CONCEPT PAPER

IMPROVING THE ASSESSMENT OF LATINO HIGH UTILIZERS IN A PRIMARY CARE POPULATION

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This concept paper represents our intent to develop a proposal investigating the assessment of Latino patients who are high utilizers of primary care services. High utilizers have been chosen as a population for study because there is widespread agreement that high utilization is a serious economic and quality of care concern for the health care field (1, 2). The proposed project will concentrate on examining differences between Latino high utilizers and three other patient groups (Latino average utilizers; Anglo average utilizers; and Anglo high utilizers) on the following dimensions: 1) Presence of psychological distress and disorders 2) Health beliefs 3) Interaction patterns with physicians. These dimensions have been selected specifically because they represent cognitive and behavioral characteristics amenable to intervention. Further, the study will also investigate whether the distinction between "inappropriate" and "appropriate" high utilizers that has sometimes been made in the literature, is a useful one for Latino patients.

Because very little is known about Latino high utilizers, the research proposed here focuses on improving understanding of factors that contribute to high utilization, as well as comparing and contrasting such factors to other relevant populations. The long-term intention of the overall program of research is to develop a series of brief educational interventions for both Latino high utilizing patients and their physicians to improve the care of these patients, the effectiveness of which would be assessed by measurable changes in patient satisfaction, physician satisfaction, patient psychological distress, and inappropriate utilization of health care services and resources.

BACKGROUND AND RATIONALE: Patients who have been designated "high utilizers" of health care resources are a difficult and frustrating problem confronting the medical system. Although constituting only between 10-15% percent of the patient population, they are responsible for 50% of medical visits (3). While "high utilization" can be measured objectively in comparison to local and regional norms, "inappropriate" utilization is necesarily a subjective determination, often derived from physician nomination (*). Many high utilizers are considered "inappropriate" when the nature and severity of their symptoms do not, according to medical opinion, warrant their high level of resource consumption, and when they are perceived as somatizers (4).

Most high utilizers suffer from multiple psychological and physical problems (5). It has been estimated that over 50% of high utilizers have a diagnosable psychiatric illness, while even greater numbers are characterized by subthreshold syndromes (3). Depression (2,6), somatization (7), generalized anxiety (8) and panic disorder (9) in particular are all predictors of high utilization. Compared to average utilizers, high utilizers tend to score as significantly more psychologically distressed on screening measures, yet their self-experienced need for formal psychiatric services is very low (10). High users are also more likely than average users to seek care for mild or psychological symptoms (11,12). Inappropriate compared to appropriate high utilizers tend to express more concern about their mental health and rate their psychological symptoms as more

serious (4). One study concluded that high utilizers who are also depressed use an average of $1490 more annually than high utilizers without depression, and only a small percentage of this figure was attributable to depression-specific treatment (2). The presence of minor psychiatric morbidity often appears to be the trigger that urges patients with physical symptoms toward care (13).

Little is known about Latino high utilizers. Overall, Latinos tend to be underutilizers of the health care system because of a variety of barriers to access (14), and they tend especially to underutilize mental health services due to language differences and perceived stigma (15). Nevertheless, in public sector health care settings, a subset of Latino patients can be identified as high utilizers, in part because low income, minority patients are more likely to seek treatment for mental health care symptoms from primary care providers (16).

Although it is well-established that the introduction of cross-cultural issues into the physician-patient dyad, such as language differences, or different health belief assumptions, can seriously compromise the quality of care (17,18), little attention has been paid to the special problems of Latino high utilizers. In particular, no microanalytic studies of physician interactions with such patients have been undertaken. Recent research demonstrates that the presence of depression alters the content of the physician-patient interview in terms of length, physical history, and counseling (19), but we have no information on how ethnicity and background of high utilization might affect the encounter.

While intervention studies with psychologically distressed Latino patients are to be found in the literature (15,20), these do not specifically target high utilizers, and have shown less demonstrated efficacy than when compared to similar interventions with white, medically healthy, middle-class subjects (21,22). In general, somatizing patients are perceived as resistant to psychological intervention (23). However, a provocative study by Arean & Miranda (15) using a public sector, minority population concluded that, at least on self-report, this population expressed high rates of acceptance for a range of psychological treatments. Furthermore, somatizers and high users were just as willing to attend psychological treatment groups as other patients. Thus treatment to improve the care of low-income minority psychologically distressed population appears potentially promising.

SPECIFIC GOALS OF THIS PROJECT: 1) To determine whether Latino high utilizers are characterized by greater psychological distress and disorders than their average utilization Latino counterparts, as well as in comparison to Anglo high and average utilizers 2) To determine whether Latino high utilizers exhibit greater dissatisfaction with health care than the three comparison groups 3) To determine whether the physicians of these patients exhibit greater dissatisfaction with the care they are able to provide these patients in comparison to the three other patient groups 4) To determine whether key interaction patterns of high utilizing Latino patients with their physicians differ significantly from those of the three comparison groups 5) To determine whether high utilizing Latino patients hold significantly different health beliefs than the three comparison groups. 6) To determine whether the subjective distinction between "inappropriate" and "appropriate" high utilizers can be empirically validated for Latino patients on the dimensions of psychological distress, health beliefs, or doctor-patient interaction.

While not a formal goal of this particular project, the overall intent of this program of research is to develop culturally competent brief educational interventions for high utilizer Latino patients and their physicians to improve the assessment and treatment of these patients. To this

end, variables have been selected for investigation in this study that do not reflect relatively immutable characteristics, ie., gender, ethnicity, socioeconomic status, but rather represent cognitive and behavioral dimensions that might appropriately be considered susceptible to intervention once relevant baseline knowledge is obtained.

METHODS: Subjects and Recruitment Strategies. Subjects will be 200 Latino patients and 200 Anglo patients recruited through two primary care practices in Santa Ana, CA, whose patient populations are primarily Latino and Anglo. One hundred of the Latino patients will be categorized as "high utilizers" according to a criterion number based on a mean split of average number of annual clinic visits, and 50 of these will be further identified as "inappropriate high utilizers" by physician designation (4). These subjects will be matched on key criteria including ethnicity (including country of origin), age, sex, and diagnosis to 100 patients identified by the mean split as "average utilizers." Using a comparable method, 50 Anglo "inappropriate" and 50 Anglo "appropriate" high utilizers will also be identified, as will 100 average utilization Anglo patients.

Subjects will be recruited by a letter from project investigators and their primary care physician briefly explaining the study as an investigation of patients' health beliefs and doctor-patient interaction. The patient's pcp will specifically endorse the value of the project. Each subject who agrees to be videotaped will receive $10 for the inconvenience.

A subset of patients from the inappropriate high, high and average utilizer groups will be randomly selected to participate in a qualitative in-depth interview regarding their perceptions of their medical treatment, clinical symptoms, health beliefs, and overall wellbeing. Subjects who participate in this aspect of the study also will be compensated for their time in the form of $20.

Potential subjects are expected to enroll in the project primarily because of their primary care physician's endorsement of the value of the project and secondarily because of the monetary compensation offered.

Pregnant women and minors will be excluded from the study, as will any patients whose visits involve primarily minor surgical procedures or counseling (these latter exclusions are made because it is assumed that the nature of the doctor-patient interaction would be substantially altered by these reasons for seeking care).

Physician subjects will be the family physicians who provide continuity care to these patients. It is expected that a minimum of four family physicians will participate from each practice. All participating physicians will be residency-trained, board-certified, and will have been in practice a minimum of three years.

Measures: a) Screening for Psychological Distress. One of the following instruments will be selected: 1) HSCL-25, a standardized measure of psychological distress consisting of a depression and an anxiety scale (25) 2) The SDDS-PC, a 16-item screen with acceptable sensitivity, specificity, and positive predictive value that measures six common mental disorders in primary care (26) 3) A version of the General Health Questionnaire, a first-stage screening tool that measures psychiatric caseness (27). In addition, a Daily Hassles measure will be selected to assess situational stress.

b) Diagnostic Psychological Assessment. All patients falling above screening cut-offs will also be evaluated by a trained interviewer using either the Composite International Diagnostic Interview (CIDI) (28) or the PRIME-MD (29,30), both structured face-to-face or telephone diagnostic interviews . (Instruments mentioned in this concept paper will be evaluated in terms of appropriateness for the present study before final selection according to criteria such as existence of

a Spanish language version, compatibility with DSMIV etc. All instruments not previously used on a Latino population will be validated for this purpose as part of the proposed study).

c) Patient Satisfaction. The Patient-Doctor Interview Schedule, a valid, reliable, and useful instrument to assess patient satisfaction in family practice settings (31), will be used to measure satisfaction with quality of care patients have received.

d) Physician Satisfaction. A scale will be developed to assess physician satisfaction with the quality and efficacy care they have provided the patient. Physicians will also be assessed regarding their beliefs about the appropriateness and efficacy of addressing psychosocial issues in the primary care setting (*).

e)Health beliefs. Patient health beliefs will be solicited quantitatively based on an instrument derived from Lewin's health belief model (*). Four dimensins that influence the way patients use health care services will be assessed: susceptibility, seriousness, barriers, and benefits of treatment. A series of common presenting symptoms will be assessed, including both somatic and psychological problems (*). Mental health and physical health concerns, overall perceived health status will also be assessed, as will internality or externality of patients' health locus of control (*).

f) Interaction Analysis. Videotapes will be analyzed by independent student raters trained to a performance criterion. The coding instrument will be based on generalized scoring systems such as the Roter Interactional Analysis System (RIAS) (32) and the Davis Observation Scale (33), as well as Badger et al.'s work examining the effect of patient depression on physician-patient interaction (34). Coding will emphasize the following interaction patterns: 1) Interruptions 2) Close-ended questions 3) Ability to elicit patient agenda 4) Ratio of doctor-talk to patient-talk 5) Therapeutic alliance 6) Psychosocial material 7) Cultural sensitivity of physician to patient presentation (35).

g) Qualitative Interview. A semi-structured interview schedule will be developed to assess patients' satisfaction with the overall care they are receiving from the health care system, relevant health beliefs, including expectations for care, perceived severity of clinical symptoms, perceived susceptibility to illness, need for symptoms to be legitimated, health worries, concerns about their mental and physical health, and their perceived general health status.

Implementation: Upon entry into the study, patient subjects will complete the following: 1) the psychological screens 2) the health belief questionnaire 3) the patient satisfaction survey 4) one videotaped physician-patient encounter. A subset of patients will also complete 1) the structured diagnostic psychological interview and 2) the in-depth qualitative interview. Physician subjects will complete 1) a questionnaire reflecting their level of satisfaction with the care they have provided their patient 2) a questionnaire measuring their attitudes toward psychosocial issues in primary care 3) one videotaped physician-patient encounter.

Hypotheses and Research Questions: 1) Latino high utilizers will be characterized by significantly greater psychological distress in comparison to Latino and Anglo average utilizers, and equal or greater distress compared to Anglo high utilizers 2) Latino high utilizers will be characterized by significantly greater perceived daily hassles than will Latino and Anglo average utilizers, and equal or greater distress compared to Anglo high utilizers 3) Latino high utilizers will have significantly higher frequency of diagnosable mental disorder than will Latino and Anglo average utilizers (specifically greater depression, anxiety, panic disorder, and somatization, either subthreshhold or fullblown), and equal or lower diagnosable disorders compared to Anglo high utilizers. 4) Latino high utilizers will hold significantly different health beliefs than will Latino and

Anglo average utilizers, and will be more similar to Anglo high utilizers, but will nevertheless differ from this latter group on dimensions such as external vs. internal locus of control, need to have authoritative figure validate symptoms, and understanding of and expectations for the health care system. Such differences will also include greater concern for mental and physical health symptoms, greater perceived symptom severity, greater perceived susceptibility to illness, and poorer overall health. 5) Latino high utilizers will express significantly more dissatisfaction with care than will Latino and Anglo average utilizers, but less than Anglo high utilizers. 6) Physicians of Latino inappropriate high utilizers will express significantly more dissatisfaction with their ability to effectively treat these patients than will physicians of Latino and Anglo average utilizers, but equal or less dissatisfaction compared to physicians of Anglo high utilizers. 7) Interaction patterns between physicians and Latino high utilizers will be characterized by significantly more maladaptive behaviors than will interactions between physicians and Latino and Anglo average utilizers, and overall equal but different maladaptive patterns compared to physician-Anglo high utilizing patient dyads.

Analysis Plan and Power Analysis. Multiple comparisons will be addressed through use of the Bonferroni correction. A content analysis of the qualitative interview data will be performed using methods of grounded theory (46).

BUDGET: We anticipate that this project will require three years to complete for a total cost of $350,000. This budget includes partial salary support for the Principal Investigator and Co-Principal Investigators, as well as support for consultants, a research assistant, two student raters, payment for patients participating in the semistructured interviewing, two bilingual interviewers, statistical support during the first and third years, purchase of audiovisual tapes, telephone, postage, office supplies and photocopying of educational materials.

PERSONNEL: Dr. Shapiro will serve as Principal Investigator and will devote 40% time to the project. Dr. Shapiro is a full professor with prior research experience including published empirical studies in the area of doctor-patient communication (35,47) and cross-cultural doctor-patient encounters (22,32,48). She will have responsibility for overall coordination of the project. Thomas Bent, M.D., Residency Director, will serve as Co-Principal Investigator, and will function as the physician consultant on the project. Dr. Bent is fluent in Spanish and has spent much of his professional life working as a primary care provider for Latino patients. He will play a key role in introducing the educational intervention component into the residency curriculum and into the patient education program. Olivia de la Rocha, Ph.D. is a medical anthropologist who will provide statistical expertise to the study and will assist in the preparation of the interaction analysis coding instrument and the qualitative interview. Patricia Lenahan LCSW, Co-Principal Investigator and Behavioral Science Director, will serve as the behavioral science and cross-cultural expert to the project. She is fluent in Spanish and has expertise in cross-cultural health care issues. A research assistant will be hired to coordinate the project. Two student raters will be trained to code tapes, and will then be responsible for coding of all videotapes, including random coding for reliability purposes. Two bilingual interviewers will be hired to conduct the qualitative interviews.

Consultants. The success of this project is contingent on a team of expert consultants whose role is to provide guidance in and integration of the various dimensions brought together in this study. Wayne Katon, M.D. will serve as a consultant in the areas of service utilization, and the role of mental distress as a contributory factor to inappropriate utilization. Debra Roter, Ph.D. will

provide guidance in terms of which dimensions of content analysis of interaction will prove most fruitful to examine. Howard Waitzkin, M.D., MPH, and Jeanne Miranda, Ph.D. will give input regarding somatization in Latino populations.

SIGNIFICANCE: The value of this research will be to confirm differences in terms of psychological distress, health beliefs, doctor-patient interactions and satisfaction with care in a low-income Latino high utilizer patient population that have already been shown to exist to some extent between Anglo high and average health care utilizers, as well as begin to identify differences on these dimensions between Latino and Anglo high utilizers.. Further, the study will lay crucial groundwork for the development of culturally sensitive brief interventions targeting low-income, Latino high utilizer patients and their physicians with the goals of improved patient care, greater patient satisfaction, and more appropriate health care utilization

QUESTION ROUTE * HIGH UTILIZER STUDY

KEY QUESTION 1:

WHAT KINDS OF THINGS MAKE YOU DECIDE TO SEE A DOCTOR?

QUE TIPOS DE COSAS LE HACE UD. DECIDIR IR AL MEDICO?

Moderator Example: I might go to the doctor because I have a lot of pain in my back . Or I might go to the doctor because I have a high fever. On the other hand, if I feel very sick, I might just stay in bed and not go at all. Sometimes, when my kids were young and they were all sick, and I was only feeling a little bit sick, I would still go to the doctor, just because I knew I needed to stay healthy enough to take care of them. Or sometimes, I might go to the doctor because my husband told me I had been feeling crummy for long enough and I needed some medicine.

PROMPT 1: ***What kinds of physical symptoms are most likely to make you decide to go to the doctor?***
Que tipos de sintomas fisicos son los mas probable hacerle decidir ir al medico?

Pain
Dolor

Stomach or intestinal problems (nausea, gas, indigestion)
Problemas del estomago o de los intestinos (nausea, indigestion)

Back pain
Dolor de la espalda

Shortness of breath, problems breathing
Problemas respirar

Headache
Dolor de cabeza

Dizziness
Mareo

Palpitations, heart pounding
Palpitaciones de su corazon

Numbness or tingling in hands, feet
Entumecimiento u hormigueo en sus manos o sus pies

Loss of appetite
Perdida su apetito

Inability to sleep
Incapacidad de dormir

Tiredness
Cansancio

Sweating
Sudamiento

Dry mouth
La boca seca

Constipation, irregularity, loose bowels or diarrhea
Estrenimento o iregularidad, diarrea

Menstrual cramps, or problems with your period
Calambres menstruales, problemas con la menstruacion

Pain or problems during sexual intercourse
Dolor o problemas con relaciones sexuales

Fainting spells

PROMPT 1A:
How long do the symptoms have to last before you decide to go to a doctor?
Cuanto dura los sintomas antes que decidir. ir al medico?

Less than a day
Menos que un dia

One or two days
Uno o dos dias

Three days
Tres dias

A week
Una semana

Ten days
Diez dias

Two weeks
Dos semanas

A month
Un mes

PROMPT 1B:
How severe does the symptom have to be before you decide to go to the doctor?
Cuanto serio debe ser el sintoma antes que decidir ir al medico?

Mild
Benigno

Moderate (you are uncomfortable, but you can get on with your daily life)
Moderado (Ud. es incomoda, pero puede vivir la vida diaria)

Severe (interferes with your everyday life)
Grave (estorba con su vida diaria)

Very severe (you aren't able to function anymore)
Muy grave (no puede fonccionar)

PROMPT IC: ***How do you decide how serious a particular symptom is?***
Como decide Ud. cuanto serio es un sintoma particular?

How intense the discomfort is
Cuanto fuerte es el incomodidad

How long it lasts
Cuanto dura la sintoma

Where it is in your body (what regions are most serious?)
Donde esta el sintoma en your cuerpo (cuales partes estan las mas serias?)

Whether I've ever had this symptom before
Si he tenido esto sintoma antes

Whether someone I know has ever had this symptom before
Si alguien que conozco ha tenido esto sintoma

Whether I have knowledge that having this kind of symptom (eg., unexplained weight loss, blood in stools) can be the sign of something serious
Si se que esto sintoma (eg., perdida de peso, sangre en los) puede ser una cosa seria

PROMPT 2: ***What about other types of (emotional) symptoms that might cause you to decide to go to the doctor?***

Que otros tipos de sintomas (emocionales) hacerle decidir ir al medico?

Crying for no reason
Llorando sin razon

Having little interest or pleasure in doing things
No teniendo interes o placer en hacer las cosas

Trouble concentrating
Problemas concentrando

Feeling down or blue
Sentiendose triste o deprimida

Feeling anxious or nervous
Sentiendose anciosa o nerviosa

Feeling so restless it is hard to sit still
Sentiendose tan desasosegada que es dificil sentarse quieta

Feeling hopeless about life
Sentiendose desesperada por la vida

Becoming easily annoyed or irritable
Poniendose iritada o enojada

Feeling out of control of (alcoholic) drinking
Sentiendose sin abilidad de controlar tomar alcohol

Being worried all the time
Preocupandose todo el tiempo

Not being able to stop a bad habit (smoking, gambling, drug use, drinking)
No pudiendo bastar una mala costumbre(fumar, drogas, tomar alcohol)

Feeling very lonely
Sentiendose solitaria

Worrying about being sick or having a terrible disease
Preocupandose de estar enferma o tener una enfermedad terrible

PROMPT 2A:

How long does a symptom like this have to last before you decide to go see a doctor?
Cuanto dura un sintoma como esto antes que decidir ir al medico?

A day or two
Uno o dos dias

A few days
Pocos dias

A week
Una semana

Two weeks
Dos semanas

A month
Un mes

Two or three months
Dos o tres meses

More than three months
Mas que tres meses

PROMPT 2B:
How severe does a symptom like this have to be before you decide to go see a doctor?
Cuanto serio debe ser un sintoma como esto antes que decidir ir al medico?

Mild
Benigno

Moderate (you are uncomfortable, but you can get on with your daily life)
Moderado (Ud. esta incomoda, pero puede vivir la vida diaria)

Severe (interferes with your everyday life)
Grave (estorba la vida diaria)

Very severe (you aren't able to function anymore)
Muy grave (no puede fonccionar)

PROMPT 2C: *How do you decide how serious this type of symptom is?*
Como decide Ud. cuanto serio es este tipo de sintoma?

How intense the discomfort is
Cuanto fuerte es el incomodidad

How long it lasts
Cuanto dura el sintoma

Whether I've ever had this symptom before
Si he tenido esto sintoma antes en mi vida

Whether someone I know has ever had this symptom before
Si alguien que conozco ha tenido esto sintoma

Whether I have knowledge that having this kind of symptom (eg., crying for no reason, feeling like you want to die) can be the sign of something serious
Si se que esto sintoma (eg., llorando sin razon, sentiendose como quiere morir) puede ser serio

PROMPT 3: ***What about other types of (social) problems that might cause you to go to the doctor?***
Cuales otros tipos de problemas (sociales) debe hacerle ir al medico?

Having problems with your children (school, drugs, gangs)
Teniendo problemas con sus ninos (en la escuela, con drogas, bandas)

Having problems with your spouse (drinking, violence, quarreling)
Teniendo problemas con su esposo (tomando alcohol, violencia, disputando)

Having problems at work
Teniendo problemas al trabajo

Having financial difficulties
Teniendo problemas economicas

Having problems with neighbors or relatives
Teniendo problemas con sus vecinas o sus parientes

Just feeling you have too many problems to deal with
Sentiendo que tiene demasadios problemas

Not feeling safe in your neighborhood
No sentiendo seguo en su vecindad

Having no one to turn to when you have a problem
No teniendo nadie para ayudarle cuando tiene problema

Thinking about something terrible that happened to you in the past (like a bad accident, being beaten or assaulted, being forced to

commit an unwanted sexual act, your house burning down)
Pensando que alguna cosa terrible que le paso en el pasado (como accidente seria, estando asaltada, estando violanda, la casa incendiando)

Having something terrible happening in your life right now
Teniendo alguna cosa terrible teniendo lugar en su vida ahora misma

Feeling the doctor did not understand your problem at your last visit
Sentiendo que el medico no entiendo su problema en la ultima visita

PROMPT 3A: ***How long does a problem like this have to last before you decide to go see a doctor?***
Cuanto dura un problema como este antes que decidir. ir al medico?

A day or two
Uno o dos dias

A few days
Pocos dias

A week
Una semana

Two weeks
Dos semanas

A month
Un mes

Two or three months
Dos o tres meses

More than three months
Mas que tres meses

PROMPT 3B: ***How severe does a problem like this have to be before you decide to go see a doctor?***
Cuanto serio debe ser un problema como este antes que decidir ir al medico?

Mild
Benigno

Moderate (you are uncomfortable, but you can get on with your daily life)
Moderado (esta incomoda, pero puede vivir su vida diaria)

Severe (interferes with your everyday life)
Grave (estorba la vida diaria)

Very severe (you aren't able to function anymore)
Muy grave (no puede fonccionar)

PROMPT 3C: ***How do you decide how serious this type of problem is?***
Como decide Ud. cuanto serio esta este tipo de problema?

How much it bothers me
Cuanto me molesta el problema

How long the problem lasts
Cuanto dura el problema

How much it bothers other people
Cuanto le molesta otras personas

Whether I've ever had this problem before
Si he tenido este problema antes

Whether someone I know has ever had this problem before
Si alguien que conozco ha tenido este problema antes

Whether I have knowledge that having this kind of problem (eg., kids truant from school, husband doing a lot of drinking) can be the sign of something even more serious down the road
Si se que este tipo de problema (eg., ninos que no van a la escuela, esposo que tomando mucho) puede ser serio

KEY QUESTION 2: **WHAT KINDS OF THINGS PREVENT YOU FROM GOING TO SEE THE DOCTOR WHEN YOU DO HAVE SYMPTOMS?**
QUE TIPOS DE COSAS LE IMPIDE IR AL MEDICO CUANDO TIENE SINTOMAS?

PROMPT 1: ***What about reassurance that your symptoms are not too serious?***
Recibiendo confianza restablecida que sus sintomas no estan tan serios

From husband
De su esposo

From trusted friend or relative
De una amiga o una pariente

Previous reassurance from doctor regarding similar symptom
Confianza restablecida en el pasado del medico con respecto de un sintoma similar

From pharmacist
De farmaceutico

From self (self-talk)
De Ud. misma (dandose confianza restablecida)

PROMPT 2: ***What about something good happening that makes you feel better?***
Alguna cosa tiene lugar que le hace Ud. mejor?

You get a bonus at work
Recibe Ud. un extra a su trabajo

Your kid brings home a good report card
Su nino tiene notas buenas

You get a nice telephone call
Recibe una llamada buena de telefono

PROMPT 3: ***What about taking good care of yourself?***
Cuidandose Ud. misma?

Getting extra sleep
Toma mas sueno

Taking time off from work
Toma tiempo de trabajo

Eating more healthily
Come mas saludable

Relaxing and taking it easy
Relajandose

PROMPT 4: ***What about informal remedies?***
Remedios informal o tradicional?

Over the counter medications
Medicaciones de la farmacia

Consulting a knowledgeable friend or relative

Hablando con una amiga sabia o una pariente informada

Consulting some sort of healer (curandero, chiropractor etc.)
Consultando con un curandero

Homeopathic, herbal, and alternative remedies
remedios herbarios

PROMPT 5: ***What about problems that might prevent you from going to the doctor?***

Transportation difficulties
Problemas con transportacion

Money/insurance difficulties
Problemas con dinero; falta de asurguenza

Childcare difficulties
Problemas cuidando los ninos

Difficult to take time off from work
Problemas saliendo do su trabajo

Don't like waiting to see doctor
No le gusta esperar para ver el medico

Don't feel comfortable with doctor
No se siente confortable con el medico

Can't communicate easily with doctor because of language differences
No puede comunicar facilmente con el medico a causa de problemas de lengua

Don't have a regular place of care
No tiene Ud. un lugar regular para cuidado de la salud

KEY QUESTION 3: **WHEN YOU DO GO TO THE DOCTOR, WHAT ARE SOME OF THE THINGS THAT MAKE YOU FEEL IT WAS A WORTHWHILE VISIT?**
CUANDO UD. VA AL MEDICO, QUE SON ALGUNAS DE LAS COSAS QUE LE HACE SENTIR QUE LA VISITA VALE LA PENA?

PROMPT 1: ***What about when the doctor has good communication skills?***
Cuando el medico puede communicar bien con Ud.

Doctor listens carefully to your concerns
El medico escucha con cuidado a sus problemas

Doctor explains his or her assessment of your problem
El medico explica su diagnostico de su problema

Doctor acknowledges your point of view
El medico comprende su punto de vista sobre sus problemas fisicos

Doctor recommends a specific course of treatment
El medico recomenda un curso de tratamiento especifico

Doctor is willing to negotiate with you to find an acceptable treatment plan
El medico de buena gana habla con Ud. para encontrar un tratamiento acceptable a los dos

PROMPT 2: ***What about when the doctor gives you a prescription?***
Cuando el medico le da a Ud. una receta

How important is it to receive a prescription each time you visit the doctor?
Cuanto importante es para Ud. recibir una receta cada vez visita al medico?

PROMPT 3: ***What about when you are given a return appointment?***
Cuando Ud. recibe una cita para regresar al medico?

How important is it to be scheduled for a return visit?
Cuanto importante es para Ud. tener una cita devuelta?

PROMPT 4: ***What about receiving a referral if you feel you need one?***
Recibiendo una cita al especialista si piensa Ud. que es necesario

PROMPT 5: ***What about how the clinic is run?***
La administracion de la clinica

Being seen on time
Veyendo el medico a la hora

Being treated courteously by the clerical staff
el personal clerico le trata con cortesia

Being registered efficiently
La registracion esta eficiente

Being treated respectfully by the nursing staff
Las enfermeras le trata con respeto

PROMPT 6:***What about being able to see your regular physician?***
Veyendo su medico regular

KEY QUESTION 4: **WHAT THINGS MAKE YOU FEEL THAT YOUR VISIT WITH THE DOCTOR WAS A WASTE OF TIME?**
QUE TIPOS DE COSAS LE HACE QUE SU VISITA CON EL MEDICO NO VALE LA PENA?

PROMPT 1: ***What about when you have communication problems with the doctor?***
Cuando tiene problemas de communicacion con el medico

Doctor does not treat you respectfully
El medico no le trata con respeto

Doctor does not seem to know who you are
El medico no le conozco

Doctor seems rushed and impatient
El medico le parece llevar prisa y impaciente

You and the doctor speak different languages
Ud. y el medico hablan lenguas diferentes

You cannot understand the doctor's explanations
No puede comprende las explicaciones del medico

The doctor does not seem to understand your problems
El medico no entiende sus problemas

The doctor does not seem to appreciate the seriousness of your symptoms
El medico no le parece darse cuenta de la seriedad de sus sintomas

There does not seem to be a clear plan of treatment for your problems
No hay un plano claro para el tratamiento de sus problemas

PROMPT 2: ***What about when you don't receive a prescription?***
Cuando no recibe Ud. una receta?

How important is it to receive a prescription each time you visit the doctor?
Cuanto importante es para Ud. recibir una receta cada vez que ir al medico?

PROMPT 3: ***What about when you are not given a return appointment?***
Cuando no recibe Ud. una cita devuelta?

How important is it to be scheduled for a return visit?
Cuanto importante es para Ud. recibe una cita devuelta?

PROMPT 4: ***What about when you don't receive a referral even though you feel you need one?***
Cuando no recibe una cita con especialista, aunque piensa Ud. que es necesario?

PROMPT 5: ***What about how the clinic is run?***
La administracion de la clinica

Not being seen on time
No veyendo al medico a la hora

Being treated discourteously by the clerical staff

El personal clerical no le trata con cortesia

Being registered inefficiently
La registracion no es eficiente

Being treated disrespectfully by the nursing staff
Las enfermeras no le trata con respeto