COMMENTARY

Patient–Physician Language Concordance: A Strategy for Meeting the Needs of Spanish-Speaking Patients in Primary Care

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Abstract

The Hispanic/Latino community increased by 58% in the last decade (1990-2000) and it is estimated that Hispanics/Latinos will be 30% of the population by 2050. Many of the Hispanic/Latino households (40%) surveyed by the census bureau in 2000 spoke Spanish. Because of its location, the Southern California Permanente Medical Group, which provides the medical services for Kaiser Permanente Southern California (KPSC) serves a large and growing Hispanic/Latino community. It is estimated that by 2010, the KPSC region will be between 30-50% Hispanic/Latino. A Spanish language task force (the task force) was created in 2006 to address the needs of the KPSC Spanish-speaking membership using primary care services. This task force examined data from a variety of sources including electronic medical databases and focus group reports from Spanish-speaking members. Using the task force findings and the literature in this area, we make recommendations to increase patient-physician language concordance in other health care settings so that organizations can effectively serve a growing Hispanic/Latino, Spanish-speaking patient population.

Introduction

As of 2008, 15% of the US population was Hispanic/Latino,[1] the majority of whom had Mexican ancestry (66%).[2] The size of the Hispanic/Latino community increased by 58% between 1990 and 2000, and it is estimated that Hispanics/Latinos will comprise 30% of the population by 2050.[1] A supplemental survey for the US census in 2001 estimated that 33% of Spanish speakers had limited English proficiency.[3] Many health-related settings provide interpreter services for their non-English-speaking patients; however, there is mounting evidence that patients need to communicate with a language-concordant physician, not simply an interpreter, in order to receive the best medical care, to bond with the physician, and to be satisfied with the care experience.[4–6] Having patient-physician language-discordant pairs (ie, a Spanish-speaking patient with an English-speaking physician) may also lead to greater medical expenditures and thus higher costs to a health care organization.[7,8]

Because of its location, the Southern California Permanente Medical Group (SCPMG), which provides medical services for the Kaiser Permanente Southern California (KPSC) Region, serves a large and growing Hispanic/Latino community. We estimated that by 2010, the makeup of the KPSC Region will be between 30% and 50% Hispanic/Latino. A Spanish-language task force (the task force) was created by the first four authors in 2006 to address the needs of this growing KPSC Spanish-speaking membership using primary-care services. Primary Care Departments were chosen because of their long-term relationships with patients and because they are the initial point of contact for any patient in the KPSC system. The leadership of KPSC chose to explore issues for Spanish-speaking patients first (as opposed to other languages) because this was

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the largest group of patients in KPSC with limited English proficiency (11% of the membership). Using the task force's findings and the literature in this area, we make recommendations in this article to increase patient–physician language concordance in other health care settings so that organizations can effectively serve a growing Hispanic/Latino, Spanish-speaking patient population.

Methods

Formation of the Task Force

The task force was designed to include a variety of KPSC stakeholders who were directly involved in providing primary care for Spanish-speaking patients or were involved in the administrative work to provide culturally and linguistically appropriate services for these patients. Physicians were invited to participate in the task force if they passed a Spanish-language test to objectively verify their self-reported proficiency. Initially, 433 primary care physicians (PCPs) were invited to be tested for Spanish-language proficiency, 45 (10%) agreed to be tested, 23 were invited, and 16 agreed to join the task force. An effort was made to have at least one PCP represented from each KPSC medical center. Other stakeholders who were invited to serve on the task force included medical directors; medical group administrators; regional chiefs of Family Medicine, Pediatrics, and Internal Medicine Departments; and other physicians and administrators who were key to the implementation of any cultural or linguistic initiative in primary care.

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Focus Groups

To begin its efforts, the task force used the data from a series of six focus groups of Spanish-speaking KPSC members that were conducted by KP National Market Research. These focus groups were designed to determine the experiences of Spanish-speaking Hispanic/Latino patients with their care at KPSC. A total of 29 people participated with 4 to 7 members in each focus group. All focus groups were conducted by Poza Consulting Services (Los Angeles, CA) in December 2004. Focus groups were designed to have participants who had been active KPSC members for two or more years as well as those who had been active members for less than two years. Groups contained men and women and participants ranged from 21 to 65 years old. The following topics were discussed: 1) getting help in Spanish, 2) interacting with a physician, 3) issues with the language barrier, 4) experiences with in-person interpreters, 5) experiences with the language line, 6) quality of treatment when speaking English vs Spanish, 7) adequacy of Spanish-language services in different health care settings, and 8) experiences with the Health Education Department. Data from these focus groups were qualitative transcripts that were summarized by KP National Market Research. This summary is presented in the Results section of this article.

Administrative Data Analyses

In addition to seeking the opinions of Spanish-speaking members, the task force examined a number of indicators related to language concordance and patient care from existing 2006 electronic data sources: actual rates of language concordance and the unmet need, rates of patient bonding, primary-care visit rates, and rates of missed appointments in primary care. Language concordance was defined as a patient having an appointment with his or her assigned PCP who was highly proficient in the patient's preferred language. Member language preference was obtained from medical records. Patient bonding was defined as the number of visits a patient had with his or her assigned PCP, divided by the total number of visits the patient made to primary and urgent care. Visit and missed appointment rates were based on scheduled appointments in primary care.

To present a convincing case to the PCPs so that they would increase the number of Spanish-speaking patients on their panels, we analyzed data to determine how language concordance affected visit rates, missed appointments, and patient–PCP bonding. All three of these indicators are often considered when assessing how satisfied a patient is with the care s/he received. High rates of bonding and low rates of missed appointments may serve as an indicator of how "connected" a patient feels to his or her PCP, which may in turn increase the patient's compliance with medical instructions and improve the patient's perception of the care provided.

Results

Focus Groups

Spanish-speaking patients reported that they mostly had English-speaking physicians and understood approximately half of what the physicians told them. They reported being able to understand a routine visit and simple after-care instructions in English. However, they raised a number of concerns because they could not fully communicate the details of a situation, injury, or condition to the PCP in order to receive comprehensive care. In addition, if members received information in English, they worried that they did not fully understand the instructions and did not have any recourse for asking questions in Spanish about this information.

Those patients who had Spanish-speaking PCPs self-reported a high degree of satisfaction with their care and confidence in treatment decisions made by their PCPs.

KPSC offers both face-to-face and over-the-phone interpreters for a number of languages. The service available by phone is called the AT&T Language Line because it is offered as a commercial service by AT&T. None of the focus-group participants had heard of this service. They asked why it was not advertised. Some patients also gave reasons related to confidentiality and culture for not wanting to use the language line, including a perception that it was not personal enough (they believed that the person on the phone would not care about their situation) and that they would be insulting their English-speaking physician by using the service.

In addition to providing the language line, KPSC provides a number of its health-education classes in Spanish. Focus-group participants expressed that they did not know about these classes, and many said they *would* use this service. They mentioned that having a physician refer them to a class would be the best way to ensure that they attended. Interestingly, members said that even if they did not attend the classes, just knowing that KPSC made the effort to provide these classes in Spanish would substantially improve their opinion of the organization.

Language Concordance in Primary Care

Actual rates of Spanish-language concordance as well as of the unmet need for Spanish-speaking PCPs for 2006 are shown in Figure 1. There were a total of 7,866,522 primary-care visits for KPSC in 2006. Of these visits, 800,322 were with patients who preferred Spanish (10% of all visits). Of the visits with Spanish-speaking patients, only 199,549 (25%) were with a highly proficient Spanish-speaking PCP. This left a patient need of 600,733 visits for highly proficient Spanish-speaking PCPs in 2006. In comparison, highly proficient Spanish-speaking physicians had 917,746 visits in primary care. Of these visits, only 199,549 (22%) were with patients who indicated they preferred Spanish. The remainder of the visits with highly proficient Spanish-speaking PCPs was with non-Spanish-speaking patients. Thus, the unmet patient need for Spanish language was 600,733 visits, and the potential supply of highly proficient Spanish-speaking PCPs was 718,197.

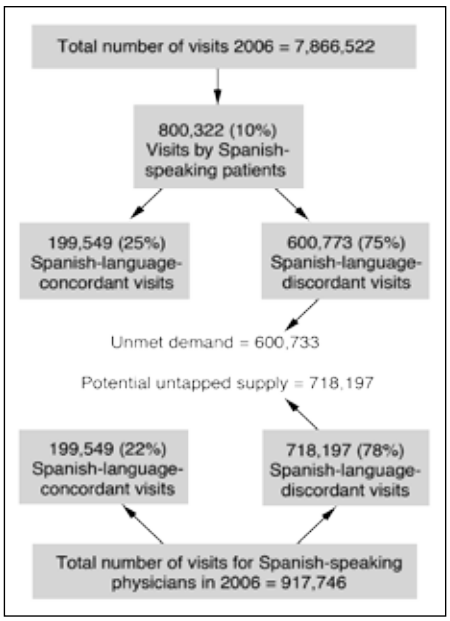

Figure 1. Supply of and demand for Kaiser Permanente Southern California Spanish-speaking primary care physicians in 2006.

Rates of Visits, Missed Appointments, and Bonding in Spanish-Speaking Patients

Table 1 presents the results for the KPSC rates of bonding, visits, and missed appointments during 2006 for language-concordant and language-discordant patient–PCP pairs. Visit rates were highest for language-concordant pairs (either English or Spanish). The number of missed appointments was comparable for all patient–PCP language pairings, although marginally higher rates were seen when a Spanish-speaking patient was scheduled with an English-speaking PCP. The clearest effect of language concordance was seen for bonding rates. Bonding rates ranged from 42% for Spanish-speaking patients paired with English-speaking PCPs to 72% for Spanish-language-concordant pairs.

Discussion

There was a clear need for Spanish-language PCPs at KPSC, as only 25% of the demand for Spanish-speaking PCPs was being met. This was not necessarily because KPSC did not have enough Spanish-speaking physicians. When the patient panels of these Spanish-speaking physicians were examined, only 22% were with Spanish speakers. When Spanish-speaking patients had an appointment with a PCP who was *fluent* in Spanish, they expressed in focus groups that they were very satisfied with the encounter. These sentiments were also supported in analyses of bonding rates. Bonding rates were higher for Spanish-speaking patients who were matched with a Spanish-speaking PCP than they were for such patients who were matched to an English-speaking PCP. Spanish-speaking participants in focus groups said that being connected to and respected by their physicians was important to their use of KPSC primary care services.

Initial Task Force Plan

On the basis of the findings from the focus groups and from

Table 1. Bonding, visit, and missed appointment rates in 2006 by concordance category

Physician language	Patient language	
	English	Spanish
English	48% (1,775,957/3,662,640) bonding	42% (129,031/304,509) bonding
	1.88 (3,622,538/1,922,533) visits per member	1.74 (366,287/209,918) visits per member
	11% (43,321/3,909,990) missed appointments	14% (57,784/416,481) missed appointments
Spanish	55% (356,154/651,946) bonding	72% (115,134/160,103) bonding
	1.58 (692,551/439,356) visits per member	1.86 (198,962/106,771) visits per member
	11% (83,285/764,825) missed appointments	12% (29,056/234,898) missed appointments

Bonding rate was defined as the total number of visits to patients' assigned primary care provider divided by the total number of visits to primary care (Departments of Internal Medicine, Family Practice, and Pediatrics). Visit rates were calculated as the total number of visits to primary care divided by the total number of patients for those visits. Rates for missed appointments were obtained by dividing the total number of missed appointments in primary care by the total number of scheduled appointments in primary care.

the concordance, bonding, and visit rates analyses, it was estimated that if KPSC could improve visit rates of Spanish-speaking patients with a Spanish-speaking PCP from 22% to 87%, this would meet the entire need for Spanish-speaking patients. This increase necessitated a multifaceted strategy that included the following: testing all PCPs with self-identified moderate- to high-Spanish proficiency to verify their skills, increasing the number of Spanish-speaking patients on the panels of highly proficient Spanish-speaking PCPs, increasing the recruitment and retention of Spanish-speaking PCPs, and improving the Spanish-language ability of existing nonfluent Spanish-speaking PCPs.

Fluency is an essential component of effective patient-physician communication in any language.

Barriers to the Plan and Solutions

It was estimated that as much as 65% of the members of a panel for a fluent Spanish-speaking PCP would have to be reassigned to an English-speaking PCP for 100% language concordance to be achieved. This strategy was not well received by the Spanish-speaking PCPs on the task force. In addition to the obvious disruption in their relationships with their English-speaking patients, Spanish-speaking PCPs often did not have fluent bilingual staff in their units to support the care of these patients. Thus, there would be a "hidden" cost to the Spanish-speaking PCPs because they would be the only ones in their units who could explain after-care instructions, listen to complaints, and guide the patients through their visit.

In response to these objections, it was recommended that newly hired PCPs who were fluent Spanish speakers be targeted to receive a patient panel that had a majority of Spanish speakers. In addition, the KPSC leadership would provide an incentive for both newly hired and existing PCPs who were fluent Spanish speakers to add Spanish-speaking patients to their panel when they had openings. This could not be done by adding patients to an already full panel (~2000 patients). In addition, Spanish-fluent PCPs' numbers of English-speaking patients would be gradually reduced through normal attrition and replaced by Spanish-speaking patients. It was recognized that this process would take time but that it would be less disruptive to existing patient–physician relationships.

Conclusions

The task force began implementing its language-concordance initiative in 2008, and its evaluation is ongoing. Plans have been made to examine not only visit, bonding, and missed appointment rates but also patient health outcomes. It is our hope that sharing the process of KPSC's task force may provide other organizations with a guide for making changes to accommodate patients from multiple cultures, speaking any number of languages.

First and foremost, physicians should be given a formal test for language proficiency. We have found that this can be easily done with large numbers of physicians. Fluency is an essential component of effective patient-physician communication in any language. Once this is done, the current state of concordance in an organization should be calculated, and then a plan can be made specific to the needs of the organization for increasing patient–physician language concordance. We found that knowing the rate of concordance was an important tool for enlisting the help of medical center leadership to change how physicians were trained and how patient panels were formed.

Consideration should be given to public reporting of language concordance rates among health plans to promote greater transparency and allow both employers and patients to be better able to choose

their health plans. Given that the US population will be 30% Hispanic/Latino by 2050,[1] at least 33% of whom may be monolingual Spanish speakers,[3] having high concordance rates will present a substantial advantage to any health plan.

Finally, language concordance is only one element of effective care delivery for non-English-speaking patients. Efforts should also be made to improve the health literacy of these patients in their native languages. In addition, in view of the findings from our patient focus groups, these efforts should be coupled with foreign-language medical and health-related vocabulary training for both physicians and translators. ❖

Disclosure Statement

The author(s) have no conflicts of interest to disclose.

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A Common Language

The call for the "old-time physician" is not a call for a wise old man with a little black bag and a few harmless (and useless) nostrums, but a yearning for communication in a common language.

—The Midnight Meal and Other Essays, *Jerome Lowenstein, physician and professor of medicine at New York University*