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### Title

IMPROVING VULNERABLE PATIENT'S TRUST IN HEALTHCARE IN LATINX AND INDIGENOUS MEXICAN FARM WORKING COMMUNITIES IN THE EASTERN COACHELLA VALLEY

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IMPROVING VULNERABLE PATIENT'S TRUST IN HEALTHCARE IN LATINX AND  
INDIGENOUS MEXICAN FARM WORKING COMMUNITIES IN THE EASTERN  
COACHELLA VALLEY

By

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A capstone project submitted for Graduation with University Honors

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University Honors

University of California Riverside

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## ABSTRACT

*Background:* The lack of trust in medical institutions among LatinX and Indigenous Mexican farm working communities prevents some from seeking medical attention. This study focuses on building trust in medicine among LatinX and Indigenous Mexican immigrant patient populations in the Eastern Coachella Valley, a rural desert region in Inland Southern California. These populations face barriers to culturally appropriate medical care contributing to health disparities. My capstone project focused on increasing trust in medical institutions and physicians and compared patients' healthcare experiences. . This project was carried out in collaboration with the Coachella Valley Free Clinic (CVFC), a student-led and community engaged clinic that serves rural, low-income farm working communities in the ECV, and community health workers (promotoras).

*Methods:* Individuals who had not yet assessed healthcare services at the CVFC but had accessed other local medical institutions were invited to participate in the study. s. The study team conducted surveys and one-on-one interviews with each patient. These surveys were administered before and after attending the CVFC to understand how perceptions of trust in medicine and physicians change based on the type of clinic where patients access services.

*Results:* A total of 15 patients were part of the study. Prior to accessing CVFC healthcare services, all participants reported higher scores for mistrust in medicine and poor satisfaction with their medical provider. After accessing CVFC healthcare services, participants reported increased trust in medicine and satisfaction with their physician.

*Conclusion:* The findings from my capstone study demonstrate that implementation of innovative models focused on the health care needs of patients while offering culturally and linguistically appropriate care, are important to increase trust in medicine and satisfaction with physicians when vulnerable patient populations access healthcare services.

## ACKNOWLEDGMENTS

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Furthermore, I would like to express my gratitude to the two community health workers/promotoras that helped with the data collection. Their dedicated work and efforts to better their community helped motivate the study team. I had the pleasure of working with these amazing community leaders where I had the opportunity to learn how to conduct qualitative interviews. I had my eyes opened by these experiences which has propelled my goal of bettering my community in the medical sector as a future physician.

As someone from the Coachella Valley, I still learned a lot about the communities East of the Valley that will forever be with me. I would like to extend my sincere gratitude to all participants of the study; their eagerness to express their voices while showcasing the differences in healthcare experiences was inspirational. I appreciated the opportunity to engage and work with the Purépecha communities where I learned about their culture and similarities in their native language to my second language, Spanish. Throughout my two year capstone progression, I learned from various leaders and had the opportunity to engage with them. I truly believe that they were the key foundations to my success.

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## **Introduction**

Communities in the Eastern Coachella Valley (ECV) are shadowed by other wealthier cities west of the CV (London et al. 2014). Cities like Palm Springs, which are known as the secret getaway for wealthy individuals, shadow the communities in the ECV such as: North Shore, Thermal, and Mecca. These cities are now home to the Purépecha communities who are an indigenous group from the Mexican state of Michoacán. The lack of recognition has played a major role in the development and access for ECV residents. The ECV has had a lack of resources such as new infrastructure, working stability, and access to healthcare (Cheney et al., 2018). Furthermore, ECV residents face additional barriers that are created by education and health illiteracy (Vamos et al., 2020)

Many residents of the ECV do not have medical health insurance, and those who do, have to pay high co-pays. Those with medical insurance have limited options for healthcare services in terms of the number of providers and clinics available. There are only two primary care clinics in the ECV that are open for ECV residents. It is believed that there is one doctor for every 8407 ECV residents (Potter et al. date). Many residents are undocumented and underinsured farm working immigrants. The undocumented status of many residents in the ECV have led them to live in constant fear of being deported which has caused them to not trust in positions of power such as police or landlords (Cheney et al., 2018). This lack of trust has extended into medical institutions such as hospitals and clinics.

The lack of trust in medical institutions is a commonality in most of the CV. As someone born and raised in the CV, I hated having to go to see the doctor because of the treatment and quality of care I received from physicians. Because of the low quality of care being offered in

the CV, residents have further lost trust in medical institutions. This lack of trust is a deterrent for those who want to access medical services, and it is affecting the health of the community.

A recent study by Gehlbach et al., 2022 found during the COVID-19 pandemic LatinX and Indigenous Mexican patients feared using hospitals in the CV as they reported hospitals being perceived as a place where members of their community went to die. Trust is key in the healthcare setting as it shapes patients' relationships with healthcare systems and healthcare providers. The lack of trust in medical institutions among LatinX and Indigenous Mexican communities prevents some from seeking medical attention.

This study was carried out in collaboration with promotoras (community healthcare workers) and medical students at the Coachella Valley Free Clinic (CVFC), a student-led and community engaged free clinic. The CVFC was made in response to what communities in the ECV were asking for: increased access to medical services for residents of the ECV (López Jaramillo et al., 2022). Student Run Free Clinics (SRFC) have shown that medical students can achieve significant and long term clinical improvement (Gorrindo et al., 2014). Medical students ensure that patients have the best experience and care, so patients come back and refer the clinic to other members of the community. Furthermore, recent studies show that medical student involvement in SRFC improved student knowledge and skills but also increased interest to work with the underserved (Smith et al., date). Given the lack of medical providers in the ECV, the possibility of having students who understand the community come back to serve the communities could further increase trust. Previous research indicates patients report greater satisfaction with the care they receive at free clinics than other health care settings (Gertz et al., 2010).

The purpose of this project is to examine the role of trust in physicians in the healthcare experiences of Latinx and Indigenous Mexican patients accessing care in rural communities in the desert region of Southern California. This study focuses on understanding trust in medicine among LatinX and Indigenous Mexican farm working patient populations in the ECV. We hope to be able to increase trust in medical institutions by giving good quality care therefore increasing the access to medical services.

## **Methodology**

### Study overview

The study's objectives were to: analyze how a patient's trust in medicine plays a role in accessing medical care, showcase SRFC as a viable option for healthcare, and increase trust in medicine to overall increase access to healthcare. My research was in part funded by a stipend from the UCR Chancellor's Research Fellowship. The investigative team included community health workers/promotoras, UCR SOM faculty, and a UCR undergraduate student. The study team collaborated with the CVFC to deliver surveys and one on one interviews. Approval of this research and procedures was done by the University of California Riverside Institutional Review Board (IRB). As a study team member, I completed my social and behavioral research with human subjects CITI training. I analyzed all qualitative and quantitative data collected from participants.

A total of 15 patients participated in the study. Study team members recruited a clinical sample of 15 patients who are accessing medical services (mental health, primary care, chiropractic care, and acupuncture care) at the CVFC. Our sample eligibility criteria was based on being Spanish or Purépecha (Indigenous people from the Mexican state of Michoacan) speaking, low income, 18 years of age or older, must have had previous experience at other local



medical institutions (John F Kennedy Memorial Hospital, Eisenhower Medical Center, Desert Regional Medical Center etc.), and have yet to visit CVFC for medical services. The research study collaborated with promotoras who work with CVFC to recruit patients into the study and help with the data collection.

The study team began by inviting members of the Latinx and Indigenous Mexican Purépecha communities in the ECV to participate in the research. Study team members shared the recruitment flier with potential participants. The flier was disseminated through social networks like the: Unidas por Salud and CVFC social media platforms. Study team members also printed the flier and disseminated it to members of the ECV community. Interested individuals would contact the number on the study flier, and the study team member would administer the eligibility screening tool via a zoom call. If eligible, the study team members would obtain their contact information to reach out to them prior to the upcoming clinic to administer the consent and the initial survey as well as schedule the research activity for the day of the clinic.

In addition, we recruited participants during the clinic. Study team members shared the study flier with patients who accessed the clinic. A study team member administered the eligibility screening tool to determine eligibility in person during clinics for these patients. If eligible and interested to participate in the study, the study team member enrolled them in the study at that point, administered the consent form, and set up the research activities for that clinic (i.e., baseline survey, attend CVFC for medical services, follow up survey, and qualitative interview). After study team members recruited new eligible patients to the CVFC and obtained consent, they administered a survey to patients reflecting their prior healthcare service

experience and trust in medicine. Following care at CVFC, the study team then administered the same survey to reflect the care and experience with the CVFC.

While obtaining consent, a team member reviewed the information on the consent form, asked the participant if they had any questions. The consent form is available in Spanish and English with oral translation in Purépecha. The consent and eligibility screening tool were all administered through qualtrics. All members of the study team speak fluent Spanish and the CHWs/promotoras (Maria Pozar and Yesenia Pozar) are bilingual Spanish and Purépecha. Only members of the study team listed on the project roster will be permitted to obtain participant consent.

#### Compensation & Study Support

We considered the time and day of our study (e.g, Saturday afternoons when the clinic is held) so that we can accommodate participants who do not have the option to leave work or ask for time off to participate in research. We carefully considered that the research study would take a total of 60-90 minutes, so we compensated participants in a way that addressed any potential costs to research participation (e.g., gasoline and mileage to travel to the CVFC site). Participants received a \$50 *Walmart* gift card for their participation once they finished the qualitative interview. We gave the gift card in person as some participants may not have a reliable postal service and may not be able to access their compensation via email or postal services.

To alleviate participants potentially feeling undue pressure to participate in the study, we let patients know that participation is an option and not required to access clinic services. Additionally we informed potential participants that research is voluntary and deciding to participate or not will not affect their relationship with the clinic. If participants become

distressed at any point of the study, the CVFC has onsite mental health therapists. Participants can access this service if they feel emotional/psychological risk. Additionally, subjects can choose to skip any question they feel necessary during the survey and interview.

### Data Collection

There were two main types of data collected for this study: data included qualitative and quantitative data. Quantitative data included socio demographic data and likert scales that graded patient satisfaction and trust in doctors. The qualitative data was in the form of one on one interviews that were led by our promotora team members using an interview guide.

### *Sociodemographics*

The qualitative data collected: age, gender, country of origin, ethnicity, maternal language, highest level of education, health insurance coverage, employment status, and if the participant had received care at local medical institutions.

### *Quantitative Surveys*

Participants completed two surveys. Upon entering the clinic for the research activity, study team members administered two surveys: the first survey to participants was prior to using healthcare services at the CVFC (baseline) and the second survey at the end of using services at the CVFC (follow-up). Questions were related to socio demographic information, patient satisfaction with the care they receive, trust in medicine, and evaluating the provider.

Study team members administered the surveys to participants using Qualtrics. For participants recruited via social media and social networks, a study team member administered the pre survey via the phone and recorded the responses in Qualtrics. For participants recruited at

the clinic, a study team member administered the pre survey in person at the clinic and recorded the responses in Qualtrics. The last survey was administered in person at the clinic through Qualtrics for participants recruited both, over the phone and in person. We then conducted brief interviews about their past use of healthcare services in comparison to the healthcare services they received at the CVFC.

### *Qualitative interviews.*

These 15 survey participants also were invited to participate in one-on-one qualitative interviews. Recordings will not be an optional component to the research because the quantitative survey data will be analyzed for descriptive statistics (total number and frequency), and the qualitative interview will be important to analyze what any changes in the survey data. The justification for 15 participants is 12 to 15 participants who are similar in terms of background characteristics is sufficient for data saturation (Guest et al., 2006). Study team members used an interview guide with open-ended questions to obtain patients' perspectives of trust in medicine. We asked patients about their perspectives of trust in doctors in training (medical students) and looked for any differences or similarities from their experiences with other medical providers from local medical clinics and hospitals. The participants were assured that their responses would remain confidential and all identifying information would be removed. The team then recorded the qualitative interviews in person via zoom to then be transcribed for data analysis.

## Data Analysis

### *Qualitative interviews.*

Zoom recordings were downloaded as audio files, and *Microsoft Word* was used to transcribe the audio recordings into a transcript. We first began cleaning up the transcripts of any improper transcriptions by listening to the audio and cross checking the transcription. The transcripts were then inputted to MAXQDA, a qualitative data analysis software, to retrieve key themes among the 15 patients. Next, the study team utilized a line-by-line reading of the transcripts to identify key themes and patterns that emerged across participants' interviews (Ryan & Bernard, 2003). The study team then developed a codebook which was composed of similar themes across participants. Once a code book was formulated, the study team applied the codes to each participant transcript. Axial coding was then implemented to compare different themes that emerged across participants. This data was then merged to report on any potential changes in trust in medicine after having accessed care at a student-led free clinic.

### *Quantitative Surveys*

The quantitative surveys assessed patient trust in physicians using a trust in physician scale and patient satisfaction using a patients satisfaction scale. Data on trust in physicians was collected using the Anderson and Derick (1990) scale that measures patient trust in physicians in clinical settings. This is a validated tool that is widely used as a measure of trust. Additionally, data on patient satisfaction was collected using the Patient Satisfaction Questionnaire III (PSQ-III). The PSQ-III is a tool that assesses satisfaction with medical care as well as satisfaction with care more generally. For both scales, the response options were on a 3-point likert scale from 1 (disagree) to 3 (agree) where a 2 represented "neither". Both scales included negatively worded

items that were noted in *figure 2 and 3* by a “D” , so the study team had to reverse code these items. Each survey took 15 to 20 minutes to complete. The study team first assessed trust in physicians using a trust in physician scale then followed by assessing trust in medicine before and after CVFC clinic use. The first set of questions were related to patient satisfaction with the care they received, the second set of questions were related to the trust participants had in their doctor. Both sets of questions were composed of 11 questions for a total sum of 22 questions per survey. Participants were asked the same set of questions before and after they received care at the CVFC, but the posttest focused on the care they received from the medical students.

Using Qualtrics, the study team collected all pretest and posttest surveys and then organized it into an Excel file for analysis. The quantitative survey data was analyzed for descriptive statistics (total number and frequency) and comparisons were made between the pretest and posttest responses for trust in medicine and healthcare providers and satisfaction with care. The study team looked at all 15 sets of data comparing pretest and posttest scores for each of the 22 questions. For the trust in physicians scale, we looked at individual scores per question ( 3 =disagree, 2= neither, and 1= disagree) and summated all scores to obtain a question mean for both pre and post test. The study team also collected a sum score of all question means and compared between pre and post tests.

## Results

### Participants characteristics

The research sample of 15 participants all completed the socio-demographic survey portion. All participants self-identified as either Hispanic or Latino (53%) and /or Purépecha (47%). Majority of participants were males (53%) with the other (47%) being females. Most participants were aged between 20-59 years of age with: (40%) being 20-29, (13%) being 30-39, (40%) being 40-49, and (7%) being 50-59. All participants were born in Latin America (73%) and/or the United States (27%). Participants who were born in Latin America mentioned Mexico as their native birth country, Majority of participants noted Spanish as their preferred language (47%) while 20% noted Purépecha as their preferred language. Among survey respondents, the general trend was that most participants had elementary or primary school as their highest level of education (47%) and 13% attended college or a 4 year university. More than half of the sample were farmworkers (60%), study participants also noted full time employment status (47%). On the other hand, study participants also were unemployed during the study (40%). Our socio-demographic characteristics of study participants reflect ECV community profiles. Figure 1 below shows the sociodemographic data recorded for this study.

*Figure 1. Sociodemographic Table*



<b>Demographic Characteristics</b>	
	N=15
Demographics	N(%)
<b>Gender</b>	
Female	7(47%)
Male	8(53%)
<b>Ethnicity/ Race</b>	
Hispanic or Latino	8(53%)
Indigenous Latin American	7(47%)
<b>Age</b>	
20-29	6(40%)
30-39	2(13%)
40-49	6(40%)
50-59	1(7%)
<b>Country of Birth</b>	
Latin America	11(73%)
United States	4(27%)

<b>Preferred Language</b>	
English	5(33%)
Spanish	7(47%)
Purépecha	3(20%)
<b>Highest Level of Education</b>	
Attended elementary or primary school	7(47%)
Attended middle or secondary school	1(7%)
Completed high school or GED	5(33%)
Completed college or 4 year university	2(13%)
<b>Current Employment Status</b>	
Full Time (40 hours/week)	7(47%)
Self-employed	2(13%)
Out of work	6(40%)
Other	1(7%)
<b>Farmworkers</b>	
Yes	9(60%)
No	6(40%)

### Trust scale findings

Majority of the participants reported a greater trust in medicine following care at the CVFC. In the pretest, participants noted mistrust in physicians and in the posttest participants decreased their feelings of mistrust. Across all posttest trust scale questions, participants scored greater trust. Score averages per question improved leading to an overall sum score increase. In the beginning of the pretest survey, 27% of participants trusted their physician so much to always try to follow their advice while 60% did not trust their doctor to always try and follow their medical advice. After attending the CVFC, all participants noted they would trust the medical student that attended them, to try to follow their medical advice. The trust scale for the pretest also highlighted how more than half of participants believe their doctor does not do everything for their medical care. Following care at CVFC, participants all scored that they felt the medical student did everything for their medical care. During the pretest, 53% of participants noted that sometimes they distrust their doctor's opinion and would like a second one. However, during the posttest, 93% of the participants disagreed that they sometimes distrusted the medical student's opinion and would like a second one. The pretest data also shows how only 27% of participants disagreed that they don't trust their doctor to tell them if a mistake was made about their medical care. Following care at the CVFC, 87% of participants agreed that they trusted the medical student to tell them if a mistake was made about their medical care. Figure 2 shows how after receiving medical care at the CVFC participants increased their trust in medicine. Participants noted greater trust in medical students was able to create an environment for the patient to feel that their needs were put first while making the patient feel that the medical student did everything for their medical care.

*Table 2. Patient Trust Pre and Post-tests Mean and Sum Scores*

<b>Patient Trust Scale</b>		
<b>Question</b>	<b>Pre -Test</b>	<b>Post test</b>
I doubt that my doctor really cares about me as a person. <i>D</i>	1.80	2.67
My doctor is usually considerate of my needs and puts them first.	2.20	3.00
I trust my doctor so much I always try to follow his/her advice.	1.67	3.00
If my doctor tells me something is so, then it must be true.	2.20	2.87
I sometimes distrust my doctor's opinion and would like a second one. <i>D</i>	1.67	2.93
I always trust my doctor's judgment about my medical care.	2.20	2.93
I trust my doctor to put my medical needs above all other considerations when treating my medical problems.	2.20	3.00
My doctor is a real expert in taking care of medical problems like mine.	2.27	3.00
I trust my doctor to tell me if a mistake was made about my treatment.	1.67	2.80
I sometimes worry that my doctor may not keep the information we discuss totally private. <i>D</i>	1.80	2.87
I feel my doctor does not do everything he/she should do for my medical care. <i>D</i>	1.67	2.73
<b>Sum Score</b>	1.94	2.89

Patient Satisfaction scale findings

Majority of the participants also reported a greater satisfaction following care at the CVFC. In the pretest, participants noted a lack of satisfaction in the care they received and in the posttest participants showed satisfaction with the care they received from the medical student. Across all posttest trust scale questions, participants scored greater patient satisfaction. Score averages per question improved leading to an overall sum score increase. Similar to the trust scale findings, the patient satisfaction scale also has a more positive response after receiving services at the CVFC. 73% of participants agreed that there were things about the medical system they receive care from that need to be improved while only 20% disagreed. When evaluating their satisfaction with the medical care at the CVFC, 93% of participants disagreed with the statement that there were things about the medical system they receive care from that need to be improved. A factor that needs to improve according to participants is explanation for medical tests. In the pretest, 47% of participants agreed while only 27% disagreed with the statement. However, when answering the same question about CVFC, all participants agreed that the medical student was good about explaining the reason for medical tests. The biggest area for improvement that was noted by the pretest was the lack of advice doctors would give participants to help avoid illness and stay healthy. 80% of participants during the pretest noted their doctor rarely gave them medical advice, but all participants in the posttest noted the medical student gave them advice to stay healthy. Figure 3 shows how after receiving medical care at the CVFC participants increased their satisfaction with the medical provider.

*Table 3. Patient Satisfaction Pre and Post-tests Mean and Sum Scores*

<b>Patient Satisfaction Scale</b>
-----------------------------------

<b>Question</b>	<b>Pre -Test</b>	<b>Post test</b>
Doctors need to be more thorough in treating and examining me. <i>D</i>	1.53	2.93
I am very satisfied with the medical care I receive.	2.47	3.00
My doctor is good about explaining the reason for medical tests.	1.80	3.00
During my medical visits, I am always allowed to say everything that I think is important.	2.07	3.00
When I go for medical care, they are careful to check everything when treating and examining me.	2.27	3.00
There are things about the medical system I receive my care from that need to be improved. <i>D</i>	1.47	2.93
My doctors treat me in a very friendly and courteous manner.	2.00	3.00
Those who provide my medical care sometimes hurry too much when they treat me. <i>D</i>	1.80	2.93
If I have a medical question, I can reach out to my doctor for help without any problem.	2.07	2.86
Doctors rarely give me advice about ways to avoid illness and stay healthy. <i>D</i>	1.40	3.00
All things considered, the medical care I received is excellent.	2.13	3.00

<b>Sum Score</b>	1.91	2.97
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Qualitative findings

After analyzing the qualitative interviews, we found various commonalities among the research participants. The key themes that emerged were a lack of: proper medical examination, hospitality /etiquette, and connection with the medical provider. These three factors are determinantal in establishing trust and in maintaining patient satisfaction. Participants felt that during their medical visits their physician rushed through their medical examination and didn't explain the reason for medical visits.

During the qualitative interviews, a participant talked about a time in which he fractured his wrist and his doctor rushed the physical examination, the participant said:

“They didn't pay as much attention to the parts that were fractured, they just pointed to one fracture when it had 3 parts that were fractured”.

Because of this bad medical experience, the participant noted he lost trust in his doctor after that misdiagnosis. The participant also conveyed how after a month of pain he traveled across the border to Mexicali to get a second medical opinion, and the doctor there discovered the first fracture and two missed fractures. The participant said, “from the bad experience it has taken away my confidence to go to a doctor from here I have always gone to Mexicali services, because it's cheaper and they know more”. When evaluating the care he received at CVFC, he highlighted the clinic's hospitality and effort in examining him but also trying to get to him better which made him feel more comfortable. Through this experience, we are able to see how

important a proper physical examination is for establishing trust within patients. In the pretest, this participant disagreed that when he received medical care they are careful to check everything when treating and examining him but after CVFC he agreed. This participant lost trust in his medical provider which led him to seek medical care across the border.

Other participants were in a similar situation, one participant said she was having a lot of problems with her stomach and was in a lot of pain, diarrhea, and had blood in her urine but her doctor said everything was normal. After insisting various times, she was sent to a specialist for a colonoscopy where they found she had a Precancerous polyp. She said:

“I lasted over 6 months having blood in my urine, so I mean, no, they didn't give me the medical attention they had to give me for a long time. If it had taken me longer or if I didn't have a colonoscopy, I don't know, maybe I'd get cancer.”

Misdiagnosis is a common theme among participants, but we also noticed that not being heard by physicians was also an outlet for patients to begin to distrust their doctor. The participant talks about her experience with having an ingrown hair in her buttocks and that her doctor said the cause was because she didn't take prenatal vitamins and proceeded to prescribe her antibiotics. After a few days, the participant called her doctor because she felt worse and began to have diarrhea. Her doctor proceeded to tell her: “I can't do anything for you anymore. If you want to continue taking the antibiotic it's up to you and if not, then don't.”

After that call, the participant said she ended in the emergency room due to the pain and other complications she faced. Since that experience, she hasn't sought medical care there. When asked about the medical care at CVFC she said, “here the students did take their time in examining me and asking me questions”. The participants highlighted how she was able to ask



questions and the medical students had answers to her questions even providing different forms of treatment. Given the participants' encounter, we can see how the idea of being heard by medical providers is key in helping shape trust in a medical environment. In the pretest, this participant disagreed when responding that I can reach out to my doctor for help without any problem if I have a medical question but after CVFC he agreed. Given this response and interview, we can infer that this participant is not satisfied with her medical provider and the care she received.

Another participant noted a similar experience where he felt not heard by his provider when asking for further diagnostic tests. The participant mentioned how he was feeling weak and drowsy, so he asked his physician for a blood test to see if he was deficient in any vitamins. The participant was denied access to further medical tests that he asked his provider for. He states, “here they hear you, they were asking questions, basically giving us things that could help treat my problem”. After the medical care at CVFC, the participant felt like he was being heard by the medical students and given good advice to mitigate his medical issue.

The lack of connection patients had with their medical provider led to feelings that their medical provider did not care for them enough to get to know them outside the clinic. One participant noted her experience with a previous medical provider and his staff. She said:

Because I used to go to the clinic here in Mecca, and the truth is that they are very bad. That's why I changed, because neither the doctors nor the nurses, much less the ones in the front desk treat you right, they are lousy. And very rude that I once said to one of them, well, if you are not happy with your work, then don't come, you are there to assist us and you have work for us.

The attitude that providers and their staff employ to patients is a first impression for patients. When providers fail to employ an environment that makes patients feel, patients begin to get frustrated and look for care elsewhere where they will be treated properly by staff and medical providers. When asked about the CVFC, she highlighted how the medical students took really good care of her and how during her medical visits sometimes it was hard for her to follow along but not at the CVFC. The participant went on to say that the medical school that attended her was very attentive and gave her well explanations of everything she asked her. The participant went along to say, “If I didn't know, she's a medical student, I'd tell you, she's a doctor. A professional”. This quote goes to show that medical students exhibit professionalism and know how to hold clinical conversations to the point where patients could believe they are fully trained doctors. This finding is further reinforced by her scoring in the pretest where she agreed that Those who provide my medical care sometimes hurry too much when they treat me but after care at CVFC she disagreed.

Being able to establish a connection between the provider and the patient is determinetal in shaping trust, patients want to form connections with physicians. As is the case for a participant in the study that said, “I would recommend to my doctor that she try to talk to me about how I'm doing in my life, what I like. Like the medical students did, making me feel at ease”. This quote shows how CVFC is making healthcare more personal, taking away from being in a medical clinic.

## Discussion

Study findings indicate that residents in the ECV have a high level of patient dissatisfaction leading to mistrust in medical institutions overall. The study team noted how not being heard, not being examined properly, and not being connected with their medical provider all played to complications arising for these participants further increasing barriers to access healthcare. These barriers presented themselves in the form of missed diagnosis, having to seek follow up care, or having to find a new medical provider. The CVFC helped prevent these complications from arising by offering personalized care, speaking Spanish to patients to help them understand, and maintaining professionalism through hospitality and etiquette. These attributes allowed patients to feel heard, being examined properly, and establishing a personal connection with the medical students.

Quotes from participants allowed the study team to better understand the quantitative data. The interviews suggested that there is a need for importance in the way that patients are treated and examined. We found trust to be a key commonality in increasing patient satisfaction which is why the CVFC implements the use of community health workers who know the community and its needs. Having a trustworthy reference point for community members allows them to feel comfortable and not in fear.

Although our sample size was small, the findings of this study are important. First, we successfully recruited a vulnerable patient population that is often not engaged in research. Many participants fell within the category of educationally/economically disadvantaged as the patient population served by the clinic is primarily low-income, immigrant Latinx and/or Indigenous Mexican. This population has limited access to formal education and also tends to have limited literacy. We successfully engaged this population in several ways. First, CHWs/promotoras, who

are members of the community with similar educational and economic backgrounds, were part of the research team and recruited participants into the study as well as lead data collection and analysis efforts. Second, we built trust. Via our engagement approach, our team was able to build trust with vulnerable community members and ensured their confidentiality and protection as human subjects in research. Trust building is important to minimize coercion. Third, CHWs/promotoras were available to answer participants' questions and provided information for participants to make informed decisions about research participation.

A limitation of our study was the measurement tools. We used validated tools that have been used in the past by other clinical institutions (ie, hospitals and clinics) to gauge the quality of care that they give to their patients. However we did not use all questions in the scales or subscales limiting the analysis and interpretation of the quantitative data specifically regarding patient satisfaction. It was only after data collection that we noticed that scoring could be further analyzed using subscales that were grouped into specific sectors of patient satisfaction in healthcare. Future studies could look into implementing the subscales in a greater sample size to better measure patient satisfaction in medical institutions.

## **Conclusion**

The findings from my capstone study demonstrate that implementation of innovative models focused on the health care needs of the patient while offering culturally and linguistically appropriate care, are important to have vulnerable populations feel comfortable and content with the quality of care they receive at medical institutions. In doing this, vulnerable populations will increase the trust that they have with their medical providers and in their medical system to further encourage patient visits.

My capstone results highlight the need to implement cultural competence into the healthcare setting shifting the traditional standards of care to account for different diverse underserved communities. Reducing barriers that farm working populations endure when seeking medical care can also increase the access to healthcare. While increasing trust in medicine and access to healthcare, SRFC can help increase access to healthcare and fill the current gaps in healthcare that is seen in underserved communities like the ECV. SRFC has been shown as an innovative form of care that helps overcome significant challenges for immigrant communities. Hopefully these findings can help increase the number of SRFC in the CV and Southern California to increase trust and access to healthcare.

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