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Comprehending care in a medical home: The association between a usual source of care and patient's perceptions about communication with healthcare providers

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Abstract

Context—The recent emphasis on improving health literacy highlights the importance of building strong relationships between patients and healthcare providers. Patients perceiving good communication in healthcare settings report better health status. Having a usual source of care (USC) may play a key role in achieving optimal communication between patients and physicians.

Objective—To determine if having an identified place for usual care is more often associated with positive patient perceptions about their communication and relationships with healthcare providers.

Design—Cross-sectional descriptive and multivariable analysis of the 2002 Medical Expenditure Panel Survey (MEPS), a nationally representative survey.

Setting/Participants—Civilian non-institutionalized US population aged ≥18 years who had visited a healthcare provider in the 12 months prior to the survey (N=approximately 16,700).

Outcome Measures—Respondents perceptions of their physicians' communication skills, measured in six related survey questions. Responses along a four-point Likert scale were dichotomized into "always" and "not always."

Results—Approximately 78% of U.S. adults reported having a USC in 2002. Among those who visited a healthcare provider in the 12 months prior to the 2002 MEPS survey, positive patient perceptions about physician communication were significantly associated with having an identified USC. When compared with adults reporting no USC (reference group, OR=1.0), adults with a USC were more likely to report that their providers always listened to them (OR=1.31, 95% CI 1.16-1.48), always explained things so they can understand (OR=1.26, 95% CI 1.13-1.41), always showed respect (OR=1.24, 95% CI 1.10-1.40), and always spent enough time with them

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(OR=1.20, 95% CI 1.07-1.35). Among those with an identified USC, several demographic factors were associated with patient perceptions of autonomy in making healthcare decisions, including: non-Hispanic ethnicity, private health insurance coverage, having a rural residence, living in a Western census region, and having a higher income.

Conclusions—Patients who have a usual place to go for healthcare needs are more likely to report positive communication and interactions with their healthcare providers. This study suggests that one way to improve communication in healthcare settings is to develop policies and practices to ensure that all patients have consistent access to a usual source of care.

INTRODUCTION

For many patients, navigating the US healthcare system can be daunting. With increasingly complex medical procedures and an explosion of media messages about pharmaceutical products, it is sometimes difficult to comprehend care. The ability to understand professional recommendations and to communicate with providers is important in the receipt of good quality healthcare services.[1] In turn, establishing good lines of communication can lead to better patient reported health status and health outcomes.[2-4]

Establishing care with a specific provider or at a familiar primary care site is associated with higher receipt of recommended preventive healthcare services.[5-7] A consistent source of care helps to minimize inappropriate use of the emergency department and to shorten lengths of stay in the hospital.[8-13] The development of a continuous relationship with a medical caregiver is especially important to people with chronic illnesses and mental health problems.[14, 15] Continuity of care is linked to better health outcomes.[16-21] Conversely, when people lack a regular source of care, their access to necessary services is reduced,[22-27] which may result in poorer health outcomes.[28]

Noting these favorable effects of having a usual source of care (USC), it is surprising to see recent trends that contribute to discontinuity. For some health plans, negotiating lower cost contracts is sometimes more important that preserving patient-physician continuity.[29] These shifts in insurance coverage can force a patient to choose a new USC.[30] In other cases, patients choose to change providers or clinics for various reasons,[31] and some patients just prefer convenience rather continuity.[32]

The association between continuity of care and better health outcomes is well established.[16-21] There is also increasing evidence establishing a link between good patient/ physician communication and better self-reported health status.[2-4] Less is known, however, about whether or not patients who have a usual place to go for needed care perceive their healthcare providers to be better communicators. The purpose of this study was to examine the extent to which having a USC increases the likelihood of achieving optimal communication between patients and healthcare providers. Additionally, another main study objective was to look for disparities in the perception of healthcare decision-making autonomy among demographic covariates with a USC in order to identify populations whose healthcare communication difficulties need to be further addressed.

METHODS

This cross-sectional analysis of nationally representative data was conducted to determine the extent to which a USC had an independent and combined influence on the likelihood that patients report positively about their communication and interactions with healthcare providers.

Data Source

Data used in this cross sectional study were obtained from the 2002 Medical Expenditure Panel Survey (MEPS) files, sponsored and made available to the public by the Agency for Health Care Research and Quality (AHRQ).[26] The MEPS consists of information on a nationally representative sample of civilian, non-institutionalized persons in the United States.[33] Computer-assisted personal interviewing was used for data collection. Our study was restricted to approximately 16,700 MEPS participants over the age of 18 who had visited a healthcare provider in the 12 months immediately prior to the fielding of the survey.

Study Variables

Predictor Variable: Usual Source of Care (USC)—The potentially explanatory variable of primary interest was whether or not each respondent had a usual source of care. To determine usual source of care (USC), respondents were asked: “Is there a particular doctor’s office, clinic, health center, or other place that you usually go to if you are sick or need advice about your health?”

Outcome Variables: Patient Perceptions of Provider Communication—Patient perceptions of their communication with healthcare providers were ascertained from responses to six MEPS questions. All participants who reported going to a doctor’s office or clinic in the 12 months prior to the survey were asked questions about how they perceived the interactions, including how often their healthcare providers listened carefully to them, explained things clearly to them, showed respect for what they had to say, and spent enough time with them. Two items were asked of only those patients who identified having a USC. This subgroup of respondents were asked two questions about their interactions with USC providers, including: (1) “If there were a choice between treatments, how often would a provider at your USC ask you to help make the decision?” and (2) “How often does a provider at your USC give you some control over your treatment?” Responses to all six survey questions were reported on a four-point Likert-type scale (always, usually, sometimes, never). A large majority of respondents reported either always or never, so for the purposes of creating logistic regression models, the responses were dichotomized into “always” and “not always.”

Analytical Strategy

Initially, descriptive analysis was conducted on the entire MEPS adult population to determine the relationship between demographic covariates and the predictor variable (having a USC) (See Table 1). The remaining analysis was done on a more limited group of just the MEPS adults who had seen a healthcare provider in the 12 months preceding the 2002 survey. Among this group, descriptive analysis was conducted to determine the relationship between demographics and the initial four outcome variables (patient perceptions of physician communication) (See Table 2). Multivariable logistic regression was then performed to control for significant covariates in determining the strength of associations between the predictor variable and the outcome variables (Table 3). Based on results from the descriptive analysis, these demographic characteristics included: sex, age, race, ethnicity, family income, completion of high school (head of household), geographic residence, residence within or outside of a Metropolitan Statistical Area (MSA), and type of current health insurance. Among the subgroup of participants who had a USC, two additional logistic regression models were performed (Table 4). SUDAAN software was used to conduct the statistical tests and to make national estimates with variance adjustment required for the complex sampling design of the 2002 MEPS. In all tables provided, the reported percentages have been weighted to produce estimates for the entire US population.

RESULTS

Demographics

More than 78% of U.S. adults had a usual source of care (USC) in 2002. Several demographic variables were strongly related to having a USC (Table 1). For example, more than 94% of people over the age of 64 reported having a USC, compared to only 65.1% of those between the ages of 18-24. A higher percentage of females (83.0%) had a USC when compared to their male counterparts (73.2%). Over 25% of the black reported no usual source of care, compared to less than 21% of whites. A large discrepancy existed based on ethnicity with only 59.9% of Hispanic with a USC, compared to 80.8% of the non-Hispanics. Adults who had completed high school were more likely to have a USC (79.5%) versus those who had not completed high school (73.2%). Only 70% of adults in the lowest income group had a USC, compared to nearly 84% of those with the highest incomes. Among those with insurance, over 82% with private insurance had a USC, while fewer than 47% of the uninsured had a USC.

Several of these same demographic variables were also strongly related to positive perceptions about physician communication skills (Table 2). In the bivariate analysis of all four questions, respondents consistently more likely to report positive perceptions of communication with healthcare providers were older (> 65 years of age), Hispanic, and/or had public health insurance. Participants living in non-Metropolitan statistical areas and those living in the northeast were also more likely to respond favorably to these questions.

Positive Patient Perceptions About Communication Associated with Having a USC

After controlling for the effects of all demographic characteristics reported in Tables 1 and 2, positive patient perceptions about physician communication were significantly associated with having an identified usual source of care (see Table 3). When compared with adults reporting no USC (reference group, OR=1.0), adults with a USC were more likely to report that their physician always listens to them (OR=1.31, 95% CI 1.16-1.48), always explains things so they can understand (OR=1.26, 95% CI 1.13-1.41), always shows respect (OR=1.24, 95% CI 1.10-1.40), and always spends enough time with them (OR=1.20, 95% CI 1.07-1.35).

Disparities in Perceptions About Provider Interactions Among Patients with a USC

Among the 78.3% of the population with a USC, there were demographic differences in who perceived having more autonomy in their own healthcare decision-making (Table 4). Respondents who reported that their providers gave them control over treatment choices were more likely to be white, compared to other races. Ethnicity was also significant with Hispanics feeling providers gave them less control over treatment decisions. This association with ethnicity is in contrast to the higher likelihood of Hispanic respondents in the overall population reporting positive communication with their providers (Table 2). Although no significant differences were seen between age groups when responding to the question about having control over treatments, the younger respondents (18-44 years of age) were less likely to report that their providers asked them to help make decisions.

In response to both questions about healthcare decision-making, patients living in households with the lowest family incomes were least likely to report that their providers offered autonomy in health care decision-making. When considering location of geographic residence, respondents living in the West and/or living in a Metropolitan Statistical Area were less likely to be given control over treatments or to be asked to help make decisions. Having private insurance was associated with a higher likelihood of reporting autonomy in making decisions about one’s own health care (Table 4).

DISCUSSION

These findings add further evidence to the importance of having a USC. As shown in Table 3, having a USC leads to a higher likelihood that a patient will report positive communication and interactions with healthcare providers. What can be done to help Americans without a USC? This study reveals that access to a USC is not randomly distributed among the US population. Efforts aimed at ensuring that more people have a USC should target populations who have historically been left without reliable access to healthcare providers. One way to expand this access is to strengthen the fragile safety net to provide more underserved populations a secure USC.[34-39] Once a USC is more widely available, continuity relationships can be more easily established. The priority should be on continuity of care, rather than aiming to maximize profits. Patients should always be involved in decisions to switch providers.[40]

However, simply having a place to go for usual care is often not good enough. This study revealed disparities in how providers at an identified USC involve patients in making their own health care decisions. What can be done to help eliminate disparities in care that is provided? As noted in this study and elsewhere, access to a USC is not a guarantor of health care decision-making autonomy, nor does it assure provision to buy prescriptions, to access specialty care, to obtain certain needed procedures, or to receive home care services.[38] Regardless of having a USC, insurance coverage plays a major role in how healthcare decisions get made.[41] Any policies that would improve access to a USC must also take into account the effects of insurance status and other factors that impact receipt of services and patient autonomy.[34, 42-44] More work can be done to increase awareness among healthcare providers about how to actively involve all patients in decisions about their health.[45] Providers can be offered education about how to assess patient health literacy skills in order to better communicate and improve shared decision-making.[1]

There are important limitations to this study analysis. As in all surveys, responses are subject to possible reporting error and response bias not accounted for by statistical adjustments. Our findings are associations between variables and do not establish causal relationships. This study uses secondary analysis of existing data; therefore, it is limited by the questions asked on the MEPS. For example, MEPS survey asks about a USC site and not a specific continuity provider. Although this study was not able to narrowly define the outcome as a specific continuity provider, having a USC is essential in order to build a continuity relationship with one or more providers.

CONCLUSIONS

This study suggests that one way to improve communication in healthcare settings is to develop policies and practices to ensure that all patients have consistent access to a usual source of care. Once this relationship is established, further work can be done to eliminate disparities in the way care is provided and received.

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Table 1

Demographic Characteristics of US Adults Who Have a Usual Source of Care

Demographics	Percent with a Usual Source of Care (Unweighted N=25,851) [weighted %]
Total	78.3%
Sex**	
Male	73.2%
Female	83.0%
Age Group**	
18-24 years	65.1%
25-44 years	70.5%
45-64 years	85.1%
≥65 years	94.0%
Race**	
White	79.3%
Black	74.3%
American Indian	74.4%
Asian	69.9%
Native Hawaiian	77.5%
Multiple Races	72.9%
Ethnicity**	
Hispanic	59.9%
Not Hispanic	80.8%
Family Income**	
Poor	70.0%
Near Poor	71.5%
Low Income	72.0%
Middle Income	77.7%
High Income	83.4%
Completed High School**	
Yes	79.5%
No	73.2%
Geographic Residence**	
Northeast	85.6%
Midwest	81.4%
South	74.9%
West	74.2%

Demographics	Percent with a Usual Source of Care (Unweighted N=25,851) [weighted %]
Residence Location [*]	
MSA	77.5%
Non-MSA	81.8%
Health Insurance [**]	
Any Private	82.5%
Public	85.8%
Uninsured	46.7%

Note: Percentages rounded to nearest tenth.

[*] $p<0.01$

[**] $p<0.001$

Table 2

US Adults Reporting Positive Perceptions of Healthcare Provider Communication

Demographics	Percent reporting provider "always" listened carefully to them Unweighted N=16,669 [weighted %]	Percent reporting provider "always" explained things so they understood Unweighted N=16,700 [weighted %]	Percent reporting provider "always" showed respect for what they had to say Unweighted N=16,781 [weighted %]	Percent reporting provider "always" spent enough time with them Unweighted N=16,773 [weighted %]
Total	55.2%	56.9%	58.9%	45.7%
Sex				
Male	56.2%	57.6%	59.6%	46.9%
Female	54.5%	58.1%	58.5%	44.9%
Age Group				
18-24 years	51.5%	57.9%	54.9%	40.4%
25-44 years	50.9%	56.3%	55.6%	41.4%
45-64 years	56.2%	58.9%	59.6%	47.0%
≥65 years	63.0%	60.4%	65.8%	53.9%
Race				
White	54.7%	57.8%	58.4%	45.1%
Black	63.4%	63.9%	67.5%	52.9%
American Indian	54.2%	63.6%	54.3%	48.1%
Asian	47.8%	49.2%	51.2%	41.5%
Native Hawaiian	46.4%	60.5%	48.0%	45.5%
Multiple Races	44.8%	48.1%	50.6%	37.2%
Ethnicity				
Hispanic	57.5%	59.0%	63.1%	46.0%
Black/not Hispanic	55.0%	57.8%	58.5%	45.7%
Family Income				
Poor	56.4%	56.9%	59.1%	46.9%
Near Poor	55.7%	53.8%	59.5%	46.3%
Low Income	57.2%	57.4%	59.7%	46.0%
Middle Income	54.2%	57.9%	58.1%	45.5%
High Income	55.1%	58.5%	59.2%	45.5%
Completed High School				
Yes	54.4%	57.9%	58.4%	44.9%
No	59.3%	57.9%	61.7%	49.7%
Geographic Residence				
Northeast	58.2%	61.0%	62.9%	49.4%
Midwest	57.5%	59.4%	60.0%	46.8%
South	55.0%	56.9%	58.2%	45.7%
West	50.3%	55.0%	55.2%	41.2%

Demographics	Percent reporting provider “always” listened carefully to them Unweighted N=16,669 [weighted %]	Percent reporting provider “always” explained things so they understood Unweighted N=16,700 [weighted %]	Percent reporting provider “always” showed respect for what they had to say Unweighted N=16,781 [weighted %]	Percent reporting provider “always” spent enough time with them Unweighted N=16,773 [weighted %]
Residence Location				
MSA	54.5%	57.5%	58.7%	44.8%
Non-MSA	58.3%	59.3%	60.1%	49.5%
Health Insurance				
Any Private	54.6%	57.8%	58.8%	44.9%
Public	61.0%	60.5%	62.5%	52.4%
Uninsured	50.4%	53.8%	53.5%	41.1%
Usual Source of Care				
Yes	56.4%	57.9%	59.9%	46.7%
No	47.1%	51.3%	52.3%	39.0%

Table 3

Differences in Patient Perceptions about Physician Communication Among Patients With and Without a Usual Source of Care (USC)

MEPS Questions Regarding Physician Communication	Percent responding "always" to questions regarding physician communication (weighted %)	Multivariate OR (95% CI) (Odds of responding "always" to the key questions)
Provider listened carefully to them (N=16,699)		
Yes USC	56.4%	1.31 (1.16, 1.48)
No USC	47.1%	1.0
Provider explained things so they understood (N=16,700)		
Yes USC	57.9%	1.26 (1.13, 1.41)
No USC	51.3%	1.0
Provider showed respect for what they had to say (N=16,781)		
Yes USC	59.9%	1.24 (1.10, 1.40)
No USC	5.3%	1.0
Provider spent enough time with them (N=16,773)		
Yes USC	46.7%	1.20 (1.07, 1.35)
No USC	39.0%	1.0

Adjusted for gender, age, race, ethnicity, family income, education, geographic region, MSA status, health insurance status.

Note: OR=odds ratio; CI=confidence interval

Table 4

Demographic Variation Among those with a Usual Source of Care in Their Perceptions about Their Degree of Health Decision-making Autonomy

Demographic Variable	Provider "Always" Gives Person Control of Treatment		Provider "Always" Asks Person to Help Make Health Care Decisions	
	Weighted %	Multivariate OR (95% CI)	Weighted %	Multivariate OR (95% CI)
Total	50.1%		52.2%	
Sex				
Male	49.7%	0.95 (0.91, 1.00)	51.8%	0.95 (0.89, 1.00)
Female	50.4%	1.00	52.6%	1.00
Age Group				
18-24 years	48.0%	0.88 (0.74,1.04)	48.0%	**0.78 (0.66, 0.92)**
25-44 years	50.9%	0.92 (0.81,1.03)	50.9%	**0.85 (0.75, 0.96)**
45-64 years	53.5%	0.99 (0.87, 1.13)	53.5%	0.91 (0.80, 1.03)
≥65 years	54.7%	1.00	54.7	1.00
Race				
White	51.1%	**1.56 (1.09, 2.23)**	53.2%	1.39 (0.96, 2.01)
Black	47.1%	1.37 (0.95, 1.96)	50.4%	1.28 (0.87, 1.89)
American Indian	46.6%	1.36 (0.80, 2.33)	46.2%	1.09 (0.63, 1.88)
Asian	39.0%	1.04 (0.66, 1.65)	41.0%	0.95 (0.59, 1.53)
Native Hawaiian	37.2%	0.98 (0.36, 2.63)	36.1%	0.77 (0.29, 2.02)
Multiple Races	38.5%	1.00	43.2%	1.00
Ethnicity				
Hispanic	42.6%	**0.83 (0.72, 0.95)**	46.0%	0.88 (0.76, 1.01)
Black/not Hispanic	50.8%	1.00	52.9%	1.00
Family Income				
Poor	43.7%	**0.80 (0.69, 0.93)**	46.9%	**0.84 (0.72, 0.98)**
Near Poor	54.2%	1.17 (0.94, 1.47)	56.4%	1.16 (0.93, 1.45)
Low Income	47.8%	0.88 (0.77, 1.01)	50.4%	0.90 (0.78, 1.04)
Middle Income	48.8%	**0.87 (0.79, 0.97)**	51.5%	0.90 (0.81, 1.00)
High Income	52.6%	1.00	54.1%	1.00
Completed High School				
Yes	51.0%	1.09 (0.98, 1.21)	52.9%	1.06 (0.95, 1.18)
No	46.0%	1.00	49.3%	1.00
Census Region				
Northeast	53.4%	**1.41 (1.17, 1.70)**	54.7%	**1.36 (1.14, 1.62)**
Midwest	50.7%	**1.21 (1.01, 1.43)**	52.8%	**1.20 (1.02, 1.42)**
South	51.5%	**1.29 (1.07, 1.55)**	54.2%	**1.30 (1.09, 1.55)**

Demographic Variable	**Provider "Always" Gives Person Control of Treatment**		**Provider "Always" Asks Person to Help Make Health Care Decisions**	
	Weighted %	**Multivariate OR (95% CI)**	**Weighted %**	**Multivariate OR (95% CI)**
West	43.7%	1.00	46.0%	1.00
Urban/Rural				
MSA	49.9%	**0.81 (0.68, 0.96)**	51.1%	**0.81 (0.68, 0.96)**
Non-MSA	54.6%	1.00	56.9%	1.00
Health Insurance				
Any Private	51.4%	**1.16 (1.02, 1.32)**	53.4%	**1.16 (1.01, 1.34)**
Public	45.4%	0.98 (0.83, 1.17)	48.7%	0.99 (0.84, 1.16)
Uninsured	46.0%	1.00	48.0%	1.00

Note: OR=odds ratio; CI=confidence interval; MSA=metropolitan statistical area