ANALYZING ACCESSIBILITY AND BEST PRACTICES OF LANGUAGE ACCESS SERVICES

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Contents

Abstract 3

Introduction 4

Review of Literature 6

Methods 13

Results 18

Discussion 25

Conclusion 32

References 33

Abstract

Language differences present a significant challenge in health systems' efforts to mitigate health disparities within the United States. Access to healthcare resources is severely strained for individuals with Limited English Proficiency (LEP). LEP individuals are less likely to partake in screening procedures, vaccinations, and other preventive interventions due to the language gap between themselves and medical providers (Ortega et al., 2021). In turn, the lack of preventative health services causes LEP individuals to have worse health outcomes, such as experiencing higher rates of chronic diseases, depression, hospitalizations, and poorer physical health compared to English-proficient counterparts (Haldar et al., 2023; Twersky et al., 2024). This capstone paper assesses the language access services, such as interpreters and translators, provided by PACE-Rhode Island (PACE-RI), a not-for-profit health plan for adults aged 55 and older within Rhode Island. The objectives were to assess whether the language access services of PACE-RI (1.) comply with language access regulations, (2.) adhere to practices under the Culturally and Linguistically Appropriate Services (CLAS) standards, and (3.) recommend opportunities to improve language services at PACE-RI that are aligned with best practices. The methods used included phone and video call interviews with PACE-RI personnel to assess current language access services, followed by phone interviews with Day Center Supervisors from two external PACE organizations, On Lok PACE and Fallon Health Summit Elder Care. After the interviews, a gap analysis was conducted to compare PACE-RI's language service practices to language access regulations and to compare the language service practices of the two external PACE organizations under the CLAS standards. The gap analysis findings indicate that PACE-RI complies with language access regulations and has an inventory of language access services. However, improvements are needed to fully align with CLAS standards. The findings suggest that PACE-RI should consistently utilize trained language access professionals for all

medical appointments and services and develop performance indicators to evaluate the quality of their language access services.

Introduction

The United States is one of the world's most diverse countries, with people from different cultural backgrounds. Different cultural backgrounds mean different ideas, family structures, religions, and potentially languages other than English. One of the most glaring issues amongst nonproficient English speakers in the United States is health disparities. A significant factor that ties into these disparities is language barriers. Language barriers disrupt access to healthcare and affect the quality of healthcare. All age ranges of nonproficient English speakers experience health disparities, especially among the elderly population (Ponce et al., 2006). A notable health model that focuses on the needs of elderly, nonproficient English speakers is the PACE model. The Programs of All-Inclusive Care for the Elderly (PACE) model is a comprehensive approach that assists the medical, functional, and social needs of elderly individuals who are considered frail and sick (Medicaid, 2011).

The PACE model originated at On Lok Senior Health Services in San Fransico during the 1970s to enable program enrollees, or participants, to meet their healthcare needs while enabling them to live safely within the community for as long as feasible (Medicaid, 2011). Eligible participants must be aged 55 or older, reside within the organization's service area, and be certified as eligible for nursing home care by their state, with the ability to safely reside in a community setting at the time of enrollment (2011). By enrolling in a PACE program, participants forgo their regular sources of care and receive all necessary services through a PACE organization (PO). An interdisciplinary team reviews authorized care and other services for each participant (2011). Participants receive various contracted services, including primary care,

hospital care, prescription drugs, nursing, personal care, emergency, and various therapeutic interventions. These services are tailored to each participant's needs and enable participants to maintain their autonomy and dignity while receiving the necessary support to remain within their homes and communities (2011). This health program is financed through combined Medicare and Medicaid capitation payments, and POs receive monthly capitation payments for each eligible participant. These funds are pooled to cover all necessary health expenses, which allows POs to provide comprehensive services to their participants. POs assume the entire financial risk for all required health services.

PACE programs are a considerable alternative for elder care by providing comprehensive health services to participants, focusing on keeping them within the community for as long as feasible. According to the National PACE Association (n.d.), “there are 163 PACE organizations operating in 32 states and the District of Columbia. More than 300 PACE centers serve nearly 76,000 participants across the country.” One of these POs includes the PACE Organization of Rhode Island (PACE-RI). PACE-RI has diligently served over 2,000 participants and their families across Rhode Island since 2005, further expanding its reach with the establishment of day centers in East Providence, Newport, Westerly, and Woonsocket, ensuring comprehensive coverage across the entirety of the state (PACE-RI, n.d.).

The Organizational Performance Department of PACE-RI requires an assessment of its language services. This assessment aims to determine compliance with language access regulations and determine if these services adhere to best practices. In addition, if language services do not comply with regulations or adhere to best practices, evidence-based interventions must be recommended. Before assessing PACE-RI’s language services, this paper will explore the concept of limited English proficiency (LEP), statistics of health disparities for the LEP

population in the United States, the usage of interpreters and translators, and various federal language access laws and care standards.

Review of Literature

Individuals who struggle with speaking proficient English can face significant barriers in various aspects of life, including education, employment, and accessing essential services like healthcare. Ortega, Shin, and Martinez (2021) define Limited English Proficiency (LEP) as the limited ability to speak, read, write, or understand English, which hampers individuals' comprehension and communication skills. While potentially fluent in another language, LEP individuals struggle conceptually with understanding and communicating in English, particularly in medical contexts (2021). This linguistic barrier places LEP patients in the United States at a disadvantage, as they may need help comprehending medical instructions in English. Consequently, LEP patients experience various healthcare disadvantages, including extended hospital stays, surgical delays, increased infection risks, falls, pressure ulcers, readmissions, and other adverse medical events (CMS, 2022). Using qualified language access professionals, such as interpreters and translators, is crucial to improving the quality and coordination of healthcare services. However, despite the availability of language access services, some healthcare providers opt not to utilize them, instead relying on ad-hoc interpreters, such as untrained bilingual staff and family members (2022).

Formidable challenges in accessing and receiving healthcare can arise from limited English proficiency, leading to disparities in utilization and quality of services for LEP patients. As of 2021, the United States has a significant number of individuals with LEP, totaling 25.7 million people, according to Haldar, Pillai, and Artiga (2023). This demographic represents 8% of the population aged five and older within the United States. Hispanics comprise the majority of the LEP population, accounting for approximately 62%, while Asians represent over a fifth at

22%. Among the primary languages spoken by LEP individuals in the United States are Spanish, Chinese, Vietnamese, Arabic, and Tagalog (2023). These statistics highlight the considerable linguistic diversity within the country and the importance of addressing language barriers to ensure equitable access to healthcare services among diverse linguistic communities. Challenges and barriers to accessing high-quality healthcare arise from language barriers between LEP patients and healthcare providers, as Haldar, Pillai, and Artiga (2023) highlighted. Language barriers can lead to decreased patient satisfaction, reduced comprehension of health information, and increased adverse effects. Patients with LEP are more likely to experience more extended hospital stays, surgical delays, and readmissions, reflecting disparities in healthcare outcomes. LEP individuals also report reduced access to care, fewer preventive services, and difficulties finding providers who can communicate effectively in their preferred language (2023). Twersky et al. (2024) further emphasize that LEP patients are less likely to have a regular source of care, leading to a higher likelihood of forgoing necessary medical treatment and missing preventive care visits than English-proficient counterparts. The quality of healthcare is diminished for LEP patients because there is no clear communication between the patient and the provider. If the provider cannot understand and communicate with their patients on a linguistic, the probability of adverse health outcomes is more likely (Wilson, 2013).

The disparities in healthcare access and outcomes are particularly pronounced among older individuals with LEP, as outlined by Ponce, Hays, and Cunningham (2006). Older LEP patients face more significant difficulties in accessing care, with a higher likelihood of lacking a usual source of care compared to their English-proficient counterparts. Moreover, they are at increased risk of experiencing fair or poor health, with notable disparities in emotional well-being. Older Latinos and Asians with LEP tend to report poorer self-rated physical health and

higher psychological distress, exacerbating overall health disparities (2006). Furthermore, older LEP patients exhibit lower utilization of health services and encounter barriers to service use, including difficulties understanding written information provided by healthcare providers (2006). These findings underscore the urgent need for targeted interventions to address the unique healthcare needs of older LEP populations and ensure equitable access to quality care for all individuals, regardless of language proficiency.

Language barriers pose a severe complication to access and quality of health care services, making health disparities within LEP populations more apparent. When language barriers exist in the healthcare system, medical interpreters and translators are crucial. The first kind of language service professional is an interpreter. Either qualified or certified, interpreters can be linguistic medical personnel or third-party professionals who interpret spoken language in medical settings between an LEP patient and medical personnel. Interpreters also consider cultural backgrounds and linguistic dialects from patient to patient. Incorporating cultural backgrounds can allow interpreters to understand the perspectives of LEP patients, and equipping themselves to speak dialects of languages makes them versatile. Interpreters can be available in two ways: (1) bilingual medical staff on-site, and (2) through an associated credible third-party language access company that can be reached in-person, over online video communications, or through a three-way telephone call (Juckett & Unger, 2014). To become a qualified interpreter, a candidate must demonstrate fluency in at least two languages and undergo formal training that teaches professional standards and ethics (NCIHC, n.d.). A candidate must undergo additional formal testing by a professional organization (such as the National Council on Interpreting Healthcare) or a government entity to become a certified interpreter. Any form of training or certification ensures that candidates have met the essential criteria to become

professional medical interpreters (n.d.). It should be noted that using family members or friends as interpreters in healthcare settings is widely discouraged due to several factors. Studies such as Kale and Syed (2010) point out that utilizing non-professional interpreters (ad-hoc interpreters) such as family members and friends can impede accurate interpretation due to emotional attachment. Non-professional interpreters often lack the necessary comprehension of medical terminology, which can lead to potential misinformation, and the presence of a family member can potentially breach a patient's right to confidentiality and privacy, especially if the patient feels pressured to accept their presence as an interpreter (2010).

The second kind of language service professional is a translator. Many people associate being an interpreter and a translator with the same discipline, but interpreting and translating differ in technicality and profession. Interpreting focuses on oral communication in real-time between a patient and a medical professional, whereas translators work with written language (NCIHC, n.d.). As provided in a description by the National Bureau of Labor Statistics (2023), the responsibilities of translators include converting written materials from one language to another to make the target language read as naturally as their native language. The written materials translators work with are information on websites, medical documents, marketing, and user documentation (2023). Their work involves preserving the original structure and style of the text while ensuring accuracy in conveying ideas and facts. Additionally, translators must adapt to cultural references, slang, and expressions that may not have direct equivalents, ensuring that the translated content remains true to the original meaning and tone (2023). Unlike medical interpreters, the translation profession is relatively unregulated, with no universal certification or licensing requirements. Recognition as a professional translator may come from holding staff positions, working as a freelancer, obtaining academic certificates, or earning certification from

professional associations such as the American Translators Association (National Bureau of Labor Statistics, 2023; American Translators Association, n.d.).

There are clear distinctions between the work of interpreters and translators in healthcare services. However, having them present at a healthcare organization (regardless of whether it is bilingual medical staff or through a third-party company) benefits the quality of care for LEP patients. In a study by Jacobs et al. (2001), 4,380 adults continuously enrolled in a health maintenance organization over two years were examined. Among this number, 327 individuals utilized comprehensive interpreter services (ISG), while the remaining 4,053 were randomly assigned to a 10% comparison group (CG) of other eligible adults (2001). The research for this study showed that both groups experienced an increase in clinical service use and preventative services from year one to year two. Clinical service usage significantly increased in the ISG compared to the CG for office visits, prescriptions written, and prescriptions filled. Preventative services such as rectal examinations increased significantly more in the ISG compared to the CG. Also, disparities in the rates of fecal occult blood testing, rectal exams, and flu vaccinations between Portuguese and Spanish-speaking patients and a comparison group were significantly reduced after the implementation of interpreter services (2001). This study highlights the impact of language access services during healthcare appointments. Utilizing these language access services caused increased usage of clinical, prescription, and preventive services from LEP patients, which stems from enhanced patient-clinician interactions (2001). According to Masland, Lou, and Snowden (2010), having medical interpreters present during appointments allows for both LEP patients and clinicians to understand each other on a linguistic level, allowing for a level of trust between the two parties. Creating trust between LEP patients and medical personnel can improve health outcomes and reduce adverse health events.

Although disparities in linguistic competencies exist between LEP and EP populations, the United States government enacted many federal provisions to protect LEP patients' rights to healthcare. These regulations include access to care and an acceptable quality of care by providing interpreter-translator services. In the context of Title VI of the Civil Rights Act of 1964 (HHS, 2000), this regulation stands as a rampart against discrimination based on race, color, and national origin within programs and activities that are supported by federal financial assistance, which applies to healthcare organizations that receive this type of monetary assistance from the federal government. This legislation requires covered entities to provide people - regardless of their proficiency level in English and national origin – equal access to healthcare services, explicitly providing interpreter-translator services free of charge (2000).

Section 1557 of the Affordable Care Act (CMS, 2022) is a similar nondiscrimination provision for language access services as it prohibits discrimination against "race, color, national origin, sex, age, or disability under any program or activity that an Executive Agency administers [and] to take reasonable steps to provide meaningful access to each LEP individual eligible to be served in covered entities' health programs and activities." Section 1557 differs from Title VI as it requires covered healthcare entities to provide 'significant communications' for the 15 most common languages spoken by LEP individuals in each state (2022). The provision describes significant communications in written notices, handbooks, and outreach publications online and in physical spaces that make it easily visible for LEP patients. It also requires covered entities to provide small, significant communications such as postcards and tri-fold brochures (CMS, 2022).

Title VI of the Civil Rights Act and Section 1557 of the Affordable Care Act serve as safeguards for LEP patients. They are critical for LEP patients in the context of access to healthcare services and nondiscrimination. However, Executive Order 13166 plays a crucial role

in establishing a system that focuses on improving both access and quality of language access services that a covered healthcare entity provides. This order, signed on August 11, 2000, by U.S. President Bill Clinton, requires federal agencies and their entities to examine the services they provide, identify any need for services to those with limited English proficiency (LEP), and develop and implement a system to provide those services so LEP persons can have meaningful access to them. It also requires Federal agencies to work to ensure that recipients of Federal financial assistance provide meaningful access to their LEP applicants. This EO includes every single federal agency and its entities to improve access and quality of language access services continuously; this also includes the Department of Health and Human Services and one of its entities, the Centers for Medicare and Medicaid (CMS) (2022).

Four months after Executive Order 13166 was signed, the Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) were enacted on December 22, 2000, by the Office of Minority Health (OMH) (HHS, 2000). These standards are meant to serve as guidelines to improve the quality of care provided to all LEP patients and reduce health disparities. At its core, the CLAS emphasizes respect and responsiveness to diverse cultural backgrounds and health needs. To start with the first of the CLAS, the Principal Standard emphasizes the provision of providing "effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs" (OMH, n.d.). The following three standards, Governance, Leadership, and Workforce, focus on promoting health equity through promoting a diverse workforce willing to help people from all different cultural backgrounds. This includes advancing diversity in leadership and staff, educating them in culturally and linguistically appropriate policies, and sustaining ongoing training (n.d.). The

Communication and Language Assistance standards ensure access to language assistance for LEP individuals and other communication needs at no cost to them. This involves informing individuals about the availability of language assistance services, ensuring the competence of language assistance providers, and providing materials and signage in commonly used languages in service areas (n.d.). The last grouped standards, Engagement, Continuous Improvement, and Accountability, emphasize establishing CLAS goals, policies, and management accountability throughout the organization. These standards include ongoing assessments of CLAS-related activities, demographic data collection to monitor impact, community health assessments, partnerships with communities and stakeholders, and conflict resolution processes (OMH, n.d.). These CLAS standards serve as a framework for healthcare organizations to provide equitable care, engage with diverse cultural backgrounds, continuously monitor and improve services, and be accountable for achieving overall health equity (HHS, 2000).

Methods

In order to evaluate PACE-RI's language services, a gap analysis was conducted to compare current practices against critical language access regulations, the Culturally and Linguistically Appropriate Service (CLAS) standards, and two external Pace Organizations' language services (POs). The gap analysis has three different components: (1) determining compliance with regulations, (2) assessing adherence to best practices under the CLAS standards, and (3) comparing PACE-RI's language services to two other PACE organizations.

The gap analysis was conducted through structured phone and video call interviews with certain PACE-RI employees to understand how PACE-RI conducts their language services. The information obtained from the interviews was compared to existing language access regulations, the CLAS standards, and two other PACE organizations. The interviewees were selected based on references from both PACE-RI's Chief of Organizational Performance and Health Center

Manager, who deemed the interviewees appropriate resources to provide insight into PACE-RI's language services. The interviewees included the Vendor Contract Manager, Chief Human Resources Officer, Director of Quality and Compliance, Chief of Growth, and a physician. (Table 1) PACE-RI's Vendor Contract Manager is responsible for organizing contracts with third-party companies that provide interpreting and translating services. PACE-RI's Chief Human Resources Officer possesses data on the number of qualified bilingual PACE-RI employees. PACE-RI's Director of Quality and Compliance is responsible for the knowledge of PACE-RI's regulatory adherence to language access regulations, including necessary signage and points of contact to initiate language services. PACE-RI's Chief of Growth is responsible for knowing the enrollment process for PACE-RI participants, including allocating language services prior to enrollment. The physician provides knowledge on the technical aspects of using language services during medical appointments. (Table 1) Separate sets of questions were developed for the PACE-RI interviewees due to different areas of expertise. Each question was developed to understand PACE-RI's language service capabilities and practices. The questions for the Vendor Contract Manager and Chief Human Resources Officer were developed to understand the language service capabilities of PACE-RI, which includes knowing the number of languages provided through both external language services and qualified bilingual PACE-RI staff. The questions for the Director of Quality and Compliance, Chief of Growth, and the physician were developed to understand how language services are practiced. This includes how PACE-RI participants access language services and how PACE-RI clinicians use interpreters and translators during medical appointments.

Table 1. Questions for PACE-RI Personnel

Questions for PACE-RI Personnel	
Position (Area of Expertise)	**Questions**

Vendor Contract Manager (Contracts with third-party language companies)	1. *What are the 3rd party language access services that are utilized at PACE? From your perspective, how does it help providers at PACE - that are not bilingual – with participants that are not fluent in English?* 2. *Do you monitor the quality and compliance of Voyce? If so, how do continuously track to see if the language access service is allowing PACE providers to deliver proficient medical care to limited English speaking participants?)* 3. *Have you noticed any issues with any of the language access services?*
Chief Human Resources Officer (Internal on-site interpreters and translators)	1. *How many staff and medical personnel at PACE-RI are bilingual?* 2. *In addition, are these employees qualified or certified interpreters and translators?*
Director of Quality and Compliance (Regulatory adherence)	1. *In regards to compliance to language access regulations, such as Section 1557 of the Affordable Care Act, is there any signage – notices of nondiscrimination or taglines - in another language?* 2. *Who would be the points of contact for participants who have Limited English Proficiency? (Such as reception, medical personnel (exam room), call center, security, written communications)*
Chief of Growth (Enrollment process)	1. *How do participants who have LEP get language services to begin with? Are the services given prior to enrollment into the PACE program?* 2. *Has there ever been an instance where a participant with LEP did not receive language access services after enrolling into the PACE program?*
Physician (Clinical experience with language access services)	1. *From a clinical perspective, how do the language access services work when you are interacting with your patients?* 2. *I've been told by colleagues you are a big advocate for language access services, what is your rationale? Why is it important in your line of work?* 3. *Do you have any issues using these interpreter services? Have you seen any indicators that point to differences in quality of care between proficient English-speaking participants and limited English-speaking participants?* 4. *If there were one aspect of the language*

	access services at PACE-RI you would change, what would it be?

In addition to the interviews with PACE-RI personnel, there were two phone interviews with personnel from two external PACE organizations: On Lok PACE (San Fransico, California) and Fallon Health Summit Elder Care (Worcester, Massachusetts). On Lok PACE was chosen due to the fact that it was the first PACE Organization to be established in the United States. Since this PO has been an established source of care for older adults for a long duration within the San Fransico service area (Medicaid, 2011), gathering information on their experienced language service practices would be insightful in developing further recommendations. After failed phone call inquiries to three PACE Organizations, Fallon Health Summit Elder Care was chosen randomly. The personnel that were interviewed from both POs were Day Center Supervisors. Both Day Center Supervisors have similar roles overseeing the participant operations and activities within their respective day centers, and the questions for both supervisors were the same. The questions were developed based on the Day Center Supervisors' roles with language services within their organizations. Their roles involve knowing the amount of language services available for PACE participants and the processes for language services. The questions were also developed to understand the POs' language service inventory, access of language services, utilization of language interpreters, and health metric and utilization tracking. (Table 2) The purpose of these interviews was to gather how On Lok PACE and Summit Elder Care conduct their language access services in comparison to the language access practices of PACE-RI and to identify best practices.

Table 2. Questions for Day Center Supervisors (On Lok PACE and Summit Elder Care)

Questions for Day Center Supervisors (On Lok PACE and Summit Elder Care)

1. *What are the types of language access services that you provide to LEP participants? Do the services include bilingual trained staff or professional language interpreter services?*
2. *How does your organization provide meaningful access to language access services for LEP participants? Who are the points of contact for participants to access language assistance services?*
3. *How are best practices conducted in medical appointments and other services under the CLAS standards?*
4. *Do any personnel at your organization track metrics such as health outcomes, utilization, or participant feedback to determine the quality of language access services?*

Once the Day Center Supervisors' interviews from On Lok PACE and Summit Elder Care were complete, the information (language access practices) from all interviews was gathered and analyzed to determine compliance with language access regulations and best practices under the CLAS standards, and to compare how other POs operate their language services. (Table 3) PACE-RI's language services were compared to the provisions of Title VI of the Rights Act, Section 1557 of the Affordable Care Act, and Executive Order 13166. Each separate language access regulation specifically states how healthcare organizations must provide meaningful access to language services for LEP patients. The information on the practices of PACE-RI's language services was compared to the criteria of each individual regulation. If an aspect of PACE-RI's language services matched the criteria, that aspect was deemed compliant. (Table 4) Then, to determine if PACE-RI's language access practices adhere to best practices or not, the practices were categorized as 'Adherence to Practices' or 'Gaps in Practice' underneath the main three parameters of the Culturally and Linguistically Appropriate Service (CLAS) Standards: (1)

Governance, Leadership, and Workforce, (2) Communication and Language Assistance, and (3) Engagement, Continuous Improvement, and Accountability. The practices were compared to the criteria under each individual CLAS standard group and were deemed to be adherent or to have gaps in language service practice. (Table 5) The information from the Day Center Supervisors' interviews was categorized under four Service and Practice Capability components such as (1) Language Access Service Inventory, (2) Access to Language Access Services, (3) Language Access Service Practice, and (4) Utilization and Health Metric Tracking.

Results

Through the interviews with the selected PACE-RI personnel, PACE-RI language service practices were assessed and then compared to existing language access regulations, the CLAS standards, and to practices of two external PACE organizations. The results for the first part of the gap analysis compare PACE-RI's language access service practice to existing language access regulations. The following results (Table 3) provide a comprehensive view of the organization's language access services and compliance with language access regulations. The table below distinguishes how PACE-RI's language services comply with language access regulations. The table maps three language access regulations – Title VI, Section 1557, and Executive Order 13166 – and what healthcare organizations must provide and contain how PACE-RI's language service practices comply with each regulation. The following language service regulations were chosen based on instruction from PACE-RI's Chief of Organizational Performance to determine compliance. Part of the rationale was that these three language regulations are essential in driving equitable access to language services for LEP individuals.

Table 3. PACE-RI Compliance with Language Access Regulations

PACE-RI Compliance with Language Access Regulations	
Regulation	**PACE-RI Compliance**
Title VI of the Civil Rights Act	- PACE-RI have 41 qualified staff members out of the 177 PACE-RI staff census who self-report a language capacity other than

(Provide free and effective language access services to individuals with LEP)	English, languages such as Arabic, Creole, Cape Verdean, French, Greek, Indonesian, Khmer, Lao, Portuguese, Russian, Spanish, Thai, and Yoruba. - PACE-RI also provides external services to LEP participants from three different interpreting and translating companies – Voyce, Pinpoint Dorcas, and Certified Languages. These companies have interpreters and translators that speak over 200 different languages. These services provide virtual (phone or video call) and in-person mediums for medical appointments and services. - These services are free of charge for LEP participants.
Section 1557 of the Affordable Care Act (ACA) (Provide timely language access services such as interpreters and translated materials. This provision also includes posting notices of nondiscrimination and availability of language assistance around physical facilities and website in top 50 spoken languages in the service area)	- PACE-RI has posted signage such as notices of nondiscrimination and availability of language assistance in all day center facilities. These notices are presented in the top languages spoken within the PACE-RI service area. - The duration it takes LEP participants to access language assistance services is under 30 seconds to 1 minute, either in-person or virtually. Even if an in-person interpreter is a no-show, medical providers opt for virtual language assistance services over the phone or through a computer interface, or they opt for bilingual staff that are qualified to speak in the LEP participant's preferred language.
Executive Order 13166 (Identify any need for language access services to people with LEP. Develop and implement a system to provide meaningful access to language assistance services for individuals with LEP)	- Prior to enrollment into the PACE program, the PACE-RI Enrollment team interviews the new participant and gathers his or her medical needs, including access to language assistance services in their preferred language. - Points of contact, or designated PACE-RI staff, are established in order for LEP participants to access language assistance services. Once the LEP participant requests language assistance, the following points of contact initiate the interpreter or translator services for that participant: o (1) Day Center Receptionist o (2) Members of the Interdisciplinary Team

Under the provisions of Title VI of the Civil Rights Act, PACE-RI complies with this act by providing participants with an array of language access services. PACE-RI provides participants access to 41 qualified bilingual staff members who speak over 14 different languages for medical appointments and services. Additionally, PACE-RI has contracts with three external interpreting and translating companies—Voyce, Pinpoint Dorcas, and Certified Languages—

which collectively offer services in over 350 languages. These services are available both virtually and in person. Under Section 1557 of the ACA, PACE-RI complies with this act by posting language access availability notices and providing timely language access services. PACE-RI has effectively posted notices of nondiscrimination and the availability of language assistance in all Day Center facilities in the top languages spoken within PACE-RI's service area. The duration it takes participants to connect with an interpreter or a translator is notable as it takes between 30 seconds and 1 minute. Under Executive Order 13166, PACE-RI's Enrollment team assesses new participants' language needs before enrollment, ensuring that appropriate language access services are identified and provided. Moreover, PACE-RI has established points of contact for LEP individuals to interact with and access language assistance services. Points of contact, such as the Day Center Receptionist and members of the Interdisciplinary Team, facilitate access to interpreter or translator services upon the request of a participant. These results for the first part of the gap analysis indicate that PACE-RI has implemented comprehensive practices to comply with language access regulations.

The results for the second part of the gap analysis compare PACE-RI's language access practices to the parameters of the CLAS standards. These results (Table 4) show strengths and areas for improvement. The following table shows three groups of all the CLAS standards and compares how PACE-RI's language services adhere to best practices under the CLAS standard parameters. Based on the interviews with PACE-RI personnel, the findings of the language service practices were compared to CLAS standard criteria. If the findings did meet the criteria of a specific CLAS standard group, then the language service practices were deemed to be adherent. On the other hand, if the findings did not meet the criteria of a specific CLAS standard group, then the language service practices were considered to have gaps in care. Each CLAS

standard group touches upon an aspect of care that health organizations must practice in order to provide equitable access and quality care to LEP individuals (OMH, n.d.).

Table 4: PACE-RI Adherence and Gaps through CLAS Standard Parameters

PACE-RI Adherence and Gaps Under CLAS Standard Parameters		
CLAS Standard	**PACE-RI Adherence**	**PACE-RI Gaps**

Governance, Leadership, and Workforce	- PACE-RI is equipped with a workforce that comes from different cultural backgrounds
	  o This also includes PACE-RI provides participants access to qualified bilingual personnel who speak 14 different languages for medical appointments and services.
	- PACE-RI has established contracts with external language access companies such as Voyce, Pinpoint Dorcas, and Certified Languages:
	  o These companies have interpreters and translators that speak over 200 languages and dialects. These services provide virtual - phone and video call sessions – and in-person services between the participant and the provider during medical appointments and services.
		- No gaps underneath this standard were identified.

Communication and Language Assistance	- During the intake process before enrollment into the PACE program, PACE-RI participants are asked if they require language access services. This is completed either in person or over a three-way phone or video call with a qualified interpreter. - PACE-RI participants with LEP are given extensive language assistance from qualified bilingual employees or external interpreter and translator service companies during medical appointments and other services. - Participants with LEP are able to receive language assistance through points of contact: (1) Day Center Receptionist, and (2) members of their Interdisciplinary Team. Once	- Inconsistent practice of utilizing qualified interpreters; some providers utilize ad hoc interpreters (family members, friends, or untrained bilingual staff) during medical appointments and services.

	requested, the points of contact initiate the interpreter or translator services for that participant. - On average, the time to connect LEP participants with interpreter and translator services is under 30 seconds to 1 minute via phone or video call. - PACE-RI provides comprehensible print and multimedia materials and signage in several different languages in all four day center facilities.	
Engagement, Continuous Improvement, and Accountability	- Health providers understand the importance of utilizing language access services for LEP participants during medical appointments and other services. These services establish a clear line of communication for providers to understand participants' feelings, medical needs, and requests.	- Other than tracking utilization of 3rd party language access companies, there is no evidence of tracking metrics to determine the quality of language access services for LEP participants (ex. hospitalizations, patient feedback, etc.).

PACE-RI adheres to best practices under the Governance, Leadership, and Workforce standards. PACE-RI has a diverse workforce with qualified bilingual staff members who speak 14 languages, giving LEP participants access to immediate resources at the various PACE-RI day centers. Also, PACE-RI provides LEP participants access to external language access resources during medical appointments and other services through Voyce, Pinpoint Dorcas, and Certified Languages. These services provide competent interpreters who speak over 350 languages and dialects, available virtually and in person. No gaps in practices were identified under the Governance, Leadership, and Workforce standards.

PACE-RI's language service practices adhere to some of the Communication and Language Assistance standards; however, further evidence suggests that PACE-RI's language service practices fall short in some areas. Before a participant enrolls in the PACE program, PACE-RI's language access practices involve the Enrollment team gathering information on the needs of the new participant. This process is completed either in the participant's home in person

with a qualified interpreter or over a three-way phone or video call. Language assistance is also accessible through established points of contact, such as the Day Center Receptionist and members of the Interdisciplinary Team. These personnel guide and initiate interpreter or translator services for the LEP participant. In the context of medical appointments, virtual sessions with a qualified interpreter can be conducted over the phone or on a video call, and the time to connect LEP participants with interpreter and translator services is under 30 seconds to 1 minute. Additionally, PACE-RI provides comprehensible print and multimedia materials and signage in several languages in all four-day center facilities. While the language access practices meet most of the Communication and Language Assistance standards, PACE-RI is inconsistent in the practice of utilizing qualified interpreters. Some PACE-RI medical personnel utilize ad hoc interpreters such as family members, friends, or untrained bilingual staff during medical appointments and services. Using ad hoc interpreters is a discouraged practice under the CLAS standards.

PACE-RI's language access practices adhere to and fall short under the Engagement, Continuous Improvement, and Accountability standards. PACE-RI's language access practices adhere to these standards by ensuring PACE-RI medical personnel and providers understand the significance of utilizing language access services for LEP participants during medical appointments and other services. Medical staff at PACE-RI understand that these services establish a clear line of communication between themselves and the participants, and these services allow providers to understand participants' feelings, medical needs, and requests. While the language access practices adhere to these standards, they also fall short of them by not tracking key performance indicators to determine the quality of language access services for LEP participants. PACE-RI does track the utilization of external interpreter and translator-interpreter

services but does not track metrics such as hospitalizations, patient feedback, and other health outcome measures to assess the effectiveness of provided language access services.

The results for the third part of the gap analysis examine two external POs – On Lok PACE and Summit Elder Care – and their language service practices to compare PACE-RI's language service practices. These results (Table 5) show how On Lok PACE and Summit Elder Care conduct language services. The language service practices of both POs are sorted into four different categories: (1) Language Service Inventory, (2) Access to Language Services, (3) Utilization Practices of Language Services, and (4) Health Metric and Utilization Tracking:

Table 5: Language Access Practices of On Lok and Summit ElderCare

Language Access Practices of On Lok and Summit ElderCare		
Service and Practice Capabilities	**On Lok PACE**	**Summit Elder Care – Worcester**
Language Service Inventory	- Have only 3 on-site bilingual staff that speak Chinese, Korean, Spanish, and Vietnamese. - Utilizes Language Line, an interpreter and translator telephone and video call service. They possess qualified interpreters and translators that speak in over 400 languages and dialects.	- Have 16 on-site bilingual staff that speak Arabic, Chinese, Korean Spanish, Portugeuse, French, and Vietnamese. - Utilizes its own Customer Service Department with interpreters and translators that speak over 350 languages and dialects.
Access of Language Services	- (In-Person) Administrative Assistant requests for a bilingual staff member to escort participant to medical appointment or service. (Over the phone) Administrative Assistant has a 3-way phone call with the participant and a qualified interpreter.	- (In-Person) Receptionist requests for a bilingual staff member to escort participant to medical appointment or service. - (Over the phone) Receptionist initiates a 3-way phone call with the participant and a qualified interpreter.
Utilization Practices of Interpreter Services	- The usage of ad hoc interpreters is highly discouraged in medical appointments and other services. A family member or friend can be present during appointment but can't interpret on their behalf.	- The usage of ad hoc interpreters is highly discouraged in medical appointments and other services. Providers do allow family members and friends to be present at appointments, but not to interpret on their behalf.
Health Metric Tracking and Utilization	- No evidence of health metric and utilization tracking.	- No evidence of health metric and utilization tracking.

On Lok PACE and Summit Elder Care operate their language services with specific structures and functions under the four categories of Language Service and Practice Capabilities. For the Language Service Inventory, On Lok PACE has three on-site bilingual staff members who speak Chinese, Korean, Spanish, and Vietnamese. On Lok PACE also uses a third-party interpreter and translator service, Language Line. This service offers qualified interpreters and translators who speak over 400 languages and dialects. Summit Elder Care has 16 on-site bilingual staff who speak Arabic, Chinese, Korean, Spanish, Portuguese, French, and Vietnamese. Summit Elder Care utilizes its Customer Service Department, which provides qualified interpreters and translators in over 350 languages and dialects. Under the category Access to Language Services, On Lok PACE has Administrative Assistants that assist LEP participants by requesting a bilingual staff member to escort participants to their medical appointments in person, or participants can use a qualified interpreter on a three-way phone call to understand what medical personnel are saying them. Similarly, Summit Elder Care's receptionist coordinates in-person support by requesting bilingual staff escorts and initiates three-way phone calls for interpretation needs. Under the Utilization of Interpreter Services category, both On Lok PACE and Summit Elder Care discourage ad hoc interpreters - such as family members, friends, or untrained bilingual staff members - during medical appointments to ensure transparent communication of medical terminology. Under the category Health Metric and Utilization Tracking, neither On Lok PACE nor Summit Elder Care track health metrics and utilization to evaluate the effectiveness and quality of their language services.

Discussion

PACE-RI's language service practices comply with language access regulations such as Title VI, Section 1557, and Executive Order 13166. These three regulations require healthcare organizations (those that receive federal financial assistance) to not discriminate against any

individual regardless of ethnicity, color, or national origin and not exclude them from receiving medical services. These regulations also require healthcare organizations to take considerable steps in providing individuals with LEP meaningful access and notice of competent language services free of charge (HHS, 2000; CMS, 2022; U.S. Department of Justice, 2022). PACE-RI's language service practices comply with these regulations by providing LEP participants access to a notable inventory of language services free of charge, timely connections with an interpreter or translator, having legal signage posted throughout their day center facilities, gathering their linguistic needs prior to enrolling into the PACE program, and has established points of contact to guide them to the necessary language services. PACE-RI's language service practices comply with language access regulations.

The practices of PACE-RI's language services adhere to many of the CLAS standards, but some practices do not comply with the standards. The first section of the CLAS standards, 'Governance, Leadership, and Workforce,' emphasizes the importance of promoting diversity throughout an organization. This first section of the CLAS Standards further emphasizes that having a diverse workforce allows patients or clients to feel comfortable knowing they have the necessary language services to help them effectively interact with the services of a health organization (OMH, n.d.). In the context of these standards, PACE-RI possesses a diverse workforce, making the organization an all-inclusive environment for participants of different backgrounds. (Table 4) PACE-RI consists of a workforce with several employees who speak various languages. Even if PACE-RI employees do not speak a particular language, they still guide participants to the necessary language services by collaborating with external interpreter-translator companies. Since PACE-RI has a diverse workforce that promotes inclusivity and is dedicated to helping LEP participants efficiently, there is no evidence that PACE-RI's language

services fall short of Governance, Leadership, and Workforce standards. PACE-RI's language service practices comply with the first section of the CLAS standards.

The second section of the CLAS standards (OMH, n.d.), 'Communication and Language Assistance,' highlights that an organization must develop and execute effective communication practices for LEP individuals. These standards include understanding a LEP individual's linguistic needs, offering language services free of charge, providing "easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area" (n.d.), and ensuring interpreters and translators are qualified while discouraging the usage of ad-hoc interpreters (n.d.). As mentioned in Tables 4 and 5, PACE-RI has a robust intake process, a wide range of language services free of charge, established points of contact, and necessary signage posted throughout PACE-RI's facilities. From these results, PACE-RI's language service practices comply with the second section of the CLAS standards; however, there are some gaps in care regarding the use of competent interpreters and translators. While most PACE-RI medical personnel use professional and qualified language services, some utilize ad hoc interpreters and translators. From the perspectives of the medical community (Kyle & Syed, 2010), using family members, friends, or untrained bilingual staff as interpreters or translators is highly discouraged. This ill-advised practice assumes that unqualified individuals will understand medical terminology and interventions. This lack of understanding can lead to misinterpretation and adverse health outcomes (2010). Compared to On Lok PACE and Summit Elder Care (Table 5), they similarly possess extensive options for language services and aid to LEP participants. However, both POs do not use ad hoc interpreters at all, and their medical personnel consistently use qualified interpreters and translators to communicate with LEP participants effectively.

The third section of CLAS standards (OMH, n.d.), 'Engagement, Continuous Improvement, and Accountability,' underscores that an organization must develop practices of empathy towards the importance of providing competent language services, collect demographic data to understand the linguistic needs of the communities an organization serves, and develop language services by monitoring key performance indicators (n.d.). PACE-RI medical personnel care about providing services to LEP participants because they know that utilizing the expertise of a language interpreter or translator creates a clear line of communication. Having a clear line of communication allows for transparency between medical personnel and the LEP participant, which allows for higher quality of care. PACE-RI further demonstrates best practices by showing accountability for understanding the linguistic needs of the communities they serve throughout Rhode Island. PACE-RI demonstrates this by having a solid intake process that gathers every need of each participant, including linguistic needs. Gathering the linguistic needs of individual participants allows PACE-RI to understand the majority of languages spoken in the service area and provide needed language services. From these results, PACE-RI's language service practices comply with the third section of the CLAS standards; however, there are some gaps in care regarding tracking performance indicators and health outcomes. According to Pantaleon (2019), tracking health outcomes – hospitalizations, health status indicators, and patient feedback - can improve the quality of patient care. Noticing differences in health outcomes between patient populations can allow a health organization to decide on necessary interventions to improve health services (2019). The only evident metric of language services tracked at PACE-RI is the utilization of language services (Table 4). This metric analyzes the number of times an external language service was used within a month, the type of clinician that uses the services (physician, nurse, or social worker), the connection time to connect with an interpreter or translator, and the

duration using the service during a medical appointment. This metric helps understand how much external language services are used by PACE-RI personnel, but it does not indicate the effectiveness of their language services on the health outcomes of LEP participants. Similarly, there is no evidence that On Lok PACE and Summit Elder Care (Table 5) also track health metrics to evaluate the effectiveness of their language services. Not tracking the health outcomes of LEP participants does not allow PACE-RI to understand if its language services effectively mitigate health disparities.

The results from the gap analysis indicate that PACE-RI's language service practices comply with language access regulations and adhere to most CLAS standards. However, improvements to PACE-RI's language service practices - including consistently using qualified language service professionals during medical appointments and tracking metrics to determine the effectiveness and quality of language services - are needed to fully align with the CLAS standards that emphasize 'Communication and Language Assistance' and 'Engagement, Continuous Improvement, and Accountability.' There are two recommendations PACE-RI must consider implementing into their language service practices:

The first recommendation is for PACE-RI to create a policy in which medical personnel consistently use qualified interpreter and translator services and restrict the usage of ad-hoc interpreters during medical appointments. PACE-RI possesses a considerable inventory of professional language services internally and externally. However, medical personnel should consistently use competent interpreters and translators as recommended by the CLAS standards (HHS, n.d.) and from the medical field (Kyle & Syed, 2010). It is imperative to note that using family members and friends as interpreters and translators can hinder accurate interpretation due to emotional attachment and inexperience in comprehending medical terminology. A LEP patient

may feel pressured to accept their family member or friend as an interpreter, impacting their decision-making for medical interventions (2010). This pressure also potentially breaches a patient's right to confidentiality and privacy. Using untrained bilingual staff as interpreters and translators can also hinder LEP patients' decision-making. This inefficiency is due to a need for more experience interpreting and translating medical terminology on behalf of a LEP patient (2010). For comparison, both On Lok PACE and Summit Elder Care consistently use professional language services to provide equitable care to LEP participants effectively, and this is due to implemented policies that discourage the usage of ad-hoc interpreters. PACE-RI should apply the same concept to its language service practices. The timeframe to transition PACE-RI language services in utilizing qualified interpreters and translators depends on how long it takes for a policy to be developed, but once the contents of this policy are developed, PACE-RI should focus on transitioning all language services to fully utilize qualified interpreters and translators (internally or externally) by the end of a month. A policy as significant as this will be moderately challenging to implement since this policy will require medical language services to change. Any change in any healthcare organization will be hard to adjust, but selecting a healthcare champion can further emphasize this policy.

According to George et al. (2022), healthcare champions are "defined as individuals who are committed to supporting and marketing an innovation at each stage of development and implementation…(they are) key factors for the successful implementation of quality improvement initiatives within the health care sector." George et al. (2022) emphasizes that healthcare champions use their passion and experience to influence positive change toward a new healthcare intervention among other clinicians. This influence can drive other clinicians to want to improve their line of work with patients, further facilitating trust and accountability

(2022). PACE-RI should select one to five healthcare champions (PACE-RI personnel) of their own – who emphasize the importance of using qualified language service professionals with LEP participants – and speak about the importance of implementing a policy that restricts the usage of ad-hoc interpreters to their peers through informational sessions. These PACE-RI champions can educate other clinicians about the concept of Limited English Proficiency, the differences between translators or interpreters and their impact on the quality of care for LEP patients, discourage the usage of ad-hoc interpreters and inform them of available language services both internally and externally.

The second recommendation is for PACE-RI to track metrics to determine the effectiveness and quality of its language services. As the gap analysis results mentioned, PACE-RI only tracks using external language services (Table 4). This metric only entails tracking the number of times an external language service is used within a month, the type of medical personnel that use the services, the connection time to connect with an interpreter or translator, and the duration of using language services during medical appointments. This metric helps understand how much external language services are used by PACE-RI medical personnel and the languages requested, but it does not include the usage of internal language services or the quality of PACE-RI's language services overall. For comparison, the gap analysis indicated no evidence that On Lok PACE and Summit Elder Care track specific metrics to evaluate the quality of their language services. PACE-RI can evaluate the quality of its language services by adopting practices the New York City Health and Hospital Corporation (HHC) has implemented to evaluate its language services. HHC (2009) is one of New York's most significant health providers, and its medical services cover many people who speak different languages. In order to effectively evaluate their language services, they track three performance indicators: the number

of interpreter and translator sessions within a given duration, languages requested, and patient feedback on language services. HHC tracks these performance indicators to understand how much time is spent on language service sessions and identify potential practice errors. Identifying potential errors allows HHC to develop interventions that improve the quality of language services (2009). This intervention would be easy to implement since it would require PACE-RI to use its internal data on the usage of language services and the number of hospitalizations between LEP and English-proficient participants. Also, PACE-RI medical personnel could receive feedback from LEP participants or caretakers by giving them an optional anonymous survey. This survey would ask the participant or caretaker if they have any concerns or suggestions about the language services that PACE-RI provides. To start with, PACE-RI could track the number of specific languages requested and compare hospitalization metrics between 10 LEP participants and 10 English-proficient participants for a week. In addition, PACE-RI could collect feedback from 10 LEP participants using the surveys for three weeks to determine any positive and negative feedback about the organization's language services. From then on, PACE-RI could gradually increase the metrics collection and gain more feedback from LEP participants on a systems scale.

Conclusion

Limited English Proficiency can significantly impact the health of individuals whose primary language is not English, particularly among older populations who potentially face multiple health challenges. Despite enacted language access regulations, health disparities persist, highlighting the importance of consistent language service practices that provide equitable health care. The PACE Organization of Rhode Island is crucial in supporting elderly individuals across the state, making it essential for all medical services to be equitable for participants speaking different languages. The gap analysis revealed that PACE-RI's language

services comply with regulations, but its practices fall short of fully adhering to the Culturally and Linguistically Appropriate Service (CLAS) standards. These findings indicate that PACE-RI must improve its language service practices to ensure high-quality care for LEP participants. PACE-RI can further improve its language services to the diverse population it serves and mitigate potential health disparities by stopping the usage of ad-hoc interpreters and tracking performance indicators. PACE-RI can discontinue the usage of ad-hoc interpreters by implementing a policy that emphasizes that medical personnel to use competent language service professionals instead of ad-hoc interpreters. PACE-RI can start tracking performance indicators such as languages requested, the duration of language services used, hospitalizations, and patient feedback to evaluate the effectiveness of its language services.

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