CHCF

AI and Language Access in Health Care:
Opportunities, Risks, and Early Lessons

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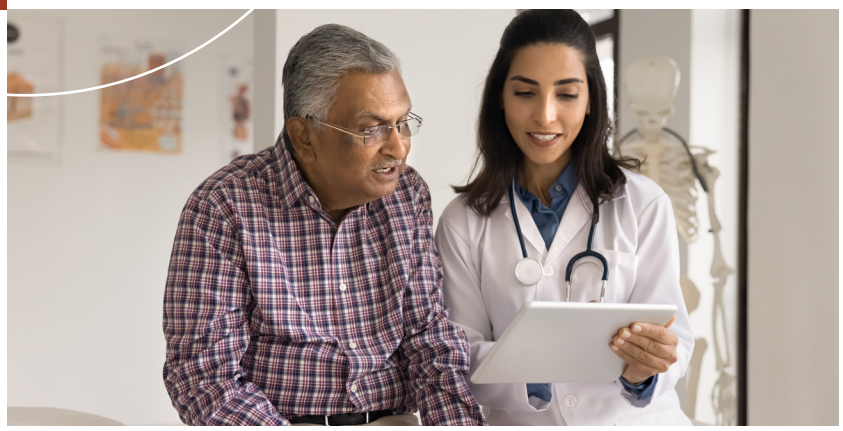

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About the Author

Katy Haynes is a Bay Area–based consultant with 15+ years of experience in product development, public policy, and health care. She specializes in digital strategy, health technology, and public sector innovation, and has led initiatives at the intersection of AI, data infrastructure, and health systems through work with the White House, the US Digital Service, the Chan Zuckerberg Initiative, and Nightingale Open Science

About the Foundation

The California Health Care Foundation is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Executive Summary

California is one of the most linguistically diverse states in the US. More than 200 languages and dialects are spoken statewide;[1] 44.1% of Californians age 5+ speak a language other than English at home;[2] and an estimated 6.4 million Californians (17.2%) speak English less than "very well."[3]

Language access is a foundational component of safe, equitable, and compliant health care delivery. Language barriers have been documented to reduce access to high-quality health care services, impede patient-provider communication, and are associated with increased hospital readmissions, higher risk of medical errors, and worse chronic disease outcomes among those with limited English proficiency.[4]

Many people rely on health systems and community clinics to provide reliable interpretation and translation services (together, "language access services"), and federal and state regulations — including Title VI of the Civil Rights Act, the Affordable Care Act, and Medi-Cal managed care contracts — mandate it.

To provide language access services, California health care plans and provider organizations have historically relied on a small number of large vendors operating remotely, coupled with a handful of local or regional providers for specific capabilities. Today, a new wave of artificial intelligence–enabled tools and services has begun to transform the traditional vendor landscape.

Advances in automated speech recognition, machine translation, and text-to-speech now allow computers to listen, translate, and speak across many languages in real time, while large language models add medical context, fluency, and basic safety checks. Together, these shifts have potential to enable faster, more scalable language access and could significantly reduce per-encounter cost, especially for low-risk interactions.

CHCF is exploring whether AI can help people get care in their own language by making high-quality language services easier to access while keeping it safe, reliable, and affordable. This brief draws on a literature review, online research, and interviews with state and local implementers, health system leaders, community-based advocates, and AI vendors to map current pilots, emerging governance frameworks, and early lessons from the field.

Key Findings

- California's health care providers and payers have traditionally purchased translation and interpretation services from a small number of large national organizations, together with a handful of regional and local vendors for specific services. Those large vendors have begun to integrate AI tools into their offerings, and new AI-first start-ups are working hard to challenge those legacy organizations.
- Health care providers' and payers' early explorations with AI-enabled language access tools are focused on low-risk use cases, such as the translation of pre-visit instructions, preventive care reminders, education materials, and post-discharge patient notes, as well as the real-time interpretation of routine administrative conversations between patients or members and conversational AI agents. These tools are being tested as support for human translation and interpretation, not to replace it.
- AI use for language access is tightly bounded by federal and state regulations and guidelines, including Title VI, ACA § 1557, Joint Commission, Dymally-Alatorre, Knox-Keene, and Medi-Cal rules, which require that patients have access to qualified interpreters and translated materials. The US Department of Health and Human Services has clarified that AI may supplement translation workflows and cannot substitute for a human interpreter in

clinical, legal, or consent-related contexts,[5] but federal guidance leaves flexibility for non-critical and administrative use cases.

- Pilots at Children's Hospital Los Angeles, Contra Costa Health System, and the California Health and Human Services Agency indicate efficiency gains are possible when AI tools are paired with structured human oversight, while emerging vendors claim AI-assisted workflows can reduce costs by 50%–70% and enable staff to be used for higher purposes, depending on the use case and quality assurance (QA) requirements.[6]
- Without federal and state regulatory clarity and robust QA benchmarks, interviewees suggest the adoption of AI tools will remain fragmented and confidence low, even as technical capacity expands. With supports in place, however, AI-enabled services can responsibly expand access for administrative and educational content. Health care organizations may increasingly rely on hybrid models where AI improves efficiency while humans ensure safety and compliance.

Language Access Services in Health Care

Language access services for people with limited English proficiency (LEP) — people who do not speak English as their primary language and who have a limited ability to read, write, or understand English — include spoken-language interpretation and written-language translation to ensure they can understand health care information and communicate effectively when accessing services or making decisions.

The quality of language access services, and health care organizations' ability to meet the needs of diverse populations, varies tremendously including by the number of available languages, mode of service delivery (e.g., over-the-phone interpretation, video remote interpretation, and on-site interpretation), and operational performance measures (e.g., time needed to connect, fill rate, interpreter training), and presence of QA systems (e.g., call monitoring, performance evaluation, feedback). Services are also distinguished by how well the technology integrates into established workflow and technology systems (e.g., whether services can be requested and launched in the electronic health record [EHR] or telehealth platform, or whether real-time analytics dashboards are embedded).

The price of the product is critically important. Health systems are required to provide access to qualified interpreters and translated materials across a broad range of languages at no cost to the patient. Health plans pay when language access is needed for enrollment and eligibility, member materials, call centers, and care management, and reimburse providers for interpretation services used during encounters with their Medi-Cal patients. Contracted rates are negotiated directly with language access vendors and vary based on language rarity, delivery mode, interpreter credentials, contract volume, minimums, tiered volume discounts, and setup fees. See Table 1.

Translation versus Interpretation

Language translation applies to *written communication*, including paper documents (forms, notices, letters), digital content (websites, patient portals, text messages), and educational and instructional materials.

Translated materials can be prepared and corrected in advance. EHR-hosted patient-education and other stock materials are often pre-translated, while custom content is prepared by outside translators.

Language interpretation is for *spoken or real-time communication*, such as a conversation between a patient and provider, delivered in person, over the phone, or by video. Interpretation happens live, leaving no time for human review or correction.

Table 1. Pricing Models Used in Health Care Contracts

MODALITY	TYPICAL PRICING MODEL	EXAMPLE COST INDICATORS
Remote interpretation	Per-minute billing	~$2–$5 for phone; video typically higher
On-site interpretation	Hourly billing	~$45–$150+ with minimums
Document translation	Per-word pricing	~$0.10–$0.30 depending on language, technical content, and turnaround time

Source: Author interviews with California health care plans, provider organizations, and language access vendors, 2025.

Traditional Vendors and Emerging AI Capabilities

To deliver language access services, health care plans and providers have long relied on a small number of large vendors operating remotely, supported by regional providers and technology platforms. But a new wave of AI-enabled language access tools has begun to transform the traditional landscape. Advances in automated speech recognition, machine translation, and text-to-speech now allow computers to listen, translate, and speak across many languages in real time, while large language models (LLMs) add medical context, fluency, and basic safety checks. Traditional vendors, Big Tech companies, EHR and ambient scribe companies, and AI-first start-ups are all positioned to leverage these capabilities to build, strengthen, or expand their existing services, and have potential to enable faster, more scalable language access at a significantly reduced per-encounter cost. See Table 2.

Table 2. AI Utilization Strategies by Vendor Category

VENDOR CATEGORY	EXAMPLES	AI-ENABLED LANGUAGE CAPABILITIES
Traditional health care focused language access vendors (see Table 3)	AMN, LanguageLine, Propio	Adding functionality to support real-time computer-generated voice interpretation and backend processes, such as automated call routing, interpreter matching, and document pretranslation
Large technology company language tools (see box "Large Technology Companies")	Apple, Google, Microsoft	General-purpose language solutions that use neural machine translation, an approach where advanced computer models translate sentences based on context rather than on individual words
Electronic health record and ambient scribe vendors	Ambience, Abridge, Cerner, EPIC, Nuance DAX	Potential to extend basic EHR and ambient scribe services to include integrated document translation or interpretation (e.g., bilingual patient notes, computer-generated voice interpretation)
AI-First language access start-ups (see Table 4)	Jaide, Lexi, No Barrier, Opalite	Direct competitors to legacy vendors, entering pilot phases with hospitals, clinics, and payers

Source: Author analysis based on interviews with vendors and health care leaders, 2025.

A small number of large language access providers have long dominated the health care markets because they meet regulatory requirements and maintain large pools of certified medical interpreters (see Table 3). Some have begun to incorporate formal AI offerings into their traditional frameworks.

Table 3. Select Traditional Health Care–Focused Language Access Vendors

VENDOR	INDUSTRY	MODES	LANGUAGES	NOTABLE ATTRIBUTES
LanguageLine	Health care dominant	OPI, VRI, on-site, document translation	240+ spoken, 40+ via video; translation in 290+	Long-standing market leader; deep hospital footprint; EHR and telehealth integrations; mature reporting and analytics portal.
Propio	Multiple industries	OPI, VRI, on-site, document translation	300+ spoken, translation in 200+	Aggressive investment in technology with recent acquisitions including Akorbi, CyraCom, Telelanguage, ULG; progressing toward more unified platform and APIs after acquisitions.
AMN Health Care Language Services	Health care	VRI, OPI, on-site, document translation	Not publicly listed	Strong inpatient and ambulatory video footprint and telehealth integration; tie to AMN staffing infrastructure; formerly Stratus Video.
GLOBO Language Solutions	Multiple industries	OPI, VRI, chat, document translation	430+	Midsized API-enabled platform with strong reporting dashboards and operational transparency.
Equiti	Health care	VRI, OPI, on-site (through partners), document translation	250+	Native telehealth integration; historically strong in emergency department and acute video interpretation carts; formed from Cloudbreak Health (Martti platform) and the acquisition of Voyce.
Certified Languages International	Multiple industries	OPI-led, limited VRI compared to competitors	230+	Midsized veteran; phone-first; often plays role as secondary or backup vendor.
Interpreters Unlimited	Multiple industries	OPI, VRI, on-site	Not publicly listed	Long-standing language service provider historically optimized for scheduled and in-person interpretation; especially strong in specific regions and metro areas.
Boostlingo	Multiple industries	OPI, VRI, marketplace platform	300+ via interpreter network	A technology or marketplace intermediary rather than a traditional language services provider. Aggregates interpreters of smaller agencies via APIs.

Notes: *API* is application programming interface; *OPI* is over-the-phone interpreting; *VRI* is video remote interpreting. Language counts reflect companies' marketed capabilities. Vendors typically calculate "languages spoken" by counting any language with at least some interpreter coverage, even if availability is limited, and rare languages with long wait times.

Source: Company websites, product documentation, and marketing materials, reviewed January–February 2026.

LanguageLine, for example, markets AI-powered interpreting and translation solutions, including LanguageLine Automated Interpreter (LLAI)[7] for real-time interpretation with human escalation. The company also provides AI translation services for written content and workflow automation using LLMs and machine translation. GLOBO has launched an AI interpreter product called "GLOBO KAI,"[8] which integrates AI for on-demand interpreting to help reduce barriers in clinical or administrative settings. Boostlingo's platform includes AI-based translation and interpreting tools, such as live AI translation, captioning, and speech-to-speech conversion. In "speech-to-speech" conversion, speech recognition technology converts speech in Language A to text. That text is then translated by machine or LLM technology to text in Language B. Finally, text-to-speech technology converts the translated text into spoken audio.

Large technology companies like Google, Microsoft, and Apple (see box "Large Technology Companies' General-Purpose Language Capabilities") have developed general-purpose language solutions that can be powerful and inexpensive. However, the quality of basic machine translation without extensive health care training can be inconsistent across languages and does not account for cultural nuance, nonverbal communication, tone, or the sensitivity often required in medical conversations. Studies show AI translation tools in health care workflows often deliver high accuracy (for example, 83%–98% in some settings)[9] when translating from English into well-resourced languages such as Spanish or Portuguese, but performance declines considerably for more complex content or less-resourced languages,[10] and earlier research documented common idiomatic failures in discharge instructions such as "take with food" rendered as "eat it as food."[11] Another challenge is that language access touches personal health information (PHI) constantly. Without specific configuration to support HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance, using these technologies in health care can expose an organization to standard of care violations, privacy breaches, malpractice risk, and HIPAA enforcement actions.

Electronic health record (EHR) and ambient scribe companies are not currently providing language translation and interpretation services but, if the investment made business sense, these companies could build and integrate language access services into their core offerings. EHR companies already

Large Technology Companies' General-Purpose Language Capabilities

Google Translate. Free public website/app optimized for broad language coverage and scale. The service is not HIPAA compliant, and Google does not sign BAAs for it. Health care organizations needing HIPAA-compliant translation must build solutions using Google Cloud Platform services covered by Google's Business Associate Agreement and configured with proper safeguards.

Microsoft Azure / Microsoft Translator. Azure's cloud platform and Microsoft Translator offer neural machine translation that developers can add to apps. With appropriate configuration and a signed BAA for Azure services, Microsoft's translation tools can be used in health care environments under HIPAA-compliance frameworks, but compliance depends on proper deployment and management.

Apple AirPods. Paired with an iPhone or iPad, AirPods can run Apple's Translate app, Live Listen, Conversation Mode, Siri dictation, and integrate with some third-party translation apps. But these features are not designed for HIPAA-regulated health care, and Apple does not sign BAAs for these services. These tools may transmit data to Apple's servers for processing, and Apple's terms of service do not accommodate HIPAA-compliant PHI handling. There is no HIPAA-compliant version of Apple Translate or its audio features.

Source: Author interviews and industry research.

store patient education information in multiple languages and, if regulation allowed, integrated ambient scribes could auto-generate bilingual encounter summaries, discharge instructions, and patient-specific education materials based on the patient's preferred language.

Finally, early-stage, AI-first approaches to health care language access (see Table 4) focus on automated speech-to-speech interpretation and AI-enabled translations of documents and clinical text, primarily for real-time or near-real-time use cases, and unlike legacy vendors (e.g., LanguageLine, AMN), do not operate large networks of human interpreters.

Jaide Health, for example, is a HIPAA-compliant platform that positions itself as augmenting interpreters, helping them focus on nuance, context, and quality oversight, and enabling hospitals to tailor glossaries, tone, and terminology to their own clinical environments. Jaide supports roughly 30 spoken and 100 written languages and is being piloted at Cambridge Health Alliance, Children's Hospital Los Angeles, and North Bay Health.

Jaide uses a rubric, developed with translator input, to rate AI-generated drafts in "medical acceptability." Translators categorize edits as stylistic, clarity-related, or critical meaning errors. This process not only improves quality but also creates

Table 4. Select AI-First Health Care Language Access Start-Ups

COMPANY NAME	LOCATION	DESCRIPTION	QUALITY ASSURANCE	KNOWN PILOTS / USERS	INVESTMENT STAGE
Jaide Health	Boston, MA	Real-time HIPAA-compliant and SOC 2 Type II–certified AI interpretation and document translation, including after-visit summaries.	Interpreter-led rubric for "medical acceptability"; ongoing model retraining and human in the loop for high-risk and clinical use cases.	Commercial contracts in California and Massachusetts, including with Children's Hospital Los Angeles, Cambridge Health Alliance, and NorthBay Health.	$2.5M seed funding by venture firms including Inovia, Flare, and Innovation Global Capital.
Lexi	Boston, MA	Real-time, HIPAA-compliant speech-to-speech medical interpretation available via telephony and web-based applications on computer, tablet, and mobile. Supports non-clinical use cases (e.g. front desk administrative tasks, insurance, navigation) and clinical conversations in common and underserved languages and dialects.	Live transcription of every conversation with session logs. Regular audits by a multilingual team including clinicians and certified interpreters. Model performance measured quantitatively and in real-world clinical environments.	Initial commercialization with clinics, including Lowell Community Health Center (MA). Early pilots and Letters of Interest with health systems, including Harvard-affiliated academic hospitals.	$1.4M seed funding from venture firms including Informed Ventures; prize and grants capital from Harvard Business School New Venture Competition Grand Prize and Massachusetts eHealth Institute (MeHI).

COMPANY NAME	LOCATION	DESCRIPTION	QUALITY ASSURANCE	KNOWN PILOTS / USERS	INVESTMENT STAGE
No Barrier	San Francisco, CA	Medical-grade AI interpretation built to handle complex clinical care at scale, designed to meet healthcare privacy and regulatory requirements (e.g., HIPAA-compliant, ACA-compliant, and SOC 2–certified). Speech to speech experience for in-person visits, telehealth phone calls, and video encounters.	Multi-layer quality assurance combining real-time automated safety guardrails, human-in-the-loop oversight, and escalation to a human interpreter to support safe and accurate medical interpretation.	Deployed across 150+ sites in 12 states, including FQHCs and specialty networks such as People's Community Clinic, CAN Community Health, Community Clinic NWA, Primary Health Care Iowa, Dr. Tavel and Cancer Center of Hawaii.	$3M raised. Seed round led by A Squared, Esplanade, Rock Health Capital, and Fusion.
Opalite Health	Palo Alto, CA	Real-time speech-to-speech AI medical interpretation in 150+ languages, available 24/7 with no wait time. Integrates into the EHR and generates documentation automatically. Works on any device - mobile, tablet, web, telephony, and telehealth.	Validated in a peer-reviewed study with Johns Hopkins Medicine, showing superior translation quality compared to certified medical interpreters. Certified human medical interpreters remain in the loop.	Selected by NACHC as a partner for translation. Deployed in hospitals, community health centers, home health, and telehealth organizations across 10+ states.	$700K led by Y Combinator and Forum Ventures

Note: The market is still fluid; many are pre-scale compared to incumbent vendors.

Source: Author interviews and company websites and product materials, reviewed January–February 2026.

feedback data that Jaide uses to retrain its model and to benchmark interpreter trust over time. This approach demonstrates how vendors can build measurable QA systems that feed back into compliance and continuous improvement — something regulators could eventually standardize.

Hospitals using Jaide describe it as a way to lighten workloads, not to replace translators. Automation eliminates rote translation tasks and "lets interpreters practice at the top of their license." Many report improved patient comprehension and higher interpreter satisfaction. Yet technical integration remains shallow, as most hospitals still rely on staff copying and pasting content across technology platforms rather than full EHR connectivity. For now, adoption is constrained by both integration hurdles — such as authentication, audit trails, and data-storage compliance — and by regulatory ambiguity about where AI translation can safely be used. As attorney Deeana Jang explained, existing federal rules make it clear that a "human in the loop" is required, but they don't clearly define what counts as a "critical" conversation. That lack of granularity leaves it to individual systems to determine when AI translation is appropriate and when a certified interpreter is needed.

Opalite Health, a newer entry launched in 2025, began as an academic research project focused on

building, training, and validating multilingual language models for health care. "Before we could even think about the market, we had to get the model right: the data, the training, the validation," said CEO Cathleen Kuo. "Everything else flows from the foundation." While some vendors limit their focus to administrative content, Opalite's customers are already using its tools in a range of patient care interactions — including clinical discussions — where accuracy, tone, and cultural context are essential.

To manage risk in translations, Opalite applies a tiered framework: low-risk (routine reminders or educational content), medium-risk (nonurgent clinical discussions), and high-risk (complex or sensitive patient conversations). Medium- and high-risk content is automatically flagged for human review, either by internal staff or certified interpreters connected through Opalite's oversight portal.

Opalite's system maintains real-time monitoring, allowing staff to view and correct translations as they happen, rather than relying on edits afterward. Internally, Opalite benchmarks performance using human annotators who assess whether outputs preserve meaning and tone rather than literal word matching. Early deployments have demonstrated measurable reductions in critical interpretation errors compared with traditional interpretation models.

Regulation and Compliance

Despite growing interest, the use of AI for translation and interpretation is tightly bound by federal and state civil rights laws — notably Title VI of the Civil Rights Act and Section 1557 of the Affordable Care Act (see Table 5, next page). Under federal civil rights laws, health care entities receiving federal funds must ensure that people with LEP have meaningful access to their health care programs and services. The Affordable Care Act's Section 1557 prohibits language-based discrimination in health programs, requiring patient access to qualified interpreters and translated materials. The Joint Commission on Accreditation of Health Care Organizations embeds language access into patient-centered care standards. In California, the 1973 Dymally-Alatorre Bilingual Services Act, state Medicaid requirements, and Knox-Keene regulations expand obligations — particularly for Medi-Cal managed care plans — to ensure access to qualified interpreters and translated materials based on threshold languages, with clearer expectations regarding timeliness, quality, and availability.

AI is not currently recognized as a stand-alone substitute for qualified medical interpreters under federal or California rules. Most legal frameworks assume human interpretation or human-validated translation. The US Department of Health and Human Services has clarified that AI may supplement translation workflows, but cannot substitute for a human interpreter in clinical, legal, or consent-related contexts,[12] but federal guidance leaves flexibility for non-critical and administrative use cases.

Deeana Jang, a longtime civil rights and language access attorney who has advised both federal and state agencies, noted that "meaningful access" is being tested by AI, and regulators must now rethink how "vital" versus "nonvital" communications are classified in modern care environments that rely on portals, texting, and remote care.

Mara Youdelman of the National Health Law Program (NHeLP) noted that sharp swings in federal policy over recent years have made consistent enforcement challenging. The first Trump administration (2017–20) rolled back Obama-era Section 1557 guidance.[13] In 2024, the Biden administration restored most requirements, defined "machine translation" as the automated translation of text-based material without assistance or review by a

Table 5. Laws and Regulations Governing Health Care Translation and Interpretation

LAW/POLICY	KEY REQUIREMENTS	APPLIES TO	NOTES
Title VI of the Civil Rights Act (1964)	Prohibits discrimination on the basis of national origin, interpreted as requiring health care organizations to provide "meaningful language access services" including oral interpretation, written translation of critical documents, clear notice that language assistance is available, and timely access without undue delay or burden.	All federally funded health care programs	Legal foundation of interpretation and translation requirements
ACA Section 1557 (and implementing regulations)	Prohibits use of unqualified interpreters, minors, or family members in clinical interactions, defines "machine translation" as the automated translation of text-based material without assistance or review by a qualified human translator, and explicitly requires human review for critical, complex, and high-accuracy contexts.	All federally funded hospitals, clinics, health systems, and health plans	ACA's civil rights provisions that clarify operational obligations under Title VI
Joint Commission on Accreditation of Health Care Organizations	Requires health systems to identify patients' language needs and ensure communication is accurate, timely, and understandable; use trained, competent interpreters and avoid relying on unqualified staff or family members (except in limited circumstances); and establish clear language access policies and demonstrate compliance during accreditation surveys.	Accredited hospitals	National accreditation body that enforces language access regulations by holding hospitals accountable through accreditation
Culturally and linguistically appropriate services (CLAS) standards	Encourages health care organizations to provide timely, free language assistance to patients with LEP; use qualified interpreters and translators, not untrained staff or family members; inform patients of their right to language assistance in a language they understand; and ensure translated materials are accurate and easy to understand.	Health care providers, plans, public health agencies, and health-related service organizations	Voluntary guidelines issued by the US Department of Health and Human Services' Office of Minority Health
Knox-Keene Health Care Service Plan Act (1975)	Requires managed care plans to ensure meaningful access to services for members with LEP, provide interpretation services at no cost to members at all points of care, translate key member materials into threshold languages, and maintain language access policies and ongoing monitoring.	California managed care health plans	Focused on consumer protections; enforced by the California Department of Managed Health Care
California Medi-Cal managed care plan contracts (2024–26)	Require plans to provide translated vital/critical member information in threshold languages, ensure timely access to oral interpretation at no cost to the member, and require contracted providers to offer interpreter services and comply with language assistance standards.	Medi-Cal plans and contracted providers	Enforced by the California Department of Health Care Services
Dymally-Alatorre Bilingual Services Act (1973)	Requires California state agencies to provide bilingual staff and translated materials when 5% or more of those served speak a single non–English language, ensuring meaningful access to public services for people with LEP.	California state agencies and public programs	More narrow, operational, and staffing-focused than Section 1557

Sources: Author interviews and federal/state regulator websites; Civil Rights Act of 1964, Pub. L. No. 88-352, § 601, 78 Stat. 241 (1964); Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1557, 124 Stat. 119 (2010); 89 Fed. Reg. 37522 (May 6, 2024); *Medi-Cal Managed Care Contract Language on Language Assistance Services*, California Department of Health Care Services; Dymally-Alatorre Bilingual Services Act, Cal. Gov't Code § 7290–7299.8; and "National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care," US Department of Health and Human Services.

qualified human translator, and explicitly required human review for critical, complex, and high-accuracy contexts. Upon taking office in 2025, President Trump issued Executive Order 14224 making English the nation's official language, and the administration's AI plan, Winning the Race: America's AI Action Plan, prioritizes deregulation of AI without setting standards for AI-enabled translation or interpretation.[14]

Experimentation in California's Health Care Ecosystem

Provider organizations, health plan networks, and state agencies are testing and piloting in parallel, each trying to understand where AI can add value and where human oversight must stay firm. Because federal and state laws still require qualified human interpreters for clinical care, stakeholders report using AI solutions to complement traditional interpretation services, including for nonclinical communication, patient navigation and scheduling, previsit questionnaires, patient portal translations, and AI preprocessing with humans validating outputs.

AI is not replacing interpreters but is instead reshaping their roles — for example, allowing staff to review and approve machine-generated drafts rather than translating from scratch. This "human-in-the-loop" model is becoming the de facto standard among safety-net providers, balancing efficiency with safety.

Following are several case studies illustrating lessons from the field.

CASE STUDY 1.

Children's Hospital Los Angeles: Defining "Critical" Versus "Non-Critical" Translation

Context

Roughly 70% of Children's Hospital Los Angeles (CHLA) patients are Spanish-speaking, and before adopting AI tools, interpreters spent up to two hours per discharge manually translating summaries and patient education materials. This limited throughput to roughly four discharges per day and delayed communication with families at a critical point in care.[15]

Approach

CHLA partnered with Jaide Health, a HIPAA-compliant AI translation vendor, to generate bilingual drafts that interpreters review and finalize before release. Jaide built an integration with CHLA's Cerner EHR, but staff primarily use a simpler workflow — copying and pasting materials into Jaide's secure web platform, accessed through single sign-on — to automatically produce draft translations for interpreter review. The pilot began with after-visit summaries from outpatient clinics and later expanded to inpatient discharge summaries, drastically reducing interpreter time. Interpreters review and finalize AI-generated drafts before release, ensuring clinical accuracy while dramatically improving throughput and turnaround times for Spanish-speaking families.

Impact

Since launch, 100% of CHLA's interpreters now use Jaide for written discharge instructions, reporting higher clarity for Spanish-speaking patients and reduced effort for staff. The workload dropped from

roughly two hours per discharge to 5–10 minutes, freeing time for more complex cases and "letting interpreters practice at the top of their license." In internal evaluations conducted by Jaide using CHLA interpreter feedback, more than 99% of Spanish discharge summaries were rated "medically acceptable," with most edits considered stylistic rather than substantive.[16]

CASE STUDY 2.

Contra Costa Health: Managing Interpreter Shortages While Testing AI Tools

Context

Contra Costa Health (CCH) employs 11 full-time interpreters across its hospitals, clinics, and detention facilities, yet must support more than a dozen languages, including rare ones such as Khmu and Mayan. Interpreter coverage is especially strained overnight, and staff report frequent dropped calls, outdated equipment, and poor connections. "We've had ER and [labor and delivery] patients come in speaking languages we cannot cover, even with a fallback to LanguageLine," one staff member said. Maintaining translation and interpretation services creates ongoing budget pressures.

Approach

To expand access while managing costs, CCH supplements its in-house team with external vendors and is piloting Epic-integrated translation tools that use AI to generate draft translations for human review. County policy requires a human in the loop for all direct patient communication, though clinicians have limited discretion in emergencies; for example, sharing lab results or treatment instructions when no interpreter is available. The health system is also exploring Microsoft Copilot and other Azure-based tools for pretranslation of MyChart and benefit documents. Leadership emphasized that the goal is augmentation, not replacement: "AI is fine for pre-drafting, but the county insists humans validate anything clinical."

Impact

For CCH, AI is a practical tool to ease pressure on a strained system, not a substitute for human expertise. The tools show promise for translating educational and administrative materials, but core challenges — such as nighttime coverage, rare languages, and aging technology — persist. Leaders view AI as a supplement, not a substitute: the county requires a human to validate anything clinical.[17]

CASE STUDY 3.

Asian Health Services — Community Codesign as Governance

Context

Asian Health Services (AHS), based in Oakland, serves more than 50,000 patients across 14 languages. The organization has long combined translation, interpretation, and outreach within its multilingual workforce rather than relying solely on dedicated interpreters. Community health workers and frontline staff regularly provide language support as part of their broader roles.

Approach

AHS staff are piloting AI tools for written translation (such as forms and outreach content), with all outputs reviewed by qualified multilingual staff, but they are not applying AI to interpretation, which remains fully human-mediated. This "human-in-the-loop" translation model has significantly reduced

turnaround time for documents and freed staff to focus on more complex interpretation tasks. Julia Liou, AHS CEO, noted that "within a year, things have improved a lot" — accuracy and reliability have increased, but the technology still requires oversight. AHS is currently testing additional platforms to evaluate quality and language coverage, recognizing that the tools are "not bad, but not there yet."

Funding pressures remain a major concern. With anticipated budget cuts and persistent demand, AHS is balancing innovation with the need to sustain staff jobs and high quality. The organization's 25–30 multilingual staff members handle language support as part of their broader roles, and AI is seen as one way to stretch limited capacity without eliminating human involvement.

Impact and Lessons

Efficiency. AHS's hybrid AI workflow has reduced translation turnaround times, allowing multilingual staff to focus on higher-value work.

High quality and trust. AI translations still require human review; community health workers remain essential for ensuring cultural and linguistic nuance.

Equity. Especially for less common languages, accuracy remains uneven, reinforcing the need for pilots that include community reviewers before broader rollout.

Sustainability. AI is viewed not as a cost-cutting measure but as a tool to increase capacity where budgets are shrinking.[18]

CASE STUDY 4.

Aliados Health: Leading with Effective Governance Design

Context

Networks such as Aliados Health — which supports 14 community health centers across Northern California, including Petaluma Health Center — illustrate how regional systems can lead with governance rather than tools.

Approach

Clinicians and staff in Aliados' member clinics manually translate forms, documents, and portal messages, creating a heavy administrative burden that the network aims to address. Rather than rushing to deploy AI translation, Aliados is forming a governance committee through OCHIN, its health IT partner network, to vet vendors, define acceptable use cases, and clarify provider liability.

"If you sign it, it's your responsibility," one clinician said, underscoring the accountability principle guiding their approach. The network is piloting Abridge for ambient listening and is watching how the company — and others — extend their products to support multilingual communication. Abridge's new partnership with AltaMed Health Services signals how language access features may soon be embedded into existing clinical tools rather than arriving from stand-alone translation vendors.[19]

Aliados' approach reflects a broader theme: AI adoption is outpacing policy development. By building governance first, such as shared glossaries, QA standards, and escalation protocols, networks can pool their expertise and negotiate stronger vendor accountability before broad deployment.

CASE STUDY 5.

Health Plan of San Joaquin: Balancing Efficiency and Quality

Context

Health plans too are grappling with the appropriate use of AI from a member-services perspective. Jeffrey Miller, director of health equity at Health Plan of San Joaquin (HPSJ), emphasized that efficiency gains must not erode quality: "If cost, getting patients in and out of the system efficiently, and reducing interpretation time become the focus with AI, quality will not have enough of a voice." He noted that both human and machine interpreters are fallible, but the stakes depend on where the error occurs: "When errors happen, is it critical information or just a missed word here or there?"

HPSJ provides interpretation on-site, over the phone, via video, and through remote vendors. Following a vendor merger, the plan continues to refine workflows while maintaining strict human oversight. Interpreter coverage for less common languages remains difficult to sustain. Demand can spike when a small number of members have high communication needs but then drop off, making it challenging for the plan and vendors to align staffing levels, given such fluctuating needs.

Approach

HPSJ uses computer-assisted translation tools that leverage prior translation memory to improve consistency and turnaround. Machine-generated drafts are always reviewed by human translators, and AI interpreting is not used. The organization maintains written expectations around human translator involvement and quality assurance.

Impact

HPSJ is monitoring national conversations on "safe AI" use in interpreting but has not yet begun internal pilots. The plan sees potential value in future AI tools for rare languages but stresses the importance of clear regulatory and quality guardrails before implementation.[20]

CASE STUDY 6.

California Health and Human Services Agency

California's leaders in health and human services are working to turn early AI pilots into coordinated policy. Through the California Health and Human Services Agency (CalHHS) Generative AI Pilot, departments are testing translation of web content, benefit forms, and presentations into more than a dozen languages using LLM tools paired with human review.[21]

CalHHS is focusing on understanding where AI can safely extend human capacity and where it cannot, drawing a clear line between translation and interpretation: "Translation is relatively straightforward — you can review it with a real human being. Interpretation is instantaneous and on demand; there's no time for a human to check or fix it." This distinction underpins state policy discussions on where AI fits into existing compliance frameworks.

CalHHS leaders emphasize that accuracy metrics carry more weight when they're specific, broken down by language, content type, and glossary depth — and that vendors transparent about those variations earn greater trust. For example, a model that performs at 95% accuracy in Spanish discharge summaries may fall below 80% when translating culturally nuanced behavioral health materials into Hmong or Tagalog.

CalHHS leaders also point out that machine translation and computer-assisted translation tools have existed for decades and that language service vendors are now folding generative AI into those established workflows. CalHHS's pilot is examining which tools could best support its own in-house linguists and translators, increasing capacity while maintaining oversight.

"AI should be treated as one piece of a larger strategy, not a silver bullet," they said. The pilot — rooted in human oversight, user training, and transparency — is expected to inform how California builds capacity for language access at a larger scale.[22]

Conclusions and Recommendations

AI-enabled language access tools hold real promise for expanding language access and easing the daily strain on California's safety net, but only if human oversight, clear governance, and regulatory guardrails stay at the center. Pilots reviewed in this brief offer an early glimpse of what responsible innovation can look like: technology used to extend scarce interpreter capacity, speed up turnaround times, and reach patients in languages too often left out.

However, turning these lessons into lasting progress will take more than pilots. Clarity on regulatory requirements, shared validation standards, transparent vendor testing, and coordinated leadership across systems are essential if AI is to strengthen California's language access infrastructure in a meaningful and equitable way. Appendix A outlines a hypothetical risk-tiered framework to help policymakers distinguish between AI-only, AI-assisted, and human-interpreter–required use cases.

Recommendations for Policymakers

- Clarify where AI-only applications are acceptable, where humans are needed in the loop, and where exclusively human language access supports are appropriate, including guidance on what's meant by "critical," "vital," and "meaningful" access in digital and AI-enabled care environments.
- Update model contract language for Medi-Cal plans and delegated providers to distinguish "qualified human interpreter services" from AI-assisted tools, require that AI use does not replace required human interpreters where law mandates them, and include reporting on AI usage (e.g., volume, languages, and incident reporting).
- Consider operative frameworks that are risk-tiered rather than binary, reserving full interpreter involvement for high-risk content and allowing AI-assisted workflows for low- and medium-risk interactions with documented review. (See Appendix A.)
- Require transparency and validation from vendors, including clear description of training data, accuracy benchmarks, and QA methodology.

Recommendations for Providers

- Pilot new AI-enabled language access solutions beginning with low- and medium-risk use cases, documenting and auditing all human-reviewed AI output.
- Train interpreters to supervise AI workflows and conduct QA, not just translate.
- Establish clear internal thresholds: which communications require a certified interpreter, and which can use AI with human validation.

- Engage community-based organizations and LEP community members to engage in evaluating outputs, especially for less common languages.

Recommendations for Advocates

- Recommend disclosure and patient-facing disclaimers in AI-enabled translation workflows.
- Ensure representation from all non–English language communities, including underresourced ones, in pilot evaluation and standard setting.
- Ensure cultural nuance testing is part of any state procurement.
- Continue public education so community members know they have a right to language access and are empowered to assert it.

Recommendations for Funders

- Fund technical assistance and pilot programs for county and community providers adopting AI-assisted language tools safely. Build evaluation frameworks for accuracy, satisfaction, and disparities. Support validation studies comparing AI-assisted and interpreter-mediated translation across high- and low-resource languages.
- Fund cross-system learning collaboratives to connect safety-net providers adopting AI language access tools.
- Promote equity for less common and indigenous languages and invest in community interpreter training pathways.

Appendix A. Hypothetical Risk-Tiered Framework for Appropriate AI Utilization

The table below illustrates how regulatory requirements and human oversight could vary according to the risks related to specific administrative and clinical use cases.

HUMAN INTERPRETER MANDATORY	AI WITH HUMAN REVIEW	AI-ONLY ACCEPTABLE
Use Case Examples ▸ Informed consent (surgery, procedures, high-risk meds) ▸ End-of-life and goals-of-care discussions ▸ Behavioral health visits ▸ Emergency department high-acuity care (stroke, MI, sepsis) ▸ Complex diagnostic conversations (new cancer diagnosis, prognosis)	**Use Case Examples** ▸ Discharge instructions for complex conditions (heart failure, asthma) ▸ Previsit prep and education (e.g., "How to prepare for colonoscopy") ▸ Routine primary care follow-up ("How are you feeling? Any new issues?")	**Use Case Examples** ▸ Appointment scheduling and reminders ▸ Basic navigation and logistics ("Where is radiology?") ▸ Portal messages about nonurgent issues ▸ Mass communications including outreach (flu clinics, community events) ▸ Public education not tied to individual care
Rationale for Mandatory Human Interpreter ▸ Current federal and state rules assume qualified human interpreter. ▸ High legal and clinical risk if AI gets nuance wrong. ▸ Emotionally complex, value-laden context where misinterpretation can be devastating. ▸ Subtle language, stigma, cultural context where safety and trust rely heavily on human-mediated nuance. ▸ Complex risk/benefit trade-offs, prognostic uncertainty, high emotional stakes.	**Rationale for AI with Human Review** ▸ AI can draft written or spoken instructions, and human can review for clinical correctness and literacy level. ▸ If content is standardized, pre-vetted, and tested, AI-only delivery okay after initial translation validated by human. ▸ AI may support real-time conversation, but clinician should have ready access to a human interpreter for nuance or uncertainty.	**Rationale for AI-Only** ▸ Administrative templates can be translated and validated once, then reused safely. ▸ Little clinical content and the risk is confusion, not direct physical or emotional harm. ▸ Human QA at creation stage, then broad AI use.

Source: Author analysis informed by interviews and stakeholder engagement conducted for this brief, 2025.

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