Health Workforce Abstract
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The Use of Interpreters in Health Centers: A Mixed-Methods Analysis

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ISSUE

Health centers serve millions of patients with limited English proficiency who need interpreters when clinicians and other staff are not fluent in their language. However, health centers may not always meet their obligations to provide linguistically appropriate care to their patients, because language services are commonly implemented in inconsistent ways across health care organizations. This mixed-methods study was conducted to understand the delivery of interpreter services in health centers over the years 2009-2019.

METHODS

A two-part, mixed-methods study was conducted of federally qualified health centers in 50 states and the District of Columbia for the years 2009-2019. We used data from the Uniform Data System, the Health and Resource Service Administration's annual reporting system. Our study sample included a total of 13,528 observations, representing 1,405 health centers. We conducted descriptive and multivariable analysis to determine characteristics of centers with and without interpreters on staff. We added two variables – state Medicaid expansions and states with Medicaid coverage of language services – for regression analyses examining how implementation of Medicaid-relevant policies were associated with health centers' use of interpreters. In the qualitative component, we selected a convenience sample of health centers with maximum variation in terms of size of LEP population, use of interpreters, geographic location and other center characteristics to identify models of interpreter use over the 2009-2019 period, as well as adaptation in their language services program as a result of COVID-19. We interviewed 33 key staff at 28 health centers, qualitatively analyzed transcripts, and triangulated findings with the quantitative analysis of UDS data.

FINDINGS

Interpreter use in health centers was very stable over the period 2009-2019, with about 25% reporting some use of interpreters over the decade. However, the ratio of interpreter FTE per 1,000 LEP patients across all health centers gradually decreased from 0.48 in 2009 to 0.36 in 2019. Health centers with interpreters reported an average of 3.46 FTE in 2019. We found no statistically significant relationship between interpreter staffing and number of LEP patients served. Nor did our examination of Medicaid-relevant policies uncover a significant relationship. Our qualitative analysis uncovered a myriad of homegrown models of language services rather than a standard model. We found that bilingual staff are the backbone of language service provision in health centers, though training in medical interpreting is also highly variable, ranging from requirements for certification to a train-as-you-go approach. We identified a total of 10 key themes, including one related to a fairly smooth transition to video interpreting during the early phases of COVID-19. In our sample of 28 health centers, only 2 reported furloughing any members of their language services staff because of COVID.

DISCUSSION

Health centers rely on a combination of bilingual staff, paid interpreters, and telephone and video services to address the language needs of their patients. Since only 25 percent of centers report any interpreter FTE, it is unclear whether health centers have the right complement of staff to adequately meet patients' language needs. Platforms to share best practices, strategies for training bilingual staff in resource-stressed environments, and the development of common metrics could support start-up efforts and help health centers strengthen their language services programs.

Key Words: Health Centers, Interpreters, Language Services, LEP patient populations, mixed-methods analyses

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