Final Portfolio

Mapping Power and Language Access in the UNC Healthcare System

Refugee Community Partnership

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Savanna Ray
Master of Public Policy Capstone
The University of North Carolina at Chapel Hill

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Table of Contents

Executive Summary

This project was conducted in partnership with the Refugee Community Partnership (RCP), an Orange County-based nonprofit serving over 1,200 refugee and immigrant community members across the Triangle.

This capstone investigates the gap between what the law mandates, what UNC Health says it provides, and what patients and navigators actually experience, and equips RCP with the evidence, stakeholder knowledge, and strategic recommendations to advocate for meaningful change.

Key Findings

Five findings emerged from nine semi-structured interviews with UNC Health administrative leadership, interpreter services staff, clinical managers, and frontline nurses, analyzed alongside UNC Health's active LEP and Interpreter Services policies:

1. A significant gap exists between written policy and everyday practice. UNC Health's LEP policy requires qualified interpreters for all medically significant encounters. In practice, six of nine participants described routinely bypassing interpreters, not out of ignorance, but because the system makes compliance unrealistic.

2. Decision-making authority is hierarchical and invisible to frontline staff. Language access funding, staffing, and policy are controlled at the executive and department level. Frontline staff have no meaningful input, and most could not identify who makes decisions about language services.

3. Spanish receives substantial investment while all other LEP language groups are structurally underserved. Spanish-speaking patients have access to 24/7 in-person interpreters and written materials. Patients speaking Karen, Burmese, Dari, Pashto, Arabic, and other languages have access only to phone or Martti video interpretation, with no written discharge materials in their language.

4. Time pressure is the primary driver of policy workarounds. Calling an in-person interpreter requires navigating multiple systems and waiting upwards of 20 minutes, an unrealistic ask for nurses managing five patients simultaneously.

5. Structural funding constraints shape the advocacy landscape. North Carolina does not claim Medicaid reimbursement for spoken language services, meaning UNC Health absorbs interpretation costs entirely as overhead. The revocation of Executive Order 13166 has further weakened federal compliance infrastructure, making financial arguments, rather than moral or legal ones, the most effective lever for advocacy.

Recommendations

Three recommendations are offered, ordered by priority, and designed to work within RCP's existing organizational capacity:

1. (High) Initiate a formal partnership with UNC's Department of Community Health & Engagement (CHE), the most mission-aligned and accessible entry point into the UNC Health system.
2. (Medium) Advocate for pre-scheduling of interpreters for known LEP appointments and for written discharge materials in languages beyond Spanish. These are high-impact, low-cost changes that align with UNC Health's own FY2026 improvement goals.
3. (Lower) Expand Data VAULT and request an interpreter-specific patient feedback mechanism within UNC Health's existing satisfaction survey infrastructure.

Policy Question

What are the services available to LEP (limited English proficiency) patients in the UNC healthcare system, and what steps can be taken by Refugee Community Partnership (RCP) to advocate for patients and help them navigate these services?

Problem Statement

Limited English Proficient (LEP) individuals represent one of the fastest-growing populations in the United States, with approximately one in ten people aged 16-64 identified as LEP (Wilson, 2014). Many refugees seek asylum from war, political conflict, climate-induced disasters, environmental degradation, and economic crises, and arrive in the United States with untreated medical conditions, a lack of familiarity with U.S. healthcare systems, and limited-English proficiency, which can have a compounding effect on preexisting stressors associated with the already lengthy and mentally taxing resettlement process (WHO, 2022).

The central problem this project addresses is a three-way gap: between what federal and state law require, what UNC Health says it provides, and what LEP patients and RCP's language navigators actually experience. For example, while Title VI of the Civil Rights Act of 1964

mandates meaningful access to services for LEP individuals, LEP clients often still are forced to rely on family interpreters or untrained individuals to communicate clearly and advocate for their needs. The goal of this project will be to empower RCP with the internal tools, knowledge, frameworks, and connections to strong partners within the UNC healthcare system to effectively advocate for language access improvements externally. While we will be assisting in shaping policy recommendations and creating resources to support advocacy efforts, our role is not to directly petition or influence the UNC Healthcare System itself.

This project equips RCP with the evidence, relationships, and strategic clarity to advocate for language access improvements externally and identify how RCP can most effectively apply pressure for change. This project provides: (1) a review of federal and state language access law alongside UNC Health's publicly stated policies; (2) a practice scan of the services UNC Health actually provides; (3) semi-structured interviews with UNC Health staff to document where implementation diverges from policy; and (4) advocacy implications and recommendations for how RCP can act on these findings.

Background

This semester, I am working with Orange County's Refugee Community Partnership (RCP). With 17 staff members, over 1,200 members, and 230 volunteers, RCP's diverse team includes coordinators, community organizers, and specialists in various language groups. Their work in language justice seeks to dismantle systems that prioritize dominant languages, fostering inclusivity. Currently, RCP uses a network of vetted Language Navigators to ensure accountability in healthcare interpretation. Other key programs of the organization include Birth Allies, which supports refugee mothers in medical settings, and The Hive, a digital hub offering translated public health information, which became crucial during the COVID-19 pandemic.

RCP is funded entirely by donations and grants. In 2022, RCP was one of ten recipients of the Robert Wood Johnson Foundation's Community Research for Health Equity (CRHE) grant aimed at addressing community health issues through community-led research (Academy Health, 2024). The organization also partners with hospitals, libraries, and other local entities to offer resources and classes, such as doula training for volunteers. RCP's collaborative approach reflects a broader regional effort toward language accessibility, working alongside initiatives like the Language Access Collaborative created by UNC's Latino Migration Project to create regional language plans that support immigrant and refugee communities.

From a legal and political perspective, the issue of language accessibility is especially complicated within the current policy landscape, and important to understand in order to effectively advocate within the UNC Healthcare system. Several layers of federal and state law govern language access at institutions like UNC Health. Title VI of the Civil Rights Act, as discussed above, prohibits national origin discrimination, which courts and agencies have consistently interpreted to include language, at any federally funded entity. Additionally, section 1557 of the Affordable Care Act extends nondiscrimination protections specifically to healthcare settings, and executive Order 13166 further required federal funding recipients to develop Language Access Plans. However, in March of 2025, this Executive Order was revoked by Executive Order 14224 (“Designating English as the Official Language of The United States”), which has significantly weakened the federal compliance infrastructure, even as Title VI and Section 1557 remain in force.

At the state level, North Carolina provides minimal standalone language access infrastructure. It does not license spoken language interpreters in healthcare settings and does not claim Medicaid reimbursement for spoken language interpretation services, which leaves providers to absorb those costs entirely as overhead. For more information on federal and state legal infrastructure, please see Appendix 1.

This project will focus specifically on accessibility of services provided by the UNC healthcare system to LEP individuals. This assessment is particularly poignant in North Carolina, as it has seen significant growth in its foreign-born population, which now constitutes about 8.6% of the state's residents. Additionally, North Carolina ranks 11th nationally for refugee resettlement, with an average of 3,462 annual resettlements, surpassing the median of 2,794 among states with high resettlement numbers (Rush, 2024). Focusing on the Triangle area, comprising Raleigh, Durham, and Chapel Hill, this region has emerged as a safe haven for refugees, particularly those from Myanmar (formerly Burma). Since 2006, over 8,000 refugees from Myanmar, including persecuted Karen, Chin, and Rohingya ethno-linguistic groups, have resettled in the Triangle. Approximately 1,000, or 12.6%, of these refugees reside in the Chapel Hill-Carrboro area (Hudson, 2016).

Reliance on ad hoc interpreters, such as family members, can lead to miscommunication and therefore subpar access to and understanding of available services, and many refugees arrive with an already disadvantaged knowledge of US government systems and support that may be available to them. Some barriers to this knowledge include communication gaps, cultural understanding gaps, and, on the side of the government, lack of funding for LEP-accessible infrastructure and lack of resource standardization. Lack of awareness of the necessary services to provide and resources available to both patients and healthcare systems is at the core of this issue as well. Programs exist to reimburse hospitals for interpretation services, laws exist to protect LEP patients, but lack of urgency, awareness and cultural competency creates additional and unnecessary barriers. The goal of this project is to help RCP gain the tools to effectively communicate and collaborate with UNC healthcare to bridge these gaps and improve outcomes for LEP patients.

Methods and Data Collection

Research Design

This project uses a qualitative institutional analysis research design combined with comparative policy review. The overall analytical approach is designed to answer the central policy question.

For this project, I separated my analytical approach into two main components. Firstly, I conducted background research on the institutional and legal parameters of formal power structures within UNC health, as well as at the state and federal level. I then performed qualitative research via semi-structured interviewing as a way to document operational information. I operationalized these interviews by coding through Atlas.ti to scan for patterns, repeated codes, and key details that are relevant for RCP. The combination of both of these methods allowed for analysis of both formal and informal structures and influence within UNC Health.

I then combined this data to perform a comparative analysis, which guided my recommendations based on formal institutional analysis, operational and practical observation, and advocacy solutions. This design allows me to identify where decision-making authority is concentrated and how RCP can strategically intervene.

Data Sources

This project draws on both primary and secondary data sources. During the background stage of my research, I used secondary data such as publicly available information on UNC Health governance documents, UNC Health language access policies, federal language access requirements (e.g., Title VI guidance), North Carolina state language access requirements, peer academic medical center language access policies, and public budget documents where available.

This data was used primarily to conduct background research, inform my interview questions, and as a baseline for my comparative analysis.

Then, during the qualitative component of my research, I gathered primary data through nine interviews with stakeholders throughout UNC Health. These interviews were conducted specifically with UNC Health administrative leadership, compliance personnel, language services staff, clinical managers, and medical staff. These interviews were conducted via Zoom and accessed through professional outreach, primarily via email, as well as institutional contacts and referrals.

Data Collection Methods

For my data collection during background research, I performed a systematic review of my secondary sources to look for information on governance structures, organizational charts, language access policies, compliance documentation, and state and federal regulatory texts. I cataloged and summarized this information in the form of a legal and structural analysis brief. I also used this data to perform a comparative policy review following my interviews and based on institutions of similar size, patient population, and with similar state guidelines.

I was able to access information with very few barriers during this process as a majority of it was both displayed online through executive orders and legal documents, as well as on UNC Health websites. Because of the legal nature of the data collection of the secondary sources, the data found is very reliable, with the exception that there have been some recent and dramatic changes to the policy landscape of this project under the current administration.

My interviews were conducted using a structured interview guide. Some of the questions were generalized, while the majority will be catered to each individual interviewee and their role. The general questions focused on decision-making authority, budget control, enforcement mechanisms, discretion at clinic or departmental levels, and perceived constraints and incentives. Interviews were recorded (with permission) and transcribed for analysis.

I found that UNC Health medical staff were by far the most responsive and willing to talk. I therefore gathered a lot of information on the medical and patient interaction level, which was most helpful in understanding the policies versus reality of conduct with LEP patients at UNC Health. I also had several responses from the administrative and interpretation angle. However, I did not receive any responses from the financial side of administration, which would have been helpful in creating advocacy recommendations.

Analytical Techniques

For my interviews, I performed qualitative coding. For this technique, I used my recordings of my interviews to produce transcripts, which I then edited with intonation and key insights. I then used these transcripts to create visual and diagram-style analysis based on emerging themes and patterns throughout the interviews. Specifically, I used Atlas.ti software to find emergent patterns throughout my interviews and code for them. This analysis allowed for identification of informal power structures and key practical problem areas, such as discrepancies between policy and practice, that RCP can focus on.

Another analytical technique I used was to create a power map based on both the formal and informal institutional structures I uncovered through my research and coding. This power map provides a quick visual key for RCP, and is formatted as a hierarchical power structure. This map specifically indicates leverage points and key stakeholders within the UNC Health system.

Finally, all of these findings will be synthesized into an advocacy navigation roadmap which will identify key influential entry points and messaging strategies for RCP to use at UNC Health.

These recommendations take into account both formal and informal structures that influence the feasibility and effectiveness of certain strategies.

Limitations

There are several key limitations to this data collection. Firstly, given time and sample constraints, limited information was ultimately able to be gathered in comparison to the very large scope and population of the UNC Healthcare system. In addition, some access points were blocked off to me either because of institutional privacy, lack of response, or inaccessibility of the most high-up executive leadership. It is therefore difficult to create an entirely comprehensive image of power structures at UNC Health, particularly informal structures. This same constraint applies to my comparative analysis of other institutions. The area where this limitation is most visible is in my lack of data on the financial structures at UNC Health outside of officially documented numbers. Finally, as a researcher working in collaboration with RCP, findings are oriented toward advocacy utility rather than neutral academic analysis. While the analysis aims to be rigorous and accurate, it is ultimately designed to inform strategic action.

Expert Consultation

As a part of this research project, I consulted with Janine Barden-O'Fallon at the Odum Institute, as well as my professor of qualitative research this semester, Stephanie Shelton. I consulted at the Odum institute via Zoom on 3/16, and with my professor on both 2/16 and 2/23 in person after class.

I used my professor primarily to discuss research protocol, appropriate interview etiquette, and to design a set of research questions that were productive for my allotted interview time of 30 minutes. After these consultations, I created and edited my interview protocol, and also learned how to record and automatically transcribe zoom meetings.

My consultation with Janine at the Odum Institute focused on consolidating my findings and coding my transcripts. This was a great complement to my previous consultations as I got to use everything I had been building and transform it into the results that my capstone partner wanted. After this consultation, I was able to revise the notations in my transcripts both to be more thorough and less subjective. I also got an overview of how to use Atlas.ti and best practices for creating visualizations.

Data Findings and Analysis

The following findings are based on key findings from a data analysis of 9 semi-structured interviews done with various staff within the UNC Healthcare system, and supplemented by in-depth institutional and legal research. The interviews focused on a central question of this capstone project: how are language access services structured, funded, implemented, and experienced within UNC Health, and where should RCP direct its advocacy energy to drive meaningful change?

Interviews included the Education Specialist for Interpreter Services, the Director and Program Manager within the newly formed Department of Community Health and Engagement (CHE), two nurse and medical educators, and three clinical nurses spanning oncology, critical care, pediatrics, and outpatient infusion settings, and one nursing student completing clinical rotations at UNC and Duke. All of these interviews were recorded, transcribed, and analyzed using Atlas.ti.

These interview findings were analyzed in coordination with two active UNC Health policies: the Effective Communication for LEP Patients and Patients with Communication Disabilities policy (effective October 2025), and the Scope of Service Interpreter Services (effective January 2026), as well as the federal and state legal framework governing language access (Title VI, Section 1557 of the ACA, EO 14224, and North Carolina's Medicaid structure).

Finding 1: A Significant Gap Exists Between UNC's Written Policy and Everyday Practice

UNC Health has comprehensive formalized language access policies. The LEP policy requires that qualified interpreters are required for consent, diagnosis, assessment, discharge, and any medically significant communication, and states that minor children may not be used as interpreters except in emergencies, family members may only be used if the patient has explicitly refused a free qualified interpreter, and that use of interpreter services must be documented in Epic after every encounter.

However, according to the interviews conducted for this study, these policies are widely not being implemented in practice. This is not because staff are unaware of them, but because the system created barriers that make consistent compliance unrealistic. For example, six of nine participants described circumstances in which interpreters were bypassed for encounters that policy would classify as requiring one. The most common framing was that the interaction was 'just quick,' or that the wait for an interpreter made calling impractical or inconvenient.

One nursing student noted: "From what I've seen, no. Often they'll just go into the room and be like, 'Oh, well, this is just quick, so I don't need to call the interpreter.' Do I agree with that? No, but it is the truth of what happens."

Additionally, this gap is most pronounced for patients who speak languages other than English, and who rely on phone interpretation that participants described as frequently inaudible and unreliable. It is least pronounced in settings where in-person Spanish interpreters are physically available, or, also not in accordance with appropriate hospital policy, where a Spanish-speaking staff member happens to be working that shift.

Table 1 maps several significant policy-to-practice gaps identified across the interviews.

Table 1. Policy-to-Practice Gap Analysis

Policy Area	What UNC Policy Requires	What Interviews Revealed
Minor children as interpreters	Prohibited except in life-threatening emergencies (Sec. IV.A.4)	Nursing student observed a 10-year-old patient interpreting for parents at a Duke clinical site; no intervention documented
Family members as interpreters	Only permitted if patient explicitly refuses qualified interpreter after being informed it is free (Sec. IV.A.1)	6 of 9 participants described regular informal family interpreter use for 'quick' encounters; staff often don't document the refusal
Qualified interpreter required for consent & discharge	Mandatory for consent, diagnosis, discharge instructions, any medically significant communication (Sec. IV.5)	Multiple nurses described skipping interpreter calls when pressed for time; policy known but routinely de-prioritized
Non-English written materials	Most commonly needed forms must be provided in languages used by a significant number of patients (Sec. IV.A.6)	Spanish available; Karen, Burmese, Dari, Pashto, Arabic discharge documents do not exist; one Karen-speaking patient discharged with nothing written in their language
VRI/phone technical quality	VRI must deliver real-time, full-motion, high-quality video and audio (Sec. IV.4.a.i–iv)	5 of 9 participants described phone audio as routinely inadequate; one nurse uses personal cell phone because hospital phones and Vocera are 'terrible'
Epic documentation of interpreter use	Staff must document qualified interpreter use or vendor name/ID for non-UNC interpreters after every encounter (Sec. IV.7–8)	Awareness of this requirement varied substantially; not verified in practice across units

Pre-scheduling interpreters for known LEP appointments	Encouraged; Epic language preference flag exists to facilitate this	All clinical participants described calling interpreters at the moment of care rather than scheduling in advance; no systematic pre-scheduling protocol observed
Cultural competency training	Annual LMS-based training required system-wide; part of JCAHO and CMS compliance	Internally acknowledged as a 'checkbox' exercise; administrator overseeing revision described it as insufficient; no interpreter-specific cultural content

Finding 2: Decision-Making Authority Is Hierarchical and Largely Invisible to Frontline Staff

All nine participants confirmed that language access decisions, including funding, staffing levels, vendor contracts, and policy, flow through a fixed hierarchy. Frontline staff have discretion over how they use interpreter services in a given moment, but essentially no power over what resources exist, how the department is funded, or how compliance is enforced. Participants also seemed to not have any concrete understanding of the exact flow of this hierarchy, especially when it came to language services. When participants were asked who makes decisions about language access funding or policy, most were uncertain or gave indirect answers.

This matters for RCP because it means that advocacy directed only at frontline staff will not produce structural change. Rather, as I will go over in the recommendations section, RCP is better off interacting primarily with the Department of Community Health & Engagement (CHE), the Interpreter Services Director, and the Patient Experience & Employee Engagement Executive.

Table 2 maps the levels of authority with regards to language access at UNC.

Level	**Role / Actor**	**Authority Over Language Access**
Executive	COO Jeff Lindsay; Chief of Community Health Dr. Audreya Caesar	System-wide strategy, budget approval; sets strategic pillars including 'Reimagining Solutions'
Compliance	Leisa Powell (HCS Exec Dir, Hospital Compliance); Civil Rights Coordinator at each entity	LEP and disability communication policy; monitors compliance; handles OCR grievances
Department	Tracy Carroll (Patient Exp & Emp Engagement Exec); Interpreter Services Director	Staffing decisions, vendor contracts, service scope, FY improvement plans, Martti deployment

Program/Middle Mgmt	Joe Conway (Dir, CHE Operations); Associate Director, Interpreter Services; CHE Health Ed Program Manager	Day-to-day operations, community partnership deployment, CHW and language access staff assignments
Unit/Clinic	Charge Nurses, Nurse Managers, Oncology Care Coordinators	Unit-level implementation: interpreter scheduling, documentation, assignment of bilingual staff
Frontline Staff	Staff Nurses, Nursing Students, Per Diem Interpreters	Moment-to-moment decisions on when and how to use available resources; highest discretion, lowest formal power

Finding 3: Spanish Receives Substantial Investment; All Other LEP Language Groups Are Structurally Underserved

The most consistent structural finding across all nine interviews was the stark inequality between resources available for Spanish speaking patients versus the resources available for every other LEP language group.

At UNC Health, Spanish speaking patients have access to a variety of resources that participants frequently noted as anywhere from sufficient to "extremely helpful". These include 24/7 in-person interpreters at main campus (UNC Medical Center), written discharge documents, handouts, and patient education materials in Spanish, and existing Epic documentation infrastructure. However, most of the positive comments I received during interviews regarding interpretation services were based on what was available in Spanish. Upon further questioning, it became clear that resources in other languages are severely limited.

Non-Spanish speaking LEP patients have access to phone-based and Martti video interpretation, no in-person interpreters dedicated to their language, and no written materials at discharge in their language (with the occasional exception of Mandarin). There is no official hospital protocol for handling situations where a patient's language is not available through a Martti, though it was noted several times that the language options on a Martti are extensive. While the languages may be extensive, one outpatient oncology unit reported a single Martti device for 64 infusion chairs, forcing staff to queue or default to phone.

One nurse participant noted: "We actually recently discharged someone who was Karen-speaking, and we had nothing to give them for discharge, other than obviously using the interpreter to go over it with them. But they don't get anything written down at the end."

This disparity directly harms the communities in Orange County, and which RCP serves. RCP's 2025 membership data shows that 46% of members speak Burmese, Karen, Chin, or Rohingya, 12% speak Dari or Pashto, 6% speak Arabic, 4% speak Swahili or French from the Congo, and a

growing population also speaks Haitian Creole, and Ukrainian. None of these communities have access to in-person interpreters or written materials at UNC Health.

Finding 4: Time Pressure Is the Primary Driver of Policy Workarounds

Six out of nine participants cited time pressure as the dominant reason interpreter services are skipped over in practice. This is a critical distinction for RCP to understand because most staff know and understand the policy, meaning the workarounds are not happening out of ignorance, but rather because the current system makes policy compliance difficult in these high-pressure clinical environments.

According to participants, the core problem is that calling an in-person interpreter, which was frequently cited as the best option in terms of quality, currently requires logging into ServiceHub or paging the department, waiting for an available interpreter (which can be well over 20 minutes in some cases), and coordinating that interpreter's arrival with the provider's presence. One participant noted that she is often managing 5 patients simultaneously and cannot provide quality care under those circumstances:

"Very stressful, because I mean, I've been waiting on hold before for 20 minutes for a particular language, and I've actually told a provider before that I wouldn't give a new medication to the patient, because I don't know if they're going to react, and I can't be waiting 20 minutes for an interpreter to pop on."

Finding 5: Structural Funding is a Major Constraint, Advocacy Must Focus Here

Language access services at UNC Health are what one participant referred to as "not a direct money-maker". In alignment with this, the FY2026 Interpreter Services Improvement Plan is primarily geared toward cost reduction. At the same time, demand for language services is growing, and the political landscape is making institutional investment harder to justify.

Three main funding constraints shape the current political and advocacy landscape:

1. North Carolina does not claim Medicaid reimbursement for spoken language interpretation services, unlike more than 30 other states that reimburse at either the 50% administrative rate or the FMAP rate. This means UNC Health takes on interpretation costs entirely as overhead rather than recovering them through billing.
2. The revocation of Executive Order 13166 by Executive Order 14224 by President Trump last March eliminated the federal obligation for recipients of federal funding to develop and maintain Language Access Plans. While Title VI and Section 1557 of the ACA still apply, the compliance enforcement infrastructure has been significantly weakened.

3. UNC Health's governance structure, as part of the UNC System overseen by the Board of Governors, means the institution is subject to state political constraints that may limit how openly staff can frame work in terms of 'health equity' or 'health disparity'.

For RCP, this means that the strongest arguments for increased language access investment at UNC Health are not primarily ethical or legal, but rather financial. Participants noted that cost avoidance through reduced readmissions, malpractice liability from non-compliant consent processes, and reputational value are especially important considerations for UNC.

Recommendations

Below are four recommendations which result from the findings above. Each one identifies the linked findings, the priority level, basis in research, and action steps which have been designed to fit into RCP's existing organizational capacity (including the Language Navigator program, the Data VAULT, and RCP's Community Coordinators). Recommendations are ordered by priority.

Recommendation 1: Initiate a Formal Partnership with UNC's Community Health & Engagement Department

High priority. Linked to findings 1, 2, 4.

The Department of Community Health and Engagement (CHE) is UNC Health's newest and most externally-facing department, with its main purpose being to build community partnerships. CHE has a language access team with certified Spanish interpreters, is developing mobile medical vans, and is actively working with the Mexican Consulate and other community-based organizations. During my interview process, I spoke to two administrators in this department who expressed interest in coordinating with RCP, particularly their language navigator program. One director stated: "Our whole role is to get out in the community, rub elbows, get to know these agencies and organizations." I believe that CHE is the most natural entry point into UNC Health, and is a department which is extremely aligned with RCP's values and goals for the community.

Action Steps:

1. Follow up with the Director of CHE operations. Prepare RCP's 2025 membership demographics and a summary of relevant Data VAULT findings to illustrate the existing data that would be helpful to CHE.
2. CHE's current language access team serves primarily Spanish speakers, so it would be prudent to propose a partnership with RCP's language navigator program.
3. Request a seat in CHE's community advisory processes, particularly around the mobile medical van program launching later in 2026. RCP has existing relationships with the community organizations CHE is trying to reach, and has experience with community feedback evaluation.
4. Connect directly with CHE's Health Education Program Manager to offer RCP Community Coordinators as consultants for the cultural competency LMS revision currently underway. This is a time-sensitive opening that requires action in 2026.

Recommendation 2: Advocate for Pre-Scheduling of Interpreters for Known LEP Appointments & Multilingual Written Materials Beyond Spanish

Medium priority. Linked to findings 1, 4, 5.

These are high-impact, low-cost changes that all frontline participants described as absent from current practice. All frontline participants confirmed that interpreters are called at the moment of care, often after the provider is already in the room, which causes significant delays in care. Advocating for this change connects directly to UNC Health's own FY2026 Improvement Plan, which targets response time reduction as a departmental goal. In terms of written materials, RCP is positioned to supply both the patient population data that justifies prioritization of languages other than Spanish and the community review capacity that makes accurate translation possible.

Action Steps:

1. Present the pre-scheduling gap to the Interpreter Services Director as both a patient safety issue and a compliance issue. Reference UNC's own LEP policy, which identifies consent, discharge, and assessment as encounters that require qualified interpretation, as well as JCAHO standards, which are part of the recognized guidelines listed in UNC's Scope of Service document.
2. Propose a pilot using existing UNC Health technology through Epic, where all appointments for patients with non-English Epic language flags are automatically routed to a pre-scheduling for interpreter assignment.
3. Frame in financial terms for leadership by acknowledging that pre-scheduling reduces interpreter overtime costs and care delays.
4. Submit a formal written request identifying the specific language groups for which materials are needed, referencing UNC's own policy and Section 1557 obligations, and using RCP's population data. Prioritize common discharge scenarios.

Recommendation 3: Request an Interpreter-Specific Patient Feedback Mechanism at UNC Health (In combination with existing data VAULT)

Lower priority. Linked to finding 1.

There is currently no UNC Health patient satisfaction survey that specifically asks about language access or interpreter quality. The general survey includes open-ended responses but has no questions about interpretation services. The Martti system does collect post-call ratings from staff, but only 1-2 questions per interaction, and the questions are geared towards staff. Additionally, several nursing staff participants noted that this survey further delays patient care.

Action Steps:

1. Propose the addition of two to three language access questions to UNC's existing patient satisfaction survey to Tracy Carroll (Patient Experience & Employee Engagement Executive). These questions may include: Was an interpreter provided when you needed

one? Were you able to understand your care instructions? Were your discharge documents available in your language?

2. Propose that these questions be available in patients' preferred language, using the same QR code and paper distribution channel currently used for general satisfaction feedback.

3. Advocate for patient rights complaints related to language access be flagged to the Civil Rights Coordinator, tracked by language group, and reported to the Interpreter Services Director as part of the department's quality monitoring.

Appendices

Appendix I: Legal and Institutional Memo
(As Copied from Original Document)

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Master of Public Policy

RcP refugee community partnership

Bridging Language Gaps in UNC Healthcare:

Legal & Institutional Requirements Memo

Savanna Ray

Table of Contents

I. Introduction and Purpose

This memorandum serves as the foundational legal and institutional document for an advocacy project conducted in partnership with the Refugee Community Partnership (RCP), which focuses on language access within the UNC Healthcare system. This memo accomplishes three objectives: (1) identifying the binding federal legal requirements governing language access for limited English proficient (LEP) patients at federally funded healthcare institutions; (2) reviewing North Carolina's state-level framework for language access; and (3) analyzing UNC Health's publicly available language access policies and compliance structures. This document is intended to ground RCP's advocacy in the relevant legal landscape before engaging directly with UNC Health stakeholders.

II. Federal Legal Framework

A. Title VI of the Civil Rights Act of 1964

Title VI of the Civil Rights Act states that "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."[1] LEP patients are covered under the "national origin" section of this Act, as this includes primary language and ability to communicate in English[2].

As UNC Health receives hundreds of millions of dollars in federal funding through the Centers for Medicare & Medicaid Services (CMS) and research grants from the National Institutes of Health (NIH)[3], Title VI coverage is absolute. This policy mechanism is enforced primarily through the Office for Civil Rights (OCR) within HHS, which uses a standards test to determine "reasonable steps to ensure meaningful access"[4]. These standards include: the number or proportion of LEP persons in the service area, the frequency with which LEP individuals

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[1] United States Department of Justice. (2025, March 24). *Title VI of the Civil Rights Act of 1964*. https://www.justice.gov/crt/fcs/TitleVI

[2] Youdelman, M., & de Kervor, D. (2025, December 11). *What is required under Title VI and Section 1557 to ensure language access for individuals with limited English proficiency?* National Health Law Program. https://healthlaw.org/resource/what-is-required-under-title-vi-and-section-1557-to-ensure-language-access-for-individuals-with-limited-english-proficiency/

[3] Bostrom, N. (2026, February 24). *UNC School of Medicine among top 5 public universities to receive NIH funding in 2025*. UNC Health News. https://news.unchealthcare.org/2026/02/unc-school-of-medicine-among-top-5-public-universities-to-receive-nih-funding-in-2025/

[4] U.S. Department of Health and Human Services, Office for Civil Rights. (2025, March 6). *Summary of guidance to federal financial assistance recipients regarding Title VI and the prohibition against national origin discrimination affecting limited English proficient persons.* https://www.hhs.gov/civil-rights/for-providers/laws-regulations-guidance/guidance-federal-financial-assistance-title-vi/index.html

contact the program, the nature and importance of the services provided, and the resources available to the entity. Institutions that do not meet their standard of care risk losing federal funding.

B. Section 1557 of the Affordable Care Act

Section 1557 of the Affordable Care Act (ACA) is the first federal civil rights law focused specifically on nondiscrimination in healthcare. This law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in any health program or activity that receives federal financial assistance, in any program administered by HHS, and in any entity established under Title I of the ACA[5].

The regulations for Section 1557 have been revised multiple times, reflecting shifting values through administration changes. The most recent version of the regulations is the 2024 Final Rule, published April 26, 2024. The 2024 Final Rule expanded and strengthened protections that had been weakened under prior rulemakings. Key provisions relevant to language access include: standards for qualified interpreters (including prohibitions on requiring family members), requirements for written language access policies, requirements to notify about available services, AI standards, requirement of free services, and the prohibition of the use of minor children for interpretation except in the case of emergency.

C. Executive Order 13166 & 14224

Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency," required federal agencies to examine the services they provide and develop and implement a system by which LEP persons can meaningfully access those services[6]. In response, HHS published formal guidance in 2000 and subsequently updated it to clarify how recipients should apply the four-factor analysis (detailed above), develop Language Access Plans (LAPs), and meet document translation obligations. While the executive order did not create new rights, it significantly strengthened the infrastructure around Title VI compliance, and shifted burden from patients and onto providers.

However, in March of 2025, President Trump issued Executive Order 14224, designating English as the official language of the US. This order explicitly revokes EO 13166, though it does not require the removal of any active services. The revocation of EO 13166 means that recipients of federal funding are no longer under obligation to implement plans to ensure meaningful access to LEP individuals. In addition, EO 14224 “rescind any policy guidance documents issued pursuant to Executive Order 13166 and provide updated guidance”[7].

III. North Carolina State Legal Framework

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[5] U.S. Department of Health and Human Services. (2024, May 6). *Nondiscrimination in health programs and activities* (Final rule, 89 Fed. Reg. 37522). Federal Register. https://www.federalregister.gov/documents/2024/05/06/2024-08711/nondiscrimination-in-health-programs-and-activities

[6] Clinton, W. J. (2000, August 16). *Improving access to services for persons with limited English proficiency* (Executive Order 13166, 65 Fed. Reg. 50121). Federal Register. https://www.federalregister.gov/documents/2000/08/16/00-20938/improving-access-to-services-for-persons-with-limited-english-proficiency

[7] The White House. (2025, March 1). *Designating English as the official language of the United States*. https://www.whitehouse.gov/presidential-actions/2025/03/designating-english-as-the-official-language-of-the-united-states/

North Carolina has a relatively minimal legal infrastructure when it comes to comprehensive or standalone healthcare language access policies, relying primarily on federal guidelines, NCDHHS policy, and Medicaid managed care requirements.

A. General Statute 90D and the Licensure of Interpreters

While North Carolina does regulate licensure of interpreters under General Statute 90D, the "Interpreter and Transliterator Licensure Act," this act only applies to ASL and cued-speech interpretation for the deaf, blind, and hard of hearing[8]. North Carolina has no licensing or certification requirement for spoken language interpreters in healthcare settings.

B. NC DHHS Title VI Language Access Policy

The NC DHHS has issued formal guidance on how DHHS operated, administered, and funded programs should provide language access in order to be in compliance with Title VI and related federal requirements[9]. These requirements include, but are not limited to: notifying LEP patients of their rights, a needs assessment of both individual patients and potential patient populations, prompt and competent access to interpreters (requirements detailed), provision of written translations, documentation of compliance, staff training on language access policies and cultural awareness, and prompt and equitable resolution of complaints.

C. Medicaid Reimbursement

Under federal law, states have the option to claim Medicaid reimbursement for interpretation services as either an administrative expense (reimbursed at 50%) or as a covered medical service (reimbursed at the state's FMAP rate)[10]. However, North Carolina does not claim Medicaid reimbursement for spoken language services in any provider setting for non-English speakers, meaning providers typically absorb these costs as part of routine service delivery rather than billing them as a separate service. North Carolina does reimburse between $35-$100/hour for interpreting services for the deaf and blind[11].

IV. UNC Health Institutional Overview and Policies

A. Institutional Identity and Federal Funding Status

UNC Health Care System is a state-owned academic medical system affiliated with the University of North Carolina at Chapel Hill[12]. It is organized as an entity within the University of North Carolina System and governed by the UNC Board of Governors. As a public institution receiving Medicare, Medicaid, federal research grants, and other HHS financial assistance, UNC Health is a covered entity under Title VI, Section 1557, and the ADA.

UNC Health operates as a statewide system comprising 16 hospitals and hundreds of outpatient clinics across North Carolina, employing over 56,000 people. Each network entity

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[8] North Carolina General Assembly. (n.d.). *Chapter 90D: Interpreters and Transliterators*. In *General Statutes of North Carolina*. https://www.ncleg.gov/Laws/GeneralStatuteSections/Chapter90D

[9] North Carolina Department of Health and Human Services. (2019, August). *2019 LEP Plan template*. https://www.ncdhhs.gov/documents/files/dss/directorsmeetings/2019-lep-plan-template/download

[10] Centers for Medicare & Medicaid Services. (n.d.). *Translation and interpretation services | Medicaid administrative claiming*. Medicaid.gov. https://www.medicaid.gov/medicaid/financial-management/medicaid-administrative-claiming/translation-and-interpretation-services

[11] Youdelman, M. (2024). *Medicaid and CHIP reimbursement models for language services: 2024 update* (Issue brief). National Health Law Program. https://healthlaw.org/wp-content/uploads/2024/03/Medicaid-and-CHIP-Reimbursement-Models-FINAL-2024-1.pdf

[12] UNC Health. (n.d.). *UNC Health system network*. https://www.unchealth.org/about-us/who-we-are/unc-health-system-network

operates with some local autonomy but is subject to systemwide governance structures, compliance obligations, and shared service agreements[13].

B. Patient Rights at UNC

UNC Health's most recent systemwide Notice of Nondiscrimination (October 2025) is publicly available on the UNC Health website and confirms the system's formal commitment to federal civil rights compliance, including: free language services, notice of availability, and a systemwide grievance process through designated contacts at each network entity[14].

UNC Hospitals' page on patient responsibilities and rights also affirms that patients have the right to medical care without discrimination based on, among other characteristics, language, ethnicity, national origin, or culture. This document explicitly names the Section 1557 Coordinator and provides contact information for filing civil rights grievances[15].

UNC Medical Center also has a dedicated Interpreter Services department. Services in this department include: in-person Spanish interpretation, telephonic interpretation for other languages (often through third party interpreter services), bilingual staff evaluation, family member restriction, and documentation requirement[16].

Appendix II: Outreach Email Template

Good afternoon,

My name is Savanna Ray, and I'm a master's student at UNC Chapel Hill. I'm currently working on my capstone project as a research assistant with Refugee Community Partnership (RCP) in Carrboro.

My project focuses on understanding language access resources in healthcare settings, and I'm hoping to speak briefly with UNC Health staff about their experiences with existing systems and supports. The goal is simply to better understand what resources are currently available and how they're used in practice.

Interviews are brief (about 15 minutes) and fully anonymous. I would greatly appreciate the opportunity to learn from your experience if you're willing to connect. I'm happy to meet virtually or in person at your convenience.

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[13] UNC Health. (n.d.). *UNC Health system network*. https://www.unchealth.org/about-us/who-we-are/unc-health-system-network

[14] UNC Health. (2025, October). *Notice of nondiscrimination* [PDF]. https://www.unchealthcare.org/app/files/public/b3c9eacb-573e-40b7-8aa4-64dc25e40fd7/pdf-system-unc-health-care-nondiscrimination-notice.pdf

[15] UNC Medical Center. (n.d.). *Patient responsibilities and rights*. UNC Health. https://www.uncmedicalcenter.org/uncmc/patients-visitors/patient-responsibilities-and-rights/

[16] UNC Health. (n.d.). *Language accessibility services*. https://www.unchealth.org/about-us/accessibility-at-unc-health/language-accessibility-services

I've included my Calendly link below, or I'm happy to coordinate via reply.
Thank you very much for your time and consideration.

Best,
Savanna

Appendix III: Interview Questions (Sample)
For Healthcare Providers and Administrators:

Can you describe the current policies and procedures in place at your clinic for addressing language barriers with LEP patients?
When decisions need to be made about language access, where do those decisions typically originate?
How are these policies implemented in practice? Are there any gaps between the policy and actual practice?
How are interpreter services provided? Are they available at all times?
What are the biggest challenges you or your staff face in providing care to LEP patients?
In your opinion, what do you see as potential barriers to providing consistent and competent interpretation/communication to patients with LEP? What are some potential solutions?
What kind of training does your staff receive regarding language access? Is additional training needed?
Has there ever been a time where you have been unsure or unfamiliar with a language a patient requests for interpretation? How did this impact your interaction with them?
Are you aware of how many languages you offer written translated materials in?
How do you evaluate the effectiveness of the language access services provided?
Are there any technological tools in use? How effective are they?
Who within your organization makes decisions related to language access?
If you refer a patient to another provider, is there prior communication between you and the other provider about that patient's specific language needs?

For Language Navigators and Interpreters:

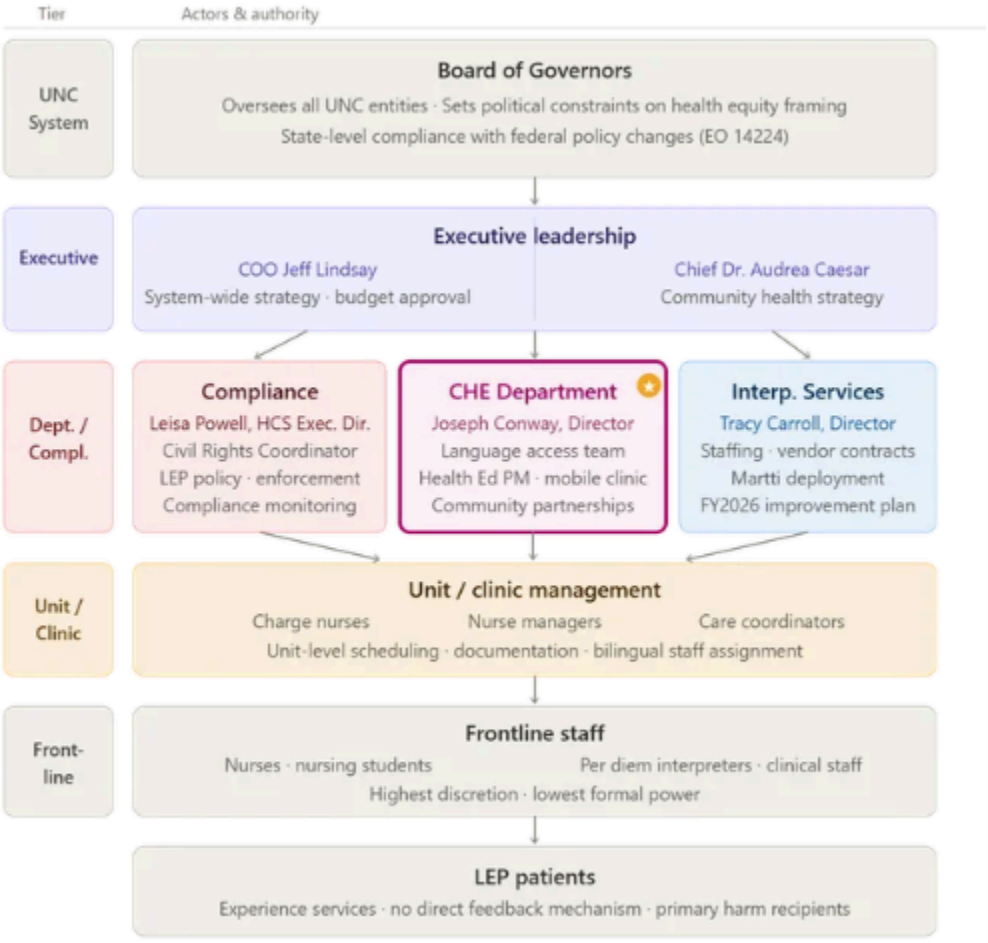
Can you describe common language barriers refugees face when navigating healthcare?
How do cultural differences affect patient-provider interactions?
Where is discretion allowed at the clinic level?
What are the most difficult situations you encounter when interpreting?
What kind of training did you receive? Are there areas where more support is needed?
How effective do you believe current language services are in improving patient outcomes?

What changes or improvements would you recommend to enhance language access for refugees in the healthcare system?
How well do healthcare providers collaborate with interpreters?
In your experience, what policies or practices could improve language access within UNC Healthcare or other local healthcare systems?

For Patient Care Coordinators:

Can you describe your role and responsibilities as PCC? Level of experience or interaction with LEP patients?
What steps do you take to assess a patient's preferred language for communication, and how do you document it in their file?
Are you aware of the linguistic makeup of LEP clients that you see frequently at your clinic?
What are the steps your clinic or department takes when a client speaks a language you don't have an interpreter available for?
What role do technology and digital tools (e.g., translation apps, telephonic/video interpreting services) play in providing language accessibility at your facility?
If you receive any state local federal funding to address language barriers and support language access policies? /Do you receive donations? Are they specifically earmarked for interpretation or language access? Can you share where they come from?
What steps do you take when language services are not covered by insurance or are financially difficult to provide?
How do you communicate important information, such as appointment reminders or discharge instructions, to patients with language barriers?
Do you have any personal experience or awareness of procedures for referring patients with LEP to other providers? How does this process look different to ensure that the process is transparent and patients fully understand their care plan?
How do you handle urgent situations where immediate language support is needed?
How do you gather feedback from patients regarding their experience with language accessibility services?
Questions about barriers (similar to questions asked to other personnel)

Appendix IV: Power Map



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