HCHS/SOL Question by Question Instructions
Health Care Use Form (HCE/HCS), Version A

General Instructions

The questions on health care cover the use of medical care, the quality of services received the use of alternative healers, and insurance coverage for medical care. The time frames for these questions generally refer to the past 12 months. This should be stressed and participants should be encouraged to think about the 12 months prior to the current month (i.e. the month in which the interview is being conducted.

Question by Question Instructions

Q1 The goal of this question is to document whether the participant typically or often receives medical care outside of the U.S. The question is read emphasizing the phrase "in the past 12 months" and the word "most." "Health care" can be understood broadly to mean any treatments that are undertaken to improve a participant's health. Because participants may have received care in multiple countries, the interviewer may need to re-emphasize the term "most" and repeat the categories to allow the participant to choose the category which best fits their typical, usual, or most common location of care.

Q2 This question aims to understand if participants have ever gone without medical care for any reason during the past 12 months. For those that have gone without medical care, additional questions are asked to identify the reasons for going without medical care.

Q3 This question is asked only of participants who answer 'YES' to question 2. Participants should be read the root question. Then, each subsequent phrase should be read. Mark 'YES' or 'NO' in the appropriate box. Participants may have forgone medical care for more than one reason. Therefore, the interviewer should read each phrase. If the participant asks for clarification on the phrase, the following clarifications can be offered:

a. COULDN'T GET THROUGH ON THE TELEPHONE	The phone for the health care provider was busy when you called.
b. COULDN'T GET AN APPOINTMENT SOON ENOUGH	There were no appointments available when you needed to schedule your visit.
c. WAIT TO LONG TO SEE THE DOCTOR	You arrived for your appointment but had to wait a long time and decided to leave before actually seeing the doctor.
d. OFFICE WASN'T OPEN WHEN YOU COULD GET THERE	You couldn't get an appointment on the days or times that you could go to the doctor.

e. DIDN'T HAVE TRANSPORTATION	You could not drive to your appointment, could not find someone to drive you, and were not able to take public transportation such as a bus.
f. NO ACCESS TO AN INTERPRETER	You needed someone to help translate for you and no one could go with you to translate or no translator was available at your doctors.
g. COULDN'T TAKE TIME OFF WORK	You felt like you had to work or your employer would not let you leave work to see the doctor.
h. CONCERNED ABOUT LEGAL CONSEQUENCES	You were worried that the health care provider might ask you about your immigration status or you thought that going to the doctor might affect your immigration status.
i. TAKING CARE OF SOMEONE THAT COULDN'T BE LEFT ALONE	You care for young children or older persons such as a parent that needed your care and couldn't go to the doctor's visit with you.
j. COULDN'T AFFORD IT	You couldn't pay for the doctor's visit because you had no insurance or couldn't pay the out-of-pocket co-payments or deductibles for your insurance.

Q4 This question is asked ONLY IF the participant indicates that they did not receive medical care because they COULDN'T AFFORD IT. It aims to determine what TYPE of medical care the participant had to forego during the past 12 months. The past 12 months should be emphasized. As with the previous question, the participant may have gone without more than one type of medical care. Therefore, the interviewer should read each phrase in sequence and mark the appropriate response.

4e. If the participant has difficulty understanding the term *anteojos* in the Spanish language version, additional terms that can be used for *anteojos* are: *lentes*, *gafas*, and *espuejelos*.

Q5 This question is intended to identify how often the participant sees a health care provider in a 12-month period. It refers to any type of medical interaction (for a general check-up or a specific problem) with a medically trained health practitioner within the past 12 months. Family doctors, specialists, physician's assistants, nurse practitioners, hospitals, and clinics all apply. Dentists do not apply. If asked for clarification, tell the participant that chiropractors, herbalists and other allied health care professionals also do not apply.

Participants who see a provider frequently may have trouble recalling the number of health care provider visits that they have had. Therefore, the interviewer will need to be patient as the participant counts up the number of visits. The interviewer may also need to help walk the participant through the counting process by asking if the participant saw a health care provider in the previous month, the month before that, etc…. The interviewer can then add up the number of visits and say, "So that is about ___ number of times during the past 12 months. Is that correct?"

Q6 This question is only asked of persons who have seen a health care provider in the past 12 months. The interviewer should emphasize the words "OFFICE STAFF" when reading this question. Clarification may be needed about the meaning of the response categories. If needed, the following clarifications can be provided:

1. ALWAYS	Every time that you have seen a physician or health care provider.
2. USUALLY	More often than not or on most of the times that you have seen a health care provider.
3. SOMETIMES	On a few of the times but not most that you have seen a health care provider.
4. NEVER	On none of the times that you have seen your health care provider.

Q7 This question is only asked of persons who have seen a health care provider in the past 12 months. To contrast with the previous question, the interviewer should emphasize that these questions pertain to how the doctors or health care providers NOT the office staff treated the participant.

Some of the items contain words or phrases that may be interpreted differently by individuals (e.g. 'carefully', 'show respect', 'enough time'). This is okay. The interviewer can clarify that these questions are about how the participant felt about the treatment they received from the doctor or health care provider.

Clarification may also be needed about the meaning of the response categories. If needed, the following clarifications can be provided:

1. ALWAYS	Every time that you have seen a physician or health care provider.
2. USUALLY	More often than not or on most of the times that you have seen a health care provider.
3. SOMETIMES	On a few of the times but not most that you have seen a health care provider.
4. NEVER	On none of the times that you have seen your health care provider.

Q8 This question is only asked of persons who have seen a health care provider in the past 12 months. <u>CAREFUL: THE RESPONSE CATEGORIES HAVE BEEN REVERSED IN THIS QUESTION.</u> Clarification may be needed about the meaning of the response categories. If needed, the following clarifications can be provided:

4. ALWAYS	Every time that you have seen a physician or health care provider.
3. USUALLY	More often than not or on most of the times that you have seen a health care provider.
2. SOMETIMES	On a few of the times but not most that you have seen a health care provider.
1. NEVER	On none of the times that you have seen your health care provider.

Q9 This question is intended to identify the use of alternative or traditional health care providers in Latin America and the Caribbean. Three examples are given in the question (*curandero, santero, espiritista*) but there may be several others in the participant's local community. This question is NOT intended to refer to alternative providers such as Chiropractors, Massage Therapists, or Acupuncturists. The interviewer may clarify before asking the question that "some participants use alternative providers and others do not."

Q10 The goal of this question is to document how participants **currently** pay for all or part of their medical care, excluding their own resources. This refers to private or public payment plans which pay for at least part of the participant's medical care, such as hospital, doctor, clinic, or surgeon's bills. It can include, but not be limited to, coverage for dental care. The third party payment options are read aloud to the participant. If the participant responds affirmatively to a category, the corresponding box is marked to indicate 'yes." To indicate, 'no' the corresponding box is left blank.

Types of coverage are not necessarily mutually exclusive; therefore, more than one option may have a positive response. Definitions of the types of medical payment plans are offered, **only if** the participant requests clarification.

a. NONE, NO INSURANCE AND CURRENTLY NOT COVERED	This should be checked if the participant does not have any medical insurance coverage at the time of the interview.
b. EMPLOYER/UNION PROVIDED COVERAGE	Private (in contrast to public) health insurance plans that individuals pay for through their employer or employee union to receive coverage for medical care, such as hospital, doctor, clinic or surgeon's bills The employer or union (i.e. workers' organization) may pay for some or all of the insurance premiums.
c. INDIVIDUAL PLAN	Private (in contrast to public) health insurance plans that individuals pay for on their own to receive coverage for medical care, such as hospital, doctor, clinic or surgeon's bills

d. MEDICAID	A government financed medical aid designed for those unable to afford regular medical service. It typically only covers low-income women and children. Some states have unique names for their programs. For example, the program in California is called Medi-Cal.
e. MEDICARE	A government payment program for medical care, especially for the aged.
f. MILITARY COVERAGE (E.G. TRICARE OR CHAMPUS)	The military provides its own health insurance plans to military employees. If the participant works full-time for the military, it is likely that they military coverage.
g. INDIAN HEALTH SERVICES	Persons of American Indian heritage can receive health care through the Indian health services. This is a federally funded health care program.
h. OTHER	This is checked **only if** none of the other categories fit the type of insurance coverage that the participant has.
i. REFUSED	This is checked if none of the other items is marked and the participant indicates that they do not want to answer this question.
j. DON'T KNOW	This is checked only if none of the other coverage items is marked and the participant indicates that they don't know.

Q11 If participants have NO HEALTH INSURANCE COVERAGE, this item is asked to determine how long they have been without coverage. Interviewers should read the question and the response categories. Participants may need time to recall this information. If participants can remember the month (year) that they lost their coverage, the interviewer should then count the number of months (years) and confirm with the participant by saying, "It is currently November and you lost your coverage in March. So, that is about 8 months. Is that correct?"

Q12 The goal of this question is to determine why persons who had insurance lost their insurance coverage. Common reasons for losing health insurance coverage are read aloud to the participant. If the participant responds affirmatively to a category, the corresponding box is marked to indicate 'yes." To indicate, 'no' the corresponding box is left blank.

Reasons for losing health insurance coverage are not necessarily mutually exclusive; therefore, more than one option may have a positive response. Clarifications regarding the reasons for losing coverage are offered **only if** the participant requests clarification.

a.	LOST OR CHANGED JOBS	If you or any one in your family has lost or changed jobs, you may have lost health insurance coverage through your or their employer.
b.	LOST COVERAGE THROUGH SPOUSE OR PARENTS	Some people receive health insurance coverage because they are a dependent of someone else such as a spouse or parent. When they are no longer a dependent, they may lose coverage. This can happen when spouses become legally separated or divorced; when a spouse dies; or when a child is no longer a legal dependent of his/her parents.
c.	BECAME INELGIBLE	There are many reasons that people may become ineligible for coverage. This response category is only marked if a participant has become ineligible due to AGE or because they are no longer enrolled in college.
d.	COVERAGE NOT AVAILABLE THROUGH EMPLOYER	Some employers (e.g., small businesses) do not offer health care insurance to their employees. In addition some types of employees such as part-time or hourly employees, may not qualify for coverage offered through the employer.
e.	COSTS OF PREMIUMS WERE TOO HIGH OR INSURANCE COMPANY REFUSED COVERAGE	Some people cannot qualify for health insurance coverage because of pre-existing medical conditions. If you have a pre-existing medical condition, the insurer may have refused to cover you or may have charged you a very high premium that you couldn't afford.
f.	MEDICAID COVERAGE STOPPED AFTER PREGNANY ENDED	Some public insurance programs only cover women during and immediately after their pregnancy. If you had Medicaid, you may have lost your coverage after you gave birth.
g.	MEDICAID COVERAGE STOPPED AFTER INCREASE IN INCOME	Medicaid and other government programs only cover low-income participants. If your income increased, you may have lost your coverage.
h.	OTHER	This is checked **only if** none of the other categories fit. The reason should be written succinctly in the space provided.
i.	REFUSED	This is checked if none of the other categories is

	marked and the participant indicates that they do not want to answer this question.
j. DON'T KNOW	This is checked only if none of the other categories is marked and the participant indicates that they don't know.