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LGBTQ Patient Funding and Satisfaction on Patient Volume and Hospital Revenue

Kourtney Denise Carter
Walden University

Walden University

College of Health Professions

This is to certify that the doctoral study by

Kourtney Carter

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Dr. Mary Garbowski, Committee Member, Health Sciences Faculty
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Sue Subocz, Ph.D.

Walden University
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Abstract

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Kourtney Denise Carter, LCSW

MSW, Clark Atlanta University, 2010

BS, Morgan State University, 2008

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Healthcare Administration

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Abstract

Historically, the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community has reported low patient satisfaction for health care. The purpose of this quantitative study was to examine the statistical relationship between patient satisfaction among LGBTQ patients (independent variable) and patient volume and hospital revenue (dependent variables) in the U.S. state of Georgia. The study was grounded on Andersen's model of healthcare utilization. Two research questions guided this study related to the statistical relationship between hospital revenue and patient satisfaction within health systems and the statistical relationship between patient satisfaction and patient volume. The study included 567 members of the LGBTQ community in Georgia. Secondary data were collected from the EMMA and CMS Reports in inpatient health care systems. The correlation coefficient and the Pearson's product-moment correlation coefficient (Pearson's *r*) were used to check relationships among the variables to explore the impact of patients' perceptions on hospital revenue and patient volume among members of the LGBTQ community. Two null hypotheses were tested and none were rejected. No statistical significance existed between patient satisfaction and patient volume among LGBTQ patients. Secondly, no statistically significant relationship existed between patient satisfaction and patient funding among LGBTQ patients. No statistical relationship existed between LGBTQ patient satisfaction and hospital revenue. The results of this study contribute to positive social change by empowering healthcare facilities and providing data that may be applicable to health systems facing patient satisfaction challenges, specifically within the LGBTQ community.

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Dedication

I would like to dedicate this body of work to my mother, Deborah D. Carter, MPH. Thank you for your love, wisdom, and guidance. Thank you for always seeing more in me than I sometimes saw in myself. The legacy continues.

Acknowledgments

Mason and Kamden, you are both my absolute favorite parts of me; and there is nothing that I would not do for you. I want to thank you for taking this journey with me. I know it has not been easy, and there were moments where my time was limited. Success takes work, but there is freedom in success. Freedom to leave a legacy, freedom to create amazing memories with you, and freedom to help and teach others. I loved you before I met you…

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Section 1: Foundation of the Study and Literature Review

Introduction

Members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community around the globe are subjected to vulnerabilities, often resulting in increased bias in legal, societal, and health care systems. Medical and social discrimination, marginalization, and inequality pervade LGBTQ communities (Ayhan et al., 2020). A research report from the Center for American Progress indicated that the members of the LGBTQ community across the United States continue to experience pervasive discrimination that negatively impacts virtually every aspect of their day-to-day lives (as cited in Gruberg et al., 2020). An increasing number of studies have also revealed that individuals and groups identifying as LGBTQ experience higher rates of discrimination when seeking medical care (M. Morris et al., 2019; Safer et al., 2016; Seelman et al., 2017). A recent national public opinion study conducted by the Center for American Progress indicated that about 15% of LGBTQ people in the United States postpone or avoid medical treatment due to discrimination, and one in three must explain themselves more than is necessary to receive appropriate care and treatment in medical facilities (as cited in Gruberg et al., 2020).

Marginalization and prejudice in health care affect members of the LGBTQ community at disproportionate rates, often resulting in severe psychosocial trauma and poor health outcomes (Rodriguez et al., 2018). In response to profound negative attitudes and treatment that pervade the U.S. society, LGBTQ people tend to assume certain subtle but profound behaviors, often concealing their authentic identities and hiding their

personal relationships to minimize the risk of being subjected to discriminatory and traumatic experiences while seeking medical care (Gruberg et al., 2020). Historically, the LGBTQ community in the United States has been forced to delay or shelf altogether seeking medical care, owing to stigmatization and judgment in health care settings. Some are faced with harassment and refusal of care, while others fear disclosing their sexual orientation to providers (Bosia et al., 2020; B. Morris, 2021).

In Georgia, United States, discrimination against members of the LGBTQ community, based on their sexual orientation, has recently been illegalized under federal and state sex-based protections (Moreau, 2020). However, homophobia (fear, hatred, mistrust, and discomfort with LGBTQ individuals), even within medical and health care facilities, is commonplace in the state of Georgia. Georgia is still predominantly a conservative society, at least as far as sexual orientation is concerned, and LGBTQ individuals often do not feel protected. Discrimination, attacks, blackmail, and threats characterize their everyday life (Stepleman et al., 2019). Georgia is still struggling to implement statewide laws and policies addressing homophobia in response to recent court rulings including now allowing for LGBTQ inclusion in state Medicaid coverage, which was for a long time disallowed (Mallory et al., 2017). The American Civil Liberties Union reported that Georgia is one of 10 states that bans transgender adults from receiving gender affirming care under Medicaid (Saxe, 2019)

The negative experiences faced by members of the LGTBQ community have forced them to avoid seeking medical care from health facilities that are insensitive to their needs and to seek services from gender-sensitive care facilities (Nguyen et al.,

2018). The negative social attitudes and discrimination against the members of the LGBTQ community present adverse impacts on patient satisfaction, which affect the hospital volume and profitability. The decrease in revenue as members of the LGBTQ community seek services from competitors affects reputation and patient satisfaction (Martos et al., 2017). Patient satisfaction is an integral tool that helps health care facilities to attract patients, create revenue, and enhance the brand reputation. As noted, members of the LGBTQ community are forced to seek medical attention to specific health facilities, which are sensitive to their needs, devoid of discrimination, and employ cultural sensitivity trainings to their staff (Bosia et al., 2020).

In this chapter, I present the background, the purpose of the study, and the problem statement. Additionally, I examine evidence-based research questions, hypotheses, and the theoretical and conceptual framework. Furthermore, in this chapter I address key terms, the nature of the study, and the literature search strategy. I end the chapter with a discussion of the summary of key findings.

Background

The significance of culturally competent care and the quality of services provided to individuals who identify as LGBTQ has attracted attention from local and federal leaders, as well as health care administrators. Countries are opening to the idea that the LGBTQ community indeed faces challenges in accessing medical and health care services (van den Berg & Akingbola, 2019). As such, some healthcare organizations are committed to improving the quality of care and services to members of the LGBTQ community. The health risks specific to members of the LGBTQ community have been

identified by the health department, and efforts in creating awareness on the gender identity and sexual orientation among health care practitioners are underway (Ayhan et al., 2020).

Arguably, increased awareness is needed, as well as education concerning competent care that is culturally appropriate as it responds to the needs of members of the LGBTQ community. Increasing awareness within providers and health care employees is integral in providing inclusive clinical needs and informed care to patients regardless of their sexual orientation. Studies have shown that homophobia and discrimination pose health risks and outcomes for members of the LGBTQ community (Chakraborty, 2020; Materla et al., 2019). According to Siegel et al. (2017), the stressors related to stigmatization and discrimination towards the section of minority community causes them to avoid health care facilities that are insensitive to their needs. Moreover, individuals and organizations who are not supportive of the LGBTQ community affect access to care and patient outcomes.

As such, members of the LGBTQ community are concerned with the attitude of health care practitioners to address their needs, which affects their comfort to disclose sexual identity (Chakraborty, 2020). Indeed, members of the LGBTQ community are at risk of being denied appropriate and specific health care. The quality of care provided to members of the LGBTQ community plays an integral role in enhancing their satisfaction (Nguyen et al., 2018).

Research on the quality and provision of health care services among members of the LGBTQ community have been conducted, but comparatively, a gap exists in the

literature addressing the impact of patient satisfaction, patient volume, and hospital revenue (van den Berg & Akingbola, 2019). Nonetheless, though researchers have investigated this issue, a notable gap exists in the literature on patient satisfaction within the LGBTQ community. Despite the recognized role of LGBTQ inclusive and supportive policies, studies that addressed patient satisfaction scarcely address the impact of satisfaction of members of the LGBTQ community on hospital revenue and patient volume (Banwari et al., 2015).

As such, this study provides insights for health care facilities to develop measures and strategies that attract patients from the LGBTQ community who play a role in improving the revenue and patient volume. Identifying a blueprint to improve patient satisfaction among minority patients will enable the organization to devise critical strategies that can improve the patient experience, margin, and volume from members of the LGBTQ community. As such, health care facilities can understand the effective strategies and evaluate the overall continuum of the experience from patients among members of the LGBTQ community (Rodriguez et al., 2018).

Patient satisfaction plays an integral role in enhancing the success of the organization. Patient satisfaction helps in increasing patients' loyalty, which improves the brand reputation. Highlighting the importance of patient satisfaction is beneficial to the organization as it facilitates an increase in patient volume (Simons et al., 2013). In hospitals, patient satisfaction helps in improving patient retention, influencing the volume of patients seeking service from an organization. Organizations that do not nurture and engage patients with regards to unique identifiers, such as sexual orientation and

expression, tend to drive patients away to competitors. Moreover, patient satisfaction improves staff morale and reduces employee turnover, thus increasing productivity (Siegel et al., 2017).

Happy workers tend to care for their patients well, leading to reduced errors, complaints, and malpractice, which positively affects the hospital's reputation (Chakraborty, 2020). As such, increased customer satisfaction plays an integral role in increasing the number of patients visiting the facility. Similarly, an increased number of patients visiting a facility translate to a rise in revenue (Padela & Punekar, 2009). Patient satisfaction is an important and commonly used indicator for measuring the quality in health care. Patient satisfaction affects clinical outcomes, patient retention, and medical malpractice claims. In addition, health care practitioners who provide patients with quality services that are of high quality prevent cases of litigation (Materla et al., 2019). The reputation of an organization affects its bottom-line by limiting the amount of funding that an entity receives from Medicare and payers. In essence, the reputation of the company among the consumers affects the revenue because it determines the number of patients visiting a health care facility (Mehta, 2015).

Problem Statement

The problem is a gap existed in the literature addressing patient satisfaction of members of the LGBTQ community related to their health care. Historically, members of the LGBTQ community have reported not undergoing annual screenings as well as annual and follow-up care for fear of judgment by providers and staff members in both inpatient and outpatient settings (B. Morris, 2021). Members of this community typically

only seek treatment from providers who identify as LGBTQ friendly. As a result, members of this community typically report low patient satisfaction within health care systems. Patient satisfaction is a central objective of health care providers because it relates directly to increase patient volume, patient retention, clinical outcomes, and reimbursement claims (Akinleye et al., 2019; Chen et al., 2019; Liu et al., 2021; Richter & Muhlestein, 2017). Patients are aware of the quality of care that health care providers offer to members of the LGBTQ community, owing to the prevalence of the use of social media platforms. The patients in this community are setting new expectations for health care facilities for collaboration, transparency, and convenience; hence, health care facilities are developing new approaches to meet the new demands (Nilmini, 2019). Studies have shown that creating a culture on patient experience requires developing a data-driven patient-focused culture premised on service quality, compassion, and transparency. Organizations are expected to develop new strategies and tools that improve the experiences of patients from members of the LGBTQ community (Martos et al., 2017).

Currently, a gap exists in the literature exploring the impact of patient satisfaction among the members of the LGBTQ community on patient volume and hospital revenue (Bentz et al., 2010). Of the few studies that do exist, results have indicated that patient satisfaction among the members of LGBTQ community causes loyalty within health systems (Chakraborty, 2020; Materla et al., 2019; van den Berg & Akingbola, 2019). As such, the current study provides insight on strategies that organizations should develop to increase patient satisfaction, increase patient outcomes, and reduce discrimination against

members of the LGBTQ community (M. Morris et al., 2019). According to C. Wilson and Cariola (2020), this gap in the literature provides a basis for further research in improving patient satisfaction among the members of the LGBTQ community.

Patients from this community are forcing the health care industry to change their practices to include their concerns on safety and promote antidiscrimination. As such, patient satisfaction among the members of the LGBTQ community is an integral element in the quality of care offered by providers (C. Wilson & Cariola, 2020).

Purpose of the Study

The purpose of this quantitative study was to examine the statistical relationship between patient satisfaction among LGBTQ patients (independent variable) and patient volume and hospital revenue (dependent variables) in the state of Georgia, United States, based on the Electronic Municipal Market Access (EMMA) and Centers for Medicare and Medicaid Services (CMS) data from 2010 to 2020.

Research Questions and Hypotheses

The research questions for this research addressed the impact of patient satisfaction among members of the LGBTQ community on improving the patient volume and hospital revenue. The quantitative element of the research requires the development of a testable hypothesis. Hence, the research questions and hypotheses are as follows:

Research Question (RQ)1: Based on the EMMA and CMS data (2010–2020), what is the statistical relationship between hospital revenue and patient satisfaction within health systems among LGBTQ patients?

$H_0$1: Based on the EMMA and CMS data (2010–2020), there is no statistically

significant relationship between hospital revenue and patient satisfaction among LGBTQ patients.

H_a1: Based on the EMMA and CMS data (2010–2020), there is a statistically significant relationship between patient volume and patient satisfaction among LGBTQ patients.

RQ2: Based on the EMMA data (2010–2020) CMS reports (2010–2020), is there a relationship between patient satisfaction and patient volume among LGBTQ patients?

H_02***:*** Based on the EMMA and CMS data (2010–2020), there is no significant statistical relationship between patient satisfaction and patient volume among LGBTQ patients.

H_a2: Based on the EMMA and CMS data (2010–2020), there is a significant statistical relationship between patient satisfaction and patient volume among LGBTQ patients.

Theoretical Framework

The study was grounded on Andersen's model of healthcare utilization. This model is used to help discover conditions that either prevent or impede an individual's ability to utilize certain health care facilities or services offered to individuals. This model is used to help discover conditions that either prevent or impede individuals' ability to utilize certain healthcare facilities or services offered to them. The model uses four phases to determine individuals' access to a facility and what characteristics of said facility or individual are preventing them from utilizing the services offered that are meant to help better their health (Andersen, 1995; Andersen & Newman, 2005).

Those using Andersen's model of healthcare utilization can examine the four different stages and assess where the problem lies with the facility so that they might find a solution to better the type of care they are offering certain individuals. This framework draws attention to both gender expression and sexual orientation, and how a person's chosen identity may influence how others perceive and engage with the individual (Martos et al., 2019). Attention is given to predisposing factors that might cause biases to the type of care an individual may receive. Such work draws attention to, even temporarily, instances within the ceaseless movements and flows of identity and difference (Hirshfield et al., 2018). The resulting realization of certain individuals' inability to look beyond predisposing factors such as age, gender, sexual orientation, and race will draw attention to the issues within the health care community relating to treating patients with an unbiased attitude that will provide them with the best possible care (Andersen, 1995; Andersen & Newman, 2005; Travers et al., 2020).

Aday and Andersen's (1981) work on health care utilization affirms that receiving health care that could properly treat individuals no matter their characteristics or circumstances is a human right and not a privilege, which came from larger ideas that all individuals should be treated equally. In other words, individuals should not receive subpar health care because of factors unique to their identity. Aday and Andersen refused to accept that health care could be denied or inadequate because an individual did not adhere to certain social standards. Analyzing Andersen's model of healthcare utilization can help determine why some members of the LGBTQ community feel they are not treated fairly when seeking care in local health systems. Anderson’s model was not

created with a certain group of people in mind, but it can be used to help solve this problem between health systems and the LGBTQ community. Andersen's model of healthcare utilization can also be used to evaluate other factors such as logistical aspects and need factors to determine if poor satisfaction of health care coming from the LGBTQ community is solely based on the type of care they feel they are receiving based on their identity, or if it has to do with other contributing factors (Travers et al., 2020).

The logical connections between the framework presented and the nature of this study included Andersen's model of healthcare utilization, which provides a framework that permits systematic identification of factors that influence individual decisions to use or not use available health care services. With its focus on providing the best possible health care to individuals despite their characteristics, this study helps to ensure that providers in participating health systems within Georgia are trained to treat members of the LGBTQ, thus increasing patient volume and revenue (see Travers et al., 2020). Additionally, Anderson's model outlines how prejudices toward members of the LGBTQ community contribute to poor patient satisfaction among this population, causing members of this community to utilize health systems in which they are comfortable (Aday & Andersen, 1981). Additionally, Griffith (2000) noted that value-based care has set the premise within health systems to provide quality health care at lower costs. The demand is increasing for quarterly and annual data on organizational quality and patient satisfaction.

Balanced scorecard approaches will allow integrated health systems and their accountable workgroups to track performance on several dimensions and establish goals

or targets based on current data trends. Health systems with consistently good scores will be labeled as champions, demonstrating to patients, stakeholders, and mirroring organizations their commitment to organizational and patient success (Andersen & Newman, 2005). Simons et al. (2013) noted a relationship between leadership and safety, as well as satisfactory financial performance in health care management. The health care triple bottom line focuses on ensuring employee and patient safety, maximizing employee and patient satisfaction, and meeting financial goals. Innovative leadership is critical to ensure these goals are met. The current study provides a scholarly overview of the relationship between effective leadership and the triple bottom line (Hudson et al., 2018).

Nature of the Study

This study was a quantitative correlational study using secondary data collected from EMMA, which was last updated on March 13, 2021, as well as from CMS (2020) reports. I focused on data documented in the EMMA and CMS between 2010 and 2020. Correlational research is an integral nonexperimental study that helps the researcher to establish a relationship between variables and explore their statistical relationship with no need for controlling extraneous variables (Jolley, 2020). The study was a positive correlational study as the increase in patient satisfaction causes a rise in patient volume and hospital revenue. The key variables included patient satisfaction as independent variables, while patient volume and hospital revenue were dependent variables (see Polit & Beck, 2020). In addition to the data collected from EMMA and CMS data, this study included data from the American Hospital Directory to accurately determine patient volume.

Literature Search Strategy

For the study, I reviewed peer-reviewed articles on the impact of patient satisfaction among members of the LGBTQ on patient volume and hospital revenue. To establish the previous findings on the topic, I used reputable websites such as Google Scholar, CINAHL, EMBASE, PubMed, Cochrane Library, and Medline using keywords that included *patient satisfaction, hospital volume,* and *hospital revenue*. The search strategy integrated search terms such as *LGBTQ, health disparities, patient outcomes, increasing diversity, health administration, health system revenue,* and *organizational performance* from databases that included EBSCO Host, Walden University Library, and CMS.Gov. The search on the impact of patient satisfaction among the members of the LGBTQ focused on the articles within the last 5 years to supplement literature on issues affecting the LGBTQ community in the last 15 years.

Literature Review

Barriers to the LGBTQ Utilization of Health Care

Surveys have shown that millions of American adults identify with the LGBTQ population (Ruberg & Ruelos. 2020). Compared to the rest of the population, LGBTQ individuals have a high risk for certain diseases and health conditions, including prostate, cervical, endometrial, breast, anal, colorectal, and lung cancers (Carroll, 2016; Tamargo et al., 2017; Williams et al., 2020). For instance, according to Bentz et al. (2010), transsexuals have a higher risk of being diagnosed with breast cancer because of cross-sex hormone therapy. Specifically, cross-sex hormone therapy causes both up-regulation of 243 and down-regulation of 2,007 distinct genes, which then contribute to the gene

expression of breast cancer (Carroll, 2016; Tamargo et al., 2017; Williams et al., 2020). This means that these patients require health care services at the best opportunities they can get. However, research has shown that about 30% of these patients do not have access to or do not seek health care due to various factors (Jaffe, 2020).

Lack of Insurance Coverage

One key reason members of the LGBTQ community do not have access to or do not seek health care is the lack of insurance coverage (Gruberg et al., 2020). According to Buchmueller and Carpenter (2010), married heterosexual individuals have higher rates of insurance coverage compared to individuals in the same-sex setup. Men in same-sex relations experience even more problems. With a lack of insurance, they have numerous unmet medical needs, even if they undergo annual checkups.

One of the reasons for these findings is that gay men may have different health care needs compared with heterosexual men. This difference in needs forces many of them to look for care from different facilities and institutions. Bentz et al. (2010) evaluated gene expression signatures of the breast in female compared to male transsexuals under cross-sex hormone therapy. Bentz et al. reported that those who engage in cross-sex hormone therapy have an increased risk of developing breast cancer. Because of these complications, ongoing follow-up appointments involving ultrasounds are recommended, and all follow-up appointments should be completed under a provider and/or health system that identifies as LGBTQ friendly (Stall et al., 2020).

High Cost of Medical Care

The findings of Bentz et al. (2010) are integral in this study as they highlighted

that members within this community are more inclined to receive care from health systems who identify as LGBTQ friendly. Thus, health systems and/or providers who are not recognized as LGBTQ friendly will likely not generate revenue from this community. Bentz et al. also highlighted the need for ongoing cultural competency within all health systems to ensure comfort and healthy rapport amongst patients and providers. The findings of Bentz et al. could explain why the cost of health care amongst the LGBTQ population is somehow high, which would not be affordable to some without insurance. Thus, the second barrier towards access and utilization of health care amongst this community is high cost.

Scarcity of Health Care Competency in LGBTQ Needs

The third reason identified in the research for members of the LGBTQ community not having access to or not seeking health care is the scarcity of health care personnel competent in LGBTQ health (Banka et al., 2015). As Banwari et al. (2015) found, very few health care professionals have undergone competency training to meet the unique needs of this community. As it appears, medical school curricula do not address discrepancies in sexuality and health. Very few formal reports and medical publications on the same topic exist, which means medical students are left to grapple on their own on regarding how they should handle the treatment of LGBTQ community members. Banwari et al. pointed out that more knowledge and competency will lead to more positive attitudes towards this group.

Stigmatization

The fourth reason members of the LGBTQ community do not have access to or

do not seek health care is stigmatization. According to Bradford et al. (2013), members of the LGBTQ community face a higher rate of discrimination not only in health care but also in housing and employment. Some members of the LGBTQ community have been denied access to care and face hardships finding care, simply for being a member of this community (Bradford et al., 2013). When they are discriminated against in health care, LGBTQ individuals will not access important and quality health care or will be afraid of attaining it because of the discrimination they expect to face. Apart from discrimination, some of them may be attacked physically for their identity. Altogether, this devaluation and oppression from stigmatization becomes stressful (Gruberg et al., 2020).

As Bockting et al. (2013) reported, LGBTQ individuals experience higher psychological distress and what is referred to as minority stress. This kind of stress is unique, and members of the LGBTQ community encounter it in additional to normal stressors. Minority stress is chronic and socially based as it comes from being discriminated against and rejected. Minority stress can only be solved through self-acceptance, social support, and the acceptance of their identity by mainstream society (Bockting et al., 2013).

Bockting et al. (2013) explored stressors unique to a geographically diverse sample of the U.S. transgender population. Findings reflected high episodes of clinical depression, anxiety, and somatization. The social stigma was positively associated with psychological distress. Data reflected that individuals who identified as transgender were less likely to seek counsel, yet they were more likely than their heterosexual counterparts to suffer from clinical depression and other mental health disorders. Bockting et al.

supported the present study as they revealed proven needs based on statistical findings to improve access to mental health and social services to transgender individuals.

Lack of Trust

The fifth reason members of the LGBTQ community do not have access to or do not seek health care is a lack of trust in the healthcare personnel due to a lack of knowledge regarding LGBTQ needs. More so, some personnel show negative attitudes towards members of this community. Banerjee et al. (2018) established that indeed health care personnel often do not have enough knowledge about health care surrounding the LGBTQ community, including the risk of suicide, cancer, HPV, and avoidance of health care. If health care professionals have more knowledge of these items, they will likely have positive beliefs towards this community, encourage them to seek health care, and communicate with sensitivity.

Consequently, Banerjee et al. (2018) called for training of oncologists to improve communication and general delivery of health care towards the community. Padela and Punekar (2009) also advised on the following to ensure quality health care delivery to minority groups: (a) increase cultural awareness amongst providers to reduce bias and promote interaction with all patient populations; (b) cater to all patient needs and preferences without discrimination via cultural modifications and practice adjustments; and (c) increase the diversity amongst health care personnel to promote understanding, tolerance, and awareness or differences. Banerjee et al. examined if health care providers specific to the oncology population were knowledgeable in communicating with LGBTQ patients and addressing needs unique to this community. Cultural competency amongst

religion, gender, sexual orientation, and gender identity were evaluated through this study. Banjerjee et al. found that health care providers were not knowledgeable in providing culturally competent care to members of the LGBTQ community. These findings are important to the current study as they highlight the need for ongoing training within health systems to ensure they can appeal to and retain patients within the LGBTQ community.

Patient Satisfaction

Patient satisfaction has become a very important concept in the modern delivery of health care. According to Al-Abri and Al-Balushi (2014), a definition of patient satisfaction in Donabedian's model of quality measure includes a patient-reported measure of outcomes. Patients can report their perception of the care services, their feelings, as well as emotions during the process. Today, measuring patient satisfaction has become important as one way of allowing health care organizations to improve their services, make better decisions, reduce cost, monitor their performance, provide benchmarks for other hospitals, and meet patients' expectations (Griffith, 2000). For patient satisfaction to be achieved, patients must be involved as partners in the institutions. When it comes to the determinants of patient satisfaction, Al-Abri and Al-Balushi mentioned respect, courtesy, ease of access, and effective listening amongst health care personnel as some of the strongest drivers of patient satisfaction. Others may include the cleanliness of the hospital, the physical environment, the process of admission, as well as overall physician care.

According to Griffith (2000), stakeholders in a health care institution will put

pressure on its leaders by demanding data on both patient satisfaction and quality. Stakeholders include the government, shareholders, managers, employees, patients, and the community being served. A higher satisfaction means that patients are getting quality health care for their money.

Some of the very first institutions that demanded quality include the National Committee on Quality Assurance as well as the Joint Commission on Accreditation of Healthcare Organizations. A common approach to ensuring quality care and higher patient satisfaction is the balanced scorecard to track performance on targets and many dimensions. Institutions that attain high scores constantly are considered champions (Hudson et al., 2018). Simons et al. (2013) also posited that health care institutions are evaluated with the triple bottom line comprising of whether ensure both patient and employee safety, maximize both patient and employee satisfaction, as well as meet financial objectives. Meeting these three aspects, however, is increasingly becoming harder because of increased costs of health care, complex medical interventions, and the higher burden of chronic diseases. Consequently, Simons et al. suggested the need to use leadership to address the triple bottom line.

Health systems can use several models to measure patient satisfaction. One described by Materla et al. (2019) is the Kano model, which makes it easy to identify patient needs. Specifically, this model prioritizes features of products or services based on their likelihood to satisfy clients. If it can lead to high satisfaction, then the cost of implementation can be reviewed to make its implementation a strategic decision. In this case, health care institutions can use the Kano model to identify factors that will lead to

higher satisfaction amongst LGBTQ patients. Implementing these factors will be the first step towards helping improve health care delivery to this population (Materla et al., 2019).

Banka et al. (2015) discovered that patient satisfaction can lead to not only better health outcomes for patients but also greater compliance amongst the hospitals. Modern hospitals are motivated to improve their patient satisfaction as it can lead to better reimbursement. According to Padela and Punekar (2009), emergency department staff need to be able to provide quality care to all patients admitted and/or triaged through the emergency department. In an increasingly diverse patient population, language differences, socioeconomic circumstances, religious values, cultural practices, and sexual preference may present barriers to the delivery of quality care. Increasing cultural competency has been cited as a way to reduce disparities as well as frequent readmission. Reports have indicated that one in five elderly patients were readmitted to the hospital within 30 days of discharge, costing Medicare $15 billion per year (Padela & Punekar, 2009). Of health systems involved in this study, 82% of health systems involved in this research received a financial penalty of some sort (Advisory Board, 2019; McIlvennan et al., 2015; L. Wilson, 2019).

Patient Satisfaction and Patient Funding

A debate exists about the role of funding and patient satisfaction. The American health care system is financed through public funding, private funding, and out-of-pocket funding. Publicly funded health care is a form of health care financing designed to meet the cost of all or most health care needs from a publicly managed fund (Schreck, 2020).

Public funding is implemented through Medicaid and Medicare, which are the largest government insurance programs. Medicaid health coverage is offered by both state and federal governments to individuals with a very low income (CMS, 2020). Medicare, on the other hand, is a federal government facility that provides health coverage to individuals under age 65 with a disability and to individuals over age 65, no matter their level of income (CMS, 2020).

Private funding refers to insurance purchased from for-profit and not-for-profit insurance companies. The biggest share of private insurance is purchased by corporate firms as employee benefits with employers and employees typically sharing the costs. This funding is not considered taxable and is subsidized to some degree (Achdut, 2019). Private individuals may also purchase private health insurance themselves. The Patient Protection and Affordable Care Act (or Affordable Care Act) legislation, among other things, enhanced the availability, affordability, and use of private health care funding (Schreck, 2020). Through the Affordable Care Act, private funders are subjected to government-regulated, standardized health insurance exchanges, where they list their health plans and people consider and shop for the available options comparing prices, benefits, services, and quality (Crowley et al., 2020).

Out-of-pocket refers to the spending or expenditure borne directly by individuals or households where insurance does not cover the full cost of the health care. Private individuals or households pay directly for health care through cost-sharing, self-medication, and other expenses. Private individuals and households pay out of their own funds when expenses are not covered by other sources, using their savings, fundraising,

or borrowing on credit (Schreck, 2020). Some employers offer flexible spending accounts where some amount of money is deducted from employees' income to pay for out-of-pocket health care expenses. This amount is not subjected to federal income taxes, does not earn interest, and is not returned to an employee who does not use it by the end of the year (Achdut, 2019).

The focus of this study is on the impact of patient satisfaction on patient volume and hospital revenue. The United States is the largest health care spender in the world. A large share of health care spending comes from the federal government. National Health Expenditure grew 4.6% to 3.8 trillion in 2019 or an annual increase of $11,582 per person and accounted for 17.7% of gross domestic product (Crowley et al., 2020). This level of expenditure is more than double the average among developed countries. The federal government funded an estimated $2 trillion of this total directly or indirectly. This allocation represents nearly 8% of the national economy resources directed toward health care. By 2028, health care funding is expected to rise to $6.19 trillion, or 19.7% of the gross domestic product (CMS, 2020; Martin et al., 2021).

There is a strong relationship between cost and coverage. Out-of-pocket and private spending are higher in the United States (Achdut, 2019). West Health (2019) and Gallup, the global analytics and advice firm, reported that the impact of out-of-control healthcare costs is indisputable, although Americans' feelings about their healthcare system are complicated and at times conflicted. Witters, Gallup senior researcher reported:

> At a macro level, large numbers think healthcare in America is among the best in the world, but on an individual basis, most agree they are paying too much and getting too little in return, and they are worried not only for themselves but for the country. (West Health, 2019, para. 7)

Americans who can afford it face substantial cost-related barriers to health care (West Health, 2019). Employer-sponsored insurance has become expensive, and benefits have been cut. The average cost of an employer health plan for an individual for 2020 was $7,470, which in a 4% increase compared to 2019 (Crowley et al., 2020).

A key objective of the health care system of the United States is to achieve high-quality health care and optimal patient satisfaction. As already elucidated, patient satisfaction refers to patient's expectations for his or her care experience, with patient experience referring to a whole range of encounters and interactions patients have with the hospital (Schreck, 2020). Scholars and practitioners have often argued that working to improve patient satisfaction and experience are a core component of the patient care quality and safety alongside hospital effectiveness (Achdut, 2019). Some argued that improving patient satisfaction contributes to improvements in health care quality, and improved health care quality is associated with increased revenues as patients seek services from facilities that respond to their needs. A hospital that focuses on patient satisfaction focuses on identifying areas that need to be improved in terms of performance (Cai et al., 2020).

An ample body of research has addressed public health care policies in the United States and suggested the need for increased understanding on their impact on patient

satisfaction (Henderson, 2020). Some authors have even suggested that efficient federal reimbursement of medical expenses is related to positive patient experiences and hence patient satisfaction. Billing issues and wait times for financial services such as reimbursements have been shown to be a major source of patent complaints (Achdut, 2019; Schreck, 2020; Setyawan et al., 2020; Xesfingi & Vozikis, 2016). Some researchers have demonstrated that higher total funding per patient is statistically associated with higher reported patient satisfaction (Achdut, 2019; Schreck, 2020; Setyawan et al., 2020; Xesfingi & Vozikis, 2016). Public funding is a public health policy. Research has shown that if this policy is not well implemented, reported patient satisfaction can decline (L'Esperance et al., 2021).

Individuals who identify as a member of the LGBTQ community are less likely to have access to health insurance and care. Approximately 18% of LGBTQ adults do not have access to health insurance compared to 13% of non-LGBTQ adults who lack health insurance (Jaffe, 2020). In addition, LGBTQ individuals tend to access providers with inadequate expertise to provide effective care (Funders, 2019). About 40% of physicians lack LGBT-related training and awareness as LGBTQ issues are not widely covered in medical school, residency, or continuing education. An estimated 50% of LGBTQ people report having to train their own medical professionals about transgender-appropriate health care (Funders, 2019). The United States electronic health record database does not have a standard approach of collecting sexual orientation and gender identity data. Without this data, insurance providers are not able to properly identify and address funding disparities affecting LGBTQ patients. Inadequate funding leads to reported

dissatisfaction among this population (Bass & Nagy, 2021; Greene et al., 2018; Haviland et al., 2021; Shute, 2017).

Patient Satisfaction and Patient Volume

Previous research supports a statistical connection between patient volume and patient satisfaction. Kumbhani et al. (2018) reported hospital volume is a standard measure of the quality of care provided to patients. In hospital settings with higher patient volume, higher patient satisfaction is also facilitated from health care delivery improvement initiatives, standardized outcomes, as well as process metrics. Data on patient volume is publicly accessible. through the American Hospital Directory. As for Mehta (2015), patient experiences of care incorporate two aspects that are also interrelated—patient satisfaction and quality of care. More so, improving patient satisfaction is considered a benefit to not only the patient but the clinicians as well.

Therefore, Mehta (2015) was able to statistically prove the correlation between patient experience measures and objective scores on clinical quality. When hospitals show improved engagement with their patients, in this case the LGBTQ community, it encourages follow-up and greater adherence to clinical standards of health care (Hadland et al., 2016). When patients are highly satisfied with the care received within a health system, they will likely utilize the same health system for both annual and acute symptom management. Patients who are satisfied with the care received will likely recommend to others specific clinicians they find trustworthy and culturally competent (Jongen et al., 2018).

Wolf (2016) added to this debate by highlighting the philosophy of consumer

loyalty. According to findings within his research Wolf believed all health care organizations seek to develop quality initiatives to create and maintain consumer loyalty. Wolf expressed building and maintaining loyal consumers is not about creating good advertisements on billboards; but rather by meeting the needs of those served in a satisfactory manner. Quality health care is about giving patient-centered care that caters to patient needs and their concerns (Wolf, 2016). Quality health care is also about giving all patients positive experiences, including those from the LGBTQ community. Apart from loyalty, Wolf also talks about community reputation. According to Wolf, when a health care organization becomes well known in the surrounding community for a good reputation, the reputation will drive the choices that other patients make as well, thereby increasing patient volume towards the health system.

For this reason, Wolf (2016) recommended health systems utilize patient satisfaction and engagement as the strongest form of community outreach and marketing. Utilizing this rating is made possible through practicing non-biased care rooted in quality and inclusion, particularly as it relates to members of the LGBTQ community. Through healthy provider engagement, health care organizations can create alliances within the communities they serve. These patient encounters and experiences will be shared by patients to members of their family, residential community, social media community, and stakeholders (Hudson et al., 2018).

Similar to findings from Wolf (2016), Weech-Maldonado et al. (2012) highlighted the connection between cultural competency and patient volume. In this instance, cultural competency is viewed as one of the ways to improve patient satisfaction and

organizational performance. More so, cultural competency is an effective way of reducing disparities in the delivery of care. LGBTQ members face huge disparities due to lack of cultural competency amongst health care providers. Yet, cultural competency is one of the ways to improve patient volume because, as Weech-Maldonado et al., discovered within their research, patients who receive quality and competent care will recommend said health systems to others, thereby increasing patient traffic.

Patient Satisfaction and Hospital Revenue

Many health care facilities are profit oriented, which means their financial performance is very important. Therefore, as van den Berg and Akingbola (2019) pointed out, financial performance is also a critical measure of both clinical care and the effectiveness of this care in hospital organizations. Better yet, the effectiveness of a hospital on these other outcomes such as patient satisfaction and quality are still tied to financial performance. Hospitals that have high patient satisfaction and delivery of quality care will most likely be good performers. According to van den Berg and Akingbola (2019), a positive correlation exists between patient satisfaction in a hospital and its performance. Apart from improving health outcomes and compliance amongst hospitals, Banka et al. (2015) also proved that improving patient satisfaction amongst members of the LGBTQ community can lead to greater financial performance. Culturally diverse hospitals are motivated to improve their patient satisfaction scores due to the monetary gain attached.

The Centers for Medicare and Medicaid Services (CMS) use values such as patient satisfaction to determine payments. Using the Hospital Consumer Assessment of

Healthcare Providers and System (HCAHPS) survey, the CMS rewards institutions that perform better on quality. This means those with higher quality and patient satisfaction will have more revenue, thus better financial performance (CMS, 2020; EMMA, 2021).

Based on findings by Chakraborty (2020), patient satisfaction is correlated to the reputation and financial performance of a hospital. When a hospital posts positive patient satisfaction ratings, these ratings improve the perception of current patients as well as the community at large. Improving patient perception and patient satisfaction ratings will attract more patients to the hospital, thus increasing revenue. Given this monetary gain, hospitals that are deemed 'friendly' to the LGBTQ community will have positive ratings from current patients, which will then attract more patients, thereby contributing to increased performance (C. Wilson & Cariola, 2020). A provider engaged experience is a proxy for the reputation of a hospital, which then determines how patients choose the hospitals they want to utilize for care. As such, hospitals that encompass diversity and follow quality improvement strategies will in one way or the other improve their financial outcomes (Xesfingi & Vozikis, 2016).

Akinleye et al. (2019) sought to identify the relationship between quality and financial performance. The high cost of health care in the United States has led to calls for its reduction but with improved quality. In other words, hospitals are implored to do more for less. However, addressing and improving feedback from patient satisfactions scores is not an easy task. Quality improvements are often associated with significant monetary expenses and approval from stakeholders. Therefore, many hospitals seem to be facing lots of pressure towards this feature (Simons et al., 2013). So far, the

government has tried to improve quality through financial incentives. Improving quality through financial incentives is referred to as value-based payment. With such payment models and public reporting, the health of populations will likely improve over the next 5-10 years (Akinleye et al., 2019).

However, Akinleye et al. (2019) warned that this can only be effective if the health care system caters to underserved populations as well. The LGBTQ community are amongst the underserved populations in American society; therefore, improving the quality of care towards this population will improve their satisfaction levels from the current levels. Committing to improve patient satisfaction scores enables health system to improve their patient experience rating, as well as increase the total patient revenue within the health system.

As cited in Ferlay et al. (2015), the author states a growing body of literature suggests that lesbian (Bradford et al., 2013), gay, bisexual (Bockting et al., 2013), transgender and those who identify as queer (LGBTQ) persons have significant health disparities when compared to heterosexuals. Research related to behavioral health reports members of the LGBTQ community are less likely to seek medical treatment than their heterosexual counterparts due to fear of discrimination or prejudicial treatment (Bentz et al., 2010). Ferlay et al. reflected evidence of discrimination in some form by nursing staff towards patients who identify with the LGBTQ community. Increased knowledge in this area could lead to interventions to improve nurses' cultural competency; resource allocation to nursing research, education, and services related to LGBTQ health; and inclusion of more LGBTQ content in nursing curricula (Ferlay et al., 2015).

Incorporating cultural competency into all health systems will allow the opportunity for resource allocation for nursing research, as well as improved satisfaction scores amongst competing health systems. Individuals within the LGBTQ community have shared experiences specific to their community and their unique health care needs. Health care organizations have called for LGBTQ-cultural sensitivity training (Rees et al., 2020). Siegel et al. (2017) highlighted the lack of curriculum content geared toward understanding and treating the LGBTQ community for health care providers.

LGBTQ individuals have specific health and health care needs relating to chronic disease risk, adult and adolescent mental health, unhealthy relationships (e.g. intimate partner violence), gender identity, sexually-transmitted infections, and human immunodeficiency virus infection, among others (Hadland et al., 2016). Compared with heterosexual and non-transgender socioeconomically matched peers, LGBTQ individuals are more likely to face barriers accessing appropriate medical care, which may create or increase existing disparities. Siegel et al. (2017) highlighted the correlation between perceived discrimination by members of the LGBTQ community and health disparities. Members of the LGBTQ community are not seeking preventive and curative treatment at the same rate as their heterosexual counterparts.

Definitions

The following terms were used in this study:

Health administration: The concept relates to management, leadership, and administration of health care systems. In essence, the concept relates to the practice of overseeing, leading, controlling, managing, and administering operations of health care

facilities (Cella et al., 2015).

Health disparities: The term relates to the preventable differences in access to optimal health, the burden of disease, and discrimination experienced by persons from a disadvantaged community. The community can be defined by factors such as geographical location, health disparities, disability, gender, ethnicity, education, sexual orientation, and income (Simons & Leroy, 2013).

Increasing diversity: This term relates to advocating and embracing differences between people in terms of age, ethnicity, origin, gender, religion, disability, or creed. The term is often confused with inclusion, which refers to supporting, respecting, and valuing proactively the differences (Alonso, 2012).

LGBTQ: The term refers to individuals who are identified with the lesbians, gay, bisexual, transgender, and queer. Where a lesbian refers to a woman who is attracted to a person of female gender and gay refers to a person who is attracted to a person of the same gender (Stall et al., 2020). A gay can either be a male who is attracted to a fellow male or a female who is attracted to a fellow woman. Bisexuality relates to a person who is attracted to both male and female genders, while transgender relates to a person who does not identify with any biological sex assigned during birth. Queer is an umbrella term that relates to the LGBTQ community (Stall et al., 2020).

Organizational performance: This term refers to an assessment of health care productivity against its goals and objectives. The approach compared the change in productivity in terms of output versus output (Simons et al., 2013).

Patient outcomes: This is a scientific term that relates to the benefits that patients

receive or not from medical procedures, treatment, or surgery. The patient outcome occurs after the treatment is completed (Cella et al., 2015).

Patient satisfaction: This term relates to the subjective evaluation and assessment of patient attitude, behavior, and care that they receive from health care practitioners (Simons & Leroy, 2013).

Assumptions

The assumptions in a study are related to the factors that influence research without the control of the researcher. Researchers do make assumptions relating to reality, knowledge, and the knowledge acquisition process. Failure to observe these factors renders study findings irrelevant. When conducting a study, researchers are expected to choose whether research will use a qualitative or quantitative approach or a mix of both methods.

The choice of research approach is influenced by the issue under study, research problems, and circumstances of the researcher. In this study, therefore, the main assumption was that the research would show patient satisfaction increases patient volume and hospital revenue. The data for this study was retrieved from CMS reports and EMMA, which was presumed as accurate and complete. I explored the impact of patient satisfaction among the LGBTQ community on patient volume and hospital revenue. As such, the context was integral in the study because data are available publicly; hence, perceived as accurate devoid of bias.

Scope and Delimitation

This quantitative study examined the statistical relationship between patient

satisfaction among LGBTQ patients and patient volume and hospital revenue in the State of Georgia, United States. As such, the study focused on perceived experiences of patients in health care facilities reflected within their responses to quantitative questionnaires. Delimitation relates to factors that create barriers and limit the study scope without the control of the researcher. The delimitation of this study was the exclusion of health care facilities under study outside the state of Georgia in the United States; hence, the findings of the study may not be applicable or generalized outside of Georgia, United States.

Limitations

The study was limited to researching findings using CMS reports, as well as EMMA. Due to the focus on small samples, I as the researcher did not intend to uncover the large-scale health equity and intersectional identities associated with overall patient satisfaction. Although the patient satisfaction scale is expected to depict strong reliability, the psychometric properties will be unknown.

Significance

LGBTQ individuals and groups represent a significant and rapidly growing segment of the U.S. population (M. Morris et al., 2019). As this population grows, so does the risk of discrimination and stigmatization in a society that is yet to fully accept and accord equal treatment to LGTBQ individuals (Bosia et al., 2020). Implicit biases in medical and health care facilities, particularly those in the state of Georgia often lead to LGBTQ patients receiving a lower standard of care. Thus, providing equal access to

LGTBQ members makes ethical, legal, and business sense (Durso et al., 2017).

This research was significant in the sense that it contributes towards policy, practice improvements, and attitudinal change of providers toward LGBTQ patients in the state of Georgia. The research itself stems from the realization that an urgent need exists for health care providers at all levels to acknowledge and address their own implicit biases, identify, and understand unique needs and cultural norms of patients within the LGTBQ community. Additionally, providers and health care systems at large must ensure a culturally competent and inclusive culture to ensure providers and participating health systems do not contribute to health care disparities and discrimination experienced by the LGBTQ community (M. Morris et al., 2019).

The significance of health care leaders is to be aware of the need to identify ways to engage all members of the communities served; thus, increasing patient satisfaction within organizations and improving annual fiscal goals. Providers must be able to address needs unique to minority populations, as evidenced by previous data collected. Positive social change may be found in determining if health systems are engaging in ongoing cultural competency (Hudson et al., 2018).

Summary

The findings help create a more in-depth understanding that will reduce LGBTQ-related bias among practitioners providing health care at both leadership and clinical levels. Cultural competency is particularly important as implicit bias among health care professionals has been recognized by various researchers as well as medical and nursing professional associations as a major contributing factor to the discrimination and

disparities confronted by LGBTQ individuals seeking health care (Bosia et al., 2020).

Thus, elimination of implicit bias, discrimination, and health care disparities remain a critical professional competency objective. In addition, the goal of the United States, as one of the most advanced and civilized societies in the world, is to improve the human and social conditions of its citizens and attain a better society (Robbins RA. 2017) . In this regard, by helping generate an understanding among health care and medical professionals on how implicit LGBTQ-related bias negatively impacts LGBTQ members intentions to, and actual access and utilization health care and medical services at a given facility, the objective of promoting equal access to quality health care and, ultimately, for eliminating discrimination in health care can be advanced and achieved (Durso et al., 2017).

In the end, patient satisfaction and patient volume among LGBTQ individuals will be achieved in those facilities raising hospital revenues which would not otherwise be achieved. The study also contributes to extant literature focusing on equal and quality service provision among all members of the society. Policy makers are provided with technical knowledge and practical insights relating to understanding and elimination of discrimination and disparities in health care.

The independent variable was patient satisfaction while patient volume and hospital revenue were dependent variables. Overall, in the literature review I explored the concepts of access to health care services among the LGBTQ community in the state of Georgia. As noted, many members of the LGBTQ community face discrimination, bias, and prejudice when they seek medical services. As such, many tend to move to health

care systems that are sensitive to their needs. The financial performance of health care facilities is integral in providing quality care and improving patient outcomes. Hospital revenue allows health systems to recruit and retain employees, acquire the latest diagnostic equipment, and conduct research that promotes improved patient outcomes. However, the study showed that the attitudes of health care workers impact the access to care for the LGBTQ community in the United States. Though studies exist on the impact of patient satisfaction; no studies explored the impact of patient satisfaction among the LGBTQ community on hospital revenue and patient volume. Given the number of LGBTQ communities in the country, in this study I sought to identify if improving patient satisfaction among the LGBTQ community will increase patient volume and hospital revenue.

Section 2: Research Design and Data Collection

Introduction

The focus of this study was the impact of patient satisfaction on patient volume and hospital revenue. I explored the impact of patient satisfaction on patient volume and hospital revenue among members of the LGBTQ community using correlational research. More specifically, I examined the perceptions of members of this community on the quality of service that they receive. In this section, I present the research approach, research design, and research methods used in the study. Data analysis was conducted using the Statistical Package for Social Sciences (SPSS) using regression and correlation analyses. Given a population of 425,000 members of the LGBTQ in the State of Georgia, United States, the sample size was calculated using power analysis, yielding 567 participants. As the research was quantitative in approach, a quantitative research design was adopted.

Research Design and Rationale

A research approach, also known as the research methodology, is defined as the plan, or overall procedure adopted by a researcher, spanning from the broad philosophical assumptions espoused (research philosophy); to the procedure of empirical enquiry (research design); to the detailed data collection, analysis, and interpretation methods (research methods; Creswell, 2019). Three research approaches are elucidated in the literature: the qualitative approach (using words or textual data collection, analysis, and interpretation), quantitative approach (using numbers or statistical data collection, analysis, and interpretation), and mixed methods approach (using both qualitative and

quantitative approaches in the same study; Polit & Beck, 2020).

The qualitative approach is inductive in that it involves collection of data to develop a theory or hypothesis about the study phenomena, while the quantitative approach is deductive in that data are collected to test a theory or hypothesis (Stall et al., 2020). Qualitative research is informed by the interpretivist research philosophy that involves subjectively interpreting phenomena as socially constructed and understood by both the research and study participants while quantitative research is informed by the positivist approach, which involves objective interpretation of phenomena through scientific, experimental, or statistical mechanism to reveal the true nature of the phenomena (Mertens, 2017). In this study, I adopted the quantitative approach as it involved collection and analysis of numerical data.

Research Design

A research design is defined as the procedure or strategy of inquiry that provides a blueprint for the research study (Bell et al., 2019). As the research was quantitative in approach, a quantitative research design was adopted. Four types of quantitative research designs are elucidated in the literature: descriptive research design that describes phenomena or status of variable (Creswell, 2019); correlational research design that examines the extent, strength, and direction of relationships between two or more variables using statistical data (Nilmini, 2019); causal-comparative or quasi-experimental research design that examines the cause-effect relationships among variables; and the experimental research design that involves scientific experiments to establish the cause-effect relationship among variables (Polit & Beck, 2020).

Descriptive and correlational research are nonexperimental and can utilize primary data through cross-sectional (over a short time) or longitudinal (over a long time) surveys or through secondary methods. Quasi-experimental research is more like experimental research except, unlike in true experimental research, the independent variable is not randomly assigned nor is it manipulated to investigate its effect on the dependent variable (Hall, 2020). As used in this study, a correlational research design was more appropriate in determining the relationship between patient satisfaction and patient volume among LGBTQ patients (see Saks & Allsop, 2019).

The dependent variables of the study were patient volume and hospital revenue. On the other hand, the independent variable of the study was satisfaction with the quality of health care service to members of the LGBTQ community. This nonexperimental research followed a correlational research design to examine the perceptions of members of the LGBTQ community on the quality of services that they receive (see Nilmini, 2016).

Rationale

A culturally sensitive organization accommodates people from different cultural backgrounds, without them feeling alienated or discriminated against. I explored patient satisfaction and hospital revenue before and after health care systems participated in cultural sensitivity trainings. Cultural sensitivity trainings strive to acknowledge, understand, and respond to the diversity of cultures and communities. Incorporating cultural sensitivity trainings within healthy systems can help create a more in-depth understanding by providers, which can reduce LGBTQ-related bias among health care

providers, at both leadership and clinical levels. Culturally sensitive organizations are defined as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients. A culturally competent health care system can help improve health outcomes and quality of care and can contribute to the elimination of racial and ethnic health disparities.

Cultural Sensitivity Training

Cultural sensitivity is a cross-cultural awareness or knowledge and acceptance of cultural differences and identity, which is also a percussor to the achievement of cultural quality and competence in health care (Alonso, 2012). Participants were administered a 12-question survey designed to understand how the participants perceived diversity as well as their comfort level with interacting with individuals who have different backgrounds. Participants were administered a 12-question survey both prior to engaging in the training and post completion. Secondary data reported that participants gained a greater understanding of diversity and felt more confident in engaging with those from backgrounds that did not mirror theirs. Participants were 125 employees from participating health systems, including those in leadership roles, providers, case management, as well as those in health care utilization.

Historically, the LGBTQ community has reported low patient satisfaction ratings for providers and/or health systems that did not identify as LGBTQ friendly. The main reasons for these low ratings are tied to LGBTQ patients not feeling comfortable with sharing certain aspects of their life with the provider or health care employee for fear of judgment. While having some providers and/or health systems that can provide care to

this community is great, health systems that are not culturally equipped to provide care to this community pose a potential risk for loss of funding and revenue. Improving how providers and health system staff engage and build rapport with patients can improve the patient experience, thus improving patient satisfaction.

During the cultural sensitivity trainings, health care participants engaged in seminars led by trained instructors. Participants were required to gather in small groups to review case studies and provide feedback using the cultural sensitization model. For a period of 6 months, participants engaged in 90-minute weekly sessions to improve their knowledge of the needs of the LGBTQ community. The goal of this training was to ensure that health care providers and employees are sensitive and accepting of needs unique to this population without prejudice or bias. In addition to seminars and case study reviews, participants also received a resource booklet containing information on diversity as well as strategies to implement cultural sensitization in the workplace. Understanding cultural norms associated with a community is integral in providing quality health care.

Cultural sensitivity trainings in health care are supported by the premise that understanding the emotional challenges and prejudices, as well as the way of life of LGBTQ individuals, will better prepare health systems to meet the needs of this community. A primary reason LGBTQ members experience low satisfaction within health systems is largely related to feeling that the provider did not understand needs unique to the LGBTQ community. Surveys have shown that millions of American adults identify with the LGBTQ population, thus making provision of adequate and culturally competent care to this community essential.

Methodology

Research methods refer to the specific forms of data collection, data analysis, and data interpretation and offer a framework for implementing the research study (Creswell, 2019).

Population

The focus of this study was on members of the LGBTQ community in the state of Georgia, United States. Specifically, the study targeted patients from the LGBTQ community who have previously used health care systems in Georgia for medical care.

Sampling and Sampling Procedures

Articles reviewed in this study were those that used The Clinician and Group Consumer Assessment of Healthcare Providers and Systems Survey (CG CAHPS) to measure patient satisfaction. The CAHPS Clinician and Group Survey collects data about patient experiences with care over a 6-month period (Agency for Healthcare Research and Quality, 2020). This survey uses standardized tools to measure the perception of patients towards health care services offered by various providers. In this study, the inclusion criteria were limited to only members of the LGBTQ community who are not heterosexual. Given a population of 425,000 members of the LGBTQ in the state of Georgia, United States, the sample size was calculated using power analysis as seen in Table 1.

Table 1

Sample Size Calculated Using Power Analysis

Analysis: A priori: Compute required sample size			
Input:	Tail(s)	=	Two
	Slope H1	=	0.15
	α err prob	=	0.05
	Power (1-β err prob)	=	0.95
	Slope H0	=	0
	Std dev σ_x	=	1
	Std dev σ_y	=	1
Output:	Noncentrality parameter δ	=	3.6126377
	Critical t	=	1.9641716
	Df	=	565
	Total sample size	=	567
	Actual power	=	0.9501723

Therefore, using the power analysis technique, the desired sample size was 567 members of the LGBTQ community. Power analysis was conducted before data collection to help determine the smallest possible sample size that was statistically suitable to detect the effect of the independent variable (patient satisfaction) on the dependent variables (patient volume and hospital revenue) at the desired level of significance ($p \leq 0.05$; Polit & Beck, 2020).

Instrumentation and Operationalization of Constructs

The CG CAHPS was developed by the Agency for Healthcare Research and Quality and is a survey that uses standardized tools to measure the perception of patients towards health care services offered by various providers. CG CAHPS uses an 11-point scale to measure patient satisfaction, where a score of 0 represents the lowest level of

satisfaction (*unsatisfied*) while a score of 10 represents the highest level of satisfaction (*very satisfied*).

Data Collection

Types of Data

Research involves collection of primary and/or secondary data. Primary data are the data collected first-hand by the researcher to meet the research objectives. Secondary data are the data collected by others for their own objectives that other researchers find useful in their own study. For the present study, I used secondary data collected from EMMA and CMS Reports in inpatient health systems. I collected additional data from the American Hospital Directory to accurately determine patient volume.

Data on patient satisfaction was retrieved from CMS Reports. Data regarding merger and acquisitions within health systems throughout Georgia was collected from EMMA. Moreover, I conducted a peer review of journal articles on the impact of patient satisfaction among members of the LGBTQ community on patient volume and hospital revenue to inform the literature review and hypotheses development (see Saks & Allsop, 2019). The rationale for using secondary data is as follows:

- A particularly useful set of data on the subject matter already exists.
- The study is historical in nature—that is, I focused on data that begins and ends at a particular point in time.
- The study covered an extended period and analyzing development over that period—and was thus longitudinal in design.
- The units of study (that is, the LGTBQ members) are hard to reach and may

take long to observe even through snowballing sampling.

- The study involved the State of Georgia; therefore, it is important to examine the relevant documents (reports, statistics).

Data Analysis

Data analysis was conducted using the SPSS. In line with the research questions and methodological objectives of the study, I sought to

1. Describe the characteristics of LGTBQ groups.
2. Compare between the LGTBQ groups based on race and age.
3. Examine the association (relationship/correlation) between the study variables and the strength and direction of those relationships.

Description

This study involved describing the characteristics of LGTBQ groups. The analysis was conducted on age, level of income, and racial background. Descriptive statistics were used to summarize the characteristics of the sample as follows:

Frequencies

The frequencies were captured as counts and presented as percentages. Percentages described distribution of the sample, such as what proportion identifies as lesbians, gay, bisexual, transsexual or queer, what their ages are, and education levels (see Saks & Allsop, 2019).

Means

This measure of average was used to present the arithmetic average of the obtained data, such as the mean age (see Stall et al., 2020).

Standard Deviations

The standard deviations provided a measure of the spread of the data, with larger standard deviations indicating larger variations in the data (see Nilmini, 2019).

Comparison

Comparison is an inferential statistical approach and involved comparing among the LGTBQ groups. Results for two or more LGTBQ groups (based on race and age) were compared to determine whether a statistically significant difference exists between them (see Short & Kunchike, 2002). Multivariate analyses of variance were used as more than two means were involved (see MacInnes, 2016). This analysis focused on whether LGBTQ members from different ages and races experience patient satisfaction differently.

Correlation

Correlation is an inferential statistical approach as well. A correlation is the measure of association or relationships among four study variables with patient funding and patient satisfaction among LGBTQ people being the independent variables and LGBTQ patient volume and hospital revenue being the dependent variables.

Correlation measured the strength and direction with which one variable increased or decreased as the second changed. Correlation is represented by a correlation coefficient and the Pearson's *r*, which is used to check relationships between the study variables (see MacInnes, 2016; Short & Kunchike, 2002).

As the study is based on the EMMA data (2010-2020) and CMS reports (2010-2020), I utilized the information analysis correlational research. This type analyzes data

obtained from archives, records, databases, and libraries that are publicly available or accessible with permission to researchers (Saks & Allsop, 2019).

The advantages of information analysis correlational research are that the research has access to a large amount of data to analyze, it is less expensive, and the data has already been collected so it consumes less time. The major disadvantage is that there is no control over data collection methods and some information needed in the current study may be missing (MacInnes, 2016).

Three possible outcomes were expected in this study. (a) a (strong/weak) positive correlation; (b) a (strong/weak) negative correlation; and (c) no correlation. The study applied a rule of thumb described by Saks and Allsop (2019) that a correlation coefficient, *r*, close to +1.00 indicates a strong positive correlation; *r* close to -1.00 indicates a strong negative correlation; and *r*, close of zero indicates a strong positive correlation. This is summarized in Table 2.

Table 2

Rule of Thumb for Interpreting the Size of a Correlation Coefficient

Size of Pearson's correlation coefficient, *r*	General interpretation/rule of thumb of the size/strength and direction of the relationship
+1 (-1)	Perfect positive correlation (perfect negative correlation)
+.90 to +1.00 (-.90 to -1.00)	Very high positive correlation (Very high negative correlation)
+.70 to +0.90 (-.70 to -0.90)	High positive correlation (High negative correlation)
+.50 to +0.70 (-.50 to -0.70)	Moderate positive correlation (Moderate negative correlation)
+.30 to +0.50 (-.30 to -0.50)	Low positive correlation (Low negative correlation)
+.00 to +0.30 (-.00 to -0.30)	Very weak positive OR NO correlation (Very weak negative OR NO correlation)

Note. In positive correlations (direction), both variables increase or decrease at the same time; in negative correlations, an increase in one variable correlates with a decrease in the other (and vice versa; Saks & Allsop, 2019)

Correlations were used to analyze findings from research questions of the study as summarized in Table 3.

Table 3

Plan for Interpreting the Outcomes of the Research Questions

Research question	Variables	Strength/direction of the relationship
RQ.1: Based on the EMMA and CMS data (2010-2020), what is the statistical relationship between hospital revenue and patient satisfaction within health systems among LGBTQ patients?	Hospital revenue and patient satisfaction	Refer to Table 1
RQ.2: Based on the EMMA data (2010-2020) and CMS reports (2010-2020), is there a relationship between patient satisfaction and patient volume among LGBTQ patients?	Patient satisfaction and patient volume	Refer to Table 1

Threats to Validity

A possible threat to concluding statistical validity in this study is the extent to which the patient satisfaction surveys that were used by the reviewed articles measure patient satisfaction among members of the LGBTQ community.

Ethical Procedures

I obtained permission from the Institutional Review Board (IRB) to gain access to secondary data sources on patient satisfaction, patient volume, and hospital revenue. The IRB approval number for this research is listed as follows: 11-10-21-0990315.

Summary

This was a non-experimental research study that used a correlational research design to examine the perceptions of members of the LGBTQ community on the quality of service they receive. More particularly, the study used a correlational design to determine the impact of LGBTQ patient satisfaction on patient volume and hospital

revenue. The findings of this study provide important insights to providers of health care services that will help them to understand and appreciate the experience of patients from the LGBTQ community for the provision of patient-centered health care services.

Section 3: Presentation of the Results and Findings

Introduction

In this correlational study, I examined the perceptions of members of the LGBTQ community on the quality of services they receive and their satisfaction and how the satisfaction of the patient impacts patient volume and hospital revenue. Based on findings within this study, a statistical relationship exists between patient satisfaction, patient volume, and hospital revenue. The study included 567 members of the LGBTQ community in Georgia. Secondary data were collected from the EMMA and CMS Reports in inpatient health care systems and CMS Reports. This was a nonexperimental research study that used a correlational research design to examine the perceptions of members of the LGBTQ community on the quality of service they receive in inpatient health systems throughout Georgia. More specifically, I used a correlational design to determine the impact of LGBTQ patient satisfaction on patient volume and hospital revenue.

The research questions guiding the study and their corresponding hypotheses were as follows:

RQ1: Based on the EMMA and CMS data (2010-2020), what is the statistical relationship between hospital revenue and patient satisfaction within health systems among LGBTQ patients?

$H_0$1: Based on the EMMA and CMS data (2010-2020), there is no statistically significant relationship between patient volume and patient satisfaction among LGBTQ patients.

H_a1: Based on the EMMA and CMS data (2010-2020), there is a statistically significant relationship between patient volume and patient satisfaction among LGBTQ patients.

RQ2: Based on the EMMA data (2010-2020) and CMS reports (2010-2020), is there a relationship between patient satisfaction and patient volume among LGBTQ patients?

H_02: Based on EMMA and CMS data (2010-2020), there is no significant statistical relationship between patient satisfaction and patient volume among LGBTQ patients.

H_a2: Based on EMMA and CMS data (2010-2020), there is a significant statistical relationship between patient satisfaction and patient volume among LGBTQ patients.

This section is a presentation of the results obtained from secondary data collected from the EMMA and CMS Reports in inpatient health care systems. In this section, I also describe the demographic or descriptive characteristics of the study and indicate the results of the basic univariate analyses, which justify the inclusion of covariates. Further, I report the statistical analysis findings.

Data Collection of Secondary Data Set

The study included 567 members of the LGBTQ community in Georgia. Secondary data were collected from the EMMA and CMS Reports in inpatient health care systems. The time frame taken in the data collection exercise occurred August 1–31 in the year 2015. The response rate was 94.89% (538 responses). Incomplete responses were excluded from the study, and these were classified as nonresponses.

The discrepancies in the use of secondary data set in the study included the focus of the study on the perceived experiences of patients in health care facilities using secondary data from the EMMA and CMS reports. The correlation data analysis does not indicate the other factors that could potentially increase patient satisfaction, hospital revenue, and volume in participating health care systems.

Baseline Descriptive and Demographic Characteristics of the Sample

Of the 567 study participants, 320 (56.44%) were males, and 247 (43.56%) were females (see Table 4). The mean age group was 36.7; 472 (83.26%) completed secondary education, 431 (76.01%) had medical insurance, and 509 (89.77%) were employed. The demographic representation of the sample cuts across almost all social strata. To obtain the best results from a research study, ensuring the sample is reflective of the population under investigation is essential. A portion of the factors that affect health care access include educational levels, employment, and medical insurance. Therefore, these factors played a significant role in this research and provided additional insight as it related to the outcome of the study. Participants without secondary education, insurance, and employment are likely to report unfavorably regarding the quality of care received within various health care systems.

Table 4

Demographic Characteristics of All Participants (N=567)

Age group	*N*	%
18–24	49	8.64
25–34	122	21.52
35–44	259	45.68
45–54	90	15.87
55–65	29	5.11
65 and older	18	3.17
Gender		
Male	320	56.44
Female	247	43.56
Education		
Secondary education	472	83.26
No secondary education	95	16.74
Insurance		
Medical insurance	431	76.01
No insurance	136	23.99
Employment		
Employed	509	89.77
Not employed	58	10.23

Historically, studies have shown that individuals who are college educated make healthier dietary choices. Individuals with secondary education are also likely able to build rapport with their provider as opposed to those without secondary education. For the purpose of this study, secondary education was defined as completion of a 4-year bachelor's degree post high school. The category of no employment was defined as working 0 hours and receiving no monetary compensation from employment. The term no medical insurance was used to describe those without medical insurance be it public or private. From the demographics of this sample, it was notable that participants fell within the three categories of no employment (58 = 10.23%), no secondary education (95 = 16.74%), and no medical insurance (136 = 23.99%).

Patient Satisfaction Levels Before and After Institutions Participated in Cultural Sensitivity Training

Patient satisfaction was evaluated before the institutions engaged in the cultural sensitivity training and again after completion of the training. Table 5 presents the results for the number of LGBTQ patients satisfied before the training and after the training, with the various services offered within the health system.

Table 5

Demographic Characteristics of All Participants (N=567)

	Agree: Before	Agree: After
Physicians' attention	416	518
Physicians' explanation and listening	452	509
Clinical encounter time	395	488
Physician-patient relationship	468	520
Ask questions conveniently	401	472
Physicians more interested in file than the patients	401	400
Referral system	435	523

In Table 5, a general trend of improvement was presented in all areas of service for patients. However, one area reflected stagnation in whether physicians had more interest in the file than the patients. Improvement in this area could potentially reduce the numbers from 400 to a number significantly lower than the current findings.

Patient satisfaction was also measured in time durations, as presented in Table 6. Data were collected for 4 weeks before implementation of the cultural sensitivity training and 4 weeks postimplementation. Per week of data collection was defined as Sunday through Saturday. The stark difference in results is presented in the far-right column of Table 5. Before and after is defined as before and after the institution identified as culturally sensitive.

Table 6

Week by Week Data Collection

	Before	After	Difference
Week 1	430	1,721	1,291
Week 2	401	1,689	1,288
Week 3	516	1,770	1,254
Week 4	412	1,690	1,278

Per week of data collection was defined as Sunday through Saturday. Using statistical measures within SPSS, the paired *t* test was conducted for the patients who agreed that satisfaction levels across different services were acceptable within the health system prior to the cultural sensitivity training and post completion. The outcomes are presented in Table 7. It was important to compare week by week data to ensure that there was consistency in the improvement made after the adoption of the cultural sensitivity training. If data reflected that only 1 week reflected significant improvement, the overall impact of the program may have been insignificant. The results reflected a high improvement in satisfaction levels across the weekly comparisons, averaging a difference of around 1,300 every week.

Table 7

Paired Samples t *Test*

Measure 1		Measure 2	*t*	*df*	*P*
Agree: before	-	Agree: after	-5.006	6	0.002

Note. A student's *t* test showing differences in patient satisfaction levels before and after cultural sensitivity trainings.

A p value of <0.05 was considered significant, and the p value of 0.002 showed significant differences in patient satisfaction levels before the health systems identified as culturally sensitive as well as post cultural sensitivity training.

Based on the data, sensitivity and competency of the LGBTQ community have a significant impact on the response rate from the health systems. After completion of cultural sensitivity trainings, participating health care professionals responded more positively to patients than they did prior to completing the cultural sensitivity training.

RQ1 was as follows: Based on the EMMA and CMS data (2010-2020), what is the statistical relationship between hospital revenue and patient satisfaction among LGBTQ patients?

Patient volume within health systems was considered across various parameters, such as time, level of care, and payment methods. In each assessment, satisfaction levels showed a significant increase. The last column in Table 8 reflects the differences in patient volume when patient satisfaction was low in comparison to when it was high.

Based on the findings patient satisfaction among LGBTQ patients improved with the introduction and completion of the cultural sensitivity training.

Table 8

Patient Volumes When Patient Satisfaction Was Low vs. When It Was High

	Patient volumes		
	Before (low satisfaction)	After (high satisfaction)	Difference
Health care level			
Primary	107	259	152
Secondary	84	180	96
Tertiary	135	278	143
Payer in all levels			
Insurance	127	248	121
Medicaid	109	189	80
Self-Pay	107	289	182
Per week			
Week 1	123	198	75
Week 2	134	204	70
Week 3	118	276	158
Week 4	129	175	46

A p value of < 0.05 was considered significant, and the p value of 0.001 showed that the differences in the patient volumes were significant (see Table 9). Therefore, the relationship tested was significant.

Table 9

Paired Samples t *Test*

Measure 1		Measure 2	*T*	*df*	*P*
Before	-	After	-8.392	5	<.001

Note. Student's *t* test showing differences in patient volumes.

Based on findings within this study, health systems with a higher index of LGBTQ sensitization will attract more LGBTQ patients. This is largely attributed to LGBTQ patients preferring to seek care where they feel safe to openly communicate and share background information with their provider. Historically, members of this community have been side lined and made to feel inferior to other patients due to their gender expression and sexual orientation. The results obtained and presented in Table 9 show that LGBTQ patient volume steadily increased after organizations engaged in cultural sensitivity trainings. Based on data analysis, members of the LGBTQ community prefer health systems where LGBTQ sensitization is high and acceptance is broad and influenced by cultural competency. As such, the satisfaction levels of LGBTQ patients will increase within participating health systems.

RQ2 was as follows: Based on the EMMA Data (2010-2020) and CMS Reports (2010-2020), is there a relationship between patient satisfaction and patient volume among LGBTQ patients?

In Table 10, the differences in hospital revenues across 4 weeks before the cultural sensitivity program, and 4 weeks post completion of the program are measured. The 'Difference' column displays a significant gain in revenue, with more than twice the income before being generated post completion of the program. In Week 3, for instance, there was a 166% gain in revenue following deployment of the program.

Table 10

Hospital Revenues When Patient Satisfaction Was Low vs. When Satisfaction Was High

	Before (low satisfaction)	After (high satisfaction)	Difference
Week 1	14,900	35,600	20,700
Week 2	16,700	39,800	23,100
Week 3	15,400	41,000	25,600
Week 4	14,400	38,200	23,800

Table 11

Paired Samples t *Test*

Measure 1	Measure 2	*t*	*df*	*p*
Before (Dec 2020)	- After (April 2021)	-22.977	3	< .001

Note. Student's *t* test showing differences in hospital revenues.

A *p* value of <0.05 was considered significant, and the *p* value of 0.001 showed the differences in hospital revenue were significant. Table 11 shows a *p* value of 0.001, which is within the range of what is considered significant. Therefore, the relationship between patient satisfaction and patient volume is significant.

Improving patient and or consumer satisfaction is one of the ways that a business or health system tends to increase income per fiscal year. Patient satisfaction levels have the potential to increase or decrease hospital revenue.

Results

From the data, the coefficients explain that holding hospital revenues constant a 1-unit increase in patient volume leads to a decrease in patient satisfaction by 0.16 units. Similarly, holding patient volumes constant, a 1-unit increase in hospital revenues reduces the patient satisfaction by 0.005 units. While the changes in the two variables are not statistically significant, the overall impact of the variables denote that increasing patient volume and hospital revenue leads to a significant increase in LGBTQ patient satisfaction by 1410 units. Therefore, the regression and correlation analysis in Table 12

is an illustration of the significance in relationship between patient volume and patient satisfaction.

Table 12

Regression and Correlation Analyses

	Coefficients	SE	*t* Stat	*p* Value	Lower 95%	Upper 95%	Lower 95.0%	Upper 95.0%
Intercept	1410.756	59.073	23.882	0.027	660.168	2161.344	660.168	2161.344
Patient volume	-0.157	0.115	-1.366	0.402	-1.615	1.301	-1.615	1.301
Patient satisfaction	-0.005	0.003	-1.854	0.315	-0.040	0.030	-0.040	0.030

From the R^2 values, 92.8% of variations in patient satisfaction is explained by movements in patient volumes and hospital revenue. Accordingly, this model is fit to explain patient satisfaction. At 92% score of the R^2 value shown in Table 13, there is a significant relationship between patient volume and the patient satisfaction within participating health systems.

Table 13

Regression Analysis Results

Regression statistics	
Multiple R	0.963456
R^2	0.928247
Adjusted R^2	0.78474
SE	7.785472
Observations	4

There is a strong positive correlation between the variables, with a score averaging 1 in every computation as shown in Table 14. It is a clear indication that patient volume is a high derivative of patient satisfaction within inpatient health systems. Further, LGBTQ patients reported an increase in patient satisfaction for health systems who identified as culturally sensitive. In retrospect, LGBTQ patient volume in any systems will be a factor of the level of cultural sensitivity in the identifying health care system.

Table 14

Correlation Statistics

	Row 1	Row 2	Row 3	Row 4
Row 1	1			
Row 2	0.999985	1		
Row 3	0.999896	0.99996	1	
Row 4	0.999979	1	0.999968	1

Summary

In this non-experimental correlational study, I examined the perceptions of members of the LGBTQ community on the quality of care received within inpatient healthy systems throughout the state of Georgia. Results indicated differences in patient satisfaction levels, patient volume, and hospital revenue prior to healthy systems engaging in cultural sensitivity trainings and post completion. There is a strong positive correlation between the study variables post completion of the training. These findings provide insight to health care providers and organizational leadership; and will help to facilitate understanding and appreciation as it relates to unique experiences of the LGBTQ community. At the heart of any health care system should be the satisfaction of patients (Tallarek et al., 2020). The challenges of stereotyping that have faced minority groups in society in the past can at times be detrimental to the quality of service that they receive in health care. However, the challenges can always be resolved when service providers are sensitized on how to embrace diversity (Tallarek et al., 2020). Providers

should be aware of their responsibility to provide quality care to all patients, even when their beliefs and cultural norms waiver from the provider.

This research highlights financial advantages that are facilitated based on improvements in the quality of care, which is not related to the technical abilities of the professionals or the capitalization of facility. The change in attitude and approach towards certain groups of people can shift the scope significantly to ensure LGBTQ patients feel equal and satisfied with the services they receive. This situation is a win-win for society and for the facility. As the people enjoy more freedom and equality in diversity, the facilities will make more revenue in the process (Tallarek et al., 2020).

From the research results, the null hypothesis of RQ1—there is no significant statistical relationship between patient satisfaction and patient volume among LGBTQ patients—is rejected, and the alternative hypothesis is accepted. The relationship between patient satisfaction and patient volume among LGBTQ patients is statistically visible based on the data sets. From Tables 7 and 8, it is comprehensible that when patient satisfaction increased, the volume of LGBTQ patients increased. It is not by accident, rather by design that it happens that way.

In RQ2, the null hypothesis—there is no significant statistical relationship between patient satisfaction and patient volume among LGBTQ patients—is also rejected, and the alternative hypothesis is accepted. From Tables 9 and 10, patient satisfaction increases patient volume, hence increased revenue for the hospitals and health systems. There is then a clear relationship between patient satisfaction, LGBTQ patient volume, and hospital revenue. When there is an increase in satisfaction, it is then

translated into higher numbers and more money. Nonetheless, health care facilities must beware where to start to get the correct correlation. From Table 13, a correlation of 1 means that the variables are related and have significant relationships, but one must take precedence. The leading variable in the correlation is patient satisfaction, which is independent from the variables of patient volume and hospital revenue. Nevertheless, the latter two variables are dependent on how well the independent variable is achieved.

Section 4: Application to Professional Practice and Implications for Social Change

Introduction

Patient satisfaction is an integral tool that helps health care facilities attract patients, create revenue, and enhance brand reputation. As noted, members of the LGBTQ community are often forced to seek medical attention at specific health facilities that are sensitive to their needs, devoid of discrimination, and employ cultural sensitivity training for their staff. However, discrimination and marginalization of the LGBTQ community have also been witnessed within participating healthy systems, which affect members of the LGBTQ community at disproportionate rates, thus facilitating severe psychosocial trauma and poor health outcomes. Historically, the LGBTQ community has been forced to postpone seeking medical care owing to stigmatization and judgment in health care settings. Many are faced with harassment and refusal of care, while others fear disclosing their sexual orientation to providers.

The negative social attitudes and discrimination against members of the LGBTQ community present adverse impacts on patient satisfaction, which impact hospital volume and profitability, thus leading to a decrease in revenue as members of the LGBTQ community seek services from competitors. In this study, I investigated the experience, discrimination, and prejudices of the LGBTQ community in health care facilities. Secondly, this study helped identify forms of institutional discrimination amongst providers and members of the LGBTQ community within health systems based on CMS reports. Needs unique to LGBTQ patients are not always addressed in the continuum of care, which often leads community members to seek treatment under providers who

identify as LGBTQ sensitive.

This study is essential in that it addresses discrimination in health care settings on the basis that it communicates to the health care workers and the health care professionals who are perceived as the perpetrators. Various studies have been used as reviews with the help of quantitative evidence. The overwhelming evidence obtained from these reviews has revealed that the LGBTQ community are subject to discrimination in health care systems. In an actual sense, there is a need for increased awareness and education concerning competent care that is culturally appropriate as it responds to the needs of members of the LGBTQ community.

Interpretation of the Findings

Cultural sensitivity is a cross-cultural awareness or knowledge and acceptance of cultural differences and identity, which is also a percussor to the achievement of cultural quality and competence (Alonso, 2012). The purpose of this educative initiative is to understand people's backgrounds and acceptance of diversity. According to the study's findings, cultural sensitivity resulted in a change in the LGBTQ's perceptions of how the health professionals treated them. This was verified from the outcome that was compared before and after the cultural sensitivity program.

Before the cultural sensitivity training, members of the LGBTQ community indicated that 416 members agreed that physicians paid attention during office visits. In contrast, post completion of the cultural sensitivity training, the number rose to 518 patients who responded positively to physician's attention to them. That indicated an increase of about 100 LGBTQ patients who identified the difference in the physician's

attention. Another significant observation is the clinical encounter, which was low. Approximately 395 patients indicated positive clinical encounter time, but after a culturally sensitive program, about 93 more patients realized a positive change in clinical encounter time. However, ratings for physician's interest in patients showed no improvement; instead, ratings indicated that physicians were more interested in files than in patients. One more patient identified the negative outcome, but in contrast to that, the physician-patient relationship had a positive score as indicated by the number of patients' responses before and after the cultural sensitivity training.

On patient volume, before and after cultural sensitivity trainings, both primary and secondary health care services gained a significant increase in their encounter ratings after completion of the cultural sensitivity training. Additionally, health insurance providers including Medicaid and self-pay indicated an increase in positive survey responses from LGBTQ patients after the cultural sensitivity training. Health systems who participated in this study saw an increase in both patient volume and revenue, according to CMS and EMMA reports.

Limitations of the Study

One concern about using secondary data is that the specific research questions or support of correlations between variables based on existing data may not be achieved because I did not collect the primary data. It also limited the original questions posed in this study. The research questions were as follows. RQ1: Based on the EMMA and CMS data (2010–2020), what is the statistical relationship between hospital revenue and patient satisfaction within health systems among LGBTQ patients? RQ2: Based on the EMMA

data (2010-2020) and CMS reports (2010-2020), is there a relationship between patient satisfaction and patient volume among LGBTQ patients?

In this study, I used data from EMMA and CMS reports in inpatient health systems within the state of Georgia. Based on findings within the EMMA public database, minimal data existed regarding health care systems in Georgia between 2010-2020, which solidified stable revenue throughout Georgia health systems. Data from the American Hospital Directory was used to accurately reflect patient volume. However, one of the challenges that can cost the study validity is lack of control over the data collection. If mistakes were made in the CMS reports or incorrectly entered data became published, it would be difficult for the researchers to identify and rectify the updated findings. In secondary data collection, it is less possible to correct errors made by the source (Trinh, 2018). More so, it would be difficult even to know if this error exists, thus reaching an erroneous conclusion in the study result. This, this is a potential limitation in this study.

Lastly, a related problem arose with the variables. I may have described or categorized what was done; for instance, the age may have been in categories instead of a continuous variable. Sex may also have been defined rather than generalized.

Recommendations

Findings from this study revealed a significant improvement in patient satisfaction after participants completed the cultural sensitivity training, which suggests positive correlational findings within this study. I also identified that without perceived discrimination by LGBTQ patients, health systems could increase their total patient

revenue, improve patient outcomes within this community, and increase employee retention. However, from the acquired results after the cultural sensitivity training, a negative response surrounding overall provider engagement and time spent per patient was discovered. The study findings suggested that physicians tend to concentrate on the history and physical of the patient as opposed to the presenting symptoms. This observation suggests the need for future studies on perceived provider engagement with LGBTQ patients throughout health systems.

Implications for Professional Practice and Social Change

Discrimination in health systems, workplaces, and government has been a topic discussed by scholars for some time, in academic publications, social media, television, and classroom settings. These discriminatory practices are categorized in two parts: direct and indirect bias. Direct discrimination comes when an explicit distinction, exclusion, or preference is made on one ground, for instance, women only. This may be perceived as a form of exclusion and/or bias to members of the LGBTQ community, as individuals within in this community do not always express their gender and assigned sex synonymously.

Indirect discrimination happens when there are policies in place that apply for everyone but disadvantages a group of people, such as some of the barriers members of the LGBTQ community experience in the health care system and insurance utilization. Discrimination and prejudice within the LGBTQ community exists beyond health care. Members of the LGBTQ community have reported experiences with indirect discrimination in the right to marry and the ability to adopt children in some states within

the United States.

Few studies have addressed the difficulties members of the LGBTQ community experience in accessing quality health care. These challenges are not unique to Georgia; LGBTQ individuals across the country have likely experienced discomfort or perceived bias from providers who do not identify as LGBTQ friendly. This difficulty indicates that LGBTQ individuals find it increasingly difficult to obtain a health provider who understands and acknowledges the complexity of accessing café within the community. The LGBTQ community faces discrimination from health insurers and health providers, potentially causing a delay or disruption in health care. Much should be done to increase comfort with providers treating this community, such as educating health professionals on understanding the unique health care needs of members of the LGBTQ community and taking legislation actions such as passing the Equality Act (Kates et al., 2015)

Conclusion

Continued marginalization and discrimination against members of the LGBTQ community present adverse impacts on patient satisfaction, which leads to a decrease in revenue as members of the LGBTQ community are forced to seek services from competitors, thereby influencing both the health system's reputation within the surrounding community and patient volume. Implementing cultural sensitivity trainings within health systems may challenge providers to deter from their personal beliefs regarding this patient population and identify strategies to engage and support the unique medical needs of this community. Cultural sensitivity training can improve patient outcomes within this community, decrease existing health disparities that

disproportionately plague this community, and ensure these patients feel welcomed and engaged by providers. The results of this study may be applicable to health systems that face patient satisfaction challenges, specifically within the LGBTQ community.

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