



Health care

Patient-health care professional gender or race/ethnicity concordance and its association with weight-related advice in the United States



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ARTICLE INFO

Article history:

Received 20 April 2015

Received in revised form 22 August 2015

Accepted 27 August 2015

Key words:

Obesity

Overweight

Health disparity

Concordance

Health care professional

ABSTRACT

Objective: Examine association between adult patients' and health care providers' (HCPs) gender or race/ethnicity concordance and patients' reported receiving weight-related advice from HCPs in USA.

Methods: Using Medical Expenditure Panel Survey (MEPS) 2004–2007 data, studied prevalence of weight-related advice (on exercise and diet) given to patients and its association with patients/HCPs concordance in gender ($n = 9,686$) and race/ethnicity ($n = 8,825$).

Results: Overall, 46% of patients received HCP advice on diet and 49% on exercise. Overweight females seeing female HCPs were more likely to receive exercise advice than those seeing male HCPs (OR = 1.44 [95% CI: 1.10–1.89]). Race/ethnicity concordance was associated with lower odds of advice-receiving in certain populations (OR = 0.80 [0.67–0.97] for exercise and OR = 0.42 [0.19–0.91] for diet among white patients, OR = 0.47 [0.23–0.98] for exercise among Hispanic overweight patients).

Conclusions: Patient/HCP gender or race/ethnicity concordance was not positively associated with HCPs providing weight-related advice. Patients with female HCPs or with racial/ethnic discordant HCPs (especially black or Asian HCPs) were more likely to receive advice.

Practice implications: Health care providers need be empowered, particularly white and male HCPs, to improve delivery of weight-related advice. It may reflect better of receiving weight-related advice based on patients' recall.

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1. Introduction

The prevalence of overweight and obesity in the U.S. has increased steadily in the past four decades [1,2]. Health care professionals (HCPs) play a key role in helping overweight and obese patients to adopt healthful lifestyles and achieve or maintain a healthy body weight. However, only 36–42% of obese patients in the US reported ever receiving weight-related advice from their HCP [3–6]. In addition to the health care systems' insufficient effort on obesity prevention and control, research has found significant gender and race/ethnicity differences in patients' receiving advice

on diet and exercise in the US [7–9]. Research has also found that HCPs' gender and race/ethnicity play a role in HCPs' provision of weight-related advice to patients [10,11].

Patients and HCPs have their own visible characteristics (e.g., gender, race/ethnicity). During a clinical encounter, concordance in these characteristics between patients and their HCPs may influence the patient–provider relationship. For example, patient–provider race concordance is related to the patient's greater satisfaction with care [12], better patient–physician communication, and higher patient involvement [13,14]. Gender concordance between patient and physician has been shown to impact communication in various dimensions, including patient agendas elicited, talk content, communication style, nonverbal communication, exhibition of power, and length of consultation [15], and therefore enhances the patient's trust and satisfaction [16].

We are aware of two studies exploring the role of gender or race/ethnicity concordance between a patient and an HCP on

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weight-related advice [7,8]. These studies, however, were both based on physicians' reports, focused only on white and black patients, and only on obese patients. The present study takes the patients' perspective and examines the impact of patient-HCP gender and race/ethnicity concordance on patients' recall of receiving weight-related advice. It is important to study the delivery of weight-related advice in practice based on patients' reported information rather than based on HCPs', since the advice recalled by patients may imply successful delivery of clinical advice.

We hypothesized that patient-HCP gender and race/ethnicity concordance would be positively associated with patients receiving such advice. Assuming that HCPs' clinical decision-making on weight-related counseling may differ by patients' weight status [17], we also explored whether the association between the patient receiving weight-related advice and the concordance of patient-HCP characteristics varies by the patient's weight status.

2. Methods

2.1. Study design and data

This is a cross-sectional study conducted using nationally representative data from the Medical Expenditure Panel Survey (MEPS) Household Components (HC), 2004–2007. All years of data were pooled for this analysis. The MEPS-HC uses a complex sampling design, incorporating stratification, clustering, multiple stages of selection and disproportionate sampling of non-institutionalized U.S. civilians [18]. Using computer-assisted personal interviewing technology, the MEPS-HC interviews were conducted in the respondent's language of choice in order to minimize language barriers for minorities. Respondents were queried about their health status, demographic and socioeconomic characteristics, health insurance coverage, and use of, access to and satisfaction with health care services.

2.2. Subjects

Eligible subjects were respondents aged ≥ 18 years old who were not pregnant during the study period, had a usual source of care and at least one visit to a doctor's office or clinic in the previous 12 months (not including emergency room visits) ($n=23,213$). We dropped 12,898 persons because they reported that their primary HCP was a facility. We also excluded patients with missing body mass index (BMI) ($n=607$), or extreme BMI values (≥ 78 , $n=4$). The final analytic sample included only those who reported that their primary HCP was an individual person ($n=9704$).

2.3. Study variables

2.3.1. Outcome variables

Patients' recall of whether they had received weight-related advice was used to create the two outcome variables used in this analysis. Specifically, "Has a doctor or other health provider ever recommended that you eat fewer fat or high-cholesterol foods?" and "When was that?" were used to create the variable on receiving advice to restrict high fat/cholesterol in the previous 12 months, and "Has a doctor or other health provider ever recommended that you to exercise more?" and "When was that?" were used to create the variable on receiving advice to exercise more in the previous 12 months. MEPS stated that the health providers referred to in the survey could be a general doctor, a specialist doctor, a nurse practitioner, a physician's assistant, a nurse or any other health professional a patient would see for health care services.

2.3.2. Primary independent variables

Gender concordance was defined as whether a patient reported his/her HCP was of the same gender as the patient (e.g., male patient/male HCP dyads and female patient/female HCP dyads); other gender combinations were defined as gender discordance.

The MEPS asked two questions to identify the HCP's race/ethnicity: (1) is the provider Hispanic or Latino? and (2) What is the provider's race/ethnicity? The first question is a yes/no question and the second lets patients check one specific race/ethnicity from a list of options. For the purpose of this study, race/ethnicity was categorized as White Non-Hispanic, black Non-Hispanic, Hispanic and Asian.

Race/ethnicity concordance was defined as when a patient and his/her HCP had the same race/ethnicity (white patient/white HCP; black patient/black HCP; Hispanic patient/Hispanic HCP; and Asian patient/Asian HCP). Other combinations were defined as race/ethnicity discordance.

2.3.3. Other covariates

Based on previous studies [7,8,19], we controlled for the following important demographic and socioeconomic factors, as well as health status, as covariates in our model:

- (1) Patients' characteristics: patients' age, language spoken/used at home (English, Spanish and other languages), educational status, residence region (Northeast, Midwest, South and West), whether the residence is in a metropolitan statistical area (MSA) and survey year.
- (2) Patients' weight status: BMI was calculated from self-reported weight and height, e.g., normal weight ($18.5 \leq \text{BMI} \leq 24.9$), overweight ($25.0 \leq \text{BMI} \leq 29.9$), and obesity ($\text{BMI} \geq 30.0$).
- (3) Count of the patient's chronic diseases based on respondents' reports of: diabetes mellitus, lipid metabolism disorder, essential hypertension, hypertension with complications and secondary hypertension, acute myocardial infarction, coronary atherosclerosis and other heart diseases, nonspecific chest pain, acute cerebrovascular disease, other cerebrovascular diseases, transient cerebral ischemia, cancers, coma, stupor and brain damage, paralysis, gout and other crystal arthropathies, and blindness. The number of chronic conditions ranged from 0 to 10.
- (4) Self-rated health status was measured on a 5-point Likert scale and further categorized into three groups: excellent/very good, good, and fair/poor.
- (5) Insurance type was categorized into three types: private, public and uninsured.
- (6) HCP specialty was categorized as general internist, family physician, specialist physician or other type of HCP (e.g., nurse, nurse practitioner, chiropractor, etc.)

2.4. Statistical analysis

All analyses were conducted using the commands for complex survey data (svy commands) in Stata, version 11.2 (StataCorp LP, College Station, Texas). The MEPS sampling weights and variance adjustment variables were incorporated to provide nationally representative estimates. Distributions of the study population's characteristics are presented in means (continuous variables) or percentages (categorical variables). Logistic regression models were used to examine the association of receiving weight-related advice with patient-HCP gender concordance and race/ethnicity concordance, controlling for patient age, gender, language spoken at home, BMI, number of chronic diseases, self-rated health status, clinic visit times, education, insurance type, region, MSA, data collection year and HCP gender and specialty. Separate models

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