

Center for a Healthy Maryland, Inc.
Affiliate of MedChi, The Maryland State Medical Society

Interpreter Resources Project:
Clinical Practice Survey for Primary Care Physicians in Maryland
Survey Results 2008-2009

Background

As many as 90 million Americans (almost half of the U.S. adult population) lack the ability to adequately understand and act on health information, leading to poor health outcomes and rising health care costs. This is attributable in part to differences in language, culture, and societal values. In Maryland, 12.6 percent of the patient population speaks a primary language other than English.

On August 30, 2000, President Clinton issued Executive Order 13166 to assist in compliance with Title VI of the Civil Rights Act of 1964. The Order, “Improving Access to Services for Persons with Limited English Proficiency,” requires Federal agencies to examine the services they provide and identify any need for services to those with limited English proficiency (LEP). The Order also requires development and implementation of a system to provide those services so LEP persons can have meaningful access to them and requires Federal agencies work to ensure that recipients of Federal financial assistance provide meaningful access to their LEP applicants and beneficiaries.

To assist with regulation of the new Order, the U.S. Department of Justice created the LEP Guidance that sets standards and principles for agencies. Within these guidelines, physicians and health care providers must abide by the new Order and “ensure that LEP persons have meaningful access to the health and social service benefits that they provide.”

The Center for a Healthy Maryland conducted a survey among physicians to:

- 1) Determine the status of health literacy, language and cultural differences among their patients, and
- 2) Identify barriers to effective communication, as well as resources needed.

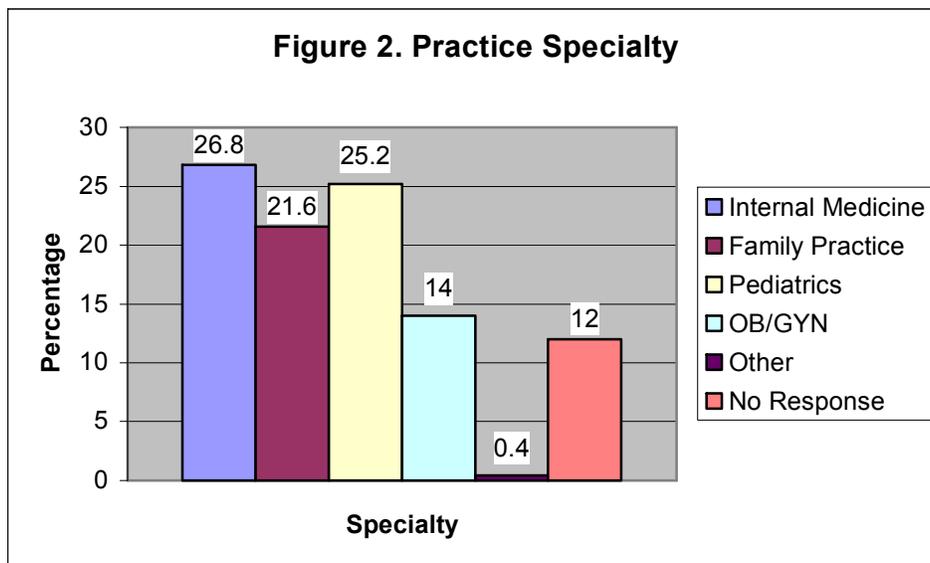
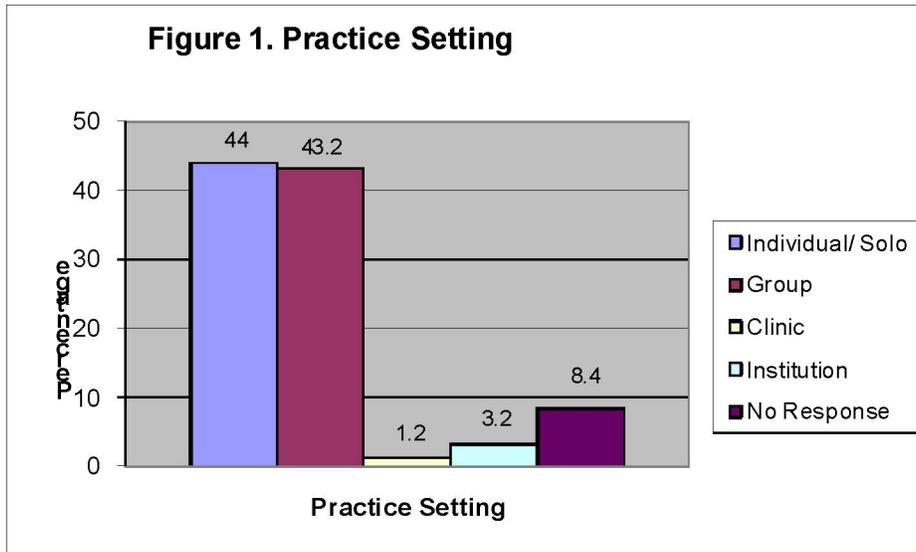
Methods

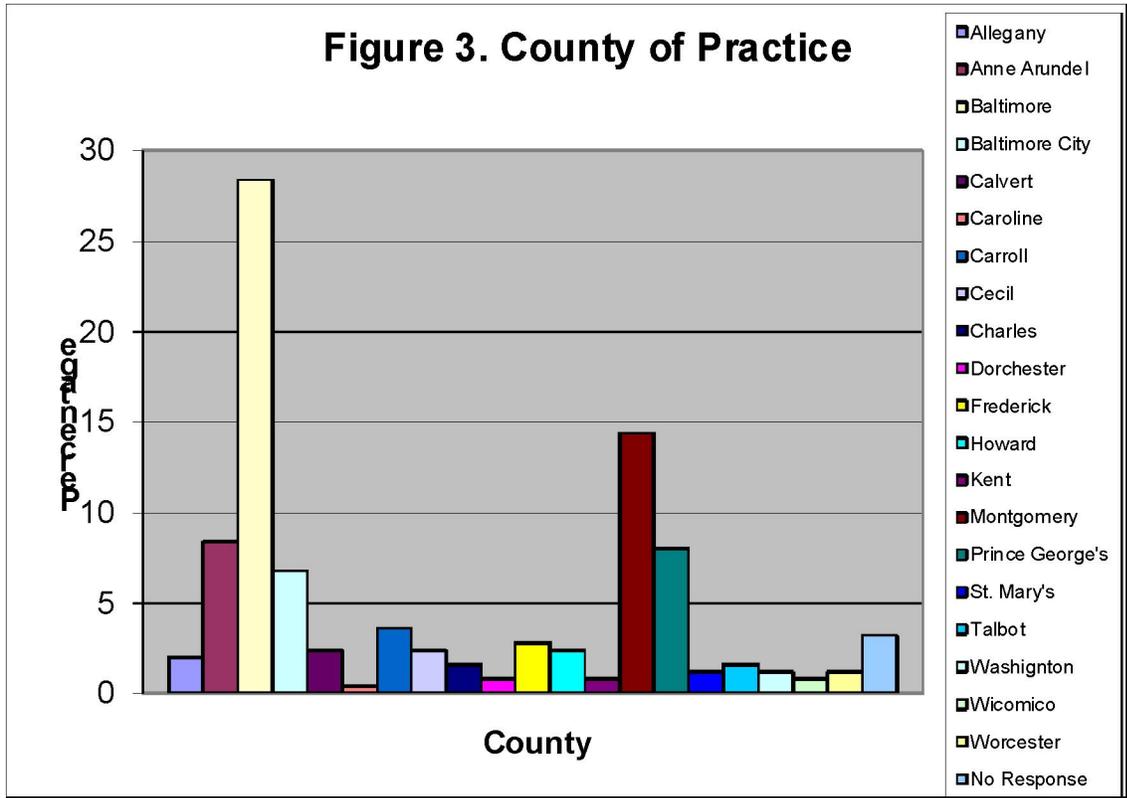
A one-page survey was developed and distributed statewide to primary care physicians in Maryland through blast fax, listserv, and website postings. The survey was distributed via blast fax on September 29, 2008 to 2,621 primary care physicians in the MedChi database. The survey was also distributed through the weekly MedChi listserv to approximately 3,500 physicians for five successive weeks from September 29 through October 27, 2008. The results are based on the 250 survey responses received as of October 31, 2008.

Summary of Survey Results

Practice Setting

The majority (87.2%) of physicians responding to the survey were equally distributed between individual and group practitioners. The distribution of practice specialty was as follows: 26.8% internal medicine, 25.2% pediatrics, 21.6% family practice, and 14% obstetrics/gynecology. Figure 1 illustrates the practice settings represented by the respondents, Figure 2 their specialties, and Figure 3 the county of practice.





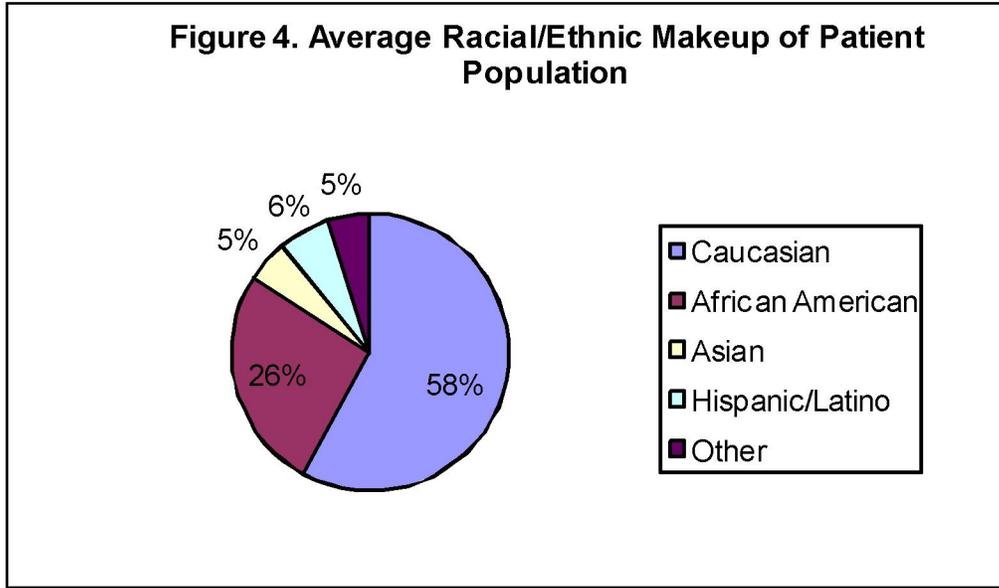
Responses were received from physician practices in 21 of the 24 Maryland jurisdictions. The largest numbers of survey respondents have practices located in Baltimore (28.4%), Montgomery (14.4%), Anne Arundel (8.4%), and Prince George’s (8.0%) counties and Baltimore City (6.8%).

Patient Population

The Maryland 2006 Census Bureau reported the following racial/ethnic breakdown: 63.6% Caucasian, 29.5% African American, 4.9% Asian, 6% Hispanic/Latina, 9.8% Foreign born persons, 0.3% American Indian, and 0.1% Native Hawaiian.

Among the physician respondents, 59% reported having a patient population between 50-100% Caucasian, and 86-89% of physicians reported having less than 10% of their overall patient to be Asian or Hispanic. The mean patient population was estimated to be the following: 58% Caucasian, 26% African American, 5% Asian, 6% Hispanic, and 5% Other (Middle Eastern, Indian, African, etc.). See Figure 4.

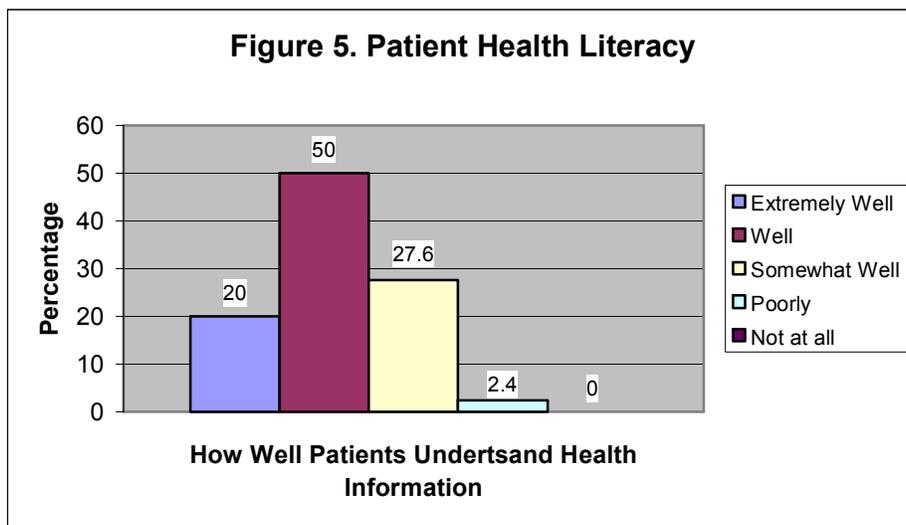
Seventy-nine percent of physicians reported having a patient population where 86-100 percent of their patients’ primary language is English. The majority of physicians reported less than 10 percent of their patient populations have other languages (Spanish, Russian, Korean, Sign Language and Other) as a primary language.



Health Literacy

Health literacy is defined in Healthy People 2010 as the degree to which individuals have the capacity to obtain, process, and understand basic health information. How well a patient understands and processes basic health information given by a physician can significantly affect the health and well being of a patient.

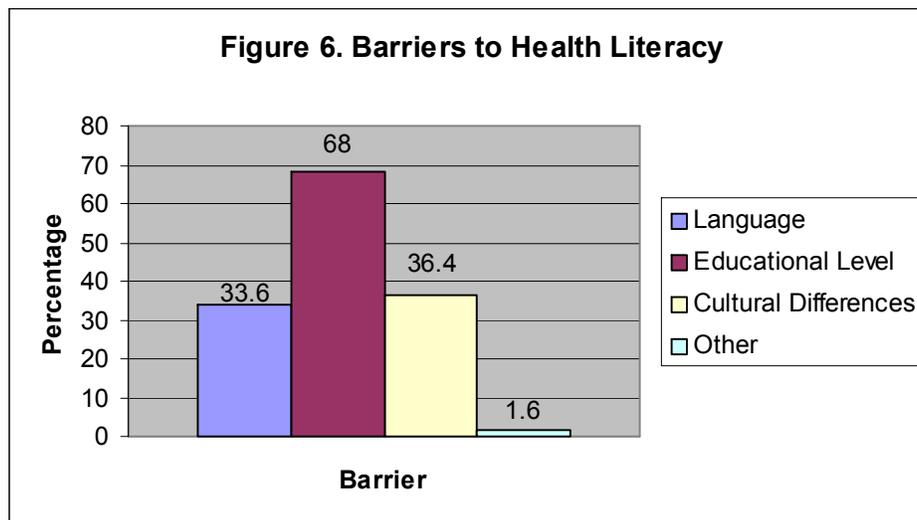
Various factors can impact a person’s health literacy such as language, educational level, culture, socioeconomic status, etc. and prevent them from benefiting from the medical visit. Figure 5 demonstrates the reported health literacy levels of the patient populations of the physician respondents.



Among the physicians who responded to the survey, 20% reported that their patients understand health information “extremely well,” and approximately 50% reported that they understand

health information “well.” A number of respondents checked more than one level of understanding for their patient population.

Figure 6 illustrates the primary barriers limiting a patient’s health literacy as observed by the physicians surveyed. Approximately 68% of the physicians reported educational level as a primary barrier to health literacy for their patients, 33% reported language, and a similar number (36.4%) identified cultural differences as a barrier.



Physician-Patient Communication

Physician-patient communication is key to providing and receiving quality healthcare. With an increasing number of immigrants coming to the United States, physicians are finding that their patient population is becoming more diverse resulting in health literacy issues attributable to language barriers. The last two decades of health communication research suggests that the information component of physicians’ messages carries more weight in influencing patients’ compliance than any other variable. Patients with language barriers have been found to be less satisfied with care, make fewer visits and receive fewer preventive services. In addition, they are less likely to use or return to clinics, score lower on health knowledge and understanding of diagnosis and treatment, and have longer hospital stays compared to English proficient patients.

Although most physicians speak only English, some are bilingual or are learning to speak various other languages in addition their native language in order to more easily communicate with some of their patients (Figure 7). The majority of physicians (99.2%) who responded to the survey can communicate with their patients in English, among whom 56% reported that they can communicate with their patients only in English. In addition to English, 21.2% of physicians can communicate in Spanish and 29.6% can communicate in another language. The most common of these other languages reported was Hindi, followed by French, Chinese, and Tagalog.

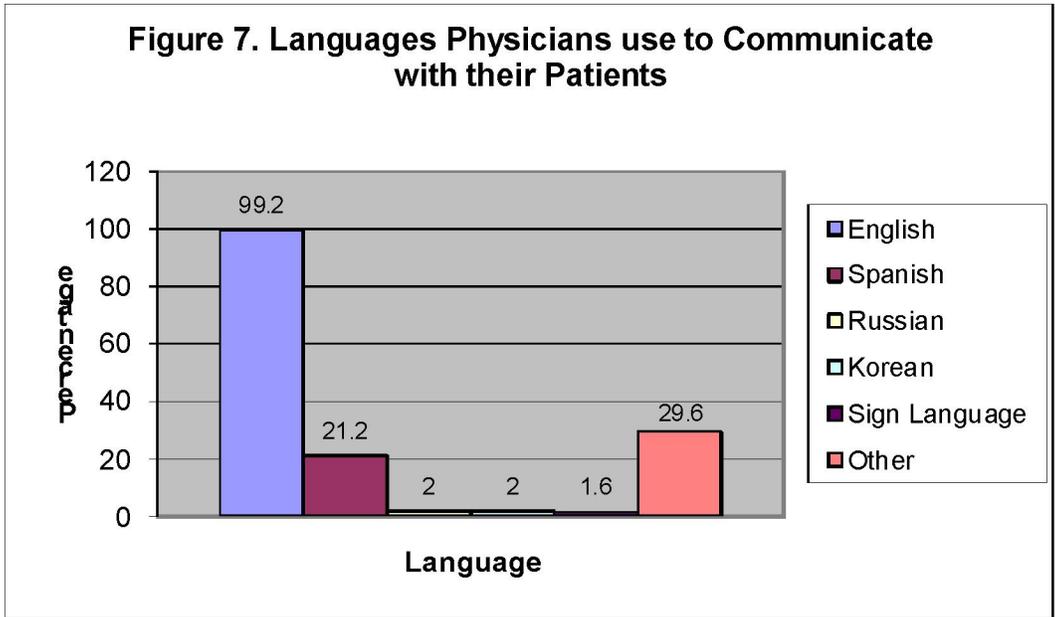
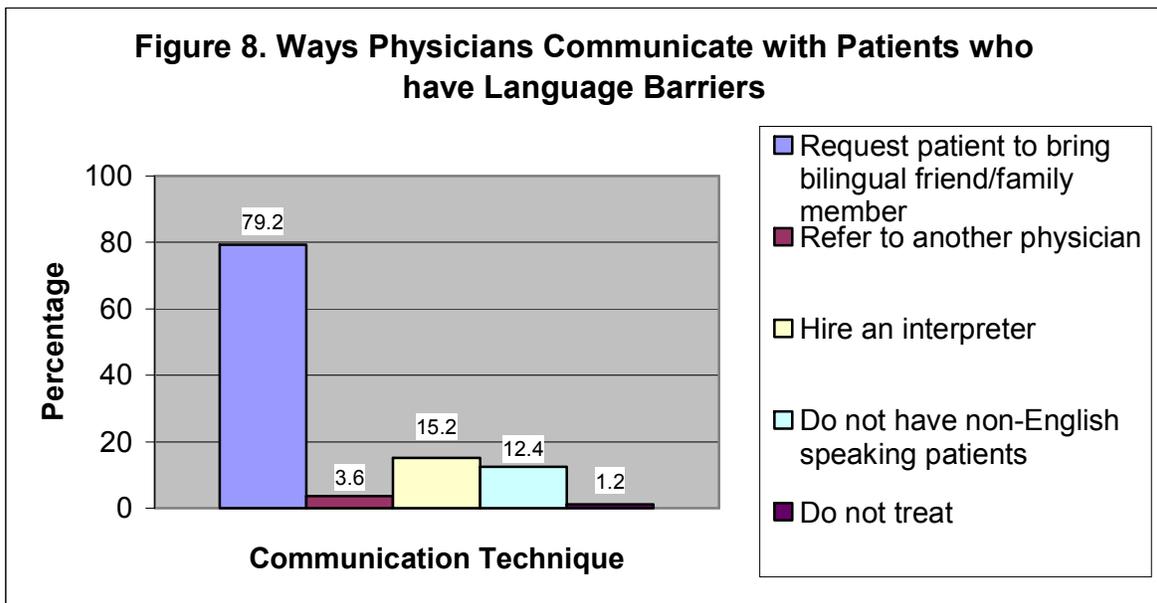
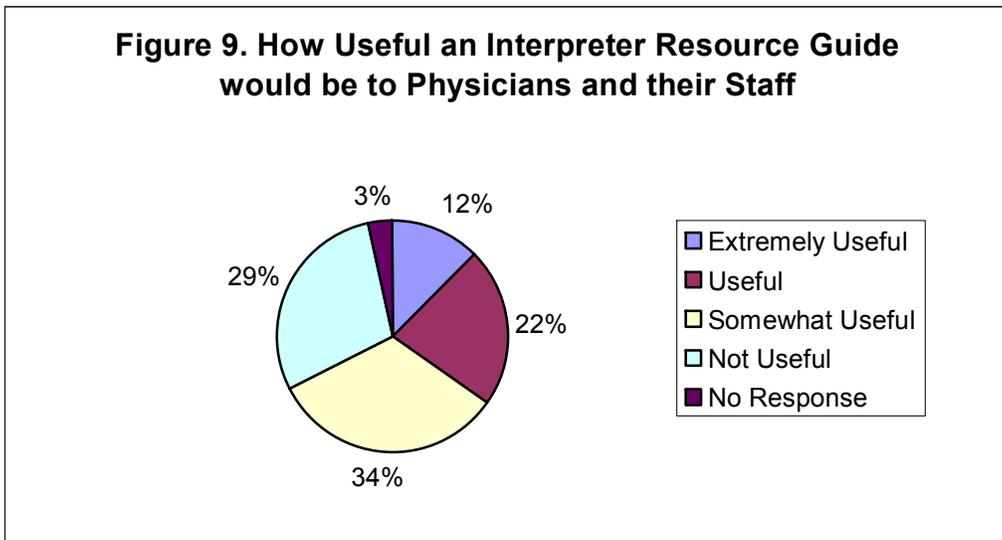


Figure 8 illustrates the techniques physicians are using to communicate with patients who have language barriers. Among the physicians who responded to the survey, the majority requests that the patient bring a bilingual friend or family member to facilitate communication. Among respondents, 15.2% reported hiring an interpreter, while 10% reported having bilingual staff. The majority of physicians (55.6%) reported that they do not have resources available to communicate with non-English speaking patients.



Two-thirds (67.6%) of the respondents felt that an online interpreter resource guide would be somewhat to extremely useful while one-third felt that an interpreter guide would not be useful (Figure 9).

Figure 9. How Useful an Interpreter Resource Guide would be to Physicians and their Staff



Recommendations/Comments for Assistance with Physician-Patient Communication

Overall feedback from physicians surveyed varied depending on whether the physician had a culturally diverse patient population or not. For many physicians, general communication with the patient was not as difficult as explaining proper medical instructions. Many physicians are able to communicate with non-English speaking patients by virtue of their command of other languages or through bilingual staff. Additionally, physicians stated a need for multi-lingual health information to distribute to the patients.

Comment (What additional resources or information would be helpful...?):

“Handouts about common diseases and prevention in difficult languages.”

“Multilanguage health pamphlets, etc.”

“Patient education pamphlets in Spanish and English.”

“More discharge instructions for common illnesses in multiple languages.”

Even though there is a significant need for interpreters and multi-lingual information for patients, many physicians are frustrated that they have to pay for these resources, while receiving low reimbursements from the insurance companies for their medical services.

“Asking physicians to bear the expense of interpreters is unreasonable.”

“We should work towards having an interpreter covered by insurance. When I have to hire an interpreter I pay her more than I make for the visit. That creates problems.”

Survey Limitations

The results presented here are based on responses from approximately 10% of all physicians surveyed, which may not be representative of all physician practices in Maryland. The survey did not include questions about the physician's ethnicity and need for multi-lingual patient education materials. Additionally, the limited language choices resulted in a high response rate for the choice "other." From the responses received, additional languages choices should have included Hindi, Tagalog, Chinese, and French. Another missing option was the physicians' use of bilingual staff as a means of communication. Of the 44% of physicians that have resources available to help facilitate communication, 23% of them reported bilingual staff as a resource.

There may have been some confusion about the specific meaning of certain questions. For instance, "In what language(s) are you able to communicate with your patients? (Check all that apply)". Physicians could interpret that to mean what languages they themselves speak or what languages their staff can speak. The question was looking for the languages that only the physicians can use to communicate with their patients. A separate question could have been used to capture the language skills of practice staff.

Summary

Cultural literacy is defined as an understanding of the values and views of those in other social classes and ethnic groups in the mosaic of cultures that exist in the United States. The minority and immigrant population in the United States, and in Maryland in particular, is changing. Estimates are that the U.S. demographics will change dramatically in the coming decades, with the Hispanic and Asian populations projected to nearly double, and the African American population increasing by more than 70%, while the white population decreases by more than 10%.

In an increasingly diverse Maryland population, providing culturally competent medical care is a strategy recommended for reducing or eliminating racial and ethnic disparities. It is inevitable that the cultural and language barriers between patient and provider will continue to erode the quality of healthcare unless cultural literacy is immediately and continually addressed.

The Center for a Healthy Maryland conducted a survey in the fall of 2008 to determine the status of patient health literacy, language and cultural barriers in Maryland primary care practices, and physicians' need for interpreter resources. A blast fax of the survey was sent to 2,621 physicians and 250 responses were received, a response rate of 9.5%. The responding physicians reported patient populations closely resembling the ethnic makeup of the state of Maryland. Most were in individual or group practices and the majority (74%) listed their specialty as either Internal Medicine, Family Practice, or Pediatrics.

Physicians reported that 70% of their patients understand health information extremely well or well. However, almost one third of the respondents felt their patients understand health information only somewhat well or poorly. This demonstrates the potential need for improved communication techniques and tools. Educational level of the patient was clearly the most reported barrier to health literacy (68%), while language and cultural differences were selected about half as often.

More than half the physicians responding to the survey reported that they are able to communicate with their patients only in English. In many instances, patients with poor English skills bring a bilingual friend or family member to serve as an interpreter, which may not be an effective solution for several reasons which will not be discussed here. About 15% reported hiring interpreters, and about 10% rely on the language skills of their staff members to facilitate communication with their patients.

An online interpreter resource guide was regarded as a useful tool by about two-thirds of the respondents. It must be noted, however, that a number of physicians voiced objections to the “unreasonable” requirement that they (not the patient or insurer) pay for the interpreter services at a time when their reimbursements are declining. Indeed, some indicated that hiring an interpreter would cause them to lose money when treating that particular patient. Many physicians expressed the need for patient education materials in other languages, most notably Spanish.

As a result of the findings of this survey an online interpreter resource guide will be developed and made available on the Center for a Healthy Maryland website at www.healthymaryland.org. The guide will identify companies, type of service, e.g. in-person or over-the-phone, cost, and lead time required. The user will be able to click on a category heading to sort the listings therein. In addition, a section listing links to online multi-lingual patient education materials and resources will be added to the web page.

References

Agency for Healthcare Research and Quality, Minority Healthcare Quality: January 2004. Available from www.ahrq.gov/clinic/tp/minqualtp.htm.

Delmarva Foundation’s Culture in Healthcare Program. Frequently Asked Questions. Available from www.delmarvafoundation.org/providers/physicians/cultureinhealthcare/downloads.html.

Giogianni SJ, ed. Responding to the Challenge of Health Literacy. *In: The Pfizer journal*. New York: Impact Communications, 1998:1-37.

Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons. January 2002. U.S. Department of Health and Human Services, Washington, DC. <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html>

Institute of Medicine Report. Health Literacy: A Prescription to End Confusion. Available from <http://www.iom.edu/CMS/3775/3827>. April 2004.

Maryland Vital Statistics 2005. Available from <http://www.vsa.state.md.us/doc/05annual.pdf>.

Providing Oral Linguistic Services: A Guide for Managed Care Plans. Summary. February 2003. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/about/cods/oralling.htm>.