

The Report

NHCSL Health Disparities Conferences

2003 - 2008

Solving problems

Working together

Fighting disparities



AstraZeneca 

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Dear Colleagues,

NHCSL members are among the most vocal advocates for forward-thinking policies that address Latino health disparities. This booklet distills recommendations and proposals from six years of health disparities conferences. It also includes a resource you can use to continue the fight for Hispanic health: a sampling of laws passed between 2003 and 2008 in various states targeted to address the most pressing community health concerns.

Since 2003, AstraZeneca has been a valued partner to NHCSL in addressing health disparities. With AstraZeneca's support, NHCSL has held this series of conferences designed to enable us to craft policy addressing the health of the communities we serve.

The conferences served as incubators for ideas. Each conference featured nationally recognized authorities in their fields; each gave us knowledge, tools, and resources needed to take effective action. Much legislation has emerged from this work—ideas and legislation that have helped Hispanics and AstraZeneca come closer to our mutual goal of making this country a healthier place.

We hope that this booklet inspires you to continue using your power as legislators to work on these issues, and to keep moving forward until all Americans receive high quality health care.

Sincerely,

A handwritten signature in black ink that reads "Joseph E. Miro". The signature is written in a cursive style.

Representative Joseph E. Miro
President, NHCSL



Dear Friends,

At AstraZeneca, we are committed to creating medicines that make a meaningful difference in people's lives. Our commitment to improving patient health for all Americans goes beyond innovations in the lab.

AstraZeneca has offered patient assistance programs side by side with our medicines for 30 years to help get those medicines to the people who need them. You see AstraZeneca's commitment in our award-winning asthma management Web site and in the mobile AstraZeneca Artery Explorer, in our partnership with the Inter-American College of Physicians and Surgeons and many other initiatives that deal with real healthcare challenges.

In 2003, we became the first pharmaceutical company to address health disparities by sponsoring joint conferences for the National Hispanic Caucus of State Legislators and the National Black Caucus of State Legislators. Our intent was to foster legislation that would help improve health in minority communities across the United States.

Through six consecutive conferences with the National Hispanic Caucus of State Legislators, we have not been disappointed. Participants have been unfailingly inquisitive, inventive, and passionate; ready, able, and willing to take new knowledge back to their communities and put it to work. This report is a testament to their energy, ideals and commitment to fight health disparities.

Sincerely,

A handwritten signature in blue ink that reads "Rich Fante".

Rich Fante
President
AstraZeneca US

overview

Health disparities remain one of this country's most pressing policy challenges. Between 2003 and 2008, AstraZeneca sponsored a unique series of conferences, bringing the Black and Hispanic caucuses of state legislators together to discuss the health issues affecting their constituents.

These conferences helped Hispanic legislators determine the most important disparities and/or disease areas to address; identify factors related to their causes and those that could contribute to their elimination; develop strategies to address the issues; and clarify the role of policy in those strategies.

The following is a compendium of recommendations from the experts who presented at the conferences, along with selected laws enacted over the past six years that demonstrate legislative efforts to address the disparities.

We hope this booklet will serve as a resource for legislators who want to pursue health disparities legislation in their states.

Hispanic Health Concerns

Hispanic health disparities are caused by many factors. Lack of cultural competence among care providers, lack of access to preventive care and absence of health insurance are among the most important issues facing the community. According to the Centers for Disease Control and Prevention (CDC), cancer, HIV/AIDS, cardiovascular disease and diabetes are among the leading causes of illness among Hispanics. The risk factors for these diseases are also much higher among the Hispanic population.

These disparities are also evident across Hispanic subgroups. Mexican Americans carry a disproportionate burden of disease from diabetes. Puerto Ricans have a low birth weight rate that is 50% higher than that for non-Hispanic whites, and also suffer from higher rates of asthma, HIV/AIDS, and infant mortality.

cardiovascular disease, stroke, and obesity

Heart disease is the leading cause of death for Hispanics, who are less likely to be screened for diabetes, high cholesterol, or hypertension than non-Hispanic whites.

Obesity, a risk factor for heart disease and stroke, is also higher in Hispanics than in non-Hispanic whites. From 2006-2008, the prevalence of obesity in Hispanics was 21% higher than the overall population. Among Mexican American women, 73% were overweight or obese compared with 61.6% of the general female population. Increasing obesity in Hispanic children is also a particularly disturbing trend.

- In 2007, Latinos were 1.1 times as likely to be obese than non-Hispanic whites.
- In 2003-2004, Mexican American children between the ages 6-11 were 1.3 times more likely to be overweight than non-Hispanic white children.
- From 2003-2006, Mexican American women were 30% more likely to be overweight than non-Hispanic white women.

- Teach adults to set good examples for themselves and their children by putting healthy foods in the refrigerator, limiting TV time, reading food labels, teaching their kids how to read them (2004), and doing some kind of physical activity with them (2004)
- Change the environment and reengineer the way we live, work, and play; for example, ensure that new developments include bike roads (2008). Bring others together to promote lifestyle change (2006)—for instance, form groups like the National Hispanic Cardiologists Leadership Network (2008)
- Create more anti-obesity programs, such as the one initiated in New York, which has kids write down what they eat every day and what activities they do, while encouraging them to increase physical activity (2004). Fight obesity in the schools and at home; put fresh fruits and vegetables in children's backpacks once a week (2004), for instance, or require 5 hours a week of physical activity and education in schools (2008)
- Provide WIC waivers that can be substituted for use in farmer's markets (2004); put farmer's markets in low income neighborhoods to increase access to healthy foods (2004, 2008); allow Hispanics to use food stamps to buy all kinds of fruits and vegetables (2008)
- Treat cardiovascular disease by promoting use of medications (2003); widen use of statins, beta blockers, and angiotensin-converting enzyme inhibitors (ACE inhibitors) (2005); establish programs to increase funding for drugs, treatment, and follow-up (2005); and open local clinics that provide medical care and preventive screenings (2008)
- Encourage health care providers and other community leaders to urge Hispanics to participate in clinical trials (2005)
- Prohibit the use of trans fat in fast foods (2008)
- Fight cardiovascular disease on a community basis, and if need be, one neighborhood at a time (2006)

Proposals by Expert Speakers at the Conferences to Address Disparities in Cardiovascular Disease, Obesity, and Stroke

- Teach the public about stroke and stroke symptoms; Hispanics need to know that if they experience stroke symptoms they should seek immediate medical help (2003)
- Encourage individuals to get their cholesterol tested and know their numbers (2003)
- Educate constituents about nutrition, supply them with healthy foods that they can buy (2004), and encourage them to make sound diet and lifestyle choices (2004, 2008).

diabetes

In 2005, Hispanics were 1.6 times as likely as non-Hispanic whites to die from diabetes.

Mexican Americans have higher rates of end-stage renal disease caused by diabetes, and are 50% more likely to die from diabetes than non-Hispanic whites.

- Mexican American adults are twice as likely to be diagnosed with diabetes by a physician than non-Hispanic white adults.
- In 2002, Hispanics were 1.5 times more likely to start treatment for end-stage renal disease related to diabetes compared to non-Hispanic white men.

Proposals by Expert Speakers at the Conferences to Address Diabetes Disparities

- Create laws that require insurers to provide adequate coverage for diabetes supplies and education, as well as timely access to tools for diabetes management (2003, 2005)
- Initiate school programs that teach kids about the importance of screening for diabetes and the dangers associated with the disease (2003); intervene early in life by identifying at-risk children and addressing lack of physical activity in schools; incorporate physical activity into and after the school day (2008); convene oversight hearings on school food options, and involve young people in the hearings (2008)
- Do research on which interventions can increase diabetes awareness (2003); look for ways to introduce legislation that will focus attention on the disease, such as a Diabetes Awareness Month (2005); provide prevention information through campaigns on healthy diet and exercise practices (2003); in all materials, public service announcements, and awareness messages, stress the link between diabetes,

heart disease, and hypertension; communicate the risks and complications of diabetes as well as the hope; help constituents understand that diabetes is a manageable disease that can be controlled (2005)



From Left to Right: Rep. John Aguilera (IN), Rep. Minnie Gonzalez (CT), Rep. Joseph E. Miro (DE), NHCSL President, Rep. Bob Henriquez (FL)

- Fund biomedical as well as community-based research on diabetes complications in Hispanics; ensure collection of data under state supervision on the cost, prevalence, morbidity, and mortality associated with diabetes, and on complications by race and ethnicity (2003, 2008); mandate a report to the state legislature (2008)
- Establish diabetes management programs in clinics to track and monitor patients' blood sugar levels; the Health Resources and Services Administration (part of HHS) started such programs in federal clinics, and state clinics could follow suit (2003)
- Support innovative uses of technology, including patient access to electronic health records (2008)
- Influence the State Children's Health Insurance Plan (SCHIP) (2007) to support use of state funds to extend SCHIP coverage to immigrant children and pregnant women who have been in the U.S. for less than five years (2008)
- Implement community-based navigator or promotora programs (2008)
- Provide safe spaces for families to use for recreation and physical activity; pass measures to create a public/private verde fund to develop those places in Hispanic communities (2008)
- Run health fairs that link Hispanics to low- or no-cost medical resources (2008)

HIV/AIDS

The HIV/AIDS epidemic is a serious threat to Hispanics. In 2006, the rate of new HIV infections among Hispanics/Latinos was 2.5 times that of whites. In the same year, HIV/AIDS was the fourth leading cause of death among Hispanic/Latino men and women aged 35–44.

- Hispanics accounted for 17% of all HIV/AIDS cases in 2007.
- Latinos were almost 3 times as likely to have AIDS in 2006 compared to white males.
- Latinas were almost 5 times as likely to have AIDS in 2006 as white females.
- Hispanic men were 2.5 times as likely as non-Hispanic white men to die of HIV/AIDS in 2005.
- Hispanic women were three times as likely as non-Hispanic white women to die of HIV/AIDS in 2005.

Proposals by Expert Speakers at the Conferences to Address HIV/AIDS Disparities

- The CDC Minority AIDS Initiative was developed to prevent AIDS transmission in minority communities; it can be used to augment funding at state and local levels for HIV prevention (2003)
- Make voluntary HIV testing a routine part of medical care (2003)
- Decrease perinatal HIV transmission by providing pregnant women with information and guidance (2003)
- Prevent new infections by providing education and guidance to HIV patients and their partners through health care providers and lay people (2003)
- Implement new models for diagnosing HIV infections outside of medical settings, such as in outreach vans that serve as testing sites (2003)
- Identify specific subgroups with a disproportionate rate of HIV/AIDS; respect cultural nuances and do outreach in languages they understand (2004)



Sen. Leticia Van de Putte (TX)

cancer

Cancer accounts for 20% of all deaths in Hispanics in the U.S. Slightly less than 1 in 2 Hispanic men and 1 in 3 Hispanic women will be diagnosed with cancer. The lifetime probability of dying from the disease is 1 in 5 in Hispanic men and a little more than 1 in 6 in Hispanic women.

- Hispanics are twice as likely to have, and to die from, liver cancer.
- Hispanic women are 2.7 times more likely to have stomach cancer than non-Hispanic white women.
- Hispanic women are twice as likely to have cervical cancer, and 1.5 times more likely to die from the disease than non-Hispanic white women.

Proposals by Expert Speakers at the Conferences to Address Cancer Disparities

- Teach Hispanics about cancer risk factors in a variety of places and in a variety of ways, such as distribution of educational pamphlets and videos in schools and churches (2003); use radio programs, public service spots on TV, and newspaper advertising to promote the advantages of prevention rather than treatment, and in so doing, help shift medicine from a disease-based health care model to one grounded in wellness/prevention (2006); promote anti-smoking efforts through multimedia campaigns; stopping smoking could eliminate about one-third of all cancer deaths (2006)
- Make it easy for Hispanics to get screened for cancer by bringing tests to them; for example, at local health fairs, retail stores, and community-based health clinics (2003, 2006)
- Recruit more minorities into clinical trials by having physicians encourage their Hispanic patients to participate in them (2003, 2006)
- Create legislation that provides a basic package of preventive health care (2006)
- Collaborate with academic researchers, community organizers, and providers on a variety of fronts, including collecting data on health disparities, facilitating involvement in community-based participatory research, and organizing local screening events and health fairs (2006)
- Teach women how to do monthly breast exams and encourage them to get mammograms; early stage breast cancer has a cure rate of over 90% (2006)
- Each state has a cancer control plan; find out if it includes disparities research and if it's being implemented in your state (2006)
- The CDC's Comprehensive School Health Index (SHI) addresses healthy nutrition and prevention of tobacco use; find out if local school departments in your state are implementing it (2006)
- The National Hispanic Cancer Research Network uses public awareness and outreach strategies that may serve as models for state anti-cancer efforts in Hispanic communities; find out what these are and if they could be adapted for use in your state (2006)
- Medicare offers free cancer screening services, such as mammograms and pap smears; make sure your constituents are aware that these services are available (2006)
- Use money from tobacco tax initiatives to screen uninsured and underinsured Hispanics for cancer (2006)
- Pave the way for legislation by investigating environmental exposure and cancer rates in Hispanic communities (2006)

mental health

Lack of access to mental health services is a serious problem in the Hispanic community. While insurance is a major obstacle to accessing care, culture and language are also significant barriers. Poverty affects mental health status as well. Hispanics living below the poverty level are twice as likely to report psychological distress as those who live at over twice the poverty level.



From Left to Right: Sen. Paul Feliciano (KS), Rep. Joseph E. Miro (DE), NHCSL President, Rep. Bob Henriquez (FL)

- The death rate from suicide for Hispanic men was 5 times the rate for Hispanic women in 2005.
- In 2005, suicide attempts for Hispanic girls in grades 9-12 were 80% higher than for white girls in the same age group.
- Non-Hispanic whites received mental health treatment 3 times more often than Hispanics in 2005.

Proposals by Expert Speakers at the Conferences to Address Mental Health Care Disparities

- Facilitate health insurance coverage among Hispanics, including policies that stress preventive care and screening services (2003), and ensure mental health parity for those with chronic mental illness and substance abuse disorders (2003,2004)
- Appropriate funding for research on the impact of ethnicity, culture, and language on delivery of mental health care services (2003); study the efficacy of psychopharmacologic agents in different subgroups of Hispanics (2003) and explore genetic differences among Hispanic populations (each ethnic group has a unique profile) (2003)
- Enact legislation requiring access to translators, and impose a minimum standard of knowledge of the likely mistakes health professionals make when assessing Hispanic

patients (2003); train clinicians to treat Hispanics in a culturally and linguistically competent manner (2003), with more culturally specific mental health programs, such as those for Dominicans, Puerto Ricans, and other Latinos (2003); create incentives for mental health facilities to attract and retain bilingual/bicultural health care professionals (2003)

- Enhance education among providers and Hispanic consumers on cultural and ethnic issues that limit access to mental health services, with preferential outreach to those who are biased against psychiatric care (2003); use clergy, teachers, and other opinion leaders to increase education and awareness of mental health issues among families, patients, and throughout the community (2007)
- Eliminate disparities in access to mental health and substance abuse treatment by addressing barriers to care, such as insurance carve-outs that raise co-pays or limit the number of covered visits for mental health care (2003), lack of health insurance, poverty, long work hours, and the need for child care (2004, 2008)
- Create a national grassroots coalition of legislators and stakeholders comprised of mental health care providers, government agency directors, community groups, professional nurses and associations, including the National Alliance on Mental Illness (NAMI); use the coalition to monitor implementation of mental health laws and educate policy makers on medication access and other mental health care issues (2008)
- Enact legislation that recognizes drug and alcohol abuse as mental health disorders; that defines the constitutional rights of mental health patients; that strengthens legislative oversight and the work of nonprofit, community- and faith-based treatment organizations; that establishes minimum requirements for multidisciplinary care; that addresses problems with transportation and police intervention; that mandates separate treatment facilities for children and adults; and that differentiates emotional disorders from mental disorders (2008)

asthma



Sen. Luz Arce-Ferrer (PR)

Hispanic children are 60% more likely to have asthma than non-Hispanic white children. In 2007, 4.6 million Hispanics were diagnosed with asthma; 3.1 million reported that they still had the disease, and 1.8 million of them experienced an asthma attack in the past year. Puerto Ricans have higher rates of asthma than other Hispanics and non-Hispanic whites.

- Puerto Ricans have almost 3 times the asthma rate of all Hispanics.
- The rate of asthma attacks for Puerto Ricans is 2.5 times that of whites.
- Hispanics are twice as likely to use outpatient clinics rather than physician's offices for asthma visits.

Proposals by Expert Speakers at the Conferences to Address Asthma Disparities

- Increase access to medications for Hispanic children who live in poverty by addressing restrictive formulary practices in state Medicaid programs (2003)
- Create disease management initiatives that follow certain fundamental principles; they should be outcome-driven, include cost-benefit analyses, identify effective intervention strategies, and be self-sustaining (2003)
- Collect reliable data on the prevalence and severity of asthma in Hispanics, as well as outcomes from disease management initiatives (e.g., lower health care costs, decreased morbidity and mortality, and improved quality of life) (2003)

infant mortality

Hispanic mothers are more than twice as likely to begin prenatal care in the 3rd trimester or receive no prenatal care compared to non-Hispanic white mothers. The infant mortality rate for Puerto Ricans is 40% higher than it is for Hispanics in general.

- In 2005, infant mortality rates for Hispanic subpopulations ranged from 4.4 per 1,000 live births to 8.3 per 1,000 live births compared to the non-Hispanic white rate of 5.8 per 1,000 live births.
- In 2005, Puerto Ricans had 1.4 times the infant mortality rate of non-Hispanic whites.
- Puerto Rican infants were twice as likely to die from causes related to low birth weight than non-Hispanic white infants.

Proposals by Expert Speakers at the Conferences to Address Infant Mortality Disparities

- Provide neonatal case management for Medicaid recipients (2003)
- Establish partnerships with physicians and teachers to bring young women, particularly teenagers, into care early in their first trimester of pregnancy (2003)
- Collect data on infant morbidity and mortality broken out by specific subgroups (2006)
- Build formal alliances with churches, hospitals, and other stakeholders; participate on boards and committees on all levels, including volunteer networks and satellite church sites; use these networks to build community capacity to reduce infant morbidity and mortality (2006)
- Collaborate with community alliances to create systems and opportunities for local hiring; get "everyone and their mammas" involved (2006)
- Appropriate funds to research sexual violence in minority communities and the criminal implications of sex with minors; determine why these issues aren't addressed (2006)

cultural and linguistic competence

Increasing cultural and linguistic competence among health care providers is critical to closing the health disparities gap. These skills empower caregivers and patients to engage in meaningful dialogue about health concerns and more accurately diagnosis symptoms. Physicians who can accurately see, hear and understand their patients' cues and interpret the unique cultural nuances of multicultural Hispanic populations, can deliver better quality care and improve health outcomes.

Proposals by Expert Speakers at the Conferences to Address Cultural and Linguistic Competence

- Appropriate funding for research and education initiatives to increase the delivery of culturally competent services (2003)
- Create incentives that attract and retain bilingual/bicultural health care professionals (2003)
- Establish culturally-specific clinics, e.g., for Dominicans, Puerto Ricans, and other Latinos (2003)
- Use formal, written cultural competency plans and multilingual enrollment and educational materials in health care facilities (2003)
- Create health care advisory boards in clinics and hospitals, with membership that reflects the cultural diversity of the population being served (2003)
- Develop cultural competency curricula for medical students and health care professionals and mandate their use in state medical schools (2004, 2008); create accreditation standards that include cultural competence (2004, 2005), and change medical and allied health profession licensing requirements to include mandatory courses on Hispanic culture and language skills (2003, 2004, 2005); in addition, require training in community-based participatory research in public health and medical schools (2004)
- Educate consumers on cultural issues that might impede therapy (2003, 2004)
- Make an Office of Minority Health and Health Disparities a statutory requirement (2004)
- Use Medicaid and SCHIP matches to reimburse medical interpretation services and establish state certification programs in cultural and linguistic competence (2008)
- Use state contracting authority to mandate standards for cultural proficiency in health plans that serve Medicaid patients (2008)



From Left to Right: Francie Plendl, Paul Pereira, David Anderson, Marta Perez, and Maria Firvida of AstraZeneca

- Create incentives to attract more medical school students into obstetrics/gynecology (2006)
- Do research on the impact of high malpractice premiums on obstetrics/gynecology doctors (2006)
- Expand and replicate Healthy Start initiatives across the country; connect with and integrate federal Healthy Start programs with other healthy family and early childhood education initiatives; increase hiring of residents from Healthy start communities (2006)



Center to Right: Sen. Garriga Pico (PR), Sen. Roberto Arango (PR)

Resources

The majority of statistics used in this report come from the CDC's Office of Minority Health & Disparities (OMHD), with additional information from the American Heart Association, American Lung Association, the American Diabetes Association, the American Cancer Society, the U.S. National Library of Medicine, and PubMed.



*Rep. Joseph E. Miro (DE) NHCSL
President*

Acknowledgments

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Health Disparities Legislation

The following pages present a selective sample of health disparities legislation enacted nationwide from 2003 to 2008. The laws are briefly summarized and links to associated websites are included for easy access to more information.

Arizona

Ariz. Rev. Stat. Sec. 15-1643

Creates a requirement that every center providing health education have a program for recruitment and retention of minority students

<http://www.ncsl.org/default.aspx?tabid=14298>

Alaska

Alaska Stat. Sec. 21.07.020(12)

Requires that all managed care organization plans include information on their translation or interpreter services.

<http://www.healthlaw.org/search/folder.185385>

Arkansas

Ark. Code Ann. Sec. 6-60-212

Allows medical schools to give additional consideration to students who intend to practice in underserved areas.

<http://www.ncsl.org/default.aspx?tabid=14298>

Ark. Public Act 1571 (SB945, 2003)

Requires the University of Arkansas for Medical Sciences, the Department of Health, and the Minority Health Commission to study health care disparities.

<http://www.ncsl.org/default.aspx?tabid=14298>

California

Cal Chapter No. 179 (SB 1498, 2008)

Requires health care service plans to implement policies that focus on the recruitment and retention of an ethnically and culturally diverse workforce.

<http://www.ncsl.org/default.aspx?tabid=14362>

Cal Chapter No. 522 (SB 139, 2007)

Addresses colleges that offer nursing degrees, and requires data collection on health care workforce diversity by specialty, race, ethnicity, and spoken languages.

<http://www.ncsl.org/default.aspx?tabid=14362>

Cal. Chapter No. 381 (SB 564, 2008)

Acknowledges the role that student health centers play in reducing health disparities and provides funding to support them.

<http://www.ncsl.org/default.aspx?tabid=14298>

Colorado

Colo Rev. Stat. Sec. 25-4-2205

Specifies that the Office of Health Disparities and the Health Disparities Grant Program have a duty to promote workforce diversity within the public health system.

<http://www.ncsl.org/default.aspx?tabid=14298>

Connecticut

Conn. Gen. Stat. Sec. 4-124dd

Establishes the Connecticut Allied Health Workforce Policy Board; goals include recommendation of policies to promote diversity in the health care and allied professions workforce.

<http://www.ncsl.org/default.aspx?tabid=14298>

Public Act No. 07-185 (1) (b) (2007)

Directs the Commissioner of Social Services to amend the state's Medicaid plan by covering use of interpreters for all beneficiaries with limited English proficiency.

http://www.healthlaw.org/library/folder.156273-Collection_of_Race_Ethnicity_and_Language_Data

** Conn. Gen. Stat. Sec. 17b-28 (b) (2009)

Directs the Medicaid Managed Care Advisory Committee to make recommendations on the linguistic and cultural competency of providers and other program facilitators.

www.healthlaw.org/library

** Conn. Gen. Stat. Sec. 19a-490i (2008)

Directs acute care hospitals to create a policy on the provision of interpreter services, review that policy on an annual basis, and use best efforts to ensure the availability of interpreter services to "qualified patients" as defined under the statute.

<http://www.healthlaw.org/search/folder.121305>

** Conn. Gen. Stat. Sec. 20-13 (b) (5) (2007)

Directs the Department of Public Health, in consultation with the Connecticut Medical Examining Board and the Connecticut State Medical Society, to create physician profiles that include information on the languages spoken by the physician and his/her staff.

<http://www.healthlaw.org/search/folder.121305>

** Conn. Agencies Regs Sec. 17a-248-7 (c) (2004)

Requires Early Intervention services for children, with notices of those services provided in languages the general public can understand, and in the native language of the children's parents.

<http://www.healthlaw.org/search/folder.121305>

Public Act No. 07-185 (1) (b) (2007)

Directs the Commissioner of Social Services to amend the state Medicaid plan by including foreign language interpretation as a covered service for beneficiaries with limited English proficiency.

http://www.healthlaw.org/library/folder.156273-Collection_of_Race_Ethnicity_and_Language_Data

Conn. Gen. Stat. Sec. 17b-28 (b) (2009)

Directs the Medicaid Managed Care Advisory Committee to make recommendations on the linguistic and cultural competency of providers and other program facilitators.

<http://www.healthlaw.org/search/folder.121305>

Conn. Gen. Stat. Sec. 19a-490i (2008)

Directs acute care hospitals to create a policy on delivery of interpreter services, review that policy on an annual basis, and use best efforts to ensure the availability of interpreters for "qualified patients" as defined under the statute.

<http://www.healthlaw.org/search/folder.121305>

Delaware

Del. Code Ann. Tit. 16, Sec. 5161

Mental health hospitals and residential treatment facilities must ensure that patients rights are displayed in both English and Spanish.

<http://www.healthlaw.org/search/item.185859>

40-800-108 Del. Code Regs. Sec. 5.1

Requires Medicaid Early and Periodic Screening, Diagnostic and Treatment providers have billing codes that allow for language interpreters for mental health services including psychotherapy.

<http://www.healthlaw.org/search/item.185859>

16-4000-4104 Del. Code Regs. Section 13.0 (II) (ii) (c)

Requires any health care facility wishing to employ J-1 physician through visa waiver program, to show that the physician has a unique set of qualifications such as fluency in same language as the population that would be served or is a cultural match to same population.

<http://www.healthlaw.org/search/item.185859>

District of Columbia

** D.C. Stat. Sec. 7-2071.01 (1) (A)-(B)

Directs the Health Care Ombudsman program to provide interpreters for Spanish-speaking consumers, and ensure that all written program materials are in Spanish, English, and other languages as required by law.

<http://www.healthlaw.org/search/folder.71243>

**29 D.C. Code Mun. Regs. Sec. 5403.6

Requires primary health care providers in Medicaid's fee-for-service program to provide education programs for their Medicaid patients in languages spoken by the population being served.

<http://www.healthlaw.org/search/folder.71243>

Florida

Fla. Chapter No. 2004-365 (SB 1178 and HB 645, 2004)

Requires the Department of Health to work with a variety of groups to assist in the education of medical professionals on health-related racial and ethnic issues.

<http://www.ncsl.org/default.aspx?tabid=14298>

Fla. Stat. No.381.0403

Creates Graduate Medical Education Innovations to increase health care workforce diversity.

<http://www.ncsl.org/default.aspx?tabid=14298>

Fla. Stat. No. Sec. 641.217

Requires HMOs to implement a plan for recruitment and retention of minority health care professionals.

<http://www.ncsl.org/default.aspx?tabid=14298>

Fla. Chapter No. 2008-96 (HB 3, 2008)

Creates "children's zones" to provide a positive social and educational environment for kids in disadvantaged areas.

<http://www.healthlaw.org/search/folder.71243>

Fla. Stat. Sec. 381 7352 (2006)

Creates a "Reducing Racial and Ethnic Health Disparities: Closing the Gap" grant program that creates partnerships between state and local governments, faith-based organizations, and private sector health care providers (including managed care, voluntary health care resources, social service providers, and non-traditional partners) to encourage the creation of community/ neighborhood projects that address ways to improve health outcomes of racial and ethnic populations.

<http://www.ncsl.org/default.aspx?tabid=14298>

Georgia

HB 943 (2007)

Mandates that all continuing education requirements for health care professionals include training in cultural competency to address medical disparities based on race, ethnicity and gender.

<http://www.ncsl.org/default.aspx?tabid=14298>

Illinois

20 II CS 2310/2310-210

Establishes the Advisory Panel on Minority Health to increase the number of minorities in the health care profession.

III. Public Act 95-0781 (HB 4456, 2007)

Establishes the Commission on Children and Youth Act to create a 5-year plan to address disparities in access to health care, and outcomes based on race, ethnicity, and other factors.

<http://www.healthlaw.org/search/folder.71243>

88III. Public Act 95-0876 (HB 2023, 2007)
Creates the Culturally Competent Healthcare Demonstration to improve the quality of healthcare for racial and ethnic minorities.
www.ncsl.org/default.aspx?tabid=14298

III. Public Act 95-0900 (SB 2012, 2007)
Creates the Chronic Disease Prevention and Health Promotion task force under the Department of Public Health.
<http://www.ncsl.org/default.aspx?tabid=14298>

III. Public Act 93-0787 (HB 686, 2003)
Includes a new requirement that recipients of grants from the Inclusion of Women and Minorities in Clinical Research Act comply with NIH guidelines on the inclusion of women and minorities as subjects in clinical research.
<http://www.ncsl.org/default.aspx?tabid=14298>

III. Public Act 93-0514 (HB 274, 2003)
Requires that grant recipients from the state-funded Inclusion of Women and Minorities in Clinical Research Act include women and minorities as subjects in research projects.
<http://www.ncsl.org/default.aspx?tabid=14298>

Indiana

Ind. Code Sec. 16-46-11-1 (2003)
Requires the State Department of Health to design and implement a structure that addresses health disparities among racial and ethnic minorities. Responsibilities include funding for minority health programs, research, creation of a campaign to raise the awareness of healthcare providers to the unique needs of minority populations, and health promotion and disease prevention programs that are culturally and linguistically relevant for the population.
<http://www.ncsl.org/default.aspx?tabid=14298>

Kentucky

Ky. Rev. Stat. Sec. 205.201 (2005)
Directs the Cabinet for Families and Children to create initiatives to address the special health needs of the minority elderly and to create an outreach program to teach them about programs that address their social and health issues.
<http://www.ncsl.org/default.aspx?tabid=14298>

911 Ky. Admin. Regs. 2:140 (1) (7) (c) (2004)
Directs the primary provider of early intervention services to give patients' families materials that advise them of their rights in a format and language they can understand.
<http://www.healthlaw.org/library/attachment.121092>

911 Ky. Admin. Regs. 2:160 (1) (2) (k) (2004)
Requires all early intervention services to provide interpreters when necessary to help families understand the services being provided and the procedures related to them.
<http://www.healthlaw.org/library/attachment.121092>

Ky. Act 71 (HB 44, 2008)
Creates guidelines and criteria stating that data on the status of women's health include ethnicity and the special health needs of minorities and the diseases that disproportionately affect them; also requires recommendations that specifically address disparities.
<http://www.ncsl.org/default.aspx?tabid=14298>

Louisiana

La. Act 19 (HB 1, 2008)
Creates a line item in the state budget to address Minority Health Access and Planning, and establish a goal to maintain minority enrollment at the Louisiana State University Health Sciences Center.
<http://www.ncsl.org/default.aspx?tabid=14298>

La. Rev.Stat. Ann. Sec. 46:447.2(E)(1) (revised 10/22/09)
Requires the creation and implementation of a program to improve the cultural sensitivity and interpersonal skills of prenatal service providers, and train them to effectively provide assistance to women who lack literacy skills or use English as a second language.
<http://www.healthlaw.org/search/folder.185398>

Maine

20-A Me. Rev. Stat. Sec. 12857
Requires governing boards at all medical schools to reflect the ethnic, cultural, and racial characteristics of the school's service area.
<http://www.ncsl.org/default.aspx?tabid=14298>

Maryland

Md. Health Code Sec. 20-902 and 20-903
Authorizes certain medical schools and CME-granting institutions to provide seminars or courses in health disparities, and may require medical staff at those sites to attend such courses.
<http://www.ncsl.org/default.aspx?tabid=14298>

Md. Chptr. No. 349 (HB 1065, 2003)
Requires the Governor to make appointments to the Health Services Cost Review Commission that promote race, gender, and ethnic diversity.
<http://www.ncsl.org/default.aspx?tabid=14298>

Md. Chptr. No. 453 (HB 883, 2003)
States the intentions of the General Assembly to authorize colleges to offer courses and/ or seminars on health care disparities among specific minorities. It further requires that the Department of Health and Mental Hygiene, in consultation with the Maryland Healthcare foundation, develop and implement a plan to reduce health care disparities.
<http://www.ncsl.org/default.aspx?tabid=14298>

Md. Chapter No. 412 (HB 524, 2007)
Directs the Office of Minority Health and Health Disparities to conduct a workshop on Cultural Competency and Workforce Development for mental health care professionals, and to provide specific recommendations on how to improve cultural competency.
<http://www.ncsl.org/default.aspx?tabid=14298>

Michigan

Mich. Comp. Laws Sec. 333.2227
Requires that the Department of Health devise and implement strategies for recruiting and retaining minorities in the health and social services professions.
<http://www.ncsl.org/default.aspx?tabid=14298>

Mich. Comp. Laws Sec. 18.302(2)(A)
Requires the Commission on Spanish-speaking Affairs to conduct studies and recommend solutions to health-related issues affecting the Spanish-speaking community.
<http://www.healthlaw.org/search/folder.185400>

Minnesota

Minn. Stat. Sec. 137.42
Invites the University of MN-Duluth School of Medicine to apply for a federal Area Health Education Center Program grant that would allow it to plan, create, and operate area health education center programs on recruitment and health care awareness among minority and other students in medically underserved areas of the state.
<http://www.ncsl.org/default.aspx?tabid=14298>

Minn. Stat. Sec. 256B.0943(5)(b)(1)(2003)
Requires potential Medicaid health care providers of pediatric therapeutic services and support to prove that they have a process in place for recruiting, hiring, training, and retaining culturally and linguistically competent providers.
<http://www.healthlaw.org/search/folder.71249>

Minn. Stat. Sec. 256L.03(3a)(2007)
Covers language interpreters for Medicaid enrollees who receive covered services.
<http://www.healthlaw.org/search/folder.71249>

Mississippi

Miss. Code Ann. Sec.41-87-13(1)(b)
Requires Early Intervention providers to deliver services in the family's native language, and to accommodate cultural differences.
<http://www.healthlaw.org/search/folder.185401>

Missouri

Mo. Code Regs. Ann. Tit. 19 Sec. 40-9.020(6)
Requires all HMO credentialing forms to request information on languages spoken by health care providers and whether they provide interpretive services.
<http://www.healthlaw.org/search/folder.71250>

Montana

Mt. Chapter No 128 (HB. 452, 2005)
Requires all managed care plans to have a plan to address the needs of enrollees who do not speak English, have diverse cultural or ethnic backgrounds, or who may be illiterate. The plan is to ensure that these factors do not impede their ability to access services.
<http://www.healthlaw.org/search/folder.185407>

Nebraska

471 Neb. Admin. Code Sec. 10-001, 10-003 (j) (2009)
Creates an Early Intervention Act requiring that a culturally competent approach be taken to providing early intervention services to families with infants and toddlers who qualify under this Act. The service planning meeting must be conducted in the native language of the family, and if the family is not from a dominant culture, it must be given the option to have a cultural representative at the meeting.
<http://www.healthlaw.org/search/folder.185408>

482 Neb. Admin. Code Sec. 3-001, 3-002(1), (3), 3-003(k)(5), 3-003.01, 3-005 (2003)
Requires that those in charge of Medicaid managed care enrollment provide translation services to enrollees in need of such services throughout the enrollment process and during outreach efforts. In addition, all materials must be comprehensible to enrollees.
<http://www.healthlaw.org/search/folder.185408>

Nevada

Nev. Rev. Stat. Ann. Sec. 232.475 (2005)
Requires the Office of Minority Health to make every effort to incorporate bilingual communication into its programs and activities.
<http://www.healthlaw.org/search/folder.185408>

New Jersey

NJ Stat. Sec. 26:2-162

Requires that the Office of Minority and Multicultural Health devise a statewide plan for increasing the number of racial and ethnic minority health care professionals.

<http://www.healthlaw.org/search/folder.105347>

NJ Stat. Ann. Sec. 26:1A-36.6(f)

Requires those who offer intervention services to qualified infants, toddlers, and their families to respect their autonomy, interdependence, and decision-making in ways that reflect the unique racial, ethnic, cultural, and social-economic experiences and backgrounds of the families.

<http://www.healthlaw.org/search/folder.105347>

NJ Stat. Ann. Sec. 45:9-7.2; 45:9-7.3 (2008)

Requires those seeking a diploma from a school of medicine and those seeking recertification of their medical license to complete cultural competency instruction.

<http://www.healthlaw.org/search/folder.105347>

NJ Admin. Code tit. 8, Sec. 33-4.10(a)(8) (2004)

Requires that all hospitals seeking approval of a certificate of need demonstrate how the project will promote access for racial and ethnic minorities.

<http://www.healthlaw.org/search/folder.105347>

NJ Admin. Code tit. 8, Sec. 52-13.1 (2003)

Requires the accessibility of culturally and linguistically appropriate staff and materials for special populations to ensure that they are connected with preventive health care service providers.

<http://www.healthlaw.org/search/folder.105347>

NJ Admin. Code tit. 8, Sections 52-13.2(a)(6), 52-13.3(a)(2) (2003)

Requires that the Community Health Improvement Plan ensure that health care and preventive health services be culturally and linguistically appropriate.

<http://www.healthlaw.org/search/folder.105347>

NJ Admin. Code tit. 10, Sec. 11:24-2.2 (c) (13)

Requires that HMOs seeking a certificate of authority include an explanation of how they will ensure that their culturally and linguistically diverse members have access to their services.

<http://www.healthlaw.org/search/folder.105347>

NJ Admin. Code tit. 10, Sec. 73-3.21 (b) (3)

Requires each managed care organization to be evaluated on cultural, ethnic, and linguistic competency.

<http://www.healthlaw.org/search/folder.105347>

New Mexico

NM SB 165 (2008)

Provides funding to encourage participation and retention of underrepresented students in health care professions, and create a pipeline program in health careers at the Santa Fe Indian School.

<http://www.ncsl.org/default.aspx?tabid=14298>

NM Code R. Sec. 13.10.13.29 (2009)

Directs each Managed Health Care Plan to create, implement, and maintain a service plan that addresses the linguistic and cultural diversity of the population it serves.

<http://www.healthlaw.org/search/folder.185411>

New York

NY Pub. Health Law Sec. 4403 (5) (b) (2006)

Directs the Commissioner of Health to ensure that an HMO's ability to provide culturally and linguistically competent care is taken into account when evaluating its application for renewal.

<http://www.healthlaw.org/search/folder.71252>

NY Soc. Serv. Law Sec. 369-ee (3) (d) (iv) (2005)

Requires family health insurance plans to develop and implement procedures to ensure that they can effectively communicate with enrollees who have limited English proficiency.

<http://www.healthlaw.org/search/folder.71252>

NY Comp. Code R. & Regs. Tit. 10 Sec. 69-4.8 (a) (9) (v), (a) (14) (i) (2007)

Requires that evaluation or screening and subsequent assessment for early intervention services take into consideration the cultural background of a child and his/her family.

<http://www.healthlaw.org/search/folder.71252>

NY Comp. Code R. & Regs. Tit. 10 Sec. 85.40 (g)

Requires that the Prenatal Care Assistance Program take into consideration pregnant women's culture and language when providing health and childbirth education.

<http://www.healthlaw.org/search/folder.71252>

NY Comp. Code R. & Regs. Tit. 10 Sec. 86-1.89 (a) (10)- (11), (e) (7) (i)

Provides for additional financial consideration for supplemental funding for medical training programs when 80% of the total number of residents receive a minimum of 8 hours of cultural competence training in addition to any training in direct patient care.

<http://www.healthlaw.org/search/folder.71252>

NY Comp. Code R. & Regs. Tot. 10, Sec. 732-2.6 (e) (10)

Requires all Preferred Provider Organizations to create a statement of how they'll address the needs of non-English speaking enrollees

<http://www.healthlaw.org/search/folder.71252>

NY Comp. Code R. & Regs. Tit. 18 Sec. 360-10.8 (f)

Requires that Medicaid managed care plans (MCP) demonstrate that non-English speaking enrollees will be fully informed of all of the services it provides in a culturally appropriate and fully comprehensible manner, i.e., one that enables them to make informed decisions about their providers.

<http://www.healthlaw.org/search/folder.71252>

NY Comp. Code R. & Regs. Tit. 18, Sec. 508.4 (d)

Requires every local social services district to implement procedures to ensure that those who do not understand English can obtain information on the Child and Teen Health Plan services and benefits in a way they can comprehend.

<http://www.healthlaw.org/search/folder.71252>

North Carolina

10A NC Admin. Code 13B.3302 (n) (Amended 5/1/08)

Requires hospitals to provide an interpreter for patients who do not speak English, whenever possible.

<http://www.healthlaw.org/search/folder.71253>

10A NC Admin. Code 48B.0401 (b) (6) (2006)

Requires local health departments to ensure that all information they provide is culturally and linguistically representative of the populations they serve.

<http://www.healthlaw.org/search/folder.71253>

10A NC Admin. Code 48B.0801 (b) (2) ((2006)

Requires local health departments to proactively include linguistically and culturally representative people in programs to reach underserved population groups.

<http://www.healthlaw.org/search/folder.71253>

NC Session Law 2008-119 (SB 4, 2007)

Improves the process for collecting data on race and ethnicity for use by health officials.

<http://www.healthlaw.org/search/folder.71253>

North Dakota

ND Admin. Code 75.5-02-06.1-01 (3) (b) (2004)

Directs social workers to ensure that illiterate and non-English and speaking clients understand the services they'll be receiving.

<http://www.healthlaw.org/search/folder.185412>

Ohio

Ohio Admin. Code Sec. 5101:3-26--08 (D) (2) (a), (6) (f) (2) (2008)

Requires written membership selection materials from Medicaid Managed Care Programs be provided in the most prevalent languages in the population served.

<http://www.healthlaw.org/search/folder.185414>

Ohio Admin. Code Sec. 5101:3-26-08.2 (A) (1) (b), (A) (2) (i), (B) (4) (y) (i) (2008)

Requires Medicaid Managed Care Programs to create and operate a member services toll-free telephone number to assist those with limited English proficiency in their native languages.

<http://www.healthlaw.org/search/folder.185414>

Ohio Admin. Code Sec. 5123:2-1-04(E)(2)(j) (2004)

Requires native language services and support for infants and toddlers (birth through age two) who are at-risk for, or have, developmental problems.

<http://www.healthlaw.org/search/folder.185414>

Oklahoma

Okla. Stat. tit. 63, Sec. 1-560.1 (2) (a) (2006)

Requires the Task Force to Eliminate Disparities to investigate and report on issues related to disparities in health and health access among multicultural populations.

<http://www.healthlaw.org/search/folder.185415>

Okla. Admin. Code Sec. 310:667-3-(3) (Amended 6/12/03)

Makes informed decisions on medical treatment a patient right that requires providers to deliver all medical information in the language of the patient.

<http://www.healthlaw.org/search/folder.185415>

Okla. Admin. Code Sec. 340:70-9-5(a), 340:70-9-7(a), (b) (Amended 7/1/07)

Requires special provisions in the mandatory outreach portion of Medicaid's Early and Periodic Screening and Treatment Services for illiterate and non-English speaking patients.

<http://www.healthlaw.org/search/folder.185415>

Oregon

Ore. Stat. Sec. 676.400

Requires regulatory boards of health professions to keep statistics on diversity in the health care workforce, and promote education and recruitment of underrepresented groups into the health care professions.

<http://www.ncsl.org/default.aspx?tabid=14298>

Or. Rev. Stat. Sec. 442.820(2)(a), 442.835, Notes Sec. (4)(g)(D) (2007)

Requires the Oregon Patient Safety Commission to create a patient safety reporting system for adverse events, including the frequency and types of serious adverse events associated with language barriers or ethnicity.

<http://www.healthlaw.org/search/folder.71254>

Or. Rev. Stat. Sec. 442.035(2)(b) (Amended 2005)
Requires the composition of the Oregon Health Policy Commission to represent the state's racial, ethnic, and language makeup.
<http://www.healthlaw.org/search/folder.71254>

Or. Admin. R. 410-141-0220(1)(b)(A), (7)(a-c) (2009)
Requires Medicaid prepaid health plans to provide linguistically and culturally sensitive interpreters for non-English speaking enrollees.
<http://www.healthlaw.org/search/folder.71254>

Or. Admin. R. 410-141-0320(2)(w) (2009)
Requires the Medicaid Prepaid member handbook to include information on interpreter services.
<http://www.healthlaw.org/search/folder.71254>

Pennsylvania

Penn Laws 22A (HB 2328, 2007)
Provides funding for the education of health professionals, with special attention on the recruitment and training of minorities.
<http://www.ncsl.org/default.aspx?tabid=14298>

40 Pa. Cons. Stat. Ann. Sec. 991.2136(a)(5)
Requires managed care plans to explain how they'll meet the needs of enrollees who do not speak English.
<http://www.healthlaw.org/search/folder.185416>

55 Pa. Code Sec. 4226.5
Requires that parents of patients receiving early intervention treatment or services be fully informed in their native language of all pertinent information related to proposed care prior to giving consent.
<http://www.healthlaw.org/search/folder.185416>

Rhode Island

R.I Gen. Laws Sec. 42-12.3-3(e) (2009)
Requires the Department of Human Services to provide interpreters for Medicaid-eligible pregnant women who don't speak English.
<http://www.healthlaw.org/search/folder.71255>

14-140-031 R.I. Code R. Sec. 7.72(e)
Requires that physicians seeking licensure disclose all translation services at their primary practice location to the Medical Licensing Board.
<http://www.healthlaw.org/search/folder.71255>

South Carolina

SC Acts 117 (HB 3620, 2007)
Appropriates funding for the study of and response to health disparities among minority populations in the state.
<http://www.ncsl.org/default.aspx?tabid=14298>

S.C. Code Regs. 114-1020(j)(4)(a)
Requires applicants and recipients for public assistance to provide documentation of eligibility unless unable to do so because they're can't speak English. In such cases, the agency may take the initiative to obtain the information.
<http://www.healthlaw.org/search/folder.185417>

SC Acts 256 (HB 3957, 2007)
Appropriates funding to support a study of health disparities in the minority population, responses to disparities, and progress toward Healthy People 2010 goals.
<http://www.ncsl.org/default.aspx?tabid=14298>

South Dakota

S.D. Codified Laws Sec. 34-23A-10.3 (2006)
Requires the health department to publish culturally-sensitive information about fetal development and organizations that assist with pregnancy.
<http://www.healthlaw.org/search/folder.185418>

S.D. Admin. R. 24:14:11:04
Unless infeasible, the regulation requires that early intervention screening instruments be culturally sensitive and administered in the native language or mode of communication of the client's family.
<http://www.healthlaw.org/search/folder.185418>

Tennessee

Tenn. Code Ann. Sec. 68-1-2203(2) (2004)
Requires the Office of Minority Health to recommend methods and programs that are sensitive and relevant to the unique linguistic, cultural, and ethnic characteristics of minority populations.
<http://www.healthlaw.org/search/folder.185419>

Tenn. Comp. R. & Regs. 0520-1-10-02 (9)(b)2.(vii)(III),(9)(C) (i), (9)(f)(I)(iv), (v) (2003)
Requires multidisciplinary evaluations and tests for early intervention programs and services to include family culture and language.
<http://www.healthlaw.org/search/folder.185419>

Tenn. Comp. R. & Regs. 1200-13-13-.04(6)(b)(3), (5)(b)(3) (Revised 2005)
Requires Medicaid service providers to use effective methods to inform non-English speaking Medicaid recipients about the availability of Early and Periodic Screening and Treatment services.
<http://www.healthlaw.org/search/folder.185419>

Tenn. H.J.R. 105 (2009)
Designates and names April 2003 and each following April as Minority Health Awareness Month.
<http://www.healthlaw.org/search/folder.185419>

Texas

1 Tex. Admin. Code Sec. 354.1415(b)(11) (c), (b) (14) (2006)
Requires HHS disease management contractors to provide educational materials in a language that each client can comprehend, and offer 24/7 culturally sensitive nurse consultation services.
<http://www.healthlaw.org/search/folder.133271>

25 Tex. Admin. Code Sec. 33.14(a) (2008)
Requires families to be informed of Early and Periodic Screening and Treatment Services by means that are suitable for non-English speaking clients.
<http://www.healthlaw.org/search/folder.133271>

Tex. Health & Safety Code Ann. Sec. 62.103(c) (2007)
Requires that applications for the Child Health Plan be made available in non-English languages.
<http://www.healthlaw.org/search/folder.133271>

Tex.Edu. Code Sec. 51.711, 714, 715
Establishes the Medical and Health Care Professions Recruitment Fund to support the recruitment of minority students into the health care professions.
www.ncsl.org/default.aspx?tabid=14298

Utah

Utah Code Ann. Sec. 26-7-2(3)(f) (2006)
Requires the Center for Multicultural Health to increase its capacity to ensure the timely and culturally appropriate delivery of translation services.
<http://www.healthlaw.org/search/folder.185420>

Vermont

Vt. Stat. Ann. Tit. 18, Sec. 1852(a)(15) (2007)
Requires interpreters for hospital patients who do not speak English.
<http://www.healthlaw.org/search/folder.185421>

Virginia

Virg. Chapter No. 343 (HB 3043, 2007)
Requires the Commissioner of the Department of Public Health to designate a senior staff member/physician to oversee minority health efforts.
<http://www.healthlaw.org/search/folder.104369>

Washington

Wash. Rev. Code Sec. 71.36.005 (2007)
Requires sensitivity in the delivery of mental health services to minority children who have unique cultural circumstances or are members of a non-English speaking family.
<http://apps.leg.wa.gov/rcw>

Wash. Admin. Code 246-453-020(2), (5), 246-453-010(16) (2003)
Requires hospitals that offer free care to consider non-English speaking individuals who make up more than 10% of their service area population when posting information on charitable treatment, and to provide an interpreter for non-English speaking individuals who fall below the 10% cutpoint.
<http://www.healthlaw.org/library/attachment.121084>

Wash. Admin. Code 388-472-0005(l)(k) (revised 2008)
Entitles applicants or recipients of services from the Department of Social and Health Services (DSHS) to an interpreter or translator without undue delay and at no cost.
<http://www.healthlaw.org/library/attachment.121084>

Wash. Admin. Code 388-502-0010(3)(d)(ii) (revised 2008)
Establishes that all DSHS interpreters are eligible for full reimbursement for their services.
<http://www.healthlaw.org/library/attachment.121084>

Wash. Admin. Code 388-538-110(f)(ii) (2008)
Requires that Medicaid managed care notices of action be written in the enrollee's native language and be readily comprehensible, as required by federal Medicaid managed care regulations.
<http://www.healthlaw.org/library/attachment.121084>

West Virginia

W. Va. Code Sec. 64-89A-2 (2004)
Requires that all forms on the uniform credentialing of health care practitioners inquire as to whether the practitioner speaks any languages other than English.
<http://www.healthlaw.org/search/attachment.121214>

Wisconsin

Wis. Stat. Sec. 250.20(2)(f) (2008)
Encourages economically disadvantaged minority students to enter the health care professions with recruitment materials that are culturally sensitive and appropriate; these should promote health careers, and be used by the University of Wisconsin and technical college systems, and the Medical College of Wisconsin.
www.legis.state.wi.us/RSB/STATS.HTML

The National Hispanic Caucus of State Legislators (NHCSL)

The NHCSL is the preeminent organization serving and representing the interests of Hispanic state legislators from all states, commonwealths, and territories of the United States. Its mission is to serve as a catalyst for joint action on issues of common concern to all segments of the Hispanic community; a forum for information exchange and member networking; an institute for leadership training; a liaison with sister U.S. Hispanic organizations throughout the country; a promoter of public/private partnerships with business and labor; and a partner with Hispanic state or provincial legislators and their associations representing Central and South America. NHCSL members include over 300 elected Hispanic State legislators throughout the United States, Puerto Rico and the Virgin Islands (www.nhcsl.org).

AstraZeneca

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