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Satisfaction With Care and Ease of Using Health Care Services Among Parents of Children With Special Health Care Needs: The Roles of Race/Ethnicity, Insurance, Language, and Adequacy of Family-Centered Care

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ABSTRACT

OBJECTIVES. To examine whether racial/ethnic disparities exist in parental reports of satisfaction with care and ease of using health care services among children with special health care needs (CSHCN) and to identify factors associated independently with satisfaction with care and ease of use of health care services among CSHCN.

METHODS. We analyzed data for 38 886 CSHCN <18 years of age in the National Survey of CSHCN, conducted from 2000 to 2002. Outcome variables included perceived satisfaction with care and ease of service use. Covariates included sociodemographic factors, insurance, interview language, condition severity and stability, adequacy of family-centered care measures, and having a personal doctor/nurse.

RESULTS. The prevalences of reported dissatisfaction with care and problems with ease of using services among parents of CSHCN were 8% and 25%, respectively. Black and Hispanic parents were significantly more likely than white parents to be dissatisfied with care (13% and 16% vs 7%) and to report problems with ease of service use (35% and 34% vs 23%). Hispanic/white disparities in satisfaction with care and ease of use of services disappeared only after multivariate adjustment for parental interview language. Black/white disparities in satisfaction with care disappeared after adjustments for adequacy of family-centered care measures, but black/white disparities in ease of using services persisted. The severity of the child's condition, lack of insurance, parental interview in Spanish, and inadequate family-centered care were associated significantly with dissatisfaction with care and problems with ease of using health care services.

CONCLUSIONS. Policies and strategies that reduce language barriers, promote insurance coverage and family-centered care, and improve ease of use of services among minority CSHCN have the potential to reduce racial/ethnic disparities in satisfaction with care and to promote ease of use of services among families with CSHCN.

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Key Words

children with special health care needs, patient satisfaction, language barriers, insurance, disparities, race, ethnicity, family-centered care

Abbreviations

CSHCN—children with special health care needs

NS-CSHCN—National Survey of Children With Special Health Care Needs

SCHIP—State Children's Health Insurance Program

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PATIENT SATISFACTION WITH care and ease of using health care services are important quality and access-to-care indicators and key measures for monitoring and evaluating the performance of health care systems.^{1,2} Satisfaction with care influences several health behaviors, including changing providers,³⁻⁵ adhering to treatment,^{6,7} changing health care plans,^{7,8} avoiding physician visits,⁹ and filing lawsuits.¹⁰ Satisfaction with care can vary according to practice characteristics, service organization, and site of care.¹¹⁻¹⁵

Although there is an extensive literature on satisfaction with care, little is known about satisfaction with care among children with special health care needs (CSHCN), particularly minority CSHCN. Most prior research on patient satisfaction focused on adults and children in general, with limited attention to CSHCN. A number of those studies noted that adults and children of racial/ethnic minority groups, with and without special health care needs, are more likely than white patients to be dissatisfied with their care.¹⁶⁻¹⁹ Although CSHCN have greater use of health care services and more frequent encounters with the health care system,²⁰⁻²² there continues to be little empirical work assessing racial/ethnic disparities in this population.²³ Research on CSHCN had been hampered by the lack of nationally representative data on CSHCN, but recent studies used the National Survey of CSHCN (NS-CSHCN) to examine important issues for CSHCN, including the prevalence of CSHCN,²⁴ access to medical homes,²⁵ unmet needs,^{26,27} and language and access to care.²⁸ One analysis documented significant racial/ethnic disparities in satisfaction measures for family-centered care,²⁴ but no study to date has examined such disparities in either overall parental satisfaction with care or ease of using health care services among parents of CSHCN.

The aims of this study were to examine whether there are racial/ethnic disparities in parent-reported satisfaction with care and ease of using health care services among CSHCN and to identify factors that contribute to these disparities among parents of CSHCN. Considering the challenges faced by families of CSHCN and the added difficulties experienced by minority children in our society,¹⁶⁻¹⁹ we hypothesized that minority parents of CSHCN would be more likely than white parents to be dissatisfied with care and to report that health care services for their children are not easy to use. We also hypothesized that controlling for insurance coverage, poverty status, interview language, and adequacy of family-centered care factors would reduce racial/ethnic disparities in satisfaction and ease of service use among parents of CSHCN.

METHODS

Data Source

We analyzed data from the NS-CSHCN, a population-based, random-digit-dial, telephone survey of parents/

guardians that was conducted between 2000 and 2002 and used the State and Local Area Integrated Telephone Survey mechanism as its sampling frame.²⁹ The survey was sponsored by the Maternal and Child Health Bureau and defined CSHCN as those who have "a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."³⁰ CSHCN were identified with the CSHCN Screener, a screening questionnaire developed by a multidisciplinary task force of the Child and Adolescent Health Measurement Initiative; the CSHCN Screener contains 5 multipart questions and was developed by using the Maternal and Child Health Bureau definition of CSHCN while building on the conceptual and empirical properties of the Questionnaire for Identifying Children With Chronic Conditions.³¹ The survey screened 373 055 children <18 years of age in 196 888 households, resulting in 38 866 respondents.²⁹ At least 750 detailed interviews with parents of randomly selected CSHCN were completed in each of the 50 states and the District of Columbia. Statistical adjustments were made to account for households without telephones and to reflect the total number of children in the United States.²⁹

The weighted National Council of American Survey Research Organizations response rate was 61%; it was calculated as the product of the household resolution rate (86.5%), the household-level age screener completion rate (94.9%), the household-level special needs screener completion rate, and the child-level special needs interview completion rate (97.6%). Additional details on the NS-CSHCN survey methods and weighting procedures are available elsewhere.²⁹ The survey contained questions regarding health and functional status, insurance coverage, adequacy of coverage, access to and utilization of services, care coordination, and adequacy of family-centered care.²⁹ The parent or legal guardian most knowledgeable about the child was the primary respondent in each household.²⁹ Henceforth, all references to satisfaction with care or ease of service use refer to parent/guardian reports or perceptions. Approximately 2% ($n = 807$) of the interviews were conducted in Spanish using a Spanish questionnaire that was developed by translating the English questionnaire into Spanish and then translating it back into English; independent contractors performed the 2 translation components.²⁹

Study Variables

Dependent Variables

The main dependent variables in this study were parent-reported overall dissatisfaction with care and difficulties with ease of using health care services. Satisfaction with care was assessed with the following question: "Thinking

about [your child's] health needs and the service (he/she) receives, how satisfied or dissatisfied are you with those services?" The 4-point Likert scale responses (very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied) were dichotomized as dissatisfied (somewhat/very dissatisfied) or not dissatisfied (very/somewhat satisfied), consistent with prior studies.^{32,33} Overall ease of using health care services was assessed with the following question: "Thinking about the services [your child] needs, are those services organized in a way that makes them easy to use?" The 4-point Likert responses (never, sometimes, usually, or always) were dichotomized as problems in ease of use of services (usually/always) or no problems (sometimes/never).

Independent Variables

The child's race/ethnicity was defined as non-Hispanic white, non-Hispanic black, or Hispanic, based on parental report (herein the terms white, black, and Hispanic will be used as per the terms used in the NS-CSHCN). Other independent variables included child characteristics (age in years, gender, residence, condition stability, and condition severity), socioeconomic characteristics (maternal educational attainment and poverty status), access factors (insurance coverage and having a personal doctor or nurse), interview language (English versus other languages), and family-centered care factors. The child's condition status was a categorical variable based on parental assessment of whether the child's condition changes all the time, changes once in a while, or is stable (these were the 3 main options, in addition to "none of the above," "don't know," and "refused this question," available for this question in the NS-CSHCN). The severity of the child's condition was measured on a Likert scale ranging from 0 to 10, with 0 indicating the mildest severity and 10 the greatest severity.

Maternal educational attainment was coded as less than a high school graduate, high school graduate, some college, or college graduate or higher. Poverty status was based on federal poverty guidelines for a family of 4 in the year 2001²⁹ and was classified in this study into 3 percentage categories (0–99%, 100–199%, or ≥200%). A dummy variable was used to indicate "missing" poverty data for ~9% ($n = 3406$) of CSHCN. Access factors included insurance coverage (private, public, or uninsured) and having a personal doctor or nurse (yes/no). Children were classified as uninsured if they did not have insurance coverage at the time of the interview. Residence was dichotomized as metropolitan statistical areas versus nonmetropolitan statistical areas.

We follow the American Academy of Pediatrics definition of family-centered care as a system of service planning, delivery, and evaluation of care that is grounded in collaborative relationships of patients, families, and health care providers.³⁴ In this study, adequacy of family-centered care was assessed by using parental

ratings of the following 5 NS-CSHCN measures: (1) time spent with the provider, (2) listening skills, (3) sensitivity to family customs and values, (4) information provided, and (5) partnership with the family.²⁹ These 5 measures are referred to as adequacy of family-centered care measures or factors. The amount of time spent with the provider was assessed with the following question: "In the past 12 months/since [your child's] birth, how often did [your child's] doctor or other health care providers spend enough time with [your child]?" Listening skills were assessed with the following question: "In the past 12 months/since [your child's] birth, how often did [your child's] doctor or other health care providers listen carefully to you?" Provider sensitivity to values and customs was measured with the following question: "When [your child] is seen by doctors or other health care providers, how often are they sensitive to your family's values and customs?" Adequacy of information given to families by the provider was assessed with the following question: "Information about a child's health or health care include things such as the causes of any health problems, how to care for the child, and what changes to expect in the future. In the past 12 months, how often did you get the specific information you needed from [your child's] doctor and other health care providers?" Assessment of partnership with providers was based on the following question: "In the past 12 months, how often did [your child's] doctor or other health care provider help you feel like a partner in [your child's] care?" The 4-point Likert responses (never, sometimes, usually, or always) for family-centered care were dichotomized as never/sometimes versus usually/always.

Analyses

Bivariate analyses and multivariate logistic regression modeling were used to assess associations between race/ethnicity and satisfaction with care and ease of using health care services. Sample weights are incorporated in all estimates presented. Multivariate analyses were used first to examine the association between race/ethnicity and each outcome, after adjustment for relevant covariates, and second to examine the potential contributions of other independent variables to satisfaction with care and ease of using health care services. Only variables that were significant ($P < .05$) in bivariate analyses were included in multivariate analyses. Tests of collinearity were performed in the multivariate analyses, but no substantial correlations were found among independent variables.

Independent variables were included in the analyses in a sequential manner, beginning with a base model (model 1) containing only the race/ethnicity variable, followed by a model (model 2) containing other child characteristics (age in years, condition status, and condition severity). Model 3 added socioeconomic factors (maternal educational attainment and poverty status),

and model 4 added access-to-care factors (insurance coverage and having a personal doctor or nurse). We added interview language in model 5, followed by an additional model that included family-centered care factors (model 6). The final model for dissatisfaction with care added perceived organizational ease of using health care services (model 7). In addition, to examine the influence of language barriers on satisfaction with care and ease of using health care services among Hispanic subjects, we performed analyses stratifying Hispanic parents into 2 groups, those interviewed in English and those interviewed in Spanish.

From the initial 38 866 respondents, we excluded children classified as multiracial ($n = 1366$) and other racial groups ($n = 1262$), which resulted in an overall sample of 36 238 respondents. The bivariate and multivariate analyses were limited to subjects who responded to the questions on overall satisfaction with care ($n = 14 368$) and ease of service use ($n = 14 203$). All analyses were conducted with Stata 8.0 SE software (Stata Corp, College Station, TX), to adjust for the complex survey design. Comparisons of discrete categorical variables were performed with χ^2 tests of independence, and the t statistic was used to compare means of continuous variables between groups.

RESULTS

Study Sample

The overall sample ($n = 36 238$) consisted of white (73%), black (15%), and Hispanic (12%) CSHCN, with a mean age of 10 years (Table 1). Black and Hispanic CSHCN were significantly more likely than white CSHCN to be younger, to have more severe and unstable conditions, to reside in metropolitan statistical areas, and to have mothers who had not graduated from high school. Minority parents of CSHCN also were disproportionately more likely to live in poverty or near poverty, to be uninsured, and to have no personal doctor/nurse (Table 1). On family-centered care measures, minority parents of CSHCN were significantly more likely than white parents to report that the provider sometimes or never spends enough time with their child, listens to the family carefully, is sensitive to family values/customs, provides enough information to the family, or helps the family feel like partners in the child's care.

Bivariate Analyses

Eight percent of parents of CSHCN in the United States reported being dissatisfied with care (Table 2). Parents of minority CSHCN were approximately twice as likely as white parents to be dissatisfied with care. Compared with white parents, Hispanic parents interviewed in Spanish were >4 times more likely to be dissatisfied with care, whereas Hispanic parents interviewed in English did not differ significantly from white parents in

dissatisfaction with care. Overall, children of dissatisfied parents also were significantly more likely to have unstable and more-severe conditions, to have parents with less than a high school degree, to be poor or nearly poor, to be publicly insured or uninsured, to have no personal doctor or nurse, to have been interviewed in Spanish, and to have reported inadequate family-centered care.

One fourth of parents of CSHCN reported that health care services for their children were not easy to use (Table 2). Minority parents were significantly more likely than white parents to report that health care services for their children were not easy to use, with approximately one third of parents of black and Hispanic CSHCN, compared with one fifth of parents of white CSHCN, reporting that services were not easy to use. Hispanic parents interviewed in Spanish were approximately twice as likely as white parents to report that services for their children were not easy to use. Parents of CSHCN covered by public insurance and those without insurance coverage were more likely to report that health care services for their children were not easy to use. Unstable condition status, greater condition severity, lower maternal educational attainment, poverty, having no regular doctor or nurse, being interviewed in Spanish, and inadequate family-centered care also were associated significantly with reports of services not being easy to use.

Multivariate Analyses

Satisfaction With Care

Compared with parents of white CSHCN, parents of racial/ethnic minority CSHCN had significantly greater unadjusted odds of being dissatisfied with care (Table 3). These disparities diminished slightly after adjustment for other child characteristics (age, condition status, and condition severity) but remained significant (Table 3, model 2). The addition of socioeconomic status (maternal education and poverty status) and access-to-care (insurance and presence of a personal doctor or nurse) factors reduced but did not eliminate the minority/white disparities in dissatisfaction with care (Table 3, models 3 and 4). The Hispanic/white dissatisfaction disparity disappeared after adjustment for interview language, whereas the black/white dissatisfaction disparity persisted (Table 3, model 5). Black/white disparities in dissatisfaction with care disappeared only after adjustment for family-centered care factors (Table 3, model 6). Several measures of adequacy of family-centered care were associated independently with dissatisfaction with care, including inadequate time spent with the provider, the amount of information given by providers to families, provider listening skills, and partnership with families. These factors also seemed to account for much of the black/white disparity in dissatisfaction with care.

Condition severity, lack of insurance coverage, paren-

TABLE 1 Selected Characteristics of CSHCN in the United States, According to Race/Ethnicity

Characteristic	Percent or Mean (95% CI)				P
	All (n = 35 946)	White (n = 28 916)	Black (n = 3820)	Hispanic (n = 3210)	
Child characteristics					
Race/ethnicity		73.1 (72.2–74.0)	15.2 (14.4–15.9)	11.9 (11.2–12.6)	
Gender					.6435
Male	59.8 (58.9–60.8)	59.6 (58.6–60.7)	61.0 (58.4–63.7)	59.6 (56.4–62.9)	
Female	40.2 (39.2–41.1)	40.4 (39.3–41.4)	39.0 (36.3–41.6)	40.4 (37.1–43.6)	
Age, mean (95% CI), y	10.0 (9.9–10.1)	10.2 (10.1–10.3)	9.2 (8.9–9.5)	9.5 (9.2–9.7)	<.0001
Condition stability					
Changes all the time	6.3 (5.9–6.8)	5.4 (5.0–5.9)	9.9 (8.3–11.5)	7.2 (5.7–8.7)	<.0001
Changes once in a while	29.9 (29.0–30.8)	28.6 (27.6–29.6)	33.8 (31.1–36.4)	33.2 (30.2–36.3)	
Is stable	63.8 (62.8–64.7)	66.0 (65.0–67.0)	56.3 (53.6–59.0)	59.6 (56.4–62.7)	
Condition severity score, mean (95% CI) ^a	4.2 (4.1–4.2)	4.0 (3.9–4.0)	4.9 (4.8–5.1)	4.7 (4.5–4.8)	<.0001
Residence					
MSA	80.6 (80.0–81.2)	77.5 (76.7–78.2)	87.6 (86.0–89.0)	90.6 (89.0–92.0)	<.0001
Non-MSA	19.4 (18.8–20.0)	22.5 (21.8–23.3)	12.4 (10.9–13.9)	9.4 (7.9–10.9)	
Socioeconomic status factors					
Maternal education					
Less than high school degree	14.9 (14.0–15.7)	10.2 (9.4–11.0)	20.5 (18.0–22.9)	36.5 (33.1–39.9)	<.0001
High school graduate	30.4 (29.5–31.3)	30.6 (29.6–31.6)	32.9 (30.2–35.5)	26.6 (23.8–29.4)	
Some college	31.4 (30.5–32.3)	32.5 (31.5–33.5)	31.7 (29.0–34.4)	24.2 (21.5–27.0)	
College graduate	23.3 (22.7–24.0)	26.7 (25.9–27.6)	14.9 (13.3–16.5)	12.6 (11.1–14.2)	
Poverty status ^b					
<100% FPL	13.4 (12.7–14.1)	8.1 (7.5–8.7)	29.3 (26.8–31.7)	25.4 (22.6–28.2)	<.0001
100–199% FPL	19.9 (19.1–20.7)	17.5 (16.7–18.3)	25.4 (23.2–27.6)	28.0 (24.9–31.1)	
≥200% FPL	57.8 (56.8–58.7)	65.8 (64.9–66.8)	36.5 (33.7–39.2)	36.2 (33.1–39.2)	
Missing poverty data	8.9 (8.4–9.4)	8.6 (8.0–9.1)	8.9 (7.4–10.4)	10.5 (8.7–12.3)	
Access-to-care factors					
Insurance status					
Private	61.4 (60.4–62.3)	69.3 (68.4–70.3)	36.0 (33.4–38.7)	45.1 (41.8–48.3)	<.0001
Public	21.6 (20.8–22.4)	15.4 (14.6–16.1)	41.8 (39.1–44.5)	33.9 (30.8–37.0)	
Uninsured	5.2 (4.8–5.7)	4.4 (3.9–4.9)	5.3 (4.2–6.5)	10.2 (8.4–12.1)	
Personal doctor or nurse					
Yes	89.3 (88.7–89.9)	90.4 (89.7–91.0)	86.0 (84.0–87.8)	86.9 (84.5–89)	<.0001
No	10.7 (10.1–11.4)	9.6 (9.0–10.3)	14.0 (12.1–15.9)	13.1 (10.8–15.3)	
Interview language					
English	96.5 (96.1–96.9)	99.8 (99.7–99.8)	99.9 (99.7–100.0)	71.8 (68.8–74.7)	<.0001
Spanish ^c	3.5 (3.1–3.9)	0.2 (0.2–0.3)	0.1 (0.0–0.2)	28.1 (25.2–31.1)	
Family-centered care factors					
Provider spends enough time with child					
Always/usually	83.8 (83.0–84.5)	87.4 (86.6–88.1)	74.0 (71.5–76.3)	73.5 (70.4–76.4)	<.0001
Sometimes/never	16.2 (15.5–17.0)	12.6 (11.8–13.4)	26.0 (23.6–28.4)	26.5 (23.5–29.5)	
Provider listens carefully to family					
Always/usually	88.4 (87.8–89.1)	89.6 (88.8–90.3)	85.6 (83.6–87.5)	84.6 (82.1–86.8)	<.0001
Sometimes/never	11.6 (10.9–12.2)	10.4 (9.7–11.1)	14.3 (12.4–16.3)	15.4 (13.1–17.8)	
Provider is sensitive to family values and customs					
Always/usually	87.4 (86.7–88.0)	89.9 (89.2–90.6)	80.3 (78.1–82.4)	80.2 (77.5–82.6)	<.0001
Sometimes/never	12.6 (12.0–13.3)	10.1 (9.4–10.8)	19.7 (17.5–21.8)	19.8 (17.3–22.4)	
Provider gives enough information to family					
Always/usually	81.2 (80.4–82.0)	83.3 (82.43–84.14)	80.2 (77.99–82.2)	69.5 (66.24–72.57)	<.0001
Sometimes/never	18.8 (18.0–19.6)	16.7 (15.8–17.6)	19.8 (17.7–21.9)	30.5 (27.3–33.7)	
Provider helps family feel like partners in child's care					
Always/usually	86.1 (85.4–86.8)	88.0 (87.2–88.8)	83.4 (81.3–85.4)	77.4 (74.5–80.1)	<.0001
Sometimes/never	13.9 (13.2–14.6)	12.0 (11.2–12.8)	16.6 (14.6–18.6)	22.6 (19.8–25.3)	

MSA indicates metropolitan statistical area; FPL, federal poverty level; CI, confidence interval. The data source was the NS-CSHCN (n = 36 238).

^a Continuous variable scored with a Likert scale (0 = mildest severity and 10 = most severe).

^b Based on the US Department of Health and Human Services 2001 Poverty Guidelines, in which poverty was defined as an annual combined income of ≤\$17 650 for a family of 4.

^c Of non-English interviews, 95% were in Spanish.

tal interview in Spanish, and all family-centered care factors, except for sensitivity to family values and customs, were associated independently with dissatisfaction

with care and contributed significantly to black/white disparities in satisfaction with care (Table 3, model 7). Lack of insurance coverage, for example, was associated

TABLE 2 Factors Associated With Dissatisfaction With Care and Problems With Ease of Use of Health Care Services Among Parents of CSHCN in the United States

Characteristic	Dissatisfied With Care (n = 14 368)		Services Not Easy to Use (n = 14 203)	
	% (95% CI)	P	% (95% CI)	P
Total	8.2 (7.4–9.1)		25.4 (24.0–26.8)	
Child characteristics				
Race/ethnicity		<.001		<.001
White	6.5 (5.7–7.3)		22.6 (21.1–24.0)	
Black	12.7 (9.3–16.2)		34.7 (30.3–39.1)	
Hispanic	15.5 (11.5–19.5)		34.0 (28.7–39.2)	
Interviewed in English	9.7 (6.6–14.1)		29.6 (24.2–35.6)	
Interviewed in Spanish	27.8 (19.5–38.0)		43.7 (33.4–54.6)	
Gender		.03		.9
Male	7.1 (6.0–8.3)		25.3 (23.0–27.6)	
Female	9.0 (7.7–10.3)		25.6 (23.8–27.3)	
Age, mean, y	10.7 (10.2–11.2)		10.5 (10.2–10.9)	
Condition stability		<.001		<.001
Changes all the time	15.6 (11.7–19.5)		42.5 (37.0–48.0)	
Changes once in a while	11.4 (9.2–13.7)		32.3 (29.2–35.3)	
Is stable	6.1 (5.2–6.9)		20.5 (19.0–22.0)	
Condition severity score ^a	5.7 (5.4–6.0)		5.0 (4.9–5.2)	
Residence		.890		.617
MSA	8.2 (7.2–9.3)		25.3 (23.6–26.9)	
Non-MSA	8.3 (6.9–9.8)		26.0 (23.6–28.4)	
Socioeconomic status factors				
Maternal education		<.001		<.001
Less than high school degree	14.7 (10.9–18.6)		37.1 (32.0–42.2)	
High school graduate	8.0 (6.5–9.5)		24.2 (21.9–26.5)	
Some college	7.5 (5.9–9.1)		23.0 (20.8–25.3)	
College graduate	5.7 (4.7–6.7)		22.7 (20.2–25.3)	
Poverty status ^b		<.001		<.001
<100% FPL	15.1 (12.2–18.0)		36.8 (32.6–41.1)	
100–199%FPL	11.4 (8.6–14.3)		29.2 (25.8–32.5)	
≥200% FPL	5.9 (5.1–6.8)		21.5 (19.8–23.2)	
Missing poverty data	6.8 (4.4–9.2)		26.9 (22.5–31.4)	
Access-to-care factors				
Insurance status		<.001		<.001
Private	5.8 (4.9–6.6)		20.3 (18.7–21.9)	
Public	11.4 (9.1–13.7)		29.7 (26.7–32.8)	
Uninsured	23.8 (16.4–31.2)		47.0 (39.4–54.7)	
Personal doctor or nurse		<.001		<.001
Yes	7.4 (6.5–8.3)		23.8 (22.4–25.2)	
No	15.6 (11.7–19.4)		39.5 (34.7–44.3)	
Interview language		<.001		<.001
English	7.6 (6.7–8.5)		24.8 (23.4–26.2)	
Spanish ^c	26.7 (17.8–35.7)		42.8 (32.4–53.2)	
Family-centered care factors				
Provider spends enough time with child		<.001		<.001
Sometimes/never	25.1 (22.0–28.5)		58.4 (54.4–63.3)	
Always/usually	3.9 (3.3–4.6)		17.1 (15.9–18.5)	
Provider often listens carefully to family		<.001		<.001
Sometimes/never	31.0 (27.0–35.2)		62.0 (57.2–66.5)	
Always/usually	4.2 (3.6–4.9)		19.0 (17.7–20.4)	
Provider is sensitive to family values and customs		<.001		<.001
Sometimes/never	26.1 (22.4–30.1)		59.9 (55.1–64.5)	
Always/usually	4.9 (4.2–5.7)		19.4 (18.1–20.8)	
Provider gives enough information to family		<.001		<.001
Sometimes/never	23.1 (20.2–26.2)		53.6 (49.8–57.4)	
Always/usually	4.0 (3.3–4.7)		17.5 (16.3–18.8)	
Provider helps family feel like partners in child's care		<.001		<.001
Sometimes/never	26.3 (22.8–30.2)		58.7 (54.0–63.3)	
Always/usually	4.4 (3.8–5.2)		18.6 (17.3–20.0)	

MSA indicates metropolitan statistical area; FPL, federal poverty level; CI, confidence interval. The data source was the NS-CSHCN. P values were determined with χ^2 tests or χ^2 tests for trend (for comparisons with >2 categories).

^a Continuous variable scored with a Likert scale (0 = mildest severity and 10 = most severe); significantly different from those satisfied with care (mean: 5.7; 95% confidence interval: 5.4–6.0) and those reporting services were easy to use (mean: 5.0; 95% confidence interval: 4.8–5.2).

^b Based on the US Department of Health and Human Services 2001 Poverty Guidelines, in which poverty was defined as an annual combined income of \leq \$17 650 for a family of 4.

^c Of non-English interviews, 95% were in Spanish.

TABLE 3 Multivariate Analyses of Factors Associated With Dissatisfaction With Care Among CSHCN in the United States

Characteristic	Odds Ratio (95% CI) for Dissatisfaction With Care						
	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
Child characteristics							
Race/ethnicity							
White	Referent	Referent	Referent	Referent	Referent	Referent	Referent
Black	2.26 (1.55–3.28) ^a	1.79 (1.25–2.56) ^a	1.56 (1.08–2.25) ^b	1.57 (1.09–2.27) ^b	1.60 (1.11–2.31) ^b	1.43 (0.93–2.20)	1.33 (0.85–2.09)
Hispanic	2.64 (1.84–3.80) ^a	2.38 (1.61–3.50) ^a	1.98 (1.32–2.95) ^a	1.88 (1.25–2.82) ^a	1.41 (0.86–2.32)	1.17 (0.71–1.92)	1.16 (0.68–1.98)
Child's age		1.03 (1.00–1.06) ^b	1.03 (1.01–1.06) ^b	1.03 (1.00–1.06) ^b	1.03 (1.00–1.06) ^b	1.02 (0.99–1.05)	1.01 (0.99–1.04)
Condition stability							
Is stable		Referent	Referent	Referent	Referent	Referent	Referent
Changes once in a while		1.54 (1.17–2.03) ^a	1.49 (1.14–1.96) ^a	1.50 (1.14–1.97) ^a	1.48 (1.13–1.95) ^a	1.20 (0.88–1.63)	1.11 (0.80–1.53)
Changes all the time		1.56 (1.04–2.35) ^b	1.48 (0.98–2.24)	1.51 (1.01–2.27) ^b	1.56 (1.04–2.35) ^b	1.37 (0.89–2.09)	1.17 (0.75–1.82)
Condition severity score ^c		1.22 (1.15–1.29) ^a	1.21 (1.14–1.28) ^a	1.21 (1.14–1.28) ^a	1.20 (1.14–1.27) ^a	1.16 (1.08–1.23) ^a	1.14 (1.06–1.22) ^a
Socioeconomic status factors							
Maternal education							
College graduate			Referent	Referent	Referent	Referent	Referent
Less than high school degree			1.30 (0.86–1.98)	1.21 (0.78–1.88)	1.11 (0.71–1.75)	0.92 (0.57–1.49)	0.87 (0.53–1.44)
High school graduate			1.05 (0.76–1.46)	1.01 (0.73–1.40)	1.02 (0.74–1.41)	0.89 (0.62–1.28)	0.93 (0.63–1.36)
Some college			1.07 (0.78–1.46)	1.03 (0.75–1.41)	1.05 (0.77–1.44)	0.96 (0.67–1.38)	0.99 (0.67–1.45)
Poverty status ^d							
≥200% FPL			Referent	Referent	Referent	Referent	Referent
<100% FPL			1.59 (1.10–2.30) ^b	1.48 (0.99–2.21)	1.44 (0.96–2.15)	1.25 (0.80–1.96)	1.20 (0.75–1.92)
100–199% FPL			1.29 (0.92–1.82)	1.24 (0.86–1.78)	1.21 (0.84–1.75)	1.15 (0.78–1.70)	1.15 (0.77–1.72)
Missing poverty data			0.94 (0.58–1.53)	0.87 (0.53–1.44)	0.83 (0.50–1.38)	0.75 (0.43–1.31)	0.74 (0.42–1.32)
Access-to-care factors							
Insurance status							
Private				Referent	Referent	Referent	Referent
Public				1.03 (0.72–1.47)	1.04 (0.73–1.49)	1.04 (0.70–1.56)	1.15 (0.76–1.74)
Uninsured				2.50 (1.59–3.94) ^a	2.34 (1.45–3.77) ^a	1.85 (1.13–3.02) ^b	1.71 (1.04–2.82) ^b
Personal doctor or nurse							
Yes				Referent	Referent	Referent	Referent
No				1.33 (0.96–1.86)	1.29 (0.92–1.82)	0.77 (0.52–1.13)	0.75 (0.50–1.11)
Interview language							
English					Referent	Referent	Referent
Spanish ^e					2.15 (1.03–4.47) ^b	2.21 (1.08–4.52) ^b	2.25 (1.06–4.76) ^b
Family-centered care factors							
Provider spends enough time with child							
Always/usually						Referent	Referent
Sometimes/never						2.13 (1.50–3.03) ^a	1.72 (1.20–2.45) ^a
Provider often listens carefully to family							
Always/usually						Referent	Referent
Sometimes/never						2.63 (1.74–3.99) ^a	2.36 (1.58–3.52) ^a
Provider is sensitive to family values and customs							
Always/usually						Referent	Referent
Sometimes/never						1.30 (0.89–1.89)	1.20 (0.83–1.75)
Provider gives enough information to family							
Always/usually						Referent	Referent
Sometimes/never						2.09 (1.46–2.98) ^a	1.77 (1.24–2.54) ^a
Provider helps family feel like partners in child's care							
Always/usually						Referent	Referent
Sometimes/never						1.74 (1.20–2.53) ^a	1.58 (1.10–2.28) ^b
Services are not easy to use							
Always/usually							Referent
Sometimes/never							3.40 (2.46–4.72) ^a

FPL indicates federal poverty level; CI, confidence interval. There were 13 017 subjects with complete data for all variables included in the full model (model 7); the data source was the NS-CSHCN.

^a $P < .01$.

^b $P < .05$.

^c Continuous variable scored with a Likert scale (0 = mildest severity and 10 = most severe); significantly different from those satisfied with care (mean: 5.7; 95% confidence interval: 5.4–6.0) and those reporting that services were easy to use (mean: 5.0; 95% confidence interval: 4.8–5.2).

^d Based on the US Department of Health and Human Services 2001 Poverty Guidelines, in which poverty was defined as an annual combined income of ≤\$17 650 for a family of 4.

^e Of non-English interviews, 95% were in Spanish.

with approximately twice the odds of dissatisfaction with care. Difficulties with ease of using health care services also were associated significantly with greater dissatisfaction with care (Table 3, model 7), with more than triple the odds.

Ease of Using Health Care Services

Black and Hispanic parents had significantly greater unadjusted odds, compared with white parents, of reporting that services for their CSHCN were not easy to use (Table 4, model 1). These disparities diminished slightly but persisted after adjustment for other child characteristics (Table 4, model 2), socioeconomic status (Table 4, model 3), and access factors (Table 4, model 4). Hispanic/white disparities in ease of using services disappeared after adjustment for interview language (Table 4, model 5). Black/white disparities were attenuated slightly with inclusion of family-centered care factors but persisted (Table 4, model 5). Even after adjustment for all relevant covariates, black parents still had significantly greater odds, compared with white parents, of reporting that services were not easy to use.

The child's age, condition stability and severity, lack of insurance coverage, and family-centered care factors remained significantly associated with perceived difficulty in ease of using health care services for parents of CSHCN after adjustment for relevant covariates (Table 4, model 5). Parents who reported that their child's health care provider did not spend enough time with their child and those who reported lack of adequate information from the provider had more than twice the odds of reporting that services were not easy to use. Public insurance was the only factor that seemed to protect against reported difficulties in using health care services. Compared with parents of CSHCN with private insurance, parents of publicly insured CSHCN had significantly lower odds of reporting problems with ease of using health care services (Table 4, model 6).

Parental Interview Language

Hispanic parents interviewed in Spanish had ~6 and ~3 times greater unadjusted odds than white parents of being dissatisfied with care and reporting that services for their child were not easy to use, respectively (Table 5). In contrast, Hispanic parents interviewed in English did not differ statistically from white parents in both outcomes, after multivariate adjustments. Hispanic parents interviewed in Spanish still had almost 3 times greater adjusted odds of being dissatisfied with care than white parents, but disparities in ease of service use did not persist after adjustments (Table 5).

DISCUSSION

The study findings reveal that racial/ethnic disparities exist in parent-reported satisfaction with care and ease of service (as shown by the unadjusted odds ratios in

model 1 of Tables 3 and 4). Hierarchical multivariate models, however, document that different factors are associated with these disparities for black and Hispanic parents. Adjustment for survey interview language eliminates Hispanic/white disparities in both satisfaction with care (Table 3, model 5) and ease of service use (Table 4, model 5). Black/white disparities in satisfaction with care are eliminated only after adjustment for adequacy of family-centered care factors (Table 3, model 6), whereas black/white disparities in parent-reported ease of service use persist after multivariate adjustment (Table 4, model 6). Other factors associated independently with both dissatisfaction with care and difficulties in using services among parents of CSHCN include the child's condition severity, lack of insurance coverage, and all measures of adequacy of family-centered care. In contrast, interview language is associated with dissatisfaction with care but not ease of service use, whereas the child's age and condition stability and providers' sensitivity to family values/customs are associated independently with ease of service use but not dissatisfaction with care.

A key finding of this study is the strong influence of interview language on disparities in satisfaction and ease of service use among Hispanic parents of CSHCN. Interview language is a crude proxy for language barriers. Language problems are major access barriers for Latino children^{35,36} and have been linked to fewer physician visits³⁷ and substantially lower satisfaction with care among those who need but do not receive interpreters.³⁸ The present study underscores the importance of addressing the language needs of Hispanic families with CSHCN. The findings are consistent with prior research that documented lower satisfaction with provider-patient communication among Spanish-speaking parents, compared with English-speaking parents.^{16,18,19,39} Weech-Maldonado et al,³⁹ for example, found that minority parents were less satisfied with pediatric care than white parents and that much of the dissatisfaction with care was associated with language barriers. The findings are also consistent with prior research that associated parental survey interview language with poor child health status⁴⁰ and lower odds of having a usual source of care among children.⁴¹ In this study, Hispanic parents interviewed in Spanish had almost 3 times greater adjusted odds of dissatisfaction with care, compared with white parents. These findings indicate that efforts to address disparities in dissatisfaction with care and ease of using health care services among parents of Hispanic CSHCN will need to identify and to address the language needs of Hispanic families with CSHCN who have limited English proficiency. Potential strategies for addressing these language needs may include incorporating and integrating cultural competence curricula into both medical training and continuing medical education and increas-

TABLE 4 Multivariate Analyses of Factors Associated With Problems With Ease of Using Health Care Services Among CSHCN in the United States

Characteristic	Odds Ratio (95% CI) of Problems With Ease of Using Health Care Services					
	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6
Predisposing factors						
Race/ethnicity						
White	Referent	Referent	Referent	Referent	Referent	Referent
Black	1.82 (1.46–2.28) ^a	1.58 (1.25–2.01) ^a	1.49 (1.17–1.88) ^a	1.51 (1.20–1.92) ^a	1.52 (1.20–1.92) ^a	1.36 (1.05–1.75) ^b
Hispanic	1.69 (1.29–2.22) ^a	1.59 (1.21–2.10) ^a	1.40 (1.06–1.84) ^b	1.35 (1.02–1.80) ^b	1.30 (0.96–1.76)	1.09 (0.76–1.55)
Child's age		1.04 (1.02–1.06) ^a	1.05 (1.03–1.07) ^a	1.04 (1.02–1.06) ^a	1.04 (1.02–1.06) ^a	1.04 (1.02–1.06) ^a
Condition stability						
Is stable		Referent	Referent	Referent	Referent	Referent
Changes once in a while		1.66 (1.38–2.00) ^a	1.65 (1.37–1.98) ^a	1.65 (1.37–1.98) ^a	1.65 (1.37–1.98) ^a	1.45 (1.17–1.79) ^a
Changes all the time		1.99 (1.50–2.63) ^a	1.95 (1.47–2.58) ^a	2.02 (1.52–2.68) ^a	2.03 (1.53–2.69) ^a	1.95 (1.43–2.66) ^a
Condition severity score ^c		1.14 (1.10–1.18) ^a	1.13 (1.09–1.17) ^a	1.13 (1.10–1.17) ^a	1.13 (1.10–1.17) ^a	1.10 (1.06–1.14) ^a
Socioeconomic status factors						
Maternal education						
College graduate			Referent	Referent	Referent	Referent
Less than high school degree			1.27 (0.92–1.74)	1.26 (0.90–1.76)	1.24 (0.89–1.74)	1.15 (0.82–1.62)
High school graduate			0.89 (0.72–1.10)	0.87 (0.70–1.08)	0.87 (0.70–1.08)	0.81 (0.64–1.01)
Some college			0.87 (0.71–1.08)	0.86 (0.69–1.06)	0.86 (0.70–1.06)	0.81 (0.64–1.03)
Poverty status ^d						
≥200% FPL			Referent	Referent	Referent	Referent
<100% FPL			1.26 (0.98–1.62)	1.33 (1.01–1.75) ^b	1.32 (1.00–1.74) ^b	1.13 (0.84–1.51)
100–199% FPL			1.12 (0.90–1.38)	1.14 (0.91–1.43)	1.14 (0.91–1.42)	1.07 (0.85–1.36)
Missing poverty data			1.06 (0.82–1.37)	1.06 (0.82–1.37)	1.06 (0.82–1.37)	1.03 (0.77–1.40)
Insurance status						
Private				Referent	Referent	Referent
Public				0.80 (0.63–1.01)	0.80 (0.64–1.01)	0.73 (0.58–0.94) ^b
Uninsured				2.10 (1.51–2.92) ^a	2.08 (1.49–2.91) ^a	1.76 (1.19–2.60) ^a
Personal doctor or nurse						
Yes				Referent	Referent	Referent
No				1.58 (1.25–1.99) ^a	1.58 (1.25–1.99) ^a	1.11 (0.85–1.44)
Interview language						
English					Referent	Referent
Spanish ^e					1.15 (0.63–2.11)	1.04 (0.54–2.00)
Family-centered care factors						
Provider spends enough time with child						
Always/usually						Referent
Sometimes/never						2.52 (1.98–3.22) ^a
Provider often listens carefully to family						
Always/usually						Referent
Sometimes/never						1.57 (1.17–2.10) ^a
Provider sensitive to family values ^a and customs						
Always/usually						Referent
Sometimes/never						1.77 (1.33–2.35) ^a
Family-centered care factors						
Provider gives enough information to family						
Always/usually						Referent
Sometimes/never						2.19 (1.65–2.90) ^a
Provider helps family feel like partners in child's care						
Always/usually						Referent
Sometimes/never						1.70 (1.25–2.30) ^a

FPL indicates federal poverty level; CI, confidence interval. There were 13 049 subjects with complete data on all variables included in the full model (model 6); the data source was the NS-CSHCN.

^a $P < .01$.

^b $P < .05$.

^c Continuous variable scored with a Likert scale (0 = mildest severity and 10 = most severe); significantly different from those satisfied with care (mean: 5.7; 95% confidence interval: 5.4–6.0) and those reporting that services were easy to use (mean: 5.0; 95% confidence interval: 4.8–5.2).

^d Based on the US Department of Health and Human Services 2001 Poverty Guidelines; 100% of poverty was defined as an annual combined income of ≤\$17 650 for a family of 4.

^e Of non-English interviews, 95% were in Spanish.

ing the availability of trained medical interpreter services and bilingual staff members.^{38,39}

The study findings also suggest that providing families

of CSHCN with adequate family-centered care may improve satisfaction with care and the ease of using health care services. Among parents of black CSHCN, dissatis-

TABLE 5 Multivariate Analyses of Factors Associated With Dissatisfaction With Care and Ease of Service Use Among US Hispanic Parents of CSHCN, According to Interview Language

Race/Ethnicity	Odds Ratio (95% CI)			
	Dissatisfaction With Care (n = 13 017)		Services Not Easy to Use (n = 13 049)	
	Unadjusted	Adjusted ^a	Unadjusted	Adjusted ^a
White	Referent	Referent	Referent	Referent
Hispanic				
Interviewed in English	1.57 (0.95–2.58)	1.12 (0.64–1.95)	1.37 (1.00–1.88) ^b	1.09 (0.76–1.57)
Interviewed in Spanish	5.53 (3.28–9.32) ^c	2.72 (1.42–5.22) ^c	2.56 (1.59–4.11) ^c	1.11 (0.61–2.05)

CI indicates confidence interval.

^a Adjusted for age, condition stability, condition severity, maternal educational attainment, poverty status, insurance status, availability of a personal doctor or nurse, and family-centered care factors (interview language was excluded from the models). Black subjects were included in the model, but the results are not shown.

^b $P < .05$.

^c $P < .01$.

faction with care was associated strongly with measures of inadequate family-centered care, a finding consistent with prior research with general pediatric and adult populations that showed that greater patient involvement in health care decision-making and improves patient-provider communication improved patient satisfaction and outcomes.^{10,42–46} Family-centered care factors, such as adequate listening, respect, trust, and participatory decision-making, have been linked to greater satisfaction with care among black adults, compared with other racial/ethnic groups.^{42,43} One study¹⁶ revealed that time spent with the provider and satisfaction with information given by the provider were associated with parental satisfaction with care for young children and that a dose-response relationship existed between visit duration and patient satisfaction with care. Cultural competency training,⁴³ increasing the number of minority providers,⁴³ and enhancing patients' trust of providers and the health care system⁴⁷ have the potential to improve 2 components of family-centered care, namely, patient-provider communication and participatory decision-making.

The strong association of the several measures of family-centered care with dissatisfaction with care and perceived ease of using health care services suggests that efforts to address or to improve these outcomes need to ensure that all CSHCN, and particularly minority CSHCN, receive adequate family-centered care. Prior research showed that increasing patients' communication and participatory skills led to improved communication with health care providers and better overall health outcomes.^{48,49} Street^{50,51} found that patients' communication skills, including assertiveness, willingness to ask questions, expressing concerns, and providing details about their conditions, influence physician behaviors and participatory style. Interventions focused on increasing patient-provider communication skills and participatory decision-making could have the poten-

tial to increase satisfaction with care, improve ease of service use, and decrease health disparities among parents of CSHCN.⁴³

Parental perceptions of family-centered care have a substantial impact on both dissatisfaction with care and ease of using health care services. All measures of family-centered care, except for sensitivity to family values/culture, were associated strongly and independently with dissatisfaction and ease of health care use. These findings lend support to the concept of family-centered care and highlight the potential significance and contribution of family-centered services to reducing health disparities. The findings also support other studies^{52,53} that suggested the need for systems and policy changes to make family-centered care the "best practice approach" for caring for CSHCN. Promoting and providing family-centered care has the potential not only to reduce health disparities but also to enhance the quality and performance of health care systems for families of CSHCN.

It is not clear why black/white disparities in ease of using health care services for CSHCN persist after multivariate adjustment. A core principle of family-centered care system is "flexibility in organizational policies, procedures, and provider practices so services can be tailored to the needs, beliefs, and cultural values of each child and family."³⁴ It may be that other unmeasured organizational and practice factors, such as provider and patient attitudes, bias or discrimination, transportation barriers, waiting times, and limited availability of providers and specialized services in minority communities, may contribute to black/white disparities in ease of using health care services. These findings suggest the need for additional study of how to make health care services easier to use for black CSHCN and their families.

Lack of insurance coverage was associated independently with both dissatisfaction with care and problems with ease of using health care services. Given that mi-

minority CSHCN are more likely to be poor and uninsured or publicly insured and that most poor uninsured children are eligible for public insurance,⁵⁴ our findings indicate the need for enhanced Medicaid and State Children's Health Insurance Program (SCHIP) outreach efforts to increase enrollment and retention of eligible poor and minority CSHCN.^{55,56}

Publicly insured CSHCN had parental satisfaction levels equivalent to those of privately insured CSHCN and actually reported significantly greater ease of use of services, compared with privately insured CSHCN. These findings highlight the importance of public insurance coverage for CSHCN. Our data indicate that ~22% of CSHCN in the US (~9 million) are covered by public insurance, with more than one third of poor CSHCN being covered through public programs. The data suggest that continued federal and state funding for Medicaid and SCHIP is critical for CSHCN and especially for poor and minority CSHCN. The findings also suggest that reductions in current Medicaid and SCHIP funding may result in greater dissatisfaction with care and difficulties with ease of using services for black and Hispanic CSHCN.

Certain study limitations should be noted. The data are based on parental self-report and therefore may be subject to recall and reporting bias. Because the adequacy of family-centered care measures are based on recall of the past 12 months, it is possible that parents with more-recent encounters with providers are more likely to report accurately their satisfaction with care, compared with those with more-remote encounters. Furthermore, when parent's reports are used as proxies for children's self-reports, some incongruence is possible in assessments of health care services and health status.⁵⁷⁻⁶⁰ This study also did not examine disparities within subcategories of CSHCN (ie, those classified as having special needs solely because of their dependence on medication, compared with those with complex conditions that require medication and other types of services). In a separate article, we plan to examine racial/ethnic disparities in satisfaction and ease of service across these different subcategories of special health care needs. Finally, patient satisfaction is a multidimensional construct that often is measured with more comprehensive instruments. The single overall satisfaction item in NS-CSHCN does not permit identification of specific aspects of care associated with patient satisfaction.

CONCLUSIONS

Thirteen percent to 16% of black and Hispanic parents of CSHCN in the United States report being dissatisfied with their children's health care services, and more than one third of minority parents report that health care

services for their CSHCN are not easy to use. The marked racial/ethnic disparities in dissatisfaction with care and problems with ease of service use may reflect frequently inadequate health care facilities and systems of care for minority CSHCN, particularly at a time when child health services for the poor in the United States are threatened. In addition, language barriers are key determinants of dissatisfaction and difficulties in ease of using services for Hispanic families with CSHCN. Our results underscore the importance of providing adequate medical interpreter services and bilingual resources to Hispanic families of CSHCN, particularly those with limited English proficiency. The results highlight the significance of providing adequate family-centered care and making services easier to use for black families with CSHCN. The study findings also indicate the importance of increasing insurance coverage and family-centered care for CSHCN, especially black CSHCN. Strategies and policies that reduce language barriers, promote insurance coverage and family-centered care, and improve the ease of use of health services have the potential to reduce racial/ethnic disparities and promote greater satisfaction with care and ease of use of services among families of all CSHCN.

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STUDENTS AND TEACHERS, FROM K TO 12, HIT THE PODCASTS

“Podcasting—posting an audio recording online that can be heard through a computer or downloaded to a mobile device like an iPod—is following blogs and online classes as yet another interactive technology catching on as a teaching tool. Currently, iTunes lists more than 400 podcasts from kindergarten through 12th-grade classes, while Yahoo has nearly 900 education-related podcasts. Some are produced by teachers wanting to reach other educators with teaching tips, while many are created by students, like the La Crosse seventh graders with their podcast, at lacrosseschools.com/Longfellow/sc/ck/index.htm. . . . Like other classroom technologies, podcasting requires a learning curve. As a result, teachers already using podcasts in their classes tend to be early adopters of technology. . . . ‘Just the word *podcast* scares a lot of teachers away,’ Kathleen B. Schrock [administrator for technology at Nauset Public Schools in Orleans, Mass.] said. ‘There are a lot of misconceptions.’ One of the most common is that schools need iPods or other portable audio devices, like MP3 players, to create and listen to a podcast, said David Warlick, who sifts through education-related podcasts and lists good ones for teachers on his web site, the Education Podcast Network (epnweb.org). ‘All you need is a computer, access to the Internet and a microphone that you can buy at Toys ‘R’ Us,’ Mr. Warlick said. ‘I listen to podcasts on my computer.’”

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Noted by JFL, MD

Satisfaction With Care and Ease of Using Health Care Services Among Parents of Children With Special Health Care Needs: The Roles of Race/Ethnicity, Insurance, Language, and Adequacy of Family-Centered Care

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