The Bureau of Health Equity Learning Event Series

Asian American Health



DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

Partnership for Healthy Communities
A COMMUNITY ENGAGEMENT INITIATIVE

MEET THE SPEAKER

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Jingxin Yu, MHA, BSN, RN, is an RN III in public health and a Family Nurse Practitioner student at the University of Delaware, with an expected graduation date of May 2028.

Originally from Tianjin, China, she lived in Diamond Bar, California, before moving to Delaware in 2019. Jing brings a diverse nursing background in oncology, medical-surgical nursing, and public health. She believes nursing is one of the most rewarding, diverse, and flexible careers. She also holds a master's degree in health administration and has served in the U.S. Army Reserve for approximately 10 years. Jing is passionate about patient-centered care, lifelong learning, and advancing health equity.

Outside of work, school, and military service, she enjoys traveling, exploring different cultures, and spending time with her husband and two young children.



Overview

01 Recognize how language barriers shape access, safety, trust, and mental health

02 Explain how culture, stigma, immigration, literacy, and system design interest

03 Apply practical language-access strategies in real encounters

04 Connect people with Delaware and national resources

05 Act at community, provider, organization, and policy levels



“Asian American” is not one language or one experience

Many Communities

East, Southeast, and South Asian communities differ in migration history, religion, class, and health beliefs.

Many Languages

Chinese varieties, Tagalog, Vietnamese, Korean, Hindi, Urdu, Bengali, Japanese, Hmong, and many more.

Many Identities

Generational status, age, disability, gender, sexuality, and rural location change the experience of care.

Disaggregate data whenever possible. Ask each person — do not assume.



Language access means meaningful communication

More than Translation

- People need to understand, ask questions, express emotions, make choices, and follow a plan.

A System Responsibility

- Organizations identify language needs, provide qualified help at no cost, translate vital information, and monitor quality.

Equity Question:
Can this person receive the same quality of care - not merely enter the same building?

Asian-language mental health services remain scarce

2024 National Sample

5.6%

of facilities offered treatment in at least one Asian language

6.3%

of counties had at least one such facility

0.6%

of rural facilities offered an Asian-language service

Availability does not tell us whether care was delivered by a bilingual clinician or through an interpreter.

Suryavanshi, A., Cantor, J., Choi, S., & Chang, J. E. (2026). Access to mental health treatment services in Asian languages. JAMA Health Forum, 7(2), e256858. DOI: 10.1001/jamahealthforum.2025.6858

A language barrier can grow into a health inequity



Potential results:

- misunderstanding
- missed appointments
- medication errors
- unmet needs
- stigma
- crisis-only care

Mental health depends on nuance, context, and trust

Symptoms may be indirect

Distress may be described through sleep, pain, fatigue, family conflict, or physical symptoms.

Meaning is culturally shaped

Words for depression, trauma, or anxiety may not map neatly across languages.

The relationship is treatment

A rushed or fragmented interpreted encounter can affect safety, disclosure, and alliance.

Language barriers intersect with other pressures

Health literacy	Forms, portals, prescriptions, insurance
Mental health stigma	Fear of shame, labeling, or family impact
Immigration experiences	Unfamiliar systems, trauma, eligibility fears
Inclusion and discrimination	Bias, stereotyping, anti-Asian racism
Access conditions	Cost, transport, time, broadband, workforce



Structures shape language access across time

Historial

Exclusion, segregation, medical mistrust, and uneven investment shaped who built services — and for whom.

Current

Interpreter shortages, fragmented funding, aggregated data, and English-first systems reproduce gaps.

Future

Workforce pipelines, telehealth, community partnerships, and accountable language-access plans can shift access.

Older adults may face an unfamiliar system on several fronts

What Participants Described

- Long waits
- Delayed care
- Confusing logistics
- Uncertain costs
- Hesitation to ask questions
- Perceived discrimination

What Systems Can Change

- Language-friendly navigation
- Transparent cost
- Explanations
- Teach-back
- Longer visits when needed
- Trusted community outreach

Small qualitative study: 15 Asian Americans age 50+ in West Alabama; findings are illustrative, not representative.

Choi, S., Lee, H., Noh, H., Zhang, P., & Francis, H. (2025). Healthcare access and barriers among older Asian Americans: Cultural influences and systemic challenges. Innovation in Aging, 9(Suppl. 2), igaf122.384. DOI: 10.1093/geroni/igaf122.384

Case: “I speak English —but not for this”

A middle-aged patient speaks conversational English. During a behavioral-health visit, the clinician asks about trauma, medications, and suicidal thoughts. The patient answers briefly, nods often, and declines an interpreter.



Discuss:

- What could the clinician be missing?
- How can the clinician offer language assistance without embarrassment?
- What would a safe, respectful next step look like?

Ask, document, and ask again

Preferred language	**"What language do you prefer for discussing your health?"**
Communication support	**"Would you like a qualified interpreter today?"**
Written information	**"What language do you prefer for instructions and forms?"**
Understanding	**"Please tell me in your own words what the plan is."**
Privacy	**“Is there anyone you do — or do not — want involved?"**



Use qualified interpreters for clinical communication

Do

- Brief the interpreter
- Speak directly to the patient
- Use short, plain sentences
- Pause
- Protect privacy
- Confirm understanding

Avoid

- Using children
- Relying on family for sensitive topics
- Side conversations
- Medical jargon
- Asking the interpreter to decide or explain independently

Family support can be valuable. Interpretation is a separate professional role.

A reliable encounter has three phases

Before

- Flag language preference
- Secure the right modality
- Brief the interpreter
- Allow time

During

- Introduce roles
- Speak to the patient
- One idea at a time
- Notice nonverbal cues

After

- Use teach-back
- Translate the plan
- Document service and preference
- Arrange follow-up

Every level has a role in language equity



Community Members

- Share needs
- Co-design messages
- Serve as trusted messengers



Providers

- Offer language help
- Use teach-back
- Address stigma without judgment



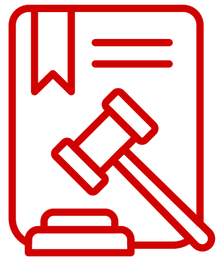
Organizations

- Fund services
- Train staff
- Collect language data
- Audit access



Schools and Educators

- Build literacy
- Support families
- Connect students to culturally responsive care



Policymakers and Funders

- Set standards
- Reimburse language services
- Expand workforce
- Require accountability

Delaware has entry points— but navigation still matters

- **Delaware 211**
  - Free, confidential, multilingual connection to health and human services
  - Dial 211 or text ZIP code to 898-211
- **DHSS Office of Minority Health**
  - State partnerships, health equity resources, and minority health information
  - Call 302-255-9040
- **Community Health Centers**
  - Primary and behavioral-health connections; listed sites note language accommodations
  - Check out the DHSS community health directory
- **Crisis Support**
  - 988 for urgent mental-health or suicide-related support
  - Call or text 988

National tools can extend local capacity



- **MedlinePlus**: Trusted health information in multiple languages; useful for patient education.
- **NAMI AANHPI resources**: Culturally relevant mental-health information and national organizations.
- **Asian Mental Health Collective**: Therapist directory with language and identity filters; verify licensure and coverage.

Use directories as starting points.
Confirm language, modality, insurance, licensure, and wait time.

Current gaps are visible — and measurable

- **Workforce**: Few bilingual and bicultural behavioral-health professionals in many areas
- **Rural Access**: Language services are concentrated in metropolitan settings
- **Data**: Aggregated Asian categories hide subgroup and language differences
- **Workflow**: Language preference is not reliably captured or acted on
- **Trust**: Services may exist but still feel stigmatizing, unfamiliar, or unsafe

Cross-sharing turns isolated efforts into infrastructure

Knowledge

- Community listening sessions
- Shared terminology
- Translated resource libraries

Training

- Joint interpreter practice
- Stigma-informed care
- Community health worker development

Funding and Strategy

- Shared grants
- Regional telehealth
- Workforce scholarships
- Common metrics

A practical 90-day starting plan

- **Days 1-30 : Listen and Map**
  - Review preferred-language data, interpreter workflow, high-risk touchpoints, and community feedback.
- **Days 31-60 : Test and Train**
  - Pilot one improved workflow
  - Train staff
  - Translate the most important patient-facing information.
- **Days 61-90 : Measure and Scale**
  - Track connection time, understanding, referral completion, and patient experience
  - Adjust and expand

Choose one commitment

In the next 30 days, what can you change?

- Ask and document preferred language consistently
- Practice working with a qualified interpreter
- Translate one high-impact resource
- Build one community partnership
- Add one language-equity measure



Language access changes who can benefit from care

See the whole system

Language interacts with stigma, literacy, culture, discrimination, and access conditions.

Design for reliability

Qualified interpretation, plain language, teach-back, translated information, and accountable workflows matter.

Share power

Community partnership and disaggregated data make services more responsive and trustworthy.

Move the burden of communication from the patient to the system.

References

Ali, P. A., & Watson, R. (2018). Language barriers and their impact on provision of care to patients with limited English proficiency: Nurses' perspectives. Journal of Clinical Nursing, 27, e1152–e1160. https://doi.org/10.1111/jocn.14204

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Chen, W.-T., et al. (2024). Lost in Translation: Impact of Language Barriers and Facilitators on the Health Care of Asian Americans Living with HIV. Journal of Racial and Ethnic Health Disparities, 11, 2064–2072. https://doi.org/10.1007/s40615-023-01674-7

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Resources and Standards

Delaware 211. About 211. https://delaware211.org/about-211/

Delaware Department of Health and Social Services. Community Health Centers. https://dhss.delaware.gov/dph/homepage/about/sections/community-health/chsservicecenters/

Delaware Department of Health and Social Services. Office of Minority Health resources and partnerships. https://dhss.delaware.gov/dph/homepage/about/sections/health-equity/minority-health/omh-resources-and-partnerships/

HHS Office of Minority Health. National Standards for Culturally and Linguistically Appropriate Services. https://thinkculturalhealth.hhs.gov/clas/standards

U.S. Census Bureau. (2022). Language Use in the United States: 2019. https://www.census.gov/content/dam/Census/library/publications/2022/acs/acs-50.pdf

988 Suicide & Crisis Lifeline. https://988lifeline.org/

Questions + Shared Practice

What is one language-access challenge your community or organization is ready to address?



Thank you for joining!
Time for Q & A

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