

Chapter 5. Patient Centeredness

The Institute of Medicine identifies patient centeredness as a core component of quality health care.¹ Patient centeredness is defined as:

[H]ealth care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care.²

Patient centeredness “encompasses qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient.”¹ In addition, translation and interpretation services facilitate communication between the provider and the patient and are often a legal requirement.¹ The patient-centered approach includes viewing the patient as a unique person, rather than focusing strictly on the illness, building a therapeutic alliance based on the patient's and the provider's perspectives.

Patient-centered care is supported by good provider-patient communication so that patients' needs and wants are understood and addressed and patients understand and participate in their own care.²⁻⁵ This approach to care has been shown to improve patients' health and health care.^{3,4,6-8} Unfortunately, many barriers exist to good communication.

Providers also differ in communication proficiency, including varied listening skills and different views from their patients' of symptoms and treatment effectiveness.⁹ Additional factors influencing patient centeredness and provider-patient communication include:

- Language barriers.
- Racial and ethnic concordance between the patient and provider.
- Effects of disabilities on patients' health care experiences.
- Providers' cultural competency.

Efforts to remove these possible impediments to patient centeredness are underway within the Department of Health and Human Services (HHS). For example, the Office of Minority Health has developed a set of Cultural Competency Curriculum Modules that aim to equip providers with cultural and linguistic competencies to help promote patient-centered care.^{10, ii} These modules are based on the National Standards on Culturally and Linguistically Appropriate Services. The standards are directed at health care organizations and aim to improve the patient centeredness of care for people with limited English proficiency (LEP). Another example, which is being administered by the Health Resources and Services Administration, is Unified Health Communication, a Web-based course for providers that integrates concepts related to health literacy with cultural competency and LEP.ⁱⁱⁱ

ⁱ For example, Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, may require the practitioner or hospital to provide language interpreters and translate vital documents for limited-English-proficient persons. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794, may require the practitioner or hospital to provide sign language interpreters, materials in Braille, and/or accessible electronic formats for individuals with disabilities.

ⁱⁱ This online program (available at <http://www.thinkculturalhealth.org>) is accredited for Continuing Medical Education credits for physicians and Continuing Education Units for nurses and pharmacists.

ⁱⁱⁱ This online program (available at <http://www.hrsa.gov/publichealth/healthliteracy/>) is accredited for Continuing Medical Education credits for physicians and Continuing Education Units for nurses, physician assistants, pharmacists, and Certified Health Education Specialists.

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In addition, the HHS Office for Civil Rights has issued Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons. This guidance explains that recipients of Federal financial assistance must take reasonable steps to provide LEP people with a meaningful opportunity to participate in HHS-funded programs. Failure to do so may violate the prohibition under Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, against national origin discrimination.¹¹

Importance

Morbidity and Mortality

- Patient-centered approaches to care have been shown to improve patients' health status. These approaches rely on building a provider-patient relationship, improving communication, fostering a positive atmosphere, and encouraging patients to actively participate in provider-patient interactions.^{3,4}
- A patient-centered approach has been shown to lessen patients' symptom burden.⁶
- Patient-centered care encourages patients to comply with treatment regimens.⁸
- Patient-centered care can reduce the chance of misdiagnosis due to poor communication.⁷

Cost

- Patient centeredness has been shown to reduce underuse and overuse of medical care.¹²
- Patient centeredness can reduce the strain on system resources and save money by reducing the number of diagnostic tests and referrals.⁶
- Although some studies have shown that being patient centered reduces medical costs and use of health service resources, others have shown that patient centeredness increases providers' costs, especially in the short run.¹³

Measures

The National Healthcare Quality Report (NHQR) and the National Healthcare Disparities Report (NHDR) track several measures of patients' experience of care. The reports also include one priority and two goals recommended by the National Priorities Partnership (NPP). NPP identified patient and family engagement as one of six national priorities. The vision is health care "...that honors each individual patient and family, offering voice, control, choice, skills in self-care, and total transparency, and that can and does adapt readily to individual and family circumstances, and to differing cultures, languages, and social backgrounds." Key goals include enabling patients to effectively navigate and manage their care and enabling patients to make informed decisions about their treatment options.

The core measure presented in this report is adults and children who reported poor communication at the doctor's office. This measure is a composite of four measures—patients' assessments of how often their provider listened carefully to them, explained things clearly, respected what they had to say, and spent enough time with them. This measure is presented separately for adults and children.

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In addition, the NHDR includes a supporting measure on adults who reported poor communication during a hospital stay. This measure is a composite of three measures—patients’ assessments during a hospital stay of how often their doctors/nurses listened carefully to them, explained things clearly, and treated them with courtesy and respect. This measure is presented separately for communication with nurses and communication with doctors.

The measures related to the NPP goals are:

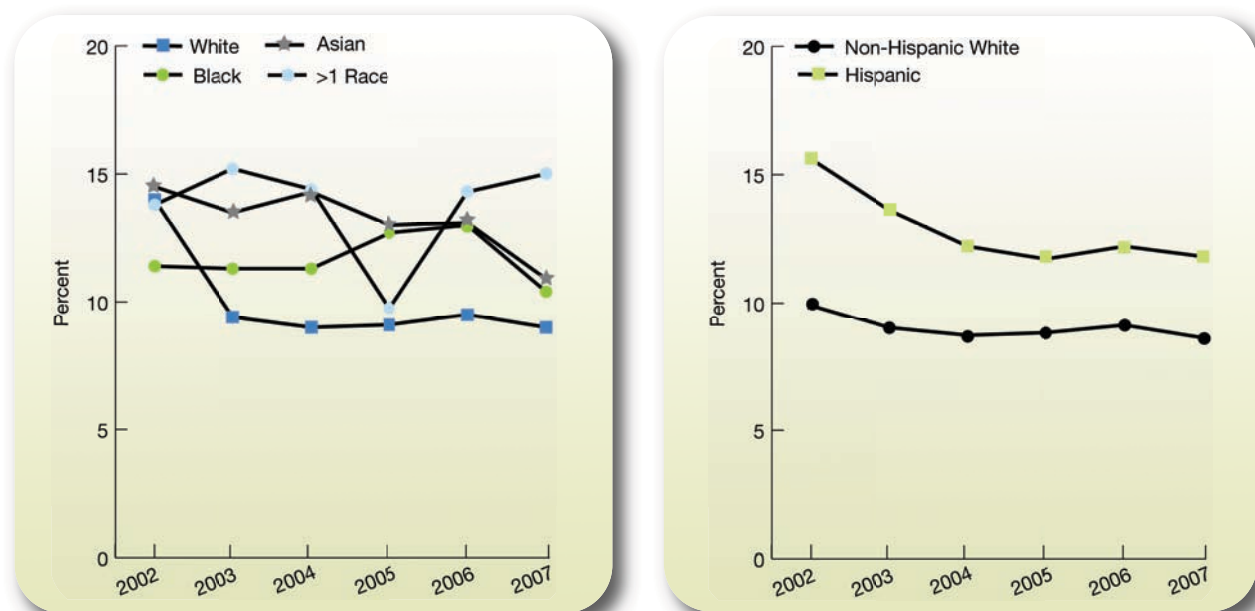
- Enabling patients to effectively navigate and manage their care.
 - Usual source of care with or without language assistance.
 - Need for a translator.
 - Ability to read the instructions on a prescription bottle.
- Enabling patients to make informed decisions about their treatment options.
 - Ability to understand information from a doctor’s office.
 - Patient participation in treatment decisions.

Findings

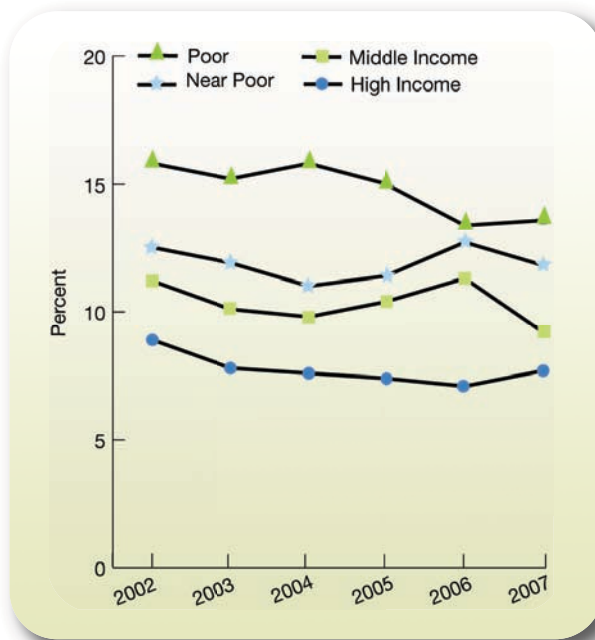
Patients’ Experience of Care—Adults

Optimal health care requires good communication between patients and providers, yet barriers to provider-patient communication are common. To provide all patients with the best possible care, providers must be able to understand patients’ diverse health care needs and preferences and communicate clearly with patients about their care.

Figure 5.1. Adults who had a doctor’s office or clinic visit in the last 12 months who reported poor communication with health providers, by race, ethnicity, and income, 2002-2007



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Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2007.

Denominator: Civilian noninstitutionalized population age 18 and over who had a doctor's office or clinic visit in the last 12 months.

Note: Patients who report that their health providers sometimes or never listened carefully, explained things clearly, showed respect for what they had to say, or spent enough time with them are considered to have poor communication.

- Between 2002 and 2007, the percentage of White, middle-income, and high-income adults who reported poor communication with their health providers significantly decreased (Figure 5.1).
- In all years, the percentage of adults who reported poor communication was significantly higher for poor, near-poor, and middle-income people than for high-income people.
- In all years, Hispanics were significantly more likely than non-Hispanic Whites to report poor communication.
- In 4 of 6 years, Black patients were more likely than Whites to report poor communication with health providers; the exceptions were 2006 and 2007.
- In 5 of 6 years, Asians were more likely than Whites to report poor communication; the exception was 2007.

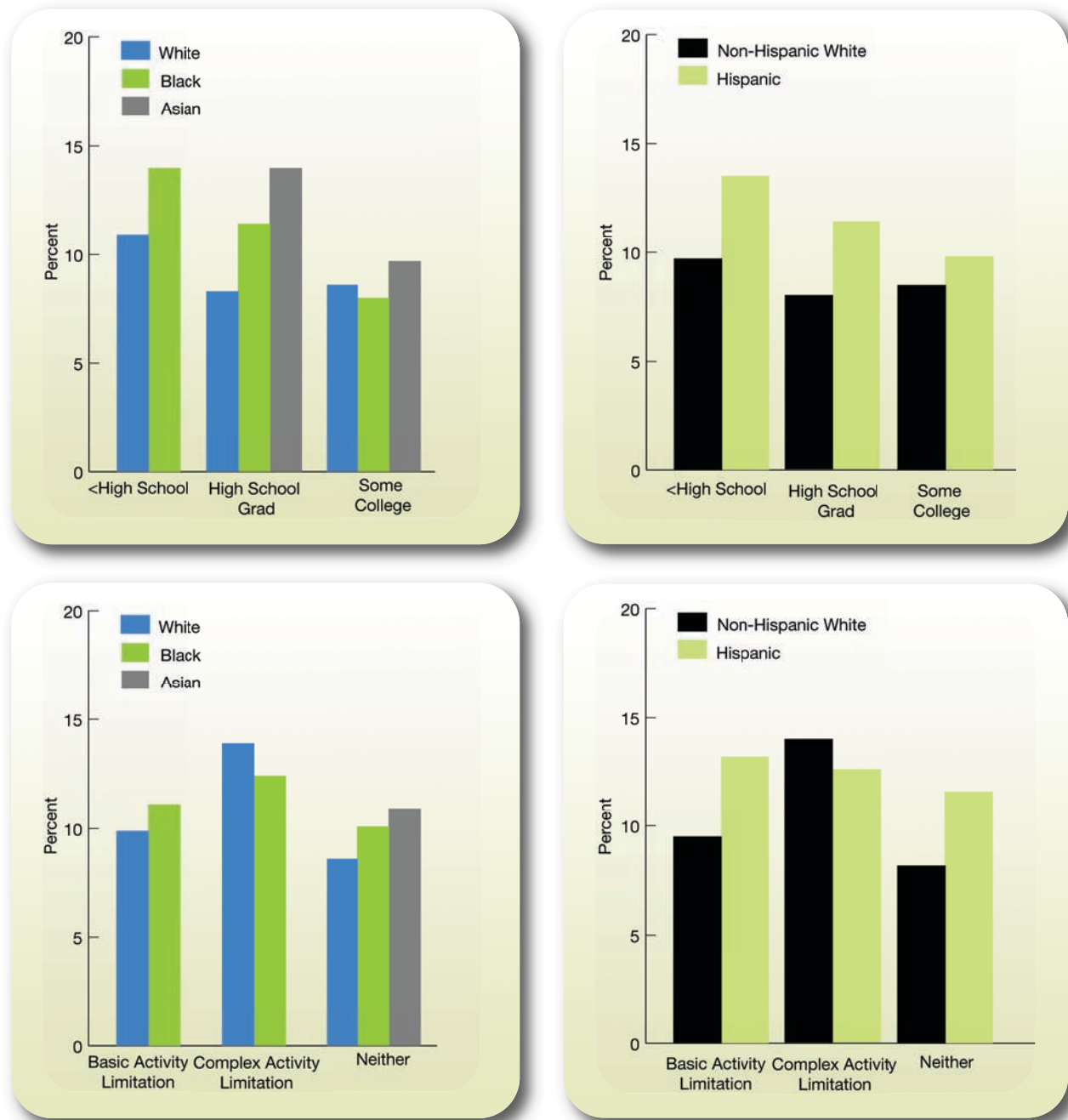
Also, in the NHQR:

- In 5 of 6 years, a significantly lower percentage of adults in large fringe metropolitan areas reported poor communication with their health providers; 2006 was the exception.

Racial and ethnic minorities are disproportionately of lower education levels. To distinguish the effects of race, ethnicity, education, and activity limitation on provider-patient communication, this measure is stratified by education level and activity limitation.

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Figure 5.2. Adult ambulatory patients who reported poor communication with health providers, by race and ethnicity, stratified by education and activity limitation, 2007



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2007.

Denominator: Civilian noninstitutionalized population age 18 and over.

Note: Sample sizes were too small to provide estimates for Asians with less than a high school education and Asians with activity limitations. Patients who report that their health providers sometimes or never listened carefully, explained things clearly, showed respect for what they had to say, or spent enough time with them are considered to have poor communication.

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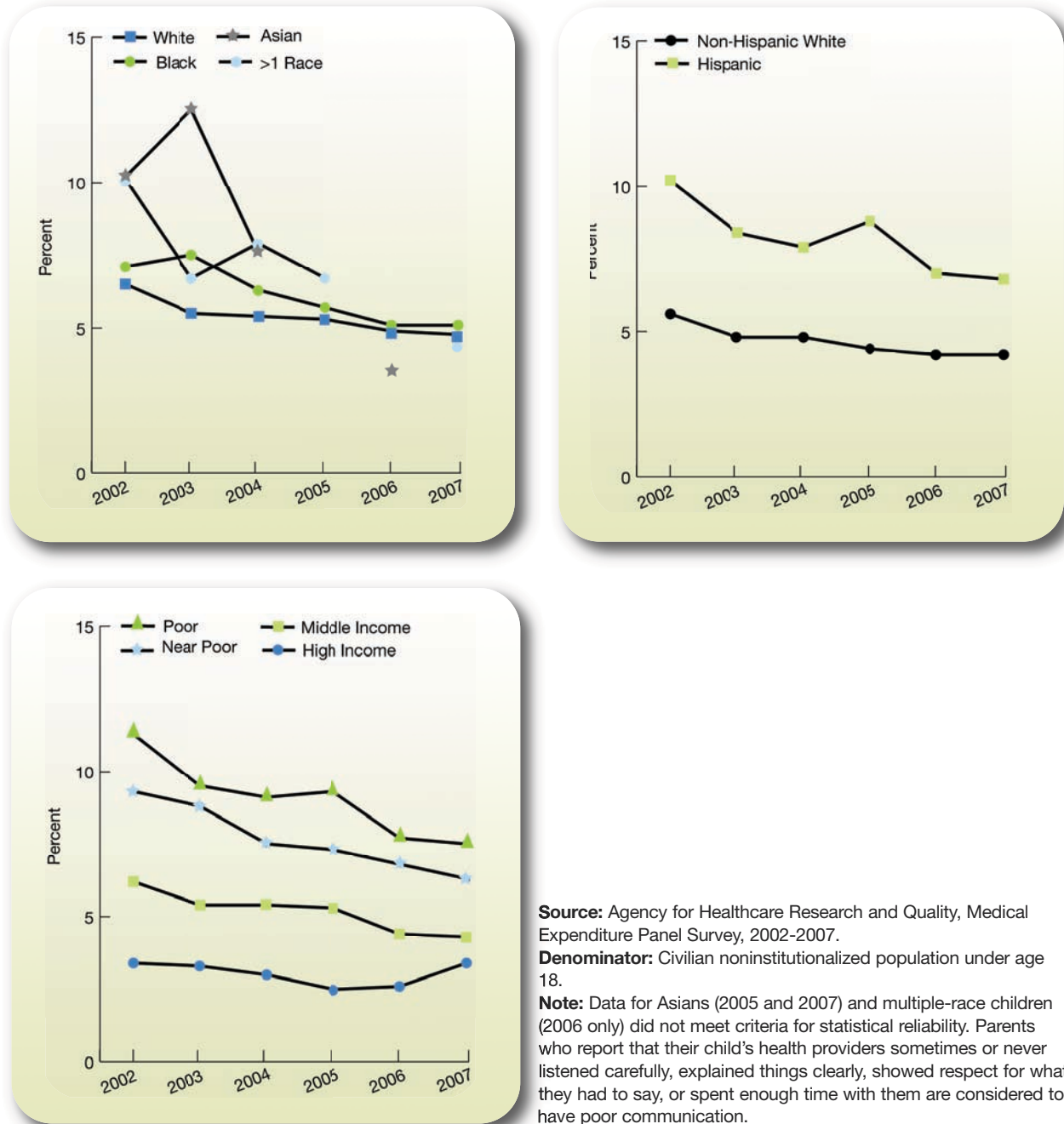
- The amount of education attained and activity limitation status explains some of the racial and ethnic differences in provider-patient communication for patients age 18 and over. A significantly higher percentage of Blacks and Hispanics with no college education reported poor communication with their health provider compared with Whites and non-Hispanic Whites with no college education. However, there is no statistically significant difference between Blacks and Whites with some college education (Figure 5.2).
- Among high school graduates, Blacks (11.4%) were more likely than Whites (8.3%) and Hispanics (11.4%) were more likely than non-Hispanic Whites (8.0%) to report poor communication with their health providers.
- Although Blacks were more likely than Whites to report poor communication overall in 2007 (10.4% compared with 9.0%), the Black versus White differences in reporting poor communication were not statistically significant within any of the three activity limitation groups: basic, complex, and neither basic nor complex.
- In 2007, Hispanics were more likely to report poor communication than non-Hispanic Whites overall (11.8% compared with 8.6%) and for adults with neither basic nor complex activity limitations (11.6% compared with 8.2%).

Patients' Experience of Care—Children

Communication in children's health care can be challenging since the child's experiences are interpreted through the eyes of a parent or guardian. During a health care encounter, a responsible adult caregiver will be involved in communicating with the provider and interpreting decisions in an age-appropriate manner to the patient. Optimal communication in children's health care can therefore have a significant impact on receipt of high-quality care and subsequent health status. This is especially true for children with special health care needs.

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Figure 5.3. Children who had a doctor's office or clinic visit in the last 12 months whose parents reported poor communication with health providers: Overall composite, by race, ethnicity, and family income, 2002-2007



- Overall, the percentage of children whose parents or guardians reported poor communication with their health providers significantly decreased from 6.7% in 2002 to 4.9% in 2007 (data not shown).

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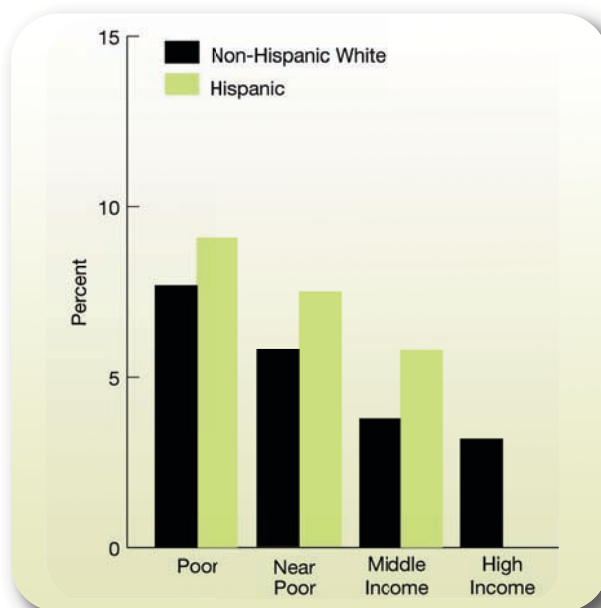
- From 2002 to 2007, Whites, Blacks, people of more than one race, non-Hispanic Whites, Hispanics; and poor, near-poor, and middle-income people all had a significant decrease in the percentage of children whose parent or guardian reported poor communication (Figure 5.3).
- From 2002 to 2007, the percentage of children whose parents or guardians reported poor communication with their health providers remained significantly higher for Hispanics than for non-Hispanic Whites. Similarly, the percentage of children from poor families whose parents or guardians reported poor communication with their health providers was significantly higher than children from high-income families.
- In all years, a significantly higher percentage of poor and near-poor parents reported poor communication than parents with high incomes. In 5 of 6 years, there was also a higher percentage of middle-income parents than high-income parents reporting poor communication; 2007 was the exception.

Also, in the NHQR:

- In 4 of 6 years, a significantly lower percentage of parents residing in large fringe metropolitan areas reported poor communication with their health provider than parents residing in large central metropolitan areas; 2006 and 2007 were the exceptions.

Racial and ethnic minorities have disproportionately lower incomes. To distinguish the effects of race, ethnicity, and income on provider-patient communication, this measure is stratified by income level.

Figure 5.4. Composite measure: Children with ambulatory visits whose parents reported poor communication with health providers, by ethnicity, stratified by income, 2007



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2007.

Denominator: Civilian noninstitutionalized population under age 18.

Note: Data were not available for high-income Hispanics. Parents who report that their child's health providers sometimes or never listened carefully, explained things clearly, showed respect for what they had to say, or spent enough time with them are considered to have poor communication.

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- Overall, there was no statistically significant difference between non-Hispanic Whites and Hispanics who reported poor communication with their health providers (data not shown).
- Among poor individuals, Hispanics were as likely as non-Hispanic Whites to report poor communication with their health providers (Figure 5.4).

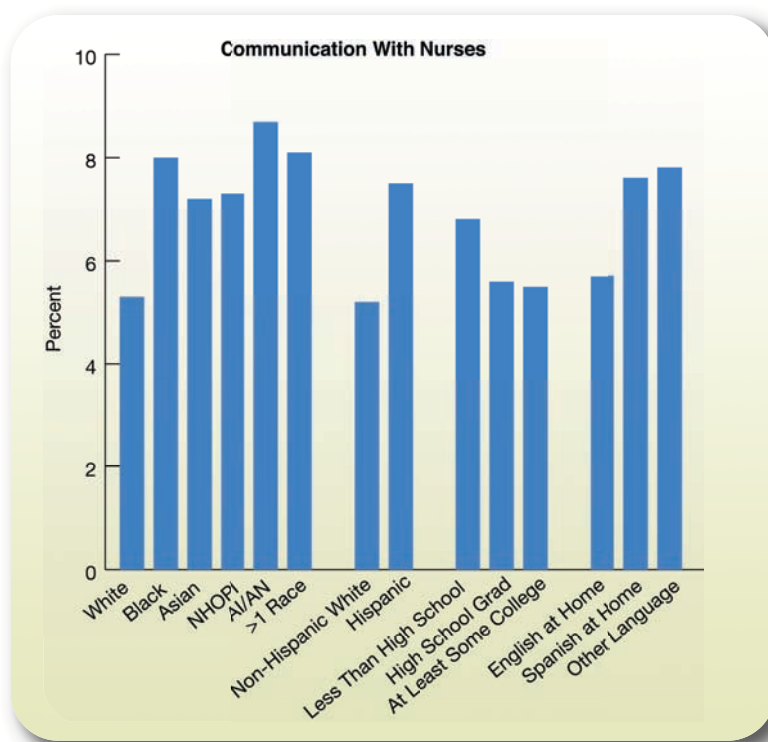
Also, in the NHQR:

- Children residing in large central and small metropolitan areas showed significant decreases in poor communication from 2002 to 2007.

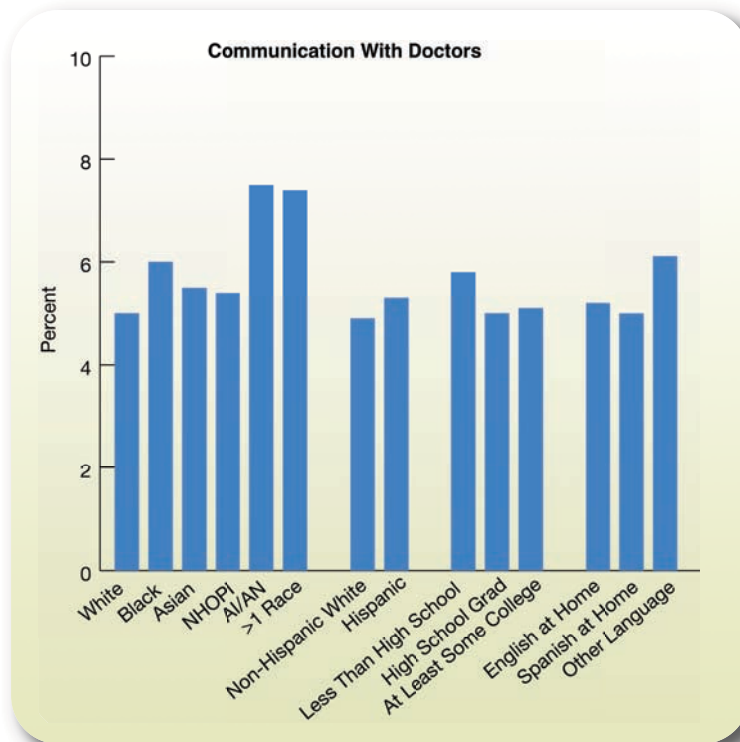
Patients' Experience of Care—Hospital

Using methods developed for the CAHPS® (Consumer Assessment of Healthcare Providers and Systems) survey,¹⁴ the NHQR and NHDR use a composite measure that combines three measures of provider-patient communication into a single core measure. The three measures are: providers who sometimes or never listen carefully, explain things clearly, and respect what patients say. These data are presented separately for communication with doctors and communication with nurses.

Figure 5.5. Adult hospital patients who reported poor communication with nurses and with doctors, by race, ethnicity, education, and language, 2007



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Key: NHOPI = Native Hawaiian or Other Pacific Islander; AI/AN = American Indian or Alaska Native.
Source: Agency for Healthcare Research and Quality, Hospital CAHPS[®] (Consumer Assessment of Healthcare Providers and Systems) Survey, 2007.
Note: Poor communication is defined as responded “sometimes” or “never” to the set of survey questions: “During this hospital stay, how often did doctors/nurses treat you with courtesy and respect?” “During this hospital stay, how often did doctors/nurses listen carefully to you?” and “During this hospital stay, how often did doctors/nurses explain things in a way you could understand?”

- Overall, 5.9% of adult hospital patients reported poor communication with nurses during their hospital stay, and 5.3% reported poor communication with doctors (data not shown).
- Compared with Whites, all minority groups were more likely to report poor communication with nurses (Figure 5.5). Blacks, American Indians and Alaska Natives, and patients of more than one race were more likely to report poor communication with doctors.
- Compared with non-Hispanic Whites, Hispanics were more likely to report poor communication with nurses but not with doctors.
- Compared with patients with at least some college education, patients with less than a high school education were more likely to report poor communication with both nurses and doctors.
- Compared with patients who speak English at home, patients who speak Spanish at home were more likely to report poor communication with nurses while patients who speak some other language at home were more likely to report poor communication with both nurses and doctors.

Also, in the NHQR:

- Compared with patients ages 18-44, patients ages 45-64 were more likely to report poor communication with doctors.
- Patients age 65 and over were less likely to report poor communication with nurses.

Patient and Family Engagement: Enabling Effective Patient Navigation and Management of Care

To effectively navigate the complicated health care system, health care providers need to provide patients with access to culturally and linguistically appropriate tools to support patient engagement. Clear communication is an important component of effective health care delivery. It is vital for providers to understand patients' health care needs and for patients to understand providers' diagnoses and treatment recommendations. Communication barriers can relate to language, culture, and health literacy.

For people with limited English proficiency, having language assistance is of particular importance, so they may choose a usual source of care in part based on language concordance. Not having a language-concordant provider may limit or discourage some patients from establishing a usual source of care.

To fill the data gap that currently exists, we examined subnational data-gathering activities and identified the California Health Interview Survey (CHIS) as a unique source of this information. CHIS is conducted by the UCLA Center for Health Policy Research in collaboration with the California Department of Public Health, the Department of Health Care Services, and the Public Health Institute.

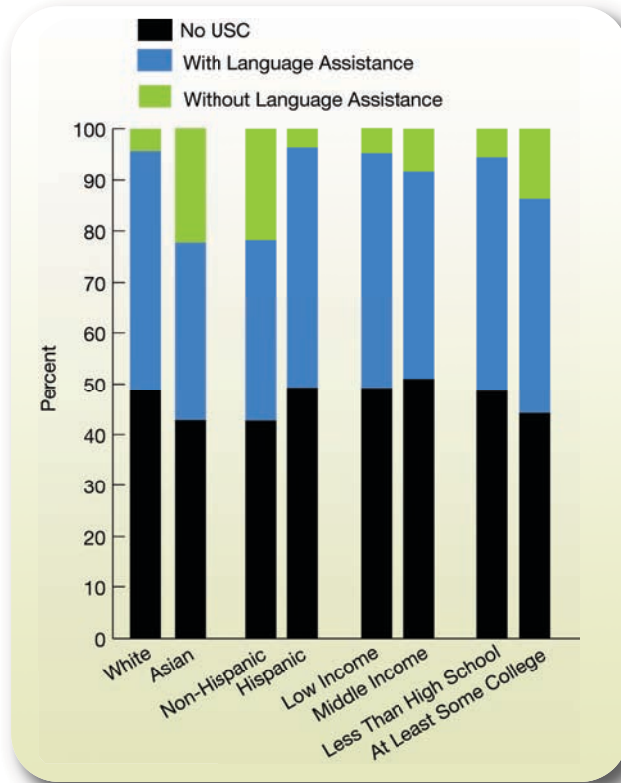
Every 2 years, CHIS involves random-dial telephone interviews with up to 50,000 California households. The people included in CHIS are a statistically representative sample of the entire State's diverse population. With each survey cycle, new households are selected to participate. Beginning in 2007, CHIS also includes a sample of cell-phone-only households, which are often younger and more mobile Californians frequently overlooked in land-line surveys.

Language Assistance

Language barriers in health care are associated with decreases in quality of care, safety, and patient and clinician satisfaction and contribute to health disparities, even among people with insurance. The Federal Government has issued 14 culturally and linguistically appropriate services (CLAS) standards. These standards, which are directed at health care organizations, are also encouraged for individual providers to improve accessibility of their practices. The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). For people with limited English proficiency, having CLAS is of particular importance and may influence the patient's choice of a usual source of care.

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Figure 5.6: Adults with limited English proficiency, by whether they had a usual source of care with or without language assistance, by race, ethnicity, income, and education, 2007



Key: USC = usual source of care.

Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2007.

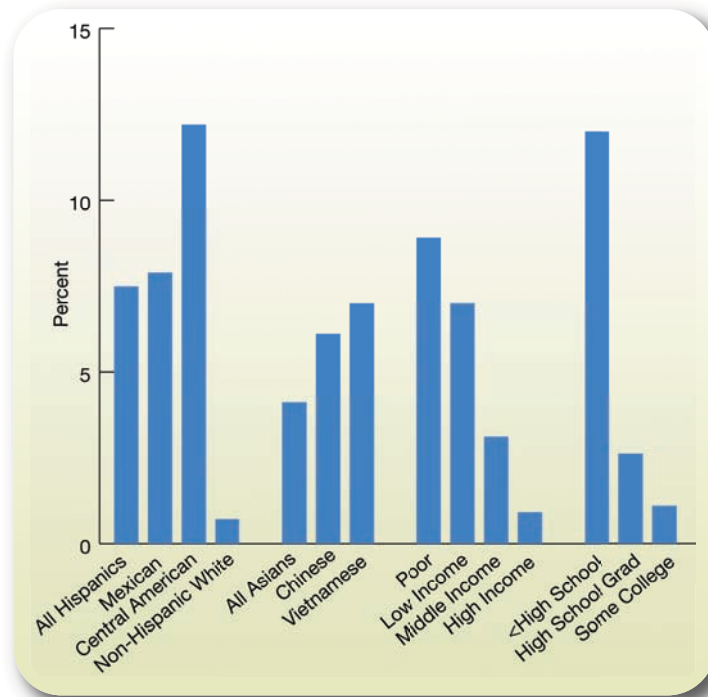
- In 2007, Hispanic adults were significantly more likely than non-Hispanic adults to have a usual source of care with language assistance (Figure 5.6).
- In 2007, White adults with limited English proficiency were significantly more likely than Asians to have a usual source of care with language assistance.

Need for a Translator

The ability of providers and patients to communicate clearly with each other can be compromised if they do not speak the same language. Quality may suffer if patients with limited English proficiency cannot express their care needs to providers who speak English only or who do not have an interpreter's assistance. Communication problems between the patient and provider can lead to lower patient adherence to medication regimens and decreased participation in medical decisionmaking. It also can exacerbate cultural differences that impair the delivery of quality health care.

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Figure 5.7. Adults age 18 and over who needed a translator during last doctor visit, California, by race/ethnicity, income, and education, 2007



Source: University of California, Los Angeles, Center for Health Policy Research, California Health Interview Survey, 2007.

- In 2007, non-Hispanic White patients in California were significantly less likely than Hispanic patients to need a translator during their last doctor visit (Figure 5.7). Non-Hispanic Whites also were less likely than Mexicans and Central Americans to need a translator. Asians were significantly more likely than non-Hispanic Whites to need a translator during their last doctor visit (4.1% compared with 0.7%). There were however, no statistically significant differences between the overall Asian population and Chinese or Vietnamese patients. There also were no significant differences between Chinese and Vietnamese patients.
- Poor (8.9%), low-income (7.0%), and middle-income (3.1%) patients also were significantly more likely than high-income (0.9%) patients to need a translator.
- Patients in California with less than a high school education and high school graduates were significantly more likely to need a translator than patients with some college education (12.0% and 2.6, respectively, compared with 1.1%).

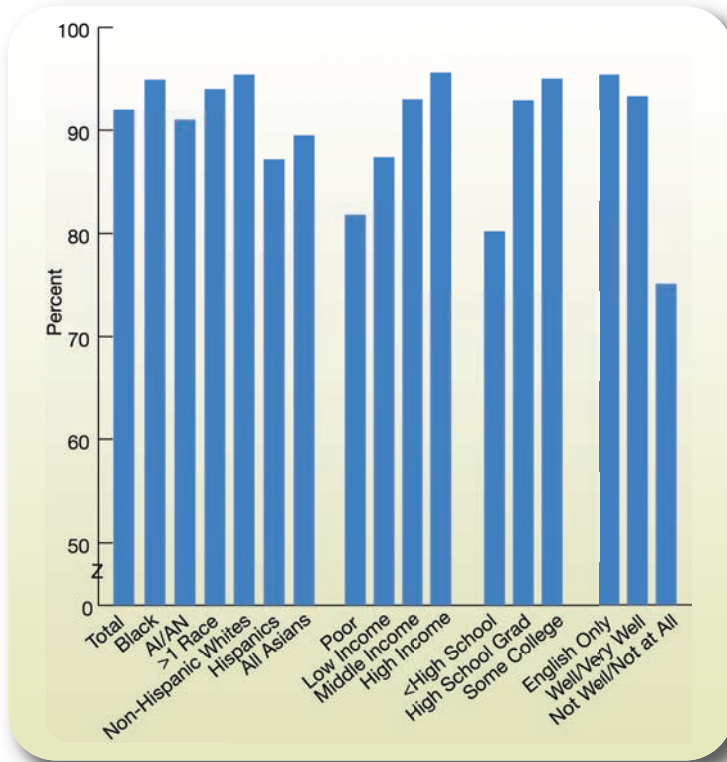
Ability to Read Instructions on a Prescription Bottle

The effectiveness of a prescription is due in large part to the patient's ability to follow dosing instructions correctly. If the patient misinterprets the amount of medication to be taken or the dosing schedule, an adverse event can occur. This is particularly true for patients taking multiple medications that require strict adherence. This misunderstanding can be due to the patient's health literacy levels, cognitive abilities, or visual

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impairment. It is important that health care providers not only rely on patients saying they understand medication instructions, but also insist that the patients clearly demonstrate their understanding.

Figure 5.8. Adults who found it easy to read the instructions on a prescription bottle, by race/ethnicity, income, education, and English proficiency, California, 2007



Key: AI/AN = American Indian or Alaska Native.

Source: University of California, Los Angeles, Center for Health Policy Research, California Health Interview Survey, 2007.

- Poor patients in California were less likely than high-income patients to find it easy to read the instructions on a prescription bottle (81.8% compared with 95.6%; Figure 5.8).
- The percentage of patients in California who found it easy to read the instructions on a prescription bottle was higher for high school graduates and people with at least some college education compared with patients with less than a high school education. (92.9% and 95.0%, respectively, compared with 80.2%).
- In 2007, patients in California who did not speak English well or at all were less likely than patients who speak English only to find it easy to read the instructions on a prescription bottle (75.1% compared with 95.4%).

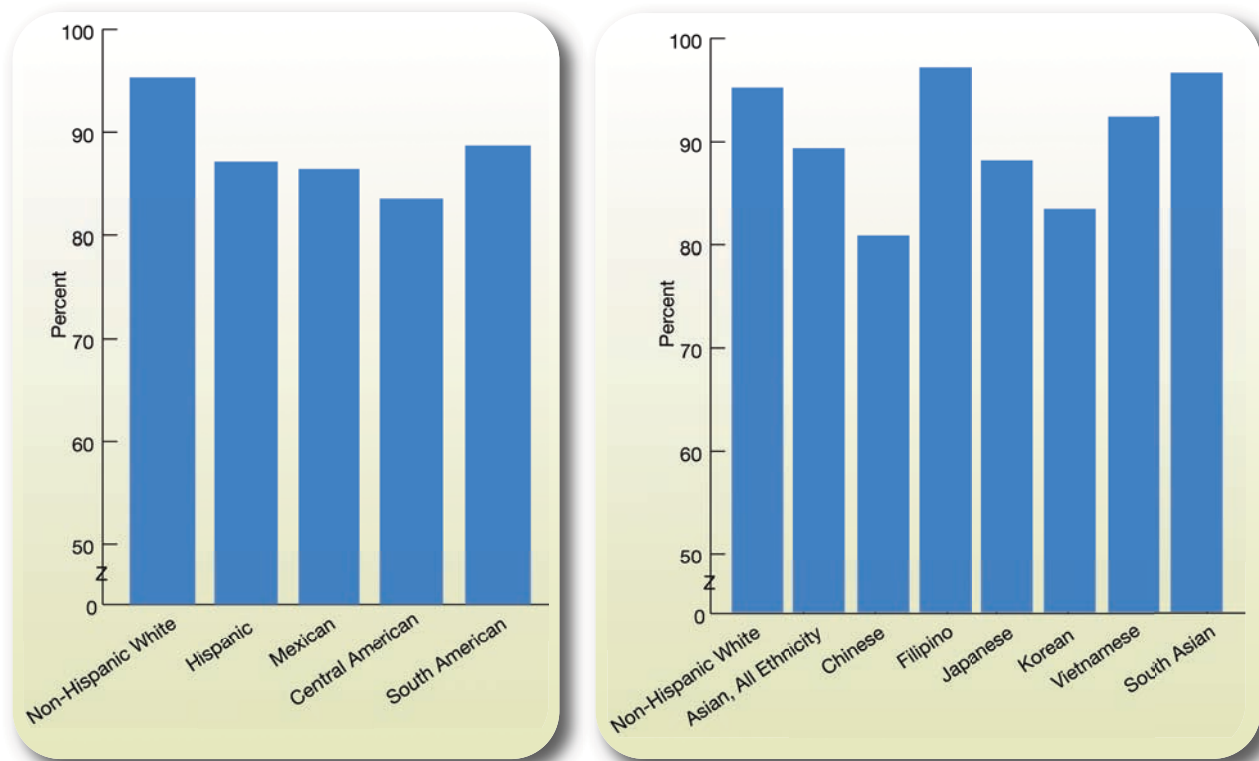
Also, in the NHQR:

- In California, patients under age 65 with public insurance and uninsured patients were less likely than patients with private health insurance to find it easy to read the instructions on a prescription bottle.

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Important individual differences exist within each ethnic group. There are national differences as well as other subgroup differences that have to be acknowledged in order to provide appropriate cultural and linguistic care. To examine these differences, we present data on Hispanic and Asian subgroups in California.

Figure 5.9. Adults who found it easy to read the instructions on a prescription bottle, by Hispanic and Asian ethnicity, California, 2007



Source: University of California, Los Angeles, Center for Health Policy Research, California Health Interview Survey, 2007.

- In 2007, among different Hispanic ethnic groups in California, there were no statistically significant differences in patients who found it easy to read the instructions on a prescription bottle (Figure 5.9).
- In 2007, Filipinos, Vietnamese people, and South Asians living in California were significantly more likely than the overall Asian population to find it easy to read the instructions on a prescription bottle.
- In 2007, Filipinos, Japanese people, Vietnamese people, and South Asians living in California were all more likely than Chinese people to find it easy to read the instructions on a prescription bottle.
- In California overall, Asians were significantly more likely than Hispanics to find it easy to read the instructions on a prescription bottle (89.5% compared with 87.2%).

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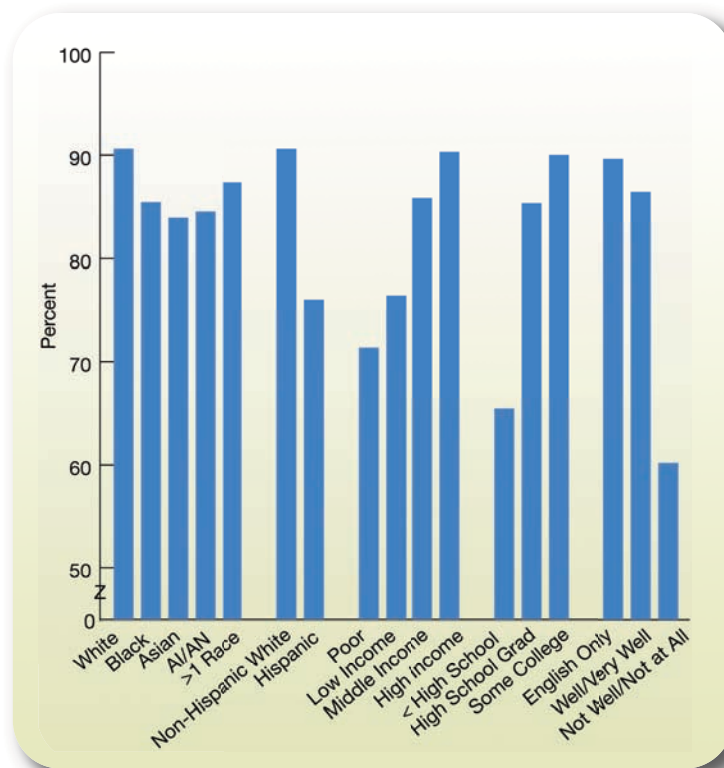
Patient and Family Engagement: Enabling Patients To Make Informed Decisions About Their Treatment Options

The NPP recommends that health care organizations and their staff use proven and culturally and linguistically appropriate strategies and tools to enable patients to understand all treatment options and to make decisions consistent with their values and preferences.

Understanding Information From a Doctor's Office

Recovery from illness and disease self-management depend in large part on patients' ability to follow their doctors' instructions at home. Patients can sometimes leave their doctors' office thinking they understand the instructions given to them only to realize later that some information is unclear. It is important that both patients and physicians not assume that instructions are understood but develop a means to show comprehension.

Figure 5.10. Adults who find it easy to understand written information from a doctor's office, by race, ethnicity, income, education, and English proficiency, California, 2007



Key: AI/AN = American Indian or Alaska Native.

Source: University of California, Los Angeles, Center for Health Policy Research, California Health Interview Survey, 2007.

- Non-Hispanic White patients living in California were more likely than all other racial and ethnic groups to find it easy to understand information from a doctor's office (Figure 5.10).

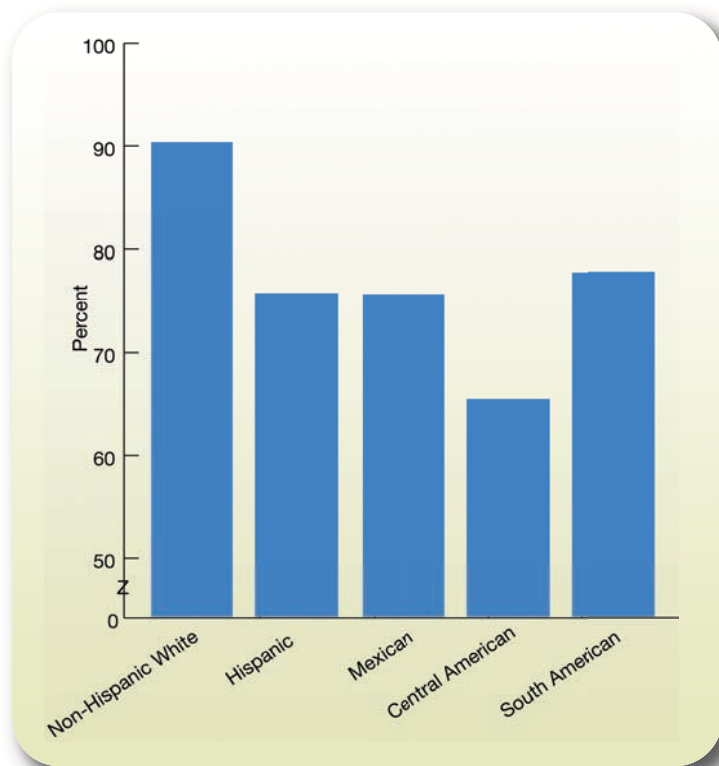
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- In 2007, poor, low-income, and middle-income patients living in California were all significantly less likely than high-income patients to find it easy to understand information from a doctor's office.
- In 2007, patients living in California with less than a high school education were significantly less likely than patients with some college education to find it easy to understand information from a doctor's office (65.4% compared with 90.0%).
- In 2007, patients living in California who did not speak English well or at all were less likely than patients who speak English only or patients who speak English well or very well to find it easy to understand information from a doctor's office (60.1% compared with 89.7% and 86.5%, respectively).

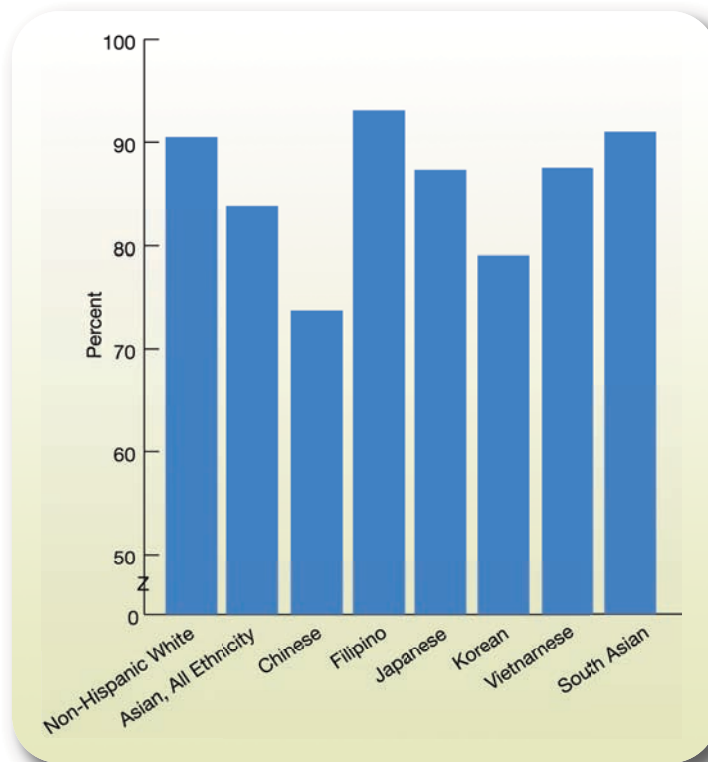
Also, in the NHQR:

- California patients age 65 and over insured by Medicare and public insurance were less likely than patients age 65 and over with Medicare and private insurance to find it easy to understand information from a doctor's office.

Figure 5.11. Adults who find it easy to understand written information from a doctor's office, by Hispanic and Asian ethnicity, California, 2007



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Source: University of California, Los Angeles, Center for Health Policy Research, California Health Interview Survey, 2007.

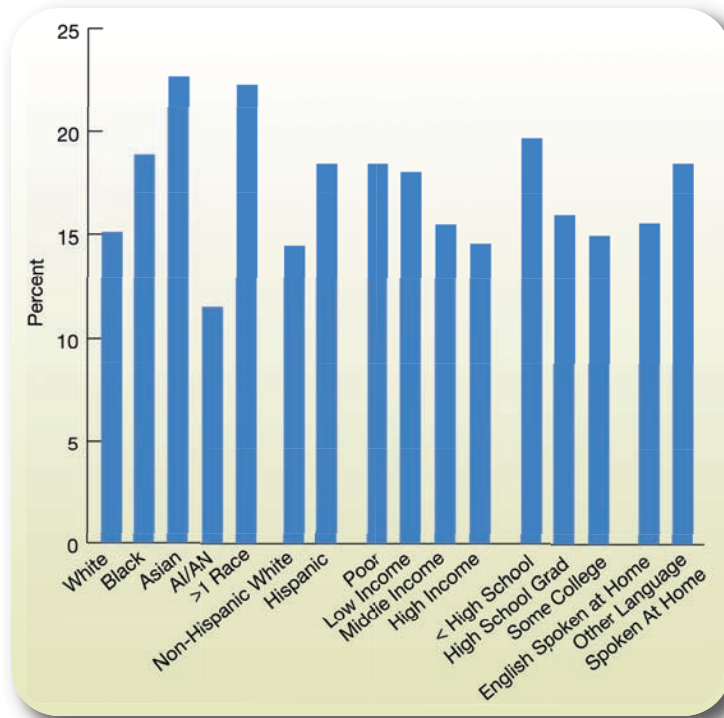
- In California in 2007, Asians were significantly more likely than Hispanics to find it easy to understand written information from a doctor's office (84.0% compared with 76.0%; Figure 5.11).
- In California in 2007, Central American patients were significantly less likely than the overall Hispanic population to find it easy to understand written information from a doctor's office (65.7% compared with 76.0%)
- In 2007, Mexican patients in California were significantly more likely than Central American patients to find it easy to understand written information from a doctor's office (75.9% compared with 65.7%). South American patients also were more likely than Central American patients to find it easy to understand information from a doctor's office.
- In 2007, Filipino and South Asian patients living in California were significantly more likely than the overall Asian population to find it easy to understand written information from a doctor's office (93.3% and 91.2%, respectively, compared with 84.0%).
- In 2007, Chinese patients living in California were significantly less likely than all other Asian ethnic groups except Koreans to find it easy to understand written information from a doctor's office.

Providers Asking Patients To Assist in Making Treatment Decisions

The high prevalence of chronic disease has placed more responsibility on patients. Conditions such as diabetes and hypertension require self-management by patients. It is vital that patients are provided with information that allows them to make informed decisions and feel engaged in their treatment and that it incorporates their values and preferences.

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Figure 5.12. Adults with a usual source of care whose health providers sometimes or never asked for the patient's help to make treatment decisions, by race, ethnicity, income, education, and English proficiency, 2007



Key: AI/AN = American Indian or Alaska Native.

Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2007.

- In 2007, Whites were significantly less likely than Blacks, Asians, and people of more than one race to have a usual source of care sometimes or never ask for the patient's help to make treatment decisions (15.1% compared with 18.9%, 22.7%, and 22.3%, respectively; Figure 5.12).
- In 2007, non-Hispanic White patients were significantly less likely than Hispanics to have a usual source of care sometimes or never ask for the patient's help to make treatment decisions (14.5% compared with 18.5%).
- In 2007, patients with some college education were significantly less likely than patients with less than a high school education to have a usual source of care sometimes or never ask for the patient's help to make treatment decisions (15.0% compared with 19.7%).
- In 2007, patients who usually spoke English at home were significantly less likely than patients who mostly spoke another language at home to have a usual source of care sometimes or never ask for the patient's help to make treatment decisions (15.6% compared with 18.5%).

Also, in the NHQR:

- In 2007, patients living in metropolitan areas were significantly more likely than patients living in nonmetropolitan areas to have a usual source of care not ask for their help in making treatment decisions.

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