NICOS Chinese Health Coalition

COMMUNITY ALLIANCE FOR CLAS

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Addressing the Needs of California’s

Limited English Proficient (LEP) Populations:

A Statistical Report and Recommendations

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1. **INTRODUCTION**

**Overview**

California is one of the most linguistically diverse states in the U.S., and is home to a multicultural population that speaks more than 70 indigenous languages derived from 64 root languages in six language families. The purpose of this report is to assess the prevalence of residents in the 58 counties of California who possess limited English language skills and to offer recommendations to address their needs.

**Languages Spoken at Home**

The 2006-2010 American Community Survey (ACS) 5-Year estimates indicates that more than half (57%) of California residents age five and older speak [English](http://en.wikipedia.org/wiki/English_language) as a [first language](http://en.wikipedia.org/wiki/First_language) at home. Of those who speak a language other than English at home, Spanish is the most prevalent (66%), followed by 22% who speak an Asian or Pacific Islander language, 10% who speak an Indo-European language other than Spanish, and 2% who speak another language.

Examples of some **Asian and Pacific Islander Languages** (in order of prevalence) include Chinese, Tagalog, Vietnamese, Korean, Japanese, Mon-Khmer/Cambodian, Hmong, Thai, and Laotian. Examples of some of the **Other Indo-European Languages** (in order of prevalence) include Armenian, Persian, Russian, Hindi, French, German, Portuguese/Portuguese Creole, and Italian. Finally, examples of some of the **Other Languages** (in order of prevalence) include Arabic, African Languages, Hebrew, and Hungarian.

**The Foreign-Born and English Proficiency**

A significant portion of Californians who are foreign-born report not speaking English well. For example, in 2009 the majority (59%) of California's total foreign-born population age five and older were considered limited English proficient (LEP), compared to only 4 %of similarly aged native-born persons.



**Implications**

The implications of this are great. According to the California Pan-Ethnic Health Network’s *Achieving Equity by Building a Bridge from Eligible to Enrolled* report, “The LEP population represents a considerable portion of those eligible for coverage under the [the Affordable Care Act], through either Medi-Cal or tax credits to purchase insurance through California’s new Health Benefit Exchange; however, language barriers may result in a difference of 110,000 fewer LEP individuals enrolled in the Exchange.”

California Health Interview Survey discovered that over 50% of Californians who do not speak English well or at all were uninsured for all or part of 2005, compared to 23.8% of those who speak English very well. In addition, the Asian American Center for Advancing Justice’s *A Community of Contrasts* report stated that, “Coupled with a lack of available English classes, language is a formidable barrier impacting access to a range of vital services, such as healthcare, social services, housing, courts, and education.”

Title VI of the Civil Rights Act of 1964 mandates that limited English proficient (LEP) individuals have meaningful access to the health services being provided. The Department of Health and Human Service’s Office of Minority Health has issued 14 standards for Culturally and Linguistically Appropriate Services (CLAS) that are required for health organizations that receive federal funding. These 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14).

There are also California laws that require that language services are accessible. The Dymally-Alatorre Bilingual Services Act (1973:CA Government Code 7290, 7299) requires local governments make their services accessible to LEP individuals and specifically refers to the employment of qualified bilingual persons for public contact positions.  California also passed SB 853 (Escutia) requiring Commercial Health Plans and Insurers to provide language services. This includes all health plans regulated by the Department of Managed Health Care (DMHC) and all insurance companies that are regulated by the California Department of Insurance (CDI). It was fully implemented in January 1, 2009.

1. **DEFINITIONS and SOURCE**

This section defines some of the terms that are commonly used in reference to individuals with limited abilities to communicate in English. It also describes the data source and rationale for data selection.

**Definitions**

**Limited English proficient (LEP)** individuals are those who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English.

**Threshold Language** is defined by The California Department of Mental Health as “a language identified on the Medi-Cal Eligibility Data System (MEDS) as the primary language of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area, per Title 9, CCR, Section 1810.410 (f) (3).” This report analyzes each of California’s 58 counties and lists their threshold languages using the same numeric criteria. However, it is based on 2010 Census data instead of Medi-Cal beneficiary data.

**Source**

The 2010 US Census and the American Community Survey are the primary data sources used to develop this report. The tables titled, “B16001: Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over” from the 2006-2010 ACS 5-Year estimates are used to analyze the percentage of Californians who speak English “less than well” or “not at all” for each of the 58 counties in California and for the whole state. The data containing estimates are based on a sample of each county’s population and are subject to sampling variability and errors. ACS is used because it provides more comprehensive data on a wide range of demographic, socioeconomic, and other characteristics compared to the Census.

This report uses data from the ACS 5-Year estimates rather than the 1year or 3- estimates because this data includes rural areas with fewer than 20,000 residents, such as Alpine County (1,065) and Modoc County (8,762). The 5-year estimates combine population and housing data from the past 60 months to produce demographic, housing, social, and economic characteristics for the nation, states, cities, counties, and other small geographic areas. The Census Bureau has produced 5-year estimates from the ACS since 2010. The estimates are updated annually by removing the earliest year and replacing it with the latest one, which allows for monitoring social and economic trends in local communities.

1. **SUMMARY OF DATA REPORTS**

California’s total population surpasses 34 million residents and its counties range in total population from Alpine County with the smallest total population of nearly 1,100 to Los Angeles with the largest population of over 9 million. There are 45 counties with populations under 650,000 and seven counties with populations under 20,000. The following are tables that provide a summary of the data collected from the 2010 US Census and the ACS regarding languages spoken at home by LEP populations.

**Appendix A: Limited English Proficiency by County Population** lists the estimated numbers of residents who speak a particular language as a percentage of the county’s total population. There are over 30 different languages listed. For those who speak a language other than English in the home, the number who are LEP is included, expressed as a percentage of *the total population*. **For example**, in Alameda County, Spanish-speaking LEP individuals comprise **8.2%** (113,735/1,380,045) of the total county.

|  |  |
| --- | --- |
| **Language Spoken/ English Fluency based on Language Spoken** | **Alameda County, California** |
| **Estimated Population** | **% of County Population** |
| **Total:** | 1,380,045 |  |
|  **Spanish or Spanish Creole:** | 231,556 | 16.8% |
|  **LEP, Spanish or Spanish Creole:** | 113,735 | **8.2%** |

**Appendix B: Limited English Proficiency by Language Spoken** also lists the estimated numbers of residents who speak a particular language as a percentage of each county’s population. In addition, it includes the number of LEP individuals, expressed as a percentage of *the population speaking that language*. **For example**, in Alameda County, **49.1%** (113,735 /231,556) of those who speak Spanish are LEP.

|  |  |
| --- | --- |
| **Language Spoken/ English Fluency based on Language Spoken** | **Alameda County, California** |
| **Estimated Population** | **% of Language Spoken** |
| **Total:** | 1,380,045 |  |
| **Spanish or Spanish Creole:** | 231,556 | 16.8% |
| **LEP, Spanish or Spanish Creole:** | 113,735 | **49.1%** |

**Appendix C: Threshold Language by County** lists the 58 counties and the threshold languages spoken in each county. Spanish is a threshold language for 43 counties while Chinese is a threshold language for 13 counties. Fourteen counties (Alpine, Amador, Calaveras, Del Norte, Humboldt, Lassen, Mariposa, Nevada, Plumas, Shasta, Sierra, Siskiyou, Trinity, and Tuolumne) did not have any threshold languages. Los Angeles County, which has the largest total population, has 22 threshold languages, the highest number in the state. There are 25 threshold languages among all the California counties.

1. **RECOMMENDATIONS**

The following are recommendations based on an analysis of the data and the Office of Minority Health’s Cultural and Linguistically Appropriate Services (CLAS) Standards. Among the 14 standards, Standards 4 through 7 pertain specifically to language access services.

**Standard 4: Free language assistance services**“Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.”

* Organizations should assess who they are currently serving and if they are providing appropriate language access. Organizations should reach out to individuals that speak their county’s threshold languages but may not be seeking services. It is important to determine if language access is one of the barriers to services for these clients and assist them in accessing the services they need.
* Organizations should increase their bilingual workforce by recruiting, hiring, promoting, compensating, and supporting staff, interns, and volunteers who are bilingual and utilize more technological tools for interpretation.
* Face-to-face interpretation should always be first provided by a bilingual staff. However, if a bilingual staff is not available, qualified interpreters should be used as back-up. Language lines should always be used as a last resort.
* Oral interpretation should be available in all languages and not just the threshold languages.

**Standard 5: Inform patients of right to receive language assistance**“Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.”

* Organizations should develop policies and procedures to ask the preferred language(s) of all clients.
* Staff should be trained in cultural and linguistic competency to provide linguistic assistance in determining the language(s) clients prefer to use. They should also receive training on how to inform all clients of their right to language assistance.
* Organizations should post visible signage offering language assistance in all local threshold languages.

**Standard 6: Quality of language assistance**“Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).”

* Organizations should *NOT* make assumptions about staff competencies and client preferences.
* Organizations should train staff on how to effectively use an interpreter
* Interpreters should be qualified to work in the health industry and have no conflicts of interest with the client.
* Providers should educate and counsel clients on when and how to use an interpreter and on confidentiality issues, reassuring clients who are not comfortable with certain interpreters.

**Standard 7: Materials and signage**
“Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.”

* Materials and signage must be available and accessible, according to local threshold language requirements.
* Organizations should follow best practices in developing translated materials.
* Other language factors such as age appropriateness and literacy levels should also be considered when developing written materials

 **5. CONCLUSION**

**Organizations should meet clients’ linguistic needs at the provider, organization and systems levels.**

PROVIDER LEVEL

Properly trained in cultural competency, staff members are either proficient in the language preferred by clients or can effectively work with properly trained interpreters. Clients are informed of their rights to language assistance and can easily indicate their language preferences.

ORGANIZATION LEVEL

Organizations develop and implement policies and strategies to attract, employ, train, and support a bilingual workforce. There is a specific person or team in organizations responsible for ensuring that CLAS standards are met. These individuals/teams would also be responsible that policies related to cultural competency are enforced and are working effectively. Organizations have written materials and signage in clients’ preferred languages that are accessible to them.

SYSTEMS LEVEL

Health systems develop and implement policies and strategies for strengthening a diverse, multilingual workforce. Health systems, organizations, clients/consumers, and community stakeholders create meaningful partnerships to advocate for more funding and resources to support the linguistic needs of LEP clients. Community members are voting for the rights of LEP clients and contacting government officials to support them. Clients are providing feedback and sharing their stories. Organizations are training providers, clients, and the community as advocates for the LEP community.