

# Relationship Between Adolescent Report of Patient-Centered Care and of Quality of Primary Care

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## ABSTRACT

**OBJECTIVE:** Few studies have examined adolescent self-report of patient-centered care (PCC). We investigated whether adolescent self-report of PCC varied by patient characteristics and whether receipt of PCC is associated with measures of adolescent primary care quality.

**METHODS:** We analyzed cross-sectional data from Healthy Passages, a population-based survey of 4105 10th graders and their parents. Adolescent report of PCC was derived from 4 items. Adolescent primary care quality was assessed by measuring access to confidential care, screening for important adolescent health topics, unmet need, and overall rating of health care. We conducted weighted bivariate analyses and multivariate logistic regression models of the association of PCC with adolescent characteristics and primary care quality.

**RESULTS:** Forty-seven percent of adolescents reported that they received PCC. Report of receiving PCC was associated

with high quality for other measures, such as having a private conversation with a clinician (adjusted odds ratio [aOR] 2.2; 95% confidence interval [CI] [1.9, 2.6]) and having talked about health behaviors (aOR 1.6; 95% CI 1.4, 1.8); it was also associated with lower likelihood for self-reported unmet need for care (aOR 0.8; 95% CI 0.7, 0.9) and having a serious untreated health problem (aOR 0.4; 95% CI 0.3, 0.5).

**CONCLUSIONS:** Many adolescents do not report receiving PCC. Adolescent-reported PCC positively correlates with measures of high-quality adolescent primary care. Our study provides support for using adolescent-report of PCC as a measure of adolescent primary care quality.

**KEYWORDS:** adolescents; patient-centered care; primary care; quality measurement

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## WHAT'S NEW

Adolescent-report of patient-centered care (PCC) is positively associated with measures of high-quality adolescent primary care. Adolescent-reported PCC may be a useful measure of the quality of primary care for adolescents.

PATIENT-CENTERED CARE (PCC)—CARE that is designed around patients' needs, preferences, circumstances, and well-being—is increasingly recognized as a key component of care quality that should be addressed as part of overall quality improvement strategies. The US Institute of Medicine stated in its influential report, *Crossing the Quality Chasm*, that PCC is both a core component of well-functioning health systems and a defining element of the patient-centered medical home (PCMH).<sup>1</sup> Conceptually, PCC has been hypothesized to improve health-related patient

behaviors such as adherence to care, patient activation and self-management, and engagement in shared decision making.<sup>2,3</sup> Evidence is growing for adults that PCC is associated with achieving better outcomes.<sup>4–6</sup> For instance, PCC is associated with lower readmission rates and greater adherence to treatment plans.<sup>4,6</sup> Studies in pediatric settings have similarly demonstrated that PCC is associated with better parent-reported experience and improved health outcomes.<sup>7,8</sup> Furthermore, studies of adults have demonstrated that PCC may help reduce racial and ethnic disparities in the quality of care.<sup>9</sup>

PCC is generally measured by surveying patients about their health care experiences because patients and families are generally considered the best reporters of these aspects of care. In the primary care setting, items assessing PCC usually address components of care such as how well providers listen, explain things, and treat patients and families with courtesy, respect, and cultural sensitivity. Measures of PCC in pediatrics typically rely on parent report, which

can be problematic for adolescent care. Adolescents often see providers without a parent present and keep some of their health care confidential, especially when seeking care for sexual health, substance use, and other sensitive issues. Therefore, parents' perspectives may be incomplete when reporting on adolescent receipt of PCC, as they are not privy to all care provided at the visit. In addition, even when parents are present for care, their own and their adolescents' perspectives on PCC might differ. Adolescent reports of PCC would not necessarily be the same as reports from adults about their own care or about the care of their children; consequently, eliciting perspectives of PCC from adolescents is important. However, few studies have examined adolescents' own reports on receipt of PCC. In addition, to our knowledge, no studies to date have examined whether adolescent self-reported experience of care is associated with other measures of adolescent primary care quality.

We thus aimed to examine in a community sample whether adolescent self-report of PCC varies by patient characteristics and whether adolescent receipt of PCC is associated with measures of adolescent primary care quality.

## METHODS

We analyzed data from Healthy Passages, a longitudinal multisite study of health among youth.<sup>10,11</sup> The Healthy Passages study team conducted interviews of students and their primary caregivers (henceforth referred to as parents) to assess risk factors, health behaviors, and health outcomes. The participants were initially recruited through public schools in and around Birmingham, Alabama; Houston, Texas; and Los Angeles County, California. The study team randomly sampled schools with probabilities designed to provide a balanced sample of children who were non-Hispanic black, Hispanic (regardless of race), and non-Hispanic white. Parents of 6663 of 11,532 children in sampled schools permitted us to contact them; 5147 (77%) participated in the study. Parents provided written informed consent; children provided written assent. The baseline wave took place in 2004–2006 when the youth were in 5th grade.

This study analyzes wave 3 data, which were collected 5 years after baseline, when most youth were in 10th grade. Data for wave 3 were collected in 2009–2011. The retention rate at wave 3 was 86.7%; 4461 children completed the wave 3 surveys (mean and SD 16.1 ± 0.5 years). Three hundred fifty-six children were omitted because they were missing information on one of the variables included in the composite measure of PCC, leaving an analysis sample of 4105. Each parent–child dyad completed computer-assisted personal interviews and audio-computer-assisted self-interviews (for sensitive questions) in English or Spanish. Institutional review boards at the study sites and the US Centers for Disease Control and Prevention approved the study.

### PATIENT-CENTERED CARE

Using items adapted from the Young Adult Health Care Survey (YACHS),<sup>12</sup> the Healthy Passages survey asked

adolescents to report on 4 key components of patient-centeredness: whether their doctors/health providers listened carefully to them, explained things in a way that was easy to understand, showed respect for what they said, and spent enough time with them. Answer options included “always,” “usually,” “sometimes,” and “never.” PCC was a derived composite of these components. Adolescents who reported that their doctor/health provider “usually” or “always” performed all of these 4 activities over the last 12 months were classified as having received PCC; others were classified as having not received PCC.

### DEPENDENT VARIABLES: MEASURES OF ADOLESCENT PRIMARY CARE QUALITY

The items that assessed adolescent primary care quality were also adapted from the YACHS.<sup>12</sup> Receipt of confidential care was measured with the following yes/no items: “During the past 12 months, did you get a chance to speak with a doctor or other health provider privately, meaning one on one, without your parents or other people in the room?” and “During the past 12 months, did a doctor or other health provider tell you that what you talked about with them was confidential, meaning it would not be shared with anyone else?”

Provider screening for specific adolescent health-related topics was assessed. Screening for health behaviors included discussing weight, healthy eating or diet, and physical activity or exercise. Screening for drugs and alcohol included discussing substance use (ie, tobacco, chewing tobacco or snuff, alcohol, or drug use) and riding in a car or other motor vehicle with a driver who has been drinking or using drugs. Screening for sexual health included talking about deciding whether or not to have sex and about contraception. Last, screening for sexual orientation was assessed by asking whether a provider talked with them about sexual orientation. Screening for health behaviors, drugs and alcohol, and sexual health were each measured through 2 (drugs and alcohol and sexual health) or 3 (health behaviors) summary dichotomous yes/no items, where “yes” for the summary variable indicates that providers had discussed at least one of the related items.

Unmet need was assessed by the following 2 yes/no items: “Has there been any time in the past 12 months when you thought you should get medical care, including a regular checkup, visit for illness or a visit for another reason but you did not?” and “During the past 12 months, have you ever had a serious health problem that went untreated?” For the overall rating of health care, adolescents were asked to rate all of the health care they received from doctors or health providers in the last 12 months from 0 to 10, where 0 indicated “worst health care possible” and 10 indicated “best health care possible.”

### INDEPENDENT VARIABLES

Child demographic variables included age, gender, race/ethnicity (Asian, black/non-Hispanic, Hispanic, white/non-Hispanic, or other), and insurance status (public, private, or no insurance). Household variables included

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