



Perceived benefits and barriers and self-efficacy affecting the attendance of health education programs among uninsured primary care patients



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ABSTRACT

Lifestyle interventions have shown to be effective in improving health status, health behaviors, and self-efficacy. However, recruiting participants to health education programs and ensuring the continuity of health education for underserved populations is often challenging. The goals of this study are: to describe the attendance of health education programs; to identify stages of change to a healthy lifestyle; to determine cues to action; and to specify factors affecting perceived benefits and barriers to healthy food choices and physical activity among uninsured primary care patients. Uninsured primary care patients utilizing a free clinic (N=621) completed a self-administered survey from September to December of 2015. US born English speakers, non-US born English speakers, and Spanish speakers reported different kinds of cues to action in attending health education programs. While self-efficacy increases perceived benefits and decreases perceived barriers for physical activity, it increases both perceived benefits and perceived barriers for healthy food choices. The participants who had attended health education programs did not believe that there were benefits for healthy food choices and physical activity. This study adds to the body of literature on health education for underserved populations.

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1. Introduction

Poverty is significantly correlated with a poor diet and physical inactivity, which lead to increased risks of chronic health conditions, such as cardiovascular disease, obesity, diabetes and other conditions (Sabanayagam & Shankar, 2012). Conversely, lifestyle interventions have shown to be effective in improving health status, health behaviors, and self-efficacy, which consequently improve long-term health behaviors (Lorig et al., 2001; Lorig, Laurent, Plant, Krishnan, & Ritter, 2014; Lorig, Ritter, & Jacquez, 2005). Lifestyle interventions have also been shown to help prevent chronic health conditions, such as diabetes (Dall et al.,

2015). Furthermore, lifestyle improvements can often be achieved through individual-level interventions (Kamimura et al., 2014a; Kamimura, Tabler et al., 2016)

Free clinics provide free or reduced-fee primary care services to the un- or under- insured (Geller, Taylor, & Scott, 2004). For most free clinic patients, free clinics provide the sole healthcare option in addition to emergency rooms (Keis, DeGeus, Cashman, & Savageau, 2004). Free clinic patients represent a population with a lower socioeconomic status, income, and education levels (Gertz, Frank, & Blixen, 2011), as well as reported lower levels of physical and mental health functioning compared to the US general population (Kamimura, Christensen, Tabler, Ashby, & Olson, 2013). Providing care for uninsured patients with chronic diseases is one of the most important tasks for free clinics (Nadkarni, & Philbrick, 2003). Previous studies strongly recommend providing much-needed health education and promotion to free clinic patients on a variety of chronic health issues such as diabetes (Gorrindo et al., 2014; Kamimura et al. 2014b, 2014c).

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To promote healthy lifestyles among underserved populations, it is important for health educators to engage a number of physical activity motives to increase the likelihood that clients will experience enjoyment and sustained adoption of exercise into their lifestyle (Kamimura et al., 2014a). Clinic or community-based lifestyle or nutrition intervention programs generally have positive effect on health behaviors among underserved populations (Pijai, Scott-Pierce, Parker, & Trochim, 2014; Ruggiero, Oros, & Choi, 2011; Rustad & Smith, 2013). However, it is challenging to identify effective recruitment strategies to the health education programs and to ensure the continuity of health education for underserved populations. Typically, free clinic patients tend to report low levels of health literacy (Kamimura et al., 2013) and may experience barriers to attend health education programs.

The Health Belief Model (HBM) and the Stages of Change Model can provide a theoretical framework to better understand how to increase participation in health education programs among underserved populations. In the HBM, individual beliefs, such as perceived benefits, perceived barriers, self-efficacy, and cues to action, are important components for individuals to change health behaviors (Champion & Skinner, 2008). The Stages of Change Model explains the process of behavioral changes and includes six stages: pre-contemplation (a person does not intend to take action in the near future), contemplation (a person is aware of the benefits of changing behavior and intends to take action in the near future), preparation (a person plans and intends to take action soon), action (a person takes action to change behavior), maintenance (a person continues behavioral changes), and termination (a person does not go back to old behaviors with total self-efficacy) (Prochaska, Redding, & Evers, 2008). While these models are useful for lifestyle interventions among underserved populations, the applications of these models to health education programs for uninsured primary care patients are under-studied.

The purpose of this study is to describe the attendance of health education programs, to identify stages of change of a healthy lifestyle, to determine cues to action, and to specify factors affecting perceived benefits and barriers to healthy food choices and physical activity among uninsured primary care patients. This study will increase knowledge necessary to promote healthy living for the underserved populations in the community and to enrich research on health education programs for the underserved.

2. Methods

2.1. Overview

The current community-based research project was conducted at a free clinic in the Intermountain West, which provides free primary care services for uninsured individuals who live below the 150% of the federal poverty level and do not have access to employer-provided or government-funded health insurance. The clinic has 6 full-time paid personnel and over 500 volunteers, has been in operation since 2005, has no affiliation with religious organizations and is funded by non-governmental grants and donations, and is open five days a week. The total number of patient visits was 15,229 in 2014.

The clinic provides four different kinds of face-to-face health education programs:

- 1) Healthy living evening classes taught by registered nurses (one hour group session held twice a month, main topics – healthy diet, physical activity, and stress management);
- 2) 30-min long healthy living education class taught by a healthy living educator trained by a health living education coordinator

(a registered nurse) (individual session, main topic – healthy diet);

- 3) Waiting room classes taught by students who have experience in community health education (one hour informal group session at the waiting room held up to several times a week, intermittently, main topics – women's health, the Affordable Care Act, and community resources); and
- 4) Living Well with Chronic Conditions classes built upon the Chronic Disease Self-Management Program taught by a healthy living educator trained by a health living education coordinator (a registered nurse) (2.5 h group session, main topics – medications, healthy diet, physical activity, interpersonal communication skills, and decision making, stress management) (Stanford Patient Education Center, 2016).

All educators (registered nurses, dietitians, social workers, and students who have received relevant training to deliver the health education classes) are volunteers of the clinic.

Each patient who attends a health education program receives a folder with a picture of a plate of healthy food choices from the categories of proteins, fruits, vegetables, and grains from <http://www.choosemyplate.gov/>. Each patient is instructed to make healthy choices for each meal as well as given a list of healthy food choices from each category in the pamphlet. The patients are also provided a pamphlet on exercise that describes the different types of exercises (warm-up, cardio, endurance, strengthening, stretching, cool down, etc.). The patients are given exercise bands and a handout of pictures and descriptions of various strengthening exercises to do. They are also given a pamphlet on stress management, which describes the risks of stress and techniques, strategies, and activities for dealing with it. Lastly, the participants receive a detailed goal setting sheet that helps them set SMART (Specific Measurable Attainable Realistic Timely) goals with a small goal tracking sheet that fits in a sleeve with a magnet to put on their refrigerator.

Before this study was conducted in the Fall of 2015, a qualitative study aiming to collect feedback regarding the services at the clinic through focus groups with the patients was conducted in the Summer of 2014 (Kamimura, Ashby et al., 2016). The results of the qualitative study suggested that it would be necessary to find effective ways to provide information about health education opportunities to patients, as patients are largely unaware of resources available at the clinic. In addition, the results indicated that health education programs for free clinic patients should focus on changing behaviors, as well as increasing knowledge of healthy lifestyle and chronic disease prevention. Furthermore, while the health education programs at the clinic primarily focused on a healthy diet and physical activity, the results of the qualitative study showed that health education classes needed to be differentiated because patients have different perspectives toward health education classes and healthy diet/physical activity.

2.2. Participants and data collection

The study protocol was approved by the Institutional Review Board (IRB) of the University. Participants were persons aged 18 years and older, were able to speak and read English or Spanish, and were patients of the clinic. The data were collected from September to December 2015 using a self-administered paper survey. All survey materials were available in both English and Spanish. Two bilingual translators conducted forward-translation, back-translation, and accuracy check. Participants were recruited at the free clinic during clinic hours by distributing flyers to patients in the waiting room. If a potential participant expressed interest in participating in the study, he or she received a consent cover letter, and a self-administered survey. This study compared

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