VARIATIONS IN THE PERCEPTIONS OF LATINOS OF NON-BASED MEDICAL HEALTHCARE COMPARED WITH THE PERCEPTION OF WHITES

by

James P. Driscoll Jr.

LUIS RIVERA, Ph.D., Faculty Mentor and Chair

KATHLEEN HENRY, Ph.D., Committee Member

SUSANNE BLEIBERG-SEPERSON, Ph.D., Committee Member

Barbara Butts Williams, Ph.D., Interim Dean, School of Business & Technology

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Philosophy

Capella University

January 9th, 2009

Abstract

This dissertation represents the different patient perceptions between Latinos and Whites in the U.S. healthcare system. This analysis looks at perceptions of soft issues (emotional and spiritual care) not medicinal treatment received. Hospitals, clinics, and physician offices that do not take into account cultural and ethnic differences are aligning themselves to provide a disservice to the Latino population as well as the public. Without meeting the needs of the Latino population, healthcare organizations are missing an opportunity to address healthcare needs of a particular large segment of the population. In addition, when healthcare organizations miss an opportunity to attract and retain a segment of the population, market share does not grow, and if the patient feels their care did not meet their needs, a loss of market share will potentially exist in the form of lost repeat business and negative word of mouth publicity.

When a healthcare organization inadvertently excludes a portion of the population for not addressing emotional needs, patients feel emotionally disconnected, as well as potentially being left with no alternative healthcare services. This scenario presents challenges in it's self, as untreated Latinos, can spread disease within their enclave, and the broader population of the community. When diseases and illnesses go untreated they are often more costly to treat, which puts a financial strain on the U.S healthcare system.

Dedication

This is dedicated to the people closest to my heart that has stood by my side and made many sacrifices along the way with me. Without your strength and understanding, this journey would have been much tougher if not impossible without your love and support. I am truly indebted to you.

James

Acknowledgments

I would like to thank my committee members Kathleen Henry Ph.D., and Susanne Bleiberg-Seperson Ph.D. who helped guide me and made me understand what it is truly like to be a Ph.D. I would also like to give a special thank you to Luis Rivera Ph.D. my mentor, for giving me the guidance, and understanding that I needed to achieve my goals not only as a scholar, but also as a professional. You certainly exceeded in defining to me what it means to be a mentor.

Table of Contents

Acknowledgments	iv
List of Tables (if tables used)	viii
List of Figures (if figures used)	ix
CHAPTER 1. INTRODUCTION	1
Background of the Study	3
Statement of the Problem	6
Purpose of the Study	8
Research Questions	8
Rationale	9
Significance of the Study	11
Definition of Terms	12
Assumptions and Limitations	13
Nature of the Study	13
Organization of the Remainder of the Study	15
CHAPTER 2. LITERATURE REVIEW	17
Background of the Latino and Latino Immigrant	17
Health Status of Illegal Immigrant	17
Barriers	20
Perceptions	22
Market Share	26
Service Excellence	30
Quality in Healthcare	32

CHAPTER 3. METHODOLOGY 41
Research Design 41
Sample 42
Setting 43
Instrumentation / Measures 43
Data Collection Procedures 44
Quantitative Analysis 46
Qualitative Analysis 52
Qualitative Content Analysis 55
Reliability 56
Intervention / Procedures 57
Data Analysis 57
Validity and Reliability 59
Dependent Variable 60
Independent Variable 61
Reciprocity 62
Anonymity 62
Ethical Considerations 63
CHAPTER 4. RESULTS 65
Introduction 65
Demographic Analysis 66
Age 66
Gender 67

Race 69

Insurance 69

Income Range 71

Descriptive Statistics 73

Correlations 75

Regression 83

Latino Results 87

White Results 98

Qualitative Comments 108

CHAPTER 5. DISCUSSION, IMPLICATIONS, RECOMMENDATIONS 109

Research question 1 110

Implications for research question 1 110

Research question 2 112

Implications for research question 2 115

Research question 3 116

Implications for research question 3 117

Suggestions for further study 119

Summary 121

REFERENCES 124

APPENDIX A. CONSENT FORM 132

APPENDIX B. ENGLISH SURVEY 136

APPENDIX C. SPANISH SURVEY 141

List of Tables

Table 1. Patient Satisfaction Score Card. 38

Table 2. Age Descriptive Statistics of Adult Latino and White Clients 66

Table 3. Gender Latino and Whites 67

Table 4. Gender/Race Latino 68

Table 5. Gender/Race Whites 69

Table 6. Latino Insurance Type 70

Table 7. Whites Insurance Type 71

Table 8. Latino Income Range 72

Table 9. Whites Income Range 73

Table 10. Descriptive Statistics 75

Table 11. Latino and White Correlations 78

Table 12. Latino Correlations 80

Table 13. Whites Correlations 82

Table 14. Latino model summary 83

Table 15. Latino ANOVA 84

Table 16. Latino Coefficients 85

Table 17. White ANOVA 86

Table 18. White Coefficients 87

List of Figures

Figure 1. Latino: Overall quality of care 88

Figure 2. Latino: Friendliness and courtesy shown to you by the receptionist and other front desk staff 89

Figure 3. Latino: Friendliness and courtesy shown to you by nurses and other medical staff 90

Figure 4. Latino: Training, skill, and experience of the nursing staff 91

Figure 5. Latino: Explanations about prescribed medicines 92

Figure 6. Latino: Ease of speaking with your primary care provider 93

Figure 7. Latino: Explanations of medical procedures and test results by primary care provider 94

Figure 8. Latino: How well your care meets your needs 95

Figure 9. Latino: Friendliness and courtesy shown to you by your primary care provider 96

Figure 10. Latino: Your primary care provider's concern for your mental health 97

Figure 11. White: Overall quality of care 98

Figure 12. White: Friendliness and courtesy shown to you by the receptionist and other front desk staff 99

Figure 13. White: Friendliness and courtesy shown to you by nurses and other medical staff 100

Figure 14. White: Training, skill, and experience of the nursing staff 101

Figure 15. White: Explanations about prescribed medicines 102

Figure 16. White: Ease of speaking with your primary care provider 103

Figure 17. White: Explanations of medical procedures and test results by primary care provider 104

Figure 18. White: How well your care meets your needs 105

Figure 19. White: Friendliness and courtesy shown to you by your primary care provider 106

Figure 20. White: Your primary care provider's concern for your mental health 107

Figure 21. Process flow for further research 121

CHAPTER 1. INTRODUCTION

The American healthcare system is dealing with an enormous problem of how to curtail expenditures. The problem is coupled with declining patient satisfaction ratings among healthcare consumers. The uninsured population in America is rising in conjunction with the large numbers of illegal immigrants entering the country who are seeking medical care. Healthcare administrators are facing a dangerous situation of either treating this uninsured population or refusing them treatment. The Medicaid and Medicare systems are become increasingly overburdened. This is partly due to the increased life expectancies resulting in many ways from better treatments and more readily available medications. As a result, traditional health management organization officials and fee for service plan officials are failing to keep hospitals financially secure. Other factors that are increasing expenditures within healthcare systems include (a) the increased numbers of outpatient procedures being performed, (b) introduction of new prescription medications, (c) the increased use of current medications, (d) the changing demographics of the population due to longer life expectancy, (e) the increased the usage of a primary physician and medical specialists, and (f) the increase in federal and state mandates (Rising medical costs and utilization drive premium increases and constrict margins, 1998).

Ratajczak (1997) estimated that by the year 2017 one third of the average household income would be spent on healthcare costs. The funding for this one third of the income will come from co-payments, deductibles, taxes and reduced wage growth

(Ratajczak). The officials at the American Hospital Association reported in a 1998 study that 29% of the nation's hospitals are in some financial trouble, with total margins of 2% or less (Rising medical costs and utilization drive premium increases and constrict margins, 1998). The officials at the American Hospital Association reported that Medicare payments would be dropping from 90 cents to 78 cents per dollar of care (U.S.'s hospitals control costs while experiencing variable profitability, 1999). As this trend continues, the staff of hospitals located in regions that have a large indigent population will experience financial strain from this situation.

The financial impact that the staff of hospitals are facing can be linked to dramatic changes in healthcare funding. Another aspect is the loss of revenue from private payer insurance groups or fee for service groups such as Health Maintenance Organizations (HMOs). Members can now choose where to receive their healthcare. When a patient senses that his or her fundamental needs have not been met by a healthcare provider, the perception of one healthcare system or physician can become tainted. In these instances, such individuals most likely choose to go to another healthcare provider or another healthcare organization. This situation can be particularly true for the Latino population. Having an emotionally fulfilling patient experience is of the most important elements for this group when seeking healthcare services. When the healthcare staff fails to meet the needs of the Latino population, the staff misses an opportunity to address healthcare needs of the fastest growing population group in the United States.

Background of the Study

Communication within the healthcare organization should be designed to ensure that patients' needs, both medically and emotionally, are addressed in a way that make the patient feel welcomed and reassured. When this balance occurs, two possible outcomes develop. First, the patient will feel the benefit of comfort, support, and understanding through this communication. Second, there is a possibility that the market share of the healthcare organization will increase based on repeat patient visits. Positive word of mouth recognition will also increase patient visits, which can help, offset any possible financial burden that the healthcare organization Administrators may be facing or addressing.

The Latino population in America is a fast growing segment of the population. This fact is important because the perception of care by the members of the Latino population from members of the United States healthcare system may be less than the expectations of the Latinos. Recently, many administrators of healthcare organizations have implemented patient satisfaction initiatives to address the emotional and spiritual care of patients, but rarely do the initiators focus on the needs of one particular ethnic population.

In many instances, the use of the emergency department as the source of primary care for an individual has not proven to be solely one ethnic group's premier method of care. In recent studies, researchers have indicated reasons why there is an increased use of emergency departments for primary care. Reasons for emergency department use for non-urgent care include (a) the erroneous self-perception of severity of ailment or injury, (b) the 24-hour open-door policy of emergency departments, (c) convenience, and (d) the

lack of a primary care provider (Liggins, 1993). Officials at the U.S. General Accounting Office (Nadel, 1993) identified causes attributed to non-urgent emergency room (ER) use as lack of a primary care provider, transportation problems, and need for after-hours care. Choudhry et al. (2007) stated:

> Privately insured Americans are the major driver in increased visits to the emergency department, accounting for more than half the increase in visits between 1996-1997 and 2000-2001. Although the number of visits made by Medicaid patients did not change, these patients made fewer visits to physician offices over this time. Actually, 17.5% of all ambulatory care visits made by Medicaid beneficiaries in 2000-2001 were in the emergency department, in comparison to only 7.6% of all ambulatory care visits for the privately insured. The number of emergency department visits for the uninsured rose by about 10% between 1996-1997 and 2000-2001, and the number of uninsured physician office visits declined 37% during this period. By 2000-2001, the uninsured went to the emergency department for 25% of all their ambulatory care. Medicaid beneficiaries actually have twice the emergency department visit rates as the uninsured, and four times the rate of the privately insured. Moreover, communities with higher levels of emergency department use actually have fewer numbers of uninsured persons, Hispanics, and non-citizens in comparison to communities with low emergency department use. Although the uninsured may not be driving the sharp increase in emergency department use, those who rely on the emergency department may do so because they lack a primary care provider. The uninsured often put off seeking medical care due to cost, thereby only turning to the emergency department when their conditions have seriously worsened. Emergency department patients have also become older and sicker over the last dozen years, requiring more resources and staff time (p.2).

Continuously improving system quality within the healthcare organization is a key factor in improving overall healthcare quality (Marley, Collier, & Meyer-Goldstein, 2004). Additionally, the use of service recovery methods need to ensure that all individuals who use the healthcare system realize and experience the same level of service excellence regardless of ethnicity. Effective service recovery is an intricate aspect of system quality that involves ongoing development of a strategy to settle customer

complaints and dissatisfaction with the ultimate goal of motivating the valued customer to continue to use the service (Schweikhart, Strasser & Kennedy, 1993).

With the American healthcare system under tremendous strain, the administrators of more hospitals are focusing on perceptions of patient care. This perception of care goes far beyond what medical staff can provide for a patient medically. In many situations, the patient places a higher value on an emotional attachment when measuring the quality of medical care received. A terminally ill patient knows the outcome of his or her disease, but often it is human compassion that the patient is seeking. The patient seeks a healthcare provider who understands and knows what the patient is feeling. These feelings could be something a family member or friend may not be able to understand or acknowledge.

Perceptions of care vary among cultures, races, sexes, religious groups and even with age may be difficult for a healthcare practitioner to understand. Catering to individuals that fall into different groups can be very difficult as many healthcare practitioners are not aware of the spiritual and emotional needs of their patients. Without addressing the patient's fundamental needs, the health practitioners are at risk of losing their current patient base as well as building upon the patient base gain more patients.

Communication is one of the biggest obstacles in meeting the emotional and spiritual needs of patients. Ineffectively translating or identifying particular body language signals or actions frustrates the healthcare professional and the patient. Researchers determined that untrained bilingual nurses who acted as medical interpreters for Latino patients created serious miscommunication problems in 50% of encounters, thus leading to lack of physician understanding of symptoms and diminished credibility

of the patient's complaint (Smith-Collins, Gullette, & Schnepf, 2002). This perception of miscommunication develops when the patient perceives that the healthcare practitioner is not listening to the patient or when the patient feels that the healthcare practitioner does not seem to care.

Statement of the Problem

Based on the increasing Latino population in the United States who have access to healthcare, a large number of Latinos will choose to seek alternative avenues for their healthcare needs rather than use the traditional U. S. healthcare system. Within the Latino community, many people will choose to go to a professional within their community or will value the recommendation of a physician who is in their enclave-due to the personal bond that exists between the physician and the patient within the Latino community. A distinct bond develops between the physician and patient as a result of a cultural understanding. A bond also develops from an acceptance point of view within the Latino culture and practices, especially when dealing with the topic of medical care. Researchers have suggested that an immigrant's location choice (whether in or outside an enclave, within the destination country) depends on his or her human capital characteristics (Toussaint-Comeau, Rhine, & Rhine, 2004).

Many times healthcare practitioners who are sought out within the Latino community or enclave are not licensed to practice medicine in the U. S. or they do not hold a valid medical degree from any institution. Many times these medical practitioners provide a more holistic based method of medical care. This approach can often further complicate the physical health of Latinos based on the lack of proper medical treatment

needed for an ailment. Furthermore, these alternative practitioners may not be diagnosing the illness or disease correctly. These alternative practitioners can potentially be giving an inappropriate dosage of medication and possibly not using the standard medication protocol, This could be due to the lack of access to or the lack of proper knowledge of advanced medications These situations can lead to the patient's suffering from drug resistant strains of bacteria which ultimately make the treatment of the illness or disease much more complicated. This predicament becomes even more complicated should the treatment be more costly especially when stronger medications or other treatment protocols are required ultimately to overcome any drug resistance.

Specifically, an immigrant who chooses to live in an enclave tends to have less education, shorter periods of residency in the U. S., less general experience in the country, and poorer English (Funkhouser & Ramos, 1993). One aspect of the Latino culture is the reliance by Latinos on holistic medicine as a cure and treatment for various ailments. Immigrants with fewer incentives to invest in learning to speak a new language, such as those who plan to repatriate in the future, would prefer to live with those who speak their language and share a similar culture (Toussaint-Comeau & Rhine, 2004). For Latinos, seeking medical care within their particular group is more important to them than seeking recent medical advancements. Yet more importantly for Latinos, there needs to be a bond established between the healthcare practitioner and the patient. The factors that shape patients' perception of care when receiving health services, including the perceptions of participants involved in this study are directly related to how healthcare administrators, practitioners, physicians, and staff treat the patient's emotional needs as well as their medical condition.

Purpose of the Study

The purpose of this academic study is to determine if the perception of care by the Latino population using the traditional healthcare system in the U. S. is different from the perception of care by the White population. This situation will ultimately affect the overall health of the Latino population. Differences in the perceived care that individuals receive from healthcare practitioners can have a negative economic impact on healthcare systems and affect the overall health of the individuals and the well-being of their community. The research questions used to guide the evolution of this study were:

1. How do the Latinos perceive the emotional care they receive using the U.S. healthcare system?
2. What emotional elements to healthcare do members of the Latinos population lack when they use the American healthcare system?
3. Do healthcare administrators incur negative social repercussions for not addressing the emotional needs of the Latino population?

Within the parameters of the first research question, there are more specific questions that will be addressed. There was a need to assess the friendliness and courtesy of nursing staff, the attention by physicians to the personal needs of the patient, and the degree of friendliness and courtesy exhibited to the patients by physicians. Further, there was the question of whether the staff addressed the emotional needs of the patient, and whether the patient received a response to his or her concerns and/or complaints.

The second research question addressed following questions: Did the staff explain treatment protocols? What was the attitude of the staff toward visitors? Was the staff sensitive to the inconveniencing of patients? Did the staff include the patient when consulting about the patient's medical treatment plan?

The last research question addressed if a patient perceives there to be a lack in personal service. Specifically, would a lack in personal service perceived by the patient negatively affect the healthcare facility? Would the patient recommend the facility?

Rationale

In order for the staff of health systems, hospitals and clinics to provide the best non-medically based care, practitioners and administrators need to understand their populations' basic needs. The study of demographics will not disclose why certain groups of individuals place more emphasis on the magnitude and type of compassion that is often perceived to be a requirement by the patient. Understanding comes from knowledge and acceptance of a culture.

As the migration patterns of the people in the world shift, there is a necessity within the American healthcare system for discreet services that cater to the needs of the individual. Providing healthcare services that serve the Latino population can ensure a healthier status among these individuals, and aid in lowering the incidence of communicable disease within communities and enclaves (Toussaint-Comeau & Rhine, 2004). Additionally, by catering to these Latino groups (assuming they have the means to pay for services rendered), the staff of health organizations will expand the market share of their organizations, enabling them to become more financially stable. It is believed that having consistent care that meets the perception of care will increase regular visits with a physician for preventative care by Latinos. From a financial point of view, it is more cost effective to prevent an illness at the onset of the symptoms than to treat the illness in full onset.

One of the major concerns of physicians who treat the Latino population is the severity of their illnesses and the increased costs associated with the late progression of illnesses. Many times when members of the Latino community present themselves to the emergency room, which often is their primary source of healthcare, their initial complaint, is actually secondary to their primary illness. This contributing factor highlights the lack of primary care available to this group of individuals. When Latinos move to the U. S. particularly when migrating from rural Third World impoverished countries or areas that have limited access to healthcare, these individuals may have illnesses that are expensive to treat (Goldman, Smith, & Sood, 2006). Often these individuals are not aware that they are hosts to illnesses. When immigrating, a Latino commonly settles in communities with high concentrations of other Latinos who have the same knowledge level about their new country a situations is created that facilitates transfer of diseases(Toussaint-Comeau & Rhine, 2004). This becomes evident in the number of cases reported. This situation can have severe consequences on the health of others in the community. This proliferation of disease is a major contributing factor to the overall ill health of the Latino population.

In many cases, it is not the cost of the medical care or a lack of insurance for individuals in the Latino community, including immigrants, but the fact that an individual chooses a practitioner who lives within an enclave. Even though the individual can usually afford to see a physician, the issue at hand is a result of a comfort level that is associated with that practitioner., There needs to be more community outreach to these individuals to inform them that there are healthcare affordable services available from healthcare staff who will meet their health needs, and their other needs. When individuals

choose to live in enclaves, Dr. Sehgal (2005), indicates that the care Latinos get is often fragmented and not of the highest quality because often patients do not have a primary care physician who knows their medical history (Mortland, 2005).

Because the immigrant Latino patients have a higher level of education and a higher human capital level, they tend to move away from the enclave, thus they do not have a primary care physician providing continuity of care. This leaves individuals remaining in the enclave with gaps in their understanding of available services. They suffer from a lack of knowledge of medical care. Immigrants with less human capital may have greater difficulty in adapting or assimilating to the new culture and therefore they may place a greater reliance on living in an ethnic enclave (Toussaint-Comeau & Rhine, 2004).

Significance of the Study

The central significance of this academic study was to discover why the Latino population perception of healthcare is different from that of the White population. In order to achieve meaningful results, a qualitative and quantitative survey was used to directly answer the research questions. Using both qualitative and quantitative methodologies provided this researcher with themes to explore as well as the results in testing the hypotheses. From the results of the study healthcare administrators will be able provide comprehensive education to healthcare staff to resulting in providing better services to the members of the Latino community. This knowledge and awareness goes further than simply addressing the perceptions of the Latino population, but it also

addressed the needs of other minority patients who widely use the U.S. healthcare system.

Meeting the fundamental requirements of the patients will create a service-oriented organization that puts forth excellence. This will become the premier choice for the healthcare needs for all ethnicities thereby resulting in sustained financial growth for the healthcare industry overall. Healthcare administrators will realize a potential increase in market share once analysis of the data shows how a lack of facilitating the needs of a minority group can financially influence the profits of a healthcare institution. Understanding the needs and expectations of a particular ethnic group in terms of healthcare services could result in an increase in local demand for services.

Another potentially result of the study may be an amelioration of the Latino population's health status. A significant decrease in the number of cases of communicable diseases (along with less complicated illnesses) for treatment due to early prevention will increase the overall health status of the Latino population. This will also reduce the spread of diseases and illnesses within the community.

Definition of Terms

Emotional care. Emotional care is that care that the patient receives in the form of compassion in which the care consists of the healthcare practitioner listening, understanding, and addressing the patients' individual needs.

Latino. Any person of Central American and/or Southern American descent who lives in the United States.

Non-medical based care. Care that does not involve therapeutic treatments, procedures, and preventative medicines or therapies.

White. Any person who is born in the United States who is of European descent.

Soft issues. Soft issues are related to the personal treatment and care given to the patient to meet their spiritual and emotional care.

Assumptions and Limitations

This researcher adhered the organizational implementation of this research study to the following assumptions:

1. Research participants have the probable option of where they prefer to receive medical care.
2. It is the perception of research participants that healthcare received using traditional U.S. healthcare organizations is not equal to the same level of non-medicine based quality as it is perceived for the non-Latino White.
3. Research participants will provide honest, unbiased representations of their perceptions based on experiences with using the American healthcare system.
4. Research participants will provide honest, unbiased representations of their perceptions that are based on non-medical factors.
5. Research participants do have the financial means to pay for healthcare services, which provides them choices as to where they receive care.

Nature of the Study, or Theoretical/Conceptual Framework

Experts do not generally agree that using two methods is a valid way to perform research; this has been challenged by Barbour (1998). Although using a triangulation method within a quantitative study is acceptable, using a triangulation method in a

qualitative study needs clarification for each paradigm (Barbour). Constructivism will obtain a more in-depth explanation of events surrounding social conditions. Although it may not have a direct link to a patients' perception on a hospital stay, it would be more useful to use constructivism to discover the health conditions of the Latino population. Crotty (1998) stated that constructivism is "the view that all knowledge, and therefore all meaningful realities as such is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context" (p. 42).

Since all participants had different perceptions and thoughts based on their personal experiences, having more than one type or research method broadened the depth and richness of the data gathered. If this calls for the use of triangulation in the constructivism paradigm, then the use of investigators, method, and data triangulations to record the construction of reality is appropriate (Johnson, 1997). Using multiple methods of research resulted in validity that is more diverse.

Duffy (1987) cited nine benefits associated with triangulation. The development of the conceptual framework, which provided the theoretical base of this academic study, is in either completely or in part from qualitative methods. The nine benefits include:

1. In areas where methods produce information overlap, certain quantitative results need verification by results obtained through qualitative methods.
2. Qualitative data gained from interviews and/or observations can be used as the basis for selecting survey items to be used in instrument construction.
3. External validation of empirically generated constructs obtained by comparison with interview and/or observation data: where discrepancies exist, the individuals taking the test can do additional probing to determine whether the mismatch was because of a weakness in the instrument or the misinterpretation.

4. Case studies can be used to illustrate statistically derived models.

5. Clarification of ambiguous and provocative replies to individual questionnaires can be observed by reexamining field notes.

6. Quantitative data can provide information about program stakeholders who were overlooked initially.

7. The use of a survey instrument to collect data from all program stakeholders in the study may serve to correct the qualitative research problem of collecting data only from an elite group within the system being studied.

8. Using quantitative assessment can correct for the "holistic fallacy"; (the perception by the researcher that all aspects of a given situation are congruent, when in fact only those persons interviewed by the researcher may have held that particular view).

9. The use of quantitative instruments can verify observations collected during informal field observations (p. 132).

Organization of the Remainder of the Study

The American healthcare system and the health status of members of all communities have much at stake if the needs of certain minority groups go unmet. Within the next few years, members of the Latino community will become the largest cultural segment in the U. S. (Stevenson, Elzey, & Romagoza, 2002). Currently, there is a concern among healthcare officials as to why members of the Latino population feel strongly that their fundamental needs are unmet. There is also a concern for the direct consequences of this situation. Without meeting the fundamental needs of members of the Latino population, officials of healthcare organizations are missing the opportunity to address the healthcare needs of this fast growing segment of the U.S. population.

In this academic study, this researcher utilized both qualitative and quantitative data to discover the perceptions held by members of the Latino population on how their

emotional and spiritual needs are unmet. This researcher endeavored to determine other areas where the officials of the U.S. healthcare system are failing to provide the correct type of care or services to the Latino population. A strategic review of literature along with other data related to this topic was examined and outcomes are the presented. Using a focused quantitative study, this researcher provided data and highlighted other areas for further research concerning this topic.

CHAPTER 2. LITERATURE REVIEW

Background of the Latino and Latino Immigrant

The Latino population in the United States is a surging population group that is highly influential in the domestic economy. In census figures, officials show that the U.S. Latino population alone increased by 13 million between 1990 and 2000 (Worrell, 2002). It is anticipated that within the next few years, the Latino community will become the largest cultural segment in the United States (Stevenson et al., 2002).

There is a tendency for the majority of Latino immigrants to migrate to large metropolitan areas. Similar to the trend in several other major U. S. cities, Latinos are one of the fastest-growing populations in the Chicago metropolitan area consisting of distinct and growing neighborhoods throughout the area (Toussaint-Comeau & Rhine, 2004). The tendency for members of immigrant groups to locate where other similar ethnic groups have already settled (in ethnic enclaves) is a common process. This tendency is due to an initial unfamiliarity with the country's labor and housing markets and the resulting need (or preference) to reunite with family members and other co-ethnic members (Bartel, 1989). Employment is more readily available in metropolitan areas. There is usually a network of friends or family there to help the new immigrants become established.

Health Status of Illegal Immigrants

Latinos perceive a lack of care compared with Whites in the healthcare sector. The prevailing perception of Latinos concerning the quality of the healthcare they receive

is far lower the perception of care by Whites. According to the researchers at the Institute of Medicine, even when holding access-related factors, such as the degree of insurance coverage and the ability to pay, the care experienced by minorities is of lower quality (as cited in Reynolds, 2004).

In order to curtail immigrant healthcare costs, there have been initiatives from federal government officials that restrict the amount of expenditures and access to care for these individuals on the federal government level, as well as initiatives with individual hospitals. Programs such as Medicaid and the State Child Health Insurance Program (SCHIP) were developed to ensure access to healthcare among low-income children and families (Kaiser Commission on Medicaid and the Uninsured, 2000). However, the access by Latino immigrants to public insurance has been affected by public policy (Kaiser Commission), and policies that bar public coverage among recent immigrants target a group that already has limited access to the healthcare system (Carrasquillo, Carrasquillo, & Shea, 2000).

A large number of members the foreign-born population have had almost no contact with the formal healthcare system (Goldman, Smith, & Sood, 2006). One quarter of the members of the population has never had a medical checkup, and one in nine never visits a doctor; these rates are twice those of the native-born persons (Goldman et al.). Women were more likely to seek out healthcare, primarily for pregnancy related conditions; however, the frequency was less than normally expected from pregnant women. If the health status of the Latino immigrant were to improve then there would be an improvement in the health of children, a decline in emergency room expenditures, and

a decline in the spread of communicable diseases within both the Latino immigrant population and the Latino nonimmigrant population

Physicians have two major concerns when treating Latino immigrants: (a) the severity of their illness, and (b) the costs associated with that illness. Many times when Latino immigrants present themselves to the emergency room, which is their primary source of healthcare, their initial complaint, is actually secondary to their primary illness. This is due to the lack of available primary care for this group of individuals. Hospitals cannot refuse to treat someone who is ill, but that is not the type of care most of the Latino immigrants need; they need ongoing and preventative care (Guest, 2002).

Often when Latino immigrants come to the U. S., especially from Third world countries or rural areas within their native country that have limited access to healthcare, they may have diseases that are expensive to treat. Many times such Latino immigrants are unaware that they are hosts to diseases. When Latino immigrants settle in the U.S. most likely in communities with other Latino immigrants, the transfer of disease begins and affects the health status of the others in the community. This spread of disease is a major contributing factor to the overall poor health of Latino immigrants. Imported diseases include tuberculosis, sickle cell anemia, hepatitis B, measles, and the potentially deadly parasitic disease called Chagas. Officials at the American Red Cross estimated that nationally the risk of a blood donor having antibodies to Chagas or actually carrying the virus with the disease is 1 in 25,000 (Howard-Price, 2005). Further, officials fear the consequences if the avian flu which flourishes among poultry in Southeast Asia, mutates so that it is capable of human-to-human transmission through casual contact (Howard-Price).

International health officials stated about a third of the world's population is infected with the bacteria, which causes tuberculosis (Howard-Price, 2005). Tuberculosis that is resistant to multiple drugs is rampant in many parts of the world, including Peru, Russia, the Baltic nations, Hunan province in China, and the Dominican Republic (Howard-Price). While Latino immigrants have come to the United States for various reasons, ultimately they immigrate for a better quality way of life. However, the U.S. government officials have not provided the necessities of clean water, proper housing, and medical care. This situation indirectly jeopardizes not only the health status of these Latino immigrants, but also the citizens of the U. S. As Cosman (2005) stated: "By default, we grant health passes to Latino aliens, yet many Latino aliens harbor fatal diseases that American medicine fought and vanquished long ago, such as drug resistant tuberculosis, malaria, leprosy, plague, polio, dengue, and Chagas disease" (p. 6).

Consequently, identifying and treating communicable diseases in the early stages requires that undocumented Latino immigrants be able to access services for all health conditions, not just those conditions that have advanced to an emergent level or include symptoms of infectious disease that endanger others in the community (Kullgren, 2003).

Barriers

The implementation of the Federal Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 greatly restricted the provision for many federal, state, and local publicly funded services to undocumented immigrants (Kullgren, 2003). Many administrators of public health institutions and healthcare institutions have

wrestled with the legal, administrative, and ethical conflicts generated by these limitations (Kullgren).

Instead of fulfilling their intended purpose of reducing Latino, immigration and conserving public resources, the wording of the PRWOR placed restrictions on access by undocumented immigrants to publicly financed health services. This has unduly burdened healthcare providers and threatened the health of the community at large (Kullgren, 2003).

To complicate issues further for Latinos, in studies researchers strongly indicated that minorities have fewer choices relative to where they can obtain healthcare and they confront quality-of-life problems that expose them to greater health risks (Minorities bear brunt of healthcare obstacles, 1995). One of the primary reasons for this perceived contrast in care received is the cultural aspect of seeing a physician. In the Latino community, it is crucial for the patient to feel a bond with and form a relationship with their physician. Because of this shifting demographic need, healthcare providers are openly tackling increased challenges in addressing the fundamental obligation to care for patients with varying cultural and ethnic backgrounds (Reynolds, 2004). Language barriers, ethnic backgrounds and beliefs systems, disparities in educational levels, use of folk medicine, discontinuous or uncoordinated care and other factors compromise the probability for mutual trust and cooperation in provider-patient relationships (Worrell, 2002).

The escalating fear of deportation is another barrier that some Latino immigrants face. It is this fear that prevents some Latino immigrants from seeking medical care at hospitals and private practices that are regulated by the U. S. officials. Therefore, these

undocumented individuals will either forfeit the care they need or seek underground resources. Under welfare reform, the extremely restrictive eligibility rules for many programs that applied historically only to Latino immigrants also apply to legal immigrants until they become citizens or to refugees 5 to 7 years after their arrival in the U.S. (Huang, Yu, & Ledsky, 2006).According to Huang et al., any child born in the U. S. to Latino immigrant parents still has difficulties accessing care though the situation for the child is not as difficult as the one that a Latino immigrant faces. These combined factors have created a poor healthcare experience, which leaves both the patient and healthcare provider dissatisfied with the interaction (Reynolds, 2004).

Perceptions

Identifying why different perceptions exist relative to the healthcare received by Latinos and Whites can be cumbersome especially when examining demographic areas where concentrations of Latinos may vary, just as the number of Latino physicians and outreach programs available to this group may vary. Even though some Latinos have access to care, there may be restrictions in place that limit their access. Often Latinos may unwillingly be placed in lower priced managed health plans with increased utilization controls (Reynolds, 2004).

Another aspect of the perception of care received by Latinos and how it is perpetuated comes from data obtained from the officials at the Institute of Medicine cited by Reynolds (2004), which listed three possible provider mechanisms that may contribute to disparities: "(1) prejudice against minorities, (2) higher levels of clinical uncertainty in

communication to ethnic populations, and (3) stereotypes held by providers about, the behavior or health minorities" (p. 239).

An important step in eliminating racial disparities in healthcare is to elucidate the mechanisms influencing the health of minority people (Gee, 2002). A variety of mixed interpretations have been offered, from financial factors such as differences in rates of insurance coverage and economic status to non-financial factors such as culturally based attitudes toward healthcare and barriers presented by language (Schur, Albers, & Berk, 1995). Patient satisfaction could also be influenced by perceived treatment costs (Andaleeb, 1998). Even with insurance coverage, patients may consider some costs to be excessive (Andaleeb). With administrators at insurance companies challenging what they feel are unnecessary claims, costs and operating procedures (Schlossberg, 1990), and employers requiring larger employee contributions to offset rising insurance premiums (Wong, 1990), healthcare consumers may have become much more sensitive to the price issues (Andaleeb).

Latinos usually protect their cultural values by maintaining some ties to their heritage and native countries (Stevenson et al., 2002). Some experts have hypothesized that Latinos who are less assimilated into the U.S. culture face more extensive barriers to healthcare than those Latinos who have become acculturated (Schur et al., 1995). Researchers have also noted that knowledge of specific cultures has permitted healthcare providers to understand how their patients' culturally based personal beliefs can change the direction and outcomes of disease (Riddick, 1997).

Latinos seek out medical care at various levels, which complicates the understanding of why they only use the U. S. healthcare system for clinical treatment of

certain aliments. It is important to understand that among such communities there is an intense desire by individuals to use Western medical services in the cases of broken bones, vaccinations and pregnancy screenings, but those individuals rely on traditional treatments for ailments such as asthma, backaches, and colds (Worrell, 2002).

Although there are some uncontrollable barriers that prevent Latino immigrants from accessing medical care, in some instances, the Latino has decided not to obtain the necessary medical care. Cultural issues are a leading cause for why some Latinos choose not to receive care. In the Latino community, it is especially important that there is a very personal, yet professional bond with the healthcare practitioner and the patient. Without this connection, many Latinos feel they are not taken seriously which results in the absence of trust and understanding. When there is a gap in cultural competency patients feel like they are not being understood, respected or valued (Burt, 2006). If this perception exists, many Latinos and members of other minority groups will decide not to use the American healthcare system until it is absolutely necessary. It is very costly to treat individuals who have had a lack of primary and preventive care and are experiencing the progression of an illness or disease.

Nearly one third of Latinos have reported that they do not have a regular source of care. Latinos were twice as likely as Whites to report long wait periods for care and that the healthcare provider failed to listen and to provide them with needed information (Phillips, Mayer, & Aday, 2000). Anderson (1995) commented about the access of care through a healthcare access model, stating service utilization affected outcomes, population characteristics, health behavior, and health practices determined service utilization. Outcomes also affect access determinants. The healthcare system and the

external environment affect health behaviors, health outcomes, and some population characteristics, such as income and education (Anderson, p. 5).

Members of the growing Latino populations centered in large urban areas like New York, Miami, Chicago and in the states of Texas, Arizona, New Mexico, and California that are near the perimeter of Mexico feel the burden of the influx of Latino immigrants. Within these regions, access to and knowledge about primary care is limited. Many Latino immigrants who come to the U. S. are unaware of the valuable resources available to them or of how the U. S. healthcare system functions. New Latino immigrants or U.S. born Latinos residing within an established Latino community often lack any knowledge, have only limited knowledge of the existence of, or function of primary healthcare services. Most Latinos will choose to go to a healthcare practitioner within their own community or to someone that has been recommended from a member of their community.

The healthcare arena is an industry in which customer satisfaction is critical to building a satisfied customer franchise; word of mouth recommendations are crucial (Plymire, 1991; Reichheld & Sasser, 1990). It has been estimated that the role of loyal patients is equal to two or three times their own value as customers based on word-of-mouth networking (MacStravic, 1995; Rubin, Gandek, Rogers, & Kosinsky, 1993; Winston, 1998).

In theory, the implementation of the Federal Personal Responsibility and Work Opportunity Reconciliation Act was intended to help ease the financial burden, In many cases officials failed to consider these restrictions based on the power and responsibility of state and local governments officials and the institutions they fund to protect the

health, safety and welfare of all who reside within the state's borders (Kullgren, 2003). The implementation of the Federal Personal Responsibility and Work Opportunity Reconciliation Act placed restrictions on healthcare that infringes on the power of state police and severely limits the essential ability of police officials to protect the health of residents (Kullgren). Due to these restrictions, hospital administrators have had to make changes in the regulation of the delivery of healthcare services.

Market Share

Today hospital administrators must compete in a market based on quality, price and product just as any business owners would who provide goods and services to the public (Panko, 1996). More pressure is falling on healthcare providers to give better service with more options. This is in part because patients are paying more for their healthcare coverage and as a result are demanding more in return. Healthcare providers are aware of this situation and realize that cost effective and efficient care is a necessity, not an option.

Hospital administrators have moved to a customer satisfaction focus, which has provided for another increase in hospital spending. More hospital administrators are offering special services that a decade ago was unthinkable. For example, the use of birthing suites has become a common facility in which many women give birth. The use of the birthing suite provides a pleasant atmosphere resembling a bedroom rather than a standard *cold feelin*g delivery room. Many hospital administrators use the term *customer* more than ever to describe patients. Today hospital administrators realize that patients do

have a choice in where they go for healthcare needs. Not addressing this, puts the hospital administrators at risk for losing revenue.

Healthcare administrators are not alone in experiencing the rise in healthcare costs. Because patients are feeling the increase in their healthcare costs also, they expect more in terms of services from their healthcare providers. When hospital administrators need to reduce expenditures, this affects not only patients in the hospital but members of the community also feel the impact.

Community health orientation refers to the organization-wide generation, dissemination and use of community intelligence to address present and future health needs (Ginn, Lee, & Ellis, 2006). Hospitals that are community health oriented have the following attributes: (a) a community-oriented mission statement, (b) resources committed for community benefit activities, (c) community health status assessments, (d) use results of assessment to design or modify services, and (e) perform long-term planning for the improvement of health in the community (Seay & Sigmond, 1989).

In past studies, researchers suggested that the administrators of healthcare organizations could develop a community organization by generating, disseminating and adeptly responding to market information, resulting in better identifying and satisfying customer needs (Proenca, 1998). Proenca, Rosko, and Zinn (2000) examined community orientation in hospitals from an institutional and resource-dependence perspective using 1994 and 1995 American Hospital Association (AHA) survey data and found that the nature of environmental pressures and hospital administration interests influence the degree of community orientation (Ginn, et al, 2006).

In many hospitals there exist volunteer offices that allow administrators to create awareness about the hospital, and learn what the community health requirements are for the community that the hospital serves The individuals who work in the volunteer offices reach out to the community members to recruit volunteers for the hospital and determine what the hospital employees can do to get involved within the local community.

The community health of Latinos can also affect the health of individuals of non-Hispanic descent that have direct contact with the members of the Latinos community. To provide complete services for the Latino community, healthcare practitioners who work in hospitals and health systems need to develop outreach programs that incorporate an understanding of the Latino community's origins and characteristics including the beliefs, institutions and expectations regarding healthcare (Stevenson et al., 2002). Jose Moreno, Director of Public Affairs, and Hispanic Marketing for GCS public relations in San Diego California stated that understanding the values and mindset of the people of a minority community is critical to any effective marketing campaign to such groups (Worrell, 2002).

The proliferation of communicable disease among Latinos and other members of the community become a visible reality when Latinos do not receive the proper preventative and therapeutic medical treatment. In many instances, Latinos were more likely then Whites to give the reason of embarrassment or fear of results for not having had tests (Schur et al., 1995).

Not seeking the proper medical treatment further compromises with the health of the Latino population and worsens the perceptions of the community at large regarding the health of Latinos. It is this model of perception that causes Latinos to feel as if the

non-Latinos members of the U. S. are looking down upon them. It is this situation that is causing Latinos to seek alternative methods of care, unless it is absolutely necessary to utilize the U.S. healthcare system. Often this syndrome can perpetuate the perception that Latinos do not take care of themselves. For instance, according to the members of the American College of Society of Internal Medicine, pregnant Latinas of all education levels are up to 1.8 times less likely than non-Latinos to receive prenatal care in the first trimester (Burt, 2006). Additionally, it is the type of work that Latinos perform, especially the Latino immigrants, which is more labor-intensive work that further compromises their health status.

There are some instances, especially with the elderly in which Latinos have misconceptions about what ailments that healthcare providers can cure or offer relief. For example, among Latinos, Alzheimer's disease is viewed as an aspect of growing old. When a Latino patient suffering from Alzheimer's disease seeks treatment in a hospital for symptoms or an illness not associated with Alzheimer's, often the patient's family will perceive that the healthcare provider is being condescending when treatments are offered to help alleviate the symptoms of the disease.

The spoken language barriers are also causing the discrepancies in perceptions between Latinos and Whites. Language and cultural barriers have become such a challenge that in 1999 the officials of the U. S. Department of Health and Human Services Office of Minority Health developed standards of care within these areas (Reynolds, 2004). Furthermore, researchers suggested from the data that the lower the education level, misperceptions that are more prevalent exist. This is especially significant during the birthing experience.

For Latino women, even if the woman is partially bilingual, there is another aspect to language barriers of care; giving birth is such a personal experience that her ability to communicate may be hampered (Burt, 2006). Cultural filtration occurs when cultural beliefs or ideas are applied and or removed due to the interpreter's bias (Reynolds). Translation of materials such as health pamphlets also can present potential issues of cultural filtration between the Latino patient and the healthcare provider (Reynolds).

Service Excellence

Many hospital administrators are implementing service excellence initiatives to increase patient satisfaction among the patients and the staff. Soft issues are those initiatives or patient experiences not related directly to the medical treatment received, but more how the physicians and staff treat the patient. Patient satisfaction initiatives are becoming increasingly popular as hospital administrators realize the vulnerability to shifts in market share as more healthcare services become available in communities. Many people can now choose where to receive their medical treatment. Patients not only make selections for the medical treatments provided, but for the services and amenities that are offered to the patient and to the patient's friends and family. By transforming the attitudes of the healthcare providers and hospital staff toward Latino patients and providing staff training, hospital administrators increase the likelihood that the facility will become the provider of choice when the Latino market share matures (Stevenson et al., 2002).

Kurz and Wolinsky (1985) and Heistand (1986) found customers are relying less on doctors to select the right hospital. Reflecting on the importance of the patients' point of view. It does not matter who is right or wrong. What matters is how the patient felt during their experience, even though the caregivers' perception of their experience may be quite different (Petterson, 1998). Often the patient's perception is that the treatment from hospital staff is not reflective of the respect and dignity they deserve. If this is the case, the hospital staff is actually performing a disservice to the patients and the patient will most likely not return to that particular hospital. Although most of these healthcare facility administrators offer staff translation services and bilingual signage, they often have ceased to make the changes necessary to become accepted by the Latino community (Stevenson et al., 2002). The reduction in these changes can be very costly to a hospital as word of mouth within community members can have devastating results to the hospital's market share. These issues are likely to exacerbate medical problems that require high quality of care provided (Reynolds, 2004). An academic study cited by the National Management Healthcare Congress (as cited in Reynolds) estimates that if healthcare disparities were eliminated in the state of Pennsylvania, dollar savings to the U.S. healthcare systems would total $30 million annually for diagnoses that are common to minority patients.

Communication is as important as respect and dignity. Healthcare managers must gradually develop strategies that promote respect for individuals and cultural dissimilarities, incorporating a trust-promoting method of inquiry (Riddick, 1997). Not only can an absence of communication have a detrimental effect on a patient's perceptions, but also the misinterpretation of verbal language and body language can be

equally damaging. The better the quality of communication perceived by the patient, the greater will be his or her level of satisfaction (Andaleeb, 1998). One Spanish interpreter described a situation in which a Mexican woman considered not having an epidural because she and her husband believed that if she did not feel pain, she would not be a true mother (Smith-Collins et al., 2002).

The delivery of excellent service will help ensure that all patients receive treatment equally with compassionate and respectful care. Good demographic data relative to the relationship between racial and ethnic composition and care is a necessary first step in identifying successful models for health plans to reduce healthcare gaps (Wechsler, 2003). Without this element, Latino patients will feel that they do not receive the best care possible. Since the spoken language barrier and the translation of English into Spanish is such a crucial aspect, hospital staff needs to shift their focus onto this area. When translating from English to Spanish, it is important not to lose the true meaning of the translated message for the patient. Researchers uncovered a 3% error rate in medical information translation when using ad-hoc interpreters (Smith-Collins et al., 2002). This scenario happens often leading to the perception by Latinos that their healthcare is significantly different from Whites. Ad-hoc interpreters provide a short-term solution, but they are not without limitations (Smith-Collins et al.).

Quality in Healthcare

Clinical quality is defined as the ability of hospital administrators to achieve high standards of patient health through medical diagnosis, procedures and treatment and ultimately creating physical or psychological effects on patients (Marley et al., 2004).

Process quality is defined as how service is delivered (Marley et al.). Examples of process quality include the level of personalization and patient-service provider interaction, the delivery of medication and food to the patient, the efficiency of admission and checkout, and the timeliness and accuracy of hospital bills (Marley et al.). All of these above examples can be measured both quantitatively and qualitatively.

Continuously improving process quality on the part of the members of the healthcare organization is a key factor in improving overall healthcare quality (Marley et al., 2004). Effective service recovery is an aspect of process quality that involves development of a strategy to resolve customer complaints and dissatisfaction with the ultimate goal of motivating the customer to continue to use the service (Schweikhart et al., 1993). These measures are undergoing constant monitoring not only from the perspective of the patients, but also from a clinical standpoint. Often these measures will overlap and depending on how the issue is handled with patients and practitioners, the data received may be both qualitative and quantitative. Efficient, timely, and accurate analysis of hospital data and information and the delivery of this information to patients can also lead to a more informed decision by hospital personnel (Li, 1997).

Cleary and McNeil examined the relationship between quality and satisfaction and found that better care, along with good communication skills and empathy, lead to greater patient satisfaction (Marley et al.). Goldstein and Schweikhart empirically tested the relationships between the six dimensions of the Baldrige model (leadership, strategic planning, focus on patients, other customers and markets, information and analysis, staff focus and process management) and their efforts on organizational performance results (Marley et al., 2004).

In light of the increasing pressures on the administrators of healthcare organizations to cut costs, three factors can be used to judge their performance: change readiness, quality improvement and cost management (West, 1998). Measuring quality in healthcare has taken on a new dimension as quality measures for clinical outcomes have now moved into the patient satisfaction realm. Clinical quality outcomes are important as in measuring the quality of care. Clinicians need to address issues that may arise from certain protocols and methods of treating patients. Using this crucial information allows the clinicians to determine better quality outcomes and to develop new treatment protocols.

Although patients find satisfaction from their perception of and examination of clinical quality, they also use soft issues to develop satisfaction levels. Soft issues undergo scrutiny based on the patient's experience and perceptions. Soft issues include, but are not being limited to: (a) being attentive to the emotional needs of the patient, (b) offering quality food, (c) offering amenities, and (d) the amount and type of compassion offered by the staff.

Responsiveness to customer needs is a relatively new topic of discussion for personnel in healthcare industry. As hospital facilities become overburdened with patients, and hospital administrators are burdened with financial constraints, maintaining staff responsiveness to patients can be a difficult target to meet and to measure. This is because the degree of responsiveness is most often a patient's own perception of time. Unless the healthcare staff is using a measure that is both qualitative and quantitative, the results can vary and be invalid. In previous studies, researchers have suggested that patients' perception of time often becomes exaggerated in the hospital due to the factors

of (a) patient anxiety, (b) the need for patients to wait for an answer, or (c) tasks to be completed by the hospital staff.

When a patient is waiting for a nurse, it generally seems to the patient that the amount of time it took for the nurse to arrive was longer than it was in actuality. Along with the aspect of responsiveness, which ties very closely to compassion and respect, is the staff's empathy for the patient. The hospital staff's responsiveness to medical needs is no more important than the ability to be empathetic to the patient's emotional needs. Empathy is difficult to measure because it deals with a patient's feelings and fears. When patients enter the hospital, their emotions can range. Some patients experience relief, as in the case of many elderly and terminally ill patients who are mentally prepared to die. Some patients also experience anxiety and fear.

With the growing number of immigrants in the U. S., addressing cultural needs is extremely difficult. In this instance, the patient-clinician bond (relationship) that the patient desires may be lacking. Many administrators of healthcare institutions today have set up cultural seminars for staff to take part in to assure they are meeting the needs of their patients. In these seminars, the staff members are instructed in how to address the patient's emotional needs, and learn what makes the patient uncomfortable. The staff members learn about simple everyday gestures that may be offensive in some cultures, which influence patient perceptions.

More hospital administrators are having residents participate in one-day seminars on how to treat a patient's individual needs. In general, residents do not receive any formal training on how to talk to patients to reassure them or in a manner that speaks with trust, dignity, and compassion. Both the residents and the permanent staff within the

healthcare organization need to be aware of the patients' thoughts and concerns. It is not an easy task, but with the proper sensitivity training, the patients can feel their emotional needs are important. It is crucial that the staff members know what the patient needs in terms of empathy and every patient are different. Understanding individual differences must be addressed by the healthcare practitioner. Satisfied patients are better able to recall a physician's advice, follow medical regimes more strictly, and change physicians less often (Braunsberger & Gates, 2002).

When the staff is self-assured, the staff inspires trust and confidence in the patient. Many hospital administrators will actually put those words in the organization's mission statement, a statement that many patients may not experience. Instilling trust and confidence in the patient is not easy. Trust and confidence must be earned, and are relative to an individual's perception of others.

Quality measures are important from the perspective of the patient as well as the perspective of the clinical staff. In order for a healthcare administrator to make an organization one of the best healthcare organizations, it is necessary for the administrator to benchmark with other institutions of similar size and demographics. This enables the administrator of a health organization to compare outcomes and learn about different measures and initiatives that other hospital's administrators may be undertaking to create a better patient experience. Benchmarking, allows the administrators of the organization to be aware of how the organization rates among peer organizations.

Managing and measuring performance become exceedingly complex as healthcare institutions evolve into integrated health systems comprised of hospitals, outpatient clinics, surgery centers, nursing homes and home health services (Curtright,

Stolp-Smith, & Edell, 2000). Administrators of healthcare institutions are realizing that in order to meet patient expectations and gain market share, there needs to be a measure of how well the healthcare institution's staff is performing, not only from a clinical standpoint, but from the patients' standpoint also. Many healthcare institutions administrators now have set up patient satisfaction or customer service staff that report findings using a balanced score card or dashboard report (Curtright et al). An example of such a report card is modeled in Table 1.

Table 1. Patient Satisfaction Score Card

	Last quarter Fiscal year	n	Fiscal year	This quarter Fiscal year	n	Fiscal year
	Mean	n	***P***	Mean	n	***P***
Overall rating						
Patient Area	77.0	469	13	75.1	490	3
AREA 1	65.0	35	0	71.4	35	0
AREA 2	70.2	31	0	73.5	34	0
AREA 3	84.6	26	76	80.9	38	37
AREA 4	78.1	41	18	76.8	41	11
AREA 5	68.0	32	0	81.3	24	41
AREA 6	78.2	47	19	67.0	47	0
AREA 7	77.4	31	15	77.8	36	16
AREA 8	76.8	28	12	76.6	32	10
AREA 9	81.6	38	45	64.2	30	0
AREA 10	76.4	35	10	78.6	42	20
AREA 11	84.3	35	73	82.5	40	52
AREA 12	73.4	16	0	66.7	15	0
AREA 13	57.5	10	0	71.2	13	0
AREA 14	83.1	34	61	74.4	39	0

When measuring quality within the healthcare system, not only is it important to measure quality from both the patient's point of view and from the clinician's point of view, but to use the right method. Using the correct methodology will produce the reliability and validity the organization's administrators need to fully understand their

current situation. When the administrators have a proper understanding of the current situation then hypotheses can be designed to correct a problem or improve a process.

By measuring the patient experiences, healthcare providers can learn where deficiencies occur in their delivery of healthcare services. A thorough understanding of the patients' needs and what must be accomplished to meet those needs has a positive impact on the patients and the overall success of the hospital. Healthcare is an industry that relies heavily on word of mouth to convey how the organization's staff meets the needs of the patients, both from a spiritual perspective and medical perspective.
In order to meet the demands of the changing demographics within the healthcare industry, healthcare providers are examining models to ensure the direction they are moving meets patient needs.

The design of the Baldrige model is a guide to help meet the emotional and spiritual needs of Latinos as well as other ethnic groups. The Baldrige Award framework has four basic elements: (a) the driver, otherwise known as senior executive leadership which creates the goals, systems and values that guide the administrators pursuit of quality and performance objectives; (b). the system which consists of processes for meeting quality and performance requirements; (c) the goal which is the deliver of ever greater value to customers; and (d) the measures of progress which are quantifiable results that lead to improvement customer value and company personnel performance (Nerenz, 1998). The leadership team who are the guiding force in organizational excellence needs to determine what quality is lacking in the organization. The leadership team may need to make improvements in order to remain competitive, or it may mean

introducing a very new concept that the leadership team will need to set the example for the rest of the staff of the organization.

CHAPTER 3. METHODOLOGY

The purpose of this study was to determine why the perception of care by Latinos using the healthcare system in the U. S. is different from the perception of Whites of the care they receive. Examination of this situation can ultimately have a positive effect on the overall health of the Latino population. Perceived differences in the care that individuals receive can have a negative economic impact on healthcare systems and carry over to affect the overall health of the individuals and community in which they reside.

Research Design

The sampling of this study took place in local Latino enclaves in Chicago, Illinois and included local physicians' offices and health clinics. Some of these clinics strictly serve the Latino population while others serve to the White population. Toussaint-Comeau and Rhine (2004) outlined the process for obtaining data on enclaves:

> The Chicago metropolitan statistical area (MSA) is divided into 47 public use micro areas (PUMA's). PUMA's are the smallest geographical unites defined by the 1990 U.S.'s Census Public Use Micro Statistics, public version of the data. Within the Chicago metropolitan area, PUMA's that are heavily populated by Hispanics are identified and compared with other PUMA's that have an intermediate proportion of Hispanics, and others where there are only few Hispanic residents. These smaller geographical units allow one to identify specific Hispanic areas and potentially to capture some ethnic enclave or ethnic affinity effects (p. 96).

The survey was composed of a series of simple questions querying the participant population on their perception of past care received using traditional U. S. healthcare facilities. This survey was written in both the participants' native languages of Spanish

and in English. The questions method of scoring used a 5-point ordinal scale. The questions rank order were; 1 (*very poor*,), 2 (*poor*), 3 (*fair*), 4 (*good*), and 5 (*very good*).

This researcher conducted this study for 3 months. This provided sufficient time to accumulate enough surveys to make the data statistically significant. Outside resources were useful in obtaining information in order to prove the hypothesis. The legal citizenship status of participants was irrelevant and there was no method to track that information in this survey. This was to protect the identity of any participants who may not be legal residents or citizens of the U. S.

Sample

The target population was any Latino and White adults (18 years of age or older) who were patients seeking non-emergent medical treatment at physicians' offices and local clinics in the enclaves of Chicago, Illinois. Of the public use micro areas (PUMAs) identified, there were only five Chicago Department of Public Health clinics that were within the boundaries of the PUMAs. These clinics were chosen based on the ability of the researcher to gain access to the population (patient base) served at these locations. All participants received a survey asking them to rate their patient experience based on non-medical procedures and treatments using U. S. physicians' offices and healthcare clinics. A total of 250 surveys were distributed among participants who meet the research parameters. It was the intent that this survey reached a broad range of individuals with very diverse socioeconomic backgrounds since the survey distribution occurred in various areas of the city of Chicago, Illinois.

Setting

Surveying the Latino population was restricted to the local enclaves of Chicago, Illinois that have a high mixed population of Latinos and Whites. Physicians' offices and local healthcare clinics appeared to be the best places to distribute and receive the completed surveys from the participants. Participants had the opportunity to return the survey to this researcher via U. S. mail in a self-addressed, stamped envelope.

This researcher chose to use various sites around the city of Chicago to collect data. Using different facilities that provide medical care to Latinos as well as to the White population from around the Chicago allowed for a more diverse set of data. In addition, the data gathered was from an area that was representative of the demographic population.

Participants had an opportunity to fill out the survey at the location from which the survey was distributed, such as the physicians' offices and health clinics or at home. The survey was written in Spanish and in English. Allowing the participants to fill the survey out at home created an unbiased atmosphere in which the participants could feel relaxed and would be able to think about their past experiences and perceptions using traditional U. S. healthcare facilities.

Instrumentation and Measures

The collection of data used written questionnaires provided by RAND, a nonprofit public policy institute for research on health and public policy. The RAND staff specializes in the quality improvement of healthcare delivery. All participants who present themselves to physicians' offices or clinics who meet the study qualifications

were presented with the opportunity to complete a survey. Participants were able to fill out the survey at the physician's office or clinic before or after their visit. This survey did not necessarily be addressing their immediate visit but any past or present interaction the participant had using traditional U. S. healthcare facilities. Participants were able to fill out the survey at home if desired and return the completed survey via self addressed stamped envelope. Although participants were encouraged to take part in the study, no participant was coerced in order to obtain data.

Questionnaires consisted of ten 5-point ordinal scale questions. The survey had an area provided for the participant to write comments pertaining to each of the questions. In addition, there was a demographic section and two questions pertaining to the socioeconomic status of the participant. This was used to determine what the participant type that responded most frequently. The intent of this data was to determine if there are any correlations between demographics and responses to the survey questions. It was also to ensure that a broad range of participants engaged in the research. Scored responses to the questionnaire were entered into a SPSS computer software database for statistical analysis. Written responses were entered into an Excel database, coded, and analyzed on key words and terms using a qualitative content analysis.

Data Collection

The sample was a non-random self-selected sample of patients. This researcher used PUMAs to define the geographical area in order to determine where the survey was distributed. Within these PUMAs, the researcher used a non-probability purposive sample to randomly select physicians' offices and clinics that have a broad patient base that

includes Latinos as well as Whites. The physicians' offices and clinics chosen were associated with the Chicago Department of Public Health. Even though the physicians' offices and clinics selected within the PUMA may serve primarily Latinos, it was necessary for the clinic to serve a White population base as well in order to determine the variations in perception between the populations. The five sites randomly selected within the PUMA were chosen based on willingness of the administrators in the physicians' offices and or clinics to participate and the composition of the patient base. In this study, administrators at all five of the selected clinics granted permission for the survey to be distributed.

This study was conducted outside (field study) at five physicians' offices within the PUMAs using a convenience sample. There were more than five offices located within the PUMA; therefore, the researcher randomly selected the facilities that were geographically distributed with the most distance between offices throughout the PUMA. Using a convenience sample did not provide results that were representative of the entire population; it did give a statistical significant indication of the perceptions of Latinos visiting the facilities used in this study. This was beneficial information for the physician groups.

Any person who completed a survey within the first 3 months (90 days) did not receive another survey. This criterion was established to prevent over sampling of the participants. Any participant who indicated they recently lost a family member was not asked to complete a survey. This was to eliminate the possibility of biased perceptions and to respect the family members during a difficult time. The survey was available to patients presenting themselves to the physicians' office or healthcare facility that agreed

to participate in this study. The survey included a brief description of what was required of each participant and the purpose of obtaining the data. A self-addressed stamped envelope was included with the survey if the respondent chose to mail the survey instead of returning it to the staff at the participating medical facility. The staff at the medical facility had no knowledge or involvement is the design of the survey tool. The various locations at which the survey distribution occurred followed a convenience sample model.

Quantitative Analysis

Researchers who use logical positivism or quantitative research employ experimental methods and quantitative measures to test hypothetical generalizations (Hoepfl, 1997). In addition, they also emphasize the measurement and analysis of casual relationships between variables (Denzin & Lincoln, 1998) which was explored in this study. By using a quantitative method, this researcher was given the opportunity to learn about specific problems and design a hypothesis.

Quantitative research differs from qualitative research in the sense that in quantitative research there is a perception that everything is measurable. A quantitative researcher attempts to fragment and delimit phenomena into measurable or common categories that can be applied to all of the subjects or to wider and similar subjects (Winter, 2000). The concept of this method is so that the researcher can assign a value to the participants' response or event to determine the response categories that fit the parameters of the study. One of the benefits of using a quantitative method is having a standardized instrument to gather the data. In order for the data to be valid, the user of the

instrument tool needs to be able to replicate the data obtained. In using a survey tool already in place such as the survey RAND has utilized, reliability and validity have previously been tested and ensured.

Quantitative studies do have a place in many areas. Quantitative studies are more prominent and share a broader range of capabilities. Quantitative research methods are often used to determine one variable and how it reacts with another variable. Using this type of study allows for monitoring or evaluation after a process change. Using this type of study allows the researcher to compare data before and after the study to determine if there is a change between the two variables or if there is a correlation relationship. When using quantitative studies, the more research that is gathered, the better the evidence for the validation of a hypothesis.

Quantitative surveying is a method used primarily in the social sciences and mainly involves interviewing the participants and recording their answers. This type of research method is time consuming and can be costly if the researcher is choosing to compensate the participants in order to obtain the information.

One problem that arises from this type of study is that not all participants will act in a natural manner. As a result, some people have a natural tendency to pull away from strangers, or overstate the truth of their experiences. A well-seasoned researcher should be able to distinguish what is truthful. However, a researcher that guesses the actual intended participant's answer will cloud the data and put the study in jeopardy.

In order to achieve the best results with this type of survey having a set of clear, concise questions is essential. In this type of study, the researcher is searching for an answer that can later be backed up with qualitative data. Another aspect in this method of

obtaining data is that the situation in which the data is obtained must be continually consistent in order to get the same responses from the participants. For example, a researcher talking to two people next to a noisy construction site will not reveal the same type of response as when the researcher is talking to the same two people in an enclosed classroom. These small details are essential to ensure valid and reliable results.

Considerations were taken into account when using this survey method of gathering data. Testing of the surveys ensured the validity of the survey tool. Measuring the validity was done through examining the means, standard deviations, and standard errors for each question. Validity was also measured through the use of regression analyses, construct validity, convergent validity, divergent validity and using Cronbach's alpha.

In quantitative data, one-way frequency tables may be conveniently displayed in a variety of ways: typically, as bar charts (though the bars should often be ordered by frequency, rather than by bar-label), and dot charts (Cleveland & McGill, 1984). Multiple strata tables are an excellent way to display data that shows the researcher an interest between two like variables.

There are debates among researchers that are centered on the argument that some methods are not valid to determine reliability. The test-retest method in which the same test is given twice to assure the same results are realized has existed for some time. Some researchers argue that the same conditions under which the test or observation are conducted, cannot be replicated based on the participants' perceptions and experiences. When this situation occurs, there will be errors in the measurement of the data, which in turn will jeopardize the reliability of testing methods used to gather the data. Although

the reliability may be proven through validation of the consistency noted, this does not mean that validity has been proven.

The quantitative analysis approach is an important 7-step process that many business executives and analysts use when looking at a process improvement initiative (Render & Stair, 1997). The first step was defining the problem. In this crucial step, it was the job of the researcher to develop a concise statement that defines and encapsulates the entire problem. This was one of the most difficult aspects of using quantitative research. Failure to develop the correct question or questions would have jeopardized the reliability and validity of this entire research project.

For the administrators at the hospital, clinic, or physician's offices, pinpointing exactly what the patients' perceived to be a failure in the quality of service was crucial. Without knowing the exact circumstances and the frequency of the incidents, the healthcare administrators and providers are unable to determine a reasonable hypothesis as to what the failure in service entailed. The data would be invalid and any initiative that was based on these data would result with no increase in patient satisfaction. In fact, it may actually be detrimental to the process and procedures already in place.

The second step was to develop a model. In this step, a model was developed to represent the problem (Render & Stair, 1997). In this particular study, a statistical model was used, but it could have been a different type of model such as a physical scale.

The third step was to acquire the data since it was known that once the problem had been defined clearly, the data gathered would be reliable and valid (Render & Stair, 1997). If the model is based on a business organization, this step may not be very difficult. If the researcher were considering performing research on a topic outside the

subject of an established organization based on a relatively new research topic, this step would have been lengthier. It would be more difficult to obtain the desired data. For this study, since the model had been developed and the hypothesis had been determined, surveying the participants was relatively easy. Because a convenience sample was used, discrepancies in the data could be identified.

The fourth step involved developing a solution. In this step, this researcher manipulated the established model (Render & Stair, 1997). Although this sounded unethical and in some circumstances it may be, for this analysis it was appropriate because this researcher was looking for a solution to a problem.

The fifth step was testing the solution. In this stage of the process, this researcher was interested in looking at reliability and validity of the data. If either the validity or reliability were invalid, then the results would also be inaccurate (Render & Stair, 1997). If this did happen, the researcher would have had to redevelop the model (step two) and repeat steps three through five. There was the possibility that the data would have been accurate, but the results would be inconsistent. Again, if this happened, the model would need to go under a redesign phase. The next logical step if the model produced data that was reliable and valid is to start the analysis. The last step, number seven is the implementation stage. In order for the implementation phase to work correctly a solid plan needs to be developed and monitored for success (Render & Stair, 1997). In the social sciences, the implementation phase may precede further analysis and quantitative research to hone in on specific problems, and may not necessarily have an implementation phase. This phase required the healthcare practice administrator to assess and monitor the survey process, and to ensure that the correct data was being obtained.

Logistic regression allows for estimating the likelihood (odds ratio) of a participant's fitting into one category such as being pleased with physician interaction versus not being pleased with physician interaction (Sharpe, 2002). The benefit of using this type of analysis was that this researcher was freed from having to make a normality assumption. In addition, many independent variables were included in the model and the independent variable was at any level of management (Sharpe, 2002).

A statistical analysis method that would show a relationship between one variable and another (also known as a correlation coefficient) shows the magnitude of the linear relationship and the direction of the relationship. The correlation coefficient scale ranges from +1 to -1. If there is a positive correlation between two variables than this was indicated by a positive linear relationship.

A regression analysis is another good way to display data. A regression analysis measures the linear association between a dependent (Latino populations) and independent variable (Latino population members perception of healthcare in the U. S.). In this type of analysis, the dependent variable can be linked to a certain predicator.

This researcher used a multivariate analysis. Using this method allowed the researcher to look at the effects and to examine more than two variables, since there were several variables being analyzed. By using this type of data analysis, the researcher made valid predictions that certain age groups among sexes were more likely to have a positive patient physician experience.

Qualitative Analysis

Qualitative research uses a naturalistic approach to understand phenomena in context-specific settings, such as "real world settings where the researcher does not attempt to manipulate the phenomenon of interest" (Patton, 2002, p. 39). One important distinction of qualitative research is that the researcher allows things to happen without influence while the researcher exercises some control when using a quantitative method For example, in a quantitative method the researcher may choose to interview only participants who were born in the United States, while in the qualitative method, the researcher will interview all participants to get a sense of what each participant is feeling and thinking.

The use of qualitative research is helpful as it allows the researcher an opportunity to gain a better understanding why a particular episode occurred. The true essence of qualitative analysis is "working with data, organizing it, breaking it into manageable units, synthesizing it, searching for patterns, discovering what is important and what is to be learned, and deciding what you will tell others" (Bogdan & Biklen 1982, p. 145). Categorizing the research and keeping it simple provides the researchers with a better understanding of what the participants are saying.

The benefit of using qualitative data is that the researcher is learning about the participants' experiences. This approach gives the researcher the opportunity to gain an understanding of the events surrounding the participant. The major difference between qualitative and quantitative methodologies is the type of data obtained. Quantitative data consists of facts that use numbers to explain an event. Qualitative data consists of written communication used to understand that same event.

Data in a quantitative research project is obtained in a controlled environment, which helps to keep the research focused. Using this type of study limits the outside influences that can deter or distract the researcher. Qualitative research is has the opposite effect. In qualitative research, data are collected in natural environments.

Choosing one method over the other is not to say that qualitative studies are more reliable and valid than quantitative studies or vice versa. In quantitative research, the researcher is more concerned with whether or not an event can be replicated. Qualitative researchers are more interested in true perceptions. When the researcher uses the two methods of qualitative and quantitative together, a technique known as triangulation occurs and the researcher ensures greater reliability and validity.

Using these two methods as a valid way to perform research is not universally agreed upon, and has been challenged by Barbour (1998). Although it is possible to use multiple paradigms, mixing methods does not work because each method has separate assumptions. It is Barbour's opinion that, using a triangulation method in a quantitative study is acceptable, using a triangulation method in a qualitative study, although also acceptable, it needs clarification for each paradigm.

Another paradigm is constructivism. Constructivism is a theory in which knowledge changes based on social conditions. Crotty (1998) stated that constructivism is "the view that all knowledge, and therefore all meaningful reality as such is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context" (p. 42). Constructivism is designed so researchers can look deeper into the issues rather than look at the surface of an issue.

Since participants do have different perceptions and thoughts, researchers cannot rely solely on one method to gather data. If this calls for the use of triangulation in the constructivism paradigm, then the use of investigators, method, and data triangulations to record the construction of reality is appropriate (Johnson, 1997). Using multiple methods of research will result in valid data that are more diverse.

The primary use of qualitative methods is based on lack of controls. There may be some methods of control. For example, a researcher may not give a survey to a participant who recently lost a family member. Qualitative researchers in the healthcare field have the opportunity to understand why patients feel a particular way about their experience and perceptions. The true essence of qualitative analysis is "working with data, organizing it, breaking it into manageable units, synthesizing it, searching for patterns, discovering what is important and what is to be learned, and deciding what you will tell others" (Bogdan & Biklen, 1982, p. 145). Categorizing data will allow the researcher or the persons who monitor the survey data a better understanding of what the participants are saying. Although depending on how many questions are included in the survey, by categorizing the data, statistical analyses will be easier to perform and the data will be richer. Qualitative data, in conjunction with quantitative data, can really explain why patients are scoring the surveys a certain way. It is this combination of data that defines a situation.

Qualitative Content Analysis

Content analysis has been defined as a systematic, replicable technique for compressing many words of text into fewer contest categories based on explicit rules of coding (Berelson, 1952; GAO, 1996; Krippendorff, 1980; Weber, 1990). The use of such a technique in this study enabled the researcher to analyze large volumes of data with relative ease in a systematic fashion (GAO).

Using description gives readers background and context and therefore descriptions need to be rich and thick (Denzin, 1989). Qualitative research is fundamentally interpretative and the interpretation represents the researcher's personal and theoretical understanding of the phenomenon under study. An interesting and readable report "provides sufficient description to allow the reader to understand the basis for an interpretation, and sufficient interpretation to allow the reader to understand the description" (Patton, 1990, p. 430).

Krippendorff (1980) addressed six components that must be addressed in every content analysis. Krippendorff identified the questions as follows:

1. Which data are analyzed? (p. 30)
2. How are they defined? (p. 31)
3. What is the population from which they are drawn? (p. 32)
4. What is the context relative to which the data are analyzed? (p. 33)
5. What are the boundaries of the analysis? (p. 35)
6. What is the target of the inferences? (p. 36)

Unfortunately, there are no well-developed weighting procedures therefore the researcher may use word counts; however, the researcher has to be aware of this situation

(Stemler, 2001). Not only will the researcher need to be familiar with frequency of the word(s) appearing, but the meanings of the words, and how the words are used will play an equally important part in the analysis. For instance, the word *state* could mean a political body, a situation, or a verb meaning *to speak* (Stemler).

Content analysis extends far beyond simple word counts. The technique is made particularly rich and meaningful due to reliance on coding and categorizing of the data (Stemler, 2001). The basics of categorizing can be summed up in these quotes: "A category is a group of words with similar meaning or connotations" (Weber, 1990, p. 37). "Categories must be mutually exclusive and exhaustive" (GAO, 1996, p. 20). Mutually exclusive categories exist when no unit falls between two data points and each unit is represented by only one data point (Stemler). The requirement of exhaustive categories is met when the data language represents all recording units without exception (Stemler).

Reliability

To ensure reliability when performing the qualitative content analysis, key words that pertained directly to the survey questions were searched. Shapiro and Markoff (1997) asserted that content analysis itself is only valid and meaningful to the extent that the results are related to other measures. Weber (1990) stated: "To make valid inferences from the text, it is important that the classification procedure be reliable in the sense of being consistent: Different people should code the same text in the same way" (p. 12). Weber further noted that, "reliability problems usually grow out of the ambiguity of word meanings, category definitions, or other coding rules" (p. 15). To help ensure reliability,

this researcher deployed a content analysis software system to perform the analyses in question.

In the past, there has been criticism when discussing content analysis methodology in particular quantitative studies. Essentially reducing text into numbers, researchers have often criticized the quantitative techniques for missing syntactical and semantic information embedded in the text (Weber, 1990). In this study, this researcher used a qualitative content analysis because it is presumed that the responses from the respondents provided richer data using the qualitative method than they did using the quantitative data.

Intervention Procedures

No intervention procedures were used in the data collection methods or with analyses of the data.

Data Analysis

The first step used in data analysis is referred to as *open coding* (Strauss & Corbin, 1990). In this process, researchers start to identify and categorize data for a rough analysis. As the data collection process continues, new categories may become known. This coding method was used strictly for providing a better understanding of the situation of the perception by Latinos of healthcare services. Once this portion was completed, this researcher proceeded with performing a statistical content analysis to determine the make-up of the population that was explored.

The solidness in quantitative research is solely dependent on the data collection method and design. In qualitative research "the researcher is the instrument" (Patton,

2001, p. 14). When speaking in terms of reliability or validity in qualitative research, this is actually referring to the credibility of the researcher and of the methods deployed.

There have been numerous scholarly articles written about the validity and reliability of qualitative research projects. The use of triangulation has raised an important methodological issue in naturalistic and qualitative approaches to evaluation in order to control bias and establish valid propositions because traditional scientific techniques are incompatible with this alternative (Mathison, 1988, p. 13). Patton (2001) promoted the use of this method by stating, "triangulation strengthens a study by combining methods. This can mean using several kinds of methods or data including as an example using both quantitative and qualitative approaches" (p. 247).

The use of qualitative research is a valuable method of research. Many researchers in the social sciences as well as academia have agreed with the latter proposition. This does not mean to say that qualitative methods are the only options for producing results that are reliable and valid. There will be an analysis in which qualitative research methods will be proven to add validity and reliability.

The statistical analysis used will be logistic regression. This method allows for estimating the effects of independent variables on a split dependent variable (Sharpe, 2002). The use of logistic regression allows for estimating the likelihood (odds ratio) of a participant fitting into one category such as satisfactory patient experience versus another such as unsatisfactory patient experience (Sharpe). The benefit to using this type of analysis was that it allowed this researcher to be freed from having to make a normality assumption. In addition, many independent variables could be included in the model and the independent variable could be at any level of management (Sharpe).

A correlation analysis showed the linear relationship between two of the responses from the questions used in the survey. When using a correlation coefficient the value returned ranges from +1 to -1. The higher the value (closer to +1) indicated that there was a positive correlation, which indicated that the response from one question directly influenced the response from another question.

Using a regression analysis determined if there was any relationship between the dependent variable and the independent variable being examined. For this study, the independent variable consisted of the demographics of the Latinos, and the dependent variable was the Latinos' perception of the U. S. healthcare system.

Validity and Reliability

This researcher used a recognized survey tool used by RAND in this study in order to ensure reliability and validity. Surveys, which have already been used, gave this researcher the confidence that reliability and validity tests had been performed to ensure the most reliable data. Certain aspects to the testing methods included the performance of Cronbach's alpha on all scales and subscales by this researcher. This researcher developed multiple versions of the same questionnaire and compared those results to the items answered. The researcher examined patterns of skewed data and clusters and used regression analysis to ensure the results obtained in the study were reliable and valid.

Joppe (2000) defined reliability as the extent to which results are consistent over time. An accurate representation of the total population under a study is referred to as reliability. If the results of a study can be reproduced, using a similar methodology the research instruments is considered reliable (Joppe, p. 1). Kirk and Miller (1986) stated

that "there are three types of reliability when it comes to quantitative research; (1) the degree to which a measurement given repeatedly remains the same, (2) the stability of a measurement over time, and (3) the similarity of measurements within a given time period" (p. 41-42).

Joppe (2000) stated, "validity determines whether the research truly measures that which it was intended to measure the truthfulness of the research results. Researchers generally determine validity by asking a series of questions and will often look for the answers in the research of others" (p. 1).

In qualitative research, the terms reliability and validity describe the method being used. This is a true reflection on the person or agency issuing a survey to the patients of the hospitals.

Dependent Variables

To accurately measure the perception of participants of non-medical based care that they received from healthcare practitioners, all eligible participants were asked to assess 10 aspects of quality of care in English or Spanish. In English and in Spanish, these 10 aspects were:

1. Ease of speaking with your primary care provider (*La facilidad de hablar con su proveedor de atención primaria*).
2. Friendliness and courtesy shown to you by the receptionist and other front desk staff (*La amabilidad y la cortesía se muestra a usted por el recepcionista y otros recepción de personal*).
3. Explanations about prescribed medicines (*Las explicaciones acerca de los medicamentos prescritos).*
4. Explanations of medical procedures and test results by primary care provider (*Las explicaciones de los procedimientos médicos y los resultados de las pruebas por proveedor de atención primaria*).

5. Friendliness and courtesy shown to you by your primary care provider (*La amabilidad y la cortesía se muestra a usted por su proveedor de atención primaria*).

6. Friendliness and courtesy shown to you by nurses and other medical staff (*La amabilidad y la cortesía se muestra a usted por enfermeras y otro personal medico*).

7. Training, skill, and experience of the nursing staff (*La capacitación, la habilidad y la experiencia del personal de enfermería*).

8. Your primary care provider's concern for your mental health or emotional well-being (*Su proveedor de atención primaria de la preocupación por su salud mental o el bienestar emocional*).

9. How well your care meets your needs (*Cómo así su cuidado se ajuste a tus necesidades*).

10. Overall quality of care (*En general la calidad de la atención*).

Each question was scored using an ordinal scale of 1 (*very poor*), 2 (*poor*), 3 (fair), 4 (*good*) and 5 (*very good*).

Independent Variables

The independent variables were designed based on the literature that was reviewed and the past patient satisfaction studies that were performed. The independent variables used in this study consisted of age and gender of the respondents, type of insurance, if any (HMO, PPO, Medicare, Medicaid, Self Pay, not applicable) and participant economic status which was categorized into the following groups: (a) Less than $5,000, (b) $5,000 to $9,999, (c) $10,000 to $19,999, (d) $20,000 to $39,999, (e) $40,000 to $74,999, (f) $75,000 to $99,999, and (g) $100,000 or more. A combination of insurance can be used and the results will be categorized accordingly. It was not the intent of this study to examine types of insurance used but to ensure that a broad spectrum of data was obtained.

Age and gender was analyzed more carefully because this researcher believes that younger patients were just as likely as older patients to be critical of services that were rendered by the healthcare provider. This researcher believes that cultural influences, not age, or assimilation to a society; affect the patients' perception of care. Medical conditions or purposes for medical visits were not solicited from the participants, as this information was not relevant to this study.

A Spanish language response variable (SLRV) was not used for this study. The survey tool used is presently used by RAND in both English and Spanish with proven validation. There was no need to assume that there would be differences in the interpretation of questions and responses (ordinal scale) for the participants completing the survey.

Reciprocity

No compensation was offered to the participants of this study or to the administrators, physicians, nurses, and any other staff associated with the selected clinics or medical centers where the survey was distributed. It was the intent to gather unbiased data. Offering compensation increased the risk that participants would complete a survey strictly for monetary gain or as a result of coercion.

Anonymity

Participants were not asked to provide any personal identification. There were no bar codes used on the survey that would allow the completed survey to be traced to an individual. No other types of identifiers were used. This study was completely anonymous in order to insure that honest answers were given.

Ethical Considerations

Confidentially was maintained through the use of an anonymous survey. There was no human contact with the participants at anytime during the study. Participants were not required to provide any information other than their experiences with the U. S. healthcare system.

Any participant over the age of eighteen who presents to a designated healthcare facility was given a survey to fill out based on past patient experiences using American healthcare facilities and/or physicians. No participant was coerced to fill out a survey nor were there any incentives to fill out the survey. The sample was a non-random self-selected sample of patients. The researcher used PUMAs to define the geographical area, which determined where the survey was distributed. The Chicago metropolitan statistical area (MSA) is divided into 47 public use micro areas (PUMAs). PUMAs are the smallest geographical unites defined by the 1990 U.S.'s Census Public Use Micro Statistics, public version of the data. Within the Chicago metropolitan area, PUMAs that are heavily populated by Hispanics are identified and compared with other PUMAs that have an intermediate proportion of Hispanics, and others where there are only few Hispanic residents. These smaller geographical units allow one to identify specific Hispanic areas and potentially to capture some ethnic enclave or ethnic affinity effects (p.96).

If there were, more then five offices located within the PUMA the researcher would randomly choose the facilities that are geographically spread out (most distance between offices) throughout the PUMA. In the instance, that the healthcare clinic or physician's office did not have 5 offices located within the PUMA, then multiple PUMAs will be used until a total of 5 offices have been identified. The consent form will be

given to the participants with the survey. No survey was counted, without the adjoining consent form.

CHAPTER 4. RESULTS

Introduction

In this chapter, this researcher presents the results obtained from this study. The purpose of this study was to examine and determine if perceptions of non-based medical care differed between Latinos and Whites. The sampling of this study took place in local neighborhoods in Chicago, Illinois. This researcher implemented the study through the use of local physician offices and health clinics serving Latinos and Whites.

The survey was a series of simple questions asking the participants their perceptions about past healthcare services received using the U. S. healthcare system. The study was conducted for three months, and concluded with 264 responses. The target population was any Latinos or White adults who were 18 years or older and were patients seeking medical attention at physicians' offices or clinics. Questionnaires consisted of ten 5-point ordinal scale questions as well as an area to write comments about each of these questions.

The financial impact that hospital administrators are facing can be linked to dramatic changes in healthcare funding; however another aspect is the loss of revenue from private payer insurance groups or fee for service groups (HMOs) whose members can now choose where to receive healthcare. When a patient senses that his or her fundamental needs have not been met by a healthcare provider, the patient's perception of one healthcare system or physician can become tainted. In these instances, these

individuals will most likely choose to go to another healthcare provider and or to another healthcare organization. This situation can be particularly true for the Latino population based on their need for having an emotionally fulfilling patient experience when seeking out healthcare. Without meeting the needs of the Latino population, administrators of healthcare organizations are missing an opportunity to address the healthcare needs of a particular segment of people who are the fastest growing population in the U. S.

Demographic Analysis

Objective 1 of the study was to describe the demographic composition of Latino and Whites using U. S. healthcare services in the city of Chicago, Illinois by gathering the following demographic characteristics: (a) age, (b) gender, (c) race, (d) type of health insurance coverage, (e) income range, (f) zip code of primary residence.

Age

Respondents were asked to identify their age. The purpose of having the individual patients identify their age was to ensure that they were over the age of 18 and that no minors were being considered in this study. Second, the question of age was used to determine if there were any trends in the perceptions of care formed by age and by race (Latino and Whites). Most respondents in this study were in their late 30s to early 60s (see Table 2).

Table 2. Age Descriptive Statistics of Adult Latino and White

	N	*Min*	*Max*	*M*	*SDn*
AGE	264	19	70	51	12.76

Gender/Race

The gender composition of the adult patients indicated that a majority of the patients (n = 134, 50.8%) were male. This number represented both Latino and Whites (see Table 3).

Table 3. Gender Latino and Whites

		f	*P*	Valid %	Cumulative %
Valid	Female	130	49.2	49.2	49.2
	Male	134	50.8	50.8	100.0
	Total	264	100.0	100.0	

When evaluated by race, the gender distribution changes little. Table 4 shows that males continued to comprise the largest number of participants within the Latino population (n = 69, 54.3%) and dropped slightly below the majority (n = 65, 47.4%) within the White race (see Table 5).

Table 4. Gender and Race Latino

	Gender	*f*	*P*	Valid %	Cumulative %
Valid	Female	58	45.7	45.7	45.7
	Male	69	54.3	54.3	100.0
	Total	127	100.0	100.0	

Table 5. Gender and Race Whites

		f	*P*	Valid %	Cumulative %
Valid	Female	72	52.6	52.6	52.6
	Male	65	47.4	47.4	100.0
	Total	137	100.0	100.0	

Race

In this study, the composition of the race of participants consisted of two groups: Latinos and Whites. The larger group of participants (*n* = 137, 51.8%) identified themselves as being Latino while a smaller group of participants (*n* = 1 27, 48.1%) identified themselves as being Whites.

Insurance

Health insurance was categorized into six groups for both Latinos and Whites. The categories used were Medicare, Health Maintenance Organization (HMO), private (i.e., Blue Cross), Medicaid, self-pay and other sources that included third party payment.

Latino composition (see Table 6) consisted of Medicare at (*n* = 23, 18.1%), HMO (*n* = 37, 29.1%), private (*n* = 30, 23.6%), Medicaid (*n* = 11, 8.7%), self pay (*n* = 19, 15.0%), and other sources at (*n* = 7, 5.5%).

Table 6. Latino Insurance Type

		f	*P*	Valid %	Cumulative %
Valid	Medicare	23	18.1	18.1	18.1
	HMO	37	29.1	29.1	47.2
	Private	30	23.6	23.6	70.9
	Medicaid	11	8.7	8.7	79.5
	Self Pay	19	15.0	15.0	94.5
	Other Source	7	5.5	5.5	100.0
	Total	127	100.0	100.0	

Similarly insurance coverage for Whites was Medicare at (*n*= 22, 16.1%), HMO (*n* = 47, 34.3%), private (*n* = 26, 19.0%), Medicaid (*n* = 14, 10.2%), self pay (*n* = 20, 14.6%), and other sources at (*n* = 8, 5.8%). The comparisons in insurance coverage indicated that both groups were very similar in composition (see Table 7).

Table 7. Whites Insurance Type

		f	*P*	Valid %	Cumulative %
Valid	Medicare	22	16.1	16.1	16.1
	HMO	47	34.3	34.3	50.4
	Private	26	19.0	19.0	69.3
	Medicaid	14	10.2	10.2	79.6
	Self Pay	20	14.6	14.6	94.2
	Other Source	8	5.8	5.8	100.0
	Total	137	100.0	100.0	

Income Range

Income was categorized into six groups for both Latinos and Whites. The groupings were designed to provide a basic understanding of the participants being surveyed and to provide representation of a broad range of participants so not to skew the data. The six groups of income range are as follows: (a) $10,000 to $19,999, (b) $20,000 to $39,999, (c) $40,000 to $74,999, (d) 75,000 to $99,999, (e) $100,000, or more. The option of no answer (f) was available for participants who were uncomfortable with responding to this question.

Latino composition (see Table 8) consisted of the following ranges. In the annual salary range of $10,000 to $19,999 ($n$ = 15, 11.8%), $20,000 to $39,999 ($n$ = 24, 18.9%), $40,000 to $74,999 ($n$ = 23, 18.1%), $75,000 to $99,999 ($n$ = 30, 23.6%), $100,000 or more ($n$ = 25, 19.7%), no answer (n = 10, 7.9%).

Table 8. Latino Income Range

		f	*P*	Valid %	Cumulative %
Valid	$10,000 to $19,999	15	11.8	11.8	11.8
	$20,000 to $39,999	24	18.9	18.9	30.7
	$40,000 to $74,999	23	18.1	18.1	48.8
	$75,000 to $99,999	30	23.6	23.6	72.4
	$100,000 or more	25	19.7	19.7	92.1
	No Answer	10	7.9	7.9	100.0
	Total	127	100.0	100.0	

The composition of Whites consisted of the following ranges (see Table 9). In the annual salary range of $10,000 to $19,999 (*n* = 11, 8.0%), $20,000 to $39,999 (*n* = 27, 19.7%), $40,000 to $74,999 (*n* = 31, 22.6%), $75,000 to $99,999 (*n* = 30, 21.9%), $100,000 or more (*n* = 28, 20.4%), no answer (*n*=10, 7.3%).

Table 9. Whites Income Range

		f	*P*	Valid %	Cumulative %
Valid	$10,000 to $19,999	11	8.0	8.0	8.0
	$20,000 to $39,999	27	19.7	19.7	27.7
	$40,000 to $74,999	31	22.6	22.6	50.4
	$75,000 to $99,999	30	21.9	21.9	72.3
	$100,000 or more	28	20.4	20.4	92.7
	No Answer	10	7.3	7.3	100.0
	Total	137	100.0	100.0	

The income range of the two groups that participated in this study provided not only a broad range of income, but showed that there were few differences between the two groups. As with the similarities in the insurance categories, it was clear that both groups of participants have the opportunity to choose where they seek medical care.

Descriptive statistics

The descriptive statistics shown in Table 10 provide the data from the questions pertaining to the patient's perception of care for both Latinos and Whites. The standard deviation shows the dispersion of data from the mean score. The standard deviation is a measure of variability of scores around the mean. The lower the standard deviation or closer to zero the result, the less dispersed the data.

Looking at the mean scores with the expectation to the question "Your primary care provider's concern for your mental health or emotional well-being" all other questions had a mean score of at least 80.0 and as high as 90.4070 for "Overall quality of care" . The mean score is the statistical average or the central tendency of the results for each question. From these descriptive statistics this researcher showed that participants are satisfied overall with the care they have received; this pertains to both Latinos and Whites who participated in the survey.

The question that caused the most concern was "Your primary care provider's concern for your mental health or emotional well-being". When compared with the other mean scores this question had the lowest mean with a standard deviation of 23.2329 (n = 233). This was also the most unanswered question in the survey that related to the care that participants received. Two of the most answered questions, both with a response rate of 264, were "Ease of speaking with your primary care provider" with a mean of 80.4976 and a standard deviation of 20.5040 and "Explanations of medical procedures and test results by primary care provider" with a mean score of 85.5167 and a standard deviation of 19.7383.

Table 10. Descriptive Statistics

	M	*SD*	*N*
Overall quality of care	90.4070	15.8277	258
Friendliness and courtesy shown to you by the receptionist and other front desk staff	88.1104	17.9594	248
Friendliness and courtesy shown to you by nurses and other medical staff	89.1820	19.2186	261
Training, skill, and experience of the nursing staff	88.6093	19.3756	261
Explanations about prescribed medicines	86.2474	18.9295	258
Ease of speaking with your primary care provider	80.4976	20.5040	264
Explanations of medical procedures and test results by primary care provider	85.5167	19.7383	264
How well your care meets your needs	83.5273	24.1292	264
Friendliness and courtesy shown to you by your primary care provider	88.0800	19.1922	260
Primary care concern for your mental health	79.9450	23.2329	233

Correlations

The following questions were assigned a numeric value in the following order for Tables 11, 12 and 13. This allowed for the correlation tables to be displayed in their entirety.

1. Overall quality of care
2. Friendliness and courtesy shown to you by the receptionist and other front desk staff
3. Friendliness and courtesy shown to you by nurses and other medical staff
4. Training, skill, and experience of the nursing staff
5. Explanations about prescribed medicines
6. Ease of speaking with your primary care provider
7. Explanations of medical procedures and test results by primary care provider
8. How well your care meets your needs
9. Friendliness and courtesy shown to you by your primary care provider
10. Your primary care provider's concern for your mental health or emotional well-being

Using correlations showed which questions on the survey were directly correlated to other questions. The correlation indicated how much of a change in one variable was associated with a concurrent, systematic change in another variable. The closer the correlation value was to 1, the stronger the relationship was between the two variables. When the correlation value was closer to 0, a weak relationship existed, therefore there was no correlation. It is important to note the correlations only showed the relationship between two variables, not the causation. This data is useful particularly when process improvement initiatives are being implemented.

Next, *t*-tests were calculated to determine the confidence level in the data. Using the *t*-test determined if the statistical difference was due to a random error or if the researcher could be confident in the data. Although some *t*-tests in the data showed that the data was approaching the critical region, further analysis of the data showed that the

values were not less than .05 (5%). This evidence confirmed that there is no need to reject the hypothesis.

Looking at the correlations for both Latinos and Whites, there were three definite correlations. First, with a Pearson correlation of 0.807, it can be said that the question of "Friendliness and courtesy shown to you by nurses and other medical staff" has a direct influence on how the patient scored "Training, skill, and experience of the nursing staff". This was an interesting point especially when looking the correlation between "Explanations of medical procedures and test results by primary care provider" and "How well your care meets your needs" with a Pearson correlation of 0.832, and the relationship between "Explanations of medical procedures and test results by primary care provider" and "Friendliness and courtesy shown to you by your primary care provider" with a Pearson correlation of 0.847. The results of these correlations confirmed a relationship to the communication between the patient and the medical staff. Table 11 shows the remaining Pearson correlations to the 10 questions pertaining to the dependent variables.

Table 11. Latino and White Correlations

		1	2	3	4	5	6	7	8	9	10
1	Pearson	1.000	.460	.506	.677	.604	.447	.461	.397	.258	.730
	∑ (2-tailed)	-	.000	.000	.000	.000	.000	.000	.000	.000	.000
	N	258	239	257	257	249	255	255	255	251	229
2	Pearson	.460	1.000	.637	.719	.686	.485	.382	.312	.375	.594
	∑ (2-tailed)	.000	-	.000	.000	.000	.000	.000	.000	.000	.000
	N	239	248	242	242	242	248	248	248	244	217
3	Pearson	.506	.637	1.000	.807	.512	.402	.448	.309	.392	.591
	∑ (2-tailed)	.000	.000	-	.000	.000	.000	.000	.000	.000	.000
	N	257	242	261	261	252	258	258	258	254	232
4	Pearson	.677	.719	.807	1.000	.634	.552	.485	.408	.500	.789
	∑ (2-tailed)	.000	.000	.000	-	.000	.000	.000	.000	.000	.000
	N	257	242	261	261	252	258	258	258	254	232
5	Pearson	.604	.686	.512	.634	1.000	.515	.528	.511	.529	.709
	∑ (2-tailed)	.000	.000	.000	.000	-	.000	.000	.000	.000	.000
	N	249	242	252	252	258	258	258	258	254	231
6	Pearson	.447	.485	.402	.552	.515	1.000	.771	.758	.726	.521
	∑ (2-tailed)	.000	.000	.000	.000	.000	-	.000	.000	.000	.000
	N	255	248	258	258	258	264	264	264	260	233
7	Pearson	.461	.382	.448	.485	.528	.771	1.000	.832	.847	.526
	∑ (2-tailed)	.000	.000	.000	.000	.000	.000	-	.000	.000	.000
	N	255	248	258	258	258	264	264	264	260	233
8	Pearson	.397	.312	.309	.408	.511	.758	.832	1.000	.794	.457
	∑ (2-tailed)	.000	.000	.000	.000	.000	.000	.000	-	.000	.000
	N	255	248	258	258	258	264	264	264	260	233
9	Pearson	.258	.375	.392	.500	.529	.726	.847	.794	1.000	.510
	∑ (2-tailed)	.000	.000	.000	.000	.000	.000	.000	.000	-	.000
	N	251	244	254	254	254	260	260	260	260	229
10	Pearson	.730	.594	.591	.789	.709	.521	.526	.457	.510	1.000
	∑ (2-tailed)	.000	.000	.000	.000	.000	.000	.000	.000	.000	-
	N	229	217	232	232	231	233	233	233	229	233

** Correlation is significant at the 0.01 level (2-tailed).

The Pearson correlations for Latinos showed which questions drive the scores for the perception of high quality healthcare. In this analysis the trend, that quality healthcare is related to the tests, treatment options and explanations given to the patient from the medical staff was evident. Questions 3 and 4, "Friendliness and courtesy shown to you by nurses and other medical staff" and "Training, skill, and experience of the nursing staff" respectively had a Pearson correlation of 0.831. Questions 4 and 10 "Training, skill, and experience of the nursing staff" and "Your primary care provider's concern for your mental health or emotional well-being" respectively had a Pearson correlation of 0.803. Questions 7 and 9, "Explanations of medical procedures and test results by primary care provider" and "Friendliness and courtesy shown to you by your primary care provider" respectively had a Pearson correlation of 0.852. The last two correlations are based on using the question "How well your care meets your needs" and "Explanations of medical procedures and test results by primary care provider" with a Pearson correlation of 0.884 and again with "Friendliness and courtesy shown to you by your primary care provider" had a Pearson correlation of0.861. Table 12 shows all the Person correlations for the remaining dependent variable questions pertaining to Latinos.

Table 12. Latino Correlations

		1	2	3	4	5	6	7	8	9	10
1	Pearson	1.000	.512	.591	.725	.600	.496	.361	.319	.181	.777
	∑ (2-tailed)	.	.000	.000	.000	.000	.000	.000	.000	.049	.000
	N	123	111	123	123	119	121	121	121	119	108
2	Pearson	.512	1.000	.629	.704	.524	.424	.096	.075	.065	.544
	∑ (2-tailed)	.000	.	.000	.000	.000	.000	.309	.426	.497	.000
	N	111	115	111	111	113	115	115	115	113	98
3	Pearson	.591	.629	1.000	.831	.370	.349	.251	.183	.198	.630
	∑ (2-tailed)	.000	.000	.	.000	.000	.000	.006	.044	.031	.000
	N	123	111	123	123	119	121	121	121	119	108
4	Pearson	.725	.704	.831	1.000	.505	.494	.253	.196	.220	.803
	∑ (2-tailed)	.000	.000	.000	.	.000	.000	.005	.031	.016	.000
	N	123	111	123	123	119	121	121	121	119	108
5	Pearson	.600	.524	.370	.505	1.000	.485	.387	.378	.326	.619
	∑ (2-tailed)	.000	.000	.000	.000	.	.000	.000	.000	.000	.000
	N	119	113	119	119	123	123	123	123	121	107
6	Pearson	.496	.424	.349	.494	.485	1.000	.706	.647	.617	.543
	∑ (2-tailed)	.000	.000	.000	.000	.000	.	.000	.000	.000	.000
	N	121	115	121	121	123	125	125	125	123	108
7	Pearson	.361	.096	.251	.253	.387	.706	1.000	.884	.852	.386
	∑ (2-tailed)	.000	.309	.006	.005	.000	.000	.	.000	.000	.000
	N	121	115	121	121	123	125	125	125	123	108
8	Pearson	.319	.075	.183	.196	.378	.647	.884	1.000	.861	.362
	∑ (2-tailed)	.000	.426	.044	.031	.000	.000	.000	.	.000	.000
	N	121	115	121	121	123	125	125	125	123	108
9	Pearson	.181	.065	.198	.220	.326	.617	.852	.861	1.000	.335
	∑ (2-tailed)	.049	.497	.031	.016	.000	.000	.000	.000	.	.000
	N	119	113	119	119	121	123	123	123	123	106
10	Pearson	.777	.544	.630	.803	.619	.543	.386	.362	.335	1.000
	∑ (2-tailed)	.000	.000	.000	.000	.000	.000	.000	.000	.000	.
	N	108	98	108	108	107	108	108	108	106	108

** Correlation is significant at the 0.01 level (2-tailed). *Note:* Correlation is significant at the 0.05 level (2-tailed).

Analysis of the Whites' correlations for the dependent variable questions produced no significant correlation relative to the questions. There were some questions that indicated a correlation existed, but since the correlation was not strong, it could not be concluded that one question directly affected the score of another question without some other influence. Table 13 shows the Pearson correlations for Whites responses.

Table 13. Whites Correlations

		1	2	3	4	5	6	7	8	9	10
1	Pearson	1.000	.404	.399	.620	.622	.412	.588	.485	.348	.679
	∑ (2-tailed)	-	.000	.000	.000	.000	.000	.000	.000	.000	.000
	N	135	128	134	134	130	134	134	134	132	121
2	Pearson	.404	1.000	.350	.515	.622	.245	.247	.178	.220	.434
	∑ (2-tailed)	.000	-	.000	.000	.000	.005	.005	.043	.013	.000
	N	128	130	128	128	126	130	130	130	128	116
3	Pearson	.399	.350	1.000	.616	.356	.156	.341	.137	.193	.330
	∑ (2-tailed)	.000	.000	-	.000	.000	.073	.000	.113	.026	.000
	N	134	128	135	135	130	134	134	134	132	121
4	Pearson	.620	.515	.616	1.000	.560	.406	.459	.399	.502	.682
	∑ (2-tailed)	.000	.000	.000	-	.000	.000	.000	.000	.000	.000
	N	134	128	135	135	130	134	134	134	132	121
5	Pearson	.622	.622	.356	.560	1.000	.303	.384	.414	.402	.678
	∑ (2-tailed)	.000	.000	.000	.000	-	.000	.000	.000	.000	.000
	N	130	126	130	130	132	132	132	132	130	121
6	Pearson	.412	.245	.156	.406	.303	1.000	.737	.774	.696	.319
	∑ (2-tailed)	.000	.005	.073	.000	.000	-	.000	.000	.000	.000
	N	134	130	134	134	132	136	136	136	134	122
7	Pearson	.588	.247	.341	.459	.384	.737	1.000	.716	.734	.466
	∑ (2-tailed)	.000	.005	.000	.000	.000	.000	-	.000	.000	.000
	N	134	130	134	134	132	136	136	136	134	122
8	Pearson	.485	.178	.137	.399	.414	.774	.716	1.000	.639	.355
	∑ (2-tailed)	.000	.043	.113	.000	.000	.000	.000	-	.000	.000
	N	134	130	134	134	132	136	136	136	134	122
9	Pearson	.348	.220	.193	.502	.402	.696	.734	.639	1.000	.428
	∑ (2-tailed)	.000	.013	.026	.000	.000	.000	.000	.000	-	.000
	N	132	128	132	132	130	134	134	134	134	120
10	Pearson	.679	.434	.330	.682	.678	.319	.466	.355	.428	1.000
	∑ (2-tailed)	.000	.000	.000	.000	.000	.000	.000	.000	.000	-
	N	121	116	121	121	121	122	122	122	120	122

** Correlation is significant at the 0.01 level (2-tailed). *Note:* Correlation is significant at the 0.05 level (2-tailed).

Linear regression analysis is a valid determinant for producing evidence that a relation exists between an independent variable and a dependent variable. The use of standardized coefficients is needed when variables are measured in different units of measurement (even when variables have a natural metric, but especially when at least some of the independent variables are not measured in a natural metric). Standardized coefficients are useful for comparing the relative influence of different predictors or independent variables within an OLS or logistic regression model (Agresti 1996, p. 129; Agresti & Finlay 1996, pp. 349-343).

The regression analysis was used to determine the relationship between variables. In this study, this was the effect of the age of Latino and Whites compared with the question "Overall quality of care". Measuring the un-standardized coefficient will measure the relationship between the variable and independent variable in units of one. Using the standardized coefficient validated that the change in the un-standardized coefficient was a significance change for the dependent variable.

Regression

For the Latino model summary using the above-defined criteria, the results produce an *R* of .007, and R^2 of .000, an Adjusted R^2 of -.008, and a *SE* of the estimate of 16.6780 (see Table 14).

Table 14. Latino Model Summary

Model	*R*	R^2	Adjusted R^2	*SE* of the Estimate
1	.007	.000	-.008	16.6780

Note. a Predictors: (Constant), AGE.

When reviewing the data through a regression analysis for the Latino participants, using age as a constant compared with the "Overall quality of care" as the variable, a relationship between Latinos, age, and their perception of quality of care exist.

When reviewing Tables 15 and 16 with a *t*-score of -0.076 and significance level of 0.940, it is clear that there was not a strong relationship on how Latinos perceived the quality of healthcare they received as they aged.

Table 15. Latino ANOVA

Model		*SS*	*df*	*MS*	*f*	∑
1	Regression	1.595	1	1.595	.006	.940
	Residual	33656.942	121	278.157		
	Total	33658.537	122			

Note: a Predictors: (Constant), AGE. b Dependent Variable: Overall quality of care

Table 16. Latino Coefficients

		Un-standardized coefficients		Standardized coefficients	*t*	∑
Model		B	Std. Error	Beta		
1	(Constant)	90.105	6.397		14.086	.000
	AGE	-9.241E-03	.122	-.007	-.076	.940

Note: a Dependent Variable: Overall quality of care

Similarly, when reviewing the data through a regression analysis for the Whites using age as a constant compared with the "Overall quality of care" as the variable, a relationship between Whites, age and their perception of quality of care existed. For the White model summary using the defined criteria, the results produced an *R* of 0.140, and R^2 of .019, an Adjusted R^2 of -.012, and a *Standard Error* of the estimate of 15.0155.

When reviewing Tables 17 and 18, with a *t*-score of 1.626 and significance level of .106, a stronger relationship existed on how Whites perceive their quality of healthcare received as their age progresses.

Table 17. White ANOVA

Model		*SS*	*df*	*MS*	*f*	∑
1	Regression	596.326	1	596.326	2.645	.106
	Residual	29987.007	133	225.466		
	Total	30583.333	134			

Note. a Predictors: (Constant), AGE. b Dependent Variable: Overall quality of care

Table 18. White Coefficients

		Un-standardized coefficients		Standardized coefficients	*t*	∑
Model		B	Std. Error	Beta		
1	(Constant)	83.143	5.067		16.408	.000
	AGE	.158	.097	.140	1.626	.106

Note. a Dependent Variable: Overall quality of care

Latino Results

Figurers, one, two, three, four, five, six, seven, eight, nine, and ten display the linear regression relationship for Latinos within the age category for the participant and how they scored on the 10 variable independent questions on the survey. On each graph, the y-axis represents how the patient scored each question from the survey, while the x-axis represents the age of the patients. A positive linear relationship is indicated by the slope rising upward from left to right. A negative linear relationship is denoted by a negative slope, sloping downward from the left to the right. When the slope is close to zero (flat line), this indicates that there is no correlation. The observed scores and the linear relationship are represented on each graph. The observed scores ranged from 0 to 100.

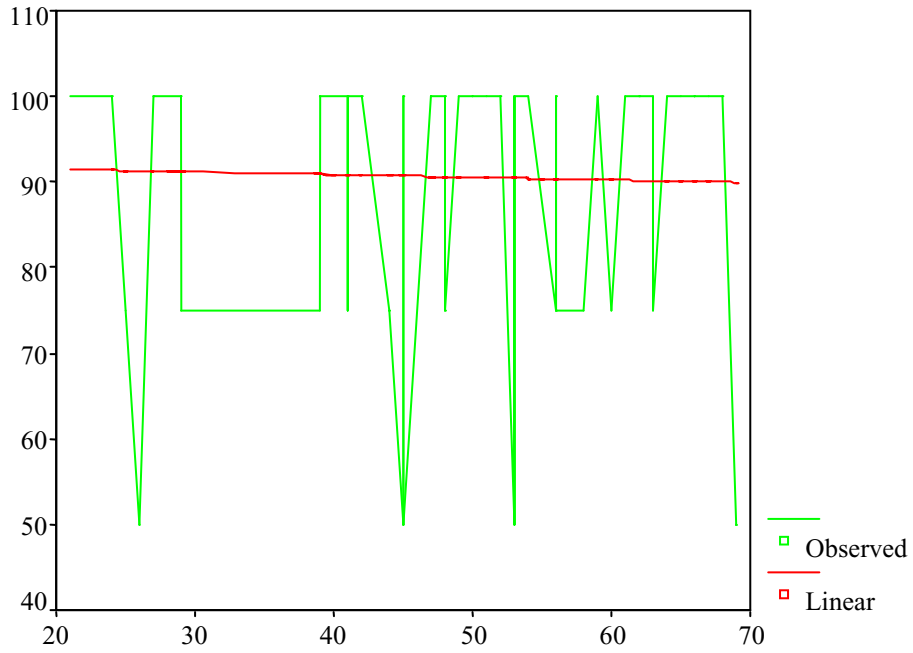


Figure 1: Overall quality of care for Latinos.

Figure 1 showing the overall quality of care for Latinos shows a slight negative slope indicating that as age increases within the Latino group, there is little difference in older persons' perceptions of overall quality of care. This was compared to those perceptions of a younger Latino. This can be seen statistically by looking at the R^2. (.001), *df.* (93), f (.05), $\sum f$ (.821), ß0 (92.10) and the ß1 value (-0.313).

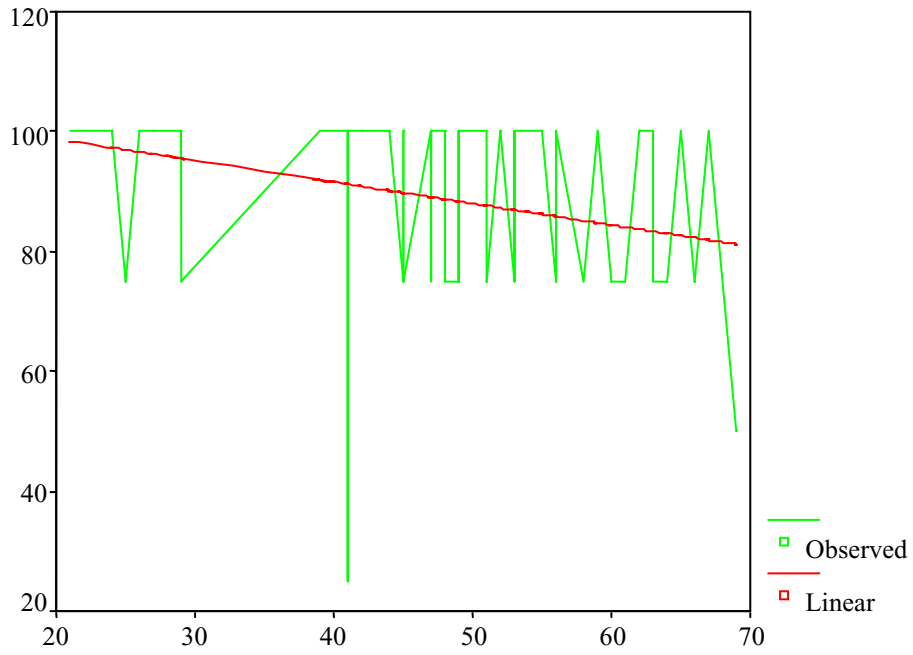


Figure 2: Friendliness and courtesy shown to you by the receptionist and other front desk staff

Figure 2 shows the results for the question relative to "Friendliness and courtesy shown to you by the receptionist and other front desk staff". The results showed a more prominent negative slope indicating that as age increases within the Latino group, there was little difference in perception of friendliness and courtesy shown by the receptionist and other front desk staff as compared to younger Latinos. This can be seen statistically by looking at the R^2 (.077), *df* (93), *f* (7.78), $\sum f$ (.006), ß0 (106.435) and the ß1 value (-.3576).

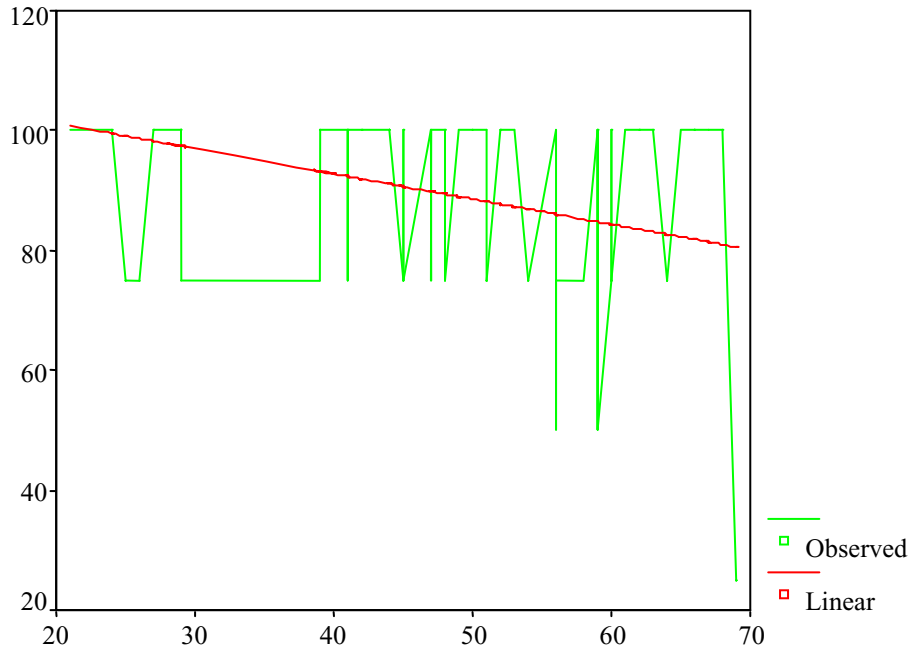


Figure 3: Friendliness and courtesy shown to you by nurses and other medical staff

Figure 3 shows that results yielded a slight negative slope indicating that as age increases within the Latino group, there is little difference in older persons' perceptions of friendliness and courtesy shown by nurses and other medical staff as compared to the perceptions younger Latinos. This can be seen statistically by looking at the R^2 (.074), *df* (93), *f* (7.39), $\sum f$ (.008), ß0 (109.637) and the ß1 value (-.4212).

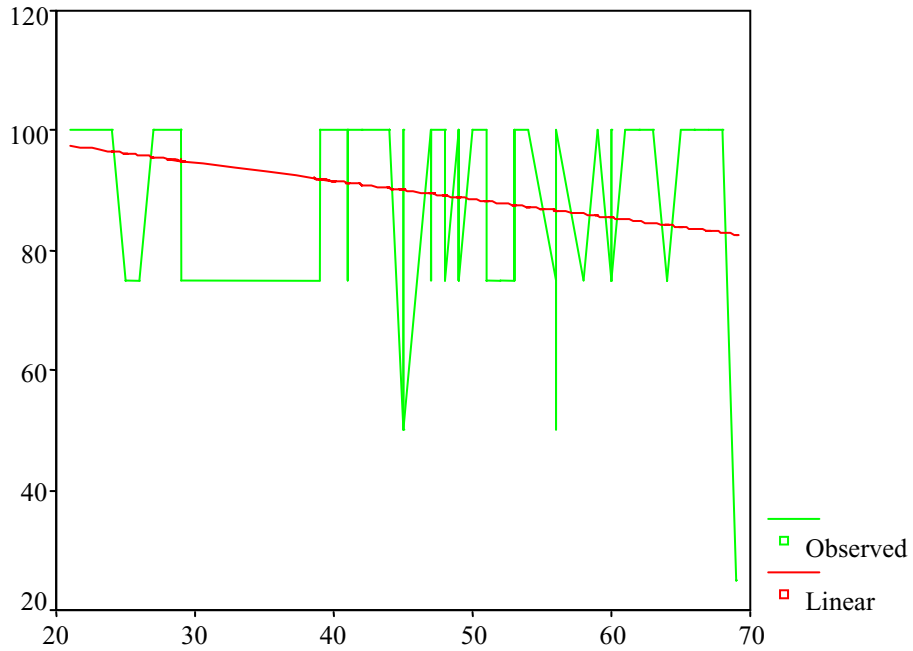


Figure 4: Training, skill, and experience of the nursing staff

Figure 4 shows a slight negative slope indicating that as age increases within the Latino group, there is little difference in perceptions of training, skill, and experience of the nursing staff as compared to the perceptions of younger Latinos. This can be seen statistically by looking at the R^2. (.038), df (93), f (3.66), $\sum f$ (.059), ß0 (103.907) and the ß1 value (-.3075).

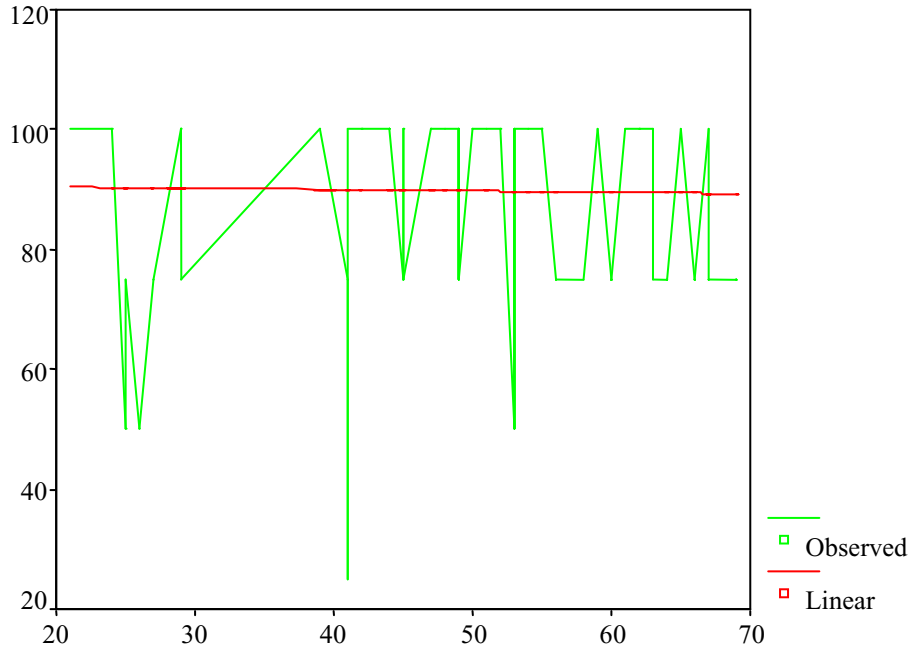


Figure 5: Explanations about prescribed medicines.

Figure 5 shows a relatively flat linear relationship indicating that as age increases within the Latino group, there is basically no difference in participant perceptions of explanations about prescribed medicines. This can be seen statistically by looking at the $R^{2.}$ (.000), *df* (93), *f* (.04), $\sum f$ (.0852), ß0 (90.88) and the ß1 value (-.0228).

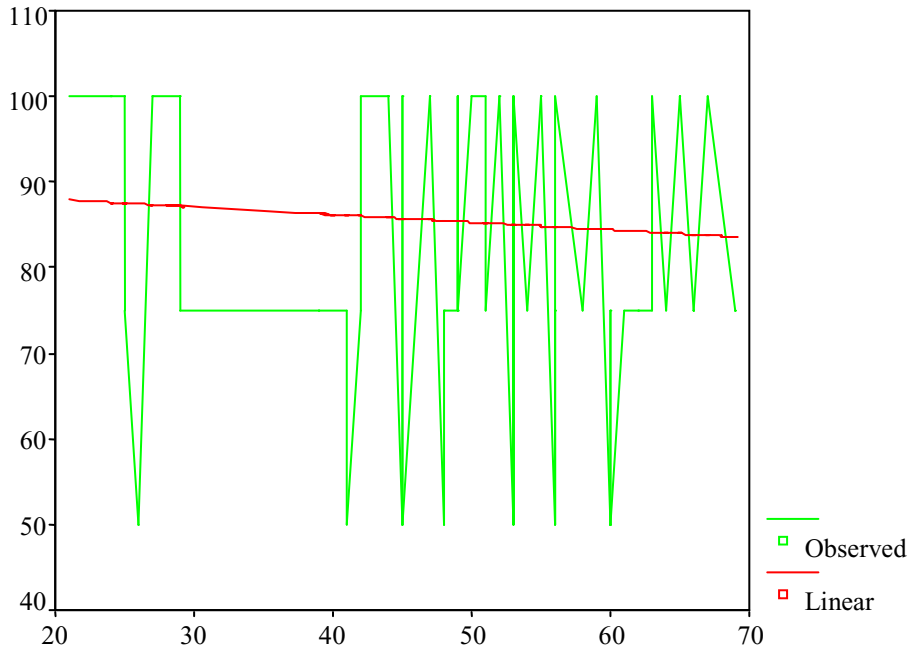


Figure 6: Ease of speaking with your primary care provider.

Figure 6 shows a slight negative slope indicating that as age increases within the Latino group, there was little difference in the perceptions of older persons relative to the ease of speaking with a primary care provider as compared to the perceptions of younger Latinos. This can be seen statistically by looking at the R^2. (.005), *df* (93), f (.43), $\sum f$ (.511), ß0 (89.76) and the ß1 value (-.0893).

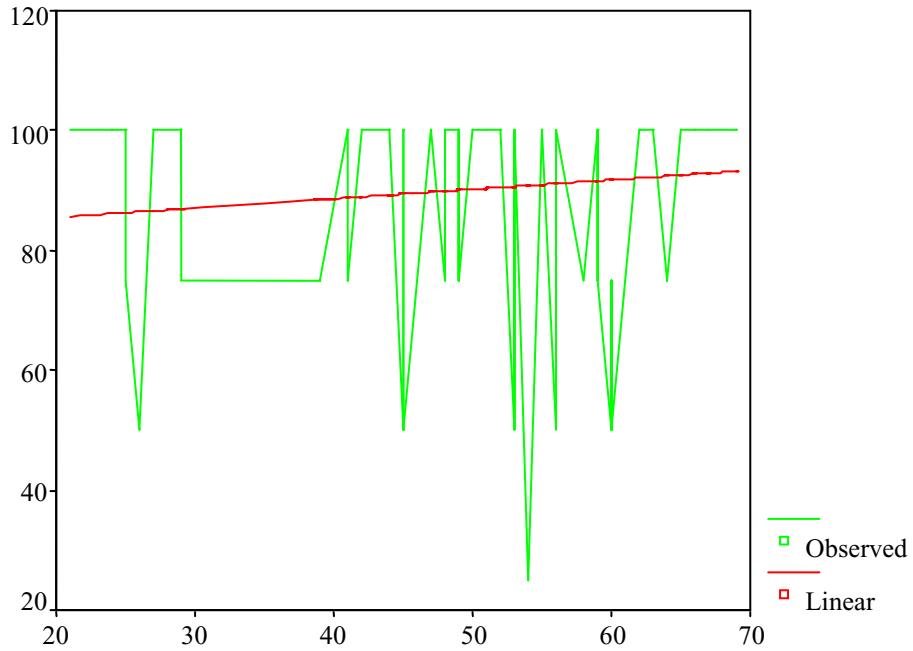


Figure 7: Explanations of medical procedures and test results by primary care provider.

Figure 7 shows a slight positive slope indicating that as age increases within the Latino group, there is an increase in the perceptions by older persons of explanations of medical procedures and test results by primary care provider as compared to the perceptions of younger Latinos. This can be seen statistically by looking at the R^2 (.012), df (93), f (.43), $\sum f$ (1.09), ß0 (82.37) and the ß1 value (-.1566). This could be correlated to the number of the incidences of tests and procedures given as one ages.

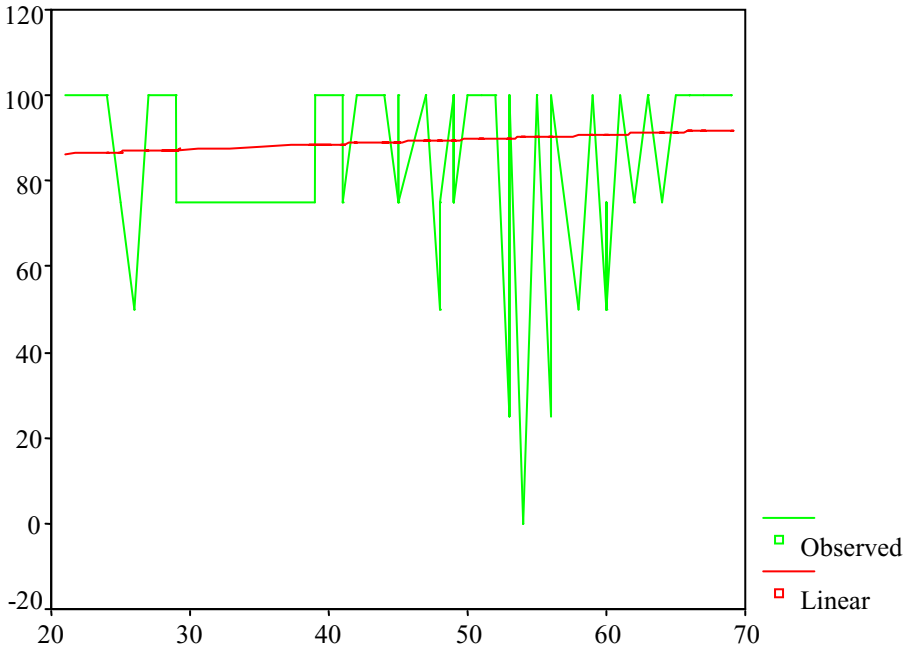


Figure 8: How well your care meets your needs.

Figure 8 shows a positive slope indicating that as age increases within the Latino group, there is a positive correlation indicating a difference in perceptions of older Latinos in how well their care meets their needs as compared to the perceptions of younger Latinos. This can be seen statistically by looking at the R^2 (.005), *df.* (93), *f* (.45), $\sum f$ (.504), ß0 (83.97) and the ß1 value (-.1144).

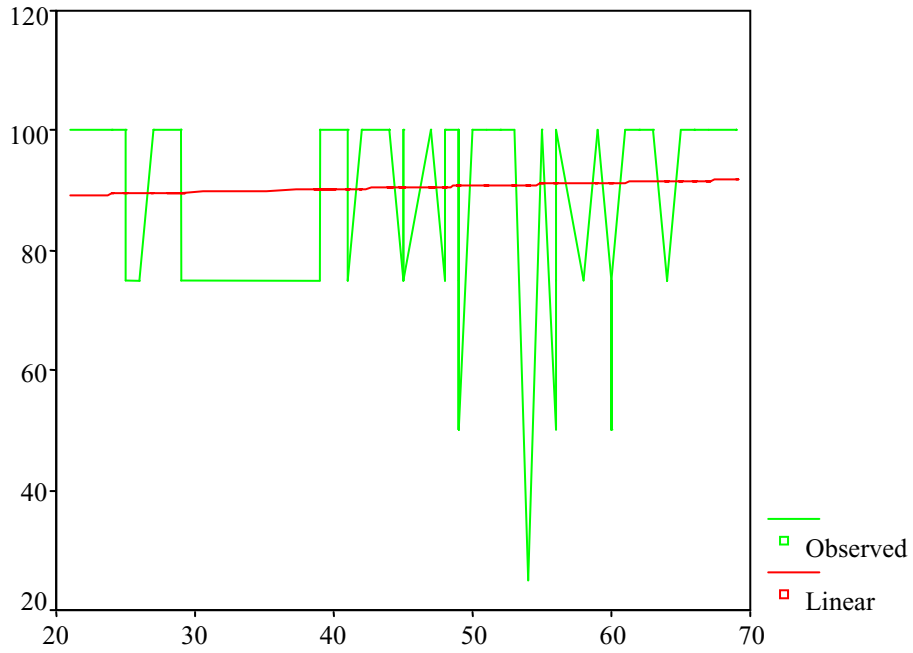


Figure 9: Friendliness and courtesy shown to you by your primary care provider

Figure 9 shows a positive slope from the data results indicating that as age increases within the Latino group, there is positive correlation in the difference in the perceptions by older persons of friendliness and courtesy shown by their primary care provider as compared to the perceptions of younger Latinos. This can be seen statistically by looking at the R^2 (.001), df (93), f (.12), $\sum f$ (.728), ß0 (88.10) and the ß1 value (-.0534).

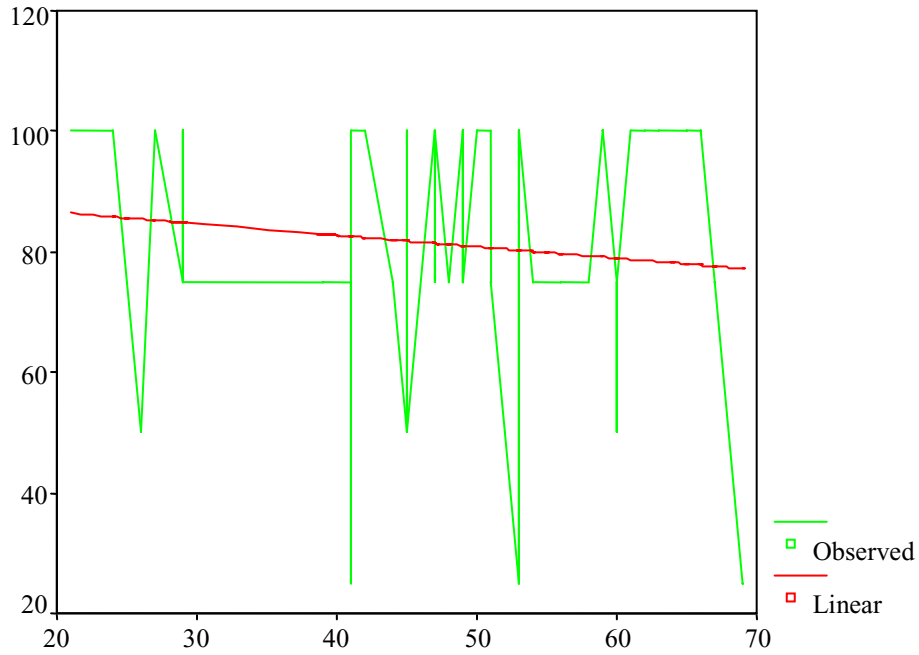


Figure 10: Your primary care provider's concern for your mental health

Figure 10 shows a positive slope indicating that as age increases within the Latino group, there is a negative correlation in the perceptions of older persons relative to the primary care provider's concern for their mental health as compared to the perceptions of younger Latinos for the same question. This can be seen statistically by looking at the R^2 (.012), df (93), f (1.12), $\sum f$ (.292), ß0 (90.40) and the ß1 value (-.1909). It is important to note that the variation in scores for this question had more observed incidences on a wider scale then the other questions.

The following questions: (a) "Friendliness and courtesy shown to you by the receptionist and other front desk staff", (b) "Friendliness and courtesy shown to you by nurses and other medical staff", (c) "Your primary care provider's concern for your mental health", (d) "Ease of speaking with your primary care provider", and (e) "Training, skill, and experience of the nursing staff" all had a negative slope indicating

that as the age group matures their experience or perception of quality in these areas decreased. Unfortunately as with any of the questions, these five questions are very important in dealing with the questions of how participants feel they are being treated, communicated with, and lastly, how seriously their concerns are being addressed.

Whites Results

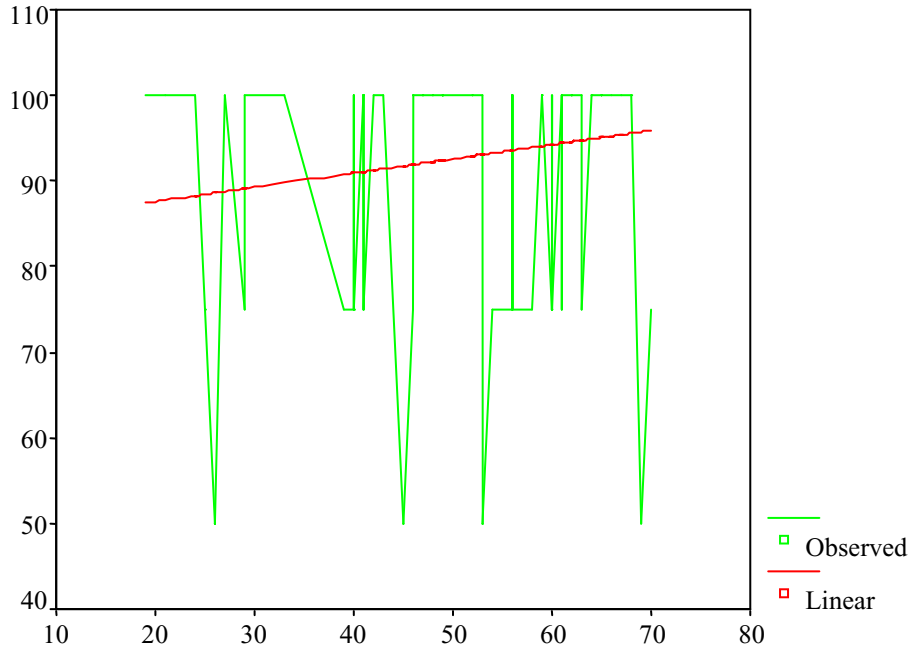


Figure 11: Overall quality of care of Whites

Figure 11 shows a strong slope indicating that as age increases within the White group, there is a positive difference in the perceptions older persons relative to overall quality of care" as compared to the perceptions of younger Whites. This can be seen statistically by looking at the R^2 (.025), *df* (109), *f* (2.74), $\sum f$ (.101), ß0 (84.26) and the ß1 value (-.1662).

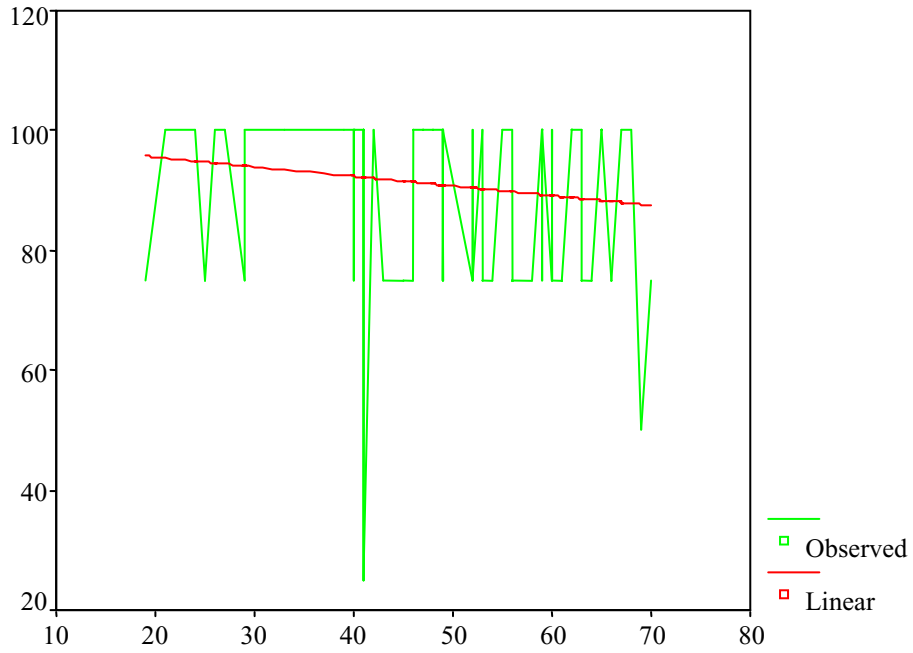


Figure 12. Friendliness and courtesy shown to you by the receptionist and other front desk staff.

Figure 12 shows a slight negative slope indicating that as age increases within the White group, there is a negative difference in the perceptions of older persons relative to friendliness and courtesy shown to them by the receptionist and other front desk staff compared to the perceptions of younger Whites. This was also the scenario within the Latino group, and was even more prominent within the Latino group. The results for White group can be seen statistically by looking at the R^2 (.021), *df* (109), *f* (2.37), $\sum f$ (.127), ß0 (98.76) and the ß1 value (-.1601).

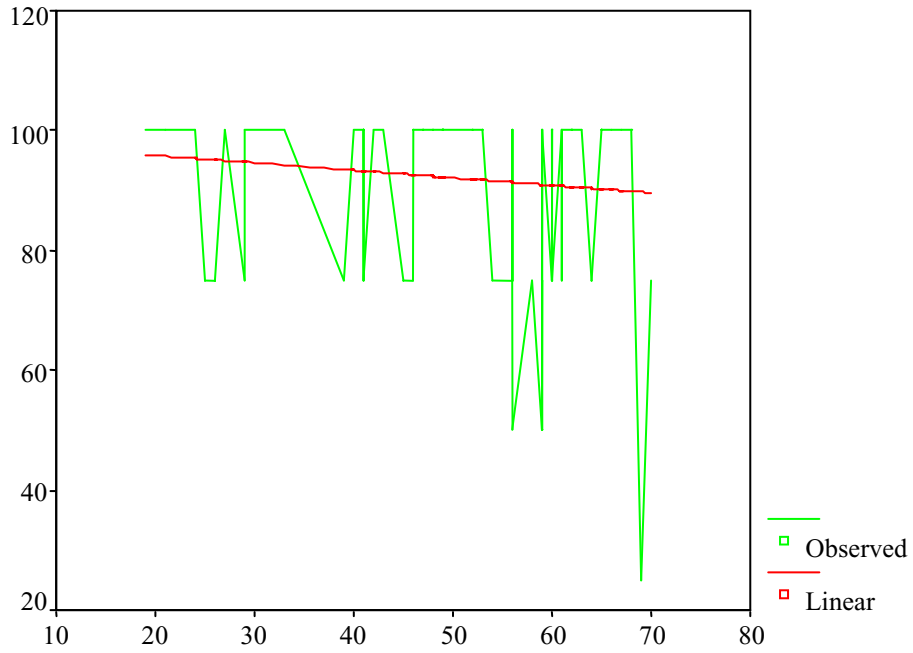


Figure 13: Friendliness and courtesy shown to you by nurses and other medical staff

Figure 13 shows a slight negative slope indicating that as age increases within the White group, there is a decline in the perceptions of older persons relative to the friendliness and courtesy shown to them by nurses and other medical staff as compared to the perceptions of younger Whites. This was also the scenario within the Latino group, as can be seen statistically by looking at the R^2 (.013), df (109), f (1.42), $\sum f$ (.237), ß0 (98.34) and the ß1 value (-.1246).

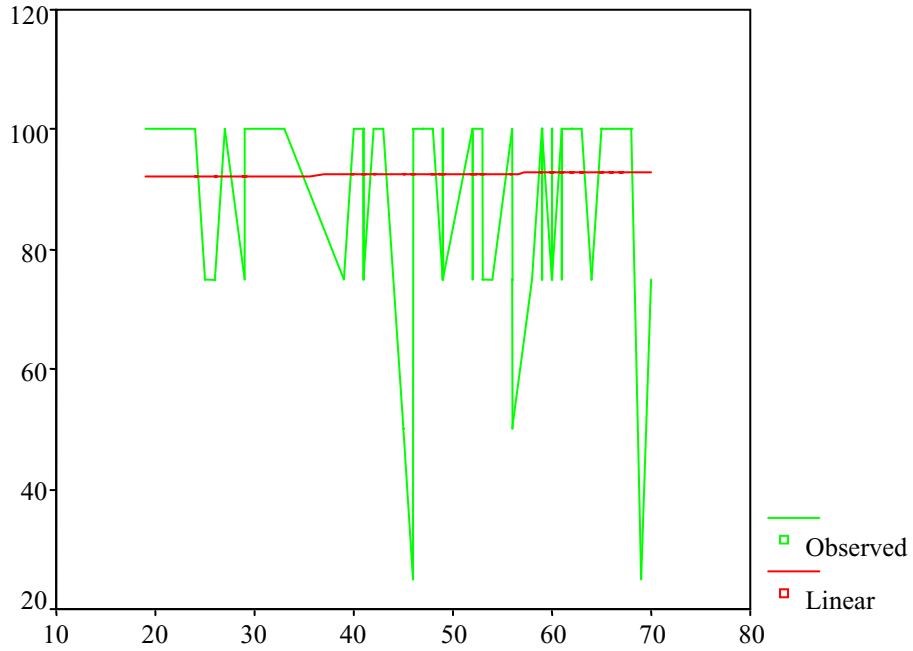


Figure 14: Training, skill, and experience of the nursing staff

Figure 14 shows a fairly straight line indicating that as age increases within the White group, there is no difference in the perceptions of older persons relative to training, skill, and experience of the nursing staff as compared to the perceptions of younger Whites. This can be seen statistically by looking at the R^2 (.000), df (109), f (.02), $\sum f$ (.878), ß0 (91.76) and the ß1 value (-.0160).

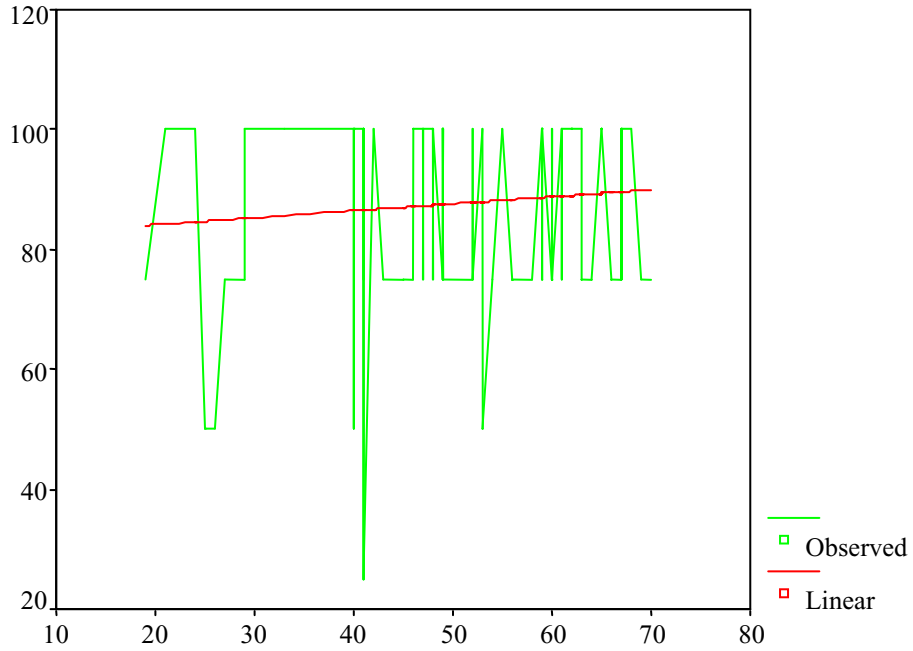


Figure 15: Explanations about prescribed medicines

Figure 15 shows a relatively strong slope indicating that as age increases within the White group, there is a positive difference in the perceptions of older persons relative to explanations about prescribed medicines as compared with those perceptions of younger Whites. This can be seen statistically by looking at the R^2 (.009), df (109), f (.99), $\sum f$ (.323), ß0 (81.80) and the ß1 value (-.1163).

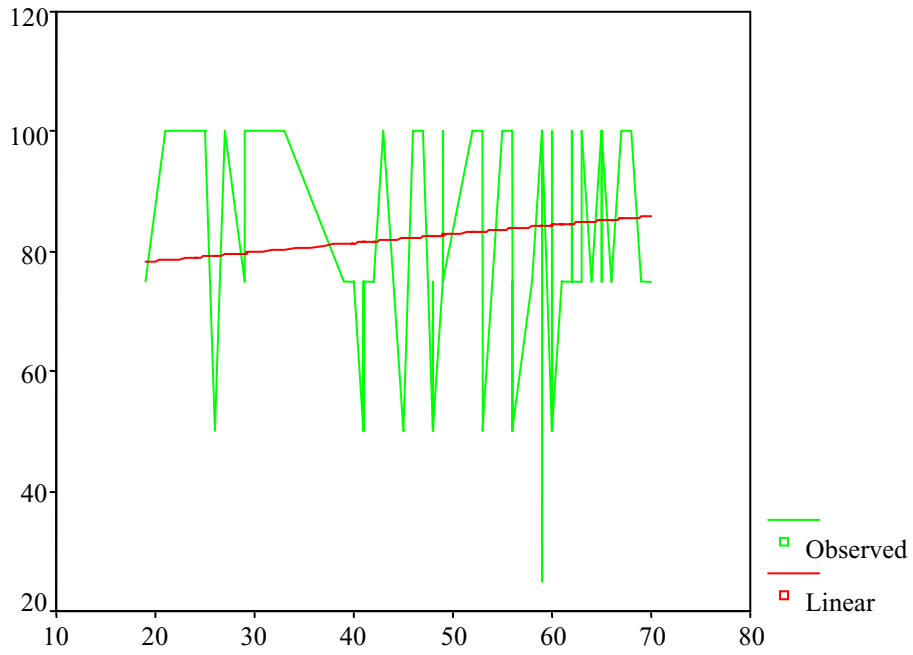


Figure 16. Ease of speaking with your primary care provider.

Figure 16 shows a positive slope indicating that as age increases among Whites, there is positive difference in perceptions of older Whites relative to the ease of speaking with their primary care provider as compared to the perceptions of younger Whites. This can be seen statistically by looking at the R^2. (.014), *df* (109), *f* (1.52), ∑*f* (.220), ß0 (75.38) and the ß0 value (-.1500). The relationship shown here was not as strong as it would have been expected in this group, but it still shows a valuable comparison with the Latino group.

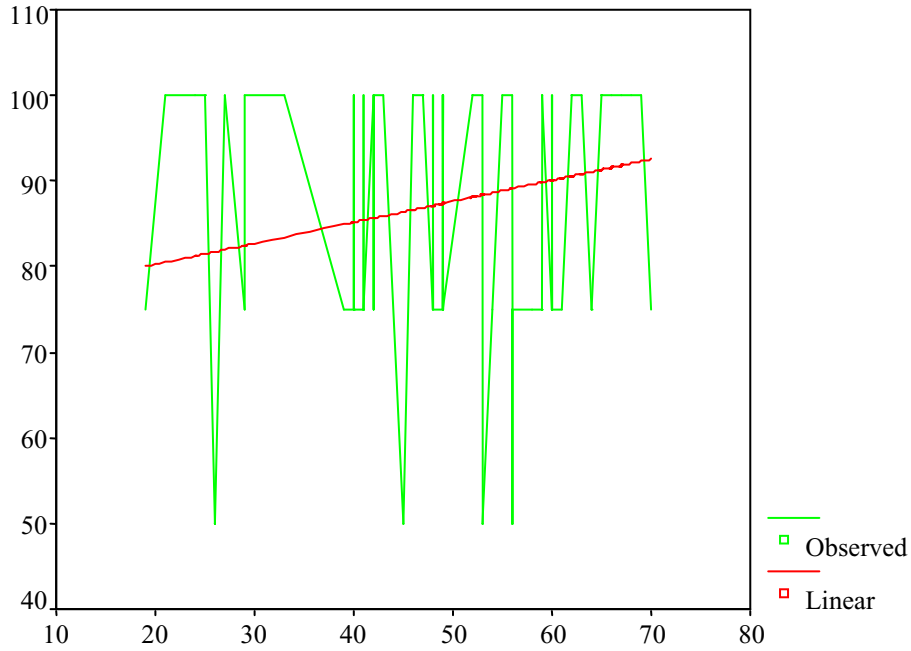


Figure 17. Explanations of medical procedures and test results by primary care provider.

Figure 17 shows a very positive slope indicating that as age increases within the White race, there is large difference in the perceptions of the older Whites relative to the explanations of medical procedures and test results from primary care providers as compared to the perceptions of younger Whites. This can be seen statistically by looking at the R^2 (.050), *df* (109), *f* (5.76), ∑*f* (.018), ß0 (75.33) and the **ß**1 value (-.2458).

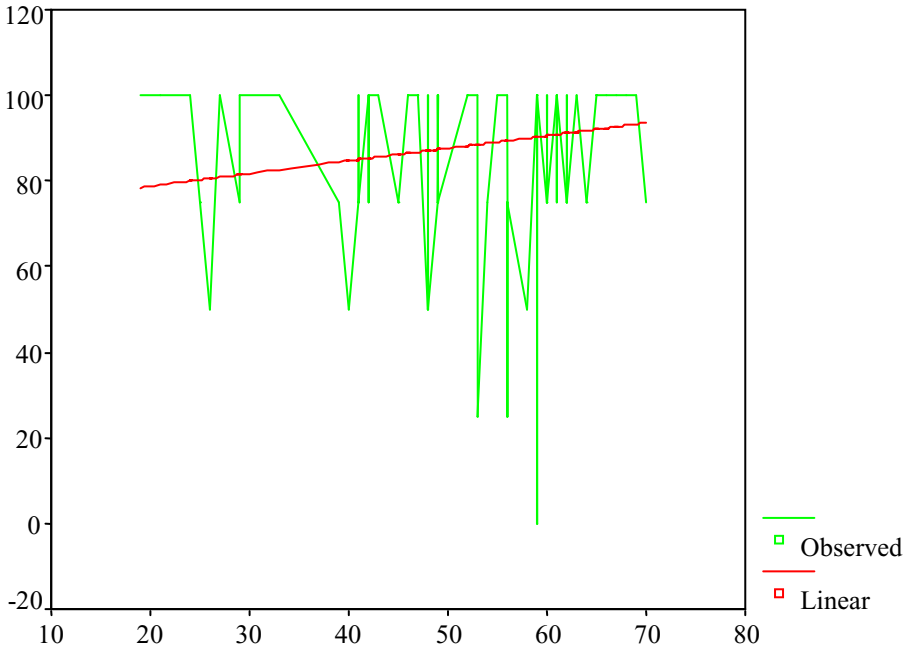


Figure 18: How well your care meets your needs

Figure 18 shows another positive slope indicating that as age increases within the White group, there is a significant positive difference in the perceptions of older White participants relative to how their care met their needs as compared to the perceptions of younger Whites. This can be seen statistically by looking at the R^2 (.060), *df* (109), *f* (6.95), $\sum f$ (.010), ß0 (72.91) and the ß1 value (-.2943).

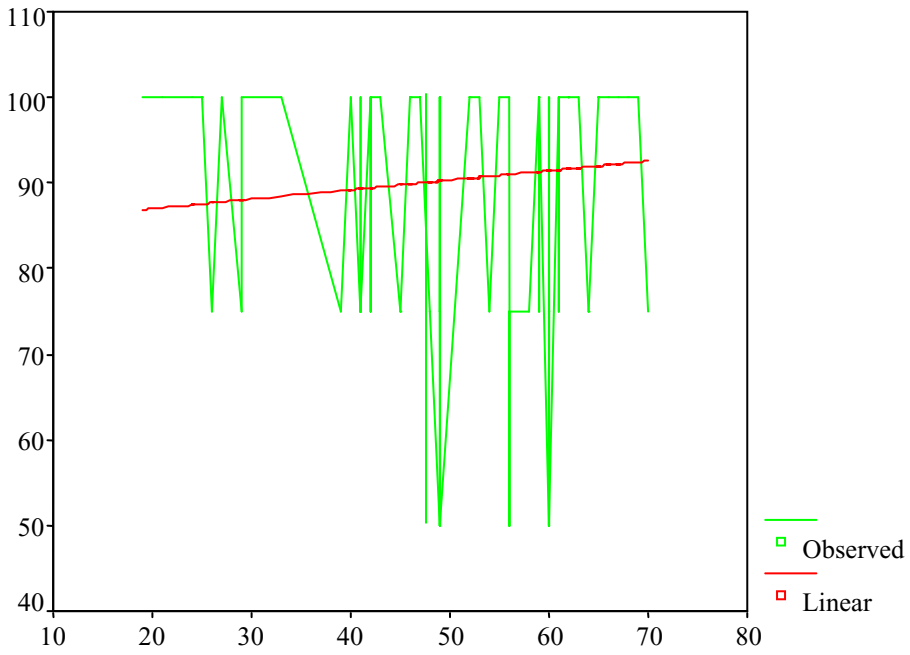


Figure 19: Friendliness and courtesy shown to you by your primary care provider.

Figure 19 shows a slight negative slope indicating that as age increases within the White group, there is a positive difference in the perceptions of the older peoples relative to friendliness and courtesy shown to them by their primary care provider as compared to those perceptions of younger Whites. This can be seen statistically by looking at the R^2 (.010), df (109), f (1.11), $\sum f$ (.294), ß0 (84.77) and the ß1 value (-.1110)

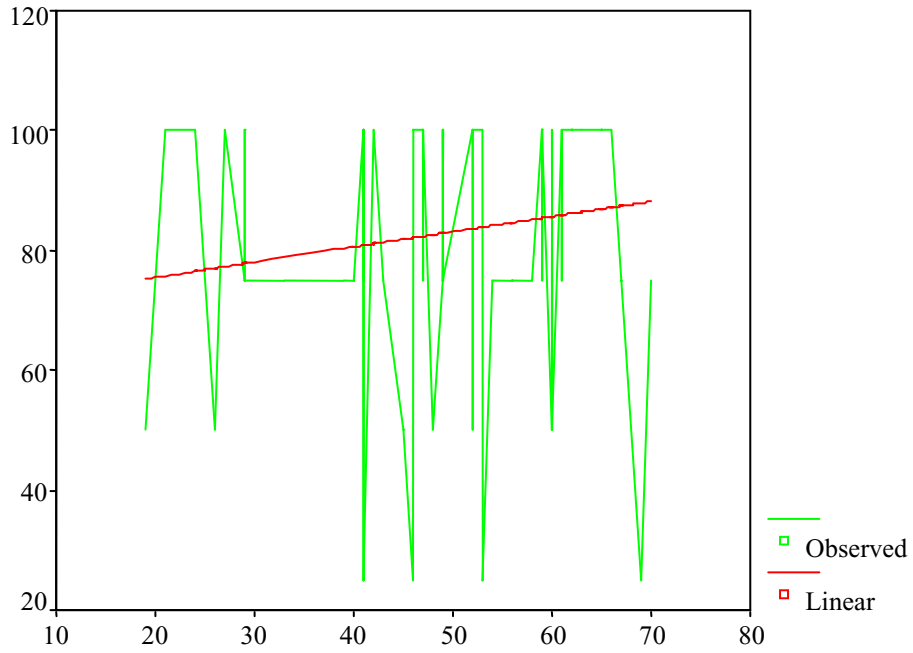


Figure 20: Your primary care provider's concern for your mental health

Figure 20 shows a positive slope indicating that as age increases among Whites, there is a difference in the perceptions of older Whites' relative to their primary care provider's concern for their mental health as compared to the perceptions of younger Whites. This is seen statistically by looking at the R^2. (.029), *df* (109), *f* (3.28), ∑*f* (.073), ß0 (70.47) and the ß1 value (-.2530).

When compared to the Latino group, the results for the White group shows stronger positive relationships (steeper slopes). This indicated that as the Whites age, their perception of the quality of care received is higher then the same perception by the Latinos. Two questions showed a negative relationship. The two questions were "Friendliness and courtesy shown to you by nurses and other medical staff" and "Friendliness and courtesy shown to you by the receptionist and other front desk staff"

These two questions had negative relationships for the Latino group as well, but the slope for the Latino's group questions was much steeper, indicating that their perception on these two questions resulted from more negative experience than those of the White participants. In all the cases that showed a positive correlation, it was evident as a person grows older more emphasis is placed on the quality of care received. From the data, this researcher indicated that having a personal relationships with healthcare providers, especially among the Latinos, was important to perception of care.

Qualitative Comments

The following comments were selected to link the statistical data to an actual person. Without comments such as these within healthcare setting, it would be difficult to fully understand why patients were dissatisfied or satisfied with their service.

1. (#114, Latino, Female, 60):"Dr. made sure I understood my condition and what to expect."
2. Latino participant (#131) who is a 69-year-old man stated, "There were times I thought the nurses and other staff were rather indifferent to my medical problems".
3. (#70, White, Male, 59): "Your staff are very concern and caring people".
4. White male participant (#34) age 41 stated, "The staff there treated me with the - utmost respect - they were really nice."
5. (#5, Latino, Male, 59): "They are very good, they talk to my family very good."

CHAPTER 5. DISCUSSION, IMPLICATIONS, RECOMMENDATIONS

This academic study was conducted with the primary goal of answering the following research questions:

1. How does the Latino population perceive the emotional care they receive using the U.S. healthcare system?
2. What emotional elements to healthcare do members of the Latino population lack when they use the U.S. healthcare system?
3. Do healthcare institutions incur negative social repercussions for not addressing the emotional needs of the Latino population?

Conclusions to each research question have been based on evidence from the literature review, tabulation of the questions from completed survey and a simple content analysis of the written responses that correlated to the questions. Conclusions to the findings of each research question are addressed and coupled with recommendations and the feasibility of further research and an overall summary.

A report on racial and ethnic disparities in healthcare by the officials of the Institute of Medicine (IOM) documented that minorities in America, as compared to the White American counterparts, receive lower quality of care across a wide range of medical conditions, resulting in poorer health outcomes and lower health statuses (American Institutes for Research, 2005). In the research conducted by the Institute of Medicine, researchers showed that language barriers could cause poor, abbreviated, or erroneous communication, poor decision making on the part of both providers and patients or ethical compromises (Smedley, Stith, & Nelson, 2003).

Research Question 1

How does the Latino population perceive the emotional care they receive using the American healthcare system?

Among the Latino participants in this study, individual patient perceptions revealed a wide range of emotions and opinions regarding the quality of care received at traditional American healthcare facilities. From the results, this researcher proved the hypotheses. The results at times were convoluted based on the emotions of the participants.

There were several themes that were discovered which this researcher considered significant to the study in terms of the participants' perceptions of healthcare in the United States. These themes were:

1. There is a lack of knowledge regarding the healthcare options available to the Latino population.
2. Generally, the Latino population prefers to receive medical services within their enclave.
3. Although there is a genuine concern by the Latino population about the emotional treatment received from a cultural standpoint, the White population also questions the quality of the emotional treatment received interactions with healthcare providers.

Implications of Findings for Research Question 1

Based on the results of the survey questionnaires, this researcher confirmed what was indicated in the literature review. From a patient perspective, these results are cause for great concern for the medical community. When members of the Latino population sought medical treatment at non-Latino healthcare facilities, their perception of their care was that it was less than could be expected had they received treatment within their

enclave. Frequently, there was a lack of understanding between the patient and the healthcare provider, relative to culture, which is an understanding that goes beyond what medical science can provide,

Based on the large percentage of the Latinos who felt less than satisfied with the interaction they received with the healthcare staff during their visit, it is evident that there is a gap in the healthcare system. The implications of this gap are of great concern. Based on the literature review, it is known that there are three places that members of the Latino population will generally seek healthcare .These places are: (a) within their enclave, (b) outside their enclave, or (c) from an alternative medical source that could include folk medicine. alternatively, unlicensed physicians.

From the data, this researcher also revealed two interesting aspects about the members of the Latino population in U. S. relative to healthcare. First, depending on the ailment or condition, Latinos will frequently forgo receiving the emotional care that is of highest importance to them in exchange for advanced medical treatments that can treat or cure conditions that traditional folk medicine may not be able to treat. Second, there are a large number of satisfied Latino patients. This fact was evident from both the qualitative and quantitative data obtained.

In order to understand why this perception relative to care exists among members of the Latino population, it would be necessary to survey the healthcare staff as well to determine why certain patients feel this difference in perceived care. One common element that has been mentioned previously in other academic studies is the amount of time that the healthcare staff spends with the patient. This element could identify a

correlation to negative patient experiences or could be a possible reason for the negative experiences.

Often due to the volume of patients seen regularly, healthcare providers feel the effects of the strict time constraints placed on them. In order for the healthcare staff to care for all their patients, less time is spent with each individual patient. This situation could easily give the perception to the patient that the healthcare staff is not genuinely concerned about their emotional and spiritual well-being.

This perception of inadequate time being spent with the patient is often exacerbated by the patient. Frequently, patients have felt that the amount of time the healthcare provider spent with them was not adequate despite the fact that the healthcare provider felt that the amount of time spent with the patient was sufficient to develop a treatment plan for the patient. Members of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) have acknowledged that patients' "psychosocial, spiritual, and cultural values affect how they respond to their care" (p. RI-8) and has addressed spirituality and emotional well-being as aspects of patient care (Clark, Drain & Malone, 2003).

Research Question 2

What emotional elements to healthcare do members of the Latino population lack when they use the U.S. healthcare system?

The biggest trend that this researcher revealed with the data was that healthcare providers are not spending enough time (extensive communication) with the patients. The patients interpret this situation to mean that the healthcare provider lacks interest in the

patient. This situation was not to be interpreted that the quality of medical treatment given to the patient population participating in this study was of poor quality, but the emotional care was less than desirable.

When a patient questions a physician's methods of practice, the patient will often doubt the physician's abilities. Several different outcomes can arise from this situation within the medical field. First, the patient may ignore the physician's advice or treatment protocol and choose to go to another physician. Second, the patient may elect to just stop seeking treatment, and third, the patient may choose alternative methods of care. The last two scenarios put the health status of the individual at risk.

Further analysis must occur before a positive assumption can be made that the language barrier is problematic for both the patient and the clinical staff. With growing concerns about racial, ethnic and language disparities in health issues and healthcare and the need for healthcare professionals to accommodate increasingly diverse patient populations, language access services (LAS) have become more and more a matter of national importance (Office of Minority Health, DHHS, 2003). According to the American Institutes for Research, the need for LAS has become increasingly important given the continued growth in language diversity within the United (Office of Minority Health, DHHS, 2003).

The number of individuals who speak a language other than English in the home has risen from 31.8 million in 1990 to 47 million in 2000 (U.S. Census Bureau, 2005). In addition, the number of individuals who speak English poorly increased from 14 million in 1990 to 21.4 million in 2000, reflecting a 53%t rise in the number of Limited English

Proficiency (LEP) individuals in the United States over the 10-year period (U.S. Census Bureau).

The implementation of appropriate LAS can increases LEP patient access to healthcare services. For example, language barriers have led to fewer physician visits and reduced receipt of preventive services among LEP patients, even after considering factors such as literacy, health status, health insurance, regular source of care and economic indicators (Yeo, 2004).

Latino children have experienced adverse health consequences such as poor medical diagnoses and inappropriate prescriptions that are a result of the failure of medical staff to speak Spanish (Flores, 1998). Spanish-speaking patients who needed an interpreter during care but did not get one were significantly more likely to report a poor or flawed understanding of their discharge diagnoses and treatment plans than those who used an interpreter or were proficient in English (Flores, 1998).

Analysis of the survey data revealed that several of the 10 questions were highly correlated with emphasis on emotional and spiritual factors as well as an emphasis on the quality of the interaction between the patients and the medical staff. The strong correlation between the survey questions regarding "Explanations of medical procedures and test results by primary care provider" and "How well your care meets your needs" suggested that some component of the care given failed to meet the patient's expectations (Clark et al., 2003).

Implications of Findings for Research Question 2

The data indicated that there are two issues at hand, which may in fact be correlated: the amount of time the physician spends with the patient and the apparent language barriers that are present between the physician and the patient. The amount of time a physician spends with the patient can determine how a patient perceives the care he or she has received. With the current trend of physicians spending less time with each patient due to patient volume, the patient may at times feel the visit was rushed. This can also make the patient feel or believe that the physician does not care about his or her needs.

When a patient communicates with their physician, frequently the patient may not know the specific questions to ask about his or her health or treatment programs. There often exists an assumption that the physician will communicate all information and address all concerns and treatment protocols without the patient having to prompt the physician. With the decreased amount of time a physician spends with the patient, the physician may address only those concerns and questions brought up by the patient.

It is possible that the communication between the physician and the patient is less than satisfying for both parties involved. The physician may make the assumption that the patient understands completely what the physician is trying to communicate about the patient's health. The physician may feel frustrated based on the inability of both parties to effectively communicate and as a result, discourage any dialogue about the patient's condition

Patients who do not understand their medical condition rely on trained medical professionals to help them understand their condition and any appropriate medical

treatment. If this source of information is lost, Latino patients feel more isolated as compared to their White counterparts. Lacking the capabilities to communicate in multiple languages is a detriment to the medical practice.

When a physician cannot communicate effectively about a disease and treatment, or when a patient cannot describe an illness or symptom, it can be difficult to build the trust and rapport needed in the physician-patient relationship. Even more importantly, the patient and physician will lack the basic connection needed to result in appropriate care. This; appropriate communication is necessary for ensuring quality and safety in healthcare (Joint Commission on Accreditation of Healthcare Organizations, 2005).

Research Question 3

Do healthcare institutions incur negative social repercussions for not addressing the emotional needs of the Latino populations?

For example, Shelton (2000) observed:

> Patients need to feel that their circumstances and feelings are appreciated and understood by the health care team member without criticism or judgment….If patients feel that the attention they receive is genuinely caring and tailored to meet their needs, it is far more likely that they will develop trust and confidence in the organization.

Unmet patient emotional needs have been associated with patient' desires to discontinue patronizing a specific hospital as patients can become confused about the services provided (Kent, 1996). Poor interpersonal care increases malpractice risk, (Hickson, 1994), and good interpersonal care reduces it (Levinson, 1994). Testimonials from persons involved in medical error lawsuits have suggested that lawsuits are filed not just for financial reasons but because people feel abandoned, aggrieved, and better

physician-patient communication and acknowledgement might alleviate this (Levine, 2002).

Although medical errors are most often the fault of the healthcare practitioners, there are instances where patients will impose constraints on the healthcare practitioner, which will ultimately affect the treatment plan for the individual. This in turn will compromise the patients' own health.

Implications of Findings for Research Question 3

A breakdown in communication creates a *snowball* effect that can harm the patient and the healthcare institution. The physician has a responsibility to inform the patient of the best treatment plan for his or her health. The physician also has a responsibility to inform the patient when there is an error, even when the error is due to communication.

There is a growing movement within the U.S. healthcare system that encourages hospital staff and physicians to begin apologizing when they make a mistake (When you're sorry, say so, 2005). The days of the solo practitioner and unfettered physician autonomy, when cost and quality were guiding principles, not causes of controversy, and when a physician's ethical path was lit and easy to follow are long over (Seward, 1997). For physicians, patients and ethicists alike, the terrain is treacherous, because the boundaries between the economics and ethics of care are breaking down in ways that have never been experienced (Seward). In many cases, the physician may feel torn between ethical morals in his or her dealings with the patient, the insurance company, and

an employer. Frequently, the physician will act under hospital and insurer protocols knowing that it is not the best treatment plan for the patient.

This demonstrates two problems. First, is the problem of the lack of support from the hospital administrators for physicians who are making the right ethical choice. Second, physicians are letting themselves be controlled in a way that puts patients at risk, when the physician knows that the best care is not being given. Not only is this a medical error, it is more importantly an ethical misjudgment. Physicians have a responsibility to provide moral and ethical treatment to patients. It is this ethical and moral value, the application of which instills trust and confidence that enables patients to allow a complete stranger treat them. Yet more importantly, patients should feel comfortable that the physician is going to provide them the best care. Without these values in the medical system, the system itself will disintegrate. When physicians let the hospitals' executives (employers) and insurance companies' administrators dictate treatment protocols, this is a blatant medical error. The patient is not receiving the best care and the physician is not acting in the patient's best interest.

Many hospitals' staffs include operation engineering or clinical quality departments. The functions of these departments' staffs are to closely examine and monitor processes or procedures that are affecting patient care, and the efficiency of such processes and procedures. If there is a high rate of medical errors taking place as a result of errors by healthcare staff, it is the responsibility of healthcare personnel to determine why, when and how of these errors occurred and suggest better methods to eliminate the errors. Most medication errors stem from improper dosage, allergic reactions, and interactions with other medications, which can occur when a language barrier presents

itself. The processes used by a hospital's staff can greatly determine how well patient care is received. There is a lesson to be learned from communication, clinical responsibility, and teamwork.

Suggestions for Further Study

From the findings of this academic study, this researcher did reinforce findings from previous studies of patient satisfaction surveys conducted throughout medical facilities and healthcare organizations in the United States. Although a majority of the researchers focused on the overall patient experience, there was enough data correlated to the overall scores to indicate that emotional care among Latinos and presumably among members other ethnic groups, does influence the satisfaction scores. Further research that is directly related to the Latino patient experience would prove to be very valuable to members of the healthcare industry. With the rapid growth of Latino populations and Latinos becoming prominent users of the U. S. healthcare system, Latinos not only contributes to the financial success of healthcare organizations, but they also influence the care they receive.

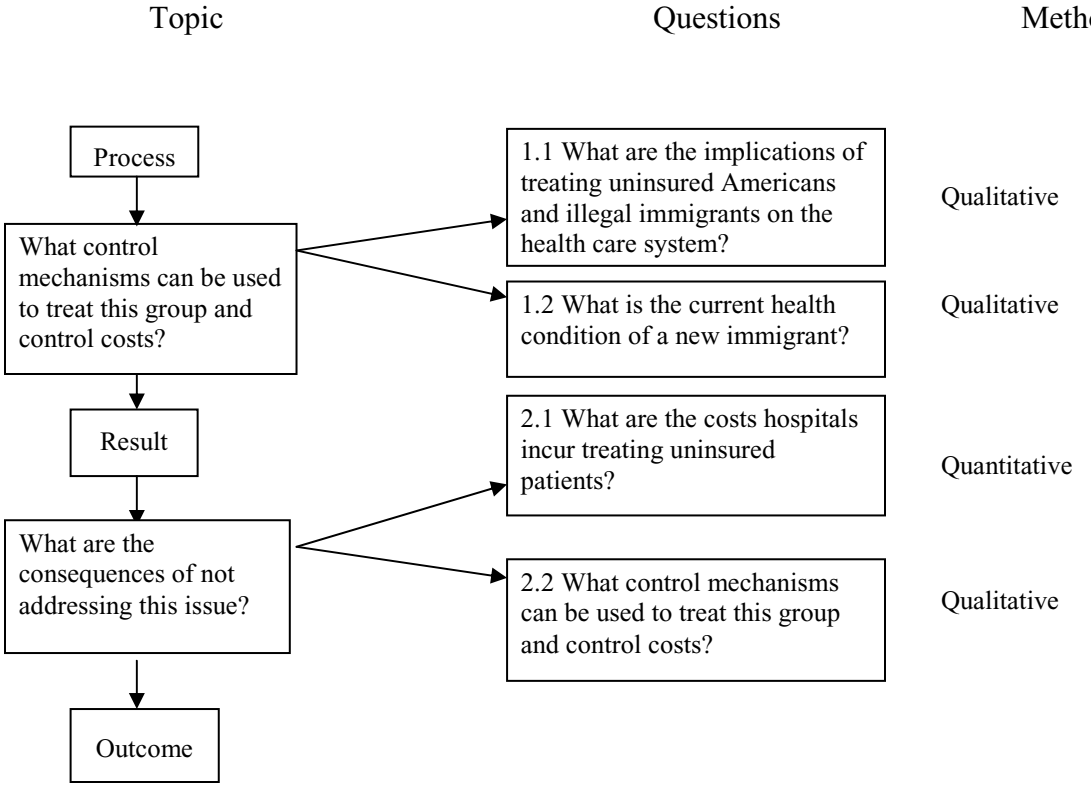
An important aspect to consider when researchers examine the possibility of further research on this topic is to consider the location for future studies. Studies conducted in areas that have a large population of Latinos but a small the number of Latino healthcare providers will have different results when compared to areas with a higher number of Latino healthcare providers. This would be true for any study conducted based on the perceptions of care by an ethnic group. The results of this study cannot be generalized across the U. S.; therefore, careful consideration is needed to

ensure that the results of future studies are not specific to one region, and that studies of the Latino perception of care identify the same issues across the nation. Recognizable patterns may emerge in terms of how Latino perceptions of healthcare are viewed with respect to emotional care received.

Although the economic status of the participants was monitored, it was to ensure that the participants had options on where to receive care. It was also to ensure that they did not choose a particular facility out of necessity. Upon analyzing the data, there was no specific information to indicate that further studies need to be conducted based on economic standing.

The following figure represents a possible area of further research by looking specifically at illegal immigrant status based on insurability. Research of this nature will specifically show economies of scale in regards to the Latino immigrant that would be tied into their perception of care.

Figure 22: Process flow for further research



Summary

In determining how Latinos perceive how their emotional care is delivered, one aspect that was not measured, but could be identified for a further study would be the perception of care given by the healthcare staff, specifically the physicians. The issues that prevent the Latino population from having a positive perception of the care they received may be different from what the physicians perceived to be breaks in service. The differences in perceptions between these two groups and the understanding of these differences may be one way to increase the positive perception of care by the members of the Latino population.

Measuring quality in healthcare has taken on a new dimension as quality measures for clinical outcomes have now moved into the patient satisfaction realm. It is important to measure clinical quality outcomes to assess the quality of care. Clinicians need to address issues that may arise from certain protocols and methods for treating the patient. The information gained may allow clinicians to determine better quality outcomes, as well as develop new treatment protocols.

Clinical quality is an important aspect in gaining accreditation with national healthcare institutes. Along with clinical quality outcomes, patient satisfaction is a relatively new measure in the care patients receive. Although proponents of patient satisfaction examine clinical quality through the patient perception, soft issues are also looked at through the patient experience. Soft issues include such elements as: (a) attentiveness of the staff to emotional needs, (b) cleanliness of the facilities, and (c) amenities offered by the staff, to name a few.

There are two prominent measures that professionals use for determining quality, which wrap patient satisfaction into the overall score; they are SERVQUAL and the Baldrige Award. Both are used by professionals in the healthcare field and other industries. The extensive use of these two quality measures have proven effective. This is why many healthcare administrators rely on these measures.

It is not solely the responsibility of the hospital's executives and administrators to develop financially responsible plans to keep the hospital profitable. Officials in the states that are most influenced by immigrants, as well as the federal government officials, need to address this issue. Some state officials have already implemented cost-cutting

measures such as limiting types of treatments, mandating insurance, and limiting the frequency of service for illegal immigrants.

One of the biggest factors is the disease and illness these individuals are bringing into the U. S. Without better control of the borders, the influx of immigrants will continue to grow at an ever-rapid rate. At that rate, the healthcare providers and administrators will not be able to maintain present levels of care. There is a need for better control mechanisms that monitor the health status of individuals coming to the United States. If the illegal immigration cannot be controlled, then officials need to shift focus on how to protect the health of American citizens from the diseases potentially being brought into this country. According to a social justice perspective which focuses on the common good, all individuals should have potential access to healthcare, and realized patient access should be determined by need, rather than by social structure characteristics (Aday, Begley, Lairson, & Slater, 1998).

REFERENCES

Aday, L., & Begley, C., & Lairson, D., & Slater, C. (1998). *Evaluating the medical* care system: Effectiveness, efficiency, and equity, 2nd edition. Health Administration Press: Ann Arbor Michigan.

Agresti, A., & Finlay, B. (1996) *Statistical Methods for the Social Sciences*. (3rd ed.). Prentice Hall.

Andaleeb, S. (1998). Determinants of customer satisfaction with hospitals: A managerial model. *International Journal of Healthcare Quality Assurance*, 11, (6), 181-187.

Anderson, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health Social Behavior*, 36, 1-10.

Babour, R. S. (1998). Mixing qualitative methods: Quality assurance or qualitative quagmire? *Qualitative Health Research*, 8, (3), 352-361.

Badri, M., & Abdulla, M. (2005). Information technology center service quality: Assessment and application of SERVQUAL. *The International Journal of Quality and Reliability Management*, 22, (8/9), 819-848.

Bartel, A. (1989). New immigrants live? *Journal of Labor Economics*, 7, (4), 371-379.

Berelson, B. (1952). *Content analysis in communication research*. Glencoe, IL: Free Press.

Bogdan, R. C., & Biklen, S. K. (1982). *Qualitative research for education: An introduction to theory and methods*. Boston: Allyn and Bacon.

Bowen, K. (1996). The sin of omission -punishable by death to internal validity: An argument for integration of qualitative and quantitative research methods to strengthen internal validity. Retrieved May 3, 2006, from http://www.bowensevaluation.com/papers/SinOfOmission/main.htm.

Braunsberger, K., & Gates, R.H. (2002). Patient/enrollee satisfaction with healthcare and health plan. *Journal of Consumer Marketing, 19*, 7, pp. 575-590 (16)

Burt, T. (2006, May/June). Closing the healthcare gap for Latinos. *Healthcare Executive*, *21*, (3), 42-43.

Carrasquillo, O., & Carrasquillo, A., & Shea, S. (2000). Health insurance coverage on immigrants living in the United States: Differences by citizenship status and country of origin. *American Journal Public Health*, 90, 917-923.

Carter, M. (1998). Overview of methods to collect information. Retrieved May 1, 2006, from http://www.managementhelp.org/evaluatn/fnl_eval.htm.

Chiswick, B., & Miller, P.W. (2002). Do enclaves matter in immigrant adjustment? Unpublished manuscript, Department of Economics, University of Illinois at Chicago.

Choudhry, L., & Douglass, M,. & Lewis, J., & Howard–Olson, C., & Osterman, R., & Shah, P. (2007). The impact of community health centers & community affiliated health plans of emergency department use. Retrieved October 04, 2007, http://www.nachc.com/research/Files/ED_Report_4.07.pdf.

Clark, P. A., & Drain, M., & Malone, M. (2003). Addressing patients' emotional and spiritual needs. *Joint Commission Journal on Quality and Safety*. 29, (12).

Cleary, P.D., & McNeil, B.J. (1998). Patient satisfaction as an indicator of quality care. *Inquiry*, 25, 25-36.

Cleveland, W. S., & McGill, R. (1984). Graphical perception: Theory, experimentation and application to the development of graphical methods. *Journal of the American Statistical Association,* 79, 531-554.

Cosman, M. (2005). Illegal aliens and American medicine. *Journal of American Physicians and Surgeons*, 10, (1), 6-10.

Crotty, M. (1998). *Foundations of social research: Meaning and perspective in the research process*. Allen & Unwin, Sydney.

Curtwright, J., & Stolp-Smith, S,. & Edell, E. (2000). Strategic performance management: Development of a performance measurement system at the Mayo clinic. *Journal of Healthcare Management,* 45, (1), 58-68.

Denzin, N.K. (1989). *Interpretive interactionism*. Newbury Park CA: Sage Publications.

Denzin, N. K., & Lincoln, Y. S. Eds. (1998). *The landscape of qualitative research: Theories and issues*. Thousand Oaks CA: Sage Publications.

Duffy, M.E. (1887*).* Methodological Triangulation: A Vehicle for merging quantitative and qualitative research methods. *IMAGE: Journal of Nursing Scholarship*, 19, (3), 130-133.

Flores, G. (1998). Access barriers to health care for Latino children. *Archives of Pediatrics and Adolescent Medicine* 152, (11), 1119–1125.

Funkhouse, E., & Ramos, F.A. (1993). The choice of migration destination: Dominican and Cuban Americans to the mainland United States and Puerto Rico. *International Migration Review*, 27, 537-556.

Gee, G. C. (2002). A multilevel analysis of the relationship between institutional and individual racial discrimination and health status. *American Journal of Public Health*, *92,* (4), 615-624.

Ginn, G., & Lee, R., & Ellis, T. (2006). Community orientation, strategic flexibility, and financial performance in hospitals. *Journal of Healthcare Management*, 51, (2), 111-122.

Goldman, D,. & Smith, J., & Sood, N. (2006). Immigrants and the cost of medical care. *Health Affairs*, 25, (6), 1700-1711.

Goldstein, S. M., & Schweikhart, S. B. (2002). Empirical support for the Baldrige Award framework in U.S. hospitals. *Health care management review*, 27 (1), 62-75.

Guest, J. (2002). Caring for a city of immigrants. *Modern Healthcare*, 32, (5), 31.

Heistand, M. (1986). NY hospitals treat marketing-ills? *Adweek*, 27, (27), 2.

Hickson G.B. (1994). Obstetricians' prior malpractice experience and patients' satisfaction with care. *JAMA* 11, (272), 1583–1587.

Hoepfl, M. C. (1997). Choosing qualitative research: A primer for technology education researchers. *Journal of Technology Education*, 9(1), 47-63. Retrieved May 18, 2006, from http://scholar.lib.vt.edu/ejournals/JTE/v9n1/pdf/hoepfl.pdf Hipps, J. A.

Howard-Price, J. (2005). Disease, unwanted import. Retrieved December 19, 2006, from www.washingtontimes.com/functions/email.php?StoryID=20050212-112200-6485r.

Huang, J., & Yu, S., & Ledsky, R. (2006). Health status and health service access and use among children in U.S. immigrant families. *American Journal of Public Health*, 94, (4), 634-640.

Institute of Medicine. (2002). Unequal Treatment: Confronting racial and ethnic disparities in health care. National Academies Press, Washington, DC.

Johnson, B. R. (1997). Examining the validly structure of qualitative research. *Education,* 118, (3), 282-292.

Joint Commission on Accreditation of Healthcare Organizations. (2003). *Comprehensive Accreditation Manual for Hospitals*: The Official Handbook. Oakbrook Terrace, IL.

Joint Commission on Accreditation of Healthcare Organizations. (2005). Joint Commission 2005 Requirements Related to the Provision of Culturally and Linguistically Appropriate Health Care. Oakbrook Terrace, IL.

Joppe, M. (2000). The research process. Retrieved May 18, 2006, from http://www.ryerson.ca/~mjoppe/rp.htm.

Kaiser Commission on Medicaid and the Uninsured. (2000). Medicaid eligibility and citizenship status: Policy implications for immigrant populations. Washington, DC.

Kent, G. (1996). Patient reactions to met and unmet psychological need: A critical incident analysis. *Patient Education Counseling* 28, 187–190.

Kirk, J., & Miller, M. L. (1986). *Reliability and validity in qualitative research*. Beverly Hills: Sage Publications.

Krippendorff, K. (1980). *Content analysis: An introduction to is methodology*. Newbury Park, CA: Sage Publications.

Kullgren, J. (2003). Restrictions on undocumented immigrants' access to health services. *American Journal of Public Health*, 93, (10).

Kurz, R.S., & Wolinsky, F.D. (1985). Who picks the hospital: practitioner or patient? *Hospital and Health Services Administration*, 30, (March/April), 95-106.

Levine, C. (2002). Life but no limb: The aftermath of medical error. Health Aff (Millwood), 7, (21) 237–241.

Levinson, W. (1994). Physician–patient communication. A key to malpractice prevention. *JAMA* 11, (272), 1619–1620.

Li, L. X. (1997). Relationships between determinants of hospital quality management and service quality performance. *Omega,* 25, (5), 533-545.

Liggins, K. (1993). Inappropriate attendance at accident and emergency departments: A literature review. *Journal of Advanced Nursing*, 18(7), 1141-1145.

MacStravic, S. (1995). Patient loyalty to physicians. *Journal of Healthcare Marketing*, 14, (4), 53-58.

Marley, K., & Collier, D., & Meyer-Goldstein, S. (2004). The role of clinical process in achieving patient satisfaction in hospitals. *Decision Sciences*, 35, (3), 349-369.

Mathison, S. (1988). Why triangulate*? Educational Researcher*, 17(2), 13-17.

Mayring, P. (2000). Qualitative content analysis. *Qualitative Social Research*. Retrieved December 20, 2007, from http://www.qualitative-research.net/fqs/fqs-eng.htm.

Minorities bear brunt of healthcare obstacles. (1995). *Trustee*, *48,* (5), 4.

Mortland, S. (2005). A growing pit of disparity: Officials search for ways to bridge the gap in service between people with insurance and those without. *Crain's Cleveland Business*, 13.

Nadel, M.V. (1993). Emergency departments: Unevenly affected by growth and change in patient use. (GAO/HRD-93-4). Washington, DC: U.S. General Accounting Office, Human Resources Division.

Nerenz, D. (1998). Tools for evaluating chronic care networks. *The Healthcare Forum Journal*, 41, (5), 31-34.

Office of Minority Health, DHHS. (2003). Improving access to health care: Draft recommendations for national standards for health care language services. Developed by the American Institutes for Research (AIR). Rockville, MD.

Patton, M. Q. (2002). *Qualitative evaluation and research methods (3rd ed.).* Thousand Oaks, CA: Sage Publications, Inc.

Petterson, M.B.H. (1988). Measuring patient satisfaction: collecting useful data. *Journal of Nursing Quality Assurance*, 2, (3), 25-35.

Phillips, K. A., & Mayer, M. L., & Aday, L. (2000, July/August). Barriers to care among racial/ethnic groups under managed care. *Health Affairs*, *19,* (4), 65-76.

Panko, R. (1996). The healthcare game: Cutting costs but not quality. *Bests Review*, 97, (4), 32-38.

Patton, M.Q. (1990). *Qualitative evaluation and research methods*. Newbury Park CA: Sage Publications.

Plymire, J. (1991). Complaints as opportunities. *Journal of Consumer Marketing*, 8, (2), 9-43.

Proenca, E.J. (1998). Community orientation in health services organizations: The concept and its implementation. *Healthcare Management Review*, 23, (2), 28-38.

Proenca, E.J., & Rosko, M.D., & Zinn, J. (2000). Community orientation in hospitals: An institutional and resource dependent perspective. *Health Service Research*, 35, (5), 1011-1035.

Ratajczak, D. (1997). On the measure of healthcare. *Journal of the American Society of CLU & ChFC*, 51, (5), 22-24.

Reicheld, F., & Sasser Jr., W. (1990). Zero defections: Quality comes to services. *Harvard Business Review*, 86, (5), 105.

Render, B., & Stair, R.M. (1997). *Quantitative analysis for management.* Prentice Hall. Upper Saddle River N.J.

Reynolds, D. (2004, July/August). Improving care and interactions with racially and ethnically diverse populations in healthcare organizations. *Journal of Healthcare Management*, *49,* (4), 237-250.

Ridick, S. (1997). Application strategies in various healthcare settings. Retrieved March 3, 2007, from http://www.diversityrx.org.

Rising medical costs and utilization drive premium increases and constrict Margins. (1998). *Healthcare Strategic Management*, 16, (5), 9.

Rubin, H.R., & Gandek, B., & Rogers, W.H. (1993). Patient's ratings of outpatient visits in different practice settings. *Journal of the American Medical Association*, 270, 835-40.

Schweikhart, S. B., & Strasser, S., & Kennedy, M. R. (1993). Service recovery in health services organizations. *Hospital and Health Services Administration*, 38, (1), 3-21.

Shelton, P. (2000). *Measuring and Improving Patient Satisfaction*. Jones & Bartlett Publishers. p. 63.

Smedley, B.D., & Stith, A. Y., & Nelson, A.R. (2003). Unequal Treatment: Confronting Racial and Ethnic Health Disparities in Health Care. *Institute of Medicine Report* Washington, DC. National Academy Press.

Winston, W. (1998). The multiplier effect on economic value of customer service. *Journal of Retailing*, 73, (3), 337-360.

Schlossberg, H. (1990). Healthcare looks for hero in marketing. *Marketing News*, 24, (2), 10.

Schweikhart, S. B., & Strasser, S., & Kennedy, M. R. (1993). Service recovery in health services organizations. *Hospital and Health Services Administration*, 38, (1), 3-21.

Schur, C. L., & Albers, L., & Berk, M. L. (1995, winter). Healthcare use by Hispanic adults: Financial vs. non-financial determinants. *Healthcare Financing Review*, *17,* (2), 10-14.

Seay, J.D., & Sigmond, R. (1989). Community benefit standards for hospitals: Perception and performance. *Frontiers of Health Services Management*, 5, (3), 3-39.

Seward, J. (1997). Restoring the ethical balance in health care *Health Affairs*, 16, (3), 195-198.

Shapiro, S., & Markoff, J. (1997). 'A matter of definition' in C.W. Roberts (Ed.). Text analysis for the social sciences: Methods for drawing statistical inferences from Texas and transcripts. Mahwah, NJ: Lawrence Erlbaum Associates.

Sharpe, D. T. (2002). The effects of demographic characteristics and insurance arrangement on the utilization of hospital emergency rooms. Unpublished doctorial dissertation, Texas Woman's University, USA.

Smith-Collins, A., & Gullette, D., & Schnepf, M. (2002). Break through language barriers. *Nursing Management*, *35,* (8), 34-38.

Stemler, S. (2001). An overview of content analysis. Practical assessment, research & evaluation, 7, (17).

Stevenson, P. B., & Elzey, T. J., & Romagoza, J. (2002). Building market share in the Latino community. *Healthcare Financial Management*, *56,* (5), 68-73.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage Publications, Inc.

Toussaint-Comeau, M., & Rhine, S. (2004). Tenure choice with location selection: The case of Hispanic neighborhoods in Chicago. *Contemporary Economic Policy*, 22, (1), 95-110.

U.S. Census Bureau. (2005). Language Use. Retrieved August 19, 2008, from http://www.census.gov/population/www/socdemo/lang_use.html.

U.S. General Accounting Office (1996). *Content Analysis: A Methodology for Structuring and Analyzing Written Material*. GAO/PEMD-10.3.1. Washington, D.C.

U.S.'s hospitals control costs while experiencing variable profitability. (1999). *Healthcare Strategic Management*, 17, (3), 7-8.

Weber, R.P. (1990). *Basic content analysis, 2nd ed*. Newbury Park CA: Sage Publications.

Wechsler, J. (2003). Health plans examine minority healthcare gap. *Managed Healthcare Executive*, *13,* (11), 8.

West, T. (1998). Comparing change readiness quality improvement and cost management among veterans administration for profit and non-profit hospitals. *Journal of Healthcare Finance*, 25, (1), 46-58.

When you're sorry, say so. (2005). *Health Care Strategic Management*, 23, (11), 10.

Winter, G. (2000). A comparative discussion of the notion of validity in qualitative and quantitative research. *The Qualitative Report*, 4(3&4). Retrieved May 20, 2006, from http://www.nova.edu/ssss/QR/QR4-3/winter.html.

Wong, W.K. (1990). Cost to remain driving force of healthcare in the 1990's. *Marketing News*, 24, (2), 8.

Worrell, B. (2002). Changing times require hospitals to reach out to minority markets. *Healthcare Strategic Management*, *20,* (11), 10-14.

Yeo, S. (2004). Language Barriers and Access to Care. *Annual Review of Nursing Research.* 22, 59–73.

Zikmund, G. W. (1997). *Business research methods*. The Dryden Press. Oklahoma State University.

APPENDIX A. CONSENT FORMS

Consent to participate in research study

VARIATIONS IN THE PERCEPTIONS OF LATINOS OF NON-BASED MEDICAL HEALTHCARE COMPARED WITH THE PERCEPTION OF NON-LATINO WHITES

The purpose of this study is to determine why the Latino population perception of care using the healthcare system in the United States of America is different from non-Latino Whites' perception of the care they receive. This situation can ultimately affect the overall health of the Latino population. Differences in the care that individuals perceive to receive can have a negative economic impact and it is important to understand and identify the differences within the American healthcare system.

By signing this consent form, you agree to answer a survey asking you about your perceptions of American healthcare facilities and/or the staff. The survey consists of several questions and is multiple choice with room to write in comments if the participant so wishes. You will be given a self addressed stamped envelop to return the survey. If one of the questions does not pertain to your past experience, the participant can leave the question unanswered.

The questions in no way will reveal citizenship, medical history, or any other private information about the participant.

Your name will not be linked to the survey you fill out. Responses to the questions will be categorized by age and gender. Once the survey is received by the researcher, the researcher will enter the data into a secured database that only the researcher will have access to, in addition the database will be password protected.

Participation in this study is limited to participants over the age of eighteen.

Participation in this study is voluntary. At any time, you may withdrawal from the study without penalty or persecution.

For information or questions about this study and how the information will be used please contact James Driscoll directly at 312-545-5798, Dr. Luis River at 516-241-5196 or Dr. Karen Viechnicki at 1-888-227-2736 extension 5730.

Your signature below gives consent to use the information provided for the study listed above. Your signature below gives you the right to withdrawal from the study at any time.

_____

Name of Participant Date

_____

Signature of Participant Date

_____

Signature of Researcher Date

Consentimiento a participar en estudio de la investigación

LAS VARIACIONES EN LA OPINIÓN DE LATINOS DE NON-BASED HEALTHCARE MÉDICO COMPARARON CON LA OPINIÓN DE LOS BLANCOS DE NON-LATINO

El propósito de este estudio es determinarse porqué la opinión de la población de Latino del cuidado que usa el sistema del healthcare en los Estados Unidos de América es diferente de la opinión de los blancos del non-Latino del cuidado que reciben. Esta situación puede afectar en última instancia la salud total de la población de Latino. Las diferencias en el cuidado que los individuos perciben para recibir pueden tener un impacto económico negativo y él son importantes entender e identificar las diferencias dentro del sistema americano del healthcare.

Firmando esta forma del consentimiento, usted acuerda contestar a un examen que le pregunta acerca de sus opiniones de las instalaciones americanas del healthcare y/o del personal. El examen consiste en varias preguntas y es opción múltiple con el sitio de escribir en comentarios si el participante desea tan. Le darán a uno mismo dirigido estampado envuelve para volver el examen. Si una de las preguntas no pertenece a su experiencia previa, el participante puede dejar la pregunta por contestar.

Las preguntas de ninguna manera revelarán ciudadanía, historial médico, o cualquier otra información privada sobre el participante.

Su nombre no será ligado al examen que usted completa. Las respuestas a las preguntas serán categorizadas por edad y género. El examen es recibido una vez por el investigador, el investigador incorporará los datos en una base de datos asegurada que solamente el investigador tendrá acceso a, además la base de datos será contraseña protegida.

La participación en este estudio se limita a los participantes sobre la edad de dieciocho.

La participación en este estudio es voluntaria. En cualquier momento, usted puede retiro del estudio sin pena o la persecución.

Para la información o las preguntas sobre esto estudie y cómo la información será utilizada por favor entre en contacto con James Driscoll directamente en 312-545-5798, el Dr. Luis River en 516-241-5196 o el Dr. Karen Viechnicki en 1-888-227-2736 la extensión 5730.

Su firma abajo da consentimiento para utilizar la información proporcionada para el estudio enumerado arriba. Su firma abajo le da la derecha al retiro del estudio en cualquier momento.

_____

Nombre de la fecha del participante

_____

Firma de la fecha del participante

_____

Firma de la fecha del investigador

Capella Universidad, Minneapolis Minnesota

APPENDIX B. ENGLISH SURVEY

The Patient's View on Health Care

Statement of Confidentiality

All information that would permit identification of you will be regarded as strictly confidential, will be used only for the purposes of operating and evaluating the study, and will not be disclosed or released for any other purposes without your prior consent, except as required by law.

You have been randomly selected for this survey. It is important to us that every person selected to participate do so in order to obtain accurate results. Your responses will be treated as confidential but will be combined with those of other participants to help improve your health care.

Instructions for Filling out Questionnaire

1 Please answer every question (unless you are asked to skip questions because they don't apply to you). Some questions may look like others, but each one is different.

2 Answer the questions by circling the appropriate number or by filling in the answer as requested.

Example: Have you ever been to the moon?

(Mark One Number)

1 No ..... 2 Yes .....

If you are unsure about how to answer a question, please give the best answer you can.

In order to obtain accurate information, we need to ask you several questions. The questions ask for your opinions about the health care you receive from your medical group and about your health plan. By health plan, we mean the health insurance plan provided by your employer or that you have purchased yourself. Please keep this distinction in mind when answering these questions.

RAND 1700 Main Street Santa Monica, California 90407-2138 (310) 393-0411

Thank You For Taking Part In This Study

The questions below refer to the health services you have received from your medical group. Thinking about the place you go for your regular health care (that is, your medical group), how do you rate the items listed below? For each question, please grade the care you receive from Very Poor (F) to The Best (A+) by circling one number on each line. If something does not apply to you, mark "N/A".

N/A	Very Poor	Poor Fair	Fair	Good	Very Good
0	**1**	**2**	**3**	**4**	**5**

Ease of speaking with your primary care provider
0 1 2 3 4 5

Friendliness and courtesy shown to you by the receptionist and other front desk staff
0 1 2 3 4 5

Explanations about prescribed medicines
0 1 2 3 4 5

Explanations of medical procedures and test results by primary care provider
0 1 2 3 4 5

Friendliness and courtesy shown to you by your primary care provider
0 1 2 3 4 5

Friendliness and courtesy shown to you by nurses and other medical staff
0 1 2 3 4 5

Training, skill, and experience of the nursing staff
0 1 2 3 4 5

Your primary care provider's concern for your mental health or emotional well-being
0 1 2 3 4 5

How well your care meets your needs
0 1 2 3 4 5

Overall quality of care

0 1 2 3 4 5

The following questions will help us to insure that the opinions of different people are represented in this study.

1. How old were you on your last birthday? _____

2. Are you male or female? (Mark One)

Male	1
Female	2

3. Which category best describes you? (Mark One)

African-American or Black	1
Hispanic or Latino	2
Native American or American Indian	3
Asian or Pacific Islander	4
White or Caucasian	5
Other	6

(Please specify _____)

4. What kind of health insurance do you have? (Circle All That Apply)

None	1
Medicare	2
Medicaid	3
Private, fee-for-service health insurance (e.g., Prudential)	4
HMO	5
PPO or IPA or other prepaid plan	6
Other	7

5. What was your total household income (income from all sources including child support, alimony, disability, SSI, unemployment) before taxes? (Please remember your answers are confidential.)
(Mark One)

Less than $5,000	1
$5,000 to $9,999	2
$10,000 to $19,999	3
$20,000 to $39,999	4
$40,000 to $74,999	5
$75,000 to $99,999	6
$100,000 or more	7
Don't know	8

Thank You for completing this questionnaire

Please return your completed questionnaire in the enclosed prepaid envelope addressed to:

P.O. Box 3008
Chicago, IL 60602

Additional Comments

APPENDIX C. SPANISH SURVEY

La opinión de los pacientes sobre la atención de la salud

Declaración de confidencialidad

Toda la información que permitiera la identificación de los que se considerarán como estrictamente confidencial, sólo se utilizará a efectos de evaluar el funcionamiento y el estudio, y no podrán ser divulgados o puestos en libertad para otros fines sin su consentimiento previo, a menos que lo requiera la ley

Usted ha sido seleccionado al azar para esta encuesta. Es importante para nosotros que cada persona seleccionada para participar que lo hagan con el fin de obtener resultados exactos. Sus respuestas serán tratadas de manera confidencial, pero se combinarán con las de otros participantes para ayudar a mejorar el cuidado de su salud.

Instrucciones para llenar cuestionario

1 Por favor, responda todas las preguntas (a menos que se le pregunte para omitir preguntas, ya que no se
aplican a los Usted). Algunas preguntas pueden tener otros, pero cada uno es diferente.

2 Responda a las preguntas en círculos el número apropiado o rellenando la respuesta a lo solicitado.

Por ejemplo: ¿Ha estado alguna vez a la luna?
(Elija un número)

1	2
No	Si .....

Si usted no está seguro acerca de cómo responder a una pregunta, por favor dé la mejor respuesta que pueda.

Con el fin de obtener información precisa, tenemos que preguntarle varias cuestiones. Las preguntas son sobre sus opiniones acerca de la atención de salud que recibe de su grupo médico y sobre su plan de salud. Por el plan de salud, nos referimos al plan de seguro médico proporcionado por su empleador o que usted ha comprado usted mismo. Por favor, tenga en cuenta esta distinción al responder a estas preguntas.

RAND 1700 Main Street Santa Monica, California 90407-2138 (310) 393-0411

Gracias por participar en este estudio

Las siguientes preguntas se refieren a los servicios de salud que ha recibido de su grupo médico. Pensando en el lugar de ir para su atención médica regular (es decir, su grupo médico), ¿cómo calificaría los temas que figuran a continuación? Para cada pregunta, por favor, el grado de atención que recibe de Muy Deficiente (F) y The Best (A +) en círculos por un número en cada línea. Si algo no se aplica a usted, marca "N / A".

N/A	Muy Mala	Mala	Feria	Buena	Muy Buena
0	1	2	3	4	5

La facilidad de hablar con su proveedor de atención primaria

0	1	2	3	4	5

La amabilidad y la cortesía se muestra a usted por el recepcionista y otros recepción de personal

0	1	2	3	4	5

Las explicaciones acerca de los medicamentos prescritos

0	1	2	3	4	5

Las explicaciones de los procedimientos médicos y los resultados de las pruebas por proveedor de atención primaria

0	1	2	3	4	5

La amabilidad y la cortesía se muestra a usted por su proveedor de atención primaria

0	1	2	3	4	5

La amabilidad y la cortesía se muestra a usted por enfermeras y otro personal medico

0	1	2	3	4	5

La capacitación, la habilidad y la experiencia del personal de enfermería

0	1	2	3	4	5

Su proveedor de atención primaria de la preocupación por su salud mental o el bienestar emocional

0	1	2	3	4	5

¿Cómo así su cuidado se ajuste a tus necesidades

0	1	2	3	4	5

En general la calidad de la atención

0	1	2	3	4	5

Las siguientes preguntas nos ayudarán a asegurar que las opiniones de diferentes personas que están representados en este estudio.

1. ¿Cuántos años tenía usted en su último cumpleaños? _____

2. ¿Eres hombre o mujer? (Elija una respuesta)

Hombre	1
Mujer	2

3. Categoría que mejor describe usted? (Elija una respuesta)

Afro-americano o Negro	1
Hispano o Latino	2
Nativo Americano o American Indian	3
De Asia o las islas del Pacífico	4
Blanco o caucásico	5
Otros	6

(Por favor, especifique _____)

4. ¿Qué tipo de seguro de salud tiene usted? (Marque todas las que se apliquen)

Ninguna	1
Medicare	2
Medicaid	3
Privada, de pago por servicios de seguro de salud (por ejemplo, Prudential)	4
HMO	5
PPO o IPA u otro plan de prepago de	6
Otros	7

5. ¿Cuál fue el total de ingresos de los hogares (de los ingresos de todas las fuentes, incluidos los hijos, pensión alimenticia, la discapacidad, SSI, desempleo) antes de impuestos? (Por favor, recuerde sus respuestas son confidenciales.)
(Elija una respuesta)

Menos de $ 5.000	1
$ 5.000 a $ 9.999	2
$ 10.000 a $ 19.999	3
$ 20.000 a $ 39.999	4
$ 40.000 a $ 74.999	5
$ 75.000 a $ 99.999	6
100.000 dólares o más	7
No sabe 8	8

Gracias por completar este cuestionario

Por favor devolver su cuestionario completado en el adjunto de prepago sobre dirigido:

P.O. Box 3008
Chicago, IL 60602

Comentarios Adicionales