Patient perspectives and characteristics

Disparities in perceived patient–provider communication quality in the United States: Trends and correlates

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ABSTRACT

Objective: This study aimed to describe disparities and temporal trends in the level of perceived patient–provider communication quality (PPPCQ) in the United States, and to identify sociodemographic and health-related factors associated with elements of PPPCQ.
Methods: A cross-sectional analysis was conducted using nationally-representative data from the 2011–2013 iterations of the Health Information National Trends Survey (HINTS). Descriptive statistics, multivariable linear and logistic regression analyses were conducted to examine associations.
Results: PPPCQ scores, the composite measure of patients' ratings of communication quality, were positive overall (82.8; 95% CI: 82.1–83.5). However, less than half (42–46%) of respondents perceived that providers always addressed their feelings, spent enough time with them, or helped with feelings of uncertainty about their health. Older adults and those with a regular provider consistently had higher PPPCQ scores, while those with poorer perceived general health were consistently less likely to have positive perceptions of their providers' communication behaviors.
Conclusions: Disparities in PPPCQ can be attributed to patients' age, race/ethnicity, educational attainment, employment status, income, healthcare access and general health.
Practice implications: These findings may inform educational and policy efforts which aim to improve patient–provider communication, enhance the quality of care, and reduce health disparities.

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1. Introduction

Effective and efficient communication is essential for achieving quality healthcare [1,2]. Communication among providers, patients, and their families is central to building trust and mutual understandings of patients' health needs and values; and to establishing decision-making processes that incorporate agreed-upon approaches, goals, and expectations [3–8]. Moreover, evidence suggests that effective communication and health outcomes are positively correlated [9–17].

Recently, advocacy for the patient-centered medical home (PCMH) [18,19] has prompted providers to enhance their biomedical style with a more patient-centered approach to care [6–8,20]. Patient-centered communication is fundamental to this approach and has been linked to increased engagement in health promotion activities, adherence to treatment recommendations, improved health status, improved quality of life, patient satisfaction [8,9,13–17,21], and improved provider satisfaction [9,14,22]. However, a growing body of research suggests that post-visit outcomes are less likely to be associated with the provider's implementation of patient-centered communication behaviors and more likely to be determined by the patient's perceptions of the quality of the information exchange and the clinical encounter [14–24]. In essence, patients' perceptions about the quality of provider communication may have greater impact on outcomes than the provider's actual behaviors.

Evidence suggests that perceived patient–provider communication quality (PPPCQ) may be influenced by a number of patient factors, such as healthcare access, health status, health information sources [12,25–27], sociodemographic characteristics and communication styles [27]. Yet, it remains unclear how PPPCQ varies across key sociodemographic and health related factors, and there is a lack of consensus on strategies to address the collective influence of these factors [12,28]. For example, some researchers suggest there are racial/ethnic disparities in PPPCQ [27,29–32], while others have found no significant sociodemographic associations [12]. Previous research has also yielded mixed results

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regarding the potential influence of other factors, such as age, gender, educational attainment, and general health status on patient–provider communication [5,28,33]. Given these inconsistencies, and the potential for improved PPPCQ to reduce disparities in healthcare and outcomes, we conducted a nationally-representative study designed to (1) describe disparities and temporal trends in the level of PPPCQ in the United States (US), and (2) identify sociodemographic, healthcare access, and health status factors associated with various elements of PPPCQ.

2. Methods

2.1. Study design, data source, and sample

We conducted a secondary analysis of cross-sectional data from the Health Information National Trends Survey (HINTS) 2011–2013 (HINTS 4 Cycles [H4C] 1–3). HINTS is a nationally-representative survey administered biennially, by the National Cancer Institute (NCI), to adults 18 years and older, irrespective of cancer history, to monitor changes in the evolution of health communication [34].

Data from each HINTS cycle were collected via self-administered mail questionnaires between 2011 and 2013. A two-stage stratified sampling design was utilized in each iteration. In stage one, an equal-probability sample of addresses was selected from a sampling frame of US residential addresses grouped into three mutually-exclusive strata (i.e., high-minority, low-minority, and Central Appalachia). In stage two, a within-household respondent selection method was utilized to select one adult in each sampled household. The final response rates for each of the survey iterations, respectively, were 36.7% (H4C1), 40.0% (H4C2) and 35.0% (H4C3). Additional details about the HINTS 4 methodology are available elsewhere [35–38].
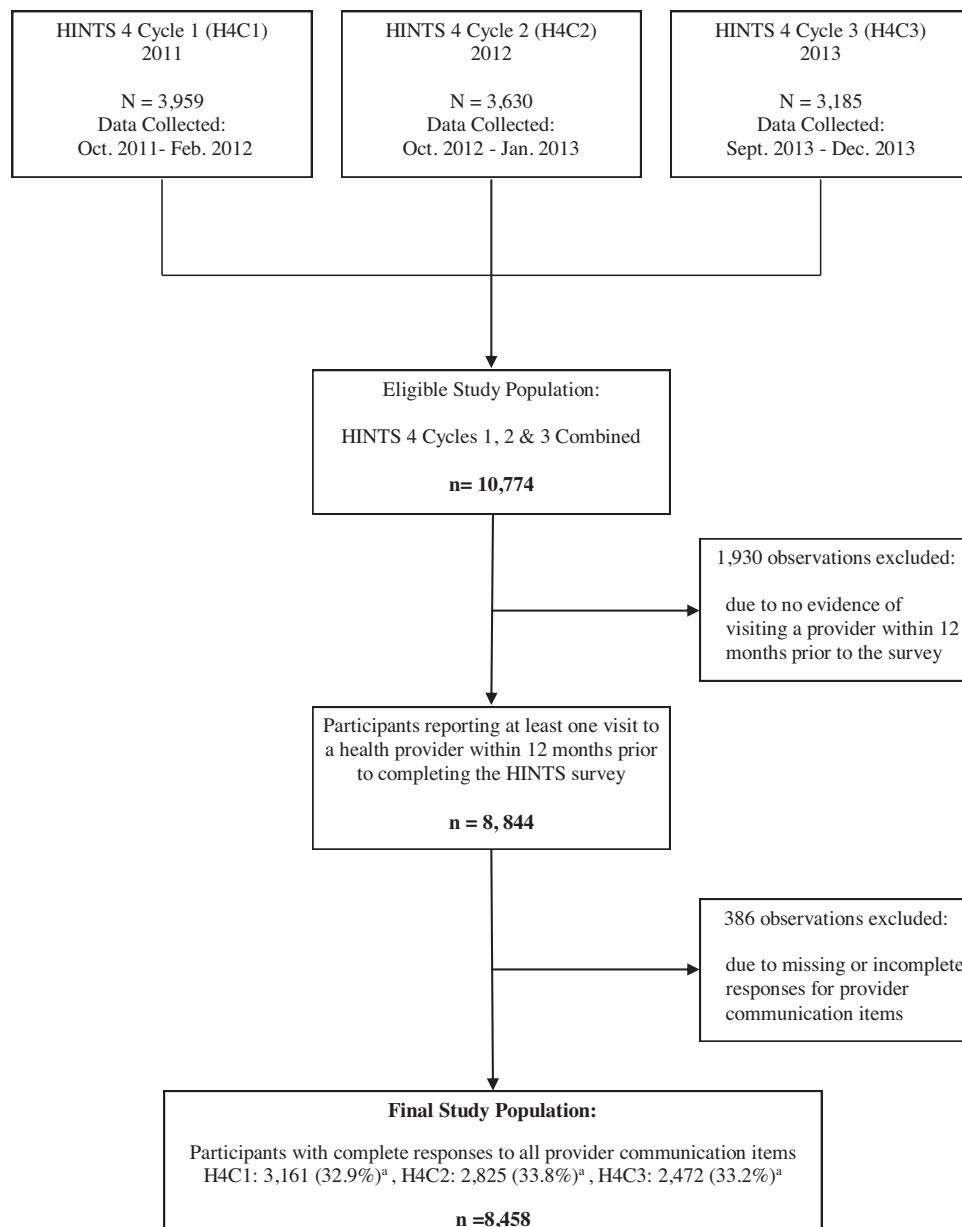
Fig 1. Selection of study population.
*Weighted percentage of respondents in the final study population, from each respective survey year.