

## Research Brief

### **RACE AT THE PERIPHERY, LANGUAGE AT THE CENTER: EXAMINING PATIENT-PROVIDER ENCOUNTERS IN NEW MEXICO**

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## Background/Introduction

Even though Hispanics, African Americans, and Native Americans represent more than 25% of the U.S. population, they comprise less than six percent of doctors. According to the New Mexico Health Care Workforce Committee Report released in 2014, 14.3% medical providers identify as Hispanic/Latino and 76.9% as not Hispanic or Latino. White medical providers often treat racial/ethnic minority patients in what are referred to as race-discordant relationships. Many research studies document ongoing racial and ethnic disparities, such as those in race-discordant relationships, in health care and link racial or ethnic concordance (or lack thereof) in the patient-physician relationship to health care processes and outcomes.

There are a number of disparities between race-concordant and race-discordant patient-physician relationships. Those patients in race-concordant relationships report higher levels of satisfaction and trust (Saha et al., 1999; Laveist and Nuru-Jeter, 2002). Additionally, patients in race-concordant relationships with their physicians rated their physicians' decision-making styles as significantly more participatory and their care more satisfactory overall than patients in race-discordant relationships (Cooper, 2003). Other studies have found that race-concordant visits are longer and have higher ratings of patient-positive affect than race-discordant visits (Cooper and Powe, 2004). There is some limited evidence that race concordance is associated with better health outcomes (Meghani et al., 2009). Scholars have also found an association between race concordance and medical adherence (Taylor et al., 2010). It is clear that increasing racial/ethnic concordance could increase diverse patients' experiences and health.

This extensive body of literature has suggested the best strategies to improve quality of health care for ethnic minorities are to increase ethnic diversity among physicians and engender trust and comfort between patients and physicians of different races. A majority of this literature has focused on African Americans, with fewer studies investigating other racial/ethnic groups, and no work to our knowledge is specific to New Mexico.

## New Mexico Context

The state of New Mexico has some of the poorest health outcomes in the United States. According to the most recent survey by the Department of Health in New Mexico, 20% of the population reported fair or poor health status. Both access to and quality of care remain a significant challenge in this state.

New Mexico clinics, hospitals, and other various entities encounter barriers to providing a high quality of care to New Mexicans. There are major physician shortages, especially on the outskirts of Bernalillo County. Currently, 32 out of 33 counties have been designated as Health Professional Shortage Areas (HPSA) for primary medical care (NM Healthcare Workforce, 2014). For example, out of the 1,957 primary care physicians in the state, nearly half (43.7%) practice in Bernalillo County. The ratio of the population to primary care providers in New Mexico is at 1,310:1 compared to the national average at 1,900:1 (New Mexico Healthcare Workforce 2014). Given the diversity of the state, our workforce diversity is another layer of inequality. According to this 2014 report, 77.6% of physicians identify as White or Caucasian, 9.9% as Asian, 3.0% as Black or African American and only 0.9% as American Indian or Alaska

Native, with the remainder identifying as other or not answered. Along ethnic lines, 76.9% of physicians are not Hispanic or Latino, while 14.3% identify as Hispanic or Latino.

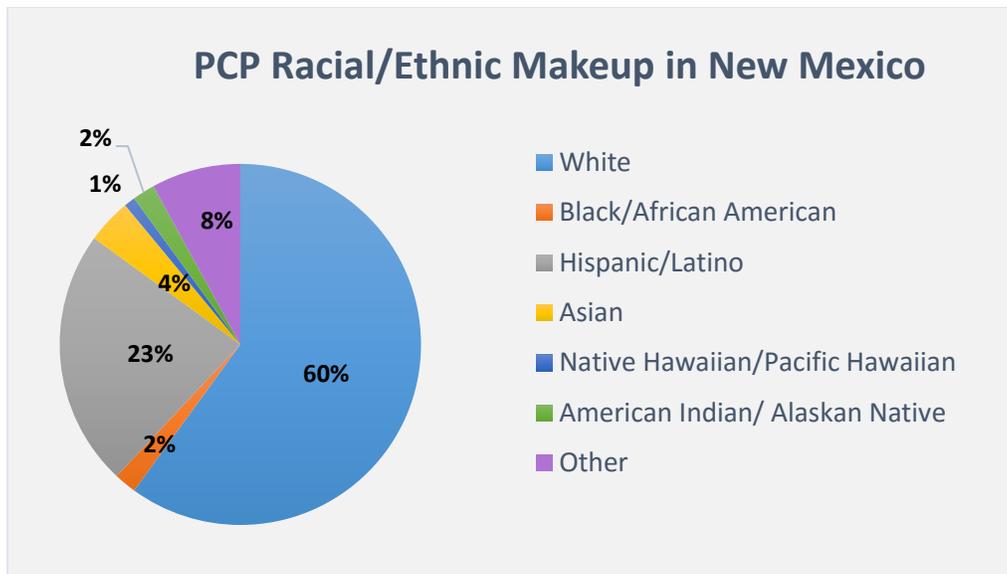
Linguistically and racially, New Mexico is in one of the most diverse states in the United States. American Indians have 23 federally recognized tribes within the state. This region has one of the largest Indian and Spanish speaking populations, and 36.5% of New Mexicans speak a language other than English. Data on language concordance is not readily available, but the findings of a cultural and linguistic competence survey indicates that language remains a significant barrier in the patient-provider relationship in New Mexico. Approximately half of the providers in New Mexico reported interacting with patients with a limited or non-English-speaking background a minimum of five times a week, and almost 19% reported such interactions ten times or more per week. Despite these numbers, 43% reported never submitting a translation request, and only 14% have done so in the last six months.

Current literature and data suggest that the medical workforce is not currently meeting the racial and linguistic needs of the New Mexican patient population, and the New Mexico Social Determinants Survey identifies similar patterns and provides evidence to explain how patient-provider racial and ethnic concordance among New Mexicans operate.

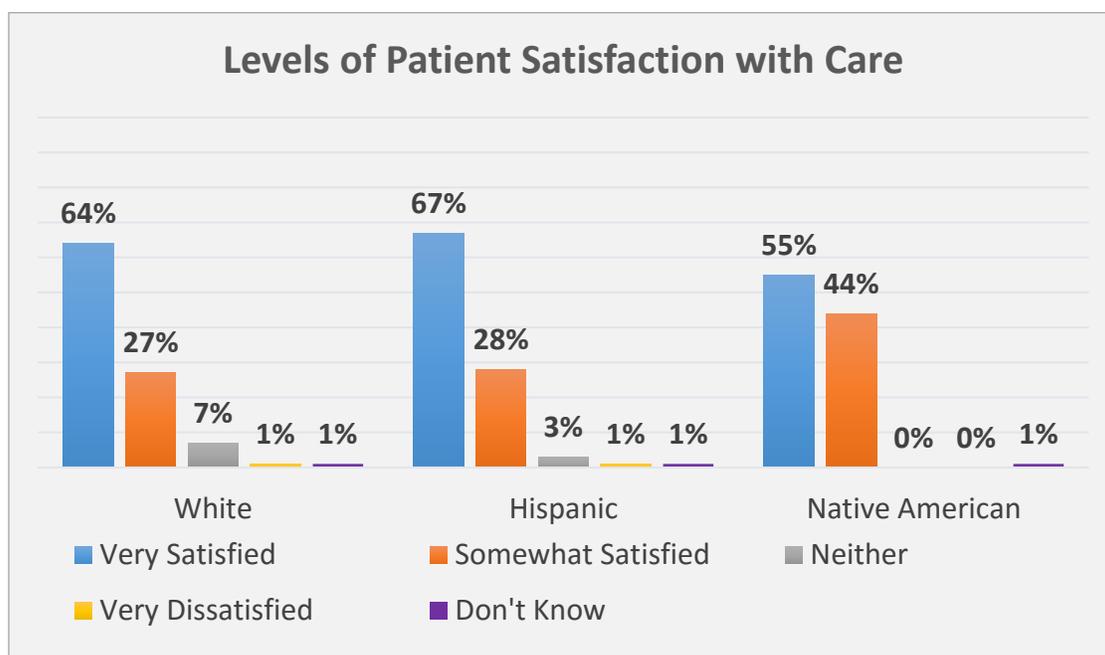
### **Findings along Race, Language, and Trust in New Mexico**

Recent data from a survey conducted by the Robert Wood Johnson Foundation (RWJF) Center for Health Policy at the University of New Mexico provides context to the issues New Mexicans face in establishing levels of trust and satisfaction with a PCP (see <http://healthpolicy.unm.edu/socialdeterminantsofhealthinNM>). The New Landscape of a Majority-Minority State study was a statewide bilingual survey conducted in September of 2016, yielding a total sample size of 1,505 respondents.

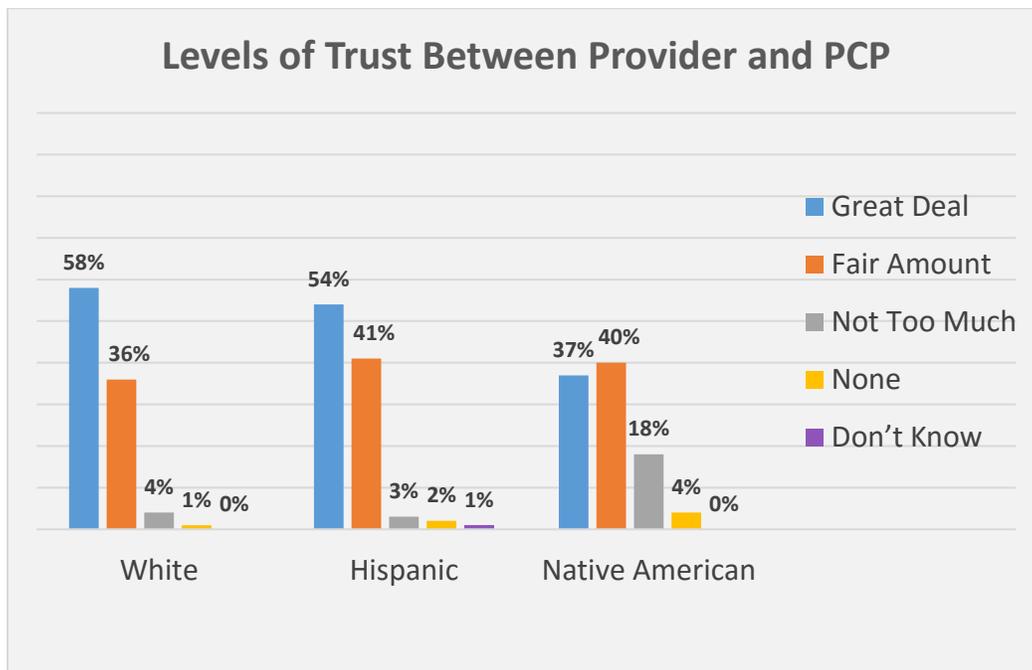
While New Mexico is a majority-minority state, over 60% of respondents in our survey report having a White primary care provider. The lack of diversity of providers directly translates into racial, linguistic, and cultural barriers people of color face when being treated by a PCP. Although 92% of participants indicated no preference in regards to being treated by a medical provider of their own race or ethnicity, 84% stated the importance of being able to be treated by a provider who speaks their primary language.



The data suggests that race and ethnicity is associated with varying levels of trust and satisfaction in patient-provider relationships. When asked how much trust respondents have in their primary care providers, Native Americans are over five times more likely to report a lower level of trust in their PCP (18% reporting “not too much”) compared to their white, black, and Hispanic counterparts (all reporting 4%), regardless of insurance status. Similarly, Native Americans are less likely to report a high level of trust in their PCP compared to their white and Hispanic counterparts (37% versus approximately 55% reporting “a great deal” of trust in their PCP). In regard to satisfaction, Native Americans are less likely, at 55%, to be very satisfied with the quality of health care received from a PCP than their White and Hispanic counterparts at 66%.



In addition, nativity is associated with levels of trust and satisfaction. The data suggest that language barriers are critical factors affecting levels of trust and satisfaction of patient-provider relationships. The survey asked respondents how satisfied respondents are with the quality of health care received from their primary care provider. The data illustrates that foreign-born respondents are twice as less likely to report that they are very satisfied (23%) with the quality of health care received during their encounter with a provider than those born in the United States (46%). Foreign born respondents are also twice as less likely to report being able to talk to their PCP in their preferred language than those born in the US (56% compared to 100%).



### The Urgency of Supporting Workforce Diversity

Our findings suggest a need for diversifying the New Mexican medical provider workforce. Trust and satisfaction vary based on the patient-provider racial/ethnic concordance relationship, especially for the Native American population. Based on a 2010 report by the Office of Equity and Inclusion at University of New Mexico, racial/ethnic minority representation among medical students remains a challenge. Among the 20,000 medical students admitted each year nationally, fewer than 1,970 (or less than 10 percent) are from groups traditionally underrepresented (URM) in medicine (Garcia, Nation, and Parker, 2004). It is well documented that URM students are more likely to serve the underserved compared to their White counterparts (Saha et al., 2008).

In regards to admitting URM students, there is often a misconception that they are not high-quality students. Studies, however, have demonstrated URM students perform equally if not better than their white counterparts; 81% of new students from underrepresented ethnic or racial background and 18% of rural background admitted through pipeline programs, despite having lower GPAs and lower mean MCAT scores, passed Step 1 and Step 2 (Girotti et al. 2015). In fact, the diversity of the student population can bring multiple positive experiences to the entire school. The degree of diversity within their medical school affects medical students' positive

attitudes towards diversity (Guiton et al., 2007). Additionally, more diversity has been shown to increase support for affirmative action policies (Whitla et al., 2003).

In New Mexico, this survey furthermore found linguistic concordance to be critical, but such concordant relationships are often absent, especially for foreign-born respondents. We recommend that the state of New Mexico expand its efforts to increase linguistic concordance. There is no data around the linguistic diversity of practicing providers in New Mexico. While linguistic progress has certainly occurred for Spanish speakers and for some Asian-language speakers, there remains work to be done, especially regarding the Native American populations. New Mexico is a leader in many health care innovations, with many impressive pipeline programs aimed at serving the state's diverse population and innovations such as telehealth, but more work remains ahead, given educational budget cuts and complex healthcare challenges. The lack of racial/ethnic and linguistic representation among the workforce has important implications for addressing health disparities (DeLisa, 2012). This literature on racial/ethnic discordance and linguistic concordance has multiple ripple effects for health policy, health care delivery, medical education, and health outcomes.

## **About the Authors**

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## **Survey Methodology**

The New Landscapes of a Majority-Minority State study was conducted from September 3rd to September 27th, 2016, and relied on a total sample of 1,505 respondents, of which 753 interviews were conducted through a mixed-mode approach over the phone (603 landline and 150 cellphone) and 752 online to capture a wider segment of the New Mexican population that lacks a land-line telephone or prefer to engage in on-line surveys. The Pacific Market Research in Renton, Washington, administered all the phone calls, and the interviewers were fully bilingual. Similarly, the survey administered online allowed respondents to complete it in either English or Spanish, and had the exact same questions as the phone interviews. For the online sample, respondents were randomly drawn from the Latino Decision's state panel of Latino adults and were weighted to be representative of the population of New Mexico. All samples were combined and weighted to match the 2013 Current Population Survey estimate for the state of New Mexico with respect to age, place of birth, race/ethnicity, gender, and state. The survey consisted of about 96 questions, including several skip pattern questions. On average, the length of the survey was about 20 minutes. With a response rate of 17.7 percent for the telephone sample, the survey has an overall margin of error of +/- 2.5 percent.

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