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Association of Psychological Distress with Reasons for Delay in Seeking Medical Care in Rural Patients with Worsening Heart Failure Symptoms

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Abstract

Background: The impact of depressive symptoms and anxiety on rural patients' decisions to seek care for worsening heart failure (HF) symptoms remains unknown. The purposes of this study were (1) to describe rural patients' reasons for delay in seeking care for HF, and (2) to determine whether depressive symptoms or anxiety was associated with patients' reasons for delay in seeking medical care for worsening symptoms.

Methods: A total of 611 rural HF patients were included. Data on reasons for patient delay in seeking medical care (The Reasons for Delay Questionnaire), depressive symptoms (PHQ-9), and anxiety (BSI-ANX) were collected. Statistical analyses included chi-square and multiple regression.

Results: A total of 85.4% of patients reported at least 1 reason for delay. Patients with higher levels of depressive symptoms were more likely to cite embarrassment, problems with transportation, and financial concerns as a reason for delay. Patients with anxiety not only cited non-symptom-related reasons but also reported symptom-related reasons for delay in seeking care (i.e., symptoms seemed vague, not sure of symptoms, symptoms didn't seem to be serious enough, and symptoms were different from the last episode). In multiple regression, patients with greater depressive symptoms and anxiety had a greater number of reasons for delay in seeking care ($P = .003$ and $P = .023$, respectively).

Conclusions: Our findings suggest enhancement of patients' symptom appraisal abilities and improvement in psychological distress may result in a reduction in delay in seeking medical care for worsening symptoms in rural patients with HF.

Keywords

anxiety; depression; reasons for care-seeking delay; rural heart failure patients

Patients with heart failure (HF) who live in rural areas face more barriers to timely care-seeking and less access to health care than those in urban areas.^{1,2} Rural patients with HF are at risk for a particularly high rate of mortality and adverse health outcomes compared to non-rural patients.^{3,4} A prompt response to symptoms, especially in patients with HF, is essential to prevent exacerbations.⁵ A HF self-check plan from the American Heart Association recommends patients who perceive the onset of signs and symptoms of worsening HF, depending on the severity, take appropriate measures such as adjusting medications, calling their health care provider, or going to the hospital immediately.⁶ Yet evidence reveals patients with HF are unable to recognize or respond to the early signs of worsening symptoms in a timely manner, and this can result in care-seeking delays of a few days to several weeks.⁷⁻⁹ Previous research has shown delays may be related to patients' sociodemographic characteristics (e.g., younger age or male gender),^{10,11} a gradual onset of symptoms,^{10,12} or living in a rural environment¹³; however, there have been no studies of reasons for delay seeking care in rural HF patients.

The prevalence of depression is higher in rural populations than urban populations in the United States, with an estimated 2.6 million rural residents screening positive for depression.^{14,15} Depressive symptoms are also common in HF patients, with a prevalence rate of approximately 22%.¹⁶ Patients with HF are more likely to have depression than those with other chronic diseases, and they are twice as likely to have depression as people in the general population.¹⁷ Importantly, depressive symptoms are associated with rehospitalization and mortality; HF patients with depressive symptoms have more than a 40% risk of readmission or death within 18 months after hospital discharge.^{18,19} Anxiety is often comorbid with depression, and it is associated with increased cardiac-related rehospitalization and poor quality of life.²⁰ In addition, depressive symptoms and anxiety are predictors of poor adherence to recommended treatment and other self-care activities in patients with HF. Patients with HF with depressive symptoms delay seeking medical care for worsening HF symptoms longer than those without depressive symptoms, with a 1.5 times higher risk for a delay of more than 3 days.¹² Thus, depressive symptoms and anxiety not only lead to poorer outcomes but also affect patients' ability to implement appropriate self-care behaviors, such as timely care-seeking for escalating symptoms.

A prompt response to worsening HF symptoms can lead to better outcomes, such as a shorter hospital stay,²¹ reduced mortality,²² improved quality of life,²³ and savings on medical expenses.²⁴ Thus, research centered on care-seeking behaviors and processes is essential. There is considerable research available about length of delay and factors associated with delay in seeking care in patients with HF.^{11,13,25} Research is limited, however, that focuses on the reasons rural HF patients delay seeking care. Delay in seeking care becomes even more important to study because higher levels of depressive symptoms are associated with longer length of delay in patients with HF^{12,26,27}; however, the reasons for delay are unknown. Furthermore, anxiety and its impacts on treatment-seeking delay have not been studied in rural HF patients. Uncovering the reasons for delay among HF patients with depressive symptoms and anxiety, particularly for patients in rural areas, will provide important data with which to design interventions to promote prompt and appropriate treatment-seeking among patients with worsening symptoms of HF. Therefore,

the purposes of this study were to (1) investigate specific reasons for delay, and (2) examine which of these reasons were predicted by depression and anxiety among rural HF patients.

Methods

Design

This was a secondary data analysis from the clinical trial, Rural Education to Improve Outcomes in Heart Failure (REMOTE-HF, clinical trial unique identifier [NCT00415545](https://clinicaltrials.gov/ct2/show/study/NCT00415545) [registered in clinicaltrials.gov]), a study designed to test an intervention to reduce hospital readmission and mortality for rural patients with HF.²⁸ Patients were recruited from cardiac clinics or hospitals located in California, Kentucky, and Nevada. Clinics and hospitals serving rural patients in these 3 states and that were accessible to the researchers were identified and asked to participate; all sites agreed. Adults aged 18 years or older who were hospitalized for HF within the past 6 months and who were dwelling in a rural location defined as a town of < 2,500 people or a large rural city of < 50,000 people were eligible.²⁹ Patients were excluded if they had renal disease requiring dialysis; did not speak English or had any other communication barrier; a coexisting terminal illness; a psychotic illness; or cognitive impairment. Cognitive impairment was measured using the Mini-Cog.³⁰

Procedure

Institutional Review Board approval for conducting the study was obtained from each participating institution. Patients were referred to study personnel by care providers at participating clinics and hospitals. Referred patients who had a confirmed diagnosis of HF were screened for eligibility and approached by research assistants. Each patient gave informed written consent to participate in the study. At the time of enrollment, cognitive function was evaluated with the Mini-Cog test by a trained research nurse. The Mini-Cog test includes a 3-word recall test for memory and a clock-drawing test for clarifying scores when the scores of a 3-word recall are less than or equal to 2. The scores on the Mini-Cog consist of 3 points for the 3-word recall test and a normal or abnormal clock-drawing. Patients from this study were excluded if they had a word recall score of 0 or a word recall score of 2 with an incorrect clock-drawing. Baseline data on sociodemographic characteristics, clinical variables, psychological factors, cognitive and behavioral factors, and reasons for patient delay were used in the current study.

Measures

Reasons for Patient Delay—Reasons for patient delay in seeking early care for worsening HF symptoms were assessed by asking patients which of a list of reasons best applied to them. Patients recruited from the hospitals were asked about their reasons for delaying seeking care for the current admission, while patients recruited from clinics were asked about reasons for delaying seeking care based on the most recent hospitalization. Reasons for patient delay in seeking medical care were collected using the REMOTE-HF Reasons for Delay Questionnaire. This instrument is a 9-item self-report questionnaire designed to determine the reasons patients with HF delay seeking medical care for their worsening symptoms. The questionnaire regarding reasons for delay consists of the following questions, the first 8 of which are “yes/no” and the last of which is an open

question: (1) Symptoms are vague or come on gradually; (2) Not sure of symptoms; (3) The symptoms don't seem to be serious enough; (4) Symptoms are slightly different from last time; (5) Embarrassment/unease about calling for help; (6) Don't want to second guess my doctor; (7) Financial concerns; (8) Transportation issues; and (9) Other reason—please describe. Content validity of the instrument was established using a panel of HF specialists including 5 physicians and nurses. In this sample, internal consistency as measured using Kuder-Richardson Formula 20 was 0.75.

Psychological Factors—Depressive symptoms were assessed using the Patient Health Questionnaire-9 (PHQ-9), a 9-item self-reported screening instrument.³¹ Each symptom is rated on a 4-point Likert scale from 0 (not at all) to 3 (nearly every day), with a total score ranging from 0 to 27. A higher score on the PHQ-9 indicates more severe depressive symptoms. A cut point score of 10 or higher, which has been found in patients with major depression,^{31,32} was used in this study to differentiate HF patients with depressive symptoms (≥ 10) from HF patients without depressive symptoms (< 10). The PHQ-9 has shown good reliability and validity in HF.³³

Patients' anxiety was measured using the anxiety subscale of the Brief Symptom Inventory (BSI).³⁴ The BSI anxiety subscale is a 6-item self-report instrument. Each item is rated on a 5-point Likert scale from 0 (not at all) to 4 (extremely). The subscale score is the mean score of the 6 items and ranges from 0 to 4. A higher score on the BSI anxiety subscale indicates worse anxiety. A cutoff score of 0.35 or higher on the BSI anxiety subscale has been suggested as an indicator of the presence of anxiety³⁵; thus, this cutoff score was adopted to classify HF patients with anxiety (≥ 0.35) and HF patients without anxiety (< 0.35) in this study. The BSI has well-established reliability and validity in HF.³⁶

Sociodemographic, Clinical, and Cognitive and Behavioral Covariates—Sociodemographic data (e.g., age, gender, educational level, number of people in the household, annual household income, and health insurance information) were obtained by patient interviews using a demographic survey. Clinical data were collected and included New York Heart Association (NYHA) functional classification³⁷ and the Charlson Comorbidity Index (CCI).³⁸ The NYHA classification was used to classify patients into 1 of 4 categories based on the extent of symptoms during physical activity from class I (no symptom limitations to performing physical activity) to class IV (unable to perform any activity and symptoms present even at rest).³⁷ The NYHA classification for each patient was determined by the patient's physician or a trained research nurse via careful interview. The CCI was used to measure comorbidity burden and data were collected through medical record review by a trained research nurse. The CCI has well-documented reliability and validity across a wide variety of disease states.³⁸

Cognitive and behavioral covariates included cognitive function, HF knowledge, and health literacy. Cognitive function was determined by the Mini-Cog. Heart failure knowledge was measured using the Heart Failure Knowledge Scale.³⁹ It is a 20-item instrument used to assess patients' knowledge about HF (3 true/false questions), HF symptoms (14 yes/no questions), and HF self-care (3 multiple-choice items). The scores can range from 0 to 20 with higher scores representing higher HF knowledge. Health literacy was assessed using

the Short-form Test of Functional Literacy in Adults questionnaire.⁴⁰ It has 36 cloze-type items consisting of 16 items with questions regarding X-ray preparation and 20 items with questions regarding Medicaid rights and responsibilities. Possible scores range from 0 to 36, with higher scores indicating greater health literacy.

Data Analysis

Data were analyzed using IBM SPSS Statistics for Windows, version 25.0 (IBM Corp., Armonk, NY). Descriptive statistics summarized the demographic characteristics of the study population. Reasons for delay in seeking medical care were analyzed using descriptive statistics and were reported as frequencies and percentages. Chi-square analysis was performed to compare reasons for delay based on the presence or absence of depressive symptoms and anxiety. Multiple linear regression was applied to examine whether psychological distress (i.e., depressive symptoms and anxiety) predicted number of reasons for delay in seeking treatment for deteriorated symptoms. In the regression model, we included factors potentially predicting the number of reasons one may delay seeking care including age, gender, education level, number of people in the household, annual household income, on Medicare coverage, on Medicaid coverage, NYHA functional class, comorbidity burden, cognitive function, health literacy, HF knowledge, depressive symptom, and anxiety. Backward stepwise selection was used in the regression model; variables greater than or equal to 0.10 level of significance were excluded. No significant violations of the assumptions for linear regression were observed.

Results

Sample Characteristics

A total of 611 rural HF patients (Table 1) were enrolled in the study. The patients were predominantly White (89%), male (59%), and married (56%). The mean age of the sample was 66 ± 13 years. Most lived with someone (77%) and had a household income of less than \$40K per year (65%).

Reasons Patients with HF May Delay Seeking Care

Among the 611 rural HF patients, 14.6% of patients ($n = 89$) selected “no” to all of the reasons patients may delay seeking medical care when their HF symptoms worsen. The remaining 85.4% of patients ($n = 522$) selected at least 1 reason for delaying. Among these 522 HF patients, 10.7% ($n = 56$) reported only 1 reason for their delay, while 11.3% of patients ($n = 59$) had 2 reasons, 17.8% ($n = 93$) reported 3 reasons, 23.4% ($n = 122$) reported 4 reasons, 17.4% ($n = 91$) reported 5 reasons, and 19.4% ($n = 101$) reported 6 to 9 reasons.

The most common reasons for not seeking early medical care were symptoms seemed vague or came on too gradually (67.4%), not sure of symptoms (62.2%), symptoms didn't seem to be serious enough (62.4%), and symptoms were slightly different from last episode (55.2%). Other reasons included embarrassment about calling for help (24.1%), not wanting to second guess the doctor (21.6%), financial concerns (20.1%), transportation issues (16.5%), and other (10.8%). Other reasons, while small proportionally, were denial/don't want to know/fear of knowing (2.9%), busy (2.1%), afraid of/don't like doctors or hospitals (1.3%), not

wanting to bother others (1.2%), stubborn (1.2%), family/pets need them (1.0%), weather (0.7%), poor recognition/poor knowledge (0.3%).

Psychological Distress and the Specific Reasons for Care-Seeking Delay

Patients with depressive symptoms were more likely to endorse 3 reasons: embarrassment, financial concerns, and transportation issues as reasons for delay compared to those without depressive symptoms (Table 2). Patients with anxiety selected more reasons one may delay seeking care: symptoms were vague, being unsure about their symptoms, symptoms didn't seem to be serious enough, symptoms were different from last time, embarrassed about calling for help, didn't want to second guess their doctors, financial concerns, and transportation issues as reasons for delay in seeking treatment as compared to those without anxiety (Table 3). Information on patients who had both depressive symptoms and anxiety in relation to reasons one may delay seeking care is also presented in Table 4.

Predictors of Number of Reasons Patients May Delay Seeking Treatment for Worsening HF Symptoms

Depressive symptoms, anxiety, and HF knowledge were significant predictors of the number of reasons one may delay seeking medical care, independent of other covariates (Table 5). Patients with greater depressive symptoms, higher levels of anxiety, and lower HF knowledge had more reasons for their delay. Every 1-unit increase in depressive symptom score was associated with a 5% increase in the number of reasons one may delay seeking treatment while other covariates were held constant (unstandardized $B = 0.054$, $P = .003$). Every 1-unit increase in anxiety score was associated with a 29% increase in the number of reasons one may delay seeking treatment while other covariates were held constant (unstandardized $B = 0.287$, $P = .023$). Every 1-unit decrease in HF knowledge score was associated with a 9% increase in the number of reasons one may delay seeking treatment while other covariates were held constant (unstandardized $B = -0.089$, $P = .008$).

Discussion

The results of this study indicated the common reasons why rural patients with worsening HF symptoms may delay seeking medical care. Of the 522 patients, over three-quarters reported 3 or more reasons for delay in care-seeking. Depressive symptoms, anxiety, and HF knowledge were independent predictors for having more reasons one may delay. This is important because a greater number of reasons one might delay seeking care for worsening HF symptoms could translate into worse patient outcomes. Additionally, this imposes potential barriers to educating patients about avoiding delay in seeking treatment for escalating HF symptoms. Health care providers should not only assess patients' psychological states (i.e., depression and anxiety) and their level of knowledge about HF symptoms and self-care, but act on these to uncover and address all of the reasons these vulnerable patients may delay seeking care.

Based on the common-sense model of self-regulation theory, illness behavior and the care-seeking process are influenced by situational stimuli (e.g., symptom occurrence), illness perceptions (e.g., symptom identification), emotional responses (e.g., worry), coping

strategies (e.g., to seek care or to avoid care), and action appraisals (e.g., evaluation of coping strategies).⁴¹ This theory illustrates that the care-seeking process is complicated and interactive, demonstrating how illness perceptions and emotional responses involved in coping strategies affect decisions to seek care. Our findings are supportive of this theory and demonstrate that even though patients perceived stimuli from symptoms, they evaluated and considered many alternative and time-consuming responses before taking care-seeking action, which could lead to substantial delays. In particular, we demonstrated that lack of HF knowledge and psychological distress contribute substantially to reasons for care-seeking delays. We also demonstrated that the symptom appraisal process in patients with HF could contribute to delays.

Similar to prior HF studies in which depressive symptoms contributed to increasing delay time,^{12,27} our findings revealed depressive symptoms and anxiety were a precipitating factor for increasing the number of reasons for delay. In addition, patients with depressive symptoms have 3 non-symptom-related reasons for delay: embarrassment, financial concerns, and transportation issues. In fact, patients with depression are more likely to feel guilty, feel bad about being ill, or feel worthless, thus making them less likely to seek help.⁴² Patients' anxiety also contributed negatively to decisions to seek care. The reasons for delay in rural HF patients with anxiety not only included non-symptom-related reasons but also involved symptom-related reasons. Hence, depressive symptoms and anxiety lead to a negative impact on the decision to seek medical care and affect patients' ability to interpret symptoms. It is vital for health care providers to promote mental health (especially focusing on depression and anxiety), including screening, consultation, and treatment in rural patients with worsening HF symptoms, to avoid delay in seeking care.

More than 50% of the reasons reported for not seeking early care were related to symptom appraisal: symptoms seemed vague, not sure of symptoms, symptoms didn't seem to be serious enough to seek care, or symptoms were slightly different from the last episode. Symptom appraisal is subjective, and it comprises the elements of recognition, identification, evaluation, and interpretation in which a patient appraises symptoms after noticing they occur. In our study, "symptoms seemed vague" was the primary reason for delay, especially if symptoms increased gradually. Corresponding with a prior HF study, a gradual onset of symptoms increased the length of delay in seeking treatment.¹⁰ Patients may feel hesitant or wait for a while to see if the symptoms will improve.^{7,9,13} An ambiguous or slow to develop symptom makes it difficult for patients to recognize the early symptom of HF exacerbation and determine the appropriate time to seek care. Our findings provide insights for health care providers who can teach patients to appraise their symptoms more critically to avoid discounting the importance of symptoms.

"Not sure of symptoms," also known as "symptom uncertainty," was another common reason for delay. In other studies, the most frequent symptoms HF patients reported were shortness of breath, swelling in legs, weight gain, or fatigue.^{8,9} These symptoms are similar to those seen in aging, comorbid conditions, or colds and flu⁴³; therefore, patients may have trouble identifying their symptoms as HF-related. This finding was also supported by studies of elderly patients with HF, in which patients postponed seeking medical care because they were not able to properly appraise the meaning of their symptoms,⁷ or they attributed the

symptoms they were experiencing to respiratory problems or general fatigue rather than HF.¹³

Patients were also confused and unsure about whether to call for treatment if their current symptoms differed from a previous episode. In fact, HF symptoms can vary from time to time. It is hard for patients to interpret the meaning of symptoms if they are not the same every time. This problem is compounded in rural patients who commonly do not have routine access to HF specialists or cardiologists and thus may not receive the training needed to properly appraise their symptoms.^{44,45} Consequently, monitoring HF symptoms using, for example, a symptom diary may help patients better appraise their symptoms by promoting careful observation and recording of symptoms and their changes.^{46,47}

Several non-symptom-related factors for delay in seeking care were also important and need to be addressed. We found embarrassment/unease about calling for help because patients did not want to be seen by any neighbors as needing assistance to be a common reason for delay. Self-sufficiency is a common characteristic among rural individuals⁴⁸ and may hinder appropriate care-seeking. Additionally, patients in our study did not want to be seen as second-guessing their doctor. It is difficult for patients to make decisions to seek care in a timely manner if they have marginal health literacy, inadequate self-care abilities, or low education, and these characteristics are common in rural residents.^{1,49} Our findings provide useful information for health care providers trying to teach patients good self-care.

Financial concerns were an important reason for delay in our study and have also been found by others in studies of both rural and non-rural patients where worries about the costs of hospital visits or other medical care costs resulted in delay.^{7,50,51} In our study, about 65% of participants had an annual household income of less than \$40K. Individuals living in rural areas suffer a greater burden from low income, where it results in more uninsured and underinsured, and worse health care access. Finally, transportation issues are often cited as barriers to health care access.⁵² Rural patients need to travel 2 to 3 times farther than urban patients to seek care from a medical specialist.² Further, a number of participants lived alone (23.3%) in our study, limiting their ability to access transportation easily.

Limitations

A large sample of White patients was included in this study. Data from the 2010 Census of Population and Housing reveal that 77.8% of the population in rural and small-town communities are White in the United States.⁵³ Our findings limit generalizability because our sample was 89% White. Another limitation is that our participants were recruited from only 3 specific rural areas and thus may not entirely be representative of the population.

Conclusions

Responding properly to symptoms that can be an early sign of exacerbation is important in HF. The findings of this study suggest that promoting attention to psychological states (i.e., depressive symptoms and anxiety) and improving psychological distress in rural patients with HF may enhance symptom appraisal and facilitate timely care-seeking to avert further deterioration.

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Table 1.

Sample characteristics (*N* = 611)

Characteristics	Mean ± SD or <i>N</i> (%)
Age, years	66 ± 13
Gender	
Male	359 (58.8)
Female	252 (41.2)
Race	
White	542 (88.7)
Black and other minorities	69 (11.3)
Education level	
High school	409 (66.9)
> High school	202 (33.1)
Marital status	
Married / cohabitating	345 (56.4)
Divorced / widowed	238 (39.0)
Never married	28 (4.6)
Number of people in the household	
Alone	142 (23.2)
One other	317 (51.9)
Two or more	152 (24.9)
Employment	
Employed	90 (14.7)
Disabled	162 (26.5)
Retired	322 (52.7)
Other	37 (6.1)
Annual household income	
< \$20,000	216 (35.4)

Characteristics	Mean \pm SD or N (%)
\$20,001 - \$40,000	180 (29.5)
\$40,001 - \$75,000	95 (15.5)
> \$75,000	46 (7.5)
Do not know/decline to report	74 (12.1)
Medicare	
Yes	402 (65.8)
No	209 (34.2)
Medicaid	
Yes	102 (16.7)
No	509 (83.3)
NYHA classification	
I / II	396 (64.8)
III / IV	215 (35.2)
Charlson comorbidity index	
	3.36 \pm 1.79
Ejection fraction (%)	
40	298 (48.8)
<40	304 (49.8)
missing	9 (1.4)
Psychological factors	
Depressive Symptoms	7.37 \pm 6.37
Anxiety	0.82 \pm 0.93
Cognitive and behavioral characteristics	
HF knowledge	13.90 \pm 2.59
Health literacy	25.55 \pm 8.81

HF, heart failure; NYHA, New York Heart Association

Table 2. Patient-reported reasons for delay in seeking treatment in relation to depressive symptoms (N= 611)

Reasons for delay in seeking care	Depressive symptoms		P value
	PHQ-9 score < 10 (n = 419) n (%)	PHQ-9 score 10 (n = 192) n (%)	
Symptoms are vague or come on gradually	280 (66.8)	132 (68.8)	.638
Not sure of symptoms	251 (59.9)	129 (67.2)	.085
The symptoms don't seem to be serious enough	254 (60.6)	127 (66.1)	.191
Symptoms are slightly different from last time	221 (52.7)	116 (60.4)	.077
Embarrassment/unease about calling for help	80 (19.1)	67(34.9)	<.001
Don't want to second guess my doctor	85 (20.3)	47 (24.5)	.242
Financial concerns	74 (17.7)	48 (25.0)	.035
Transportation issues	54 (12.9)	47 (24.5)	<.001

PHQ-9, Patient Health Questionnaire-9

Table 3. Patient-reported reasons for delay in seeking treatment in relation to anxiety (N = 611)

Reasons for delay in seeking care	Anxiety		P value
	BSI score < 0.35 (n = 291) n (%)	BSI score 0.35 (n = 320) n (%)	
Symptoms are vague or come on gradually	184 (63.2)	228 (71.3)	.035
Not sure of symptoms	161 (55.3)	219 (68.4)	.001
The symptoms don't seem to be serious enough	166 (57.0)	215 (67.2)	.010
Symptoms are slightly different from last time	137 (47.1)	200 (62.5)	< .001
Embarrassment/unease about calling for help	43 (14.8)	104 (32.5)	< .001
Don't want to second guess my doctor	45 (15.5)	87 (27.2)	< .001
Financial concerns	44 (15.1)	78 (24.4)	.004
Transportation issues	25 (8.6)	76 (23.8)	< .001

BSI, Brief Symptom Inventory

Table 4. Patient-reported reasons for delay in seeking treatment in relation to depressive symptoms and anxiety (N= 611)

Reasons for delay in seeking care	Depressive symptoms and anxiety		P value
	Yes ^a (n = 162) n (%)	No ^b (n = 449) n (%)	
Symptoms are vague or come on gradually	111 (68.5)	301 (67.0)	.730
Not sure of symptoms	112 (69.1)	268 (59.7)	.034
The symptoms don't seem to be serious enough	104 (64.2)	277 (61.7)	.573
Symptoms are slightly different from last time	101 (62.3)	236 (52.6)	.032
Embarrassment/unease about calling for help	60 (37.0)	87 (19.4)	< .001
Don't want to second guess my doctor	45 (27.8)	87 (19.4)	.026
Financial concerns	42 (25.9)	80 (17.8)	.027
Transportation issues	43 (26.5)	58 (12.9)	< .001

^aPatients who had both depressive symptoms (Patient Health Questionnaire-9 score ≥ 10) and anxiety (Brief Symptom Inventory score ≥ 0.35).

^bPatients who had either depressive symptoms or anxiety, or neither of the two.

Multiple regression analysis of factors predicting a greater number of reasons one may delay seeking care for heart failure ($N = 611$)

Table 5.

Variables	<i>B</i>	<i>SE</i>	β	95% <i>CI</i>	<i>P</i> value
Depressive symptoms	0.054	0.018	0.155	0.018 to 0.089	.003
Anxiety	0.287	0.128	0.120	0.035 to 0.538	.025
HF Knowledge	-0.089	0.034	-0.104	-0.155 to -0.023	.008

Model $R^2 = 0.090$; Adjusted $R^2 = 0.078$; $F(8, 602) = 7.472$; P value $< .001$

B, unstandardized coefficients; β , standardized coefficients; *CI*, confidence interval; HF, heart failure; *SE*, standard error