



Original article

Do patients' demographic characteristics affect their perceptions of self-care actions to find safe and decent care?



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ABSTRACT

Aim(s): This exploratory study examined the relationship of five patient demographic characteristics (residence in an urban or rural site, gender, age group, marital status, and education level) with the patients' (1) perceived importance of, (2) desire to, (3) ability to perform four patient engagement self-care actions that result in finding safe and decent care.

Background: Equitable access to health care is essential in a humanized health care system. Healthcare providers must engage patients in discussions about their desires for their care to create person-centered care plans reflecting patient values and wishes.

Methods: This secondary data analysis from a cross-sectional survey project surveyed community-dwelling adults living in the southern United States, 2015–2016. This paper only includes responses of participants aged 65 years and older ($N = 123$). Data collected in *The Patient Action Inventory for Self-Care* and demographic questions were used. Chi-square tests and multiple logistic regression analyses were used.

Results: As revealed in the Chi-square and logistic regression findings, self-care actions of “*finding a doctor or practitioner who meets your needs*,” “*using available information to choose a doctor or practitioner*,” and “*using data to choose a hospital or clinic*” showed some associations with whether seniors resided in an urban or rural community, age group, and marital status ($P < 0.05$). No significant associations between these four self-care actions with gender or education were found.

Conclusions: A community-based solution is warranted to leverage between patient demographic characteristics and their perceived self-care actions by harnessing local factors in collaboration with identified patient needs.

1. Aim

As stated in the [National Academies of Sciences, Engineering, and Medicine's \(2017a\)](#) publication, *Integrating the patient and caregiver voice into serious illness care: Proceedings of a workshop*, the importance of embracing patient engagement was emphasized. In order to create

person-centered care plans reflecting patient values and wishes, there was a call for action upon healthcare providers (e.g., nurses) to engage patients and their family members in discussions about their desires for their care and well-being earlier. Health care providers must be knowledgeable about how to communicate with their patients and family members for assuring person-centered health-related experiences

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(National Academies of Sciences, Engineering, and Medicine, 2017a).

As a result, this exploratory study aimed to understand the relationship of five patient demographic characteristics (residence in an urban or rural site, gender, age group, marital status, and education level) with the perceived importance of four patient engagement self-care actions for “finding safe and decent care” and the desire and ability of older adults to perform these actions. Patient engagement is defined in the context of the United States as patient actions individuals must take to obtain the greatest benefit from the healthcare services available to them (Center for Advancing Health, CFAH, 2014). The four self-care actions are: (1) *finding a doctor or practitioner who meets patient needs*, (2) *using available information to choose a doctor or practitioner*, (3) *using data to choose a hospital or clinic*, and (4) *finding a health care professional or group who agrees to see the patient over time*.

2. Background

Equitable access to health care, patient satisfaction, and respect for patient wishes have been recognized as a fundamental principle of any working healthcare system in delivering humanized health care (Andersen, Davidson, & Baumeister, 2013; Regan & Wong, 2009). Every patient should be accorded the opportunity to access health care services that meet their identified health needs, and promote health and wellness in a timely and judicious fashion (Regan & Wong, 2009). By addressing these issues, we bridge the widening gap in health disparities in many countries, especially geographical areas where health inequality is more prominent (Andersen et al., 2013; Meier, 2011). There are few research projects within the United States that have studied the relationships between demographic variables and self-care or utilization of available healthcare services. However, many studies in this regard were based on national survey data from patients more than a decade ago (Arbury et al., 2005; Baker & Streatfield, 1995; Cleary et al., 1991; Cooper-Patrick et al., 1999; Murray-García, Selby, Schmittiel, Grumbach, & Quesenberry, 2000).

2.1. Patients' demographic characteristics and satisfaction with healthcare

The quality of health care delivery, access and satisfaction have been demonstrated in many studies, to be related to the characteristics of patients, especially their demographic characteristics (Baker & Streatfield, 1995; Cleary et al., 1991; Regan & Wong, 2009; Saha, Arbelaez, & Cooper, 2003). These studies have consistently found some ethnic and other demographic-related disparities in the quality of health care delivery (Lauer & Houtenville, 2018; Logie & Gadalla, 2009; Osthega, Hughes, Wright, McDowell, & Louis, 2008; Regan & Wong, 2009; Saha et al., 2003; Simon, Chang, Rajan, Welch, & Dong, 2014). The causal relationships for these health indicators have yet to be starkly delineated in some literature. However, many theorize that challenges associated with cross-cultural patient-physician relationships is one of the major contributing factors to ethnic and demographic-related health disparities in many cases (Cleary et al., 1991; Cooper-Patrick et al., 1999; Meier, 2011; Murray-García et al., 2000; Regan & Wong, 2009; Saha et al., 2003; Simon et al., 2014).

A national telephone survey study in the United States conducted by Cleary et al. (1991) demonstrated the relationships and variations in reported quality of care, as perceived by patients (18 years and older) from different locations and ethnicities. They recorded high patient self-reported rates of distrust, uncertainty and dissatisfaction for the services they received in the hospitals they were admitted (Cleary et al., 1991). About half (49%) of the patients surveyed—particularly older adults (65 years and older), patients of black and non-Hispanic ethnicities, complained more about the lack of adequate information about the provided care, to help inform decisions to refer, to withdraw, or to continue care (Cleary et al., 1991). The patients in the age group of 65 years and older seem to be vulnerable when accessing care and when receiving care.

2.2. Patients' demographic characteristics and perception for utilization of healthcare

A survey study conducted by Baker and Streatfield (1995) explored the types of hospital care practices that patients preferred when assessing health care. They found that patients advocated more for personalized practice options with enhanced accessibility of care, availability of, and continuity of care. Patients' desire and preferences were associated with their age and gender (Baker & Streatfield, 1995). Additionally, a quantitative study conducted by Arbury et al. (2005) examined the relationships between geography and patient behavior as predisposing or enabling factors in rural health care utilization, while controlling for patient demographics such as age, gender, ethnicity, geographic location and socio-economic status (Arbury et al., 2005). They found that geographical distance and other behavioral factors associated with socio-economic status (e.g., car ownership, driver's license) were significantly associated with increased frequency of rural health care utilization for chronic care only (Arbury et al., 2005). Their study validated the conclusions made by many other studies (Cleary et al., 1991; Cooper-Patrick et al., 1999; Meier, 2011; Murray-García et al., 2000; Regan & Wong, 2009; Saha et al., 2003; Simon et al., 2014) that there is a valid relationship between patient demographic and quality of health care, frequency of health care utilization, and continuity of care. Patients' demographic characteristics could be a common barrier related with healthcare accessibility.

3. Study design

We conducted a secondary data analysis from a cross-sectional survey project that surveyed community-dwelling adults living in the southern United States, 2015–2016. The project was approved by the authors' Institutional Review Board.

4. Materials and method

4.1. Study subjects

Convenience sampling was used to recruit community-dwelling adult subjects 18 years and older; participation was voluntary. A total of 250 subjects (a response rate of 82%) participated in the survey project. These adults may have been well and not had a medical condition. A detailed description of the methodology employed in the study has been published (Tzeng & Pierson, 2017). This paper only includes responses of participants aged 65 years and older ($N = 123$). Power analysis for a univariate logistic regression conducted using G*Power 3.1.7 (Faul, Erdfelder, Buchner, & Lang, 2013) determined that a sufficient sample size of 71 was needed, based on the assumptions of an alpha of 0.05, a power of 0.80, a large effect size (odds ratio = 2.48) and two-tailed test (<https://www.statisticssolutions.com/logistic-regression-2-tailed/>). Here, we performed multiple logistic regression with eight regression coefficients. Based on the work of Peduzzi, Concato, Kemper, Holford, and Feinstein (1996), the following guideline for a minimum number of cases to include in this study can be suggested. Let p be the smallest of the proportions of negative or positive cases in the population and k the number of covariates (the number of independent variables), then the minimum number of cases to include is: $N = 10 k/p$. There were eight regression coefficients in the multiple logistic regression model. It is supposed that the proportion of positive outcome is 0.20 (20%), and the minimum number of cases required is $N = 10 \times 8/0.20 = 400$. This project did not have a sufficient sample size for multiple logistic regression with eight regression coefficients.

4.2. Data collection instruments

The self-administered survey of patients included multiple survey tools such as: (a) data collected in the *Patient Action Inventory for Self-*

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