Physicians Throw Money at Language Barrier

BY MARY ELLEN SCHNEIDER
New York Bureau

SAN DIEGO — Nearly two-thirds of internists provide care for patients with limited English proficiency, according to a national survey conducted by the American College of Physicians.

That language barrier can create challenges for patients and physicians, because patients who are not proficient in English tend to have a worse understanding of basic health information, have difficulty asking questions of clinical and administrative staff, and may not follow through on treatment recommendations, the survey showed.

Findings from an ACP survey of over 1,000 internists showed that 64% provide for language services for their patients who lack proficiency in spoken English.

ACP officials conducted the survey of 4,000 of its members in fall 2006 and received responses from 2,022 internists. The analysis was based on the 1,261 respondents who work at least 20 hours weekly.

The results were released at the annual meeting of the ACP in conjunction with the organization's new position paper on language services for patients with limited English proficiency (LEP).

In its position paper, the ACP called for language services to be available to improve health services for patients with LEP, and recommended that Medicare directly reimburse physicians for the added expense of language services and the extra time involved in providing care for patients with LEP.

The ACP is also pushing for the establishment of a national clearinghouse to provide translated documents and patient education materials.

"If we're unable to communicate with our patients—either understand what they are telling us or help them to understand how best to take care of themselves—we certainly aren't practicing patient-centered care," Dr. Lynne Kirk, ACP immediate past president, said at a press briefing.

Internists who care for limited English proficiency patients estimated that these patients make up an average of about 12% of their practice.

Physicians often devote additional time to their limited English proficiency patients, said Dr. William Golden, immediate past chair of the ACP board of regents.

For example, 51% of physicians who see LEP patients in their practice said they devote an average of 5-15 minutes of additional time during a visit with an LEP patient.

Another 26% report spending an extra 16-30 minutes on average, according to the survey of ACP members.

"That is time that is sometimes difficult to carve out, and at the same time [is] often unreimbursed," Dr. Golden said.

Spanish topped the list of most frequently encountered languages, but physicians reported seeing patients who spoke nearly 80 different languages or dialects, from Chinese to German. (See box.)

About 52% of respondents said they thought their practices could determine the top three languages spoken by their LEP patients, whereas 48% could not or were uncertain.

Many practices do not have processes in place for obtaining information about a patient's primary language, the survey of ACP members found.

About 28% of physicians said their practice recorded the patient's primary language in the medical record, whereas others cited informal monitoring or data provided on check-in or patient registration forms.

About 64% of survey respondents said they provide some type of language services to their LEP patients.

Those language services are usually provided by a bilingual health care provider, bilingual staff, or ad hoc interpreters.

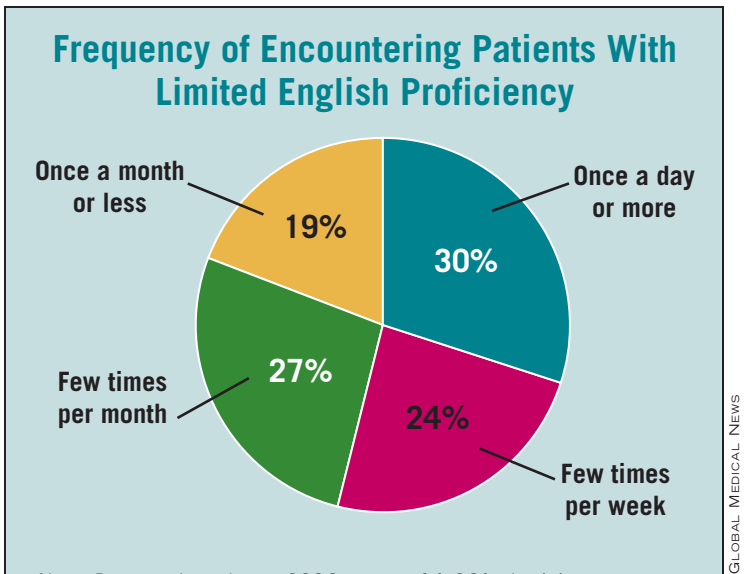
Of those physicians who reported providing language services to their limited English proficiency patients, about 64% also provided translated documents or forms to patients.

Medical practices vary in the cost they assign to providing language services to limited English proficiency patients, with cost estimates ranging from zero to $25,000 annually.

Physicians absorb most of the costs, with 75% of respondents saying they received no direct reimbursement, 24% reporting they were uncertain, and 1% reporting direct reimbursement for language services provided.

Providing payment either to physicians or translators for language services for limited English proficiency patients eventually could save a significant amount of money in direct medical costs, Dr. Golden commented.

The provision of adequate language services can lower medical costs by helping to avoid medical errors and unnecessary tests and hospitalizations. ■



Patient Demographics May Affect Physician Quality Scores

BY DEBRA L. BECK
Contributing Writer

TORONTO — Physician practices treating higher proportions of less-educated patients have consistently lower HEDIS performance scores, according to preliminary research presented at the annual meeting of the Society of General Internal Medicine.

In fact, an increase of one standard deviation in the proportion of non–college graduate patients is associated with a significant Health Employer Data and Information Set (HEDIS) performance score decrease of as much as 2.5%.

"Our concern is that practice sites caring for disproportionate shares of vulnerable patients may be penalized by public performance reporting and pay-for-performance contracts," reported Dr. Mark Friedberg, of the division of general medicine at Brigham and Women's Hospital and Harvard School of Public Health, both in Boston.

"Without adjusting HEDIS scores for patient sociodemographic characteristics—or adjusting some aspect of the way these scores are used—physicians may feel an incentive to avoid patients from vulnerable populations," he said.

The measurement of primary care quality for public reporting has become a hot issue in recent years, with physicians who care for minority patients and those with lower incomes worried that they may be at a disadvantage in a system with a one-size-fits-all approach to quality measurement.

Dr. Friedberg noted a recent study (Health Aff. 2007;26:w405-w414 [Epub doi:10.1377/hlthaff.26.3.w405]) that found that 85% of physicians polled agreed with the statement:

"At present, measures of quality are not adequately adjusted for patients' socioeconomic status."

Fully 82% were concerned that measuring quality may deter physicians from treating high-risk patients.

Dr. Friedberg and his colleagues used the Massachusetts Health Quality Partners (MHQP) statewide reporting program, which supplied data from commercial insurers aggregated at the physician level on eight HEDIS measures: breast cancer, cervical cancer, chlamydia, asthma controller medications, HbA_{1c} testing, cholesterol testing, eye exams, and nephropathy.

MHQP is a statewide collaborative that includes the five largest health plans in Massachusetts, contracting with 90% of state primary care providers and covering 63% of Massachusetts residents, or about 4 million people.

Data were collected from 241 physician practice sites (including 1,489 physicians) that provided adult primary care to insured patients during 2004.

These data were linked to patient responses from the 2002-2003 Massachusetts Ambulatory Care Experiences Survey to calculate the prevalence of sociodemographic characteristics (age, gender, race, ethnicity, and education) within each practice site's patient panel. Practice site was used as the unit of analysis.

Median site-level HEDIS scores ranged from 94% for HbA_{1c} screening (interquartile range, 90%-96%) to 43% for chlamydia screening in women aged 21-25 years (interquartile range 34%-52%).

In bivariate analyses, lower site-level proportions of college graduate patients were significantly associated with lower HEDIS scores on all eight measures. These associations remained statistically significant for seven of the eight measures even after multivariate adjustment.

Significant bivariate associations between sites' HEDIS scores and the age, race, and ethnic composition of their patient panels were present for chlamydia screening, but these associations did not remain statistically significant after multivariate adjustment.

"Primary care practice sites with disproportionate shares of patients having lower educational attainment may incur a 'performance measure penalty' on widely used HEDIS quality measures," Dr. Friedberg concluded. ■