Latino/Hispanic Community Adults' Healthcare Experience in a New Mexico Borderland Region

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ABSTRACT

This study identifies factors associated with Latino/Hispanic adults' healthcare experiences in a county along the U.S.-Mexico Border designated by the government as a geographic primary care, mental health, and dental health professional shortage area. An interpretative phenomenological approach was applied to analyze qualitative data collected through focus group interviews with ten Latino/Hispanic healthcare patients. Factors associated with positive healthcare experiences included short wait times, availability of same-day appointments, team-based care, and good interpersonal communication. Factors associated with negative healthcare experiences included long wait times, deficient communication (e.g., lack of provider-patient, provider-provider, and agency-patient communication), providers' poor interpersonal skills, and perceived discrimination by healthcare professionals based on patient age, race/ethnicity, linguistic capability, and socioeconomic status. Latino/Hispanic patients negotiate challenging barriers related to receiving effective healthcare services. Healthcare providers and administrators may improve the quality of care for Latinos/Hispanics by attending to these factors.

Keyword: Latino/Hispanic; healthcare experience; U.S.-Mexico border; qualitative; discrimination

INTRODUCTION

Racial/ethnic minorities underutilize health care more often than non-Latino Whites (Kressin & Petersen, 2001; Nelson, 2002). U.S. Latinos/Hispanics are among the most vulnerable populations to experience disparities in health care (McFadden & Ulmer, 2009; Vega, Rodriguez, & Gruskin, 2009). Large-scale surveys found that Latinos/Hispanics have worse access to health

care (i.e., having a normal and realistically accessible place to go for health needs) than both non-Latino/Hispanic Blacks and Whites (US Department of Health and Human Services [HHS], 2016). Moreover, the most recent National Healthcare Quality and Disparities Report indicates that, in all years from 2002 to 2013, Latinos/Hispanics were more likely than non-Latino/Hispanic Whites to report poor communication from providers (e.g., reporting that health providers "sometimes or never listened carefully, explained things clearly, showed respect for what they had to say, or spent enough time with them" (HHS, 2016, p. 17).

Eliminating racial/ethnic disparities in health care is one of the central missions of Centers for Disease Control and Prevention (CDC, 2011), in part through increased focus on addressing social determinants of health. Such determinants, including discrimination, poverty, low-paying jobs, underfunded schools, deficient housing, and migration generational status, describe how health is eroded through social forces and structural inequities (Commission on the Social Determinants of Health, 2008). To address the health care disparities faced by Latino communities, thus, requires a critical examination of how forces outside of individuals' control influence their experience with health care, including sociocultural discrimination and structural barriers that arise differentially in response to ethnicity, insurance, documentation, language preference, and age.

Latino/Hispanic individuals residing in the borderland region may encounter additional sociocultural barriers to quality health care. The borderland region—approximately 2,000 miles long and reaching approximately 62 miles north and south of the U.S.-Mexico border—faces challenges characterized by high unemployment rates, high poverty rates, high rates of uninsured, and high rates of chronic disease (United States-Mexico Border Health Commission, 2014). Among the borderland states, New Mexico experiences distinctive health care access challenges. Specifically, 32 of New Mexico's 33 counties are designated as geographic primary care, mental health, and dental Health Professional Shortage Areas (HPSAs) (Health Resources and Service Administration, 2015a; Health Resources and Services Administration, 2015b; Health Resources and Service Administration, 2015c). Most of these counties are also home to racially and ethnically diverse communities, with most counties having more than half of their populations identifying as Latino or Hispanic. In comparison, only one fifth of the primary care physician workforce in New Mexico self-identifies as Latino or Hispanic (New Mexico Health Care Workforce Committee, 2015). This distinct demographic characteristic, along with the existing contextual challenges (e.g., economic disadvantage, health professional shortage), may further influence issues related to access and quality of health care, including availability of culturally competent services (Metzl & Hansen, 2014; New Mexico Department of Health, 2014).

Researchers have contended that some borderland-specific sociocultural milieu may be especially relevant to health treatment and quality of care, including stigma perceived in identifying as Mexican, Mexican American, or of immigrant heritage in face of persistent political hostility, xenophobia, ethnic discrimination, and economic scapegoating (Johnson, 1997; Quesada, Hart, & Bourgois, 2011). These kinds of ethnicity-based contextual challenges can be seen as a manifestation of the larger issue of ethnic or racial discrimination, which is identified as a significant social determinant of health by the Centers for Disease Control and Prevention (CDC, 2013). In a review of 58 empirical studies (most of which consisted of African American samples) examining racial/ethnic discrimination within U.S. healthcare settings, Shavers et al. (2012) concluded that discrimination in health care is widespread and bears negative associations on the care of minority patients. A large-scale study specifically targeting Latinos/Hispanics found that higher levels of ethnic discrimination from health professionals were associated with poorer

doctor-patient communication. Furthermore, as high as 70 percent of individuals who experienced a previous discriminatory healthcare interaction reported deferring seeking services the next time they had need (Smyster & Ciske, 2001).

Another ethnicity-related challenge that may be of particular pertinence to Latino/Hispanic individuals residing in the New Mexico borderland region is health insurance coverage. The Human Services Department reports that 22 percent of Latinos residing in New Mexico are uninsured (New Mexico Department of Health, 2014-2016). Related research found that increasingly exclusionary insurance legislation directed towards immigrants might result in changes in attitudes toward Latino/Hispanic patients (e.g., suspicious, uncourteous) among medical and social workers in the forefront of care (Cacari-Stone & Avila, 2012).

Language is another important role in health care experiences. Individuals who do not speak English or speak limited English may encounter unique challenges in health care. A systematic review of empirical studies investigating language barriers to care found that 55 percent of the studies reported significant harmful consequences to access such as hardship locating and enrolling in services, communicating problems, and understanding health status updates (Timmons, 2002). These were associated with language barriers such as lack of bilingual providers, staff, and materials. In addition, 86 percent of the reviewed studies revealed significant damaging effects to quality of care including less question-asking, knowledge of medication side effects, and engagement with prevention interventions (Timmons, 2002). These barriers are especially pronounced for poor, socio-economically disadvantaged, and rural immigrants (Cristancho, Garces, Peters, & Mueller, 2008; HHS, 2016).

Among the growing body of literature documenting how discrimination and demographic disadvantages (e.g., ethnicity, language) impact negative health care experience, there is some research pointing to possible channels for enhancing positive health care and reducing disparity. In a cross-sectional study of Latina/Hispanic immigrant women, Sheppard, Williams, Wang, Shavers, and Mandelblatt (2014) found that factors related to patient-provider relationship (e.g., communication) are stronger predictors of patients' perceived discriminatory healthcare experience than demographic factors. Relatedly, Shavers et al. (2012) pointed to the significant role of unconscious bias and the need to more closely understand the communication styles, non-verbal behaviors, and specific health care workers (e.g., providers, front office) through which and whom bias may be transmitted. Cultural competency training of providers and trainees has been shown to increase cognizance of such biases and capacities to self-reflect (e.g., Jacobs, Beach, & Saha, 2010). It is unknown whether such types of positive patient-provider interpersonal processes (and embedded cultural experiences) may also be present in Latino/Hispanic adults' health care experience as they navigate through contextual-demographical challenges in the New Mexico borderland region.

The Present Study

In summary, the present study seeks to fill the following gaps in the literature: (a) to complement the healthcare literature by focusing on an understudied population of Latino/Hispanic adults in the U.S.-Mexico borderland; (b) to extend research on social determinants of healthcare by examining socio-contextual factors salient in the borderland such as disadvantaged economic status, shortage of healthcare providers, limited health insurance coverage, and linguistic and ethnic discrimination; and (c) to add to the emerging literature on channels for enhancing healthcare by exploring how and whether Latino/Hispanic communities in the borderland experience positive health care. In this paper, the term Latino/Hispanic is used to

refer to heterogeneous communities of people who trace their lineages to Mexico, Central America, and Spanish-speaking countries of the Caribbean and South America. This study sought to utilize culturally-sensitive, qualitative investigation to allow for adequate documentation and to fill the conceptualization gaps of how barriers and disparities, as well as potential facilitators, are experienced within health care in understudied communities.

METHODS

A phenomenological approach was utilized to explore Latino/Hispanic individuals' experiences with healthcare. According to Creswell (2013) the purpose of phenomenology is to capture the "common meaning" of individuals' experiences with one common phenomenon. In this case, that common phenomenon is the utilization of healthcare services in the U.S. Congruent with phenomenology, focus group interviews were used as the primary data source to acquire information pertaining to participants' experiences with healthcare. The investigation was conducted at a public university in the southwestern U.S.

Study Location and Researcher Reflexivity

This study took place in a small community in Southwestern New Mexico. According to the U.S. Census Bureau, the population of this community is an estimated 101,000 people (U.S. Census Bureau, 2016). As of 2010, it was estimated that 56.8% of residents of this community identified as Latino or Hispanic (U.S. Census Bureau, 2016). Approximately 38.7% of the population reported speaking a language other than English at home (U.S. Census Bureau, 2016).

Participants

We used purposive, snowball and homogenous sampling by distributing flyers to clinics, hospitals, community health centers, and popular dining and entertainment areas (e.g., shopping malls). We also made announcements through listservs (e.g., Craigslist, campus emails) and social media (e.g., Facebook). Eligible participants had to identify as Latino or Hispanic, be 18 or older, and have utilized healthcare services in the U.S. Initially four focus groups were conducted. One of the focus groups, however, consisted of international students with limited exposure and experiences with the U.S. healthcare system; therefore, their data were analyzed separately and excluded from this manuscript. Out of the three remaining focus groups, the largest consisted of five and the smallest of two participants.

A total of 10 individuals, 5 men and 5 women ranging in age from 19 to 63, participated in this study. This sample size is consistent with Creswell's (2013) recommendations for phenomenological research, which called for 5 to 25 participants. Although the study did not focus on the experiences of a particular age group or gender, all participants had shared experiences (all participants reported they had utilized healthcare in the Southwest region of the U.S. within the last year), meeting the criteria for phenomenological research. Each participant obtained $20 for participating in the study.

Procedures

The focus groups took place in easily accessible facilities (e.g. community center, university conference room, etc.) and varied in length from 44 minutes to one hour and 45 minutes. Prior to the start of the interview, participants were asked to read and sign the informed consent form detailing information about the study (e.g. the necessity to audio-record, identify and use a pseudonym to protect their confidentiality, etc.). A semi-structured interview guide was used during the interview process to obtain relevant information specific to the participants' experiences with healthcare. This semi-structured approach allowed for a more organic focus group experience

by increasing the flexibility for researchers to include probes or follow-up questions related to participants' responses. A sample question was, **"**What has your experience been with (a) healthcare agencies, (b) providers, and (c) staff persons?" with follow up questions like "Have issues related to race, ethnicity, culture, language, immigration status, etc. ever become an important aspect in your experience with healthcare?" Due to the fact that multiple members of the research team were present in each of the focus group interviews, debriefing sessions were included as part of the data collection process.

Data Analysis

Interviews were transcribed, de-identified, and imported into NVIVO, a computer software that was used to organize and facilitate analysis of the data. Data analysis was conducted by two of the authors. One of the authors analyzed the data and the other served as an external auditor. The role of the external auditor was to provide recommendations and observations related to interpretation of the data and conceptualization of the themes. An interpretative phenomenological approach was followed, utilizing the steps outlined by Savin-Baden and Major (2013). Specifically, the data analysis included (a) characterization of the data, (b) immersion in the data, (c) open coding, (d) categorizing data, and (e) creating themes. These steps are congruent with interpretative phenomenological data analysis, which involves procedures of in-depth reading of the text, bracketing of ideas, generating codes and structures, and arriving at essential themes (Savin-Baden & Major, 2013).

RESULTS

Participants varied in age and involvement with healthcare providers. However, all participants highlighted major themes that captured their overall experiences in healthcare settings. Data analysis revealed the following three themes as most salient: factors related to a positive experience in healthcare settings, factors related to a negative experience in healthcare settings, and experiences with perceived discrimination.

Factors related to a positive experience in healthcare settings

Many factors contributed to participants' positive experiences. For most participants, positive experiences were influenced by (1) limited wait time and (2) quality of care.

Wait time. Many participants expressed that they appreciated having a short wait time before seeing the provider as it increased the amount of time they could spend with the provider. Participants also expressed their positive experience with being seen within the same day of presenting to the medical provider for care. Having their concerns validated and being provided with immediate services by their healthcare providers contributed to an overall positive perception of the care they were receiving.

Although participants highlighted the importance of experiencing a short waiting time to see a provider, receiving quality care impacted how they responded to longer waiting periods. For example, Norma shared the following statement regarding how she negotiated between wait time and quality of care.

> *"Well see, the thing is that when you go into the room, you can hear what's going on in the next room or the room on the other side of you where the doctor's at. And you hear him go in and talk to them…You know, and of course the patient's talking in a lower voice, but when he first goes in and greets them, he talks to them with so much respect and you'll hear him discussing whatever for the longest time with them, with that patient. And if we have to sit there and wait, I don't mind it because I know he's taking time with that patient.*

You know, and he's explained it, cause that's what he does with us. And so, you can't complain…"

Participants' appreciation of quality care for all patients by medical providers reduced their frustration associated with long wait time.

Quality of care. The most salient theme related to participants' positive experience was related to quality of care. Some of the common factors that were attributed to perceived quality of care included communication with patients (e.g., follow-up with patient), thoroughness of provider, and perceived professionalism and competency of provider.

Most participants were appreciative of the multiple ways that their medical providers communicated with them. These included both being available (via phone or in-person) to answer patients' questions or concerns and following up with patients after a visit, after a procedure, or in relation to medication or the need for specialty treatment. Some of these factors were captured by Beatriz's statement about her provider:

"Very professional, I mean he [the physician] took forever. He was there talking to me a good hour or more and y'know people are waiting because I was one of them before I went into that room and then I realized, I understand why y'know he's so thorough, he's so down-to-earth, he's so, he answers, he goes above and beyond any doctor I had ever seen…He, uh, he actually he called my home after hours to follow up with me or to ask questions or do you y'know this and then when I went to his his office to visit him um, I was looking at some results because I had a complete hysterectomy with him. Yeah, he takes me into his office, on his computer! And shows me some technical stuff that, y'know, I don't really get it but... I've never had a doctor do that y'know?"

Although all factors related to providers' thoroughness were identified as important by the participants, providing patients with information and explaining diagnosis, treatment, and medication was the most valued.

Patients also identified a number of synonyms and characteristics they associated with professional behavior and demeanor. This included traits such as "down to earth," "warm," and other descriptors such as "dress nice." The primary concern for participants were interpersonal characteristics that focused on feeling respected by the provider and the provider being personable and friendly (e.g. being formally greeted by their provider). Participants also highlighted the providers' appearance as contributing to their experience of having a positive visit with their healthcare provider. Beatriz stated, "he's an excellent doctor um unlike any other doctor I have ever experienced he came in the room, a suit on. I've never seen a doctor come with a suit on!"

Perception of the competency of their medical providers also attributed to participants' positive experiences within healthcare settings. Competency was related to receiving accurate treatment, medication, and diagnosis as well as whether the provider presented himself or herself in a professional manner. Professional behavior was often seen as congruent or synonymous to competency. Many participants highlighted individual preferences such as appreciation for attention to detail, thoroughness in regards to documentation, and displaying cultural sensitivity by treating "all patients" with respect regardless of race. One participant shared her positive experience was partially attributed to observing the care with which her provider documented her concerns. "My doctor is very good. She takes her time, and I just come in and she looks at me eye to eye. And she writes everything. And I see her writing, she writes."

Finally, although most participants focused on their interactions with providers, a number of them disclosed that their positive experiences were also influenced by the interactions they had with staff, nurses, and the agency in general. Many participants, for example, shared an appreciation for medical staff that worked together as a clear team and created an easy to manage "flow" for the patient's encounter.

Factors related to a negative experience within healthcare settings

Although participants provided rich descriptions of their positive experiences, most of their narratives focused on providing detailed accounts of their negative experiences with healthcare. They often detailed negative experiences with primary care providers and medical doctors or hospitals, though some highlighted specific concerns related to medical specialists and urgent care clinics. Participants provided very brief descriptions or acknowledgements of situations that included staff, nurses, medical assistants or other professionals in the healthcare field. The most salient themes related to negative experiences included: (1) lengthy wait time to receive services, (2) lack of communication with patients and with other providers, and (3) providers' interpersonal skills.

Wait time. This was one of the most mentioned factors contributing to a negative experience. For some participants increased wait time was perceived as an indication of either providers' lack of interest in patients or lack of sensitivity to patients' medical needs. The participants did not provide a concrete amount of wait time that they perceived as acceptable; instead, as mentioned previously, reaction to wait time was often dependent on the quality of care they received.

Participants' descriptions regarding this theme included waiting to be seen by the provider, waiting for results of tests and labs, and waiting for prescriptions to be filled or ordered. For example, Loretta, a 63-year-old woman, shared her experience of having to wait for two days for her medication to treat a case of bronchitis before her physician sent appropriate orders to her pharmacy.

As captured in positive experiences, wait time was highly linked with quality of care for participants. Most participants' perceptions were that waiting to see providers was unavoidable, but the length of time tolerated seemed proportionate to the attentiveness and thoroughness of the provider during the participants' appointments. For participants, wait time applied to both office visits and inter-professional communication that can potentially cost patients days in waiting to receive needed medications and/or other services. The factor of communication in general also became a topic of importance during the focus group interviews for participants.

Communication. Participants highlighted the importance of communication. Our analysis captured participants' negative experiences related to (1) lack of communication between providers and (2) lack of communication to the patient regarding clinic procedures.

In regards to lack of communication between providers and patients, participants felt negatively about experiences in which providers provided unclear information to them about treatment procedures, medication dosage, and/or diagnoses. Most participants identified experiences in which they had left a medical appointment with a sense of confusion or lack of clarity in regards to at least one aspect of their medical care. This theme also includes participants' descriptions of the impact that lack of communication between providers had on their medical care.

Finally, participants also shared a lack of communication regarding clinic procedures that left them feeling "dumb" and contributed to their negative experience. Linda and Sandra both

related to feelings of inadequacy due to lack of explanation regarding clinic procedures. Sandra mentioned,

> *"I think when you do go into the doctor's office and you're like, oh, I don't quite know what I'm doing they treat you a little bit bad. They treat you like you're dumb. And you're not dumb you just don't know what you know…I just don't know what to expect. Do I sign here or do I stand at this window, you know, what am I supposed to do? ... I think that can be intimidating."*

The negative experiences associated with provider miscommunication or lack of thoroughness and clarity caused patients to feel frustrated and confused. Exploration of these miscommunications became a precursor to participants discussing their providers' interpersonal skills in general and how these characteristics affected their negative experiences in healthcare settings.

Providers' interpersonal skills. Participants shared their distaste for providers that made them feel dismissed, not listened to, or silenced ("like [they] should not speak up" or "advocate" for themselves) and highlighted numerous situations where they believed they had not received the appropriate attention. Beatriz shared her feelings of being dismissed as a provider left abruptly while giving her feedback about her health. Beatriz stated,

> *"In the middle of conversation y'know he [Beatriz's physician] gets a call 'oh, I've got to take this, it's an emergency' so we're left when he was just about to tell us some results so it got, so then by then something else comes up and gets and he gets taken up here or there or wherever."*

Like other participants, Wayne reported feeling that his provider did not really care about him as a person. Wayne and Norma discussed feeling viewed as "pests" by their healthcare providers when "asking too many questions" or advocating for themselves.

Participants also expressed that a provider's lack of cultural sensitivity influenced their negative experience in healthcare settings. Sandra, for example, shared her experience of a provider's awareness of culture in providing appropriate and beneficial care to her grandfather who was suffering from cancer. Sandra highlighted that cultural awareness is lacking in many healthcare providers and explained how this diminishes the quality of care received by the patient.

In regards to cultural sensitivity, some of the participants shared their perception regarding the value of non-Western healing methods and indicated that they did not feel comfortable sharing their experiences utilizing non-Western healing methods with medical providers. While many participants reported feeling uncomfortable disclosing the utilization of non-traditional healing methods to their medical providers, most participants valued these approaches and noted using non-Western methods before they considered traditional healthcare options. Although not all participants shared their experiences with non-traditional healing methods, participants indicated that understanding these methods was an important cultural factor often ignored or discounted by their medical providers.

Participants' experiences with medical staff and providers greatly affected their perception of the quality of care that they received. The factors contributing to these perceptions were both positive and negative and included such factors as wait time, interpersonal skills, etc. Additionally, participants highlighted discrete experiences in which they perceived discrimination from their

healthcare providers. In many cases, experiences with discrimination further exacerbated the numerous other factors contributing to a negative experience.

<u>Perceived discrimination</u>

Participants also discussed several aspects of identity that contributed to their overall perception of being discriminated against within healthcare settings. These aspects of identity included age, ethnicity, gender, language preference (English vs. Spanish), perceived socioeconomic status, and type of insurance the patient held. Each of these facets of identity was perceived to alter the treatment a patient received (e.g., unequal administration of services by the healthcare providers).

Age. Participants had varying experiences of perceiving discrimination due to being "too young" or "too old." Sandra shared her perception about age discrimination in healthcare:

> *"I know when my grandfather was in the hospital, being elderly they would treat him a lot differently until I would get there and made sure to be there with him at all times because he would tell me, 'you know, I've been calling the nurse and she hasn't come,' so then I would have to go get the nurse and to help um so I definitely think with the elderly too there's a big discrimination…They kind of just "ah, they're old people" kind of and yeah"*

The younger participants reported receiving less detailed health information from providers and attributed this to age discrimination due to the perception that young patients do not understand or are less invested in their treatment. John shared his experience with this, stating, "Um, yeah. I feel like age is a big part of it because when you're younger they usually don't tell you as much information because you don't understand and when you're older, I guess, like you should understand a lot more stuff and you can give more consent than when you're younger." Overall, participants indicated getting differential and often subpar treatment based on their age.

Language. Many participants expressed perceptions, both firsthand and those of loved ones,' of receiving differing services based on language preference, fluency, or accent. This included feeling dismissed due to not speaking English. Norma shared,

> *"I think, from us, like I said, we have a lot of family members who have been ill, very ill. And I think on our, my point of view anyway, is that a lot of times, they come to you, the doctor [does], and they figure 'well, their English is not very good, so they really don't know what to ask.' And I guess it's just what they don't know won't hurt them. You know? 'We'll just treat them as best as we can, and they don't ask the patient…"*

Linda also described an uncomfortable interaction in her orthodontist's office with a healthcare provider that observed her mother's accent and began asking personal and intrusive questions about Mexico. Linda described,

> *"She (the healthcare provider) was just asking my mom a lot of questions, about Mexico and they were kind of rude and I was just like, kind of like uncomfortable and I didn't really like it. It's just 'cause my mom has a heavy accent and it's not like mine, I have a, it's not a heavy accent like hers but you could tell my mom's Mexican of course so yeah you could tell she was just kind of judgmental I guess. She was just trying to figure us out…I feel like it's also in the accent it's like the way you talk and appear, yeah."*

Sandra also shared her perceptions of discrimination based on language preference and accent. She discussed her grandfather's strategy to appear more Anglo in order to receive better quality health services. Sandra shared,

> *"I know my grandfather definitely has experienced it [discrimination based on language, race, and ethnicity]. He's very light skinned with green eyes so nobody would assume he was Hispanic so he used to tell me he made sure that he didn't speak Spanish you know, I mean, he really worked hard to get rid of his accent and because he knew that there would be a difference going to the doctor between somebody who even had the slightest accent…They're not a priority."*

Language, and specifically a person's accent, was reported to be an aspect of identity that participants perceived as a target of discrimination by healthcare providers. Some of the participants also alluded to the importance of language (i.e., English fluency), indicating that many relatives who do not speak English avoid seeking medical care out of fear of being misunderstood or treated poorly. In most cases, fear of not receiving adequate treatment was related to uncertainty of whether their ethnic/cultural background or skin complexion was the basis of this discrimination.

Ethnicity/cultural background. Participants also perceived differing treatment based on the patients' ethnicity. Mario, a 19-year-old student with a monolingual Spanish-speaking mother, shared their experience of perceiving discrimination when a patient has a surname that appears to be of Mexican heritage.

> *"I feel like it's different, like a different tone [if] the last name sounds like a Mexican last name they'll be like, "oh." Like it's a different tone from another last name that's not Mexican, you know what I mean? So I feel like that also has a big role…your name too."*

Thomas expressed his perception that in order to be taken more seriously in healthcare settings, people from ethnic minority groups need to project a "higher" status. Thomas stated,

> *"But I think it [ethnicity] does play a big role in it, yeah, like I think even anything like say you're gonna go apply for a loan, you know. You have to present yourself. It's similar, same thing I would say and especially if you don't, if you can't meet that criteria of being able to like say, um, your ethnic, like that ethnic barrier you need to present yourself higher, you know, just to make up for that."*

Thomas' experiences, like that of many of the other participants, made it evident that the intersecting dimensions of patients' identities contributed to the treatment they received. According to some of the participants, although discrimination based on patients' ethnicity or cultural background did occur, the most common form of discrimination they encountered was in relation to perceived socioeconomic status.

Socioeconomic status. Most of the participants commented on their experiences receiving differing treatment based on providers' perception of their socioeconomic status, commonly signified through the way the patient was dressed. Congruent with Thomas' comment above, Linda shared her strategies of negotiating discrimination in order to counter expecting inadequate services. While considering what it would be like to give birth in a hospital, Linda commented,

> *"If I ever had to really actually go to the hospital I'd wanna dress up like…I wanna look nice 'cause I feel like they'd treat me better if I was like looking nicer or you know what I mean? Other than just looking like my normal everyday wear 'cause I feel like they'd just be like, okay, she's just like, a peasant…and I'm not gonna help her as much as she needs help because she doesn't have money or something you know? Or something like that. I'd wanna dress up better just so I can get help, you know?"*

Mario related this perception to the provider's assumption that someone who was dressed nice would be more likely to advocate for themselves and therefore should be treated better. He stated,

"I think you have to dress up to present that…not illusion, but that sense of power that if they don't treat you right, then you're gonna do something, you're gonna advocate for yourself whereas they kind of assume you're not going to because maybe you're just dressed you know normally."

Lastly, participants shared their perception that the type of insurance a patient held contributed to their discrimination experiences. These experiences ranged from patients feeling more hastily discharged to receiving faster services based on type of insurance (e.g., low-income vs. private insurance). Wayne stated,

"The thing is, now, if you don't have insurance, right away they take you out. They get you out of the hospital quick. They don't – you're sick or whatever, it don't matter. They just give you a little something and send you home."

Sandra also shared her experiences traversing insurance carriers, and therefore, socioeconomic statuses. She shared that although private insurance may garner better services from providers, it is also more expensive and therefore, a patient is less apt to seek healthcare services due to large expenditures.

"I've experienced healthcare from you know when I was younger being on Medicaid to going to Tricare with the military and then going back to private insurance and there is different, definitely different ways that they treat your within all three and each of them is hard to deal with. I think even when you have private insurance um they may treat you a little better but you're paying for it so financially it's a lot harder so therefore, you don't go to um the doctors much 'cause you just can't really afford it but then if you don't have the private insurance, you don't go to the doctor because they treat you like poop [laughs] So it's like what's the lesser of all evils, you know?"

John also described receiving differing degrees of immediacy and attentiveness in care based on his type of insurance coverage (e.g., university student athlete insurance vs. under his parents' coverage as a high school student). John shared,

"I got to see him a lot quicker and um, and I don't know if it was 'cause I was under like the student athlete insurance…or if um, I don't know what it was but um, the cooperation and the process took a lot shorter that time. Whenever I broke my foot whenever I was in college than whenever I was still in high school."

Age, gender, language, ethnicity/cultural background, and socioeconomic status were identified by participants as aspects of identity that contributed to a perception of discrimination toward patients by their healthcare providers. The perception of discrimination by these Latino/Hispanic participants sheds light on how healthcare providers may be unknowingly creating barriers in patient care that may have a large impact on the overall health of this group.

DISCUSSION

The current study used qualitative focus group data from which three major themes emerged: (a) factors related to a positive experience in healthcare settings (e.g., collaborative or team-based care, quality service), (b) factors related to a negative experience in healthcare settings (e.g., long-wait times, poor communication), and (c) factors related to perceived discrimination (e.g., differential treatment based on age, language, race/ethnicity, socioeconomic status, etc.). These themes highlight how Latino/Hispanic participants experienced the personnel, processes, and organizations associated with healthcare service delivery in the borderland region.

<u>Factors related to a positive experience in healthcare settings</u>

Many participants in our study felt positively about their healthcare experiences when they had short wait times in the waiting room, reduced wait time to meet with providers, or were able to obtain same-day appointments. Our participants also acknowledged that providers' thoroughness and positive communication could mitigate the stress of long wait times, as patients understood that providers would be thorough with each patient. These findings concur with other studies indicating that increased wait time combined with reduced time spent with providers is often associated with substantial drops in patient satisfaction (Camacho, Anderson, Safrit, Jones, & Hoffman, 2006), but that despite lengthy wait times, time spent with providers was the greatest predictor of patient satisfaction (Anderson, Camacho, & Balkrishnan, 2007). The availability of same-day appointments was another salient factor contributing to our participants' positive experience. This could be related to some of the socioeconomic background of our study population. Specifically, Latino/Hispanic patients, particular those who are immigrants or low-income (such as those in HPSA designated counties where our study took place), are less likely to own automobiles and are more reliant on ride-shares and borrowing vehicles to engage in daily activities (Karner, Rowangould, & London, 2016; McGuckin, Srinvasan, & Murakami, 2001). Another major theme discussed by participants was quality of care, which included provider communication with patients, the thoroughness of providers, perceived professionalism, and perceived competence of the provider. Patients viewed positive communication and thoroughness as synonymous with providers' availability to answer questions, explain conditions and treatments thoroughly, and follow up with them after appointments. Research indicates that physicians spend a median of 16 minutes with each patient regardless of the type or number of presenting problems (Tai-Seale, McGuire, & Zhang, 2007). It is likely that patients with more complex problems or those that have several questions about their health status may feel that providers are not thoroughly addressing their concerns. However, when providers are able to be more thorough, the extra time or effort they take may exponentially enhance satisfaction for patients. This is indicated in our study where participants felt that they received better quality care from providers who offered detailed explanations about their health status and were "warm" and "down to earth." This finding also concurs with studies indicating that Latino/Hispanic patients may uphold cultural values like *simpatía* (kindness and politeness in the face of adversity), *personalismo* (professional affability), and *respecto* (respect) that guide their thinking about healthcare encounters (Carteret, 2011; Juckett, 2013; National Alliance for Hispanic Health, 2001).

Additionally, participants in the current study associated high quality care with team-based care (i.e. interprofessional collaboration) or witnessing their providers collaborate to enhance the quality of their care. This finding is in line with studies that have identified many benefits of team-based care, including enhanced clinical effectiveness, patient satisfaction, and provider-patient and provider-provider communication (Mitchell et al., 2012; O'Daniel & Rosenstein, 2008; Wen & Schulman, 2014). It may be that team-based care and interprofessional collaboration helped

Latino/Hispanic patients in our study feel like valued members of their healthcare team because their providers worked together to understand and treat their conditions. Given that Latinos/Hispanics are more likely than non-Latino Whites to report poor communication from providers (HHS, 2016), team-based care may be a useful approach to reduce poor communication and enhance patients' perception of care quality as suggested by our study findings.

Factors related to a negative experience in healthcare settings

Many participants indicated they experienced lengthy wait times to meet with providers, to receive laboratory or test results, and to have providers process their prescriptions. Consistent with the literature (Anderson et al., 2007; Bleustein et al., 2014; Michael, Schaffer, Egan, Little, & Pritchard, 2013), patients in our study associated longer wait times with lower quality of care, lack of confidence in their providers, and staff demonstrating disinterest in their medical needs. Although the negative influence of wait time on healthcare experience is evident from our participants' narratives, it is less clear how this negative impact may be alleviated. Some studies have suggested useful ways to decrease potential negative effects, including informing patients of the reasons for an extended wait time, giving patients advance notice about the wait time, providing access to free Wi-Fi or television in the waiting room, or providers offering a personal apology to patients (Blizzard, 2005; Chan, 2014). These courtesies may be particularly beneficial for Latinos/Hispanics in HPSA designated counties (e.g., our study location) given the financial and transportation barriers that make it challenging to get to healthcare clinics and pay for appointments.

Lack of communication between providers and patients, amongst providers, and from the agency to patients were among the themes identified in our study. Our findings indicate that Latino/Hispanic patients felt less satisfied with their healthcare experiences because they received unclear and confusing information about treatment and clinic procedures, medication dosages, and/or diagnoses. This finding may be especially concerning because miscommunications and lack of communication have been cited as barriers to treatment adherence (Hartley & Repede, 2011; Zolnierek & Dimatteo, 2009). Our participants reported feeling uncomfortable or "dumb" when attempting to navigate healthcare clinics without clear communication regarding clinic procedures. This finding highlights the importance of healthcare communication in all levels where the healthcare encounters may take place, not just between providers and patients.

Many participants noted difficulties with providers' interpersonal skills citing that they were "rushed" through appointments and that providers often dismissed their questions and concerns. Our finding coincides with recent research highlighting the need to train healthcare providers with better listening skills and more composed presence when with patients (Marvel, Epstein, Flowers, & Beckham, 1999; NPR/Robert Wood Johnson Foundation/Harvard School of Public Health, 2012). Specifically, data indicated that three out of five patients believe their doctors rush through appointments, that providers often spend between 18-23 seconds listening to patients before interrupting them, and that patients complete their initial thoughts in less than 25% of all office visits (Marvel et al., 1999; NPR/Robert Wood Johnson Foundation/Harvard School of Public Health, 2012). As such, the experience of feeling rushed, unheard, or dismissed appears to be a widespread phenomenon. Adding to this prevalent concern, our participants noted experiences where they felt that healthcare providers lacked attentiveness and awareness of their needs as patients, which they believe was linked to factors beyond providers' unhelpful interpersonal skills, including cultural insensitivity and unchecked cultural biases.

Factors related to perceived discrimination

Our focus group interviews revealed themes suggesting biased or discriminative healthcare treatment experienced by participants due to their sociodemographic identities. Age was a factor identified by participants as contributing to receiving lower quality healthcare. Participants discussed the treatment of older adults in healthcare settings as being less attentive and more dismissive. This finding appears to echo research literature on ageism in healthcare that demonstrates that age-based discrimination has a negative impact on how older adults are engaged during the treatment process and on their receipt of appropriate medical procedures and prescriptions (Eymard & Doughlas, 2012; Robb, Chen, & Haley, 2002). Interestingly, some participants in our study also identified young adulthood as a potential source of ageism due to the assumption that young people do not need or want more information from healthcare providers. Although we could not find other studies documenting similar ageism experienced by young adulthood aged individuals, one study examining access to mental health care revealed that younger adults experienced significantly more barriers (e.g., inability to find a helpful provider, fear of using services, etc.) than older adults (Pepin, Segal, & Coolidge, 2009). It may be that young adulthood is typically associated with vitality and health concerns such as drug use or family planning such that when a young adult person is in need of healthcare, providers or healthcare staff may unconsciously hold undue assumptions or biases motivated by the patient's age that affect healthcare service provision (Council & Medicine, 2015; Sherman-Jones, 2003).

Language also emerged as a factor influencing healthcare encounters. Participants identified accented English and being primarily Spanish speaking as relevant to receiving differential and lower quality treatment in medical settings. Similar findings have been revealed in studies that demonstrate language as a significant barrier to access and quality of care (Calo et al., 2015; O'Brien & Shea, 2011). In addition to voicing their own experiences, many participants in our study described how some predominately Spanish-speaking Latino/Hispanic persons that they knew did not come to doctor appointments for fear of being judged or misunderstood. This finding resonates with research indicating that to ensure that linguistically disadvantaged patients can communicate their healthcare needs, healthcare agencies should use language interpreters, hire bilingual staff, and have medical documents translated in other languages (Chong, 2002).

Participants discussed their Hispanic/Latino identity as a "barrier" in healthcare settings. Disheartening as it can be, this finding is not surprising given that numerous studies have documented that race or ethnicity based discrimination is frequent in healthcare settings (LaVeist, Nickerson, & Bowie, 2000; Shavers et al., 2012; Smedley, Stith, & Nelson, 2003). There is also research indicating that perceived racial and/or ethnic discrimination may be a prevalent concern for Latinos/Hispanics in healthcare settings (Perez, Sribney, & Rodriguez, 2009). Our study participants also alluded to demoralizing healthcare experiences because of their multiple disadvantaged sociodemographic identities (e.g., minority ethnicity and older age), which seems to align with a recent study finding that African American and Latina/Hispanic older adults were provided with fewer resources in healthcare than white older adults (Jimenez, Schmidt, Kim, & Cook, 2016). In our study, some participants felt the need to project a "higher" status to "make up" for the fact that they belonged to a certain ethnic group, and to combat the stereotypes they believed healthcare providers held about Latino/Hispanic people. However, participants also commented on the possibility that the borderland region's high density of Latina/Hispanic population may be protective against discrimination based on race or ethnicity. Thus, it is possible that participants in our study were not exposed to as elevated levels of discrimination as otherwise might be experienced in other areas of the U.S. The potentially protective feature of this region

may in part owe to healthcare providers and workers interacting with large communities of Latino/Hispanic patients such that their cultural knowledge and competencies are enhanced. There may also be comparably more opportunities to meet with service providers from same-ethnic Latino/Hispanic backgrounds than in regions with few Latino/Hispanic providers.

Socioeconomic status has been found to be a major social determinant of health, influencing health outcomes and health behaviors (Adler & Newman, 2002), which is also indicated in the findings of our study. Our study participants perceived judgments from healthcare providers and personnel about patients' socioeconomic status based on attire, insurance status, or type of insurance. Participants discussed the need to "dress up" in order to receive higher quality healthcare. Some participants noticed that they were treated poorly (e.g., experienced delays to meet with providers, felt rushed out of the hospital) when they had government-sponsored insurance as compared to private insurance. This echoes research findings that patients with government-sponsored insurance or no insurance are often vulnerable to receiving inferior care (Hasan, Orav & Hicks, 2010; Spencer, Gaskin & Robert, 2013; Tajeu et al., 2015). Overall, our findings indicate that social and demographic identities play an important role in disparities in healthcare, at least from the participants' perspectives. As such, our findings support scholars' cogent calls for attending to issues of implicit bias, stereotyping, and discrimination to ensure that age, gender, language, ethnicity/cultural background, and socioeconomic status inequities are considered in ways that help to enhance quality of healthcare instead of detract from it (Blair, Steiner, & Havranek, 2011; Chapman, Kaatz, & Carnes, 2013).

Limitations

Our study findings may not be generalizable due to the somewhat unique sociocultural landscape of the southwestern "borderland" region of the US. Participants identified this particular geographical location to be somewhat protective due to the normativity of identifying as Latino/Hispanic in a region that has a large representation of this population. Furthermore, in areas close to the U.S.-Mexico border, individuals with legal ability to cross borders often seek healthcare in Mexico (which was also reported by some of our participants), where healthcare services and medications are more accessible, affordable, and, for some, interactions with providers less tense (Heyman, Nunez, & Talavera, 2009). This may mean that individuals in the borderland region respond with alternative options to help replace inequities found in the formal U.S. health system (Casteñeda & Melo, 2014). Thus, it is possible that some of our participants may have tailored their responses to reply specifically about U.S.-specific topics.

It should also be noted that many of our participants self-identified as Mexican, Chicano or Chicana, or Mexican American, which only represents limitedly the diverse ethnicities within the Latino/Hispanic community. Another limitation was that the majority of our focus groups were held in community centers and schools. While this may have afforded participants the opportunity to speak about their healthcare agencies and providers without fear of retaliation, it may have resulted in our team interviewing Latino/Hispanic healthcare patients that had the finances and time to attend a focus group away from their healthcare clinic at a different time than they usually go in for appointments. Finally, our findings are based on a small sample of adults with wide-ranging ages and thus may not adequately capture the complexity and entirety of health care needs and experiences of Latino/Hispanic individuals.

Implications for Practice

Our findings indicate that wait time plays a significant factor in Latino/Hispanic patients' healthcare experience. Healthcare providers and agencies may reduce the negative impact of wait

time by ensuring that positive interpersonal ambience (e.g., the "warm" and "down to earth" qualities noted by our participants) is present. This could entail providers' exhibiting *simpatía* and *personalismo* by being attentive, taking time to answer questions, exchanging brief pleasantries with patients once they meet with them, and explaining time constraints or necessary alterations in routine appointments. Given the importance of communication to many participants in our study, healthcare clinics may want to hold orientations with patients about the clinic procedures and provide written instructions, medical directions, and clinic procedures in the language that is most comprehensible to patients.

Additionally, our findings regarding patients' experiences with differential treatment based on ethnicity, age, socioeconomic status and other factors suggest the importance of increasing healthcare professionals' awareness about their potential bias and cultural competence. It may be necessary for healthcare clinics that serve Latino/Hispanic patients to have mandatory trainings in awareness of implicit bias and cultural competence. Some research has indicated usefulness of educational training videos on Latino/Hispanic health beliefs, healthcare seeking behaviors and cultural values in improving the cultural competency of providers (McGuire, Garces-Palacio, & Scarinci, 2012).

Future Research Directions

Our study findings converge with the large body of research literature with Latinos/Hispanics' experiences of healthcare (e.g., wait time, communication, cultural values), but also reveal potentially borderland specific phenomena such as experiences shaped by ethnic density and providers' familiarity with Latino/Hispanic culture. Building upon our study, future research could investigate whether and how the racial and ethnic demography of an area may impact Latino/Hispanic patients' experiences with healthcare. It may also be worthwhile to examine how healthcare experiences in the borderland region may be shaped by changes in political powers in the state and national levels. For example, our study was conducted before the U.S.-Mexico border wall became a heated political debate (and later an executive order), it is unknown how participants' healthcare behaviors (e.g., border crossing for healthcare in Mexico) might be different as a result of that. Another line of research could involve examination of how seemingly minute variations in sociodemographic identities (e.g., skin color, ethnic origin) may influence Latino/Hispanic persons' healthcare experience. Such within-group variations may be uniquely relevant for Latinos/Hispanics in the borderland given that intragroup differences may become more readily discerned and acknowledged in communities where ethnic minorities have a sizable presence (Dovidio, Hewston, Glick, & Esses, 2010). These lines of research may extend our findings to further elucidate healthcare experiences of Latinos/Hispanics in HPSA-designated borderland communities.

REFERENCES

Abelson, R. P., Dasgupta, N., Park, J., & Banaji M. R. (1998). Perceptions of the collective other. *Personality and Social Psychology Review, 2*(4), 243-250.

Adler, N.E. & Newman, K. (2002). Socioeconomic disparities in health: Pathways and policies. *Health Affairs, 21*(2), 60-76.

Anderson, L. M, Scrimshar, S. C., Fullilove, M. T., Fielding J. E., & Normand, J. (2003). Task force on community preventive services. Culturally competent healthcare systems. A systematic review. *American Journal of Preventive Medicine, 24*(3), 68-79.

Anderson, R. T., Camacho, F. T., & Balkrishnan, R. (2007). Willing to wait?: The influence of patient wait time on satisfaction with primary care. *BMC Health Services Research, 7*, 31

Betancourt, J. R., Green, A. R., Carrillo, J. E., Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports, 118*(4), 293-302

Bisgaier, J. & Rhodes, K. V. (2011). Auditing access to specialty care for children with public insurance. *New England Journal of Medicine, 364*(24), 2324-2333.

Blair, I. V., Steiner, J. F., & Havranek, E. P. (2011). Unconscious (implicit) bias and health disparities: Where do we go from here? *The Permanente Journal, 15*(2), 71-78.

Bleustein, C., Rothschild, D. B., Valen, A., Valantis, E., Schweitzer L., Jones, R. (2014). Wait times, patient satisfaction scores, and the perception of care. *American Journal of Managed Care, 20*(5), 393-400.

Blizzard, R. (2005, October 25). Healthcare Panel: How Do People Choose Hospitals? Retrieved from http://www.gallup.com/poll/19402/healthcare-panel-how-people-choose-hospitals.aspx

Border Region. (2014). El Paso, TX: United States-Mexico Border Health Commission. Retrieved from http://www.borderhealth.org/border_region.php

Cacari-Stone, L. & Avila, M. (2012). Rethinking research ethics for Latinos: The policy paradox of health reform and the role of social justice. *Ethics Behavior, 22*(6), 445-460.

Calo, W.A., Cubillos, L., Breen, J., Hall, M., Rojas, K. F. Mooneyham, R., Schaal, J., Hardy, C. Y., Dave, G., Jolies, M. P., Garcia, N., & Reuland, D. S. (2015). Experiences of Latinos with limited English proficiency with patient registration systems and their interactions with clinic front office staff: An exploratory study to inform community-based translational research in North Carolina. *BMC Health Services Research, 15*, 70.

Camacho, F., Anderson, R., Safrit, A., Jones A. S., & Hoffman P. (2006). The relationship between patient's perceived waiting time and office-based practice satisfaction. *North Carolina Medical Journal, 67*(6), 409-413.

Campinha-Bacote, J. (2011). Delivering patient-centered care in the midst of a cultural conflict: The role of cultural competent. *Online Journal of Issues in Nursing, 16*(2), 5.

Carteret, M. (2011). Cultural Values of Latino Patients and Families. Retrieved from, http://www.dimensionsofculture.com/2011/03/cultural-values-of-latino-patients-and-families/

Castañeda, H. & Melo, M. A. (2014). Health care access for Latino mixed-status families: Barriers, strategies, and implications for reform. *American Behavioral Science, 58*(14), 1891-1909.

Centers for Disease Control and Prevention (2013). *CDC Health Disparities and Inequalities Report – United States 2013* [PDF document]. Atlanta, GA: US Department of Health and Human Services.

Centers for Disease Control and Prevention. (2011). *CDC Health Disparities and Inequalities Report – United States 2011* [PDF document]. Atlanta, GA: Centers for Disease Control and Prevention.

Chan, T. (2014). Wait times and patient satisfaction: Perception is reality. Retrieved November 23, 2016**,** from https://www.advisory.com/research/medical-group-strategy-council/practice-notes/2014/october/wait-times

Chapman, E. N., Kaatz, A., Carnes, M. (2013). Physicians and implicit bias: How doctors may unwittingly perpetuate health care disparities. *Journal of General Internal Medicine, 28*(11), 1504-1510.

Chong, N. (2002). *The Latino Patient*. Boston, MA: Intercultural Press

Commission on Social Determinants of Health – final report (2008). Retrieved from http://www.who.int/social_determinants/thecommission/finalreport/en/

Council, N. R., & Medicine, I. O. (2015). *Investing in the Health and Well-Being of Youth Adults*. Washington: National Academies Press.

Creswell, J. W. (2013). *Qualitative Inquiry and Research Design: Choosing Among Five Approaches (3rd ed)*. Thousand Oaks, CA: SAGE.

Cristancho, S., Garces, D. M., Peters K. E., Mueller B. C. (2008). Listening to rural Hispanic immigrants in the Midwest: A community-based participatory assessment of major barriers to health care access and use. *Qualitative Health Research, 18*(5), 633-546.

Cuevas, A. G., Dawson, B. A., & Williams, D. R. (2016). Race and skin color in Latino health: An analytic review, *American Journal of Public Health, 106*(12), 2131-2136.

Dovidio, J. R., Hewstone, M., Glick, P., & Esses, V. M. (2010). *The SAGE Handbook of Prejudice, Stereotyping and Discrimination*. Thousand Oaks, CA: Sage Publications.

Eymard, A. S. & Douglas, D. H. (2012). Ageism among health care providers and interventions to improve their attitudes toward older adults: An integrative review. *Journal of Gerontological Nursing, 38*(5), 26-35.

Garces, I. C., Scarinci, I. C., & Harrison, L. (2006). An examination of sociocultural factors associated with health and health care seeking among Latina immigrants. *Journal of Immigrants and Minority Health, 8*(4), 377-385.

Hartley, M. & Repede, E. (2011). Nurse practitioner communication and treatment adherence in hypertensive patients. *Journal Nurse Practitioner, 7*(8), 654-659.

Hasan, O., Orav, E. J., & Hicks, L. S. (2010). Insurance status hospital care for myocardial infraction, stroke, and pneumonia. *Journal of Hospital Medicine, 5*(8), 452-459.

Health Resources and Services Administration. (2015a). *HPSA County and Country Equivalent Listing: Dental Care* [PDF document]. Rockville, MD: Health Resources and Services Administration of the Department of Health and Human Services. Retrieved from htpp://datawarehouse.hrsa.gov/DataDownload/DRN/E_BDC_HPSA_H6_FederalRegister.pdf.

Health Resources and Services Administration. (2015b). *HPSA County and Country Equivalent Listing: Mental Health* [PDF document]. Rockville, MD: Mental Resources and Services Administration of the Department of Health and Human Services. Retrieved from http://datawarehouse.hrsa.gov/DataDownload/FRN/F_BCD_HPSA_H7_FederalRegister.pdf.

Health Resources and Services Administration. (2015c). *HPSA County and County Equivalent Listing: Primary Care* [PDF document].

Rockville: MD: Health Resources and Services Administration of the Department of Health and Human Services. Retrieved from http://datawarehouse.hrsa.gov/DataDownload/FRN/D_BSD_HPSA.H1_FederalRegister.pdf.

Heyman, J. M, Nunez, G. G, & Talavera, V. (2009). Healthcare access and barriers for unauthorized immigrants in El Paso County, Texas. *Family Community Health, 32*(1), 4-21.

Institute of Medicine (US) Committee on Quality of Health Care in America. (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press.

Jacobs, E. A., Beach, M. C., & Saha, S. (2010). What matters in health disparities education – changing hearts or minds?. *Journal of General Internal Medicine, 2*, 198-190.

Jimenez, D. E., Schmidt, A. C., Kim, G., Cook, B. L. (2016). Impact of comorbid mental health needs on racial/ethnic disparities in general medical care utilization among older adult. *International Journal of Geriatric Psychiatry, 32,* 909-921.

Johnson, K. R. (1997). "Melting pot or "ring of fire"?: Assimilation and the Mexican-American experience. *California Law Review, 85,* 1259-1313.

Juckett, G. (2013). Caring for Latino patients. *American Family Physician, 87*(1), 48-54.

Karner, A., Rowangould, D., & London, J. (2016). *We Can Get There From Here: New Perspectives on transportation Equity* [PDF document]. Retrieved from https://ncst.ucdavis.edu/wp-content/uploads/2016/12/NCST_EquityWhitePaper-FINAL.pdf

Kelly, P. J. (2012). Should we rethink how we teach cultural competency in physician assistant education?, *Journal of Physician Assistant Education, 23*(2), 42-50.

Kressin, N. R. & Peterson, L. A. (2001). Racial differences in the use of invasive cardiovascular procedures: Review of the literature and prescription for future research. *Annuls of Internal Medicine, 135*(5), 325-366.

LaVeist, T. E., Nickerson, K. J., & Bowie, J. V. (2000). Attitudes about racism, medical mistrust, and satisfaction with care among African American and white cardiac patients. *Medical Care Research and Review, 1*, 146-161.

Marvel, M. K., Epstein, R. M., Flowers, K., & Beckham, H. B. (1999). Soliciting the patient's agenda: Have we improved? *Journal of the American Medical Association, 281*(3), 283-287.

Matthys, J., Elwyn, G., Van Nuland, M., Van Maele, G., De Sutter, A., De Meyere, M., & Deveugele, M. (2009). Patients' ideas, concerns, and expectations (ICE) in general practice: Impact on prescribing. *British Journal of General Practice, 59*(558), 29-36.

McGuckin, N., Srinivasan, N., & Murakami, E. (2001). *Do Race and Ethnicity Make a Difference in Travel and Commuting Behavior?* [PDF document]. Washington, DC: Federal Highway Administration. Retrieved from http://www.travelbehavior.us/Nancy-pdfs/Do%20Race%20and%20Ethnicity%20Make%20a%20Difference%20in%20Travel%20Behavior%20Paper.pdf

McGuire, A. A., Garces-Palacio, I. C., & Scarinci, I. C. (2012). A successful guide in understanding Latino immigrant patients: An aid for health care professionals. *Family and Community Health, 35*(1), 76-84.

Metzl, J. M. & Hansen. H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine, 103*, 126-133.

Michael, M., Schaffer, S. D., Egan, P. L., Little, B. B., & Pritchard, P. S. (2013). Improving wait times and patient satisfaction in primary care. *Journal of Healthcare Quality, 35*(2), 50-59; 59-60.

Mitchell, P., Wynia, M., Golden, R., McNellis, B., Okun, S., Webb, C. E., Rohrbach, V., & Von Kohorn, I. (2012). *Core principles and values of effective team-based health care* [PDF document]. Washington, DC: Institute of Medicine. Retrieved from http://micmrc.org/system/files/Core_Principles_%26_Values_of_Effective_Team-Based_Health_Care.pdf

National Alliance for Hispanic Health. (2011). *Quality health services for Hispanics: The cultural competency component* [PDF document]. Department of Health and Human Services. Retrieved from https://www.hrsa.gov/culturalcompetence/servicesforhispanics.pdf

National Center for Ethics in Health Care. (2006). *Teach back: A tool for improving provider-patient communication* [PDF document]. Washington, DC: U.S. Department of Veteran Affairs. Retrieved from https://www.ethics.va.gov/docs/infocus/Infocus_20060401_teach_back.pdf

Nelson, A. (2002). Unequal treatment: Confronting racial and ethnic disparities in health care. *Journal of National Medication Association, 94*(8), 6666-6668.

Nerenz, D. R., Ulmer, C., & McFadden, B. (2009). *Race, ethnicity, and language data: Standardization for health care quality improvement.* Washington, D.C.: National Academies Press.

New Mexico Department of Health. (2014). *Health Equity in New Mexico: A Report on Racial and Ethnic Health Disparities (9th ed.)* [PDF document]. Santa Fe, NM: New Mexico Department of Health. Retrieved from https://nmhealth.org/publication/view/report/1346

New Mexico Department of Health. (2014-2016). *New Mexico State Health Assessment*. Santa Fe, NM: New Mexico Department of Health. Retrieved from https://nmhealth.org/publication/view/report/407/

New Mexico Health Care Workforce Committee. (2015). *2015 Annual Report.* Albuquerque, NM: University of New Mexico Health Sciences Center. Retrieved from http://www.nmnec.org/uploads/FileLinks/933875ef41ef4474b4e844f09423bbef/NM_Hlthcr_Workforce_Comm_2015_Report.pdf

NPR/Robert Wood Johnson Foundation/Harvard School of Public Health. *Poll: Sick in America Summary* [PDF document]. (2012). Retrieved from http://www.npr.org/documents/2012/may/poll/summary.pdf

O'Brien, M. & Shea, J. (2011). Disparities in patient satisfaction among Hispanics: The role of language preference. *Journal of Immigrant and Minority Health, 13*(2), 408-412.

O'Daniel, M. & Rosenstein, A. H. (2008). Professional Communication and Team Collaboration. In Hughes, R.G. (Ed.), *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*. Rockville, MD: Agency for Healthcare Research and Quality.

O'Malley, A. S., Forrest, C. B., Feng, S., & Madelblatt, J. (2005). Disparities despite coverage: Gaps in colorectal cancer screening among Medicare beneficiaries. *Archive of Internal Medicine, 165*(18), 2129-2135.

O'Malley, A. S., Sheppard, V. B., Schwartz, M., & Madelblatt, J. (2004). The role of trust in use of preventive services among low-income African-American women. *Preventive Medicine, 38*(6), 777-785.

Pepin, R., Segal, D. L., & Coolidge, F. L. (2009). Intrinsic and extrinsic barriers to mental health care among community-dwelling younger and older adults. *Aging Mental Health, 13*(5), 769-777.

Perez, D., Sribney, W. M., & Rodriguez, M. A. (2009). Perceived discrimination and self-reported quality of care among Latinos in the United States. *Journal of General Internal Medicine, 3*, 548-554.

Quesada, J., Hart, L. K., & Bourgois, P. (2011). Structural vulnerability and health: Latino migrant laborers in the United States, *Medical Anthropology, 30*(4), 339-362.

Robb, C., Cheng, H., & Haley, W. E. (2002). Ageism in mental health and health care: A critical review. *Journal of Clinical Geropsychology, 8*(1), 1-12.

Savin-Baden, M. & Major, C. (2013). *Qualitative Research: The Essential Guide to Theory and Practice*. London: Routledge.

Shavers, V. L., Fagan, P., Jones, D., Klein, W. M., Boyington, J., Moten, C., & Rorie E. (2012). The state of research on racial/ethnic discrimination in the receipt of health care. *American Journal of Public Health, 102*(5), 953-966.

Sheppard, V. B., Williams, K. P., & Richardson, J. T. (2004). Women's priorities for lay health home visitors: Implications for eliminated health disparities among undeserved women. *Journal of Health & Social Policy, 18*(3), 19-35.

Sheppard, V. B., Williams, K. P., Wang, J., Shavers, V., & Mandelblatt, J. S. (2014). An examination of factors associated with healthcare discrimination in Latina immigrants: The role of healthcare relationships and language. *Journal of the National Medical Association, 106*(1), 15-22.

Sherman-Jones, A. (2003). Young people's perceptions of and access to health advice. *Nursing Times, 99*(30), 32-35.

Simons, M. A., Chang, E. S., & Dong, X. (2010). Partnership, reflection and patient focus: Advancing cultural competency training relevance. *Medical Education, 44*(6), 540-542.

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

Smyser, M. & Ciske, M. (2001). *Public Health Special Report: Racial and Ethnic Discrimination in Health Care Settings* [PDF document]. Kind Country, WA: Public Health – Seattle & King County. Retrieved fromhttp://www.kingcounty.gov/healthservices/health/

Spencer, C. S., Gaskin, D. J., & Roberts, E. T. (2013). The quality of care delivered to patients within the same hospital varies by insurance type. *Health Affairs, 32*(19), 1731-1739.

State & country quickfacts: Las Cruces, NM. (n.d.). Washington, DC: U.S. Census Bureau. Retrieved from https://www.census.gov/quickfacts/table/PST045215/3539380

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri J. M., Holder, A. M., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychology, 62*(4), 271-286.

Tai-Seale, M., McGuide, T. G., & Zhang, W. (2007). Time allocation in primary care office visits. *Health Services Research, 42*(5), 1871-1894.

Tajeu, G. S., Cherrington, A. L, Andreae, L., Prince, C., Holt, C. L., & Halanych, J. H. (2015). "We'll get to you when we get to you": Exploring potential contributions of health care staff behaviors to patient perceptions of discrimination and satisfaction. *American Journal of Public Health, 105*(10), 2076-2082.

Timmons, C. L. (2002). The impact of language barriers on the health care of Latinos in the United States: A review of the literature and guidelines for practice. *Journal of Midwifery and Woman's Health, 47*(2), 80-96.

United-States-Mexico Border Health Commission (2014). *Access to Health Care in the U.S.-Mexico Border Region: Challenges and Opportunities*. El Paso, TX: United States-Mexico Border Health Commission. Retrieved from http://ww.borderhealth.org/files/res_2756.pdf

US Census Bureau (2016). QuickFacts 2016: Las Cruces NM. Retrieved from https://www.census.gov/quickfacts/fact/table/lascrucescitynewmexico/PST045216

US Department of Health and Human Services (2016). *2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy*. Rockville, MD: Agency for Healthcare Research Quality.

Vega, W. A., Rodriguez, M. A., & Gruskin, E. (2009). Health disparities in the Latino population. *Epidemiology Review, 31*, 99-112.

Wen, J. & Schulman, K. A. (2014). Can team-based care improve patient satisfaction? A systematic review of randomized controlled trials. *PLoS One, 9*(7), 1-9.

Xu, P. (2012). *Using teach back for patient education and self-management* [PDF document]. American Nurse Today. Retrieved from https://www.americannursetoday.com/using-teach-back-for-patient-education-and-self-management/

Zolnierek, K. B. & Dimatteo, M. R. (2009). Physician communication and patient adherence to treatment: A meta-analysis. *Medical Care, 47*, 826-834.