2009 NEW JERSEY FAMILY HEALTH SURVEY

RUTGERS
Center for State Health Policy

Facts & Findings June 2014
The Patient-Provider Relationship among New Jersey Immigrant Adults

Key findings

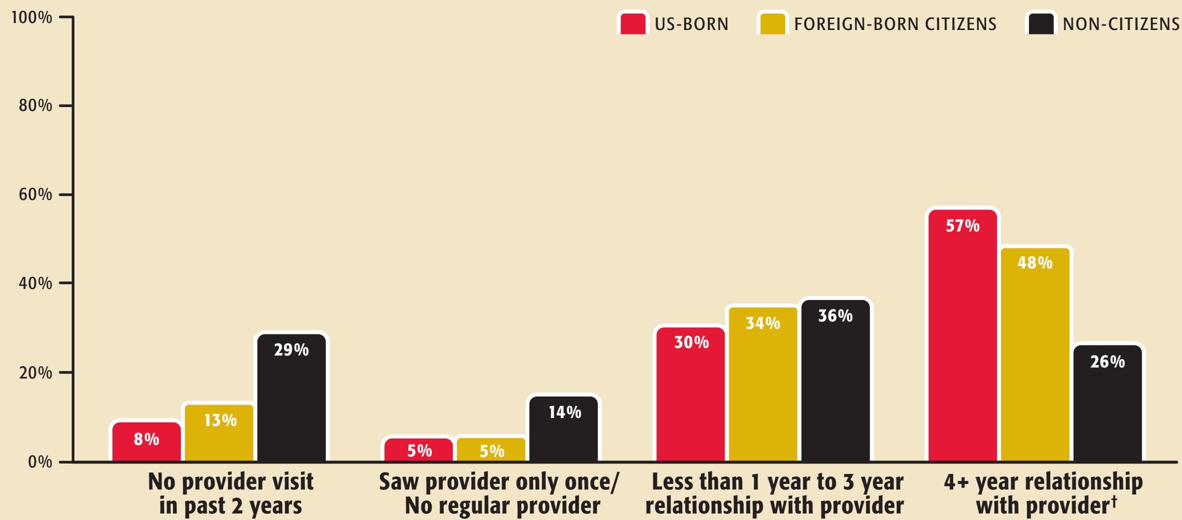
- *Non-citizen adults are less likely than foreign-born citizens and US-born adults to have a regular relationship with a healthcare provider.*
- *Among adults who have visited a doctor or nurse practitioner in the past two years, the foreign-born are less likely than the US-born to be of the same race/ethnicity as their provider.*
- *Almost half of non-citizen adults who have seen a doctor/nurse practitioner in the past two years speak Spanish and another quarter speak a language other than Spanish or English.*
- *Compared to US-born adults and foreign-born citizen adults, non-citizen adults are more likely to report some communication problem with their provider.*
- *Independent of several socio-demographic characteristics, immigrant adults (both citizen and non-citizen) have higher odds of finding it difficult to understand their providers' explanations due to the accent or language of their provider.*

The National Quality Strategy (NQS) under the Affordable Care Act (ACA) stresses person-centeredness as one of its key principles. Organizing care around the individual relies on a strong primary care model, and many of the NQS principles are achieved by care delivery through a patient centered medical home (PCMH). The National Committee for Quality Assurance's (NCQA) established model of the PCMH "strengthens the clinician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship."[1] Another NQS priority stresses patient engagement with physicians in the decision-making process and the importance of developing "culturally sensitive and understandable care plans."[2] Moreover, both the NQS and PCMH model emphasize patients' own opinions of their experience as essential indicators of quality of care.

Achieving person-centered care requires fostering effective communication between patients and clinicians. This issue is especially salient in New Jersey which has a large and diverse immigrant population. Language differences and issues of cultural competence pose additional challenges to effective communication between immigrants and their healthcare providers. On the other hand, immigrants are more likely to use public clinics as their usual source of care,[3] and many community health centers emulate the PCMH model more closely than private doctors' offices.

Given the movement towards patient-centered care characterized by a long-standing relationship with a primary care provider and communication that is effective from a patient's point of view, this Facts & Findings assesses these aspects of the patient-provider relationship among non-elderly adults in the state (ages 19–64). We use data from the 2009 New Jersey Family Health Survey (NJFHS) and compare immigrant adults by citizenship status to native-born residents to provide a baseline description of the patient-provider relationship in the period just prior to implementation of the ACA's National Quality Strategy.

Figure 1 Adults' Length of Relationship with a Healthcare Provider* by Nativity/Citizenship Status



* Provider could be either a doctor or nurse practitioner.

† Non-citizens in the US less than 5 years were removed from the denominator in determining the percentage having a 4+ year relationship with a provider.

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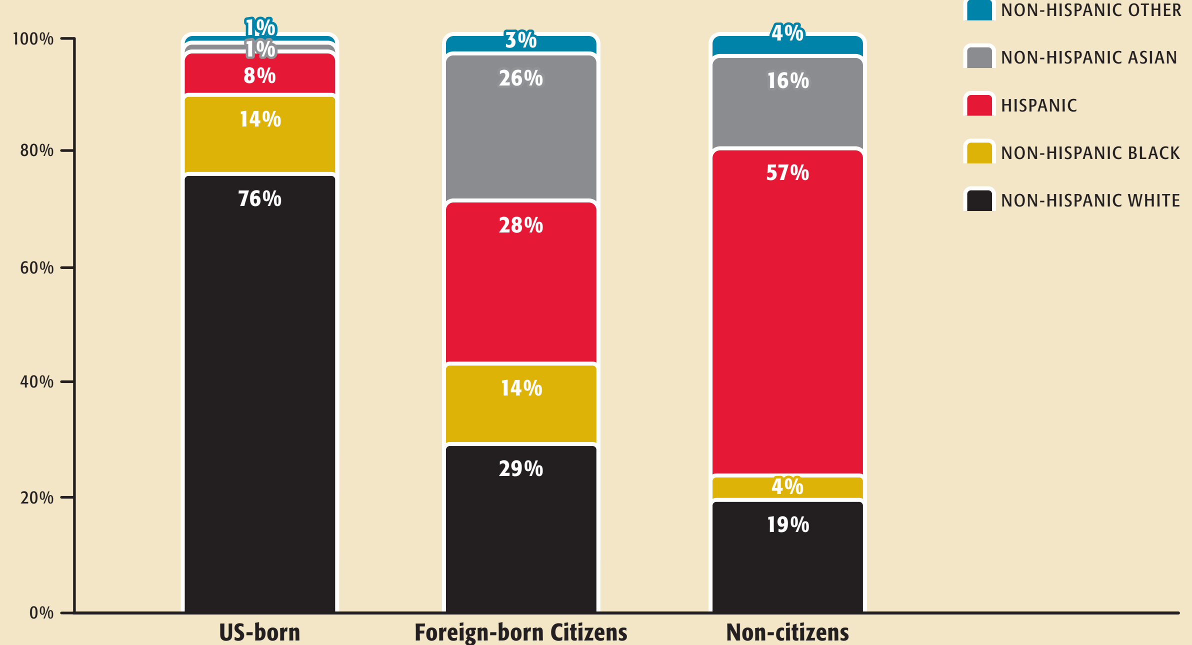
Citizenship status is related to the length of patients' relationship with a provider. As shown in Figure 1, non-citizen adults are more likely than US-born and foreign-born citizens to have not seen a doctor or nurse practitioner in the past two years (29% vs. 8% and 13%, respectively). Another 14% of non-citizens have only seen a doctor or nurse practitioner once in the past two years and therefore do not have a regular relationship with a provider either. About a third of adults in all immigration status categories have a relationship with a provider that has lasted up to three years, but citizen adults are much more likely to have a longer (4+ years) relationship with a provider than non-citizens (57% and 48% for US-born and foreign-born citizens, respectively, vs. 26%). These differences could be due to a variety of factors that are more common among non-citizens and make them less likely to have a regular healthcare provider (for example, non-citizens are younger on average and are more likely to lack health insurance).[4]

The remainder of this Facts & Findings focuses on only those adults who have seen a doctor or nurse practitioner in the past two years. This population was asked questions in the NJFHS about aspects of their relationship with the provider they visit most often (n=1,847).

Figure 2 **Race/Ethnicity of Adults Having Seen a Healthcare Provider in the Past Two Years by Nativity/Citizenship Status**



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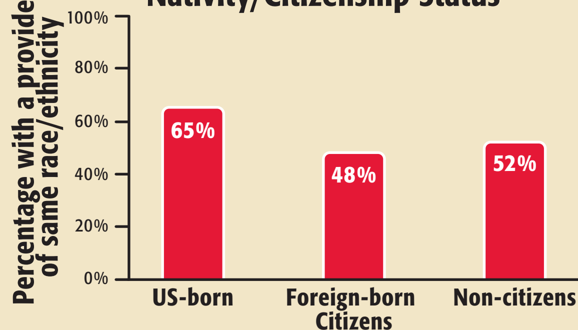
The race/ethnicity distribution of adults who have seen a provider in the past two years shows that foreign-born citizens are the most racially/ethnically heterogeneous population (Figure 2). They are nearly just as likely to be non-Hispanic asian as non-Hispanic white (29% and 26%, respectively), and just as likely to be non-Hispanic black as US-born adults (14%). The majority of non-citizen adults having seen a provider in the past two years are Hispanic (57%), but this is actually a lower percentage than would be expected given the size of the non-citizen Hispanic population in New Jersey (comparison data not shown).

Figure 3 **Race/Ethnicity Concordance of Adults and Their Healthcare Provider by Nativity/Citizenship Status**



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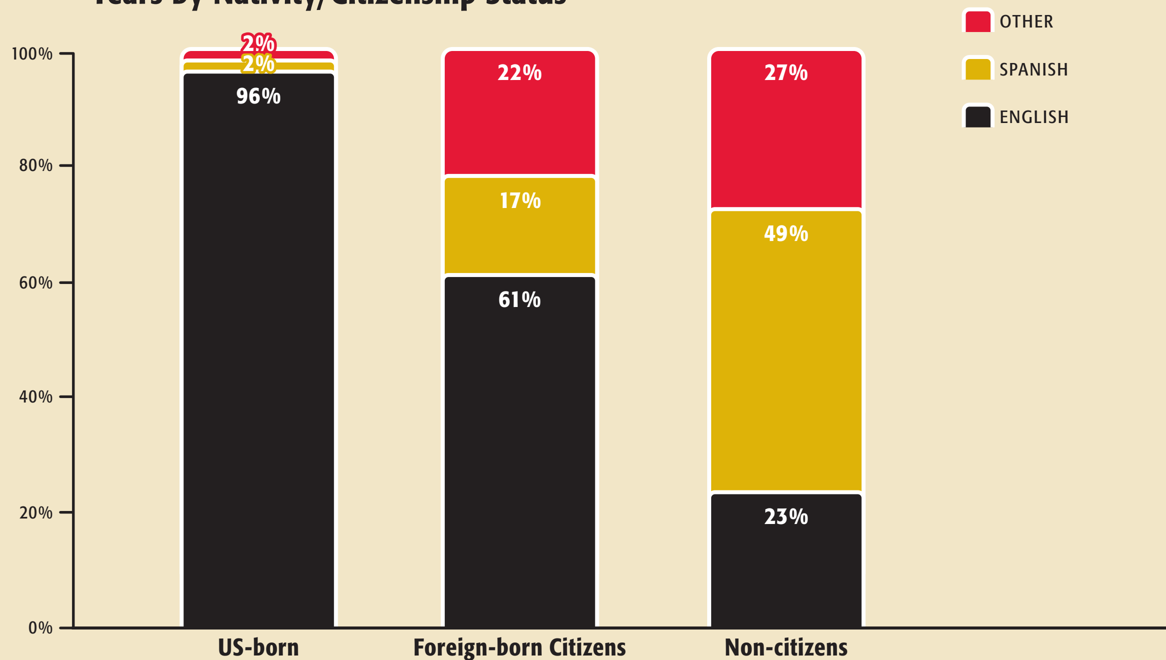
Research has suggested that patients from minority populations view their connection and involvement in decision making more positively with racially concordant physicians.[5] In New Jersey, there is some difference in the proportion of adults who have a provider of the same race/ethnicity by their nativity/citizenship status (Figure 3). US-born adults are more likely to have providers of the same race/ethnicity (65%) when compared to foreign-born citizens (48%) and non-citizen adults (52%).

Figure 4 **Primary Language of Adults Having Seen a Healthcare Provider in the Past Two Years by Nativity/Citizenship Status**



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In contrast to US-born adults who almost all use English as their primary language (96%), only 61% of foreign-born citizens and 23% of non-citizens use English as their primary language (Figure 4). The greatest diversity in primary language spoken is among non-citizens. Nearly 50% speak Spanish and over one quarter speaks a language other than Spanish or English.

To assess adult patients' perception of communication with their provider, respondents in the NJFHS who had visited a doctor or nurse practitioner in the past two years were asked questions from the Consumer Assessment of Health Care Providers and Systems Clinician & Group Survey Adult Primary Care Questionnaire (CAHPS-CG). The CAHPS is a validated survey module evaluating adults' experience of care in many of the NQS priority areas.[6] The CAHPS Clinician & Group Survey is the recommended measure set for assessing the quality of the patient experience as the nation progresses towards the goals of the NQS.[7,8] Table 1 shows the five CAHPS-CG questions asked of NJFHS respondents that are related to quality of communication with their regular healthcare provider.

Table 1 **NJFHS Questions from the Consumer Assessment of Healthcare Providers & Systems Clinician & Group Survey (CAHPS-CG) Adult Primary Questionnaire**

Question from CAHPS-CG 2.0	Domain
How often did provider listen carefully to you?	Communication
How often did provider explain things in a way that was easy to understand?	Communication
How often did provider spend enough time with you?	Communication
How often did provider show respect for what you had to say?	Communication
Were any of the explanations the provider gave you hard to understand because of an accent or the language the provider spoke?	Cultural Competence

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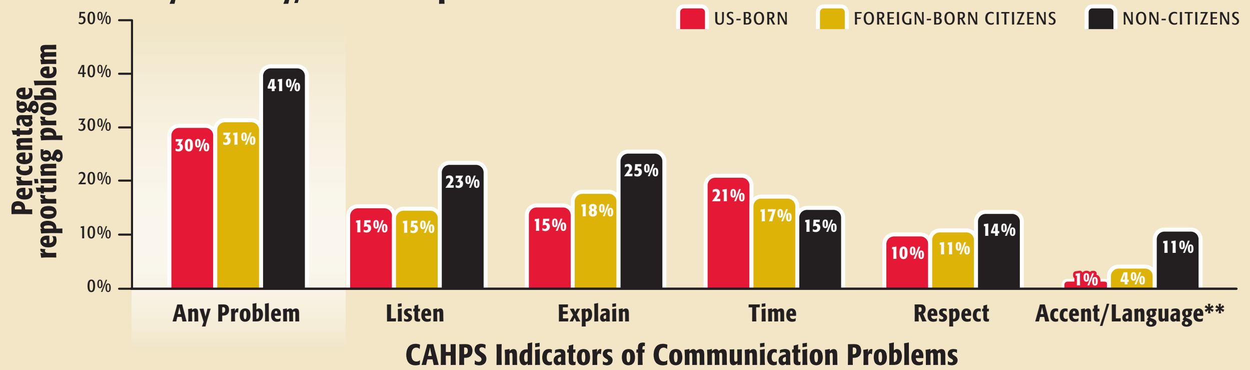
Figure 5 Adults Experiencing Communication Problems* with Their Healthcare Provider by Nativity/Citizenship Status



* See the Methods section at the end of this brief for details on how question responses were used to classify respondents as ever having a problem with these aspects of communication.
** $p<.001$

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Overall, non-citizen adults were the most likely to report experiencing communication problems with their provider (Figure 5; 41%). This pattern held for all individual measures of communication except for whether the provider spent enough time with them. The only statistically significant difference between the three groups in prevalence of a communication problem by immigration status was in whether the explanations were difficult to understand because of an accent or the language the provider spoke. Eleven percent of non-citizens found this to be a problem compared to only 4% of foreign-born citizens and 1% of US-born citizens.

To determine whether nativity/citizenship status is associated with difficulty understanding a provider's explanations due to the provider's accent or language after accounting for other characteristics of the patient, we analyzed these socio-demographic indicators as a group.

Our results (Table 2), based on a multiple logistic regression analysis, show that the odds of having a problem understanding a provider's explanations due to aspects of the provider's speech are nearly three times higher for immigrant adults, whether citizen (OR=2.7) or non-citizen (OR=2.8), than for US-born adults. This association is independent of patients' race/ethnicity, sex, age, educational attainment, insurance status, and primary language.

Table 2 Relative Odds of Problem Understanding Due to Provider's Accent/Language – NJ Adults (ages 19–64)

Characteristics	Predictor	Odds Ratio
Immigration Status (Compared to US-born)	Foreign-born Citizens	2.7*
	Non-citizens	2.8*
Education (Compared to Advanced Degree)	Less than High School	5.6
	High School or Equivalent	2.4
	Some College	1.8
	4 Year Degree (Bachelors)	0.4
Language (Compared to English)	Spanish	2.0
	Other	1.0
Race/Ethnicity (Compared to Non-Hispanic White)	Non-Hispanic Black	0.5
	Hispanic	0.5
	Non-Hispanic Other	0.7
Insurance Status (Compared to Private Insurance)	Public	1.2
	Uninsured	1.7

Results also adjusted for sex and age.
* $p < .10$

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There is more room for improvement in the quality of the patient-provider relationship among immigrant adults in New Jersey than among native-born residents of the state. Non-citizens adults are the least likely to have a regular relationship with a doctor or nurse practitioner and, even among those who have recently seen a provider, our data suggest non-citizens are more likely to perceive some problem communicating with their provider. The largest difference between immigrants, both citizen and non-citizen, and the US-born is difficulty understanding a provider's explanations due to an accent or the language spoken by their provider.

Some of the disparity in insurance coverage preventing immigrant adults from visiting a doctor/nurse practitioner is expected to lessen with the ACA's insurance expansions and will hopefully encourage this population to establish a regular relationship with a provider. Still, increased access to care under the ACA will heighten the need for a culturally competent provider workforce capable of effective communication with this newly enfranchised immigrant population. New Jersey has been a leader in enacting legislation that mandates the integration of cultural and/or linguistic competence into curricula, continuing education, and licensure requirements for health professionals.[9] More in-depth qualitative research aimed at understanding how barriers to effective communication can be overcome between providers and the foreign-born population could help inform the most beneficial content for these courses.

Our findings also support stepping up efforts to enroll students fluent in non-English languages from various racial/ethnic and immigrant backgrounds in medical and nursing schools. Incentives that encourage them to practice in the state would complement educational strategies to raise the cultural competence of New Jersey's provider workforce. Addressing communication barriers in this way can promote higher quality care and greater patient satisfaction. Available evidence suggests that patients with limited English proficiency experience optimal communication, the best outcomes, and the highest satisfaction with bilingual providers and professional medical interpreters.[10] While all health care facilities receiving federal dollars are required to provide medical interpretation services to patients, physicians and nurse practitioners in private practice have no such legal obligation. Therefore, increasing the diversity of physicians/nurse practitioners in the state would improve opportunities for minority and immigrant patients to see a racially/ethnically and linguistically concordant provider,[11] helping New Jersey achieve the goals of the ACA's National Quality Strategy.

References

1 National Committee for Quality Assurance. *NCQA Patient-Centered Medical Home 2011: Health Care That Revolves Around You: An Established Model of Care Coordination*. Washington, DC: National Committee for Quality Assurance, 2011.

2 Agency for Healthcare Research and Quality. *2013 Annual Progress Report to Congress: National Strategy for Quality Improvement in Health Care*. Washington, DC: U.S. Department of Health & Human Services, 2013.

3 Lloyd K, and D Gaboda. *Differences among New Jersey Adults Using Private Doctors, Clinics, and With No Usual Source of Care*. Facts & Findings: 2009 New Jersey Family Health Survey. New Brunswick, NJ: Rutgers Center for State Health Policy, 2011.

4 Lloyd K, JC Cantor, D Gaboda, and P Guarnaccia. *Health, Coverage, and Access to Care of New Jersey Immigrants: Findings from the 2009 New Jersey Family Health Survey*. New Brunswick, NJ: Rutgers Center for State Health Policy, 2011.

5 Ferguson WJ, and LM Candib. "Culture, Language, and the Doctor-Patient Relationship." *Family Medicine* 34, no. 5 (2002): 353–61.

6 Agency for Healthcare Research and Quality. "About CAHPS." Consumer Assessment of Healthcare Providers and Systems (CAHPS). Last modified October 11, 2011.

7 Shaller Consulting Group. *Forces Driving Implementation of the CAHPS Clinician & Group Survey*. Princeton, NJ: Robert Wood Johnson Foundation, 2013.

8 Conway PH, F Mostashari, and C Clancy. "The Future of Quality Measurement for Improvement and Accountability." *Journal of the American Medical Association* 309, no. 21 (2013): 2215–16.

9 Goode T, S Bronheim, and J Fuccello. *Final Report: State-Level Strategies to Address Health and Mental Health Disparities through Cultural and Linguistic Competence Training and Licensure*. Princeton, NJ: Robert Wood Johnson Foundation, 2009.

10 Flores G. "The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review." *Medical Care Research and Review* 62, no. 3 (2005): 255–99.

11 Saha S, SH Taggart, M Komaromy, and AB Bindman. "Do Patients Choose Physicians of Their Own Race?" *Health Affairs (Millwood)* 19, no. 4 (2000): 76–83.

Other NJFHS Reports

Susan Brownlee, Joel C. Cantor, Kristen Lloyd. *Covering the Uninsured: Which New Jersey Adults Will Decide to Enroll in 2014?: Facts & Findings*, July 2013.

Kristen Lloyd, Dorothy Gaboda, Joel C. Cantor. *New Jersey's Long-Term Uninsured Adults Eligible for Coverage under the ACA: Facts & Findings*, May 2013.

Kristen Lloyd, Dorothy Gaboda, Joel C. Cantor. *Health Needs and Access to Care of the Working-Age Uninsured in New Jersey by Length of Time without Coverage: Facts & Findings*, March 2013.

Kristen Lloyd, Dorothy Gaboda. *Differences among New Jersey Adults Using Private Doctors, Clinics, and With No Usual Source of Care: Facts & Findings*, October 2011.

Kristen Lloyd, Joel C. Cantor, Dorothy Gaboda, Peter Guarnaccia. *Health, Coverage, and Access to Care of New Jersey Immigrants: Findings from the New Jersey Family Health Survey*, June 2011.

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Table A1 **Coding of Provider Communication Problem Indicators**

Question from CAHPS-CG 2.0	Response Choices	Problem (1=Yes, 0=No)
How often did provider listen carefully to you?	Always	0
	Usually, Sometimes, Never	1
How often did provider explain things in a way that was easy to understand?	Always	0
	Usually, Sometimes, Never	1
How often did provider spend enough time with you?	Always	0
	Usually, Sometimes, Never	1
How often did provider show respect for what you had to say?	Always	0
	Usually, Sometimes, Never	1
Were any of the explanations the provider gave you hard to understand because of an accent or the language the provider spoke?	No	0
	Yes	1

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Methods

The 2009 New Jersey Family Health Survey (NJFHS) was designed to provide population-based estimates of health care coverage, access, use, and other health topics important for New Jersey policy formulation and evaluation. It was funded by the Robert Wood Johnson Foundation and designed and analyzed by Rutgers Center for State Health Policy (CSHP). The survey, conducted between November 2008 and November 2009, was a random-digit-dialed telephone survey of 2,100 families with landlines and 400 families with cell phones residing in New Jersey. It collected information about a total of 7,336 individuals and had an overall response rate of 45.4% (52.6% for landlines and 26.0% for cell phones). The adult who was most knowledgeable about the health and health care needs of the family was interviewed. All estimates presented are weighted to accurately reflect the New Jersey household population.

Population estimates of the number of non-citizens in New Jersey from the NJFHS differ from those obtained in the Census Bureau's Current Population Survey (CPS) and the American Community Survey (ACS) for similar time periods. The NJFHS underestimates the number of non-citizens compared to these sources by 20–30%. Additionally, the NJFHS does not inquire about the legal status of non-citizen immigrants.

Further information on the 2009 NJFHS, including a comprehensive methods report and the full text of the survey questionnaire, can be found on the Center's website:
The 2009 New Jersey Family Health Survey Methods Report
The 2009 New Jersey Family Health Survey Questionnaire

Rates and proportions by nativity/citizenship status shown in Figures 1–4 of this Facts & Findings were assessed using Chi-square tests for complex survey data and found to be significantly different at the 1% level. Differences by nativity/citizenship status in reporting any or a particular communication problem (Figure 5 and Table 2) were found to be significant only where noted.

The five questions from the CAHPS 2.0 Clinician & Group Survey Adult Primary Care Questionnaire used in the NJFHS were a combination of Core and Supplemental questions, four coming from CAHPS Provider Communication composite and one from the Health Literacy/Cultural Competence composite (Table 1). Four of the five questions were on a Likert scale and one required a yes/no response. Indicators of a communication problem were coded as shown in Table A1.

CSHP's Facts & Findings

Facts & Findings from Rutgers Center for State Health Policy highlight findings from major research initiatives at the Center, including the New Jersey Family Health Survey. Previous Facts & Findings, along with other publications, are available at www.cshp.rutgers.edu.

RUTGERS
Center for State Health Policy

112 Paterson Street, 5th Floor
New Brunswick, NJ 08901
www.cshp.rutgers.edu
For more information email CSHP_Info@ifh.rutgers.edu

Contributing to this issue:
Stephanie Rosas-Garcia, Undergraduate Research Intern
Kristen Lloyd, MPH, Senior Research Analyst
Dorothy Gaboda, MSW, PhD, Associate Director for Data Analysis