

MATERNAL SATISFACTION WITH PRIMARY CARE FOR CHILDREN  
WITH SELECTED CHRONIC CONDITIONS

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Forthcoming in the Journal of Community Health

Presented at the annual meeting of the American Public Health Association, Boston, November, 1988.

The authors wish to thank the following persons for their guidance and support in the completion of this study:  
Donald M. Cornely, M.D., M.P.H., Professor Emeritus, Department of Maternal and Child Health, School of Hygiene and Public Health;  
Donald M. Steinwachs Ph.D., Professor and Director of the Health Services Research and Development Center, Department of Health Policy and Management, School of Hygiene and Public Health and  
Gail Edelsohn, M.D., M.S.P.H., Director of the residency training program in the Department of Child Psychiatry, the School of Medicine; all of the Johns Hopkins University.

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### ABSTRACT

One hundred forty mothers of children with chronic illnesses seen in two pediatric specialty clinics of a major urban teaching hospital were surveyed regarding their primary care arrangements and satisfaction with care received. Three dimensions of maternal satisfaction were measured: general satisfaction, satisfaction with access to care and satisfaction with doctor conduct (physician humaneness and technical quality). Results of multivariate analyses indicate that receipt of anticipatory guidance, access to care during evening hours and having a child in excellent reported health status were significantly associated with at least two of the three dimensions of maternal satisfaction. Findings have implications for organizing comprehensive, accessible primary care in the community, which is consistent with recent trends in child health policy. Results supported the need for enrichment of primary care for children with chronic illnesses to allow for physician continuity, provision of information and advice to families and extended office hours.

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### INTRODUCTION

Primary medical care for children with chronic conditions has assumed increasing importance in child health policy in the past decade.<sup>1-3</sup> Advances in medical care and concerns with consumer rights have increased the demand for community-based services for children with chronic or handicapping conditions and their families.<sup>1</sup> Prevalence estimates of childhood chronic illness vary depending on the definition of chronic condition, whether moderate emotional disturbances are included, and whether or not measures of functional limitation are used. Chronic condition estimates for children under age 18 years in the U.S. range from ten to twenty percent.<sup>4,5</sup>

The literature indicates that like all children, children with chronic conditions need a regular source of care and a designated provider who can provide families with information and support, and who can assume responsibility in the management of the condition.<sup>6,7</sup> However, involvement with specialty care can result in fragmented care with no one assuming responsibility for coordinating health services or providing information and guidance to the family. Children who receive specialty care may have problems with access to primary care for their acute illnesses and preventive health care needs.<sup>8-10</sup>

In addition to describing primary care arrangements and access, another measure of need is patient satisfaction. Patient satisfaction is regarded as a subjective indicator of access to

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care,<sup>11</sup> as well as an ultimate outcome of the delivery of health care. Maternal satisfaction with pediatric care is important because mothers who are dissatisfied may either under or over-utilize care for their children or they may not comply with treatment recommendations.<sup>12</sup>

Little is known about determinants of maternal satisfaction with medical care among mothers of chronically ill children. Studies in the literature that have focused on care received at pediatric specialty clinics have found that physician continuity and the perceived quality of physician-patient interaction (respect, communication) are associated with maternal satisfaction.<sup>13,14</sup> These findings are consistent with those in general pediatric populations.<sup>15,16</sup> To date, maternal satisfaction with primary care per se has not been examined in a population of children with chronic conditions. Therefore, this study undertook to examine the relative importance of primary care attributes and maternal-child characteristics in explaining maternal satisfaction with primary care among mothers of children with one of two major categorical conditions: allergy (allergic rhinitis, asthma) or cerebral palsy.

## METHODS

### Population

The study population consisted of two contrasting patient populations from one of two pediatric specialty clinics (orthopedic clinic or allergy clinic) at a major urban teaching hospital in

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Baltimore. Care for acute illness and well-child care were not provided at either specialty clinic. Maternal respondents had to be English-speaking U.S. citizens with a telephone in their home and with a child under the age of nine years, seen in either specialty clinic. This age limit was selected based on the following two criteria: (1) the clinical interests of specialty clinic physicians were preschool and elementary school-age children and (2) research findings indicate that pediatric utilization decreases with age, with adolescents receiving less care.<sup>17,18</sup>

One hundred ninety mothers of children seen in either the pediatric orthopedic clinic or the pediatric allergy clinic at a large urban teaching hospital in Baltimore were selected serially between December 1985 and August 1986. Potential subjects were initially recruited during clinic sessions and informed consent was obtained. One hundred eighty agreed to participate.

The initial response rate at recruitment was 180 / 190 or 94.7%. However, diagnostic and residency criteria, non-response to the Patient Satisfaction Questionnaire, presence of an extreme response set to satisfaction items or missing data reduced the final sample size by 40. Of the remaining 140 respondents, 53 had children seen in allergy clinic and 87 had children seen in orthopedic clinic.

### Data Collection

To minimize respondent burden, data were collected in two stages. Information on characteristics of the child and family and

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primary care arrangements were obtained by telephone interview. Maternal satisfaction was measured by the short-form of the Patient Satisfaction Questionnaire (PSQ), developed by Ware and modified for mothers.<sup>19</sup> The instrument, designed for self administration, was mailed to respondents after the telephone interview. (Respondents who did not return the PSQ in a designated time period were given the option of completing the instrument by telephone interview. Fifteen respondents completed the PSQ in this manner.)

### *Measures*

**Maternal Satisfaction** The Patient Satisfaction Questionnaire (PSQ) provides a multi-dimensional measure of patient satisfaction. Three scales of the Patient Satisfaction Questionnaire were used for this study: general satisfaction, satisfaction with access to care, and satisfaction with doctor conduct, a combined scale consisting of items measuring perceived technical quality and physician humaneness (respect, communication). Item responses were on a five point scale ranging from strongly agree to strongly disagree. Examples of items from each scale are:

"I'm very satisfied with the medical care my child receives."

(General Satisfaction)

"It is hard to get an appointment for medical care right away."

(Satisfaction with Access)

"Doctors always treat children and their parents with respect."

(Satisfaction with Doctor Conduct)

Reliability analyses yielded Cronbach's alpha values of: .59 for the

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access scale (seven items), .72 for general satisfaction (four items) and .85 for the doctor conduct scale (twelve items). A description of the development and validation of this instrument is available elsewhere.<sup>20</sup>

In addition to using the PSQ, the authors developed a questionnaire measuring self-reported social-demographic characteristics, child health status, maternal well-being and pediatric primary care arrangements. Selected measures are described below.

**Anticipatory Guidance** An index was created to measure the extent to which five topics of concern to mothers of chronically ill children<sup>21</sup> were covered by the primary care provider. Mothers were asked if anyone at their child's regular source of care talked with them during the past year about community services for their child, growth and development, behavior, medical progress or treatment regimens. A value of "1" was assigned for each topic covered, for a total possible score of five.

**Maternal Distress** A four point, seven item scale developed by Pearlin and Schooler<sup>22</sup> was used to measure the degree of psychological discomfort reported by mothers specific to their experience as caretakers of children with chronic conditions. Categories are: frustrated, tense, worried, bothered or upset, unhappy, emotionally worn out or unsure of yourself. Possible scores range from seven to twenty-eight, with a score of seven indicating no distress at all.

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Maternal Activity Limitation A four point, six item index was created by the authors to measure the extent to which maternal respondents reported limitations in activities in six areas which they attributed to demands of child care: employment, education/training, caretaking of other family members, leisure time, community involvement, household management. A score of six indicates no limitation at all.

## RESULTS

Table 1 presents information regarding maternal respondents and the index child. Slightly more than one-half of the respondents were married. Over one-third were black. The majority of respondents (72.9%) completed high school (not shown). Over one-third of the women were employed either part or full time. It is noteworthy that the majority of respondents' household incomes were at or below 150% of the poverty level.<sup>23</sup> [INSERT TABLE 1 ABOUT HERE]

Reported child health status and attributes of pediatric primary care are presented in Table 2. Less than one-fifth of the respondents considered their child to be in excellent health. The sample was evenly divided between those who had Medicaid coverage and those who had either private insurance or were uninsured. Most reported that they used private, office-based practices and that they usually saw one particular provider for their children's care. [INSERT TABLE 2 ABOUT HERE]

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### Maternal Satisfaction

Distributions of the three satisfaction scales were somewhat skewed to the right, indicating relatively high levels of satisfaction. The general satisfaction scale had a mean of 13.76 (S.D. = 3.32), and a median of 14 (range = 4-20). The access scale had a mean of 26.09 (S.D. = 4.15) and a median of 27 (range = 12-35). The doctor conduct scale had a mean of 54.29 (S.D. = 9.28) and a median of 55 (range = 26-75). The Kolomogorov D statistic and a normal probability plot were used to assess the liklihood that the satisfaction data were a random sample from a normal distribution.<sup>24</sup> Results (not shown) revealed that although the three scales did not represent perfect Gaussian distributions, assumptions of normality for the multivariate analyses would not be violated.

In order to assess the relative importance of selected independent variables on measures of maternal satisfaction, a series of multiple linear regression analyses were conducted. Variables were selected for inclusion in the models if the level of statistical significance in the bivariate association with a satisfaction measure was less than or equal to .15. Two methods of linear model-building using SPSS-X software<sup>25</sup> were employed. Initially, a hierarchial linear regression model was used in which child and family characteristics were entered first, followed by characteristics of the regular source of primary care. Then a step-wise regression procedure was used to develop a parsimonious model. Both methods yielded the same statistically significant variables

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for each satisfaction measure. Results of the step-wise procedure will be reported here.

### *General Satisfaction*

Results presented in Table 3 indicate that general satisfaction was explained by receiving anticipatory guidance, having a relationship over time with the usual source of care (more than one year), having care available evenings, having a child seen in orthopedic clinic, and having a child in reported excellent health status.

### *Satisfaction with Doctor Conduct*

Maternal satisfaction with doctor conduct (Table 4) was explained by race (black), having a child seen in orthopedic clinic, having a child with excellent reported health status, having care available evenings and receipt of anticipatory guidance.

### *Satisfaction with Access*

In addition to excellent child health status and extended hours for care, satisfaction with access was explained by low to moderate maternal activity limitation (a measure of maternal burden of care), residing in a metropolitan area<sup>26</sup> and office waiting time less than forty minutes (Table 5). [INSERT TABLES 3-5 ABOUT HERE]

## DISCUSSION

Findings from this study indicated that family, child and provider characteristics contributed to maternal satisfaction. There were several common themes across the three measures of

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satisfaction. Anticipatory guidance, a global concept measuring receipt of information and advice across five areas of child behavioral and medical concerns, was important in explaining both general satisfaction and satisfaction with doctor conduct. Receiving information may be an indicator of the quality of the doctor-patient relationship. Receipt of information and advice as well as knowledge that help is available (due to extended hours, telephone availability) may be a source of support, leading to increased satisfaction.

Care accessible during evenings and weekends was also an important factor in explaining maternal satisfaction. This in conjunction with having a child in excellent reported health status may be related to perception of need. That is, satisfaction results when perceived need is low, and resources are considered available.

The finding that mothers of children seen in orthopedic clinic had higher mean scores on both the general satisfaction and satisfaction with doctor conduct was unanticipated, since it was expected that the type of chronic condition would have no effect on maternal satisfaction. The "non-categorical approach to illness" posits that as a group, children with chronic conditions have more commonalities than differences and therefore their needs can be generalized across diagnostic categories. Furthermore, there is wide variation within diagnostic categories regarding family and child adaptation and attitudes toward and access to medical care.<sup>27,10</sup> Additional analyses (not shown) indicated that children in

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orthopedic clinic were significantly more likely ( $p < .05$ ) to have more favorable primary care arrangements, e.g. provider continuity, more anticipatory guidance, increased telephone availability. It is these characteristics of the primary care source rather than diagnostic category or attributes of the specialty clinics (not measured in this study) which are likely accounting for differences in satisfaction.

A noteworthy finding was racial differences with respect to satisfaction with doctor conduct, with blacks having higher mean satisfaction scores than whites. This was unexpected since additional analyses revealed that blacks were significantly more likely to use hospital clinics for primary care ( $\chi^2 = 36.39$ ;  $df = 2$ ;  $p < .001$ ), where they were less likely to see the same doctor ( $\chi^2 = 15.47$ ;  $df = 2$ ;  $p < .001$ ). Physician continuity is important because it was positively associated with receipt of anticipatory guidance ( $\chi^2 = 8.01$ ;  $df = 2$ ;  $p < .05$ ). The racial differences in satisfaction with doctor conduct may be a result of experience with the health care system, which results in different expectations of providers.<sup>18</sup>

An alternative explanation is that mothers with more education (white mothers in this study) may have different expectations of physicians and medical care. A national study of access to care among adults found a negative association between education and satisfaction with humaneness of doctors.<sup>19</sup> Although it was not possible in this sample to disaggregate education, income and race, there was a trend for racial differences in satisfaction with doctor

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conduct to diminish as income and education increased.

Mothers clearly indicated that certain features of health care and providers were important to them. These findings offer additional evidence supporting the need for reform in health services delivery for children with chronic conditions. With recent federal legislation and regulations pertaining to the care of children with chronic conditions<sup>30,31,3</sup> opportunities exist for improving access to care and enrichment of the content of primary care through case-management. Case-management would allow accessing ancillary services, assurance of primary care and anticipatory guidance.<sup>32</sup>

In summary, maternal satisfaction can be a useful indicator of health care system performance. Satisfaction should be included as an evaluation criterion for new approaches to serving chronically ill children in the community. A major limitation in this study is its cross-sectional design which eliminates the possibility of examining temporal relationships among variables. Longitudinal studies with community based samples need to be done to gain insight into parental perception of need and care-seeking behaviors, the influence of provider characteristics (age, sex, race) on parent attitudes towards care, and the extent to which satisfaction is associated with patterns of utilization and parental well-being.

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TABLE 1

Child and Family Characteristics of the Study Sample  
N = 140<sup>a</sup>

<i>Categorical Measures</i>	<i>Number</i>	<i>Percent</i>		
Child's Age ≤ 4 years	74	52.9		
Child's Sex male	70	50.0		
Child's Health Status excellent	26	18.6		
good/ fair/ poor	114	81.4		
Race black	56	40.0		
Maternal Marital Status - Married	78	55.7		
Maternal Employment Status - Employed	54	38.6		
Family Income ≤ 150% Poverty Level	80 (135)	59.3		
Metropolitan Residence Inside MSA <sup>b</sup>	122	87.1		
<i>Metric Measures</i>	<i>Mean</i>	<i>S.D.</i>	<i>Median</i>	<i>Range</i>
Maternal Distress	17.8	4.45	18.00	7-28
Maternal Activity Limitaion	10.85	4.00	10.00	6-22

<sup>a</sup>Denominator is in parenthesis if N < 140 for any variable.

<sup>b</sup>U.S. Bureau of the Census Metropolitan Statistical Area

TABLE 2

Pediatric Primary Care Arrangements of the Study Sample  
N=140<sup>a</sup>

<i>Categorical Measures</i>	<i>Number</i>		<i>Percent</i>	
Insurance				
medicaid	70		50.0	
private	57		40.7	
none	13		9.3	
Provider Continuity (same person)	124	(139)	89.2	
24 Hour Telephone Availability (telephone contact)	104	(126)	82.5	
Same Provider for Preventive Care	121	(139)	87.1	
Health Care Facility Type				
private solo or group practice	98	(138)	71.0	
hospital clinic	40	(138)	29.0	
Facility Open Evening Hours	87	(126)	69.0	
Facility Open Weekend Hours	95	(126)	75.4	
<i>Metric Measures</i>	<i>Mean</i>	<i>S.D.</i>	<i>Median</i>	<i>Range</i>
Travel Time (minutes)	19.54	13.49	15.00	3-90
Office Waiting Time (minutes)	28.34	32.45	20.00	0-180
Provider Continuity (years)	4.66	3.38	4.00	1-15
Amount of Anticipatory Guidance (content across 5 areas)	1.45	1.56	1.00	0-5

<sup>a</sup>Denominator is in parenthesis if N < 140 for any variable.

TABLE 3

Standardized Regression Coefficients (Beta), Standard Errors and Tests of Significance for the Regression of General Satisfaction on Major Independent and Control Variables Stepwise Model

N = 140

Variables Retained in the Equation

	Beta	SE Beta	T	Sig T
anticipatory guidance	.288	.082	3.506	.001
provider continuity (years)	.290	.085	3.436	.001
care available evenings	.186	.084	2.208	.029
specialty clinic	.204	.084	2.417	.017
child health status	.164	.082	2.000	.049

Variables Excluded from the Equation

	Beta In	T	Sig T
maternal distress	-.101	-1.228	.222
telephone contact	.121	1.357	.178
preventive care at same place	.135	1.609	.111
care available weekends	.053	.528	.599

Adjusted R<sup>2</sup> = .244  
D.F. = 5; 109  
F = 8.341  
Sig F = .000

TABLE 4

Standardized Regression Coefficients (Beta), Standard Errors and Tests of Significance for the Regression of Satisfaction with Doctor Conduct on Major Independent and Control Variables  
Stepwise Model

N = 140

Variables Retained in the Equation

	Beta	SE Beta	T	Sig T
anticipatory guidance	.273	.080	3.401	.001
race	.318	.083	3.826	.000
specialty clinic	.232	.081	2.852	.005
child health status	.211	.081	2.606	.010
care available evenings	.155	.083	1.871	.064

Variables Excluded from in the Equation

	Beta In	T	Sig T
Medicaid	.108	1.27	.208
facility: private office/ clinic	-.096	-1.05	.296
child age	.060	.737	.296

Adjusted R<sup>2</sup> = .207

D.F. = 5; 120

F = 7.513

Sig F = .000

TABLE 5

Standardized Regression Coefficients (Beta), Standard Errors  
and Tests of Significance for the Regression of  
Satisfaction with Access to Care on  
Major Independent and Control Variables  
Stepwise Model

N = 140

Variables Retained in the Equation

	Beta	SE Beta	T	Sig T
care available weekends	.148	.101	1.47	.145
office wait	-.255	.084	-3.03	.003
maternal activity limitation	-.185	.083	-2.22	.029
child health status	.153	.083	1.85	.068
urban/ rural residence	.161	.083	1.94	.055
care available evenings	.172	.099	1.74	.085

Variables Excluded from the Equation

	Beta In	T	Sig T
maternal distress	-.038	-.441	.660
child race	-.033	-.366	.715
telephone contact	.118	1.259	.211
preventive care at same place	.112	1.277	.201
facility: private office/ clinic	.081	.868	.387
travel time	-.119	-1.396	.166

Adjusted  $R^2$  = .227  
D.F. = 12; 102  
F = 3.787  
Sig F = .000