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DIMENSIONS OF QUALITY OF CARE: AFRICAN AMERICANS' PERSPECTIVES

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Marie Ngetiko Fongwa

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DEDICATION

To my beloved parents Tita Fongwa and Lydia Beyogha Fongwa (late) for sowing the seed of beauty that has bloomed to its fullest. For your existence was not in vain.

To my aunt, Julia Kah Gamaga Galega (late). For assuming the maternal role for me during my first year of life following the passing of Beyogha Fongwa. For insisting that school was the best place for me. You passed on your boundless and intense love, virtues, caring, and tenderness to all of us, your children. My days are now decorated with songs you taught me, the style that we did many things, and your echoing words of love. Though you are now with the Angels, in my heart you live with me for ever. Thank you Mom.

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ABSTRACT

DIMENSIONS OF QUALITY OF CARE: AFRICAN AMERICANS' PERSPECTIVES

Marie Ngetiko Fongwa

In this descriptive study, data related to African Americans' dimensions of quality of care in the San Francisco Bay Area of Northern California were collected using focus group and a Modified Delphi approach. In-depth focus group interviews explored and described participants' (a) level of quality of care knowledge, (b) perceptions, feelings/opinions about available health care services, (c) satisfaction with available health services, and (d) perspectives on how such services can better serve their health care needs. The Delphi technique was used to validate and achieve consensus on the focus group information. Seven focus groups were conducted (N = 35). Twenty-two of the 35 people (63%) responded to the first round of the Delphi while 19 of the 22 (86.36%) responded to the second round.

The focus group data was analyzed for its content and the main idea statements (140 in all) were abstracted and submitted to the Modified Delphi process. In the first round, participants rated each statement on a scale of 1-6 (strongly disagree to strongly agree). In Round 2, participants compared their individual scores with the group mean scores on each statement to decide if they wished to change their minds. Using a preset inclusion criterion of at least 55% or more positive responses, eight statements were excluded. Following Round 2, the remaining 132 quality of care statements were organized at the issue level (30 issues) under four focus group interview guide questions. Qualitative thematic narratives and categorization of the 132 statements into Holzemer's

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(1996) Outcomes Model for Healthcare Research (3x3 model) were two other ways in which the findings were analyzed.

The analysis of the dimensions of quality of care showed congruence with what exists in the literature and as captured by the 3x3 model and two proposed quality of care models. The congruence demonstrated the well educated participants' knowledge sophistication on quality of care issues. The qualitative narratives revealed six themes (quick fixes metaphor, care-seeking militancy, proof of health insurance: no guarantee for quality care, the skin as a communication medium, assumptions about blacks, and providers' stereotype beliefs/behavior) that identify significant quality of care issues for African Americans. The study implications include the need for health care providers' value clarification and behavioral change, modification of satisfaction measures to include the variable of respect, consideration of patients' background information in care plans, and a need for further quality of care studies including development of a culturally sensitive satisfaction measure.

Suzanne Bakken Henry

Suzanne Bakken Henry, RN, DNSc, FAAN - Advisor

Marie Ngetiko Fongwa

Marie Ngetiko Fongwa, RN, MPH, PhD

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CHAPTER ONE

Introduction

The purpose of the study was to learn about African Americans' experiences and opinions about quality of health care and to use the information in establishing dimensions of quality of care from their perspectives. The study was based on the belief that learning about people's perceptions of quality will help health care providers, including doctors and nurses, to provide health care that is culturally appropriate and acceptable. Knowing African Americans' dimensions of quality of care is a precursor to developing an appropriate quality care tool (e.g., satisfaction instrument) for this population. Quality is a value-laden concept and its meaning varies among different groups and cultures. Value implies something that is intrinsically desirable. The desired attribute has degrees or ranks of desirability, reflecting social and cultural values. Quality cannot be measured directly but indirectly via the way it is perceived (Larrabee, 1996).

Background of the Problem

The assumptions that underlie the study are that (a) quality health care to all human beings is a given right and not a privilege, (b) quality may not be achieved without the incorporation of a patient's beliefs and values into the plan of care, and (c) receiving inputs from the consumers of health care services is crucial in providing them with care that is of quality. Therefore, knowing and incorporating African Americans' dimensions of quality of care (including their perceptions of quality and satisfaction variables) into health care provider's plan of care should result in culturally congruent and quality care.

Differential quality of health care across client groups takes the form of excessive

waiting periods, less thorough diagnostic evaluations, and withholding of indicated treatment. Limited access to affordable, high quality, nondiscriminatory health care results in delay in seeking care, diagnosis, and treatment in late stages of illness and poorer prognosis (Stevens, 1992). Stevens noted that rates of death due to preventable and manageable conditions are 77% higher for African Americans than Euro-Americans and are associated with poor access to existing medical, public health, and preventable services. The latter could result from health care institutional problem, patient distrust of health care provider, or both. In a literature review on the intention to helpseek for breast cancer symptoms, African American women were found to delay help seeking longer than Caucasian Americans (Facione, 1994). Facione stated that one's performance of a given behavior depends on personal and environmental factors that facilitate or constrain the behavior.

History informs the present that race has always played a role in health care (Culley, 1996; Green, 1995; Williams, 1994). Race is a socially constructed term that was arbitrarily chosen to distinguish between white and black. From 1830-1870, race concept distinguished white superiority from black inferiority as well as supported the idealogy that Negroes' (blacks) innate racial difference sanctioned them as slaves (Krieger, 1987). Then, black/white health status disparities resulted from whites' desire for cheap black labor. Instead, such disparities in disease were seen primarily as a consequence of individuals' innate constitution instead of a reflection of their intrinsic membership in group created by the social relationship of the society in which they lived. White-Means (1995) said that cultural norms of families, experiences of discrimination, and ability to cope with

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one's environment vary by race. Subsequently, ethnicity and race are resources that form a context for behavior. Edwards (1992) said that an ethnic group belongs to a social group within a cultural and social system that claims or is accorded special status on the basis of complex, often variable traits including religious, linguistic, ancestral or physical characteristics. White-Means defined race as a composite measure of social, psychological, biological, and genetic influences on a person's life. Krieger (1987) wrote that current biases between the races seem tame compared to the more virulent and florid forms of over 100 years ago though they are equally pernicious. White-Means (1995) referred to the policy-making "Report of the Secretary's Task Force on Black and Minority Health" as victim-blaming because it conveyed the familiar belief that poorer health of minority communities is the result of numerous individuals making ill-informed "life-style choices" rather than a consequence of racial oppression and the disproportionate concentration of minorities in lower strata of the working class.

Williams, Singh, Santos, Winfrey, and Mezger (1996) noted that there is a complicated legacy of distrust which holds that established institutions of medical research have both the power to cure and the intent to harm. Green (1995) cited the famous Tuskegee Study, a U.S. Public Health Service investigation that documented the course of syphilis from 1932-1972 in a sample of 400 African Americans with latent syphilis. It was argued that the injustice marked by illegal human experimentation and violation of protocols governing study with human subjects would not have occurred had the subjects been whites. Green further noted racial differences in the use of specific cardiac procedures for patients admitted to Massachusetts hospitals in 1985. Racism was

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observed to influence selection of candidates for cardiac procedures.

Facione (1994) noted that in the 1940's and 1950's doctors in some states scheduled night appointments for African American women to avoid offending their white patients. They also delayed treatment for African Americans compared to Caucasian Americans. Racial discrimination practices noted to influence African American women helpseeking behavior include (a) lack of respectful treatment (e.g., African American women refused a prenatal program to decrease low birth weight - LBW in their infants because of disrespectful treatment by providers) and (b) insensitive (e.g.,sensitive to low socio-economic status) care providers (Facione, 1994). Lack of respectful treatment and insensitivity of care providers may not be limited to African American females but to everyone from that racial background. A lack of prenatal care may result in increased incidence of poor health outcomes (morbidity and mortality).

Stevens (1992) remarks about providers and consumers of health care services include (a) clinical decisions are made with social criteria in mind, (b) the operation of health care providers' unexamined prejudices and ethnocentrism are apparent in health care interactions with groups such as persons of color, and (c) disproportionate number of ethnic minority people live in low income households and their vulnerability to access is significantly related to poor access to health care systems and poor quality of health care. Citing the Joint Commission on Accreditation of Healthcare Organizations, Corrigan and Nielsen (1993) referred to access as a shorthand term for a broad set of concerns that center on the degree to which individuals and groups are able to obtain needed services from the health care systems.

Greipp (1996) says that ethnocentrism on the part of the health care workers has been documented in the literature and has led to misdiagnosis, mistreatment, and under treatment of minority groups individuals worldwide. In a study to identify psychosocial variables (age, gender, and culture status of the client) which enhanced and/or inhibited female nurses' predicted reactions with clients and which have the power to contribute to unethical decision making and less than ethical client care, Greipp reported that (a) client gender, as a main effect, was not significant in itself when examining self and colleague predictions, (b) client age, as a main effect, was significant for self predictions ($p < .006$) and for colleague predictions ($p < .000$), and (c) client culture, as a main effect, was significant for self predictions ($p < .001$) and for colleague predictions ($p < .000$). Greipp's (1996) third finding supports the earlier statement that lack of respectful treatment and insensitiveness of care may not be limited to African American females but to everyone from that racial group.

Edwards (1992) stated that ethnicity, as a variable in health services research, has been linked with health behaviors and outcomes. The belief system and the conducts of an individual affect the person's daily living. Packer and Addison (1989) cautioned that in everyday living as well as well as in the conduct of science, one should not throw away one's culture or past because knowledge cannot be built or even rebuilt from scratch. Strickland (1992) stated that cultural experience and ethnic background influence the meaning associated with illness, responses to pain, and what people consider as appropriate and acceptable health behaviors and health care. Culture (very much linked to ethnicity) is defined as a pattern of values, beliefs, customs, and symbols that is shared by

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a group and provides meaning for group members' existence together (Henderson, Sampselle, Mayes, & Oakley, 1992). Culture does not exist in a vacuum, is not static but *is* a response to distinct historical and contemporary experiences.

Cameron and Luna (1996) stated that all human cultures have forms, patterns, and expressions that allow for knowing, explaining, and delivering culturally congruent care. Health beliefs and attitudes, symptoms expression, and utilization of services have been shown to vary across sub-groups. Leininger (1989) noted that differences in cultural values and beliefs can affect the quality of nursing care. Understanding of quality of care related issues from the people's perspective (emic) is therefore, important. One might miss accomplishing desired goal(s) when health planning activities for a cultural group include only the outsider's view point (etic) without the emic dimension. An important implication from the preceding information is that ethnicity/culture impacts health perceptions including those related to quality of care.

The conclusion at the Alma Ata conference in the Union of Soviet Socialist Republics was that Western bio-medicine was not meeting the needs of a large number of people except a privileged few. Unanimously, the world's nations endorsed an ambitious and declarative goal of "Health for all by the Year 2000" (World Health Organization - WHO, 1978) which was echoed by the WHO in 1979. Health is a universal human right and it is by no surprise that the United States (U.S.) health care objectives are related to those of the WHO. The U.S. national health objectives were published in 1979 in Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention. The targets (objectives) for 1990 were set for five major stages of life (healthy infants, healthy

children, healthy adolescents/young adults, healthy adults, and healthy older adults). These objectives were based on two goals - reducing mortality and improving quality of life by utilizing available tools for disease prevention (Alarcón, 1994; Fongwa-Asobo, 1995; U.S. DHHS, 1990; U.S. Public Health Service - PHS, 1995; Werner, 1993).

An expanded agenda, based on the above goals led to the 1990 objectives in Healthy People 2000. The objectives are based on three broad goals: (a) increase the span of healthy life for Americans, (b) reduce health disparities among Americans, and (c) achieve access to preventive services for all Americans (U.S. PHS, 1995). The PHS reported the following discrepancies: Healthy years - (a) all races = 64.0, (b) White = 65.0, (c) African American/Black = 56.0, and (d) Hispanic = 64.8. Life expectancy for (a) all races = 75.4, (b) White = 76.1, (c) African American = 69.1, and (d) Hispanic = Not applicable.

Nineteen ninety-five was the decade's midpoint for the Healthy People 2000 objectives. Reducing health disparities among Americans is the second goal but differences among the races was observed to persist. There were proportionately more (35%) objectives moving away from the targets (poorer health statistics) for African Americans. The latter was compared with percentages (moving in the wrong direction also) for the U.S. total population (18%), Hispanic (14%), Asian/Pacific Islanders (11%), and American Indian/Alaska Native (31%). These findings suggest that African Americans have disproportionately higher rates of negative health outcomes (related with poor quality of health care) when compared with other ethnic groups. Nagelkerk, Henry, and Brooten (1997) urged nurses world-wide to conduct studies that focus on health

promotion, risk reduction, and disease prevention for the most vulnerable.

The Public Health Service (1995) reported specific actions for African Americans including efforts to strengthen preventive services, research, and educational activities. Service activities include improving consolidation and flexibility in grant programs to better adapt to community needs, developing strategies to enhance the physical environment in communities, and developing a plan to broaden the reach toward young people. One can assume that an underlying assumption behind these targets (research-based) is that African Americans should have quality health care. Quality is a value-laden concept that has no universal definition which can satisfy everyone in any given situation (Donabedian, 1969; McCaughrin, 1994; Larrabee, 1996) but there is no doubt that quality of care positively affects the outcome of care. A question to ask is whether the national objectives actually address the health care needs and health care values of African Americans? In other words, is there a congruence between the targeted objectives and what African Americans see as important for their health in terms of what they need and want? This question is crucial considering the fact that African Americans have poorer health statistics than other ethnic groups. If the answer is a yes, one should take note of who is responding to the question (provider or African American consumer).

Although research-based targets are preferred to those that are not supported by research data, La Veist, Keith, and Guiterrez (1995) stated that most studies have suffered from limited samples with few African American respondents. The literature is replete with efforts that assess quality of care from the patients' perspective, but most of the studies have samples that do not include African Americans or were inadequately

represented in them. Selected research studies (23) on quality of care and patient satisfaction from three respected journals (Medical Care, Health Services Research, and Journal of Nursing Care Quality from 1991 through 1995) were reviewed with special attention to ethnic composition of their samples. The journal articles were restricted to United States-based empirical research. The selected articles had the words "quality care", "quality improvement", and "satisfaction" as part of their titles. Of the 23 studies, only six (Davis & Bush, 1995; Scardina, 1994; Carey & Seibert, 1993; Gustafson, Sainfort, Johnson, & Sateia, 1993; Ervin, Walcot-McQuigg, Chen, & Upshaw, 1992; Hays, Larson, Nelson, & Baltalden, 1991) specified the ethnic composition of their samples. Only one (16%; Ervin et al., 1992) of the six studies indicated that African Americans were part of the study sample. Mchorney, Ware, Lu, and Sherbourne (1994) stated that widespread use of standardized health surveys is predicated on the largely untested assumption that scales constructed from those surveys will satisfy minimum psychometric requirements across diverse population groups. The question of what constitutes African Americans' perspectives on quality of care remains unclear (little is known about their perceptions of quality) as long as they are not adequately represented in quality of care research. Instruments based on such research have the tendency to be biased against African Americans and information received from them with tools that are insensitive to their health care values and beliefs, as a unique cultural group, is incomplete. Developing quality of care and outcomes measures that capture African Americans' perspectives on the care they receive is an approach to increased effectiveness research. The latter is a challenge to health care providers and researchers and is in line with

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Nagelkerk et al.'s (1997) admonition to conduct studies on the most vulnerable.

Statement of the Problem

The problem that the study addresses concerns the assumption that quality patient care may not be achieved without the incorporation of a patient's beliefs and values in the plan of care. Very little is known about African American health care beliefs and values including those related to quality of care. Thus, the research question addressed is "What are African Americans' perceptions of health care quality?" Frost (1992) noted that a diligent health care worker can no longer assume what quality is but instead s/he must strive to clearly delineate its meaning so that it can be identified and measured. In order to be competitive in today's health care market, health care providers must provide quality care and they must also sought and incorporate patients' perspectives into routine quality evaluations (Chang, 1997).

Purpose of the Study

The purpose of the study was to learn about African Americans' experiences and opinions about quality of health care and to use the information in establishing dimensions of quality of care from their perspectives. It was a descriptive study that used focus group interviews (Phase 1) and a Modified Delphi (Phase 2) approach. In Phase 2 the participants in Phase 1 came to a consensus on the main ideas that described quality of care via a mailed survey. The specific objectives of the study were to elicit (a) African Americans' knowledge on quality of care, (b) their perceptions/feelings/opinions about available health care services, (c) their satisfaction with health services, and (d) how such services can better serve their health care needs.

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Significance of the Problem

The issues related to health care status of African Americans are described in the paragraphs that follow. Such issues support the idea that health care researchers, planners, and direct providers might have missed accomplishing their well intended goals in researching, planning, and delivering care for African Americans who constitute 12.3% (30 million per 1990 census report) of the population. Health care programs that include health care values of consumers are more likely to succeed than those that are based only on providers' values. Leininger (1989) wrote that by not using culture specific care, one can predict (and often see) cultural conflicts, dissatisfaction, and sometimes resistance to nursing care practices, especially where major differences exist between the client and professional nurses' values.

African Americans are almost twice as likely as whites to receive health care in hospital clinics, emergency rooms and other organized health care settings where an individual is likely to see a different provider on each visit and thus to suffer from lack of continuity in health care (Blendon, Aiken, Freeman, & Corey, 1989; Williams, 1994). Lack of continuity leaves room for poor quality care and follow-up as well as a decreased opportunity for sharing information that may be needed for initiating preventive health care services. African Americans spend more time in waiting rooms than whites, and are more likely to indicate that the seriousness of their illness or injury has not been explained, adequate information about medication has not been provided, and test or examination findings have not been done about the present health problem. It is of no surprise that African Americans are more dissatisfied than whites with quality of health care received

(Blendon et al., 1989). Evaluating the quality of care without determining if the consumer is satisfied is only half a measurement (Petersen, 1988). Even more, patient satisfaction (a) is closely linked with the growth of consumerism in public policy, (b) is regarded as an important indicator of quality of nursing and medical care, and (c) is widely used as an outcome measure that is sensitive to users' values when evaluating health care practices and organizing health services (Avis, Bond, & Arthur, 1995; Chang, 1997).

Although health outcomes indicated some improvements in access to health care for African Americans, they have one and a half times higher death rate than whites of the same age, and infant mortality rate (IMR) being twice that of whites (Blendon et al., 1989; Green, 1991). African Americans experience increased mortality and decreased life expectancy compared to whites (Schwartz, Kofie, Rivo, & Tuckson, 1990; Council on Ethical and Judicial Affairs, 1990). Among twelve sentinel causes of death in the U.S. during 1980-1986, the overall age-adjusted mortality rate among African Americans was 4.5 times that of whites (Schwartz et al., 1990). More than six-fold excess death among African Americans were due to hypertensive heart disease and only 22% of African American male hypertensives are adequately controlled.

In 1993, of the 58,538 cases infected with AIDS for all racial ethnic minority groups, 66% were African Americans (U.S. PHS, 1994). AIDS rate for African American females was noted to be 15 times their white counterparts and that for African American males was almost five times that of whites males. Cancer as a second leading cause of death for African Americans has a higher age-adjusted death rate than any other racial group. The 1994 cancer report indicated that increased mortality from cancer from 1973

to 1991 for white males was 5.6% and 23% for African American males (U.S. PHS, 1994). Higher incidence rates and poorer post-diagnosis survival, in part due to later detection, were cited as reasons for the disparities.

Pregnancy rates remain higher for African American adolescents than for their white or Hispanic peers. About 19% of all African American women aged 15-19 become pregnant each year compared to whites (8%) and Hispanics (13%). The higher rate among African Americans is linked with the possibility that they are less likely to use contraceptive methods or use them effectively. African Americans, as compared to whites and Asians, are more likely to be uninsured and that may interfere with the chance for provider and consumer to exchange the right health information (Meredith & Siu, 1995). A health provider who uses some standard to assess patients' quality scores can make a significant difference in improving their health status. Gustafson et al., 1993) observed that an important use of a quality index would be to identify opportunities to improve the practice patterns of providers. Parkerson, Broadhead, and Tse (1995) noted that patient-report questionnaire data can be used to identify those patients who are at high risk of adverse health-related outcomes and who may not be recognized as such in the more traditional medical history-physical examination-physiologic test data sets. The African American teenage pregnancy problem is directly related to the national goal of achieving access to preventive services for all Americans.

Premature birth (before 37 weeks of gestation) and LBW (<2500 grams) are related to increased incidence of infant mortality (Green, 1991). Any pregnant mother without health care insurance is likely to not receive any sort of prenatal care and thus, has

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a greater chance of having preterm delivery and/or LBW/small-for-date baby. In 1995 Kerr, Verrier, Ying, and Spears, found that preterm births for whites, Hispanics, and African Americans were 7.1%, 10.2%, and 15.7% respectively. African Americans are less likely to have a physician contact and more likely to have fewer visits per year than whites. Nickens (1995) viewed infant mortality as a key index of well-being of a population.

In 1994 the U.S. PHS referred to escalating rate of homicide among African Americans as a law enforcement issue and a public health crisis. Between 1987 and 1992 homicide rate for all (African American) 15-34-year-old females increased from 6.5 to 6.8 and all 15-34-year-old males increased from 22.0 to 31.6 per 100,000 cases. There is a need for increased family and community involvement in intervention strategies as well as evaluation of ongoing research and programs.

Summary

The U.S. lofty health goals for all Americans can only be realized when accurate information is received from all Americans and such information is incorporated into health program planning processes. There is no question that quality care positively influences patient outcomes. Of significance for African Americans is to reduce the disparities between their health outcomes and those of other ethnic groups. They have poorer health outcomes. Schwartz and colleagues (1990) noted that excess poor health outcomes for African Americans may be related to access and quality of health care services. Currently, there are no satisfaction measures specific for African Americans. A sound patient satisfaction instrument should include the patients' perspective. The latter is

crucial since quality is a multifaceted concept and its meaning tends to vary among individual groups. Research studies that identify such variations provide basis for instrument development and refinement. Thus, the need to clearly delineate dimensions of quality of care from African Americans' point of view.

It could be argued that there is no difference between African Americans' interpretation of quality and those of other ethnic groups. Thus, no need for development of evaluation tool for this specific group. Counter to such an argument include the fact that (a) people's cultural backgrounds influence their perceptions and interpretations of a phenomenon, (b) there were no studies that depict African Americans' health care values related to quality of care and quite often, they are under represented in research studies on which evaluation tools are based (c) the idea of satisfaction instrument development could not be abandoned until results of several studies support the argument of no difference among America's ethnic groups, and (d) the question(s) about why African Americans continue to have higher morbidity and mortality rates than other ethnic groups must be adequately addressed to prevent a repeat of the same processes that have failed to produce positive health outcomes for this group.

Increased consumers' knowledge-base that aids them in making educated health care decisions is common in all cultures. Consumers are entering health care settings expecting greater professional attention, timely service, and error-free treatment (U.S. Office of Technology Assessment, 1988; Kanar, 1988). Thus, African Americans' saviness about the quality of care they receive cannot be under estimated. In light of African Americans' health care experience, it was concluded that there is a critical need for

conducting quality of care studies such as one that focuses on their perspectives on quality.

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

This chapter reviews the literature on perspectives on quality of care including those of African Americans, theoretical concepts, an illustration on managing complex issues, and quality indicators. Also included are quality of care recommended models for ensuring patients' satisfaction. In this review, the words client/consumer/customer will be used synonymously with patient. Practitioner will be used synonymously with provider. Definition of terms will be provided throughout.

Perspectives on Quality of Care

The paternalistic era when health care consumers were expected to take what was made available to them by their providers is gone. The times these days including the facts that consumers of health care services (a) are questioning what they receive, (b) are expected to know as much as they can about the care they receive, and (c) are sometimes expected to ask for what they wish to get from their providers. The Congressional Office of Technology Assessment (1988) suggested three compelling reasons why better information about quality health care should be given to consumers. First, health care seekers should have information to help them determine who is a good provider or a poor provider of care. Second, specific information on providers would over time form part of the public education effort to understand health care quality, resulting in more informed consumers in the competitive marketplace. Finally, publicly shared information would stimulate the medical providers to improve.

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CHAPTER TWO

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Frederick, Sharp, and Atkins (1988) noted that the change (trend) is related to (a)

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today's health industry's competitive environment that encourages the use of business marketing techniques to attract and retain patients, (b) the world-wide consumerism trend, and (c) the growing awareness on the part of health professionals and the public that consumers have the right to be active participants in their health care. They further noted that consumer or professional's definition of quality is inadequate. The latter is based on the notion that quality is an elusive concept and its meaning varies among individuals and groups. Such variations in meanings require that providers' and consumers' perspectives on quality of care be examined separately, noting the similarities and differences. To be aware of the different perspectives on quality is critical, if provision of quality of care is an objective for providers and is also what consumers wish to get. Knowing the different perspectives reduces stereotyping tendencies and fragile (not research-based) assumptions about consumers of health care services. Kurata, Nogawa, Phillips, Hoffman, and Werblun (1992) said that understanding the differences in perceptions may help to promote better communication between health providers and their patients. They further stated that comparing provider and patient satisfaction with health care can identify areas where medical consumers and experts differ in their perceptions of satisfaction with care.

It is compelling for providers to arrive at a set of criteria by which current health care facilities/services are measured, thus, providing the consumers with concrete, definable indicators of quality (Rudolph & Hill, 1994). Although Rudolph and Hill noted that the best approach is to seek the expert judgments of health care providers themselves, such team of experts should have consumer representative(s) to prevent practice imposition on consumers. The term provider here includes physicians, nurses,

administrators, and other health care providers since they have varied perspectives on quality. For example, Rudolph and Hill (1994) noted that nurses are different from physicians in that they tend to focus on technical competence and interpersonal relations in their assessment of quality of care. Rudolph and Hill further stated that the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) addition of a nursing representative to its board of commissioners, acknowledged the vital role of the nursing profession in addressing quality of care issues. Nurses deserve a say in the processes that determine clinical policies, and therefore quality, for health care institutions.

Since perceptions of quality vary among providers and consumers of health care (Donabedian, 1969; Ludwig-Beymer, Ryan, Johnson, Hennessy, Gattuso, Epsom, & Czurylo, 1993), professional nursing values and management concerns may conflict with those of patients (Pettit & White, 1991). Pettit and White conducted a descriptive study using a 44-item self report questionnaire to find out the meaning of quality in a randomly selected sample of 397 participants (100 physicians, 100 staff nurses, 97 managers, and 100 patients from medical-surgical, and cardiac units). Three dimensions of care used were adapted from Risser's (1975) concepts of technical-professional, educational, and trusting relationships. The instrument was pilot tested to evaluate its reliability but no quantitative value was reported. Content validity was established by peer review. Scoring was on a 5-point Likert-type scale. It is uncertain if patients were given the chance to review the survey questions. The latter poses a potential limitation because the patients were important component of the sample.

The results indicated that physicians, nurses, patients, and hospital administrators

differed in their perceptions of quality of care. A significant difference between groups was revealed on the education dimension of quality. The physicians valued the items measuring consumer education significantly less than patients, nurses, and administrators ($p = 0.000$). On the contrary, patients rated education as the most important aspect of care. Between group analysis showed a significant difference regarding basic needs. Patients rated questions concerning basic needs significantly higher in importance than did the three groups of health professional ($p = 0.000$). There was no significant difference between groups on the interpersonal dimension.

Information given by care providers, especially physicians, is a primary concern. Lack of information exchange is a source of dissatisfaction for patients. Addressing this issue during new hires' (physicians, nurses, therapists, nutritionist, etc.) orientation is crucial. Since patients value basic needs significantly higher than did the professional groups, receiving a bed pan or help to and from the bathroom, and receiving pain medication should not be belittled by care providers. Ludwig-Beymer et al. (1993) reported rapid nurse response as a measure of quality. Failure to administer medications may lead to increased length of stay (LOS) subsequent to delayed healing process. An extended LOS is financially costly for both the patients and the care provider. Finkler and Kovner (1993) referred to patient's length of stay as the most important predictor of hospital cost. Even more so, there is an increasing pressure on nurse mangers to decrease patient length of stay.

Rudolph and Hill (1994) used two focus group discussions to (a) identify factors that registered nurses considered to be most important in determining the quality of care

provided by hospitals and (b) determine whether nurses and physicians hold similar opinions about the importance of the objective criteria. Data analysis showed that nurses' perceptions were very much in line with those of physicians. Overall, nurses selected the ratio of registered nurses to beds as the top indicator of hospital quality, followed by the percentage of board-certified physicians on staff, the presence of discharge planning services, the level of technology, service mix, and membership in the Council on Teaching Hospitals (COTH). Although the two groups differed somewhat, they both reached consensus around the importance of sophisticated nursing and certified medical staff as contributors to high-quality health care in hospital settings. On the whole, the nurses held much the same views as their physicians and academic colleagues on quality of care despite a different perspective.

Kurata et al. (1992) compared patient and provider satisfaction with medical care and waiting time in five outpatient family medicine clinics. Telephone interviews were conducted with 156 randomly selected English-speaking adults. The patients rated their satisfaction with 10 aspects of their medical care and the length of time they waited to see their physicians. The scale items measured four factors (technical quality of the visit, access to care in terms of waiting time to see provider while at the health care center that day and number of days to get an appointment, courtesy of medical care staff and providers, and general satisfaction with medical care). The response scale included five categories and ranged from "very satisfied" to "very dissatisfied". The patients' results were compared with those of 65 health care providers (family physicians, nurse practitioners, registered nurses, and social workers) who responded to the same survey

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items through a self-administered questionnaire. The providers rated the health centers from their perspective, not what they perceived patients' satisfaction to be, and estimated the number of minutes patients usually waited at the center before being seen by a health provider. The design was threatened by selection bias since non-English speaking patients, those under 18 years of age, first-time patients, those who had already been interviewed or had not kept their appointments that day were excluded from the study.

The results indicated that 97% of patients and 89% of providers were satisfied with the overall medical care provided. About 8% of patients and 22% of providers were dissatisfied with the waiting time; 11% of patients and about 60% of providers were dissatisfied with appointment schedules. Patients' estimates of waiting time for care (mean = 16.1 minutes) were significantly shorter than providers' estimates (mean = 27.5 minutes). Dissatisfied patients' estimated waiting time was 41.8 minutes while satisfied patients' estimated 13.3 minutes. The difference was significant at less than 0.001 level. Patients' higher (than providers') levels of satisfaction with medical care was noted to be consistent with other studies. Risser (1975) and these investigators noted that patients may hesitate to express dissatisfaction with their physicians or health care system because they (patients) must continue to rely on such resources. Both the patients and providers were dissatisfied with access to care.

Hennessy and Friesen (1994) conducted a descriptive pilot study to explore hospitalized Mexican American patients' (age 20-65 years) perceptions of quality in relation to socio-economic status (SES) and medical treatment setting using a modified 26 items short-form Patient Judgment System and Hollingshead Two Factor Index of Social

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Position. The result indicated some demographic differences between two groups but no significant difference in perception among the groups regarding SES and setting. However, a trend emerged showing that low SES group was less satisfied with care received. The latter contrasts with the U.S. Office of Technology Assessment's (1988) notion that socio-economically disadvantaged patients tend to rate the quality of their care more favorably than their more advantaged patient counterparts.

Despite the inconsistencies in the relationship between satisfaction and access, Cleary and McNeil (1988) noted that access is one of the most important determinants of patient satisfaction. Patients with higher incomes and more education tend to be less satisfied with large prepaid plans and patients with lower income status sometimes prefer clinic care. Finkler and Kovner (1993) wrote that the rich tend to pay for many items that health insurance finds beyond the customary and reasonable limits. Those who receive care from prepaid plans may tend to be less satisfied than from fee-for-service patients but their (prepaid plan patients) satisfaction level may increase with time as contrasted with decreased satisfaction over time among patients in fee-for-service (Cleary & McNeil, 1988).

An argument in the Hennessy and Friesen study is that patients' and providers' perceptions are changing from a purely biological concept of disease to experiential concept of disease. Consequently, patients' perceptions of hospital experience and their satisfaction with the experience constitute reality for them. An assumption made was that quality of care definition from the patients' perspective is crucial in assuring support of patients' needs and that of their families. Patient satisfaction was defined as a

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measurement of patients' perception of quality on a Likert scale. Perception was defined as feeling (positive or negative) regarding the quality of care. Referring to patients' perceptions as actual outcomes, Hennessy and Friesen (1994) equated patient perception to patient satisfaction. Pettit and White (1991) noted that there is no clear cut agreement distinguishing perception from satisfaction. Implied from the study is the fact that patients' expectations (criteria) constitute the standard with which they compare their perceptions of care received, thus, making perception a criterion-referenced outcome variable. Major concepts which emerged from the construct of perception were environment, staff behavior, and SES. The relationship between environment and staff behavior was illustrated by a poor rating of nursing frequency of checking received from a post surgical patient who was only checked on a two hourly basis.

Ludwig-Beymer and colleagues (1993) analyzed data from three sources (unsolicited letters to hospital administrator, Patient Satisfaction Questionnaire, and Quality of Care Survey) for the purposes of defining patient perception of quality care and caring and comparing patient satisfaction with quality of care. Their findings indicated that patients' concepts of health care environment were different from providers' concepts when considering structure, process, and outcomes. The implication is that to adequately assess the variables of structure, process, and outcomes, providers must bridge meanings with those of their patients. There is no better way of doing that than getting inputs from the patients on their definitions of the three variables. Patients' decisions to return to a health care setting are dependent upon the patients' perceptions of caring behaviors which Ludwig-Beymer and colleagues termed as the callings of the head and heart.

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Taylor, Hudson and Keeling (1991) conducted two telephone interviews with sample of 70 pairs (patient and significant other) for the purpose of getting an adequate notion of what constitutes quality of nursing care. They noted that the constituents of quality of nursing care are "rooted in the perceptions and reactions of a group of consumers" (p. 25). Basing their study on Donabedian's (1966) conceptual model, Taylor and colleagues (1991) grouped their findings into three conceptual categories - psychosocial aspects or nature of nursing attribute, care-giver or nurse attribute, and practice setting attribute. The studies just described indicate that certain attributes of quality nursing care are associated with variables of the nurse, the patient, the provider-patient interaction, and the context in which the interaction takes place.

African Americans' Perception of Quality of Care

The arguments that African Americans are inadequately represented in research and that culture/ethnicity is not always incorporated into the plan of care for all of America's ethnic groups were supported by finding only two citations (Parkerson et al., 1995 ; Revicki, Wu, & Murray, 1995) in the Medline database using keyword "African American perception of quality of care". On the other hand, it is encouraging to know that the two research studies are recent endeavors. It is hoped that a trend (quality of care researchers focusing more on African Americans than they have done so far) is likely to follow. Wu et al. (1997) and Hays et al. (1996) conducted some quality of life studies with African Americans as part of their samples. Although quality of care may influence quality of life, the focus of this study is quality of care. Therefore, the details of the latter quality of life studies are not provided.

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Parkerson et al. (1995) conducted a longitudinal (8 months period and 18 months of follow-up) study to measure the effect of patient-perceived family stress in predicting five health-related outcomes (follow-up, frequent follow-up, referral and/or hospitalization, high severity at follow-up, and high follow-up). The aim of the study was to alert primary care providers to the possible importance of assessing routinely and quantitatively the family stress experienced by their patients. The convenience sample of 413 (47.2% African Americans and 52.8% Whites) was stratified by age-gender-race categories with 30 participants in each of 12 groups. A 129-item multi-dimensional tool was the patient-report questionnaire and it included the Duke Social Support and Stress Scale (DUSOCS), the Family Inventory of Life Events and Changes (FILE), the Duke-UNC Functional Social Support Questionnaire (DUFSS), the QL-Uniscale, the Duke Health Profile (DUKE), the State Anxiety Inventory (SAI), the Center for Epidemiologic Studies Depression Scale (CES-D), and the Rosenberg Self-Esteem Scale.

The effect of family support was controlled for but the results showed that (a) participants with high family stress, when compared with those reporting low levels of family stress, had lower quality of life, functional health, and social supports, while having higher dysfunctional health and social stressors, (b) high family stress was the strongest statistically significant predictor for all five outcomes, and (c) African American race predicted one or more follow-up visits while white race predicted the other four outcomes (via logistic analyses). Does this mean that African Americans experience less stress ? A possible explanation is that poor access (finance and insurance) to health care for African Americans may result in reduced follow-up of necessary care. It was concluded that

patients who perceived high family stress were at risk of greater future severity of illness, higher utilization of health services, and higher health care expense. There were only two ethnic groups in the study sample and African Americans were well represented . The conclusion challenged family physicians to identify such high risk patients and give them the special care that they need to prevent unfavorable outcomes. Screening eligible participants with a 17-item demographic questionnaire for literacy threatened the study design with selection bias.

The study by Revicki et al. (1995) was to examine the validity using known groups approach and the responsiveness of psychometric health status and health utility measures to changes in clinical conditions. Although the sample of 160 HIV-infected patients was 65% African Americans, nothing is mentioned about the ethnic representation of the other 35%. A question to ask is "How did African Americans differ from the 35%?" Narrowing the gap between African Americans' morbidity and mortality rates implies comparing health statistics between African Americans and other ethnic groups. By incorporating race and ethnicity into Americans' health care goals and objectives, the nation's appreciation of diversity is made obvious. Thus, health care researchers are challenged to include different ethnic representations in their samples and to also report the findings on the groups involved.

The study findings included poor to moderate correlation between health/utility preference and psychometric health status measures. Utilities represent the strength of a person's subjective preferences under conditions of uncertainty. Preferences reflect the values assigned to health states when uncertainty is not a condition of measurement. In

this study, the utility/preference approach used a scaling method that directly or indirectly derived a numeric value ranging from zero (death or worst possible health states) to 1.0 (complete health or the best possible health states). Although the authors were not surprised at the stated finding, they were uncertain on whether or not the weak correlation was due to poor respondent understanding of the standard gamble (SG) measurement task or the cognitive complexity of the SG procedure. Since African Americans are usually under-represented in many studies, it should be of no surprise that they (being the largest proportion in this study) were the least or not even represented in the study(s) on which the SG tool was based. If the latter is true, then the SG measure is probably not culturally sensitive for use with African Americans.

Revicki and colleagues (1995) stated that the selection of health status measures for evaluating HIV disease requires attention to the content of the scales. Taking this further includes ascertaining that tool items are sensitive or relevant to the respondents' needs and/or are understood by them (share the same meaning with the researcher). The authors referred to the lack of responsiveness in SG utilities as troublesome because utilities are used increasingly to generate quality-adjusted life years as measures of effectiveness in economic evaluations of health care interventions. Thus, the use of insensitive measures in cost-effectiveness analyses may lead to inaccurate decisions about the impact of new medical technologies on health outcomes. White-Means (1995) said that when there is an assumption that racial disparities in utilization are the same at all income levels, a dollar increase in income is also assumed to cause identical increases in the amount of medical services use by blacks and the amount used by whites. The 1994

U.S. PHS report that 66% of all racial ethnic minority groups infected with AIDS were African Americans lends to the speculation that this population will represent over half of those infected with the disease by the Year 2000. There is an urgent need to develop tools that are sensitive to this population's health care needs and that cannot be done in isolation. African Americans must be involved in health care research, both as consumers and researchers and their health care beliefs and values (especially those related to quality) must be identified and delineated. Assumptions of such beliefs and values have been the basis for many interventions that have led to the current health statistics for African Americans. Hargrove and Keller (1993) noted that the increasingly high incidence of morbidity and mortality rates among African Americans clearly indicates a need for research into the beliefs and practices of this ethnic group. Hargrove and Keller further stated that health care providers who develop an understanding of how individuals with different socio-cultural backgrounds and values perceive or define health will be able to plan effective health/illness management. Health care providers can increase their service effectiveness with this population by incorporating African Americans' beliefs and values into their plan of care.

Some African Americans' health care beliefs and values were identified in the literature even though they are not directly related to quality of care. Camino (1989) conducted an exploratory ethnographic research with 24 African Americans (19 females and 5 males) to explore the assumption that the meaning of ethnomedical complaints and syndromes is mutually comprehended by all patients and their affiliates within community settings. The study design included an in-depth interview of a purposeful sample. Camino

analyzed the syndrome nerves/worriation as experienced by low-income black women. Hargrove and Keller (1993) defined worriation and nerves as a formed classification of folk illness linked with life stress among black women. The findings showed (a) a lack of support for nerves among family members, (b) several community forces affect the communicative power of nerves as an idiom of distress in the community and its clinic, (c) direct communication of nerves outside is restricted, and (d) severity of symptoms is ignored and experiences of nerves are equated with deemed women life conditions. Cleary and Edgman-Levitan (1997) wrote that the way people receive and respond to information is a complex process that is influenced by a wide array of social factors. They supported the second finding (b) by Camino (1989).

Culture determines the basis for condensed meanings that patients attach to their illnesses. Through illnesses, patients are able to relay messages about their experiences and situations. Misconception may result from a patient's attempt to convey experience of ethnomedical syndrome to a practitioner who holds a biomedical set of meanings for the patient's complaint. Since symptoms of nerves may be perceived as manifestations of normal feminine behavior and/or be construed as symptomatic of other ailments, there is great potential for nerves communicated through symptomatic idioms to remain undetected or misinterpreted (Camino, 1989). In this case, if the syndrome nerves is not accurately diagnosed, it would not get the right treatment. Such a patient may rate the quality of his/her care as poor. Although not all patients whose conditions are not resolved would rate their care to have been of poor quality, many who get treated may associate their cure with good quality care. Hargrove and Keller (1993) said that if family

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members and health care professionals acknowledge and understand nerves and worriation, it would help to reduce the severity and/or frequency of their symptoms.

In a study to elicit a definition of health Hargrove and Keller (1993) posed a broad questions "How do you define health?" to 22 young black women (21-40 years of age). The sample for the exploratory study came from inner city church and Head Start Centers. The results indicated that health is defined in terms of (a) having or avoiding a disease, (b) the presence or absence of obesity, (c) experiencing and reducing stress, (d) good and bad habits, (e) eating good and bad foods, and (f) engaging or not engaging in exercise. Obesity was not described as being unhealthy; was not associated with heart disease, hypertension or diabetes; and having fat babies was associated with being healthy. Stress was described as worrying about money to pay bills, raising children, having troubles with men in their lives and dealing with single parents issues, anxiety, hair loss, and miserable from work-related stress. Finally, Hargrove and Keller (1993) understood that good habits were learned through education and a lack of such habits results in illness and death. The study design was threatened by selection bias as participants were volunteers and not every young black woman is associated with a an inner city church or Head Start Center; thus, reducing the generalizability of the findings.

Race-related Health Care Issues of African Americans

Bayne-Smith (1996) wrote that race in the U.S. accounts for health differences because race is a pervasive issue that affects every area of life. Race also provides the connecting thread to the negative health status of women from four of U.S. minority groups including blacks, she added. In other words, the unifying theme of race and its

ripple effect on economic, political, and cultural conditions of people from those minority groups influence their health statuses. White-Means (1995) wrote that race is a pervasive factor that interacts with many of the measures typically used to explain medical utilization patterns - SES (income, education, and health insurance coverage), attitudes, family cultures, and incidence of disease.

Racism affects African Americans' health care issues. Two studies to illustrate the influence of racism on their health care experiences are described. Facione (1994) conducted focus groups with African Americans (women with breast cancer) to identify the domains of helpseeking behavior in that cultural group. She observed that three new variables (perceptions of racism in the health care system, religiousness, and fatalistic beliefs in relation to breast cancer) were supported both by their spontaneous presence in all the focus group discussions and the anecdotal reportings of researchers interested in helpseeking behavior.

Facione (1994) said that vast majority of her focus group participants related occurrences that effectively diminished their access to acceptable health care, such as, "If you are Black and you go to the doctor, they think you're on welfare," and "You don't get the kind of courtesies you deserve," (p. 81). Green (1991) in her study of low birth weight and preterm delivery in African American childbearing women found racism to be related to stress. Though she did not find any significant relationships with these factors and birth weight and gestational age of the newborn, Green said that the theoretical relevance of racism and stress and the documented interrelationships in her study mandate their continued investigation. Green (1991) and Facione (1994) have demonstrated in

their various studies that racism exists and are related to health care issues of African Americans.

Religion, as a source of beliefs and values, may also influence one's expectations, and interpretations of quality of care. Religion may constitute a reason for someone's desire to seek alternate or additional treatment to Western approach of managing health problems. What Facione (1994) termed as fatalistic beliefs may just be the people's cultural reaction to incurable diseases.

Racial Matching of Patients and Care Provider

The issue of matching patients and care providers by racial or ethnic background can be advantageous in some situations but one must be careful about provider burden. Such an approach may be interpreted as segregating. Promotion of matching should therefore, be done with caution. In a study by Gray and Stoddard (1997) on pairing patients with physicians, the researchers found that minority patients were significantly more likely to report having minority physicians as their regular doctors, indeed, five times as likely as non-minorities to report that their regular physician is a member of a racial/ethnic minority, a disproportional rate independent of other socio-economic factors.

The U.S. President's Position on Race Issue

The issues between the races in the U.S. and elsewhere is not about to go away. Social dynamics in American history has prompted leaders including President William Jefferson Clinton to hold Town Hall Meetings on race. The American Broadcasting Corporation (ABC) news channel reported on the town hall meetings. On December 3, 1997 the President held a town hall meeting on race in Akron, Ohio where his emphases

were on treating each other as human beings, Affirmative Action, and education. In his State of the Union Address on January 28, 1998, President Clinton urged the U.S. Congress to enforce laws that promote equal opportunity employment - the crux of Affirmative Action. Another of the President's town hall meetings reported by ABC news media on April 14, 1998 was entitled" Commission on Race". A benefit of the President's action on racial issues is that a dialogue has been opened, at least between the races. His conclusion of the State of the Union address in 1998 was "...we must live together, serve together...people from different backgrounds should serve together. ...we are many, we must be one..."

Theoretical Concepts

Systems Theory Perspectives

Bertalanffy (1975) posited that customary investigation of single parts and processes cannot provide a complete explanation of the vital phenomena since a fundamental character of a living thing is its organization. This means that no information about coordination of the parts and processes is obtained, if only single aspects are investigated. Historically, the latter concept led to the acceptance of the notion of general system theory (formulated by von Bertalanffy in the 1930s and post World War II) as a new paradigm in understanding organized entities such as human biology, social groups, personality, technological devices, etc. Bertalanffy (1975) and McKay (1992) referred to a system as a set of objects together with relationships between the objects and between their attributes. Hirtzel-Trexler (1994) in her focus on organizational strategic planning referred to systems theory as a set of elements standing in interrelation among themselves

and with the environment. Thus, in a formal organization (a planned structure) the structure consists of systematically organized interconnected and integrated concepts and elements.

The essential components of a system are the objects (parts of the system), the properties of the objects identified as attributes, and the relationship among the objects and their attributes which hold the system together. Systems are either open or closed. Bertalanffy's (1972, 1975, & 1981) basic concepts of an organism as an open system include (a) the organism maintaining itself by a continual import and export of matter which is built up and broken down, (b) a system as having holistic properties that are not found separately in its parts, and (c) emphasizing the whole more than its parts. The properties (deduced from Aristotle's dictum that the whole is more than the sum of its parts) arise from the relations taken on by the parts in forming the whole.

Humans (living organisms) are examples of an open system because they are related to and exchange matter (inputs and outputs of both energy and information) with their environment. Closed systems (e.g., isolated individuals or community) do not relate or exchange information with their environment. Bertalanffy (1975) noted that in every healing process, every dynamic restitution following a disturbance, every return to the normal state after a clinical intervention is the reestablishment of an equifinal steady state. Human phenomena, including those related to quality of care, do not occur in isolation. Systems theory captures the importance of the role of each quality-related variable. As Bertalanffy (1975) alluded, the incorporation of the various aspects of patients' statuses (including their attributes - values and beliefs) affecting the quality of their care is crucial

in the care-giving processes of such persons, if effectiveness, efficacy, and patient satisfaction are desired outcomes. The system concept is important in nursing when illness is viewed as a life process regulating toward normalcy after a disturbance. The latter is the self-preservation (includes preserving values and beliefs) of the organism. When nursing is conceived as a dyadic system between the nurse and the patient, it can be analyzed according to the inputs and outputs of information and/or energy exchange. McKay (1992) interpreted nursing functions as bringing a source of energy or information from the external environment in order to maintain the steady state in a patient's life. George (1995) captures nursing functions from the systems perspectives using Neuman's (1995) model as described below.

Neuman's Systems Theory

The Neuman's (1995) systems theory illustrates the connectedness of human-related phenomena. Neuman wrote that a systems perspective supports the recognition of the complex whole while valuing the importance of the parts. The relationships between the parts and interactions of the parts or the whole with the environment provide a mechanism for viewing the system - environment exchanges, which support the dynamic and constantly changing nature of the system. The major parts or aspects of the model are the physiological, psychological, socio-cultural, developmental, and spiritual variables; basic structure and energy resources; lines of resistance; normal line of defense; flexible line of defense; stressors; reaction; primary, secondary, and tertiary prevention; intra-, inter-, and extra-personal factors; and reconstitution.

The basic structure contains features such as the ability to maintain body

temperature within a normal range, genetic characteristics such as hair color and response to stimuli, and the functioning of various body systems and their relationships. Stability or homeostasis (available amount of energy which exceeds that being used by the system) preserves the character of the system. The stability also represents the normal line of defense or the normal wellness state. The lines of resistance protect the basic structure and become activated when the normal line of defense is invaded by environmental stressors. Flexible line of defense is a dynamic buffer for the client system that prevents stressors from invading the system. Nursing interventions occur through prevention modalities. Primary prevention focuses on strengthening the flexible line of defense through preventing stress and reducing risk factors (immunization, health education, exercise, and life style changes). The focus of secondary prevention is to strengthen the internal lines of resistance, thus, protects the basic structure through appropriate treatment of symptoms. And tertiary prevention maintains wellness or protects the client system reconstitution through supporting existing strengths and energy conservation after treatment. Reconstitution is the increase in energy in relation to the degree of reaction to the stressor.

Intra-personal factors include (a) physical (degree of mobility, range of body function), (b) psycho-socio-cultural (attitudes, values, expectations, behavior patterns, and nature of coping patterns), developmental (age, degree of normalcy, factors related to present situation), and (d) spiritual belief system (hope and sustaining factors). Interpersonal factors include resources and relationship of family, friends, caregivers that either influence or could influence the intra-personal factors. Extra-personal factors are

resources and relationship of community facilities, finances, employment, or other areas which either influence or could influence intra-personal and interpersonal factors. Neuman's model assumes that (a) each individual client or group is unique, (b) any stressor differs in its potential for disturbing a client's usual stability level, (c) the goal of prevention is included in primary prevention, and (d) client system is in dynamic, constant energy exchange with the environment.

The client in the Neuman's model may be an individual, a group, a family, a community, or any aggregate and is viewed as an open system in which repeated cycles of input, process, output, and feedback constitute a dynamic organizational pattern. The client system has a propensity to seek or maintain a balance among the various factors/forces/stressors, both within and outside the system, that seek to disrupt it. It therefore, regulates itself as output becomes feedback and input. The variables that function in harmony with stability and in relation to internal (forces within the client system) and external (forces outside the client system) environmental stressors include physiological, psychological, socio-cultural, developmental, and spiritual. The goal of the environmental exchanges is to achieve optimal system stability. When system needs are met, optimal wellness exists.

The Neuman Model and Nursing

Nursing's major concern is to help the client system attain, maintain, or retain stability. This may be accomplished through adequate assessment of both the actual and potential effects of stressor invasion and assisting the client system to make those adjustments necessary for optimal wellness. The nurse supports the system stability by

providing the linkage between client system, the environment, health, and nursing. The first of Neuman's three nursing process steps is nursing diagnosis (includes assessment). A comprehensive client database is prioritized according to the client's need and compared to or synthesized with relevant theories to explain the client's condition. Through nursing diagnosis, variances from wellness are identified and development of hypothetical interventions are made.

The second step is nursing goals (planning) which includes caregiver-client negotiation of intervention strategies to retain, attain, or maintain system stability. The perceptions of both the client and the caregiver must be considered in setting goals. The third step is nursing outcomes (implementation/intervention and evaluation) which employs the preventive modes, confirms that the desired change has occurred or reformulates the nursing goals, using the outcomes of short-term goals to determine longer-term goals, and validating the nursing process through client outcomes. Nursing actions are then based on the synthesis of a comprehensive database about the client and the theory(ies) that are appropriate in light of the client's perceptions and possibilities for functional competence within the environment. The modes for identifying the actions are the levels of prevention as interventions. Evaluation confirms the occurrence of the anticipated or prescribed outcome and if that is not true, the goals are reformulated.

Strengths and weaknesses of Neuman's model

Neuman's model is flexible for use in all areas of nursing including administration, education, and practice. Its national and international use supports the essentially universal applicability of the model. Nursing is challenged to apply the model in third

world settings since the international use does not include any of such places. A major weakness of the model lies in the need for further clarification of interpersonal, extra-personal stressors, reaction, and specifications on how to identify variances of wellness and levels of wellness. Exploring patients' perceptions on quality of care taps into the interpersonal aspects of provider-patient relationship. Neuman's model, in conjunction with the preventive modalities (as intervention) provides a unique way of viewing health care phenomena. The client's system interaction and its environments, as they relate to health, provide a useful view of the world. The emphasis on primary prevention, including health promotion, is specific to the model and increasingly important in today's health care environment.

Quality of Care Concept

Health care providers have been interested in the concept of quality of care because of the relationship of quality with the healing of physical/physiological problems and with patient satisfaction (Ludwig-Beymer et al., 1993). Although the value-laden nature of quality makes it difficult to come up with a universal definition (Donabedian, 1969; McCaughrin, 1994; Pettit & White, 1991; Taylor et al., 1991), Avedis Donabedian, a prolific writer, has attempted to theoretically define quality health care (Brown, 1992; Holden, 1989). Donabedian published a model for quality health care evaluation that includes the assessment of the structure of institutions, the process through which services are delivered, and patient outcome (Taylor et al., 1991; Meister & Boyle, 1996). Donabedian wrote that the question asked is the key to selection of an approach to use in assessing the outcome of care, though a well-rounded system of quality appraisal would

probably include concurrent or coordinate assessments of the structure, process, and results to the extent each is observed and measured under the constraints inherent in any given setting. Donabedian (1969; 1989) cautioned that structure, process, and outcome approaches to quality assessment are closely interdependent. Holzemer and Reilly's (1995) Outcomes Model for Health Care Research depicts the relationships among setting/structure, process, and outcomes.

It is possible to divide management of health and illness activities into the domains of technical and interpersonal components (Cleary & McNeil, 1988; Donabedian, 1969; Meister & Boyle, 1996). Technical care refers to "the appreciation of science and technology of medicine and of the other health sciences, to the management of personal health problems" (Cleary & McNeil, 1988, p. 25). Holden (1989) cautioned that such an appreciation should be in such a way that maximizes the benefits of science and technology without correspondingly increasing its risk. The interpersonal component of care involves the psycho-social aspects of provider-patient interaction (Cleary & McNeil, 1988; Holden, 1989; Meister & Boyle, 1996). Donabedian (1968) stated that it is possible to select a subset of normative goals to define the dimensions of quality in clinical care because there is some consensus on what constitutes "good care" (p. 198). Normative dimensions constitute general accepted societal values such as personal dignity, maintenance of autonomy, and democratic decision making.

Alternatively, Donabedian (1968) stated that one may choose not to deduce the dimensions of quality from an a priori normative system but from the dimensions of quality in the technical management of care. As an example, Donabedian (1968) said that if

participation in decision making contributes to patient compliance with provider recommendations, participant decision making becomes a dimension of quality since it will contribute to the patients' behavior regarding provider recommendations. A third domain of health and illness activities is the "amenities" (Cleary & McNeil, 1988, p. 26). Donabedian (1989) referred to such amenities as the convenience, comfort, and esthetic attributes of the setting in which care is provided.

Cultural Congruent Care

In the 1940s Leininger observed that health maintenance and recovering from illness (outcomes) resulted from human caring (Cameron & Luna, 1996). Leininger's observation in the 1950s, while working as a psychiatric nurse at a child care and guidance center, was that children came from diverse cultural backgrounds in addition to having diverse behaviors. Psycho-analytic and mental health theories provided her with no explanations for such observations. She then linked the words culture and caring to come up with Culture Care Theory. Another way of interpreting this "human caring" is to align/compare it with providing quality of care. For there is no doubt that quality care can result in health maintenance and recovery from illness. Leininger (1989) noted that differences in cultural values, beliefs systems of nurses and clients can affect the quality of nursing care as well as nurse turn-over. Thus, understanding such differences may reduce staff conflicts and discord with a subsequent increase in staff moral and job satisfaction. The tenets of Leininger's theory of culture care are described below.

The goal of the theory is to provide culturally congruent care that is acceptable, meaningful, and satisfying to individuals, families, communities, and institutions. By so

doing, health or well-being is promoted; healing and recovery are facilitated through professional nursing practice. Two major premises of the theory are that (a) cultural values, beliefs, and practices are influenced and embedded in the people's world-view - the way people view or look at their world to form a picture or value stance as their perspective of life (Leininger, 1989) and social structures and (b) there are culture care diversities (the variability of meanings, patterns, values, or symbols of care that are culturally derived and shared to improve or ameliorate a human condition or life way) and universalities (similar, common, or uniform meanings, patterns, values, or symbols of care that are culturally derived and shared to improve or ameliorate a human condition) of human care and nursing care among all cultures in the world. Discovering the features and providing nursing care in a way that blends cultural values and beliefs is more meaningful and satisfying to patients/clients.

Leininger (1989) contended that (a) all human cultures have forms, patterns, expressions that allow for knowing, explaining, and delivering culturally congruent care so that understanding of health from the people's perspective is important and (b) care modalities are so powerful in health that curing cannot occur without caring. When nurses know cultural meanings, patterns, expressions, structures of human care among different cultures, they can predict, explain, and interpret the activities and outcomes of generic (folk) care and then provide desired professional nursing care that is congruent with the individual, family, community or societal needs. Culture based care can reduce cultural conflicts, stress, and values that influence care-giving and care-receiving behaviors. Three action modes (maintenance/preservation, accommodation/negotiation, and

repatterning/restructuring) guide nursing care decisions, judgments and actions, and (b) such modes are based on social structure, cultural values, world-views, environmental factors, folk and professional care systems. The result of nursing care actions or decisions is culturally congruent/competent care. It is interesting to note that Neuman's (1995) three preventive modalities (primary, secondary, and tertiary) correspond to Leininger's three action modes.

Western Biomedical Approach and Some Health-seeking Behaviors

A brief description of some tenets of Western biomedical science is crucial. According to Bayne-Smith (1996), the biomedical model is concerned with only four concepts (patient, disease, diagnosis, and treatment). Medical training is based on this reductionistic/Cartesian model that is grounded in linear thinking. Physicians therefore, discount the feelings and emotions of the effects of social, economical, political, environmental, and cultural forces in their diagnosis and treatment recommendations. Bayne-Smith further stated that the health-seeking behavior of non-Western people does not involve a direct path from illness to physician services. Instead, the initial health-seeking behavior in many cultures, in response to any type of illness, is an attempt at self-management. Failure to regain one's health is followed by treatment suggested by family and trusted friends. The next step involves the services of an alternative or folk healer so that Western medicine is often used only as a last resort in many cultures.

Linking Quality with Culture: Simplifying a Complex Issue

Although it is not possible to come up with a universally accepted definition of quality, it is assumed that human beings are capable to and do place value on many (if not

all) things. They are then able to judge whether or not something is of good or poor quality. Quite often, the judgment is based upon previous experiences such as culturally related experience. It is not possible that everyone would accept to give up their respective background identities for the sake of coming up with a common definition of quality. A lot of work has been done using Donabedian's three dimensional framework for quality evaluation. That should be extended into using the framework with ethnic/cultural groups if health care workers really wish to reach everyone with quality of care. Holzemer (1996) and Holzemer and Reilly's (1995) heuristic Outcomes Model for Healthcare Research is an extension of Donabedian's model. The three-by-three model has inputs, processes, and outcomes on the horizontal axis and client/patient/families/communities, provider, and setting on the vertical axis. The fact that the client/inputs cell in the latter model describes the constellation of personal characteristics, cultural values and beliefs, social support, and problems, (and quality is culturally defined), constitutes a reason to link quality with culture. In other words, the variables in the client/inputs cell provide the epistemological and ontological explanations for examining and making necessary linkage(s) in the body of health care knowledge and practices. Making such linkages is essential for any health care provider who sincerely wishes to provide quality care to patients.

Some health care workers view tailoring their services to meet the general and specific needs of their consumers as being complex. Consequently, they come short of meeting all the needs of some of their patients. Putting a situation/complex issue into its context allows one to review the variables/factors that are related to the issue. The next

logical thing to do is prioritize the variables and then handle them according to their level of importance to the health care problem at hand. Holzemer's (1996) model can then be used to examine the complex issue.

Client

As stated above, the client/inputs cell describes the constellation of personal characteristics, cultural values and beliefs, social support, and problem. As Holzemer (1996) noted, the interventions (provider/processes) interact with the client/inputs to produce related outcomes of care. A question to ask is "How does the patient's constellation of personal characteristics influence the provider-processes and subsequent outcomes of care?" The client/processes may be self-care or using folk type treatment. Self-care implies some level of independence and confidence on the part of the client but whether or not the interaction with provider/processes produce desired outcomes needs to be evaluated and not just ignored or rejected by the provider because s/he is unfamiliar with the client's processes. Lepler (1996) noted that most traditional practices and beliefs are not dangerous and do not seriously interfere with treatment, but some nurses resist incorporating them into care. Client/outcomes should be evaluated in terms of physiological, psychosocial, functional status, behavior, knowledge, symptom control, quality of life, home functioning, family strain, goal attainment, safety, and resolution of nursing diagnosis.

Provider

In terms of the provider/inputs, technical competence and interpersonal skills are considered. Workers' credentials should be matched with their levels of competence

especially with the current upsurge in scientific technology. Adequate evaluation should result in confirmation of individual's capabilities, inservice retraining or training. Although some individuals may just have difficulty with interpersonal relationship, provider's self confidence to technically execute the desired and expected care may positively affect the provider/client interpersonal relationship. For the provider/processes, an important goal is to demonstrate the relationship between provider/processes or interventions and client/outcomes given some control over setting variables. In other words, it is challenging to make the link between specific conditions and good care (Holzemer, 1996; Holzemer & Reilly, 1995). One should ask the question "How does the interaction between the provider/processes and client/inputs affect the outcome variables in the management of health and illness?" The respective roles of the provider and client need to be clarified in terms of how they affect the outcomes. Provider/outcomes should be concerned with question(s) such as "Does the client/inputs worsen or improve the provider outcomes?" (e.g., provider satisfaction and continuation of business).

Setting

The most important setting/inputs that must be understood focus upon the values and philosophy of an organization. A question to ask is "Do the setting/inputs such as available resources lay the foundation for good care?" Donabedian (1969) assumed that when certain structural conditions are specified, good care is likely to follow. Setting/processes deal with utilization of resources and its effect on continuous quality improvement principles, patient-focus care plans, critical paths, and care planning. Holzemer (1996) noted that the communication patterns among physicians and nurses in

the critical care environment have been shown to have a direct effect on patient mortality. A question to ask then is "How do the communication patterns among providers affect patient outcomes?" Finally, setting/outcomes have to do with rates of malpractice suits, resource utilization rates, readmission and mortality rates, and general cost. A legitimate question to ask is "Do the latter variables improve or worsen because of the interaction between client/inputs and provider/inputs?"

Although Holzemer's (1996) model does not address measurement issues, it increases one's awareness of the multitude of variables that impact health care outcomes. The use of the model should shed some light on (a) some ethical concerns about quality when cost control is the driving force, (b) the issue of cost containment efforts and diminishing quality or depriving patients of access to it, (c) the multidisciplinary commitment needed for an integrated and coordinated health care systems that aspires quality patient care, (d) the availability of resources, and (e) the effective incorporation of patient's cultural background information into caring processes. Once the variables related to patient outcomes are identified, deficiencies should be adequately addressed toward the desired outcomes and quality of care.

Quality of Care Indicators

What is an indicator? The Joint Commission (1993) described an indicator as a valid and reliable quantitative value that provides an indication of the condition or direction over time of an organization's performance of a specified process, or an organization's achievement of a specified outcome. Mark and Burleson (1995) and Rantz (1995) referred to quality outcomes as indicators. But Mark and Burleson (1995)

cautioned that patient outcomes are a single indicator of quality so that quality cannot comprehensively be evaluated only through the use of patient outcomes. Thus, when making comparative judgments about quality across hospitals, a complete analysis of patient outcomes should take into account contextual factors including hospital ownership (profit versus non-profit), the extent to which a hospital is involved in teaching, the complexity of patient illness, the volume of patients treated (particularly surgical volume), hospital size, and the extent to which a hospital engages in high tech procedures.

The Joint Commission has advocated the development of clinical indicators as a means to measure quality through performance (Strzalka & Havens, 1996). Strzalka and Havens defined a clinical indicator as a qualitative measure of an aspect of patient care that can be used as a guide to monitor and evaluate the quality and appropriateness of health care delivery. Strzalka and Havens (1996) and the Joint Commission (1990) agreed that a quality indicator is not a direct measure of quality. Instead, it is a tool (flag for locating) that can be used to assess performance (areas of patient care) and which can direct attention to potential performance issues that may require more intense review within an organization (JCAHO, 1990; Strzalka & Havens, 1996). Although the latter statement seems to limit the authors view toward the negative (i.e. identifying areas of care needing attention), identifying the positive aspects of an organizational performance is also part of the process of quality evaluation. A limitation of quality indicators was highlighted by Androwich and Hastings (1996) when they noted that all quality is not captured by indicators, so that it is important to supplement quantitative information with qualitative data, observations, and judgment.

A performance indicator refers to the state-of-the-art assessment tool that offers valid and useful information concerning organizational performance. Androwich and Hastings' (1996) key principles to be considered when developing a measurement system include (a) relevance to clinicians or consumers of data, (b) valid and reliable, (c) sensitive to change, (d) based on an adequate representative sample, and (e) be interpretable. Thus, a good measurement system should measure what one does as well as what is important to both the external and internal customers; the measure should be feasible to collect and to report as well as being meaningful to clinicians. When indicators support reliability and validity, they are consistent and relate closely to quality/appropriateness of the aspect of care of interest.

Quality of care indicators may be used to assess the following components of care: (a) accessibility (the ease with which patients can obtain needed care when they need it), (b) appropriateness (the degree to which the correct care is provided, given the current state-of-the-art), (c) continuity (the degree to which the care needed by patients is coordinated among practitioners and across organizations and time), (d) effectiveness (the degree to which care - procedure is provided in the correct manner - without error, given the current state-of-the-art), (e) efficacy (the degree to which a service has the potential to meet the need for which it is used), (f) efficiency (the degree to which the care received has the desired effect with a minimum of effort, experience, or waste), (g) patient perspective issues (the degree to which patients and their families are involved in the decision-making processes in matters pertaining to their health and the degree to which they are satisfied with their care), (h) safety of the care environment (the degree to which

the environment is free from hazard or danger), and (i) timeliness of care (the degree to which care is provided to patients when it is needed) (JCAHO, 1990; Williams, 1993).

Performance indicators of interest can be identified through a single brainstorming session by members of a multi-disciplinary team. In order to carefully articulate the teams' decisions about the indicators, Androwich and Hastings (1996) described the use of an Indicator Matrix. The matrix is a data dictionary that describes the type of indicator being measured - key quality requirement, the type and operational definition of the indicator, the sources and availability of the needed data, the plan for data collection, reporting, and action. Androwich and Hastings said that quality indicators can be selected using the framework of disease specific measures (biomedical, microbiologic, physiologic, signs or symptoms, related to physical, mental, or social states); general health measures (function or well-being, related to physical, mental, or social states); patient behavior measures (related to patient knowledge or understanding and patient compliance); and patient satisfaction measures (related to the amenities of care [structure], the art of carer [process], and the results [outcome] of care). Suber, Martin, Jones, Reeves, and Duncan (1996) said that the selection of an indicator depends on its usefulness to an organization and/or the lack of comparative data from other sources.

Androwich and Hastings (1996) demystified the process and measuring of quality and outcomes in ambulatory care by taking concepts that are universal to process-outcome management and measurement and applying them to unique setting and requirements of the ambulatory care system. The authors provided a list of sample indicators that a multidisciplinary team can rank in terms of importance, urgency,

feasibility, and ease of collection. Typically, the most useful measures are those related to high-volume, high-cost, high-risk, or high-profile conditions (e.g., medication errors per month, % of patients very satisfied with clinic wait, number of equipment failures per month, number of patients experiencing blood transfusion reaction, etc.).

Larrabee (1995) noted that quality is influenced by objective indicators of quality of goods or services. Thus in health care, patient-perceived quality is influenced, to some extent, by provider-defined quality indicators of given care. Patient-perceived quality can be measured by assessing a patient's level of satisfaction with care received. Meister and Boyle (1996) referred to patient satisfaction as a desired outcome of care . One of their four dimensions of satisfaction survey that must be accounted for to ensure results upon which quality improvement programs can be reliably based is the choice of indicators to be reported on by respondents. A broad-based patient involvement in the development of such indicators is necessary so as to accurately capture the true levels of measured satisfaction.

In a Canadian cross-sectional satisfaction survey of randomly selected samples of long term care (LTC) patients, families, families of deceased patients, and nursing staff, Meister and Boyle (1996) used a two part structured questionnaire to obtain information on the importance and rate of success of 15 indicators of quality. The first section (subject values) consisted of 15 indicators of quality of care related to geriatric facilities. The domains of the 15 indicators were derived from Donabedian's construct of quality (interpersonal and technical aspects of care and attributes of the setting). Each of the three domains contained 5 indicators. The interpersonal domain indicators included (a)

statements on the aspect of residents' rights, (b) nursing staff attitudes about work, (c) homelike atmospheres for residents, (d) respect of families' rights, and (e) availability of clear ways to solve problems. The attributes domain included indicators such as food served hot, and cleanliness of residents' rooms. The technical aspect of care domain concerned indicators such as the availability of doctors to see residents when needed and availability of qualified nursing staff.

The second part of the questionnaire assessed the perceived rate of success of the 15 indicators at the LTC facility. The concluding section of the questionnaire included a global satisfaction question about the LTC facility and socio-demographic information. Besides the traditional socio-demographic information, the nursing staff variables included shift worked (days, evenings, or nights), classification (registered nurse, registered nursing assistant, and nursing aide/orderly), and ethnicity. Residents variables included length of time at the hospital, mobility status, and frequency of contact with relatives. Family variables included frequency of visits and relationship to the residents, among others.

In another study, Rantz, Mehr, Conn, Hicks, Porter, Madsen, Petrowski, & Maas (1996) developed quality indicators from the Minimum Data Set (MDS) - a provision of the 1987 Omnibus Budget Reconciliation Act (OBRA) established for improving nursing home care. Rantz and colleagues identified 14 quality indicators that were based on prevalence of problems. The indicators were operationalized so that a lower score on an indicator suggested better facility performance. Examples of quality indicators included: injuries, falls, behavior problems, 9 and more scheduled medications, incontinent bowel/bladder, bowel/bladder incontinence without toileting plan, indwelling catheter,

fecal impaction, weight loss, bedfast state, daily physical restraints, little or no activity, stage 1-4 pressure ulcers, and diabetic without foot care. Five of the analyzed indicators (falls, behavior problems, incontinence bowel/bladder, bedfast state, and pressure ulcers) were risk adjusted to account for variation in resident acuity within facilities. By risk adjusting, one controls for case mix across institutions so that those with more severely ill patients are not penalized when institutions are compared.

In summary, quality of care indicators should be selected based upon their usefulness to an organization (acute, ambulatory, or LTC care setting). Sources of indicators include (a) patient focused indicators (disease specific, general health, patient behavior, patient satisfaction measures, etc.), (b) provider focused indicators (% of staff with current CPR card, number of complaints about skill with venipuncture, etc.), and (c) setting focused indicators (number of equipment failures per month, average time to schedule initial visit, etc.). One may prefer to examine quality indicators in terms of Donabedian's interpersonal, technical aspects of care and setting attributes (Meister & Boyle, 1996). Provider, patient, and setting variables related to quality care were identified. Quality indicators can also be selected by type (rate-based or event-based). Androwich and Hastings (1996) recommended that whenever possible, rate-based indicators are preferable to event-based ones. For without using a rate, it would be impossible to ascertain if a 10% rise in the number of infections reflect an increased volume of patients at risk. Once the indicators are identified (such as through brain-storming), one should rank them in terms of their importance, urgency, feasibility, and ease of collection. Importantly, most useful indicators are those related to high-volume,

high-cost, or high-profile conditions. The use of an indicator matrix helps in their identification as well as ranking them through examination of their respective operational statements.

One thing is clear in the way researchers address the issue of quality indicators. They do not deal with the issue of culture/ethnicity. One cannot clearly decipher from the literature how researchers and health care providers relate quality indicators to culture/ethnicity. A possible assumption here is that what is good for one ethnic group is also good for any other group. Most research-based standards in the U.S. represent the beliefs and values of the dominant group. Quite often, the rest of the population is then expected to abide by such standards and when the standards conflict with beliefs and values that are not part of the standards, health care providers fail to achieve their well intended care health goals. Lavizzo-Mourey and MacKenzie (1995) said that to be culturally competent is to incorporate and integrate critical health related cultural factors and treatment outcomes peculiar to a population into the caring processes. An implication here is that health care systems, individually and collectively, can provide high quality care that is cost-effective to all populations only if researchers and funders of research invest in an aggressive agenda that pursues (a) the validation of existing quality indicators in minority populations and (b) the development of new quality indicators that assess the organization's ability to develop culturally competent care. Lavizzo-Mourey and MacKenzie concluded that only by doing the latter will medical professionals be able to fulfill their calling to relieve suffering without discriminating against some populations.

Measures of Quality

Most of a patient's health care facility-time is managed by nursing related activities. Naylor, Munro, and Brooten (1991), in their review of the measures of the effectiveness of nursing practice, said that nurses as a major provider of health care must assume a leadership role in measuring the quality of their services as well as documenting their cost. This constitutes an important rationale to review measurement of quality of health care from the nursing perspective. Even more so, Rantz (1995) noted that nursing has a long history in quality measurement that can be invaluable to other members of the health care team.

The measurement of quality can be centered about Donabedian's classic triad of structure, process, and outcome. Nightingale's structural standards or criteria relating to quality of patient care include noise and its control around the sick, consistency of food and when it should be served, type of mattress to be used, position of bed in relation to the window, airness and cleanliness of the room and personal cleanliness. Nightingale thus initiated a process in which care being provided can be compared with standards so that action can be taken to bring about any needed change (Maibusch, 1984).

Donabedian's (1969) evaluation of the structure includes (a) the appraisal of the instrumentalities of care and their organization (properties of facilities, equipment, manpower, and financing), and (b) the approach used in drawing specification for assessment, certification or accreditation by officials and voluntary agencies. The assumption is that when certain conditions are specified, good care is likely to follow. Holzemer and Reilly's (1995) model challenges researchers to link specified conditions

with good care. Interactions between the input constituents and the outcome variables in the management of health and illness must be linked. Tarlov, Ware, Greenfield, Nelson, Perrin, and Zubkoff (1989) outlined structural variables of quality of care as follows: (a) system characteristics (organization, specialty mix, financial incentives, work load, and access/convenience), (b) provider characteristics (age, gender, specialty training, economic incentives, beliefs/attitudes, preferences and job satisfaction), and (c) patient characteristics (age, gender, diagnosis/conditions, health habits, beliefs/attitudes, and preferences).

The evaluation of the process involves the appraisal of care itself. The process tests the assumption that certain structural characteristics are related to a certain level of performance. The process is subject to professional judgment on the elements and detail of care. For example, Hayward, Bernard, Rosevear, Anderson, & McMahon (1993) described structural implicit review as a process whereby a physician reviewer provides a series of judgments concerning different aspects of quality of care received by patient. Cleary and McNeil (1988) defined quality of care process in terms of the norms of scientific medicine, and the ethics and values of society. Holzemer and Reilly's (1995) model viewed process of care in terms of client, provider, and setting.

One is not satisfied with mere presumption of quality in any specified setting, thus, the interest in outcomes. The assessment of outcomes looks at the end result of care in specified terms of patient health, welfare, and satisfaction (Eriksen, 1995; Henry, Partridge, Lenert, & Middleton, 1993; Holden, 1989; Lohr, 1988). The extent to which the agreed-upon desired outcomes are achieved is the ultimate test of assumptions

inherent in the use of structure and process of care. Meister and Boyle (1996) wrote that patient satisfaction may be considered both a desired outcome of care and an integral component of structure and process.

Although evaluations of hospital care have tended to focus on structure and process, many consider outcome measures to be the most valid indicators of quality of care (Naylor et al., 1991). The reasons for the swing to focusing on outcome measures include (a) dramatic escalation of health care cost led experts to question whether levels of spending produce commensurate improvements in health, (b) the introduction of prospective payment system (PPS) as a rigorous cost containment strategy, (c) growing concern about quality of care and patient well-being with the implementation of PPS based on diagnosis related groups (DRG) introduced in the early 1980s, and (d) the National Center for Nursing Research launched a major nursing initiative on outcomes research in May 1990 by convening an expert planning group to discuss patient outcomes and nursing research (Naylor et al., 1991; Rantz, 1995).

Nurses are directly concerned with the well-being of patients and thus, play a pivotal role in assuring the delivery of quality of care. The latter challenges nurses to measure and document the impact of their services on patient outcomes. Naylor and colleagues (1991) explored this challenge by examining patient outcome variables deemed appropriate for measuring the impact of nursing care and they included mortality, morbidity, and length of stay (LOS) in hospitals. Mortality is a gross and rare indicator of quality so that differences in rates are detected only with very large sample size. In a study of Veterans Administration (V.A.) facilities, Goldman and Thomas (1994) identified

2398 cases that may have been unusually likely to have quality concerns. Analyses of the cases showed that 100 (4.2%) were found to contain quality of care concerns. Both mortality rate analysis and medical record review indicated that care was more likely to be problematic in predominantly psychiatric medical centers than in other facilities.

Morbidity measures include infection rates or unexpected complications. Although nursing has an effect on the incidence of infection or unexpected complications, such influence is confounded by the practices of other health care workers. Since the advent of diagnostic-related groups, additional problems in accurately documenting the morbidity rates of hospitalized patients have been identified (Naylor et al., 1991). Naylor and others provided an example to illustrate the latter. Prior to PPS, approximately 75% of nosocomial urinary tract infections (UTI) were identified because of the screening of urine culture results. From 1982-1985, the number of urine cultures decreased by almost 25% with a corresponding decline in diagnosed urinary tract infections of almost 29%. At least in part, the decreased nosocomial infection rate may be attributed to a decreased surveillance system. Length of stay has assumed prominence since the introduction of PPS. The rationale behind its use as quality measure is that the provision of high quality care will result in faster recuperation so that patients can be discharged earlier. The use of LOS as a measure needs to be accompanied by data on rehospitalization, post discharge acute care visits, and the burden on care-givers. Naylor et al. (1991) commented that such data are rarely collected. They concluded that nurses who use LOS as a quality outcome measure need to (a) be able to demonstrate how their interventions effect this outcome, (b) link this measure with other post discharge outcome measures, and (c) describe the

extent to which they influence the patient's discharge date decision.

Other outcomes of interest to nurses are (a) functional status (independent functioning, focus on mobility, self-care, role, and social activities), (b) mental status (awareness of time, place, personal information, events outside one's area of personal interaction both currently and in the recent past, ability to maintain a reasonable attention span), (c) stress level (loss of privacy, role and self image changes, and adaptation to strange routines for hospitalized patients), (d) satisfaction with care (attitudes and expectations related to socio-demographic characteristics, physical and psychosocial status, process and outcomes of care), (e) burden of care (all care-givers are subject to adverse emotional social, financial, and physical health consequences), and (f) cost of care (the cost of nursing services, personnel time - salary and benefits, administrative costs, and supplies) (Naylor et al., 1991).

The literature, thus, has various approaches to examining the quality and satisfaction with health care. There are overlaps in some of the models. Donabedian's (1969) triad of structure, process, and outcome are incorporated in Holzemer's (1996) three by three model (client, provider, and setting on the vertical axis and inputs, processes, and outcomes on the horizontal axis). Cleary and McNeil (1988) and Avis et al. (1995) addressed three groups of patient characteristics (inputs) that influence satisfaction (socio-demographic - age, social class, and race; health status - prior health status; attitudes and expectations - background beliefs and expectations; others - organization and financing). Meanwhile, Tarlov et al. (1989) outlined structural quality variables to include system characteristics, provider characteristics, and patient

characteristics.

Regarding process evaluation of care, Tarlov and colleagues agreed with Donabedian (1969) on the technical style (visits, medication, referrals, test ordering, hospitalization, expenditures, continuity of care, and coordination) as well as on the interpersonal style (interpersonal manner, patient participation, counseling and communication level). Holzemer's (1996) model is a heuristic one. Tarlov and colleagues' (1989) structural variables are included in Holzemer's setting/inputs/processes/outcomes cells and Cleary and McNeil's (1988) groups of patient characteristics known to influence satisfaction are contained in his client/inputs cell. Avis et al. (1995) captured the lack of consensus on the multi-dimensional nature of patient satisfaction by various authors. The variables of the different dimensions can still be conveniently contained in the various cells of the three-by-three model. Attempts to assess quality and patient satisfaction with care in terms of Holzemer's model are likely to capture some of the factors that influence quality and satisfaction.

Issues Related to Outcome Measures

Mark and Burleson (1995) addressed two difficulties in studying patient outcomes. First, patient outcomes of interest to executives and nursing systems researchers are those that describe a group of patients i.e., an aggregate (members are heterogeneous). Thus, disease or condition-specific outcome indicators are not likely to be suitable for evaluating outcomes of care for heterogeneous group of patients. Mark and Burleson further said that outcome measures differ depending on whether one is interested in the results of specific care and treatment given to an individual patient, the effectiveness of services

provided to an aggregate clientele or the quality of a health care system as it relates to the health of the population. Hegyvary (1991) said that a clearly stated purpose of a study should help one determine the unit of analysis. She further said that different levels of analysis require different types of indicators and methodology. Second, current measures reflecting outcomes are not comparable across institutional systems in addition to incompatibility among databases and systems. Thus, it is difficult to conduct multisite nursing systems research.

Mark and Burleson (1995) investigated the measurement of five global patient outcome measures (medication administration errors, patient falls, occurrence of new hospital-acquired decubitus ulcers, nosocomial infections, and unplanned readmission to the hospital) in a randomly selected sample of acute care hospitals. Twenty hospitals (2 from each of 10 southeastern states) were involved in the study. Findings confirmed the following issues: (a) the appropriateness of outcome indicators for nursing, (b) level of analysis, (c) lack of standardized documentation of patient outcomes, and (d) measuring variations in outcomes across institutions as a measure of quality of care.

Although nurses constitute only one group of those contributing to patient care (Mark & Burleson, 1995), the University of Iowa research team has taken the position that while patient outcomes reflect the coordinated efforts of a multi-disciplinary health care team, identification of nursing-sensitive outcomes will ensure that a wide range of patient outcomes are assessed, thus, allowing for the unique contributions of nursing to be recognized (Rantz, 1995). Nurse-sensitive outcomes refer to those patient outcomes that are sensitive to nursing interventions. Hegyvary (1991) said that nursing outcomes should

rarely ever be used because the focus of outcomes is not the provider but the recipient of care. But Holzemer and Reilly's (1995) three-by-three model addressed outcomes in terms of patient, provider, and setting. Hegyvary (1991) recommended the use of multivariate analytical approach to determine the levels of variance explained by nursing, medicine, organizational, demographic, environmental, and other variables.

Lack of standardization in documentation of patient outcomes makes it difficult to calculate rates such as of medication errors and patient falls because the total number (denominator) of patients involved is required and such information may not be available. Mark and Burleson (1995) suggested fostering standardizing information of use to nurses through the incorporation of the elements of the Nursing Minimum Data Set - NMDS (nursing diagnosis, nursing interventions, nursing outcomes, and nurse provider, Rantz, 1995) into the Uniform Hospital Discharge Data Set, a publicly available data set. In a study to analyze the terms used by nurses in a variety of data sources and to test the feasibility of using Systematized Nomenclature of Medicine (SNOMED III) to represent nursing terms, Henry, Holzemer, Reilly, and Campbell (1994) found that SNOMED III, a leading classification scheme that includes North American Nursing Diagnosis Associations' (NANDA) terms, was able to capture 69% of nursing terms that describe patient problems.

Rantz (1995) reviewed 158 articles on nursing quality measurements studies in the last five years. She found that hospital-based nursing quality studies outnumbered (N = 83) those of V.A. Medical Centers (N = 10), home care settings (N = 19), ambulatory care settings (N = 9), long-term care settings (N = 9), and studies that cross all settings (N

= 5). Just like in the Mark and Burleson (1995) study, clinical issues mostly studied included medication administration, patient falls, universal precaution, discharge planning, and patient teaching. Measures of quality in V.A. centers was found to be the same as in other hospital settings except the inclusion of topics reflective of geropsychiatric and long term nature of some of the clients they serve. The latter indicated the apparent need to expand capabilities for monitoring more nurse-sensitive quality outcomes. This expansion can be done through using the elements of NMDS, which constitute the essential elements for quality measurement and analysis, and such elements need to be routinely collected and analyzed. Other elements include organization delivery systems variables (critical paths, use of case management, presence or absence of an organized nursing delivery system that designates a nurse who is accountable for coordinating patient care).

Most home care quality measurement studies identified by Rantz (1995) were related to instruments designed to measure the process of nursing care and the general quality of care in the home care setting. Such instruments were multidimensional and depicted physical evaluation, medical management, psychosocial issues, environment, human rights, financial issues, discharge planning, and patient satisfaction. A critical issue for home care is determining what constitutes an appropriate outcome for a client (e.g., recovery, self-care, rehabilitation, maintenance, or terminal). Three outcome classification for home care nursing goal attainment include level I (all objectives met), level II (some objectives met), level III (no objectives met).

Ambulatory care and long term care settings have received the least attention from nurses conducting quality measurement studies. Needs for such settings include (a) data

specific to the educational preparation of nurse provider and the role played in delivering care, (b) implementation of NMDS in order to facilitate the measurement of nursing quality indicators, (c) collecting data regarding nursing diagnosis, specific interventions, and residents outcomes related to those interventions. The Nursing Home Case Mix and Quality Demonstration Project is focused toward the use of large data sets to assess quality of care - using NMDS as a database.

The issue of time in outcome research was addressed by Hegyvary (1991). She said that the timing of desired achievements at various points in the process of life is the underlying theme of outcome studies. She further said that timing must be taken into account in any care and treatment. Thus, it is desirable that evaluation of care and treatment include more than one time, as in a repeated measures approach.

Evaluation Models

Based upon a process/outcome frame of reference, Mayers, Norby, and Wastson (1977) described two mechanisms of evaluating care - retrospective and current. Retrospective evaluation encompasses all assessment mechanisms that are utilized to review care after the patient is discharged. Such an approach includes (a) closed chart auditing where the strengths and deficits of care are identified as reflected in the patient's records, (b) post-care patient interview which involves interviewing a patient or group of patients sometimes after discharge, (c) post-care staff conferences conducted by the individuals who cared for the patient, and (d) post-care questionnaires which are instruments designed to elicit subjective indications of patient satisfaction. The patient may complete a questionnaire at time of discharge which is left with the health care agency

or returned at a later date. Periodic sending of questionnaires to a patient at some point after discharge can be done. The post-care patient interview is a patient-centered approach that helps in providing excellent information regarding patient and his/her family perception of care. An advantage of the post-care staff conference is that various members of the health team review the patient in relation to the care plan from many perspectives.

Concurrent evaluation assesses the "in progress" activity and includes such mechanisms as (a) open chart auditing which means reviewing the patient's record against predetermined criteria while the patient is still receiving care for immediate (an advantage) feedback to staff, (b) patient interview and inspection also called bedside audit provide the basis for specific interview questions and relevant physical inspection, observation, and assessment of the patient, (c) staff interview or observation on what care is actually being performed is guided by a predetermined criteria, and provides opportunity to experience a real life view of care that a chart audit may not provide, and (d) group conferencing which helps to evaluate the satisfaction of patients who are still undergoing care. The mechanisms of quality assessment just described provide various methods of evaluating patient care. Just as Donabedian (1969; 1989) stated, Mayers and colleagues (1977) noted that a combination of several mechanisms is necessary for a well-rounded, comprehensive quality assessment.

Outcomes Evaluation Studies

The growing interest in professionalism, the desire for autonomy, and control over nursing practice spurred the philosophy of self-governance in professional nursing

(Maibusch, 1984). This interest was characterized by the formation of a unit-based system of quality assurance (QA). Accountability for assuring quality was placed in the hands of those actually delivering the care. The unit-based system resulted in problem-oriented evaluation studies. The studies that follow embrace some aspects of the retrospective and concurrent approaches to quality evaluation.

Cost containment strategies (DRG, Prepaid health plans - HMOs, Preferred Provider Organization - PPOs) have focused their attention on restraining the use of high-cost health care services and have paid little attention to how patients' health and level of functioning in daily activities are affected by such strategies. Tarvlov and colleagues (1989) designed the medical outcomes study (MOS) to determine whether variations in patient outcomes are explained by differences in system of care, clinician specialty, patients' diagnosis and level of illness severity, the intensity of resource use, and clinician's technical and interpersonal styles. The MOS was also aimed at developing more practical tools for the monitoring of patient outcomes in routine medical practice. A total of 303 physician offices (family medicine, general internal medicine, endocrinology, or cardiology) in solo and group practices in Boston - Massachusetts, Chicago - Illinois, Los Angeles - California were involved in the MOS study. Seven outcomes indicators (measures) of primary care quality in the MOS included accessibility (financial and organization), continuity, comprehensiveness, coordination, and accountability (interpersonal and organizational). Safran, Tarvlov, and Rogers (1994) examined the data on the MOS for the differences in quality of primary care delivered in prepaid and fee-for-service (FFS) health care systems. The results (entirely based on patient reports on self

administered questionnaires) indicated that financial access and coordination of care were highest in prepaid systems (HMOs) whereas organizational access, continuity, and accountability were highest in FFS system. Comprehensiveness of care was lowest in HMOs. Payment system was most predictive of financial access and accounted for more than three quarters of the variance explained by the regression model used. Again, payment system was the most important predictor of patient-clinician continuity and accounted for about half of the variance explained by the model. Most important about the work of Safran and colleagues (1994) is that of high-lighting the strengths and weaknesses of each system, thus, offering information that guide continuous quality improvement (CQI) in the existing U.S. health care systems.

From the results of the cross-sectional portion of the MOS, Riesenberg and Glass (1989) reported interrelationships among emotional well-being, health perceptions, and physical functioning. For example, patients with diabetes, myocardial infarction or congestive heart failure experienced decreased physical and social functioning. The MOS paid particular interest in improving methods of identifying key features of health care that are associated with favorable patient outcomes so that such features can be preserved despite the constraints imposed by an increasingly cost-conscious health care environment. Outcomes variables, as described by Tarlov and colleagues (1989) and Stewart, Greenfield, Hays, Well, Rogers, Berry, McGlynn, and Ware (1989), include (a) clinical end-points (symptoms and signs, laboratory values, and death), (b) functional status (physical - capacity to perform variety of physical activities; mental - general mood or affect; social - interaction with others; and role - ability to work, school or do other

activities expected of one), (c) general well-being (health perceptions, energy/fatigue, pain, and life satisfaction), and (d) satisfaction with care (access, convenience, financial coverage, quality and general).

Prior to the MOS, Ware, Rogers, Davies, Goldberg, Brook, Keeler, Sherbourne, Camp, and Newhouse (1986) conducted a study to determine whether health outcomes in a HMO differed from those in a FFS system. Individuals (1673 total and ages 14-61 years) were randomly assigned to one HMO or a FFS insurance plan for 3 to 4 years. For non-poor individuals assigned to the HMO who were initially in good health, there were no adverse effects. However, health outcomes in the two systems of care differed for high and low income individuals who began the experimental study with problems. The use of HMO produced significant improvement in cholesterol levels and general health ratings of those in high income (40% of income distribution) initially sick group as compared to those with free FFS care. The low income initially sick group assigned to the HMO reported significantly more bed-days per year due to poor health and more serious symptoms than those assigned to free FFS care, and they had a greater risk of dying when compared with pay FFS plans.

The results suggested that high and low income groups may realize different benefits from prepaid group practice and FFS systems. Although health care cost in the HMO was about 25% lower than in the FFS system when care in both systems was free to the patient, HMO places greater responsibility on the individuals for follow-up and adherence to medical regimens than do FFS system. FFS systems have more immediate financial incentive to ensure that needed follow-up care is obtained but poor people may

not be able to afford for FFS care.

Ware and colleagues (1986) noted that the importance of a well-coordinated health care for Medicaid poor in HMOs has been recognized. Coordination of care was highest among HMO patients as compared with FFS patients. Coordination is particularly important for chronically ill patients who tend to require periodic attention from various health care specialists for complex and interrelated problems. Without coordination, duplication and unnecessary services may be rendered by providers who are unaware of one another's role in patient care management. On the other hand, patients rated providers less favorably on treatment manner and technical skills (accountability) in HMOs than FFS patients although the differences were not statistically significant. Reduced patient-physician continuity and comprehensiveness of care, diminished organizational access and interpersonal treatment are considered less satisfactory by patients.

Proposed Models

Perception of quality is very much linked with satisfaction of care received (Pettit & White, 1991). The eventual outcome of interest in this study of African Americans' perceptions of quality of care (as depicted in Figures 1 and 2) is patient satisfaction with care. It is therefore, crucial to identify the quality-related variables that directly or indirectly affect satisfaction with care. Prior work in the literature on the subject of quality and access to care, and patient satisfaction form the basis for the models (Figures 1 and 2) presented here. Androwich and Hastings (1996) noted that efforts to define and measure quality in ambulatory settings have lagged behind similar efforts in acute care settings. Reasons for the latter include the historical focus of the U.S. health care system

on in-patient care and the fact that delivery system, roles, and processes in ambulatory care have been poorly understood. There are differences between acute and ambulatory care settings in terms of care-giving roles (including nursing), the process and timing of care, and the episode of care considered an appropriate focus of measurement. However, the process of defining the mission and purpose of setting program, identifying patient and other stakeholder requirements, defining major care processes, and identifying measurement priorities is the same in both in-patient and ambulatory care settings. Universal concepts of input, process, and outcome management and measurement, therefore, constitute the basic elements of Figures 1 and 2.

A close examination of the information from the literature on the phenomenon of patient satisfaction reveals some consistencies among findings by different authors. Most refer to satisfaction as an attitudinal construct that is influenced by expectations of quality of care and its measures should be multidimensional (Cleary & McNeil, 1988; Hennessy & Friesen, 1994; Hinshaw & Atwood, 1992; La Monica et al., 1986; Ludwig-Beymer et al., 1993; Taylor et al., 1991). Research findings overlap in certain areas. A common deficiency is the absence of patient background information in most of the studies.

One approach to link an outcome variable such as patient satisfaction to related variables is to do a substruction. A substruction is defined as a strategy to critique the theory and methodology of research (Dulock & Holzemer, 1991) and consists of theoretical and operational systems. Three constructs are related in the following manner as shown in Figure 1: Patient characteristics influence patient's perception of quality of care attributes which in turn influences patient satisfaction. The outcome here is overall

patient satisfaction. This is because all aspects of care that contribute to that outcome must be considered together. Just as in Gestalt concept, the sum of the aspects of care does not result in the overall satisfaction level with care received (Holzemer, personal communication, September 18, 1997). Bertalanffy (1981) alluded to the latter concept when he said that the holistic properties of a system are not found separately in its parts. Taylor and colleagues' (1991) findings are quite encompassing in the sense that Risser's (1975) technical-professional and trusting relationship subscales correspond to Taylor and colleagues' nurse attribute (modified as provider qualities) while the educational relationship subscale corresponds to Taylor and colleagues' practice attribute (practice style). Taylor and colleagues' practice setting attribute (setting environment) corresponds to Donabedian's (1968) structure. Ludwig-Beymer and colleagues' (1993) "calling of the head and heart" (p. 46) are included in Taylor and colleagues' subconcepts of proficiency and personal qualities respectively. Donabedian's (1968) recommendation to deduce dimension of quality from interpersonal interaction corresponds to the criterion for technical management when satisfaction is ensured. This criterion (standard of care) has been used as a fourth quality of care attribute. The four attributes feed into how a patient perceives and interprets the quality of care received. The attributes, various characteristics of the patient, and technical and human/interpersonal care constitute the theoretical system. Relationships among the constructs, and concepts of the theoretical system are depicted by the arrows.

In the operational systems, various methods were used to identify and measure concepts and they include - questionnaires and surveys (self report), face-to-face

interviews, telephone interviews, and analyzing unsolicited letters to administrator. Scales mentioned in the literature were Risser's (1975); LOPSS and MAACL (La Monica et al., 1986); Patient Satisfaction Scale (PSI) (Hinshaw & Atwood, 1982); PJS-20 and Hollingshead (Hennessy & Friesen, 1994); Nursing Home Resident Satisfaction Scale (HRSS) and MMSE (Zinn, Lavinzzo-Mourey, & Taylor, 1993); and Home Care Satisfaction Instrument (HCCSI-R) (Westra, Cullen, Brody, Jump, Geanon, & Milad, 1995). Likert-type method of scaling was a common method and most ranged from a 4-point to a 10-point level to achieve greater sensitivity (La Monica et al., 1986; Risser, 1975) as well as summated scoring scale (Hinshaw & Atwood, 1982). Details on level of scaling (nominal, ordinal, interval, and ratio) were not always discussed. There was only one stated hypothesis testing study (Hennessy & Friesen, 1994) and one quasi experimental design (La Monica et al., 1986). All the studies stated their various purposes and used appropriate statistical methods in data analysis. Figure 1 is a heuristic perceptual model and modification may be required depending upon the health care situation at hand. In the operational system, different tools may be used instead of the ones shown in the model.

Figure 1.

PATIENT'S PERCEPTION OF QUALITY: A SUBSTRUCTION

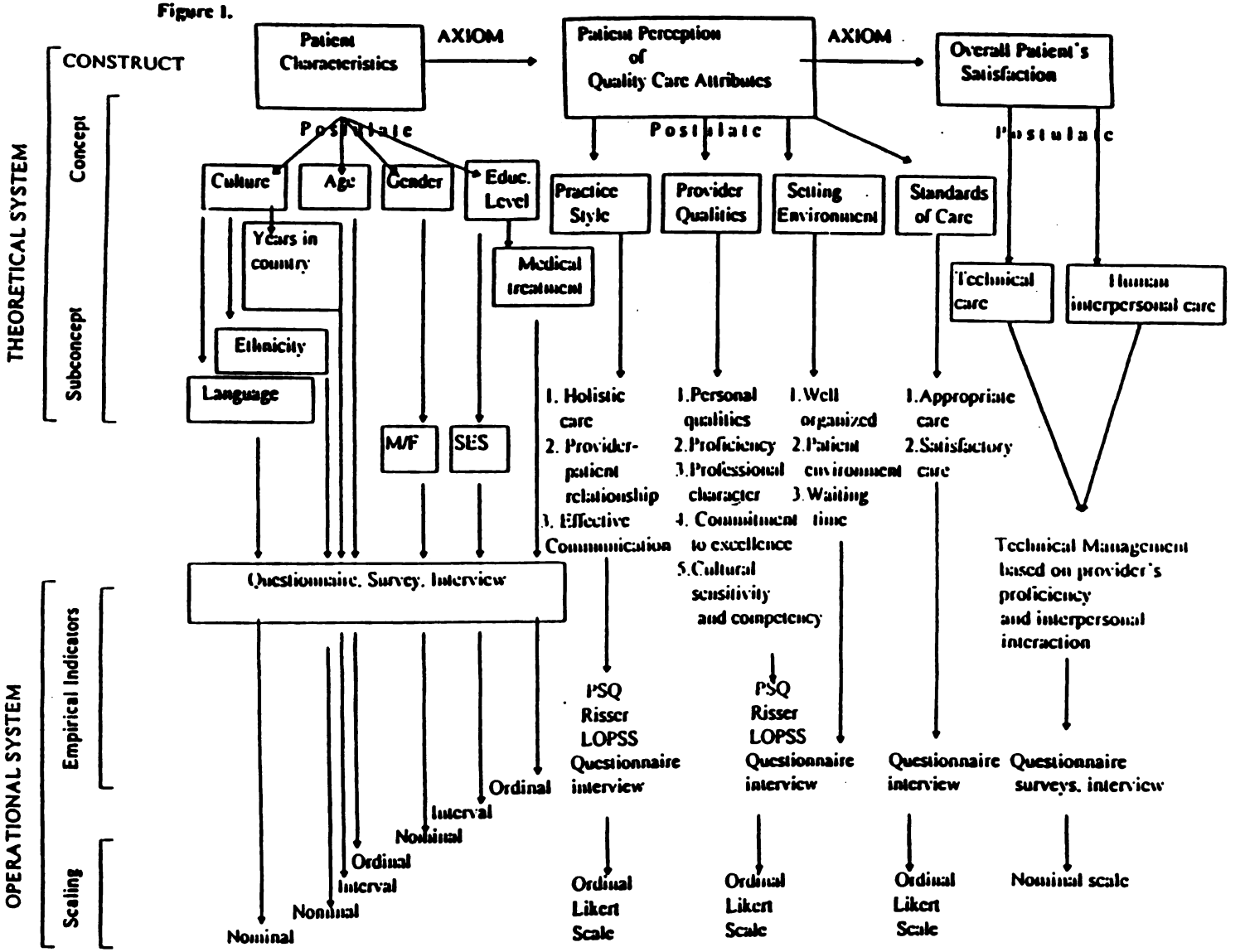
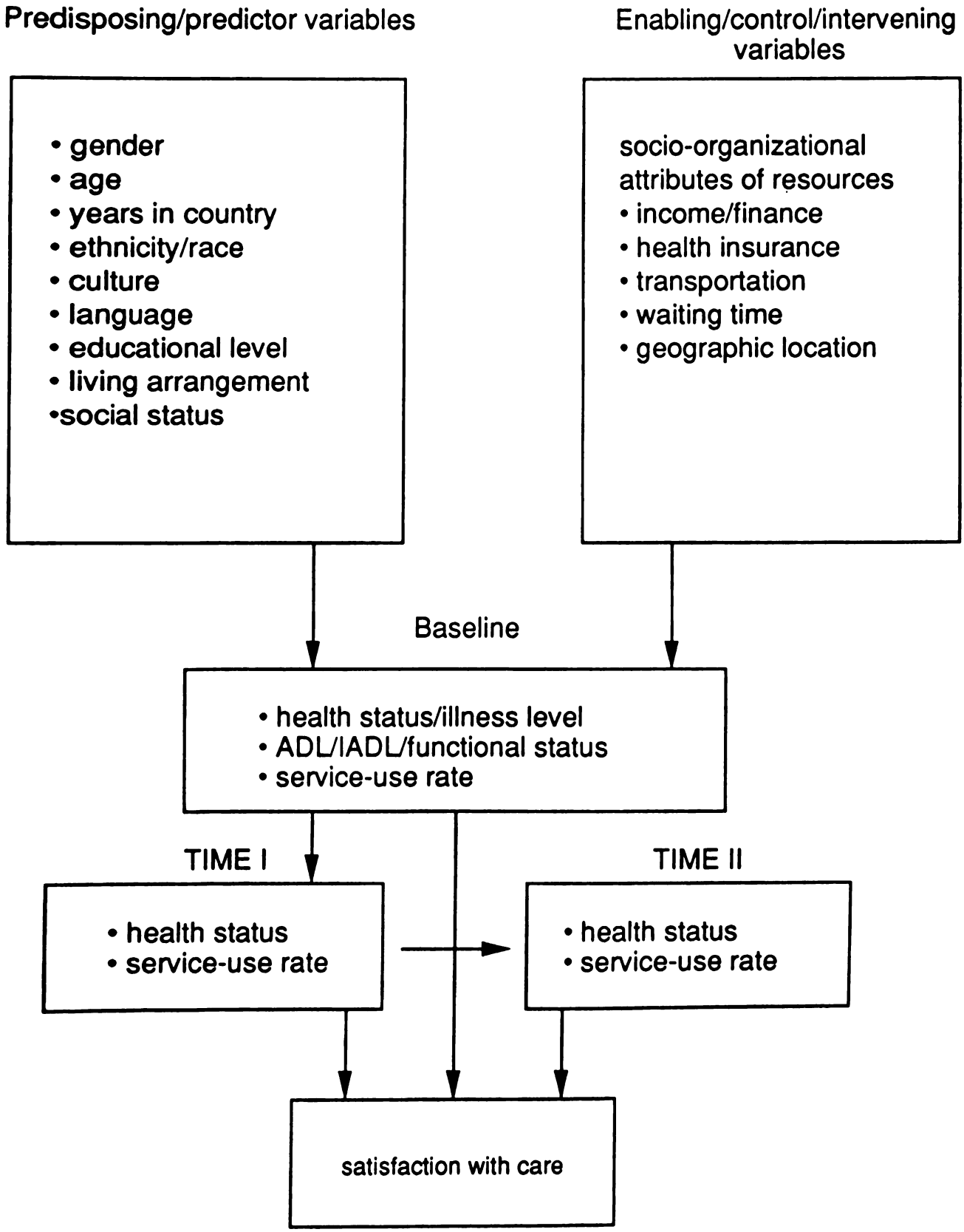


Figure 2

Satisfaction with Quality of Health Care: A Conceptual Framework



Donabedian's (1966) model of structure, process, and outcome constitute the basic elements of evaluating health care. Abdellah and Levine (1957) interviewed patients to identify satisfying and dissatisfying events encountered during hospitalization (U.S. Office of Technology Assessment, 1988; Murdaugh, 1992). Such events could be related to the process and outcomes of care. Three groups of patient characteristics (inputs) that influence satisfaction scores include (a) socio-demographic (age, social class, and race), (b) health status (prior health status may cause a person to be more or less satisfied with care received), and (c) attitudes and expectations (patient background beliefs, and expectations) (Cleary & McNeil, 1988; Avis et al., 1995). Other than patient characteristics, satisfaction with care may be related to various structural components of health care (e.g., organization and financing - prepaid plans, fee-for-service, large or small health care setting, care continuity with specific provider, and appointment scheduling methods) (Cleary & McNeil, 1988).

The lack of consensus on the multi-dimensional nature of patient satisfaction as captured in the literature is described below. Avis et al. (1995) provided two views on the dimensions of patient satisfaction. The first includes examining patients' perceptions of quality of care, patients' satisfaction with their own health, and patients' level of well-being including their sense of control and feelings of anxiety. The dimensions in their second view include examining medical care and information, physical facilities, non-tangible environment, quality of food, nursing care, and visiting arrangements. The dimensions of satisfaction described by Murdaugh (1992) include admissions (procedure and planning), ward care (nursing care, medical care, ancillary care, and communication), living

arrangements (structure, accommodations, and food), and discharge (instructions, planning, and procedure). Ware and Berwick's (1990) dimensions include nursing and daily care, hospital environment and ancillary staff, medical care, information, admission, and discharge and billing.

Another view of satisfaction with care includes global or general and specific dimensions (Cleary & McNeil, 1988; Zastowny, Roghmann, & Cafferata, 1989). Global and specific measures of patient satisfaction yield different results. Global measures often reflect numerous features of care and may not necessary reflect on the aspects of care that closely relate to quality of care. Unless a study is conducted in extremely well controlled circumstances, it is difficult to interpret global measures. Subscales of global measures may assess attitudes about health care in general and will ask questions on the overall behavior of health care providers and care delivered. Westra et al. (1995) mentioned three global subscales - likely to recommend agency, overall satisfaction, and satisfaction that expectations were met. Specific satisfaction measures assess more acutely the specific episodes of care actually received. They are generally more discriminating and result in significantly lower satisfaction scores than global assessment (Cleary & McNeil, 1988). If the reason for assessing satisfaction is to improve the quality of care, the assessment of specific episodes is preferable (Zinn et al., 1993). Patients are more likely to base responses to satisfaction items on a specific episode of care if the questions are presented soon after care received. Petersen (1988) recommended requesting for patient feedback on care received two to three days post discharge.

Having a conceptual framework is one of Norbeck's (1985) minimum criteria for

instrument development. Cleary and McNeil (1988) said that a lack of theoretical background on measures of patient satisfaction makes assessment of many empirical findings difficult. Eriksen (1995) noted that concept clarity is essential for instrument development and validity of research findings. Methodological considerations emphasizes the provision of sufficient basis for evaluating an instrument's psychometric properties. The minimal standard for publishing results of an instrument should include at least one type of content validity, test-retest reliability, internal consistency reliability, and at least one type of criterion-related (predictive, concurrent validity estimates) or construct validity. Substantive considerations should also emphasize the conceptual basis underlying an instrument, methods and results of item generation and refinement, characteristics of the intended respondents, ease of use and method of administration, method of scoring, type of data obtained, and other features that are specific to the instrument (Norbeck, 1985).

Currently, the literature is replete with patient satisfaction measures. Ross, Steward, and Sinacore (1995) stated that accepting satisfaction as a quality indicator is qualified by well known measurement problems. There is considerable variability in the study of satisfaction across different measurement approaches. For instance Ross and colleagues (1995) found (a) that the percentage of positive responses for five different measurements approaches administered to the same respondents ranged from 1-77% and (b) considerable variation in satisfaction between three commonly used measures - a global measure of general satisfaction, Likert, and semantic differential scaled measures of health service dimensions. Table 2.1 captures some patient satisfaction instruments and how they

meet Norbeck's (1985) minimum criteria and Table 2.2 provides the details on each instrument. The different studies depict some of the variabilities observed by Ross and colleagues (1995) as well as commonalities.

Table 2.1. Patient Satisfaction Instruments in terms of Norbeck's minimum criteria

Author & Year	Instrument	Items	Meets Norbeck's Criteria
Risser, 1975	Patient Satisfaction Instrument	25	Theoretical framework, content validity, internal consistency reliability
Hinshaw & Atwood, 1982	Patient Satisfaction Scale (PSI)	18	Theoretical framework (based on Risser's study), construct validity, internal consistency reliability
La Monica et al., 1986	La Monica-Oberst Patient Satisfaction Scale (LOPSS)	41	Content and construct validity, internal consistency reliability, theoretical framework (based on Risser's study)
Zinn et al., 1993	Nursing Home Resident Satisfaction Scale (NHRSS)	10	Reliability, provision of descriptive statistics
Forbes & Brown, 1995	Patient Satisfaction Scale	21	Internal consistency by Cronbach's alpha, content validity
Westra et al., 1995	Home Care Satisfaction Instrument	12	Reliability, construct and criterion-related validity, theoretical framework

Figure 2 (Satisfaction with Quality of Health Care: A Conceptual Framework) is a proposed model for the study of satisfaction with care. It is adapted from Andersen's behavioral model for the study of access (Adey & Andersen, 1994). Andersen's framework is an integrated model on health care services use designed to reflect the relationship between health care delivery system, the population at risk (inputs), and

patient services and outcomes (outputs).

The outputs are defined by actual utilization of health care services and consumer satisfaction with the services. Health care services use refers to the continuity or number of providers seen before a health care problem is resolved, number of visits to each provider, and reasons for or sources of referral, hospitalization and out-of-plan use. Figure 2 summarizes the predisposing/predictor and enabling/control/intervening dimensions that comprise the model. When one considers disparities in health care resources use, race/ethnicity may be the variable that determines how all predisposing and enabling dimensions interact. White-Means (1995) said that race is a pervasive factor that interacts with many of the measures typically used to explain medical utilization patterns - SES (income, education, and health insurance coverage), attitudes, family cultures, and incidence of disease. This type of interaction requires (from a methodological standpoint) that each racial group be considered as a unique population whose behavior is affected by distinct social, psychological, and genetic environments.

Andersen's original model has been modified to include length of time in the country, culture, and social status as refinements to race/ethnicity. These refinements are important because people may be of the same race but behavior may differ among them because of years spent in one's country of birth, one's country of education, the language and model of education system to which they were exposed, the ethnic origins of one's parents and grandparents, and circumstances under which one immigrated (Edwards, 1992). Race/ethnicity as used here refers to a social group within a cultural and social system that claims or is accorded special status on the basis of complex, often variable

traits including religious, linguistic, ancestral or physical characteristics (Edwards, 1992). Time factor has also been added. The time series aspect consummates the need for a longitudinal study where variations in health care events over time and their relationship to the delivery of and use of services are considered. Avis et al. (1995) stated that a central problem with satisfaction research lies in the almost exclusive use of cross-sectional designs and the consequent failure to observe changes over time.

Table 2.2. Patient Satisfaction Instruments

Author(s) & Year	Purpose	Instrument & Administration	Design	Reliability & Validity	Design validity threats
Risser (1975)	To develop instrument that measures patient satisfaction with nurses and nursing care in ambulatory care settings	A 25-item tool (Patient Satisfacttion Instrument) from an original 58-item instrument. 3 subscales: technical-professional (I), educational relationship (II), and trusting relationship (III). Scored on a 5-point Likert-type scale. Self report.	Descriptive design using convenience sample. Trial 1: N = 78 Trial 2: N = 52. Collecting data from variety of sources for similar kinds of information supported content validity.	Cronbach's alphas for: Trial 1 subscale I = 0.80 subscale II = 0.87 subscale III = 0.89 Trial 2 subscale I = 0.64 subscale II = 0. 83 subscale III = 0. 82 Total scale = 0.91	Selection bias
Hinshaw & Atwood (1982)	To develop an instrument that measures in-patient satisfaction with nurses and nursing care	An 18-item Patient Satisfaction Instrument (PSI) with 3 subscales that uses Likert-type summated scoring scale. Subscales (trust, education & technical) are based on Risser' study. Self reporting	Descriptive correlational study using five different studies. Sampling methods include convenience, random, and purposive. Sample size: study 1 = 130 study 2 = 57 study 3 = 52 study 4 = 319 study 5 = 88	Precision by replication over an 8 years period. Total scale coefficient alpha calculated from 4 of 5 studies with values ranging from 0.64-0.97. Subscale alphas: trust = 0.88 education = 0.78 technical = 0. 79. Validity established in 3 of 5 studies included convergent, discriminant and predictive modeling.	Selection bias Instrumentation History

Author(s) & Year	Purpose	Instrument & Administration	Design	Reliability & Validity	Design validity threats
La Monica, Oberst, Madea, & Wolf (1986)	To develop an instrument that measures hospitalized patient satisfaction with nursing care in acute care setting.	La Monica-Oberst Patient Satisfaction Scale (LOPSS) is a 41-item tool scored on a 7-point Likert-type scale. Based on Risser's study and has 3 subscales. Takes 35 minutes to complete. Self report. Accompanying scale - Multiple Affective Adjective Checklist (MAACL)	A series of 3 studies. Study 1 assessed content of a 50-item tool; used 5-point Likert-type scale with 75 cancer patients. Study 2 assessed the internal consistency of the tool with a sample of 100 cancer patients. Study 3 - LOPSS used as a criterion outcome measure to experimentally test the effects of an Empathy Training Program with 533 patients using pre and post test at 4 weeks interval.	Internal consistency coefficient alphas: Technical-Professional = 0.88; Educational = 0.80; Trusting = 0.84. Total scale = 0.92. Subscales intercorrelations ranged from 0.81-0.84. Discriminant validity supported by negative correlation of LOPSS with MAACL's subscale on anxiety, depression, and hostility.	Selection bias Effect of testing

Author(s) & Year	Purpose	Instrument & Administration	Design	Reliability & Validity	Design validity threats
Zinn, Lavizzo-Mourey & Taylor (1993)	To develop a reliable measure of satisfaction with care that can be easily administered to nursing home residents with the intent of facilitating the use of self reported levels of satisfaction as outcome indicator of quality of nursing care.	A 10-item Nursing Home Resident Satisfaction Scale (NHRSS) with 3 domains (evaluating physician services, nursing services, & environment) and a global satisfaction item. Original tool had 26 items. Scaled on a 4-point Likert-type measure. Has an accompanying instrument (MMSE). Self report.	Cross-sectional study. Pilot tested a 26-item tool at 2 nursing homes. Final tool with 10 items tested in 4 nursing homes within a 50-mile radius with 118 residents.	Item test-retest reliabilities ranged from 0.05-0.75; percentage of agreement coefficient from 0.43-0.94. Test-retest and interrater reliabilities were 0.71 for physician services, 0.64 for nursing services, and 0.79 for environment. Internal consistency reliabilities alphas were 0.79 for physician services, 0.79 for nursing services, and 0.74 for environment. Instrument ranged from 0.47-0.90. Item-tool correlations ranged from 0.40-0.70	Selection bias History

Author(s) & Year	Purpose	Instrument & Administration	Design	Reliability & Validity	Design validity threats
Forbes & Brown (1995)	To develop a valid and reliable instrument for measuring patient satisfaction with nursing care they receive in an out-patient surgery center	21-item tool (effectiveness of nursing care instrument) with 4 domains of patient satisfaction (caring, continuity, competency, & education). Has 19 closed- and two open-ended questions. Responses scored on a 5-point Likert-type scale. Self report	Descriptive design with 2 phases. Phase 1: provider-focused with 30 questions generated by Delphi technique; N = 12 nurses. Phase 2: interviewed 20 surgical out-patients and 18 families members in hospital setting within 7 days prior to surgery. Test-retest with 42 patients and their families during a two weeks interval. Test-retest reliability determined with a final sample of 30.	Internal consistency by Cronbach's alpha: subscale = 0.19-0.80 total scale = 0.83. Item-total = 0.30- 0.75; Test-item correlation = 0.77-0.87. Validity established by nurse experts' and patients' domains.	Selection bias

Author(s) & Year	Purpose	Instrument & Administration	Design	Reliability & Validity	Design validity threats
Westra, Cullen, Brody, Jump, Geanon, & Milad (1995)	To test the reliability and validity of the Home Care Client Satisfaction Instrument (HCCSI)	12-item unidimensional tool. Responses scored on a 5-point Likert-type scale. Additional 3 global satisfaction measures rated on a 10-point scale. 10 minutes to complete. Self report	Correlational descriptive. 3 pilots: Pilot 1: validated items domains. A convenience sample of 6 patients using open-ended interviews. Pilot 2: 12 patients and 12 nurses to validate importance of items. Pilot 3: 20 stable nurse-identified patients were used to establish test-retest reliability within 2 weeks interval. State-wide mailed out questionnaire to 400 clients - only 59 had complete data. 10 minutes to complete Self report	Content validity and test-retest reliability established via pilot studies. Cronbach's alpha and factor analysis not done due to extensive missing data. Item analysis: Time1-Time2 responses correlation = 0.59; Item-total = > 0.59; Criterion-related validity using Spearman Rank correlation, 0.37, p = 0.0001; item analysis supported construct validity	Selection bias

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Summary

This chapter reviewed the literature on perspectives on quality, theoretical concepts, quality indicators and measures, and proposed models for examining patient satisfaction with care received. Health care providers and consumers may have varying perspectives about quality of care and such variations affect health care behavior, expectations, communication patterns, and satisfaction levels among the parties involved. Patients place higher importance on basic needs issues such as bath room use (Ludwig-Beymer et al., 1993). Very little exists in the literature on African Americans' perception of quality of care. Culture determines the meanings that patients attach to health and illness situations. For example, nerves syndrome is an example of a female condition that is rooted in African Americans' culture. Individuals with high family stress tend to have lower quality of life and functional health and higher dysfunctional health and social stressors (Parkerson et al., 1995).

Quality is a value-laden concept and five theoretical frameworks (Andersen's, 1994; Bertalanffy's, 1981; Donabedian's, 1969; Holzemer's, 1996; Leininger's, 1989) were used to examine the concept. It is unclear from the literature what African Americans' beliefs and values are on quality of care. Researchers are challenged to validate existing quality indicators in minority populations including African Americans. Holzemer's (1996) model can be used to link patient care situations with related variables toward a desired outcome. Some outcomes related issues include those of measurement, standardizing documentation, and identifying nursing-sensitive outcomes. The relationships between patients' characteristics, patients' perceptions, and their satisfaction with care were

explored via a substruction (Figure 1). Figure 2 depicts a suggested model for studying patient satisfaction as a desired outcome of patient care.

CHAPTER THREE

METHODOLOGY

Research Design

The intent of the descriptive study was to identify and describe the dimensions of quality of health care from the African Americans' perspectives. Phase 1 was conducting focus groups to identify terms that African Americans use in describing behaviors, beliefs, and opinions relating to quality of health care. Focus group techniques provided in-depth personal interviews with the participants. The focus groups' information (opinions on quality of care and satisfaction with care) was treated like the opinions of knowledgeable experts at the beginning of the Delphi technique described by Stewart and Shamdasani (1990).

Phase 2 was the Modified Delphi process where the participants (Phase 1 participants) came to a consensus on the terms that describe quality of care. The Delphi process begins when experts are asked to provide independent opinions on a topic. In a similar way, the focus groups solicited participants' (health care recipient experts) perspectives on the quality of care they receive. A modification here in the Delphi technique was that the participants provided the information in a group instead of individually. The focus group sessions were the first of two iterations for the Delphi technique.

Purpose of the Study

The purpose of the study was to establish dimensions of quality of care from the perspectives of African Americans(vocabulary and thinking patterns) using focus groups

and a Modified Delphi approach. The objectives of the group sessions were to learn about (a) African Americans' level of knowledge related to quality health care, (b) their perceptions, feelings/opinions about available health care services, (c) their satisfaction with the available health services, and (d) how such services can better serve their health care needs. The objective of the Delphi process was to gain consensus on the identified main ideas/phrases/terms describing quality of care.

Phase 1

Historical Overview of Focus Group Interviews

A focus group is defined as a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive non-threatening environment (Krueger, 1988). The first account of the focus group interview method was written by Bogardus in 1926. The dearth of information about group interviews between 1926 and 1946 indicates that this approach to collect data was not widely used or developed in the early part of the 20th century (Dilorio, Hockenberry-Eaton, Maibach, & Rivero, 1994). Social scientists (Lazarfeld, Merton, Fiske, & Kendall) from the late 1930s used focus groups to investigate the values of non-directive-individual interviewing as an improved source of information. The emphasis was on shifting attention from the interviewer to the respondent. Since the 1960s, the focus group method has become a widely used marketing strategy. Marketing and advertising professionals use it to elicit consumers' opinions/thinking about products and to develop strategies that influence consumer buying habits (Dilorio et al., 1994; Krueger, 1988). Social and health scientists rediscovered focus group strategies in the late 1970s. Dilorio et al. (1994) said that the strategy is used

in many areas of nursing.

Focus Group Advantages and Why It Works

Morgan (1988) said that focus groups are better suited to topics of attitudes and cognition while participant observation is superior for studies of roles and organizations. Dilorio et al. (1994) stated that the strength of the focus group lies in the ability of the researcher to gather data from a number of participants at the same time and to explore different perspectives on a specific issue. Krueger (1988) said that the researcher serves as a moderator, listener, observer, and eventually analyzes the data using an inductive process (derives understanding based on the discussion as opposed to confirming a preconceived hypothesis or theory). Focus groups (relatively low in cost in terms of time and collecting a lot of data within a short time) can be used to gather preliminary information about a phenomenon of interest and such information can then be used to develop hypotheses for subsequent quantitative study (e.g., using focus group information to develop research instruments). Focus groups have been used as a tool-development method in social science and nursing (Holzemer, Spicer, Wilson, Kemppanain, in press). Through focus groups, a researcher learns the participants' terminology (most meaningful in tool item construction) as well as gets in tune with the respondents and discover how they see reality (Dilorio et al., 1994; Krueger, 1988). Krueger said that focus groups insights can also be used to develop efficient follow-up quantitative procedures like telephone or mailed surveys. Stewart and Shamdasani (1990) said that focus groups allow direct interaction between the researcher and the respondents. They added that the method can be used to collect data from children or from those who are not particularly

literate.

Krueger (1988) provided the following rationale for why focus groups work: (a) Focus groups tap into human tendencies - attitudes and perceptions about a subject are developed in part by interaction with others (people are products of their environment and are influenced by those around them regarding opinion and comments on a subject); (b) discussion in a skillful environment and nourished by skilled probing results in candid portraits of customer perceptions, (c) a permissive group environment gives individuals the chance to divulge opinions and emotions that often do not emerge in other forms of questioning), and (d) self-disclosure is promoted (participants sense that they are alike and are not likely to ever see one another again and the environment is non-threatening). Krueger further noted that the rule for participants is commonality not diversity. Thus, a focus group interview underscores the commonality, of the group in the following manner: "We have invited people with similar experiences to share their perceptions and ideas on this topic. You are selected because you have certain things in common that are of particular interest to us" (p. 26).

Limitations of Focus Groups

The focus group methodology is not without limitations. Social desirability affects results, (e.g., development of conformity and unwillingness of group members to disagree with one another) especially if the participants are friends. Members may be unwilling to discuss sensitive topics in a group setting. Focus group sessions can vary considerably in terms of lethargy/boredom/dullness versus excitement/energy/invigoration. Krueger (1988) said that enough groups should be used to balance the idiosyncrasies of individual

sessions. Focus groups have a narrow purpose (to determine the perceptions, feelings, and manner of thinking of consumers about the subject at hand). Thus, the goal is not to reach consensus, provide recommendations, or make decisions among alternatives but to pay attention to participants' perceptions on the topic.

Focus group data are more difficult to analyze than individual interviews and comments must be interpreted within the context of the interview. Although in-depth information is obtained from a focus group session, the data may not be generalized because the sample is not necessarily intended to be reflective of the entire population. On the other hand, when multiple methods, including focus groups, are used to arrive at the same conclusion, one can be more confident in generalizing the results. The researcher has less control in the focus group interview as compared to an individual interview. Group members influence and interact with each other. Consequently, members influence the course of the discussion which may lead to detours and raising irrelevant issues. The researcher must keep the discussion focused. Finally, groups are difficult to assemble and this difficulty was quite apparent in this study, as will be discussed later. People take time to come to a designated place at a prescribed time to share their perceptions with others (Krueger, 1988).

Validity of Focus Group Results

The claim to validity lies in the intense involvement between the researcher and the participants. Probing for the most truthful responses can yield a more in-depth analysis. Tape recording of the discussion provides an opportunity for another researcher to verify the conclusions drawn from the data. Deviating from the established procedures of focus

group interviews raises the issue of validity. Considerable efforts to ensure that the procedures measure what they are proposed to measure include pilot testing of the procedures under varying conditions, developing a protocol on how to conduct the groups, and building-in questions that check on the truthfulness of the respondents. Face validity is high in focus groups due to the believability of participants' comments. Predictive or convergent validity is assessed by examining the extent to which the results are confirmed by future behaviors, experiences, or events (Krueger, 1988). Combining focus groups with another method takes care of some validity issues (Pinderhughes, personal communication, January 22, 1997). In this study, the focus group method was linked with the Modified Delphi process. Capturing variety (no individual outlier) was achieved by collecting the data from different parts of the Bay Area. Denzin and Lincoln (1994) referred to the latter as triangulating by data site. Triangulation also helps in resolving some of the threats to internal validity of focus group discussions by enabling the investigator to compare findings with data from another source.

Focus Group Interview Guide

The questions for the interview guide were derived from the general quality of care literature as well as from specific studies related to African Americans' health care experiences. Important areas of quality health care for African Americans should include their perceptions of racism in relation to the care they receive as well as their beliefs and values. An assumption in the choice of questions for the focus group was that a person's satisfaction level indicates the degree of quality of care, as seen and interpreted by that individual. Quality here is relative to a person's beliefs and expectations. Appendix D

provides a list of the original questions prior to pilot testing as well as the final version - the interview guide.

Pilot Testing

The specific objectives of the pilot test were to (a) determine whether the questions would be acceptable to the participants, (b) estimate respondent burden in terms of time and redundancy, (c) determine whether all possible areas relating to quality were covered (Davies & Ware, 1988), and (d) determine if questions elicited discussion (Stewart & Shamdasani, 1990). The guide was pilot tested in two stages. In stage one, experts in quality of care and other pertinent areas reviewed the questionnaire (original 13 questions - Appendix D) to ascertain its content validity. Of the six experts who were sent the questionnaire, only three (50%) responded. Two of the responses came by mail and the third was received over the telephone. The experts' responses were invaluable as they were used to modify (including elimination of redundancies and revision of semantics) the original list of questions to a shorter list of four main questions and one open-ended statement (Appendix D - final version). Two questions dealing with folk/traditional treatment were completely removed from the guide because they introduced objectives different from those specified or implied by the study aim.

In stage two, the guide (Appendix D - final version) was tested with an existing group of African American women. Eleven participants were invited but only four (36.3%) attended the focus group. All participants were members of an on-going focus group on the subject of "Engaged Mothering within a Racist Environment: Transition to Motherhood" (Sawyer, 1995). The mock focus group started with "Please tell me about

your health care experiences"; you are not limited to hospital experiences; you may talk about care received from doctor offices, clinics, and elsewhere. This first statement is unstructured and broad in scope. Dilorio et al. (1994) and Stewart and Shamdasani (1990) wrote that questions serving as guide for focus group discussion should be arranged from general to specific and from neutral to sensitive. Conceptually, the statement addressed specific questions dealing with knowledge/perceptions/opinions about quality of care such as (a) what does quality of health care mean to you?, (b) what do you consider to be high quality care?, (c) if the health care that you receive or have received is of high quality, what is especially good about the care?, and (d) what do you think is/was the reason(s) for the high quality care? The investigator used probing, as needed, to address such specific questions - (a) through (d). For instance, if someone used the word "quality" and did not elaborate on it, the researcher followed with "You mentioned quality, what do people mean when they talk about quality of health care?" If the same participant happened to elaborate on the word, other participants were invited to voice their experiences/opinions on the concept. Probing in this way specifically addressed the questions (a) through (c). The investigator also looked for examples of high and low quality care and posed question (d) just in case participants did not talk or allude to it in the discussion. The word "quality" is a health care provider's terminology and may introduce some selection bias if used first by the investigator (Welch, personal communication, August 20, 1997).

The second question was "Please tell me about your feelings, including what you like or do not like, about the people and the place where you receive health care". This

statement conceptually deals with satisfaction with available services. The third question "How should quality health care be improved?" addressed needed or desired services. The fourth question was "Please tell me about how racism affects or influences the quality of health care that you receive." The issue of racism is a sensitive one and, as Dilorio et al. (1994) and Shamdasani (1990) recommended, it should be introduced toward the end. But whenever the participants started talking about racism earlier in the discussion, the investigator facilitated the discussion as it relates to the quality of health care they receive. A final question was "What else do you feel should be added to or removed from this discussion about the quality of health care you receive?" Such an open-ended question allowed the participants to voice their opinions on other quality-of-care-related issues in their community that were not addressed in the discussion.

The questions were posed to the mock focus group in similar fashion as planned for the study participants. The pilot participants did not have to sign a consent form and the session was not tape recorded. Verbal agreement to participate was all that was needed. Content validation by experts, as members of a mock focus group would have been preferred but that was not done in this study because of the variation in the participants' expertise. Stewart and Shamdasani (1990) said that conducting a focus group with such expertise variation may inhibit the responsiveness of the group as a whole. The analysis of the mock focus group did not indicate any further changes in the interview guide. For instance, the members suggested adding a question or statement about support staff which is addressed by the question dealing with likes and dislikes of the people and place where health care is received. The group also suggested adding

specific question(s) about the elderly and navigation of the system. That too is imbedded in the question on how low quality care can be improved. The four questions and one open-ended one sufficed for the allotted time of one and a half to two hours needed for a focus group session.

The pilot study participants' perspectives on quality of care are described below under four main headings (a) quality of care defined, (b) interpersonal relationship, (c) health care provider's beliefs, and (d) improving quality of care.

Quality of care defined: People defined quality in terms of (a) health care provider's activities (what and how he/she does them - treatment of patients as individuals, clean, friendly, efficient provider who listens, cares, and understands), (b) health care setting arrangements (accessible, affordable, and informative health education department), and (c) patient outcomes (cured and satisfaction with care).

Interpersonal relationship: People liked personable (comforting, supporting, and nice), trusting, friendly, considerate, and knowledgeable health care providers who listen, provide answers to questions asked, and follow up with patients as needed. They disliked condescending and disdainful attitudes of some workers including doctors and nurses. Participants disliked doctors who read charts instead of talking with patients and who fail to follow up with patients. Health care visits associated with parking problems and long waits were also disliked.

Health care provider's beliefs: The issue of health care providers' beliefs were centered on preconceived ideas and assumptions about African Americans and women in general. Negative preconceived ideas manifest as covert racism, stereotyping, and prejudgement of

patients prior to knowing them as individuals. Participants complained that doctors who do not believe in women asking questions simply ignore those who ask questions. The investigator deliberately asked members of a men's group session in phase 1 of the study if doctors sometime ignore their questions. Participants also said that when African American patients demand answers to questions relating to their health, some providers view them as having "an attitude" but white patients behaving in the same manner would be viewed as being assertive.

Improving quality of care: (a) African Americans' 'militancy' role ("speaking out, not taking the back seat, writing letters of complaint to petition for the disbarring of incompetent providers from practice, asking questions and demanding answers, and switching providers and setting when there are reasons to do so") is a strategy for getting the needed quality care, (b) passing laws at national, local, and community levels, (c) educating health care providers and providing sensitivity training, (d) providing the same health care for everyone, and (e) treating people as individuals.

On the whole, the pilot study enabled the investigator to refine the focus group interview guide in the following way: (a) Elimination of redundancies and statements that were not related to the focus of the study and (b) rephrasing the questions to capture the ideas implied by the objectives of the study in a simple way.

Focus Group Participants

Participants were working African Americans who were 18 to 65 years old, had health insurance coverage, were working at least 50%, were able to read and write standard English at the sixth grade level at minimum, and had a permanent mailing

address. It was assumed that study participants ' primary language is English and that participants' ability to communicate in "Ebonic" or "Black English" would not prevent individuals from understanding a sixth grade level standard English. Another inclusion criterion was that participants would have received health care services in the U.S. within the last year. Without recent experience, participants might not have been able to recall and describe the phenomena. Only those who consented to participate were included. African Americans born outside of the U.S. and those with auditory and vocal impairments were excluded from the group sessions.

Selecting a population of working African Americans was crucial when satisfaction with care received is a desirable outcome. Quite often those who receive health care services are those who have health care insurance coverage through their jobs. Knowing such a population's perspectives on quality of care is crucial for health insurance carriers since consumers' satisfaction or dissatisfaction with quality of care received may influence decision to stay in or opt out of an insurance plan.

Data Collection Site/Setting

Participant recruitment was in the San Francisco Bay Area. Some sites were used more than once for conducting group sessions. The study flyers were posted at the ambulatory clinics in two facilities of a Bay Area Health Maintenance Organization (HMO), child day care centers, and the community (churches, stores, beauty and barber shops, schools, etc.). A focus group meeting was held when ever there were enough participants to conduct one and it did not matter whether or not prospective participants responded to flyers posted at the HMO facilities or some place else.

The settings for the group sessions were neutral but familiar and easily located by participants. All the group sessions were held at the homes of the key participants except for the last two which took place in a barber shop. Dilorio et al. (1994) said that people are less likely to get lost or be late and familiarity leads to a certain degree of comfort which can enhance group interaction. Attention was given to the physical location of the room and room characteristics (size, temperature, light, and sitting arrangements) as much as possible. When ever it was possible, circular sitting arrangements was made to promote conducive group discussion. When a rectangular table was used, as a center piece, the researcher took a seat at the side instead of being at the end of the table where an authority figure usually sits. Dilorio et al. (1994) said that the researcher, for most part, should assume a non-authoritarian and non-judgmental stance. Sitting at the head or the end of the table may convey an impression of authority. Child care arrangements were available for parents in need to facilitate participation but none of the participants expressed a need for it.

Number of Focus Groups and Size

Focus groups were stratified or distinguished by gender with five women's groups (N=29) and two men's groups (N=6). Facione, (1994) noted that inviting both genders to a focus group may possibly inhibit disclosure. Ten to twelve participants were invited for each group session. Though participants' commitment to attend ranged from 6-12, the smallest group had only two participants while the largest had eleven. The planned sample size for Phase 1 was 36-72 (six focus groups with the possibility of conducting more groups in order to recruit 36-50 participants for Phase 2). Having the allowance to

conduct more session(s) was important because of possible attrition problem in Phase 2.

Morgan (1988) said that conducting separate focus groups because of background or role-based differences requires about 4 groups per type. Peters (1993) considered a group of 10 to 12 to be more ideal as opposed to that of 3 to 4 while Stevens (1996) considered 6 to 12 as ideal. Morgan (1988) talked of a moderate sized group (6 to 10). Morgan also suggested to over recruit by 20%. The recruitment difficulty in the study did not allow me to fullfil such recommendations. However, the problem of losing data due to group members breaking into smaller conversations among neighbors around the table (a danger of very large groups) was not experienced in this study, as the largest group had only eleven participants in it.

Morgan (1988) and Pinderhughes (personal communication, January 22, 1997) said that an indication for more focus group sessions is the emergence of new information. Morgan added that a goal in conducting focus groups is to do as many groups as are required to provide an adequate answer to the research question. For instance, if the goal is to get content analysis with relatively unstructured groups, 6 to 8 (or more) groups are needed. Morgan further stated that the more homogeneous the groups are in terms of background and role-based perspectives, the fewer the groups needed. Meanwhile, several distinct population segments in the group under study require running separate groups in each (e.g., groups composed entirely of men or women) and running a minimum of two groups in each distinct segment will obviously increase the total number of groups. Content analysis was the goal in this study. Beginning of data saturation was observed following the analysis of the fifth group data, especially with the female participants.

Focus group six and seven yielded little new information.

Given the resources for this study, it was not possible to purposively recruit participants by income, gender, and age at the same time. Instead, the income and age information was obtained as part of a participant's demographic profile. Morgan (1988) said that older and younger participants may have difficulty communicating with each other either because they have different experiences with a topic or because similar experiences are filtered through age-based perspectives. Stewart and Shamdasani (1990) noted that when other things are equal, a mix of ages may be appropriate for most focus groups. Age difference mixes better than varying SES levels (Facione, personal communication, July 15, 1997).

Participant Recruitment

Participants' recruitment flyers (Appendix A) were posted as earlier described. Quite often people became interested via word of mouth through a key person. The investigator and the key person then set a date to conduct a focus group interview. Attempts to get a complete list of prospective participants (their full addresses, phone numbers, etc.) prior to group meetings proved difficult when one had to go through a key person. The burden on key persons to gather such information was limited by having participants fill out the needed information on the recruitment log (Appendix B) when they arrived for the meeting. The confirmation of agreement to attend focus group (see Appendix C) was instead done via the phone with the key persons. A key person received a reminder telephone call from the investigator 24 hours prior to the group session. A written proposal was defended prior to recruiting participants through the Bay Area HMO

facilities. Immediately following each focus group meeting, each participants received a $15.00 (cash) token of appreciation for participating. Each participant was mailed another $15.00 (personal check) following his/her response to the second round of the Modified Delphi process. Participants were given the choice of money order or cashier's check, but they were not concerned with cashing personal check.

Focus Groups Data Collection

The investigator and observer arrived earlier to prepare the setting (lay out refreshments, consent and demographic data form [Appendices E and H], pens, set sitting arrangement and audio tape recorder). The specific role of the observer was to take hand written notes on the group process including main points on the discussion and non-verbal behavior of the group participants. Group sessions were held around mid morning, late afternoon and early evening (Monday to Friday) and on the week-ends for about one and a half to two hours (Peters, 1993). Stewart and Shamdasani (1990) said that discussions that exceed 2 hours may result in participant exhaustion. Focus group discussions was tape recorded with participants' permission (see Appendices E, consent, and F). The consent form (CHR Approval # H2483-1432-01 of 09-12-97) reflected all ethical and legal considerations according to the University of California San Francisco (UCSF) Committee on Human Research and Institutional Review Board (IRB) form as required by the Bay Area HMO. A sample of the UCSF IRB (Appendix G) form is attached. Participants chose pseudo first names for themselves and the names were later substituted with numbers from one to twelve for each focus group. The focus group protocol (Appendix I) is attached.

Analysis of Focus Group Data

The goal of the focus group data analysis was to identify main ideas or phrases related to perceptions about quality of care. Content of focus group tapes was transcribed and the transcripts were coded (identify terms used to describe behavior and beliefs, and opinions about quality and satisfaction) following each group session. The method of open coding allowed the investigator to identify areas needing further probing. For instance, during a women's focus group session, the investigator learned that doctors sometime ignore women's questions. During a subsequent men's group session, she deliberately asked participants if doctors sometime ignore their questions. The identified terms were classified into main ideas or phrases (Dilorio et al., 1994). Each transcript was reread by the investigator to validate the term classifications and necessary changes made to refine the main ideas or phrases. Each group session was analyzed in the same manner until all seven focus groups were completed. The main ideas from all the groups were merged accordingly to observe the emerging/recurring main ideas describing quality of care. This final list of main ideas was then used for the second phase of the study - the Modified Delphi technique. The list's items were shuffled and randomly selected to reduce response set bias. Restating some of the items positively or negatively further reduced the response set bias concern. The non-categorized list of main ideas (140 statements in all) was sent to the participants.

Extraction of Main Idea Statements

This section describes how the main ideas were extracted from each focus group transcript. Following each focus group session, the investigator read the transcript to

glean the main points representing the participants' responses to each of the interview guide questions. The points were then categorized according to emerging themes/issues for each of the guide questions. Sometime there were overlaps in some of the responses to questions asked. In such cases, the investigator placed the responses (based upon the literature and practical experiences) under the appropriate questions. The investigator then reviewed all the responses for each question and related themes. The latter was followed by writing up statement(s) also called main idea(s) from the responses.

The next step was to create a file containing all four interview guide questions and related categorized participants' responses. The categorized responses for each focus group were matched with those of the other six focus groups for each question to remove redundancies. It must be cautioned that the main idea statements may not be precise statements from any of the focus group transcripts because they have to be abstract enough to subsume the same ideas from all groups even if they were expressed differently. Following the removal of redundancies, the identified focus group number for each question were removed leaving just a categorized list of 140 main idea statements. Each main idea statement was then assigned a variable name (up to 8 characters) to facilitate SPSS computer program use. The main idea statements were then cut out on 140 pieces of paper which were mixed up, randomly selected, and assigned numbers from 1-140 (Appendix J). The following examples illustrate the stages through which focus group participants' responses became main idea statements. The study guide question in the given examples is "**Please tell me about your health care experiences** (not limited to hospital experiences, include emergency rooms, doctor offices, clinics, and elsewhere)".

Example 1

1. Focus group transcript responses:

> ...I can just start with the emergency room... My experience when I get there is not lot going on but its just wait so long... It seems like to me that there is not much going on but its just get so long to get to the problem. What we think is emergent may not be emergency to them but there is always a long wait. ...have a nurse come out and assess your problem and they say go and take a seat and there is a long period of time before you get there...

2. Analyzed/categorized participants' responses:

Emergency room in general - (a) seems like not much is going on but there is always a long wait to get to the problem, (b) first the nurse assesses, then tells you to take a seat followed by a long wait before getting to the problem, and (c) it seems like what we see as emergencies may not be emergencies for them.

3. Extracted main idea statement:

The long wait at the emergency room is because patient's view of emergency is different from the health care provider's (Appendix J. # 24).

Example 2

1. Focus group transcript responses:

> ...I have asthma ... for about 15 years and one of the things that I was really surprised to find out ... when I was first diagnosed ... I went to see the doctor... it ended up not being an emergency room, so they just basically gave me breathing treatments, they gave me some medication and sent me home and really didn't give me any good education. So needless to say I was back in the emergency room 3 days later, and when they asked me to demonstrate how to use the inhaler, I used it all wrong. And I hadn't realized the importance of taking every single of the medications. That was one medication that affected all the others. I did not have an education at all, ...I learned early on was that whenever I go to the emergency room, I always write down when I got treatment, what medication ... because I cannot leave it up to them. Cos they don't know me. I am just some one who came to the ER, so I found out I have to be on top of stuff and not be afraid to ask questions.

2. Analyzed/categorized participants' responses:

Emergency room situation/experience: First time diagnosis with asthma
(a) ...female surprised at her diagnosis of asthma, (b) given breathing treatments and sent home with no education on the medications (the importance of every single drug and the effects of one drug on the others, etc.), (c) patient back in the emergency room in 3 days with the same problem and her demonstration on how she was using the treatments was all wrong, (d) she then learned early on that she must take some responsibility when she goes to the emergency room by writing down the medications and what the doctor says about them, and (e) must be on top of things and not be afraid to question because the people at the emergency room do not know you other than one who is there to use their services.

3. Extracted main idea statements:

A patient may not be able to follow direction for a new medication if the care provider assumes that the patient knows already (Appendix J # 62). A patient can improve the quality of his/her care by educating him/herself on the health problem (Appendix J # 71). A patient may not recognize the side effects of a new medication if the care provider assumes that the patient knows already (Appendix J # 83).

Participants were also specifically asked what they understood by quality of care just in case none of them brought it up in their responses to the health care experiences question on the interview guide. Participants' responses on the definition of quality of care often had overlaps as the investigator went from one focus group to another. Below are excerpts from two focus group transcripts on the definition of quality. The manner in which redundancies were removed from the list of main idea statements is illustrated. Three main idea statements were extracted from focus group 2 and four from group 4. Statement number 55 appears in both focus group two and four so only one of them was used.

Definition of quality of care

1. Focus group 2 transcript responses:

> ...treatment of whatever is wrong with you. I think on one hand, quality care is do you get the results, for instance get better. So the other part is how are you treated. Do they do all the tests, do they give you the medication, do they take you to the specialist, do they keep you waiting for ever? Quality is also decided by the consumer, what you think. if you feel that you have been taken care of, you will feel that is quality of care. ...some of these people thought they had quality care because they had real food. It didn't make any difference if the nurse knew what she was doing. They had a glass of wine on their dinner tray and someone came in and answered their bell on time and they thought that was quality care. So if you feel like it is quality, well if you feel good about what you are getting, then that defines quality. ...If you do not know any better that is quality. Quality is quality of outcome. I think quality is when you are getting better. ...yes ...outcome is what you need and you feel good about what has happened ... what is happening to you and what they are doing... you have confidence in this people and what they are doing, ...confidence determines quality.

2. Analyzed/categorized participants' responses:

Meaning/definition of quality of care

(a) Quality of outcome especially if one does not know any better/you start getting better
(b) One has confidence in the people and what they are doing
(c) Seeing a specialist when needed
(d) Quality care is whether or not you get better results
(e) The consumer's feelings and thinking about how the care received ("So if you feel like it is quality, well if you feel good about what you are getting, then that defines quality")
(f) What you find or feel comfortable about

3. Extracted main idea statements:

Quality health is the type of care that a patient receives (Appendix J # 5. Quality health care is to be treated/cured as best as possible (Appendix J # 67). Quality health care is how the health care treatment processes are done (Appendix J # 55).

1. Focus group 4 transcript responses:

> I think it starts with how you are dealt with interpersonally with your provider or your physician or whatever. How they treat you, how they talk to you, whether they are concerned, whether they genuinely seem like they are concerned with what may be ailing you. As opposed to factory or assembly line thing. Where there is no expression, no emotion, you know

> this is wrong, you know this and that. I know that goes a long way when someone genuinely care about what is wrong with you. You know, and when they talk to you in that manner you get those vibes and they go down the check list from what could be wrong with you...the communication, just communicate with you. ....I think that when it comes down to high and low quality some people tend to look at results, after the fact, you know when you are cured or whatever. And some people tend to look at the actual process leading up to that point. And high quality, low quality, I think , I do not care if you have great insurance, you got a doctor who has sixty patients to see in eight an a half hours ... a large patient list, how much quality is that, you are in there for ten minutes, and bam bam bam, this is what needs to be done and we will see you next time, stop at the scheduling desk and schedule another appointment. ...to the ... desk..we do not have any spot open for three months... Even though you know that some doctors are the best, is that considered high quality...

2. Analyzed/categorized participants responses:

Meaning/definition of quality of care

(a) Quality of care starts with the interpersonal relationship between the patient and the care provider (how they treat, talk to you; are they genuinely concerned with the health problem instead of the "assembly line thing"; does the provider express appropriate emotion...)
(b) Quality of care revolves around money; if you have money that is all.
(c) High quality is looking at the result of care i.e., whether or not the person is cured.
(d) Some people look at the process that lead to being cured.
(e) It means that I am cured and that during the process of my treatment, the person made me feel like they cared about what was wrong with me.
(f) Even if one is insured, the large patient load that doctors have in about eight hours allows them with little time to provide patients with care that is of high quality.
(g) If you have high quality insurance, you get high quality health care.

3. Extracted main idea statements:

People like caring and nice health care workers (Appendix J # 100). Quality health care is how the health care treatment processes are done (Appendix J # 55). Anyone with no health insurance has little or no chance for health care services (Appendix J # 117). Seeing more patients means more money, so care providers spend a short time with each patient (Appendix J # 15).

Phase 2

The Modified Delphi Technique

The Delphi technique was developed at the RAND Corporation in the late 1940s to obtain technical and scientific estimates from experts. The technique is a method for systematic collection and aggregation of informed judgements from a group of experts on specific questions or issues (Williams &Webb, 1994; Stewart & Shamdasani, 1990). Jairath and Weinstein (1994) discussed four major designs encompassed within the Delphi method - conventional, real time, policy, and decision Delphi. The conventional Delphi or classical design (the choice for the proposed study) is the traditional design used in gathering information and building consensus. Participants' responses are summarized/analyzed and reported to the experts who are again asked to review and provide their opinions on the issue. This iterative process continues until full consensus is reached or no further changes occur in individual responses. The technique seldom requires more than three or four iterations (Stewart & Shamdasani, 1990; Jairath & Weinstein, 1994). Jairath and Weinstein further stated that the structure of the iterations is flexible and can be adjusted after any round. For instance, the number of rounds may be decreased to minimize reductions in the amount of new information and reductions in response rates resulting from respondent fatigue. Conversely, the number of rounds may be increased based on respondents' recommendations about additional information which should be gathered.

The real time Delphi is a simplified version of the conventional design and is used to gather information and build consensus via teleconferencing, electronic mail, modems

and other types of interactive networks. Policy Delphi design is used to generate decisions which shape future developments. Finally, decision Delphi is used for generating decisions that shape future developments. Unlike the other Delphi designs, information gathering in the decision Delphi design is secondary to decision making and restricted to information necessary to support and generate decisions.

The Delphi technique encourages honest opinion/anonymity that is free from peer group pressure (Leape, Freshour, Yntema, & Hsiao, 1992; Stewart & Shamdasani, 1990). Since successive rounds of information reach each expert member, views can be retracted, altered or added with the benefit of considered thought especially when experts can see how their personal stance compares with the group's (Ashton et al., 1994; Williams & Webb, 1994). Leape et al. (1992) said that controlled feedback, an essential characteristic of the Delphi technique, reduces noise thus, maintaining the focus of the judgments. Ashton et al. (1994) used a modified Delphi method to ascertain that a criteria list describing specified clinical conditions, study setting, and data sources contained all necessary items and that individual items clearly and accurately reflected the norms of current practice. Limitations of the Delphi technique include the fact that (a) no agreement has been made on the size of the panel of experts or any recommendations concerning sampling technique although Leape et al. (1992) said that group sizes between 15 and 25 yield satisfactory results, (b) the researcher arbitrarily decides on the sample size, and (c) random selection is rarely used.

In round one, the analyzed main ideas describing quality of care (from the focus groups; see Appendix J) were mailed out to all 35 participants from phase 1. Each

participant was asked to rate each main idea on a scale of 1 to 6 where strongly disagree = 1, moderately disagree = 2, slightly disagree = 3, slightly agree = 4, moderately agree = 5, and strongly agree = 6. Davis and Bush (1995) said that Likert-type scales are most often used to elicit opinions or attitudes and La Monica et al. (1986) used a scale of 1-7 to achieve greater sensitivity. Holzemer (personal communication, July 15, 1997) said that floor and ceiling effects are reduced by using wider range scale (1-7) as opposed to a narrower scale (1-5). Using a scale of 1-6 (excluding the uncertain choice) allowed participants to only agree or disagree with each statement.

The introducing statement for the participants in round one was "Here is a list of main points which you and other focus group members gave on the subject of the quality of health care that you receive. Please rate each on a scale of 1-6 to indicate your agreement or disagreement on each main point. Please circle a number to indicate your choice. (strongly disagree = 1, moderately disagree = 2, slightly disagree = 3, slightly agree = 4, moderately agree = 5, and strongly agree = 6)" (Appendix J). Participants were instructed to return their feedback within two weeks in a stamped return envelope. Two days prior to the return deadline, a reminder phone call was made to each participant who had not responded - by then only only eleven (11 - 31%) had responded. Two participants indicated that they could not remember where they had kept their questionnaire copies but were still willing to continue as study participants. They were mailed new forms and yet only one of them responded. The slow response rate led to a second follow-up call during the third week of the first round of Delphi. By the end of the fourth week, only twenty-two (22) responses had been received. Round one closed at the end of the fourth week.

Those who had not responded by then were appreciated over the phone for their participation in phase one of the study and were informed that the study was proceeding without their feedback. Response group mean scores and standard deviations including individual scores on each item were obtained using the SPSS computer program.

In round two, individual scores and group means on all the main ideas were reported to the remaining 22 participants (see Appendix K). The purpose of this second round was to give participants a chance to compare their scores with the group mean scores on the items and for them to determine if they wished to change their minds. Opinion change was therefore left for participants to decide. For instance, a person who wished to be closer to the group mean score subsequently selected a number that represented or brought him/her closer to group mean score. Each main idea statement was followed by the following: Your score __ (the previously selected number) and Group mean score __ (a number ranging from 1-6). Participants were given a chance to choose a new number (by circling) for each main idea in the column labeled "Your new score". It was also all right for participants to not change their minds on any or all of the main ideas/points. Round two was the last round of mail exchange with participants (they reached consensus with their responses).

Participants were asked to return their feedback within another two weeks. Their responses were again analyzed and main ideas with highest positive ratings (strongly agree) were given priority selection. A main idea was included if at least 55% of the participants positively identify the item as a descriptor of quality of health care. There is no universal cut-off point in the literature for the selection of positive responses.

Following the inclusion criterion of 55% and above, eight main idea statements were excluded from the list following round 2 of the Delphi process. The excluded statements were numbers 117 (insurance issue - 26.4%), 118 (appointment issue - 47.4%), 91 (provider's beliefs/preconceived ideas - 42.1%), 4 (interpersonal and communication process - 36.9%), 52 (choosing a new care provider - 26.3%), 1 (changes in health care - 31.6%), 64 (administrative issue and ethics - 21%), and 134 (racism and its effects - 52.6%). The final list of main ideas (used in developing the dimensions of quality of care) consisted of 132 statements. The final sample size was 19. The planned factor analysis and comparison between female and male's groups could not be done because of the small sample size and extremeness of their representation - sixteen women and three men. Subsequently, a decision was made to use Holzemer's (1996) three-by three model to categorize the 132 statements upon which consensus was reached. A conscious decision was then made to group the statements under three main headings also called dimensions. The groupings were based upon pragmatic or practical experience and feasibility.

It should be kept in mind that the 132 statements were views of African Americans who participated in the study on how they saw and described quality of health care from their experiences. Gerteis, Edgman-Levitan, Daley, and Delbanco (1993) referred to the latter as the subjective experience (its texture and substance), its sentient quality. The dimensions of quality health care from the participants' perspectives were then described in terms of the various roles that people and health care setting play in care-giving and receiving situations. The roles include (a) patient/consumer/client role, (b) provider role/patient-provider interpersonal relationship, and (c) setting role. Sub-categories for

the provider role are what Donabedian (1969) called interpersonal and technical aspect of care. The latter is depicted in Figure 1 as Technical care and Human interpersonal care. Following Holzemer's (1996) three-by-three model, the variables for each of the dimensions were viewed in terms of inputs, processes, and outcomes. Although overlapping occured with some variables/statements, they were placed in the best category. In addition, attention was paid to any variable that would not fit in any of the stated categories.

Some major themes were conceptually derived from the list of main idea statements. The themes were based on some overriding ideas in some of the statements as well as phrases/expressions used by the participants. For instance, the word "militant" captures statements/phrases that describe assertive behavior to get the best out of the health care system. "Quick fixes" is an exact phrase used by study participants to describe hurried behavior of health care providers.

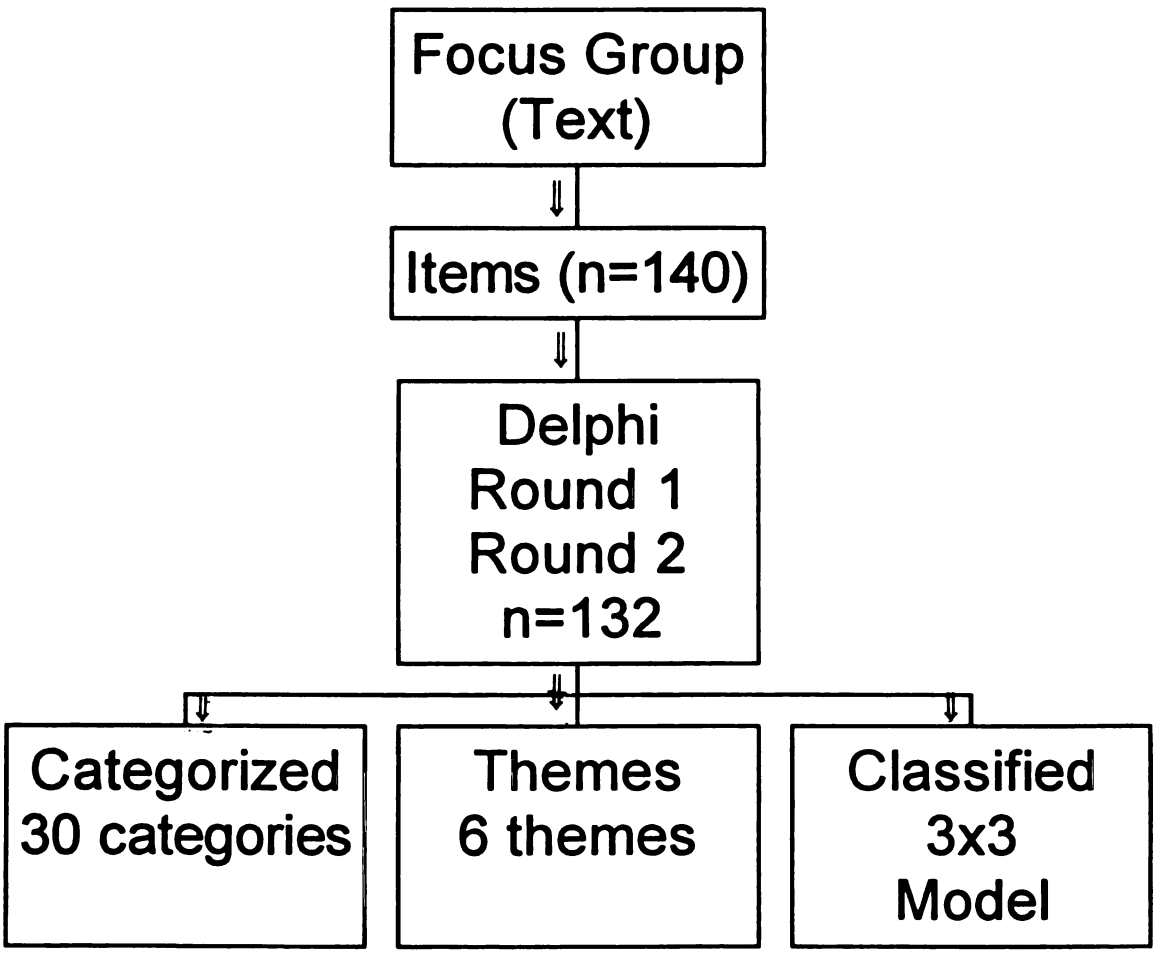
CHAPTER FOUR

RESULTS

Introduction

This chapter presents findings from the study. The information is based on the (a) focus group interviews with 35 participants, (b) findings from the 22 participants who responded to Round 1 of the Modified Delphi process, and (c) findings from the final 19 participants who remained to the end of the study. Following the analysis of the focus group interviews, 140 main idea statements were extracted from the seven focus groups' transcripts. The main idea statements were submitted to a Modified Delphi process with 132 items remaining at the end of Round 2. Three separate analyses were conducted. First, the statements were organized at quality of care issue level (a total of 30 issues) under each interview question. Second, qualitative thematic narratives depicting some of the issues and main idea statements were abstracted. The third analysis was classifying the main idea statements into an existing quality of care model - Holzemer's (1996) Outcomes Model for Healthcare Research (3x3 model). Based upon the 3x3 model and Donabedian's interpersonal and technical domains of care, three dimensions of quality of care (patient role, provider role/patient-provider interpersonal relationship, and setting role) are presented (Appendix N). Figure 4.0 provides a summary of how the focus group data were used to accomplish the aim of the study.

Figure 4.0. Steps in Focus Group and Delphi Data Analysis



Demographic Data

Thirty-five (N=35 - 29 women and 6 men) African Americans participated in the seven focus group sessions. Only twenty-two (22 or 63% - 19 women and 3 men) responded to the first round of the Modified Delphi process. Of the 22, 19 (86.36% - 16 women and 3 men) responded to the second and last round of the Delphi process and they constitute the final sample size. The sample characteristics presented below are for all the focus group participants.

Table 4.1. Focus Group participants' demographics

	Frequency	Percent
Total in focus group (N)	35	100.00
Women	29	82.86
Men	6	17.14
Age range	Frequency	Percent
18-25	3	8.8
26-35	5	14.7
36-45	8	23.5
46-55	12	35.3
56-65	4	11.8
66 and over	2	5.9
Level of education	Frequency	Percent
High school 5 - 12 years	2	5.9
College 1	4	11.8
College 2	12	35.3
College 3	5	14.7
College 4	5	14.7
Graduate school 1	1	2.9
Graduate school 2	4	11.8
Graduate school 4	1	2.9
Graduate school	1	2.9
Mean education years	14.94; SD = 1.87	

Table 4. (continued)

Special training	Frequency	Percent
Beauty school	1	3.4
Business school	7	24.1
Other	21	72.4

"Other" types variable of special training included:

Records administration	Adult education
Medical	Computers (n=4)
Psych tech	Computer software application
Social work (n=2)	Fashion Consultant
Nursing (n=4)	Machine work
Healthcare	Health education
General	Healthcare textile
Labor	

Marital status	Frequency	Percent
Single	10	28.6
Married	11	31.4
Divorced	8	22.4
Widowed	4	11.4
Separated	1	2.9
Living with a partner	1	2.9

Employment status	Frequency	Percent
Fully out of home	29	82.9
Part time basis	5	14.3
Self employed	1	2.9

People living in household	Frequency	Percent
1	10	28.6
2	11	31.4
3	7	20.0
4	4	11.4
5	2	5.7
6	1	2.9
Mean household occupancy	2.43; SD = 1.34	

Table 4. (continued)

Children living in household	Frequency	Percent
0	16	45.7
1	13	38.2
2	2	5.9
3	1	2.9
4	2	5.9
Mean	0.82; SD = 1	

Household income from	Frequency	Percent
Work	32	97
Public Assistance	0	0
Family help	0	0
Spousal support	0	0
Student loan	3	8.6
Other sources	7	20.0

Health insurance status	Frequency	Percent
None	2	5.7
Has health insurance	33	94.3

Health insurance coverage	Frequency	Percent
Full coverage	31	93.9
Partial coverage	1	3.0
No coverage	1	3.0
	2	5.7

Main Idea Statements

Each of the seven focus groups transcript was coded and terms used to describe behavior, beliefs, and opinions about quality and satisfaction with care were identified. The identified terms from each group were analyzed to observe the emerging/recurring main ideas describing quality of care. A final list consisted of 140 main idea statements were obtained and were used for the Modified Delphi technique.

Modified Delphi Process

The purpose of the Modified Delphi process was to achieve consensus on each of the 140 main idea statements describing quality of care. A total of two iterations or rounds were conducted. Group means and standard deviations for each main idea statement were obtained. Using the inclusion criterion of at least 55% agreement, 132 items were retained after the second round.

Table 4.2 shows the differences between the standard deviations on the items in Delphi Round 1 to Round 2. The differences represent the consensus arrived at after Round 2. Most of the 132 items (109=82.58%) showed shrinkages in SD from Round 1 to 2 while 23 items (17.42%) indicated increases. The increase in SD for the 23 items ranged from -1.15 (item number 63 on Table 4.2) to 1.01 (items numbers 20, 30, 38, 68, 127, and 132 on Table 4.2). The total difference in SDs from Round 1 to Round 2 was the average SD shrinkage and that value was 0.237. All participants (100%) in Round 2 selected 49 (37.12%) items as quality of care descriptors and those items are indicated on Table 4.2 by the asterisk sign (*). The shrinking SDs suggest consensus was being achieved within the sample.

Table 4.2. Consensus or shrinkage of standard deviations from Round 1 to Round 2

Item (statement)	Round 1 SD	Round 2 SD	SD Diff.
1. A doctor is cold to a black patient because s/he does not want to deal with such a patient.	1.65	1.24	.41
2. Unemployment means no health insurance and high crime rate among blacks.	1.86	1.34	.52
3. Quality health care is the type of care that a patient receives.	1.92	1.67	.25
4. The health care system is positively influenced by the U.S. society being a NOW society and one that puts money first before ethics.	1.46	1.57	-.11
5. Those with health insurance may still receive low quality care.	1.29	1.32	-.03
6. Low quality care is doctors discussing what insurance will pay for.	1.61	1.71	-.1
7. At the emergency room, time and life are saved when stab wounds are attended to first before paper work. *	1.01	.77	.24
8. Elderly patients find it hard to handle when they are pushed fast through the system. *	.74	.60	.16
9. Wrong diagnosis can result in delayed treatment and permanent or long lasting disability. *	.29	.23	.06
10. Quality health care is getting top-of-the-line or best treatment.	.95	.99	-.04
11. Today, patients are expecting care providers to use language that patients can understand. *	.39	.37	.02
12 The beliefs that blacks are usually overweight and eat greasy foods may result in failure to properly examine and treat.	1.41	.98	.43
13. Seeing more patients means more money, so care providers spend a short time with each patient.	1.02	1.06	-.04

Table 4.2 continued

Item (statement)	Round 1 SD	Round 2 SD	SD Diff.
14. A patient can improve the quality of his/her care by knowing how to get through the health care system. *	.65	.56	.09
15. The health care system is negatively influenced by the U.S. greater financial expenses on defense more than on health care.	1.13	1.00	.13
16. To say that a health problem that has been for a while does not need a "rush action" discounts the problem and the patient's feelings.	1.05	1.17	-.12
17. There is a need for health care workers who look like me (black). *	.58	.58	0
18. People do not like the idea that some patients receive better health care than others. *	.53	.54	-.01
19. The health care system is negatively influenced by mis-management of funds.	.97	.92	.05
20. A care provider's experience may influence how a patient is treated. *	.73	.56	.17
21. It is <u>not</u> disrespectful for a patient to wait for a doctor for no good reason on the doctor's part.	1.72	1.48	.24
22. The long wait in at the emergency room is because patient's view of emergency is different from the health care provider's.	1.43	1.30	.13
23. The care provider's gender (sex) may influence diagnosis and treatment.	1.72	1.63	.09
24. One's racial background does <u>not</u> influence the quality of care that one receives.	1.78	1.57	.21
25. Taking prescribed medication such as a narcotic for a chronic condition does not mean that one is a drug addict.	1.30	1.25	.05
26. Patients are having <u>longer</u> length of stay at the hospital.	1.64	1.16	.48

Table 4.2 continued

Item (statement)	Round 1 SD	Round 2 SD	SD Diff.
27. The level of care has gone down from what it used to be.	1.17	1.24	-.07
28. Voicing surprise when patient is able to express him/herself on the health problem at hand is disrespectful.	1.82	1.83	-.01
29. These days, patients are discharged sooner from hospitals because insurance companies require early discharge. *	.91	.45	.46
30. Black men should not tell their doctors exactly what is going on with them. *	1.09	.32	.77
31. Asking questions and following health care instructions show that blacks care and are serious about their bodies. *	.39	.37	.02
32. Education of the public about health-care-related issues does not influence the quality of patient care.	1.84	1.39	.45
33. Black women can improve the quality of their care by not forgetting to take care of themselves while caring for their children, husbands, etc.	1.49	1.22	.27
34. Preconceived assumptions (including ideas about persons from a particular race, living location, socio-economic status) affect the quality of care that a person receives.	1.45	1.02	.43
35. Asserting self means being frank with care providers. *	.69	.61	.08
36. The emergency room health workers do not tell patients/families why they are waiting.	1.37	1.38	-.01
37. Health care setting's guidelines prevent delaying diagnosis, treatment, and allay a patient's anxiety about the health problem.	1.52	1.52	0.0
38. Class issues between care provider and assistant do not affect patients in a negative manner.	1.30	1.26	.04

Table 4.2 continued

Item (statement)	Round 1 SD	Round 2 SD	SD Diff.
39. Teaching and role modeling for children on what they should do to keep healthy affects the quality of care that the people receive.	1.56	1.21	.35
40. Doctors who have problems touching black patients tend to ask a lot of questions and do more writing than touching.	1.79	1.24	.55
41. Physicians should not educate themselves about black people and their common health problems. *	2.2	.32	1.88
42. Patients like being attended to by medical students.	1.63	1.30	.33
43. The outcome of care such as cured and outstanding bills must be considered in quality improvement.	1.41	1.46	-.05
44. Asserting self also means that a patient does not allow a care provider to discount him/her. *	.84	.81	.03
45. People do not like the paper work associated with visits where they receive health care.	1.47	1.40	.07
46. People do not like scheduling appointment several weeks later than they need them. *	1.50	.50	1.0
47. Asserting self means asking doctors for referrals to experts.	1.33	1.41	-.08
48. High quality care is rushing patients out of hospitals. *	.35	.32	.03
49. Quality health care is the conditions surrounding the type of patient care.	1.36	1.26	.10
50. Patients prefer centralized health care settings where the workers know patients beyond their health problems.	1.40	1.19	.21
51. Changing insurance companies interferes with the bonding/trust between the provider and the patient.	1.93	2.0	-.07

Table 4.2 continued

Item (statement)	Round 1 SD	Round 2 SD	SD Diff.
52. Quality health care is how the health care treatment processes are done.	1.59	1.48	.11
53. People like it when the waiting room is not crowded. *	.61	.60	.01
54. People do not mind the long waits during appointments.	1.45	1.07	.38
55. A surgery patient may not like the pressure associated with early discharge such as getting up and walking soon after surgery.	1.00	.91	.09
56. The health care system is negatively influenced by conflicts of interest with management personnel.	.85	.83	.02
57. Restructuring or re-organizing of the Food and Drug Administration (FDA) can improve the quality of patient care.	1.69	1.33	.36
58. Quality health care is considering patient's health problem(s) first before cost. *	1.08	.90	.18
59. A patient may not follow direction for a new medication if the care provider assumes that the patients knows already.	1.36	.96	.40
60. Not everyone who seeks health care should be given the best possible quality care.	0	1.15	-1.15
61. Fewer doctors are in private practice today.	1.47	1.57	-.10
62. Adequate qualified staff and available health information must be considered in quality improvement. *	.69	.61	.08
63. Quality health care is to be treated/cured as best as possible. *	1.14	.90	.24
64. Elderly patients have less experience in managing their way through the health care system so they need assistance from care providers and their families. *	.41	.42	-.01

Table 4.2 continued

Item (statement)	Round 1 SD	Round 2 SD	SD Diff.
65. Quality health care is getting to the root of the patient's health problem. *	1.17	.70	.47
66. Quality health care is having no hassle about seeing specialists when needed. *	1.18	.42	.76
67. A patient cannot improve the quality of his/her care by educating him/herself on the health problem.	1.60	.82	.78
68. A care provider may not educate black patients because of the belief that blacks do not take pride in their health care issues.	1.82	1.95	-.13
69. People do not like 'public' health care settings where Medicare/Medicaid patients go because there are usually too many patients to be seen there and too few doctors.	1.43	1.00	.43
70. Doctors should look for the uniqueness of each patient's situation rather than assume that things have to be the way they (doctors) were trained to see things.	1.24	.76	.48
71. Poor examination of a patient may result in wrong treatment. *	1.34	.32	1.02
72. A doctor's beliefs about a patient's age may influence the diagnosis of a health problem.	1.61	1.24	.37
73. People tend to be most comfortable with health care providers from their own racial background.	1.23	.90	.33
74. People should not be kept waiting more than 15 minutes for an appointment.	1.27	.89	.38
75. Addressing an elderly black patient by his/her first name is disrespectful.	1.95	1.71	.24
76. Quality of health care may be influenced by the patient's societal position. *	1.33	.89	.44
77. A doctor's choice of words can have a bad or good effect on the patient. *	1.22	.77	.45

Table 4.2 continued

Item (statement)	Round 1 SD	Round 2 SD	SD Diff.
78. High quality care is talking with a patient about health problem(s) first and then cost later. *	.90	.77	.13
79. A patient may not recognize the side effects of a new medication if the care provider assumes that the patient knows already.	.96	.84	.12
80. High quality care is allowing a patient to see a specialist. *	1.25	.84	.41
81. Patients like it when the insurance company pays for things such as eye glasses. *	1.18	.00	1.18
82. Today racism is covert and whites still receive better care than blacks. *	1.21	.51	.70
83. Patients do not like it when their doctors and staff know them by their names.	1.73	1.22	.51
84. Anyone without insurance may receive only minimal health care that may relief discomfort for only a short time.	1.26	1.22	.04
85. The health care system is negatively influenced by the U.S. failing to take examples from other Western countries.	1.40	.91	.49
86. Quality health care is the patient-provider relationship.	1.18	1.20	-.02
87. A patient prefers a doctor from any race who does not rush and give incomplete responses to questions. *	.86	.69	.17
88. People do not like dirty, shabby, and smelly health care environments. *	.00	.00	.00
89. Excluding blacks from life-saving related research studies does not influence the quality of their health care.	2.14	1.87	.27
90. Untrained health care staff can be condescending impatient, ignoring, prejudicial, and stereotyping with patients. *	.58	.58	0

Table 4.2 continued

Item (statement)	Round 1 SD	Round 2 SD	SD Diff.
91. Quality health care is a patient's feelings about the care received.	1.49	.91	.58
92. Patient do not like anxiety-raising situations in the health care settings while waiting to be attended to. *	.89	.76	.13
93. Going to the dentist and returning home with little or no pain is a an advancement in medical care that people like. *	.59	.48	.11
94. Health care providers can improve the quality of care by talking to people about prevention, education, and engaging with the community through organizations like churches and Lions. *	.74	.70	.04
95. People like caring and nice health care workers.*	.47	.00	.47
96. At the emergency room workers should consider the patient's bathroom needs and anxiety about the health problem.	1.03	.96	.07
97. A new doctor that is selected should be a person that you trust. *	.73	.68	.05
98. Health care providers at under-staffed settings may not attend to a patient's health care need.	1.05	.96	.09
99. High quality care is being able to choose your own doctor. *	.08	.77	.03
100. Sometime a patient must insist that a care provider sees him or her. *	1.06	.69	.37
101. The type of treatment that one gets does <u>not</u> depend on the type of insurance coverage.	1.57	1.47	.10
102. People like or are pleased with a clean and conveniently located health care environment. *	.21	.23	-.02
103. Most black doctors are <u>not</u> personable to patients and <u>do not</u> work in their communities as role models for young people.	1.62	1.42	.02

Table 4.2 continued

Item (statement)	Round 1 SD	Round 2 SD	SD Diff.
104. When a doctor is cold to me, I feel like not asking questions but just leaving as quickly as possible. *	1.25	.58	.67
105. Patients like being able to speak with their doctors when they want to. *	1.12	.61	.51
106. Improving the quality of health care means self diagnosing and treatment.	1.78	1.18	.60
107. A doctor's beliefs about a patient does not influence the diagnosis of a health problem.	1.47	.94	.53
108. A responsible patient insists on being seen and has a regular health follow-up schedule. *	1.16	.60	.56
109. Family doctors are rare these days. *	1.09	.90	.19
110. A patient can improve the quality of his/her health care by providing the doctor with a copy of problem list preferably prior to the scheduled visit. *	1.25	.81	.44
111. People do not like provider's scheduling to see many patients because it results in patients receiving poor care.	1.57	1.22	.35
112. Blacks' experience with the health care system makes some people seek only emergency care.	1.68	1.59	.09
113. Patients and families are left to guess what is going on in emergency rooms because the workers do not tell them.	1.14	1.12	.02
114. Sometime a patient may have to assert him/herself by demanding for the right tests in order to get the needed quality of care.	1.46	1.22	.24
115. Conducting research studies that advance progress on different diseases can improve the quality of care. *	.70	.67	.03

Table 4.2 continued

Item (statement)	Round 1 SD	Round 2 SD	SD Diff.
116. Health insurance that covers 80% or more of health care expenses is preferable.	1.73	1.63	.10
117. Discussing patient's examination room findings with those outside of the exam room is disrespectful.	1.68	.96	.72
118. Rushing and giving incomplete answers to questions is anxiety raising for patients.	.80	.84	-.04
119. An option from the health insurance company to seek care anywhere can improve the quality of care.	1.41	1.29	.12
120. Doctors can only order what the insurance will cover.	1.22	1.23	-.01
121. Quality health care is having the means to seek health care.	1.44	1.34	.10
122. One can receive low quality care at a popular health care facility.	1.07	1.05	.02
123. Doctors who do not like touching blacks perform incomplete and inadequate exams on such patients.	1.38	1.02	.36
124. Quality health care is <u>not</u> related to the care provider's level of knowledge.	1.81	.90	.91
125. Some health insurance "...pays doctors to keep patients out of the hospital".	.97	.98	-.01
126. Asserting self means <u>settling</u> for less. *	1.29	.56	.73
127. Blacks make health care choices based on what they have available to them.	1.41	1.17	.24
128. Health insurance companies do not pay for pre-existing conditions.	1.30	1.08	.22
129. To be seen by a Nurse Practitioner when payment checks are made to the doctor is disrespectful.	1.43	1.33	.1

Table 4.2 continued

Item (statement)	Round 1 SD	Round 2 SD	SD Diff.
130. The way that the care provider does what s/he does (knows his/her job and expectations) does not influence the quality of care.	1.46	1.04	.42
131. People do not like to make payment at the emergency room when they are seeking care.	1.06	1.10	-.04
132. Quality health care is responding to a patient's health problem when care is needed. *	1.23	.58	.70
Total difference between SDs on 132 retained items from Round 1 to Round 2			**31.31**
Average SD difference on 132 items = 0.237			

SD = Standard Deviation Diff = Difference * = Statements with score of 100% agreement responses in Delphi Round 2

Focus Group Interview Guide and related Quality of Care Issues

The emerging themes or issues from the main idea statements were organized according to the four interview guide questions. Each of the issues is depicted by one or more main idea statements in Appendix J (used for the Modified Delphi technique). The issues level grouping was not based on any criterion other than as deemed to be related to the specific question. There were eighteen issues for the question dealing with health care experiences, four on likes and dislikes, five for the quality improvement question, and three for racism related question. The four questions and their related quality of care issues are presented below.

Question: Please tell me about your health care experiences.

- Health care insurance
- Provider's beliefs/perception/preconceived idea
- Definition of quality of care
- Emergency room situation
- Interpersonal and communication processes
- Health care setting arrangements and popularity
- Treatment delay
- Changes in health care
- Provider's gender and preventive health care
- Respect/disrespect
- Choosing a new health care provider
- Class issue
- Employment/crime rate
- Family doctor issue
- Administrative issue and ethics
- Shorter length of stay
- High and low quality care
- Cost /payment

Question: Please tell me about your feelings including what you like and do not like about the people and places where you receive or have received health care.

- Anxiety-raising situations
- Environment
- Appointments
- Differential treatment

Question: How should quality of health care be improved?

- Setting's role in quality improvement
- Patient's role in quality improvement
- Provider's role in quality improvement
- Patient outcome
- Care of the elderly

Question: Please tell me how racism affects/influences the quality of health care that you receive

- Racism and its effects
- Minority and health care research
- Victim blaming

Quality of Care Thematic Narratives

Based upon the review of the quality of care main idea statements and emerging themes, six abstract themes (quick fixes, care-seeking militancy, skin as a communication medium, health insurance proof does not guarantee for quality care, assumptions about blacks, and providers' stereotype beliefs and behaviors) were identified and are described below.

Quick Fixes Metaphor

"Quick fixes" is a metaphor describing hurrying over things that may lead to misdiagnosing, using treatment methods that do not effectively cure, and treating to pacifier the patient/not using judgment in treatment and care decisions. Quick fixes occur for two reasons - (a) to satisfy patients who want quick answers and (b) to maintain productivity regulations as health care providers may be required to see so many patients within an allotted time period. The result is pushing people through the health care system to the point where patients hardly have time to talk about all their health concerns. The following quotation from the transcripts of focus groups is what two participants said about quick fixes.

> One of the things that bothers me sometimes about physicians is you've lived with the body for a long time and you complain about something and they want a quick fix on things. ...I guess part of it is us, we want an answer when we go in. you are hurting and you go into the doctor, you want an answer ... or something that is going to make you feel better. So we gotten into the habit of perhaps, we wanting quick fixes when the problems didn't come quickly or we did not get the problems over night. ..it takes time to look at us. Part of it is us but part is on the physician too... You have to be able to go in and discuss ... and 15 minutes sometimes isn't enough but doctors sometimes have to be willing to listen. You can't get quality care unless folks know exactly what that person

needs...

> ...doctors are not really taking the time or listening. Are people having the right words to say about what is going on with them? Or being comfortable enough with their physicians to really discuss what they need? So quality could be just anything about the person's medical needs and whether or not ... doctor is able to meet those needs. ...a person has to have a way to the doctors and letting them know exactly what they are feeling because they have those bodies.

Quick fixes may serve the need for quick answers for some patients and allow the care providers to meet setting quota time line. For the elderly African American patients, quick fixes worsens their impressions of the health care system. Elderly blacks were brought up when the issue of race kept blacks from ever going to seek health care from professionally trained providers. Thus, today's quick fixes concept only strengthens some blacks patients' prior-racially-induced impressions about the health care system. Also, elderly patients' health problems may be more complex than they actually describe them; so that the provider may need more time to uncover all the health-related problems.

Care-Seeking Militancy

Some African American health care consumers have evaluated the health care system - how it operates and have set strategies for themselves toward getting what they believe they deserve. They do that by (a) demanding for the right test, (b) being frank with their health care providers, (c) asking doctors to refer them to specialists, (d) not settling for less care, and (e) not allowing their care providers to discount them. Below are some of the statements from focus group participants depicting assertiveness.

- Patients should use the right words (comfortable enough to tell the doctor exactly how you feel and stay with it.
- Don't let them put you off by telling you it is something else that you are feeling.
- Don't let doctors put you down because you know your body quite well so that you can be able to feel good and comfortable telling them how you feel or how things are changing and stick with it.
- When the provider puts someone down by making the person feel like a whiner or a complainer, it is time to make a change to some one else.
- Don't put doctors on pedestal if they don't belong there
- Patient should put away old ideas of being selective about what to tell a doctor; instead, they should feel comfortable to tell the doctor about their physical condition.
- Tell them to send you somewhere else if they can't treat successfully treat you.
- Let them know up front about how we feel about ourselves to prevent them from discounting us and taking someone else. If not, they will discount us.
- Do not settle for less.

The study participants said that African Americans who demand for the right types of treatments are sometimes viewed as having attitudes (has negative connotation). On the other hand, when some white patients behave in similar manner, they are described as being assertive. The militancy attitude therefore allows people to be brave about getting their share of what the health care system can offer. An assumption about the militancy may be that one may not get the needed care if not asked for or show that one knows something about what is going on.

Proof of Health Insurance: No Guarantee for Quality Care

Many African Americans use public health care settings because they do not have insurance coverage. Also, having insurance determines the type of health care that one

receives. The participants said that an insured black person may still receive poor quality care. The following quotations are some of what participants said on the issue of having health insurance but still receiving below acceptable standard care.

> I have insurance and I am treated in the same way. Are the doctors not explaining things to me because as an African American, I am not worthy of it or is because my insurance is not worthy of it or because of both?
>
> Who gets health care first when three people, all involved in a recent natural disaster such as earth quake go to the same health care setting? The first man came in driving a Lexus, the second, driving a BMW, and the third, just walk out from a gas station. Taking that race is not an issue here, the man in the Lexus would tend to get care first. Class is determined by the amount of money that one has. When race becomes the issue in this given scenario, the owner of the Lexus being black, the owner of the BMW being an Asian, and the person from the gas station being white, there is a tendency that the white person will receive care first even though all three persons have good health insurance coverage.

The last two quotations point to the issue of racial background as a determining factor in the quality of health care that a black patient receives. It would then not be surprising for a black patient to exhibit the militancy behavior, if he/she believes that the chance for a black persons to receive poor quality care is greater than for whites. In a way, militancy is a sort of defense mechanism that some black patients exhibit to get the best out of the health care system that serve them.

The Skin: Communication Medium

Touching is a human gesture that black cultures cherish. Many black people are used to close family and friends ties. The "we" concept (Orque, 1983) in black cultural value emphasizes group unity, togetherness or oneness. This sense or extended self may

promote touching/hugging of others. This is not to suggest that health care providers should be hugging their black patients unnecessarily but to alert them that black patients may attach deeper meaning to the distance between them and their care providers. Orque (1983) described Hall's (1963) four categories of space organization and they include (a) intimate zone (0-1.5 feet), (b) personal distance (1.5-4 feet), (c) social distance (4-12 feet), and (d) public distance (12 feet or more). A participant described quality care following an abdominal surgery this way.

> Being there all night long. Responding to call light right away. Touching you, not just saying "turn over and let me take your temperature". Rubbing your hands and feet and asking you how you feel...

Personal closeness to each other is the key in the above. Orgue, Block and Monrroy (1983) said that "oneness of being" principle among black people makes it possible for blacks to view illness as a family affair so that family and friends usually go to the hospital to "sit up" with the ill person on admission (p.100). Also, blacks may prefer to rehabilitate a black patient at home where the person will be closer to others instead of placing him/her in a nursing home.

Assumptions about Blacks

Having preconceived ideas or beliefs about blacks can negatively influence the quality of their health care. Over and over, the study participants said that some care providers believe that black people do not take pride in their health care issues. When a black patient's treatment is delayed because of wrong diagnosis, it could be related to provider's incompetence, or because of a provider's belief that black people do not take pride in their health issues. When a provider fails to order diabetes screening tests for a

patient with classic signs and symptoms of the disease, does one say it is incompetence or it is due to the belief that it would not make any difference with this particular person or is a combination of both? The case example below depicts the ideas suggested by the latter question.

> A Veterans Administration (VA) doctor says you have something else other than what you really have. A 46 year old African American man had all symptoms of stroke (right arm numb, inability to swallow, couldn't speak, couldn't write or raise right arm) and was allowed to walk around for two to three weeks with the diagnosis of Bell's Palsy. The patient was continuously told "... that's fine, it will go away". It was not fine and it never went away. On the third visit, the patient's wife insisted that something was actually wrong with her husband and that something should be done. An EKG showed evidence of a stroke and the patient had been sent away two other times with Bell's Palsy diagnosis. Participant said the patient was treated "like a pig" when workers knew he could not speak to express himself and yet they talked to him using statements like "... what do you want?". Consequently, the patient went for 2-3 weeks without appropriate treatment, the signs and symptoms of his stroke became irreversible, and he ended up in a nursing home where he is receiving therapy (speech and occupational).
>
> The same patient received care at the same Veterans Hospital for 12 years for feet problem. The patient's family history indicated that his mother and cousin had diabetes. He was ordered whirl-pool feet treatment, special shoes, and told to walk in a special way but never was he asked about his excessive thirst and urination or ran diabetes tests on him. One time the patient was told that he had something wrong with his mind and he was going to be sent to see a psychiatrist. Patient heard about signs and symptoms of diabetes on television and upon telling his care provider the signs and symptoms he was having, he was sent to a specialist who ran only one test and diagnosed him as a diabetic. At one time patient had to go against medical advice and get himself out of the VA hospital to get care for his feet.

Although individuals who do not take care of their health are not unique to black people, focus group participants said that:

> Some doctors do not want to deal with black people. This is a really bad

> stigma or stereotype that people of color don't care about their health. They believe that we do not take care of ourselves and we are going to do what we want to do such as eating what we want. ...we know this is going to kill us and we are going to eat it anyway. They think that black people do not take any pride in their health issues so they are not going to bother to sit and talk with us and teach us how to be healthy because they feel like we are going to do what we want to do. I do not know where that came from, but that is the experience that I have had and that is what I have seen.

The Veterans Administration scenario illustrates how provider's behavior influences patient outcomes. The participant said that her husband was treated as described because he was black and because the doctor was incompetent (Medical students at the VA emergency room were associated with lesser level of expertise than regular doctors). If the patient received such a poor care because he was black, it then appears that preconceived ideas about blacks may be generalized to any person from that racial background. One study participant said "they do not treat you as an individual; instead you are treated as a race and they just make all these assumptions about you as a person." Griepp's (1996) finding supported the idea that lack of respectful treatment and insensitiveness of care may not be limited to one person from an ethnic group but to everyone from that racial background.

<u>Providers' Stereotype Beliefs/Behaviors</u>

Stereotyping supports the superiority/inferiority concepts that underlie the definition of race as a socially constructed taxonomy. It influences the quality of patients' health care as well as their health outcomes. Provided below are some excerpts from the focus group transcripts in support of the stereotype attitudes that exist in health care.

> Public health stereotype people. For instance at Planned Parenthood when I was a teenager, ...first I'm black then they ask. Are you from ...., how

> many kids you got? ...that kind of thing automatically because majority of those people might be black or Latino and they might have a lot of kids or whatever; what kind of job do you do or are you on welfare. I mean it is just the stereotype. Because that is what they deal with on a daily basis, and so that is understandable...
>
> Some whites are surprised when blacks can articulate themselves or answer questions intelligently. ...a form of stereotyping when experience is mostly with blacks who do not behave that way...
>
> At the emergency department, many African Americans with heart attacks did not have the benefits of certain diagnostic tests. White patients had full work ups and all medicines, and all surgical treatments and everyone in the team came up to see them on admission...
>
> I went in with abdominal pains and was left waiting indefinitely...I learn that they were waiting for a gynecologist and said what! I am like ain't nobody going to look up in here tonight, you know. I have abdominal cramping. I have gastro-intestinal problems, don't have no PID going on in there. ...they figured you have one of those STD's girl, they have even assumed you have had some kind of miscarriage. So the type of care that you receive also depends on where you live.

Excluding some patients from clinical trials reduces their chances of benefitting from the results of such studies. Subsequently, rules, regulations, and evaluation methods that are based on findings from the studies are never culturally fair to everyone. Preconceived assumptions and or stereotype about others affect people's quality of care. Such assumptions may include ideas about persons from a particular race, living location, socio-economic status, etc.

Classification of Quality of Care Items: Three-by-Three Model

The third analysis used Holzemer's (1996) model to see if African Americans' perceptions (the 132 items) on quality of care fit into an existing model and to discover the perspectives that are not included in the model. The 3x3 model is based on Donabedian's

(1966) three dimensional framework for quality evaluation (structure, process, and outcome). On the horizontal axis of the 3x3 model are the inputs, processes, and outcomes and client/patient/families/communities, provider, and setting are on the vertical axis. The 132 items represent consumers' views (not the providers') on what represents quality from their perspectives. The statements depict certain roles that the patient, provider, and the health care setting play in providing quality care.

Three main quality of care dimensions (Appendix N) were conceptualized from the 132 items and they include (a) Patient/Consumer/Client Role, (b) Provider Role (also called Patient-Provider Interpersonal Relationship, and (c) Setting Role. The Provider Role was further broken down into Donabedian (1969) and Cleary and McNeil's (1988) technical and interpersonal domains of care. The technical care domain refers to "the appreciation of science and technology of medicine and the other health sciences to the management of personal health problems" (Cleary & McNeil, 1988, p.25). The interpersonal domain of care involves the psycho-social aspects of provider-patient interaction (Cleary & McNeil, 1988; Holden, 1989). On Appendix N and Table 4.2, statements that were negatively worded to reduce response set bias are high-lighted by the underline of some key word(s). Table 4.3 shows the frequencies of the quality of care items (from Appendix N) in the 3x3 model. There were a total of 69 items constituting the processes dimension, 47 for the inputs, and 16 for the outputs dimensions of the model. On the vertical side, the provider role items (interpersonal and technical domains) total up to 52, next by the setting role with 49 items, and patient role with 31.

Table 4.3. Quality of Care Item Frequencies in the Three-by-Three Model

	Inputs	Processes	Outputs	Total
Patient/Consumer/Client Role	10	14	7	31
Provider Role/Patient-Provider Relationship				
Interpersonal	10	26	0	36
Technical	1	13	2	16
Setting Role	26	16	7	49
Total	**47**	**69**	**16**	**132**

Table 4.4 shows the rank order of the statements means at the end of Round 2 of the Delphi process. The mean range for the retained items (n=132) was as low as 1.84 with a standard deviation of 1.57 and as high as 6.00 with a standard deviation of 0.00. Three (3=0.02.27%) of the retained items each had a mean score of 6.0. Seventy-nine of the items (79=59.84%) had scores of 5.00 and above but less than 6.00. Forty (40=30.30%) items had scores of 4.00 and above but less than 5.0. Nine of the retained items (9=06.81%) had scores of 3.11 and above but less than 4.0. Only one retained item had a mean score of less than three (1.84).

Table 4.4. Rank order of item means after Delphi Round 2

Item	Mean	SD
People like caring and nice health care workers.	6.00	.00
People do not like dirty, shabby, and smelly health care environments.	6.00	.00
Patients like it when the insurance company pays for things such as eye glasses.	6.00	.00
People like or are pleased with a clean and conveniently located health care environment.	5.95	.23
Wrong diagnosis can result in delayed treatment and permanent or long lasting disability.	5.95	.23
Poor examination of a patient may result in wrong treatment.	5.89	.32
High quality care is rushing patients out of hospitals.	5.89	.32
Physicians should not educate themselves about black people and their common health problems.	5.89	.32
Black men should not tell their doctors exactly what is going on with them.	5.89	.32
Today, patients are expecting care providers to use language that patients can understand.	5.84	.37
Asking questions and following health care instructions show that blacks care and are serious about their bodies.	5.84	.37
Quality health care is having no hassle about seeing specialists when needed.	5.79	.42
Elderly patients have less experience in managing their way through the health care system so they need assistance from care providers and their families.	5.79	.42
People do not like the idea that some patients receive better health care than others	5.79	.54
A patient can improve the quality of his/her care by knowing how to get through the health care system.	5.74	.56
Asserting self means settling for less.	5.74	.56

Table 4.4 continued

Item	Mean	SD
Not everyone who seeks health care should be given the best possible quality care.	5.74	1.15
These days, patients are discharged sooner from hospitals because insurance companies require early discharge.	5.74	.45
A care provider's experience may influence how a patient is treated.	5.74	.56
When a doctor is cold to me, I feel like not asking questions but just leaving as quickly as possible.	5.68	.58
Going to the dentist and returning home with little or no pain is a an advancement in medical care that people like.	5.68	.48
A patient cannot improve the quality of his/her care by educating him/herself on the health problem.	5.68	.82
There is a need for health care workers who look like me (black).	5.68	.58
Quality health care is responding to a patient's health problem when care is needed.	5.68	.58
Untrained health care staff can be condescending impatient, ignoring, prejudicial, and stereotyping with patients.	5.68	.58
Doctors should look for the uniqueness of each patient's situation rather than assume that things have to be the way they (doctors) were trained to see things.	5.63	.76
A new doctor that is selected should be a person that you trust.	5.63	.68
Elderly patients find it hard to handle when they are pushed fast through the system	5.63	.60
A responsible patient insists on being seen and has a regular health follow-up schedule.	5.63	.60
People do not like scheduling appointment several weeks later than they need them.	5.63	.50
Patients are having longer length of stay at the hospital.	5.63	1.16
A patient prefers a doctor from any race who does not rush and give incomplete responses to questions.	5.58	.69

Table 4.4 continued

Item	Mean	SD
Rushing and giving incomplete answers to questions is anxiety raising for patients.	5.58	.84
Patients like being able to speak with their doctors when they want to.	5.58	.61
A patient may not recognize the side effects of a new medication if the care provider assumes that the patient knows already	5.58	.84
Adequate qualified staff and available health information must be considered in quality improvement.	5.58	.61
Black women can improve the quality of their care by not forgetting to take care of themselves while caring for their children, husbands, etc.	5.58	1.22
Today racism is covert and whites still receive better care than blacks.	5.53	.51
Health care providers can improve the quality of care by talking to people about prevention, education, and engaging with the community through organizations like churches and Lions.	5.53	.70
A doctor's choice of words can have a bad or good effect on the patient.	5.53	.77
High quality care is being able to choose your own doctor.	5.47	.77
At the emergency room workers should consider the patient's bathroom needs and anxiety about the health problem.	5.47	.96
Patients do not like it when their doctors and staff know them by their names.	5.47	1.22
Discussing patient's examination room findings with those outside of the exam room is disrespectful.	5.47	.96
Quality health care is getting to the root of the patient's health problem.	5.47	.70
Sometime a patient must insist that a care provider sees him or her.	5.42	.69
High quality care is talking with a patient about health problem(s) first and then cost later.	5.42	.77
People do not mind the long waits during appointments.	5.42	1.07
High quality care is allowing a patient to see a specialist.	5.42	.84

Table 4.4 continued

Item	Mean	SD
Preconceived assumptions (including ideas about persons from a particular race, living location, socio-economic status) affect the quality of care that a person receives.	5.42	1.02
At the emergency room, time and life are saved when stab wounds are attended to first before paper work.	5.42	.77
Doctors who do not like touching blacks perform incomplete and inadequate exams on such patients.	5.42	1.02
Asserting self means being frank with the care providers.	5.42	.61
Some health insurance "...pays doctors to keep patients out of the hospital".	5.39	.98
Quality health care is not related to the care provider's level of knowledge.	5.37	.90
Patient do not like anxiety-raising situations in the health care settings while waiting to be attended to.	5.37	.76
A patient may not follow direction for a new medication if the care provider assumes that the patient knows already.	5.37	.96
People like it when the waiting room is not crowded.	5.37	.60
Health care providers at under-staffed settings may not attend to a patient's health care need.	5.37	.96
Quality health care is to be treated/cured as best as possible.	5.37	.90
Quality health care is considering patient's health problem(s) first before cost.	5.37	.90
Patients like being attended to by medical students.	5.37	1.30
Conducting research studies that advance progress on different diseases can improve the quality of care.	5.32	.67
People should not be kept waiting more than 15 minutes for an appointment.	5.32	.89
Quality of health care may be influenced by the patient's societal position.	5.32	.89

Table 4.4 continued

Item	Mean	SD
Taking prescribed medication such as a narcotic for a chronic condition does not mean that one is a drug addict.	5.32	1.25
Quality health care is getting top-of-the-line or best treatment.	5.26	.99
Asserting self also means that a patient does not allow a care provider to discount him/her.	5.26	.81
A patient can improve the quality of his/her health care by providing the doctor with a copy of problem list preferably prior to the scheduled visit.	5.26	.81
The health care system is negatively influenced by mis-management of funds.	5.21	.92
Family doctors are rare these days.	5.16	.90
A doctor's beliefs about a patient does not influence the diagnosis of a health problem.	5.11	.94
A doctor's beliefs about a patient's age may influence the diagnosis of a health problem.	5.11	1.24
Asserting self means asking doctors for referrals to experts.	5.11	1.41
The level of care has gone down from what it used to be.	5.11	1.24
Improving the quality of health care means self diagnosing and treatment.	5.05	1.18
Quality health care is a patient's feelings about the care received.	5.05	.91
A surgery patient may not like the pressure associated with early discharge such as getting up and walking soon after surgery.	5.05	.91
One can receive low quality care at a popular health care facility.	5.00	1.05
People do not like 'public' health care settings where Medicare/Medicaid patients go because there are usually too many patients to be seen there and too few doctors.	5.00	1.00
The health care system is negatively influenced by the U.S. greater financial expenses on defense more than on health care.	5.00	1.00
Health insurance companies do not pay for pre-existing conditions.	4.95	1.08

Table 4.4 continued

Item	Mean	SD
Sometime a patient may have to assert him/herself by demanding for the right tests in order to get the needed quality of care.	4.95	1.22
Education of the public about health-care-related issues does not influence the quality of patient care.	4.95	1.39
An option from the health insurance company to seek care anywhere can improve the quality of care.	4.89	1.29
Doctors who have problems touching black patients tend to ask a lot of questions and do more writing than touching.	4.89	1.24
Blacks make health care choices based on what they have available to them.	4.84	1.17
Most black doctors are not personable to patients and do not work in their communities as role models for young people.	4.84	1.42
People tend to be most comfortable with health care providers from their own racial background.	4.84	.90
The health care system is negatively influenced by conflicts of interest with management personnel.	4.84	.83
Addressing an elderly black patient by his/her first name is disrespectful	4.84	1.71
Teaching and role modeling for children on what they should do to keep healthy affects the quality of care that the people receive.	4.84	1.21
The long wait at the emergency room is because patient's view of emergency is different from the health care provider's.	4.84	1.30
To say that a health problem that has been for a while does not need a "rush action" discounts the problem and the patient's feelings.	4.84	1.17
The way that the care provider does what s/he does (knows his/her job and expectations) does not influence the quality of care.	4.83	1.04
Doctors can only order what the insurance will cover.	4.79	1.23
The type of treatment that one gets does not depend on the type of insurance coverage.	4.79	1.47
Excluding blacks from life-saving related research studies does not influence the quality of their health care.	4.79	1.87

Table 4.4 continued

Item	Mean	SD
Those with health insurance may still receive low quality care.	4.79	1.32
The beliefs that blacks are usually overweight and eat greasy foods may result in failure to properly examine and treat.	4,79	.98
People do not like the paper work associated with visits where they receive health care.	4.79	1.40
It is not disrespectful for a patient to wait for a doctor for no good reason on the doctor's part.	4.78	1.48
Patients prefer centralized health care settings where the workers know patients beyond their health problems.	4.74	1.19
Health insurance that covers 80% or more of health care expenses is preferable.	4.74	1.63
Quality health care is the patient-provider relationship.	4.68	1.20
Unemployment means no health insurance and high crime rate among blacks.	4.68	1.34
Fewer doctors are in private practice today.	4.68	1.57
The health care system is negatively influenced by the U.S. failing to take examples from other Western countries.	4.67	.91
One's racial background does not influence the quality of care that one receives.	4.63	1.57
Quality health care is having the means to seek health care.	4.63	1.34
People do not like provider's scheduling to see many patients because it results in patients receiving poor care.	4.58	1.22
Patients and families are left to guess what is going on in emergency rooms because the workers do not tell them.	4.58	1.12
Class issues between care provider and assistant do not affect patients in a negative manner.	4.58	1.26
People do not like to make payment at the emergency room when they are seeking care.	4.50	1.10
Anyone without insurance may receive only minimal health care that may relief discomfort for only a short time.	4.47	1.22

Table 4.4 continued

Item	Mean	SD
Quality health care is the conditions surrounding the type of patient care.	4.42	1.26
The outcome of care such as cured and outstanding bills must be considered in quality improvement.	4.35	1.46
The emergency room health workers do not tell patients/families why they are waiting.	4.32	1.38
The care provider's gender (sex) may influence diagnosis and treatment.	4.32	1.63
Blacks' experience with the health care system makes some people seek only emergency care.	4.11	1.59
To be seen by a Nurse Practitioner when payment checks are made to the doctor is disrespectful.	4.00	1.33
Health care setting's guidelines prevent delaying diagnosis, treatment, and allay a patient's anxiety about the health problem.	3.89	1.52
A doctor is cold to a black patient because s/he does not want to deal with such a patient.	3.89	1.24
Changing insurance companies interferes with the bonding/trust between the provider and the patient.	3.89	2.00
Quality health care is how the health care treatment processes are done.	3.74	1.48
Voicing surprise when patient is able to express him/herself on the health problem at hand is disrespectful.	3.63	1.83
Low quality care is doctors discussing what insurance will pay for.	3.63	1.71
Quality health care is the type of care that a patient receives.	3.63	1.67
One needs variety of care experiences to decide the effect of racism on quality of care. *	3.58	1.61
A care provider may not educate black patients because of the belief that blacks do not take pride in their health care issues.	3.53	1.95
A care provider will listen to a patient who is believed to be unimportant. *	3.37	1.50
Restructuring or re-organizing of the Food and Drug Administration (FDA) can improve the quality of patient care.	3.33	1.33

Table 4.4 continued

Item	Mean	SD
Patients waiting to see their doctor like it when they are told the doctor(s) is running late. *	3.26	2.08
In the emergency room, asking a patient why s/he did not wait for the regular doctor indicates a nasty attitude. *	3.11	1.33
There is less respect for the patients today than there used to be. *	2.89	1.24
Anyone with no health insurance has little or no chance for health care services. *	2.68	1.38
The health care system is positively influenced by big business such as pharmaceutical companies. *	2.53	1.71
A female pediatrician from any race can substitute for a black pediatrician. *	2.42	1.87
The health care system is positively influenced by the U.S. society being a NOW society and one that puts money first before ethics.	1.84	1.57

SD = Standard deviation; * = items deleted using criterion of 55% and more; 1=strongly disagree, 2=moderately disagree, 3=slightly disagree, 4=slightly agree, 5=moderately agree, and 6=strongly agree

CHAPTER FIVE

DISCUSSION

Findings

This chapter discusses the findings of the quality of care study. In the discussion, linkages are made between and among some of the qualitative thematic narratives from the findings and the dimensions of quality of care from African Americans' perspectives. The discussion also relates the findings back to the literature. Significance of the findings and implications for practice and future research are described.

Thematic Narratives and the Dimensions of Quality of Care

Thematic Narrative Analysis

The main themes in the qualitative analysis include "quick fixes", "care-seeking militancy", "skin as a communication medium", "health insurance proof does not guarantee for quality care", "assumptions about blacks", and "providers' stereotype beliefs and behavior". The themes are discussed as they relate with one another, educating oneself, being comfortable with somebody, and racism.

The study participants described "quick fixes" from the health care consumer and provider's perspectives. Quick fixes means hurrying over things with possible consequences of misdiagnosing, using ineffective treatment methods, and treating to pacify the patient without necessarily using proper judgment in care decision and treatment. The participants said that health care consumers should be able to

"know exactly what they are feeling... use the right words to describe what is going on with them, and to feel comfortable with their physicians..."

On the other hand, they said that "...doctors are not really taking the time or listening..." Patients can learn about their health care issues from their local libraries, the media, the Internet, etc. By educating themselves that way, they reduce their chances of settling for less effective methods of treatment such as quick fixes. For a patient to be comfortable with a health care provider also means that the provider has to feel comfortable working with the patient. Taking the time to listen influences a patient's level of comfort with the provider as well as his/her satisfaction with care received. A care provider who has poor listening skills needs to personally work on that aspect of his/her professional life to avoid poor feedback from patients and others.

To be comfortable with a care provider goes beyond the provider listening to the patient. How can black patients feel comfortable with providers they describe as (a) tending to read charts or avoid touching the patient because of his or her skin color?, (b) discussing health problems when the patient believes (from experience) that the provider will discount what s/he says about the health problem?, and (c) interpreting the patient's assertive behavior on health care issue(s) as negative attitude. It is, therefore, not surprising that some African Americans assume the militancy role as a defense mechanism. To be militant means asserting oneself to get the best from the health care system. That comes as a result of one's believing that one may not get what he/she deserves without asking or pushing for it. Quality health care to every patient should be a right and not a privilege. People should not have to demand what they deserve. It appears that people may not ask for the right tests or to be referred to see a specialist, if they know, understand, and believe that the care provider is providing them with the best possible

care.

It is possible that some health care providers hurry over certain care processes because of the guidelines within which they work. The study participants said that some health care settings' regulations allow only 15 minutes for each patient's visit with a care provider. One must be careful not to compromise factors that constitute positive provider-patient relationship as well as desirable patient outcomes. Quick fixes should not result in people returning home with the same health problems following visits to their health care providers. This is even more crucial in the care of elderly patients who may have complex health problems.

Providers' having certain assumptions about blacks can negatively influence the quality of their care. Trying to cover up or mask some negative beliefs about a black patient by only reading the chart or avoiding touch with black patients is not only hurtful to a patient from that racial background but also opens the door for undesirable scrutiny and law suits. It must be appreciated that theories about blacks include one that posits blacks as having a lower level of intelligence than whites. Thus, expressing surprise when black patients adequately articulate their knowledge of health care issues (Appendix J, # 30) may remind some people of the negative and demeaning belief about their level of intelligence.

The study participants said that having health insurance does not guarantee a black patient receiving quality care. Many blacks do not have health care insurance. The U.S. Public health Service report (1995) indicated that in 1987, 76% of people under age 65 had private insurance and that number had dropped to 70.8% by 1993. Those not covered

by any sort of insurance went from 14.4% in 1987 to 17.2% in 1993. The percentage of the uninsured was even greater among African Americans and Hispanics. In 1993, the Census Bureau data population Survey (including all people regardless of age) estimated that 39.7 million Americans (15%) were uninsured and that 20.5% of African Americans had no health insurance coverage. No insurance often translates into having no health care.

The study participants said that African Americans do not like using public health care institutions but some go to such settings because they do not have a choice. These persons are using what they have. Using what is available and being blamed for poor outcomes alerts one to "blaming the victim" phenomenon (Appendix J # 135). For instance, telling those with undesirable health outcomes that they should assume responsibility for their health habits without also appreciating the environmental and social factors associated with such persons' behavior and health outcomes is not only an inadequate strategy to health improvement but insulting. White-Means (1995) referred to the policy-making "Report of the Secretary's Task Force on Black and Minority Health" as victim-blaming because it conveyed the familiar belief that poorer health of minority communities is the result of numerous individuals making ill-informed "life-style choices" rather than a consequence of racial oppression and the disproportionate concentration of minorities in the lower strata of the working class. A unitary or narrow-minded approach to problem solving does not work in a diverse society like the U.S. (Crawford, 1988). That narrow approach may constitute one factor among many reasons why many minority groups in the U.S., including blacks, have poorer health outcomes compared to the

dominant group's.

An assumption in this study was that one's background influences the person's perception and interpretation of a phenomenon. A person's background constitutes several variables that make up the (a) inputs cell of the Outcomes Model for Healthcare Research (Holzemer, 1996), (b) patient's characteristics in the Proposed Model for ensuring patient satisfaction (Substruction - Figure 1), and (c) the predisposing factors in the Proposed Framework for studying patient satisfaction (Figure 2). As implied by Systems Theory (Bertalanffy, 1975), the sum of the individual parts do not give the full meaning of the whole. Considering all the possible parts that constitute health care consumers' backgrounds in their initial plan of care, reduces the chance of leaving loop holes that may later influence patients' outcomes in negative ways.

Analysis of the Quality of Care Dimensions

It is not unusual that the "process" variables for the Patient and Provider Roles should out-number the "inputs" and "outcomes" variables. On Table 4.3, the interpersonal domain of the Provider Role had a total of 36 items and 26 (72.22%) of the items were provider process-related ones. Table 4.2 is a consensus table showing the mean difference standard deviation (shrinkage) from Delphi Round 1 to Round 2 for each item. Out of the 132 retained items (using an inclusion criteria of 55% or more), 109 (82.58%) showed standard deviation shrinkage from Round 1 to 2. Of the 109 items, 54 (49.51%) were process-related. Such findings point to the importance of the "how" things are done. In Figure 1, "Practice Style, Human Interpersonal Care", and some aspects of "Provider Qualities - professional character, cultural sensitivity, and

commitment to excellence" subsume the aspects of caring processes. Caring here is not limited to nursing but extends to everyone who interacts with another human being in any health-related situation. In this situation, one is referring to the interaction between and among health care workers (including policy makers, administrators, direct care providers, etc.) and consumers (patients/families) of health care services. We must ask the question whether or not the care processes are humane. The "how" is heavily influenced by interpersonal processes. Locsin (1995) wrote that the nursing-as-caring perspective makes assumptions including that (a) persons are caring by virtue of their being human, (b) persons are caring moment to moment, (c) persons are whole or complete in the moment, (d) personhood is the process of living grounded in caring, and (e) personhood is enhanced through participating in nurturing relationships with caring others.

Another approach to examining processes is on how activities are prioritized in patient care. For instance, when all necessary human needs are considered in health care situations, an emergency room patient who is confined in bed or on a stretcher should not be suffering with a full bladder (Appendix J # 101). Taylor, Hudson, and Keeling (1991) noted that the constituents of quality of nursing care are "rooted in the perceptions and reactions of a group of consumers" (p. 25). In the Pettit and White (1991) study, it was observed that patients valued basic needs (receiving bed pan or help to and from the bathroom, and receiving pain medication) significantly higher than health care professionals valued these needs. The latter should not be surprising to anyone familiar with Maslow's (1970) motivational theory/hierarchy of needs which starts with physiological needs (Stanhope & Lancaster, 1992). Basic needs must be fulfilled before

someone can concern him/herself with higher level ones.

Gerteis and colleagues (1993) wrote that in health care, it is quality in the subjective dimension that patients experience most directly - in their perception of illness or well-being and in their encounters with health care professional and institutions. Although health care professionals and decision makers are uneasy about addressing this "soft" subject, given the hard, intractable, and unyielding problem of financing, access, and clinical effectiveness in health care, the experiential dimension of quality is not trivial, (p. xi). It is the heart of what patients want from health care, enhancement of their sense of well-being, and relief from their suffering (Gerteis et al., 1993). It is because of those who use the services that health care systems exist in the first place. Therefore, any health care system, however it may be financed or structured, must address all aspects of quality (including the patient's perspectives). In this study, the perspectives on quality of care of African Americans, who constitute more than 12% of the U.S. population and whose health outcomes are among the poorest, are delineated. It is therefore, significant that the plan of care for such a group of consumers reflect their perspectives on quality of care.

In a 1996 study by Meister and Boyle to obtain information on the importance and rate of success of quality indicators, the authors described the interpersonal domain to include five indicators of quality and they are (a) statements on the aspect of residents' rights, (b) nursing staff attitudes about work, (c) homelike atmospheres for residents, (d) respect of families' rights, and (e) availability of clear ways to solve problems. As quality indicators in this study, items 13 and 38 (using language that health care consumers can understand and keeping patients/families informed when they have to wait; Appendix J)

are subsumed by Meister and Boyle's (1996) "statements on the aspects of residents' rights. Item number 53 (centralized health care settings where workers know patients beyond their health problems) is closely tied to Meister and Boyle's "homelike atmosphere".

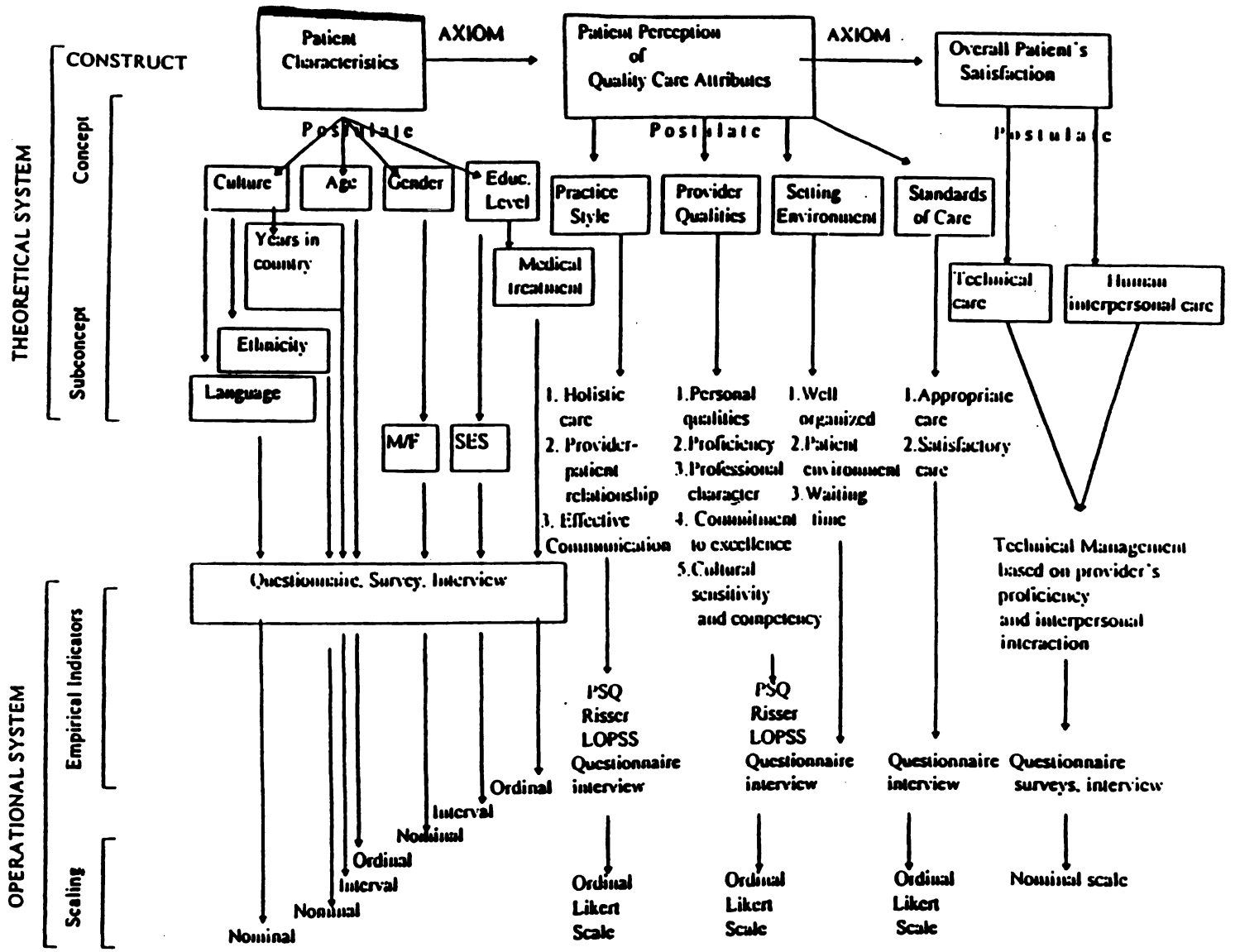
The technical aspects of care, as part of provider role in assuring quality is the same as the Technical Care on Figure 1. Based on Donabedian's construct of quality, Meister and Boyle (1996) wrote that the technical aspect of care domain is related to indicators such as availability of doctors and qualified nursing staff. The latter is the same as provider's proficiency. This study participants' definition of quality of care (e.g., level of provider's knowledge, top-of-the-line or best treatment, ability to diagnose and treat, etc.) have direct bearings on providers' technical management and proficiency. How the health care consumer sees and interprets the care provider's practice style, qualities, setting environment, and standard of care (appropriate and satisfactory) determines the overall satisfaction with the care received as shown on Figure 1. The appropriate and satisfactory care here may be interpreted in terms of the consumer's prior experience or background, which may be culturally related. Edwards (1992) and Strickland (1992) said that ethnic and cultural background experience influence meanings associated with illness, responses to pain, and what people consider as appropriate and aceptable behaviors and health care.

The Health Care Setting Role in assuring quality is as described by some of the variables (e.g., waiting time and organization of the setting, guidelines on staffing, education, research, payment, diagnosis and treatment, etc.). These variables are captured

in Figure 1 by the Setting Environment dimension.

Figure 1.

PATIENT'S PERCEPTION OF QUALITY: A SUBSTRUCTION



Other Emerging Issues

Other emerging issues from the study findings are related to outcomes of care, provider's technical aspect of care and health care setting versus inputs. Starting with the outcome dimension, a patient's prior experience can influence that person's subsequent behavior. For instance, participants in this study talked of leaving a doctor's office as quickly as possible when the doctor is cold to them (Appendix J # 109). A possible outcome of the latter is that those African American patients may tend to avoid seeking health care, especially for preventive purposes and during early stages of their health problems, and instead show up at the emergency rooms with more serious and costly conditions. It is well documented that African Americans are twice as likely as whites to use the emergency room where an individual is likely to see a different provider on each visit and thus suffer from lack of care continuity (Blendon et al., 1994). The cost of emergency room use may be in terms of both the patients' lives and economics. Participants in the study suggested that such outcomes of care as being cured and having outstanding bills, be considered in quality improvement (Appendix J # 45). Health care workers believe that their work saves lives. When a negative health care experience (such as just described) results in a patient postponing to seek needed health care and that patient ends up dying, does one talk of the provider who initially exhibited a cold attitude with the black patient as a life saver or not? The possible answers to this question are subjective and based on one's personal value system. Racism is now mostly covert and some intangible behaviors (e.g., being cold to a black patient) can lead to more serious consequences. Therefore, personal value clarification is a must for anyone who works in

the field that places great importance on saving people's lives.

Regarding the provider's technical aspect of care, updates and continuing education arm the care provider with choice-making tools and set the stage for best care delivery. A fully informed care provider can make choices that affect quality of patient care such as (a) getting to the root of the health problem (Appendix J # 69), (b) providing the best treatment (Appendix J # 12), and having no hassles about referring to specialists (Appendix J # 84). A professional is able to judge the extent to which nursing care given measures up to professional standards (Donabedian, 1969) when he/she is well informed about the professional standard. Donabedian further assumed that when certain structural conditions are specified, good care is likely to follow. The setting structures and qualified staff constitute inputs variables that are needed for good care (output) so that hiring criteria must be such that portray the goals and objectives of a health care institution.

The health care setting versus provider processes allows one to relate what is available to a desired goal. The main idea statement number 99 in Appendix J challenges health care providers to provide health care consumers with preventive education through community organizations like churches and social organizations (Lions Club, etc.). The church is very important in the lives of African Americans and should be considered when planning health care activities/programs for them. Facione (1994) observed that religiousness emerged from her focus group discussions with African Americans on the subject of help-seeking among breast cancer patients. Donabedian (1969) said that setting inputs lay foundations for practice. It is assumed that proper inputs will result in desired outcomes. A health care provider can also only succeed in reaching African Americans via

certain community organizations if the health care setting provides the support in terms of needed personnel, finance, equipment, and insurance.

Finally, the issue of shorter length of hospital stay must be considered - is it only money-driven? Finkler and Kovner (1993) referred to length of stay (LOS) as the most important predictor of hospital cost and nurse managers have an increasing pressure to decrease patient LOS. Focus group participants did not like the idea of having to walk soon after surgery. The overriding comment was that money is the driving force behind the push.

> ...everything is so money and care managed-driven... the insurance companies are responsible for the early patient discharge and not the workers. ...want to make money.

Other than going to the dentist and returning home with little or no pain, focus group participants did not refer to advances in surgical technology such as improved anesthesia, better pre and post operative management, and pain management practices. In view of the fact that one of the advances in post surgical patient management is early ambulation (associated with better pain management, anesthesia, surgical techniques, etc.), patients need to be educated on reasons for the early ambulation post surgical procedures. It should not be assumed that they already know because a finding from this study indicates that the participants' focus was mainly on the finance factor. Patients need to know (during routine orientation or preparation for surgery) that early ambulation (a process) results in shorter length of stay (an outcome) and is also associated with quicker return to pre-surgical states besides insurance caps on hospitalization days. Naylor et al. (1991) wrote that LOS as a measure needs to be accompanied by data on

rehospitalization, post discharge acute care visits, and the burden on care-givers.

Significance of the Study findings

Cleary and Edgman-Levitan (1997) wrote that much work on quality assessment is based on implicit assumptions about how people define quality and what information they value. They also said that important criteria for making decisions about the subset of measures to develop and collect from consumers are their values and preferences. Cleary and colleague expressed a need for larger sample studies to understand how people value and use different types of quality information. They suggested that persons with different educational, racial or ethnic backgrounds, financial resources, and health status may differ substantially in the value they attach to indicators of quality. This study sheds some light on what constitutes San Francisco Bay Area African Americans' values, opinions, and beliefs about health care quality in general. Although the sample size and the geographic area from which the data were collected prevent generalizing the results, the study challenges health care providers to avoid making implicit assumptions about their African American health care consumers. The congruence of the dimensions of quality of care with what currently exists in the literature points to the knowledge sophistication of the study participants.

Direct health care providers can increase their service effectiveness with their African American patients by incorporating the beliefs and values from this study into their plan of care. Hargrove and Keller (1993) said that health care providers who develop an understanding of how individuals with different socio-cultural backgrounds and values perceive or define health will be able to plan effective health/illness management. This

research study contributes to the body of health care knowledge in the area of African Americans' health care issues. Some participants recommended that more studies, such as this, be conducted in their community. The literature has no information on quality of care studies spcific to African Americans despite their population size and poor morbidity and mortality statuses. That is a gap that health care researchers must strive to narrow if improving African Americans' health care issues is a major objective for the nation. Doctor Kenneth Shine's (personal communication, March 5, 1998) suggestion for narrowing the gap means assessing the various levels of care - high quality care, mediocre, and poor care to delineate the various factors that depict them as different parameters in health care. A comparison among the three levels of care should provide evidence that can be used to improve or up-grade quality of care.

Regarding the issue of matching patients with providers of their own racial background, the participants' view did not seem to support matching African American health care consumers with their ethnic or racial counter-parts. For instance, statement number 52 on Appendix J alludes to having a black pediatrician as opposed to a non-black. That statement did not meet the inclusion criterion of at least 55% agreement responses following round 2 of the Delphi process and is therefore not one of the 132 items that constitute the quality of care dimensions. Much of their preference for doctors of their own racial background seemed to have been motivated by their negative experiences with health care providers from other ethnic backgrounds.

Donabedian (1968) said that if participation in decision making contributes to patients' compliance with health care recommendations, then participation in decision

making becomes a dimension of quality of care since it will contribute to the patient's behavior regarding provider recommendations. It was possible to organize the item statements from the study into the patient, provider, and setting roles because the participants described them to fit those roles. The results of this study show that patients' role in defining quality of care and provision is significant and therefore, should be considered in planning, executing, and evaluating health care.

Study Implications for Practice

Because racism is more covert these days, one should really watch out for the hidden or non-verbal indications of the phenomenon. Some indicators described by the study participants include providers (a) not wanting to touch black patients and tending to ask many questions and doing more writing, (b) skipping some needed tests and examinations during physicals like breast and pelvic exams, (c) being cold to patients (no smile, hello, hand shake or "how are you doing", no eye contact or bedside manners, s/he starts with a stethoscope, and talks to the chart instead of the patient), (d) making patients feel like just leaving as quickly as possible because s/he cannot ask any question, (e) making condescending statements, (f) ignoring the patient, and (g) not treating patients like human beings but like a piece of meat, etc.

It is crucial for health care providers to examine their own values and beliefs about the patient populations that they attend to in order to prevent misdiagnoses and improper treatments. Health care facilities can provide value clarification opportunities through in-service educational programs. Such a program should address issues about working with people from diverse populations with emphasis on minority groups. A better

understanding of self lays the ground for understanding of others. The latter may also promote better communication between the providers and patients (Kurata et al., 1992). Participants recommended that providers should educate themselves on the ailments that are common among their client population. Changing provider's behavior is an important implication for practice from this study. The emphasis is changing toward what patients desire and is rationally good for their health. To be competitive in today's health care market, health care providers must provide quality care and they must also seek and incorporate patients' perspectives into routine quality evaluations (Chang, 1997). They must therefore, make positive attempts in learning about those patients.

Cleary and Edgman-Lavitan (1997) noted that issues as being treated with respect and involvement in treatment decisions (paramount to patients) are aspects of care that are not included in many satisfaction surveys. The findings of this research raise issues about respect/disrespect as a variable on a quality of care measure. It was so prominently discussed by the participants that it would be considered negligent if one does not include respect/disrespect as a variable on a quality of care measure. Citing from the focus group data, people said the following about respect/disrespect: It is disrespectful to (a) address an elderly African American by his/her first name, (b) discussing examination room experiences with those who were not in the exam room, (c) have to wait for a doctor who is late for no good reason, and (d) write payment checks to a doctor but being seen by a nurse practitioner, etc.

Neuman's nursing diagnosis implies noting the variance from wellness and developing hypothetical interventions (George, 1995). Possible solutions to one's health

problems must incorporate socially-related ones. One of the main idea statements is that African Americans make health care choices based upon what they have available to them (Appendix J, # 135). A patient's background information should enlighten the health care provider about the patient's socially related issues that may be affecting that person's health status. Link and Phelan's (1995) argument that greater attention be paid to basic social conditions (if health reform is to have its maximum effect in the future) should be taken seriously by those wishing to make a difference in the lives of those in need of better health care, for social factors are associated with health and disease phenomena. Examination of social factors relating to a health problem should shed light on the situation in the context from which it arose. Any provider who examines a patient's background in respect to the health care situation in question and who makes recommendations based upon the information received, is making the patient's access to care better. Providing access to care for a patient may positively influences the patient's satisfaction with care received. Cleary and McNeil (1988) noted that access is one of the most important determinants of patient satisfaction.

Managed care systems in the San Francisco Bay Area are challenged to examine their care processes to be sure that patients do not return home with several health problems after visits to their health care providers just because the providers can only attend to one problem per visit. A managed care system may need to re-evaluate providers' time spent with patients and ask whether or not a check-list should be used for each patient during each visit, especially with the elderly. Elderly persons' health care issues may be much more complex than actually presented. Thus, an extra step toward

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holistic care provision may actually make a lot of difference in the health status of the client such as the person's satisfaction level. Gustafson et al. (1993) observed that an important use of a quality index would be to identify opportunities to improve the practice patterns of providers.

The aspects of the dimensions of quality of care in this study were congruent with those reported in the literature. What does that mean in terms of the intent of the study - to understand and describe the dimensions of quality of care from the African Americans' perspectives? Should there then be no concern about African Americans' quality of care issues since the study findings are congruent with the proposed model - Figure 1which is based on what already exists in the literature? An appropriate response is an emphatic NO! First, several studies are needed to learn whether there are differences between African Americans' perspectives on quality of care and others perspectives and what currently exists in the literature. During the literature review for this study, the investigator did not find studies that delineate African Americans' health care values related to quality of care.

Inputs affect outputs and the level of quality influences the outcome(s) of health care. Poor quality care most likely yields poor health outcomes. One can ask why African Americans' health outcomes tend to be worse when compared with other America's ethnic groups when the dimensions of quality of care from their perspectives are congruent with the literature. An assumption here is that the literature represents mainstream perspectives. A possible explanation is that what is reported in the literature is based on research studies that did not have adequate African American representation. Why

African Americans continue to have more unfavorable health outcomes (morbidity and mortality) than other ethnic groups must be adequately addressed to prevent repeating the same processes that have failed to produce positive health outcomes in their communities. Thus,more quality of care studies on African Americans using larger samples are needed.

Second, despite the fact that the study participants were well educated (most people had at least two years of college education), for them to adequately describe what exists in the literature demonstrates their sophistication on quality of health care related knowledge. Health care providers should neither take such clients for granted nor should they assume the clients would not understand what is going on during health care processes. The U. S. Office of Technology Assessment, 1988; Knar, 1988) wrote that consumers are entering health care settings expecting greater professional attention, timely service, and error-free treatment. Consumers' sophistication is therefore not limited to any particular culture. For instance, care providers should not conclude that African Americans who exhibit the militancy role have "attitude". If assertiveness has a positive connotation, then militant African American health care consumers should be described as assertive consumers and not as those with attitudes (has negative connotation).

Evidence-based research findings are needed to aid in setting up effective strategies. This study provides data that can be used for evidence-based approach(es) for African Americans in the San Francisco Bay Area where the study was conducted. At the inaugural of the University of California San Francisco-Stanford Evidence-based Practice Center (EPC) on March 5, 1998 at Stanford University, Doctor Kenneth Shine, the President of the Institute of Medicine at the Georgetown University School of Medicine,

in his keynote speech said (a) that the patient-physician joint decision-making requires a good knowledge of the patient's values, (b) evidence from patients is needed for quality improvement, and (c) the problem in health care practice is how to close the gap - there is high quality care, mediocre level care, and poor care. Doctor Shine noted that physicians are conservative and tend to behave the way they were trained. A focus group participant in this study said

> ...as a people, we are different. ...physicians need to be more aware of the make-up of the black person as far as genetic... ...the general way you are trained in your subjects; it can't be something else; it has to be this. You know, just look at each individual and black people do have different symptoms than other nationalities. ...but I think that our bodies have different effect when disease or something affects our bodies... it affects it differently. ...when it comes to black people take extra bit more time. Do the extra step.

A practical implication in the above data excerpt is that of health care provider's attitudes and behavioral change.

Strengths of the Study

This study had several strengths. The researcher and the observer in this study were black. Key people in the community recruited the study participants. Focus groups were conducive to participants sharing their views openly. The anonymity in the Delphi process of data collection reduced respondent bias when compared with feasible alternatives (e.g., collecting information only from focus groups). Since information was shared without direct contact between respondents, the biasing effects of contextual factors such as personality traits, seniority, and experience were minimized.

Decisions on sample size and heterogeneity depend upon the purpose of the

project, design selected and time frame for data collection. For the conventional Delphi, a heterogeneous sample is used to ensure that the entire spectrum of opinion is determined. In this study, heterogeneity was achieved through the inclusion of both males and females that meet the stated criteria, varying ages from 18 to 65, and participants coming from different sources in the San Francisco Bay Area. The analyzed data constitute participants' terminology used in describing quality of care.

Limitations of the Study

Methodological Issues

Recruitment and attrition were major problems with the study resulting in a smaller sample size (N=19) than was originally planned for, although it fell within Leape et al'.s (1992) suggested range of 15-25. Participant recruitment was slow and very difficult especially with the men. Thrice, planned men's group sessions were not held because those who said they would attend could not make it for one reason another. Only two men were present in the last focus group session. Regarding an incentive to increase study response rate, Rubin (1990) cited from the literature that personal contact prior to hospital discharge enhances response rate when compared with no personal contact before discharge. The focus group contact with participants was expected to create a relationship that should positively influence participants' response rate. The response rate in Round 1 and 2 of the Delphi process were Round 1: 63% - 22 of 35; Round 2: 86.26% - 19 out of 22. However, a number of the participants personally expressed the idea that this type of study was very much needed in their community and encouraged the investigator to continue working in the area of African Americans' quality health care

issues.

Williams and Webb (1994) said that attrition rates may alter the range of opinion from round to round in the Delphi technique. Participants were given deadlines to return their opinions. Attrition rate was carefully monitored during round one to ensure that the range of participant opinion was adequately represented in round two. Williams and Webb (1993) recommended follow-up of non-respondents. Follow-up calls were made to non-respondents and new questionnaires mailed to those who had misplaced copies earlier mailed to them. Yet, not everyone responded. The attrition rate likely introduced response bias. To begin with, there were not many men in the sample at the end of phase one of the study. Following the conclusion of round one of the Delphi, only 50% (3 out of 6 - one from the north and two from the south Bay Area) were still in the study. Although all three men responded in Round 2 of the Delphi, a sample of three is skewed when compared with sixteen for women.

Regarding response format, La Monica et al. (1986) found that acquiescence response bias is common in positive and negatively worded items such as found in agree-disagree scales. Rubin (1990) recommended carefully balancing agree-disagree scales with identical positive and negative items to adjust for acquiescence. Some of the statements in Appendix J were negatively worded to reduce response set. Balancing the statements in positive and negative terms made the desired response direction for the negative ones to be strongly to slightly disagree. A review of the participants' response show that they did not have problems with understanding the directionality of the positive and negatively worded statements. Random assignment of numbers to the main idea

statements reduced response set bias.

Ethical issues constituted another area of concern. Smith (1995) noted that although the question of ethics is not unique to focus group interview, there are ethical issues that are specified for this approach. Participants' made informed decisions on whether or not to participate in the study because the advertisement flyer contained adequate information to support the principle of informed decision-making.

Notes and audio-tapes from the research were not used for anything other than to fulfill the purpose of the study. The signed informed consent forms were in safe custody/locked up (separate from the typed transcripts and tapes). Although the investigator had no control over what focus group participants did after the sessions, members were informed that respect for one another in the group extended to not discussing group experiences outside the group, especially sensitive topics. Sensitive topics may trigger over disclosure by some participants. The participants' stress level was continually monitored and never was there any point when the investigator had to intervene.

Selection Bias

Selection bias limited the generalization of study findings. To minimize bias, the participants were from the community rather than being hospitalized or waiting to receive health care. The sample included only English speaking participants and excluded those with verbal and auditory handicaps, and those who had not used the U.S. health care system in the last year, adults over 65 years of age, and those not working/without health insurance. The unit of analysis for the focus group was the group and the demographic

data was collected without linking any piece of data to a participant. The high education level of the sample is the only obvious source of a bias because it may not represent the opinions of those less educated.

Future Research

A future step is to use the data in developing a patient satisfaction measure from the African Americans' perspective. One may question whether or not there is a need for such an instrument when the participants' perceptions fit with what currently exists in the literature. There is a need for such a measure for these reasons. First, the current existing tools are based on research data underrepresenting African Americans. Also, such values as respect (identified as important in this study) are not usually included on survey tools (Cleary & Edgman-Levitan, 1997). The findings of this study suggest that variables relating to racism (e.g., avoiding touching blacks, inhumane treatment, etc.) need to become part of satisfaction measures. Including specific variables that constitute African Americans' quality care values, beliefs, and preferences on a quality of care measure makes the tool sensitive to their specific needs. That is the way to adequately address their perspectives on the quality of care that they received. Second, observing the similarities and differences that may exist between or among the different ethnic/racial groups is important when one considers using standardized quality of care processes and measures. Standardization reduces possible care providers' concern(s) about providing culturally competent care to patients from different cultural backgrounds. The specific differences challenge health care researchers to make sure that the unique variables that a particular ethnic group considers to be important are included on evaluation measures.

A replication of the study with a larger sample size will allow for a confirmatory factor analysis on the dimensions of quality of care from the present study. This replication may be with African Americans in different parts of the country. Replication with people over age sixty-five and with non-African American populations is recommended. The latter provides an opportunity for data comparison while noting similarities and differences.

Another important research implication from this study is to conduct studies with African Americans to find out from them the best recruitment strategies as well as what it takes for them to remain as study participants. Pletsch, Howe, and Tenney (1995) said that health intervention researchers face participant recruitment challenges when potential subjects are difficult to locate or engage in research. They added that people of color and people who are socio-economically disadvantaged have been missed or they have been difficult to access for intervention research. It is respected that skepticism due to the black experience in America and the Tuskegee syphilis experiment may discourage some people to participate in health services research. However, times have changed and continue to change, as shown by current positive societal developments including increased number of blacks in health care research, present emphasis on human research ethics, the poor health outcomes for blacks, and the fact that health care policies are research based are some reasons for why many blacks should want to participate in health care research studies.

Federal mandates now require that minorities be included in National Institutes of Health (NIH Guidelines, 1994) funded research (Pletsch et al., 1995). Without African

Americans' inputs in research data, health care policies and regulations will continue to be biased against them. Passing health care laws at national, state, and local levels require the support of research data. In other words, health care laws require inputs from everyone, including African Americans. They must, therefore, play their role by providing health care researchers with facts that constitute the evidence. On the other hand, non-black health care researchers must also do their part to regain the trust of black participants. More black health care researchers are also needed. Graduate schools, including medical schools, nursing, etc., are challenged to recruit and retain health care professional. The complicated legacy of distrust that established institutions of medical research having both the power to cure and intent to harm that William et al. (1996) referred to, did not happen in one day but over time. Thus, efforts to simplify the related issues must be started and continued persistently.

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APPENDIX A

RECRUITMENT FORM

Appendix A. **RECRUITMENT FORM**

African Americans: Voice Your Opinions about the Quality of Health Care
What is the Study For? To describe African Americans' experiences and opinions on quality of health care.
Place: San Francisco Bay Area.
Who can participate?

* Be African American/Black and born in the U.S.
* Be a worker (at least 50%)
* Be 18 to 65 years old
* Have health care insurance
* Had health care in the U.S. within the last year
* Read and understand at least 6th grade English
* No hearing or speech problems
* Have a permanent mailing address

What You Will Do

* Meet in a group for 1.5-2 hours to talk about your experiences and opinions about quality of health care.
* Be mailed a summary of the groups' opinions; read it and mail back your agreement or disagreement. Each of 2-3 mailings will take 10-15 minutes.

Child care will be provided if needed for the group meeting.
Refreshments Will Be Provided.
Reimbursement: You will be appreciated with **$15.00** after the focus group and **another $15.00** at completion of the study.
Please call today to register at (415) 476-6702. It is about the care that you receive.

Suzanne Henry, RN, DNS, FAAN

Marie Fongwa-Asobo RN, MPH, PhD Candidate

Department of Community Health Systems
University of California, San Francisco

APPENDIX B

PARTICIPANT RECRUITMENT LOG

Appendix B. **PARTICIPANT RECRUITMENT LOG**

Phone #: (415) 476-6702

Date called	**Name**	**Gender**	**Address**	**Phone #**	**Site**	**Child care**		**Comment**	
						Yes	**No**	**M-F**	**S-S**

APPENDIX C

CONFIRMATION OF AGREEMENT TO ATTEND FOCUS GROUP

Appendix C.

CONFIRMATION OF AGREEMENT TO ATTEND FOCUS GROUP

[Insert Date of Letter]
1580 Southgate Avenue
212 Daly City, CA. 94015

Dear Mr/Ms_____

Thank you very much for agreeing to attend a focus group meeting on African Americans' opinions on quality of health care. Below is the information you need for a scheduled focus group meeting. Your opinions and experiences are valuable to us. At the meeting you will be asked to sign and receive a copy of consent to take part in the study.

Place:_____
Room:_____
Date: _____
Time: _____

Please arrive on time. Refreshments will be provided and you will be appreciated with $15.00 after the focus group and additional $15.00 at the completion of study. Please call (415) 476-6702 with questions. See you there and thank you very much.

Marie Fongwa-Asobo RN, MPH, PhD Candidate
University of California, San Francisco

APPENDIX D

FOCUS GROUP INTERVIEW GUIDE (Original draft and final version)

Appendix D. FOCUS GROUP INTERVIEW GUIDE (Original draft)

Here are the questions that guide the focus group discussion.

1. I will like us to start this discussion by asking **What does quality of health care mean to you?**

2. Leading from the last question **What do you consider to be high quality care?**

3. Now **If the health care that you receive or has received is of high quality, what is especially good about the care?**

4. **What do you think is the reason(s) for the high quality care?**

5. Now let us turn to the opposite of the last two questions we just discussed **If the health care that you receive or have received is of low quality, please describe it giving example(s) that you can think of.**

6. **What do you think is or was the reason(s) for the low quality care?**

7. Now that we have talked about what quality is, and you have used examples from your experiences to describe or illustrate it **How should low quality health care be improved (who should do what, where, when, and why)?**

8. Now I will like you to **Please describe how you feel (likes and dislikes) about the place where you receive health care.**

9. Let us now turn to the people who serve you **Please describe your feelings (likes and dislikes) about the people you receive care from and how they treat you as a person.**

10. **Please describe how racism influence/affect the quality of care that you receive.**

11. Now let us discuss forms of treatment different from those from your medical provider. **Please discuss the types of health problems that can best be treated by traditional/folk healers or alternative treatment in your community.**

12. **Please describe the reasons why you will consult or go to traditional/folk healers with your health problems.**
13. **What else do you feel should be added to or removed from the discussion regarding the quality of health care you receive?**

Appendix D. FOCUS GROUP INTERVIEW GUIDE (Final version)

1. Pease tell me about your health care experiences. Your are not limited to hospital experiences; you may talk about care received from doctor offices, clinics, and elsewhere.
2. Please tell me about your feelings, including what you like or do not like, about the people and the places where you receive health care.
3. How should quality health care be improved?
4. Please tell me how racism affects/influences the quality of health care that you receive.

APPENDIX E

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Appendix E.

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

RESEARCHER: Marie Ngetiko Fongwa-Asobo, PhD Candidate
c/o Dr. Suzanne Henry
Department of Community Health Systems
School of Nursing
N319Y, Box 0604
University of California, San Francisco
San Francisco, CA 94143-0604
(415) 476-6702

SUPERVISOR: Suzanne B. Henry, RN, DNS
Department of Community Health Systems
School of Nursing
N319Y, Box 0604
University of California, San Francisco
San Francisco, CA 94143-0604
(415) 476-5849

PROJECT TITLE: QUALITY OF HEALTH CARE DIMENSIONS: AFRICAN AMERICANS' PERSPECTIVES

A. PURPOSE AND BACKGROUND

Suzanne Henry, DNS and Marie Fongwa-Asobo, PhD Candidate, are conducting a study to learn about African Americans' experiences and opinions of quality of health care. They believe that learning about people's perceptions of quality will help health care nurses and doctors to provide health care that is culturally appropriate and acceptable. I am being asked to participate because I am African American and have experience with health care in the last year.

B. PROCEDURES

If I agree to participate in this study, the following will happen: The study has two parts.

Part I

I will participate in one group discussion with six to twelve other African Americans of my own gender. The discussion will last for one and a half to two hours and we will talk about our experiences, opinions, and feelings related to the quality of care that we receive. The group leader will ask general questions and the group discussion will be tape recorded. An African American observer will be in the room to assist the leader but will not participate in the group discussion.

I do not have to talk if I do not want to. I will not be expected to answer any particular question. If I want to leave the group, I can do so at any time. After the six groups have met, Ms. Fongwa-Asobo will write up the main ideas or phrases describing

quality of care from my group discussion and the discussions of other groups of African Americans.

Part 2

The main ideas from all groups will be mailed to me. I will read the paper and make any changes that I think are necessary. I will be asked to choose a number to judge whether each main idea is part of quality of care. This will take about 10-15 minutes. Then I will return my review and ratings in a stamped envelope to Ms. Fongwa-Asobo. She will read everyone's opinions and find the average. Then she will mail the results back to me a second time. I will compare my score/rating with the group average and decide whether or not I wish to change my opinion by choosing a different number. I will return the paper to Ms. Fongwa-Asobo in the stamped envelope. At this time, we will be finished unless I or Ms. Fongwa-Asobo decide that another mail exchange is needed.

C. RISKS/DISCOMFORTS

Even though the questions to guide the group discussion are not meant to make anyone feel uncomfortable or embarrassed, it is possible that some part of the discussion may make me uncomfortable. However, I do not have to answer any question and I can stop talking or leave the group at any time. I can call Ms. Fongwa-Asobo later if I want to talk about why I was uncomfortable. To protect my privacy, this consent form will be kept in a separate locked file cabinet from the tapes and typed transcripts of the discussion. Other people in the group will hear my opinions, but my name will not be put on the written transcripts. My opinions will be put together with those of the other people in the groups. All of our ideas will be presented as group ideas and no individual will be identified. After the tapes are typed up (with no names typed), they will be erased.

D. BENEFITS

I will receive no personal benefits from participating in the study. However, my participation may be help doctors and nurses to better understand African Americans' experiences, opinions, and feelings about the quality of health care. This understanding might improve health care for African Americans and to make it more culturally sensitive.

E. ALTERNATIVES

I am free to choose not to participate in this study.

F. COSTS and Payment

There will be no cost to me as a result of taking part in the study. Ms. Fongwa-Asobo will provide refreshments during the group discussion and childcare if I need it.

Immediately after the focus group meeting, I will receive a $15.00 (cash) token of appreciation for participating in the group discussion. I will also receive another $15.00 (personal check within 4 weeks) after I mail back the papers at the end of the study. If I would prefer money order or cashier's check, I will let Ms Fongwa-Asobo know immediately after the focus group meeting.

G. QUESTIONS

Ms Marie Fongwa-Asobo has explained this study to me and has answered all questions. If I have further questions, I may call her at (415) 476-6702 or her advisor Dr. Suzanne Henry at (415) 476-5849, Monday through Friday 9:00 a.m. to 5:00 p.m. If for some reason I do not want to call Ms Fongwa-Asobo or Dr. Henry, I may contact the Committee on Human Research which is concerned with the protection of human volunteers in research projects. I may reach the Committee office between 8:00 a.m. and 5:00 p.m. by calling (415) 476-1814 or by writing the Committee on Human Research, P.O. Box 0962, University of California, San Francisco, CA. 94143.

H. CONSENT

I will be given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. I have the right to stop participating at any time without any negative consequences.

_____

Date Signature

_____ _____

Participant's Phone Number Person Obtaining Consent

APPENDIX F

FOCUS GROUP NARRATIVE INTRODUCTION

Appendix F. FOCUS GROUP NARRATIVE INTRODUCTION

Welcome to you all. My name is Marie Fongwa-Asobo and I am a nurse researcher from the University of California, San Francisco. I was born, grew up and was educated as a nurse-midwife in Cameroon, West Africa. I have lived, worked as a nurse, and gone to school in California and I am aware of the health care issues of African Americans including those related to quality of care. I am very interested in your health care issues and experiences. As a black person, things that affect the quality of care that you receive influence the type of care that I receive too. As you know from the letter I sent you, this study is about African Americans' experiences, opinions and feelings on the quality of health care. You have been asked to take part in this study because you have received health care services in the last year and you have information to share regarding about this health care.

This group discussion is the first part of the study. I will ask you to talk about your experiences, opinions, feelings and beliefs about the quality of health care that you receive. There are no right or wrong answers to these questions. I just want to hear about what you think. If you remember someone else's experience who is not part of this group you can tell us, as long as you do not mention the person's name.

Please choose a name for yourself to use in the group. Put it on the name tag. I will tape record our discussion. Our helper will take notes for me but she will not talk. Please try to speak clearly and one at a time. I don't want to lose any of your valuable ideas. To protect your privacy, I will combine everyone's opinions and talk about them as the opinions of the group, not yours alone. When the study is finished, all the tapes will be erased. None of the information in this group will ever go on anyone's medical chart. I am asking you to respect each other by not talking about anything that anyone else says here to anyone outside of this group.

The second part of the study will be all by mail and I invite you all to participate. I will send you the main ideas that you have come up with and ask you to read them and see if you agree with them. It will take about 10 to 15 minutes. You will mail back your opinions to me in a stamped envelope by a certain date. I will read all of this mail and then send you another version, and ask you to read it and send it back again.

If anyone becomes uncomfortable with the discussion or finds it upsetting, feel free to quietly leave the room. You do not have to answer any question that you do not want to. At the end of the group discussion, I will thank you for your time and help with $15.00. Remember, you are here strictly as a volunteer. Are there any questions?

If you want to be part of this study, please read and sign the consent form. Please keep one copy for yourself. From the bottom of my heart, let me thank you very much in advance for participating in this study.

APPENDIX G

University of California San Francisco, Experimental Subject's Bill of Rights

Appendix G

:

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

EXPERIMENTAL SUBJECT'S BILL OF RIGHTS

The rights below are the rights of every person who is asked to be in a research study. As an experimental subject I have the following rights:

1) To be told what the study is trying to find out,
2) To be told what will happen to me and whether any of the procedures, drugs, or devices is different from what would be used in standard practice,
3) To be told about the frequent and/or important risks, side effects, or discomforts of the things that will happen to me for research purposes,
4) To be told if I can expect any benefit from participating, and, if so, what the benefit might be,
5) To be told of the other choices I have and how they may be better or worse than being in the study,
6) To be allowed to ask any questions concerning the study both before agreeing to be involved and during the course of the study,
7) To be told what sort of medical treatment is available of any complications arise,
8) To refuse to participate at all or to change my mind about participation after the study is started. This decision will not affect my right to receive the care I would receive if I were not in the study,
9) To receive a copy of the signed and dated consent form,
10) To be free of pressure when considering whether I wish to agree to be in the study.

If I have other questions: I may call Ms Marie Fongwa-Asobo at (415) 476-6702, or Dr. Suzanne Henry at (415) 476-5849, Monday through Friday, 9:00 a.m. to 5:00 p.m. In addition, I may contact the Committee on Human Research, which is concerned with protection of volunteers in research projects. I may reach the committee office by calling: (415) 476-1814 from 8:00 am to 5:00 p.m. or by writing: Committee on Human Research, P. O. Box 0962, University of California, San Francisco, CA. 94143.

APPENDIX H

DEMOGRAPHIC DATA: PERSONAL INFORMATION

8 Ho

9 How

Appendix H. Personal Information - About Your Self

Please do not write your name anywhere on this form. The information you give here will help us understand something about the group of African Americans who took part in this study.

1. I would describe myself as an African American or Black (Mark an X)
   ___ Yes ___ No

2. My age is (Mark an X)
   ___ 18 - 25 ___ 46 - 55
   ___ 26 - 35 ___ 56 - 65
   ___ 36 - 45 ___ 66 and over

3. I was born in _____ (City) _____
(State)_____ _____ (Country) WRITE IN

4. Circle the highest level of school completed

Grade School	High School	College	Grad School
1 2 3 4 5 6 7 8 9 10 12		1 2 3 4	1 2 3 4

5. I have had special training in (Mark an X)
   ___ Beauty School
   ___ Business School
   ___ Other _____

6. I am currently (Mark an X)
   ___ Single ___ Widowed
   ___ Married ___ Separated
   ___ Divorced ___ Living with a partner

7. I am (Mark an X)
   ___ Fully employed outside of home
   ___ Employed on part-time basis
   ___ Self employed
   ___ Disability

8. How many people live in your household? _____ WRITE IN

9. How many of these are children _____ WRITE IN

10. Check all sources of household income that apply (Mark an X)

____ employment
____ public assistance (AFDC/welfare)
____ family helps
____ child/spousal support
____ student loan/scholarships/educational grants
____ other (please specify)

_____

11. Do you have health insurance coverage? (Mark an X)
___Yes ___No

12. If your answer to question 11 was a "Yes", which of the following describes your health insurance?
___ Full insurance coverage through work
___ Partial insurance through work
___ No insurance through work

Any other comment about your health insurance coverage?

_____
_____
_____

APPENDIX I

FOCUS GROUP PROTOCOL

Appendix I. **Focus Group Protocol**

- Participant arrival 20 minutes earlier.
- Completion of demographic form/refreshments.
- Welcome, self introduction by investigator as well as introduce the observer.
- Reading of consent form and explanation of procedures (one person to speak at a time, respect for privacy, choice of pseudo first name, and bathroom privileges) and answering questions.
- Completion of consent form.
- Group discussion of interview guide questions, taping/transcribing.
- 15 minutes break after first hour/refreshment.
- Complete discussion.
- Remind participants that they will be receiving the analyzed content of the focus group interviews via the mail for their review and opinions about two more times.
- Appreciation with envelopes, each with $15.00, to participants.

APPENDIX J

DELPHI QUESTIONNAIRE

Appendix J. Delphi Questionnaire - Main Idea Statements

Here is a list of main points which you and other focus group members gave on the subject of quality of health care that you receive. **Please rate each one on a scale of 1-6 to indicate your agreement or disagreement with each main point. Please CIRCLE a number to indicate your choice**	**Agreement** strongly disagree = 1 moderately disagree = 2 slightly disagree = 3 slightly agree = 4 moderately agree = 5 strongly agree = 6					
1. There is <u>less</u> respect for the patients today than there used to be.	1	2	3	4	5	6
2. A doctor is cold to a black patient because s/he does not want to deal with such a patient.	1	2	3	4	5	6
3. Unemployment means no health insurance and high crime rate among blacks.	1	2	3	4	5	6
4. In the emergency room, asking a patient why s/he did not wait for the regular doctor indicates a nasty attitude.	1	2	3	4	5	6
5. Quality health care is the type of care that a patient receives.	1	2	3	4	5	6
6. The health care system is <u>positively</u> influenced by the U.S. society being a NOW society and one that puts money first before ethics.	1	2	3	4	5	6
7. Those with health insurance may still receive low quality care.	1	2	3	4	5	6
8. Low quality care is doctors discussing what insurance will pay for.	1	2	3	4	5	6
9. At the emergency room, time and life are saved when stab wounds are attended to first before paper work.	1	2	3	4	5	6
10. Elderly patients find it hard to handle when they are pushed fast through the system.	1	2	3	4	5	6
11. Wrong diagnosis can result in delayed treatment and permanent or long lasting disability.	1	2	3	4	5	6
12. Quality health care is getting top-of-the-line or best treatment.	1	2	3	4	5	6
13. Today, patients are expecting care providers to use language that patients can understand.	1	2	3	4	5	6

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14. The beliefs that blacks are usually overweight and eat greasy foods may result in failure to properly examine and treat.	1	2	3	4	5	6
15. Seeing more patients means more money, so care providers spend a short time with each patient.	1	2	3	4	5	6
16. A patient can improve the quality of his/her care by knowing how to get through the health care system.	1	2	3	4	5	6
17. The health care system is negatively influenced by the U.S. greater financial expenses on defense more than on health care.	1	2	3	4	5	6
18. To say that a health problem that has been for a while does not need a "rush action" discounts the problem and the patient's feelings.	1	2	3	4	5	6
19. There is a need for health care workers who look like me (black).	1	2	3	4	5	6
20. People do not like the idea that some patients receive better health care than others.	1	2	3	4	5	6
21. The health care system is negatively influenced by mis-management of funds.	1	2	3	4	5	6
22. A care provider's experience may influence how a patient is treated.	1	2	3	4	5	6
23. It is <u>not</u> disrespectful for a patient to wait for a doctor for no good reason on the doctor's part.	1	2	3	4	5	6
24. The long wait at the emergency room is because patient's view of emergency is different from the health care provider's.	1	2	3	4	5	6
25. The care provider's gender (sex) may influence diagnosis and treatment.	1	2	3	4	5	6
26. One's racial background does <u>not</u> influence the quality of care that one receives.	1	2	3	4	5	6
27. Taking prescribed medication such as a narcotic for a chronic condition does not mean that one is a drug addict.	1	2	3	4	5	6
28. Patients are having <u>longer</u> length of stay at the hospital.	1	2	3	4	5	6
29. The level of care has gone down from what it used to be.	1	2	3	4	5	6

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30. Voicing surprise when patient is able to express him/herself on the health problem at hand is disrespectful.	1	2	3	4	5	6
31. These days, patients are discharged sooner from hospitals because insurance companies require early discharge.	1	2	3	4	5	6
32. Black men should not tell their doctors exactly what is going on with them.	1	2	3	4	5	6
33. Asking questions and following health care instructions show that blacks care and are serious about their bodies.	1	2	3	4	5	6
34. Education of the public about health-care-related issues does not influence the quality of patient care.	1	2	3	4	5	6
35. Black women can improve the quality of their care by not forgetting to take care of themselves while caring for their children, husbands, etc.	1	2	3	4	5	6
36. Preconceived assumptions (including ideas about persons from a particular race, living location, socio-economic status) affect the quality of care that a person receives.	1	2	3	4	5	6
37. Asserting self means being frank with care providers.	1	2	3	4	5	6
38. The emergency room health workers do not tell patients/families why they are waiting.	1	2	3	4	5	6
39. Health care setting's guidelines prevent delaying diagnosis, treatment, and allay a patient's anxiety about the health problem.	1	2	3	4	5	6
40. Class issues between care provider and assistant do not affect patients in a negative manner.	1	2	3	4	5	6
41. Teaching and role modeling for children on what they should do to keep healthy affects the quality of care that the people receive.	1	2	3	4	5	6
42. Doctors who have problems touching black patients tend to ask a lot of questions and do more writing than touching.	1	2	3	4	5	6
43. Physicians should not educate themselves about black people and their common health problems.	1	2	3	4	5	6
44. Patients like being attended to by medical students.	1	2	3	4	5	6

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45. The outcome of care such as cured and outstanding bills must be considered in quality improvement.	1	2	3	4	5	6
46. Asserting self also means that a patient does not allow a care provider to discount him/her.	1	2	3	4	5	6
47. People do not like the paper work associated with visits where they receive health care.	1	2	3	4	5	6
48. People do not like scheduling appointment several weeks later than they need them.	1	2	3	4	5	6
49. Asserting self means asking doctors for referrals to experts.	1	2	3	4	5	6
50. High quality care is rushing patients out of hospitals.	1	2	3	4	5	6
51. Quality health care is the conditions surrounding the type of patient care.	1	2	3	4	5	6
52. A female pediatrician from any race can substitute for a black pediatrician.	1	2	3	4	5	6
53. Patients prefer centralized health care settings where the workers know patients beyond their health problems.	1	2	3	4	5	6
54. Changing insurance companies interferes with the bonding/trust between the provider and the patient.	1	2	3	4	5	6
55. Quality health care is how the health care treatment processes are done.	1	2	3	4	5	6
56. People like it when the waiting room is not crowded.	1	2	3	4	5	6
57. People do not mind the long waits during appointments.	1	2	3	4	5	6
58. A surgery patient may not like the pressure associated with early discharge such as getting up and walking soon after surgery.	1	2	3	4	5	6
59. The health care system is negatively influenced by conflicts of interest with management personnel.	1	2	3	4	5	6
60. Restructuring or re-organizing of the Food and Drug Administration (FDA) can improve the quality of patient care.	1	2	3	4	5	6
61. Quality health care is considering patient's health problem(s) first before cost.	1	2	3	4	5	6

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62. A patient may not follow direction for a new medication if the care provider assumes that the patient knows already.	1	2	3	4	5	6
63. Not everyone who seeks health care should be given the best possible quality care.	1	2	3	4	5	6
64. The health care system is positively influenced by big business such as pharmaceutical companies.	1	2	3	4	5	6
65. Fewer doctors are in private practice today.	1	2	3	4	5	6
66. Adequate qualified staff and available health information must be considered in quality improvement.	1	2	3	4	5	6
67. Quality health care is to be treated/cured as best as possible.	1	2	3	4	5	6
68. Elderly patients have less experience in managing their way through the health care system so they need assistance from care providers and their families.	1	2	3	4	5	6
69. Quality health care is getting to the root of the patient's health problem.	1	2	3	4	5	6
70. Quality health care is having no hassle about seeing specialists when needed.	1	2	3	4	5	6
71. A patient cannot improve the quality of his/her care by educating him/herself on the health problem.	1	2	3	4	5	6
72. A care provider may not educate black patients because of the belief that blacks do not take pride in their health care issues.	1	2	3	4	5	6
73. People do not like 'public' health care settings where Medicare/Medicaid patients go because there are usually too many patients to be seen there and too few doctors.	1	2	3	4	5	6
74. Doctors should look for the uniqueness of each patient's situation rather than assume that things have to be the way they (doctors) were trained to see things.	1	2	3	4	5	6
75. Poor examination of a patient may result in wrong treatment.	1	2	3	4	5	6
76. A doctor's beliefs about a patient's age may influence the diagnosis of a health problem.	1	2	3	4	5	6
77. People tend to be most comfortable with health care providers from their own racial background.	1	2	3	4	5	6

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78. People should not be kept waiting more than 15 minutes for an appointment.	1	2	3	4	5	6
79. Addressing an elderly black patient by his/her first name is disrespectful.	1	2	3	4	5	6
80. Quality of health care may be influenced by the patient's societal position.	1	2	3	4	5	6
81. A doctor's choice of words can have a bad or good effect on the patient.	1	2	3	4	5	6
82. High quality care is talking with a patient about health problem(s) first and then cost later.	1	2	3	4	5	6
83. A patient may not recognize the side effects of a new medication if the care provider assumes that the patient knows already.	1	2	3	4	5	6
84. High quality care is allowing a patient to see a specialist.	1	2	3	4	5	6
85. Patients like it when the insurance company pays for things such as eye glasses.	1	2	3	4	5	6
86. Today racism is covert and whites still receive better care than blacks.	1	2	3	4	5	6
87. Patients do <u>not</u> like it when their doctors and staff know them by their names.	1	2	3	4	5	6
88. Anyone without insurance may receive only minimal health care that may relief discomfort for only a short time.	1	2	3	4	5	6
89. The health care system is negatively influenced by the U.S. failing to take examples from other Western countries.	1	2	3	4	5	6
90. Quality health care is the patient-provider relationship.	1	2	3	4	5	6
91. A care provider <u>will</u> listen to a patient who is believed to be unimportant.	1	2	3	4	5	6
92. A patient prefers a doctor from any race who does not rush and give incomplete responses to questions.	1	2	3	4	5	6
93. People do not like dirty, shabby, and smelly health care environments.	1	2	3	4	5	6

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94. Excluding blacks from life-saving related research studies does not influence the quality of their health care.	1	2	3	4	5	6
95. Untrained health care staff can be condescending impatient, ignoring, prejudicial, and stereotyping with patients.	1	2	3	4	5	6
96. Quality health care is a patient's feelings about the care received.	1	2	3	4	5	6
97. Patient do not like anxiety-raising situations in the health care settings while waiting to be attended to.	1	2	3	4	5	6
98. Going to the dentist and returning home with little or no pain is a an advancement in medical care that people like.	1	2	3	4	5	6
99. Health care providers can improve the quality of care by talking to people about prevention, education, and engaging with the community through organizations like churches and Lions.	1	2	3	4	5	6
100. People like caring and nice health care workers.	1	2	3	4	5	6
101. At the emergency room workers should consider the patient's bathroom needs and anxiety about the health problem.	1	2	3	4	5	6
102. A new doctor that is selected should be a person that you trust.	1	2	3	4	5	6
103. Health care providers at under-staffed settings may not attend to a patient's health care need.	1	2	3	4	5	6
104. High quality care is being able to choose your own doctor.	1	2	3	4	5	6
105. Sometime a patient must insist that a care provider sees him or her.	1	2	3	4	5	6
106. The type of treatment that one gets does not depend on the type of insurance coverage.	1	2	3	4	5	6
107. People like or are pleased with a clean and conveniently located health care environment.	1	2	3	4	5	6
108. Most black doctors are not personable to patients and do not work in their communities as role models for young people.	1	2	3	4	5	6
109. When a doctor is cold to me, I feel like not asking questions but just leaving as quickly as possible.	1	2	3	4	5	6

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110. Patients like being able to speak with their doctors when they want to.	1	2	3	4	5	6
111. Improving the quality of health care means self diagnosing and treatment.	1	2	3	4	5	6
112. A doctor's beliefs about a patient does not influence the diagnosis of a health problem.	1	2	3	4	5	6
113. A responsible patient insists on being seen and has a regular health follow-up schedule.	1	2	3	4	5	6
114. Family doctors are rare these days.	1	2	3	4	5	6
115. A patient can improve the quality of his/her health care by providing the doctor with a copy of problem list preferably prior to the scheduled visit.	1	2	3	4	5	6
116. People do not like provider's scheduling to see many patients because it results in patients receiving poor care.	1	2	3	4	5	6
117. Anyone with no health insurance has little or no chance for health care services.	1	2	3	4	5	6
118. Patients waiting to see their doctor like it when they are told the doctor(s) is running late.	1	2	3	4	5	6
119. Blacks' experience with the health care system makes some people seek only emergency care.	1	2	3	4	5	6
120. Patients and families are left to guess what is going on in emergency rooms because the workers do not tell them.	1	2	3	4	5	6
121. Sometime a patient may have to assert him/herself by demanding for the right tests in order to get the needed quality of care.	1	2	3	4	5	6
122. Conducting research studies that advance progress on different diseases can improve the quality of care.	1	2	3	4	5	6
123. Health insurance that covers 80% or more of health care expenses is preferable.	1	2	3	4	5	6
124. Discussing patient's examination room findings with those outside of the exam room is disrespectful.	1	2	3	4	5	6

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125. Rushing and giving incomplete answers to questions is anxiety raising for patients.	1	2	3	4	5	6
126. An option from the health insurance company to seek care anywhere can improve the quality of care.	1	2	3	4	5	6
127. Doctors can only order what the insurance will cover.	1	2	3	4	5	6
128. Quality health care is having the means to seek health care.	1	2	3	4	5	6
129. One can receive low quality care at a popular health care facility.	1	2	3	4	5	6
130. Doctors who do not like touching blacks perform incomplete and inadequate exams on such patients.	1	2	3	4	5	6
131. Quality health care is not related to the care provider's level of knowledge.	1	2	3	4	5	6
132. Some health insurance "...pays doctors to keep patients out of the hospital".	1	2	3	4	5	6
133. Asserting self means settling for less.	1	2	3	4	5	6
134. One needs variety of care experiences to decide the effect of racism on quality of care.	1	2	3	4	5	6
135. Blacks make health care choices based on what they have available to them.	1	2	3	4	5	6
136. Health insurance companies do not pay for pre-existing conditions.	1	2	3	4	5	6
137. To be seen by a Nurse Practitioner when payment checks are made to the doctor is disrespectful.	1	2	3	4	5	6
138. The way that the care provider does what s/he does (knows his/her job and expectations) does not influence the quality of care.	1	2	3	4	5	6
139. People do not like to make payment at the emergency room when they are seeking care.	1	2	3	4	5	6
140. Quality health care is responding to a patient's health problem when care is needed.	1	2	3	4	5	6

APPENDIX K

DELPHI QUESTIONNAIRE - ROUND 2

Appendix K. Delphi Questionnaire - Round 2

Here are the numbers that you selected to describe your agreement or disagreement with each main point on the subject of quality of health care. Next to your choice for each point is the average choice for the group of everyone who is in the study. **Please compare the number you chose for each main point with the group's average. Decide whether or not you wish to choose a different number. If you wish to choose a new number, please CIRCLE one in the section labeled "Your New Score". If you do not wish to change your mind on any of the main points, do not choose a new number for that point. If you did not choose a number during the first time and wish to do so now, circle a number for that main point.**	**Your New Score** strongly disagree = 1 moderately disagree = 2 slightly disagree = 3 slightly agree = 4 moderately agree = 5 strongly agree = 6					
1. There is less respect for the patients today than there used to be. **Your choice:** **Group average:**	1	2	3	4	5	6
2. A doctor is cold to a black patient because s/he does not want to deal with such a patient. **Your choice:** **Group average:**	1	2	3	4	5	6
3. Unemployment means no health insurance and high crime rate among blacks. **Your choice:** **Group average:**	1	2	3	4	5	6
4. In the emergency room, asking a patient why s/he did not wait for the regular doctor indicates a nasty attitude. **Your choice:** **Group average:**	1	2	3	4	5	6
5. Quality health care is the type of care that a patient receives. **Your choice:** **Group average:**	1	2	3	4	5	6
6. The health care system is positively influenced by the U.S. society being a NOW society and one that puts money first before ethics. **Your choice:** **Group average:**	1	2	3	4	5	6
7. Those with health insurance may still receive low quality care. **Your choice:** **Group average:**	1	2	3	4	5	6
8. Low quality care is doctors discussing what insurance will pay for. **Your choice:** **Group average:**	1	2	3	4	5	6

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9. At the emergency room, time and life are saved when stab wounds are attended to first before paper work. **Your choice:** **Group average:**	1	2	3	4	5	6
10. Elderly patients find it hard to handle when they are pushed fast through the system. **Your choice:** **Group average:**	1	2	3	4	5	6
11. Wrong diagnosis can result in delayed treatment and permanent or long lasting disability. **Your choice:** **Group average:**	1	2	3	4	5	6
12. Quality health care is getting top-of-the-line or best treatment. **Your choice:** **Group average:**	1	2	3	4	5	6
13. Today, patients are expecting care providers to use language that patients can understand. **Your choice:** **Group average:**	1	2	3	4	5	6
14. The beliefs that blacks are usually overweight and eat greasy foods may result in failure to properly examine and treat. **Your choice:** **Group average:**	1	2	3	4	5	6
15. Seeing more patients means more money, so care providers spend a short time with each patient. **Your choice:** **Group average:**	1	2	3	4	5	6
16. A patient can improve the quality of his/her care by knowing how to get through the health care system. **Your choice:** **Group average:**	1	2	3	4	5	6
17. The health care system is negatively influenced by the U.S. greater financial expenses on defense more than on health care. **Your choice:** **Group average:**	1	2	3	4	5	6
18. To say that a health problem that has been for a while does not need a "rush action" discounts the problem and the patient's feelings. **Your choice:** **Group average:**	1	2	3	4	5	6
19. There is a need for health care workers who look like me (black). **Your choice:** **Group average:**	1	2	3	4	5	6

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20. People do not like the idea that some patients receive better health care than others. **Your choice:** **Group average:**	1	2	3	4	5	6
21. The health care system is negatively influenced by mis-management of funds. **Your choice:** **Group average:**	1	2	3	4	5	6
22. A care provider's experience may influence how a patient is treated. **Your choice:** **Group average:**	1	2	3	4	5	6
23. It is <u>not</u> disrespectful for a patient to wait for a doctor for no good reason on the doctor's part. **Your choice:** **Group average:**	1	2	3	4	5	6
24. The long wait in at the emergency room is because patient's view of emergency is different from the health care provider's. **Your choice:** **Group average:**	1	2	3	4	5	6
25. The care provider's gender (sex) may influence diagnosis and treatment. **Your choice:** **Group average:**	1	2	3	4	5	6
26. One's racial background does <u>not</u> influence the quality of care that one receives. **Your choice:** **Group average:**	1	2	3	4	5	6
27. Taking prescribed medication such as a narcotic for a chronic condition does not mean that one is a drug addict. **Your choice:** **Group average:**	1	2	3	4	5	6
28. Patients are having <u>longer</u> length of stay at the hospital. **Your choice:** **Group average:**	1	2	3	4	5	6
29. The level of care has gone down from what it used to be. **Your choice:** **Group average:**	1	2	3	4	5	6
30. Voicing surprise when patient is able to express him/herself on the health problem at hand is disrespectful. **Your choice:** **Group average:**	1	2	3	4	5	6
31. These days, patients are discharged sooner from hospitals because insurance companies require early discharge. **Your choice:** **Group average:**	1	2	3	4	5	6

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32. Black men should not tell their doctors exactly what is going on with them. **Your choice:** **Group average:**	1	2	3	4	5	6
33. Asking questions and following health care instructions show that blacks care and are serious about their bodies. **Your choice:** **Group average:**	1	2	3	4	5	6
34. Education of the public about health-care-related issues does not influence the quality of patient care. **Your choice:** **Group average:**	1	2	3	4	5	6
35. Black women can improve the quality of their care by not forgetting to take care of themselves while caring for their children, husbands, etc. **Your choice:** **Group average:**	1	2	3	4	5	6
36. Preconceived assumptions (including ideas about persons from a particular race, living location, socio-economic status) affect the quality of care that a person receives. **Your choice:** **Group average:**	1	2	3	4	5	6
37. Asserting self means being frank with care providers. **Your choice:** **Group average:**	1	2	3	4	5	6
38. The emergency room health workers do not tell patients/families why they are waiting. **Your choice:** **Group average:**	1	2	3	4	5	6
39. Health care setting's guidelines prevent delaying diagnosis, treatment, and allay a patient's anxiety about the health problem. **Your choice:** **Group average:**	1	2	3	4	5	6
40. Class issues between care provider and assistant do not affect patients in a negative manner. **Your choice:** **Group average:**	1	2	3	4	5	6
41. Teaching and role modeling for children on what they should do to keep healthy affect the quality of care that the people receive. **Your choice:** **Group average:**	1	2	3	4	5	6
42. Doctors who have problems touching black patients tend to ask a lot of questions and do more writing than touching. **Your choice:** **Group average:**	1	2	3	4	5	6

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43. Physicians should not educate themselves about black people and their common health problems. **Your choice:** **Group average:**	1	2	3	4	5	6
44. Patients like being attended to by medical students. **Your choice:** **Group average:**	1	2	3	4	5	6
45. The outcome of care such as cured and outstanding bills must be considered in quality improvement. **Your choice:** **Group average:**	1	2	3	4	5	6
46. Asserting self also means that a patient does not allow a care provider to discount him/her. **Your choice:** **Group average:**	1	2	3	4	5	6
47. People do not like the paper work associated with visits where they receive health care. **Your choice:** **Group average:**	1	2	3	4	5	6
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55. Quality health care is how the health care treatment processes are done. **Your choice:** **Group average:**	1	2	3	4	5	6
56. People like it when the waiting room is not crowded. **Your choice:** **Group average:**	1	2	3	4	5	6
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65. Fewer doctors are in private practice today. **Your choice:** **Group average:**	1	2	3	4	5	6
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67. Quality health care is to be treated/cured as best as possible. **Your choice:** **Group average:**	1	2	3	4	5	6
68. Elderly patients have less experience in managing their way through the health care system so they need assistance from care providers and their families. **Your choice:** **Group average:**	1	2	3	4	5	6
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71. A patient cannot improve the quality of his/her care by educating him/herself on the health problem. **Your choice:** **Group average:**	1	2	3	4	5	6
72. A care provider may not educate black patients because of the belief that blacks do not take pride in their health care issues. **Your choice:** **Group average:**	1	2	3	4	5	6
73. People do not like 'public' health care settings where Medicare/Medicaid patients go because there are usually too many patients to be seen there and too few doctors. **Your choice:** **Group average:**	1	2	3	4	5	6
74. Doctors should look for the uniqueness of each patient's situation rather than assume that things have to be the way they (doctors) were trained to see things. **Your choice:** **Group average:**	1	2	3	4	5	6
75. Poor examination of a patient may result in wrong treatment. **Your choice:** **Group average:**	1	2	3	4	5	6
76. A doctor's beliefs about a patient's age may influence the diagnosis of a health problem. **Your choice:** **Group average:**	1	2	3	4	5	6
77. People tend to be most comfortable with health care providers from their own racial background. **Your choice:** **Group average:**	1	2	3	4	5	6

Appendix K continued

78. People should not be kept waiting more than 15 minutes for an appointment. **Your choice:** **Group average:**	1	2	3	4	5	6
79. Addressing an elderly black patient by his/her first name is disrespectful. **Your choice:** **Group average:**	1	2	3	4	5	6
80. Quality of health care may be influenced by the patient's societal position. **Your choice:** **Group average:**	1	2	3	4	5	6
81. A doctor's choice of words can have a bad or good effect on the patient. **Your choice:** **Group average:**	1	2	3	4	5	6
82. High quality care is talking with a patient about health problem(s) first and then cost later. **Your choice:** **Group average:**	1	2	3	4	5	6
83. A patient may not recognize the side effects of a new medication if the care provider assumes that the patient knows already. **Your choice:** **Group average:**	1	2	3	4	5	6
84. High quality care is allowing a patient to see a specialist. **Your choice:** **Group average:**	1	2	3	4	5	6
85. Patients like it when the insurance company pays for things such as eye glasses. **Your choice:** **Group average:**	1	2	3	4	5	6
86. Today racism is covert and whites still receive better care than blacks. **Your choice:** **Group average:**	1	2	3	4	5	6
87. Patients do <u>not</u> like it when their doctors and staff know them by their names. **Your choice:** **Group average:**	1	2	3	4	5	6
88. Anyone without insurance may receive only minimal health care that may relief discomfort for only a short time. **Your choice:** **Group average:**	1	2	3	4	5	6

Appendix K continued

89. The health care system is negatively influenced by the U.S. failing to take examples from other Western countries. **Your choice:** **Group average:**	1	2	3	4	5	6
90. Quality health care is the patient-provider relationship. **Your choice:** **Group average:**	1	2	3	4	5	6
91. A care provider will listen to a patient who is believed to be unimportant. **Your choice:** **Group average:**	1	2	3	4	5	6
92. A patient prefers a doctor from any race who does not rush and give incomplete responses to questions. **Your choice:** **Group average:**	1	2	3	4	5	6
93. People do not like dirty, shabby, and smelly health care environments. **Your choice:** **Group average:**	1	2	3	4	5	6
94. Excluding blacks from life-saving related research studies does not influence the quality of their health care. **Your choice:** **Group average:**	1	2	3	4	5	6
95. Untrained health care staff can be condescending, impatient, ignoring, prejudicial, and stereotyping with patients. **Your choice:** **Group average:**	1	2	3	4	5	6
96. Quality health care is a patient's feelings about the care received. **Your choice:** **Group average:**	1	2	3	4	5	6
97. Patients do not like anxiety-raising situations in the health care settings while waiting to be attended to. **Your choice:** **Group average:**	1	2	3	4	5	6
98. Going to the dentist and returning home with little or no pain is a an advancement in medical care that people like. **Your choice:** **Group average:**	1	2	3	4	5	6
99. Health care providers can improve the quality of care by talking to people about prevention, education, and engaging with the community through organizations like churches and Lions. **Your choice:** **Group average:**	1	2	3	4	5	6
100. People like caring and nice health care workers. **Your choice:** **Group average:**	1	2	3	4	5	6

Appendix K continued

101. At the emergency room workers should consider the patient's bathroom needs and anxiety about the health problem. **Your choice:** **Group average:**	1	2	3	4	5	6
102. A new doctor that is selected should be a person that you trust. **Your choice:** **Group average:**	1	2	3	4	5	6
103. Health care providers at under-staffed settings may not attend to a patient's health care need. **Your choice:** **Group average:**	1	2	3	4	5	6
104. High quality care is being able to choose your own doctor. **Your choice:** **Group average:**	1	2	3	4	5	6
105. Sometime a patient must insist that a care provider sees him or her. **Your choice:** **Group average:**	1	2	3	4	5	6
106. The type of treatment that one gets does not depend on the type of insurance coverage. **Your choice:** **Group average:**	1	2	3	4	5	6
107. People like or are pleased with a clean and conveniently located health care environment. **Your choice:** **Group average:**	1	2	3	4	5	6
108. Most black doctors are not personable to patients and do not work in their communities as role models for young people. **Your choice:** **Group average:**	1	2	3	4	5	6
109. When a doctor is cold to me, I feel like not asking questions but just leaving as quickly as possible. **Your choice:** **Group average:**	1	2	3	4	5	6
110. Patients like being able to speak with their doctors when they want to. **Your choice:** **Group average:**	1	2	3	4	5	6
111. Improving the quality of health care means self diagnosing and treatment. **Your choice:** **Group average:**	1	2	3	4	5	6
112. A doctor's beliefs about a patient does not influence the diagnosis of a health problem. **Your choice:** **Group average:**	1	2	3	4	5	6

Appendix K continued

113. A responsible patient insists on being seen and has a regular health follow-up schedule. **Your choice:** **Group average:**	1	2	3	4	5	6
114. Family doctors are rare these days. **Your choice:** **Group average:**	1	2	3	4	5	6
115. A patient can improve the quality of his/her health care by providing the doctor with a copy of problem list preferably prior to the scheduled visit. **Your choice:** **Group average:**	1	2	3	4	5	6
116. People do not like provider's scheduling to see many patients because it results in patients receiving poor care. **Your choice:** **Group average:**	1	2	3	4	5	6
117. Anyone with no health insurance has little or no chance for health care services. **Your choice:** **Group average:**	1	2	3	4	5	6
118. Patients waiting to see their doctor like it when they are told the doctor(s) is running late. **Your choice:** **Group average:**	1	2	3	4	5	6
119. Blacks' experience with the health care system makes some people seek only emergency care. **Your choice:** **Group average:**	1	2	3	4	5	6
120. Patients and families are left to guess what is going on in emergency rooms because the workers do not tell them. **Your choice:** **Group average:**	1	2	3	4	5	6
121. Sometime a patient may have to assert him/herself by demanding for the right tests in order to get the needed quality of care. **Your choice:** **Group average:**	1	2	3	4	5	6
122. Conducting research studies that advance progress on different diseases can improve the quality of care. **Your choice:** **Group average:**	1	2	3	4	5	6
123. Health insurance that covers 80% or more of health care expenses is preferable. **Your choice:** **Group average:**	1	2	3	4	5	6

Appendix K continued

124. Discussing patient's examination room findings with those outside of the exam room is disrespectful. 1 2 3 4 5 6
Your choice: **Group average:**

125. Rushing and giving incomplete answers to questions is anxiety raising for patients. 1 2 3 4 5 6
Your choice: **Group average:**

126. An option from the health insurance company to seek care anywhere can improve the quality of care. 1 2 3 4 5 6
Your choice: **Group average:**

127. Doctors can only order what the insurance will cover. 1 2 3 4 5 6
Your choice: **Group average:**

128. Quality health care is having the means to seek health care. 1 2 3 4 5 6
Your choice: **Group average:**

129. One can receive low quality care at a popular health care facility. 1 2 3 4 5 6
Your choice: **Group average:**

130. Doctors who do not like touching blacks perform incomplete and inadequate exams on such patients. 1 2 3 4 5 6
Your choice: **Group average:**

131. Quality health care is <u>not</u> related to the care provider's level of knowledge. 1 2 3 4 5 6
Your choice: **Group average:**

132. Some health insurance "...pays doctors to keep patients out of the hospital". 1 2 3 4 5 6
Your choice: **Group average:**

133. Asserting self means <u>settling</u> for less. 1 2 3 4 5 6
Your choice: **Group average:**

134. One needs variety of care experiences to decide the effect of racism on quality of care. 1 2 3 4 5 6
Your choice: **Group average:**

135. Blacks make health care choices based on what they have available to them. 1 2 3 4 5 6
Your choice: **Group average:**

Appendix K continued

136. Health insurance companies do not pay for pre-existing conditions. **Your choice:** **Group average:**	1	2	3	4	5	6
137. To be seen by a Nurse Practitioner when payment checks are made to the doctor is disrespectful. **Your choice:** **Group average:**	1	2	3	4	5	6
138. The way that the care provider does what s/he does (knows his/her job and expectations) does not influence the quality of care. **Your choice:** **Group average:**	1	2	3	4	5	6
139. People do not like to make payment at the emergency room when they are seeking care. **Your choice:** **Group average:**	1	2	3	4	5	6
140. Quality health care is responding to a patient's health problem when care is needed. **Your choice:** **Group average:**	1	2	3	4	5	6

APPENDIX L

MODIFIED DELPHI TECHNIQUE - End of Round 1

Appendix L. Modified Delphi Technique - End of Round 1

Main Ideas Category - # in Appendix J	N	Item retention % agreement	Mean Response	SD
Emergency room situation				
24 (positively rated statements)	18	81.9	4.68	1.42
38	18	81.9	4.50	1.37
120	17	85	4.65	1.13
101	20	90.9	5.27	1.03
9	21	95.4	5.41	1.00
Insurance				
7	19	86.4	4.68	1.29
117	9	42.9	3.14	1.65
88	15	68.1	4.55	1.26
106* (*: negatively worded statements)	16	72.7	4.55	1.57
123	17	77.3	4.64	1.73
Setting arrangements and popularity				
10	22	100.0	5.45	0.74
103	20	90.0	5.18	1.05
19	22	100.0	5.64	0.58
129	21	95.5	5.00	1.06
Cost/payment				
15	20	90.8	5.27	1.02
132	20	95.2	5.33	0.97
127	19	86.4	4.81	1.22
136	20	90.9	4.82	1.29
139	17	85	4.8	1.05
85	21	95.5	5.59	1.18

Appendix L continued

Main Ideas Category - # in Appendix J	N	Item retention % agreement	Mean Response	SD
Changes in health care				
1*	15	68.1	2.73	1.45
13	22	100	5.81	0.39
65	17	85	4.45	1.47
28*	19	86.4	5.27	1.64
29	19	86.4	5.14	1.17
114	20	90.9	4.96	1.09
Environment				
44*	19	86.3	5.09	1.63
97	21	95.4	5.32	0.89
93	22	100	6	0
73	18	81.9	4.68	1.43
107	22	100	5.96	0.21
56	20	100	5.5	0.61
53	17	77.3	4.59	1.40
Appointments				
47	16	72.7	4.41	1.47
57*	18	90	1.75	1.45
78	20	90.9	5.09	1.27
48	19	86.4	4.96	1.49
105	19	86.4	5.09	1.07
116	18	81.8	4.09	1.57
118	12	54.5	3.55	2.15
98	22	100	5.59	0.59

Appendix L continued

Main Ideas Category - # in Appendix J	N	Item retention % agreement	Mean Response	SD
Provider's beliefs/preconceived ideas				
112*	17	77.3	4.59	1.47
76	19	86.4	4.73	1.61
36	19	86.3	5.23	1.45
18	19	86.3	4.82	1.05
62	17	85	5.05	1.36
83	20	90.8	5.50	0.96
14	18	81.8	4.55	1.41
72	13	59.1	3.46	1.82
27	20	90.9	5.18	1.29
91*	10	45.4	3.36	1.62
22	22	100	5.59	0.73
Quality of care definition				
5	14	63.6	3.81	1.92
12	21	95.5	5.32	0.95
69	21	95.7	5.31	1.17
51	16	76.2	4.52	1.37
90	19	86.4	4.64	1.18
131*	16	76.2	4.76	1.81
140	19	95	5.4	1.23
128	17	77.3	4.5	1.43
96	19	86.4	4.73	1.49
67	19	95	5.35	1.14
55	13	68.4	3.89	1.59

Appendix L continued

Main Ideas Category - # in Appendix J	N	Item retention % agreement	Mean Response	SD
61	19	95	5.3	1.08
70	21	95.5	5.41	1.18
Treatment delay				
11	22	100	5.91	0.29
75	20	90.9	5.5	1.34
Interpersonal and communication processes				
81	21	95.4	5.36	1.22
87*	19	86.3	5.05	1.73
100	22	100	5.86	0.47
4	9	40.8	3.14	1.67
2	11	50	3.55	1.65
Respect/disrespect				
30	12	54.5	3.5	1.81
23*	14	66.7	4.48	1.72
137	13	65	3.95	1.43
124	18	81.8	4.96	1.68
79	15	68.1	4.46	1.95
Provider gender and preventive care				
25	15	68.2	4.23	1.72
110	20	95.2	5.43	1.12
Anxiety raising situations				
125	21	95.4	5.55	0.8
Choosing a new care provider				
52	6	27.3	2.55	1.92

Appendix L continued

Main Ideas Category - # in Appendix J	N	Item retention % agreement	Mean Response	SD
92	21	95.5	5.50	0.86
102	22	100	5.59	0.73
Racism and its effects				
26*	15	71.4	4.48	1.78
95	22	100	5.64	0.58
77	20	90.9	4.77	1.23
109	21	95.5	5.32	1.25
119	16	72.7	4.05	1.68
108*	18	81.8	4.64	1.62
134	13	59.1	3.46	1.68
86	20	90.9	5.14	1.21
130	19	86.4	5.00	1.38
42	16	72.7	4.41	1.79
Class issue				
40*	15	68.2	2.59	1.29
80	19	86.4	5.05	1.33
Employment/crime rate				
3	16	72.8	4.27	1.86
Family doctor issue				
54	15	68.2	3.91	1.93
Administrative issue and ethics				
21	20	90.9	5.23	0.97
59	19	95	4.9	0.85
6*	20	90.8	5.14	1.46

Appendix L continued

Main Ideas Category - # in Appendix J	N	Item retention % agreement	Mean Response	SD
17	20	91	4.86	1.13
89	16	76.1	4.19	1.40
64*	4	20	4.5	1.61
60	12	66.7	3.6	1.69
Shorter length of stay				
31	21	95.5	5.55	0.91
58	18	90	5.05	0.99
High and low quality care				
50*	22	100	1.14	0.35
8	15	68.2	2.73	1.61
84	21	95.4	5.14	1.25
82	21	95.4	5.36	0.90
104	22	100	5.41	0.79
Equal health care/universal concept				
63*	20	100	1.00	0.00
Differential treatment				
20	22	100	5.77	0.53
Patient's role in quality improvement				
41	17	77.3	4.59	1.56
115	20	90.9	4.96	1.25
113	20	95.3	5.38	1.16
16	22	100	5.68	0.65
33	22	100	5.81	0.39
121	19	86.4	4.68	1.46

Appendix L continued

Main Ideas Category - # in Appendix J	N	Item retention % agreement	Mean Response	SD
37	22	100	5.23	0.69
49	19	86.4	5.05	1.33
133*	20	90.9	5.36	1.29
46	21	99.9	5.00	0.84
111*	13	61.9	4.19	1.78
71*	19	86.4	1.77	1.60
32*	21	95.5	5.68	1.09
35	20	90.8	5.32	1.49
Provider's role in quality improvement				
43*	15	71.4	4.67	2.19
74	20	90.9	5.27	1.24
138*	14	73.7	4.37	1.46
99	22	100	5.50	0.74
Setting's role in quality improvement				
39	13	65	4.00	1.52
126	19	86.4	4.91	1.41
122	22	100	5.27	0.70
66	20	100	5.5	0.69
34*	15	68.1	4.55	1.85
Care of the elderly				
68	20	90.9	5.80	0.41
patient outcome				
45	14	77.8	4.33	1.41

Appendix L continued

Main Ideas Category - # in Appendix J	N	Item retention % agreement	Mean Response	SD
Minorities and research				
94*	14	63.6	4.14	2.15
Victim blaming				
135	19	86.3	4.77	1.41

APPENDIX M

MODIFIED DELPHI TECHNIQUE - End of Round 2

Appendix M. Modified Delphi Technique - End of Round 2

Main Ideas Category: # in Appendix J	N	Item retention % Agreement	Mean Response	SD
Emergency room situation				
24	17	89.4	4.84	1.30
38	15	79	4.31	1.38
120	16	84.2	4.58	1.12
101	17	89.5	5.47	0.96
9	19	100	5.42	0.77
Insurance				
7	17	89.4	4.79	1.32
117# (excluded)	5	26.4	2.68	1.38
88	13	68.4	4.47	1.22
106* (negatively worded statements)	16	84.2	4.79	1.48
123	15	79.0	4.74	1.63
Setting arrangements and popularity				
10	19	100	5.63	0.59
103	18	94.7	5.37	0.96
19	19	100	5.68	0.58
129	18	94.7	5.00	1.05
Cost/payment				
15	17	87.5	5.32	1.06
132	17	94.5	5.39	0.98
127	17	89.4	4.79	1.23
136	17	89.5	4.95	1.08
139	14	77.8	4.5	1.09
85	19	100	6.00	0.00

Appendix M continued

Main Ideas Category: # in Appendix J	N	Item retention % Agreement	Mean Response	SD
Changes in health care				
1* #	13	31.6	2.89	1.24
13	19	100	5.84	0.38
65	16	84.3	4.68	1.57
28*	18	94.7	5.63	1.17
29	17	89.5	5.11	1.24
114	19	100	5.16	0.89
Environment				
44*	17	89.4	5.37	1.30
17	18	94.7	5.00	1.00
97	19	100	5.37	0.76
93	19	100	6.00	0.00
73	17	89.5	5.00	1.00
107	19	100	5.95	0.23
56	19	100	5.37	0.59
53	15	79	4.74	1.19
Appointments				
47	16	84.3	4.79	1.39
57*	16	84.2	5.42	1.07
78	18	94.7	5.31	0.89
48	19	100	5.63	0.49
105	19	100	5.42	0.69
116	18	94.7	4.58	1.22
118#	9	47.4	3.26	2.08

Appendix M continued

Main Ideas Category: # in Appendix J	N	Item retention % Agreement	Mean Response	SD
98	19	100	5.68	0.48
Provider's beliefs/preconceived ideas				
112*	18	94.7	5.11	0.94
76	17	89.4	5.11	1.24
36	17	89.5	5.42	1.02
18	15	78.9	4.84	1.18
62	17	89.5	5.37	0.96
83	18	94.7	5.58	0.84
14	18	94.7	4.79	0.98
72	11	57.9	3.53	1.95
27	18	94.7	5.32	1.25
91* #	8	42.1	3.37	1.49
22	19	100	5.74	0.56
Quality of care definition				
5	13	68.4	3.63	1.67
12	18	94.8	5.26	0.99
69	19	100	5.47	0.69
51	16	84.2	4.42	1.26
90	17	89.6	4.68	1.20
131*	18	94.7	5.37	0.89
140	19	100	5.68	0.58
128	16	84.2	4.63	1.34
96	18	94.7	5.05	0.91
67	19	100	5.37	0.89

Appendix M continued

Main Ideas Category: # in Appendix J	N	Item retention % Agreement	Mean Response	SD
55	11	57.9	3.74	1.49
61	19	100	5.39	0.89
70	19	100	5.79	0.42
Treatment delay				
11	19	100	5.95	0.23
75	19	100	5.89	0.32
Interpersonal and communication process				
81	19	100	5.53	0.77
87*	18	84.8	5.47	1.22
100	19	100	6.00	0.00
4#	7	36.9	3.11	1.33
2	12	63.2	3.89	1.24
Respect/disrespect				
30	10	52.7	3.63	1.83
23*	14	77.8	4.78	1.48
137	14	72.8	4.00	1.33
124	18	947	5.47	0.96
79	14	73.8	4.84	1.71
Provider gender and preventive care				
25	14	73.7	4.32	1.64
110	19	100	5.58	0.61
Anxiety raising situations				
125	18	94.7	5.58	0.84

Appendix M continued

Main Ideas Category: # in Appendix J	N	Item retention % Agreement	Mean Response	SD
Choosing a new care provider				
52#	5	26.3	2.42	1.87
92	19	100	5.58	0.69
102	19	100	5.63	0.68
Racism and its effects				
26*	15	78.9	4.63	1.57
95	19	100	5.68	0.58
77	18	94.7	4.84	0.89
109	19	100	5.68	0.58
119	14	73.7	4.11	1.59
108*	17	89.4	4.84	1.43
134#	10	52.6	3.58	1.61
86	19	100	5.53	0.51
130	18	94.7	5.42	1.02
42	16	84.2	4.89	1.24
Class issue				
40*	15	79	4.58	1.26
80	19	100	5.32	0.89
Employment/crime rate				
3	17	89.4	4.68	1.34
Family doctor issue				
54	12	63.2	3.89	1.99
Administrative issues and ethics				
21	18	94.7	5.21	0.92

Appendix M continued

Main Ideas Category: # in Appendix J	N	Item retention % Agreement	Mean Response	SD
59	18	94.7	4.84	0.83
6*	17	89.6	5.16	1.57
17	18	94.7	5.00	1.00
89	17	94.4	4.67	0.91
64* #	15	78.9	2.53	1.71
60	10	55.6	3.33	1.33
Shorter length of stay				
31	19	100	5.74	0.45
58	18	94.7	5.05	0.91
High and low quality care				
50*	19	100	5.89	0.32
8	12	63.2	3.63	1.71
84	19	100	5.42	0.84
82	19	100	5.42	0.77
104	19	100	5.47	0.77
Equal health care/universal concept				
63*	18	94.7	5.74	1.15
Differential treatment				
20	19	100	5.79	0.54
Patient's role in quality improvement				
41	17	89.5	4.84	1.21
115	19	100	5.26	0.81
113	19	100	5.63	0.59
16	19	100	5.74	0.56

Appendix M continued

Main Ideas Category: # in Appendix J	N	Item retention % Agreement	Mean Response	SD
33	19	100	5.84	0.38
121	17	89.4	4.95	1.22
37	19	100	5.42	0.61
49	16	84.3	5.11	1.41
133*	19	100	5.73	0.56
46	19	100	5.26	0.81
111*	17	89.4	5.05	1.18
71*	18	94.8	5.68	0.82
32*	19	100	5.89	0.32
35	18	94.7	5.58	1.22
Provider's role in quality improvement				
43*	19	100	5.89	0.32
74	18	94.7	5.63	0.76
138*	16	89.9	4.83	1.04
99	19	100	5.53	0.69
Setting's role in quality improvement				
39	11	59.9	3.89	1.52
126	17	89.4	4.89	1.29
122	19	100	5.32	0.67
66	19	100	5.57	0.61
34*	15	79	4.95	1.39
Care of the elderly				
68	19	100	5.79	0.42

Appendix M continued

Main Ideas Category: # in Appendix J	N	Item retention % Agreement	Mean Response	SD
Patient outcome				
45	13	76.4	4.35	1.46
Minority and research				
94*	15	79	4.79	1.87
Victim blaming				
135	17	89.4	4.84	1.17

APPENDIX N

DIMENSIONS OF QUALITY OF CARE

Appendix N. Dimensions of Quality of Care
Patient/Consumer/Client Role

Inputs

Unemployment means no health insurance and high crime rate among blacks. (Appendix J # 3)
A patient can improve the quality of his/her care by knowing how to get through the health care system. (# 16)
One's racial background does not influence the quality of care that one receives (# 26)
Black men should not tell their doctors exactly what is going on with them. (# 32)
Black women can improve the quality of their care by not forgetting to take care of themselves while caring for their children, husbands, etc. (# 35)
Quality of health care may be influenced by the patient's societal position. (# 80)
A patient can improve the quality of his/her health care by providing the doctor with a copy of problem list preferably prior to the scheduled visit. (# 115)
Quality health care is having the means to seek health care. (# 128)
Blacks make health care choices based on what they have available to them. (# 135)
Elderly patients have less experience in managing their way through the health care system so they need assistance from care providers and their families. (# 68)

Processes

Asking questions and following health care instructions show that blacks care and are serious about their bodies. (# 33)
Asserting self means being frank with care providers. (# 37)
Teaching and role modeling for children on what they should do to keep healthy affects the quality of care that the people receive. (# 41)
A new doctor that is selected should be a person that you trust. (# 102)
Sometime a patient must insist that a care provider sees him or her. (# 105)
Most black doctors are not personable to patients and do not work in their communities as role models for young people. (# 108)
Improving the quality of health care means self diagnosing and treatment. (# 111)
A responsible patient insists on being seen and has a regular health follow-up schedule. (# 113)
Blacks' experience with the health care system makes some people seek only emergency care. (# 119)
Sometime a patient may have to assert him/herself by demanding for the right tests in order to get the needed quality of care. (# 121)
Asserting self means settling for less. (# 133)
Asserting self means asking doctors for referrals to experts. (# 49)
Asserting self also means that a patient does not allow a care provider to discount him/her. (# 46)
A patient cannot improve the quality of his/her care by educating him/herself on the health problem. (# 71)

Appendix N continued

Outcomes

Patients like being attended to by medical students. (# 44)
The outcome of care such as cured and outstanding bills must be considered in quality improvement. (# 45)
People tend to be most comfortable with health care providers from their own racial background. (# 77)
Quality health care is a patient's feelings about the care received. (# 96)
When a doctor is cold to me, I feel like not asking questions but just leaving as quickly as possible. (# 109)
Patients like being able to speak with their doctors when they want to. (# 110)
Patients do not like it when their doctors and staff know them by their names. (# 87)

Provider Role/Patient-Provider Interpersonal Relationship

A. Interpersonal Aspect of Care

Inputs

The beliefs that blacks are usually overweight and eat greasy foods may result in failure to properly examine and treat. (# 14)
A care provider's experience may influence how a patient is treated. (# 22)
The care provider's gender (sex) may influence diagnosis and treatment. (# 25)
Taking prescribed medication such as a narcotic for a chronic condition does not mean that one is a drug addict. (# 27)
Preconceived assumptions (including ideas about persons from a particular race, living location, socio-economic status) affect the quality of care that a person receives. (# 36)
Physicians should not educate themselves about black people and their common health problems. (# 43)
A surgery patient may not like the pressure associated with early discharge such as getting up and walking soon after surgery. (# 58)
A doctor's beliefs about a patient's age may influence the diagnosis of a health problem. (# 76)
Addressing an elderly black patient by his/her first name is disrespectful. (# 79)
A doctor's beliefs about a patient does not influence the diagnosis of a health problem. (# 112)

Processes

A doctor is cold to a black patient because s/he does not want to deal with such a patient (# 2)
Low quality care is doctors discussing what insurance will pay for. (# 8)
Today, patients are expecting care providers to use language that patients can understand. (# 13)
To say that a health problem that has been for a while does not need a "rush action"

Appendix N continued

discounts the problem and the patient's feelings. (# 18)

It is not disrespectful for a patient to wait for a doctor for no good reason on the doctor's part. (# 23)

The long wait in at the emergency room is because patient's view of emergency is different from the health care provider's. (# 24)

Voicing surprise when patient is able to express him/herself on the health problem at hand is disrespectful. (# 30)

The emergency room health workers do not tell patients/families why they are waiting. (# 38)

Class issues between care provider and assistant do not affect patients in a negative manner. (# 40)

Doctors who have problems touching black patients tend to ask a lot of questions and do more writing than touching. (# 42)

Patients prefer centralized health care settings where the workers know patients beyond their health problems. (# 53)

Changing insurance companies interferes with the bonding/trust between the provider and the patient. (# 54)

A patient may not follow direction for a new medication if the care provider assumes that the patients knows already. (# 62)

A care provider may not educate black patients because of the belief that blacks do not take pride in their health care issues. (# 72)

A doctor's choice of words can have a bad or good effect on the patient. (# 81)

A patient may not recognize the side effects of a new medication if the care provider assumes that the patient knows already. (# 83)

Today racism is covert and whites still receive better care than blacks. (# 86)

Discussing patient's examination room findings with those outside of the exam room is disrespectful. (# 124)

Rushing and giving incomplete answers to questions is anxiety raising for patients. (# 125)

Doctors who do not like touching blacks perform incomplete and inadequate exams on such patients. (# 130)

Quality health care is the patient-provider relationship. (# 90)

A patient prefers a doctor from any race who does not rush and give incomplete responses to questions. (# 92)

Untrained health care staff can be condescending impatient, ignoring, prejudicial, and stereotyping with patients. (# 95)

People like caring and nice health care workers. (# 100)

At the emergency room workers should consider the patient's bathroom needs and anxiety about the health problem. (# 101)

Patients and families are left to guess what is going on in emergency rooms because the workers do not tell them. (# 120)

Appendix N continued

B. Technical Aspect of Care

Inputs

Quality health care is not related to the care provider's level of knowledge. (# 131)

Processes

Wrong diagnosis can result in delayed treatment and permanent or long lasting disability. (# 11)

The way that the care provider does what s/he does (knows his/her job and expectations) does not influence the quality of care. (# 138)

Quality health care is responding to a patient's health problem when care is needed. (# 140)

Quality health care is the type of care that a patient receives. (# 5)

Those with health insurance may still receive low quality care. (# 7)

Quality health care is getting top-of-the-line or best treatment. (# 12)

Quality health care is how the health care treatment processes are done. (# 55)

Not everyone who seeks health care should be given the best possible quality care. (# 63)

Quality health care is getting to the root of the patient's health problem. (# 69)

Quality health care is having no hassle about seeing specialists when needed. (# 70)

Doctors should look for the uniqueness of each patient's situation rather than assume that things have to be the way they (doctors) were trained to see things. (# 74)

Poor examination of a patient may result in wrong treatment. (# 75)

High quality care is allowing a patient to see a specialist. (# 84)

Outcomes

Quality health care is to be treated/cured as best as possible. (# 67)

Going to the dentist and returning home with little or no pain is an advancement in medical care that people like. (# 98)

Setting Role

Inputs

The health care system is positively influenced by the U.S. society being a NOW society and one that puts money first before ethics. (# 6)

Elderly patients find it hard to handle when they are pushed fast through the system. (# 10)

Education of the public about health-care-related issues does not influence the quality of patient care. (# 34)

Health care setting's guidelines prevent delaying diagnosis, treatment, and allay a patient's anxiety about the health problem. (# 39)

There is a need for health care workers who look like me (black). (# 19)

People like it when the waiting room is not crowded. (# 56)

Quality health care is the conditions surrounding the type of patient care. (# 51)

Appendix N continued

Restructuring or re-organizing of the Food and Drug Administration (FDA) can improve the quality of patient care. (# 60)
Fewer doctors are in private practice today. (# 65)
Adequate qualified staff and available health information must be considered in quality improvement. (# 66)
People do not like 'public' health care settings where Medicare/Medicaid patients go because there are usually too many patients to be seen there and too few doctors. (# 73)
Health care providers at under-staffed settings may not attend to a patient's health care need. (# 103)
High quality care is being able to choose your own doctor. (# 104)
Family doctors are rare these days. (# 114)
People do not like provider's scheduling to see many patients because it results in patients receiving poor care. (# 116)
To be seen by a Nurse Practitioner when payment checks are made to the doctor is disrespectful. (# 137)
Doctors can only order what the insurance will cover. (# 127)
Health insurance that covers 80% or more of health care expenses is preferable. (# 123)
An option from the health insurance company to seek care anywhere can improve the quality of care. (# 126)
High quality care is talking with a patient about health problem(s) first and then cost later. (# 82)
Health insurance companies do not pay for pre-existing conditions. (# 13)
People do not like to make payment at the emergency room when they are seeking care. (# 139)
The type of treatment that one gets does <u>not</u> depend on the type of insurance coverage. (# 106)

<u>Processes</u>

Seeing more patients means more money, so care providers spend a short time with each patient. (# 15)
The health care system is negatively influenced by the U.S. greater financial expenses on defense more than on health care. (# 17)
At the emergency room, time and life are saved when stab wounds are attended to first before paper work. (# 9)
People do not like the idea that some patients receive better health care than others. (# 20)
People do not like scheduling appointment several weeks later than they need them. (# 48)
<u>High</u> quality care is <u>rushing</u> patients out of hospitals. (# 50)
People do <u>not</u> mind the long waits during appointments. (# 57)
Quality health care is considering patient's health problem(s) first before cost. (# 61)
People should not be kept waiting more than 15 minutes for an appointment. (# 78)

Appendix N continued

Anyone without insurance may receive only minimal health care that may relief discomfort for only a short time. (# 88)

Patient do not like anxiety-raising situations in the health care settings while waiting to be attended to. (# 97)

Conducting research studies that advance progress on different diseases can improve the quality of care. (# 122)

Health care providers can improve the quality of care by talking to people about prevention, education, and engaging with the community through organizations like churches and Lions. (# 99)

Patients like it when the insurance company pays for things such as eye glasses. (# 85)

Some health insurance "...pays doctors to keep patients out of the hospital". (# 132)

One can receive low quality care at a popular health care facility. (# 129)

Outcomes

People do not like the paper work associated with visits where they receive health care. (# 47)

The level of care has gone down from what it used to be. (# 29)

Patients are having longer length of stay at the hospital. (# 28)

These days, patients are discharged sooner from hospitals because insurance companies require early discharge. (# 31)

The health care system is negatively influenced by conflicts of interest with management personnel. (# 59)

The health care system is negatively influenced by mis-management of funds. (3 21)

The health care system is negatively influenced by the U.S. failing to take examples from other Western countries. (# 89)

People do not like dirty, shabby, and smelly health care environments. (# 93)

Excluding blacks from life-saving related research studies does not influence the quality of their health care. (# 94)

People like or are pleased with a clean and conveniently located health care environment. (# 107)

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