

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.

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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.

In addition, the NHQR 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.
 - Reading the instructions on a prescription bottle.
- Enabling patients to make informed decisions about their treatment options.
 - Understanding information from a doctor's office.
 - Enabling patient participation in treatment decisions.

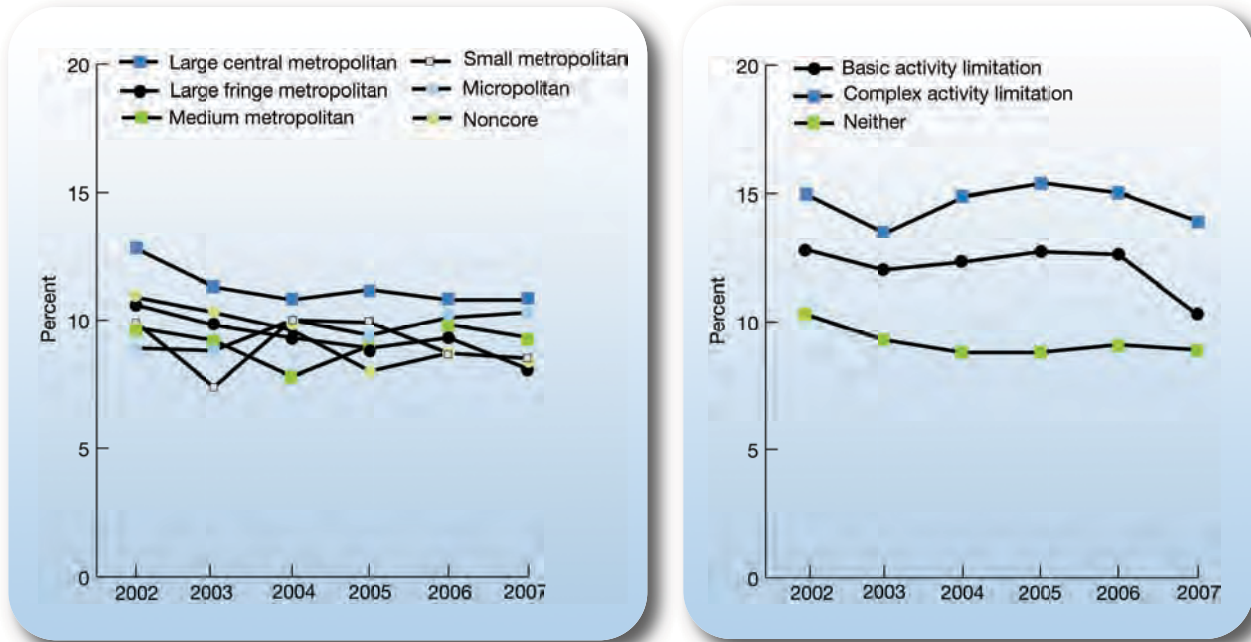
Findings

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.

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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: Overall composite, by residence location and activity limitation, 2002-2007



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.

- From 2002 to 2007, the percentage of adults with a doctor's office or clinic visit who reported poor communication significantly decreased, from 10.8% to 9.3% (data not shown).
- In 5 of 6 years, a significantly lower percentage of adults in large fringe metropolitan areas reported poor communication with their health providers than adults in large central metropolitan areas; 2006 was the exception (Figure 5.1).
- From 2002 to 2007, there was a significant decrease in the percentage of adults with a doctor's visit who reported poor communication in large fringe and large central metropolitan areas. Micropolitan residents were the only group to report an increase in the percentage of patients who reported poor communication.
- In all years, adults with basic or complex activity limitations were more likely to report poor communication than adults with neither basic nor complex activity limitations. In 2004, 2005, and 2007, a significantly higher percentage of adults with complex activity limitations reported poor communication than adults with basic activity limitations.
- From 2002 to 2007, the percentage of adults with a doctor's office or clinic visit who reported poor communication decreased from 12.8% to 10.3% for adults with basic activity limitations and decreased from 10.3% to 8.9% for adults with neither basic nor complex activity limitations.

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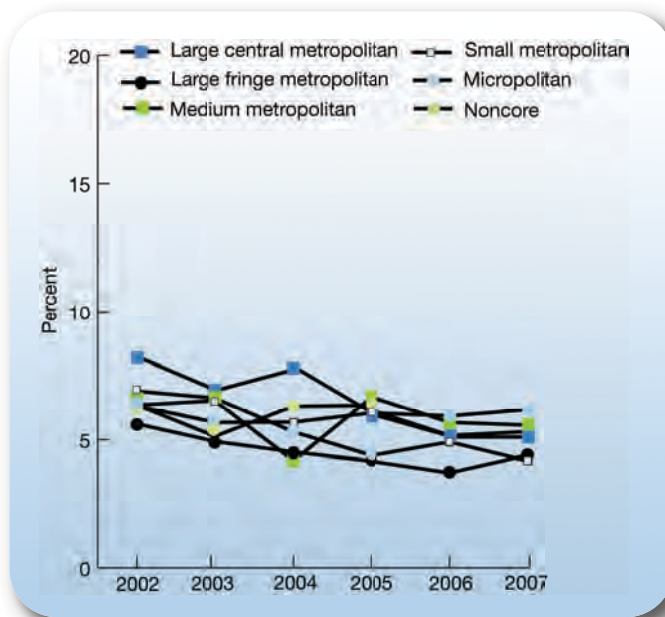
Also, in the NHDR:

- In all years, Hispanics were significantly more likely than non-Hispanic Whites to report poor communication.
- In most years, Black and Asian patients were more likely than White patients to report poor communication with health providers.

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.

Figure 5.2. 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 residence location, 2002-2007



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

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

Note: 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. Data for noncore areas in 2006 did not meet criteria for statistical quality, confidentiality, or reliability.

- In 2007, 4.9% of parents of children who had a doctor's office or clinic visit in the last 12 months reported poor communication with health providers. This rate is a significant improvement over the 2002 rate of 6.7% (data not shown).
- The percentage reporting poor communication between 2002 and 2007 decreased significantly for children residing in large central and small metropolitan areas (Figure 5.2).

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- 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 did parents residing in large central metropolitan areas; 2006 and 2007 were the exceptions.

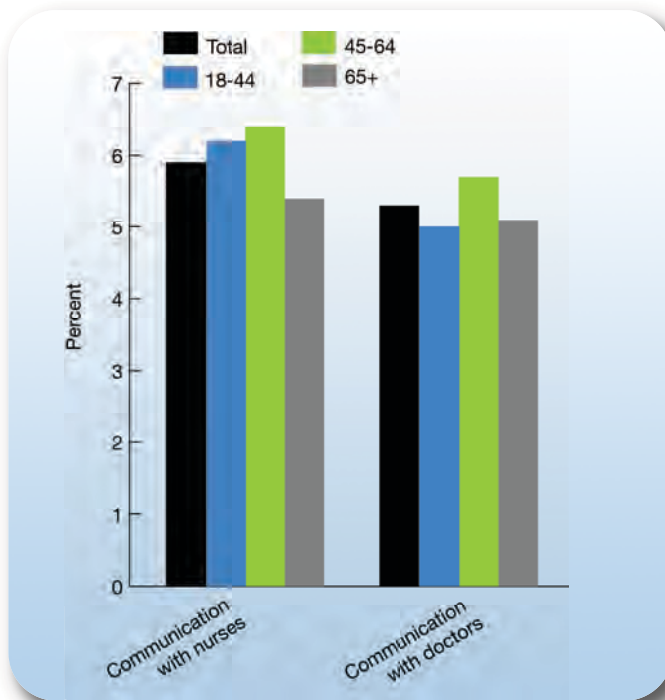
Also, in the NHDR:

- From 2002 to 2007, the difference in 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.
- In all years, poor and low-income parents were significantly more likely than high-income parents to report poor communication with their child's health provider.

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 four measures of provider-patient communication into a single core measure. The composite measure presented includes data on providers who sometimes or never listened carefully, explained things clearly, respected what patients had to say, and spent enough time with patients. These data are presented separately for communication with doctors and communication with nurses.

Figure 5.3. Adult hospital patients who reported poor communication with nurses and doctors, by age, 2007



Source: Agency for Healthcare Research and Quality, Hospital Consumer Assessment of Health Plans 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?”

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- Overall, 5.9% of adult hospital patients reported poor communication with nurses during their hospital stay and 5.3% reported poor communication with doctors (Figure 5.3).
- Compared with patients ages 18-44, patients age 65 and over were less likely to report poor communication with nurses.
- Compared with patients ages 18-44, patients ages 45-64 were more likely to report poor communication with doctors.

Also, in the NHDR:

- Compared with Whites, all minority groups were more likely to report poor communication with nurses.
- Blacks, American Indians and Alaska Natives, and patients of more than one race were more likely than Whites to report poor communication with doctors.
- Racial minorities, Hispanics, patients with less than a high school education, and patients who speak a language other than English at home were also more likely to report poor communication with nurses and doctors.

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

To effectively navigate the complicated health care system, providers need to give patients access to culturally and linguistically appropriate tools to support patient engagement. Culturally and linguistically appropriate services (CLAS) are important components of effective health care delivery. It is vital for providers to understand patients' health care needs and for patients to understand providers' diagnosis and treatment recommendations. Communication barriers can relate to language, culture, and health literacy.

Health literacy is the capacity to obtain, process, and understand basic health information and services to make appropriate health decisions.¹⁵ Patients with limited health literacy are more likely to have difficulties understanding and executing proper medication use. It has also been shown that communication barriers such as limited English proficiency are associated with lower quality of care and place patients at risk for poor clinical outcomes.¹⁶

About one-third of Americans are not "health literate."^{17, 18} Individuals with inadequate health literacy incur higher medical costs and are more likely to have an inefficient mix of service use compared with those with adequate health literacy.¹⁹ They may experience many difficulties, including:

- Less preventive care.²⁰
- Poorer understanding of their conditions and care.^{17, 21, 22}
- Higher use of emergency and inpatient services and higher rates of rehospitalization.^{23, 24}
- Less adherence to medication schedules.²³
- Less participation in medical decisionmaking.²⁵

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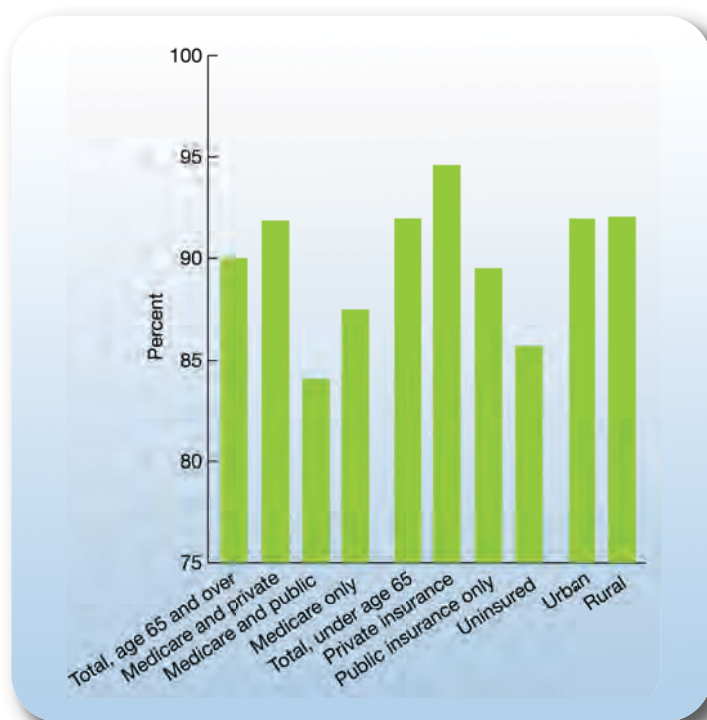
To fill the data gap that currently exists, we examined subnational data-gathering activities and identified the California Health Interview Survey (CHIS) as a unique source of this information. CHIS is conducted by the UCLA Center for Health Policy Research in collaboration with the California Department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

Reading the 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 misunderstands 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 to protocol. A patient's health literacy levels, cognitive abilities, or visual impairment can lead to an imprecise, unsafe medication regimen. It is important that health care providers not only rely on patient's assurance that they understand medication instructions, but also insist on having patients clearly demonstrate their understanding.

Figure 5.4. Adults who found it easy to read the instructions on a prescription bottle, by insurance status and location, California, 2007



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

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- In 2007, patients age 65 and over insured by Medicare and public insurance in California were less likely than patients with Medicare and private insurance to find it easy to read the instructions on a prescription bottle (84.1% compared with 91.9%; Figure 5.4).
- In 2007 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 (89.5% and 85.7%, respectively, compared with 94.6%).

Also, in the NHDR:

- In 2007, patients in California who did not speak English well or at all were less likely than patients who only speak English to find it easy to read the instructions on a prescription bottle.

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, 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.

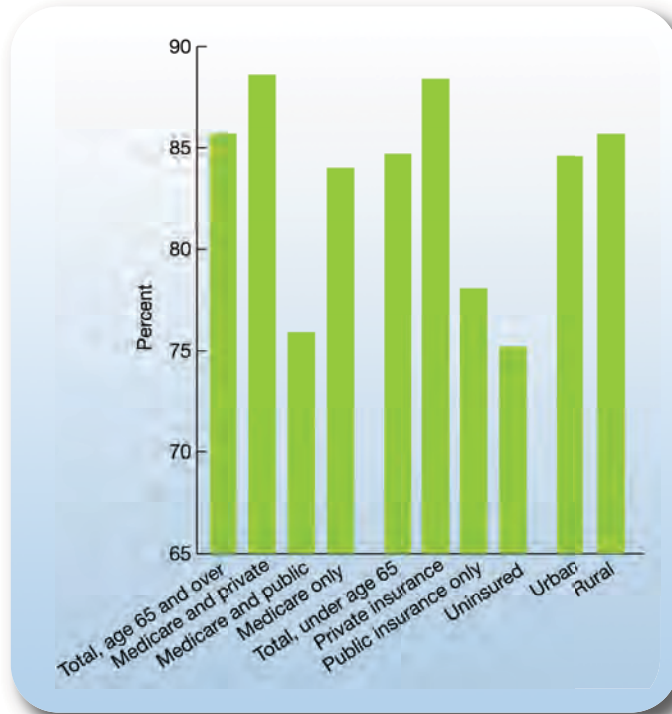
Understanding Information From a Doctor's Office

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 health care provider's 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.



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Figure 5.5. Adults who found it easy to understand written information from a doctor's office, by insurance status and location, California, 2007



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

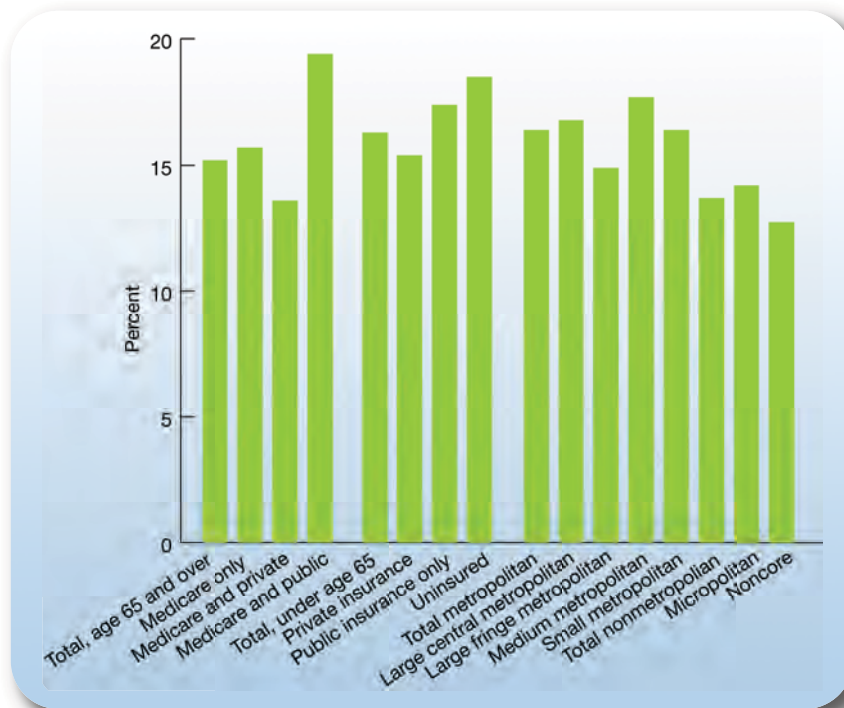
- In 2007, California patients age 65 and over with Medicare and private insurance were significantly more likely than patients with Medicare only and those with Medicare and public insurance to find it easy to understand written information from a doctor's office (88.6% compared with 84.0% and 75.9%, respectively; Figure 5.5).
- In 2007, patients under age 65 with private health insurance were significantly more likely than patients with public insurance and uninsured patients to find it is easy to understand written information from a doctor's office (88.4% compared with 78.1% and 75.2%, respectively).
- In 2007, there were no statistically significant differences between the percentage of patients in urban and rural areas of California who found it easy to understand written information from a doctor's office.

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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.

Figure 5.6. Adults with a usual source of care whose health providers sometimes or never asked for the patient's help to make treatment decisions, by insurance status and location, 2007



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

- In 2007, patients under age 65 who were uninsured were significantly more likely than patients with private health insurance to have a usual source of care who did not ask for their help in making treatment decisions (18.5% compared with 15.4%; Figure 5.6).
- In 2007, patients age 65 and over with Medicare and public insurance were significantly more likely than patients with Medicare and private insurance to have a usual source of care not ask for their help in making treatment decisions (19.4% compared with 13.6%).
- 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 (16.4% compared with 13.7%).

Also, in the NHDR:

- In 2007, patients who most often spoke English at home were significantly more likely than patients who mostly spoke another language at home to have a usual source of care always ask for the patient's help to make treatment decisions (61.6% compared with 51.9%).

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