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Measuring Healthcare Quality for Sexual Minority Women

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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Walden University
2025

Abstract

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by

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MS, University of South Florida, 2015

BS, University of Florida, 2014

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Healthcare Administration

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May 2025

Abstract

Women who identify as lesbian, bisexual, or other sexual orientations (i.e., sexual minority women) experience poorer health outcomes compared to heterosexual women. Despite the increasing prevalence of sexual minority women in the United States, little research exists to identify their unique health needs. Healthcare administrators play a critical role in promoting a higher standard of patient care by identifying systemic issues and leveraging data-driven solutions. The purpose of this study was to examine various aspects of care delivery in clinical encounters involving sexual minority women and evaluate their perception of care quality. Donabedian's model of healthcare quality served as the theoretical framework for this study. Secondary data from the Association of American Medical Colleges' Consumer Survey of Health Care Access were explored using chi-square tests of independence and multivariable logistic regression. The chi-square analysis revealed lesbian or bisexual women were less likely to report receiving clear explanations ($p = .043$), sufficient time with the provider ($p < .001$), or being treated with respect ($p = 0.001$). The results of these analyses also found no significant difference in patient satisfaction between sexual minority and heterosexual women ($p = .377$), while controlling for covariates. A study of this framework contributes to positive social change by identifying patient satisfaction predictors for this patient population and perceptions of care delivery among diverse patient populations. Healthcare administrators can use these insights to address the complexities of delivering equitable care to diverse patient populations and develop inclusive quality measures, improving the organization's overall standard of care.

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Dedication

I dedicate this doctoral study to my parents for their unwavering support. From an early age, my father instilled in me the importance of being a lifelong learner. He nurtured my passion for knowledge and taught me to believe that the mind can achieve the impossible. This study stands as a testament to the success my parents envisioned for our family when they emigrated from Haiti.

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I am forever indebted to my husband and daughter for the love they bring into my life. From staying up late with me as I completed assignments to serving as my sounding board during mental roadblocks, my husband has been my most dedicated supporter.

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Section 1: Foundation of the Study and Literature Review

Introduction and Background

As the lesbian, gay, bisexual, and transgender (LGBT) community become increasingly visible in society, the healthcare system is faced with incomplete information about the population's health disparities, needs, and overall status. Most healthcare systems do not systematically collect sexual orientation and gender identity data in patient satisfaction surveys, patient questionnaires, and medical records, nor have they developed structured systems to address this gap (Centers for Disease Control and Prevention [CDC], 2020). The Association of American Medical Colleges (AAMC, n.d.) Center for Workforce Studies is one of the few surveys to provide a data source to examine consumer trends in accessing healthcare while also including sexual orientation data for its participants.

Although research on LGBT health is in its early stages, there is substantial evidence of health disparities between sexual minority and heterosexual individuals (Tabaac et al., 2020). Similar to the broad umbrella term "LGBT", the healthcare needs of LGBT individuals are often grouped together. However, each subgroup within this community is a distinct population with its own health needs. Research has specifically documented that sexual minority women—defined as lesbians, bisexuals, or women who have sex with women—as having unmet medical needs (Baptiste-Roberts et al, 2017). Sexual minority women are more likely to report poorer health outcomes or multiple chronic conditions yet have lower participation rates in preventative health services compared to other minority groups (Waugh et al., 2021).

At the interpersonal level, women are more likely than men to discontinue care from a provider due to dissatisfaction. Health research examining women satisfaction with care has found that sexual minority women report lower satisfaction with their healthcare providers (HCPs) compared to their heterosexual counterparts (Scott et al., 2023). Both perceptions of quality and clinical indicators of care drive service utilization. Addressing these factors is essential when evaluating the overall quality of healthcare services.

The purpose of this study was to examine various aspects of care delivery in clinical encounters involving sexual minority women patients and to assess their perceptions of care quality. For the purposes of this study, healthcare quality and sexual minority status were key independent variables, while perceptions of care and patient satisfaction served as key outcomes (dependent variables) of interest. The study accounted for other covariates that may affect healthcare quality and patient satisfaction, including age, race/ethnicity, language, insurance status, and usual source of care. Study findings in this area can contribute to positive social change by expanding knowledge on system-level quality indicators for minority patient populations.

Highlighted in the remainder of this chapter are the problem statement, the purpose of study, the research questions and corresponding hypotheses, the conceptual framework, as well as the nature of the study.

Problem Statement

LGBT individuals experience significant individual and system-level barriers to receiving quality healthcare. Sexual minority women are less likely to seek preventive

health services than their heterosexual counterparts, and those who do seek or utilize healthcare experience unique challenges, including physician ignorance regarding lesbian health issues, inappropriate questioning, and even refusal of services (Lund & Burgess, 2021). There is a limited understanding among healthcare administrators regarding how sexual minority women perceive and measure healthcare quality in ambulatory settings. As leaders in the healthcare business, administrators must be well-informed about the health needs of this marginalized population and work to operationalize process improvements that promote equitable care. At a time when sexual minorities are advocating for equitable treatment, health professionals and researchers lack sufficient data on this marginalized group. The federal government's decade-long prevention agenda for improving population health, *Healthy People 2030*, clearly defined LGBT health as a key objective. The national initiative recognizes LGBT people experience many specific health-related challenges and disparities. Healthy People 2030 further asserted that collecting population-level data is key to meeting the health needs of this demographic, revealing a study regarding the healthcare quality of sexual minority women is both relevant and timely to the industry of health administration (Office of Disease Prevention and Health Promotion [ODPHP], 2022). Despite this national focus, only eight of more than 80 national data systems have collected sexual orientation statistics over the past decade. Furthermore, these surveys do not provide meaningful background into the healthcare experiences of sexual minority women in primary and urgent care setting (ODPHP, 2022).

Healthcare administrators play a critical role in the operational effectiveness of healthcare organizations and have the power to influence cultural and structural conditions that enhance provider performance. Understanding a patient's sexual orientation and behaviors enables HCPs to identify disproportionate health risks and deliver inclusive, competent care (ODPHP, 2022). Although researchers have investigated health disparities of sexual minority women, there is little to no literature exploring the specific factors within patient-physician encounters that shape how sexual minority women may perceive the quality of care. Most studies available in empirical literature have relied on qualitative interviews of sexual minority women's healthcare experiences and have based their findings on convenience population samples or narrowly focus on a single health disparity (e.g., mental or reproductive health; Ayhan et al., 2020; Eliason, 2014).

A study grounded in this framework provides insight into the organizational performance of ambulatory settings in providing care for sexual minority women. It can also equip healthcare administrators with pertinent information to better measure care quality for this population subset. The knowledge gained through this study can strengthen healthcare administrators' ability to implement improved practices focused on enhancing organizational performance and healthcare quality for a broader spectrum of patients.

Purpose of the Study

Health outcomes and patient experiences can vary significantly across different populations, highlighting the need to target research on marginalized groups. The purpose

of this quantitative study was to examine various aspects of care delivery in clinical encounters involving sexual minority women and assess their perceptions of care quality. For the purposes of this study, care delivery was the key independent variable, while patient satisfaction and perceived quality of care functioned as dependent variables.

The Institute of Medicine (IOM; n.d.) defined healthcare quality as care that is effective, efficient, equitable, patient-centered, safe, and timely. These six domains of quality represent the gold standard of care in a wide variety of healthcare settings but manifest differently across patient populations. Healthcare service quality is a multidimensional target encompassing system-level factors (e.g. time, medical history, staff knowledge), clinical factors (e.g. diagnosis, treatment), and interpersonal factors (e.g. provider communication, respect, cultural competency; James et al., 2017). Given their leadership role in healthcare organizations, hospital administrators are responsible for ensuring that operational processes and workforce management strategies align with these quality standards to deliver equitable and effective care.

Patient satisfaction plays a crucial role in healthcare engagement. A recent survey conducted by West's Engagement Center found that 91% of patients would consider switching providers, and 74% would delay seeking care if they were not completely satisfied with their healthcare experience (West Corporation, n.d.). These findings have underscored the importance of patient-centered care, as satisfaction directly influences patients' willingness to engage in their care and compliance to treatment plan directives (Vogus & McClelland, 2016). Sexual minority women, a historically marginalized group, experience stigma and discrimination in a variety of environments, including healthcare

settings. Addressing these challenges requires a deeper understanding of how sexual minority women perceive their healthcare experiences. By examining these perceptions, healthcare professionals can refine their ability to guide physical examinations, differential diagnosis, and treatment plans during the patient-provider encounter (CDC, 2020).

Research Questions and Hypotheses

Research Question 1 (RQ1): Are there significant differences between sexual minority and heterosexual women in their perceptions of healthcare delivery, specifically regarding receiving adequate answers to questions, receiving clear explanations, spending sufficient time with HCPs, being treated by a provider of the same race, and being treated with respect?

$H_0$1: There is no significant association between sexual minority status and perceptions of healthcare delivery across the specified care delivery measures.

H_a1: There is significant association between sexual minority status and perceptions of healthcare delivery across the specified care delivery measures.

RQ2: Are there differences in patient satisfaction between sexual minority and heterosexual women when controlling for insurance status, primary language, age, and race/ethnicity?

$H_0$2: There is no statistically significant difference in patient satisfaction of sexual minority and heterosexual women when controlling for insurance status, primary language, age, and race/ethnicity.

H_a2: There is statistically significant difference in patient satisfaction of sexual minority and heterosexual women when controlling for insurance status, primary language, age, and race/ethnicity.

For the purposes of this study, health care quality (care delivery) and sexual minority status were key independent variables of interest, and patient satisfaction as well as their perceptions of care were the key outcome (dependent variable) of interest. The study accounted for other covariates that may affect healthcare quality and patient satisfaction including age, race/ethnicity, language, insurance status.

Theoretical Foundation for the Study

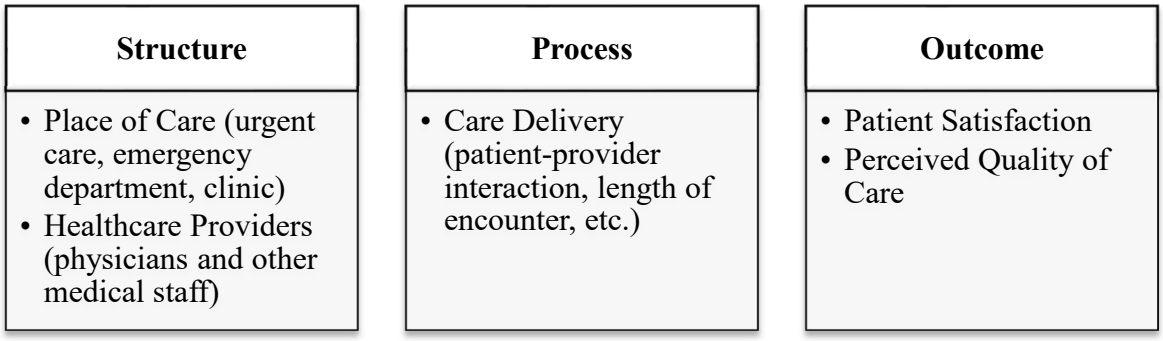
This study was grounded in Donabedian's (2005) conceptual model of healthcare quality, which assesses and compares healthcare quality through the triad of structure, process, and outcomes. Donabedian (1966) defined "structure" as the environment, qualifications of health providers, and the administrative systems through which care occurs; "process" as how the care is administered; and "outcomes" as the resulting health status or overall quality of care.

Patient-provider communication is a cornerstone of the patient experience and can have a strong impact on the patient's perception of care (Donabedian, 2005). Patients often do not always have the background to assess the technical quality of the care process, but they are acutely aware of the interpersonal relationship or how the care is delivered. The classic framework on healthcare quality describes the symmetry between process and outcomes in assessing quality. Processes and outcomes are complementary measures and there lies the assumption of causal linkage between the two.

This doctoral study aligned directly with Donabedian's methods for measuring healthcare quality because it evaluated how both structure (HCPs) and process (care delivery) relate to outcomes (satisfaction or perceived quality) within the patient population of interest. Figure 1 shows Donabedian's model of healthcare quality and the AAMC Health Consumer Survey.

Figure 1

Donabedian's Model of Healthcare Quality and AAMC Health Consumer Survey



Nature of Study

To address the RQs in this quantitative study, I adopted a correlational study design employing multivariable logistic regression. The study used secondary data from the (AAMC's *Consumer Survey of Health Care Access* (AAMC, n.d.). AAMC conducts this survey twice a year to examine the healthcare access and the quality of the services rendered to the patient. The survey includes a panel of 1.5 million people in the United States and evaluates healthcare quality and health status through questions focused on patient satisfaction, recent medical care experiences, and provider performance (e.g., communication, diagnoses, and care delivery).

This study examined the relationship between patients' perceptions of care quality and their sexual minority status. Specifically, the dependent variables related to care delivery were used to measure patients' understanding of the quality of care received and to assess potential differences between sexual minority women and heterosexual women. Because the study aimed to examine and quantify the quality of care for sexual minority women through various care quality measures, a quantitative method was most appropriate. For the purposes of this study, sexual orientation (SEX_ORIENT, SEX_ORIENT_OTH) and sex (SEX) served as the variables that represent the patient population of interest. The dependent variable patient satisfaction was measured on an ordinal level with a 5-point Likert scale. Covariates were measured at the nominal level. The dependent variables related to care delivery (PROV_ANS, UNFAIR_SEX) were examined at the nominal level.

The December 2023 wave of the AAMC Health Consumer Survey included 3,500 participants. The study focused exclusively on sexual minority women and heterosexual women who were assigned female at birth. There are obvious reasons for this inclusion criteria. The focus of this study was the key factors in the quality of care provided to sexual minority women; therefore, it was important to incorporate a sex inclusion criterion. Chi-squared tests of independence conducted in SPSS were used to examine both RQs and determine if a statistically significant difference exist between sexual minority and heterosexual women within various categories of healthcare quality.

Literature Search Strategy

Several keywords were identified in conducting a literature review of current topics regarding healthcare quality and satisfaction of sexual minority women. The articles in the literature review highlight research regarding women's health care coordination and delivery, patient satisfaction, and administrative concerns involving care for sexual minority populations. The keywords *sexual minorities, lgb*, lesbian, homosexual*, and *bisexual* were searched in conjunction with *care coordination, care delivery, patient satisfaction, patient experiences,* and *patient perceptions and patient attitudes* in Walden University's electronic library databases (CINAHL, Medline, and PubMed) and online websites such as Google Scholar or LGBT Health.

Literature Review Related to Key Variables and/or Concepts.

The literature review focuses on research related to the independent variable sexual minority women and the dependent variables of care delivery and patient satisfaction.

Care Delivery

Primary care is foundational to the healthcare system, serving as the primary setting for preventive screenings and early interventions that improve long-term health outcomes. According to a report published by Commonwealth Fund and Manatt Health, improving primary care access for women will require an updated care strategy that is sex-specific, sex-aware, and gender-sensitive (as cited in Zephyrin et al., 2020). The primary health system is well positioned to play the distinctive role of addressing women's physical health, behavioral health, and social needs across the course of life.

Through extensive planning and system support, care coordination and delivery prevent gaps in care and permits women to receive consistent care at all stages of life (Zephyrin et al., 2020).

Care delivery is recognized as a central fixture to patient-centered, high-quality care, particularly for high-risk populations. Elliott et al. (2021) found that care delivery scores are positively related to clinical performance on 9 of 13 quality measures for women, such as breast cancer screening, colorectal screening, cardiovascular care, and diabetes care. Healthcare quality is associated with better measures of care delivery and greater receipt of preventive services, lower mortality rates, fewer hospital admissions, and better patient experiences (AHRQ, 2022). Similarly, Boehmer et al.'s (2020) study on the perceived quality of care across sexual orientation groups concluded patients' perception of quality care are shaped by care delivery and interactions with clinicians, both of which have positive associations with the rating of care. Among the sexual minorities present in the study, women were less likely to rate care as excellent. The positive perception of care delivery significantly increased the likelihood of an excellent rating in overall care (Boehmer et al., 2020).

Healthcare administrators and other organizational leadership are often responsible for participating in taskforces to advance healthcare quality and recommend the components requiring the most attention (Doherty et al., 2021). To be useful for healthcare consumers, quality measures must include aspects of healthcare they deem important and effective communication between patients and HCPs is a foundation for high-quality care delivery. Care delivery is produced through concerted actions of each

actor involved, including the patient, provider, and even more distant actors such as administrators (Gengler & Jarrell 2015). Clinical interactions in any setting or format require a level of communication between the HCPs and the patient. Though healthcare delivery, in a broad sense, encompasses the care settings, data systems, organizational infrastructure, standardized policies and practices used to support the health services, at the most basic level, care delivery is an exchange of health information between those administering the care and those receiving the care (Gengler & Jarrell 2015).

Healthcare Interactions

Many sexual minority women do not conform to traditional gender norms and may present themselves in a way that disrupts conventional gendered social interactions. Women who do disrupt gendered norms are vulnerable to negative experiences with HCPs, including confrontational or dismissive encounters (Mitchell et al., 2023). Lesbian and bisexual women have reported negative healthcare interactions such as "rough" treatment from their provider, diagnosis of their sexual orientation as a medical condition, and even being refused care (Kamen et al., 2019).

Although homosexuality has been removed from the Diagnostic and Statistical Manual (DSM) classification of mental disorders in 1973, remnants of stigma remain in the U.S. healthcare system (Thomas-Castillo, 2023). Given the history of the medicalization of homosexuality, it can be argued that discrimination against sexual minority women is endemic to healthcare. Therefore, administrators have a genuine need to determine whether the care rendered to sexual minority women meets the expectations of the population and industry standards for equitable treatment. Health administrators

are responsible for establishing the policies and procedures for promoting high-quality care. Without any reference to the experiences and perceptions of each patient subset, healthcare administrators cannot confirm that care is being delivered in a manner that does not have negative implications for health outcomes. Negative implications can present themselves in patients withholding pertinent information from the provider due to lack of trust, inhibiting healthcare professionals from making sound treatment decisions or patients delaying care for fear of discrimination (Lerner et al., 2020).

Provider Attitudes and Bias

Across several studies, researchers have recommended healthcare organizations to support physicians undergoing additional training to increase the providers' awareness of negative attitudes and behaviors towards sexual minorities (Karakaya & Kutlu, 2020). Sexual minority patients admitted to neglecting treatment because of former experiences and their general awareness of biases towards the LGBT population (Hsieh & Mirzoyan, 2021; Mitchell et al., 2023). In a 2015 study, researchers discovered that heterosexual male physicians displayed a strong implicit preference for heterosexual patients than their female peers and heterosexual male and female nurses both showed strong preferences for heterosexual patients (Sabin et al., 2015). Sabin et al.'s study findings support the idea that providers prefer to treat patients with identities like their own. This preference can put sexual minority women at a clear disadvantage from their heterosexual peers when seeking health services.

Provider Competency in Treating Sexual Minority Women

Sexual minority women patients have difficulty finding culturally competent HCPs. Sexual minorities are nearly twice as likely to delay or avoid necessary medical care when compared to their heterosexual peers (Lerner et al., 2020; Scott et al., 2023). In *Healthy People 2020*, the CDC described a shortage of healthcare professionals who are culturally competent in LGBT health, a systems-level characteristic that affects equitable care for sexual minorities (CDC, 2020).

Khalili et al.'s 2015 study queried all U.S. accredited medical schools to evaluate current education, policies, and procedures surrounding LGBT health. Researchers of the study discovered that less than 9% of institutions had a procedure to identify LGBT-competent physicians affiliated with their institution and even fewer institutions (4%) had a policy in place to identify LGBT-competent physicians. Overall, 52% of the participating institutions do not have any LGBT cultural competency training in their curriculum (Khalili et al., 2015). In a study conducted by Nowaskie and Sowinski (2019), 70.1% of primary care providers disclosed that they did not feel well informed on specific LGBTQ health needs and 78.7% were unfamiliar of how to refer patients with LGBTQ issues. The primary care providers in Nowaskie et al.'s survey obtained only 51% accuracy on LGBTQ knowledge questions.

Unique Health Needs of Sexual Minority Women and Health Outcomes

The most basic step a provider can take to reduce healthcare failures for sexual minority women is to encourage identity disclosure during the clinical encounter, as sexual orientation concealment can exact negative mental and physical health. Sexual

orientation concealment has been linked to depressive and anxious symptoms, substance abuse, infectious disease susceptibility, and premature mortality (Everett et al., 2021; Pachankis & Bränström, 2019). Bostwick et al. (2015) found that lesbian and bisexual reported high incidences of depressive symptomology and sexually transmitted infection (STI) diagnoses—two indicators that have long-term implications for cardiovascular disease, cancer, or infertility. Everett et al.'s study (2021) linked sexual minority women to a higher mortality risk than their heterosexual peers due to health risk behaviors, health conditions, and sexual-minority-specific sources of stress like nondisclosure. Population studies on sexual minority women have shown the population is disproportionately susceptible to preventable chronic conditions such as heart disease, hypertension, diabetes, and certain cancers (Simenson et al., 2020; VanKim et al., 2021).

Compared with their heterosexual counterparts, sexual minority women are more likely to exhibit health risks, such as, obesity, heavy drinking, and smoking (Lund & Burgess, 2021). Despite controlling for sociodemographic factors such as health insurance status, education, income, and race, Simenson et al.'s (2020) study results showed significant health disparities between sexual minority women and their counterparts. Lesbian and bisexual women were more likely to report mental distress, obesity, and other chronic disorders that are future indicators of negative health outcomes like cancer or cardiovascular issues (Salomaa et al., 2022; Simenson et al., 2020). Conducting more in-depth research on how to properly administer care to sexual minority women can assist healthcare administrators in

formulating the necessary policies and care standards to encourage the population to utilize health services and follow recommended guidelines for preventive screenings.

Patient Satisfaction

Attempts to establish a higher quality of care for patients can often be underpinned by the biomedical understanding of quality and a focus on conceptualizing clinical guidelines (Hanefeld et al., 2017). Patient satisfaction studies have emphasized that clinical quality is critical for patient outcomes but perceptions of the quality of care, which may not align with clinical benchmarks, are likely to be the key drivers of service utilization (Hanefeld et al., 2017). Patient satisfaction is an outcome measure of a patient's experience, reflecting whether the care provided has met the patient's expectations. Research studies have suggested satisfaction measures are useful for identifying areas of service provision that are a priority for patients and self-reported questionnaires are the standard practices to examine patients' satisfaction with healthcare services (Elliott et al., 2021; Larson et al., 2019).

Definitions

I defined the following key terms relevant to this study to provide further clarification:

Care delivery: Piña et al. (2015) defined healthcare delivery as the organization of people and resources to deliver healthcare services to meet the needs of a target population.

Patient satisfaction: Patient satisfaction is defined as an evaluation of distinct dimensions of healthcare and may be considered as the perception of clinical encounters or the desired outcomes of care (Linder-Pelz, 1982).

Sexual minority: Math and Seshadri (2013) noted that sexual minority describes an individual whose sexual identity, orientation, and behaviors differ from the majority in society. In the United States, this encompasses people who identify as lesbian, bisexual, gay, transgender, questioning, or queer.

Sexual minority women: Lesbian and bisexual women (Simoni et al., 2017).

Assumptions

This study was based on several assumptions:

1. The AAMC's Consumer Survey of Health Care Access is a reliable, accurate cross-sectional study. The survey instrument must be a valid and reliable study to allow for accurate measurement of the variables of interest.
2. The Consumer Survey of Health Care Access was completed by individuals who received some level of patient care in the most recent 12 months from the date of the survey. This assumption was critical in determining the performance of healthcare organizations in that particular year. Respondents referencing healthcare experiences too far in the past could skew data for the period of interest.
3. The variables under investigation were clearly defined and measurable (e.g. care delivery and satisfaction).

4. Respondents in the survey answered all questions independently and truthfully. Candid evaluations revealed the patient's perspective of healthcare quality and performance with minimal external influences. I also assumed that patients understood the intent of each question. If this assumption was inaccurate, it would impact on the validity of the survey's results.
5. To better represent the adult population in the United States, data are weighted by sex, age, race, ethnicity, income, education, and geographic region. For the instrument to be valid, the study must be representative of the population of interest. Adjusting the data corrects any imbalances between the survey sample and the populations, reduces selection bias in opt-in surveys, and helps prevent the data from over or under projecting the true quality of care for each population subset.

Scope and Delimitations

The study was based on AAMC's 27th wave (December 2023) of the Consumer Survey of Healthcare Access, which examined how people in the United States access and perceive healthcare services. The scope of the study was to measure the quality of healthcare of sexual minority women respondents. The focus of the study was narrowed to sexual minority women because such patients are known to have significant health disparities and low healthcare utilization rate (Hsieh & Shuster, 2021). The survey's questions regarding patient satisfaction, recent care experience, health status, provider competency, and care delivery assisted in identifying quality of care indicators for sexual minority women.

Limitations

Information collected from the data source is self-reported and subject to personal biases. AAMC administers the survey biannually and not after each provider-patient interaction. Survey participants may be responding with different time references in mind (most recent healthcare experience versus a broad overview of care). Software licenses and fees applied to access the raw data from AAMC.

Significance

Study findings in this area can contribute to positive social change by adding to the growing knowledge of quality indicators of the healthcare experience. Health administrators can use this information to understand how their health service organizations compare in quality across various patient populations. A study of this nature highlights potential quality concerns in healthcare delivery and identifies areas needing further investigation or restructuring. Hospital systems, hospital associations, ambulatory care settings, and urgent care facilities benefit from study findings by improving how quality is assessed in measures such as patient-centeredness, equitable care, and physician performance from research evidence. Healthcare administrators can apply the data from this study to determine whether there are disparities in the health needs, care quality, and satisfaction of sexual minority women by evaluating health consumer data with sexual orientation identifiers. This doctoral project may be used to support new clinical practice guidelines, provider communication strategies, and business systems inclusive of the identified needs for sexual minority women to positively impact the domains of healthcare quality and performance. The study aims to add another

dimension in how the healthcare industry currently reviews care quality and promotes a high quality of care for all patient populations.

The few studies focusing on healthcare experiences of sexual minority women, such as Huang et al. (2024) and Simenson et al. (2020), included populations tied to a small geographic region or experiences in a recorded interview format. These research methods create barriers in objectively applying study results to a larger patient population. This study, on the other hand, reflects a more representative analysis of the care quality provided to sexual minority women. Part of understanding sexual minority women health is to determine how the current healthcare system is underserving the subgroup and identify methods to better care for sexual minority women. With this study, healthcare administrators can redesign care models to integrate sexual minority women to the standard of service delivery experienced by other patient populations.

Summary and Conclusions

The review of literature on the healthcare quality of sexual minority women revealed that the existing measurement approaches of quality have failed to address the complexities involved in understanding quality of care. The execution of quality-related factors may not always align with the patients' perception of care, especially for minority patient populations (Hanefeld et al., 2017). Therefore, both aspects of care must be assessed. Key themes presented in the overview of literature include improving provider competencies related to sexual minority health needs, examining provider attitudes and bias, assessing the healthcare environment's influence on healthcare-seeking behavior, and discussing sexual minority women's high prevalence of risk factors for poor health

but low uptake of preventive services. Section 2 will introduce and address the study's research design and rationale, methodology, and threats to validity.

Section 2: Research Design and Data Collection

The purpose of this quantitative correlational study was to examine various aspects of care delivery in clinical encounters involving sexual minority women patients and measure their perception of care quality. A quantitative research method was required to determine the existence and strength of relationships between organizational performance, from the perspective of sexual minority women, and the associated health outcomes and patient satisfaction. Secondary data from the 27th wave of the AAMC Consumer Survey of Health Care Access were used to perform multivariable logistic regression. In the next sections, I will address the research design and rationale, methodology, and threats to validity.

Research Design and Rationale

Chi-square tests of independence were used to analyze if a significant relationship exists between care delivery and patient satisfaction for the populations of interest. This quantitative study will use the outcome variables of care delivery to measure the patients' understanding of the quality of care received and examine what type of relationship the organization's performance has, if one exists, with the dependent variable of patient satisfaction.

RQ1 was as follows: Are there differences in healthcare quality (e.g., care coordination, care delivery) between sexual minority and heterosexual women when controlling for insurance status, primary language, age, and race/ethnicity? RQ2 was as follows: Are there differences in patient satisfaction between sexual minority and heterosexual women? For the analysis, I examined the impact of performance metrics

(care coordination and delivery) on patient satisfaction. I also investigated if there is positive association between care quality and health outcomes for sexual minority women. The three components from the Donabedian framework (i.e., structure, process, and outcome) were applied in the study as follows: healthcare setting and the cultural competency of associate providers and staff (structure) care coordination and delivery (process), and overall patient satisfaction (outcome). Batbaatar et al.'s (2017) systematic review of patient satisfaction and chronic conditions revealed that patients with more chronic illnesses report higher satisfaction. The researchers attributed the positive correlation to better reports of patient-provider interaction and support.

Methodology

Target Population

The target population for this study was women, ages 18 and older, living in the United States who participated in the AAMC Consumer Survey of Health Care Access in December 2023. In the 2023 iteration of the survey, half of the 3,446 survey respondents identified as women, with about 200 identifying as lesbian, gay, or bisexual. The target population was distinguished by patients who sought out healthcare services from 2022-2023. Patient demographics considered sex (female), sexual minority status (lesbian or bisexual), and age (18 years or older). Table 1 shows the population demographics for the study.

Table 1

Population Demographics Considered for This Study

Demographic characteristics	Inclusion criteria
Age group	18 years and above
Sex	Women
Race group	All race groups
Education	Any level of education
Employment status	Employed and unemployed
Annual household income	All household incomes
Sexual orientation	Heterosexual, lesbian, and bisexual
Health insurance	Insured and uninsured
Preferred language	English, Spanish, and other

Sampling and Sampling Procedures

AAMC fields the Consumer Survey twice each year, with each wave consisting of a core sample of 2,000 survey participants drawn from a nationally representative panel of 1.5 million people (AAMC, n.d.). Panelists were asked a series of demographic questions followed by a filter question if they needed medical care within the most recent 12 months. Panelists indicating they needed or sought out healthcare were invited to complete the consumer survey. Survey participants are not allowed to participate in two consecutive waves of the survey.

Samples are used in research to make inferences about the population of interest due to practicality. According to Saks and Allsop (2012), large samples improve the reliability of study results because it considers a larger proportion of the target population; however, the process to collect the data can become too costly, time-consuming, and even wasteful. Conversely, small sample sizes are more susceptible to

biases and inconclusive results because they lack depth and variability (Meyers et al., 2016).

The sample size for the study was determined using G*Power (Version 3.1.9.7) software for Windows. The G*Power software supports sample size and power calculation for statistical analyses using for variables: large effect size, alpha level, power level, and the calculated minimum sample size (Kang, 2021). For this study, a medium effect size of 0.5, alpha level of 0.05, and power level of 0.95 was used to calculate a minimum total sample size of 176. Table 2 shows the sample size calculation.

Table 2

Sample Size Calculation Using G Power*

Sample size calculation using G*Power	
Input	
Tail	One
Effect size	0.5
α err probability	0.05
Power (1-β err probability)	0.95
Output	
DF	174
Total sample size	176
Actual power	0.95

Operationalization of Variables

In this quantitative study, two key outcomes of interest were explored: care delivery and patient satisfaction. Patient satisfaction for each healthcare quality topic area is measured on a nominal scale. AAMC's Consumer Survey assesses the participants' perspective on their recent health experience with questions surrounding various aspects

of care delivery such as time the HCP spent with the patient, to the degree the HCP explained information, and how the patient felt the provider treated them. Each question or statement has yes or no responses to capture whether the participant agreed with the question or statement. Table 3 illustrates the operationalization of variables.

Table 3

Operationalization of Variables

Care delivery dimension	Measurement	Responses
HCP explained clearly	Nominal	Yes, no, Don't know
HCP provided adequate answers	Nominal	Yes, no, Don't know
HCP spent enough time	Nominal	Yes, no, Don't know
HCP treated with respect	Nominal	Yes, no, Don't know
Patient satisfaction		
Level of satisfaction with the most recent medical care visit	Ordinal	1 Don't Know 2 Very Dissatisfied 3 Somewhat Dissatisfied 4 Neither satisfied nor dissatisfied 5 Somewhat Satisfied 6 Very Satisfied

Data Analysis Plan

For this study, a descriptive analysis was performed to determine if there are statistically significant differences in healthcare quality in relation to sexual minority women patients. Chi-square tests of independence were used as the most suitable method to analyze the relationships between the variables and answer the RQs. I completed the following statistical tests and data analysis using IBM SPSS Version 30. I developed RQs for the study using Donabedian's conceptual framework for healthcare quality.

To determine whether the differences between the mean ratings of care are statistically significant, I compare the *p*-value for each RQ to my significant level to assess the null hypothesis. If the *p*-value exceeded the significance level, I concluded there is a statistically significant difference between the qualities of care provided. I further examined the perceptions of quality care for sexual minority women by reviewing the means for all population groups for each question. Chi-square tests of independence assume that each observation is independent of one another, data are normally distributed, and the variance among the groups should be approximately equal.

RQs and Hypotheses

RQ1: Are there significant differences between sexual minority and heterosexual women in their perceptions of healthcare delivery, specifically regarding receiving adequate answers to questions, receiving clear explanations, spending sufficient time with HCPs, being treated by a provider of the same race, and being treated with respect?

$H_0$1: There is no significant association between sexual minority status and perceptions of healthcare delivery across the specified care delivery measures.

H_a1: There is significant association between sexual minority status and perceptions of healthcare delivery across the specified care delivery measures.

RQ2: Are there differences in patient satisfaction between sexual minority and heterosexual women when controlling for insurance status, primary language, age, and race/ethnicity?

$H_0$2: There is no statistically significant difference in patient satisfaction of sexual minority and heterosexual women when controlling for insurance status, primary language, age, and race/ethnicity.

H_a2: There is statistically significant difference in patient satisfaction of sexual minority and heterosexual women when controlling for insurance status, primary language, age, and race/ethnicity.

For the purposes of this study, health care quality (care delivery) and sexual minority status were key independent variables of interest, and patient satisfaction as well as their perceptions of care were the key outcome (dependent variable) of interest.

Threats to Validity

External Validity

A primary goal of research, particularly in healthcare, is the ability to extend inferences drawn from the sample to the greater population. External validity is a construct that aims to answer the question of whether researchers can apply study findings to individuals outside of the sample (Murad et al., 2018). Given the AAMC Consumer Survey's focus on medical treatment received in primary healthcare settings, findings from this study may not be transferable to the individuals accessing healthcare services from alternative medical care facilities such as community centers, assisted living facilities, or homecare.

Internal Validity

Internal validity calls into question the outlying variables or events impacting the causal conclusion between the independent and dependent variables (Meltzoff & Cooper,

2018). In experimental research designs, researchers can help to ensure internal validity through careful sampling, comprehensive piloting of instruments and procedures, and accurate data analysis (Meltzoff & Cooper, 2018). This quantitative study was a nonexperimental design based on secondary data. Appropriately, threats to internal validity are not applicable to this study.

Construct or Statistical Conclusion Validity

Healthcare quality is not a single, observable entity that can be observed and measured. Rather, the quality of care is a collection of indicators such as health outcomes, patient satisfaction and other performance metrics that qualify the level of quality. The Agency of Healthcare Research and Quality (AHRQ; 2022) defined the six domains of healthcare quality as care that is safe, effective, patient-centered, timely, efficient, and equitable. This study aimed to measure quality of care for sexual minority women patients by examining the performance of healthcare service organization across these six domains.

Ethical Procedures

The primary basis for recruiting respondents for the Consumer Survey of Healthcare Access was purely scientific in nature. Data sets obtained from AAMC do not identify the survey participants by name or include any identifiable information such as phone number, address, or social security number to protect the participant's anonymity. AAMC restricts access to the data set by only releasing the data involving the variables requested specifically for the study.

Prior to any data collection, I gained approval from Walden University's Institutional Review Board (IRB) to conduct the study. All data received for the study were downloaded and stored on a password-protected personal computer to which only I have access. At the conclusion of the study, all raw data will be deleted, and correspondence will be sent to AAMC confirming the date and time the files were disposed of.

Summary

In this section, I outlined the research design and methodology for the study. Fundamental concepts including sampling procedures, data collection, data analysis, threats to validity, and ethical considerations were explained in relation to the study's RQs. Section 3 will outline the RQs and present the study results and findings.

Section 3: Presentation of the Results and Findings

Introduction

A quantitative correlational study was conducted to examine various aspects of care coordination delivery in clinical encounters involving sexual minority women patients and measure their perception of care quality. Secondary data from the AAMC Consumer Survey of Health Care Access conducted in December 2023 were examined. The target population for this study comprised sexual minority women and heterosexual women, ages 18 and older. In the next sections I will outline the RQs and present the study results and findings.

Two RQs and their accompanying hypotheses were investigated for this study:

RQ1: Are there significant differences between sexual minority and heterosexual women in their perceptions of healthcare delivery, specifically regarding receiving adequate answers to questions, receiving clear explanations, spending sufficient time with HCPs, being treated by a provider of the same race, and being treated with respect?

$H_0$1: There is no significant association between sexual minority status and perceptions of healthcare delivery across the specified care delivery measures.

H_a1: There is significant association between sexual minority status and perceptions of healthcare delivery across the specified care delivery measures.

RQ2: Are there differences in patient satisfaction between sexual minority and heterosexual women when controlling for insurance status, primary language, age, and race/ethnicity?

$H_0$2: There is no statistically significant difference in patient satisfaction of sexual minority and heterosexual women when controlling for insurance status, primary language, age, and race/ethnicity.

H_a2: There is statistically significant difference in patient satisfaction of sexual minority and heterosexual women when controlling for insurance status, primary language, age, and race/ethnicity.

For the purposes of this study, health care quality (care delivery) and sexual minority status were key independent variables of interest and patient satisfaction as well as their perceptions of care were the key outcome (dependent variable) of interest. The study accounted for other covariates that may affect healthcare quality and patient satisfaction including age, race/ethnicity, language, insurance status.

Accessing the Data for Secondary Analysis

Secondary data were obtained from the AAMC Consumer Survey of Health Care Access from December 2023 wave of the survey consisting of 3,051 respondents who met the initial criteria. Inclusion criteria for the study comprised sexual minority women whose sexual orientation was lesbian or bisexual and heterosexual women. Furthermore, the women had to be 18 years and older and living in the United States, which resulted in 1,602 women meeting these criteria. Of these respondents, 1,010 women indicated that they had visited a HCP in the most recent 12 months. A postweight weighting variable was applied based on the sample demographics and need for medical care in the past 12 months to ensure a balanced demographic sample. The demographic weighting is based on the U.S. adult population using the Census Bureau's Current Population Survey based

on sex, age, ethnicity/race, employment status, household income, marital status, education, and region.

Frequencies were computed for all study variables to ensure the final dataset contained no inconsistencies, outliers, or unexplained missing values. Missing values were handled using pairwise deletion. Cross-tabulation with chi-square tests of independence was chosen as the most suitable method to analyze the relationships between the variables and answer the RQ.

Univariate Analyses

Preliminary univariate analyses were conducted to determine whether the inclusion of covariates in the model was justified. The independent variable, sexual minority status, was cross tabulated with each of the covariates. Chi-square tests for independence were specified to determine whether there were any significant associations between the independent variable and each of the covariates.

Age group*:* A statistically significant association was found between sexual minority status and age group, $\chi2(5) = 64.547$, $p < .001$. All expected cell frequencies were greater than 5.

Race group: A statistically significant association was found between sexual minority status and race group, $\chi2(9) = 19.206$, $p < .05$. However, 12 cells had expected counts less than 5.

Insurance status: A statistically significant association was found between sexual minority status and insurance status, $\chi2(2) = 6.5000$, $p < .05$. One cell had an expected count less than 5.

Preferred language*:* No significant association was found between sexual minority status and the language preferred to consult with a healthcare practitioner, $\chi 2(2) = 1.400$, $p = .497$. Three cells had an expected count less than 5.

Except for preferred language consultation, the preliminary univariate analyses provided sufficient justification for the inclusion of age group, race group, and insurance status as covariates in the proposed model.

Results

The following section provides the results of the study. Firstly, demographic and descriptive statistics of the sample are presented. This is followed by the evaluation of statistical assumptions for the study. Hereafter, the statistical analysis findings are presented organized by RQs and hypotheses.

Descriptive and Demographic Characteristics

The demographic characteristics of the sample presented in Table 4 provide a comprehensive overview of age, race, education, employment, income, sexual orientation, health insurance coverage, and language preference.

Table 4

Characteristics of Patient Population

Demographic characteristics	*f*	%
Age group		
18 - 24	112	11.10%
15 - 34	120	11.90%
35 - 44	129	12.80%
45 - 54	226	22.40%
55 - 64	207	20.50%
65 and above	216	21.40%
Race group		
Native American	5	0.50%
Asian	26	2.60%
Black	99	9.80%
Hispanic/Latino/Spanish alone	35	3.50%
Pacific Islander	5	0.50%
White	780	77.20%
Other	1	0.10%
Middle Eastern/North Africa	2	0.20%
Hispanic/Latino/Spanish combine	27	2.70%
More than one race, non-Hispanic	30	3.00%
Prefer not to say	0	0.00%
Education		
Less than high school	9	0.90%
Some high school	19	1.90%
High school graduate	227	22.50%
Some college	250	24.80%
College graduate	312	30.90%
Postgraduate	191	18.90%
Prefer not to answer	2	0.20%
Employment status		
Employed full time	396	39.20%
Employed part time	147	14.60%
Home maker	92	9.10%
Unemployed	107	10.60%
Student	22	2.20%
Retired	246	24.40%
Annual household income		
Under $25,000	184	18.20%

Demographic characteristics	*f*	%
$25,000 - 49,999	217	21.50%
$50,000 - 74,999	193	19.10%
$75,000 – 99,999	185	18.30%
$100,000 – 124,999	94	9.30%
$125,000 – 149,999	62	6.10%
$150,000 and over	67	6.60%
Do not know	8	0.80%
Sexual orientation		
Heterosexual or straight	897	88.80%
Gay or lesbian	32	3.20%
Bisexual	62	6.10%
Other	5	0.50%
Asexual	4	0.40%
Pansexual	10	1.00%
Health insurance		
Yes	874	86.50%
No	126	12.50%
Don't know	10	1.00%
Preferred language with HCP		
English	988	98.70%
Spanish	7	0.70%
Other	6	0.60%
Sexual minority status		
Heterosexual	897	90.50%
Lesbian and bisexual	94	9.50%

Age distribution: Table 4 shows that the sample is evenly distributed across different age groups, with the largest proportion in the 45-54 age range (22.4%). The 55-64 (20.5%) and 65+ (21.4%) age groups also make up a significant portion. Younger individuals aged 18-24 and 25-34 account for 11.1% and 11.9%, respectively, while those aged 35-44 make up 12.8%.

Race and ethnicity: Most respondents identified as White (77.2%). Black or African American respondents made up 9.8% of the respondents, while Hispanic, Latino or Spanish (both alone and in combination) accounted for 6.2%. Smaller proportions

were American Indian or Alaska Native (0.5%), Asian (2.6%), Native Hawaiian or another Pacific Islander (0.5%), Middle Eastern or North African (0.2%), and those identifying as more than one non-Hispanic race (3%). Only 0.1% selected "Other," and no respondents chose "Prefer not to say."

Education level: A diverse range of educational backgrounds is present, with the largest group being college graduates (30.9%). Some college experience accounted for 24.8%, while 22.5% were high school graduates. Postgraduates represented 18.9% of the sample. A small portion had less than a high school education (0.9%) or some high school experience (1.9%), while 0.2% chose not to answer.

Employment status: Employment status varied, with 39.2% employed full-time and 14.6% part-time. A notable portion was retired (24.4%), while 10.6% were unemployed. Homemakers accounted for 9.1%, and students represented 2.2%.

Annual household income: Income distribution was spread across different brackets. The largest group earned between $25,000-$49,999 (21.5%), followed by those earning under $25,000 (18.2%). Households making $50,000-$74,999 (19.1%) and $75,000-$99,999 (18.3%) were also well-represented. Higher-income brackets ($100,000 and above) collectively accounted for about 22%, while 0.8% of respondents were unsure of their income.

Sexual orientation and minority status: The majority identified as heterosexual (88.8%), with 3.2% identifying as gay or lesbian and 6.1% as bisexual. Smaller percentages identified as pansexual (1%), asexual (0.4%), or "other" (0.5%). When

categorized more broadly, 90.5% identified as heterosexual, while 9.5% fell into the sexual minority category (lesbian and bisexual).

Health insurance coverage: A strong majority (86.5%) reported having health insurance, while 12.5% did not. A small portion (1%) was unsure.

Preferred language with HCPs: Nearly all respondents (98.7%) felt the most comfortable using English when communicating with HCPs, with only 0.7% selecting Spanish and 0.6% choosing another language.

To summarize, this sample consisted predominantly of middle-aged and older adults, with a racial majority of White individuals. Most had at least some college education, and employment was diverse, with a notable retired population. Income distribution was balanced across various levels. The majority identified as heterosexual, and a high percentage had health insurance and preferred speaking English in healthcare settings.

Table 5 provides a cross-tabulation between sexual minority status (heterosexual vs. lesbian or bisexual women) and having a particular HCP's office, clinic, health center, or other place that is usually visited in case of illness or seeking health advice. A chi-square test of independence found a statistically significant association between sexual minority status and having a usual place of healthcare, $\chi 2(3) = 20.575$, $p < .001$.

Table 5

Cross-Tabulation Between Usual Place of Healthcare and Sexual Minority Status

Usual place of health care	Sexual minority status		Total
	Heterosexual	Lesbian or bisexual	
Yes	785	66	851
Row %	87.8%	71.0%	86.2%
No	84	20	104
Row %	9.40%	21.50%	10.50%
Don't know	9	2	11
Row %	1.0%	2.2%	1.1%
Telehealth	16	5	21
Row %	1.8%	5.4%	2.1%
Total count	894	93	987
Total %	100%	100%	100%

The most notable difference is in the percentage of respondents with no usual place of healthcare with 21.5% of lesbian or bisexual women not having a usual place for healthcare compared to only 9.4% heterosexual women. Furthermore, compared to heterosexual women, lesbian or bisexual women were also more likely to rely on telehealth (5.4%). Thus, heterosexual women were more likely (87.8%) to have a regular place for healthcare compared to lesbian or bisexual women (71%), suggesting that sexual minority status could be a factor affecting access to a place of healthcare.

Table 6 shows the relationship between sexual minority status (heterosexual vs. lesbian or bisexual women) and whether respondents believe their gender influenced their HCP to treat them unfairly.

Table 6

Cross-Tabulation Between Perception That Gender Influenced Unfair Treatment by the HCP and Sexual Minority Status

Treated unfairly	Sexual minority status		Total
	Heterosexual	Lesbian or bisexual	
Yes	111	19	130
Column %	12.7%	20.9%	13.4%
No	730	65	795
Column %	83.2%	71.4%	82.1%
Don't know	36	7	43
Column %	4.1%	7.7%	4.4%
Total count	877	91	968
Total %	100%	100%	100%

A larger percentage of lesbian or bisexual women (20.9%) reported unfair treatment due to their gender compared to heterosexual women (12.7%). This suggests that sexual minority women may experience gender-based discrimination in healthcare more frequently. In addition, a larger proportion of heterosexual women (83.2%) reported not experiencing unfair treatment, compared to 71.4% of lesbian or bisexual women. A chi-square test of independence showed a statistically significant relationship between sexual minority status and perceptions of unfair treatment due to gender, $\chi 2(2) = 7.939$, $p = .019$.

Table 7 gives a breakdown between the race group or ethnicity of the respondents and their perception of whether their own language influenced their HCP to treat them unfairly.

Table 7

Cross-Tabulation Between Race Group and Perception of Influence of Language on Unfair Treatment by Healthcare Provider

Race group	Unfair treatment due to own language			Total
	Yes	No	Don't know	
American Indian or Alaska Native	1	3	1	5
% within race	20.0%	60.0%	20.0%	100.0%
% within your language	0.9%	0.4%	2.0%	0.5%
Asian	3	18	4	25
% within race	12.0%	72.0%	16.0%	100.0%
% within your language	2.8%	2.2%	8.0%	2.5%
Black or African American	20	68	8	96
% within race	20.8%	70.8%	8.3%	100.0%
% within your language	18.3%	8.3%	16.0%	9.8%
Hispanic/Latino alone	8	23	2	33
% within race	24.2%	69.7%	6.1%	100.0%
% within your language	7.3%	2.8%	4.0%	3.4%
Native Hawaiian or Pacific Islander	0	3	1	4
% within race	0.0%	75.0%	25.0%	100.0%
% within your language	0.0%	0.4%	2.0%	0.4%
White	66	666	29	761
% within race	8.7%	87.5%	3.8%	100.0%
% within your language	60.6%	80.8%	58.0%	77.4%
Other	0	1	0	1
% within race	0.0%	100.0%	0.0%	100.0%
% within your language	0.0%	0.1%	0.0%	0.1%
Middle Eastern or North African	1	1	0	2
% within race	50.0%	50.0%	0.0%	100.0%
% within your language	0.9%	0.1%	0.0%	0.2%
Hispanic, Latino or Spanish alone or combined	6	19	2	27
% within race	22.2%	70.4%	7.4%	100.0%

Race group	Unfair treatment due to own language			Total
	Yes	No	Don't know	
% within your language	5.5%	2.3%	4.0%	2.7%
More than one race, non-Hispanic	4	22	3	29
% within race	13.8%	75.9%	10.3%	100.0 %
% within your language	3.7%	2.7%	6.0%	3.0%
Total	109	824	50	983
% within race	11.1%	83.8%	5.1%	100.0 %
% within your language	100.0%	100.0%	100.0%	100.0 %

Table 7 shows that among all respondents, 11.1% reported that they experienced unfair treatment due to their language, 83.8% said they did not, and 5.1% were unsure. Based on the percentage within each race group, the groups most likely to report unfair treatment due to their language were Middle Eastern or North African (50%), although this group had a very small sample size (n = 2). Furthermore, 24% respondents of Hispanic, Latino/Latina/Latinx, or Spanish origin (alone) and 22.2% respondents of Hispanic, Latino/Latina/Latinx, or Spanish origin (alone or in combination) perceived that their language influenced the healthcare practitioner to treat them unfairly.

Only 8.7% of White respondents perceived unfair treatment due to their language. White respondents represented the majority (77.4%) of the total sample. Therefore, their experiences heavily influenced the overall percentages. Although 60.6% among those who said “Yes” to experiencing unfair treatment due to language were White, this reflects the size of the White respondent pool rather than a higher rate of perceived unfair treatment. Although a chi-square test of independence showed a statistically significant

association, the assumption regarding expected cell counts was violated, as 70% of the cells had expected cell counts below 5.

Statistical Assumptions

Four assumptions need to be met to conduct ordinal logistic regression. The following section addresses these assumptions.

Assumption #1

The first assumption was that the research design had one dependent variable that was measured at the ordinal level. Patient satisfaction was specified as the dependent variable and was measured with a 5-point Likert scale meeting the assumption.

Assumption #2

The second assumption was that one or more independent variables were continuous, ordinal, or categorical (including dichotomous variables). Sexual minority status was specified as the independent variable with two categories, namely, women with a heterosexual orientation and women with a lesbian or bisexual orientation.

Assumption #3

The third assumption was that there was no multicollinearity between two or more continuous variables. Because sexual minority status was specified as the only independent variable measured at the nominal level, this assumption did not apply.

Assumption #4

The fourth assumption required that there are proportional odds. This means that the relationship between the predictors and the log odds of being in a higher category versus a lower category is assumed to be the same across all thresholds. This assumption

was assessed with the Test of Parallel Lines. Table 8 shows a nonsignificant result (p = .062), indicating parallel lines and meeting the assumption.

Table 8

Assumption 4: Test of Parallel Lines

Model	Log likelihood	Chi-square	*df*	*p*
Null Hypothesis	554.323			
General	480.02	74.303	57	0.062

RQ1

The following RQ and hypotheses were examined:

RQ1: Are there significant differences between sexual minority and heterosexual women in their perceptions of healthcare delivery, specifically regarding receiving adequate answers to questions, receiving clear explanations, spending sufficient time with HCPs, being treated by a provider of the same race, and being treated with respect?

$H_0$1: There is no significant association between sexual minority status and perceptions of healthcare delivery across the specified care delivery measures.

H_a1: There is significant association between sexual minority status and perceptions of healthcare delivery across the specified care delivery measures.

Each of the healthcare delivery dimensions were cross tabulated with sexual minority status and chi-square tests of independence were run to assess for statistically significant associations between the variables. Table 14 presents the results of chi-square tests assessing whether there are significant differences between sexual minority women and heterosexual women in their perceptions of various aspects of healthcare delivery,

including receiving explanations, answers to questions, time spent with the HCP, having a same-race provider, and being treated with respect.

HCP Explained Things in an Easy-to-Understand Way

A statistically significant association was found between sexual minority status and whether they felt that the HCP explained things in an easy-to-understand way, $\chi 2(2) = 6.312$, $p = .043$ (see Table 14). One cell had an expected cell count of less than 5. Table 9 shows that 92.1% of heterosexual women reported that the HCP explained things clearly, compared to 84.6% of lesbian or bisexual women. Thus, lesbian or bisexual women were less likely to feel that HCPs explained things in an easy-to-understand way.

Table 9

Cross-Tabulation Between Sexual Minority Status and HCP Easy-to-Understand Explanation

Easy to understand	Sexual minority status		Total
	Heterosexual	Lesbian or bisexual	
Yes	806	77	883
Column %	92.1%	84.6%	91.4%
No	58	11	69
Column %	6.6%	12.1%	7.1%
Don't know	11	3	14
Column %	1.3%	3.3%	1.4%
Total count	875	91	966
Total %	100%	100%	100%

HCP Provided Adequate Answers to Questions

No statistically significant association was found between sexual minority status and whether the respondents felt that the HCP provided adequate answers to their questions, $\chi 2(2) = 3.422$, $p = .181$ (see Table 14). One cell had an expected cell count of

less than 5. Table 10 shows that 87.9% of heterosexual women reported that the HCP provided adequate answers, compared to 81.1% of lesbian or bisexual women. The difference between the two groups was not statistically significant. Both heterosexual and sexual minority women reported similar perceptions of receiving adequate answers to questions from their HCPs.

Table 10

Cross-Tabulation Between Sexual Minority Status and HCP Providing Adequate Answers

HCP provided answers	Sexual minority status		Total
	Heterosexual	Lesbian or bisexual	
Yes	765	73	838
Column %	87.9%	81.1%	87.3%
No	93	15	108
Column %	10.7%	16.7%	11.3%
Don't know	12	2	14
Column %	1.4%	2.2%	1.5%
Total count	870	90	960
Total %	100%	100%	100%

HCP Spent Enough Time with the Patient

A statistically significant association was found between sexual minority status and whether the respondents felt that the HCP had spent enough time with them during the consultation, $\chi 2(2) = 15.603$, $p < .001$ (see Table 14). One cell had an expected cell count of less than 5. In Table 11, 87.3% of heterosexual women reported that their HCP spent enough time with them, compared to 73% of lesbian or bisexual women. Furthermore, 21.3% of lesbian or bisexual women felt that their provider did not spend enough time, compared to 11.1% of heterosexual women. Thus, lesbian or bisexual women were significantly less likely to feel that their HCP spent enough time with them.

Table 11

Cross-Tabulation Between Sexual Minority Status and Enough Time Spent by HCP

HCP spent enough time	Sexual minority status		Total
	Heterosexual	Lesbian or bisexual	
Yes	764	65	829
Column %	87.3%	73.0%	86.0%
No	97	19	116
Column %	11.1%	21.3%	12.0%
Don't know	14	5	19
Column %	1.6%	5.6%	2.0%
Total count	875	89	964
Total %	100%	100%	100%

HCP Was the Same Race as the Patient

A statistically significant association was found between sexual minority status and whether the respondents were treated by an HCP of the same race, $\chi 2(2) = 6.785$, $p = .034$ (see Table 14). One cell had an expected cell count of less than 5. Table 12 shows that 70.3% of heterosexual women were treated by a provider of the same race, compared to 58.9% of lesbian or bisexual women. Lesbian or bisexual women were significantly less likely to be treated by a HCP of the same race.

Table 12

Cross-Tabulation Between Sexual Minority Status and HCP the Same Race as Patient

HCP same race	Sexual minority status		Total
	Heterosexual	Lesbian or bisexual	
Yes	616	53	669
Column %	70.3%	58.9%	69.3%
No	223	29	252
Column %	25.5%	32.2%	26.1%
Don't know	37	8	45
Column %	4.2%	8.9%	4.7%
Total count	876	90	966
Total %	100%	100%	100%

HCP Treated the Patient with Respect.

A statistically significant association was found between sexual minority status and whether the respondents were treated by the HCP with respect, $\chi 2(2) = 14.845$, $p = .001$ (see Table 14). One cell had an expected cell count of less than five. Table 13 shows that 92.2% of heterosexual women reported being treated with respect by their provider, compared to 80% of lesbian or bisexual women. Furthermore, 14.4% of lesbian or bisexual women felt that they were not treated with respect, compared to 5.9% of heterosexual women. Thus, lesbian or bisexual women were significantly less likely to feel that they were treated with respect by HCPs.

Table 13

Cross-Tabulation Between Sexual Minority Status and HCP Treating the Patient With Respect

HCP treated me with respect	Sexual minority status		Total
	Heterosexual	Lesbian or bisexual	
Yes	799	72	871
Column %	92.2%	80.0%	91.0%
No	51	13	64
Column %	5.9%	14.4%	6.7%
Don't know	17	5	22
Column %	2.0%	5.6%	2.3%
Total count	867	90	957
Total %	100%	100%	100%

In summary, the results of the chi-square analysis in Table 14 reveals significant disparities between sexual minority women and heterosexual women in several key aspects of healthcare delivery:

- Lesbian or bisexual women were less likely to report receiving clear explanations ($p = .043$), sufficient time with the provider ($p < .001$), or being treated with respect ($p = 0.001$).
- Sexual minority women were also less likely to be treated by a provider of the same race ($p = 0.034$).
- However, there was no significant difference in receiving adequate answers to questions ($p = 0.181$).

Table 14

Chi-Square Tests of Independence for Healthcare Delivery Dimensions

Healthcare delivery dimension	Chi-square ($\chi 2$)	*df*	Significance
HCP explained clearly	6.312	2	0.043
HCP provided adequate answers	3.422	2	0.181
HCP spent enough time	15.603	2	0.000
HCP was same race	6.785	2	0.034
HCP treated with respect	14.845	2	0.001

These results suggest that sexual minority women may face significant barriers in healthcare delivery, particularly in terms of communication, time spent with providers, and perceptions of respectful treatment.

RQ2

The RQ and hypotheses below were examined:

RQ2: Are there differences in patient satisfaction between sexual minority and heterosexual women when controlling for insurance status, primary language, age, and race/ethnicity?

$H_0 2$: There is no statistically significant difference in patient satisfaction of sexual minority and heterosexual women when controlling for insurance status, primary language, age, and race/ethnicity.

$H_a 2$: There is statistically significant difference in patient satisfaction of sexual minority and heterosexual women when controlling for insurance status, primary language, age, and race/ethnicity.

An ordinal logistic regression analysis was conducted to examine the difference in patient satisfaction between sexual minority and heterosexual women while controlling

for insurance status, primary language, age, and race. Chi-square tests of independence were run to justify the inclusion of the covariates. Statistically significant associations were found between sexual minority status and age group, $\chi2(5) = 64.547$, $p < .001$; race group, $\chi2(9) = 19.206$, $p < .001$; and insurance status, $\chi2(2) = 6.5000$, $p < .05$. No significant association was found between sexual minority status and the language preferred to consult with a healthcare practitioner, $\chi2(2) = 1.400$, $p = .497$. However, when language preference was included as a covariate, the model validity improved, meeting the assumption of proportional odds, and strengthening the overall reliability of the regression. Therefore, the decision was made to retain language preference in the model. A total of 955 valid cases were included after filtering.

The independent variable, sexual minority status, comprised two categories, heterosexual and lesbian or bisexual, which was set as the reference category. The dependent variable patient satisfaction was measured on an ordinal level with a 5-point Likert scale. The covariates were all measured at the nominal level. The reference group for age group was 65 and older, for race more than one race, non-Hispanic, for health insurance don't know, and preferred language other.

Table 15 shows that the overall model was statistically significant, $\chi2(19) = 80.62$, $p <.001$, indicating that the predictors, when taken together, significantly predicted patient satisfaction. The goodness-of-fit tests (Pearson $\chi2[393] = 378.67$, $p = .689$; Deviance $\chi2[393] = 335.37$, $p = .984$), suggest that the model fits the data well. The Test of Parallel Lines (see Table 8) met the assumption of proportional odds ($p = .062$), allowing for valid interpretation of the model. The pseudo-*R*-squared values (Nagelkerke

= .091) in Table 16 suggest that the predictors explain 9.1% of the variance in patient satisfaction.

Table 15

Model Fit and Goodness-of-Fit Tests

Model fitting	Chi-square	*df*	*p*
Final model	80.615	19	0.000
Goodness-of-fit			
Pearson	378.671	393	0.689
Deviance	335.368	393	0.984

Table 16

Pseudo R-Square Values

Measure	Value
Cox and Snell	0.081
Nagelkerke	0.091
McFadden	0.039

The parameter estimates in Table 17 shows that there is no significant difference in patient satisfaction between sexual minority and heterosexual women ($p = .377$), while controlling for insurance status, primary language, age, and race. Regarding the effects of the covariates, age and race/ethnicity were significant predictors of patient satisfaction. Younger women aged 18-24 years ($OR = 0.31$, 95% CI: 0.19 - 0.52, $p < .001$) and 25-34 years ($OR = 0.34$, 95% CI: 0.21-0.56, $p < 0.001$) were significantly less likely to report higher satisfaction compared to older women (65 years and over). Similarly, racial and ethnic background influenced satisfaction, with Black/African American women ($OR =$

2.33, 95% CI: 1.02 - 4.55, $p = .044$) and Hispanic/Latino women ($OR = 2.80$, 95% CI: 1.01 - 7.79, $p = .049$) reporting significantly higher satisfaction compared to the reference race/ethnic group (more than one race, non-Hispanic). However, health insurance status ($OR = 1.35$, $p = .655$) and preferred language ($OR = 0.59$, $p = .615$) were not significant predictors of patient satisfaction, suggesting that these variables do not play a major role in satisfaction when controlling for age, race, and sexual minority status.

Table 17

Ordinal Logistic Regression Parameter Estimates

Predictor	Estimate (Log-Odds)	95% CI for estimate		Odds Ratio (OR)	*p*
		LL	UL		
Heterosexual	0.195	-0.237	0.627	1.22	0.377
Age 18-24	-1.158	-1.668	-0.648	0.31	0.000
Age 25-34	-1.066	-1.552	-0.581	0.34	0.000
Age 35-44	-0.639	-1.105	-0.172	0.53	0.007
Age 45-54	-0.729	-1.131	-0.326	0.48	0.000
Age 55-64	-0.54	-0.95	-0.131	0.58	0.010
Native American	-0.074	-1.85	1.703	0.93	0.935
Asian	0.684	-0.37	1.737	1.98	0.203
Black/African American	0.845	0.023	1.668	2.33	0.044
Hispanic/Latino/Spanish alone	1.03	0.005	2.054	2.80	0.049
Pacific Islander	0.643	-1.323	2.608	1.90	0.522
White	0.944	0.205	1.683	2.57	0.012
Other	-2.947	-6.59	0.696	0.05	0.113
Middle Eastern/North Africa	-0.327	-3.16	2.505	0.72	0.821
Hispanic/Latino/Spanish combine	0.673	-0.355	1.701	1.96	0.200
Health Insurance	0.303	-1.026	1.632	1.35	0.655
No Health Ins	-0.449	-1.814	0.916	0.64	0.519
Prefer English	-0.529	-2.592	1.534	0.59	0.615
Prefer Spanish	-1.839	-4.333	0.655	0.16	0.148

The findings indicated that sexual minority status did not significantly predict satisfaction, indicating no major disparities between heterosexual and sexual minority

women. Thus, the alternative hypothesis was rejected, and the null hypothesis was accepted. However, the findings suggested that patient satisfaction is significantly associated with age and race/ethnicity, with younger women reporting lower satisfaction and Black/African American and Hispanic/Latino women reporting higher satisfaction. These findings highlight the need for targeted interventions focusing on improving satisfaction among younger women and addressing cultural factors in healthcare delivery.

Summary

The findings of this study revealed valuable information into healthcare experiences and patient satisfaction among sexual minority and heterosexual women. Significant disparities in several key aspects of healthcare delivery were found. Sexual minority women were significantly less likely than heterosexual women to receive clear explanations from their providers, felt they had sufficient time during medical visits, and perceived respectful treatment. In addition, sexual minority women were less likely to be treated by a provider of the same race. However, no significant differences emerged in receiving adequate answers to their questions. These findings suggest that communication, time allocation, and perceptions of respect represent key areas where sexual minority women may face barriers in healthcare.

However, no statistically significant difference was found in patient satisfaction of sexual minority and heterosexual women, when controlling for insurance status, primary language, age, and race/ethnicity. Instead, age and race/ethnicity emerged as significant factors. Younger women reported lower satisfaction with healthcare, whereas Black or African American and Hispanic or Latino women reported higher satisfaction.

Taken together, these findings highlight disparities in healthcare experiences among sexual minority women, even in the absence of significant differences in overall satisfaction. While patient satisfaction levels appear to be influenced more by age and ethnicity than by sexual minority status, the disparities in provider communication, time spent with patients, and perceptions of respect suggest that healthcare delivery may not be equitably experienced across all groups. The following section builds upon these findings by discussing this within the context of the theoretical framework and with what has been found in peer-reviewed literature, offering recommendations in addressing these disparities.

Section 4 will provide an interpretation of the study's findings, examine the limitations of study, propose recommendations to address gaps in care, and discuss implications for positive social change.

Section 4: Presentation of the Results and Findings

Introduction

This quantitative study to examined various aspects of care delivery involving sexual minority women and assessed their perceptions of care quality. Donabedian's model of healthcare quality served as the theoretical framework for this study. Using data from the AAMC Consumer Survey of Health Care Access, the study analyzed responses from survey participants regarding their most recent healthcare visit and utilized multivariable logistic regression and chi-squared tests of independence to assess patient satisfaction as well as the quality of care delivery for the patient population of interest. Understanding how patients perceive the care they receive is crucial information for healthcare systems, as it is the foundation for building and maintaining high performing teams prepared to deliver quality care for all patient populations. Previous research in patient satisfaction and healthcare quality has detailed the unique challenges sexual minority women encounter in clinical settings, including limited provider awareness of sexual minority women health issues, a lack of inclusive care practices, and, at times, unwillingness to provide services. This study examined differences in provider communication on both an interpersonal and clinical level, the amount of time spent with patients, and the overall perception of the medical visit to determine whether sexual minority patients perceive and rate their healthcare experience differently than their counterparts. In the next sections, I will provide an interpretation of the study results, examine the limitations of the study, propose recommendations, and discuss implications for professional practice and positive social change.

The study results found significant differences in care delivery and patient satisfaction between sexual minority women and their counterparts. Sexual minority women were less likely to report receiving clear explanations from their provider, feeling that they had a sufficient amount of time with the provider, or perceiving respectful treatment during the visit. Study results did not reveal a statistically significant difference between the two patient groups for the care delivery benchmark of receiving adequate answers to their health questions from the provider. Though sexual minority patients reported lower satisfaction with the time spent with the provider and provider communication, there was no statistically significant difference found in overall satisfaction based on sexual orientation after controlling for factors such as insurance status primary language, age, race/ethnicity. Instead, age and race/ethnicity emerged as more influential predictors of satisfaction with young women reporting lower satisfaction, while Hispanic or Latino women reported higher satisfaction with care.

Though overall satisfaction did not vary significantly between the two groups, study results revealed that healthcare delivery is not equitably experienced across all patient populations and highlighted the specific areas where providers and systems can improve to better support marginalized groups.

Interpretation of the Findings

The findings of this study support that sexual minority women experience significant gaps in key aspects of healthcare delivery. Compared to their heterosexual counterparts, sexual minority women were less likely to receive clear explanations from their providers, felt they had sufficient time with their provider during visits, and

perceived respectful treatment. They were also less likely to have a provider of the same race, which could influence their comfort and transparency during the visit. Despite these differences in experience, there were no significant differences in receiving adequate answers to their questions during the visit and overall satisfaction between sexual minority and heterosexual women.

Patient satisfaction was evaluated in this study as a benchmark for provider performance and healthcare quality. The results showed no significant differences in satisfaction between sexual minority and heterosexual women after controlling for factors like insurance status, language, age, and race/ethnicity. Instead, age and race appeared to be stronger predictors of satisfaction, with younger women reporting lower levels of satisfaction, with younger women reporting lower satisfaction and Hispanic or Latino women reporting higher satisfaction. These findings suggest that while overall satisfaction is not necessarily linked to sexual minority status, there are still critical issues in communication and time allocation impacting care delivery for sexual minority women.

The findings of this study align with Donabedian's theoretical framework of healthcare quality, which emphasizes the interplay of structure, process, and outcomes in healthcare quality. Structural factors such as provider communication, inclusive care practices, and visit time constraints play a fundamental role in shaping care delivery. Sexual minority women reported lower rates of clear communication, respectful treatment, and adequate time, which suggests that providers may lack the necessary training and time to build rapport with patients. These care delivery challenges can lead

to breakdowns in communication and the perception of disrespectful treatment. Additionally, the racial discord between providers and patients, which may reflect broader structural limitations in workforce diversity, can negatively impact the quality of care delivery for marginalized groups. When examining the outcomes domain of the framework, the study did not find a significant difference in overall patient satisfaction, which may indicate that patients adapt their expectations in response to systemic barriers that affect the structural and process domains of healthcare system. Overall, these results reinforce the need to strengthen structural conditions such as provider training, staffing levels, and scheduling practices, to promote equitable, high-quality care in line with Donabedian's model.

Limitations of the Study

This quantitative study presented several limitations. The cross-sectional design of the study limits our ability to draw causal conclusions about the relationship between sexual minority status and healthcare experiences. Surveys that rely on self-reported data may introduce response bias, as participants' perceptions of their most medical visit are likely influenced by past experiences or personal expectations. To add, patients' perceptions may change over time, and participants may rate provider performance and satisfaction differently depending on the time elapsed between the clinical encounter and the completion of the survey. The survey includes patient experiences from encounters occurring up to 12 months prior, and participants whose medical visits occurred shortly before completing the survey may recall more detailed information and have stronger

feelings regarding the healthcare experience compared to those whose visits occurred a year earlier.

It is also important to recognize that sexual identity is fluid and dynamic, unlike biological sex, which is normally fixed. An individual's sexual orientation may evolve over time due to personal, social, or cultural influences. As a result, the study findings may include greater variability since participants' reported identities could have shifted between the time of their most recent medical visit and the time of data collection for the survey. This fluidity introduces nuances in interpreting the data and may affect the consistency and comparability of responses across the study population. Future research in this area should incorporate longitudinal data and larger, more diverse population samples to improve our understanding of how to provide more robust care for this patient population.

Recommendations

Addressing disparities in care delivery and patient satisfaction faced by marginalized populations within the healthcare system will require a multifaceted approach. A critical area of focus involves the development of robust provider education and training in culturally competent care. A recent study of leadership perspectives regarding the barriers to providing culturally competent care to sexual minority patients identified challenges in several key areas. Personnel-related factors included a lack of adequate training on how to effectively care for diverse patient populations, as well as provider fear or discomfort in addressing sensitive topics such as sexual orientation and gender identity. Additionally, HCPs were often faced with competing clinical priorities

that limited their ability to engage with their patients in a more personalized manner and limited their time spent on implementing care practices tailored to their patients. Leaders found that many clinical settings operated under a standardized approach, emphasizing uniform treatment of all patients to maximize operational efficiency. While this approach may seem equitable on the surface, it often overlooks the unique needs and experiences of marginalized groups, contributing to gaps in care quality and patient satisfaction (Loo et al., 2023).

To overcome the challenges in care delivery found from this study and improve healthcare quality as well as patient satisfaction, comprehensive education in cultural competency, with a specific emphasis on sexual minority women, is recommended for HCPs. Education in competent, inclusive care should be introduced early in a provider's medical training and reinforced throughout their professional career. Increased exposure to courses on inclusive care may increase the likelihood that these practices will be implemented in the clinical setting. Continuous learning also ensures that providers stay abreast with best practices and have the tools to meet the evolving needs of diverse patient populations. This includes understanding the unique health needs faced by sexual minority women and learning how to deliver care in a manner that is respectful and free from bias.

Another recommendation is increasing representation within the healthcare workforce. Deliberate efforts should be made to recruit and retain HCPs from underrepresented minority groups. A diverse workforce not only enhances the cultural sensitivity of care, but it promotes a more inclusive healthcare environment where

patients are more likely to be open with their provider and feel seen and understood. Representation matters in bridging the communication gap and encouraging patient engagement, particularly for populations that have historically experienced systemic discrimination.

Communication is the foundation of the patient-provider relationship and a critical component of patient satisfaction. However, the study findings revealed that communication continues to be a challenge in care delivery, particularly with sexual minority women patients. Healthcare organizations should aim to incorporate evidence-based communication strategies such as gender-neutral language, open and inclusive questioning, active listening, and the provision of adequate consultation time to ensure that patients feel heard and respected (Willging et al., 2020). Educating providers in these communication methods can reduce misunderstandings, increase treatment adherence, and build stronger relationships between sexual minority patients and their providers.

Healthcare organizations can further support the patient satisfaction of their sexual minority women patients by establishing support services tailored to their unique care needs. This includes establishing patient advocacy programs, hiring dedicated support staff, and creating welcoming environments within the clinical setting. These strategies play a critical role in acknowledging the need to address the health system's shortcomings as it pertains to the healthcare experiences of sexual minority women. Health systems should aim to offer support to patients throughout their entire journey within the system, helping to navigate care and promote a positive experience at every stage of the healthcare lifecycle.

Implications for Professional Practice and Social Change

The implementation of these recommendations has positive implications for both clinical practice and broader social change. In the clinical setting, initiatives that prioritize inclusive care, respectful treatment, and effective communication can dramatically improve the patient experience of sexual minority women. Increased patient satisfaction promotes health consumerism as well as treatment adherence—two factors that can positively impact health outcomes. On a global level, these strategies align with initiatives directed at promoting health equity and advancing social justice. Eliminating gaps in healthcare delivery not only benefits sexual minority women but it also strengthens the overall health system by ensuring that healthcare is fair and responsive to the needs of the people it serves. Policymakers, healthcare administrators, and leaders must commit to enacting inclusive policies, advocating for robust healthcare protections for minority groups, and ensuring equitable distribution of resources. These systemic changes will be key for building a healthcare system that genuinely serves all individuals and strives for a gold standard of care.

Conclusion

This study examined differences in provider communication at both interpersonal and clinical levels, the amount of time spent with patients, and overall perceptions of the medical visit to determine whether sexual minority patients perceive and rate their healthcare experiences differently from their counterparts. While age and race/ethnicity were found to significantly influence the perception of quality care, no statistically significant differences in patient satisfaction were observed overall between the groups.

Improving provider education on inclusive care practices and effective communication strategies is necessary to address the gaps identified in care delivery and quality. A healthcare system equipped with resources such as competent and diverse staffing, care guidelines, and patient-centered scheduling protocols is better positioned to serve diverse patient populations. High-performing systems that prioritize healthcare quality and inclusive care can promote positive social change by improving health outcomes for all women.

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