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GOING IT TOGETHER: Persistence of Older Adults' Accompaniment to Physician Visits by a Family Companion

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Abstract

Background/Objectives—Although older adults are often accompanied to routine physician visits and commonly receive disability-related task assistance, the overlap and persistence of this help is not well understood. This study investigates whether older adults who are accompanied to routine physician visits (1) also receive task assistance and (2) continue to be accompanied at 12-months by the same family companion.

Design—Observational study.

Setting and Participants—Community-dwelling adults ages 65 and older who responded to the Medicare Current Beneficiary Survey (MCBS) in 2006 (n=11,582), and a subset (n=7,510) who responded in 2005 and 2006.

Measurements—Accompaniment to physician visits by a family companion and receipt of task assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs).

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None of the authors received corporate financial support, consultantships, speaker arrangements, company holdings, or patents that were specifically related to the research described in this article.

Author Contributions:
Dr. Wolff conceptualized this paper, obtained funding, designed and interpreted analyses and drafted the manuscript with Drs Boyd, Gitlin, Bruce, and Roter. Dr. Boyd collaborated in the design and and interpretation of data, critical revision of this manuscript for important intellectual content. Dr. Gitlin was responsible for collaborating in the following activities for this paper: study design and implementation, interpretation of data and critical revision of the manuscript for important intellectual content. Dr. Bruce was a co-investigator responsible for collaborating in the following activities: conceptualization of the paper, interpretation of data, and critical revision of the manuscript for important intellectual content. Dr. Roter was a co-investigator responsible for collaborating in the following activities for this paper: design and implementation, analysis and interpretation of data, and critical revision of the manuscript for important intellectual content.

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Persistent accompaniment and consistent family companion involvement was ascertained from 2005 and 2006 survey responses.

Results—Among community-dwelling older adults, 18.6% were accompanied to physician visits only and 12.7% were both accompanied to physician visits and received task assistance. Accompanied older adults who received task assistance were older, less educated, and self rated worse health than their counterparts who were accompanied only. Family companions who provided task assistance (versus those who did not) were more actively engaged in physician visit processes and more often identified as "always" present. Three-fourths (74.5%) of accompanied older adults were persistently accompanied to physician visits at 12 months, nearly always (87.9%) by the same family companion. Receipt of task assistance was strongly associated with persistent accompaniment (aOR=2.52; 95% CI: 1.93–3.29).

Conclusions—Older adults' accompaniment to physician visits typically persists, most often by consistently involved family companions. Findings have implications for the patient-physician partnership and the patient-centered medical home.

Keywords

physician-patient relationship, doctor-patient interaction; companion; accompany; family member

INTRODUCTION

Family members are the predominant providers of long-term care to disabled adults in the home and community.[1] They are also routinely present and engaged in health care processes.[2] Family is acknowledged as relevant to the health care workforce for an aging America,[1] to productive chronic care interactions,[3, 4] and to the patient-centered medical home.[5, 6] Recent observational studies and meta-analyses provide compelling evidence that family has a bearing for valued patient endpoints such as information recall,[7] engagement in medical decision-making,[8] and adherence to medical treatments.[9] In view of this evidence, several position papers and commentaries from professional societies have set forth policies to promote the "patient-family-physician" partnership.[10–12]

Despite broad consensus that family is relevant to health care processes, few health system innovations to date have explicitly or systematically involved patients' family.[13, 14] Actionable knowledge regarding *when* and *how* providers might best partner with families is notably lacking.[1, 2, 13] In regard to physician visits, information regarding the scope and persistence of family involvement is sparse. Contributing studies have typically relied on small convenience samples in relation to a single physician encounter.[7, 8] To our knowledge, no studies have empirically examined the extent to which family companions who accompany patients during physician visits also engage in more traditionally defined long-term task assistance with activities of daily living(ADLs) or instrumental activities of daily living (IADLs), or whether their involvement in physician visits persists over time. Such knowledge could prove useful to targeting care management interventions and to establishing provider practice infrastructure that better supports the patient-family companion dyad.

This paper informs initiatives to advance the patient-family-physician partnership by elaborating upon the existing profile of community-dwelling older adults who are accompanied to physician visits as well as their accompanying family companions. First, we examine family involvement in activities that span traditionally defined spheres of long-term care (provision of personal care and household task assistance) and health care (accompanying patients during routine physician visits). Second, we investigate the potential relevance of family in regard to older adults' continuity of care, a central tenant of an

effective partnership between a patient and their usual care physician,[15] by investigating persistence of patient accompaniment and consistency of involved family companions at one year follow-up.

METHODS

Data Source and Sample

The Medicare Current Beneficiary Survey (MCBS) is a rotating panel survey that is conducted in-person with a nationally representative sample of Medicare beneficiaries.[16] The MCBS is a rich data source because of its large sample, extensive information on a wide range of health issues, and ability to link survey waves across years. In-person interviews are conducted with persons living in the community, or proxy respondents when participants are unavailable or unable to respond. The MCBS response rate for the incoming 2006 panel was 83%.[17] First, accompaniment to routine physician visits and receipt of task assistance are described among 11,582 community-dwelling study participants ages 65 and older who were continuously-enrolled throughout the calendar year and responded to the 2006 edition of the MCBS. Second, persistence of physician visit accompaniment and consistency of family companion involvement was determined at one-year follow-up for a subset of 7,510 participants who responded to both 2005 and 2006 waves.

Study Measures

Study participant attributes included age, gender, race, education, marital status, living arrangement, race, self-rated health, and presence of 14 physician-diagnosed chronic conditions, hearing, and vision impairment. Disability was defined as difficulty with instrumental activities of daily living (IADLs: using the telephone, light housework, meal preparation, shopping, money management) and activities of daily living (ADLs: bathing, dressing, eating, transferring, toileting) that were due to a health or physical problem. Calendar year hospitalization was examined for the subset of participants (n=8,752; 75.6%) enrolled in fee-for-service Medicare during calendar year 2006. Participants were categorized as accompanied during routine physician visits if they responded that they were “usually” accompanied to their usual care physician, and identified a helper as “always” or “sometimes” present while with their doctor. Participants were categorized as receiving task assistance if they indicated that they were assisted with any of 5 IADLs or 5 ADLs due to a health or physical problem.

The identity of the person who accompanied participants to physician visits was elicited for a single person, subsequently referred to as participants’ “family companion” throughout this paper. Study participants reported relationship to their family companion, co-residence (yes/no), if their family companion was a trained health professional, and whether their family companion also provided task assistance, as defined previously. Study participants also reported functions performed by their family companion during physician visits across activities encompassing *logistics* (transportation, physical assistance, appointment scheduling), *engagement in care processes* (taking notes, asking questions, providing information to the doctor about the patient’s medical condition, explaining physicians’ instructions to the patient, and acting as an English language translator), and *provision of company and moral support*.

Statistical Analyses

Characteristics of older adults and family companions were examined, stratified by receipt (or provision) of task assistance in 2006. Statistical significance of observed differences in participant and family companion attributes for those who did and did not receive (or provide) task assistance was evaluated on the basis of the 95% confidence interval for each

estimate. These analyses were conducted with SAS version 9.1[18] using participant cross-sectional sampling weights in conjunction with SAS survey procedures to account for the complex multistage survey design of the MCBS.

We examined persistence of accompaniment and consistent family companion involvement for the subset of 7,510 participants who responded to both 2005 and 2006 waves of the MCBS. Persistent accompaniment, defined as being accompanied during physician visits in both years, was ascertained for 2,380 participants who were accompanied to physician visits in 2005. Consistent family companion involvement, defined on the basis of identifying the same person who fulfilled the role of family companion in both years, was determined for 1,817 participants who were accompanied to physician visits in both 2005 and 2006. Simple and multivariate logistic regression models were constructed to examine the association between participant and family companion attributes in 2005 in regard to the two outcomes of interest at 12 months follow-up. These analyses incorporated 2005 longitudinal weights in conjunction with SAS survey procedures to account for the MCBS multistage survey design.

This study was reviewed by the Johns Hopkins University School of Public Health Institutional Review Board. As a secondary data analysis of a pre-existing, de-identified/de-linked dataset, this study was determined to be “not human subjects” research.

RESULTS

Characteristics of Accompanied Older Adults

Nearly 1/3 (31.3%) of community-dwelling adults ages 65 and older were accompanied during routine physician visits in 2006; 12.7% were both accompanied and received task assistance with ADL or IADL activities, while 18.6% were accompanied to physician visits only (Table 1). Relative to individuals who were exclusively accompanied in physician visits, those who also received task assistance were older, less likely to have completed high school, less likely to be married or live with a spouse, and possessed worse self-rated health. Accompanied older adults who received task assistance were twice as likely to be hospitalized throughout the calendar year relative to their counterparts who were accompanied only (41.0% vs. 19.9%).

Family Companion Attributes, Functions Performed, and Regularity of Accompaniment

Older adults’ companions were overwhelmingly family members (93.3%; Table 2). There was variability in family companions’ relationship to participant on the basis of task assistance provision. Persons who exclusively accompanied older adults to physician visits were most often spouses (62.1%), whereas adult children and spouses were equally represented among companions who provided task assistance (42.6% respectively). Approximately 70% of companions co-resided with older adults; few companions (<2%) were trained health professionals.

Family companions who provided task assistance were more actively engaged in physician visit communication and logistics. They were more likely to communicate information about participants’ medical conditions (70.5% versus 43.6%), to record physician comments and instructions (69.2% versus 45.7%), ask questions (67.1% versus 47.4%), and explain physician instructions to participants (54.5% versus 30.0%). They were more likely to assist with logistical issues including transportation (69.1% versus 41.7%), scheduling appointments (38.6% versus 19.2%), and provision of physical assistance during the visit (23.1% versus 3.3%), but were half as likely to be identified as present for the provision of company and moral support (14.4% versus 31.6%).

Family companions typically accompanied older adults to physician visits on a regular basis; 70.3% of companions were identified as “always” (versus “sometimes”) present. Family companions who provided task assistance were more often identified as “always” present during physician visits compared with family companions who accompanied patients only (81.8% versus 63.9%).

Persistence of Accompaniment and Consistency of Family Companion Involvement

Three-fourths (74.5%) of community-dwelling older adults who were accompanied to physician visits in 2005 were also accompanied in 2006. Study participants who were older (aOR=1.06; 95% CI: 1.04–1.07), male (aOR=1.35; 95% CI: 1.05–1.74) and who possessed less than high school education (aOR=1.37; 95% CI: 1.08–1.74) were more likely to be persistently accompanied to physician visits; each additional chronic condition incrementally increased the likelihood of persistent accompaniment (aOR=1.08; 95% CI: 1.02–1.15; Table 3). Relative to older adults who were accompanied by spouse, those who were accompanied by an adult child in 2005 were more likely (aOR=1.34; 95% CI: 1.03–1.74), and those with a non-family companion were approximately half as likely to be persistently accompanied (aOR=0.55; 95% CI: 0.32–0.93). Receipt of task assistance was strongly associated with persistent accompaniment (aOR=2.54; 95% CI: 1.95–3.33).

Nearly 9 in 10 (87.9%) persistently accompanied beneficiaries were accompanied in both 2005 and 2006 by a consistently involved family companion. Few patient factors were associated with consistent family companion involvement; receipt of task assistance was not among them (aOR=0.90; 95% CI: 0.65, 1.24). Persistently accompanied beneficiaries who were non-white were less likely to have consistent family companion involvement (aOR=0.70; 95% CI: 0.55, 0.89). Family companion relationship was strongly related to consistency of involvement at one-year follow-up. Adult children (aOR=0.24; 95% CI: 0.16–0.37), other family (aOR=0.15; 95% CI: 0.08–0.29), and non-family companions (aOR=0.13; 95% CI: 0.08–0.23) were overwhelmingly less likely to be consistently present relative to spouse companions.

DISCUSSION

This study advances knowledge regarding the dynamics of older adults’ accompaniment to routine physician visits by providing the first empirical evidence as to its co-occurrence with receipt of ADL or IADL task assistance and its persistence over time.. We found nearly one-third of community-dwelling older adults were accompanied by a family companion during routine physician visits, of whom less than half received ADL or IADL assistance. Family companions who also provided ADL or IADL task assistance were more regularly present and actively engaged in routine physician visit processes. Persistent accompaniment of older adults to routine physician visits was found to be the norm rather than the exception. Three-fourths (76.3%) of older adults who were accompanied to physician visits in 2005 continued to be accompanied in 2006, almost always (87.1%) by the same family companion.

Although family is acknowledged as important for the health care workforce for an aging America,[1] productive chronic care interactions, [3, 4] and the patient-centered medical home,[5] surprisingly little is known about family involvement in health care delivery processes. A small evidence base finds nearly 4 in 10 disproportionately old, sick, and less educated patients are accompanied during routine physician visits,[2] and family companion presence to be influential to valued patient endpoints.[2, 7, 8] Our study extends this literature in documenting that accompaniment most often persists longitudinally, that more than half of accompanied older adults are functionally independent, and that family companions are more verbally active when accompanying functionally disabled patients who receive ADL or IADL task assistance. Several national quality initiatives argue for more effective

integration and partnership between health care professionals and patients' families and friends,[4, 5, 19] highlighting a need to advance "best practice" professional educational competencies and provider practice infrastructure to facilitate effective patient-family-provider partnerships. [11, 20]

We are unable to comment on activities or processes beyond those specified in the MCBS, but it is reasonable to speculate that accompanying helpers who are consistently present and involved in physician visit communication may be better prepared to facilitate health care management activities at home and in the community.[21] For example, the MCBS does not field questions regarding medication management, but it is plausible that some number of accompanying family companions assist patients with medications. To the extent that physicians discuss medication names, treatment effects, and intended outcomes during physician visits, we surmise that the presence and engagement of family members during physician visits might benefit desired outcomes such as medication adherence, safety, and information exchange between physicians.

There is a growing awareness that families commonly help coordinate care across a fragmented health system.[1, 13, 22] The range of activities they assume, in what settings, and under what circumstances requires further investigation. The fact that 41% of accompanied older adults receiving task assistance were hospitalized during the calendar year confirms the relevance of family to transitional care efforts. Identifying strategies and resources that prepare family companions for the roles they assume in physician visits and in chronic disease self management also merits consideration. For example, decision aid interventions have been found to benefit patients' knowledge and participation in treatment decisions.[23] The extent to which families already assume relevant "coach" functions,[24] and the potential to further develop family companions' skills to motivate patient engagement in treatment decisions and self management has to our knowledge been unstudied.

This study establishes that older adults are commonly accompanied during physician visits by the same family companion, and that such arrangements most often persist over time. Results substantiate the importance of health care workforce initiatives that advance the patient-family-physician partnership.[10–12] Most health care professionals receive limited formal training to prepare them for interactions with an accompanied patient-family companion dyad.[11] Guidelines and competencies for optimizing professional health care workers' interactions with patients and their "family caregivers" have been recently advanced by, or on behalf of, several physician, nurse, and social work professional societies.[12, 20] Results from this study confirm the practical importance of these initiatives, and the potential benefit of educational innovations that prepare physicians and other health care professionals to interact with accompanied patients and the broad range of family companions involved in their care.

We found variability in the scope of assistance received by accompanied older adults, the behaviors assumed by family companions during physician visits, and the temporal stability of the patient-family companion dyad. Indicators of accompanied older adults' vulnerability, including age, education, and numbers of chronic conditions were associated with receipt of task assistance as well as persistence of accompaniment at one-year follow-up. Although spouses were most consistently involved in the capacity of family companion during physician visits, older adults accompanied by an adult child were most likely to be persistently accompanied at one year. That family companions exist within a broad and dynamic social network, with greater fluidity in adult child involvement is consistent with what has been reported in regard to ADL and IADL assistance provision.[25] Collectively, findings suggest merit to developing effective strategies that build the capacity of patients

within the context of their existing support systems[13, 26] and that improve information transfer and care coordination across both professional and lay caregivers.[5, 22, 27]

The role of family companions who accompany older adults to physician visits without providing ADL or IADL task assistance has been less recognized to date. Our results indicate that more than half of family companions, most often spouses, fit this description. Although these family companions were less active during physician visits, it is not clear that implications of their presence is less influential in regard to patient-provider communication or outcomes of care. A complex set of issues preclude broad generalizations in regard to patient-family provider communication dynamics, including the nature, severity, and sensitivity of conditions being managed, patient concerns regarding confidentiality, variability in family dynamics, and the roles and behaviors assumed by family companions outside the physician office.[26] In light of the high prevalence of older adults' accompaniment to physician visits, there is a striking lack of knowledge regarding optimal approaches and supportive infrastructure to facilitate productive patient-family-provider partnerships that are responsive to patients' needs and preferences. For example, systematic elicitation and documentation of patients' authorization for information access (preferably in an electronic health record) would benefit family companions seeking medical information for the purposes of coordinating patients' health care or adjudicating insurance documentation, and for patients or health care professionals concerned about ensuring patient privacy.[28]

Several limitations of this study merit comment. Although the MCBS provides a wealth of information from a nationally representative sample, information regarding helpers and helping arrangements was sparse. We were unable to examine hours of care, attitudes toward provision of care, whether helpers were paid, or their gender, education, age, or employment. Because we could not differentiate between proxy respondents who were also family companions, we were unable to ascertain the extent to which proxy reporting introduced measurement error or bias to study findings. Questions regarding receipt of assistance are fielded annually; therefore analyses regarding the extent to which helping arrangements persist were necessarily one-year in duration. We were unable to empirically examine family companion involvement in conjunction with recovery from health event, (e.g. discharge from the acute hospital), or their exchanges with physicians or physician practices by phone or email. Articulating the evolution and trajectory of helping arrangements was beyond the scope of this study.

Our study is particularly important in the context of recent efforts to establish the patient-centered medical home. Although the patient-centered medical home conceptually encompasses family, and places the "patient and his or her family at the center of care"[5, 6, 27] the extent to which the medical home infrastructure extends to patients' families has not been well articulated. In establishing that older adults' accompaniment to routine physician visits typically persists over time in the presence of actively engaged and consistently involved family companions, findings support recent effort by the Centers for Medicare and Medicaid Services to improve care for individuals with multiple chronic conditions[4] and to better equip families with information and resources (e.g., www.Medicare.gov/caregivers). Efforts to advance the "patient and family-centered" medical home[5] make now an opportune time to expand the evidence base around *how* physicians, physician practices, and other health care providers might partner with older adults' existing family supports – who are already present, actively engaged, and consistently involved in care provision.

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Dr. Gitlin serves on the Phillips Life Line Falls Advisory Board. Her services include advising on the scientific literature concerning falls at home but this activity was unrelated to the research described in this paper. Martha Bruce has served as a consultant to Medispin, Inc., a medical education company. Her services included providing educational content to a website developed by the company, but this activity was unrelated to the research described in this paper.

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Table 1

Receipt of Task Assistance Among Community Dwelling Older Adults (65+) Who Were Routinely Accompanied to Physician Visits in 2006

	Accompanied Older Adults %, (95% CI)	Receives Task Assistance %, (95% CI) //	
Care Recipient Characteristics	**(31.3%)**	**No (18.6%)**	**Yes (12.7%)**
Weighted Sample *	9,552,000	5,665,000	3,887,000
Mean age (years)	78.0 (77.7, 78.3)	76.4 (76.1, 76.8)	80.3 (79.9, 80.7)
Female gender	56.3 (54.8, 57.8)	52.1 (49.8, 54.4)	62.4 (60.1, 64.6)
Marital status †			
Married	62.2 (60.2, 64.1)	71.9 (70.0, 73.8)	47.9 (44.8, 51.1)
Widowed	31.7 (29.9, 33.4)	23.3 (21.4, 25.1)	43.9 (40.9, 46.8)
Divorced/separated/never married	6.2 (5.4, 7.0)	4.8 (3.8, 5.8)	8.2 (6.7, 9.7)
Less than high school education	37.9 (35.6, 40.1)	33.3 (30.7, 35.9)	44.5 (41.4, 47.5)
Living arrangements			
Lives alone	19.0 (17.7, 20.3)	16.3 (14.8, 17.8)	23.0 (20.9, 25.2)
Lives with spouse only	50.5 (48.4, 52.7)	59.2 (56.6, 61.7)	38.0 (35.0, 40.9)
Lives with spouse and/or children	25.3 (23.6, 27.1)	20.7 (18.7, 22.7)	32.1 (29.6, 34.7)
Other arrangements	5.1 (4.4, 5.8)	3.9 (3.0, 4.8)	6.8 (5.7, 8.0)
Race †			
White	84.8 (83.1, 86.6)	86.2 (84.3, 88.2)	82.8 (80.3, 85.3)
Black	8.5 (6.8, 10.2)	7.1 (5.5, 8.7)	10.5 (7.9, 13.1)
Other	6.7 (5.4, 7.9)	6.6 (5.2, 8.0)	6.7 (5.0, 8.4)
Perceived health status †			
Excellent/very good	33.6 (31.7, 35.5)	43.7 (40.9, 46.5)	18.8 (16.7, 20.9)
Good	33.6 (31.9, 35.3)	35.9 (33.6, 38.2)	30.2 (28.0, 32.4)
Fair/poor	32.9 (31.2, 34.5)	20.4 (18.3, 22.4)	51.0 (48.3, 53.8)
Mean numbers of chronic conditions †,‡,§	3.8 (3.7, 3.8)	3.2 (3.1, 3.2)	4.6 (4.5, 4.8)
Disability //			
IADL	55.3 (53.4, 57.3)	26.8 (24.8, 28.8)	96.9 (95.9, 97.9)
ADL	19.9 (18.3, 21.5)	0.0%	48.8 (46.0, 51.6)
Calendar year inpatient hospitalization#	28.7 (26.9, 30.4)	19.9 (17.8, 21.9)	41.0 (38.3, 43.7)

Source: Medicare Current Beneficiary Survey, 2006.

* Data are weighted to reflect the national population of continuously enrolled community-dwelling Medicare beneficiaries ages 65 years or older. Results in this table correspond to 3,900 study participants who were accompanied to routine physician visits in 2006.

† <1% of observations with responses of "don't know", "refused", or "not ascertained"; categorized as "married", "white", "poor" self-rated health, and absence of chronic condition.

‡ Self or proxy response to physician diagnosis for: hypertension, osteoarthritis, "other heart condition", diabetes, osteoporosis, coronary artery disease, psychiatric disorder (including depression), cancer, emphysema-asthma-chronic obstructive pulmonary disease, rheumatoid arthritis, stroke, vision impairment§, hearing impairment§, dementia, hip fracture, and Parkinson's disease

[§] Includes: "a lot of trouble" seeing or "no usable vision" while wearing glasses or contact lenses; "a lot of trouble" hearing or deaf (with a hearing aid).

[//] Health-related difficulty with any of 5 IADL tasks (using the telephone, light housework, meal preparation, shopping, paying bills) and ADL tasks (bathing, dressing, eating, transferring, toileting).

[#] Fee-for-service beneficiaries only.

Table 2

Accompanying Family Companions in Older Adults' Physician Visits Attributes, Functions, Regularity of Presence, Stratified by Task Assistance Provision, 2006

	Task Assistance Provision % (95% CI) *	
Companion Attributes	**No (64.5)**	**Yes (35.5)**
Relationship to Participant		
Spouse	62.1 (59.9, 64.3)	42.6 (39.4, 45.8)
Adult Child	27.9 (25.6, 30.2)	42.6 (39.6, 45.6)
Sibling	1.5 (1.0, 1.9)	2.2 (1.3, 3.0)
Grandchild	1.4 (0.9, 1.9)	1.6 (1.1, 2.1)
Other Relative	1.7 (1.2, 2.1)	2.2 (1.5, 3.0)
Roomate/Friend/Neighbor	4.4 (3.5, 5.3)	3.0 (2.1, 3.8)
Other Nonrelative	1.1 (0.6, 1.5)	5.8 (4.5, 7.2)
Coresides with Participant	72.5 (70.5, 74.6)	69.9 (67.4, 72.4)
Health Professional	0.07 (0.0, 0.2)	1.8 (1.2, 2.4)
Assistance Provided, by Category		
ADL †	-	48.7 (45.8, 51.6)
IADL‡	-	91.9 (90.4, 93.4)
Functions Performed		
Visit Communication		
Provide information, explain needs	43.6 (40.9, 46.2)	70.5 (67.4, 73.6)
Record instructions, take notes, remember	45.7 (42.9, 48.6)	69.2 (66.0, 72.3)
Ask questions	47.4 (44.1, 50.8)	67.1 (64.3, 69.9)
Explain doctor's instructions	30.0 (27.0, 32.9)	54.5 (51.1, 57.8)
Translate language	2.9 (2.0, 3.8)	3.6 (2.5, 4.7)
Keep company/moral support	31.6 (28.6, 34.5)	14.4 (11.5, 17.3)
Logistical assistance		
Transportation	41.7 (38.8, 44.7)	69.1 (65.6, 72.7)
Schedule appointments	19.2 (16.2, 22.2)	38.6 (35.1, 42.1)
Provide physical assistance	3.3 (2.4, 4.2)	23.1 (20.5, 25.8)
Regularity of Accompaniment		
Always	63.9 (61.3, 66.5)	81.8 (79.6, 84.1)
Sometimes	36.1 (33.5, 38.6)	18.1 (15.9, 20.4)

* Data are from the 2006 Medicare Current Beneficiary Survey (MCBS). Estimates are weighted using MCBS sample weights for study participants who completed the community interview. Results in this table correspond to 3,900 study participants who were accompanied to routine physician visits in 2006.

† ADL=Activities of daily living (bathing, dressing, eating, transferring, toileting)management).

‡ IADL=instrumental activities of daily living (telephone, light housework, meal preparation, shopping, and money management).

Table 3

Simple and Multivariate Logistic Regression Analyses of Persistence of Accompaniment to Routine Physician Visits and Consistency of Family Companion at One Year Follow-Up Among Community-Dwelling Older Adults (65+) Who Were Routinely Accompanied to Physician Visits in 2005

	Persistent Accompaniment *		Consistent Family Companion *	
Participant Attribute	**Simple OR (95% Cl)**	**aOR (95% Cl)**	**Simple OR (95% Cl)**	**aOR (95% Cl)**
Age (years)	1.07 (1.08, 1.08)	1.06 (1.04, 1.07)	0.96 (0.94, 0.97)	0.98 (0.97, 1.01)
Male gender	1.00 (0.81, 1.25)	1.35 (1.05, 1.74)	2.44 (1.76, 3.39)	1.22 (0.81, 1.86)
Black or "other"(vs. white) †	1.02 (0.75, 1.39)	0.97 (0.78, 1.21)	0.37 (0.26, 0.52)	0.70 (0.55, 0.89)
Less than high school education	1.58 (1.28, 1.95)	1.37 (1.08, 1.74)	0.46 (0.35, 0.62)	0.79 (0.58, 1.06)
Numbers of chronic conditions (0–12) †,‡,§	1.16 (1.10, 1.23)	1.08 (1.02, 1.15)	0.95 (0.90, 1.01)	1.02 (0.95, 1.11)
Fair or poor self rated health (vs. all other) †	1.42 (1.13, 1.80)	1.03 (0.78, 1.36)	0.59 (0.45, 0.78)	0.76 (0.55, 1.03)
Receives task assistance for disability ¶	3.13 (2.40, 4.10)	2.54 (1.95, 3.33)	0.53 (0.41, 0.69)	0.90 (0.65, 1.24)
Family Companion Relationship to Participant				
Adult child (vs. spouse)	2.02 (1.60, 2.55)	1.34 (1.03, 1.74)	0.17 (0.12, 0.24)	0.24 (0.16, 0.37)
Other family (vs. spouse)	1.07 (0.68, 1.70)	0.73 (0.42, 1.25)	0.11 (0.06, 0.20)	0.15 (0.08, 0.29)
Nonfamily (vs. spouse)	0.92 (0.56, 1.50)	0.55 (0.32, 0.93)	0.10 (0.06, 0.17)	0.13 (0.08, 0.23)

Source: Medicare Current Beneficiary Survey, 2005 and 2006.

* Data are weighted using 2005 MCBS longitudinal sample weights. Persistent accompaniment was examined for 2,380 study participants who were accompanied to routine physician visits in 2005. The presence of a consistent family companion was examined for 1,817 study participants who were accompanied to routine physician visits in 2005 and 2006.

† <1% of observations with responses of "don't know", "refused", or "not ascertained"; categorized as "white", "poor" self-rated health, and absence of chronic condition.

‡ Self or proxy response to physician diagnosis for: hypertension, osteoarthritis, "other heart condition", diabetes, osteoporosis, coronary artery disease, psychiatric disorder (including depression), cancer, emphysema-asthma-chronic obstructive pulmonary disease, rheumatoid arthritis, stroke, vision impairment d, hearing impairment d, dementia, hip fracture, and Parkinson's disease.

§ Includes: "a lot of trouble" seeing or "no usable vision" while wearing glasses or contact lenses; "a lot of trouble" hearing or deaf (with a hearing aid).

¶ Health-related difficulty with any of 5 IADL tasks (using the telephone, light housework, meal preparation, shopping, paying bills) and ADL tasks (bathing, dressing, eating, transferring, toileting).