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Pediatric Primary Care Relationships With African American Families: A Critical Review

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ABSTRACT

Introduction: High-quality primary care is critical to help African American families mitigate the effects of social determinants of health that negatively affect child health and well-being. At the core of primary care is a healthy relationship between the parent and provider. This critical review of the literature evaluates what is known about the parent–provider relationship for African Americans.

Methods: We identified 277 studies in Ovid MEDLINE and screened them for inclusion. Data extraction and qualitative synthesis were used to describe what is known and identify themes.

Results: Twelve cross-sectional analyses and one mixed cross-sectional and longitudinal design research studies were identified. Studies identified parent factors, provider factors, parent–provider interaction factors, and health care system factors that affected the parent–provider relationship.

Discussion: The results identify best practices and future research directions for providers, which would improve pediatric primary care quality for African American children. *J Pediatr Health Care.* (2019) XX, 1–14

KEY WORDS

African American, pediatric, patient-provider, primary care

High-quality primary care, including a healthy relationship between parents and providers, is critical to help African American families mitigate the negative effects of social determinants of health. Among other individual social determinants, the toxic stress caused by structural racism negatively affects African American children's health and well-being (Pachter & Coll, 2009). Mounting scientific evidence and cultural awareness have already brought public attention to the impact of structural racism on the health of adult African Americans (Khazan, 2018; Turner, Brown, & Hale, 2017). Data continue to show substantial racial disparities in children's health and health care (Children's Defense Fund, 2017). As we look ahead to Healthy People 2030, we find that "Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all" is the second overarching goal (U.S. Department of Health and Human Services, 2018, "Overarching Goals" section, para. 1). The National Institute of Nursing Research (2016) also highlights in its agenda a call for research to promote wellness and prevention for minority populations. It is critical that the pediatric nursing community, long committed to the work of health equity for children, explore the factors contributing to the racial disparities experienced by African American children and their parents in the primary care setting.

A healthy relationship between parents and their child's health care provider has the potential to positively affect the long-term health and development of a child. Research on adults has shown that a poor patient–provider relationship contributes to racial health disparities (Van Ryn & Fu, 2003). The relationship between parents and their child's pediatric care provider is significant for its role in supporting and educating parents to promote the child's health, growth,

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and development. Pediatric primary care provides the opportunity for providers and parents to interact in long-term, meaningful ways through well-child visits and the provision of anticipatory guidance and serves as the first point of contact before a child enters school for early intervention. The life course perspective of child development shows that this parent education and access to health care can facilitate a child attaining a healthy life trajectory otherwise impeded by toxic stress or poverty (Halfon, Larson, Lu, Tullis, & Russ, 2014). The American Academy of Pediatrics encourages providers to use their roles in health care to identify child strengths and protective factors as well as risks, to understand families' cultural and personal beliefs and roles in decision making, and to connect families to resources (Hagan, Shaw, & Duncan, 2017). A current approach to improving primary care outcomes and improving parental perceptions of care was the Affordable Care Act's emphasis on the patient-centered medical home (PCMH) in 2010; however, as reported in this review, that attempt has not improved access to PCMHs for minority families or improved parent experiences of primary care (Diao, Tripodis, Long, & Garg, 2017).

The purpose of this critical review is to identify what is currently known about the nature of the relationship between African American parents and providers in pediatric primary care to reveal the factors contributing to lower-quality primary care experiences and persistent health disparities. In addition to individual family factors and health care setting factors, social factors, such as biases and assumptions, likely play a significant role in the formation of relationships between African American parents and providers (Stevens & Shi, 2002a). The Institute of Medicine (2003) report "Unequal Treatment" found that despite providers' intentions, bias and stereotypes do affect care and contribute to health care disparities. Although most providers do not engage with patients in explicitly racist ways, the effects of structural racism and implicit bias are more insidious and challenging to identify (Hardeman, Medina, & Kozhimannil, 2016). Other concepts, such as decreased trust and poor communication, coupled with the quantitative data that support an overall disparity in care quality, may indicate that they contribute to the problem. A previous review of the literature looked at the racial and ethnic disparities in primary care experiences of children and families of many races and ethnicities (Stevens & Shi, 2003). This review will focus specifically on the experiences of African American families with their child's provider and update what was previously evaluated.

A healthy relationship between parents and their child's health care provider has the potential to positively affect the long-term health and development of a child.

METHODS

Search Strategy

A review of the literature was conducted in Ovid MEDLINE for studies that answered the review question *What is known about the relationship between pediatric primary care providers and African American parents?* A broad search was conducted with the keywords *primary care* or *primary health care* and *African Americans*. Additionally, the search queried studies with either *child*, *pediatric*, *adolescent*, or *parent* in the title to capture articles pertaining to the population of interest. Because there are no consistently used subject headings to capture the parent-provider relationship (e.g., racism, trust, communication, etc.), the search was not limited by these concepts. Several searches were attempted with these concepts, and this narrowed the literature down to only a few studies, so these search terms were removed, and instead, a broad search was used to capture all related concepts. A search in ProQuest using the same strategy did not retrieve any additional relevant studies.

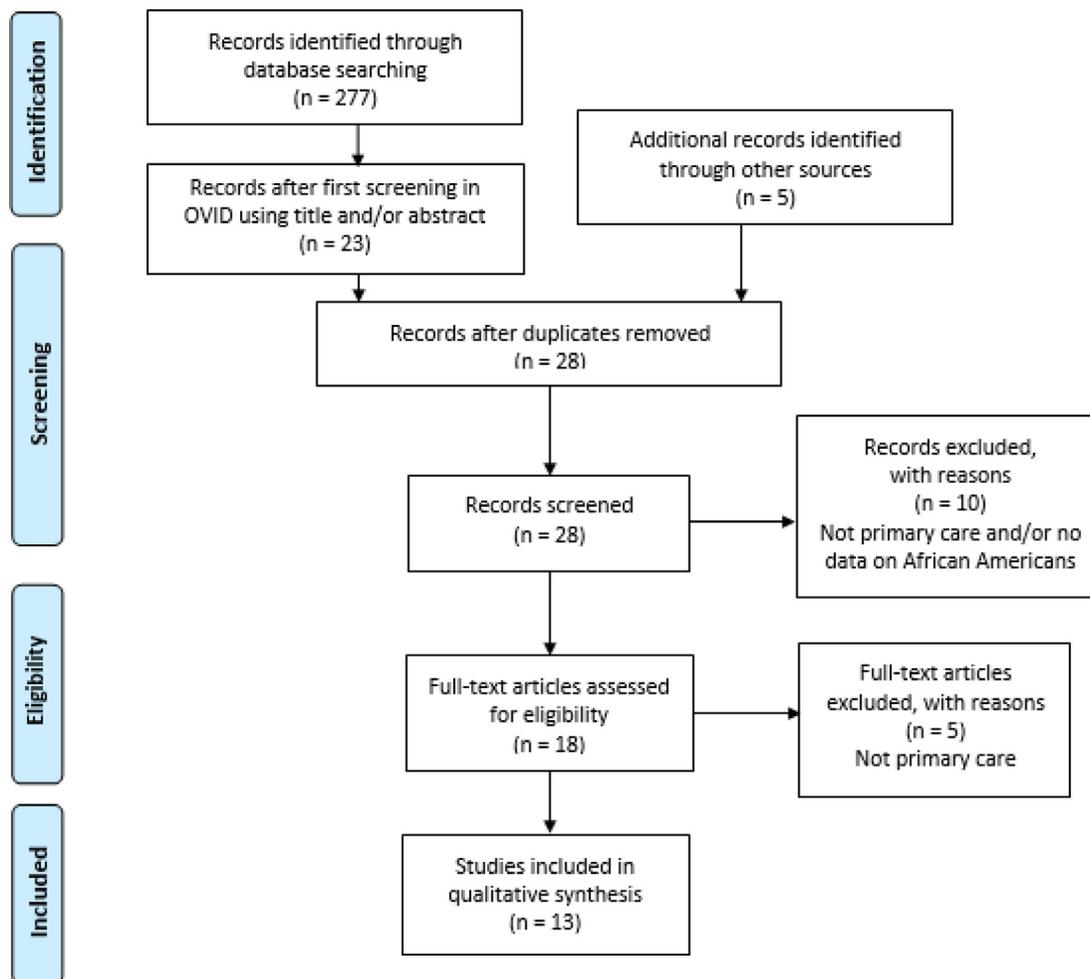
Study Selection

For this review, included studies were published from 2000 forward to focus on studies with cultural relevance in the current sociopolitical and health care environment. Additionally, studies must have taken place in the pediatric primary care setting, rather than inpatient, emergency department, or specialty care settings. This review focuses on primary care, which ". . . provides person-focused (not disease-oriented) care over time . . . [and] is the means by which the two main goals of a health services system, optimization and equity of health status, are approached" (Johns Hopkins University, n.d., para. 1). Primary care plays a pivotal role in addressing health disparities, and the parent-provider relationship in that setting is unique in its formation and purpose. Articles about the parent-provider relationship in the presence of specific chronic diseases, such as asthma, were excluded. Studies must have also contained specific data on African Americans and were excluded if findings pertained to general ethnic or racial minority populations.

The Ovid MEDLINE search resulted in 277 identified studies, which were then screened by title review. The Preferred Reporting Items for Systematic Reviews and Meta-analyses (i.e., PRISMA) checklist was used to guide the process of identifying and selecting studies (see Figure). All but 23 studies were excluded because they pertained to one particular diagnosis or health topic (e.g., asthma) or were conducted in a specialty, hospital, or emergency room setting. These 23 abstracts were then screened, resulting in 13 studies. A third screening conducted by thoroughly reading the entire study eliminated five additional studies. Reference lists from all eight studies were screened, resulting in five added studies that met the inclusion criteria. This process resulted in the final identification of the 13 studies analyzed in this review.

Data Synthesis

A qualitative summary was used to describe the review findings, rather than meta-analysis. The data extracted did not

FIGURE. Preferred Reporting Items for Systematic Reviews and Meta-Analyses (i.e., PRISMA) flow diagram.

(This figure appears in color online at www.jpeds.org.)

lend itself to meta-analysis because there was a high degree of heterogeneity between the studies in terms of how the parent–provider relationship was evaluated. In addition, many of the studies presented significant findings about other races and ethnicities or other factors affecting African Americans in the health care setting that did not directly pertain to the relationship between parent and provider. This review limited the data synthesis to only data addressing the target review question.

RESULTS

Study Characteristics

All included studies were published between 2002 and 2017. Study characteristics are summarized in Table 1. Studies varied in location, with three being nationally representative of the entire United States (Diao et al., 2017; Flores, Olson, & Tomany-Korman, 2005; Stevens, Mistry, Zuckerman, & Halfon, 2005). Only three of the studies were limited to African American parents (Godoy, Mitchell, Shabazz, Wissow, & Horn, 2014; Horn, Mitchell, Joseph, & Wissow, 2011; Horn, Mitchell, Wang, Joseph, & Wissow, 2012). None of the

studies were limited to low-income families, although many used either parental education attainment or family income as a proxy for socioeconomic status and used these as covariates. The two studies by Wissow et al. from 2003 and 2010 used the same sample, but both were included in this review because they identify different concepts of the parent–provider relationship (see study aims in Table 2).

Risk of Bias

Studies that met inclusion criteria in this review were appraised for quality at the outcome and study level using checklists from the Joanna Briggs Institute (JBI; JBI 2017a, 2017b; Table 3). Although none of the studies included are randomized control trials, all cross-sectional studies showed a relatively low risk of bias, aside from their inherent design limitations, and should not hinder the reliability or validity of this qualitative review. One study contained a cross-sectional group and also a longitudinal group; however, the details of the longitudinal data collection were detailed in a prior publication (Wissow et al., 2002, 2003). By using the JBI (2017b) cohort study criteria, this previous study was

TABLE 1. Summary of study characteristics

Study	Setting	N/n AA (%)	Age of children	Parent education	Annual income/employment
Stevens & Shi (2002a)	Southern California	377/100 (27%)	5–8 years: 52% 9–11 years: 48%	HS graduate: 74%	>\$36,000: 69% Employed: 80%
Stevens & Shi (2002b)	Same as Stevens & Shi (2002a)	403/106 (26%)	5–8 years: 52.7% 9–11 years: 47.27%	HS graduate: 72.48%	>\$36,000: 64.15% Employed: 78.90%
Seid, Stevens, & Varni (2003)	Urban school district in California	3,390/458 (14%)	Kindergarten to grade 3: 53.5%	<HS graduate: 21.0% HS or some college: 61.6% College graduate+: 17.5%	NR
Stevens, Shi, & Cooper (2003)	Southern California	358/94 (26%)	NR	NR	NR
Wissow et al. (2003)	Urban teaching hospital primary care clinic	309 (90% AA/8% White)	Mean: 62 days	HS: 51% Some college: 14%	NR
Flores, Olson, & Tomany-Korman (2005)	All 50 states	2,068/477 (23%)	Mean: 19.5 months	<HS graduate: 26% HS: 40% Some college: 34%	\$0–\$7,500: 16% \$7,501–\$17,500: 33% \$17,501–\$35,000: 27% \$35,001–\$60,000: 14% \$60,001–\$75,000: 4% >\$75,000: 6%
Stevens, Mistry, Zuckerman, & Halfon (2005)	All 50 states	1,996/444 (22%)	19–35 months: 54.1% 4–18 months: 54.1%	HS graduate: 73.5%	NR
Wissow, Brown, & Krupnick (2010)	Same as Wissow et al. (2003)	50/21 (42%)	Mean: 2.4 years ^b	HS graduate: 66% ^b	NR
Horn, Mitchell, Joseph, & Wissow (2011)	Washington, DC (3 CHCs, 3 private practices, 1 hospital-based)	425 (100%)	Mean: 24 months	<HS graduate: 9.7% HS graduate: 38.4% Some college: 43.3%	<150% FPL: 48.7%
Horn, Mitchell, Wang, Joseph, Wissow (2012)	Los Angeles, CA (23 community practices)	405/52 (13%)	Median: 3.5 years	<HS: 17.3% HS graduate+: 67.3% College degree or >: 15.4%	<\$20,000: 35.6% \$20,000–\$39,999: 26.7% \$40,000–\$79,999: 26.7% >\$80,000: 11.1%
Cox et al. (2012)	Los Angeles, CA (23 community practices)	405/52 (13%)	Median: 3.5 years	<HS: 17.3% HS graduate+: 67.3% College degree or >: 15.4%	<\$20,000: 35.6% \$20,000–\$39,999: 26.7% \$40,000–\$79,999: 26.7% >\$80,000: 11.1%
Godoy, Mitchell, Shabazz, Wissow, & Horn (2014)	Washington, DC (2 CHCs, 5 private practices, 1 hospital-based)	199 (100%)	Mean: 3.3 years	<HS: 9% HS/high school equivalency: 33% Some college: 32% College degree or >: 27%	>200% FPL: 48%
Diao, Tripodis, Long, & Garg (2017) ^{a,b}	Nationally representative	87,774/ 8,185 (9%)	1–5 years: 28.7% 6–11 years: 35.4% 12–17 years: 35.9%	<HS: 14.1% HS: 21.7% >HS: 64.2%	≥400% FPL: 28.1% 200%–399% FPL: 28.4% 100%–199% FPL: 21.6% <100% FPL: 22.0%

Note. AA, African American; CHC, community health center; FPL, federal poverty level; HS, high school; NR, not reported.

^aData shown for 2011–2012 only.

^bData are for entire sample, not just African American participants.

TABLE 2. Summary of study results

Study	Aims/design	Independent variables	Outcome measure	Results for African American parents
Stevens & Shi (2002a)	To explore the associations between three managed care policies and sustained parent–provider relationships by racial and ethnic group while adjusting for covariates Cross-sectional, random telephone survey	Managed care policies: (a) requirement to select a PCP from a panel of providers, (b) requirement to obtain a referral to specialists, and (c) financial restrictions on seeing out-of-network providers	PCAT-CE to measure longitudinality of care (2 subdomains: strength of affiliation and interpersonal relationship, range = 1–4)	Strength of affiliation Mean: 3.27 AA vs. 3.57 White ^a Required to stay in network: –0.97 mean ^a Interpersonal relationship Mean: 3.40 AA vs. 3.53 White ^a Sign up with specific PCP: –0.40 mean ^a Specialist referral policy: –0.36 mean ^b Average length of relationship: 6–11 months AA vs. 1–2 years White ^b Care quality (controlling for socioeconomic status and health system factors): $\beta = -0.9154^a$ (White as reference group)
Stevens & Shi (2002b)	Compare the quality of primary care experienced specifically by children of different racial and ethnic groups Same as Stevens & Shi, 2002a	Race/ethnicity	PCAT-CE to measure total care quality	
Seid, Stevens, & Varni (2003)	To examine the effects of race/ethnicity, language, and access on parents' reports of pediatric primary care experiences Cross-sectional survey of parents of children in 228 classrooms (kindergarten through 8th grade) at 18 schools	Race/ethnicity, language, mother's education level, chronic health condition status, regular source of care and insurance type	Six components of primary care using P3C (scores are 0–100 for total scale and subscales)	No difference: access, continuity, contextual knowledge, communication, coordination, or total Comprehensiveness: 54.0 AA vs. 46.1 White ^c
Wissow et al. (2003)	To examine if longitudinal pediatric care reduces disparities in parent disclosure of PI associated with ethnic and sex discordance between parent and physician Descriptive, longitudinal, observational study of parent–provider interactions over 1 year. Parents split into early visits group and longitudinal group. Parent–provider talk was audiotaped.	Sex and race of physician	Parent disclosure of PI. RIAS used to measure provider patient-centeredness. Coefficients represent the change in PI-giving utterances associated with a unit change in each factor.	Early visit: AA: –21.2 Provider patient-centeredness: 0.23 Mothers >24 years: 15.4 Longitudinal: No difference in PI giving for AA and White 2.3 utterances per visit over time 2.9 White female physician –0.12 White male physician
Stevens, Shi, & Cooper (2003)	Examine the association of race/ethnicity concordance with parent reports of children's primary care experiences Cross-sectional, random telephone interviews	Race/ethnicity concordance between child and provider	PCAT-CE	No statistically significant difference in dependent variables for concordant or discordant groups
Flores, Olson, Tomany-Korman (2005)a	To study disparities in early childhood health care (sociodemographic factors, health care use, parental perceptions of care, and interactions with providers) Secondary data analysis from 2000 NSECH	Race/ethnicity of children	Sociodemographic factors, provider characteristics, use of health services, parental satisfaction, and topics discussed	Parental satisfaction: Not likely to recommend provider: OR = 1.21 Provider never or only sometimes understands child's specific needs: OR = 1.45 Provider never or only sometimes understands how parent prefers to rear child: OR = 1.56
Stevens, Mistry, Zuckerman, & Halfon (2005)	To identify the distribution and methods by which families have a race/ethnicity-concordant provider of well-child care and examine	Race/ethnicity of mother, race/ethnicity of provider, racial/ethnic concordance	BPS, FCC from NSECH	BPS: No statistically significant disparities FCC:

(continued on next page)

TABLE 2. (Continued)

Study	Aims/design	Independent variables	Outcome measure	Results for African American parents
	whether differences exist in the receipt of BPS and FCC among those with concordant, discordant, and no regular provider Secondary data analysis from 2000 NSECH			Takes time to understand needs: 84.8% AA vs. 89.6% White ^a Respects parent expertise on child: 78.7% AA vs. 85.6% White ^b Understands parent preferences: 54.6% AA vs. 64.7% White ^b Asks how you feel as a parent: no difference Provider concordance: No significant differences in BPS or FCC for concordant, discordant, or no regular provider VTAS average total scores: -7.7 compared with White parents
Wissow, Brown, & Krupnick (2010)	To test an adaptation of the VTAS for rating parent-provider interactions in pediatric primary care compared with coding using the RIAS in a previous study (2003) Cross-sectional, recoding 50 visits	VTAS	Parent satisfaction survey	
Horn, Mitchell, Joseph, & Wissow (2011)	To identify family, provider, and health care setting characteristics associated with AA parents' perceptions of partnership with their child's primary care provider Cross-sectional, nonrandom, telephone survey 1-2 weeks after a health care visit	Socioeconomic status, provider characteristics, health care setting factors	Parent perception of provider partnership building (grouped into high, moderate, and low groups)	Moderate vs. high partnership: Some college: RR = 5.87 ^b Post-bachelor degree: RR = 23.3 ^c Low vs. high partnership: Private practice: RR = 7.96 ^c Hospital clinic: RR = 4.30 ^c Low vs. moderate: Some college: RR = 0.17 ^b Post-bachelor degree: RR = 0.13 ^a Private practice: RR = 4.60 ^b Hospital clinic: RR = 3.32 ^b Average rating of trust: 36.5 Association between increased trust in provider and attendance at a CHC is mediated by higher partnership building.
Horn, Mitchell, Wang, Joseph, & Wissow (2012)	To extend the previous research findings and test whether parent education and provider practice setting (both associated with higher levels of parent-reported partnership building) also predict increased parent trust Same as Horn et al. (2011)	Same as Horn et al. (2011) + partnership building (moderate, high)	Parent's trust in child's provider measured by ITPS (range = 10-50)	
Cox et al. (2012)	To understand the association of race/ethnicity with engagement in pediatric primary care and examine how socioeconomic status influences this Cross-sectional design including parent surveys and coding encounter videos.	Parent race/ethnicity, education, and income.	RIAS (family or physician engagement in relationship building, information exchange, decision making)	Relationship building/Information exchange: No difference for AA or AA/SES Decision making: OR = 0.32 ^a (W as reference group)

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TABLE 2. (Continued)

Study	Aims/design	Independent variables	Outcome measure	Results for African American parents
Godoy, Mitchell, Shabazz, Wissow, & Horn (2014)	To examine if SE in AA mothers is associated with the disclosure of psychosocial concerns with their child's PCP. Cross-sectional design including parent surveys and coding encounter audiorecordings	Maternal SE in communicating, mother rating of child behavior, parent distress, trust in provider, poverty status, sociodemographic factors	RIAS (maternal disclosure of psychosocial issues)	Poverty status moderates association between high SE and PI disclosure For families <200% FPL: Maximum parental SE in communicating with provider: OR = 5.62 ^b
Diao, Tripodis, Long, & Garg (2017) ^b	To evaluate SES and racial disparities in the parental perception and experience of having a medical home Cross-sectional, random telephone survey, secondary data analysis of 2007 and 2011–2012 NSCH data	Race/ethnicity, SES	PCMH (personal doctor or nurse, usual source of care, FCC, problems getting referrals, and care coordination)	Personal doctor or nurse: 86.4% AA vs. 93.6% White ^a Usual source of care: 87.8% AA vs. 95.8% White ^a FCC: 56.2% AA vs. 77.5% White ^a No statistically significant difference in problems getting referrals or care coordination

Note. For information on measuring tools, see Table 3. AA, African American; BPS, Basic Preventive Services; CHC, community health center; FCC, Family-Centered Care; ITPS, Interpersonal Trust in a Physician Scale; NSECH, National Survey of Early Childhood Health; OR, odds ratio; P3C, Parent's Perceptions of Primary Care; PCAT-CE, Primary Care Assessment Tool—Child Edition; PCMH, Patient Centered Medical Home; PCP, primary care provider; PI, psychosocial information; RIAS, Rotor Interaction Analysis System; RR, risk ratio; SE, self-efficacy; SES, socioeconomic status; VTAS, Vanderbilt Therapeutic Alliance Scale.

^aResults shown are statistically significant after adjustment for covariates.

^bData shown for 2011–2012 only.

^a $p < .05$.

^b $p < .01$.

^c $p < .001$.

TABLE 3. Quality appraisal

JBI Analytic Cross-Sectional Study criteria	Stevens & Shi (2002a)	Stevens & Shi (2002b)	Seid et al. (2003)	Stevens et al. (2003)	Wisow et al. (2003)	Flores et al. (2005)	Stevens et al. (2005)	Wisow et al. (2010)	Horn et al. (2011)	Horn et al. (2012)	Cox et al. (2012)	Godoy et al. (2014)	Diao et al. (2017)
Inclusion criteria defined?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Subjects and setting described in detail?	Y	Y	Y	Y	U	Y	Y	U	Y	Y	Y	Y	Y
Valid methods used to identify conditions?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Condition measured reliably?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Confounding factors identified?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Strategies to deal with confounders stated?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Outcomes measured in valid/reliable way?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Appropriate statistical analysis?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Note. N, no; NA, not applicable; U, unclear; Y = yes.

appraised for risk of bias and was also found to be at low risk. The two groups were recruited from the same population, outcomes were measured in a standard and reliable way and measured over a sufficient period of time, and statistical strategies were used to ensure that the loss to follow-up was not related to the outcome factors (Wissow et al., 2002).

Measurements in Studies

Many of the studies in this review used measures of primary care quality or measures of patient–provider relationship quality in their analyses. The commonly agreed on components of quality primary care can be either directly or indirectly linked to the quality of the parent–provider relationship. In general, *quality primary care* is defined as being “accessible, longitudinally continuous, adequately communicated, contextual (based on a provider’s accumulated knowledge of the patient and family), comprehensive, and coordinated” (Seid, Stevens, & Varni, 2003, p. 1011). The studies in this review used a variety of measures to evaluate elements of the parent–provider relationship, including communication and primary care quality; these measures are summarized in Table 4.

Individual Study Results

Individual study results show a broad spectrum of approaches to measuring the quality of the parent–provider relationship in primary care. Table 2 summarizes the aims, design, independent variables, outcome measures, and results for African American parents for each study. The diverse outcome measurements are predictable, given the inherent difficulty in quantifying the many components that go into a caring relationship. Through qualitative synthesis, however, some broad themes emerged that give greater meaning to the studies as a whole.

Qualitative Synthesis

The studies in this review confirmed the underlying problem of disparities in pediatric primary care quality for African American parents and children that link back to challenges in the parent–provider relationship. These challenges can be viewed broadly as parent factors, interaction factors, and health care system factors. Through identifying these factors, future research directions and best practices for provider training can be identified to promote strong parent–provider relationships, thereby improving health promotion outcomes in pediatric primary care for African American families and improving health equity.

Parent factors

Parent factors are those that are internal to parents, such as their comfort with sharing psychosocial information, their self-efficacy in communicating, and how their income affects care. Sharing psychosocial information is essential to monitor a child’s health and detect parental, emotional, or social problems that would affect child development (Wissow et al., 2003). The willingness of parents to share

TABLE 4. Description of key measurement tools

Measurement tool	Description	Used by
Interpersonal Trust in a Physician Scale (ITPS)	10-item scale modified for use in pediatrics. Five-point Likert-like responses. Range of total score: 10–50. Example item: <i>You completely trust your child's doctor's decisions about which medical treatments are best for your child.</i>	Horn, Mitchell, Wang, Joseph, & Wissow (2012)
National Survey of Early Childhood Health (NSECH; 2000)	Nationally representative random telephone survey. Parental report of events in previous 12 months. Includes sociodemographic factors, provider characteristics, use of health services, satisfaction with care, and topics discussed with parents. Includes the Basic Prevention Services (BPS) and the Family Centered Care (FCC) subset measures.	Flores, Olson, & Tomany-Korman (2005) Stevens, Mistry, Zuckerman, & Halfon (2005)
National Survey of Child Health (2007, 2011–2012)	Nationally representative random telephone survey. Includes measure of patient-centered medical home (PCMH) based on AAP-defined medical home concept and other primary care quality measures.	Diao, Tripodis, Long, & Garg (2017)
Parent's Perceptions of Primary Care (P3C)	Based on IOM definition of primary care. Six components of primary care: longitudinal continuity (length of time with regular place or provider); access (timely and convenient); communication (how well provider listens and explains); contextual knowledge (how well provider knows parents' values and preferences about child's health and history); comprehensiveness; coordination of care	Seid, Stevens, & Varni (2003)
Primary Care Assessment Tool—Child Edition (PCAT- CE)	Developed by Johns Hopkins Primary Care Policy Center. Measures four components of primary care: first-contact care, longitudinality, comprehensiveness, coordination	Stevens & Shi (2002a, 2002b) Stevens et al. (2003)
Rotor Interaction Analysis System (RIAS)	Method for coding medical dialogue. Examples of codes used to count utterances during encounters: information giving, question asking, empathy, and partnership facilitation, relationship building, information exchange, and decision making.	Wissow et al. (2003) Wissow, Brown, & Krupnick (2010) Cox et al. (2012) Godoy, Mitchell, Shabazz, Wissow, & Horn (2014)
Vanderbilt Therapeutic Alliance Scale (VTAS)	A 38-item scale that an independent observer uses to rate each visit. Three sections include provider behaviors, parent behaviors, and provider–patient interaction.	Wissow et al. (2010)

Note. AAP, American Academy of Pediatrics; IOM, Institute of Medicine; JBI, Joanna Briggs Institute.

would presumably increase over time as trust and rapport develop (Wissow et al., 2003). Wissow et al.'s study supported this hypothesis and further defined it to suggest that long-term relationships, particularly with a female physician, led to greater sharing of potentially sensitive or intimate information. Not only does a longer relationship with the provider increase parents' comfort with sharing psychosocial concerns, but Godoy et al. (2014) found that higher maternal self-efficacy was also associated with more willingness to share psychosocial information. Interventions targeted at increasing self-efficacy for African American parents, especially for low-income families, may help strengthen the relationship between parents and providers so that parents feel more comfortable sharing psychosocial information with them and more confident getting what they need out of their visits (Godoy et al., 2014, p. 385).

Although there are many shared experiences for all African American parents, this review identified some unique associations for parents who have low income. Godoy et al. (2014) found that high self-efficacy in parents with lower income was associated with greater disclosure of psychosocial information. Cox et al.'s (2012) contention was that family income, more so than race, affected the engagement of African American families in pediatric primary care. Active family engagement during decision making was reduced for African Americans, but factoring in socioeconomic status eliminated that association (Cox et al., 2012). That controlling for income made the effect of race disappear may make it seem as though income is a factor in family engagement, but not race. However, it is important to remember that statistically controlling covariates to make the participants appear equal does not change the fact that the unadjusted statistics show that African Americans have a far greater likelihood of having low income than their White peers, meaning that socioeconomic status does not confound, but rather mediates, the effect of race (Meghani & Chittams, 2015).

Parent–provider interaction factors

Several factors that would strengthen the parent–provider relationship involve the way providers approach the interaction with the family. One measure of this is family-centeredness of care, which was measured by several studies as part of both the National Survey of Early Childhood Health and National Survey of Child Health. Parents were asked to rate the items as *always*, *usually*, *sometimes*, and *never* pertaining to how often the provider took time to understand the child's needs, respected the parent as the expert, asked how the parent was feeling, and understood how the parent wanted to raise the child (Stevens et al., 2005, p.564). One study, using the 2000 National Survey of Early Childhood Health data, found significantly lower measures for African American parents compared with White parents regarding providers respecting parents as the expert on the child and also understanding parenting preferences (Stevens et al., 2005). However, another study, using the same data set but a different sample, did not find any lower family-centered care measures (Flores, 2005). Most recently, Diao et al.

(2017) found a lower total family-centered care measure for African American parents in their study using the 2011–2012 NSCH data.

Partnership-building communication and trust are essential relationship-strengthening factors for providers working with African American families. Horn et al. (2011) found that African American parents with higher education were more likely to rate the provider's communication as moderate (vs. high or low) partnership building, which they hypothesized was because more educated parents may have higher expectations of the provider. Also, parents were more likely to report high partnership-building communication if they were seen in a community health center (Horn et al., 2011). They note, however, that the tool used to measure partnership-building communication (the Street parent–provider communication instrument) has unknown validity and reliability in the African American population (Horn et al., 2011). In their subsequent article, Horn et al. (2012) tested their theoretical basis, that partnership-building communication builds trust, to see if parent education level and practice setting, which predicted partnership-building communication, also predicted increased trust. They found that, in general, parents' trust was greater when providers used more partnership-building communication and, specifically, that the higher partnership-building communication used by providers at community health centers explained the parents' greater levels of trust in those providers (Horn et al., 2012).

Therapeutic alliance shares some conceptual overlap with partnership building and is another proposed means of measuring interactions between parents and providers (Wissow, Brown, & Krupnick, 2010). This measurement also has limitations, however, in that it is primarily used in mental health and, as noted, was correlated with rapport-building statements and parent reports of interpersonal sensitivity but not with partnership or informativeness (Wissow et al., 2010). Cox et al. (2012) used the Rotor Interaction Analysis System to measure patient and provider engagement in relationship building, information exchange, and decision making. Whether it is called *family-centered care*, *partnership building*, *trust*, *engagement*, or *therapeutic alliance*, this review shows the many ways researchers have tried to describe and quantify the relationship traits needed to promote a healthy and effective relationship between parents and providers in pediatric primary care to improve not only parent satisfaction but also positive outcomes.

Health care system factors

This review identified several key findings of parent–provider relationships that are the result of health system factors, such as insurance, type of clinic, and provider

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characteristics. Related to provider characteristics, several studies in this review reported that, unlike in adult health care, racial/ethnic congruency in the patient–provider relationship does not affect the quality of the relationship. Stevens, Shi, and Cooper (2003) hypothesized that this may be because pediatric providers do not have the same biases or assumptions when caring for children as adult providers do when caring for adults. Horn et al.'s 2011 study also confirmed that racial concordance did not lead to significant differences in partnership-building communication with parents. Again, Godoy et al. (2014) found that maternal disclosure of psychosocial information during visits was not associated with provider race. That these findings differ from the research of African American adult patient–provider relationships is further evidence of the need for additional research on the effects of race specifically on pediatric health care, because the adult research is not generalizable to this population.

Restrictive insurance policies, both from the public insurance standpoint and also the employer-based standpoint, are one way that health care systems can contribute to the impact of structural racism. Stevens and Shi (2002a) found that African American parents, who were more likely to have managed care plans, had reduced lengths of relationship with their child's providers and also reported a lower affiliation with and poorer interpersonal relationship with that provider. Later findings by Stevens et al. (2005) indicated that having a regular provider was one way to improve the family-centeredness of pediatric health care.

This review identified community health center providers as having higher partnership-building communication and trust (Horn et al., 2011, 2012). Community health centers already care for millions of African American families with managed care plans and are facing challenges with the large influx of patients after the implementation of the Affordable Care Act. The PCMH is recommended by the American Academy of Pediatrics as the ideal setting for all children to receive medical care and is supported by the Affordable Care Act as a model to reduce socioeconomic disparities in health (Diao et al., 2017). However, as Diao et al. (2017) found, African American children were less likely than White children to receive care from a PCMH and were more likely to be seen in practices with limited resources and high patient volumes, which may lead to less family-centered care. In addition, they found that there has not been an improvement in the number of children with access to a PCMH from 2007 to 2011–2012 (Diao et al., 2017). It would seem, given the research and recommendations, that community health centers that are also PCMHs would provide the highest quality of care for African American families.

Longitudinality is one factor influenced by the provider and setting that is a definitional component of pediatric primary care (Stevens & Shi, 2002a). Any relationship takes time to establish trust and rapport, yet African American parents reported seeing their provider for only 6 to 11 months on average, as opposed to White parents, who

reported an average relationship of 1 to 2 years (Stevens & Shi, 2002a). In pediatrics, longitudinality is critical for establishing trust (Horn et al., 2012; Stevens & Shi, 2002a), which allows for a greater transfer of anticipatory guidance and efficiency in addressing parent concerns. Length of relationship also increases the sharing of important psychosocial information, according to Wissow et al. (2003). A large number of African American families use community health centers for care or have Medicaid insurance plans, where both a high turnover of providers or changes in state contracts for managed care organizations can interrupt the caregiver relationship.

DISCUSSION

This review is important in revealing the complexities of the parent–provider relationship in the context of race, and it therefore compels providers to consider their approach to interactions with African American parents in light of what is known. For parents, the willingness to share psychosocial information with their child's provider is related to their perceived self-efficacy in communicating with the provider and the length of the relationship (Godoy et al., 2014; Wissow et al., 2003). As parents interact with providers, issues of trust, therapeutic alliance, engagement, partnership-building communication, and family-centered care come to the forefront (Cox et al., 2012; Horn et al., 2011, 2012; Stevens et al., 2005; Wissow et al., 2010). Behind the scenes, factors such as the type of health care setting, insurance, and the length of relationship also contribute to the parent–provider relationship (Horn et al., 2011, 2012; Stevens & Shi, 2002a; Wissow et al., 2003).

Implicit and Explicit Bias

Behind the disparities research that evaluates the way providers interact with African American patients is the effect of bias, both implicit and explicit, on those relationships. Although none of the studies in this review directly surveyed or interviewed providers to measure explicit bias, the results of this review do show possible assumptions and implicit biases of providers affecting the parent–provider relationship. According to the Institute of Medicine's (2003) findings, bias is challenging to measure and identify, yet substantial research now shows that clinical uncertainty can cause providers to “act in a racially biased manner” (p. 167). This can result in patients receiving either more or less care than White patients (Institute of Medicine, 2003). African American parents in Seid et al.'s (2003) study had significantly higher adjusted mean scores for comprehensiveness of care. Although Seid et al. (2003) do not draw any conclusions on this finding (perhaps because there were many other conclusions for other races/ethnicities to focus on), it is striking that African American parents would report more comprehensive care than their White counterparts. Unlike the remainder of the 23-item survey, four out of five of the questions on the Parent's Perceptions of Primary Care survey measuring comprehensiveness began with the wording *Does the doctor talk to you about . . .* (Seid et al., 2003, p. 1027).

Because of the design, we are limited to associational conclusions. However, a critical analysis of the tool, along with these results, may indicate that there is a bias or assumption that African American parents need to be given more direct care and education. Talking to families rather than with families would not characterize the partnership-building or engagement communication style invoked by others.

In addition to higher comprehensiveness scores, the findings presented by Flores et al. (2005) regarding the common topics discussed with African American parents at visits also points to potential bias and stereotypes, which can negatively affect the communication and partnership with the provider. Providers more often discussed household smoking, trouble paying for children's needs, spouse/partner parenting support, child care, and reading to children with African American families than with White families (Flores et al., 2005). This tendency to select certain topics based on a parent's race, rather than addressing parents' own identified concerns, shows potential stereotyping that can erode a family's trust and rapport.

Research and Policy

Many of the identified factors show gaps in the literature or possibilities for political or institutional policy reform. Future research may be helpful identify whether the same patterns of partnership-building communication and trust found in community health center providers (Horn et al., 2011, 2012) holds true for PCMH providers (Diao et al., 2017). If so, exploring best practices to improve access for African American families to community health centers that are also PCMHs would be indicated. A better understanding of the places where African American families seek care may help identify additional structures and processes that warrant further study and application to private practices and hospital-based clinics to improve their outcomes. In response to the Flores et al. (2005) findings of increased comprehensive of care, future descriptive research comparing parents' stated concerns before visits with topics actually discussed would make it more clear if these topics are selected based on assumptions and bias or based on parents' identified needs. Given the shortened length of the primary care relationship associated with managed care insurance (Stevens & Shi, 2002a), policies and strategies aimed at sustaining a family's connection to a particular clinic or provider must be developed and implemented.

For many of the identified factors, the difficult-to-elucidate effect of implicit bias and structural racism likely compounds the parent-provider relationship further. The lack of literature exposing the effects of bias and racism on

pediatric primary care for African American children represents a gap in the literature. Studies aimed at exposing the underlying factors affecting the parent-provider relationship will place what is already known into the cultural and sociopolitical context in ways that can more fully inform and guide providers and clinics.

Limitations

This review is limited in generalizability because of the nature of the results of cross-sectional studies being associational rather than causal. However, individually, the studies carried a low risk of bias, and several of the studies had congruent findings, further increasing the rigor of the results. Despite having 13 studies, there were only 10 unique data sets, and many of the articles were written by the same or similar groups of researchers, who would share a similar lens through which they view the data. Also, five of the studies relied on samples from southern California (Cox et al., 2012; Seid et al., 2003; Stevens & Shi, 2002a, 2002b; Stevens et al., 2003), which, although a diverse region, may not be the most representative of African American parents across the United States. This review also does not adequately capture the within-group variability among African Americans that other factors, such as socioeconomic status, might affect. However, current research suggests that African Americans of all income levels are subject to the adverse health effects of structural racism (Sanders-Phillips, Settles-Reaves, Walker, & Brownlow, 2009; Turner et al., 2017).

Another limitation of this review is that it seeks to use quantitative data to explain African American parents' relationships with their child's health care provider. The surveys and tools used in these studies were not created from participant involvement and relied on assumptions regarding the important covariates and outcomes measures. This quantitative data is helpful for identifying the degree to which something is a problem, and the data from these studies show that there is indeed a disconnect in the relationship between parents and providers that has an impact on care quality. However, without talking to people involved through rich dialogue, we are unable to identify the depth and breadth of the challenges or the best strategies to overcome these disparities.

Although this review identified parents' perceptions of their relationship with their child's provider, it did not identify the experiences of the health care providers caring for African American families. To understand the gap between African American parents and their child's provider, it is essential to understand not only the parents' perspectives but also how the provider approaches caring for this population. Future research should include interviews and data collection from providers to better understand their perceptions. Qualitative interviews would allow for greater analysis of assumptions and potential implicit or explicit biases in care that are difficult to elucidate from quantitative surveys with structured response options.

Both geographic location and provider role are additional limitations of the current body of literature. The majority of studies in this review came from either southern

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California or Washington, DC. These two regions do not represent the most variation within African American culture in the United States, which limits the generalization of findings from these studies. However, the addition of several nationally representative studies counteracts this limitation (Diao et al., 2017; Flores et al., 2005; Stevens et al., 2005). Regarding providers, only Godoy et al. (2014) mentioned pediatric nurse practitioners as provider participants in their study, whereas the remaining 12 articles referred only to pediatricians, physicians, residents, or providers generically. With more than 18,000 pediatric nurse practitioners in the United States and almost 59,000 general pediatricians, pediatric nurse practitioners should be better represented in pediatric health care research (American Academy of Pediatrics, 2011; National Association of Pediatric Nurse Practitioners, 2015).

CONCLUSION

The results of this literature review confirm much of what is known regarding the impact of race on African American health and how this is both affected by and manifested in the relationship between patients and health care providers. What this review adds is a synthesis of the findings specifically for parents in the pediatric primary care setting. For pediatric providers, this review compels reflection on current practices to identify ways of improving longitudinality of care, partnership building, trust, and family-centeredness of care for African American patients. Those who educate pediatric health care providers should continue to emphasize in their teaching the importance of understanding the context of patient encounters and how race and culture affect relationships, the quality of care, and, ultimately, patient outcomes. Future qualitative research with both parents and health care providers will help further explicate the parent, provider, and health care system factors that contribute to lower-quality pediatric primary care for African American families. With additional data, the results of this literature review can serve as the start of a best practices model for pediatric health care providers serving this population and will support policy reform. To stop the continued march of health care disparities for African Americans in the United States, research-driven provider education, interventions, and policies at the prevention-focused pediatric primary care level are imperative.

SUPPLEMENTARY MATERIALS

Supplementary material associated with this article can be found in the online version at <https://doi.org/10.1016/j.jpchc.2019.03.004>.

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