



NATIONAL ASSOCIATION OF  
Community Health Centers

# Serving Patients with Limited English Proficiency: Results of a Community Health Center Survey



# Serving Patients with Limited English Proficiency: Results of a Community Health Center Survey

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## Executive Summary

Community Health Centers serve a disproportionate share of persons with limited English proficiency (LEP) as a direct result of their mission to serve the poor and uninsured. Community Health Centers (CHCs) serve three times the portion of LEP patients as their percentage in the U.S. population. In 2006 more than four million CHC patients were best served in a language other than English. That is almost one in every three patients seen in CHCs. Ninety-five percent of CHC patients surveyed in 2001 reported that their clinicians spoke their language. This contrasts with data on other service settings where many more patients said that they had trouble understanding their provider because of a language barrier.<sup>1,2</sup>

In 2007 the National Association of Community Health Centers (NACHC) surveyed a sample of its member health centers (N=650) to gain additional information about their experiences in serving patients with limited English proficiency. The response rate to the survey was 40% (N=260). The respondents are federally qualified health centers, and a comparison shows that they have characteristics similar to all Public Health Service Act, Section 330 grantees. The sample may slightly over-represent centers that serve persons needing language assistance. The findings of the survey include:

- ◆ ***CHCs serve large LEP populations even in states that, on average, have few people with limited English skills.*** Both urban and rural CHCs often serve communities with a high proportion of LEP patients. For example, Iowa as a whole only has 2.8 percent of its people who speak English less than “very well,” yet some CHCs in Iowa have patient populations whose LEP portion is 31 to 60 percent. The NACHC survey has respondents from 48 states, and the respondents express a growing demand for language services across the country.
- ◆ ***Three-fourths of CHCs, that provide language access services, estimate that more than ten percent of each of their active patient populations has LEP.*** Forty-two percent of the CHCs report that 30 percent or more of each of their patient populations has LEP.
- ◆ ***Language services are offered by CHCs of all sizes; language service needs are not concentrated solely in large CHCs.***
- ◆ ***CHCs hire staff to address the language needs of their patients but often find it challenging to recruit them.*** The health centers encounter patients who speak a wide variety of languages with Spanish, Creole, Vietnamese, Chinese,

French, and Russian mentioned most frequently. CHCs have hired staff members that speak over fifty languages to help remove language access barriers. Eighty-eight percent of the CHCs sampled have at least one staff member that speaks a language other than English fluently. Ninety percent of the CHCs describe finding bilingual staff challenging and one-third of these say it is “very challenging.”

- ◆ ***Eighty-seven percent of health centers inquire about a patient’s need for language services during registration/intake, and 73 percent of the CHCs record this need in the patient record.*** Determination of need for language services is a joint effort of staff and patients. Just 16 percent of CHCs find determining a patient’s need for language services difficult. This low percentage may be attributable to CHCs’ experience in serving patients with LEP.
- ◆ ***Most CHCs with language services rely on bilingual staff to serve LEP patients: 74 percent use bilingual nonclinical staff, 59 percent use bilingual clinical staff, and 47 percent use staff interpreters.*** Some CHCs also frequently use telephonic and/or video services (27%), ad hoc interpreters like family members (24%), external language agencies (15%), community language banks (8%) and volunteers (3%).
- ◆ ***Eighty-four percent of CHCs provide clinical services daily to LEP patients in non-English languages by utilizing bilingual clinical staff without the aid of an interpreter.*** Forty-five percent of the CHCs provide clinical services to more than ten patients a day. Another 39 percent see from one to ten LEP patients a day. Ten percent were unsure of their daily LEP patient visit numbers. Twice as many urban as rural sites serve more than ten LEP patients daily.
- ◆ ***CHCs use a variety of staffing models to tailor their language services programs to the needs of their patients and the resources available to CHCs.*** The models are based on the methods that CHCs say they use most often; the frequency of these staffing models among the CHCs is:
  - ◆ 25%—Bilingual health care provider + bilingual non-clinical staff + staff interpreter
  - ◆ 25%—Bilingual health care provider + bilingual non-clinical staff
  - ◆ 13%—Bilingual nonclinical staff + staff interpreter
  - ◆ 10%—Bilingual nonclinical staff
  - ◆ 7%—Bilingual health care provider
  - ◆ 6%—Staff interpreter
  - ◆ 2%—Bilingual health care provider + staff interpreter

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These CHCs may also supplement their staff by reaching out to language banks and telephonic services. Eleven percent of CHCs do not have bilingual staff and therefore solely depend on external sources such as ad hoc interpreters, telephonic services, external language agencies or volunteers.

***Eighty-five percent of CHCs tell us that LEP patient visits require more time.*** Forty-nine percent of the CHCs report that a patient care visit is extended by an extra five to 15 minutes. Thirty-one percent report an extra 16 to 30 minutes is required, and five percent report more than 30 additional minutes per patient visit.

***Twenty-nine percent of CHCs pay bilingual staff additional compensation specifically to provide interpretation services in addition to their other job duties.***

***Five percent of CHCs report receiving direct reimbursement specifically for language services*** (e.g., from Medicaid and other state/local government programs, private payers or others).

◆ ***Lack of reimbursement and the lack of tools and resources for training are the major barriers that CHCs say they face in providing language services.*** The portion of health centers that cite specific barriers as “very important” follows:

- ◆ 46% Lack of reimbursement
- ◆ 39% Lack of tools and resources for training
- ◆ 20% Lack of community-level data on language needs
- ◆ 12% Lack of identification of patient language needs before arrival for an appointment (e.g., database)
- ◆ 11% Lack of staff comfort in asking questions about primary language needs.

◆ Seventy-one percent of the CHCs find it challenging to obtain community level data to help design language service programs although only 12 percent rated it “very challenging.”

◆ ***Fifty-seven percent of CHCs assess the language skills of their bilingual staff and they rely on their own staff to do so.*** When clinical or nonclinical bilingual staffers are assessed for their language ability, few CHCs require a competency test (13%) or accreditation by an outside agency (3%). They instead rely on their own evaluation (72%).

◆ ***CHCs would like guidance on how to improve language access services. The following percentage of respondents rated different types of training tools as “very important” needs:***

- ◆ 52% Model approaches/best practices for providing language services
- ◆ 46% Packaged in-service training programs
- ◆ 45% Resources for accrediting interpreters
- ◆ 42% Self-assessment tools
- ◆ 39% Translation assistance
- ◆ 22% Case studies

◆ ***When asked to rate specific topics for training, the majority of CHCs (63%) rated cultural competency training as “very important.”*** Other subjects CHCs rated as “very important” include: methods of how to respond to patients who do not speak English (by 40% of CHCs), methods of data collection on primary language from patients (36%) and how to use language data (37%).

Caring for persons with limited English proficiency has a significant impact on CHC staff time and other resources. In 2000 the Centers for Medicare & Medicaid Services conveyed to states that language services could be included as an “optional covered service” for Medicaid and SCHIP; only 12 states and the District of Columbia have done so, primarily for payment to outside language agencies.<sup>3</sup> According to the Kaiser Commission on Medicaid and the Uninsured, low income non-citizen adults are relying on clinics and health centers for their medical home rather than emergency rooms, especially when they are uninsured.<sup>4</sup> Since welfare reform measures in 1996, most legal immigrants are not eligible for federally matched Medicaid assistance during their first five years of residence. Both federal and state action could improve access to language services by improving reimbursement levels. Only five percent of the CHC survey respondents report that they receive direct reimbursement for language services, yet 84 percent of these health centers care for LEP patients daily.

## OVERVIEW

Reduced quality of care, adverse health outcomes, and health disparities can persist unless communication barriers are addressed in the delivery of health services.<sup>5</sup> Ethnic disparities for numerous preventive health measures are largely explained by lack of fluency in English.<sup>6</sup> Community Health Centers (CHCs) have a commitment to removing language barriers to health services, but caring for persons with limited English proficiency (LEP) has a significant impact on health center staff time and other resources. In 2006 more than four million CHC patients nationwide were best served in a language other than English. To gain more information about health center experiences in serving patients with limited English proficiency, the National Association of Community Health Centers (NACHC) surveyed its member health centers in 2007.

Thirty-one percent of the patients served by the CHC survey respondents need language services. CHCs seek to address these patients' linguistic and cultural needs; however, doing so requires additional staff time, staff training and translation of patient documents (e.g., patient education materials, prescription instructions, informed consent). Ninety percent of the survey respondents report that LEP patients require additional patient care time, and more than two-thirds of the responding health centers indicate that it takes at least 15 minutes or more per visit.

Survey respondents estimate their total aggregate costs (gross, not net) for language services at more than \$45 million yearly; this estimate only covers the costs incurred for less than one-quarter of all health centers nationwide. The respondents also estimate that they pay external sources (e.g., language banks, telephonic services) \$2.6 million for interpretation/translation services. Despite the high costs of serving LEP patients, only five percent of the CHCs report receiving any direct reimbursement specifically for language services (e.g., from Medicaid and other state/local government programs, private payers or others). So far only twelve states and the District of Columbia provide direct reimbursement for language services through Medicaid and SCHIP. Other states may incorporate language services into a center's general reimbursement rate but a bundled payment may not sufficiently cover the actual costs of providing language services.

The survey results showed that more health centers report staff with language capability for each language spoken by their health center patients than report having more than ten percent of their patients with that language.

This suggests additional language capability of health center staff even when there are lower percentages of LEP patients to be served. In order to provide services to LEP patients, health centers most often rely on bilingual clinical and nonclinical staff and staff interpreters. Despite the effort to provide services through bilingual staff, most of the health centers surveyed find it challenging to recruit bilingual staff.

## HEALTH CENTER SURVEY

Community Health Centers (CHCs) are local, non-profit, community-owned health care providers serving low income and medically underserved communities. They provide high-quality, affordable primary care and preventive services, and often provide on-site dental, pharmaceutical, and mental health and substance abuse services. In 2006 the 1002 health center programs served over 15 million people in 3600 urban and rural communities in every state and territory.<sup>7</sup> Centers are open to all, regardless of insurance status, and provide free or reduced cost care based on ability to pay. Seventy-one percent of the patients served have family incomes below poverty (\$20,650 for a family of four in 2007), and 40 percent are uninsured.<sup>8</sup>

The Health Resources and Services Administration, Bureau of Primary Health Care administers funding for the program under the authority of Section 330 of the Public Health Service Act. Centers that receive grants under this authority to operate Community Health Centers, Migrant Health Programs, Health Care for the Homeless Programs or Health Care in Public Housing Programs are also known as federally qualified health centers (FQHCs). Other centers that do not receive Public Health Service Act funds but meet the standards of the programs are also FQHCs for purposes of reimbursement.

The National Association of Community Health Centers (NACHC) is a non-profit organization founded in 1970 to foster access to quality community-based care for the medically underserved and uninsured. NACHC serves as the major source for information, data, research and advocacy on key issues affecting FQHCs. Since almost one in three health center patients are best served in a language other than English, NACHC, in partnership with the National Health Law Program, NHeLP surveyed its member health centers in the summer of 2007 to gather more information on language services.

While the survey results are based on a convenience sample of NACHC FQHC members, the respondents closely

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resemble characteristics of all Public Health Service Act, Section 330 grantees in regard to size, urban/rural distribution, receipt of migrant health center grants, portion of uninsured patients, and type of reimbursement received. However, the sample may slightly over-represent centers that serve proportionally more patients needing language services and more patients with Hispanic ethnicity. On other language-related measures of direct provision of interpretation/translation services and receipt of migrant health center grants, there are not significant differences between the sample and all Section 330 health centers.

- ◆ Nationwide data for all 1002 health center grantees reveal that 29 percent of patients were best served in a language other than English during calendar year 2006.<sup>9</sup> The survey sample centers have 31 percent of their patients needing language services.<sup>10</sup> This is a statistically significant difference.<sup>a</sup>
- ◆ Nationwide 34 percent of health center patients are Hispanic compared with 36 percent of the survey respondents' patients.<sup>9,10</sup> This is a statistically significant difference.<sup>a</sup>
- ◆ Nationwide 89 percent of all health centers provide interpretation/translation directly; 92 percent

of the NACHC survey sample provides interpretation/translation directly.<sup>10,11</sup> This difference is not statistically significant.<sup>a</sup>

- ◆ Nationwide 14 percent of grantees receive migrant health program grants, as do 13.6 percent of the survey respondents.<sup>12</sup> This difference is not significant.<sup>a</sup>

The representativeness of the survey sample is examined in more detail in the Appendix.

## DISPROPORTIONATE RESPONSIBILITY

CHCs serve a disproportionate share of persons with limited English proficiency as a result of their mission to serve the poor and uninsured (Figure 1). They serve three times the portion of LEP patients as their representation in the U.S. population (i.e., 28.9% of all CHC patients vs. 8.7% of the U.S. population). Seventy-one percent of all CHC patients fall below 100 percent of the Federal poverty line compared with 12.7 percent of the U.S. population and 17.7 percent of those who speak a language other than English at home.

**Figure 1**

Language, Poverty and Insurance Status	Percent %
<b>English Ability *</b>	
All CHC patients best served in a language other than English	28.9
Survey sample CHC patients best served in a language other than English	31.2
U.S. population 5 years and over who speak English less than "very well"	8.7
U.S. population 5 years and over who speak a language other than English at home	19.7
<b>Below 100% poverty level **</b>	
All CHC patients (all ages)	70.7
Survey sample CHC patients (all ages)	69.7
U.S. population five years and older	12.7
U.S. persons five years and older who speak another language at home	17.7
<b>Uninsured †</b>	
All CHC patients	39.8
Survey sample CHC patients	39.6
U.S. non-elderly population	16.3-18.3
Low income, nonnative adults in U.S. for less than 5 years	67.0
more than 5 years	60.0

\* All CHC patients: 2006 Uniform Data System (UDS) Table 3b; U.S. figures 2006 American Community Survey S1601: Language Spoken at Home, American Factfinder, <http://factfinder.census.gov>.

\*\* All CHC patients: 2006 UDS Table 4; U.S. figures 2006 American Community Survey S1603: Characteristics of People by Language Spoken at Home.

† All CHC patients: 2006 UDS Table 4; U.S. non-elderly figures from Kaiser Commission on Medicaid and the Uninsured, (Report #7553, Aug 2006); Low income, non-native adult figures from Kaiser Commission, (Report #7651, June 2007).

<sup>a</sup>The difference in proportions was examined for significance at the 95% confidence level.

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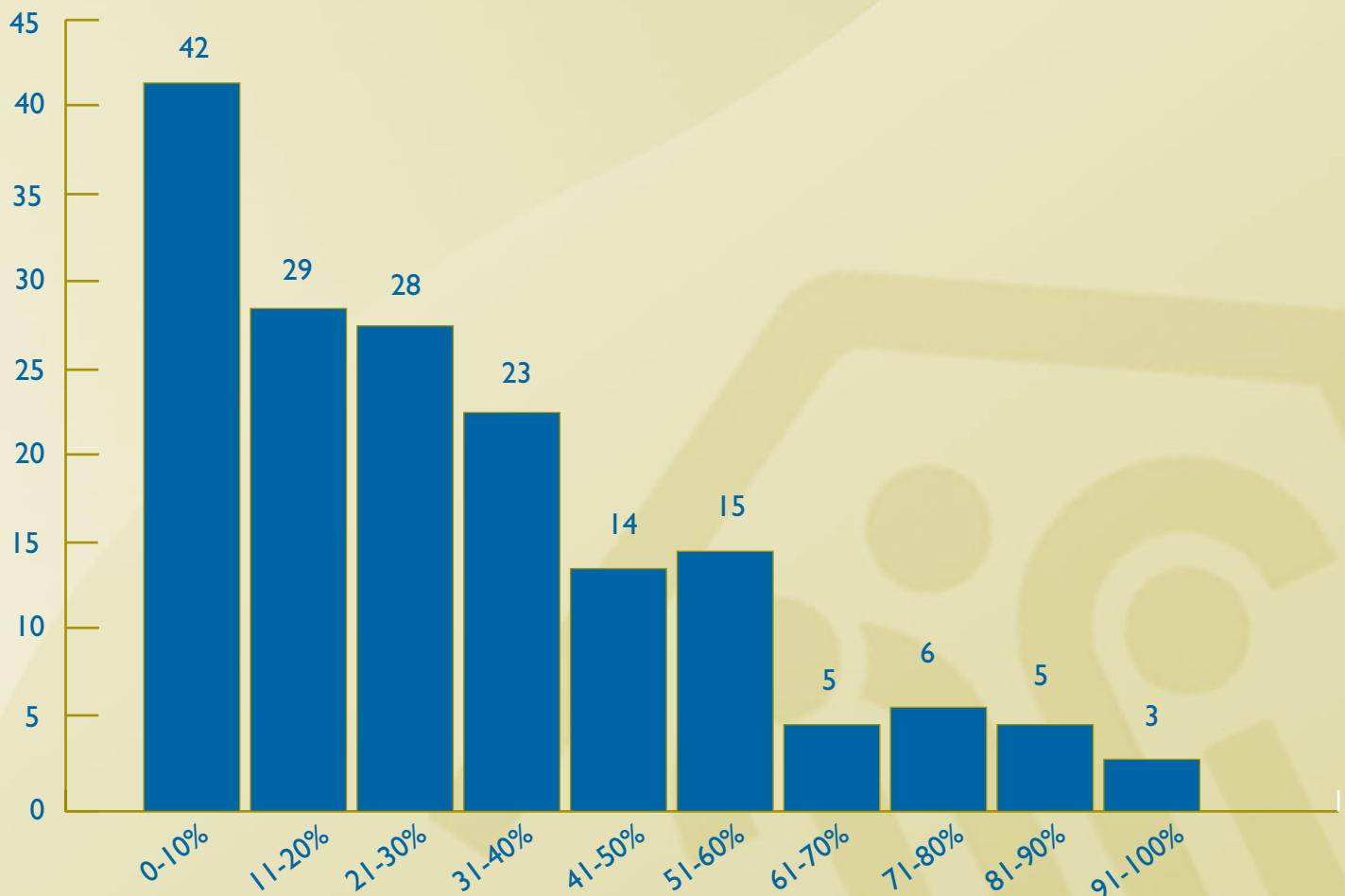
Of all CHC patients, 39.8 percent were uninsured in 2006. According to the Kaiser Commission on Medicaid and the Uninsured, low income non-citizen adults are relying on clinics and health centers for their medical home rather than emergency rooms, especially when they are uninsured.<sup>13</sup> Since welfare reform measures in 1996, most legal immigrants are not eligible for federally matched Medicaid assistance during their first five years of residence. Two-thirds of low-income non-native adults living in the United States for less than five years are uninsured, and even after five years in the United States sixty percent are still uninsured. While there are some exceptions for life-threatening conditions, federal Medicaid funds are not available for preventive care and thus CHCs present a place to receive care.

The NACHC survey sample has a higher percentage of patients best served in English (31.2%) than all CHCs (28.9%), but it has comparable portions of uninsured patients and patients in poverty.

## NEED FOR LANGUAGE ASSISTANCE IN COMMUNITIES

CHCs are faced with a growing need for language services across the country. The percentage of patients needing these services at health centers varies community to community. Overall 75 percent of the survey respondents report that more than ten percent of each of their active patient populations have LEP (128 of 179 centers with language services (Figure 2)).<sup>b</sup> Forty-two percent of the CHCs report that 30 percent or more of each of their patient populations has LEP (71/170), and 20 percent of CHCs each have over 50 percent of their patient population with LEP (34/170).

**Figure 2. Number of CHCs by Estimated Percentage of Health Centers' Active Patient Population Who Have LEP (n=170)**

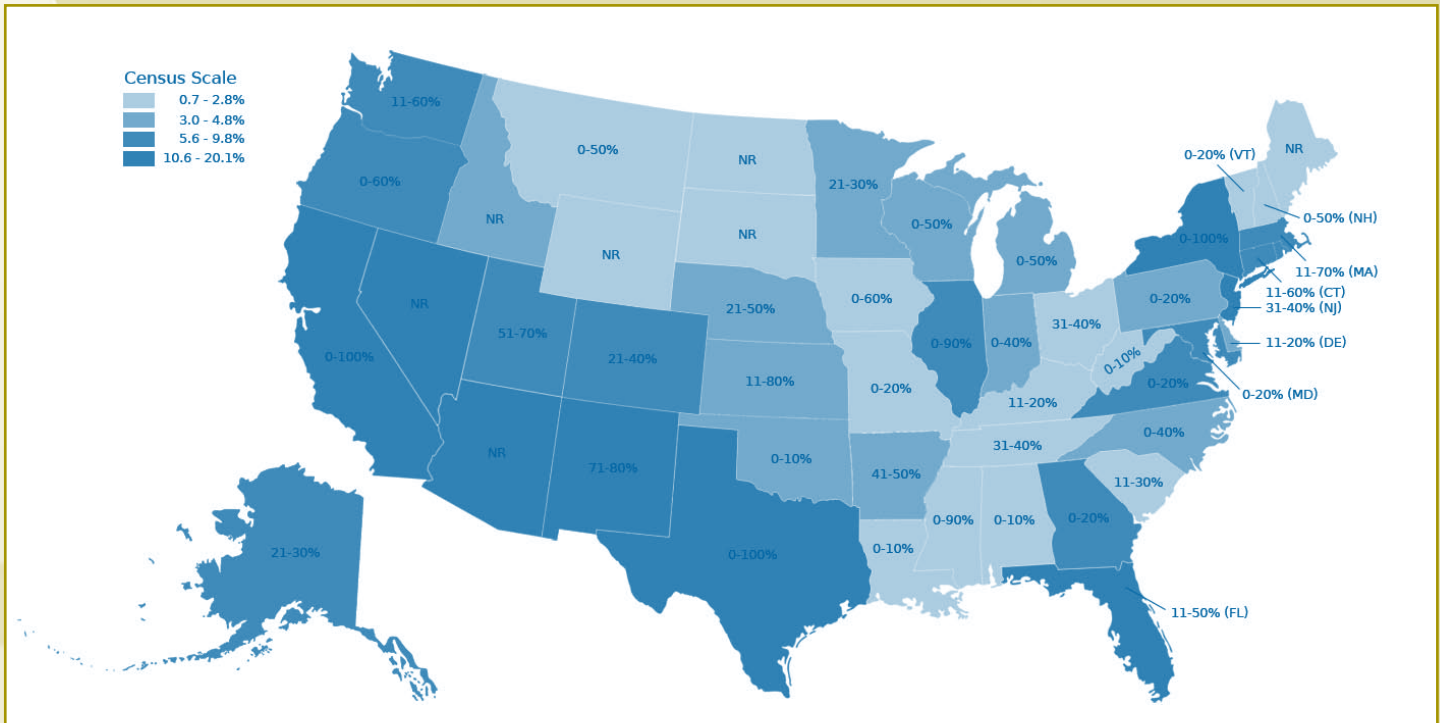


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The NACHC survey results include responses from 48 states, and CHCs from each state express a demand for language services. The gray scale on the U.S. Census continental map (Figure 3) indicates the portion of each state's population that does not speak English "very well."<sup>14</sup> The numbers printed on the states indicate the range of LEP populations at CHCs in each state based on the survey results. NR (not reported) is printed on a state if no CHC from that state provided this specific data.

- ◆ Asian Pacific Health Care Venture in Los Angeles serves an "81-90%" LEP population speaking Chinese, Spanish, Tagalog, Thai, Vietnamese and other languages.
- ◆ At the Nuestra Clinica Del Valle in San Juan, Texas the LEP population is "91-100%" Spanish-speaking.

Even in Midwestern states that have lower overall LEP populations, some CHCs report serving primarily LEP



## High State LEP Rates and Highly Concentrated LEP Populations at CHCs

The U.S. Census finds that California, New York, Texas, Arizona, New Mexico, Nevada and Florida have overall populations that fall into the range of 10.6 to 20.1 percent not speaking English very well. It is not surprising in these linguistically diverse states that some CHCs serve patient populations in which almost all patients have limited English proficiency (Figure 3). For example,

- ◆ The Mission Neighborhood Health Center in San Francisco serves a LEP population of Spanish speakers in the "91-100%" range.
- ◆ The Charles B. Wang Community Health Center in New York City serves a "91-100%" LEP population speaking Chinese, Korean, Vietnamese and other languages.

patient populations like at United Methodist Mexican American Ministries in rural Garden City, Kansas (71-80% LEP).

## Growing State LEP Rate Brings New Challenges to CHCs

During the 1990s, immigration growth patterns moved beyond Border States to push the highest rates into states like North Carolina, Georgia, Nevada, and Arkansas. And from 2000 to 2005, South Carolina, Tennessee, Delaware, Arkansas,<sup>15</sup> Georgia, and Alabama have had the greatest foreign-born growth rate particularly of newly arrived Mexican and other Latin American immigrants with limited English skills; Arkansas had the greatest rate increase in its Hispanic population of all states.<sup>16, 17</sup> CHCs are serving in these growth areas, for instance:

- ◆ The Community Clinic at St. Francis in urban Springdale on the western edge of Arkansas estimates

<sup>b</sup>Each CHC reported the portion of its LEP population in increments of ten percentage points.



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that “41-50%” of their patient population are Spanish speakers with LEP; the Executive Director finds it very challenging to recruit bilingual staff so they depend on nonclinical staff for the interpretation services that they are able to offer.

- ◆ At Eau Claire Cooperative Health in Columbia, South Carolina, “21-30%” of their patients are Spanish speakers with LEP. The Chief Operating Officer finds it somewhat challenging to recruit the appropriate staff and they too depend primarily on nonclinical staff to provide interpretation services.
- ◆ United Neighborhood Health Services in Nashville, Tennessee has an LEP population of “31-40%” and most often depends on bilingual clinical staff to address patient needs.
- ◆ Greene County Health Care in Snow Hill, North Carolina finds it moderately challenging to recruit the bilingual clinical and nonclinical staff to serve their “31-40%” LEP population.

in Iowa serve high LEP populations of Spanish and Laotian speakers: Primary Health Care in Urbandale has a “31-40%” LEP population and the rural United Community Health Center in Storm Lake has “51-60%” of patients having LEP.

- ◆ Ohio has an overall state average of 2.2 percent speaking English less than “very well” while Butler County CHC reports serving an LEP population of “31 to 40 percent.”

## Low State LEP Rate But Still High Impact on CHCs

Even in states that have a small overall population who do not speak English “very well” (according to Census figures less than 2.8 percent), urban and rural CHCs often serve communities with a high proportion of LEP patients (Figure 3). For example,

- ◆ Iowa as a whole only has 2.8 percent of its people speaking English less than “very well,”<sup>18</sup> yet CHCs

## Urban versus Rural Need

CHCs, whether they are located in urban or rural areas, have a demand for language services.<sup>19</sup> However, there is somewhat more demand in urban locations. Only three percent of the surveyed urban-based CHCs do not provide clinical services in a language other than English but 12 percent of rural ones do not. Additionally, more urban locations have a larger portion of LEP patients: 81 percent of urban ones versus 60 percent of rural locations have an LEP population of more than ten percent; 48 percent of urban areas versus 29 percent of rural locations have an LEP population of more than 30 percent.<sup>c</sup>

## DIVERSE LANGUAGE NEEDS OF PATIENTS SERVED BY CHCs

CHCs encounter patients who speak a wide variety of languages; fifteen language choices were listed as options in the NACHC survey. The portion of respondents having more than ten percent of their patients speak individual languages is listed in Figure 4.

**Figure 4**

Language Choices	Percent of CHC Respondents (%)
Spanish	68.0
Other Languages (unspecified)	8.0
Creole	6.0
Vietnamese	5.0
Chinese	4.0
French	3.0
Russian	3.0
Tagalong	2.0
Korean	2.0
Thai	2.0
Laotian	1.0
Polish	1.0
German	1.0
Hindi	0.4
Arabic	0.4

<sup>c</sup>The difference in proportions between urban and rural is significant at the 95% confidence level.

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Spanish-speaking patients make up the most widespread single language group; 68 percent of CHC respondents have more than ten percent of their patients speaking Spanish. Similarly, U.S. Census figures confirm, that other than English, Spanish is the language most frequently spoken at home in the United States - 62 percent of those who speak a language other than English at home speak Spanish or Spanish Creole.<sup>20</sup> However, in contrast to the U.S. population, it appears that CHCs care for a larger portion of Asian/Pacific Islander speakers.

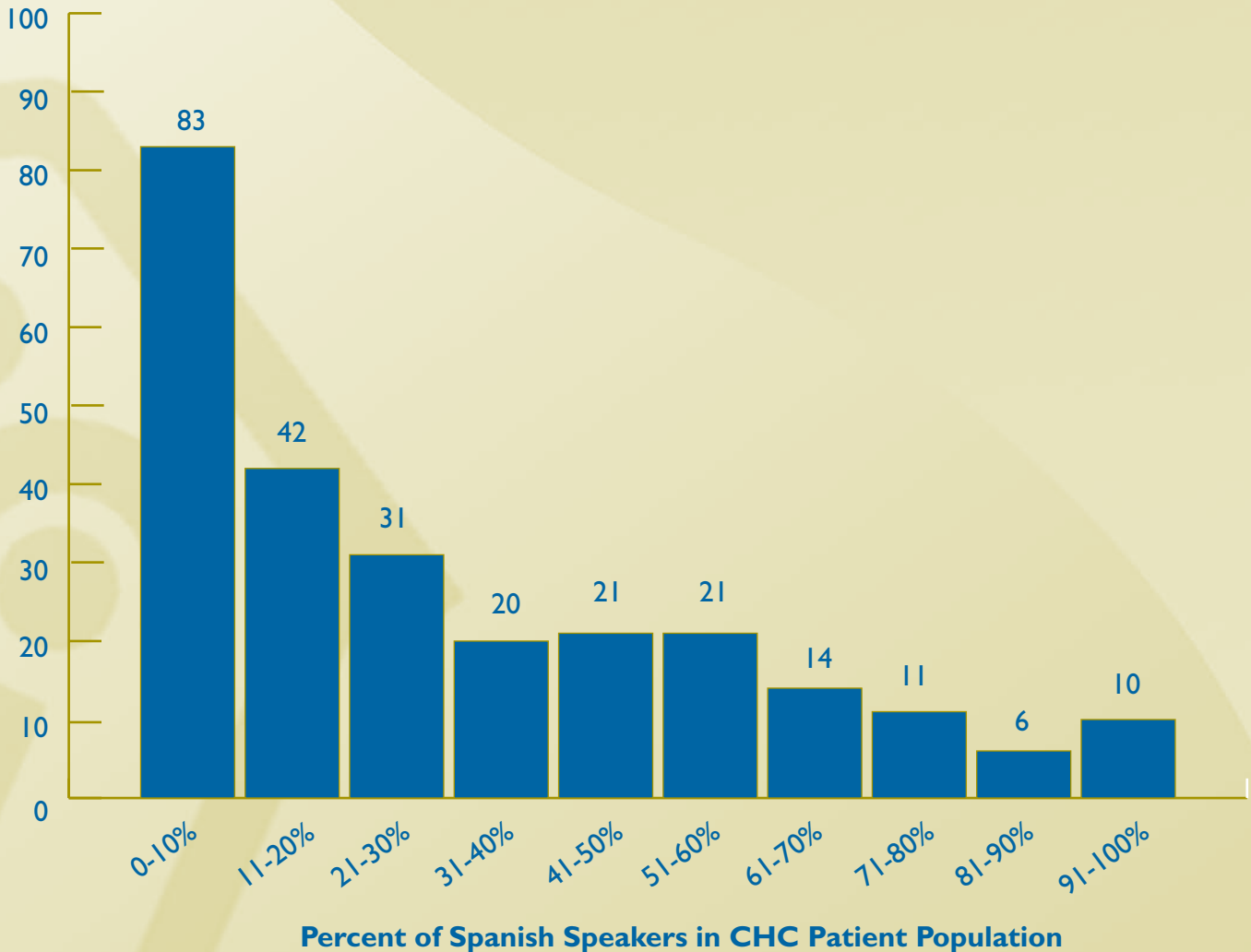
The portion of Spanish-speakers in their patient populations varies widely among CHCs. Figure 5 displays how many of the survey respondents serve Spanish-speaking LEP populations on the spectrum from “0-10%” to “91-100%.”

## LANGUAGE SERVICE STAFF AVAILABLE AT CHCs

In a 2001 study of CHC patient experiences, 95 percent of CHC patients reported that their clinician spoke their language and another three percent said that they were able to communicate in their own language with someone else on the CHC staff. This contrasts with data on other service settings where twelve percent or more of patients said that they had trouble understanding their provider because of a language barrier.<sup>21</sup> For example, the Kaiser Family Foundation survey of health care experiences found that about three in ten Latinos had problems communicating with a health care provider and when Spanish was the Latinos primary language half of the patients had problems communicating with a provider.<sup>22</sup>

The current NACHC survey assesses the availability of language services at CHCs by site rather than asking patients whether their clinician speaks the same language.

**Figure 5. Number of CHC Respondents by Proportional Share of their Spanish-Speaking Patient Population (n=259)**



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Eighty-eight percent of CHCs have at least one staff member (clinical or administrative) that fluently speaks a language other than English. Figure 6 breaks these data down by the specific languages CHC staff members speak and compares these percentages with the percent of CHCs that have patients speaking those languages. More CHCs report staff with language capability for each language than report having more than ten

percent of their patients with that language. Thus there appears to be additional language capacity at CHCs even when there are lower percentages of LEP patients to be served. Almost all of the responding CHCs that have staff speaking another language have a member of the staff that speaks Spanish, which mirrors the largest LEP patient pool.

**Figure 6**

Languages	CHCs with Staff Member Speaking Language * (%)	CHCs with 10% of Patients Speaking Language (%)
Spanish	84.0	68.0
Other Language Not List on Survey	29.0	8.0
French	26.0	3.0
Chinese	15.0	4.0
Vietnamese	14.0	5.0
Arabic	13.0	0.4
Hindi	12.0	0.4
Russian	12.0	3.0
Tagalong	11.0	2.0
Korean	11.0	2.0
Creole	10.0	6.0
German	10.0	1.0
Laotian	19.0	1.0
Thai	8.0	2.0
Polish	5.0	1.0

\* To determine this overall CHC percentage, CHCs reporting staff speaking a language were multiplied by 88% (CHCs with staff that speak another language)

The “other” languages written in as spoken by staff were numerous, but Somali and Hmong were mentioned by more CHCs:

- ◆ African languages: Somali, Sudanese, Swahili, Amharic, languages of Ghana (e.g., Asante-Twi, Fanti), Bambara, and other African languages
- ◆ American Sign Language
- ◆ European languages: Serbo-Croatian, Bosnian, Ukrainian, Greek, Romanian, Albanian, Lithuanian, Portuguese
- ◆ Native American languages: Lakota, Otham
- ◆ Asian/Pacific languages: Samoan, Japanese, Indonesian, Khmer, Hmong, Mien, Davaweno, Visayan
- ◆ South Asian languages: Hindi, Pakistani, Tamil, Bangladeshi, Punjabi, Farsi, Urdu, Hindko
- ◆ Chinese dialects: Mandarin, Cantonese, Fukien, Trisanese, Shanghainese
- ◆ Latin America: Mixteco

The twelve percent of CHCs that do not have a staff member fluent in a language tend to be in rural areas, have “91-100%” of their population speaking English, and have non-physician clinical and administrative support staff sizes of 11-50 FTEs.

Only about 57 percent of the CHCs assess the language skills of bilingual staff (clinical and/or non clinical) that provide services in non-English languages. When bilingual staffers are assessed for their language ability, few CHCs require a competency test (13%),<sup>d</sup> or accreditation by an outside agency (3%). Instead they rely on their own staff’s evaluation (72%).

## RECRUITING AND PAYING BILINGUAL STAFF

Only 29 percent of CHCs provide bilingual staff with additional incentives (e.g., compensation) to provide interpretation services over others in a comparable position. Two-thirds of the CHCs giving additional incentives use staff interpreters most frequently; this might be an employee of the practice who is hired in a dual-role (e.g., office manager who interprets) or a dedicated interpreter position.

Most of the health centers find it challenging to recruit bilingual staff:

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- ◆ 31% Very challenging
- ◆ 32% Somewhat challenging
- ◆ 27% Moderately challenging
- ◆ 10% Not challenging at all

To find bilingual staff, CHCs use word of mouth (81%), paid advertisements (79%), staff referrals (75%), internet postings (60%), and free advertisements (38%).

## ASSESSING NEED FOR LANGUAGE ASSISTANCE FOR INDIVIDUAL PATIENTS

Typically, health centers inquire about a patient's need for language services during registration/intake, particularly if the center serves a more linguistically diverse population. Of the 12 percent of CHCs who answer that they do not inquire,<sup>e</sup> their patient populations are almost all English speaking (52%), all Spanish speaking (3%), or equally split between English and Spanish speakers (19%) aiding easy recognition of language needs without a specific inquiry.

Eighty-seven percent of the health centers inquire about a patient's need for language services at intake, but only 73 percent record the patient's preferred language within their medical record. Additionally, 60 percent of CHCs maintain a database on the primary languages patients speak, and three-fourths of those with a database can track this information over time. However, the survey did not distinguish whether the database includes individual patient specific needs or only tracks the portion of the population with a specific language need; each CHC may have chosen to monitor this information in different ways.

Sixteen percent of the health centers find determining a patient's need for language services difficult; this low percentage may reflect CHC experience in serving language minorities. The primary methods of staff assessment or patient self-assessment of need for help with either spoken and written language are used equally by CHCs. For example, 94 percent have staff and the patients themselves determine a patient's spoken language need during the intake assessment; only four percent prefer the staff solely to make the assessment and two percent solely by the patient. Eighty-nine percent of the CHCs make documents available to patients in their primary or preferred language. Those that do not are predominantly rural CHCs with a minimal LEP population.

<sup>d</sup>For example American Translators Association, American Medical Interpreters/Translators Association.

<sup>e</sup>32 centers out of 262 answering question.

## SERVING PATIENTS IN A LANGUAGE OTHER THAN ENGLISH

CHCs tailor their services to the needs of their patients and the resources available. To most effectively address the cultural and linguistic needs of their patients, CHCs offer a variety of language access services. Most offer a series of formal rather than ad hoc services.

### Types of Language Services

Centers tell us that they most frequently use the following variety of services, relying most often on bilingual clinical and nonclinical staff and staff interpreters:<sup>f</sup>

- ◆ 74% use Bilingual Non-Clinical Staff
- ◆ 59% use Bilingual Clinical Staff
- ◆ 47% use Staff Interpreters
- ◆ 27% use Telephonic and/or Video Services
- ◆ 24% use Ad hoc Interpreters (e.g., family members)
- ◆ 15% use External Language Agencies
- ◆ 8% use Community Language Banks
- ◆ 3% use Volunteers (e.g., students, AmeriCorps member)

Six percent of the responding health centers only relied on ad hoc interpreters for their occasional needs for interpretation and none relied solely on volunteers.

### Staffing Models

Health centers with LEP patients use different staffing combinations to provide the needed language services. The frequency of using these distinct staffing models follows, and the brackets include the average range of their LEP population:

- ◆ 25%–Bilingual health care provider + bilingual non-clinical staff + staff interpreter
- ◆ 25%–Bilingual health care provider + bilingual non-clinical staff
- ◆ 13%–Bilingual nonclinical staff + staff interpreter
- ◆ 10%–Bilingual nonclinical staff
- ◆ 7%–Bilingual health care provider
- ◆ 6%–Staff interpreter
- ◆ 2%–Bilingual health care provider + staff interpreter

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Some but not all of these CHCs supplement their staffing model with a variety of external sources such as external language agencies and telephonic services. Eleven percent of the CHCs does not have bilingual staff and therefore depends on sources such as ad hoc interpreters of family and friends, telephonic services, external language agencies and/or volunteers. These CHCs have an average range of LEP penetration of 9-19% LEP which is much less than that of the CHCs with dedicated bilingual staff or interpreters.

## Daily Provision of Language Services

Eighty-four percent of the CHCs provide clinical services daily to LEP patients in non-English languages by utilizing bilingual clinical staff without the aid of an interpreter (Figure 7). This compares to a nationwide survey of hospitals that revealed that only 63 percent of hospitals are seeing LEP patients regularly and then often only weekly rather than daily.<sup>23</sup>

Forty-five percent of the CHCs provide clinical services to “more than ten patients” a day (Figure 7). Another 39 percent see from “one to ten” LEP patients a day. Ten percent were unsure of their daily LEP patient visit numbers. Twice as many urban sites (67%) as rural ones (33%) serve “more than ten” LEP patients daily without the aid of an interpreter.

## CHCs of All Sizes Serve LEP Populations

As noted earlier, 75 percent of all of the responding CHCs serve patient populations with more than ten per-

cent having LEP. CHCs with large and small numbers of non-physician support staff serve a substantial portion of LEP patients, illustrating that language service needs are not concentrated solely in large CHCs. The percentage of CHCs that serve an LEP population of more than 10% by staffing level follows:

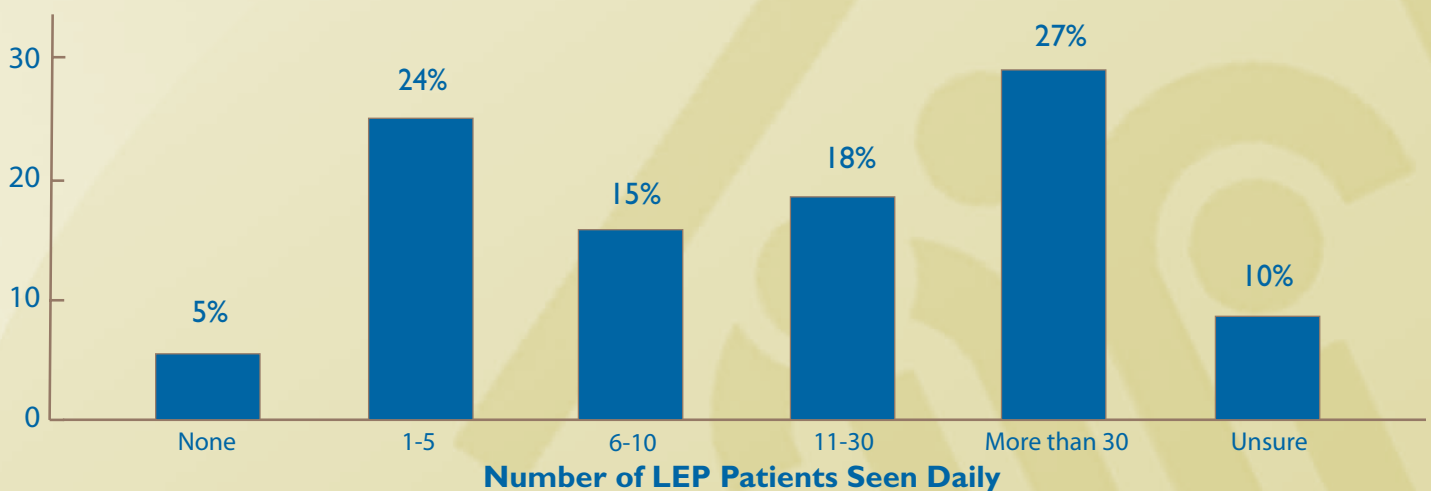
- ◆ 75 % of all CHCs surveyed
- ◆ 62% of CHCs with less than 10 FTEs of non-physician support staff
- ◆ 75% of CHCs with 11-25 FTEs
- ◆ 55% of CHCs with 26-50 FTEs
- ◆ 69% of CHCs with 50-100 FTEs
- ◆ 87% of CHCs with over 100 FTEs

The difference in these proportions is significant only in comparing CHCs with support staff over 100 FTEs to CHCs with 26-50 FTEs, but not with any other staffing level.<sup>9</sup> Thus there is not a consistent pattern emerging that would show that the portion of CHCs increases as staff size increases.

The overall percentage of CHCs that serve an LEP population of “more than 30 percent” is 40 percent. Separating CHCs by staffing level also reveals no significant difference in the portion of CHCs that serve a patient population where about one in three has LEP:

- ◆ 40% of all CHCs surveyed
- ◆ 31% of CHCs with less than 10 FTEs of non-physician support staff
- ◆ 45% of CHCs with 11-25 FTEs
- ◆ 28% of CHCs with 26-50 FTEs

**Figure 7. Percentage of CHCs Whose Bilingual Clinical Staff Provide Interpretation Directly to LEP Patients Without Aid of an Interpreter (n=237)**



<sup>9</sup>CHCs could provide multiple answers and thus the percentages do not add to 100%.

# Serving Patients with Limited English Proficiency: Results of a Community Health Center Survey

- ◆ 36% of CHCs with 50-100 FTEs
- ◆ 49% of CHCs with over 100 FTEs

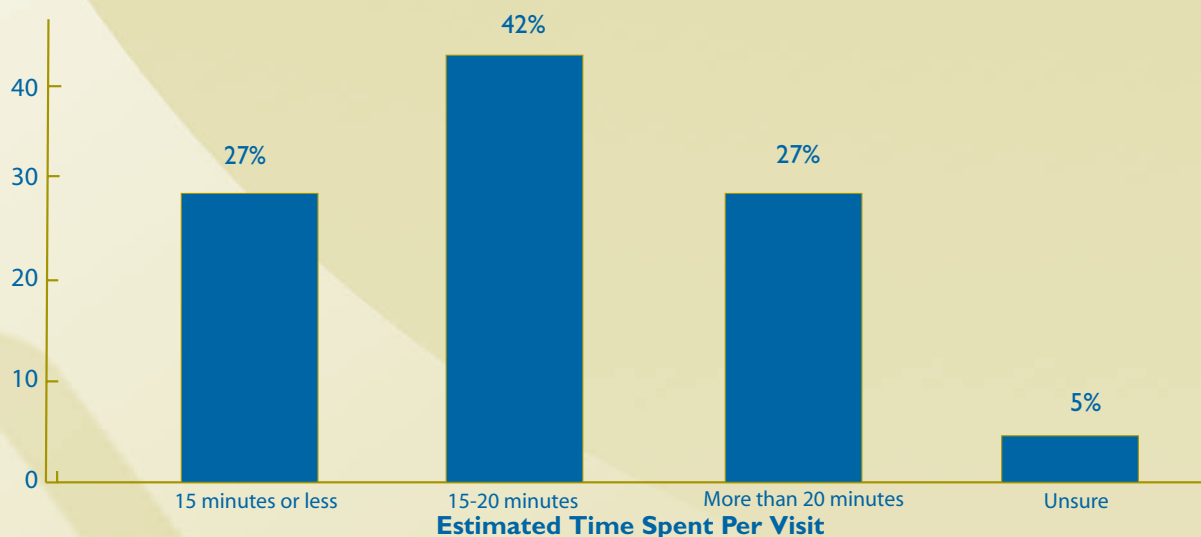
median 15.7 minutes in another; visits lengthen with the number of procedures (e.g., Pap smear) and patient complexity.<sup>24</sup>

## IMPACT OF LEP PATIENTS ON PATIENT CARE VISIT LENGTH

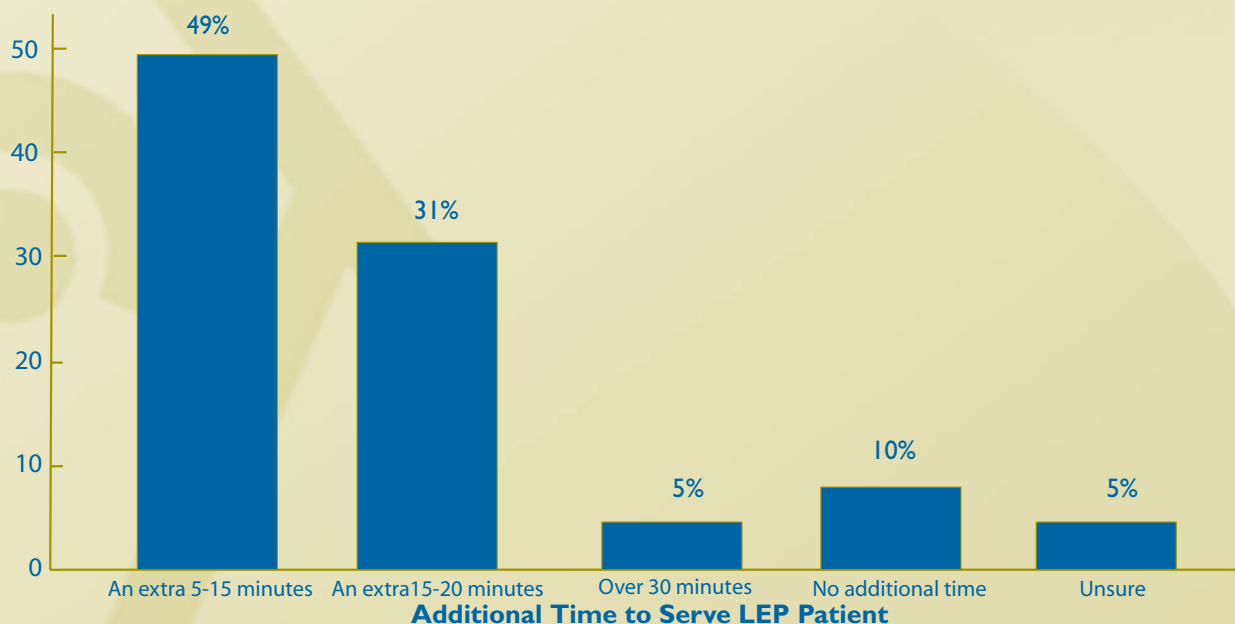
When asked how much time do staffs normally spend with an English-speaking patient, the survey respondents report that 42 percent of their patient visits were for 15 to 20 minutes (Figure 8a). This is consistent with national data on the average length of patient visits in primary care practice in which the mean visit length for adults is 16 minutes in one study and the

Next CHCs were asked approximately how much additional time does it take to care for an LEP patient versus a non-LEP patient requiring similar care. Eighty-five percent of the responding CHCs say LEP patients require more time, generally five to 30 minutes more than a typical English-speaking patient visit (Figure 8b). Ten percent of CHCs say that serving LEP patients required no extra time; these CHCs tend to have a smaller English speaking population (less than 50 percent) and thus may have sufficient bilingual staff.

**Figure 8a. Estimated Time Spent with English-Speaking Patients Per Visit by CHCs (n=173)**



**Figure 8b. Additional Time Required for LEP Patients Per Visit by CHCs (n=173)**



<sup>9</sup>Significant at 95% confidence level.

## LIMITED REIMBURSEMENT BUT CONSIDERABLE COSTS FOR LANGUAGE SERVICES

Only five percent of the CHC respondents say that they receive direct reimbursement for language services. No question was asked whether reimbursement for language services is included in the centers' general reimbursement for Medicaid. The health centers were asked how they pay for the language services that they provide:

- ◆ 55% Health center funds for staff
- ◆ 38% Per hour charges (e.g., interpretation)
- ◆ 16% Subscription or retainer to an external agency
- ◆ 18% Other (not described)
- ◆ 8% Unsure
- ◆ 3% Annual or monthly support payment (e.g., contribution to language bank).<sup>h</sup>

On the survey, the responding health centers estimate that the total aggregate costs (gross, not net) to their health centers for providing language services is more than \$45 million. This is an estimate for approximately one-quarter of all Section 330 grantees (250 respondents/1002 Section 330 grantees). This estimate contrasts with the \$24 million allocated to translation and interpretation according to the Health Resources and

Services Administration Uniform Data System national report for all 1002 grantees.<sup>25</sup> HRSA data may underestimate the full cost of providing language services as the full costs associated with recruiting, training and supporting bilingual staff not specifically designated as translators or interpreters may not be included. Additionally, the aggregate costs reported on the survey are inclusive of all staff costs (including benefits), supplies, office space, and forms.

Eighteen percent of the respondents report that they have no aggregate costs for language services while others find that it costs millions of dollars a year (Figure 9). Further definition of the actual costs associated with language access services will help make a case for additional reimbursement. Twenty percent of the respondents were unwilling to make an estimate.

In addition to their staff costs, CHCs pay others for language assistance. The survey respondents estimate that they pay out \$2.6 million for interpretation and translation (including \$1.3 million just for interpretation services); the survey sample makes up about one quarter of all Section 330 grantees. Figure 10 displays the range of payments that centers make in a year for these services. Forty-two to fifty percent of the respondents say they have no external payments for translation and interpretation

**Figure 9**

Dollar Range of Total Aggregate Costs	Distribution of CHCs (%)	Average Payment within Dollar Range (\$)
\$0	18.0	0
\$100-1,000	7.0	519
\$1,001-10,000	11.0	5,726
\$10,001-50,000	12.0	30,056
\$50,001-100,000	9.0	92,130
\$100,001-500,000	16.0	267,811
\$500,000+	5.0	2,443,331
Unsure	20.0	
Volunteer/In-Kind/Other	0.4	

<sup>h</sup>CHCs could provide multiple answers and thus the percentages do not add to 100%.

# Serving Patients with Limited English Proficiency: Results of a Community Health Center Survey

**Figure 10**

External Payment for Materials & Interpretation (n=250)			External Payment for Interpretation Services Only (n=250)		
Dollar Range	CHCs (%)	Average Payment within Dollar Range (\$)	CHCs (%)	Average Payment within Dollar Range (\$)	
\$0	42.1	0	50.0	0	
\$100-1,000	12.5	558	12.0	365	
\$1,001-10,000	17.7	5,029	14.0	3,470	
\$10,001-50,000	10.0	26,748	8.0	25,902	
\$50,000+	3.9	180,000	3.0	103,428	
Unsure	10.2	11.0			
Volunteer/In-Kind/Other	3.5	2.0			

## BARRIERS FACED IN PROVIDING LANGUAGE SERVICES

Lack of reimbursement and lack of tools and training resources are the major barriers that at least half of CHCs cite as impeding their efforts to provide adequate language services to patients. Ninety-five percent of CHCs do not receive any direct reimbursement for language services (e.g., from Medicaid or other state/local government programs, private payers, or others). Seventy-one percent of CHCs found it “challenging” to obtain community level data to help design their language service programs although only 12 percent of these rated this as “very challenging.”

The portion of CHCs that cites these as “very important” barriers to providing language services follows:

- ◆ 46% Lack of reimbursement
- ◆ 39% Lack of tools and resources for training
- ◆ 20% Lack of community-level data on language needs
- ◆ 12% Lack of identification of patient needs before arrival for an appointment (e.g., language database)
- ◆ 11% Lack of staff comfort in asking questions about primary language needs.<sup>i</sup>

Only 25 percent of CHCs report that they do not face any barriers in providing language services. These CHCs do not have a common profile although more than half are rural: about four out of 10 are rural with an English speaking population; another one out of 10 are rural with less than 60% speaking English; about one out of 10 are urban with an English speaking population; two out of 10 are urban with less than 60% speaking English. CHCs serving an all English-speaking population do not face the barriers others do. Some CHCs with a high LEP population may already have adapted to the situation and find it easy to recruit bilingual staff.

<sup>i</sup>CHCs could provide multiple answers and thus the percentages do not add to 100%.

<sup>j</sup>CHCs could provide multiple answers and thus the percentages do not add to 100%.

## TOOLS AND TRAINING RESOURCES NEEDED

The portion of CHCs that rate as “very important” specific tools and training programs, which they would find useful to improve their language services, follows:

- ◆ 52% Model approaches/best practices for providing language services
- ◆ 46% Packaged in-service training programs
- ◆ 45% Resources for accrediting interpreters
- ◆ 42% Self-Assessment tools
- ◆ 39% Translation assistance
- ◆ 22% Case Studies<sup>j</sup>

A sizeable percentage of CHCs (10-20 percent) are unsure if they would find these tools helpful; additional descriptive information on the survey might have clarified the usefulness of these programs.

With respect to the content of any training, more CHCs identify cultural competency as a needed training component. The following percentage of CHCs rate the content options as “very important:”

- ◆ 63% Cultural competency training
- ◆ 40% Methods of how to respond to patients who do not speak English
- ◆ 36% Data collection methods on primary language from patients
- ◆ 37% How to use language data<sup>k</sup>

Thirty percent of CHCs indicate that they are engaged in specific initiatives to improve the provision of language services at their health centers. Four out of five of these CHCs are willing to share lessons learned from their language initiatives with others.



## CONCLUSION

CHCs have historically provided a safety net for persons with LEP. Many CHCs are located in communities with larger and long-standing populations; these have more developed bilingual staff and other language resources. Other CHCs have to adapt to newly emerging immigration patterns and growing need for bilingual staff and interpreters. In both cases, the cost of providing language access services is considerable.

Under Title VI of the Civil Rights Act of 1964, discrimination on the basis of national origin is prohibited for any recipient of federal funding.<sup>26</sup> The U. S. Department of Health and Human Services (DHSS) clarified this in a memorandum to affirm that denial or delay of care because of language barriers constitutes discrimination. Furthermore, language barriers compromise the health of patients.<sup>27</sup> U.S. Census data clarify that 60 to 64 percent of LEP citizens are citizens and documented immigrants,<sup>28</sup> yet legal immigrants are not eligible for federally matched Medicaid assistance during their first five years of residence. States also determine which language services will be reimbursed within their state.

A recent study by the Center for Studying Health System Change notes the lack of adequate resources in local com-

munities to remove barriers to care for linguistically isolated groups. To alleviate the strained safety net, they recommend that the federal government consider revisiting the reimbursement limits placed on providing care to immigrants within five years of their entry into the United States.<sup>29</sup> Although in 2000, the Centers for Medicare & Medicaid Services conveyed to states that language services could be included as an optional covered service for Medicaid and SCHIP, only 12 states and the District of Columbia have done so.<sup>30</sup> Medicare does not now pay for language services. Expanded reimbursement for CHC language services and bilingual staff would help health centers further diminish language barriers in communities across the country.

## APPENDIX:

### Survey Methods and Respondent Characteristics

FQHCs that are members of the National Association of Community Health Centers (NACHC) were asked to respond to an online survey on language services. The response rate is 40 percent with one response per CHC. Responses were received from all states except Wyoming and Maine; both Wyoming and Maine provide direct reimbursement for language services to certain providers.

This is a convenience sample but is similar to all Section 330 grantees based on descriptors derived from the Health Re-

**Figure AP I**

	LEP Sample (n=251)		National Rollup (n=1002)	
	# of Respondents	%	# of Respondents	%
Type of Location				
Urban	119	47.8	526	52.5
Rural	130	52.2	476	47.5
Patient Population Size *				
Less than 5,000 users	102	41.0	489	48.8
5,001-10,000	75	30.1	279	27.8
10,001-20,000	63	25.3	198	19.8
20,001-50,000	9	3.6	36	3.6
50,001 and up				
Receives Migrant Health Center Grant **	34	13.6	140	14.0
Delivery Method of Interpretation/Translation †				
Provided by Grantee	230	91.9	894	89.2
By Referral/Grantee Pays	56	22.5	234	23.4
By Referral Grantee Doesn't Pay	66	26.5	294	29.3

\* Derived from UDS Table 3a data  
 \*\* Derived from list of sites and their grants from UDS Rollup  
 † Derived from UDS Table 2 line number 49

<sup>h</sup>CHCs could provide multiple answers and thus the percentages do not add to 100%.

# Serving Patients with Limited English Proficiency: Results of a Community Health Center Survey

sources and Services Administration's Uniform Data System although patients who might need language services are somewhat over-represented in the sample centers:

- ◆ There is not a significant difference between the survey respondents and 1002 grantees reporting in the Uniform Data System on rural/urban distribution, the portion of centers receiving migrant health grants or on any delivery method for interpretation/translation (Figure AP-1).<sup>1</sup>
- ◆ The sample under-represents the smallest CHCs (less than 5000 users) (AP-1), but there is not a significant difference for other size categories. Based on the survey results, the smallest CHCs, as assessed by FTE increments, did not differ significantly

from larger CHCs in the portion having the same degree of LEP penetration in the patient population.

- ◆ The sample somewhat over-represents Hispanic patients and the portion of patients best served in a language other than English. While the percentage difference is small, these differences are statistically significant (AP-2). Thus there may be a somewhat higher availability of language services in the sample centers.
- ◆ AP-3 shows a similar profile for the survey sample of centers and all Section 330 grantees on degree of poverty and insurance source.

**Figure AP 2**

	LEP Sample (n=251)		National Rollup (n=1002)	
	# of Patients	%	# of Patients	%
Number of Patients *				
Total Asian/Hawaiian/Pacific Islander	133,601	3.2	493,415	3.3
Black/African American	835,991	19.7	3,242,746	21.6
American Indian/Alaska Native	37,357	0.9	161,258	1.1
White	1,455,555	34.4	5,131,206	34.1
Hispanic or Latino	1,519,140	35.9	5,099,259	33.9
Unreported / Refused to report	250,361	5.9	906,239	6.0
Total	4,232,005	100.0	15,034,123	100.0
Patients best served in a language other than English *	1,323,473	31.2	4,349,357	28.9

\* Derived from UDS Table 3b data

**Figure AP 3**

	LEP Sample (n=251)		National Rollup (n=1002)	
	# of Patients	% of Known	# of Patients	% of Known
Income as Percent of Poverty Level*				
100% and Below	2,363,792	69.7	8,204,840	70.7
101-150%	486,971	14.4	1,694,087	14.6
151-200%	250,961	7.4	768,982	6.6
Over 200%	289,012	8.5	945,222	8.1
Unknown	841,269		3,420,992	
Total Known	3,390,736		11,613,131	
Principal Third Party Insurance Source*				
None/Uninsured	1,675,952	39.6	5,988,537	39.8
Total Medicaid	1,518,434	35.9	5,275,937	35.1
Medicare	326,128	7.7	1,134,251	7.5
Total Public Insurance	89,787	2.1	346,537	2.3
Private Insurance	621,704	14.7	2,288,861	15.2
Total	4,232,005		15,034,123	

\* Derived from UDS Table 4 data

<sup>1</sup>The difference in proportions was examined for significance at the 95% confidence level.

## ENDNOTES

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- <sup>5</sup>Institute of Medicine, Board on Health Sciences Policy. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academy Press, 2003.
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- <sup>8</sup>HRSA, BPHC. 2006 UDS Table 4: Patients by Socioeconomic Characteristics, and U.S. Department of Health and Human Services. The 2007 HHS Poverty Guidelines. Available at <http://aspe.os.dhhs.gov/poverty/07poverty.shtml> Accessed 3/16/08.
- <sup>9</sup>HRSA, BPHC. 2006 UDS Table 3b Patients by Race/Ethnicity/Language.
- <sup>10</sup>Data provided by Shira Gitmer, NACHC using site specific 2006 UDS data.
- <sup>11</sup>HRSA, BPHC. 2006 UDS Table 2 Services Offered and Delivery Method.
- <sup>12</sup>HRSA, BPHC. 2006 UDS List of Grantees.
- <sup>13</sup>KCMU. Schwartz and Artiga, *op.cit.*, June 2007.
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- <sup>25</sup>HRSA, BPHC. 2006 UDS Table 8B: Enabling Services line 8 Translation/Interpretation.
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- <sup>30</sup>Youdelman M. Medicaid and SCHIP Reimbursement Models for Language Services. 2007 Update. Washington, DC: National Health Law Program. April 2007. The 12 states are Hawaii, Idaho, Kansas, Maine, Minnesota, Montana, New Hampshire, Utah, Vermont, Virginia, Washington, and Wyoming.



The **National Association of Community Health Centers** (NACHC) represents the nation's health safety net: over 1,150 Community Health Centers, serving over 17 million people at 6,000 sites located throughout all 50 states and U.S. territories. Community Health Centers provide health care to low-income and medically underserved Americans, and they never turn anyone away – regardless of insurance status or ability to pay. They are local, non-profit, community-owned and federally funded.

NACHC is the leading source for information, data, research and advocacy on key issues affecting Community Health Centers. NACHC provides education, training, technical assistance and leadership development to promote excellence and cost-effectiveness in health delivery practice and community board governance. In addition, it builds partnerships that stimulate public and private-sector investment in quality health care services.

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