Medi-Cal or Healthy Families.
- Legislative districts with the highest rates of children uninsured-and-eligible for public health insurance were primarily located in Los Angeles County and in the greater Southern California region.
- Among children, with a non-citizen father, 21% had no health insurance, 12% did not visit a doctor in the last year, 12% had no usual place of care, and 45% of those with a usual place of care went to a clinic or a community hospital for care.
- Community and hospital clinics are the usual source of care for 50.1% of Latino children in households below 100% FPL and only 9.4% in households at 300% FPL and above.

Farmworkers

- 96% of farmworkers are Latino of which 34 to 42% are undocumented.
- 95% of California's migrant agricultural workers use Spanish as their primary language.
- 61% of migrant families are impoverished; often they are not paid the minimum wage and the State lacks enough inspectors to enforce existing regulations.
- Approximately 70% of migrant agricultural workers lack public or private health insurance.
- Over 16% of farmworkers say their employer offers health insurance but 1/3 of these workers did not participate due to high premiums or inability to afford the co-payments.
- 11% of farmworkers receive insurance through their employer, 7% participate in public insurance, and less than 5% purchase personal private insurance.

- 56% of migrant Latino children 6 and under experienced cavities.
- Approximately 40% of women farmworkers surveyed had had a medical visit in the prior 5 months, but 44% had never been to a dentist.
- In 1999, the California Agricultural Worker Health Survey found that nearly 1/3 of male agricultural workers had never been to a doctor or clinic in their lives; half had never been to a dentist, and 2/3 had never had an eye care visit.

Cultural/Linguistic Access and Competence

- In California, 40% of its population speaks a language other than English at home.
- Less than 4% of physicians in California are Latino and only 5% of the state's medical residents were Latino in 2000.
- While the population-to-physician ratio is 335:1, the Latino population-to-physician is almost 3000:1.
- Latino physicians are two to three times more likely to practice in underserved areas, such as migrant health centers and free county safety net clinicis, than their non-Latino white counterparts.
- A study in the journal Pediatrics found an average of 31 errors per visit for Spanish-speaking patients using interpreters at pediatric clinics.
- Almost 2/3 of the errors had clinical consequences which included wrong instructions on dose and duration of prescribed drugs and omission of important information about patient drug allergies or medical history.
- A poll by New California Media found that:
- a majority of all California immigrants are unaware that they have a right to ask for an interpreter when seeking medical care;
- more than one out of three Hispanics say they have problems understanding a medical situation when it's not explained to them in their language;
- over half of Hispanics are confused by instructions when discharged from hospitals; and
- over half of Hispanics report problems over how to use their prescription medicine.

Medi-Cal

- Medi-Cal serves one in six Californians or about six million residents.
- 47% or 2.9 million of the Medi-Cal beneficiaries are Latino.
- Medi-Cal or Healthy Families outreach could extend coverage to uninsured Latino children, more than 460,000 in all.
- California has 90,000 licensed physicians, but only about 26,000 physicians and physician groups are certified to care for Medi-Cal patients.
- At least 10,500 medical doctors statewide who want to treat the poor find their applications still being processed, sometimes a year or more after being submitted. If this backlog were alleviated, the state's poor would have about 40% more physicians from whom to choose.
- Outstationing eligibility workers in the community is associated with lower odds of Medi-Cal enrollment. For every additional outstation per 1,000 eligible children in the community, the odds of enrollment decreased by 2/3.
- Children who lived in counties with county-sponsored expansion program had three times the odds of being enrolled in Medi-Cal compared with children from a county without an expansion program.

Healthy Families

- Of the 650,000 children enrolled in Healthy Families, 57.8% are Latino children.
- 61.2% of the total Healthy Families program enrollment are in Los Angeles, Orange, San Diego, San Bernardino, and Riverside Counties which have a high Latino population.
- Almost 40% of the Healthy Families applications received were from Spanish-speaking applicants.
- Outreach money is associated with increased enrollment in both Healthy Families and Medi-Cal. Every additional dollar spent on outreach per eligible child in the county increases the odds of enrollment by 6% in Medi-Cal and 7% in Healthy Families.
- Outreach money spent on media is associated with decreased enrollment in Healthy Families. For every $1 increase in media per 1,000 eligible children the odds of enrollment decreased by 11%.

Diabetes

- Nearly one out of five Latino adults over the age of 50 (19.7%) report they have diabetes, which is twice the rate for Whites (10.1%) and among the highest for all racial/ethnic groups.
- In California, only 67.5% of Latinos with diabetes report that they are taking medications for their condition, compared to 78.2% of Whites.
- Only one out of three Latinos with diabetes (35.6%) report being uninsured all year compared to less than one out of ten Whites (6.4%).
- Among adults with diabetes, Latinos are nearly four times more likely to have no usual source of care than Whites (12.3% vs. 3.4%)
- Insured Latinos with diabetes are significantly more likely to report medication use (72.5% vs. 48.9%) and daily glucose monitoring (39.4% vs. 21.7%) compared to uninsured Latinos.
- Among Latinos with diabetes, nearly one out of three is primarily a Spanish speaker (31.3%), more than one out of three are non-citizens (39.7%), and nearly three out of four (68.6%) have incomes below 200% of the Federal Poverty Level.

Cancer

- Latina women suffer the highest rate of invasive cervical cancer in California.
- Latina women are twice as likely as white women to develop cervical cancer and along with African American and Asian Pacific Islander women, are far more likely to die from cervical cancer than Whites.
- The proportion of Latinas who have never had a Pap test, 10%, is more than double that of Whites.
- Only one in three (33%) Latina women report having a recent colorectal cancer screening test.
- More than 60% Latino men aged 50 and older have never been screened for prostrate cancer.
- Within family incomes below 200% FPL, only 67% Latina women older than the age of 40 have had a mammogram compared to Whites (72%).
- 92% among Latinas with Medi-Cal vs. 80% of uninsured Latinas received a PAP test within the last three years.

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Latino Coalition for a Healthy California

RESEARCH BRIEF
JANUARY 2005

Latino Health in California

Introduction

California's eleven million Latino residents are destined to have a unique impact on the future of the state's economy and public health. Their disparate demographics and phenomenal population growth exacerbates a basic flaw in societal infrastructure: the failure to provide for the socio-economic, educational and environmental well-being of all persons. As a major population group, Latinos are a critical component of the fulfillment of the vision for a healthy California. It is critical to improve the health of Latinos and thereby the health of all Californians. The health and economic prowess of the state depends on the health of all its residents.

Demographics

The U.S. Latino immigrant population is growing in unprecedented proportions. In two generations, the United States will be second only to Mexico in the size of its Latino population. In California between 1970 and 2000, the Latino population ballooned from 12% to over 30%. Currently, one of every two children is Latino, one in every three Californians is Latino, and 45% of California Latinos are immigrants. By 2020, a majority of children entering high school, workers entering the workforce and newly-eligible voters will be Latino.

Despite Latinos' contribution to the state and national wealth, more than one in three Latinos, or 3.2 million, live below the federal poverty level. This is a greater proportion than any of the major racial and ethnic groups in California.

Uninsured Rate

Latinos are disproportionately represented in the uninsured population. Although Latinos represent 32% of the state's population, they account for 54% of the uninsured. More than one in four Latinos ages 0-64 in California are uninsured, 28% of Latinos compared to 9% of whites. Latinos high uninsured rate is largely due to the very low rate of health insurance provided by their employers, 43% compared with 76% for whites.

The uninsured rate for Latino children is disturbingly higher. The uninsured rate for Latino children between the ages of 0 to 17 is 38%. Latino adolescents between the ages of 12 and 17 have the highest uninsured frequency of all groups, 22.5% compared with 4.4% for Whites. For Latino children between the ages of 0 to 11, they have the highest uninsured occurrence of all groups, 15.5% compared with 2.6% for African-American children, 3.9% for Asian children, and 4.3% for White children. In fact, of the children eligible-yet-not enrolled into public health programs, two-thirds are Latinos.

Immigrants

Forty-five percent of the Latino population is immigrant. The health status of Latino immigrants is a paradox. While Latino immigrants tend to be younger and healthier, environmental, economic and social factors result in a worsening health condition. In addition, Latino immigrants are more likely than U.S.-born Latinos to be uninsured. Mexican immigrants are less likely to have a usual source of care, 53.5% compared to 24.1% for U.S. born Mexican ancestry and 15.2% for U.S.-born Non-Latino White. Further,

about one in five children of undocumented parents are in fair or poor health, and one in four undocumented children of undocumented parents are without a usual source of care.

Farmworkers

For more than 50 years, California has been ranked the major agricultural producer in the United States providing more than 50% of the nation's fruit, nuts, and vegetables, and more than 90% of its grapes. California leads the nation in agricultural exports with almost 20% of its production going to feed the world.

Ninety-six percent of the farmworkers are Latino of which 34% to 42% are undocumented. A majority (61%) of the farmwokers who toil in the fields are impoverished – often not being paid the minimum wage, living in substandard housing and lacking a usual source of health care. In fact, approximately 70% lack public or private health insurance. A dismal 16% of farmworkers say their employer offers health insurance but one-third are unable to participate due to expensive premiums or co-payments. Low parental education, transportation problems, long wait times in community clinics, decreased preventive screening, language and cultural differences, and lack of a regular source of care impact farmworker's access to health.

Health Disparities

Health disparities are the inequities in social, economic, and environmental conditions that increase risk of illness and injury, and reduce opportunities for good health. Social injustice leads to unequal treatment and unequal access.

The percentage of Latinos applying to, matriculating in, and completing medical or dental schools in California has been and remains low. In 2000, approximately 10% of medical school degrees recipients, less than 8% of dentistry degree recipients, and fewer than 5% of physicians actively practicing in California were Latino. There is currently just one Latino physician for every 2,893 Latinos in California, compared to one non-Latino doctor for every 334 non-Latinos.

Community Health

Community health encompasses the aggregate physical, emotional, environmental conditions in communities that lead to either well-being, or to disease/dysfunction of a population and includes health promotion and/or health risk factors in the environment.

Latinos are disproportionately affected among preventable diseases, such as diabetes, cervical cancer, and AIDS/HIV. Nearly one in five Latino adults over the age of 50 (19.7%) report they have diabetes, which is twice the rate for Whites (10.1%) and among the highest for all racial and ethnic groups. Latina women suffer the highest rate of invasive cervical cancer and are far more likely to die from cervical cancer than Whites. Furthermore, the proportion of Latinas who have never had a Pap test, 10%, is more than double that of Whites. As of December 2003, the cumulative number of reported AIDS cases by race/ethnicity and age showed that 41% of the adult/adolescent cases and 72% of the pediatric cases occurred in people of color. For Latinos, they represented 21% of adult/adolescent cases and 38% of pediatric cases, a greater proportion among other major ethnic and racial groups.

The Latino Coalition for a Healthy California (LCHC) is a non-profit public policy and advocacy organization dedicated to impacting Latino health improvements through enhanced information, policy development and community involvement. LCHC's mission of developing and supporting policies, services, and conditions that improve the health of Latinos is accomplished by operating research, public policy advocacy, and community education programs to establish and improve policies and practices that promote the health status of Latinos.

Sources:

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UCLA Health Policy Fact Sheet

April 2005

One out of Three Latino Adolescents Overweight or At Risk

Michael A. Rodríguez, Marlena Kane, Lupe Alonzo-Diaz, and George R. Flores

The number of overweight adolescents has reached epidemic proportions—both nationwide and in California. More than one out of three Latino adolescents in California are overweight or at risk for overweight. Overweight adolescents are at increased risk for becoming obese adults and for developing chronic, serious and costly medical problems, such as diabetes, heart disease and certain cancers. The annual cost of obesity in California is more than $6.4 billion.[1]

Latino Adolescents Demonstrate Highest Prevalence of Overweight

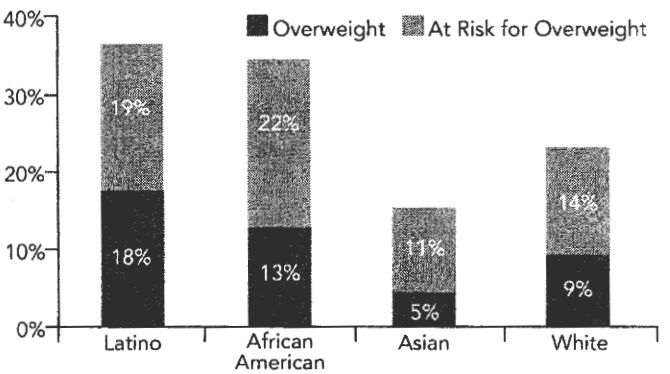
Among California adolescents, certain groups are more likely to be overweight or at risk for overweight. Latino adolescents were the most likely to be overweight and more likely to be at risk for overweight than Asian or white adolescents, leading to higher risks for overweight in adulthood (Exhibit 1).

Among Latino adolescents, the prevalence of overweight was twice as high in males as females (23% and 12% respectively; Exhibit 2). In addition, the prevalence of overweight among Latino adolescents who are U.S. born (20%) was nearly twice as high as among non U.S.-born Latino adolescents (11%). Other studies have shown that among U.S. immigrants, the number of years in this country is associated with an increase in overweight.[2]

Risk Factors for Overweight Among Latino Adolescents

Regular physical activity and a healthy diet are important to maintain healthy weight. An imbalance between these two factors contributes to overweight. Many Latino adolescents do not consume a healthy diet and do not get enough physical activity, which are behaviors that increase their risk for overweight and poor health.

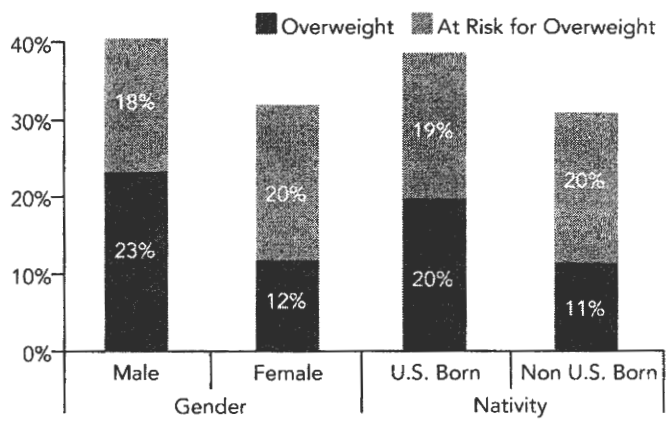
Exhibit 1: Prevalence of Overweight and At Risk for Overweight by Race/Ethnicity, Adolescents (Ages 12-17), California 2003



Note: Race/ethnicity is based on single race or the race/ethnicity with which the respondent most identifies. Body mass index (BMI) was calculated based on respondent reports of weight and height. A gender appropriate growth chart was used to compare reported BMI for age. Adolescents in the 85th-94th percentile are considered at risk for being overweight and adolescents in the 95th percentile and higher are considered overweight.

Source: 2003 California Health Interview Survey

Exhibit 2: Prevalence of Overweight and At Risk for Overweight by Gender and Nativity, Latino Adolescents (Ages 12-17), California 2003



Source: 2003 California Health Interview Survey

A joint publication of the UCLA Center for Health Policy Research and the Latino Coalition for a Healthy California

www.healthpolicy.ucla.edu

In California, three out of four Latino adolescents (76%) drank at least one soda every day, compared with just over half of white adolescents (57%). Sodas are one example of drinks popular among adolescents that are high in calories and low in nutritional value. Among Latino adolescents, 81% of males and 71% of females consumed at least one soda per day.

In addition, one in ten Latino adolescents (10%) reported engaging in no physical activity at all; with Latina girls (13%) being twice as likely to not participate in physical activity compared with Latino boys (6%).[3] Of even greater concern is the disparity in the proportion of Latino adolescents (10%) who get no physical activity at all, which was more than twice that of white adolescents (4%).

Discussion

Overweight disproportionately affects Latino adolescents, and is a serious threat to the health and well-being of Latino communities—and consequently to California. Unhealthy eating and inactivity are behaviors that are influenced by conditions in the home, school, neighborhood and in the media. Latino adolescents are not alone in the obesity epidemic. Families, schools, communities, health professionals and policymakers throughout California need to become engaged in efforts to change the conditions that foster unhealthy eating and inactivity. Latino adolescents especially need to be involved as peer educators, thought leaders and advocates for practices, programs and policies that promote healthy eating and regular physical activity.

Policy solutions to the obesity epidemic must be considerate of the unique social, cultural and environmental circumstances that face Latinos. More research is needed to uncover the impact of immigration, social and environmental inequities, and cultural experiences on behaviors contributing to obesity; as well as to uncover the most effective means to prevent overweight among Latino youth. Policymakers should consider the following recommendations to reverse these alarming trends:

1) **Educate** and **require** schools to provide healthier food choices for children and adolescents; for example, replacing sugary snacks and sodas available in vending machines with more nutritious snacks and healthier drinks.

2) **Ensure** that children are receiving physical education programs in all schools and after school programs.

3) **Encourage** the availability of affordable fresh fruits, vegetables and healthy food choices by locating grocery stores rather than liquor stores in all neighborhoods, and addressing the large presence of fast food restaurants in communities of color and low-income neighborhoods.

Author Information

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The Latino Coalition for a Healthy California (LCHC) is forming strategic alliances to address issues related to overweight and obesity, and suggests supportive sites such as The Strategic Alliance (*www.eatbettermovemore.org*) and the California Latino 5 a Day Campaign (*www.dhs.ca.gov/ps/cdic/cpns/lat5aday/default.htm*).

Data Source

Based on data from the 2003 California Health Interview Survey (CHIS 2003), this fact sheet examines overweight among Latino adolescents. CHIS 2003 provides the most recent information available on overweight among Californians. For more information on the California Health Interview Survey, please visit *www.chis.ucla.edu*.

Funders

The Latino Coalition for a Healthy California, The California Endowment and The California Wellness Foundation funded the research and development of this fact sheet.

1 *The Economic Costs of Physical Inactivity, Obesity, and Overweight in California Adults.* California Department of Health Services, 2005.

2 Goel MS, McCarthy EP, Phillips RS, Wee CC. Obesity among U.S. immigrant subgroups by duration of residence. JAMA. 2004; 292: 2860-2867.

3 Engaging in "no physical activity" was defined as performing no vigorous activity (activity that made the respondent sweat or breathe hard) and no moderate activity (such as walking or bicycling) on any of the seven days prior to the survey.

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As part of our commitment to keep you up to date on legislation, federal programs, court decisions and private sector actions that affect your work with children, we publish InFocus, an in-depth look at emerging issues in school-based health and health care. Written by long-time ejournal editor Virginia Robinson, issues of InFocus explore current topics in school health. We invite you to contribute your own thoughts and look forward to hearing from you.

Julia Graham Lear
Director, Center for Health and Health Care in Schools

February 25, 2005

Children in Immigrant Families

Noting that one in five children in the United States lives in an immigrant family, a panel of experts convened by the Brookings Institution and the Woodrow Wilson School of Public and International Affairs has pointed out that most children of immigrants will be lifelong U.S. residents and their presence will affect basic institutions, including the health system, that currently are not well equipped to handle their special circumstances.

"Children of immigrants face several difficulties that children of native-born parents do not, including adapting to cultural norms that may differ from those of their parents and learning a language that may not be spoken at home," said the Brookings Institution's Ron Haskins. "The poverty rate of children in immigrant families is 21 percent, as against 14 percent for children in native-born families. Nearly half of children in immigrant families have family incomes below 200 percent of poverty, compared with only 34 percent of native children. They are more likely to be in families worried about or encountering difficulties paying for food. They are nearly twice as likely to lack health insurance, and they are more than four times as likely to live in crowded housing."

Though children in immigrant families experience higher poverty and hardship rates, they are less likely to receive public assistance, including Medicaid, than other low-income children—children of immigrants are about half as likely to participate in Medicaid, a gap that has widened in recent years. Changes in federal welfare law in 1996 made most noncitizens ineligible for Temporary Assistance to Needy Families (TANF) and Medicaid during their first five years in the United States and also restricted their eligibility for food stamps. Although these restrictions do not apply to children who were born in the United States to immigrant parents—those children are citizens entitled to all benefits enjoyed by other citizens—but the restrictions on parents have had a chilling effect on families' participation in the programs. An Urban Institute report also indicates that young children of immigrants are less likely to be in center-based child care, potentially limiting their preparation for schooling.

A report on immigrant children prepared in 2004 by the David and Lucile Packard Foundation for the *Future of Children* series summarized strengths and challenges that set immigrant families apart from the mainstream. Authors Margie Shields and Richard Behrman noted that:

- Compared with children of U.S.-born parents, children of immigrants are more likely to be born healthier and to live with both parents. The percentage of immigrant children living in single-parent households is only about 16 percent, compared with 26 percent for children of U.S.-born families.
- Immigrant children are more likely to be living in poverty and to be without health insurance.
- Immigrants from Mexico, Asia, Central America, and the Caribbean, who make up the largest part of current immigrant populations, tend to be poorly educated, have limited English skills, and have poor job prospects. The fact that many are undocumented may subject their children to hardships greater than those experienced by children from other poor families.
- Immigrant families generally come to America eager to work hard, and they expect their children to do the same. "Children of immigrants typically are imbued with a strong sense of family obligation and ethnic pride, and with the importance of education," and they tend to do better in school, at least through middle school, though by adolescence they may become disillusioned and their attitudes toward teachers and scholastic achievement can turn negative.
- Immigrant families tend to settle in communities with others from their same country of origin, which may give children a cohesive and culturally consonant community that can buffer some of the negative influences of mainstream society, but that may also make acquisition of a new language more difficult. Seventy-two percent of children in immigrant families speak a language other than English at home, and 26 percent live in linguistically isolated households where no one over the age of 14 has a strong command of the English language.

"Regardless of how one might feel about our nation's immigration policies, there is no turning back the clock on the children of immigrants already living here," and the implications of those populations for all aspects of our lives, including health care, the authors pointed out.

The Futures of Immigrant Children

Both the *Future of Children* report and the Brookings panelists suggested steps that might be taken to improve the health and well-being of children in immigrant families.

- *Birth to age eight*. Early learning experiences, extended into kindergarten and the early elementary grades, and special education might benefit many immigrant children, though children in immigrant families tend not to participate in any of these activities.
- *Middle childhood*. During middle childhood, it is critical to understand how experiences with racism and discrimination and perceptions of diminished life opportunities can influence the paths of immigrant children. Maintaining respect for parents and preserving connections to their cultural heritages seem very important in these years.
- *Adolescence*. Finishing school, acquiring work skills, postponing parenthood, and being physically and mentally healthy can help immigrant children negotiate the difficult passage to adulthood. Barriers include lack of health insurance and access to health care.

But not all children in immigrant families are the same. The *Future of Children* report describes the circumstances and needs of two groups, in particular—Latinos and Southeast Asians.

Latino Children

"One of the most profound demographic shifts in the United States during the past two decades has been the dramatic increase in the Hispanic population, driven both by high birth rates relative to other racial and ethnic groups, and by immigration," writes Sonia Perez of the National Council of La Raza. Two characteristics of the Latino population are especially noteworthy, she points out. For one, it is a very young—more than one-third of Latinos in this country are under 18 years of age, and almost half are under 25. And second, while many of the children were born in the United States, they are likely to live in households that include immigrants and in which Spanish is the language most often spoken.

In school, Latinos now make up the second-largest population group, after non-Hispanic whites. Under the Bush administration's No Child Left Behind education law, these children, even if they are have limited proficiency in English, are expected to meet the same academic benchmarks as English-proficient students.

In another part of their lives—health—young Latinos also face significant challenges, Perez notes. They have disproportionately high rates of diabetes, asthma, and HIV/AIDS and the highest teen birth rate in the nation. These conditions result in part from, or are exacerbated by, widespread lack of health insurance. Latino young people are less likely to receive coverage through their parents' jobs, which are often in industries such as construction, agriculture, and service, in which there are low wages and no benefits; and the 1996 federal welfare reforms bar many immigrants from federally funded health programs.

The *Future of Children* report points to one particular group of Latinos—immigrants from Mexico—as examples of both the strengths and the litany of challenges faced by all immigrants. Currently, it's estimated that more than 5.1 million children in this country are children of Mexican immigrants, both documented and undocumented, who have come to the United States in search of economic opportunity. The level of parental education tends to be very low, and many work only part-time or seasonally. Mexican-Americans must contend with a long history of what the authors describe as "stigmatization, economic exploitation, and racial exclusion." But children of Mexican immigrants also exemplify some of the strengths of immigrant groups in general—children are more likely to be living in intact families with one or more working parents and to be part of well-established and supportive communities.

Southeast Asian Children

Policymakers tend to look at Asian Americans as one large, undifferentiated group that is on the whole doing quite well in American society, and they are often cited as a "model minority." But large numbers of children who emigrated, or whose parents emigrated, from Southeast Asia—Cambodia, Laos, and Vietnam—have problems with language, access to health care, and utilization of federal benefits that are very similar to those of Latino children, according to Ka Ying Yang, a former director of the Southeast Asia Resource Action Center.

Nearly three decades after the beginning of the refugee flight from Southeast Asia, many children in these immigrant families continue to struggle with formal education, due to

factors that include limited English language skills; discrimination; miscommunication between children and parents and between families and schools; and feelings of alienation from mainstream schools.

And as with Latinos, many Southeast Asian immigrant children are without health insurance or a usual source of health care. That may be particularly true of mental health care, where surveys indicate that Asian American youth are less than half as likely as white youths to receive counseling.

Authors Shields and Behrman conclude: "Implementing programs that promote the healthy development of children in immigrant families and that provide them with opportunities for achievement more equal to those of children in U.S.-born families clearly places an added financial burden on society. However, failure to implement such programs will also place a financial burden on society, a burden that will grow over time as these children enter adulthood and their lifetime earnings and tax contributions are less than they might have been had they received more supports earlier in life. To assure a cohesive society, a prosperous economy, and a strong safety net for the elderly, poor, and disabled into the next century, more attention must be paid to the developmental needs of the large numbers of children in immigrant families living in this country, especially those who are at greatest risk of failure."

The Future of Children report, "Children of Immigrant Families," is online at www.futureofchildren.org/pubs-info2825/pubs-info.htm?doc_id=240166. "The Health and Well-Being of Young Children of Immigrants", a research report by the Urban Institute, is online at www.urban.org/url.cfm?ID=311139. Also see: "Caring Across Cultures: Achieving Cultural Competence in Health Programs at School: Survey Results" at www.healthinschools.org/sh/cultresults.asp.

THE CALIFORNIA ENDOWMENT

Maximizing Societal Contributions of Latino Adults by Investing in Latino Children's Health Care

April 2005

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Cover California's Kids

This report was funded by The California Endowment. Cover California's Kids is a program of The California Endowment. The views in this report are those of the authors and not The California Endowment.

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Introduction

With health care costs on the rise, population increase, and growing state and federal deficits, paying for insurance has become as difficult for individuals and families as it is for the federal government. While Congress debates how to pay for Medicare and Social Security for the elderly, more and more younger workers are striking for better health coverage, and stories about individuals paying the lion's share of their income for health insurance fill the news. We know what the costs of health insurance are, but equal attention needs to be devoted to the costs of *not* having health insurance. A regular type of health care promotes continuity of care and makes possible the major cost-effective approach to health care: preventive care. Without some form of insurance, either public or private, individuals are unlikely to receive preventive care, which leads them to wait until they are seriously ill and then to seek expensive, episodic emergency room care. It is well-documented that children who receive necessary preventive services are generally in better health than children who do not. It is our contention that the lack of health insurance has far-reaching social consequences. In this study, we propose to look at those consequences by focusing on Latino children, their lack of insurance coverage, how this lack of coverage affects their health and school performance, and how these phenomena impact their ability to contribute as adults to the state's economy and society.

To establish the relationship that health care coverage and access to care have on long-term positive societal contributions, our analysis used publicly available data sources and an extensive literature review. No primary data source, to date has sufficient data elements to make a direct link between health care coverage and long-term societal contributions.

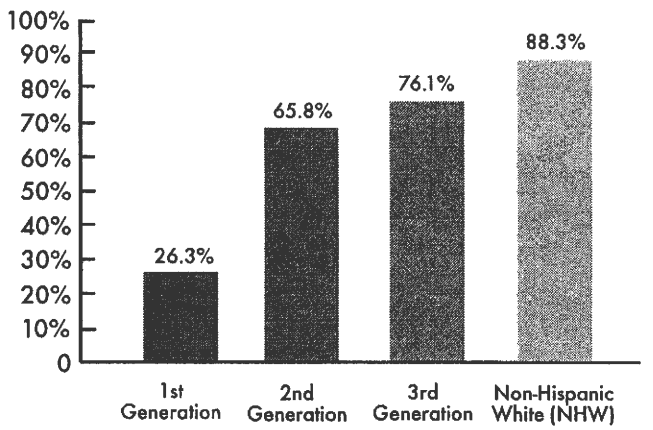
Health Insurance and Access to Care

Disparities between Latinos and the non-Hispanic white population are seen in every measure of health insurance status. Overall, a lower percentage of Latinos than whites have some form of insurance. In California, 24 percent of all Latino children, whether they are first-, second- or third-generation*, are uninsured.[1] Focusing on children of Mexican-American descent, data from the 1999-2000 and 2001-2002 National Health and Nutrition Examination Surveys (NHANES) show patterns of health insurance and access for first- to third-generation children. The data from NHANES reveal that:

* First generation means the child and at least one parent was born in a foreign country; second generation means that the child is U.S.-born but at least one parent was born in a foreign country; third generation means that the child and both parents are U.S.-born.

Lower percentage of Latinos are insured: 26 percent of first-generation Latino children have health insurance, compared to 88 percent of non-Hispanic white children. (Figure 1).

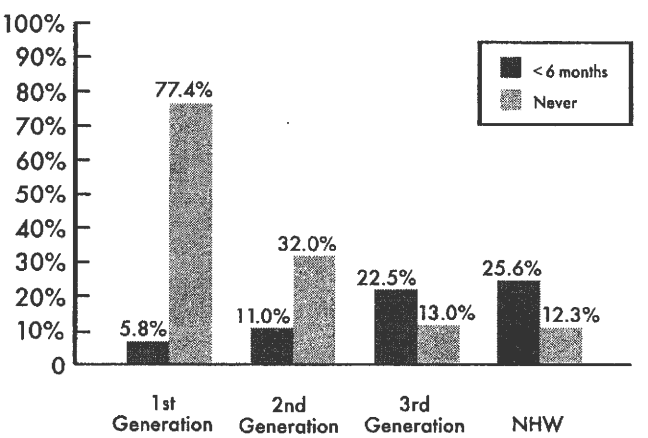
FIGURE 1:
Percentage insured, by generational status



Source: 1999-2000 and 2001-2002 National Health and Nutrition Examination Survey.

Latinos are more likely never to have been insured: 77 percent of first-generation Latino children have never been insured, compared to 12 percent of non-Hispanic white children. (Figure 2).

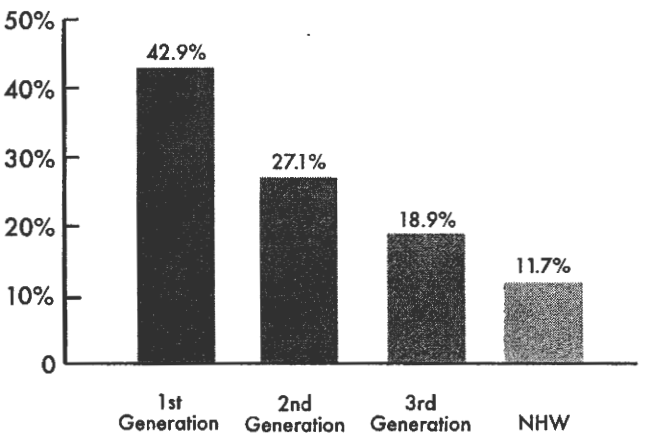
FIGURE 2:
Length of time since last insured, by generational status



Source: 1999-2000 and 2001-2002 National Health and Nutrition Examination Survey.

Latinos are more likely not to have received care in the last 12 months: 43 percent of first-generation Latino children did not receive care in the last year, compared to 12 percent of non-Hispanic white children. (Figure 3).

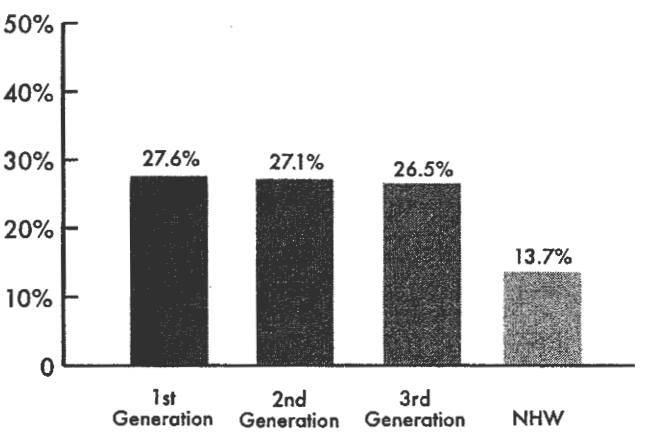
FIGURE 3:
Not receive care in last 12 months



Source: 1999-2000 and 2001-2002 National Health and Nutrition Examination Survey.

Latinos are more likely not to have received care in more than three years: 28 percent of first-generation Latino children have gone more than three years since their last health care visit, compared to 14 percent of non-Hispanic white children. (Figure 4).

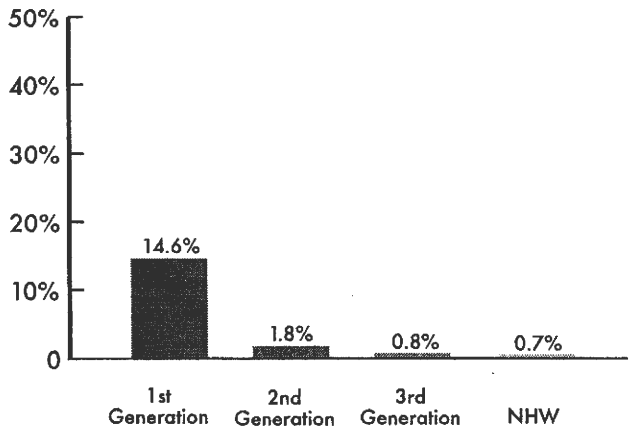
FIGURE 4:
Time since last health care visit: 3+ years



Source: 1999-2000 and 2001-2002 National Health and Nutrition Examination Survey.

Latinos are more likely to have never received care: 15 percent of first-generation Latino children have never received medical care compared to 1 percent of non-Hispanic white children. (Figure 5).

FIGURE 5:
Time since last health care visit: Never



Source: 1999-2000 and 2001-2002 National Health and Nutrition Examination Survey.

The American Academy of Pediatrics (AAP) recommends that a child should receive 11 well-baby visits by the time she is 24 months old, assuming that the child has no illnesses during this time (a child with an illness should receive more visits). Between the ages of 2 and 21, the AAP recommends 17 additional well-child visits, again assuming no other illnesses.[2] This is a total of 28 regular checkups that a number of Mexican-American children never have. If a child were to have an illness, the number of well-care visits would greatly exceed the 28 regular checkups recommended for a child without illness.

Childhood Illnesses and Chronic Conditions Disproportionately Affect Latino Children

In general, Latino children miss more days of school than do their non-Hispanic white counterparts, and they suffer from vaccine-preventable childhood illnesses in staggering numbers. Access to preventive care and timely reception of immunizations can eliminate absences due to common vaccine-preventable illnesses. If a child has not been immunized and contracts a childhood disease, but has access to medical care, she will lose an average of 16 days of school per year. However, an un-immunized child without access to treatment will lose an average of 24 days, for illnesses that could have been prevented.*

The chronic conditions that affect school attendance so heavily are also disproportionately present in Latino children:

> **Cancer:** Analysis of California Hospital Discharge data revealed that Latino children are more than twice as likely to be hospitalized for a cancer-related diagnosis than non-Hispanic whites. Latino children generated 48 hospitalizations per 100,000 compared to 21 for non-Hispanic white children.[3]

* Loss of school days is associated with incidence of hepatitis A and pertussis. Twenty-six days are lost per incidence of hepatitis A. Twenty-one days are lost per incidence of pertussis for those with no access to treatment. With access to treatment for pertussis, a child loses only five days. Data from: http://www.health.vic.gov.au/ideas/diseases/gr_vacc.htm

Diabetes: Data from the 2001 California Health Interview Survey indicated that when children aged 12-21 years were asked if they had been diagnosed with diabetes, 44 percent of Latinos said yes, compared to 31 percent of non-Hispanic whites.[4] The American Diabetes Association warns that recent clinic-based reports and regional studies indicate that Type 2 diabetes is becoming more common among Native American/American Indian, African-American, and Hispanic and Latino children and adolescents.[5]

Asthma: One study, which controlled for the effect of insurance by examining only children in managed Medicaid plans, found that although Latino children and non-Hispanic whites had equivalent scores on the AAP's Children's Health Survey for Asthma, Latinos had missed more school days in the previous two weeks.[6] Study results revealed that Latino children were 42 percent less likely to be using anti-inflammatory medications to prevent attacks. The study also revealed that Latinos had fewer outpatient visits than non-Hispanic whites, again indicating that their asthma was not being managed as well and that preventive care was not being administered. Lieu, *et al.*, concluded that the asthma status for Latino children was worse and that they were less likely to be engaged in preventive care.

Additional developmental conditions, such as dental, vision and hearing problems, attention deficit and hyperactivity disorder, also affect Latino children disproportionately and may affect both school attendance and school performance.

Dental: Data from the 2002 National Health Interview Survey (NHIS) commissioned by the National Center for Health Statistics (NCHS) show that 8 pecent of Mexican-American children aged 2-17 years had unmet dental needs in the past 12 months, compared to 5 percent of non-Hispanic white children.[7] The percentage of Mexican-American children going between two and five years without dental contact was almost triple that of non-Hispanic white children (6 percent and 2 percent, respectively). On a national scale, the Dental Health Foundation found that tooth decay is the single most common chronic childhood disease, which greatly affects school absenteeism. Children lose more than 51 million school hours each year to dental-related illness.[8]

Vision: According to a study using data from the 1982-1984 Hispanic Health and Nutrition Examination Survey (HHANES), which was also commissioned by NCHS, the prevalence of uncorrected binocular distance visual impairment is 15 percent for Mexican-American children aged 6 to 19 years.[9] One study found that having uncorrected vision was significantly associated with below-average IQ scores, which was significantly associated with school performance.[10]

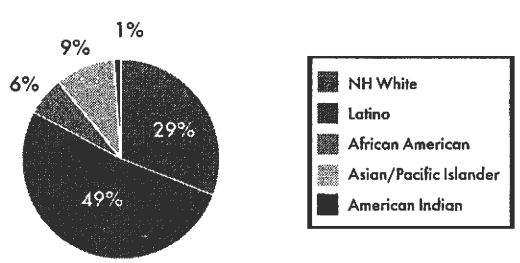
Hearing: In a study estimating the prevalence of sensorineural hearing loss (SNHL) and the rate of cochlear implantation among children with SNHL, it was found that while non-Hispanic white children comprised 51 percent of the study population, they comprised 73 percent of those being given cochlear implants.[11] On the other hand, Mexican-American children comprised 27 percent of the population of children with SNHL, and only 9.0 percent of those who received cochlear implants. Cochlear implants help children with understanding their environment and speech. It is clear that Mexican-American children are being implanted at far lower rates than non-Hispanic white children, again contributing to disparately unmet needs in the Mexican-American population.

Attention Deficit and Hyperactivity Disorder (ADHD): There are great disparities concerning attention deficit and hyperactivity disorder (ADHD). A study by Stevens, *et al.*, involving children aged 3-18 found that Latino children were less likely to receive a diagnosis of ADHD and less likely to receive a stimulant prescription than non-Hispanic white children. After adjusting for both insurance status and region, Latino children still were nearly 75 percent less likely to receive an ADHD diagnosis during an outpatient visit to a primary care provider, and nearly 75 percent less likely to receive a stimulant prescription, compared with white children in the same setting.[12]

California Children in the 21st Century

The Department of Finance population data project found that in the fall of 2006, 1,522,221 children, aged 4-6 years,[13] will be eligible to enroll in the state's kindergarten classrooms. This group of children, born at the dawn of the 21st century, will complete their education and enter the work force by 2026. The goal now is to prepare these children so that they will maximize their contributions to the state's economy and society, be productive employees, establish self-sustaining families and become active civic participants. About half of these children (741,997) will be Latino. This demographic fact has the potential to influence the productivity of the state's 21st century work force and citizens to a great extent. (Figure 6).

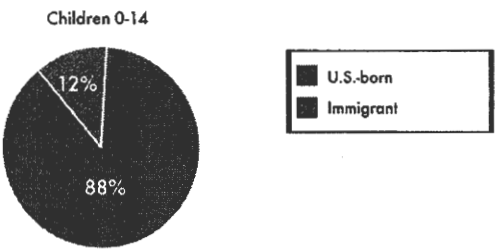
FIGURE 6:
Ethnic composition of children age 4 to 6 years, California, 2006



Source: California Department of Finance, California Projections.

According to the 2000 U.S Census, 88 percent of Latino children in California, ages 0-14 years, are U.S born citizens.[14] (Figure 7). U.S.-born and immigrant children are usually siblings in a single family, and both will live their adult lives in California.

FIGURE 7:
Latino children by nativity, California, 2000



Source: U.S. Census 2000.

School Absence Affects Achievement

Many studies show that healthy children are more likely to succeed in school, largely because they avoid many illness-caused absences. One researcher estimates that students who miss even as few as 10 days of school a semester have difficulty staying at grade level.[15] In a report titled "The Influence of Health on School Outcomes," Wolfe found an association between absenteeism and lower school achievement.[16] Students with chronic health conditions missed significantly more days than students without them.[17] In her study, Wolfe also found that children who had absences due to chronic illness had even lower school achievement, compared to children who were absent for other non-chronic illness reasons.[18]

> *"Many studies show that healthy children are more likely to succeed in school, largely because they avoid many illness-caused absences."*

An ethnic breakdown of Los Angeles Unified School District (LAUSD) students demonstrated that in 2000-2004 enrollments, on average 72 percent of students were Latino, 12 percent African-American and 9 percent non-Hispanic white.[19] Clearly, Latinos are the largest population in the LAUSD school population. In the Los Angeles Unified School District, students had an average attendance rate of 85 percent, or less in 1999-2000.[20] This means that in a 180-day school year, students on average missed at least 27 days (15 percent of all days missed) during the school year.

Currently, no formal studies link health insurance directly with school performance. Yet, researchers have begun to look at the connection between insurance, regular access to health care and school performance. In one study, Judith Lave and her research team found that after 12 months of enrollment in a health plan, 99 percent of previously uninsured

children had a regular source of medical care and 85 percent had a regular dentist.[21] The percentage of children with unmet needs or delayed care decreased from 57 percent to 16 percent. In addition, Lave reported that the grades of children suffering from headaches and visual impairment improved after insurance paid for glasses.

A study conducted by Keane, *et al*, examined the effect of enrollment in a health insurance program among different age groups of children. Before obtaining health insurance, older children (11-19 years) were more likely than younger children (0-5 years) to: a) have had unmet or delayed care, b) have not received health care, c) have low access, and d) have had activities limited by their parents.[22] Health insurance coverage eliminated low usage, low access and limited activities in the older age groups. Additionally, after year one of enrollment, unmet needs and delayed care were practically nonexistent in all groups.

A study conducted by the Managed Risk Medical Insurance Board (MRMIB), funded by the David and Lucile Packard Foundation, examined the positive effects of being enrolled in the Healthy Families Program (HFP), California's S-CHIP program. MRMIB completed a longitudinal survey of families whose children were newly enrolled in HFP in 2001 to measure changes in health over two years of enrollment in the Healthy Families Program. The report demonstrated that after one year of enrollment, there was a dramatic increase in the quality of life and improvements in school performance for children who are in the poorest health.[23] The authors reported that the greatest increases that occurred within school performance were related to paying attention in class and keeping up with school activities. The most significant improvement in health status and school performance occurred in the first year of enrollment, with most of the gains sustained through the second year of enrollment.

Prepared Adult Latinos Contribute More

By failing to receive adequate, regular access to health care, Latino children are, quite simply, failing to achieve their potential in school. As a result of this failure, Latino children are not being prepared to maximize the contributions they will make as adults. Analysis of educational attainment across major racial and ethnic groups in California demonstrates tremendous disparity. Among Californians aged 25 and older, U.S.-born Latinos were more likely to have less than a high school education (9 percent) than non-Hispanic whites (3 percent). In a similar fashion, college completion is substantially lower for U.S.-born Latinos (13 percent), compared to non-Hispanic whites (34 percent).[24] Under current policy and with current population composition – nearly 50 percent Latino – such sub-optimization of Latino children will affect everyone, not just Latinos themselves.

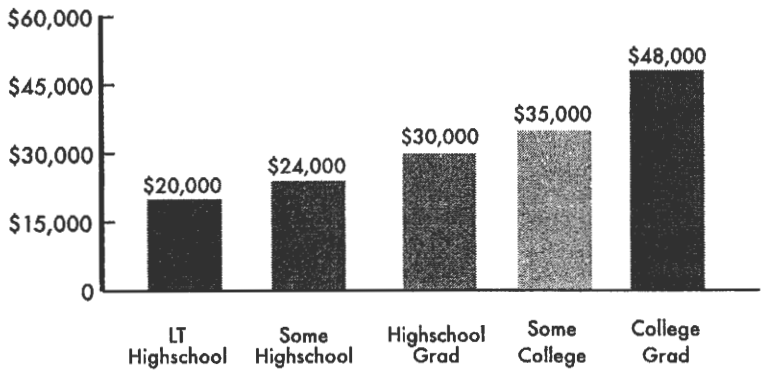
"By failing to receive adequate, regular access to health care, Latino children are, quite simply, failing to achieve their potential in school."

Analysis of the 2000 U.S. Census for societal contributions demonstrates that a Latino adult with more education in general makes more contributions to society than a Latino adult with less

education. We have created surrogate measures to examine societal contributions that include indicators such as income,* family sustainability,* home ownership and voting.**

Income: U.S.-born Latino college graduates earn 140 percent more than U.S.-born Latinos with less than a high school education. (Figure 8).

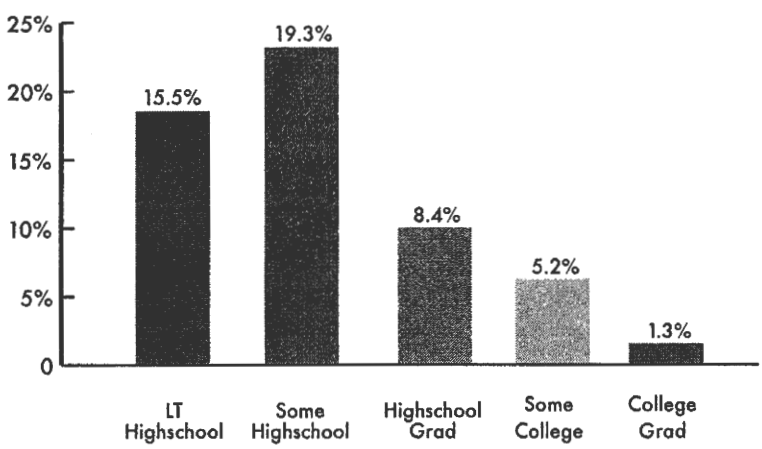
FIGURE 8:
U.S.-born Latino median income by educational attainment (Age 25+), California, 2000



Source: U.S. Census 2000.

Family Sustainability: Children raised in better-educated families are less likely to grow up relying on public assistance. U.S.-born Latino college graduates rely 92 percent less on public assistance than U.S.-born Latinos with less than a high school education. (Figure 9).

FIGURE 9:
U.S.-born Latino family sustainability by educational attainment (Age 25+), California, 2000

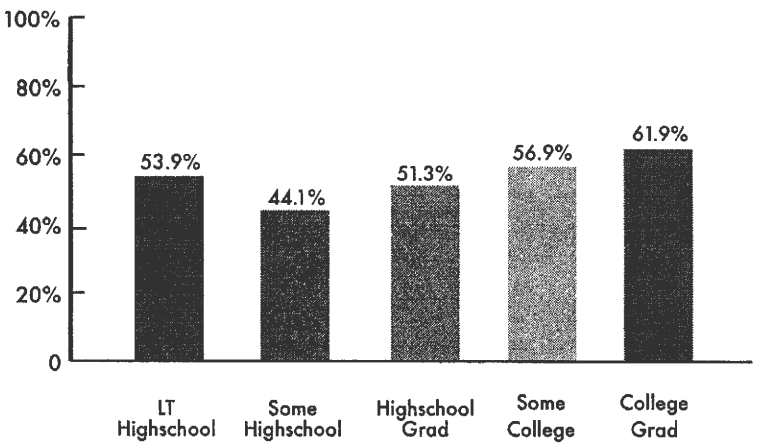


Source: U.S. Census 2000.

* Income is defined as: earned income year round, of a full-time worker working 32+ hours and employed 52 weeks.
* Family sustainability is defined as: one that did not need to rely on public assistance for any part of its income.
** Voting data from 2000 U.S. Census, Voting and Registration Supplement.

Home ownership: U.S.-born Latinos with a college degree are 15 percent more likely to own a home than U.S.-born Latinos with less than a high school education. (Figure 10).

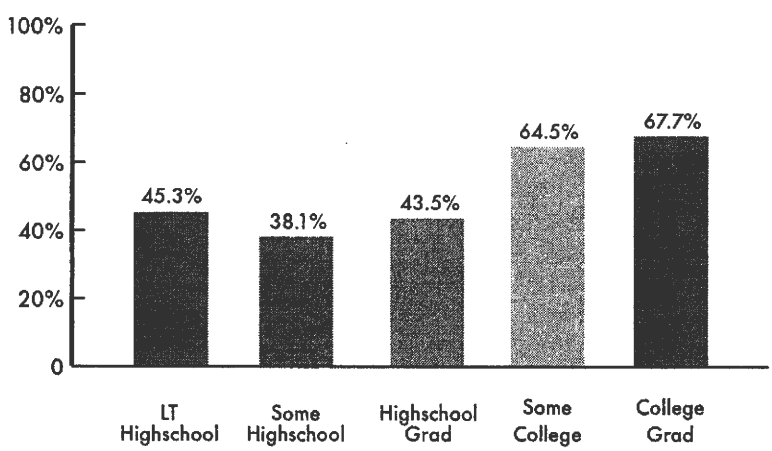
FIGURE 10:
U.S.-born Latino homeowners by educational attainment (Age 25+), California, 2000



Source: U.S. Census 2000.

Voting: U.S.-born Latinos with a college degree are 50 percent more likely to vote than U.S.-born Latinos with less than a high school education. (Figure 11).

FIGURE 11:
U.S.-born Latino voter participation by educational attainment (Age 25+), California, 2000



Source: U.S. Census 2000.

Under current policy, Latino children are not receiving the necessary investments to maximize the contributions they will make as adults. However, if these same Latino children were to receive better preparation and increased opportunities as a direct result of providing increased access to health care, societal contributions would greatly increase and could result in great strides towards economic parity.

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21650 Oxnard Street, Suite 1200
Woodland Hills, CA 91367
1.800.449.4149
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CPA/Investing in Latino Child Health
10-04-3-2005

Latino Caucus
Member Information

Legislator	Address	Phone	Fax	Email	Committees
Senator Martha Escutia, Chair Latino Caucus	State Capitol Room 5080 Sacramento, CA 95814	(916) 651-4030	(916) 327-8755	senator.escutia@sen.ca.gov	Energy, Utilities and Communication (Chair), Appropriations, Environmental Quality, Judiciary, Joint Committee on Rules
Assembly member Joe Coto, Vice Chair Latino Caucus	State Capitol P.O. Box 942849 Sacramento, CA 94249-0023	(916) 319-2023	(916) 319-2123	assemblymember.coto@assembly.ca.gov	Budget, Education, Governmental Organization, Human Services, Joint Committee on Rules Select Committee on Urban Education in California (Chair)
Senator Richard Alarcon	State Capitol Room 4035 Sacramento, CA 95814	(916) 651-4020	(916) 324-6645	senator.alarcon@sen.ca.gov	Labor and Industrial Relations (Chair), Appropriations, Energy, Utilities and Communications, Public Employment and Retirement
Senator Gill Cedillo	State Capitol Room 5100 Sacramento, CA 95814	(916) 651-4022	916) 327-8817	senator.cedillo@sen.ca.gov	Judiciary, Public Safety, Rules, Transportation and Housing
Senator Denise Moreno Ducheny	State Capitol, Room 4081 Sacramento, CA 95814	(916) 651-4040	(916) 327-3522	senator.ducheny@sen.ca.gov	Budget and Fiscal Review Subcommittee No. 3 on Health and Human Services (Chair), Agriculture (Vice-Chair), Budget and Fiscal Review, Government Modernization, Efficiency and Accountability, Transportation and Housing, Joint Legislative Budget
Senator Liz Figueroa	State Capitol, Room 4061 Sacramento, Ca 95814	(916) 651-4010	(916) 327-2433	senator.figueroa@sen.ca.gov	Business, Professions and Economic Development (Chair), Government Modernization, Efficiency and Accountability (Chair), Banking, Finance and Insurance, Environmental Quality, Health, Judiciary

Latino Caucus
Member Information

Legislator	Address	Phone	Fax	Email	Committees
Senator Dean Florez	State Capitol, Room 5061 Sacramento, Ca 95814	(916) 651-4016	(916) 327-5989	senator.florez@sen.ca.gov	Governmental Organization (Chair), Agriculture, Appropriations, Business, Professions and Economic Development, Government Modernization, Efficiency and Accountability, Human Services
Senator Deborah Ortiz	State Capitol Room 5114 Sacramento, CA 95814	(916) 445-7807	(916) 323-2263	senator.ortiz@sen.ca.gov	Health (Chair), Appropriations, Banking Finance and Insurance, Agriculture, Joint Legislative Audit Committee
Senator Gloria Romero	State Capitol, Room 313 Sacramento, CA 95814	916) 651-4024	(916) 445-0485	senator.romero@sen.ca.gov	Budget and Fiscal Review Subcommittee No. 5 on Public Safety, Labor, and Veteran Affairs (Chair), Appropriations, Budget and Fiscal Review, Education, Elections, Reapportionment and Constitutional Amendments, Natural Resources and Water, Public Safety, Education Subcommittee on Higher Education
Senator Nell Soto	State Capitol, Room 313 Sacramento, CA 95814	(916) 651-4032	(916) 445-0128	senator.soto@sen.ca.gov	Public Employment and Retirement (Chair), Veterans Affairs (Vice-Chair), Education, Governmental Organization, Local Government, Transportation and Housing,
Assembly member Juan Arambula	State Capitol P.O. Box 942849 Sacramento, CA 94249-0031	(916) 319 - 2031	(916) 319 - 2131	assemblymember.arambula@assembly.ca.gov	Jobs, Economic Development and the Economy (Chair), Budget, Budget Subcommittee 4: State Administration, Education, Human Services

Latino Caucus
Member Information

Legislator	Address	Phone	Fax	Email	Committees
Assembly member Joe Baca, Jr	State Capitol P.O. Box 942849 Sacramento, CA 94249-0062`	(916) 319-2062	(916) 319-2162	assemblymember.baca@assembly.ca.gov	Committee on Housing and Community Development, Committee on Jobs, Economic Development, and the Economy, Committee on Utilities and Commerce Committee on Water, Parks and Wildlife
Assembly member Rudy Bermúdez	State Capitol P.O. Box 942849 Sacramento, CA 94249-0056	(916) 319-2056	(916) 319-2156	assemblymember.bermudez@assembly.ca.gov	Budget Subcommittee #4: State Administration (Chair), Aging and Long-Term Care, Governmental Organization, Water, Parks and Wildlife
Assembly member Ronald Calderon	State Capitol P.O. Box 942849 Sacramento, CA 94249-0058	(916) 319-2058	(916) 319-2158	assemblymember.calderon@assembly.ca.gov	Democratic Freshman Legislative Caucus (Chair), Appropriations, Banking and Finance, Insurance, Governmental Organizations, Rules, Utilities and Commerce
Assembly member Ed Chavez	State Capitol P.O. Box 942849 Sacramento, CA 94249-0057	(916) 319-2057	(916) 319-2157	assemblymember.chavez@assembly.ca.gov	Arts, Entertainment, Sports, Tourism & Internet Media (Chair), Banking & Finance, Governmental Organization, Veterans Affairs
Assembly member Hector De La Torre	State Capitol P.O. Box 942849 Sacramento, CA 94249-0050	(916) 319-2050	(916) 319-2150	assemblymember.delatorre@assembly.ca.gov	Budget Subcommittee #1 Health and Human Services (Chair), Joint Committee on Legislative Budget, Utilities and Commerce, Committee on Environmental Safety and Toxic Materials, Local Government, Budget
Assembly member Dario Frommer	State Capitol P.O. Box 942849 Sacramento, CA 94249-0043	(916) 319-2043	(916) 319-2143	assemblymember.frommer@assembly.ca.gov	Committee on Business and Professions, Committee on Health, Committee on Insurance

Latino Caucus
Member Information

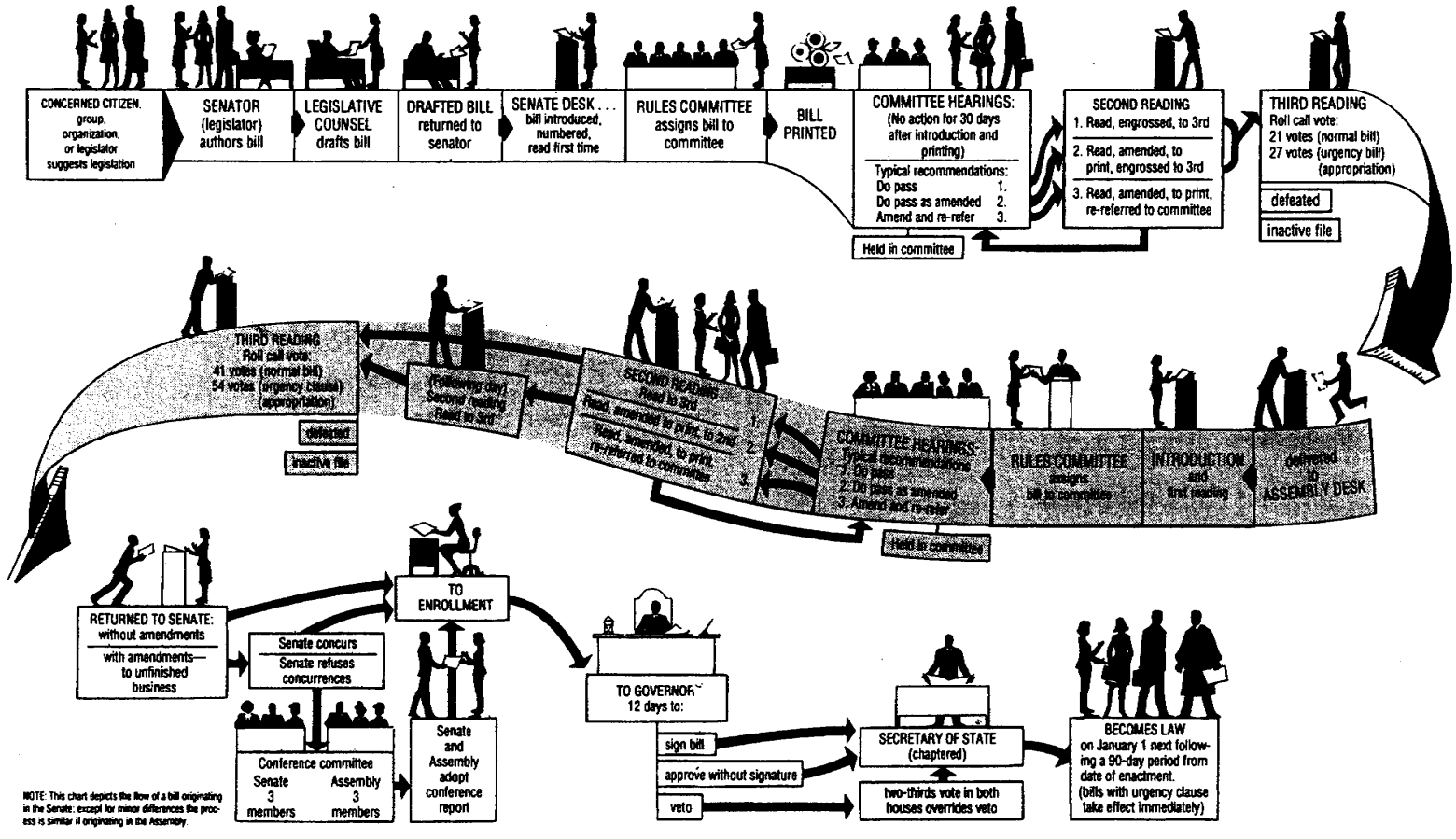
Legislator	Address	Phone	Fax	Email	Committees
Assembly member Cindy Montañez	State Capitol P.O. Box 942849 Sacramento, CA 94249-0039	(916) 319-2039	(916) 319-2139	assemblymember.montanez@assembly.ca.gov	Rules (Chair), Health, Budget, Judiciary
Assembly member Gloria Negrete-McLeod	State Capitol P.O. Box 942849 Sacramento, CA 94249-0061	(916) 319-2061	(916) 319-2161	assemblymember.negretemcleod@assembly.ca.gov	Business and Professions (Chair), Health, Government Organization, Public Employees, Retirement and Social Security
Assembly member Pedro Nava	State Capitol P.O. Box 942849 Sacramento, CA 94249-0035	(916) 319-2035	(916) 319-2135	assemblymember.nava@assembly.ca.gov	Chair, Budget Subcommittee No. 5 on Information Technology/Transportation Budget, Higher Education, Insurance, Natural Resources, Joint Legislative Audit, Joint Legislative Budget
Assembly Speaker Fabian Nuñez	State Capitol P.O. Box 942849 Sacramento, CA 94249-0046	(916) 319-2046	(916) 319-2146	assemblymember.nunez@assembly.ca.gov	
Assembly member Jenny Oropeza	State Capitol P.O. Box 942849 Sacramento, CA 94249-0055	(916) 319-2055	(916) 319-2155	assemblymember.oropeza@assembly.ca.gov	Transportation (Chair), Appropriations, Jobs Economic Development and the Economy, Veterans Affairs
Assembly member Nicole Parra	State Capitol P.O. Box 942849 Sacramento, CA 94249-0030	(916) 319-2030	(916) 319-2130	assemblymember.parra@assembly.ca.gov	Joint Legislative Audit Committee (Chair), Agriculture, Budget, Banking and Finance, Water, Parks and Wildlife
Assembly member Lori Saldaña	State Capitol P.O. Box 942849 Sacramento, CA 94249-0076	(916) 319-2076	(916) 319-2176	assemblymember.saldana@assembly.ca.gov	Select Committee on Bioethics, Medicine and Technology (Chair), Appropriations, Natural Resources, Water, Parks and Wildlife, Veterans Affairs

Latino Caucus
Member Information

Legislator	Address	Phone	Fax	Email	Committees
Assembly member Simón Salinas	State Capitol P.O. Box 942849 Sacramento, CA 94249-0028	(916) 319-2028	(916) 319-2128	assemblymember.salinas@assembly.ca.gov	Local Government (Chair), Transportation, Housing and Community Development, Agriculture
Assembly member Alberto Torrico	State Capitol P.O. Box 942849 Sacramento, CA 94249-0020	(916) 319-2020	(916) 319-2120	assemblymember.torrico@assembly.ca.gov	Public Employees, Retirement and Social Security (Chair), Transportation, Housing and Community Development, Governmental Organization
Assembly member Juan Vargas	State Capitol P.O. Box 942849 Sacramento, CA 94249-0079	(916) 319-2079	(916) 319-2179	assemblymember.vargas@assembly.ca.gov	Insurance (Chair), Agriculture, Banking and Finance, Business and Professions
Lieutenant Governor Cruz Bustamante	State Capitol Room 1114 Sacramento, CA 95814	(916) 445-8994	(916) 323-4998		University of California Regent, California State University Trustee

HOW A BILL BECOMES LAW

(A simplified chart showing the route a bill takes through the California Legislature)



NOTE: This chart depicts the flow of a bill originating in the Senate; except for minor differences the process is similar if originating in the Assembly.

Glossary of Legislative Terms

A

ABBREVIATIONS - The following abbreviations are commonly used by the California Legislature:

AB - Assembly Bill

SB - Senate Bill

ACA - Assembly Constitutional Amendment

SCA - Senate Constitutional Amendment

AJR - Assembly Joint Resolution

SJR - Senate Joint Resolution

ACR - Assembly Concurrent Resolution

SCR - Senate Concurrent Resolution

HR - House Resolution (Assembly)

SR - Senate Resolution

ACT - a bill passed by the Legislature

ACROSS THE DESK - official act of introducing a bill or resolution. The measure is given to the Chief Clerk at the Assembly Desk or the Secretary of the Senate at the Senate Desk. It then receives a number and becomes a public document available in the bill room.

ADJOURNMENT - a motion to end session for that day, with the hour and day of the next meeting being set prior to adjournment or by rule.

ADJOURNMENT SINE DIE - "Adjournment without day." The final termination of a regular or special legislative session.

CALIFORNIA CHANNEL

Legislative floor sessions and committee hearings are carried on the California Channel week days from 9:00 a.m. to 3:45 p.m. During hectic times of the legislative calendar there are many committee hearings happening at the same time. Only one floor session or committee hearing can be aired. Conversely, when the Legislature is out of session, previous hearings or floor sessions may be shown.

To give citizens an opportunity to directly express an opinion on an issue, some committee hearings are conducted as interactive hearings. This format allows viewers to call in to the committee to ask questions and make comments about the issue under discussion.

Another interactive meeting is the LegiSchool Project Town Hall Meeting. The LegiSchool Project is a bipartisan collaboration between the Legislature and California State University. The purpose is to develop an issues-oriented civics curriculum for high school students and teachers.

California
Latino Legislative Caucus

Member Biographies

2005 – 2006 Legislative Session

Senator Martha Escutia, Chair
Assembly Member Joe Coto, Vice Chair

2005 – 2006 Legislative Session

Dear Friends,

As members of the Latino Legislative Caucus, we hope that this biography book will be helpful in familiarizing you with the membership of our Caucus. Each member brings a unique background and contribution to the Latino Caucus ensuring success for the Caucus as a whole.

Our membership is comprised of 9 Senators and 18 Assemblymembers, many of whom hold leadership positions within their respective houses. This is the largest membership in the more than thirty year history of the Latino Caucus, evidencing the growing political clout and participation of Latinos in California. As a Caucus, we are committed to addressing issues that affect all Californians and those issues relevant to Latinos living, working, and studying in California. Our goals are not exclusive, since the Latino Caucus agenda reflects many common goals of all Americans and Californians. We are working to provide affordable housing, invest in our children, ensure that higher education is affordable and accessible, create well-paying jobs for working California families, and improve the quality of life for all Californians.

For additional information or questions, we urge you to contact our individual offices or log onto the Caucus web site at:
http://democrats.assembly.ca.gov/LatinoCaucus/default.htm.

Sincerely,

SENATOR MARTHA ESCUTIA
Caucus Chair

ASSEMBLYMEMBER JOE COTO
Caucus Vice Chair

SENATOR MARTHA ESCUTIA
Caucus Chair
30th District – Montebello

Martha M. Escutia was first elected to the California Legislature in November 1992 to represent the heavily Latino 50th Assembly District in southeast Los Angeles County. As an Assemblywoman, Escutia became the first woman to Chair the Assembly Judiciary Committee. In 1998 she was elected to the California Senate and now represents the 30th Senate District. As a freshman Senator, Escutia was honored to receive the Chairmanship of the Senate Health and Human Services Committee, and in 2000, she was the first Latina appointed as Chair of the Senate Judiciary Committee. Today, as Chair of the Energy, Utilities and Communications Committee, Senator Escutia focuses on safeguarding the economy, protecting the consumer and preserving the environment as she navigates through the complex energy issues challenging the state.

In recognition of her leadership, Senator Escutia became Chair of the California Legislative Women's Caucus in January 2002, serving in that capacity for one year. In concert with the Women's Caucus, the Senator highlighted the lack of quality child-care for the state's working poor and has worked to make the expansion of subsidized care a priority within the Legislature. In yet another of many firsts for her, Senator Escutia is the first Latina to be elected Chair of the Latino Caucus. She will lead the 27 member strong Latino Caucus through 2006.

Senator Escutia's varied accomplishments are highlighted by landmark legislation that protects health and the environment, improves opportunities for education, and protects the rights of consumers and workers. Along with state educators, Senator Escutia reduced class sizes and made Advanced Placement classes readily accessible for all students in California. In addition, she worked tirelessly to ensure that struggling students have access to high-quality remedial education programs. To reduce the incidence of childhood obesity, Senator Escutia has established nutritional standards for elementary and middle schools which she is now working to extend to the high schools. Her environmental protection efforts remove poisonous lead from our schools, establish the first-ever Children's Environmental Health Protection Act, and makes California the first state to initiate an environmental health tracking network. In the health arena, Senator Escutia is the creator of Healthy Families and is presently championing universal health care for all children.

Senator Escutia's outstanding public service and landmark legislation have earned her numerous awards. The California Labor Federation AFL-CIO named her "Legislator of the Year" for her advocacy on behalf of working men and women. Her outstanding work on environmental issues has generated recognition from the California League of Conservation Voters, the Sierra Club and the American Lung Association. The Los Angeles County Board of Supervisors has commemorated her "Commitment to the People of Los Angeles County". She was also awarded the Good Housekeeping Award for Women in Government for her work on the Children's Environmental Health Protection.

Senator Escutia is an honors graduate of the University of Southern California with a degree in Public Administration, and received her law degree from Georgetown University. She holds certificates in Advanced International Legal Studies of Trade and Tariffs from the World Court in The Hague, Netherlands, and in Foreign Investment from the National Autonomous University in Mexico City.

A native of East Los Angeles, she is married to Leo Briones and has two young sons, Andres and Diego.

Martha M. Escutia fue elegida por primera vez a la asamblea estatal en noviembre 1992 para representar el Distrito 50, un distrito mayormente latino en el sudeste del condado de Los Angeles. En 1998 fue elegida a representar el Distrito 30 del Senado. En su primer año como Senadora fue nombrada presidente del Comité de Salud y Servicios Humanos. En el 2000, fue la primer Latina designada como Presidente del Comité Judicial del Senado. Actualmente, como Presidente del Comité de Energía, Utilidades y Comunicaciones, la Senadora se enfoca en fomentar la economía, proteger el consumidor y preservar el ambiente mientras navega por los asuntos complejos de energía que desafían al estado.

En reconocimiento a su liderazgo en la Legislatura, la Senadora Escutia llegó a ser Presidente de la Asociación de Mujeres Legisladoras en enero 2002 en cuya capacidad sirvió un año. Conjunto con la Asociación, la Senadora destacó la falta de calidad en el cuidado de niños para las familias con bajos recursos y ha luchado para que sea una prioridad dentro de la Legislatura. A parte de todos sus logros, la Senadora Escutia es la primer Latina de ser elegida como Presidente del Asociación Latino y dirigirá al los 27 miembros del Comité Latino hasta el 2006.

Junto con los educadores del estado, la Senadora Escutia redujo el tamaño de la clase e incremento los cursos avanzadas para hacerlos mas accesibles para todos estudiantes en California. Además, trabajó incansablemente para asegurar que nuestros estudiantes tengan acceso a los recursos necesarios para ser exitosos en la escuela. Para reducir la obesidad en niños, la Senadora Escutia ha establecido los estándares nutricionales para la primaria y ahora trabaja para extenderlos a las preparatorias.

Su legislación ambiental incluye la protección en contra del plomo en nuestras escuelas, y estableció el Acto Ambiental de la Protección de la Salud de Niños para asegurar que los niños de California sean protegidos de los contaminantes en el medioambiente. En el área de la salud, la Senadora Escutia creó el programa de Healthy Families y actualmente defiende asistencia médica universal para los niños. Igual en el area de desarrollo, la Senadora Escutia ha trabajado para mejorar la economía local simultáneamente mejorando nuestra calidad de vida y medioambiente.

Por su excelente trabajo de servicio público, la Senadora Escutia se ha ganado numerosos premios. La Federación de Trabajo de California AFL-CIO la nombró "Legisladora del Año" por su apoyo a favor de los trabajadores. Su trabajo excepcional en asuntos del ambiente le han otorgado reconocimiento del *League of Conservation Voters, Sierra Club* y el *American Lung Association.* El Condado de Los Angeles ha conmemorado su "Compromiso a la Gente del Condado de Los Angeles". También se le otorgó el Premio de *Good Housekeeping* para Mujeres en el Gobierno por su trabajo en la Protección de Salud Ambiental para Niños.

La Senadora Escutia se graduó con honores de *University of Southern California* (USC) con un diplomado en Administración Pública y recibió su título de la facultad de derecho de la Universidad de Georgetown. Cuenta con diplomas en Estudios Internacionales Legales Avanzados de Comercio y Tarifas de la Corte Mundial en la Haya, y en Inversiones Externas de la Universidad Nacional Autónoma de México.

La Senadora Escutia es oriunda del Este de Los Angeles; está casada con Leo Briones y tiene dos niños pequeños, Andrés y Diego

ASSEMBLY MEMBER JOE COTO
Caucus Vice Chair
23rd District – San Jose

Joe Coto is an educator whose primary commitment has always been to the advancement of all students and their families. He has spent half of his professional life as superintendent of schools in two of Northern California's most challenging ditricts, Oakland Unified School District and the East Side Union High School District in San Jose. In recognition of his contributions as superintendent of the East Side Union High School District, the Association of California School Administrators (ACSA) named him the 2003 "Superintendent of the Year".

Joe Coto began his career as a teacher in the Oakland Unified School District where he experienced first hand the influence of public policy on education. After serving on the Oakland City Council, he was asked to fill the position of Superintendent of the Oakland Unified School District. In 1998 he accepted the position of Superintendent of the East Side Union High School District in San Jose.

During his fourteen year tenure as Superintendent, Mr. Coto used his leadership and experience to craft policies that reached beyond the East Side Union High School District. Coto organized the East Side Consortium of districts which led to the approval of SB 1051, the Voluntary Integration Program. Since its inception, the program has brought over $80 million for participating districts and contributed to increased diversity and integration in East San Jose schools. During his tenure in the East Side Union High School District, Mr. Coto was able to bring nearly half a billion dollars in grant moneys and improvement bonds East San Jose.

Joe Coto understands that schools are integrally woven into the tapestry of their communities and cannot be successful without the support of the residents and of the business community. In addition to his commitment to excellence in education, Mr. Coto has continued to serve the community by serving as Chair of the Mexican Plaza Cultural Arts Center in San Jose and as President of the Latino Democratic Forum. He has served on the boards of Joint Venture Silicon Valley and on the Catholic Council to investigate abuse within the Roman Catholic Church.

A healthy community is one that builds on the strengths of all its residents. Joe Coto has demonstrated through a life of service and commitment, that he will empower and defend the people to maintain the building blocks of a strong and healthy community; jobs, quality education and affordable housing.

Joe and his wife Camille, have been married for 33 years and have 2 daughters.

Joe Coto es un educador cuyo compromiso primario siempre ha estado al adelantamiento de todos estudiantes y sus familias. El ha gastado la mitad de su vida profesional como supervisor de escuelas en dos de California Septentrional LA MAYORIA de LOS ditricts DESAFIANTES, Oakland Unificó el Distrito de la Escuela y el Distrito Oriental de la Preparatoria de la Unión del Lado en San Jose. En el reconocimiento de sus contribuciones como supervisor del Distrito Oriental de la Preparatoria de la Unión del Lado, la Asociación de Administradores de Escuela de California (ACSA) le denominó el 2003 "Supervisor del Año".

Joe Coto empezó su carrera como un maestro en el Oakland Unificó el Distrito de la Escuela donde él experimentó entrega primero la influencia de la política pública en la educación. Después que servir en el ayuntamiento de Oakland, él fue pedido llenar la posición de Supervisor del Oakland Unificó el Distrito de la Escuela. En 1998 él aceptó la posición de Supervisor del Distrito Oriental de la Preparatoria de la Unión del Lado en San Jose.

Durante su catorce ocupación de año como Supervisor, Sr. Coto utilizó su liderazgo y la experiencia para hacer a mano las políticas que alcanzaron más allá del Distrito Oriental de la Preparatoria de la Unión del Lado. Coto organizó el Consorcio Oriental del Lado de los distritos que llevaron a la aprobación de SB 1051, el Programa Voluntario de la Integración. Desde que su principio, el programa ha traído $80 millones para participar los distritos y contribuido a la diversidad y la integración aumentadas en el Este San escuelas de Jose. Durante su ocupación en el Distrito Oriental de la Preparatoria de la Unión del Lado, Sr. Coto era capaz de traer casi medios un billones de dólares en dinero de beca y mejora vinculan el Este San Jose.

Joe Coto entiende que las escuelas se tejen integrantemente en el tapiz de sus comunidades y no pueden tener éxito sin el apoyo de los residentes y de las esferas empresariales. Además de su compromiso a la excelencia en la educación, Sr. Coto ha continuado servir la comunidad sirviendo como Silla de la Plaza mexicana las Artes Culturales Centran en San Jose y como Presidente del Foro demócrata latina. El ha servido en las tablas de Silicon Valley de Empresa Conjunta y en el Concilio católico investigar el abuso dentro de la Iglesia Católica romana.

Una comunidad de la salud es uno que construye en las fuerzas de todos sus residentes. Joe Coto ha demostrado por una vida del servicio y el compromiso, que él autorizará y defenderá a las personas para mantener los componentes de una comunidad fuerte y sana; los trabajos, la educación de la calidad y la vivienda razonable.

Joe y su esposa Camille, se han casado durante 33 años y tienen a 2 hijas.

SENATOR RICHARD ALARCÓN
20th District - Los Angeles

The Majority Whip of the California State Senate, Senator Richard Alarcón is a former teacher, community activist, and a champion for working families. In 1993, Richard Alarcón was elected to serve on the Los Angeles City Council representing the residents of the Northeast San Fernando Valley in the 7th District. Five years later, in 1998, he was elected to the California State Senate. Today, he is serving his second term in the State Senate representing nearly 1 million residents of the 20th Senate District in the heart of the San Fernando Valley.

In the Senate, he led the effort to obtain more than $200 million in state funds to help recruit, train, and credential more than five thousand new public school teachers. He is a supporter of class-size reduction and is working to continue to improve the system. He also strongly supports modernization of our schools. Senator Alarcón obtained $50 million to fix and expand 300 health clinics for low-income patients across our state. He convinced the Governor and the Legislature to allocate $550 million for affordable housing programs and created the Cal Home program.

As Chairman of the Senate Committee on Labor and Industrial Relations he passed legislation to increase unemployment benefits in California - which had previously been among the lowest in the Nation. He successfully pushed for the creation of the Senate Select Committee on the Status of Ending Poverty in California to bring together a diverse group of Senators to create a master plan that will focus on addressing the severe poverty which millions of Californians face each and every day.

Education, community, health, safety, labor, poverty - these are the issues important to California's working families. And these are the issues Senator Richard Alarcón is working hard to improve.

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El Jefe Disciplinario de la Mayoría del Senado Estatal de California, el Senador Richard Alarcón es un antiguo profesor, activista de la comunidad y un defensor de las familias trabajadoras. En 1993, Richard Alarcón fue elegido para servir en el Gobierno Municipal de Los Ángeles representando a los residentes del Noroeste del Valle de San Fernando en el Distrito 7. Cinco años más tarde, en 1998, fue elegido al Senado Estatal de California. Hoy día, está sirviendo su segundo término en el Senado Estatal representando a casi a un millón de residentes del Distrito 20 del Senado en el corazón del Valle de San Fernando.

En el Senado, él condujo el esfuerzo para obtener más de $200 millones en fondos estatales para ayudar a emplear, entrenar y permitir a más de cinco mil nuevos profesores de la escuela pública. Él es un partidario de la reducción de estudiantes en los salones de clases y está trabajando para continuar mejorando el sistema. Él también apoya enérgicamente la modernización de nuestras escuelas. El Senador Alarcón obtuvo $50 millones para arreglar y ampliar 300 clínicas de salud para los pacientes de bajo ingreso por todo nuestro estado. Convenció al Gobernador y a la Legislatura asignar 550 millones para programas de viviendas económicas y creó el programa Cal Home.

Como Presidente del Comité del Senado sobre Trabajo y Relaciones Industriales él aprobó la legislación para aumentar los beneficios de desempleo en California – que previamente había estado entre los más bajos en la Nación. Con éxito insistió en la creación del Comité Selecto del Senado sobre el Estado para Terminar la Pobreza en California juntando a un grupo diverso de Senadores para crear un plan maestro que se concentrará en enfocar la pobreza severa que millones de Californianos afrontan todo y cada día.

Educación, comunidad, salud, seguridad, trabajo, pobreza – estos son los asuntos importantes para las familias trabajadoras en California. Y estos son los asuntos que el Senador Richard Alarcón está trabajando duro para mejorar.

SENATOR GILBERT CEDILLO
22nd District – Los Angeles

Gilbert Cedillo was elected, unopposed, to the Senate in 2002. He is a member of the Senate Rules, Joint Legislative Audit, Public Safety, Revenue and Taxation, Transportation & Housing, and Judiciary Committees.

First elected to represent the 46th Assembly District in 1998, Gilbert Cedillo has emerged as a dedicated champion for California's working poor and disenfranchised communities. He has become a statewide leader for increasing and expanding access to health care, protecting the rights of working men and women, assimilating immigrants into California's social and economic fabric, and providing new economic development opportunities throughout the state and in his downtown Los Angeles District. While in the Assembly, Cedillo authored legislation to provide Filipino WWII Veterans with state assistance, develop the "Downtown Rebound" program to provide funding for housing opportunities in urban areas, protect state workers' rights by prohibiting the use of state money to discourage unionization, worked on legislation to prevent the abuse of elderly and dependent adults, and advocated for the conversion of a former Catholic Cathedral into a community and regional performing arts center.

In the Senate, Cedillo has been instrumental in providing leadership to address the current health care crisis in California. As Chair of the Budget Subcommittee on Health & Human Services, he expanded the Medi-Cal and Healthy Families programs and simplified the eligibility process. In addition, Gilbert has secured $50 million for community clinic grants as well as additional state money for the California Cancer Registry. Most recently, he authored legislation to crack down on abusive tax shelters which generated $1 billion for the state budget. Gilbert is also authoring legislation that will allow immigrants to apply for California driver's licenses. In sponsoring this public safety measure, he has created a diverse coalition of support.

Gilbert Cedillo grew up in Boyle Heights and is a lifelong resident of the 22nd Senatorial District. He attended local schools, graduated from UCLA and received his law degree from People's College of Law.

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Gilbert Cedillo fue elegido, sin oposición al Senado en el 2002. Es un miembro de de los Comités de Reglas del Senado, Auditoría Legislativa Unida, Seguridad Pública, Ingresos y Contribución de Impuestos, Transporte y Vivienda y Judicatura.

Elegido primero para representar al Distrito 46 de la Asamblea en 1998, Gilbert Cedillo ha emergido como un defensor dedicado para las personas trabajadores de California y comunidades privadas de derechos civiles. Él se convirtió en un líder estatal para aumentar y ampliar el acceso al cuidado médico, protegiendo los derechos de mujeres y hombres trabajadores, integrando inmigrantes dentro de la fábrica social y económica de California, y proporcionando nuevas oportunidades de desarrollo económico por todo el estado y en su centro del Distrito de Los Ángeles. Mientras se encuentra en la Asamblea, Cedillo creó la legislación para proveer a los Veteranos Filipinos de la II Guerra Mundial con asistencia del estado, desarrolla el programa de "Recuperación del Centro" para proporcionar financiamiento para las oportunidades de vivienda en áreas urbanas, proteger los derechos de los trabajadores estatales prohibiendo el uso del dinero estatal para desalentar la sindicalización, trabajó en la legislación para prevenir el abuso de los ancianos y de los adultos dependientes, y defender por la conversión de una antigua Catedral Católica en una comunidad y un centro regional de artes interpretativas.

En el Senado, Cedillo ha sido el instrumento para proporcionar el liderazgo para enfocar la crisis actual del cuidado médico en California. Como Presidente del Subcomité de Presupuesto sobre Salud y Servicios Humanos, él amplió los programas de Medical y Familias Saludables y simplificó el proceso de elegibilidad. Además, Gilbert ha asegurado los $50 millones para las subvenciones de la clínica comunitaria así como también dinero adicional del estado para el Registro de Cáncer en California. Más recientemente, él creó la legislación para tomar medidas enérgicas contra los refugios de impuestos abusivos que generaron 1,000 millones para el presupuesto. Gilbert también está creando una legislación que permitirá a los inmigrantes aplicar por licencias de conducir en California. Patrocinando esta medida pública de seguridad, él ha creado una coalición diversa de apoyo.

Gilbert Cedillo, creció en Boyle Heights y es un residente de toda la vida del Distrito 22 del Senado. Asistió a las escuelas locales, graduado de UCLA y recibió su título de derecho de People´s College of Law.

SENATOR DENISE MORENO DUCHENY
40th District – San Diego

Denise Moreno Ducheny was elected to the California State Senate in November, 2002. She is Chair of the Senate Budget Subcommittee on Health & Human Services and serves on the Senate Committees on Agriculture, Budget & Fiscal Review, Transportation & Housing, and Government Modernization & Constitutional Amendments. She also Chairs the Senate Select Committees on California-Mexico Cooperation, and the Colorado River and serves on the Select Committees on California's Horse Racing Industry, Defense & Aerospace, Global Environment, and Mobile & Manufactured Homes. She is also a member of the Joint Legislative Budget Committee. Senator Ducheny served as Chair of the Senate Committee on Housing & Community Development from 2002-2004.

Prior to her election to the California State Senate, Senator Ducheny served in the State Assembly from 1994 - 2000. There, she served as Chair of the Assembly Budget Committee from 1997 - 2000, and as Vice Chair in 1996. She was the first Latina appointed to the post. She also served as Chair of the Select Committee on California-Mexico Affairs, as Co-Chair of the Special Committee on Welfare Reform, as Vice-Chair of the Joint Legislative Budget Committee, and as Vice-Chair of the Latino Legislative Caucus. While in the Assembly, Senator Ducheny authored landmark legislation including the CalWORKS Welfare Reform Act of 1997, the Reverse Mortgage bill, the CA Public School Library Act, the California development certificate to teach K-12 students, and legislation which enabled local government to rehabilitate vacant dwellings to improve the quality of life in their communities.

As a legislator in both houses, Senator Ducheny has worked diligently to improve California's bi-national relationship with the Republic of Mexico, including establishment of a permanent Office of Binational Border Health. She also spearheaded organization of the Border Legislative Forum, comprised of legislators from the ten U.S.-Mexico Border states, and the Legislative Forum of the Three Californias.

Denise Moreno Ducheny has been married to Al Ducheny, a political consultant and community activist in San Diego, since 1980.

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Denise Moreno Ducheny fue elegida al Senado Estatal de California en Noviembre del 2002. Ella es Presidenta del Subcomité de Presupuesto sobre Salud y Servicios Humanos del Senado y sirve en los Comités sobre Agricultura, Presupuesto y Revisión Fiscal, Transportación y Vivienda, y Enmiendas Constitucionales y Modernización del Gobierno. Ella también es Presidenta de los Comités Selectos del Senado sobre la Cooperación California-Méjico y el Río Colorado y sirve en los Comités Selecto sobre la Industria de Carreras de Caballos de California, Defensa y Aeroespacial, Medio Ambiente Global, y Hogares Móviles y Fabricados. Ella también es un miembro del Comité Unido del Presupuesto Legislativo. La Senadora Ducheny sirvió como Presidenta del Comité del Senado sobre Vivienda y Desarrollo Comunitario desde el 2002 al 2004.

Antes de su elección al Senado Estatal de California, la Senadora Ducheny sirvió en la Asamblea del Estado desde 1994 hasta el 2000. Allí sirvió como Presidenta del Comité de Presupuesto de la Asamblea desde 1997 – 2000, y como Vicepresidenta en 1996. Ella fue la primera Latina nombrada al puesto. Ella también sirvió como Presidenta del Comité Selecto sobre los Asuntos California-Méjico, como Copresidenta del Comité Especial sobre Reforma de Bienestar, como Vicepresidenta del Comité Unido del Presupuesto Legislativo, y como Vicepresidenta de la Camarilla Política Legislativa Latina. Mientras se encontraba en la Asamblea, la Senadora Ducheny creó la legislación importante que incluye el Acta de 1997 de Reforma de Bienestar Cal Works, el proyecto de ley de Reponer la Hipoteca, el Acta de Biblioteca Escolar Pública de California, certificado de desarrollo de California para enseñar a los estudiantes del K al 12, y la legislación que permite al gobierno local rehabilitar las vivienda vacantes para mejorar la calidad de vida en sus comunidades.

Como una legisladora en ambas cámara, la Senadora Ducheny ha trabajado diligentemente para mejorar la relación binacional de California con la República de México, incluyendo el establecimiento de una Oficina permanente de la Salud Binacional de la Frontera. Ella encabeza también la organización del Foro Legislativo en la Frontera, compuesta de Legisladores de los diez estados de la Frontera EU.-Méjico, y el Foro Legislativo de las Tres Californianas.

Dense Moreno Ducheny ha estado casado con Al Ducheny, un consultante político y activista comunitario en San Diego desde 1980.

SENATOR LIZ FIGUEROA
10th District – Sunol

Liz Figueroa was elected to the California State Senate as a Democrat from the 10th District (Alameda and Santa Clara Counties) in 1998 and re-elected in 2002. Prior to her election to the State Senate, she served two terms in the California State Assembly from 1994-1998. Senator Figueroa is dedicated to improving access to and the quality of health care, while protecting citizens and their privacy.

Senator Figueroa has worked on landmark legislation in California and Washington D.C., that provides a two-day hospital stay for mothers and their newborns. She helped implement California's Healthy Families Program, and has been a leader in the fight to reform managed health care in California, authoring legislation giving patients the right to sue their HMO. Figueroa has been a leader in protecting consumers' privacy and helping victims of identity theft. Her Medical Records Privacy Act made California the nation's leader in guaranteeing that a patient's medical records are confidential. Her SB 27 opened up the multi-billion dollar business of buying and trading customer lists for direct marketing purposes. She authored two first-in-the-nation measures allowing Californians to obtain free credit reports, and imposing fines on credit bureaus that fail to place consumer-requested security alerts on credit reports. Her SB 771 created the "Do Not Call List" in California, prompting enactment of a national "Do Not Call" program.

Other significant efforts include work on behalf of women and human rights. She has spearheaded action on issues such as outlawing female genital mutilation, banning California's use of products made by slave labor, prohibiting insurance companies from discriminating against victims of domestic violence, and fast-tracking restraining orders for domestic violence victims. Figueroa worked tirelessly to secure funding for domestic violence shelters and restitution for victims of domestic violence.

Senator Figueroa serves as chair of the Government Modernization, Efficiency, & Accountability Committee, the Joint Committee on Boards, Commissions, & Consumer Protection, the Senate Committee on Business, Professions, & Economic Development and the Subcommittee on International Trade Policy & State Legislation. She is a member of the Senate Committees on Judiciary, Health, Banking, Finance & Insurance, Environmental Quality, and Labor & Industrial Relations. The Senator was born and raised in the San Francisco Bay Area and was the first Northern California Latina to be elected to the Legislature. Both of her parents are from El Salvador. She is the mother of AnaLisa Luippold and Aaron Bloom and the grandmother of Andrew and Cameron.

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Liz Figueroa fue elegida al Senado estatal del Distrito 10 en 1998 y fue reelegida en 2002. Antes de su elección al Senado, sirvió dos términos en la Asamblea estatal de 1994-1998. Entre las prioridades de la Senadora Figueroa esta el mejoramiento al acceso y la calidad de asistencia médica, y proteger la privacidad de la población.

La Senadora Figueroa ha luchado para sacar adelante legislación clave en California y Washington D.C. que proporciona que madres y su recién nacido permanezcan al menos dos días en el hospital después de dar a luz. Ella ayudó a implementar el programa de *Healthy Families*, y ha sido un líder para reformar el cuidado médico de los *HMO's* y paso legislación dándole el derecho a los pacientes de demandar su Seguro Medico. Figueroa ha sido líder en proteger la privacidad de los consumidores y a las víctimas del robo de identidad. Su *Medical Records Privacy Act* hizo a California un líder de la nación en garantizar que los registros médicos del paciente sean confidenciales. También es autora de dos propuestas, primeras en la nación, permitiendo que los californianos obtengan informes gratuitos de su historial de crédito, e impuso multas en las oficinas de crédito que fallan en colocar alarmas de seguridad para el consumidor. Su SB 771 creó el "Do Not Call List" en California, incitando la promulgación del programa nacional "Do Not Call."

Otros esfuerzos significativos incluyen su trabajo a favor de mujeres y derechos humanos. Ella ha luchado para prohibir la mutilación genital femenina; prohibiendo el uso en California de productos hechos por mano de obra barata, y prohibiendo que las compañías de seguros discriminen en contra de víctimas de la violencia doméstica. Figueroa trabajó para asegurar el financiamiento de refugios y restitución para victimas de la violencia doméstica.

La Senadora Figueroa sirve como Presidente del Comité sobre la Modernización, Eficiencia y Contabilidad del Gobierno; del Comité bicameral de Comisiones y Protección del Consumidor; el Comité de Negocios, las Profesiones, y el Desarrollo Económico y la Subcomisión de Comercio Internacional. Además, es miembro de los Comités del Senado en La Salud, Las Finanzas & el Seguro, la Calidad Ambiental, y Partido Laborista & las Relaciones Industriales. La Senadora Figueroa nació en San Francisco de padres salvadoreños. Figueroa es madre de AnaLisa Luippold y Aaron Florece y abuela de Andrew y Cameron.

SENATOR DEAN FLOREZ
16th District - Shafter

Senator Dean Florez grew up in the heart of the Central Valley and began representing the Valley as a legislator in 1998. As a freshman Assemblyman, Florez passed landmark legislation requiring seatbelts and latched toolboxes on farm labor vehicles. He then went on to outlaw all wooden benches on farm labor vans. These efforts led to an enormous reduction in traffic deaths in the Valley that for too long had become associated with the harvest season.

In his first year in the California State Senate, Florez tackled the Valley's air pollution crisis. After taking on many powerful interests he won historic victories for asthmatic children and families throughout the Central Valley, with five new laws aimed at cleaning the air we breathe.

Florez is Chair of the Senate Governmental Organization Committee which has oversight of gaming, emergencies and disaster response, alcoholic beverages, the use of state-controlled lands and buildings, bonds, and other government services. Under the jurisdiction of the committee, Florez has already held hearings on gaming compacts, the state lottery and on how they are expected to impact local communities and the state's budget.

Florez began his political life working in the Legislature as a Senate Fellow and later as a fiscal consultant to the Senate Budget Committee. After attending Bakersfield College, Florez earned his bachelors degree in political science from the University of California at Los Angeles, where he served as student body president. He went on to receive his MBA from Harvard Business School. Florez lives in Shafter with his wife, Elsa, and their daughter Faith and son Sean.

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El Senador Dean Florez creció en el centro del Valle Central. En la sesión legislativa más reciente, Florez enfocó sus energías para encontrar soluciones laborables para la crisis de la contaminación del aire del Valle y fue premiado con una victoria histórica para los defensores de la salud pública y el aire puro, conforme el Gobernador Davis firmó en ley cinco medidas de Florez que toma un primer paso dramático hacia el aire más puro. Como el actual Presidente del Comité Selecto del Senado sobre la Calidad del Aire en el Valle Central, Florez tiene la intención de continuar trabajando en la legislación de sentido común que enfoca las varias causas de la contaminación del aire en el Valle, incluyendo desarrollos comerciales más grandes y locomotoras diesel.

La última Sesión, Florez pidió una revisión del registro de delincuentes sexuales del estado después que los medios publicitarios reportaron que tanto como 33,000 delincuentes requieren tener sus paraderos colocados en la base de datos de la Ley de Megan no estuvieron contados.

Flores actualmente Preside el Comité del Senado sobre la Banca, Comercio y Comercio Internacional, que ha explorado tales asuntos como la prioridad de compras federales de las leyes bancarias del estado, la realización del programa de Empresa Comercial de Veteranos Minusválidos del estado, y ha propuesto reglas federales que habrían permitido la formación de conglomerados de un promedio aún más grandes. Florez está sirviendo su primer término en el Senado del Estado, después de dos términos exitosos en la Asamblea. Mientras se encontraba en la Asamblea, Florez presentó la legislación para proporcionar un medio seguro del transporte para los campesinos, y la legislación aprobada para ordenar los cinturones de seguridad y las cajas de herramientas cerradas en los vehículos de trabajo en el campo, y declaró fuera de la ley reemplazar sitios instalados de fabricantes en bancos paralelos para aumentar el número de asientos.

Florez comenzó su vida política trabajando en la Legislatura como un consultante para el Comité de Presupuesto del Senado. Después de asistir al College de Bakersfield, él ganó su Grado de Bachillerato en Ciencias Políticas de UCLA, donde sirvió como presidente del cuerpo estudiantil. También recibió su MBA de la Escuela de Negocios de Harvard. Florez vive en Shafter con su esposa Elsa, y su hija Faith e hijo Sean.

SENATOR DEBORAH ORTIZ
6th District – Sacramento

Deborah V. Ortiz was elected to the 6th Senate District in November of 1998 and re-elected in 2002. She is the Chair of the Senate Health Committee and also Chairs the Subcommittee on Stem Cell Research & Oversight, the Subcommittee on Medicine & Health Care, and the Select Committee on Capital Area Flood Protection. Senator Ortiz is a member of the Banking, Finance & Insurance, Appropriations, Joint Legislative Audit, and Joint Rules Committees.

Senator Ortiz is the author of the nationally recognized law protecting stem cell research in California and is also responsible for the state's landmark program guaranteeing college scholarships, Cal Grants, to students with good grades and financial need. Her work on childhood obesity prevention is seen as the model for the rest of the Nation.

An outspoken advocate for those facing catastrophic illness - as well as their families and caregivers - Senator Ortiz wrote legislation directing millions of dollars into ovarian, breast and prostate cancer research and awareness programs. She is currently authoring a bill to create a biomonitoring program to expand the limited research into human environmental exposures.

One of Senator Ortiz's legislative highlights is the Michelle Montoya School Safety Act, which prohibits schools from hiring anyone convicted of a serious or violent felony and requires criminal background checks to be completed before employees are hired. She continues to lead the effort to improve the State's low-performing schools, establish statewide universal pre-kindergarten programs, and expand successful after-school programs.

Born and raised in Sacramento, Senator Ortiz attended the University of California at Davis and graduated from McGeorge School of the Law.

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Deborah V. Ortiz fue elegido al Distrito 6 del Senado en Noviembre de 1998 y vuelta a elegir en el 2002. Ella es la Presidenta del Comité de Salud del Senado y también Preside el Subcomité sobre Investigación y Supervisión de las Células Madres, el Subcomité sobre Cuidado Médico y Medicina, y el Comité Selecto sobre Protección de la Inundación del Área Capital. La Senadora Ortiz es miembro de la Banca, Finanzas y Seguro, Asignaciones, Auditoria Conjunta Legislativa y Comités de Reglas Unidas.

La Senadora Ortiz es la autora de la ley nacionalmente reconocida que protege la investigación en California y es también responsable del programa histórico del estado que garantiza becas del colegio preparatorio para la universidad, Cal Grants, a estudiantes con buenas notas y necesidad financiera. Su trabajo sobre la prevención de obesidad en la niñez es visto como el modelo para el resto de la Nación.

Una defensora franca para aquellos que enfrentan enfermedades catastróficas – así como también sus familias y cuidadores – la Senadora Ortiz ha escrito una legislación dirigida a millones de dólares para programas de investigación y percepción de cáncer ovárico, seno, y próstata. Actualmente ella es creadora de un proyecto de ley para crear un programa de biomonitorización para ampliar la investigación limitada en las exposiciones humanas al medio ambiente.

Uno de los puntos legislativos más destacados es el Acta de Seguridad Escolar Michelle Montoya que prohíbe a las escuelas que empleen a cualquier convicto de una felonía violenta o seria y requiere una verificación de los antecedentes criminales que sean completados antes que los empleados sean contratados. Ella continúa conduciendo los esfuerzos para mejorar el bajo desempeño de las escuelas en el Estado, establece programas estatales universales antes de kindergarten, y amplía los programas exitosos después de la escuela.

Nació y se crió en Sacramento, la Senadora Ortiz asistió a la Universidad de California en Davis y es graduada de la Escuela de Derecho McGeorge.

SENATOR GLORIA ROMERO
24th District - Los Angeles

As Senate Majority Leader, Senator Gloria Romero is the highest ranking woman in the California Legislature, and is the first woman to hold this leadership position. She is a legislator, an educator, a dedicated social activist, an aggressive prison reformer, and a forceful advocate for California's most disadvantaged citizens.

She currently serves on the Senate Committees on Budget & Fiscal Review, Education, Public Safety, Elections, Reapportionment & Constitutional Amendments, and Natural Resources & Water. One of her most crucial committee assignments is that of Chair of the Select Committee on the California Correctional System where she has taken on the formidable task of investigating and authoring reforms for the state's massive array of youth and adult correctional facilities. She has conducted hearings on employee contracts, treatment of juveniles, codes of silence among correctional officers, and inmate health care costs in her effort to bring fiscal accountability and reforms to the system.

Senator Romero was first elected to the State Assembly in 1998 and then to the Senate in a special election in March, 2001. In the Assembly, she was appointed Majority Whip during her first term in office. Senator Romero has taught at every level of the State's university system. She has received numerous awards from various faculty organizations, student associations, consumer groups, union locals, and law enforcement associations.

Senator Romero is a graduate of Barstow Community College and California State University Long Beach. She earned her Ph.D. in psychology from the University of California at Riverside. Senator Romero has one daughter who is attending UC Santa Barbara.

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Como Líder de la Mayoría del Senado, la Senadora Gloria Romero es la mujer de más alto rango en la Legislatura de California, y es la primera mujer en sostener la posición de liderazgo. Ella es una legisladora, una educadora, y una dedicada activista social, una reformadora agresiva de la prisión, y una defensora con carácter fuerte para los ciudadanos más perjudicados de California.

Actualmente sirve en los Comités del Senado sobre Presupuesto y Revisión Fiscal, Educación, Seguridad Pública, Elección, Repartición de Distritos Electorales y Enmiendas Constitucionales, Recursos Naturales y Agua. En una de sus asignaturas más cruciales del comité es esa de Presidenta del Comité Selecto sobre el Sistema Correccional de California donde ella ha tomado la tarea formidable de investigar y crear reformas para el despliegue masivo de las facilidades correccionales para adultos y jóvenes del estado. Ella ha conducido audiencias sobre contratos de empleados, tratamiento de menores, códigos de silencio entre los oficiales correccionales, y costos de cuidado médico para los presos en su esfuerzo de traer la responsabilidad fiscal y reformas al sistema.

La Senadora Romero fue elegida primero a la Asamblea del Estado en 1998 y después al Senado en una elección especial en Marzo del 2001. En la Asamblea, ella fue nombrada a Jefa Disciplinaria de la Mayoría durante su primer término en función. La Senadora Romero ha enseñado en todo nivel del sistema universitario del Estado. Ella ha recibido numerosos premios de varias organizaciones de la facultad, asociaciones estudiantiles, grupos del consumidor, uniones locales y las asociaciones de policía.

La Senadora Romero es una graduada del Colegio Comunitario Barstow y la Universidad del Estado de California, Long Beach. Ella obtuvo su Doctorado en psicología de la Universidad de California en Riverside. La Senadora Romero tiene una hija que está asistiendo a la Universidad de California, Santa Bárbara.

SENATOR NELL SOTO
32nd District – Pomona

Nell Soto has devoted much of her adult life to community and public service. A sixth-generation resident of Pomona, she was elected to the State Senate in a special election in March of 2000, and then re-elected to a final four-year term in November of 2002.

In the Senate, Soto's focus is on issues that most directly improve the lives of her constituents. Her legislative priorities include such issues as education, child safety, health care, and infrastructure. Soto is constantly working to create high-paying jobs, and ensuring that communities are safe from crime and violence. Senator Soto is Chair of the Senate Public Employment & Retirement Committee. In addition, she serves on the Senate Transportation & Housing, Local Government, Governmental Organization, and Veteran's Affairs Committees. She also serves as Chair of the Select Committee on Urban Economic Development, and the Select Committee on Perchlorate Contamination. In June of 2002, Soto formed the Inland Empire Perchlorate Task Force to investigate the spread to the toxic contaminant in the region's water supply.

Prior to her arrival in the State Senate, Soto served as the Assemblywoman for the 61st Assembly District. In the Assembly, Soto authored several pieces of legislation such as Safe Routes to School, the Parental Involvement Act, Education Technology, and HMO reform. Soto also spearheaded the Select Committee on the Alameda Corridor East, a rail corridor project spanning from Long Beach to San Bernardino County. She worked to secure over $5 million from the state budget for various parks and community centers throughout the cities in her Assembly District.

With her election to the Assembly in 1998, Soto became the first woman elected to represent the Inland Empire in the Legislature. She is the mother of six, grandmother of eleven, and great-grandmother of three. Her late husband, Philip, served two terms in the State Assembly from 1962 - 1966.

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Nell Soto se ha dedicado mucha de su vida adulta a al servicio público y la comunidad. Una residente de la sexta generación de Pomona, fue elegida al Senado del Estado en una elección especial en Marzo del 2000 y después vuelta a elegir para un término final de cuatro años en Noviembre del 2002.

En el Senado, la Senadora Soto se concentra en asuntos que más directamente mejoran las vidas de sus constituyentes. Sus prioridades legislativas incluyen tales asuntos como educación, seguridad al niño, cuidado médico e infraestructura. La Senadora Soto constantemente está trabajando para crear sueldos más altos, y asegurando que las comunidades sean seguras de crímenes y violencia. La Senadora Soto es la Presidenta del Comité de Jubilación y Empleos Públicos. Además, ella sirve en el Comité de Transporte y Vivienda del Senado, Gobierno Local, Organización Gubernamental, y Comités de Asuntos para los Veteranos. También sirve como Presidenta del Comité Selecto sobre Desarrollo Económico Urbano, y el Comité Selecto sobre Contaminación del Perclorato. En Junio del 2002, Soto formó el Destacamento de Fuerzas del Perclorato de Inland Empire para investigar la extensión del contaminante tóxico en el abastecimiento de agua de la región.

Antes de su llegado al Senado del Estado, Soto sirvió como Asambleísta para el Distrito 61 de la Asamblea. En la Asamblea, Soto creó varias piezas de legislación tales como Rutas Seguras a las Escuelas, el Acta de Participación de los Padres, Educación y Tecnología y reforma de HMO. Soto también encabezó el Comité Selecto sobre el Corredor Este de Alameda, y el proyecto ferroviario que atraviesa de Long Beach al Condado de San Bernardino. Ella trabajó para asegurar más de 5 millones de dólares del presupuesto estatal para varios centros comunitarios y parques en todas las ciudades en su Distrito de la Asamblea.

Con su elección a la Asamblea en 1998, Soto se convirtió en la primera mujer elegida para representar el Inland Empire en la Legislatura. Ella es madre de seis, abuela de once, y bisabuela de tres. Su difunto esposo, Philip, sirvió dos términos en la Asamblea del Estado desde 1962 a 1966.

ASSEMBLY MEMBER JUAN ARAMBULA
31st District – Fresno

Assembly Member Juan Arambula was elected to the State Assembly in November of 2004. Arambula is Chair of the Jobs, Economic Development & the Economy Committee and is a member of the Assembly Budget, Budget Subcommittee No. 4 – State Administration, Education, and Human Services Committees.

Prior to his election to the Assembly, Arambula served as a member of the Fresno County Board of Supervisors from 1997 to November 2004, where he worked to diversify the Central Valley's economy and create jobs, improve access to quality health care, and reduce youth violence.

From 1987 to 1996, he served two terms on the Fresno Unified School Board, where he worked to meet the needs of a diverse student population while maintaining financial stability during lean budget years. He also served as president of the Fresno County Trustees Association, and as a member of the Board of Directors of the California School Boards Association and the California State Association of Counties.

Arambula graduated with honors from Harvard University, earning a B.A. degree in Comparative Literature in 1975. In 1978, he earned a Master's Degree in Educational Administration and Policy Analysis from Stanford University. In 1981, he earned his law degree from Boalt Hall School of Law at the University of California, Berkeley.

Arambula is the son of immigrant farm workers and the fifth of seven children.

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El asambleísta Juan Arambula fue elegido a la asamblea estatal en noviembre de 2004. Arambula es presidente del comité de Trabajos, Desarrollo Económico y la Economía y es miembro de los comités Presupuesto, subcomité No. 4- Administración del Estado, Educación, y Servicios Humanos.

Antes de su elección a la asamblea, Arambula sirvió como miembro de la junta de supervisores del condado de Fresno de 1997 a noviembre de 2004, donde luchó para diversificar la economía del Valle Central y crear fuentes de trabajos, mejorar la calidad y el acceso al cuidado médico, y reducir la violencia juvenil.

De 1987 a 1996, sirvió en la mesa directiva escolar de Fresno donde luchó para resolver las necesidades de una población diversa estudiantil mientras mantenía la estabilidad financiera durante años de presupuesto limitado. También sirvió como presidente de la asociación de los administradores del condado de Fresno, y fue miembro de la junta directiva escolar de California y la asociación de condados del estado de California.

En 1975 Arambula se graduó con honores de la universidad de Harvard con su licenciatura en literatura comparativa. En 1978, Arambula terminó su maestría en administración y análisis político de la universidad de Stanford. En 1981, Arambula completó sus estudios en la facultad de derecho en la Universidad de California, Berkeley.

Arambula es el quinto de siete hijos de padres inmigrantes agricultores.

ASSEMBLY MEMBER JOE BACA, JR.
62nd District – Rialto

Assemblyman Joe Baca was elected to the State Assembly in November of 2004. Among his highest legislative priorities are education, health care, safe drinking water, public safety, economic development, transportation, and improving the overall quality of life of his constituents.

He currently Chairs the Assembly Select Committee on Perchlorate Contamination and serves on the Assembly Rules Committee as well as the Assembly Jobs & Economic Development, Housing & Community Development, Utilities & Commerce, and Water, Parks & Wildlife Committees.

Assemblyman Baca has a deep commitment to improving opportunities for youth. In 2002, Assemblyman Baca established an annual free baseball clinic for local youth, exposing them to recreational opportunities available in the community. He is also a volunteer member of the San Bernardino Youth Accountability Board to help keep at-risk youth from getting into crime.

Assemblyman Baca has a long record of public service in the Inland Empire. After completing college, he became a correctional officer for the California Department of Corrections and went on to work as a probation officer, hoping to influence young people who were starting to get into trouble as juveniles. He decided that helping young people get a good education was the best way to give them options and keep them out of trouble and so subsequently he taught students at Inland Empire Area schools including Rialto High School.

Assemblyman Joe Baca, Jr., was born in Barstow and graduated from Eisenhower High School in Rialto. He earned an A.A. degree from San Bernardino Valley College and a B.S. degree from Cal State San Bernardino. He also earned a Master's Degree in Public Administration from Cal State San Bernardino. Assemblyman Baca and his wife, Jennifer, live in Rialto. He has one daughter, Kaylie, age 13.

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El asambleísta Joe Baca fue elegido a la asamblea estatal en noviembre de 2004. Entre sus prioridades legislativas están la educación, el cuidado médico, el agua potable, la seguridad pública, el desarrollo económico, el transporte, y mejorar la calidad de la vida total de sus constituyentes.

Baca es miembro del comité de Reglas de la Asamblea y los comités de Trabajos y Desarrollo Económico; Vivienda y Desarrollo Comunitario; Servicios Públicos y Comercio; y Agua, los Parques y la Naturaleza.

El asambleísta Baca tiene un compromiso personal de mejorar las oportunidades de la juventud. En 2002, el asambleísta Baca estableció una organización anual de béisbol para la juventud local, exponiéndolos a las oportunidades recreacionales disponibles en la comunidad. Baca también es miembro voluntario de la junta Responsabilidad Juvenil de San Bernardino para que la juventud se mantenga libre de la criminalidad y otros peligros.

El asambleísta Baca tiene una historia extensa de servicio público en el *Inland Empire*. Después de terminar la universidad, trabajó como oficial para el Departamento de Correcciones y después como oficial del departamento de libertad condicional. Allí trabajaba con el objetivo de influenciar a la juventud para que llegarán a tener una vida mejor y libre de violencia. Baca concluyó que la juventud podría salir adelante teniendo más oportunidades educativas y dándoles el apoyo necesario. A raíz, Baca decidió ser maestro en escuelas en el *Inland Empire,* incluyendo la secundaria de Rialto.

El asambleísta Joe Baca, Jr., nació en Barstow y se graduó de la escuela secundaria de Eisenhower en Rialto. Baca completo un grado de A.A. de San Bernardino Valley Collage y un B.S. de la universidad estatal de San Bernardino. Baca completo su maestría en administración pública de la universidad estatal de San Bernardino. El asambleísta y su esposa, Jennifer, residen en Rialto. El tiene una hija, Kaylie, de 13 años.

ASSEMBLY MEMBER RUDY BERMÚDEZ
District 56 – Norwalk

For more than 20 years, Assembly Member Rudy Bermúdez has served the people of California by promoting public safety, improving education, and championing the rights of working men and women. A law enforcement officer by profession, Bermúdez was first elected to the State Assembly in November of 2002. Assembly Member Bermúdez, now in his second term in office, currently serves as Chair of the Assembly Budget Subcommittee #4 on State Administration, and on the Assembly Committees on Aging, Governmental Organization, and Water, Parks & Wildlife.

In his first term in office, Bermúdez authored and secured passage of legislation that ensured the most egregious sexual predators would never be able to practice medicine in California and legislation that allows school districts to begin implementation of full day kindergarten.

Before being elected to the State Assembly, Bermúdez was an active Council Member in the City of Norwalk, the fifteenth largest city in Los Angeles County. As a City Council Member, he worked to attract new businesses and retain existing ones, promote strong fiscal policies, eliminate the utility user tax and encourage development to strengthen the city's economy. He strengthened law enforcement by enacting community-based policing and helped enhance senior and youth community services. Before joining the Norwalk City Council, Bermúdez served eight years as a member of the Norwalk-La Mirada Board of Education.

Assembly Member Bermúdez graduated from UCLA in 1983, with a Bachelor's degree in sociology. He received a Master's degree in public administration from California State University at Long Beach. Bermúdez and his wife, Nancy, live in Norwalk and have two sons, Rudy and Nicolas.

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Por más de 20 años, el asambleísta Rudy Bermúdez ha servido a la gente de California promoviendo seguridad pública, mejorando la educación, y defendiendo los derechos del trabajador. Bermúdez, un policía por profesión, fue elegido a la asamblea estatal en Noviembre de 2002. Bermúdez, ahora en su segundo término en oficina, actualmente sirve como presidente del subcomité #4 de Administración del Estado, del comité del presupuesto. Además, es miembro de los comités de la asamblea sobre el Envejecimiento; Organización Gubernamental; y Agua, Parques y Naturaleza.

En su primer término, Bermúdez fue autor de la legislación que aseguró que los depredadores sexuales más notorios nunca podrán practicar como médicos en California. Tambien fue autor de legislación que permite que los distritos escolares comiencen ofrecer *kindergarten* gratuito el dia completo.

Antes de ser elegido a la asamblea, Bermúdez era concejal de la ciudad de Norwalk, la quinta ciudad más grande del condado de Los Ángeles. Como concejal, trabajó para atraer y conservar el comercio, promover un presupuesto municipal responsable, eliminar el impuesto del usuario y para mejorar el desarrollo económico de la ciudad. Bermúdez reforzó el departamento policial y exigio que la policia se involucrara mas en la comunidad. Al mismo tiempo, ayudó a realzar servicios para la juventud y personas de la tercera edad. Antes de hacerse concejal de Norwalk, Bermúdez sirvió 8 años como miembro de la mesa directiva escolar del distrito unificado de Norwalk-La Mirada.

El asambleísta Bermúdez se graduó de Universidad de California Los Ángeles (UCLA) en 1983, con una licenciatura en sociología. Bermúdez completó su maestría en administración pública en la universidad estatal de Long Beach. Bermúdez y su esposa, Nancy, viven en Norwalk y tienen dos hijos, Rudy y Nicolas.

ASSEMBLY MEMBER RON CALDERÓN
58th District – Montebello

Assemblyman Ron Calderón was elected to the State Assembly in November of 2002 and re-elected to serve his second term in November of 2004. Assemblyman Calderón was born and raised in Montebello and is a graduate of Montebello High School. He received a Bachelor of Arts degree in psychology from UCLA and attended Western State University of Law.

Along with a history of strong community involvement, Assemblyman Calderón has substantial experience in business and finance, giving him the background necessary to ensure California's economy continues to rebound. He has served as a manager in the manufacturing industry and as a mortgage banker and a real estate agent. He also owned a small financial services sales and marketing firm for several years.

Assemblyman Calderón's legislative package demonstrated his dedication to developing an honest and balanced state budget, promoting economic development through retention and growth opportunities for all businesses, strengthening state and local infrastructure, and protecting the rights of consumers.

Assemblyman Calderón served as the Assistant Majority Leader during his first term and was appointed Chair of the Banking & Finance Committee by Speaker Fabian Núñez in January of 2005.

Assembly Ronald S. Calderón lives in Montebello with Ana, his wife of 24 years, and their two children Jessica and Zachary.

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El asambleísta Ron Calderón fue elegido a la asamblea del estado en noviembre de 2002 y fue reelegido para servir su segundo término en noviembre de 2004. El asambleísta Calderón se graduó de la secundaria de Montebello, su ciudad natal. Recibió su licenciatura en psicología de UCLA y acudió a la universidad Western State University of Law.

Junto con un historial de participación comunitaria, el asambleísta Calderón tiene experiencia substancial en comercio y las finanzas, dándole el conocimiento necesario para asegurar que la economía de California continúe a desarrollar. Ha servido como gerente en fabricas, como un banquero de hipoteca y como agente de bienes y raíces. Calderón también inició un negocio de servicios financieros y marketing por varios años.

El paquete legislativo del asambleísta Calderón ha demostrado su dedicación para desarrollar un presupuesto de estado honesto y equilibrado, promoviendo el desarrollo económico por medio de la retención y del crecimiento del desarrollo económico para todos los negocios, consolidando la infraestructura local y estatal, y protegiendo los derechos del consumidor.

El asambleísta Calderón sirvió como el líder auxiliar de la mayoría durante su primer término y fue designado presidente del comité de finanzas y asuntos bancarios por el portavoz de la asamblea,Fabián Núñez, en enero de 2005.

El asambleísta Ronald S. Calderón vive en Montebello con su esposa de 24 años, Ana, y sus 2 hijos Jessica y Zachary.

ASSEMBLY MEMBER ED CHAVEZ
57th District – La Puente

Assemblyman Ed Chavez was born and raised in La Puente, the youngest of seven children. His father was a steelworker at Bethlehem Steel. His mother was also a union worker, holding a job with McDonnell Douglas' Machinist Union.

He graduated from Bassett High School in 1981 and later received his A.A. degree in General Education from Rio Hondo College in 1985. He received a Bachelor of Arts degree in Political Science from UCLA in 1989 and later earned a Long Term Single Subject Credential from Claremont Graduate University and a Designated Subjects Adult Education Teaching Credential from the California State University at Los Angeles.

Assemblyman Chavez was first elected to public office in 1987, earning a seat on the Board of Education for Bassett Unified School District. In 1990, he ran for and won a seat on the La Puente City Council where he ultimately served as Mayor Pro Tem then Mayor.

In the State Assembly, his legislative priorities have focused on public safety, education, economic development, and transportation. During his first term in office he established the San Gabriel Valley Legislative Caucus, working across party lines to bring together representatives from across the San Gabriel Valley to address issues of regional concern. He continues to serve as Chair of the bicameral, bipartisan caucus.

Assemblyman Chavez currently serves as Chair of the Assembly Arts, Entertainment, Sports, Tourism & Internet Media Committee, as well as a member of the Banking & Finance, Governmental Organization, and Veteran's Affairs Committees.

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El asambleísta Ed Chávez nació y fue criado en La Puente, California. Es el más joven de siete hijos. Su padre era un trabajador para la compañía *Bethlehem Steel*, un fabricante de acero. Su madre trabajaba para el sindicato de maquinistas de *Mcdonnell Douglas*.

Chávez se graduó de la secundaria de Bassett en 1981 y más adelante recibió su grado de A.A. en educación general de Río Hondo College en 1985. Recibió su licenciatura en ciencia política de UCLA en 1989 y completo estudios posgrados en la Universidad de Claremont y en la Universidad Estatal de Los Angeles donde recibio sus credenciales de maestro. .

En 1987 el asambleísta Chávez fue elegido por primera vez a cargo público cuando lo eligieron miembro de la mesa directiva del Distrito Escolar Unificado de Bassett. En 1990, Chávez fue elegido como concejal de La Puente donde sirvió en última instancia como alcalde.

En la asamblea estatal, sus prioridades legislativas se han enfocado en la seguridad pública, la educación, el desarrollo económico, y el transporte. Durante su primer término Chávez estableció el comité legislativo del Valle de San Gabriel, y trabajó con ambos partidos políticos para reunir representantes a través del Valle de San Gabriel para resolver problemas regionales. Chávez continúa sirviendo como líder del comité bicameral.

El asambleísta Chávez sirve actualmente como presidente del comité asambleísta de los Artes, el Entretenimiento, los Deportes, el Turismo y los Medios del Internet. Tambien es miembro de los comites de actividades Bancarias y las Finanzas, Organización Gubernamental, y el comité de Veteranos.

ASSEMBLY MEMBER HECTOR DE LA TORRE
50th District – South Gate

Assembly Member Hector De La Torre was elected to the State Assembly in November of 2004. He currently serves as the Chair of the Budget Subcommittee on Health & Human Services and he serves on the Assembly Budget, Environmental Safety & Toxic Materials, Local Government, and Utilities & Commerce Committees. Additionally, he is one of two first-term members to serve on the Joint Legislative Budget Committee. He was also appointed to serve on the California Cultural and Historical Endowment.

De La Torre served nearly 8 years on the City Council of his native City of South Gate, including two years as mayor. As a city councilmember, Assembly Member De La Torre worked to enhance the quality of life in South Gate by building new parks, investing in local infrastructure, attracting economic development, and improving communications between the police and the community. In order to alleviate overcrowding, De La Torre fought for new and better school facilities.

In the Assembly, De La Torre aims to bring health care solutions to the residents of the 50th Assembly District and is honored to serve on the Select Committee on the Los Angeles Health Care Crisis. Assembly Member De La Torre majored in Diplomacy and World Affairs at Occidental College in Los Angeles and attended graduate school at the George Washington University in Washtington, D.C. While in Washington, he was appointed the Assistant to the Deputy Secretary of Labor in the Clinton Administration.

Assemblymember De La Torre and his wife, Christine, live in South Gate with their children Elinor, Henrik, and Emilia.

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El asambleísta Hector De La Torre fue elegido a la asamblea en Noviembre de 2004. De La Torre actualmente sirve como presidente del subcomité del presupuesto en Salud y Servicios Humanos y también es miembro de los comités del presupuesto; la seguridad ambiental y los materiales tóxicos; el gobierno local; y las utilidades y el comercio. Además, De La Torre es uno de dos asambleístas en sus primeros términos que sirve en el comité legislativo común sobre el presupuesto. También, fue nombrado a la Fundación Cultural e Histórica de California.

De La Torre sirvió casi 8 años como concejal de su ciudad natal de South Gate, incluyendo dos años como alcalde. Como concejal, De La Torre luchó para mejorar la calidad de vida en South Gate construyendo parques, invirtiendo en la infraestructura local, atrayendo desarrollo económico, y mejorando comunicaciones entre la policía y la comunidad. Para mejorar las circunstancias bajo cual aprendían los estudiantes, De La Torre luchó para las nuevas y mejores instalaciones de las escuelas.

Unos de los objetivos del asambleísta De La Torre es traer cuidado médico a los residentes del distrito 50 y fue se honra en formar parte del comité selecto sobre la crisis del cuidado médico de Los Ángeles. El asambleísta De La Torre se graduó en relaciones exteriores y la diplomacia de la Universidad Occidental en Los Ángeles y hizo sus estudios posgraduados en George Washington University en Washington, D.C. Mientras vivió en Washington era asistente al subsecretario de trabajo en la administración de Clinton.

El asambleísta Hector De La Torre y su esposa, Christine, viven en South Gate con sus hijos Elinor, Henrik, y Emilia.

ASSEMBLY MEMBER DARIO FROMMER
43rd District – Glendale

Assembly Majority Leader Dario Frommer was first elected to the State Assembly in 2000. In February, 2004, he was appointed Majority Leader of the California State Assembly.

During his tenure in the Assembly, Frommer has introduced key legislation addressing California's ailing health care system – including bills to expand health care coverage to working Californians, reigning in runaway health care costs, and increasing Californians' access to affordable, lifesaving prescription drugs. He has also authored bills to reduce teen smoking, stop runaway film production, ban the sale of cigarettes to children over the Internet, ensure working mothers have proper accommodations for expressing breast milk, and prevent the release of MTBE and other harmful contaminants in our drinking water systems.

In addition, Frommer authored the Urban Parks Act of 2001, the state's first permanent program to assist local communities to acquire and build new neighborhood parks and recreation areas and secured a critical $12 million from the state to help the city of Glendale preserve 244 acres of open space through the Oakmont Hillside V property.

Frommer received his Juris Doctorate from the University of California, Davis after receiving a Bachelor of Arts degree in International Relations from Colgate University. As an active member in his community, Frommer serves on the Governing Board of the YMCA Model Legislature and Court Program. He is also a member of the Los Feliz Improvement Association, the Glendale Rose Parade Float Committee, the Glendale and Burbank Chambers of Commerce, and the American Federation of Teachers Glendale College Guild Local 2276.

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El líder mayoritario de la asamblea, Dario Frommer, fue elegido por primera vez a la asamblea en el año 2000. En febrero, 2004, fue designado líder mayoritario de la Asamblea del Estado de California.

En la asamblea, Frommer ha introducido legislación clave que se dirige a mejorar el sistema de salud médica de California – incluyendo legislación para que gente de bajos recursos tengan a su alcance asistencia médica y acceso a medicamentos. Frommer ha introducido legislación para prevenir que fuman los jóvenes; para prevenir la perdida de producción cinematográfica en California; prohibir la venta de cigarrillos a niños por el Internet; asegurar que madres que trabajan tengan alojamientos apropiados para el amamantamiento; y prevenir la emanación de contaminantes perjudiciales en nuestros sistemas de agua potable.

Además, Frommer escribió el Acto Urbano de Parques de 2001, el primer programa permanente del estado para ayudar comunidades locales adquirir y construir parques y campos deportivos. Aseguro $12 millones del estado para ayudar que la ciudad de Glendale conserva 244 acres de naturaleza para Oakmont Hillside.

Frommer se recibió de abogado en la Universidad de California, Davis después de recibir una licenciatura en Relaciones Internacionales de la Universidad de Colgate. Como miembro activo de su comunidad, Frommer es miembro de la mesa directiva del Modelo Legislativo y Programa Tribunal del YMCA. Modelo. Frommer es miembro de la Asociación Para el Mejoramiento de Los Feliz, , el Comité del desfile de Glendale, la Cámara de Comercio de Glendale y Burbank, y la Federación Americana de Maestros de Glendale College Guiad, Local 2276.

ASSEMBLY MEMBER CINDY MONTAÑEZ
39th District – San Fernando

Cindy Montañez and her five brothers and sisters were raised by their immigrant parents, Manuel and Margarita Montañez, in the Northeast San Fernando Valley. Cindy's experience in public service has been diverse. Her experience as a community advocate for battered women, her internship with then Los Angeles City Councilman Richard Alarcón, and her appointment to the San Fernando Cultural Arts Commission, helped Cindy develop a firm grounding for her future as an elected official.

In 1999, Assembly Member Montañez became the youngest person ever elected to the San Fernando City Council. She became the city's Mayor in 2001 and created a strong resume of accomplishments in the City during her tenure including building a new Library, expanding a Community Center and developing a new plan for commercial business development. In 2002, she was elected to the California State Assembly at age 28, where she is the youngest woman ever elected to the California Legislature.

Cindy's legislative work has focused on issues most important to her working class district. Her areas of focus are education, the environment, health care, and consumer/worker protection. Enacted bills include statues to improve the management of urban landfills, brownfields redevelopment, recycling, a law to protect children from a sexually abusive parent, and laws to ensure the safety of temporary construction workers. In addition, Cindy was the author of several bills on education to ensure healthier students and to reduce school overcrowding.

Cindy was appointed Chair of the Assembly Rules Committee in February of 2004 by Assembly Speaker Fabian Núñez. At 30 years old, Montañez is the youngest woman, the first Democratic woman, and the first Latina to serve as Chair of the powerful committee.

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Cindy Montañez y sus cinco hermanos y hermanas fueron criados por sus padres inmigrantes, Manuel y Margarita Montañez, en el Noreste Valle de San Fernando. La experiencia de Cindy en el servicio a la comunidad ha sido diversa. Su experiencia como una abogada de comunidad para mujeres azotadas, sus puestos de interno con entonces Concejal de Ciudad de Los Angeles Richard Alarcon, y su cita al Comisión de San Fernando de los Artes Culturales, ayudaron a que Cindy desarrolle su experiencia para su futuro como un funcionario elegido.

En 1999, la asambleísta Montañez llegó a ser la persona más joven elegida al ayuntamiento de San Fernando. Además, ella llegó a ser el Alcalde de la ciudad en 2001 y creó un fuerte currículo de logros en la ciudad incluyendo la construcción de una Biblioteca, expandiendo un centro comunitario y desarrollando un nuevo plan para el desarrollo comercial. En 2002, ella fue elegida a la Asamblea del Estado de California a los 28 años, haciéndola la mujer más joven elegida a la Legislatura de California.

El trabajo legislativo de Cindy se ha enfocado en asuntos muy importantes para su distrito que consiste con gran mayoría de la clase obrera. Sus áreas de enfoque son: la educación, el medio ambiente, la asistencia médica, y protección del consumidor/trabajador. Su legislación incluye el mejoramiento de la administración de vertederos urbanos, una ley para proteger a niños de abuso sexual de parte de un padre, y legislación para asegurar la seguridad de trabajadores temporarios de construcción. Además, Cindy fue la autora de varias propuestas legislativas para la educación con el objetivo de asegurar la salud de estudiantes.

Cindy fue nombrada presidente del Comité de Reglas de Asamblea en febrero de 2004 por el portavoz de Asamblea, Fabián Nuñez. A los 30 años de edad, Montañez es la mujer más joven, la primera mujer demócrata, y la primer Latina de servir como líder de este poderoso comité.

ASSEMBLY MEMBER GLORIA NEGRETE McLEOD
61st District – Montclair

Assembly Member Gloria Negrete McLeod was first elected to represent the 61st Assembly District in November of 2002. She was re-elected and sworn into office on December 6, 2004 to serve her third term.

Assembly Member Negrete McLeod is the Chair of the Assembly Committee on Business & Professions, which serves to protect California consumers, along with serving as Co-Chair of the Assembly Ethics Committee and as Vice-Chair of the Joint Committee on Boards, Commissions & Consumer protection.

In addition, she serves on the Assembly Government Organization, Health, and Public Employees, Retirement & Social Security Committees, is a member of the Women's Caucus and the State of California Commission on the Status of Women.

As a 35-year resident of a community that encompasses the West End, Assembly Member Negrete McLeod is actively involved in the clean-up of groundwater contamination. One of the top legislative priorities is to improve the quality of California's current water supply and to ensure that there is a reliable plan in place that will adequately provide for the State's growing water needs.

Improving the affordability of and access to higher education, enhancing the quality of health care, improving our current transportation system to reduce traffic congestion, and promoting the growth of quality employment opportunities for Californians are also among her highest legislative priorities.

Assembly Member Negrete McLeod has been an active member in her community for more than 30 years. Prior to being elected to the State Assembly, she served as President of the Chaffey Community College Board and was a Chaffey Board member for five years total. She and her husband, Gilbert L. MeLeod, a retired police lieutenant, have ten children, 27 grandchildren, and 9 great-grandchildren.

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La asambleísta Gloria Negrete McLeod fue elegida por primera vez para representar el Distrito 61 de la Asamblea en noviembre de 2002. Ella fue reelegida para servir, el 6 de diciembre de 2004 en su tercer término.

La asambleísta Negrete McLeod es presidente del Comité de la Asamblea de Comercio & Profesiones, donde protege los consumidores de California. Además, es co-presidente del Comité de Ética de la Asamblea y es vicepresidente del Comité Conjunto de Mesas, Comisiones & el Comité de Protección al Consumidor.

Además, ella es miembro del la Organización del Gobierno de la Asamblea, de la Salud, y Empleados Públicos, la Jubilación & los Comités de Seguro Social. Negrete McLeod es miembro del Asociación de Mujeres Legisladores y la Comisión del estado de California en la Posición de Mujeres.

Como residente de 35 años de una comunidad que abarca el *West End*, la asambleísta Negrete McLeod es muy activa en los proyectos de decontaminación de agua subterránea potable. Unas de las prioridades legislativas es mejorar la calidad de abastecimiento de agua actual en California y para asegurar un plan que proporcionará adecuadamente para las necesidades crecientes de agua del Estado.
Mejorando el precio y el acceso a la educación superior, aumentando la calidad de cuidado médico, mejorando nuestro sistema actual del transporte para reducir la congestión del tráfico, y promover el crecimiento de oportunidades de empleo para los californianos son sus prioridades legislativas.

La asambleísta Negrete McLeod ha sido miembro activo en su comunidad por más de 30 años. Antes de ser elegida a la Asamblea del Estado, ella sirvió como Presidente de la Mesa Directiva de Chaffey Community College y era un miembro de la Mesa Directiva de Chaffey por cinco años. Ella y su marido, Gilbert L. McLeod, un teniente jubilado policial, tienen diez niños, 27 nietos, y 9 bisnietos.

ASSEMBLY MEMBER PEDRO NAVA
35th District – Santa Barbara/Ventura/Oxnard

Assembly Member Nava grew up and attended public schools in Southern California. He is a strong supporter of public education. He studied at San Bernardino Community College, graduated from San Bernardino State University, and obtained his law degree from the University of California, Davis, Martin Luther King, Jr. Hall, School of Law.

After graduation from law school, he worked in job training programs for the economically disadvantaged in Fresno. He later became a Deputy District Attorney in Fresno County and was involved in targeted narcotics prosecution, the county-wide drug crime task force, was a board member of the Fresno Rape Crisis Center, and President of the Fresno Community College President's EOP&SS Advisory Committee. In 1985 he joined the Santa Barbara District Attorney's Office and in 1987 moved into private practice as a civil litigator.

In 1997, Nava was appointed by now-Lt. Governor Cruz Bustamante to the California Coastal Commission and has received many awards for his coastal protection efforts. He has a long history of community involvement, having served as President of the Board of Trustees of the Santa Barbara & Ventura Colleges of Law, President of the Santa Barbara Hispanic Chamber of Commerce, Board Member of the Santa Barbara Women Lawyers, Trustee of the Santa Barbara Museum of Art, and a long time member of the Santa Barbara Jewish Roundtable.

Nava was elected to the California State Assembly in November of 2004 and currently serves as Chair of the Assembly Budget Subcommittee Number 5 on Information Technology/Transportation. He also serves on the Assembly Budget, Higher Education, Insurance, Natural Resources, Joint Legislative Audit and Budget Committees and the Select Committee on Wine.

Pedro is married to Susan Jordan, co-founder of the California Coastal Protection Network, and Vote the Coast. They are parents to a 17-year old Dos Pueblos High School student, Jedd.

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Pedro creció y asistió a escuelas del sur de California. El es un gran partidario de la educación pública. Estudio en el San Bernardino Community College, y es graduado del San Bernardino State y obtuvo el titulo de abogado de la Escuela de Leyes Martin Luther King Jr. de la Universidad de California, Davis.

Después de graduarse de la escuela de leyes, trabajo en programas de entrenamientos de empleo para las personas de bajos recursos en Fresno. Mas tarde, Pedro fue nombrado como Segundo de a bordo del Procurador del Distrito en la oficina del Procurador General del Condado de Fresno, el cual involucra los Procesos sobre Objetivos específicos del Narcótico, encabezando la Fuerza de Tarea Conjunta contra el Crimen de Drogas de todo el condado, fue miembro de la Junta del Centro de Crisis de Violaciones de Fresno y presidente del Comité de Asesor del EOP&S del presidente del Fresno Community College. En 1985, se integro a la oficina del Procurador de Santa Barbara donde por un tiempo, fue asignado a la sección de leyes del Consumidor/Comercio.

En 1997, Pedro fue nombrado por el actualmente vicegobernador Cruz Bustamante a la Comisión Costera de California y ha recibido varios reconocimientos por sus esfuerzos en la Comisión Costera. Pedro tiene una larga historia de participación en la comunidad, prestando servicios como presidente de la Junta de Administración de las Universidades de Leyes de Santa Barbara y Ventura, presidente de la Cámara de Comercio Hispana de Santa Barbara, miembro del directorio de las Mujeres Abogadas de Santa Barbara, miembro del Museo de Arte de Santa Barbara y miembro antiguo de la Mesa Redonda Judío-Latino de Santa Barbara. Pedro recibió el primer premio del "Hombre de la Equidad" de parte del grupo de Mujeres Empresarias.

Pedro fue elegido a la Asamblea Estatal el 2 de noviembre del 2004. Actualmente sirve comó presidente del subcomité #5 del presupuesto de la Asamblea en Información Tecnológica y Transporte. Pedro también presta servicios en el Comité de Presupuesto, Educación Superior, Seguros, Recursos Naturales, y en el Comité Conjunto de Auditoria de la Legislatura.

Pedro esta casado con Susan Jordan, una de las fundadoras de la Red de Protección Costera de California (CCPN) y Vote por la Costa. Son los padres de Jedd, un estudiante de 17 años de la secundaria Dos Pueblos High School

ASSEMBLY SPEAKER FABIÁN NÚÑEZ
46TH District – Los Angeles

Speaker Fabián Núñez was elected to the State Assembly in 2002 and sworn in as the State's 66th Speaker on February 9, 2004. He has laid out clear legislative goals including providing affordable prescription drugs, protecting jobs and wages for working families, and keeping the doors of the state's public universities open to all qualified students.

During his first year in office, Núñez scored several legislative victories, including measures providing greater rights to renters when nuisances or substandard conditions are not corrected and ensuring school bathrooms are given funding priority when maintenance funds are spent. This past Session, Núñez authored bills to curb pollution, aid small businesses, discourage predatory lending, improve working conditions for hotel attendants, and offer solutions to California's long-term energy needs. His deep commitment to improving our State's business climate is reflected in his efforts last Session to implement critical energy reforms and his successful overhaul of the State's beleaguered Workers' Compensation System.

In his February, 2004, inaugural speech, Speaker Núñez called on members of the Assembly to commit to passing a fiscally and socially responsible budget. In addition, he is committed to using his post to continue efforts to protect and improve education in our State. He believes that ensuring a quality education for all Californians is not only good for business, it is essential to leveling the playing field and building a state in which every child, no matter their background, can gain the skills necessary to make their own dreams into reality.

Prior to being elected to the Assembly, Núñez served as government affairs director for the Los Angeles Unified School District from 2000-2002. In this capacity he tackled a broad range of education issues and secured millions in funding for school construction projects, children's health insurance, and low-performing schools. From 1996 – 2000 he served as political director for the Los Angeles County Federation of Labor. Speaker Núñez, 37, earned a Bachelor of Arts degrees in Political Science and Education from Pitzer College in Claremont. He resides in downtown Los Angeles and has three children.

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El presidente de la Asamblea Fabián Núñez fue elegido a la Asamblea Estatal en 2002 y fue proclamado como el 66avo. Presidente de la Asamblea el 9 de febrero del 2004. El ha declarado sus metas legislativas claramente que incluyen el encontrar soluciones al costo de las medicinas, proteger trabajos y sueldos para familias trabajadoras y abrir las puertas de las universidades publicas del estado para todos aquellos que califiquen

Durante su primer año como Legislador, Núñez gano varias victorias legislativas, inclusive medidas hechas ley que proporcionan mayores derechos para los inquilinos cuando problemas o condiciones inferiros no son corregidas y asegurando que los distritos escolares usen fondos de mantenimiento del estado para mejorar las condiciones de los baños en las escuelas. Esta sesión pasada Núñez fue autor de legislación que limita la contaminación, ofrecer ayuda a los pequeños empresarios, desanimar los prestamos predadores, mejorar las condiciones de trabajo para los trabajadores hoteleros y ofrecer soluciones a las necesidades energéticas de largo plazo en California. Su compromiso profundo para mejorar el clima comercial de nuestro Estado es reflejado en sus esfuerzos de la última sesión para poner en práctica las reformas críticas de energía y su revisión exitosa del Sistema de Compensación para los trabajadores atribulados del Estado

En su discurso inaugural en febrero del 2004, el presidente Núñez pidió a miembros de la Asamblea que se comprometieran a pasar un presupuesto balanceado y a tiempo. También esta comprometido a utilizar su puesto para continuar los esfuerzos de proteger y mejorar el sistema de educación en nuestro estado. El cree que asegurando una buena educación para todo californiano no es solo bueno para el clima comercial de nuestro Estado, también es esencial para nivelar el campo de juego y la construcción de un estado en el cual cada niño, sin importar sus antecedentes, puede obtener las habilidades necesarias para hacer sus propios sueños una realidad.

Antes de ser elegido a la Asamblea, Nuñez era el director de asuntos gubernamentales para el distrito escolar unificado en los ángeles (LAUSD) del 2000- 2002. En esta capacidad aseguro millones de dólares para asuntos de educación, proyectos de construcción escolar, seguro medico para los niños, y para las escuelas de bajo desempeño. Anteriormente, del año 1999 al 2000, sirvió como director político para la federación de trabajadores del condado de Los Ángeles. El presidente del la asamblea Nuñez tiene 37 años y obtuvo su licenciatura en Ciencias Políticas y Educación de la universidad Pitzer en la cuidad de Claremont en California. El reside en el centro Los Ángeles y tiene a tres hijos.

ASSEMBLY MEMBER JENNY OROPEZA
55th District – Long Beach

In November of 2004, Jenny Oropeza won re-election to her third and final term representing the 55th Assembly District, capping a lifetime of civic involvement, local government leadership and commitment to improving education, air quality, transportation and gender and minority issues. She began elected service in 1988 by winning a seat on the Long Beach Board of Education, serving two terms. In 1994 she won the first of two four-year terms on the Long Beach City Council, becoming the first Latina member.

Assembly Member Oropeza also represented southeast Los Angeles County cities while a member of the Metropolitan Transportation Authority from 1996 – 2000, serving on the Planning & Programming and Construction committees. She later chaired the Goods Movement Committee of the Southern California Association of Governments. She tirelessly championed transportation issues, including infrastructure improvements, grade-crossing safety and solving several long-standing transportation problems in the Long Beach region.

In the Assembly, Oropeza chairs the Assembly Transportation Committee and expects to lead the way to improve highway and transit funding policies. She supports Proposition 42 and has introduced legislation to ensure transportation tax dollars reach communities. She also serves on the Assembly Appropriations, Jobs, Economic Development & the Economy and Veterans Affairs committees.

Oropeza and her husband, Tom Mullins, married in 1977 and live in a 1930s-era Craftsman bungalow in Long Beach that showcases impressionistic oil paintings by her late father, the son of Mexican immigrants. The oldest of three children, she enjoys reading political biographies. In early 2005, at the age of 47, she successfully recovered from cancer surgery.

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En noviembre de 2004, Jenny Oropeza ganó la reelección a su tercer y último término representando al Distrito 55 de la Asamblea. Ella se ha dedicado a la participación cívica, liderazgo local de gobierno y su compromiso a la educación, calidad aérea, transporte, y asuntos del género y la minoría. Ella empezó su carera política en 1988 cuando fue elegida al distrito escolar unificado de la cuidad de Long Beach, sirviendo dos términos. En 1994 ella fue elegida al consejo de la cuidad de Long Beach convirtiéndose en el primer miembro Latino.

La asambleísta Oropeza también sirvió en la Tabla de MTA de 1996 – 2000 donde ella sirvió en los Comités de Planificación y Programación. Ella también servio como presidenta del Comité del Movimiento de Bienes de la Asociación Meridional de California de Gobiernos. Ella utilizó estas posiciones para defender asuntos de transporte incluyendo mejoría de infraestructura, y la resolución de problemas antiguos de transporte específicos a la región de Long Beach.

En la Asamblea, Oropeza es la presidenta del Comité de Transporte de la Asamblea y se espera que ella mejore las autopistas y los reglamentos del financiamiento de transito. Ella ha sido una partidaria constante de la Proposición 42 y ha introducido legislación para asegurar que dólares de impuesto de transporte alcancen las comunidades mas necesitadas de dólares. Ella también sirve en el Comité de Agricultura; el Comité de Nombramientos; el Comité sobre Organización Gubernamental y el Comité sobre Trabajos, Desarrollo Económico y la Economía.

Oropeza y su marido, Tom Mullins, se casaron en 1997. Ellos viven en una que fue construida en 1930 en Long Beach, California donde expone pinturas al óleo hechas por su padre fallecido, el hijo de inmigrantes mexicanos. Ella es la mayor de tres hijos, y goza la lectura y compartiendo tiempo con su marido.

ASSEMBLY MEMBER NICOLE PARRA
30th District – Hanford

Assemblywoman Nicole M. Parra was first elected to the State Assembly in November of 2002. She currently serves as Chair of the Joint Legislative Audit Committee, which ensures the efficient expenditure of taxpayers' money through oversight of public officials and institutions. In addition, she currently serves on the Assembly Agriculture, Banking & Finance, and Water, Parks & Wildlife Committees and is an Assistant Majority Whip. She previously Chaired the Select Committee on Megan's Law & Sex Offender Registration, and authored several key bills aimed at strengthening and expanding Megan's Law in California.

Parra has focused her legislative career on efforts to accelerate economic development and secure more jobs for struggling communities in the state, and has authored and co-authored several measures regarding military personnel, their families, and military veterans as well as issues specific to disabled veterans. She has been a leader in efforts to eliminate poverty in the Central Valley and arranged a safe drinking water supply for the small town of Alpaugh.

A resident of Hanford, Assemblywoman Parra was born in Bakersfield and attended Highland High School where her brother, Peter, now teaches. She studied Economics at the University of California, Berkeley, and completed law school in Washington, D.C. After completing law school, she returned to the Central Valley to work as District Director for Congressman Cal Dooley. Assemblywoman Parra follows her family's long tradition of public service. Her father, Pete Parra, was a Kern County Supervisor and is a former school board member; her mother, Yolanda, works for Bakersfield Adult School.

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La asambleísta Nicole M. Parra fue primer elegida a la Asamblea del Estado en noviembre de 2002. Ella actualmente sirve como presidente del comité legislativo de Auditoria, que asegura el gasto eficiente de dinero de contribuyentes de funcionarios e instituciones públicos... Además, ella sirve actualmente en los Comités de Agricultura, Banca y Finanzas, y Agua, Parques y Vida Silvestre y es una Jefa Disciplinaria de la Mayoría. Ella previamente sirvió como presidente del comité selecto de la Ley de Megan.

Parra ha enfocado su carrera legislativa en esfuerzos para acelerar el desarrollo económico y asegurar más trabajos para aquellas comunidades en el estado que están luchando, y ha escrito y apoyado varias medidas con respecto al personal militar, sus familias, y veteranos militares así como asuntos específicos a veteranos incapacitados.. Ella ha sido un líder en el esfuerzo para eliminar la pobreza en el Valle Central y arregló un abastecimiento de agua potable seguro para el pueblo pequeño de Alpaugh.

Un residente de Hanford, la asambleísta Parra nació en Bakersfield y atendió la Preparatoria Highland donde su hermano, Peter, ahora enseña. Ella estudió Economía en la Universidad de California, de Berkeley, y termino sus estudios de leyes en Washington, D.C. Después de completar sus estudios de leyes, ella volvió al Valle Central a trabajar como Directora del Distrito para el Congresista Cal Dooley. La asambleísta Parra sigue la tradición larga de su familia del servicio a la comunidad. El padre, Pete Parra, era un Supervisor del Condado de Kern y es un miembro anterior de la junta escolar, su madre, Yolanda, trabaja para la Escuela Adulta en Bakersfield.

ASSEMBLY MEMBER LORI SALDAÑA
76th District – Clairemont

Lori Saldaña was born in San Diego, the third of four daughters. She attended San Diego public schools, graduating from Clairemont's Madison High School. She went on to earn a Bachelor of Arts Degree in Physical Education and a Master of Arts Degree in Education, both from San Diego State University. She began her career as an educator coaching field hockey at Clairemont and Madison High Schools and women's basketball at San Diego City College.

Throughout her life, she has been active in public causes at the local, state, national and international levels. Believing in the importance of a skilled and educated workforce to San Diego's economy, Ms. Saldaña has devoted much of her 20-year career as an educator in San Diego for workforce development and programs providing educational, vocational, and public service opportunities for at-risk youth. Additionally, she has spent a majority of her career in education as a professor of Business Information Technology throughout the San Diego Community College District. In 2002, Ms. Saldaña was named Associate Dean, Director of Service Learning Program, at San Diego Mesa College. This successful program provides students with experience working in local volunteer organizations while earning college credit.

Since being elected to the California State Assembly in November of 2004, Assemblymember Saldaña was appointed to Leadership as the Assistant Majority Whip and has been assigned to the Assembly Appropriations, Natural Resources, Veterans Affairs, and Water, Parks & Wildlife Committees. These assignments reflect her life long passions for protecting the environment and improving water quality in California.

San Diegans may remember Lori's father, Frank Saldaña, from his post-military career as a reporter for the San Diego Tribune.

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Lori Saldaña nació en San Diego, la tercera de cuatro hijas. Asistió las escuelas públicas de San Diego, graduándose de Clairemont Madison High School. Recibió su licenciatura en Educación Física y una maestría en Educación, de la Universidad Estatal de San Diego. Empezó su carrera entrenando estudiantes en hockey en Clairemont and Madison High Schools y el baloncesto en San Diego City College.

A través de su vida, ella ha sido activa en causas públicas a niveles locales, estatales, nacionales e internacionales. Creyendo en la importancia de una población hábil y educada para mejorar la economía de San Diego, la Sra. Saldaña ha dedicado gran parte de su carrera de 20 años a ser profesora en San Diego para el desarrollo de trabajos y programas que proporcionan oportunidades educativas, vocacionales, y servicio público para la juventud en riesgo de cometer actos violentos. Adicionalmente, ha pasado la mayor parte de su carrera como profesora de Business Information Technology en el Community College District de San Diego. En 2002, la Sra. Saldaña la denominaron como Decano Asociado, Directora del Programa de Servicio de Aprendizaje, en San Diego Mesa College. Este programa exitoso proporciona a los estudiantes con trabajos voluntarios en organizaciones locales a cambio de crédito universitario.

Desde que fue elegida a la Asamblea Estatal en noviembre de 2004, la asambleísta Saldaña fue designada al liderazgo como Asistente Mayoritaria y ha sido asignada a Apropiaciones de la Asamblea, Recursos Naturales, Asuntos de Veteranos, y al Agua, Parques & Comités de Fauna. Estas responsabilidades reflejan su dedicación para proteger el medio ambiente y mejorar la calidad de agua en California.

Los residentes de San Diego recuerdan al papá de Lori, Frank Saldaña, por su carrera pos-militar como periodista para la Tribuna de San Diego.

ASSEMBLY MEMBER SIMON SALINAS
28th District – Salinas

Assemblymember Salinas was born in Slayton, Texas, and is one of 12 children of migrant farm workers. He graduated from Watsonville High School and went on to Claremont McKenna College where he received a Bachelor of Arts Degree in Political Science and Latin American Studies. He subsequently earned a Bilingual Teaching Credential from San Jose State University and graduated with a Jurispridence Doctorate from Santa Clara Law School.

After earning his law degree, Assemblymember Salinas put his Teaching Credential to good work as a 6th grade teacher. He later expanded his academic career as a professor at Hartnell Communtiy College from 1989 – 1993.

Assemblymember Salinas began his public service career in June of 1989 when he was elected as the first Mexican-American to serve on the Salinas City Council. During his tenure with the City of Salinas, he served as Mayor Pro-Tem. Assemblymember Salinas was elected to the Monterey County Board of Supervisors in 1993 and again in 1997. During his second term, he was elected Chair of the Board and was the first Mexican-American to serve on the Board in more than 100 years.

During his first term, Assemblymember Salinas authored legislation that addressed issues including education, agriculture, housing, health care, and transportation. He currently Chairs the Assembly Local Government Committee. Reflecting the most pressing needs of the 28th District, his Committee assignments also include the Transportation, Agriculture, and Housing & Community Development Committees.

Assemblymember Salinas has lived most of his life in the Salinas area, growing up around agri-business and on the farm. He has one son and, like many other parents, enjoys watching soccer games on the weekends.

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El Asambleísta Salinas nació en Slayton, Tejas, y es uno de 12 hijos de padres inmigrantes y trabajadores agrícolas. Salinas se graduó de Watsonville High School y recibió su licenciatura de Claremont McKenna College en Ciencia Política y Estudios Latinoamericanos. El sacó un Credencial de Enseñanza Bilingüe de la Universidad Estatal de San José y finalizo sus estudios de la facultad de derecho de Santa Clara Law School.

Después que sacar su licenciatura de la facultad de derecho, el Asambleísta Salinas trabajó como maestro del sexto grado. De 1989-1993 fue profesor en Hartnell Community College.

El asambleísta Salinas empezó su carrera de servicio público en junio, 1989 cuando fue elegido como el primer mexicano-americano a servir en el ayuntamiento de Salinas. Como concejal de Salinas, sirvió como Pro –Tem al Alcade. El Asambleísta Salinas fue elegido a la Mesa de Supervisores del Condado de Monterrey en 1993 y nuevamente en 1997. Durante su segundo término, fue elegido como Presidente de la Mesa siendo el primer mexicano-americano de servir en más de 100 años.

Durante su primer término, el asambleísta Salinas introdujo legislación en las áreas de educación, agricultura, vivienda, asistencia médica, y el transporte. Actualmente sirve como Presidente del Comité de Gobierno Local de la Asamblea. Reflejando las necesidades más importantes del Distrito 28, sus responsabilidades del Comité incluyen el Transporte, la Agricultura, y el Desarrollo Comunitario y la Vivienda.

El asambleísta Salinas ha vivido la mayor parte de su vida en Salinas. El tiene un hijo y, como muchos otros padres, goza de los partidos de fútbol los fines de semana.

ASSEMBLY MEMBER ALBERTO TORRICO
20th District – Newark

Alberto Torrico was elected to the State Assembly in November of 2004. He Chairs the Assembly Committee on Public Employees, Retirement & Social Security and serves on the Assembly Committees on Transportation, Housing & Community Development, and Governmental Organization. He was also selected by Assembly Speaker Fabian Núñez to act as Assistant Majority Whip.

Before his election to the Assembly, he was Vice Mayor of the City of Newark and served four years as an elected member of the Newark City Council. In that role, he worked to keep the city budget balanced during tough economic times while still fighting for his top priorities. He championed the creation of affordable housing and the development of regional solutions to the area's traffic problems. Assemblymember Torrico is proudest of his work to expand a city-sponsored educational program that gives teens a chance to "drop-in" instead of dropping out.

After graduating from Irvington High School in Fremont, he graduated from Santa Clara University and went on to earn a law degree from the University of California's Hastings Law School in San Francisco. After law school, he worked as an attorney, helping people throughout the state improve their lives on the job and in the community.

Assembly Member Torrico began his public service career as a policy aide for former Santa Clara County Supervisor Ron Gonzales, focusing on criminal justice and transportation issues. He has worked on efforts to extend BART from Fremont to San Jose since 1992. In 2000, he began work as an Assistant General Counsel with the Santa Clara Valley Transportation Authority. Assemblymember Torrico continues to serve on a number of community boards, including Second Chance and Kidango, and the advisory boards of Justice for New Americans and the Alameda County Hispanic Chamber of Commerce. He is the first Legislator to belong to both the Latino and Asian Pacific Islander caucuses.

Torrico lives in Newark with his wife, Raquel, and their 4-year-old-son Mateo and baby daughter Amy-Elyzabeth.

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Alberto Torrico fue elegido a la Asamblea Estatal en noviembre de 2004. El sirve como Presidente del Comité de la Asamblea de Empleados Públicos, la Jubilación & el Seguro Social y sirve en los Comités de la Asamblea de Transporte, Desarrollo Comunitario y Vivienda, y la Organización Gubernamental. También, fue escogido por el portavoz de la Asamblea, Fabián Núñez para actuar como el Asistente Mayoritario.

Antes de su elección a la Asamblea, Torrico fue co-Alcalde de la Ciudad de Newark y sirvió cuatro años como concejal de Newark. Torrico trabajó para mantener un presupuesto balanceado durante tiempos económicos difíciles mientras luchaba por sus prioridades. El defendió la creación de la vivienda razonable y el desarrollo de soluciones regionales a los problemas del tráfico. Torrico está más orgulloso de su trabajo de expandir el programa educativo que les da a los jóvenes una oportunidad de mantenerse en el sistema escolar.

Después de graduarse de Irvington High School en Fremont, se graduó de la Universidad de Santa Clara y recibió su licenciatura de la facultad de derecho en Hastings de la Universidad de California en San Francisco. Después, trabajó como abogado ayudando a personas mejorar sus vidas en el trabajo y la comunidad.

El asambleísta Torrico empezó su carrera de servicio a la comunidad como ayudante para el Supervisor del Condado de Santa Clara Ron Gonzáles, enfocándose en asuntos de justícia criminal y el transporte. El ha trabajado para extender BART de Fremont a San Jose desde 1992. En 2000, empezó su trabajo como Ayudante Concejal General con la Agencia del Transporte del Valle de Santa Clara. Torrico continúa sirviendo en varias Mesas de la comunidad, incluyendo la Segunda Oportunidad y Kidango, y las juntas consultivas de Justícia Para Nuevos Americanos y la Cámara de Comercio Hispano del Condado de Alameda. El es el primer legislador que pertenece a los dos Comités de Latinos y Asiáticos.

Torrico vive en Newark con su esposa, Raquel, su hijo Mateo de cuatro años y su hija Amy-Elyzabeth de 6 meses.

ASSEMBLY MEMBER JUAN VARGAS
79th District – San Diego

Juan was born the third son of ten children in National City, California. His parents moved to the US from Mexico in the 1940's and raised their children on an egg ranch. Juan graduated from the University of San Diego with a BA in Political Science and subsequently earned a Master's in Humanities from Fordham University and a Juris Doctorate from Harvard.

Juan entered the Jesuits, a Catholic religious order, where he worked with many disadvantaged communities, including orphaned children and internally displaced people in El Salvador. He eventually left the Jesuits to pursue a family life and married Adrienne D'Ascoli. He was elected to the San Diego County City Council in February of 1993 where he assumed a leadership role in planning, funding, and advocating for public safety, municipal infrastructure, and improving schools.

He was first elected to the State Assembly in November of 2000. During his first term he was appointed Assistant Majority Leader, using the position to expand on his work with children's issues including a bill to ban smoking in and around playgrounds. He also introduced legislation aimed at protecting young children from graphic sex and violence in arcade games and worked on bills to expand before- and after-school programs. During the energy crisis he was named to the Energy Oversight Committee and was instrumental in forcing utility companies to divulge tax irregularities and in reducing energy prices and prevent further blackouts.

During his second term, he assumed the position of Chair of the Assembly Insurance Committee, which he still holds, as well as currently serving on the Agriculture, Banking & Finance, and Business & Professions Committees. He is Chair of the Select Committee on California Latin American Affairs.

Juan and Adrienne have two daughters, Rosa Celina and Helena Jeanne. They live in the San Diego community of Golden Hill where they are restoring their craftsman home.

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Juan nació, el tercer de diez niños en National City, California. Sus padres su mudaron a EEUU de México en los años 40 y crearon a sus hijos en una hacienda. Juan se graduó de la Universidad de San Diego y recibió su licenciatura en Ciencia Política y terminó su maestría en la Universidad de Fordham y su licenciatura de la facultad de derecho en la Universidad de Harvard.

Juan entró a los Jesuitas, una orden religiosa católica, donde trabajó con comunidades de bajos recursos, inclusive niños huérfanos y personas desplazadas de El Salvador. Eventualmente dejó los Jesuitas para seguir una vida familiar y se casó con Adrienne D'Ascoli. Fue elegido como concejal del condado de San Diego en febrero de 1993 donde asumió un papel de liderazgo en la planificación, la financiación, y abocando por la seguridad pública, la infraestructura municipal, y para mejorar las escuelas.

Fue elegido a la Asamblea Estatal en noviembre del 2000. Durante su primer término fue designado Asistente Líder Mayoritario, usando su posición para seguir trabajando con asuntos de niños inclusive una propuesta para prohibir el fumar en alrededor de campos de juegos. El también introdujo la legislación para proteger a niños jóvenes de juegos gráficos del sexo y la violencia y trabajó para expandir y los programas antes y después de-escuela. Durante la crisis energética, fue denominado al Comité del Descuido de la Energía y fue instrumental en forzar las empresas de servicio público divulgar las irregularidades de impuesto y en reducir los precios de energía y prevenir los apagones adicionales.

Durante su segundo término, asumió la posición de Presidente del Comité del Seguro de la Asamblea, y sirve actualmente en el Comité de Agricultura; Banco y Finanzas; y el Comité de Comercio y Profesiones. Es Presidente del Comité Selecto en la Revitalización Urbana, el Copresidente de Idioma & Acceso al Gobierno, y un miembro de las Comisiones de Investigación de **California Latin American Affairs** .

Juan y Adrienne tienen dos hijas, Rosa Celina y Helena Jeanne y viven en San Diego en la comunidad de Golden Hill.

Appointments Information

SENATE RULES COMMITTEE
APPOINTMENTS UNIT
STATE CAPITOL, ROOM 420
SACRAMENTO, CA 95814

PHONE (916) 651-4151
FAX (916) 445-0596

1. Mr. / Mrs. / Ms. _____
Last First Middle

2. Position (s) appointed to or sought: _____

3. Driver's License #: _____ 4. Birthdate: _____

5. Social Security #: _____ 6. Ethnicity: _____ (optional)

7. Gender: ___ 8. Name of Spouse: _____ 8a. Maiden Name: _____

9. Are you a registered voter? _____Yes _____No County: _____

Please indicate party affiliation _____

Who is your State Senator? _____ Assembly Member? _____

10. Occupation: _____

11. Business Title: _____

Company: _____

Address: _____

_____

_____
City County State Zip

Phone (___) _____

Fax (___) _____

12. Residence: _____

_____
City County State Zip

Phone (___) _____ Cell Phone (___) - _____

13. Please list licenses held pertaining to the desired position (s) sought.

License	Date Secured (mo/yr)

14. Educational History:

College/Graduate School	From (mo/yr)	To (mo/yr)	Degree/Major

15. Work History:

Employer	From (mo/yr)	To (mo/yr)	Occupation/ Title	City/State

If additional space is needed, please attach a separate sheet.

16. List all professional organizations and societies you have been a member of:

Organization/Society	From (mo/yr)	To (mo/yr)

If additional space is needed, please attach a separate sheet.

17. Many positions require the appointment of persons with special background, experience, etc. Please indicate below those categories for which you may qualify.

_____ Advanced Technology	_____ Agriculture	_____ Attorney
_____ Education	_____ Environment	_____ Financial Institution
_____ Higher Education	_____ Insurance	_____ Labor
_____ Law Enforcement	_____ Health	_____ Local Government
_____ Small Business	_____ Student	_____ Veteran

18. _____ Yes _____ No Are you a citizen of a country other than the United States? If so, please list country.

19. _____ Yes _____ No Have you or your immediate family been affiliated (as an officer, owner, director, trustee, partner, advisor, or consultant) with any institutions (corporations, firms, partnerships, business enterprises, nonprofit organizations, etc.) within the past five years which might present a potential conflict of interest or appearance of conflict of interest with your requested appointment? If yes, please explain.

20. _____ Yes _____ No Do you own real property, personal property, or financial holdings which might present a potential conflict of interest or appearance of conflict of interest with your requested appointment? If yes, please explain.

21. _____ Yes _____ No Are you currently or have you ever been involved in a civil litigation, undergone an investigation or been convicted of a violation of any federal, state, county or municipal law, regulation or ordinance? (Traffic violation for which a fine of less than $100 was imposed should not be included.) If yes, please explain.

22. _____ Yes _____ No Has a tax lien or other collection procedure ever been instituted against you by federal, state, or local authorities? If yes, please explain.

23. _____ Yes _____ No Have you ever been disciplined or cited for a breach of ethics or unprofessional conduct by, or been the subject of a complaint to any court, administrative agency, professional association, disciplinary committee or other professional group? If yes, please explain.

24. _____ Yes _____ No Have you ever run for political office, served on a political committee, or been identified publicly with a particular political organization, candidate or issue? If yes, please explain.

25. _____ Yes _____ No Have you ever been a member of any organization which you believe is relevant to the appointment you are seeking?

26. _____ Yes _____ No Have you ever written any books or articles? If yes, please explain.

27. _____ Yes _____ No Do you know anyone who might take any steps, overtly or covertly, to attack your appointment? If yes, please explain.

28. _____ Yes _____ No Is there anything in your background which, if made known to the general public through your appointment, would cause embarrassment to you and/or the Senate? If yes, please explain.

29. _____ Yes _____ No Are you presently on partial or full employment disability or retirement or have you applied for same? If yes, please explain in full detail.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize any person or other entity in possession of information regarding any of the following to release that information to the California Senate Committee on Rules:

*Education *Credit Record *Employment
*Military Service *Medical History *Drivers License Record
*California State Summary Criminal History Information
*Economic interest as reported in my Statement of Economic Interest

Check box if you wish to receive a copy of your credit report ☐

I authorize the California Senate Committee on Rules to use information obtained pursuant to this release for any purpose relating to the Legislature's review and deliberation concerning my nomination to public office, including, but not limited to, its use by Members and staff in preparation for, and during, committee hearings and other public debate on the floor of either house of the Legislature.

This authorization is valid for one year following the date of the signature below.

(Signed)_____(Date)_____

Form SRC 9507 (Revised 2003)

TO ALL PERSONS SEEKING A POSITION APPOINTED BY ASSEMBLY SPEAKER FABIAN NÚÑEZ

Thank you for your interest in serving the people of the State of California. To be considered for an appointment with the Speaker of the Assembly, please complete and return the attached application form.

In completing the form, please note the following:

1. ***The application form must be completed in full.*** If a particular question does not apply to you, please make some indication (e.g., "not applicable" or N/A) rather than leave the space blank. In addition to the completed application form, please attach your resume and/or biography.

2. Please *type or print legibly* your information in the spaces provided on the form. If it is necessary to explain any of your answers, or if you wish to provide more information than the space allows, feel free to use attachments. Please number the entries on your attachments according to the question on the application form.

3. Your completed application form and all attachments should be stapled together and submitted to the Speaker's Office at the address below. We also ask that you fax us a copy at 916-319-2351.

Honorable Fabian Núñez
Speaker of the California State Assembly
State Capitol, Room 219
Sacramento, CA 95814
Attention: Lisa Dominguez, Appointments Unit

Again, thank you for your interest in serving the people of California.

Sincerely,

FABIAN NÚÑEZ
Speaker of the California State Assembly

Enclosure

SPEAKER'S APPOINTMENT APPLICATION FORM

First Name | Middle Initial | Last Name

Home Address (Number, Street) | (City) | (Zip) | County

Home Phone Number | Cell/Car Phone Number | Home Fax Number

Resident since (date):

(If less than five years, please attach a list of all residences for the last five years.) | Email

APPOINTIVE POSITION SOUGHT:

PERSONAL INFORMATION

Social Security Number | Ethnicity (optional) | Sex: F ☐ M ☐

Driver License Number | Date of Birth | Full Name of Spouse

Are you registered to vote? ☐ Yes ☐ No

County in which you are registered to vote

Political Party Affiliation | Country of Citizenship (if other than U.S.A.)

Your State Assembly Member | Your State Senator | Your Congress Member

EMPLOYMENT HISTORY

Current Employment

Employer Name | Job Title

Business Address (number, street, city, zip)

Business Phone Number | Business Fax Number

Past Employment (List all positions held in the last 10 years, with most recent employer first; attach separate sheet of paper if necessary.)

Employer/Firm Name	Title/Occupation	City & State	DATES From - To

HIGHER EDUCATION

Name and Location of School/College	Major	Degree	Number of Years Completed & Date

Professional Licenses and/or Certificates Description	Date Issued	Date Expiration

PROFESSIONAL/CIVIC ACTIVITIES (List organizations of which you are *currently* a member.)

Name of Organization	Member Since

SUPPORT/RECOMMENDATIONS (List the people and organizations that support your appointment; attach their letters.)

BACKGROUND INFORMATION

(Please be sure to answer every question; explanations should be typed on another piece of paper.)

1. ☐ Yes ☐ No Have you ever been affiliated in any capacity with any institutions within the past five years that might present a potential conflict of interest or appearance of conflict of interest with your requested appointment? If yes, please explain.

2. ☐ Yes ☐ No Do you own real property, personal property or have financial holdings that might present a potential conflict of interest or appearance of conflict of interest with your requested appointment? If yes, please explain.

3. ☐ Yes ☐ No Are you or have you ever been a registered lobbyist? If yes, please explain.

4. ☐ Yes ☐ No Have you ever been convicted of a violation of any federal, state, county or municipal law, regulation or ordinance (including traffic violations for which a fine of $100 or more was imposed, including driving under the influence of alcohol or drugs)? If yes, please explain.

5. ☐ Yes ☐ No Are you currently under federal, state or local investigation for possible violation of a criminal law, regulation or ordinance? If yes, please explain.

6. ☐ Yes ☐ No Has a tax lien or other collection procedure ever been instituted against you by federal, state or local authorities? If yes, please explain.

7. ☐ Yes ☐ No Have you ever been disciplined or cited for a breach of ethics or unprofessional conduct by, or been the subject of a complaint to, any court, administrative agency, professional association, disciplinary committee or other professional group? If yes, please explain.

8. ☐ Yes ☐ No Have you ever been involved in civil litigation, or administrative or legislative proceedings of any kind, either as plaintiff, defendant, respondent, witness or party in interest? If yes, please explain.

9. ☐ Yes ☐ No Have you ever run for political office, served on a political committee, or been identified publicly with a particular political organization, candidate or issue? If yes, please explain.

10. ☐ Yes ☐ No Have you ever been publicly identified, in person or by organizational members, with a particularly controversial national, state or local issue? If yes, please explain.

11. ☐ Yes ☐ No Have you ever submitted oral or written views to any government authority or the news media on any particularly controversial national, state or local issue, other than in an official government capacity? If yes, please explain.

12. ☐ Yes ☐ No Have you ever written any particularly controversial books or articles? If yes, please explain.

13. ☐ Yes ☐ No Do you know anyone or any group that might raise questions about your character and qualifications for your requested appointment? If yes, please explain.

14. ☐ Yes ☐ No Is there anything in your background that, if made known to the general public through your appointment, would cause embarrassment to you, the Speaker or the State Assembly? If yes, please explain.

QUALIFICATIONS/SPECIALTIES

(Many positions require the appointment of persons with special background and experience. Please indicate below those categories for which you may qualify.)

- ☐ Advanced Technology
- ☐ Agriculture
- ☐ Attorney
- ☐ Consumer Protection
- ☐ Education (K-12)
- ☐ Education (post-secondary)
- ☐ Environment
- ☐ Financial Institutions
- ☐ Housing
- ☐ Insurance
- ☐ Judicial
- ☐ Labor
- ☐ Law Enforcement
- ☐ Health
- ☐ Local Government
- ☐ Small Business
- ☐ Student
- ☐ Transportation
- ☐ Utilities/Energy
- ☐ Veteran
- ☐ Welfare

PERSONAL STATEMENT

(Please explain why you would like to serve as an appointee of Speaker Núñez)

AUTHORIZATION AND RELEASE

I understand that in connection with this application for appointment an investigation of my personal and business background will be conducted. I hereby authorize the release of any and all information pertaining to me or any business in which I participated, including information of a confidential or privileged nature in the possession of government or private agencies or individuals. I hereby release all such agencies or individuals who furnish such information from liability for damages that may result from furnishing the information requested. I also am aware that a consumer credit report may be requested and used in connection with this appointment application. The source of the report shall be a major national credit reporting agency, such as TRW, TRANSUNION, or EQUIFAX. In the event such a request is made, I understand that a copy of the report should be provided to me by the credit agency.

Signature Date

Biographies
Press Room
Contact the Governor
Speeches
Appointments
California's Governors
Español

State Resources

Watch video of Governor Schwarzenegger giving his 2004 State of the State Address

Watch streaming video from the inauguration of Arnold Schwarzenegger as Governor of California.

Appointments

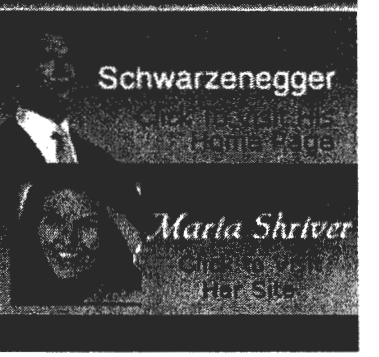
To all persons interested in applying for a position in the Office of Governor Arnold Schwarzenegger: *Thank you for your interest in being considered for an appointment to a position in California State government.*

1. For individuals interested in interning with the Governor's office, please fill out the application accordingly. Please indicate that you are applying for an internship in the "position sought" field.
2. Please fill out all the information. Your application will not be accepted if your First Name, Last Name, Social Security number, Driver's License, Date of Birth and a valid e-mail address are not included.
3. Ensure that all dates are in the correct format. 2 digit month/2 digit day/4 digit year. Example: 01/31/2004.
4. You must click on the "SUBMIT" button at the end of the application. The application will not go into our system if you do not click submit.
5. Follow the instructions after submitting the application.
6. We require that you print, sign and mail in the authorization form at the end of the application. The completed original application must also be mailed in with the signed authorization form.
7. We also ask that you include a copy of your current resume along with the completed original application.
8. Please keep a copy of all documents for your records.
9. Application materials should be returned to the Governor's Office at:

Office of Governor Arnold Schwarzenegger
Attn: Appointments
State Capitol Building
Sacramento, CA 95814

Online Application Form Click below

http://appointments.ca.gov/en/form/form.php



Search
How Do I...? Advanced Search

Bottom of Form

OFFICE OF GOVERNOR ARNOLD SCHWARZENEGGER

Statutory Index of Positions 2005

Accountancy, California Board of
Acupuncture Board
* Admin. Hearings, Dir. of Office of
* Administrative Law, Deputy Dir. of
* Administrative Law, Dir. of Office of
Adult Offender Supervision, CA Interstate Council
Aging, California Commission on
* Aging, Director of California Department of
Agnews State Hospital Advisory Board
Agri. Bargaining Assoc., Adv. Comm.
** Agricultural Labor Relations Board
*** Air Resources Board
Alarm Co Operator Disciplinary Rev Comm
*** Alcoholic Beverage Control Appeals Bd
* Alcoholic Beverage Control, Dir. of
Allocation Board, State
Apprenticeship Council
* Apprenticeship Stds, Chief, Div of
* Architect, State
Architects Board, CA
Arts Council
* Arts Council, Deputy Director
* Arts Council, Director
Asian & Pacific Islander Amer Affrs
Atascadero State Hospital Adv Board
Athletic Commission, State
Attorney Diversion & Asst Prog Oversight Board
* Automotive Repair, Chief of Bureau of
Baldwin Hills Conservancy Govn Bd
Bar of Calif., Bd of Gov., State
Bar of Calif., Examining Comm., State
Barbering and Cosmetology, State Bd of
Bay Conservation & Develop. Comm., SF
Bay-Delta Authority, CA
* Bay-Delta Authority, Director
Behavioral Sciences, Bd
Boating and Waterways Commission
* Boating and Waterways, Dir. of Dept of
Building Standards Commission, State
Business, Trans., & Housing Agency, Dep Sec of Housing
* Business, Trans., & Housing Agency, Sec
CA Science Center, Bd of Dir
* CA Science Center, Expo Park Mgr
CA Service Corps
* California-Mexico Affairs, Dir., Office
Californias Border Environ Coop Comm
Campus Sexual Assault Task Force
Capitol Area Committee
* Child Support Services Dept, Dep Dir
* Child Support, Chief Dep Dir
* Child Support, Director
Chiropractic Examiners, State Bd of
Citizens Compensation Commission, CA
Climate Action Registry, CA
Coachella Valley Mtns Conserv Govn Bd
Coastal Commission, California
Coastal Conservancy, State
* Collection & Investigative Services, Chief of Bureau of
Colorado River Board of California
Community Colleges, Board of Governors of California
* Community Serv & Devel, Chief Dep Dir.
* Community Serv & Devel, Dep Dir.,Dept
* Community Serv & Devel, Dir of Dept of
Compensation Insurance Fund, State Board of Directors,
* Conservation Corps, CA, Director
* Conservation, Director of
* Consumer Affairs, Chief Dep Dir. of
* Consumer Affairs, Dir, Dept of
* Consumer Services, Chief, Div. of
Continuing Care Adv Comm, Dept of Social Services
Contractors' State License Board
* Corporations, Commissioner of
Correctional Peace Officer Standards & Trng
Correctional Peace Officer Standards & Trng
Corrections, Board of
* Corrections, Deputy Director, Paroles HearingsSvcs Div
* Corrections, Director of Dept of
* Corrections, Warden Avenal State Prison
* Corrections, Warden, CA Inst. for Men
* Corrections, Warden, CA Inst. for Women
* Corrections, Warden, CA Medical Fac
* Corrections, Warden, CA Men's Colony
* Corrections, Warden, CA Rehab. Center
* Corrections, Warden, CA State Prison - San Quentin
* Corrections, Warden, CA State Prison at Calipatria
* Corrections, Warden, CA State Prison at Folsom
* Corrections, Warden, CA State Prison at Pelican Bay
* Corrections, Warden, CA State Prison-Corcoran
* Corrections, Warden, Centinela State Prison
* Corrections, Warden, Chuckawalla Valley State Prison
* Corrections, Warden, Correctional Ctr., Susanville
* Corrections, Warden, Correctional Inst. Tehachapi
* Corrections, Warden, Deuel Voc Inst
* Corrections, Warden, Ironwood State Prison
* Corrections, Warden, Lancaster State Prison
* Corrections, Warden, Mule Creek State Prison
* Corrections, Warden, North Kern State Prison
* Corrections, Warden, Richard J. Donovan
* Corrections, Warden, Sacramento State Prison
* Corrections, Warden, Sierra Conser Ctr
* Corrections, Warden, Solano County State Prison
* Corrections, Warden, Valley State Prison for Women
* Corrections, Warden, Wasco State Prison
Court Reporters Board of CA
* Criminal Justice Planning, Exec Dir
Criminal Justice, CA Council on
Cultural & Historical Endowment
Curriculum Develop. & Supplemental Materials Commission
Dental Auxiliaries, Committee on
Dental Board of California
* Devel Disabilities Council, Dep Dir, Area Bd Oper
Develop. Disabilities Area Bds (1-13)
* Developmental Disabilities, State Council on Dep Directors
* Developmental Services, Chief Dep Dir
* Developmental Services, Dir. of
Diablo Canyon Indpt Safety Committee
Domestic Violence Prog Adv Council
Domestic Violence Prog Adv Council (OES)
Economic Strategy Panel
Educ of Topeka Adv Comm, Brown v Bd of
Education Comm, CA Quality
Education Comm., CA Postsecondary
Education, Advisory Comm. on Special
Education, State Board of
Education, Western Interstate Comm. for Higher (WICHE)
Educational Commission of States
Educational Facilities Authority, CA
Electricity Oversight Board
* Electronic & Appliance Repair, Chief
Emergency Council, California
* Emergency Medical Services Auth., Dir.
Emergency Medical Srvs, Comm. on
Emergency Response Training Adv Comm
* Emergency Srvs, Dep Dir., Office
* Emergency Srvs, Dir. of Office of
* Employment Development Dept, Chief Dep
* Employment Development Dept, Dep Dir
* Employment Development Dept., Director
Employment Training Panel
* Employment Training Panel, Asst Dir
* Employment Training Panel, Exec Dir
** Energy Commission, State
Engineers & Land Surveyors, Board for Professional
Enterprise, Business Devel Corp., State Asst Fund
Exposition & State Fair, Bd of Dir., CA
* Exposition & State Fair, Dep Gen Mgr
* Exposition & State Fair, Marketing Mgr

* Full Time Salaried
** Full Time Salaried Boards/Commissions
*** Part Time Salaried Boards/Commissions

OFFICE OF GOVERNOR ARNOLD SCHWARZENEGGER

Statutory Index of Positions 2005

* Exposition & State Fair, Program Mgr
F.A.I.R. Plan Governing Committee
Fair Bds Agric. Assn, Bd of Dirs (54 dist)
* Fair Employment & Housing Dept, Dir.
Fair Employment and Housing, Comm. on
Fair Political Practices Commission
Fairview State Hospital Adv Bd
Film Commission, CA
* Finance, Chief Deputy Dir of
* Finance, Director of
Financial Institutions, Commissioner
Financial Institutions, Dep Comm/Credit Unions
* Fire Marshal, State
Fire Services, State Bd of
Fish and Game, Commission
* Fish and Game, Deputy Director of
* Fish and Game, Director of
* Food and Agriculture, Secretary of
Food and Agriculture, State Board of
* Food and Agriculture, Undersecretary
* Forestry & Fire Protection Dept, Chief Counsel
* Forestry & Fire Protection, Director
Forestry & Fire Protection, State Bd of
Fraud Assessment Commission
Gambling Control Commission
* General Services, Chief Dep Dir of
* General Services, Director
* General Services, Local Assist Officer
* General Services, Planning Officer
* General Services, Procurement Officer
Geologists & Geophysicists, Bd for
Gov't Org. and Economy, Milton Marks Comm on(Little Hoover)
Guide Dogs for the Blind, State Bd of
Hastings College of Law, Board of Dir.
* Health & Human Services Agency, Dep Secty of
* Health & Human Services Agency, Secty of
Health & Safety & Wkrs Comp, Comm on
Health Care Quality Imprv & Cost Containment Comm
Health Facilities Financing Authority,
Health Policy & Data Adv Comm., CA
Health Professions Ed. Foundation, Bd of Dir.
* Health Services, Chief Deputy Director
* Health Services, Director of
Healthcare Workforce Policy Commission, CA
Hearing Aid Dispensers Advisory Committee
Heart Disease & Stroke Prev & Treatment Task Force
Heritage Preservation Commission, CA
High-Speed Rail Authority
* Highway Patrol, CA, Commissioner of
* Historic Preservation Officer, State
Historical Resources Comm., State
Holocause Era Insurance Claims Oversight Committee
Holocaust, Genocide, Human Rights, Tolerance Educ Task Force
* Home Furnishings Bureau, Chief of
** Homeland Security, Dir of
Horse Racing Board, California
* Housing & Community Develop., Director
* Housing and Community Dev, C&S Manuf Hous., Asst Chief
* Housing and Community Dev, C&SD Housing, Ast Chief
* Housing and Community Dev, Codes and Standards, Chief
* Housing and Community Dev, Community Affairs, Chief
Housing Finance Agency, Bd of Directors
* Housing Finance Agency, Dir of Financing
* Housing Finance Agency, Dir of Insurance
* Housing Finance Agency, Ex. Director
Housing Partnership Corp, Calif.
Independent System Operator Govn Bd
Indpt Citizen's Oversight Committee (Stem Cell)
* Industrial Relations, Chief Deputy Dir.
* Industrial Relations, Director of
* Industrial Relations, Wkrs Comp, Court Admin
Industrial Welfare Commission
Infrastructure & Economic Devel Bank
* Infrastructure and Economic Devel Bank, Exec Dir
Inspection and Maintenance Review Committee
* Inspector General
* Inspector General, Chief Dep
* Insurance Comm, Dep Comm, External Affairs
* Insurance Dept, Asst Chief Dep of Operations
** Integrated Waste Management Board, CA
x Interagency Aquatic Invasive Species Council
Interagency Coordinating Council on Early Intervent.
Intern'l Studies Project Adv Comm
Interstate Oil Compact Commission
Joint Venture Policy Advisory Bd
Judicial Performance, Commission on
Juvenile Justice & Delinquency, Adv Comm
Klamath Fishery Management Council
Klamath River Basin Fisheries Task Force
* Labor & Workforce Devel Agency, Dep, Employment
* Labor & Workforce Devel Agency, Sec
* Labor & Workforce Devel, Dep Sec, Wage
* Labor Standards Enforcement, Chief of Div
* Labor Statistics & Research, Chief of Div
Landscape Architect Technical Committee
Lanterman Develomental Center Adv Bd
Law Revision Commission, CA
* Librarian, State
Library of California Board
Lottery Commission, California
* Lottery, Director, The CA State
* Low-Income Oversight Board
* Managed Health Care Dept, Dir of
* Managed Health Care Dept, Patient Advocate
Managed Health Care, Adv Comm on
Managed Risk Medical Insurance Board
Mandates, Commission on State
*** Medical Assistance Commission, CA
Medical Board of California
* Mental Health, Chief Dep Dir
* Mental Health, Chief Deputy Director of
* Mental Health, Dep Dir
Mental Hlth Serv Oversight & Accountability Comm
Mentally Ill Offenders, Council on
y Metropolitan State Hospital Adv Bd
Mexican American Veterans' Memorial
* Military Forces, Adjutant Gen.
Mining and Geology, State Bd of
* Motor Vehicles, Chief Dep Director
* Motor Vehicles, Director of
* Motor Vehicles, Info Officer
Mt. San Jacinto Winter Park Authority
Museum, CA African-American, Bd of Dir
Napa State Hospital Advisory Board, Mentally Disordered
*** Narcotic Addict Evaluation Authority
* Native American Heritage Comm, Exec Sec
Native American Heritage Commission
Naturopathic Medicine Adv Council
New Motor Vehicle Board
Nursing & Psych. Technician Examiners, Bd. of Vocational
Nursing, Board of Registered
* Occupational Health, Deputy Chief for
* Occupational Safety and Health Administration, Chief
Occupational Safety and Health Stds Bd
* Occupational Safety, Deputy Chief for
** Occupational Safety/Health Appeals Bd
Occupational Therapy
Off-Highway Motor Vehicle Rec Comm
Optometry, State Board of
Osteopathic Medical Board of CA
Pacific Fishery Management Council
Pacific Marine Fisheries Commission
* Parks & Recreation, Deputy Dir for Legis
* Parks & Recreation, Dept. of, Director
Parks and Recreation, Commission on
Patton State Hospital Advisory Board for Mentally Disordered
Peace Officer Stds & Training, Comm.

* Full Time Salaried
** Full Time Salaried Boards/Commissions
*** Part Time Salaried Boards/Commissions

OFFICE OF GOVERNOR ARNOLD SCHWARZENEGGER

Statutory Index of Positions 2005

Performance Review Commission, CA
* Personnel Admin, Dept of, Dep Director
* Personnel Admin, Dept, Chief Counsel of
* Personnel Admin, Dept, Dir
* Personnel Admin, Dept, Labor Rel Offcrs
*** Personnel Board, State
Pharmacy, California State Board of
Physical Fitness & Sports, Gov's Council
Physical Therapy Examining Committee
Physician Assistant Committee
* Pierce's Disease, Statewide Coordinator
Pilot Comm. SF, San Pablo, Suisun, Bd
Podiatric Medicine, Board of
* Poet Laureate, CA
Porterville State Hospital Adv Bd
* Printer, State
Prison Industry Board of Dir.
** Prison Terms, Board of
Private Postsecondary & Voc Ed Bureau, Program Admin
Private Security Disciplinary Review Comm (North)
Private Security Disciplinary Review Comm (South)
Project Adv Bd, CA Arts
Project Adv Bd, CA Mathematics
Project Adv Bd, CA Reading & Literature
Project Adv Bd, CA Science
Project Adv Bd, CA Writing
Project Adv Bd, Foreign Language
Project Adv Bd, History-Social Science
Project Adv Bd, Phy Educ-Health
Project Adv Bd, World History & Intl Studies
Psychology, Board of
* Public Defender, State
Public Employees' Retirement System, Bd. of Admin.
** Public Employment Relations Board
Public Library Construction & Renovation Bd
* Public Utilities Comm, Dir, Advocacy Div
** Public Utilities Commission
Public Works Contract Arbitration Comm.
Pupil Assessment Review Panel
Race Track Leasing Commission, State
Racial Profiling Panel
* Real Estate Commissioner
Reclamation Board, State
Recreational Trails Committee, CA
* Rehab, Dep Dir, Blind, Vis Impaired, Deaf
Rehabilitation Appeals Board
Rehabilitation Council, State
* Rehabilitation, Dept. of, Director
* Rehabilitation, Dept., Chief Dep Dir
Repatriation Oversight Commission
* Repatriation Oversight Commission, Exec Sec
Research Advisory Panel
* Resources Agency, Asst to Sec
* Resources Agency, Secretary of
Respiratory Care Examining Comm
San Diego Co Regional Airport Auth, Govn Bd
San Diego Reg Govt Efficiency Comm
San Diego River Conservancy Govn Bd
San Francisco Bay Area Water Transit Auth
San Gabriel & Lower LA Rivers & Mntns Conserv Govn Bd
San Joaquin River Conservancy Govn Bd
Santa Monica Mountains Conser Adv Comm
Santa Monica Mountains Conservancy
Scholarshare Investment Board
Science Adv Bd, Carcinogen Identification Comm
Science Adv Bd, Devel & Repro Toxicant Iden Comm
Seismic Safety Commission
* Senior Staff Counsel, Dept. of Veterans Affairs
* Service & Volunteerism
Sierra Nevada Conservancy
Small Business Reform Task Force
* Small Business Advocate, Dir of Office
Small Business Development Board
* Social Services, Chief Dep Dir. of
* Social Services, Director
Sonoma Developmental Center Advisory Board
y South Coast Air Quality Mgmt Dist Bd
Southwestern Low-Level Radioactive Waste Commission
Speech-Language Pathology and Audiology Bd
* State & Consumer Services Agency, Secty
State 911 Advisory Bd
State Bar Court
State Independent Living Council
* Statewide Health Planning & Devel, Dir
Structural Pest Control Board
Student Aid Commission
Summer School for the Arts, Bd of Trustees
Tahoe Regional Planning Agency (Tahoe Reg. Planning Compact)
Teacher Credentialing, Commission on
Teachers' Retirement Board
* Teale Data Center, Stephen P., Dir
Tobacco Education Oversight Comm
Tourism Marketing Commission
Transportation Comm, Riverside County
Transportation Comm, San Bernardino Co
Transportation Comm., Orange County
Transportation Commission, California
Transportation Commission, LA County Metropolitan
Transportation Commission, Ventura Co
* Transportation, Chief Dep Director
* Transportation, Deputy Director of
* Transportation, Director of
** Unemployment Insurance Appeals Bd
Uniform State Laws, Commission of
Univ of Calif., Governor's Adv. Selection Comm. for Regents
University of California, Regents of
University, Trustees of the CA State
* Veterans Affairs, Inspector General
Veterans Board, California
Veterans Cemeteries, Gov's Comm on State
* Veterans' Home at Chula Vista
* Veterans' Home, Dep Sec
Veterinary Medical Board
Victim Compensation and Government Claims Board, CA
Voting Modernization Board
Water Commission, California
Water Council, Western States
Water Quality Control Board, Central Coastal Region
Water Quality Control Board, Central Valley Region
Water Quality Control Board, Colorado River Basin Region
Water Quality Control Board, Lahontan
Water Quality Control Board, Los Angeles
Water Quality Control Board, North Coastal Region
Water Quality Control Board, San Diego
Water Quality Control Board, San Francisco Bay Region
Water Quality Control Board, Santa Ana
** Water Resources Control Board
* Water Resources, Chief Counsel
* Water Resources, Chief Dep Dir.
* Water Resources, Deputy Dir.
* Water Resources, Director of
Workers' Compensation Appeals Board
* Workers' Compensation, Admin Dir., Div.
* Youth & Adult Correc. Agency, Dep Secty
* Youth & Adult Correc. Agency, Secretary
** Youth Authority Board
* Youth Authority, Director of

* Full Time Salaried
** Full Time Salaried Boards/Commissions
*** Part Time Salaried Boards/Commissions