

# **Patient-Provider Relationships in an All-Inclusive Specialized Geriatric Program: A Longitudinal Qualitative Study among Older Foreign-Born Latinos with Multimorbidities**

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## ABSTRACT

**Objective:** The quality of patient-provider relationships (PPR) is directly related to delivering patient-centered care and improved healthcare outcomes (e.g., adherence to medical treatments) and differs across types of patients to the point of health disparities. PPRs are further complicated when factoring in multiple chronic health conditions, language barriers, and limited time. This qualitative longitudinal study explored the perceived acquiring of high-quality PPR among older foreign-born Latinos over time. **Methods:** We recruited 13 patients with multi-morbidities from nine Program of All-Inclusive Care for the Elderly (PACE) centers. Researchers conducted three rounds of in-depth interviews in Spanish (N=39 interviews) over 13 months. The first interviews were conducted face-to-face and lasted one hour on average. The second and third were conducted over the phone and ranged from 60 to 90 minutes. Data were analyzed using line-by-line *in vivo* coding, identifying

categories, and themes. **Results:** Patients reported their perceived PPR as a continuum across time, establishing three hypothesized hierarchical developmental levels to the PPR: the good doctor, the doctor of trust, and the advocate. The layers of levels built upon each other. The first level, the good doctor, was the most superficial as it focused on the physicians' technical expertise. The second level, the doctor of trust demonstrated trustworthy characteristics over time. The third level, the advocate, embodied all that a person of trust was plus an additional advocacy dimension. **Conclusion:** Unique study characteristics allowed for an exploration of PPRs. Findings elucidate factors (e.g., expertise, trust, advocacy) that contribute to the development of strong PPRs. To enhance PPRs, strategies should be considered to develop trust and advocate for patients' needs.

*Keywords:* closed system, Latino, aging, trust, qualitative research, semi-structured interview, longitudinal studies, continuity of care

## **Relaciones paciente-proveedor en un programa geriátrico especializado con todo incluido: un estudio cualitativo longitudinal entre personas mayores nacidas en Latinoamérica y con multimorbilidades**

### RESUMEN

**Objetivo:** La calidad de las relaciones paciente-proveedor (PPR) está directamente relacionada con la prestación de atención centrada en el paciente y la mejora de los resultados de la atención médica (p. ej., cumplimiento de los tratamientos médicos) y difiere entre los tipos de pacientes hasta el punto de las disparidades en la salud. Los PPR se complican aún más cuando se tienen en cuenta múltiples condiciones de salud crónicas, barreras del idioma y tiempo limitado. Este estudio longitudinal cualitativo exploró la adquisición percibida de PPR de alta calidad entre latinos mayores nacidos en el extranjero a lo largo del tiempo. **Métodos:** Reclutamos a 13 pacientes con multimorbilidades de nueve centros del Programa de atención integral para ancianos (PACE). Los investigadores realizaron tres rondas de entrevistas en profundidad en español (N=39 entrevistas) durante 13 meses. Las primeras entrevistas se realizaron cara a cara y duraron una hora en promedio. El segundo y el tercero se realizaron por teléfono y duraron entre 60

y 90 minutos. Los datos se analizaron usando codificación in vivo línea por línea, identificando categorías y temas. Resultados: Los pacientes informaron su PPR percibido como un continuo a lo largo del tiempo, estableciendo tres niveles de desarrollo jerárquicos hipotéticos para el PPR: el buen médico, el médico de confianza y el defensor. Las capas de niveles construidos unos sobre otros. El primer nivel, el buen médico, era el más superficial ya que se centraba en la experiencia técnica de los médicos. El segundo nivel, el médico de confianza demostró características de confianza a lo largo del tiempo. El tercer nivel, el defensor, encarnaba todo lo que una persona de confianza era más una dimensión adicional de defensa. **Conclusión:** Las características únicas del estudio permitieron una exploración de los PPR. Los hallazgos aclaran los factores (p. ej., experiencia, confianza, promoción) que contribuyen al desarrollo de PPR sólidos. Para mejorar los PPR, se deben considerar estrategias para desarrollar la confianza y defender las necesidades de los pacientes.

**Palabras clave:** sistema cerrado, latino, envejecimiento, confianza, investigación cualitativa, entrevista semiestructurada, estudios longitudinales, continuidad del cuidado

## 老年人全面护理计划中的医患关系：关于外国出生的、患有多种疾病的老年拉美裔人的纵向定性研究

### 摘要

目的：患者-医疗提供者关系（PPR）的质量与提供以患者为中心的护理和改善医疗结果（例如，药物治疗依从性）直接相关，并且会因不同患者类型而出现健康差异。当考虑到多种慢性病状况、语言障碍和有限的时间时，PPR变得更加复杂。本文采取定性纵向研究，探究了外国出生的老年拉美裔人对获取高质量PPR的感知随时间推移发生的变化。方法：我们从9个老年人全面护理计划（PACE）中心招募了13名患有多种疾病的患者。研究人员在13个月内用西班牙语进行了三轮深度访谈（N=39）。第一轮访谈是面对面进行的，平均持续一个小时。第二轮和第三轮访谈是通过电话进行的，时间从60分钟到90分钟不等。使用逐行内部编码（in vivo coding）、识别类别和主题，从而进行数据分析。结果：患者将其对PPR的感知报告为具有时间跨度的连续体，为PPR建立了三个假设的阶层式发展层面：好医生、可信赖的医生和

倡导者。各层面彼此依赖。第一个层面（好医生）是最表面的，因为它侧重于医生的技术专长。第二个层面（可信赖的医生）随时间推移表现出值得信赖的特征。第三个层面（倡导者）体现了可信赖的人，再加上额外的倡导维度。结论：独特的研究特征允许探究PPR。研究发现阐明了一系列有助于发展稳固的PPR的因素（例如，专业知识、信任、倡导）。为加强PPR，应考虑相关策略来建立信任和倡导患者需求。

关键词：封闭系统，拉丁裔，老龄化，信任，定性研究，半结构化访谈，纵向研究，护理的连续性

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## Introduction

An important part of quality health care rests with the patient-provider relationship (PPR), but the current fragmented healthcare system in the U.S. threatens its nature and effectiveness. Four foundational elements compose an optimum PPR including trust, knowledge, regard, and loyalty, and factors affecting the PPR may exist with either the doctor, patient, both, and/or the healthcare system (Chipidza et al., 2015). What each wants in the PPR may not agree or overlap. For example, Berger et al. (2020) found that physicians ranked fairness, reliability, devotion, and serviceability in their technical expertise and skills high, but gave lower scores for warmth and sociability. In contrast, patients highly value interpersonal skills including caring, empathy, and appreciation (Egman-Levitan et al., 2021). While these values hold true for all patients, older patients with multimorbidities often have more medical visits

to ensure appropriate management. As such, these values become even more important, but the fragmented medical social services system increases the risk for poor PPR. More specifically, the long-term care system's interface with medical services contains gaps such that patients and their care partners may even act as knowledge brokers (Wust et al., 2022). Experiences within such a fragmented system especially for older adults include a lack of continuity of care, poor communication between providers, medical mistakes, no integration between medical and social services, access issues due to different funding streams, and a general disincentive to build relationships with patients from lack of primary care (Clarfield et al., 2001).

Some long-term care models exist that reduce fragmentation, so in such settings the encounters may include extended time with their clinician so that providers can go into more depth with managing their chronic health issues. Among older adults with

multiple chronic conditions, availability and continuity emerged as important domains of health and social care management (Meranius et al., 2017). The Program for All Inclusive Care (PACE) represents one such model that offers both availability and continuity of health and social care management for older adults who otherwise would need institutionalization (Clarfield et al., 2001). However, PACE eligibility includes low-income older adults who are duals: Medicare and Medicaid, even though not all have to be duals. Vulnerable subgroups of PACE recipients include ethnic minorities such as older foreign-born Latinos, who face increased risk of disability relative to other ethnic groups (National PACE Association, 2022; Usher et al., 2021).

Research exploring patient provider relationships among older foreign-born Latinos are scant (Alegría et al., 2009; González et al., 2010). In general, patient-provider relationships impact patient outcomes and patient satisfaction, but for ethno-racial minorities may be more complicated given potential language and cultural barriers. However, changes in the delivery of health care such as systemic forces due to managed care policies, the fragmentation of the medical system (e.g., waiting time, access to consultants, ability to contact physicians, time spent with physicians), and policies aimed at standardizing care and controlling costs have impaired the PPR leading to unsubstantial care and patient dissatisfaction. These components may interfere with optimal relationship development (Friedenberg, 2003). Furthermore, no

studies have longitudinally explored processes contributing to the development of PPR among foreign-born Latinos, despite their increased risk for disability. These gaps obscure the development of culturally-tailored and patient-centered care among a population that is the largest ethnic minority group in the U.S., an aging population, and a group facing high risk and rising rates of multimorbidities (Quiñones et al., 2019). To address this gap and to inform culturally-tailored recommendations for patient-centered care, this study explored the perceived acquiring of high-quality PPRs among foreign-born older Latinos participating in an all-inclusive specialized program, PACE, aimed at controlling patients' costs and enhancing access to care. As such, PACE supplements older foreign-Latinos' social support for their multimorbidities with non-kin, professional relationships in a context with a lower risk for health disparities.

### ***Social Convoys and Healthcare Disparities***

A quality PPR can provide an important part of foreign-born Latino older adults' support system as they manage their chronic conditions in a community setting. One way to conceptualize the PPR exists with it being part of a larger social system composed of kin and non-kin. This social system forms a convoy around the older adult across the life course that fluctuates over time (Antonucci et al., 2013), but foreign-born Latino older adults may experience "broken convoys" from later life migration (Maleku et al., 2022). For

these older adults, they needed more kin when they immigrated to the U.S., but after living here they also need non-kin such as PPR to help them manage their worsening chronic health conditions (Goldman, 2016).

Embedded within their need for a quality PPR are risks for not only poor PPR but also less access and higher costs in accessing the health care system depending on their citizenship status (Ornelas et al., 2020). Even with citizenship, foreign-born Latino older adults face an increased risk for health disparities or issues plaguing their interaction with the healthcare system that extend beyond basic difference in utilization. Disparities stem from structural and interpersonal barriers that hinder the optimal access and quality relative to those without such disparities. Structural disparities may arise when foreign-born Latino older adults lack health care insurance, accessible locations for healthcare, transportation, and the like (Maleku et al., 2022). Interpersonal disparities may occur even when a foreign-born Latino older adult have a PPR, if the provider communicates or behaves in a discriminative manner during interactions (Berger et al., 2020; Ornelas et al., 2020). More specifically, a poor PPR may occur when a provider does not make sure to understand the needs of the patient by not asking, asking for too much, not listening, or failing to take the time (Lyles et al., 2016; Maleku et al., 2022).

If many of these factors contributing to health disparities were removed, one could better understand

the characteristics of PPR in vulnerable groups of older adults. By selecting patients from the PACE program, this study minimizes these factors and allows a more focused examination of the PPR from the older foreign-born Latinos themselves. Moreover, this study explored their perceptions over time to better understand the evolution of the PPR. The main research question is: How do older foreign-born Latinos perceive their PPR over time?

## **Methods**

This longitudinal qualitative study used a convenience sample from nine Program of All-Inclusive Care for the Elderly (PACE) centers in Southern California. The longitudinal nature of the study design allowed investigators to follow people and observe their evolving stories, attitudes around communication, and relationship development. Investigators were able to study facets of the PPR not always observed in community-dwelling foreign-born Latino elders managing multimorbidities. These patients were hyper-exposed to biomedicine and had increased opportunities to interact with medical practitioners, thereby giving investigators an insight look to gain a deeper understanding of the contextual factors surrounding communication (e.g., power imbalances and culturally appropriate interactions).

This study was approved by the UCLA Office of the Human Research Protection Program (IRB # 15-000208).

### ***Program of All-Inclusive Care for the Elderly (PACE)***

PACE is a Medicare and Medicaid managed-care program for adults over 55 years old. The program uses an interdisciplinary team approach to provide patients with medical, social, nutritional, and rehabilitative services. The care is comprehensive and integrated, including pharmacological and non-pharmacological treatments and interventions (e.g., referral to specialists, physical and occupational therapists, and alternative treatments such as acupuncture and massage therapy), screening, prevention, diagnostic tests, follow-up, and advanced care illness preparation. Prospective patients must have met nursing home *care* eligibility criteria to enroll. The advanced care program uses a social worker and adult day health care center model (California Department of Health Care Services, 2022).

According to the National PACE Association, the typical PACE participant is similar to the average nursing home resident—an 80-year-old female with eight medical conditions and limitations of three activities of daily living. The goal of PACE is to maintain frail adults outside of long-term institutions and allow them to remain to live safely in their communities.

### ***Recruitment, Data Collection, and Analysis***

Investigators were blinded from initial participant selection. PACE site coordinators announced study details to patients and provided investigators

with contact information for clinic patients who expressed interest. Participants were not compensated for their time; therefore, investigators ensured participants understood they had a right to decline participation without repercussion to their medical services. If the participant consented to be interviewed, the location and time of interview were negotiated, and interviews were scheduled. Thirteen foreign-born older adults over the age of 65 with multimorbidities were identified.

*Semi-structured in-depth interviews* took place in patients' homes and at the medical facilities. An interview guide was developed to direct discussion and provide probes when necessary (Bernard, 2006). The interview covered topics around medical decisions, their communication, and relationship with providers. Investigators focused on one or two chronic conditions that were being managed and asked their experiences in speaking to their doctor about that condition. In addition, investigators used questions from the AHRQ Consumer Assessment of Healthcare Providers and Systems (CAHPS) Adult Supplemental to help initiate conversations around decision making and elaborate on communication process. Investigators asked participants to share about the most impactful clinicians' modes of communication, characteristics, and overall and examples of how communication processes occur.

Three rounds of in-depth qualitative interviews were conducted with each participant over a 9-month peri-

od (range of elapsed time between interviews was 6 to 12 weeks). The first round of interviews (T1) were conducted face-to face and lasted approximately one hour. Subsequent interviews Time 2 (T2) and Time 3 (T3) were conducted over the phone and ranged between 30 to 90 minutes. All interviews were conducted in Spanish and audio recorded by investigator with an emic perspective (RLB). Approximately three months transpired between interview rounds (T1, T2, and T3).

Investigators transcribed audio files verbatim in Spanish (original language) to prevent loss of concepts in translation. We analyzed three interviews for each of the 13 participants, 39 original transcripts and their respective interview process documentation (e.g., written and oral interview summaries) using Dedoose version 7.1.3, a web application for managing and analyzing qualitative data (Lieber, 2015).

An inductive approach was used to analyze interview data and summaries to deconstruct explicit reality and reconstruct implicit reality (Bernard, 2006; Corbin & Strauss, 2014; Creswell & Poth, 2016; Miles & Huberman, 1994). Drawing from grounded theory (Glaser & Strauss, 1967) and constructivist grounded theory principles (Charmaz, 2006), we used an iterative process of adding and updating codes so there was a blurring between steps (Figure 1). We used five transcripts using a line-by-line technique to develop an initial set of *in-vivo* codes. These codes captured a specific act, feeling, or response from the respondents in

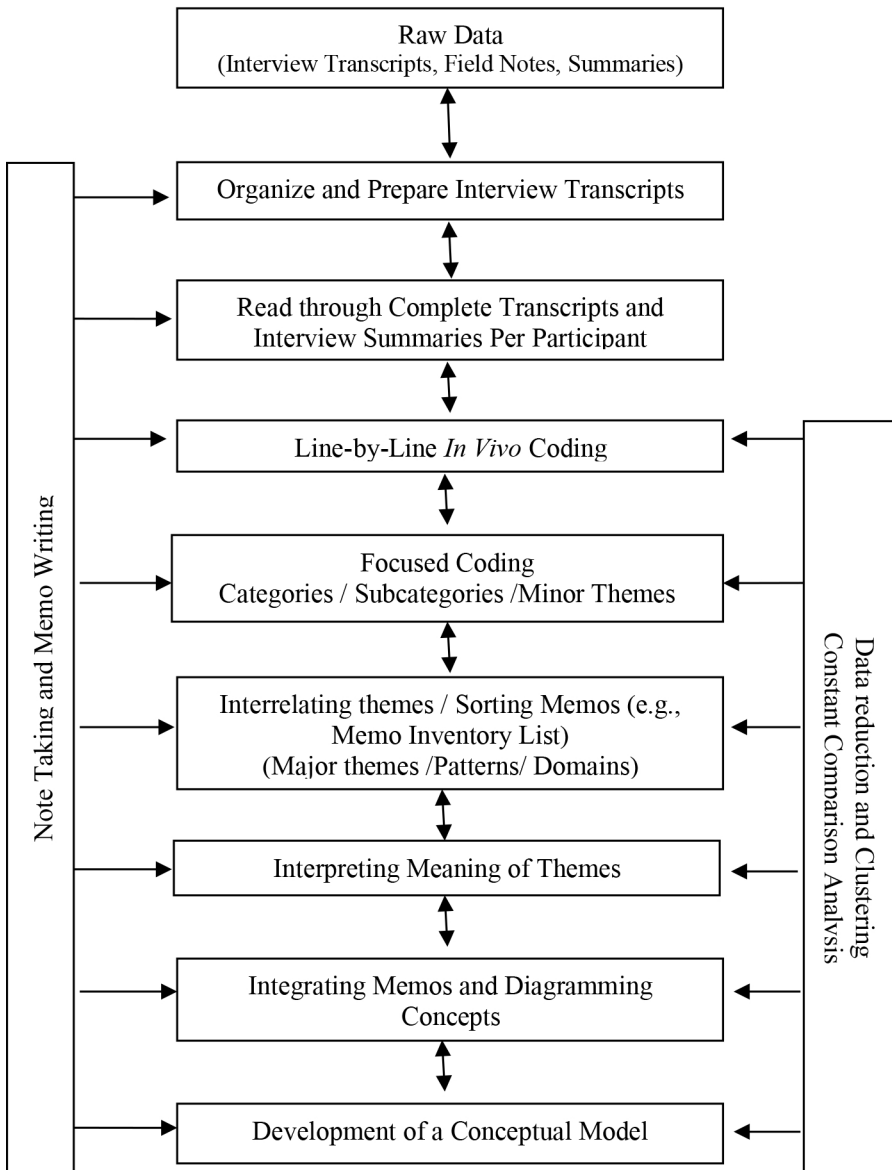
their own words. After completing the initial set of codes, line-by-line codes were grouped into broader categories, then into higher-level coding schemes by grouping them into themes, and eventually into domains. In the results sections, excerpts were translated from Spanish to English.

## Results

### *Patient Characteristics*

Table 1 illustrates participants descriptors. Most participants were monolingual Spanish-speakers (77%) and female (77%). Although a few were bilingual (23%) and spoke English as their second language, they preferred to speak Spanish with their providers. They felt more comfortable managing the nuances of Spanish language over English. Over half of the participants were born in Mexico (54%), while the remaining were from Central and South America. On average, participants were 75 years of age and had four years of education. Just over three quarters were unmarried, with the highest percentage being widowed at baseline, a percentage that only increased for subsequent interviews. The number of comorbidities per participants ranged between seven to 13 chronic conditions. Finally, under one quarter lived alone at baseline.





**Figure 1: Visual Representation on the Overview of the Data Analysis**  
Schematic diagram outlining simplified analytic steps.

**Table 1**

*Patients Demographics from PACE (n=13)*

	Frequency (%) or <i>M</i> (range)
<b>Age</b>	75 years (65-85)
<b>Gender</b>	
Male	3 (23%)
Female	10 (77%)
<b>Ethnicity</b>	
Central /South American	6 (46%)
Mexican	7 (54%)
<b>Marital Status @ T1<sup>a</sup></b>	
Married	3 (23%)
Widowed	7 (54%)
Separated/Divorced	3 (23%)
<b>Living Arrangements</b>	
Alone	3 (23%)
Family	10 (77%)
<b>Language</b>	
Spanish	10 (77%)
Bilingual	3 (23%)
<b>Years in the United States</b>	21 years (3-52)
<b>Education</b>	4.5 years (0-16)

*Note.* *M* = mean.

<sup>a</sup>T1 refers to interview at Time 1. Marital status changed between some of the participants in subsequent interviews with death of partner.

### ***Patient-Provider Relationship Patterns***

Findings identified relationship patterns between older Latino adults and providers participating in the Programs of All-Inclusive Care for the Elderly (PACE), a capitated Medicaid and Medicare program that provides comprehensive services. For the patients, barriers to accessing care (e.g., costs, transportation, language) were elimi-

nated. Studying patient experience and their perceived relationship without interference from the business of practicing medicine allowed researchers to observe relationship patterns develop over time. Three positive relationship patterns (the good doctor, a person of trust, the advocate) are presented here and hypothesized to positively grow and build upon each other. These patterns were described as patients perceived level of trust in their practitioners improved.

**The Good Doctor / “El Buen Doctor.”** In probing to seek what patients deemed were desirable provider characteristics, patients saturated the concept of “the good doctor.” Respondents shared their belief that doctors have the basic technical information and capability to make an accurate diagnosis. These were doctors who primarily performed their skill competently by correctly diagnosing and prescribing accurate medications to eradicate or ameliorate the problem. Lucia spoke about still being in the process of evaluating her current clinician to see if he might be considered a good doctor. She needed to wait and see if he was able to correctly diagnose and provide her with the accurate medication to eliminate her ailment. The patient expected an accurate diagnosis irrespective on the amount of detail about their ailments she provided to the practitioner. Similarly, Alma received a cancer diagnosis that went undetected by two physicians before a “good doctor” diagnosed her and started her on a proper treatment regimen.

**A Good Doctor Finds the Disease.** “This doctor is the one who is treating me, but he was not able to diagnose me...until I went with doctor P. He did diagnose me and started me on treatment...Good doctor...The other two were not as good, as doctor P because they did not find the disease” (Female – Time 3).

A good doctor was willing to look at all possibilities and run a battery of tests to identify the problem to offer an effective solution. When Francisco

was recuperating from prostate cancer surgery, he had bladder complications. His specialist prescribed medications, but his symptoms went unmanaged, severely impacting his quality of life. He went to Mexico and consulted with a doctor to obtain a second opinion. The doctor in Mexico embodied how a *buen doctor* was expected to behave.

“I went to Mexico to see a doctor, and **he told me the truth** of what was happening with my bladder. He told me my bladder was fine; it just needed more time to recuperate. He said ‘I am going to prescribe this medicine and you take it for about 2-3 years. And don’t stop doing the exercises. That medicine that you have is the wrong medication because that is for a prostate and you no longer have a prostate.’ He then did an ultrasound and he told me ‘all that medicine you have instead of curing you is producing more liquid.’” (Male-Time 3).

Francisco’s incontinence did not immediately disappear. As his doctor had explained, Francisco’s bladder needed time to heal. The physician from Mexico had discovered the problem, and Francisco’s symptoms improved. The physician in Mexico was categorized as a good doctor because he had run the adequate number of tests needed and identified the problem, explained the facts to Francisco and delivered a treatment regimen that improved the patient’s symptoms, which meant Francisco was on the road to a speedier recovery. In addition, the doctor in Mexico looked out for Francisco’s future well-being by providing the

patient with the required paperwork to take to his primary care provider in the United States to continue the treatment regimen he had started in Mexico. A good doctor identifies the disease and **tells you the truth**; they also listen to your preferences and either refer you to another good doctor or give recommendations.

Claudia previously spoke about not trusting U.S. doctors to perform complicated and risky procedures, such as back surgeries. She expressed her desire to seek care in her home country, and her doctor provided her with the tools to seek specific specialists needed for her back pain. Bertha sums it all, “that the [doctor] talk to me, that they tell me the truth” (Female, Time 1).

**A Person of Trust / “Una Persona de Confianza.”** Participants spoke about ideally wanting to have a doctor that embodied characteristics of a person of trust (*una persona de confianza*). A provider who is deemed to be a person of trust (*una persona de confianza*) is a clinician who embodies truth-telling, irrespective of what mainstream America perceives as informed decision-making. The characteristics repeatedly used to describe trust-worthy individuals personified benevolent qualities (e.g., kind, always smiling, open and sincere *amable, risueña, abierta, sincera*). Another common phrase used to refer to the concept of a person of trust is a person with heart (*una persona de corazón*). In this phase, the doctor’s heart is deemed to be in the right place, with the patient and not their pocket, therefore trust is placed in the

doctor’s hands. A clinician who embodies the characteristics of a person of trust speaks from the heart (*habla con el corazón*), and thus sincere care is transmitted and felt by the patients. *Una persona de confianza* (a person of trust) is willing to make their opinion clear to the patient with what they think is the best method or strategy. The provider must go out on a limb stating their preferences, personal ideas and opinions about what they foresee to be the best treatment by clarifying the decision-making process.

**Tells me the Truth.** “A person of trust that could tell me the truth...for example, if there was a solution that they would tell me ‘Francisco’ it’s all right. Having that confidence to give us that encouragement, right? That they tell me, you know what is good...that they do not put in doubt, but if they do make you doubt that they say ‘think about it.’ I would still appreciate it, right?” (Male – Time 3).

A person of trust understands how these patients view truth-telling. Francisco wanted someone to tell him the truth, which meant providing a word of encouragement when the course of action was clear to the provider and not adding doubt to an already difficult decision. However, if doubt was in order, it meant making it clear that the course of action would need to be thought out by the patient. Unfortunately, few of the patients had ever experienced a doctor in the United States as a person of trust. Most have described this kind of relationship with physicians as they had long-standing

relationships in their home countries. The relationships crossed over from a mere professional relationship filled with one-way technical information to a two-way process where there was a prominently perceived level of trust.

*My Favorite Provider Someone Like Me* “To have a favorite provider, it would have to be me...it’s that I would need a person of trust...and well right now I don’t have one” (Male – Time 3).

The concept of truth-telling is crucial because it has the power to build up a relationship or destroy what little if any trust was already established. If the doctor provides the patient with information, and that information turns out to be incorrect, the patient is often left feeling as if they have been lied to. Francisco, for example, was told by his physician that he would fully recuperate from the prostate surgery side-effects in seven years. He believed that timing, and seven years later he is still suffering from the side-effects and left feeling disheartened.

“[The urine] is what has bothered me the most since I had surgery...They have already checked me, all of the specialists, and well they say I am fine. [But the urine comes] Yes and I am still leaking, right? Yeah, but it’s already a lot of time...So, the doctors say that I should have already recuperated 100 percent” (Male – Time 3).

***Value and Perception of Truth-Telling.*** An important feature that builds a patients’ trust is the concept of truth-telling. Older foreign-born Lat-

inos do not equate truth telling as mainstream America views informed decision-making. Truth-telling is not “informed decision-making.” Truth-telling is being able to appropriately tell the patient what they are to expect and to go out in a limb to share their private opinions as to what treatment they feel will be the best for the patient. Truth telling is not informing patients of all available treatment options and describing the benefits and consequences of each. The expert’s function is to provide clarity; it is not to muddy a decision by introducing doubt. Older adult Latinos did not expect the doctor to share information that did not pertain specifically to their circumstances. The “expert” who cares about his patients must be willing to display what they deem are the good, bad, and ugly things for patients to consider. This means only displaying those cards on the table that pertain to the patient’s unique situation. Participants did not want the physician to lay out all the cards on the table, particularly if they were not viewed as viable treatment options by the physician. The good doctor is supposed to know the trajectory and course of the patients’ condition, have expected timelines, and know the patient’s preferences as to what issues must be brought up to the patient and family and which ones can be left unspoken.

Patients do not expect clinicians to know everything, but they do expect the doctor to be skilled and understand the basics of science which are informed from their schooling and from their firsthand experiences in working with other patients with similar conditions.

*Tell Me what I Should Do.* “A sincere person that tells me exactly what is best for me. Like when we are going to die and we say, ‘Doctor how many days do I have left?’ No, well I can’t tell you [laugh], right? What I want is that he puts the cards on the table. Seeing my health, my way of living and all of that, that he tells me exactly what I can do. That he explains it to me” (Female – Time 3).

Respondents respected clinicians who provided information benefiting the patients’ wellbeing. Participants would have the physician answer, “Please put yourself in my shoes and tell me what you would do if you were in my position?” Then explain why you think this is the best treatment option for me. Bertha summed up “that the [doctor] talk to me, that they tell me the truth” (Female – Time 1).

**The Advocate.** The advocate embodies the features of a person of trust and more. Similarly, to the person of trust, an advocate goes out on a limb to state their opinion and support the patient’s positive health and well-being. Based on the clinicians’ expertise and knowledge of the patient, the clinician actively aimed to prevent undesired health consequences (e.g., side-effects from radiation, cancer diagnosis). Unlike a person of trust who speaks honestly and broaches situations as they arise, an advocate sees a potential problem likely to happen and takes action to prevent it from occurring. The advocate can play a persuasive role in the patient’s decision-making process. Usually at this level of the relationship, the

patient and physician share values and belief systems. This gentleman, for instance, has a provider that shares many cultural perspectives. They both share the value of limited use of drugs and increased use of natural medications.

*Discouraged me from Having Additional Tests.* “He [My doctor] prevented me from going to take a cardiology test. He told me, ‘Francisco don’t go! Don’t go to the cardiologist!’ They were going to do a nuclear test where they give you a lot of liquids. They had already done it one time. He told me ‘Don’t go, look they give you a lot of liquids. See, your heart is fine so you don’t need it. The only thing is that your heart is a little big, that’s it. Look’ he said, ‘it seems to me that it being a little big could be due to inflammation.’ He said, ‘it gets a little large when one suffers a stroke or when one is really stressed, but I recommend you do not do the exam.’ I didn’t go!” (Male – Time 1).

At this level of the relationship, there is a significant degree of trust that has been established between the patient and the provider. The patients’ confidence in their physicians’ recommendations weighs heavily on the patients’ medical decisions. Putting your trust in something means you are relinquishing some of your control over the situation (e.g., stop getting information and go forward based on what the physician has said). The physician has established a great influential power. Some of the patient-clinician relationships reported within GraciaMed PACE evolved from a professional realm, where the value of respect (*respecto*) for

those in positions of power was reported to a relationship within the realm of friendship and family-like. This transition manifested in the way the participants spoke about their medical practitioners. In the Spanish language there are two forms of speech, a formal and informal. Cultural norms and rules guide the usage of these forms of speech in addressing others, especially those who are deemed to be respected such as those in positions of power (e.g., elders, physicians). In the first level of relationship development of the good doctor (*el buen doctor*), the patient often speaks about the physician in a formal sense. As the patient acquired a higher level of trust, and the perception that the clinician opened the opportunity for more emotional and social types of engagement, the dynamics between the two people were leveled, and the forms of speech intermixed between formal “*usted*” and informal “*tu*” both meaning (you) in English. The formality remained because a physician is someone to be respected, but the number of times less respectful forms of speech were included increased. A more familiar way of addressing each other (e.g., first person) was reported in patients who had established relationships with the medical practitioner in the realm of a person of trust (*persona de confianza*) or an advocate.

In sum, the patient-practitioner relationship has the potential to flourish into a true partnership where open and honest conversations are had and the spirit of delivering patient-centered care is embodied.

## Discussion

Prior research underscores the critical role of the patient-provider relationship (PPR) for patient outcomes and satisfaction (Drossman et al., 2021; Huang et al., 2020). Relational trust is key to developing high-quality genuine relationships between patients and providers, and vital for effectively managing chronic comorbidities. As older foreign-born Latino adults have high rates of multiple chronic comorbidities, poor day-to-day functioning, and high rates of mortality (Fortin et al., 2004; Marengoni et al., 2011; Ryan et al., 2015), management of multimorbidities is a public health priority among this population. As management of multimorbidities necessitates ongoing attention, requiring numerous medical encounters, investigating PPRs between foreign-born older Latinos and their providers is critical to address health disparities among this growing segment of the U.S. population. Yet a shortage of qualitative longitudinal research exists exploring PPRs among older foreign-born Latinos. Therefore, this qualitative longitudinal study aimed to explore the perceived acquiring of high-quality PPRs among older foreign-born Latinos.

Consistent with prior research, this study found that perceived relational continuity was a valued commodity in delivering healthcare and maintaining a positive patient experience for patients with multimorbidities (Murphy & Salisbury, 2020). Participants from this study perceived the PPR as a continuum across time, establishing three

developmental stages in the PPR. The first stage established the concept of *el buen doctor* (a good doctor). Among the Latino medical community, the idea of a good doctor is a familiar concept. An editorial piece titled *Ser Un Buen Medico* (Being a Good Doctor) was delivered to graduating medical students and surgeons in December of 2008 in Colombia. It embodies what a future practicing physician aspires of their future relationships with their patients:

*To those who patients call 'good doctor:' one of those aspects, and maybe the most important one, is trust, which is built from scientific competence, truthfulness, integrity, respect, and good relations with patients and colleagues (Gómez, 2009, p. 10).*

The foundation of an effective patient-clinician relationship falls upon trust, which is built on mutual respect and empathy. All other characteristics, such as respect, integrity, and good relations, are value-driven characteristics with unspoken culturally relevant dynamics most likely to be met by a person with an emic perspective. The quote embodies aspects of the findings regarding relationship development. What participants may be identifying as skillset may be the manifestation of the different paradigms and values between providers practicing in the U.S. and those in Latin America. However, additional research to identify what drives the idea needs further investigation.

Furthermore, participants emphasized that a good doctor listens to

their patients' medical concerns and treatment preferences. When participants were not satisfied or felt their concerns went unheard, they would seek a second medical opinion. These findings diverge from prior research that suggests that Latinos do not want to engage in medical decision-making (Levinson et al., 2005). In other words, our sample of foreign-born Latinos with multimorbidities were active participants in their health care and the decision-making process.

During the second stage of relationship development, the patients perceived the clinician to be a person of trust. Trust was already established and strengthened as the clinician demonstrated trustworthy characteristics over time. The clinician embodied truth-telling, irrespective of the status quo. The features repeatedly used to describe trust-worthy individuals personified benevolent qualities (e.g., kind, always smiling, open and sincere *amable, risueña, abierta, sincera*). These findings are consistent with prior research that documents Latino patients valuing warm personal relationships with their providers (American Medical Association, 1994; Alegria et al., 2009).

The last stage embodied the characteristics of a person of trust plus an advocacy component: doctors who advocated for the patient's well-being and were willing to express their opinion, occasionally sticking their necks out for their patients. This finding extends prior research on PPRs among foreign-born Latinos in the U.S. Prior research in this area typically assesses confusion,



frustration, and perception of poor quality of care, language concordance, and health care discrimination (Gonzalez et al., 2010; Lopez-Cevallos & Harvey, 2016). However, findings from this study underscore the importance of advocacy in fostering a strong PPR and sense of trust with foreign-born Latino patients.

Patients reported relational trust as the key to developing high-quality genuine relationships that increased their satisfaction with their receipt of care, health outcomes, and quality of life. This kind of relationship is satisfying to patients and protective against burnout and improvement to practitioners' mental health and well-being (Hojat et al., 2011; Huang et al., 2020). However, the deterioration of the patient-provider relationship is a problem for the patients' health outcomes and providers' mental health and well-being. The COVID-19 pandemic has increased the percentage of burnout to an unprecedented threat to doctors' physical and psychological health (Chatterjee et al., 2020). Before the pandemic, it was estimated that 46% of the U.S. physician workforce suffered burnout (Bansal et al., 2020; Nanda et al., 2017). Innovative solutions that reduce the pressure to see more patients in less time and to reduce administrative tasks and increase opportunities to organically engage the patients in listening sessions within the medical encounter are critically needed. The patient-clinical relationship must be redefined and operationalized to include new relational dynamics introduced by innovations in care delivery (e.g., telehealth).

When older foreign-born Latinos describe their PPR over time, one can understand that the PPR is not an incident but, rather, part of their lifestyles and management of multimorbidities. As such, PPR compose part of their social convoy in addition to spouses, children, and other family. Their social convoys represent especially important aspects of their social support network, because of their increased risk for broken convoys following migration to the U.S. (Lerman Ginzburg et al., 2021).

## **Policy Recommendations**

**T**he number of foreign-born Latino elders experiencing multimorbidities is expected to grow and is projected to increase the health-care costs associated with its management. The costs associated with managing multimorbidities are generally higher for people with multimorbidities compared to the general population (Quiñones, 2019). Multiple chronic conditions pose many challenges, one being how to provide patient-centered care in the context of competitive health care priorities and increasing complexity. The findings contribute to practice-based conversations around the implementation of specialized models of geriatric care, particularly hard-to-reach vulnerable geriatric populations, such as predominantly monolingual foreign-born Latino elders.

The PACE Model of Care was a unique setting for this research project. The programmatic features/characteristics allowed the observation of

patient provider relationship (PPR) development under the best of controlled circumstances for older adults foreign-born Latinos. Although the participants in this study were all foreign-born, the issues around access to care due to immigration status were not a factor. The participants were dual-eligible for Medicare and Medi-Cal and met nursing-homebound eligibility requirements upon arrival at the center. Again, the participant eligibility and the capitated feature of the program helped control costs. The issues around language barriers were also not a factor, since the number of PACE staff and professionals were ethnoculturally concurrent with the center patients. During the study, only the primary care providers and some nurses were non-Spanish speakers; most spoke the language and cultural nuances around communication were understood.

Because these were PACE participants, researchers recorded the development of PPRs. Automatically, the program removed the challenges often observed in other disparity studies (e.g., access, cost, quality of healthcare delivery, and transportation). Under these optimal conditions, our study found that high quality PPR is attainable. Therefore, we recommend the following PACE Care Model modifications to expand findings to minimize health care disparities among older adults of color. First, increase the number of states to expand PACE programs to more medically underserved areas (MUA) and medically underserved populations (MUPs). PACE programs deliver Medicaid and Medicaid services. The National

PACE Association estimated that over 1.2 million of the Medicaid beneficiaries who could benefit from PACE failed to have access to a PACE program. The greatest barrier to this service is accessibility (Kaye, 2019). Secondly, increase the number of Federally Qualified Health Centers (FQHCs) and FQHC look-alikes serving MUA or MUPs to incorporate a PACE program. Although PACE is a fundamentally different payment model with different delivery of care, FQHCs are well-positioned to take on the opportunity to incorporate PACE program. Finally, broaden the eligibility criteria to include non-nursing home bound and community-bound / home-bound people having trouble managing multiple chronic conditions.

In addition, we recommend training to replicate similar findings in traditional models of care with non-inclusive, non-capitated, and non-comprehensive components that serve aging adults. One is to train and hire case workers specializing in aging, immigrants, and Latino culture and language to advocate and oversee the healthcare coordination needs of each adult. Second, to incorporate additional training for physicians in relationship building for patients who are older and whose language of preference is other than English.

Incorporating even some of these recommendations would increase the likelihood of replicating similar results in other communities where ethnic enclaves predominate. Doing so would allow for the development of better quality PPR by controlling documented

barriers to access to health care and increase the equity that predominates in the social determinant of health literature (Hall et al., 2015). We advocate for healthcare models and environments that support equitable outcomes, and minimize adverse health effects and increase access to comprehensive services to promote health and reduce health care disparities.

## **Limitations**

**F**indings from this study should be considered in light of several limitations. First, participants for this study are foreign-born Latinos with multimorbidities who participated in PACE in Los Angeles County in Southern California. Given the regional nature of our study, the PPR development experiences may be unique to individuals who are foreign-born Latinos, living in Los Angeles County, and involved in PACE centers that share predominant ethnocultural concordance with providers and staff. Therefore, future research should assess PPR development in different settings, as the transferability of these findings to other populations may be limited. Second, this qualitative study sought to identify the uniqueness of PPR development among foreign-born Latinos in Los Angeles County and, therefore, not a nationally representative sample. Future research should seek to use quantitative study designs to assess whether these patterns differ among foreign-born Latinos in distinct areas of the U.S. Finally, our study was comprised of dual-eligible foreign-born Latinos with multi-

morbidities from Mexico and Central America. As prior research documents differences in patient-provider communication between foreign-born and U.S.-born Latinos (Alegria et al., 2009), future research should qualitatively assess PPR development among U.S.-born Latinos. Furthermore, given the heterogeneity of the Latinx population, future research should assess whether these patterns vary by time in the U.S. and by gender.

## **Contributions**

**D**espite the aforementioned limitations, this study makes several contributions to the PPR literature. First, prior studies did not longitudinally explore processes contributing to developing of PPRs among foreign-born Latinos. This gap in the research literature obscures the development of culturally tailored and patient-centered care among a population that is the largest ethnic minority group in the U.S., an aging population, and a group facing high rates of multimorbidities. To address this gap and to inform culturally-tailored recommendations for patient-centered care, this study explored the perceived acquiring of high-quality PPRs among foreign-born older Latinos participating in an all-inclusive specialized program aimed at controlling patients' costs and enhancing access to care. Second, the longitudinal nature of the study design allowed investigators to follow foreign-born Latinos over time and to observe their evolving stories, attitudes around communication, and relation-

ship development. Relatedly, because the PACE model controls patients' medical costs and increases opportunity for interactions with medical professionals, investigators were able to study facets of the PPR that are seldomly observed among community-dwelling foreign-born Latino elders managing multimorbidities. The unique study characteristics allowed for an exploration of PPRs among an understudied population: foreign-born Latinos. Findings elucidate factors (e.g., expertise, trust, advocacy) that contribute to the development of strong PPRs. As prior research documents differences in patient-provider communication between foreign-born and U.S.-born Latinos (Alegria et al., 2009), this study was able to capture PPR development over time among foreign-born Latinos specifically. Finally, although prior research has used data from a nationally-representative sample of foreign-born Latinos to assess patient-provider communication (Gonzalez et al., 2010), we extend this body of work to capture *how* PPRs develop over time among a sample of foreign-born Latinos with multimorbidities.

## Conclusion

Findings from this study underscore how relationships within the healthcare system and continuity of care are valued commodities for patients. Patients want to feel genuinely cared for by their providers. Value-based care with coordination and continuation are ideal for developing relationships. Fragmented care does not work for managing multiple conditions when the broker to the patient's care is the patient. The PACE model has been shown to increase those characteristics of relationship development between patients and providers. Efforts should be made to incentivize initiatives to achieve relational continuity between providers and patients within a modern healthcare system. To address the high burden of multimorbidities among older foreign-born Latinos, continuity of care and development of PPRs (especially trust) should be a priority. To enhance PPRs among older foreign-born Latinos with multimorbidities, providers should consider strategies to develop trust and advocate for patients' needs.

## Authorship Contribution Statements

**Rosana Bravo:** Conceptualization, methodology, investigation, analysis, and writing. **Ángela Gutiérrez:** Writing, reviewing, and editing. **Lené Levy-Storms:** Writing, reviewing and editing. All authors approved the final version.

## Declaration of Competing Interest

The authors declare no conflict of interest.

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