blue of california foundation

on the cusp of change

the healthcare preferences of low-income californians

june 2011

Langer Research Associates

introduction

The Patient Protection and Affordable Care Act outlined broad changes to the healthcare financing and delivery system, including major expansions in health coverage for low-income Americans. Estimates suggest that as many as 1.7 million additional low-income Californians will enroll in Medi-Cal (the state's Medicaid program) in 2014 and another 4 million individuals are expected to obtain health insurance through the newly created Health Benefits Exchange.

To date, there has been tremendous effort across the nation and in California to implement changes in the health insurance system and prepare for these major coverage expansions. While the contours of the major polices are becoming clearer, less is known about the expectations of people who will be living through these changes. Blue Shield of California Foundation commissioned Langer Research Associates to conduct research about the current experiences and future expectations of low-income Californians under health reform. As some of the primary intended beneficiaries of health reform, it is important to hear first-hand about their expectations, aspirations and concerns as part of the planning process.

This report contains the results of a new statewide survey of low-income adults (those earning less than 200% of the Federal Poverty Level, or about $45,000 household income for a family of four) providing authentic and fresh insights on how these families might take advantage of the expanded access to care provided through health reform. The good news is that low-income Californians are ready to exercise their choice in a changed health care environment. The challenge is that providers, within the next few years, must hear them and meet their expectations of improved coverage, greater choice and better quality if we are to achieve better health care for all Californians.

I want to thank David Glass for his guidance, the experts who participated in the instrument review, Foundation staff, particularly Brenda Solorzano, Cecilia Echeverria, Julie Apana, and Christine Maulhardt and the Langer Research Associates team of Gary Langer, Julie Phelan and Greg Holyk for their work conceptualizing the project, designing the survey instrument, implementing it, analyzing the results, and drafting the report. Their tireless efforts have provided us with important insights and new knowledge to guide the implementation of health reform.

Peter V. Long, Ph.D.
President and CEO
Blue Shield of California Foundation

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executive summary

Low-income Californians stand on the cusp of change in their healthcare services – with millions poised to take the leap.

In findings with broad implications for both clinics and policymakers, a sizable number of the poor and near-poor in this Blue Shield of California Foundation (BSCF) survey express dissatisfaction with their current care, and six in 10 say they'd be interested in switching to a new facility.

That portends a potentially vast transformation in the delivery of health care as the federal Patient Protection and Affordable Care Act (ACA) takes effect. Many low-income Californians clearly hunger for the choice the legislation will bring. As they exercise it, clinics and other providers face a new world of opportunities and risks alike.

It is with this changing healthcare landscape in mind that BSCF undertook this statewide survey, based on a representative sample of Californians age 19 to 64 with household incomes below 200 percent of the federal poverty level. The study assesses their current health care experiences and wants and needs for future care in detail, examining the potential impact of each of these factors on the provision of future services to poor and near-poor patients.

Among the key results:

- Forty-four percent of low-income Californians currently have no choice of where they go for care, and about as many lack a regular personal doctor – a prime factor in satisfaction with care and an anchor of patient loyalty.

- Just 48 percent rate their care as excellent or very good, with lower levels of satisfaction fueling desire for change. The equivalent of more than 3.8 million Californians express interest in switching to a different care facility if they had insurance to cover it.

- Five factors best predict satisfaction: courtesy of staff, patient involvement in medical decisions, cleanliness of facility, the amount of time the doctor spends with a patient and having a highly regarded personal doctor. Facilities that fail here are at risk.

- The strongest predictors of interest in changing facilities include the desire to have a regular personal doctor, the current facility's quality-of-care rating, the lack of choice of a facility and demographic factors including age, employment and insurance status.

- In considering a new place for care, prospective patients prioritize cost, being able to see the same doctor, convenience, the availability of continuing care services and clear communication with a doctor. Patient services – not cost alone – are key priorities in choosing a new facility.

- A one-size-fits-all approach will be insufficient for facilities positioning themselves for the future, as there is considerable variation in priorities across groups. Distinctly different groups, for example, are interested in having an equal say with their doctor as are interested in having a range of services available under one roof, major tenets of patient-centered care and a health care home.

The results show a health-stressed population with unmet care needs, but with some hopes for the future: Four in 10 of the poor and near-poor think the ACA will bolster their options – a far better reception than it has received among the general population.

Across 19 areas of care measured, all facilities average excellent or very good ratings of 46 percent, ranging from 56 percent for private doctor's offices to 38 percent for hospital emergency rooms. California community clinics and health centers (CCHCs) roughly match the average, at 45 percent – but do better than average in affordability, while worse in getting an appointment when desired.

One in three low-income Californians reports a disability or chronic condition. Just a third say their own health is excellent or very good.

Grounded in patient perspectives, this survey offers guidance on how clinics and other facilities are perceived and might position their services in the changing healthcare landscape. For policy makers it underscores the complexities inherent in serving this health-challenged population, in California and across the United States, as full implementation of the ACA draws near.

A summary of key points follows, each expanded upon in the full report.

current health care experiences

Choice and current care: Ongoing care is broadly available to poor and near-poor Californians. But while 93 percent have a "usual place" for health care, more than four in 10 also say they have no choice in where they go – for most, because their current facility is the only one they can afford.

- In terms of current facility usage, a plurality, 44 percent, relies on a clinic or health center for their care. Nearly three in 10 visit a private doctor's office, about one in 10 uses a Kaiser Permanente facility and an additional one in 10 relies on a hospital emergency room.

- Among those who do have a choice, just 12 percent say the least expensive option drove their decision – another indication that, in the ACA-inspired future, competition for patients will be based on more than cost alone. Many more picked their facility either because of its convenience, or by referral. This is a finding of particular interest to clinics, whose currently uninsured patients will find cost less of a concern with the ACA in place.

- Lack of a regular personal doctor rises to 60 percent among clinic patients (including those using community, public hospital, county or city, private or other clinics), raising particular challenges for these facilities in retaining patient allegiance.

Satisfaction with Care: Quality-of-care ratings vary across facility types. Satisfaction is higher among patients who use a private doctor's office or the Kaiser Permanente system, and lower among clinic patients.

- Beyond overall care, 18 individual elements of care were measured in this survey; their ratings vary substantially, and all show room for improvement. Highest ratings (54 to 59 percent excellent or very good) were given to items such as cleanliness and appearance of the facility, and courtesy and helpfulness of the staff. Two elements of convenience were given the lowest ratings: waiting times and availability of night or weekend hours.

- While their ratings match the average, CCHCs have an image problem: Just 31 percent of low-income Californians say these facilities have an excellent or very good reputation. At the same time, a third of CCHC patients say the quality of their care has improved in their time there, compared with fewer than a quarter of all others.

Health Status: Health problems are widespread. One in three low-income Californians reports a disability or chronic condition. Just a third say their own health is excellent or very good, significantly below the levels reported by adults of all incomes in statewide and national surveys.

- CCHC patients are a less-healthy population even than other low-income Californians. Just 21 percent of CCHC patients rate their health as excellent or very good, compared with 36 percent of those who go to private doctor's offices or Kaiser Permanente facilities.

- While they are disproportionately less healthy, poor and near-poor Californians are no more likely than others to obtain medical care, suggesting an access gap or pent-up demand that may lead to increases in use when the ACA is fully implemented. Thirty-four percent have seen a doctor no more than once the past year, similar to all adults statewide and nationally.

implications for future care

Interest in Alternatives: While a substantial 58 percent express interest in changing facilities if they had the insurance do so, this goes higher in some groups – soaring to 86 percent, for example, among those who lack a personal doctor but want one.

- Interest in moving peaks, at 73 percent, among patients of county or city and private clinics. It's 64 percent among users of hospital emergency rooms, CCHCs and public hospital clinics alike; and 49 percent among Kaiser Permanente and private doctor's office patients.

Overall, four in 10 don't have a personal doctor, and this rises to 60 percent among clinic patients.

Among those who lack a personal doctor but want one, interest in changing facilities soars to 86 percent.

- Interest in changing facilities also is higher among people who currently lack a choice, as well as among the uninsured – two groups particularly served by clinic care. Indeed, while 28 percent overall are *very* interested in change, strong interest is highest among CCHC patients, with 42 percent very interested in finding a new place for care.

Levers of Change: Cost, the ability to see the same doctor every visit, convenience, continuing care and clear communication with a doctor are all compelling elements in choosing a new facility. But there are differences among population groups, meaning the emphasis should depend on the community, the population individual facilities' serve, and those facilities current strengths and weaknesses.

- Perhaps surprisingly, cost is not the prevailing issue in overall concerns when picking a facility. About a third pick cost as a prime mover, but about as many are most concerned with their ability to see the same doctor each time. The rest divide between two other choices, the convenience of the facility and short waiting times.

- On convenience, ability to get an appointment when wanted is the highest priority for a new facility, albeit followed closely by availability of walk-in visits. On services, continuing care for long-term problems trumps wellness programs and whether other family members can get their care at the same facility. And on doctor-patient relationships, the clarity of a doctor's explanation is key – more so than simple face time.

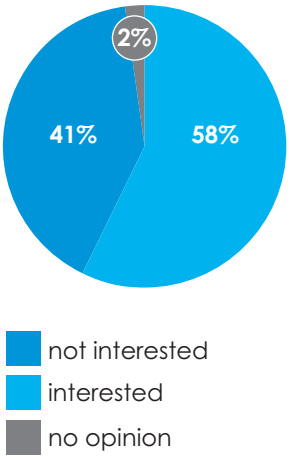
Patient-Centered Care: Low-income Californians express substantial and strong interest in a basic precept of the patient-centered care model of healthcare delivery.

- Fifty-nine percent seek "an equal say with the doctor or nurse" in decisions about their care; 48 percent feel that way strongly. Nonetheless, a not-insubstantial minority, 39 percent, prefers the more traditional model of leaving care decisions mostly up to health professionals.

- Another result shows significant interest in the "healthcare home" model, in which facilities offer a range of additional services beyond regular medical care. Sixty-three percent overall say this would be extremely or very important to them in choosing a new place for care.

Blue Shield of California Foundation's survey of low-income Californians is based on interviews with a random statewide sample of 1,005 Californians age 19 to 64 with household incomes less than 200 percent of the poverty level. The project was designed, managed and analyzed, and this report written, by Langer Research Associates of New York, NY, with sampling, data collection and tabulation by SSRS/Social Science Research Solutions of Media, PA. The results have a margin of sampling error of plus or minus 4 points for the full sample.

interest in changing facility



project overview

Healthcare services for the poor-and near-poor traditionally have focused mainly on the goals of payers and care delivery systems rather than on the desires and interests of end users. With few if any options for their care, low-income patients in effect have been a captive audience, reducing the imperative to delve into their preferences for care.

The federal Patient Protection and Affordable Care Act (ACA) changes this paradigm. Through the extension of Medicaid benefits and creation of insurance exchanges, low-income Americans stand on the cusp of a new world of healthcare options. Healthcare facilities face a revamped marketplace – with their success or failure in serving low-income patients dependent as never before on a client-focused approach.

This study was commissioned by Blue Shield of California Foundation to gain insights into the views of low-income Californians about their primary care today and expectations for the future. The state's poor and near-poor residents age 19 to 64 comprise approximately 6.5 million adults, including the primary users of community clinics and health centers, many of whom will gain health insurance under ACA reforms. Their views are critical to inform clinics' preparations for successful implementation of healthcare reform.

The project grew out of the Foundation's long history of support for California community clinics and health centers (CCHCs). The Foundation's safety net portfolio has allowed more than $58 million in funding to flow to community clinics and health centers through its Community Clinic Core Support Initiative and the Clinic Leadership Institute. This study represents a new direction in Foundation efforts, one that reflects the precepts of the movement toward "patient-centered care" by rigorously measuring the attitudes, experiences, expectations and desires of low-income Californians, a key segment of CCHCs' target market.

This study began with an extensive review of the existing research literature, summarized in Appendix A. Our review found a wealth of satisfaction-with-care measurements focused on patient experiences from a consumer perspective, with some touching upon key components of patient-centered care, but with less attention to healthcare preferences – what people want and need from the healthcare system beyond what they may be receiving today. That is a focus of this study, along with current-care measurements used both to understand patient concerns and to model the levers for change.

The survey included a highly detailed effort to identify the types of health facilities now used by poor and near-poor Californians.

Based on a representative, random sample of the state's poor and near-poor population (see Section IX, Methodology), the approximately 21-minute survey was conducted among 1,005 respondents, by landline and cellular telephone, in English and Spanish, from March 29 to April 25, 2011.[1]

The survey included a highly detailed effort to identify usage of various types of healthcare facilities. See details in Section IX, Methodology.

One key focus: what people want and need from the healthcare system beyond what they may be receiving today.

sections guide

Key results are outlined in the Executive Summary. The full report provides extensive details of the findings, presented as follows:

part a: current healthcare experiences

- **section i: choice and current care**. Where low-income Californians obtain their care, factors in choice of facility and the presence of a regular doctor or pediatrician in their current health care.

- **section ii: satisfaction with care**. An examination of ratings of the delivery of care overall and across a variety of domains, focused on differences across facility types and demographic and health-status groups within the broader population.

- **section iii: health status**. An evaluation of health self-assessments and self-reports of chronic conditions among poor and near-poor Californians.

part b: implications for future care

- **section iv: interest in alternatives**. A look at the levels of interest among low-income Californians in changing their current facility, their likelihood of recommending their facility to others, and the strongest predictors of both.

- **section v: levers of change**. A detailed evaluation of priorities when choosing a new health care facility, including preferences among options in interactions with doctors, convenience and services offered by care facilities.

- **section vi: patient-centered care**. A review of interest in the patient-centered care precept of patient involvement in decision making, and the "healthcare" home concept of a spectrum of services under one roof.

part c: los angeles county, demographics and methodology

- **section vii: care in los angeles county**. An analysis of results among low-income Los Angeles residents, who comprise 30 percent of the state's poor and near-poor population age 19 to 64, with comparison to attitudes elsewhere.

- **section viii: population profile**. A review of groups within California's poor- and near-poor population, including education levels, employment status and other demographic data, compared with the broader public.

- **section ix: methodology**. A detailed review of the survey's methodology, including sample design, questionnaire design, fieldwork protocols, data processing, response rate information and healthcare facility identification.

The report concludes with appendices detailing the literature review, statistical modeling used in this analysis, the survey's topline results, the full questionnaire and source references.

Questions on any aspect of this study, and requests for further data analysis, should be directed to Cecilía Echeverría, Blue Shield of California Foundation, 50 Beale Street, San Francisco, California, 94105-1819, telephone (415) 229-6147, cecilia.echeverria@blueshieldcafoundation.org.

endnotes

1 The California Health Information Survey (2009) estimates that 6 percent of the target population speaks neither English nor Spanish at home. Seven percent of BSCF interviews were conducted with respondents who said they "mainly" speak neither English nor Spanish at home, but did complete the interview in one of those languages.

section i: choice and current care

Ongoing health care is broadly available to the vast majority of low-income Californians. Yet many lack a choice of their care facility or the anchor of a personal doctor – two important factors in interest in changing healthcare facilities.

Ninety-three percent report having a "usual place" for care, and there is continuity, with nearly three-quarters going to the same facility for at least two years. But more than four in 10 also say they have no choice of where they go for care (rising to six in 10 of the uninsured); about as many don't have a personal doctor; and, among those with a child under 18 at home, one in five lacks a regular pediatrician.

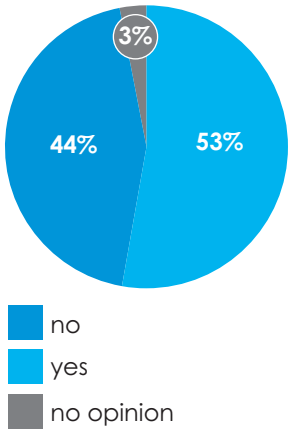
Among those who say they have no choice where they go, 51 percent also lack a personal doctor. Among those who did choose their current facility, far fewer, 33 percent, lack a regular doctor. And it matters: Those without a personal doctor are 18 points more apt to express interest in changing facilities if they could, 68 percent vs. 50 percent among those with their own doctor (see Section IV).

For those without choice, cost is the central issue in where they receive care. Fifty-seven percent in this group say they go to their current facility because it's the only one they can afford (45 percent) or the only one their insurance covers (12 percent). Fewer, albeit a non-negligible 29 percent, say they go there because it's the only place nearby.

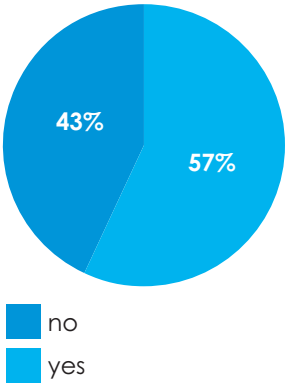
For those who do have a choice, by contrast, convenience and referrals are larger deciding factors, and lowest cost much less so. Thirty-nine percent say they picked their facility because it was the most convenient; about as many, 33 percent, took the recommendation of a friend or relative (23 percent) or a health or social services professional (10 percent). Just 12 percent of those with a choice say picking the least expensive facility chiefly drove their decision.

While cost surely is a factor, this result shows that it's far from the sole consideration for patients who have a choice of provider (a point buttressed in results on interest in other facilities, see Section IV). This suggests that when low-income Californians have a choice, competitive pricing rather than absolute lowest pricing may be adequate, as two other influences – convenience and word of mouth – play a larger role in the selection of a care facility.

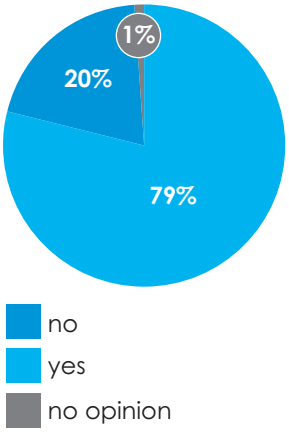
have a choice of provider



have a personal doctor?



have a pediatrician (among parents)

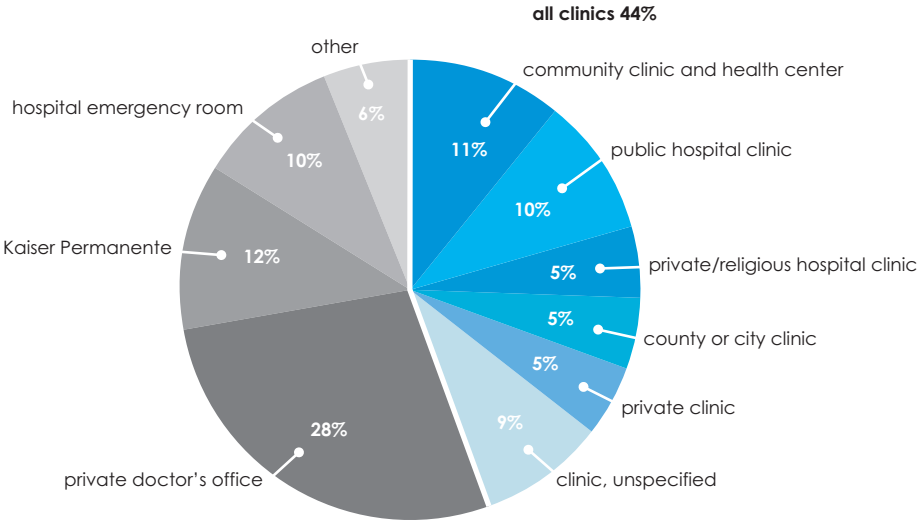


clinic use

A plurality of low-income Californians, more than four in 10, turn to a clinic or health center when they're sick or need care. Community clinics and health centers (CCHCs) and public hospital clinics account for just under half of these patients, with the rest divided among county- or city-run clinics, private clinics and others. (See Section IX, Methodology, for a detailed description of facility categorization.)

Among the rest, nearly three in 10 visit a private doctor's office, about one in 10 go to a Kaiser Permanente facility and an additional one in 10 rely on hospital emergency rooms.

facility use



Among all clinic users, 52 percent say they have no choice of provider (including no other place they can afford). The next largest group, 22 percent, goes there because the location is convenient. Other reasons are cited less often.

Clinic use is especially high, more than half of respondents, among those with no insurance, with federal or state-sponsored insurance (Medi-Cal and other state and federal coverage), and with incomes less than $15,000 a year. Clinic use also peaks among those without a high school degree (59 percent), the unemployed (56 percent), non-citizens (56 percent) and Latinos (52 percent).

Just 40 percent of clinic patients overall report that they have a personal doctor, compared with 97 percent of private doctor's office patients and 66 percent of Kaiser Permanente patients (see figure on p.16). But there's variability within clinic type: Among CCHC users, 54 percent say they have a personal doctor. At other clinic types this drops to 36 percent.

other care choices

Low-income Californians with private insurance plans are more likely to go to private doctors' offices (42 percent) or Kaiser Permanente facilities (23 percent) than are those without insurance or with government-financed insurance. In the latter groups, fairly few report going to private doctors' offices (21 percent), and even fewer turn to Kaiser Permanente (6 percent; Kaiser Permanente participation in Medi-Cal is limited).

More than six in 10 of those who go to a private doctor's office choose to go there, rather than doing so out of necessity. Use of private doctors' offices is more prevalent among the poor and near-poor who have a college degree (39 percent vs. 26 percent), and also is relatively high, 39 percent, among retirees in this population (under 65 years old).

Among those with incomes more than $30,000 a year, a quarter go to a Kaiser Permanente facility, compared with just 7 percent of those with lower incomes. Kaiser Permanente is most popular in the greater Bay Area and Sacramento, drawing about a quarter of low-income Californians under 65 in both regions. In L.A. County and Southern California, Kaiser Permanente usage drops to about one in 10, and Kaiser Permanente facilities have little uptake in rural Northern California (excluding the Bay Area and Sacramento) and the San Joaquin Valley, as well as in small towns or rural areas generally.

personal doctor

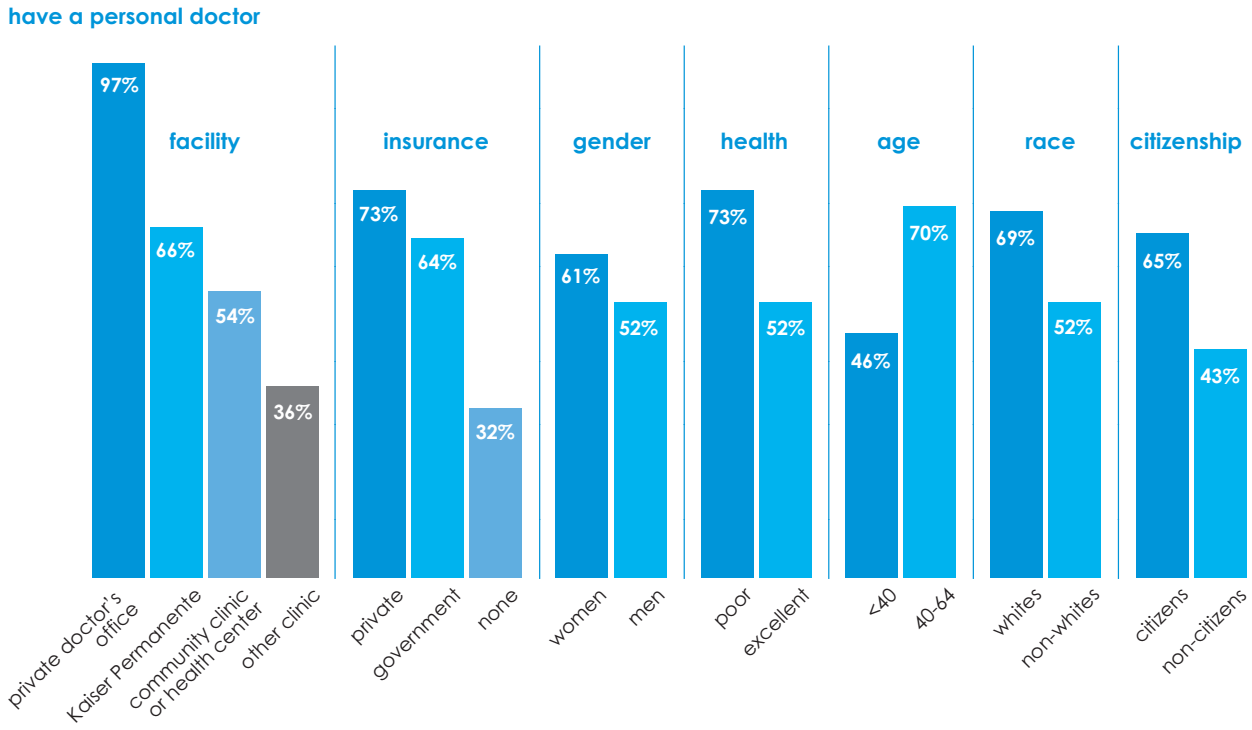
Having a personal doctor matters in attitudes and behavior alike. Patients with a personal doctor, especially a well-liked one, have been at their facility longer, rate their overall quality of care higher and express less interest in changing facilities, as detailed in subsequent sections of this report.

Nearly three-quarters of those with private insurance have a regular personal doctor; that drops to 64 percent for people with Medi-Cal or other government-sponsored insurance, and plummets to 32 percent of the uninsured. Likewise, just 68 percent of uninsured parents have a regular pediatrician for their child, compared with 79 percent of parents with government-sponsored insurance and 89 percent of those who are privately insured.

Among groups, women are more likely than men to have a personal doctor (61 percent vs. 52 percent). And there's an age division, likely relating to health status. Among low-income Californians under age 40, fewer than half, 46 percent, have their own doctor. Among those 40 to 64, it's 70 percent.

Patients with a personal doctor, especially a well-liked one, have been at their facility longer, rate their overall quality of care higher and express less interest in changing facilities.

As noted, there's variability among facility type in having a regular personal doctor – for example, 66 percent among Kaiser Permanente patients, 54 percent among CCHC patients, but just 36 percent among uses of non-CCHC clinics.



Self-reported health status itself plays a role. Among those in "poor" health, 73 percent have their own doctor, although this means that 27 percent do not. Across the spectrum, among those in "excellent" health, many fewer have a personal doctor, 52 percent.

Reflecting the socioeconomic divide even within the poor-and near-poor population, whites are much more likely to have a personal doctor than non-whites (69 vs. 52 percent), as are citizens compared to non-citizens (65 vs. 43 percent). College graduates (11 percent of the population) are more likely to have a personal doctor than those without a college degree (71 vs. 55 percent); among those who did not finish high school, fewer than half have their own doctor.

tenure

On average, low-income Californians report that they have been using the same healthcare facility for slightly more than six years (median, four). Patients at Kaiser Permanente facilities report a longer tenure, on average 10 years.

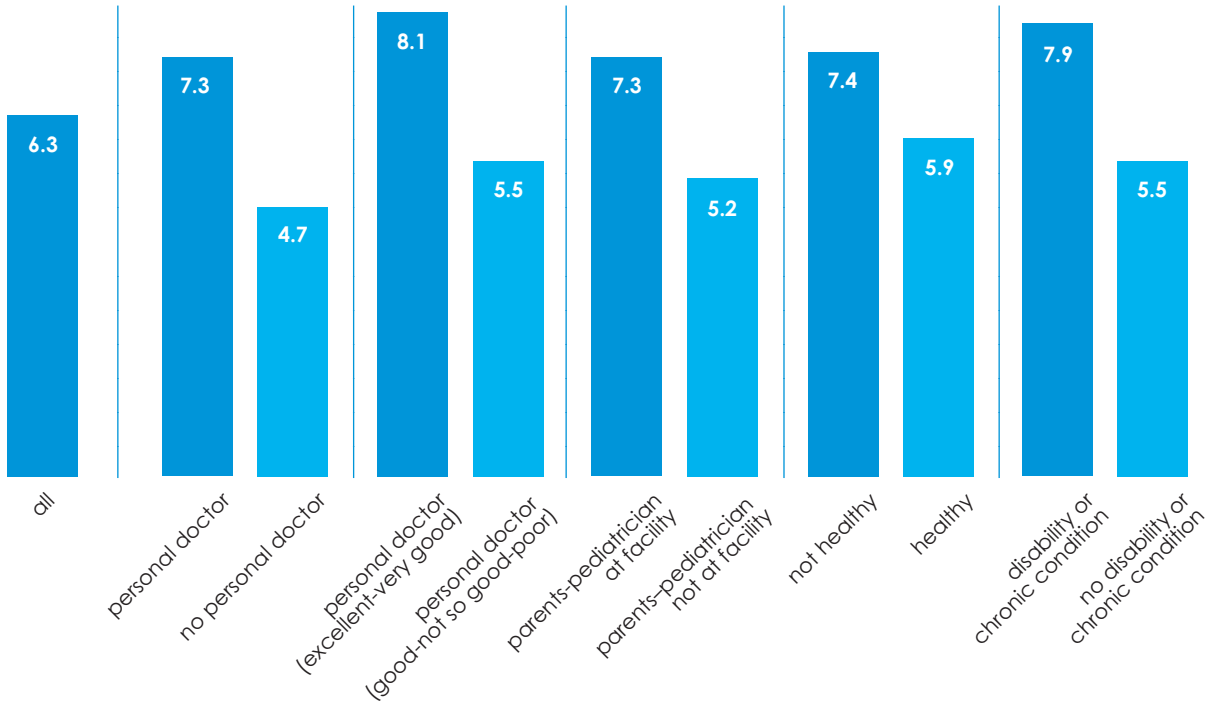
Tellingly, respondents with a personal doctor indicate a longer tenure at their facility – an average of 7.3 years, vs. 4.7 years among patients who lack a personal doctor. Those with a well-liked doctor are especially likely to be loyal, with an average tenure just over 8 years, compared with 5.5 years for those with a doctor whom they rate as less than "very good."

In addition, parents whose child has a pediatrician at the same facility where they receive their care have been at their facility for 7.3 years on average, while parents without a pediatrician at the same facility have been there for an average 5.2 years.

Whites and citizens report longer tenures at their care facility than do their counterparts. Naturally, older respondents also report longer tenures.

Despite being less likely to rate their healthcare facility positively (see Section II), less healthy respondents (those who say their health is "fair" or "poor") have stayed with their healthcare facility longer than healthy respondents (those who rate their health as "excellent" or "very good"), 7.4 vs. 5.9 years, respectively. Respondents with chronic conditions also have been patients of their facility for longer than respondents without chronic conditions, 7.9 vs. 5.5 years.

average tenure at current facility (in years)

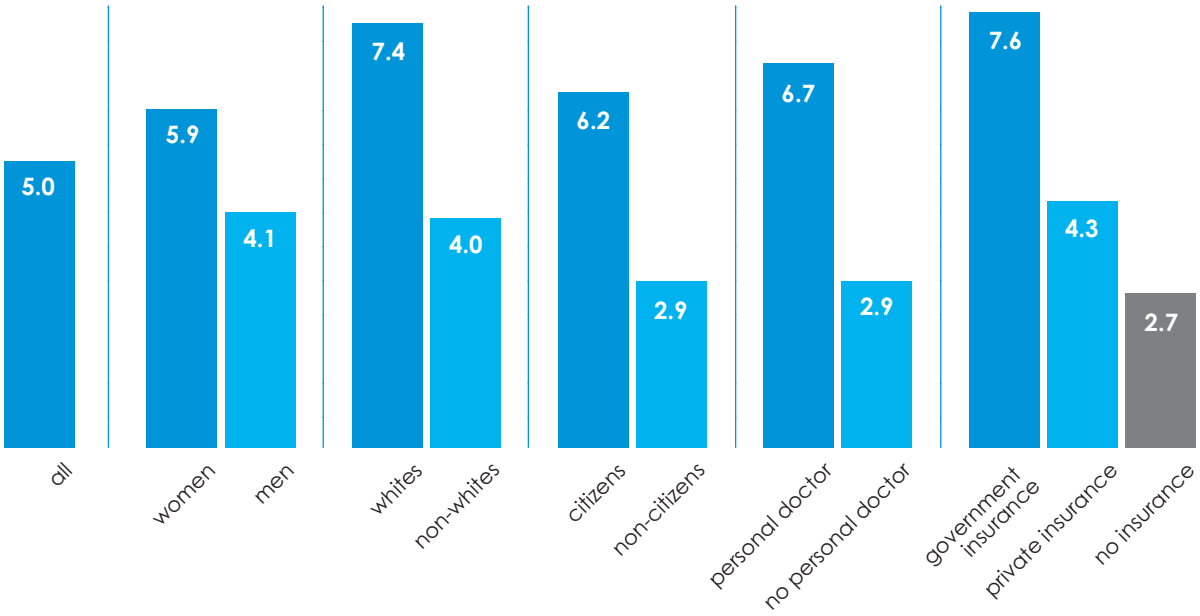


frequency of care

Overall, respondents indicate averaging 5.0 visits to a healthcare professional in the past year.[1] There's no meaningful variance by facility type, but there are differences among groups. One example: Those with a regular personal doctor report an average of 6.7 visits, vs. just 2.9 among others.

Additionally, women visit the doctor more often than men, an average of 5.9 times in the past year vs. 4.1, respectively. Citizens report more than twice as many trips to the doctor as non-citizens, 6.2 times vs. 2.9. And, as noted in Section III, whites frequent the doctor almost twice as often as non-whites.

frequency of healthcare visits (average in past year)



Low-income Californians who lack a job (including those looking for work as well as retirees and homemakers) report more trips to the doctor than those with a part- or full-time job, 6.2 vs. 3.3 and 4.3, respectively. One explanation is that those who lack a job are more likely to have a disability or chronic condition.

In a related result, individuals with government-provided insurance report more trips to the doctor than those with private plans, 7.6 vs. 4.3. Those without any insurance at all report the fewest number of doctor visits a year, an average of 2.7 – suggesting that the out-of-pocket costs they face for medical care may push them to go without.

modeling usage patterns

In addition to confirming the impact of the factors reported above, a statistical model also finds a relationship between quality of care and doctor visits (See Appendix B). Patients who rate their facility's services more positively (overall and on a variety of domains, see Section II) report more visits to the doctor than do those who rate their facility less favorably.

This is true even after controlling for the factors mentioned above, including sex, race, citizenship, having a personal doctor, employment status and insurance. In other words, those who have a negative view of their healthcare facility's services also are less willing to seek medical care when they need it. Improving quality of care could increase utilization simply by encouraging those who are sick or injured to see a doctor.

endnotes

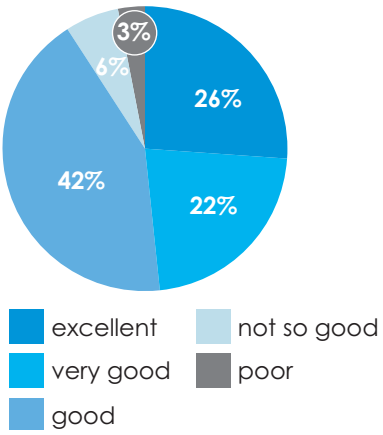
1 Two outlier responses were removed. See endnote 2 in Section III.

section ii: satisfaction with care

While health care is broadly available to low-income Californians, there's wide room for improvement in its delivery – a finding that underscores the potential for significant movement among facilities once patients have more options.

Fewer than half of poor and near-poor residents aged 19-64, 48 percent, rate the overall quality of their health care today as either excellent or very good. For most of the rest, quality of care ratings are "good," 42 percent – rather than outright negative, "not so good" or "poor," 9 percent combined. These could be worse, but they're hardly a glowing report on the current healthcare experiences of low-income Californians.[1]

quality of care

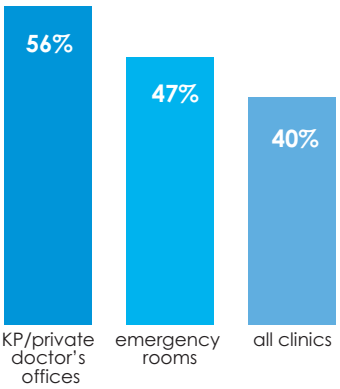


As detailed below, overall satisfaction is lowest among facilities that lack well-regarded doctors, are perceived to have less courteous staff or less clean offices, and those in which patients spend less time with the doctor and have less involvement in healthcare decisions.

Overall satisfaction ratings matter. Interest in switching to a new provider increases, and likelihood of recommending one's current facility decreases as ratings of current care decline. Among those who say their care is excellent or very good, fewer than half are interested in changing facilities, and 75 percent are very willing to recommend their facility to friends. By contrast, among those who say their care is good, not so good or poor, seven in 10 are looking for a change, and fewer than four in 10 are very willing to recommend their facility (see Section IV).

Overall quality-of-care ratings are highest for private doctors' offices and the Kaiser Permanente system – 56 percent of their patients rate their care as excellent or very good. Top ratings are markedly lower, 40 percent excellent or very good, among patients using clinics of any type, including community, hospital, county or city, or privately operated clinics. (Users of hospital emergency rooms fall in the middle, at 47 percent.)

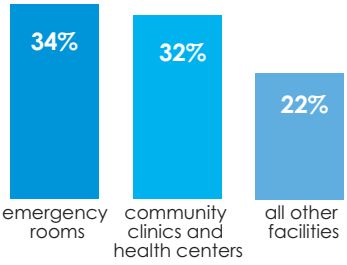
quality of care – excellent or very good



In terms of momentum, however, there's been more change for the better in quality of care than for the worse. Twenty-four percent of poor and near-poor Californians say the care they receive has improved in the time they've been with their current facility. Fewer, 11 percent, say it's gotten worse; 63 percent say the quality of their care has remained unchanged.

Two facility types – hospital emergency rooms (ERs) and community clinics and health centers (CCHCs) – outshine others in terms of positive momentum on quality. Users of ERs and CCHCs are more likely to report that their care has improved in the time they've been a patient there; 34 and 32 percent, respectively, say so, compared with 22 percent in other facilities.

care: improved



influence of doctors

Among the nearly six in 10 poor and near-poor Californians who have a doctor, 72 percent rate their physician as excellent (51 percent) or very good; 24 percent say their doctor is good, just 3 percent say not so good or poor. Having a personal doctor, especially one that is well-liked, makes a significant difference in satisfaction with care.

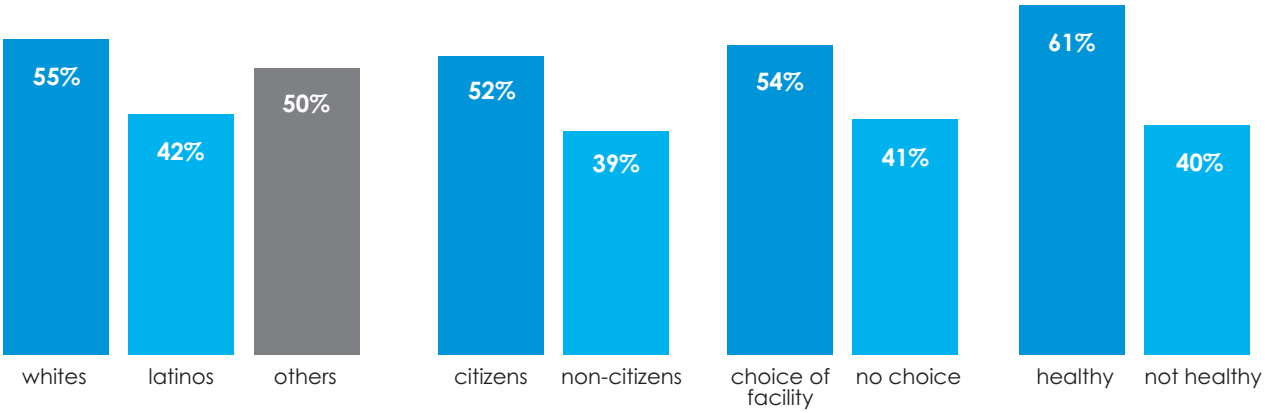
Those who have their own doctor are 13 points more likely than others to give the highest ratings to their overall care (53 vs. 40 percent). And those who don't have a doctor but want one are 16 points less apt to rate their overall care as excellent or very good than are those who neither have nor want a doctor (33 vs. 49 percent, respectively).

But the biggest difference in quality-of-care ratings depend on how patients with a personal doctor rate that physician. Among those who see their doctor as excellent or very good, 66 percent give the same ratings to their care overall. Among those who rate their doctor as just "good" or worse, by contrast, this plummets to 18 percent.

overall care among groups

There are other differences in satisfaction with overall care. Whites are more likely to rate their care as excellent or very good than are Latinos (55 vs. 42 percent), and citizens more so than non-citizens (52 vs. 39 percent). Perhaps in part because whites already are more satisfied, they're less likely to say their care has improved – 16 percent do so, vs. 28 percent of non-whites.

quality of care – excellent or very good



Six in 10 of those in excellent or very good health rate their care positively, declining to 40 percent of those in ill health; the less healthy are also more apt to say their care has gotten worse, 17 percent vs. 6 percent.

Those who have a choice of where they go for care are more satisfied with the care they receive than are those who have no choice, 54 percent vs. 41 percent. And those who say their care has improved are more likely to rate their current care as excellent or very good (61 percent) than are those who say it's stayed about the same (48 percent) or worsened (29 percent).

rating aspects of care

In addition to rating their care overall, respondents rated their healthcare facilities on a range of topics including access, communication and services. Ratings across these specific domains vary substantially. They're highest (54 percent to 59 percent excellent or very good) for the cleanliness and overall appearance of the facility, courtesy and helpfulness of the staff, being welcoming to "people like you," quality of communication with the doctor and convenience of the location.

Ratings are more mid-range, 44 to 50 percent excellent or very good, on a second tier of items including how well staff at the facility understand the patient's medical history, involve the patient in decision-making and accommodate non-English speakers; as well as how much time the doctor spends with the patient, whether patients can see the same doctor on each visit and ease of getting an appointment when needed.

Other measures produce generally lower ratings, 38 to 41 percent excellent or very good, including whether other family members are able to receive care at the same place, affordability, the availability of continuing care for ongoing health problems, and the ability to see a specialist if needed. Facilities perform worst on two other factors: time spent in the waiting room and night or weekend availability.

In another question, just more than half of patients indicate that their facility offers services in addition to regular medical care, such as wellness programs, care for pregnant moms and children, a dentist, a nutritionist and elder care (aspects of the "health care home" concept, see Section VI). There's likewise room for improvement here: Among patients who report having these services available, 52 percent rate the variety of services as excellent or very good.

domain ratings among groups

Differences among groups on individual items tend to parallel differences on ratings of care overall. Whites rate their facilities higher than non-whites in general, and Latinos in particular, on 12 of 17 aspects of care.[2] Citizens are more likely than non-citizens to rate their care positively on 14 of 18 domains. These results, in tandem with the ethnicity and citizenship differences in

overall quality of care, suggest that the health needs of lower-income non-whites in general, and Latinos and non-citizens in particular, are not being met to the same extent as they are for lower-income whites.

As with global ratings, low-income Californians who are in good health rate their facilities much more positively in many areas than do less-healthy respondents. There are exceptions; health status has no impact on ratings of the availability of continuing care, accommodation of non-English speakers, the amount of the time the doctor spends with the patient, the variety of services available and night/weekend availability. That leaves 13 domains that are rated significantly differently depending on the overall health of the patient.

These rating results reinforce the importance of having a well-liked personal doctor. Across nearly every item tested, respondents who have a personal doctor rate their care better than those who don't (even on less-obviously related aspects of care, such as cleanliness and convenience). And those who have a highly rated personal doctor rate individual areas of care significantly higher than those who see their personal doctor as only good, fair or poor. Indeed having a less-than well-rated doctor is often no better, and sometimes worse, than having no doctor at all.

comparing facility types

In addition to receiving the most positive ratings on overall care, private doctors' offices and Kaiser Permanente also fare best, on average, on the 18 specific aspects of care rated. Nonetheless, patterns in specific ratings illuminate areas in which different types of facilities excel, or struggle (see table on pg 25).

Private doctors' offices, for example, score best on the ability to see the same doctor each time and on being welcoming to "people like you" – more than two-thirds of their patients rate them as excellent or very good on these items, higher than any other facility type. (Patients in these offices disproportionately are whites, citizens, better-off and insured.) Still, while private doctors' offices outperform other facilities on most items, they do no better on some – such as affordability, on which they're matched by CCHCs, and the availability of night/weekend hours.

Kaiser Permanente, for its part, excels on "cleanliness and appearance of the office" – more than three-quarters of Kaiser Permanente patients rate their facility as excellent or very good on this domain, compared with 56 percent across other facility types. Kaiser Permanente also is rated higher than others on availability of appointments (65 percent positive vs. 41 percent across other facilities) and the ability of family members to receive care there (59 vs. 38 percent among others).

Community clinics and health centers and private doctors' offices share top billing on one element, affordability. Forty-eight percent of CCHC users rate the affordability of their care as excellent or very good, as do 45 percent of private doctor's office patients (who disproportionately are

privately insured). Affordability is highly rated by fewer non-CCHC clinic patients (37 percent), emergency room patients (34 percent) and Kaiser Permanente customers (31 percent).

excellent or very good ratings[3]

	Total	All clinics	CCHCs	Other clinics	Private doctor	Kaiser Permanente	E.R.
Cleanliness	59%	52%	54%	51%	66%	76%	49%
Courtesy	58	49	55	48	68	65	57
Communication	55	50	58	47	66	60	48
Feel welcome	56	48	57	46	69	59	45
Convenience	54	49	48	50	65	59	53
Medical history	50	40	46	39	64	54	53
Involvement	49	41	49	39	64	54	35
Overall care	48	40	45	38	56	55	47
Time with doctor	48	43	51	40	60	55	35
Same doctor	45	36	44	34	69	45	27
Appointment	44	37	37	37	54	65	29
Affordability	41	40	48	37	45	31	34
Family care	41	36	41	34	46	59	30
Continuing care	39	33	41	31	48	47	32
Specialist	38	30	42	26	49	52	28
Wait time	31	23	33	20	47	35	15
Night/weekend hours	20	17	19	16	18	29	35

CCHCs receive notably higher ratings than non-CCHC clinics (including public and private hospital clinics, county or city clinics, privately operated and other clinics) in two areas – the ability to see a specialist (42 percent positive vs. 26 percent for non-CCHCs), and waiting times (13 points better for CCHCs than for non-CCHCs clinics). CCHCs are slightly better-rated in other areas as well – communication and time spent with a doctor, and how welcome patients feel.

five critical factors

As noted above, the variables described in this section were combined in a statistical model predicting overall ratings of care on the basis of facility ratings across individual dimensions, with demographics and health status included as control variables (see Appendix B). This approach illuminates specific areas on which healthcare facilities might focus if they wish to improve overall patient satisfaction.

The analysis suggests that courtesy of staff, patient involvement in medical decisions, cleanliness of facility and the amount of time a doctor spends with the patient are the individual aspects of care that most contribute to overall quality-of-care ratings. It also confirms the influence of having a well-rated personal doctor on overall satisfaction with care.

While the other 14 areas tested all are significantly related to overall quality-of-care ratings, they have much less of a unique impact on quality ratings when other ratings are held constant. This suggests that facilities might be best served by focusing on these five critical aspects of care.

Top predictors of quality-of-care ratings:

- Courtesy of staff
- Patient involvement in medical decisions
- Cleanliness of facility
- Amount of time a doctor spends with the patient
- Highly regarded personal doctor

different facilities, different factors

As noted in Section I, different facilities tend to serve somewhat different populations, to which different elements of care may be more or less important. That means that the most influential aspects of care may differ by facility type.

To test this possibility, regression analyses were conducted for each of these facility types: Kaiser Permanente, private doctors' offices, community clinics and health centers and all other clinic types combined.[4] And indeed there are differences.

Quality-of-care ratings by CCHC patients mainly are driven by two factors: how knowledgeable the doctor and staff are about their patients' medical histories, and ratings of the availability of a specialist. Again, that's not to say that the other 16 aspects of care measured in this survey don't matter; in fact all of them significantly correlate with overall quality-of-care ratings. Rather it's that all else equal, being knowledgeable about patients' medical histories and being able to see a specialist when needed set better CCHCs apart in the views of low-income CCHC patients.

For non-CCHCs (including public and private hospital clinics, county or city clinics and private clinics), amount of time spent with the doctor, courtesy of the staff, cleanliness of the facility and amount of time spent in the waiting room are all significant independent predictors of overall quality of care.

For Kaiser Permanente patients, overall ratings of care are most influenced by involvement in medical decisions, and wanting a personal doctor (a negative predictor). For private doctor's office patients, cleanliness of the facility, the doctor's communication with patients and personal physician ratings all significantly contribute to overall satisfaction with care.

Another factor is the amount of room for improvement. Many facilities have less room to improve in better-rated areas, such as cleanliness and courtesy, than they have in some others, such as waiting times. With every factor having some importance, facilities need to calibrate these findings to their own customers, and their existing strengths and weaknesses.

It should be noted, too, that these are current care ratings. Drivers of interest in switching to a new facility for future care are covered in Sections IV and V.

endnotes

1 In a test of this same question among all Americans, 55 percent rated the health care they receive as "excellent" or "very good," 7 points higher than the rating among low-income Californians. This peaked among better-off Americans, at 71 percent of those with household incomes more than $75,000 a year; and among those age 55 and up. The question was included in a national SSRS omnibus survey from June 3-6, 2011, among 893 respondents.

2 Facilities were rated on their "ability to speak with you in the language you prefer" only among respondents who don't mainly speak English at home. Whites and Latinos cannot be compared on this item.

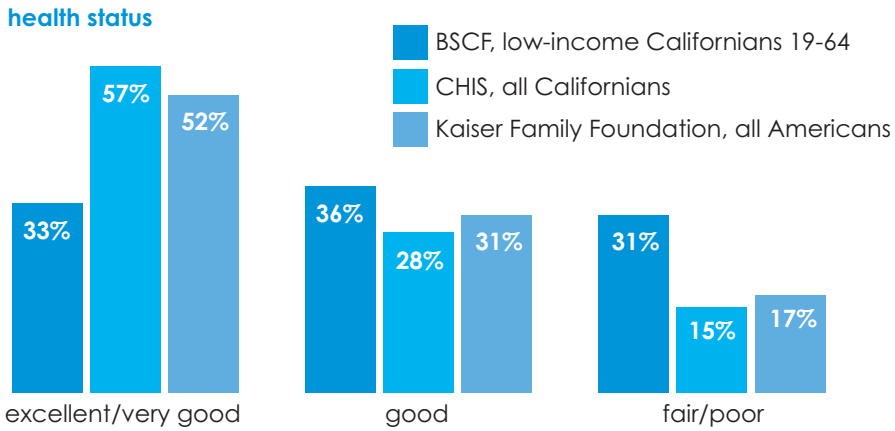
3 "Ability to speak with you in the language you prefer" and "ratings of the variety of services available" were omitted from this table given small sample sizes in some facility types. See Appendix C, questions 15-17, for full wording of items.

4 The sample of hospital emergency room users was too small for meaningful inclusion in these models.

section iii: health status

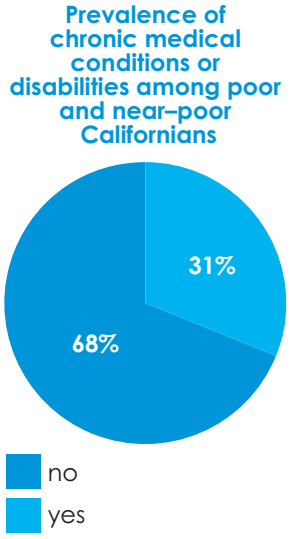
Low income-Californians under age 65 are a health-stressed population: Three in 10 report a disability or chronic condition that requires ongoing care, and ratings of their own health seriously lag those of the state and national populations overall.

Two-thirds of the state's poor or near-poor residents say their health is "good" or worse; just one in three is in excellent or very good health, about 20 points fewer than in state or national studies of the general population.[1] That's especially striking given that this survey excluded seniors.



Race, income and other socioeconomic measures play a role. Health status is lower among groups such as the poorest low-income Californians, the unemployed, Medi-Cal users, African Americans and Latinos. Among the examples:

- Four in 10 not healthy respondents report household incomes of less than $15,000 a year, compared with just a quarter of healthy respondents.
- More than 60 percent of healthy respondents are employed (33 percent full-time), while just 38 percent of respondents in ill health have a job, and only a quarter work full-time.
- Among Latinos and African Americans, just 27 percent rate their health as excellent or very good, compared with 41 percent of whites, Asians and others.
- Over half of those who rate their health as excellent or very good have at least some college education. That falls to a quarter of those who are unhealthy.



- Just two in 10 Medi-Cal patients say they're in excellent or very good health, compared to a third of those without insurance and 43 percent of low-income Californians with private insurance.

The differences are important given the dramatic variation in health services usage by health status. People with chronic conditions or disabilities who've seen a doctor in the past year have done so, on average, more than three times more often than those without such a condition, 9.9 times vs. 2.8 (the medians are five visits vs. two).[2]

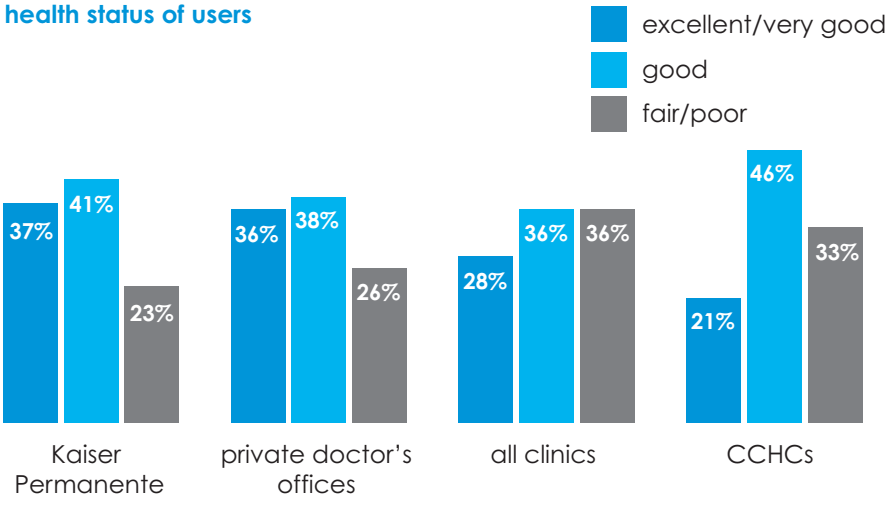
Similarly, those in excellent or very good health have seen a doctor in the past year an average of 3.3 times; those in good health, 4.2 times. But among those in fair health this jumps to an average of 6.2 times, and among those in poor health it rises to 13.3 doctor visits in the past year. The medians are two, two, three and eight visits, respectively.

Again given their socioeconomic status, the challenge of serving this higher-use, unhealthy population does not fall evenly across facilities. Among patients in excellent or very good health, 38 percent use clinics as opposed to other facility types (this encompasses all clinic types, including community clinics and health centers, public hospital, county or city, private and other clinics). Among those in ill health, by contrast, 52 percent identify themselves as clinic users.

Evaluating these results another way, within the state's poor-and near-poor population under age 65, patients in the top two health-status categories outnumber less-healthy ones by 14 points among users of the Kaiser Permanente system and by 10 points among those who see private doctors. But less-healthy patients outnumber the healthiest ones by 8 points among clinic users.

As the chart shows, patients in excellent or very good health are particularly underrepresented among users of community clinics and health centers (CCHCs).

health status of users



As noted in Section II, health and socioeconomic status interact with attitudes about care. Among healthy respondents, six in 10 rate the overall quality of their care positively; that falls to 40 percent of those in ill health ("not so good" or "poor"). Those in ill health also are 11 points more likely to be interested in switching healthcare facilities (62 vs. 51 percent).

Not surprisingly, health ratings decline with age. Nearly half of 19- to 29-year-olds say they're in excellent or very good health, compared with just 18 percent of 50- to 64-year-olds. And more than half of the oldest group reports a disability or chronic condition, compared with 15 percent of those under 30.

Low-income whites are twice as likely to indicate having a disability or chronic condition as are non-whites, 50 percent vs. 24 percent. One contributing factor is that whites in this population are significantly older than non-whites (their average age is 40.9, compared with non-whites' 36.9). Additionally, whites go to the doctor nearly twice as often, on average, as non-whites (7.4 doctor visits in the last year among whites vs. 4.0 among non-whites), and may therefore be more likely to be diagnosed with a chronic condition. And whites in this population are substantially more educated than non-whites, raising the odds they're in the low-income group as a result of illness or disability, rather than as a result of income restrictions related to educational attainment.

Overall, these results underscore the challenges faced by facilities seeking to meet the healthcare needs of poor and near-poor Californians. Despite being in poorer health than all Californians and all Americans, low-income Californians are no more apt to obtain health care: Thirty-four percent have seen a doctor once or less in the past year, in line with statewide and national full-population estimates.[3] Combined, these results suggest that substantial work remains in overcoming the barriers preventing low-income Californians from obtaining the health care they need.

Despite being in poorer health than all Californians and all Americans, low-income Californians are no more apt to obtain health care.

endnotes

1 In a Kaiser Family Foundation survey of the full U.S. population (2011), 52 percent reported excellent or very good health, 31 percent good, 17 percent fair or poor. In the California Health Interview Survey (2009) of the general public statewide, 57 percent rated their health as excellent or very good, 28 percent good and 15 percent fair or poor. (CHIS results for low-income Californians age 19-64 closely resemble those reported here.)

2 Means were skewed by two respondents who indicated they had been to the doctor more than 200 times in the past year. These responses were removed from the calculation.

3 In a Kaiser Family Foundation survey of the full U.S. population (2008), 31 percent reported seeing a doctor once or less in the past year; in the California Health Interview Survey (2009), sampling the general public statewide, it was 37 percent.

section iv: interest in alternatives

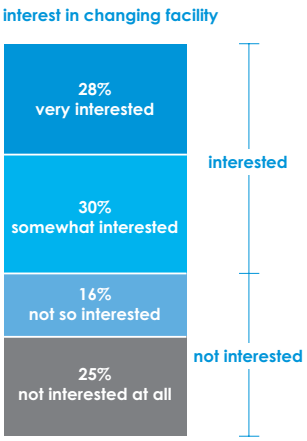
Should they act, enough low-income Californians are open to changing their place of care to produce dramatic shifts in the healthcare landscape. This section examines the sources of their interest in change; the next looks at factors likeliest to inform where they might go.

As noted in the Executive Summary, a substantial 58 percent express interest in changing facilities if they had the insurance to do so, with 28 percent very interested. Forty-one percent are not so interested, or not interested at all.

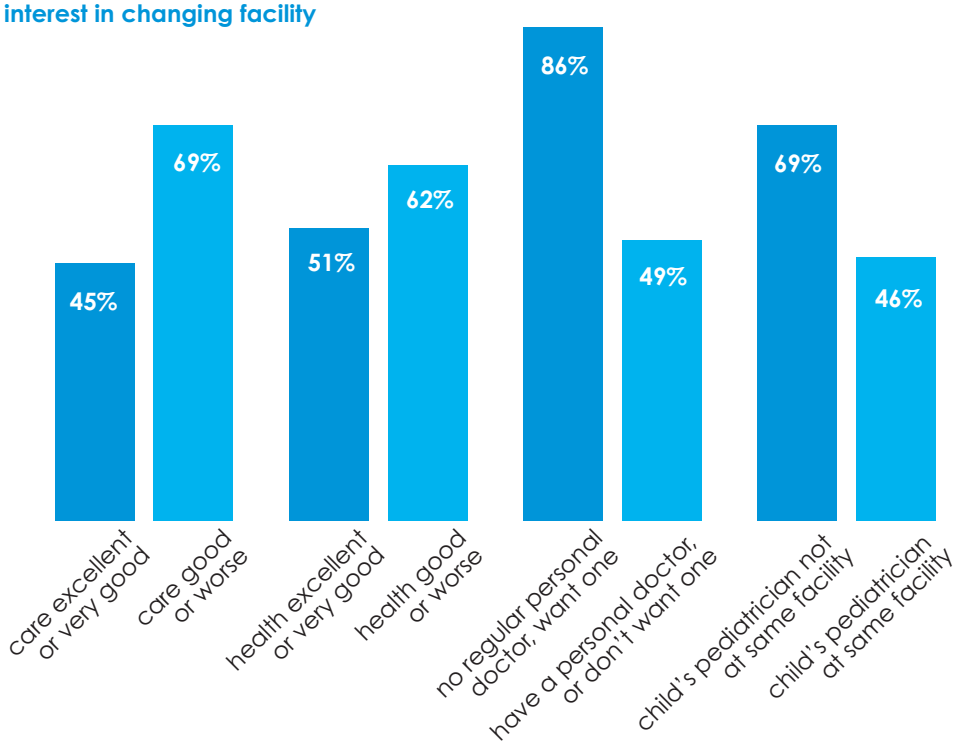
Overall quality-of-care ratings are a strong factor in interest in change, as are ratings of specific care items – a challenge, since many low-income Californians are less than fully satisfied with their current care (see Section II). Health status (Section III) matters as well, with less-healthy patients more interested in change. And a personal doctor is a strong anchor; patients who want but currently lack a regular doctor are especially apt to express interest in moving on, while those who have a well-liked doctor are much less interested in making a move.

Among low-income Californians who rate their care as excellent or very good, 45 percent are interested in a new facility; but among those who rate their care less positively this jumps to 69 percent. Likewise, interest in change is 17 points higher among those who say their care has gotten worse vs. those who say it's stayed the same or improved, 72 percent vs. 55 percent.

In terms of health status, 62 percent of those who say they're only in good, not so good or poor health are interested in changing facilities; interest in change drops, albeit to a still-substantial 51 percent, among those in excellent or very good health. Those with the worst health status, poor, are especially likely to be "very" interested in new alternatives for care, 38 percent vs. 27 percent of those in better-than-poor health.



factors associated with interest in changing facility



Absence of a personal doctor has an especially strong impact on interest in change. Among the more than two in 10 who don't have a regular personal doctor but want one, 86 percent express interest in finding a new care facility (53 percent "very" interested). That's nearly 40 points higher than the interest in change among those who have a regular doctor, or neither have nor want one.

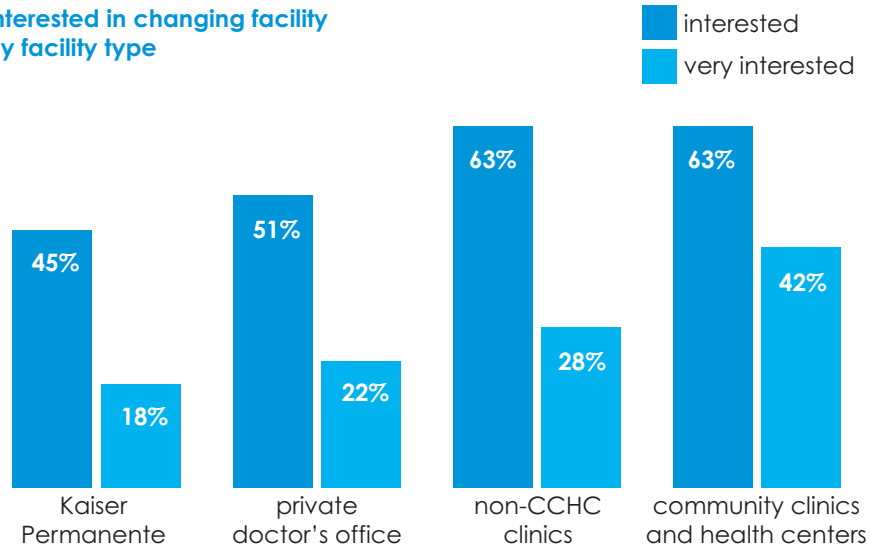
Interest in change also is much higher among parents whose children don't have a pediatrician at the same facility as theirs, vs. parents with a pediatrician at the same facility, 69 percent vs. 46 percent.

loyalty and opportunity for choice

The type of facility also plays a role. In addition to being best rated for quality of care (Section II), Kaiser Permanente and private doctor's offices have the most loyal patients. Fewer than half say they're interested in going to a different place; that compares with 64 percent of clinic and emergency room patients. Indeed a third of Kaiser Permanente and private doctor's office patients alike would not even consider looking for a new facility; that falls to only two in 10 of those who currently use clinics or emergency rooms for their care.

Community clinics and health centers (CCHCs) have a particular loyalty challenge: Forty-two percent of their patients are "very" interested in changing facilities, significantly more than at Kaiser Permanente, private doctor's offices and non-CCHC clinics alike (24 percent). CCHCs, as noted below, also suffer from a significant image problem more generally.

interested in changing facility by facility type



One motivating factor for some clinic patients is to leave the clinic model entirely. Among clinic patients (including CCHC, hospital, county or city, private and other clinics alike) who are interested in change, more than half, 56 percent, say that if they were to switch facilities they'd look for non-clinic care. Thirty-eight percent would stick with a clinic, just a different one.

Naturally, those who currently have no choice of where they go for health care are particularly eager to seek out alternatives; 67 percent are interested in change. Nonetheless, even among those who do have a choice of facility, 51 percent express interest in a new one.

In addition, low-income Californians with no insurance are the most interested in moving to a new healthcare facility (the question posited that they would have insurance to cover it), at 73 percent, followed by those with government-sponsored insurance, 57 percent. Respondents with private insurance express the least interest in looking around, but still 47 percent do.

These results on no-choice and uninsured patients, it should be noted, represent more pressing challenges for clinics, since they serve a higher percentage of these patients.

factors

Respondents rated factors that were most important to them in choosing a new facility – cost, the ability to see the same doctor each time, a short waiting time, or the convenience of the location (see Section V for a full discussion). Those who prioritize cost or the ability to see the same doctor are more motivated to change facilities than are those who cite waiting times and convenience as chief concerns, 63 percent vs. 48 percent.

In addition, those who express interest in the "health care home" model of care (Section VI) are nearly twice as motivated to leave their current facility as are those who aren't interested, 63 percent vs. 33 percent.

There also are a few demographic differences in interest in changing facilities. Low-income Californians under 40 are more interested in looking around than are those over 40 (62 percent vs. 52 percent), while retired respondents are much less interested in changing healthcare facilities than are all others, 29 percent vs. 59 percent.

modeling interest in changing facilities

Statistical modeling (detailed in Appendix B) parses out the strongest factors in predicting a desire to change healthcare facility. Wanting but not having a personal doctor and satisfaction with current quality of care are the strongest predictors – but there are other independent factors as well. Going to a facility where the quality of care has deteriorated and having no current choice of facility both predict greater interest in change. Additionally, being older, having no job and having private insurance all independently predict less interest in switching facilities.

Top predictors of interest in change:

- Lack a personal doctor and want one
- Lower ratings of current care
- No insurance or government-financed insurance
- Younger
- Employed
- No choice of facility
- Deteriorating care

a challenge for CCHCs

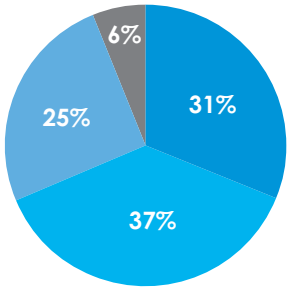
Particular challenges confront California's community clinics and health centers. In addition to weaker loyalty among their patients (as described above), CCHCs have a broader image problem: Just 31 percent of poor and near-poor Californians see these facilities as having an excellent or very good reputation.

Of the rest, 37 percent rate the reputation of CCHCs as good – not a negative assessment, but neither a particularly positive one. Twenty-five percent rate the reputation of CCHCs outright negatively, as not so good or poor. If unaddressed, these results suggest difficulty attracting new patients in the future.

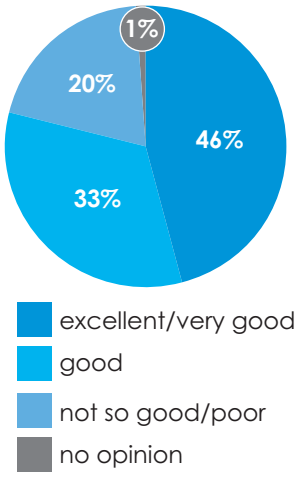
CCHCs do better reputationally among their own patients, but, at 46 percent excellent or very good, there is still considerable room for improvement. There is little variation among most other groups in ratings of the reputation of CCHCs.

reputation of community clinics and health centers

among all



among CCHC patients



willingness to recommend

While ratings of health facilities serving the poor and near-poor are not strongly positive, it should be noted that they're not deeply negative, either. Indeed they're good enough to produce substantial recommendation scores: Concerns aside, eight in 10 low-income Californians are willing to recommend their current facility to friends, with 56 percent "very likely" to do so.

Concerns aside, eight in 10 low-income Californians are willing to recommend their current facility to friends.

This broad willingness to recommend suggests these facilities are meeting acceptable standards for care, and perhaps especially, cost. At the same time, it looks like a relatively low threshold – a reflection of adequacy rather than of loyalty. Even among those who are most interested in change, nearly seven in 10 would recommend their current facility. And among respondents who rate their care as less than very good, three-quarters would recommend it to their peers nonetheless, suggesting that other factors, such as cost and convenience, are at play.

Unlike overall satisfaction and interest in changing facilities, willingness to recommend one's facility does not differ by facility type. Nor does it differ by insurance status, and does so only slightly among those who do and don't have a choice of facility.

While willingness to recommend is high across groups, there are some differences. A regression model (see Appendix B) finds that the strongest predictors of willingness to recommend one's current facility are an index of the facility's performance ratings, the impression that care has deteriorated (a negative predictor), citizenship and education.

section v: levers of change

Cost, continuity, ease of access and clear communication are prime levers for change in low-income Californians' potential choice of a future healthcare facility, with each of these outstripping other considerations in importance ratings.

Respondents to this survey were asked a set of questions gauging the factors of greatest concern if they were choosing a new place for care. In sum, it finds more want a healthcare facility that is affordable, with sufficient appointment slots and walk-in services, where they can receive care from the same doctor, one who both explains and listens well.

Each of these corresponds to aspects of care – overall concerns, convenience, services, the doctor-patient relationship and cultural sensitivity – likely to inform ultimate decision-making. Among the items offered, the following priorities emerged, albeit with significant differences among population groups:

- Overall: When selecting the single most important factor in choice of a new facility, cost and the ability to see the same doctor each time rank about evenly, trumping convenience and short waiting times.

- Aspects of convenience: Ability to get an appointment is the highest convenience-related priority, followed closely by availability of walk-in services. Night and weekend hours are a lesser concern.

- Services: Continuing care for long-term problems ranks as the most important service; wellness programs and whether or not other family members can go there, less so.

- Doctor-patient relationships: The quality of a doctor's explanations is more important than his or her willingness to take a patient's opinions and concerns into account (a somewhat challenging result vis-à-vis one principle of patient-centered care, see Section VI). Time spent with the patient is a lower priority in selecting a new provider, although it is a significant independent predictor of current quality-of-care ratings (see Section II).

- Background: Relatively few say it's important that their healthcare facility cater to people of their own background; 79 percent say this doesn't matter much to them, and just 8 percent feel "strongly" that it's important.

Those interested in change are more likely to prioritize cost, doctors' explanatory skills and the availability of a variety of services.

This is a challenging enough set of criteria for any health facility to satisfy; the task is further complicated by differences among groups. Perhaps surprisingly, cost is a bigger concern for the near-poor compared with the poor (a result partly explained by Medi-Cal coverage). And Latinos and whites have consistent differences in preferences, suggesting the need for a varying focus depending on community composition.

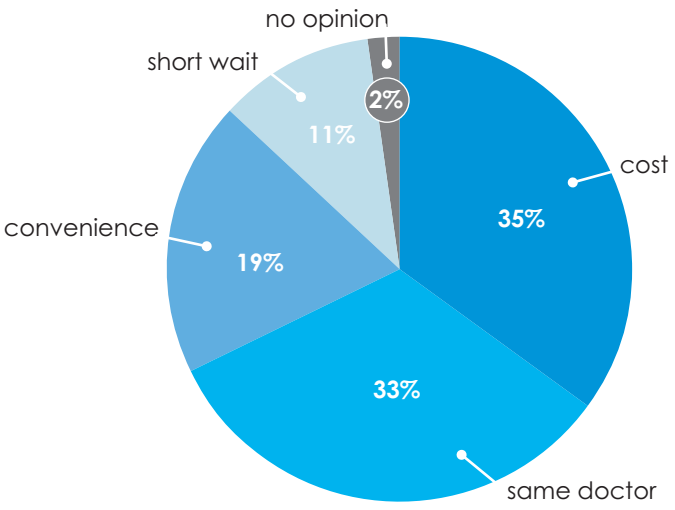
Priorities are somewhat different among those most interested in changing facilities compared with those who are not so interested in finding a new place for care. Those interested in change are more likely to prioritize cost, doctors' explanatory skills and the availability of a variety of services under one roof (e.g., dental care, elder care and care for pregnant women and children). Given that these are the people most likely to switch facilities if the opportunity arises, their priorities may be of particular interest to healthcare facilities seeking to attract new patients.

a new place for care: chief concerns

Cost, while clearly important, is not paramount in choosing a new facility. Given a list of four factors, about as many cite "the ability to see the same doctor each time" (33 percent) as say cost would be their main concern (35 percent). And slightly more pick the "same doctor" option as their 1st, 2nd or 3rd priority, 83 percent, as select cost, 78 percent. The two other options tested, convenience and short waiting times, rank well behind in importance.

Cost is a greater concern for those who are interested in changing facilities vs. those who aren't interested in looking around, 41 vs. 27 percent. Cost also is a greater priority in some other groups: Those without insurance (50 percent), young people (42 percent among 19- to 29-year-olds) and people who feel they have no choice in a facility (42 percent) all have a higher-than-average focus on cost. Focus on cost also peaks among those who use Kaiser Permanente facilities (50 percent) and community clinics and health centers (CCHCs), 42 percent.

most important in choosing new facility



Cost more often is cited as a concern among those with household incomes more than $30,000 a year – 45 percent say it would be the most important factor in their choice of a new facility, compared with 33 percent of lower-income Californians who say the same. Part of this could be explained by Medi-Cal coverage, which is much more prevalent among the poorest group, thus alleviating some of their cost sensitivity. Indeed, only a quarter of Medi-Cal patients mention cost as their top priority, instead nearly four in 10 are concerned with the ability to see the same doctor each time.

Emphasis on continuity with the same doctor also increases with age – 40 percent in the oldest group (age 50-64) call it the most important factor, compared with 23 percent of the youngest (age 19-29). Patients in private doctors' offices are more likely to prioritize seeing the same doctor each time than are those in CCHCs (40 vs. 21 percent), as are those who currently have a personal doctor (38 percent vs. 27 percent of those who don't have their own doctor). This suggests that those who currently have a doctor-patient relationship are motivated to keep it in the future. (Additionally, those with a private doctor or who go to a private doctor's office are more likely to have insurance, so less likely to have to worry about cost.)

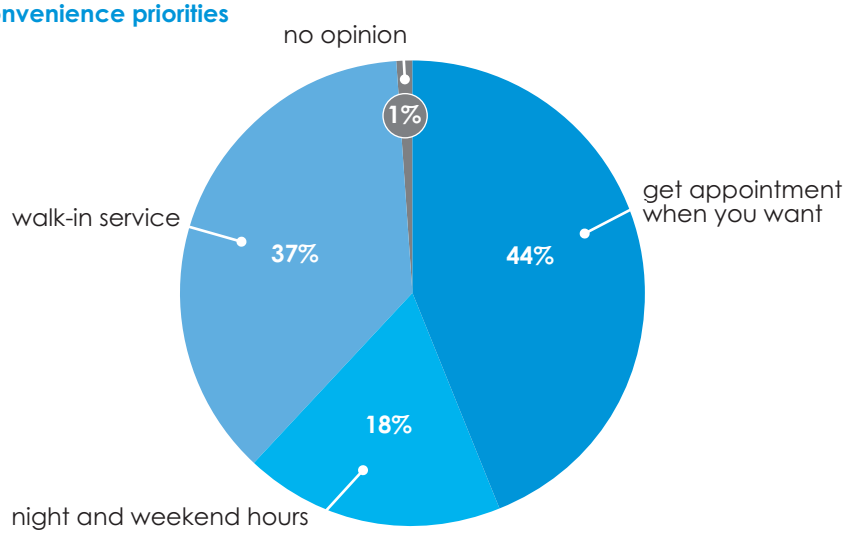
Perhaps for similar reasons, whites also place greater relative emphasis on seeing the same doctor when choosing a new place, with an 11-point gap vs. Latinos. Views among those of other racial and ethnic groups fall in between the two.

While fewer than one in five mentions convenience as their primary concern when choosing a new facility, those who go to the doctor most often (five times or more in the past year) are more likely to prioritize this concern than are those who have been one time or fewer in the past year, 24 percent vs. 13 percent. In addition, those who aren't so interested in switching their facility are more likely to stress convenience than those who are interested in switching, 25 percent vs. 15 percent.

aspects of convenience

Aspects of convenience were measured in a separate question. Forty-four percent cite the ability to get an appointment when they want one as the most important convenience factor in choosing a new place for care, followed closely by walk-in services (37 percent). Fewer, 18 percent, choose night and weekend hours as their greatest access priority.

convenience priorities



Unlike overall priorities, convenience priorities do not differ among those interested in changing facilities. Latinos and non-citizens, however, have different priorities in this area than do whites and citizens. Latinos prioritize the availability of walk-in services more than do whites (43 percent vs. 26 percent), as do non-citizens compared with citizens (45 percent vs. 32 percent). The opposite holds for the priority of getting an appointment when desired. Views among those of other racial and ethnic groups again fall in between the two.

Men are more interested in finding a facility that has walk-in hours than are women, 42 percent vs. 33 percent; and those with less than a high school education are more interested in these services than are those with more education (45 percent vs. 32 percent). More than half of respondents age 50 and over prioritize the ability to get an appointment when needed, compared with 41 percent among other age groups.

People with minor children at home are less concerned than others with the ability to get an appointment when they want one (38 percent vs. 49 percent), and somewhat more concerned with the availability of walk-in services (42 percent vs. 33 percent).

Results on convenience present challenges for facilities, e.g. in balancing patients' desires for timely appointments with accommodation for walk-ins; accommodating the former may be a more traditional role for private doctors' offices, the latter, for clinics. Patients, though, divide in their preference, suggesting that facilities should seek, as possible, to provide both.

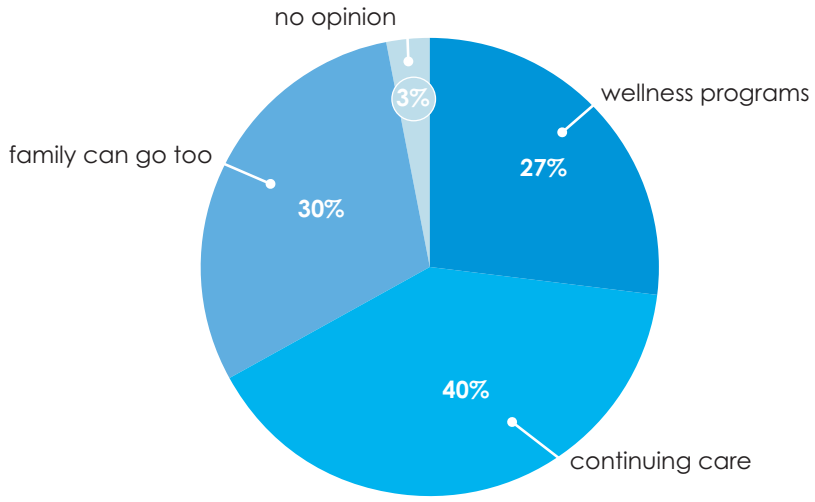
additional services

More than six in 10 say it would be extremely or very important to them when picking a new healthcare facility that it offers a variety of additional services beyond medical care, such as wellness programs, continuing care for ongoing medical problems and care for children and pregnant women (see Section VI for details). That rises to nearly seven in 10 among those who are most interested in finding a new healthcare facility, compared with 56 percent of those who are less interested in alternatives for their care.

When asked a specific want-list for additional services, the availability of continuing care tops the ratings, followed, about evenly, by whether other family members can go to the same facility, and the availability of wellness programs. The pattern is nearly identical among those who are most interested in change.

These results raise the challenge of balancing patients' desires for timely appointments with their interest in accommodation for walk-ins.

priorities for extra services



Life stage is one important factor in these concerns. Wellness programs are relatively more important for people in their 30s (12 points higher than in other age groups), while continuing care is relatively more important for those 40 and older (nearly half pick it, 16 points more than in younger groups). It's sensible; people approaching their middle-age years are more concerned with information on maintaining good health, while their elders think more about managing ongoing and long-term health problems.

Poor and near-poor Californians who are married, and those with children at home, emphasize the ability of other family members to get care at the same facility (14 and 12 points higher than in other groups, respectively), and tend to deprioritize continuing care.

Understandably, those with chronic conditions are much more focused on the availability of continuing care – they are 22 points more apt to say it's their highest priority than those without chronic conditions. Likewise, more than half of those in poor health prioritize continuing care, compared with 39 percent of those in excellent or very good health.

Among other groups, Latinos and non-citizens are more focused than whites and citizens on wellness programs, and less concerned with continuing care.

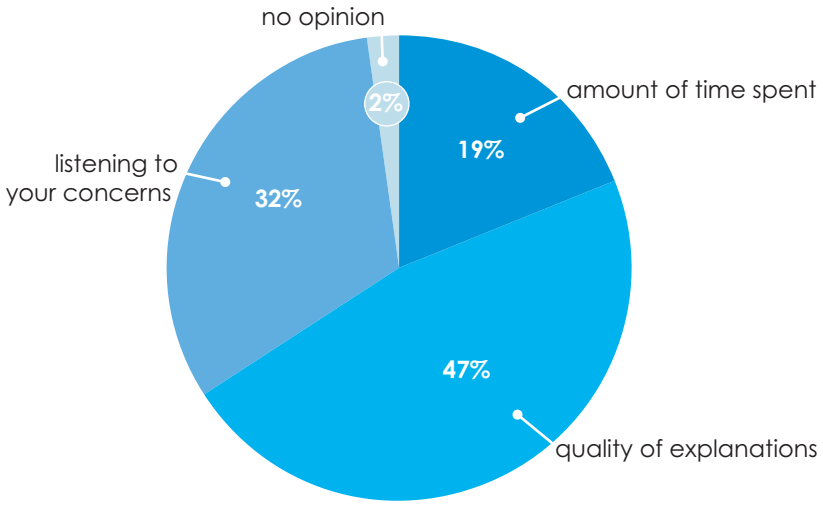
The leading attribute in a doctor: One who explains things well.

the doctor-patient relationship

Doctors are a critical component of healthcare delivery, but what kind of doctor? The leading answer, for this population overall, and especially for those most interested in changing healthcare facilities: One who explains things well.

A plurality prioritizes a doctor's ability to explain things (47 percent) over one who takes their opinions and concerns into account (32 percent). Fewer, two in 10, say that the amount of time the doctor spends with them is most important.

priorities in doctor-patient relationship



This doesn't mean most patients don't want their own voices heard; in another result, 59 percent say they'd like an equal say in their healthcare decisions (see Section VI), and the amount of time the doctor spends with a patient is a predictor of current quality-of-care ratings (see Section II). But when pitted against a doctor's ability to communicate, the latter prevails.

Preference for a doctor who can explain things well peaks among non-citizens (55 percent, 13 points more than it is among citizens), those who mainly speak a language other than English at home (54 percent, 13 points higher than it is among those who speak English at home), Latinos (53 percent, 17 points more than it is among whites), and the least educated (55 percent, 12 points more than among others).

As noted, people who are interested in changing facilities are more likely to prioritize a doctor's ability to explain things (51 vs. 41 percent) and relatively less likely to stress the amount of time the doctor spends with them (15 vs. 25 percent), compared with people who are not interested in change. Doctors who can communicate clearly likely will be an asset for facilities seeking to attract new patients.

Again there are differences among groups. Having a doctor who listens well and who takes the patients' concerns into consideration, for example, are relatively more important for citizens, whites and those with more education.

In another difference, community clinic and health center users differ from non-CCHC clinic patients in their preferences regarding doctors. (Non-CCHC refers to patients of any clinic type other than CCHCs.) CCHC users are less concerned than patients at other types of clinics with the amount of time the doctor spends with them (11 vs. 25 percent), and more concerned with having a doctor who takes their opinions into account (41 vs. 24 percent). In these the concerns of CCHC patients are much more in line with Kaiser Permanente and private doctor's office patients.

similar background?

Finally, as noted above, eight in 10 say it "doesn't matter much" to them whether they go to a healthcare facility that "has a focus on serving people of similar backgrounds as your own." Nine out of 10 non-Latinos say it doesn't matter, as do fewer but still 72 percent of Latinos. Similarly, 87 percent of citizens aren't concerned about a facility that focuses on serving those of similar backgrounds; this declines among non-citizens, albeit to a still-sizable 68 percent.

Part of this – but not a lot – relates to services already being provided. People who rate their facility positively for making people like them feel welcome are 15 points less apt than those who rate their facility negatively on this domain to say that a focus on serving people of similar backgrounds matters. That could help CCHCs, since, as noted in Section II, they do somewhat better than other clinics in this rating. Nonetheless sizable majorities simply don't prioritize this kind of focus.

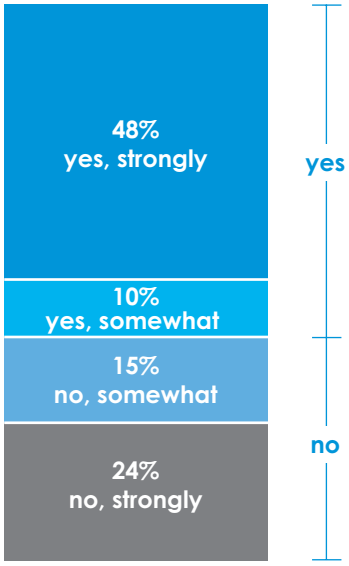
section vi: patient-centered care

Poor and near-poor Californians express substantial interest in two principles that have driven efforts in recent years to reform the delivery of healthcare services: Shared decision-making and the concept of a "health care home." But there's great variation among groups, with the poorest and least-educated far more reluctant to take a strong role in decisions about their care.

These concepts are among the many elements of the movement toward "patient-centered care" (PCC); others, mentioned elsewhere in this report, include items such as quality of communication, knowledge of medical histories and user-friendly services and hours. Shared decision-making is prominent among them – and perhaps surprisingly, this survey finds, not universally desired.

Overall, 58 percent say they'd like an equal say in their healthcare decisions with their doctor or nurse, and most of them, 48 percent overall, feel that way strongly. Nonetheless, a not-insubstantial minority, 39 percent, prefers the more traditional model of leaving care decisions mostly up to health professionals.

want an equal say in health decisions



Other results on patient-centered care underscore those divisions. On one hand, more people prioritize a doctor's ability to explain things (47 percent) over his or her willingness to listen to their opinions and concerns (32 percent, see Section V). On the other, patients' ratings of their

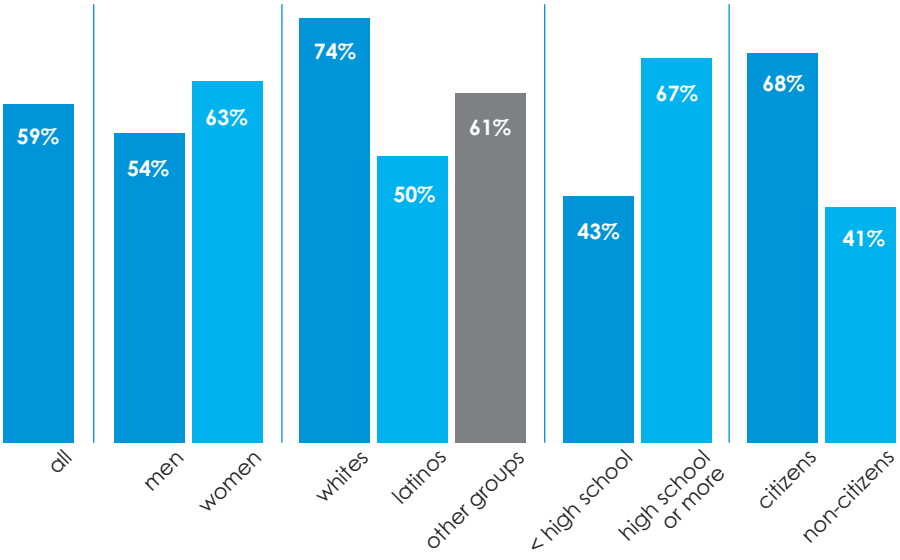
involvement in medical decision-making are a significant, independent predictor of their overall satisfaction with care (Section II). The precept of PCC is important, but not universally shared, a result that suggests a need for adaptability in its presentation.

PCC by group

Among groups, English speakers are much more interested than Spanish speakers in having an equal say in decisions about their health care, 72 percent vs. 44 percent. In related results 74 percent of whites seek an equal say, compared with 50 percent among Latinos (those of other racial and ethnic groups are in between the two) as do 68 percent of citizens vs. 41 percent of non-citizens. Preference for a shared say is higher among those who've gone through high school or beyond, (67 percent, vs. 43 percent among those who lack a high-school diploma); and (more narrowly) among those with incomes more than $15,000 per year vs. the poorest, 62 percent vs. 53 percent.

In another difference, interest in having an equal say in care decisions is higher among women (63 percent) than it is among men (54 percent). This gender gap is especially wide in Los Angeles County, where men are disproportionately uninterested in having an equal say with their doctor in treatment decisions. As noted, having an equal voice is of less interest to poorer patients overall, and compared to others, men in L.A. County have lower incomes.

want an equal say in care decisions



Indeed, among the least educated and non-citizens, majorities prefer to leave the decision-making to the professionals. That underscores the notion that facilities seeking to encourage a patient-centered care approach should calibrate their efforts; the prospect of shared decision-making may well be more intimidating than appealing to substantial segments of the low-income population.

While popular overall, the prospect of shared decision-making may well be more intimidating than appealing to substantial segments of the population.

As covered in Section V, the same pattern emerges when people choose the most important element in their relationship with a doctor – groups such as Latinos, the least educated and non-citizens are more concerned with a doctor's ability to explain things, while women, whites, those with more education and citizens are more interested in having their own concerns heard by their provider.

Majorities of the least educated and non-citizens prefer to leave decision-making to the professionals.

There also is some variation among health status in desire for an equal say in decision-making. Two-thirds of low-income Californians with chronic conditions or disabilities want to have an equal say in their treatment, 9 points higher than among those without such health problems.

Preference for an equal voice differs across facility types. People who go to Kaiser Permanente facilities, private doctor's offices, community clinics and health centers (CCHCs) and emergency rooms (ERs) are more likely to seek an equal say than are those who go to non-CCHC clinics (i.e., hospital, county or city, private or other clinics), 64 percent vs. 48 percent, a 16-point difference. A similar pattern also holds for "strong" desires for an equal say – higher among Kaiser Permanente, private doctor, CCHC and hospital ER users.

a home for care

The concept of a "health care home," proposes that patients are well-served by an array of related services under one roof beyond basic medical care, including, for example, maternity, wellness and elder care services. Support for the principle follows a very different attitudinal profile than do views on shared decision-making. While popular overall, a health care home is particularly attractive to some of the same groups that are more skeptical about taking an equal role in medical decision-making.

Overall, 63 percent of low-income Californians express keen interest in a health care home, calling it extremely or very important in choosing a new facility. That peaks at 76 percent of those with less than a high-school education, 71 percent of non-citizens, 71 percent of Latinos, 71 percent of Medi-Cal patients, 69 percent of the uninsured and 69 percent of those in ill health. Many of those who may have difficulty obtaining services elsewhere are more interested in a health care home.

interest in a health care home

High-interest groups	
Less than high school	76%
Non-citizens	71
Latinos	71
Medi-Cal patients	71
Uninsured	69
Not healthy	69
Lower-interest groups	
Whites	50
College graduates	50
Not interested in change	56
Healthy	57
Have private insurance	59

Interest meanwhile is lowest among whites (50 percent), college graduates (50 percent), those who are in excellent or very good health (57 percent), and those with private insurance (59 percent).

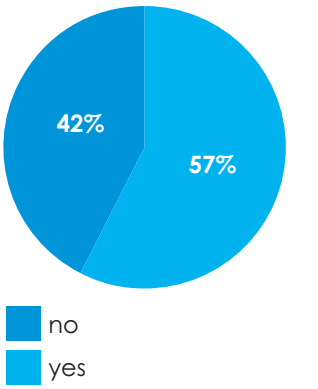
Interest in a health care home is related to whether or not someone already has these services at their facility, and how they rate them. The share of people who say extra services would be extremely or very important in choosing a new place is 17 points higher (72 percent) among those who already use facilities with a variety of services.

Health care homes also are more attractive to people who are dissatisfied with their present situation: Among those who are very or somewhat interested in switching to a new facility, 69 percent say the additional services that comprise a health care home are important, compared with 56 percent of those who are not interested in changing.

Similarly, people who rate their personal doctor less positively are more likely to think additional services are extremely or very important. And interest in a heath care home is higher among people who do not have a personal doctor but want one, compared with those who neither have nor want one (69 vs. 54 percent).

Interest and opportunity for the health-care home concept are there. However, just as PCC is more attractive to some segments of the poor and near-poor population, interest in a health-care home cannot be blanket-marketed to all. Programs will best be tailored and targeted.

interested in reaching doctor by e-mail or text



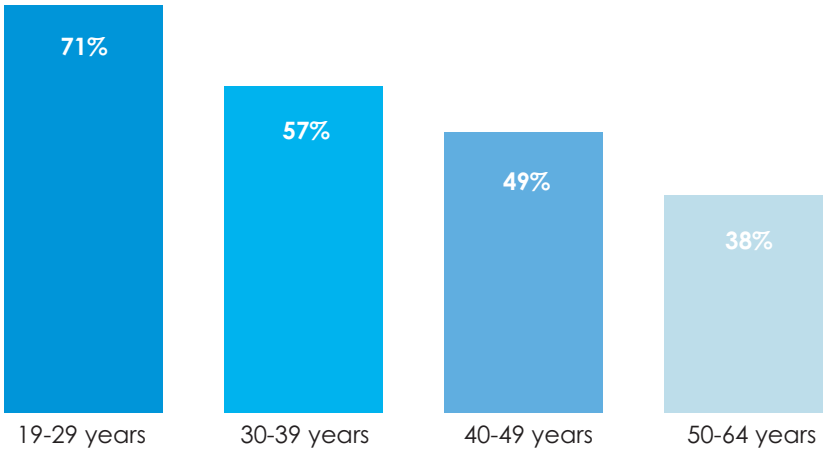
e-mail and texting

There are many other aspects of patient-physician interactions than a strong patient voice in decision-making (see Appendix A for a summary), from quality record-keeping and coordination of medical services to new means of doctor-patient communication. Indeed even in the low-

income population this survey finds that most, 57 percent, are interested in being able to reach their doctor in non-traditional ways, by e-mail or text messaging. A third are very interested.

Not surprisingly, interest is inversely related to age, peaking at 71 percent of 19- to 29-year-olds and bottoming out at 38 percent among 50- to 64-year-olds. This doesn't mean young adults will necessarily be the highest-volume e-mailers and texters, though; since they have far fewer health complaints (see Section III), they'll likely have less to ask about. Rather, it's as they age that these tools may come most prominently into use.

interest in e-mail/text



Alternative ways of communicating with the doctor are another factor that could attract those dissatisfied with their current situation. Interest is higher among people who don't have a personal doctor but would like one, and among those who are inclined to find a different facility; in these groups 66 and 64 percent, respectively, are interested in e-mail and text options. Interest is 20 and 18 points lower among those who lack a personal doctor but don't feel they'd like to have one, and those who are not interested in switching facilities, respectively.

Providing alternative, tech-savvy ways to reach a doctor, then, is a potentially effective approach to attracting some healthcare users. And based on the high interest of young people shown here, reaching the doctor remotely may become an integral aspect of tomorrow's patient-centered care.

section vii: care in los angeles county

Fewer than half of the poor and near-poor residents of Los Angeles County give high marks to their current health care, with particularly low ratings for doctor-patient interactions – a situation that opens the door wide to significant upheaval as the federal Patient Protection and Affordable Care Act (ACA) takes full effect.

Indeed, six in 10 low-income Los Angeles County residents age 19 to 64 are interested in changing their healthcare facility if they had the insurance to do so – coverage that, for many, the ACA will provide. The impact may well be strongest on clinics, given the extent of their use: As is the case statewide, 44 percent in L.A. County currently go to some type of health clinic for their care.[1]

The population earns focus by dint of its concentration: Three in 10 of California's 6.5 million low-income residents age 19 to 64 live in L.A. County, a population density unlike any other in the state. Twenty-six percent, by comparison, live in all of the rest of Southern California, 14 percent in the Bay area and 13 percent in the San Joaquin Valley. And Los Angeles residents differ in some respects from their counterparts elsewhere, attitudinally and demographically – distinctions that are integral to understanding their healthcare concerns and preferences.

Some bottom-line measures are similar to the population as a whole. Forty-five percent of low-income Los Angeles residents rate their overall quality of care as excellent or good, about the same as their counterparts elsewhere in the state. And 61 percent would be interested in changing health care facilities if they had insurance to pay for it, as are 56 percent elsewhere. (The difference is not statistically significant.)

In other key metrics, 44 percent say they currently have no choice where they go for care. About as many lack a regular personal doctor. Fewer than three in 10 say their own health is excellent or very good, far below the health levels reported by the general public in California and nationally.

Despite greater health challenges, health care usage among the poor and near-poor in L.A. County (and in the state as a whole) is not greater than the broader population's, suggesting a pent-up demand for services that may break once their insurance coverage improves. And there's hopeful expectations of what the future may hold: Forty-six percent expect their

coverage or ability to get insurance will get better as a result of the ACA, a more positive reception than health care reform has received among national samples and even among low-income Californians in the rest of the state.

satisfaction and change

A statistical model finds several top independent predictors of overall satisfaction with care for Los Angeles residents – the cleanliness and appearance of their facility, having a well-regarded personal doctor who communicates clearly, having a facility that offers continuing care for ongoing problems and the ability to get an appointment. Each is a critical hurdle in earning patient satisfaction and, as discussed below, healthcare facilities serving low-income residents of L.A. County do particularly poorly on some of these key factors.

Satisfaction matters because of its relationship with loyalty. Among L.A. patients who rate their current care as "excellent" or "very good," 49 percent are interested in changing facilities, but among patients who are less than well-satisfied now, interest in change jumps to 70 percent. Interest in alternatives is high enough among both groups, however, to cause even well-regarded facilities some concern.

If they were to change facilities, a third of Los Angeles County residents say cost would be the main concern when choosing a new place, but another third prioritize being able the see the same doctor each time, and the rest divide among two other factors, the convenience of the facility and short waiting times. These results, similar to those statewide, indicate that cost, while significant, is not the paramount concern once insurance is in place.

attitudinal and demographic differences

In a variety of specific domains, L.A. residents are markedly more negative about their current care than are low-income Californians elsewhere. They are 13 to 18 points less likely to give strongly positive ratings (excellent or very good) to factors such as how well their doctor communicates with them, the amount of time the doctor spends with them, the level of involvement they're given in decisions about their care and basics such as how welcome they feel at their healthcare facility and its cleanliness and appearance.

Specifically, compared with other low-income Californians, residents of L.A. County are:

- Eighteen points less apt to give a strongly positive rating to how well their doctor communicates with them – 43 percent in Los Angeles vs. 61 percent elsewhere.

- Sixteen points less apt to give a strongly positive rating to the amount of time the doctor spends with them – 37 percent in L.A. County vs. 53 percent elsewhere.

- Thirteen points less likely to rate the cleanliness and appearance of their healthcare facility as excellent or very good, 50 percent vs. 63 percent elsewhere.

- Thirteen points less apt to give a strongly positive rating to the amount of involvement they're given in making decisions about their care, 40 vs. 53 percent.

- Again, 13 points less apt to feel strongly that "people like you are welcome there," 47 percent vs. 60 percent in the rest of the state.

- Ten points less positive on their ability to see a specialist, 31 percent vs. 41 percent elsewhere.

- Ten points less positive on the continuing care offered for long-term or chronic conditions, 32 percent in L.A. vs. 42 percent excellent or very good elsewhere.

- Nine points less positive on their current facility's understanding of their medical history, 44 percent vs. 53 percent.

- Nine points less positive on staff courtesy, 52 percent vs. 61 percent elsewhere.

Despite this, as mentioned, L.A. residents do not rate their overall quality of care any differently than low-income residents in the rest of the state. This suggests that L.A. residents may have lower expectations of their healthcare facilities.

There are demographic differences as well. Compared with their counterparts in the rest of the state, low-income L.A. County residents are poorer – 13 points more apt to have incomes under $15,000, 39 percent vs. 26 percent. They're 16 points more likely to be Latino, 64 percent vs. 48 percent; 10 points more likely to be single (which rules out dual incomes); and less educated – 11 points more apt to have less than a high-school education, 42 percent vs. 31 percent. They're also a slight 8 points less likely to report having a disability or chronic condition.

patient-centered care

Their demographic profile informs some additional attitudinal differences. The poor and near-poor in Los Angeles, for example, are 10 points less likely than others in the state to want an equal say with their doctor or nurse in medical decisions, 52 percent vs. 62 percent, and 12 points less apt to "strongly" want an equal say. That's because this central concept of patient-centered care is less popular with Latinos, lower-income and lower-education groups, all more prevalent in Los Angeles than elsewhere.

There's also a much larger gender gap on this issue in Los Angeles than appears elsewhere: Men in the county are disproportionately uninterested in having an equal say with their doctor in treatment decisions. Interest is considerably higher among men elsewhere, and higher among women regardless of their locale.

The likely reason for the difference is that male Los Angeles residents have particularly low incomes and disproportionately lack a high school diploma – two strong factors in diminished interest in having an equal voice in healthcare decisions. These findings suggest that involving patients in their care decisions, while appealing for some, could in fact prove off-putting to others, particularly poor and near-poor men in Los Angeles County.

On the other hand, two-thirds of low-income L.A. County residents are interested in having a variety of health related services under one roof, such as a dentist, nutritionist, and care for pregnant women and children. This idea of having a "health care home" is one that is particularly popular among those who are interested in finding a new healthcare facility – and one that has broad support among Latinos, those with less education, and with lower incomes. Therefore, while not universally desired, facilities emphasizing a health care home approach to care may find particularly strong traction in L.A. County in the coming ACA-inspired future.

endnotes

1 Including community clinics and health centers, public hospital, county or city, private or other clinics. Among non-clinic users, 31 percent report going to a private doctor's office, 11 percent use a Kaiser Permanente facility and 10 percent visit a hospital emergency room when they need care.

section viii: population profile

More than just low-incomes mark poor and near-poor Californians: It's a population with health problems, low education and a disproportionate share of non-citizens – all raising distinct challenges in healthcare delivery.

Californians with household incomes of less than 200 percent of the federal poverty level were interviewed for this survey, with the sample further restricted to those age 19 to 64 to exclude most Medicare-eligible individuals, given their different healthcare profile and access.

Three-quarters in the selected population report household incomes of less than $30,000 a year, including 30 percent with incomes of less than $15,000. (The latter group rises to 39 percent in Los Angeles County.) Statewide six in 10 are at less than 133 percent of the federal poverty level, the threshold for Medi-Cal coverage under the new federal health care law.

The poor and near-poor include a disproportionate number of non-citizens – 35 percent, according to the U.S. Census Bureau's American Community Survey (ACS). Among all 19- to 64-year-olds in the state, by contrast, far fewer, 20 percent, are not U.S. citizens.

Fifty-nine percent in the low-income population have no more than a high school diploma, including 34 percent who haven't completed high school (rising to 42 percent in Los Angeles County). Again that's much higher than the level of non-graduates among all 19- to 64-year-olds in the state, 17 percent.

At the other end of the educational spectrum, while 30 percent have some college experience or an associate's degree, just 11 percent hold a college degree. By contrast, 28 percent of all Californians in this age range have a college degree.

In terms of employment, only about one in three poor and near-poor 19- to 64-year-olds hold full-time jobs; 21 percent work for pay but just part-time. Nearly half are single (33 percent) or divorced, separated or widowed (an additional 15 percent). The largest age group is the youngest – a third are under age 30, with the rest about equally divided in the 30-39, 40-49 and 50-64 categories.

Fifty-three percent of poor and near-poor Californians are Latino, rising to 64 percent in Los Angeles County. Twenty-nine percent of the full sample is white, while 7 and 6 percent are African American and Asian, respectively. Thirty-eight percent of low-income Californians speak mainly Spanish at home; in Los Angeles County, 51 percent.

This survey measured insurance status in a single question, drawn from a 2009 Kaiser Family Foundation survey in New Orleans, that did not go into the granular level of detail used in some other assessments of insurance status. Twenty-nine percent report being uninsured, a lower number than was reported by the California Health Information Survey, which found 40 percent in this population uninsured two years ago. Insurance status questions can produce varied results based on the options they offer, respondents' understanding of those options, and actual variability in insurance status.

Geographically the sample reflects the distribution of the population of low-income Californians aged 19-64 per Census data. The largest proportion – 30 percent – lives in Los Angeles County. An additional quarter lives elsewhere in Southern California, while 14 and 13 percent live in the greater Bay Area and San Joaquin Valley, respectively. Fewer than 6 percent live in each of the three other regions, the central coast, Sacramento, and northern and Sierra counties.

Within these regions, half live in urban centers, 27 percent in smaller cities and 11 percent in suburbs. The remaining 12 percent reside in small towns or rural areas.

As noted elsewhere in this report, low-income Californians have other differentiating characteristics that are related specifically to health care. They are markedly less healthy than others. Yet they are no more likely to obtain care, many lack a doctor-patient relationship, more than four in 10 have no choice of facility now and nearly six in 10 are interested in finding a new healthcare facility if they have the opportunity – as, under the new federal healthcare law, many will.

section ix: methodology

This Blue Shield of California Foundation study was conducted March 29 to April 25, 2011, via telephone interviews with a representative statewide sample of 1,005 Californians age 19 to 64 with family incomes below 200 percent the federal poverty level.[1] The sample was comprised of landline (*n* = 704) and cell phone (*n* = 301) components, with 705 interviews conducted all or mostly in English and 300 conducted in Spanish. The survey was produced, managed and analyzed by **Langer Research Associates** of New York, NY, with sampling, fieldwork and data tabulation by SSRS/Social Science Research Solutions of Media, PA.

sample design

Samples from landline and cell phone telephone exchanges were generated by Marketing Systems Group (MSG). The landline sample was designed to reach the target population as efficiently as possible, accounting for the high-incidence of Latino families within the low-income California population and addressing the regional distribution of low-income households in the state. Three main strata were identified: (1) the *High Latino* stratum, comprised of landline telephone exchanges associated with Census-block groups in which Latinos were at least 57.5 percent of the population; (2) a *High Low-Income* stratum, which consisted of all remaining landline phone numbers whose exchanges were associated with Census-block groups in which more than 40 percent of the population had annual household incomes less than $35,000; and (3) a *Residual* stratum, which included all exchanges other than those in the first two strata. In addition, a separate phone stratum was constructed of all phone numbers associated with households whose records in the infoUSA database indicated there was at least one household resident between the ages of 19 and 64 with household annual income less than $23,000. These numbers were removed from their respective telephone strata and considered a fourth, *Listed Low-Income*, stratum. Thus the four landline strata were mutually exclusive.

Within each of these strata, the sample was broken down by geographical designations: (1) Los Angeles area: phone numbers whose 6-digit NPA-NXX exchange was associated with numbers in the Los Angeles metropolitan statistical area (MSA); (2) San Francisco/San Diego/Sacramento areas: phone numbers whose exchanges were associated with these MSAs (3) Other areas: All remaining California landline exchanges.

Population figures for each of the 12 stratum-by-area sampling cells were estimated through MSG's GENESYS system, and a sampling design was implemented oversampling those cells with an estimated higher incidence of respondents matching the survey criteria for eligibility (that is, family income below 200 percent of the federal poverty level). An initial estimate of the eligible population was created based on the percentage in each one of these cells who, according to the GENESYS data, had an annual household income of less than $35,000.[2] In estimating the size of the eligible population in each cell, two adjustments were made: (1) Correction for the proportion of non-working numbers in the listed sample. Because the size of the unlisted sample in each stratum was calculated as the total population minus the number of listed records, the size of the listed sample in each stratum was decreased by the percentage of non-working numbers found among the listed numbers; and (2) Correction for the cell-phone-only (CPO) population. The initial total estimated number of unlisted households in each stratum included any household that did not have a listed landline number. However, since about a third of the qualifying population was estimated to be CPO, the estimated number of people in each of the unlisted cells was reduced by a third.

Cell phone numbers were not stratified, but generated from all numbers corresponding with California cell phone exchanges. Each record was labeled based on the exchange's geographic affiliation with the three sampling areas used for the landline (LA; SF/SD/Sac; and Other). CPO California residents with non-California phone numbers could not be included.

In Table 1 we compare the (adjusted) estimated population in each of the landline sampling cells and their share among landline interviews. "SF/SAC/SD" (second row) refers to the sample in the San Francisco, Sacramento and San Diego metropolitan statistical areas. Data in the third and fourth columns represent original estimates of the number and percentage of low-income households in the cell. The fifth column represents each cell's share among landline households based on the observed incidence of those meeting survey eligibility.

table 1 – estimated and observed share of low-income households compared with number of interviews, by stratum and area

		Low-Income Households			Interviews	
Stratum	**Area**	**Estimated #**	**Estimated %**	**Observed %**	**%**	**#**
Residual	Los Angeles	804,033	21%	18%	7%	47
Residual	SF/SAC/SD	728,980	19	19	8	59
Residual	Other	277,150	7	7	6	39
High Latino	Los Angeles	243,770	6	11	15	105
High Latino	SF/SAC/SD	20,380	1	1	3	19
High Latino	Other	35,322	1	2	3	20
High Low Income	Los Angeles	369,120	10	10	14	97
High Low Income	SF/SAC/SD	111,931	3	2	2	17
High Low Income	Other	256,080	7	6	9	65
Low Income Listed	Los Angeles	426,118	11	11	14	99
Low Income Listed	SF/SAC/SD	253,434	7	6	9	65
Low Income Listed	Other	283,731	7	8	10	72
Total		**3,810,049**	**100%**	**100%**	**100%**	**704**

Sample numbers were generated within each sampling cell using an *epsem* (equal probability of selection) method from active blocks (area code + exchange + two-digit block number) that contained three or more residential directory listings ("3+ listed RDD sample"). The cellular sample was not list-assisted, but was drawn through a systematic sampling from dedicated wireless 100-blocks and shared service 100-blocks with no directory-listed landline numbers. Following generation, the landline RDD sample was prepared using MSG's GENESYS IDplus procedure, which not only limits sample to non-zero banks, but also identifies and eliminates approximately 90 present of all non-working and business numbers. (At present, there is no capability to scrub such sample or to run it through listed databases.)

field preparations, fielding and data processing

Before the field period SSRS programmed the study into CfMC Computer Assisted Telephone Interviewing (CATI) system. Extensive checking of the program was conducted to assure that skip patterns followed the questionnaire design. The questionnaire was translated into Spanish so respondents could choose to be interviewed in English or Spanish, or to switch between these languages according to their comfort level.

In advance of interviewing, CATI interviewers received formal training on the survey and written materials including an annotated questionnaire containing information about the goals of the study as well as the meaning and pronunciation of key terms. Additional written materials detailed potential obstacles to overcome in obtaining meaningful responses, potential respondent difficulties and strategies for addressing them.

Interviewer training was conducted before the study pretests and immediately before the survey was launched. Call-center supervisors and interviewers were walked through each question in the questionnaire. Interviewers were given instructions to help maximize response rates and ensure accurate data collection. Interviewers were monitored throughout the study and project staff provided feedback to interviewers throughout the survey period.

Three live pretests of the survey instrument and procedures were conducted March 23, March 24 and March 28, 2011. In all, 37 pretest interviews were completed (including 15 in Spanish). Langer Research Associates and Blue Shield of California Foundation representatives monitored the interviewing live, along with SSRS project managers, for approximately two hours each pretest. Additional interviews were digitally recorded and placed on a secure FTP site for review. Several questions were reworded based on pretest results.

The questionnaire screened for eligible households by establishing the respondents' family size and annual family income[3], then selecting only respondents between the ages of 19 to 64 with family incomes lower than 200 percent FPL.[4] In households that were reached by landline, respondents were randomly selected from the age-qualifying household residents, by asking for the male or female (gender chosen at random) with the most recent birthday.

Interviews in the *High Latino* and *Listed Low-Income* strata were initiated by bilingual interviewers. All interviews were conducted using the CATI system, ensuring that questions followed logical skip patterns and that complete dispositions of all call attempts were recorded.

In order to maximize survey response, SSRS enacted the following procedures during the field period:

- Each non-responsive number not already set up with a callback (answering machines, no answers and busies) was called approximately 10 times, varying the times of day and days of the week that callbacks were placed using a programmed differential call rule.
- Interviewers explained the purpose of the study and offered to give the respondent the name of the sponsor at the completion of the interview.
- Respondents were permitted to set the schedule for a return call.
- The study offered reimbursement of $5 for any cell phone respondent who mentioned concerns with the costs of cell phone usage.

- Respondents who initially refused to participate in the survey but were considered 'soft' refusals (respondents who simply hung up the phone, stated the time was bad or indicated a disinterest in participating) were contacted at least once more and offered a $10 participation incentive.

procedures for identifying healthcare facility usage

The survey included a highly detailed effort to identify usage of various types of healthcare facilities. Respondents first were asked if they usually go for health care to a Kaiser Permanente facility, a private doctor's office, a community clinic or health center, a hospital or someplace else. (These options were offered in randomized order, with "someplace else" always last.)

Those who said they have no usual place of care (7 percent) were asked where they last went for care (using the same options listed above), and whether it was in California. Those who said they went for care to a non-professional location (e.g., a relative or friend) were asked where they go for professional care. Verbatim responses were taken for those who said "somewhere else."

Respondents who said they see a doctor were asked if that was a private doctor's office or a doctor at one of the other listed facility types. Respondents who said they use a hospital for care were asked if that was a hospital clinic or a hospital emergency room. If a hospital clinic, they were asked the type of hospital, county or private/religious.

Those who said they use a clinic were asked the clinic's name and location. These were compared with a list of California community clinics and health centers (CCHCs) compiled by the California Primary Care Association and a list of California public hospital clinics compiled by the California Association of Public Hospitals and Health Systems (CAPH).

For clinics not initially matched to the lists, respondents were asked if the clinic was operated by a hospital. If yes, they were asked the type of hospital, county or private/religious. If the clinic was not operated by a hospital, they were asked if it was run by a county/city, or privately.

All clinics that did not match to the CCHC and CAPH lists during the interview were later back-checked to ensure the lack of match wasn't due to a misspelling or the respondent's use of a shortened version of a clinic name. Clinic type was further confirmed for ambiguous codings by Internet searches or, in about 80 cases, by directly calling the clinics named and asking.

Some facilities were not subcategorized, either because the respondent provided insufficient information or because their facility type did not fall into any of the other categories. These were coded, using available information, as "clinic, unspecified," "hospital, unspecified" or "someplace else."

This procedure produced the following breakdown of facility usage: Clinics, 44 percent; private doctors' offices, 28 percent; Kaiser Permanente, 12 percent; and hospital emergency rooms, 10 percent. Remaining categories were hospital, unspecified, 2 percent; someplace else, 2 percent; never have received health care, 2 percent; and no opinion, 1 percent.

Clinics were subcategorized as follows: CCHCs, 11 percent; public hospital clinics, 10 percent; clinic, unspecified, 8 percent; private hospital clinics, 5 percent; county or city clinics, 5 percent; private clinics, 5 percent; and hospital clinic, unknown type, 1 percent.

weighting procedures

A multi-stage weighting design was applied to ensure an accurate representation of the target population. Weighting involved the following stages:

1. Sample Design Correction. In order to correct for over- or undersampling of each of the 12 stratum-by-area landline cells, each landline case was assigned a weight equal to the estimated percentage of the cell among landline-qualifying households divided by the percentage of the cell among completed landline interviews. For example, cases in the *Residual-LA* cell received a weight equal to their estimated share among the low-income households, based on observation (18 percent) divided by their share among the landline interviews (7 percent). Using more exact values, the calculation for the weight for this cell ($W_{resid\text{-}LA}$), is calculated:

$W_{resid\text{-}LA}$ =.18078/.06761=2.67386.

Cell phone design weights were based on the three sampling areas. The estimated share of target cell phone completes was based on the percentage of Cell Phone Only households in each area (i.e., the number of CPO households in each sampling area was estimated to be one third of the unlisted households in the area). The percent of qualifying low-income households was then estimated based on the actual data (qualified households divided by qualified+unqualified). Weights were assigned to each cell phone case equal to the estimated percent of qualifying households in the area divided by the area's percentage of cell phone interviews.

2. Within-household selection correction. This stage corrected for the unequal probabilities caused by some households having more qualified adults than others. Households with a single adult received a weight of 1, whereas households with two or more qualifying adults received a weight of 2. Cases were adjusted so that the sum of this weight totaled the unweighted sample size. Cell phone respondents were given the mean landline weight (1).

The product of these two corrections (design weight and within-household correction) was then calculated as the sampling weight, or baseweight.

3. Post-stratification weighting. With the baseweight applied, the sample was put through iterative proportional fitting (IPF, or 'raking'), in which the sample was balanced to reflect the known distribution of the target population along specific demographic parameters. These parameters were based on the 2009 American Community Survey (ACS) for California, based on residents ages 19 to 64 and members of families who are below 200 percent FPL. In addition, a balancing target was set for the CPO population, based on an estimate provided by Dr. Stephen Blumberg of the Centers for Disease Control and Prevention, a leading CPO researcher.

The weighting parameters used were: age (18-29; 30-39; 40-49; 50-64), education (less than high school; high school; some college; college or more); race (white non-Latino; African American non-Latino; other non-Latino and Latino), gender by Latino status (i.e. Latino-male; Latino-female; non-Latino-male; non-Latino-female), citizenship status (citizen; non-citizen), region (Northern and Sierra counties, Greater Bay Area, Sacramento area, San Joaquin Valley, Central Coast area, Los Angeles County and Other Southern CA)[5] and percent CPO.

4. Weight truncation ('trimming'). In order to minimize the influence of outlier cases on the data and to contain variance, the weights were truncated so that no one case received a weight greater than 4.0 or smaller than .25.

The design effect of the weighted data is 1.6.

ACS estimates and unweighted and weighted sample percentages are listed below. (Percentages for several parameters do not add to 100 percent because of "don't know" responses.)

table 2 – ACS, unweighted, and weighted sample percentages

	ACS	Unweighted Sample	Weighted Sample
Race			
White non-Latino	28.0%	31.6%	28.2%
Black non-Latino	6.9	7.9	7.0
Latino	52.6	49.5	52.1
Other non-Latino	10.9	9.5	10.9
Sex/Race			
Male, non-Latino	21.7%	19.8%	21.8%
Female, non-Latino	25.7	30.7	26.0
Male, Latino	26.0	21.6	25.8
Female, Latino	26.7	27.9	26.8
Education			
Less than High School	33.8%	33.0%	33.4%
High School Education	24.9	25.6	24.9
Some College	28.9	25.2	28.9
College Graduate +	10.4	14.2	10.6
Age			
19-29	33.1%	20.9%	32.7%
30-39	24.1	14.3	23.5
40-49	21.6	19.3	21.6
50-64	21.1	45.4	22.2
Region			
Sierra and Northern Counties	4.5%	10.3%	4.8%
Greater Bay Area	13.9	11.0	13.9
Sacramento Area	5.4	5.9	5.5
San Joaquin Valley	12.9	13.4	13.0
Central Coast	5.8	6.3	5.9
LA County	30.1	29.1	30.0
Other Southern CA	26.5	23.1	25.9
Citizenship			
Citizen	64.6%	75.7%	63.2%
Non-Citizen	35.4	22.2	34.7
Phone Status			
Cell Phone Only	34.9%	21.7%	35.1%
Some Landline Use	65.1	78.3	64.9

response rate

The response rate for this study is calculated at 29.3 percent for the landline sample and 19.8 percent for the cell phone sample using the "Response Rate 3" formula of the American Association for Public Opinion Research.

table 3 – full survey sample disposition

	Landline	Cell	Total
Eligible, Interview (Category 1)			
Complete	704	301	**1005**
Eligible, non-interview (Category 2)			
Refusal (Eligible)	303	57	**360**
Answering machine household	32	20	**52**
Physically or mentally unable/incompetent	6	1	**7**
Language problem	13	86	**99**
No interviewer available for needed language	0	3	**3**
Unknown eligibility, non-interview (Category 3)			
Always busy	532	1632	**2164**
No answer	8696	3866	**12562**
Technical phone problems	144	20	**164**
Call blocking	8	0	**8**
No screener completed	2634	2126	**4760**
Housing unit, unknown if eligible	2623	4085	**6708**
Not eligible (Category 4)			
Fax/data line	1814	409	**2223**
Non-working number	28517	6865	**35382**
Business, government office, other organizations	947	609	**1556**
No eligible respondent	1930	1311	**3144**
Total phone numbers used	48903	21304	**70294**

endnotes

1 The federal poverty level is calculated on the basis of family size and the combined income of family members.

2 These numbers were then adjusted based on the actual share of qualifying households found in each stratum during the course of the survey.

3 If respondents were uncertain about their annual income, they were asked about the corresponding monthly income.

4 Families were defined in accordance with the definition applied by the U.S. Census bureau and FPL was based on the 2011 HHS poverty guidelines.

5 Regions were defined following the California Health Interview Survey (CHIS) operationalization of regions. Each California county was assigned to one of the seven regions. County was derived from respondents' self-reported ZIP code. Where respondents refused ZIP codes, region was derived from the ZIP code associated with their landline exchange. Cell phone respondents who refused ZIP code were considered region-unknown.

appendix a – literature review

Preparation for this survey of low-income Californians began with an extensive review of existing literature, focused in particular on the precepts of patient-centered care (PCC) and the concept of a "health care home," as well as on existing measurements of patients' experiences with the healthcare system.

Existing surveys tend to have focused on the patient experience from a consumer perspective. Most questions measure satisfaction with the health care experience; some of these measures touch upon important components of patient-centered care such as access, coordination, information, continuity and transition, and involvement of family and friends. Few, however, have focused on healthcare preferences – what people want and need from the healthcare system, beyond what they may be receiving today.

Many previous surveys also have spent a great deal of time collecting basic information on the current and past health status of the respondent, frequency and location of use of the healthcare system and demographic information. While covering the basics on such matters, the present survey attempted to maximize the time and space dedicated to questions on the healthcare preferences of patients.

Summaries follow of some of the key reports focused on patient-centered care that were included in our review. Separately, Appendix E lists all relevant reports, surveys and literature used in the conceptualization and design of the BSCF questionnaire.

The Institute for Alternative Futures on behalf of The Picker Institute (2004) – Patient-Centered Care 2015: Scenarios, Vision, Goals & Next Steps

The Picker Institute's guidelines for patient-centered care are widely respected within medical and research communities. Their designated core features include respect, access, coordination and integration, information, communication and education, physical comfort, emotional support, involvement of family and friends, and continuity between healthcare settings. Patients should be empowered to take part in their own care and decision-making. In the case of children and the elderly, special attention should be given to their specific care, education, and information needs.

Davis, Schoenbaum, & Audet (2005) – A 2020 Vision of Patient-Centered Primary Care

This article summarizes core features of PCC. These include access, patient engagement, care that utilizes appropriate technology, care based on scientific evidence, coordination, integration and comprehensive team care, regular patient surveys and providing publicly available information on care practices. Access to care involves ease of making an appointment, timely appointments and responses to e-mails and phone calls, efficient use of time, electronic prescription refills and availability on nights and weekends. Patient engagement includes patient access to important information about their condition, treatment and medical records, recasting the role of the doctor as an advisor and refocusing the locus of decision-making to the patient.

Starfield, Flocke, & Stange – as referenced in Patient-Centered Care Measures for the National Health Care Quality Report (2000)

This report provides an informative list of non-PCC patient experiences, some of which include: hurried and unavailable providers, use of jargon, discouragement in sharing information, lack of understanding of conditions, treatment and recommendations, lack of discussion of treatment options, no consideration of cultural context, avoidance of difficult issues by physicians, and insensitivity to physical pain and emotional distress.

American Medical Association (2006) – Improving Communication – Improving Care

The American Medical Association's definition of PCC is "care that is respectful of and responsive to individual patient preferences, needs, and values." The AMA highlights the importance of effective communication, which includes active listening, courtesy and respect, answering questions, providing clear information, and discussing concerns. Other important aspects of PCC include language congruence, inter-health professional communication, patient involvement in decisions, consideration of family, convenience of office hours/location, timeliness of appointments/ treatment, and attention to physical and psychological comfort.

Silow-Carroll, Alteras, & Stepnick (2006) – Patient-Centered Care for Underserved Populations: Definition and Best Practices

This report is especially relevant to the present survey due to its focus on underserved populations. It lists the core components of PCC for underserved populations as a welcoming environment, respect for patients' values and expressed needs, patient empowerment or "activation," socio-cultural competence, coordination and integration of care, comfort and support, access and navigation skills, and community outreach. Noted

difficulties with underserved populations include: language barriers, lack of "health care literacy," deference to authority, mistrust of "Western medicine," misunderstanding in filling and taking prescriptions, and lack of physician "cultural competency."

Shaller (2007) – Patient-Centered Care: What Does it Take?

This Commonwealth Fund report summarizes a long list of different conceptualizations of PCC, including the Picker Institute criteria. This report reduces the list to six core elements of PCC: education and shared knowledge, involvement of family and friends, collaboration and team management, sensitivity to non-medical and spiritual dimensions of care, respect for patient needs and preferences, and free flow and accessibility of information. The most notable difference here is the inclusion of sensitivity towards spiritual/religious/non-Western approaches. Included are details of the Planetree organization's model of PCC involving nontraditional concepts such as the healing power of touch and music. A health professional notes in the report, "We've gathered tons of data, done many focus groups: We know what patients want. The hard part is delivering it (p. 5)." But as previously noted, most of the patient surveys conducted so far do not really focus on what patients "want" from their health care, but rather on their satisfaction with what they "get."

Epstein & Street (2007) – Patient-Centered Communication in Cancer Care: Promoting Healing and Reducing Suffering

This National Cancer Institute report provides examples of clinician PCC behavior such as maintaining eye contact, nodding to indicate understanding, avoiding interruptions, encouraging patient participation, soliciting the patient's beliefs, values, and preferences, eliciting and validating the patient's emotions, asking about family and social context, providing sufficient information and clear, jargon-free explanations, checking for patient understanding, and offering reassurance, encouragement and support. Examples of patient PCC behavior include: asking questions, offering opinions, stating preferences, sharing beliefs about health, introducing topics for discussion, expressing concerns and feelings, and telling one's health "story" in the context of everyday life.

Kaiser Family Foundation (2008) – Kaiser Low-Income Coverage and Access Survey

Kaiser surveyed low-income adults regarding insurance, access, and coverage. This study is important for the present survey because of its focus on the healthcare experiences of low-income Americans. It provides useful information on problems of access and coverage and how patients feel about the service they have received in the past.

Australian Commission on Safety and Quality in Health Care (2010) – Patient-Centered Care: Improving Quality and Safety by Focusing Care on Patients and Consumers

Much of the report details various competing characterizations of PCC. Most are very close to the Picker Institute's criteria. The report recommends that: "patient surveys used to assess patient care experience need to include questions specifically addressing recognized patient-centered care domains and assess more than patient 'satisfaction.'" This is precisely the niche that the present survey attempts to fill. The report also provides good lists of leading organizations in PCC and relevant surveys.

The Joint Commission (2010) – Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals

The Illinois Joint Commission divides up the PCC approach by stages of interaction with the healthcare system. These stages include admission, assessment, treatment, discharge and transfer. The most important part of the admission process is to inform the patient of their rights and collect important personal information (e.g., language needs). Important components of the assessment and treatment stages are effective communication, respect, ensuring understanding, and identifying patient needs (spiritual, family, diet, comfort).

appendix b – statistical analyses

Several sections of this study refer to regression analyses used to measure the relationships among various attitudes, demographic variables and predicted outcomes such as the frequency of doctor visits, overall quality-of-care ratings and interest in changing healthcare facilities. This appendix provides details of those statistical analyses.

A regression is a form of statistical modeling that measures the independent strength of the relationship between each predictor with the posited outcome, known as the dependent or outcome variable. While it does not establish causality, a regression reveals the strength of the relationship between a predictor (e.g., health status) and the dependent variable (e.g., frequency of doctor visits), with all other possible predictors in the model held constant.

Many variables may be related to a given outcome. A regression identifies which of them explain the most unique variance in the dependent variable, after adjusting for these other relationships. Below we describe the variables used in the regression analyses reported in this study, followed by details of the regression results.

key variables

Health rating (W1): A continuous variable reflecting respondents' self-reported health status, with 1 = poor health and 5 = excellent health (Mean = 3.1, Standard Deviation = 1.1).

Number of doctor's visits in the past year (Q1): A continuous variable indicating the number of times respondents went to the doctor in the past year (*M* = 5.0, *SD* = 9.4).

Facility type (Q2-4): The type of facility used by each respondent was coded using a series of binary variables, indicating, separately, whether they received care at a community clinic and health center (CCHC), or not; a Kaiser Permanente facility, or not; a private doctor's office, or not; a non-CCHC clinic, or not; and a hospital emergency room (ER), or not. For each facility type, respondents were coded 1 if a patient, 0 if not.

Overall quality of care rating (Q5): A continuous variable reflecting respondents' overall ratings of their health care, on a scale from 1 = poor to 5 = excellent (*M* = 3.6, *SD* = 1.0).

Care worse (Q7): A binary variable indicating whether the patient's care has worsened in their time with their current facility (0 = has not worsened, 1= has worsened).

Choice of facility (Q8): A binary variable indicating whether the respondent has a choice of where they go for health care (0 = no choice, 1 = choice).

Interest in changing facility (Q11): A continuous variable indicating how interested respondents would be in changing where they go for health care if they had the opportunity to do so, ranging from 1 = not at all interested to 5 = very interested (*M* = 2.6, *SD* = 1.1).

Index of health care quality (Q5, Q15-17, Q33a): A composite measure of quality of care was computed by recoding the overall quality-of-care rating, as well as the 18 domain-specific ratings, so that 1 = poor and 5 = excellent. Responses on these 19 items then were averaged to form an overall rating index (α = .92), which ranged from 1.11 (indicating a poor rating on nearly every domain tested) to 5.00 (indicating an excellent rating on every domain tested). The average index value was *M* = 3.5, *SD* = .7.

Ability to get an appointment (Q15a): A continuous variable reflecting respondents' ratings of their ability to get a healthcare appointment as soon as they want one, on a scale from 1 = poor to 5 = excellent (*M* = 3.4, *SD* = 1.2).

Convenience (Q15b): A continuous variable reflecting respondents' ratings of the convenience of the location of their healthcare facility, on a scale from 1 = poor to 5 = excellent (*M* = 3.8, *SD* = 1.0).

Cleanliness (Q15c): A continuous variable reflecting respondents' ratings of the cleanliness and appearance of their healthcare facility, on a scale from 1 = poor to 5 = excellent (*M* = 3.9, *SD* = 1.0).

Courtesy (Q15d): A continuous variable reflecting respondents' ratings of the courtesy and helpfulness of the staff at their healthcare facility, on a scale from 1 = poor to 5 = excellent (*M* = 3.8, *SD* = 1.1).

Time spent in waiting room (Q15e): A continuous variable reflecting respondents' ratings of the amount of time they have to spend in the waiting room, on a scale from 1 = poor to 5 = excellent (*M* = 3.1, *SD* = 1.2).

Availability on nights/weekends (Q15f): A continuous variable reflecting respondents' ratings of the availability of night and weekend hours at their healthcare facility, on a scale from 1 = poor (or not offered) to 5 = excellent (*M* = 2.7, *SD* = 1.3). Respondents who said they don't use such services were coded out of the model.

Ability to see the same doctor each time (Q15g): A continuous variable reflecting respondents' ratings of their ability to see the same doctor each time, on a scale from 1 = poor to 5 = excellent (*M* = 3.5, *SD* = 1.2).

Ability to see a specialist (Q15h): A continuous variable reflecting respondents' ratings of their ability to see a specialist if they need one, on a scale from 1 = poor (or not offered) to 5 = excellent (*M* = 3.3, *SD* = 1.2). Respondents who said they don't use such services were coded out of the model.

Time spent with the doctor (Q16a): A continuous variable reflecting respondents' ratings of the amount of time the doctor spends with them, on a scale from 1 = poor to 5 = excellent (*M* = 3.6, *SD* = 1.1).

Communication with the doctor (Q16b): A continuous variable reflecting respondents' ratings of how well the doctor communicates with them, on a scale from 1 = poor to 5 = excellent (*M* = 3.7, *SD* = 1.1).

Involvement in decisions (Q16c): A continuous variable reflecting respondents' ratings of the amount of involvement they can have in making decisions about their health care, on a scale from 1 = poor to 5 = excellent (*M* = 3.6, *SD* = 1.1).

Availability of continuing care (Q16d): A continuous variable reflecting respondents' ratings of the continuing care they are offered, on a scale from 1 = poor (or not offered) to 5 = excellent (*M* = 3.5, *SD* = 1.1). Respondents who said they don't use such services were coded out of the model.

Availability of family care (Q16e): A continuous variable reflecting respondents' ratings of the ability of other family members to get health care at their current facility, on a scale from 1 = poor to 5 = excellent (*M* = 3.5, *SD* = 1.2). Respondents in single-person households were not asked this question, and were coded out of the model.

Understanding of medical history (Q17a): A continuous variable reflecting respondents' ratings of how well the doctors and staff understand their medical history, on a scale from 1 = poor to 5 = excellent (*M* = 3.6, *SD* = 1.1).

Welcoming to people like you (Q17b): A continuous variable reflecting how welcoming respondents feel their healthcare facility is to people like them, on a scale from 1 = poor to 5 = excellent (*M* = 3.8, *SD* = 1.0).

Language accommodation (Q17c): A continuous variable reflecting respondents' ratings of the ability of doctors and staff to speak with them in the language they prefer, on a scale from 1 = poor to 5 = excellent (*M* = 3.7, *SD* = 1.1). Respondents who primarily speak English at home were not asked this question, and were coded out of the model.

Affordability (Q17d): A continuous variable reflecting respondents' ratings of the affordability of the health care they receive, on a scale from 1 = poor to 5 = excellent (*M* = 3.4, *SD* = 1.5).

Lacking a personal doctor (Q19): A binary variable indicating whether or not the respondent has a personal doctor (0 = personal doctor, 1 = no personal doctor).

Ratings of personal doctor (Q20): A continuous variable reflecting respondents' ratings of their personal doctor, with 1 = poor and 5 = excellent (*M* = 4.2, *SD* = .9).

Wanting a personal doctor (Q19, Q21): A binary variable indicating whether or not the respondent desires a personal doctor (0 = has a personal doctor already or does not want one, 1 = does not have a personal doctor but wants one).

Pediatrician at same facility (Q24): A binary variable indicating whether the respondent has children with a pediatrician at the same facility where they receive their care or not (0 = no child, no pediatrician or pediatrician at different facility, 1 = pediatrician at the same facility).

Ratings of variety of services (Q33/Q33a): A continuous variable reflecting respondents' ratings of the variety of health-related services available, on a scale from 1 = poor (or not offered) to 5 = excellent (*M* = 2.55, *SD* = 1.5).

Disability (Q38): A binary variable indicating whether the respondent reported having a disability or chronic condition or not (0 = no disability or chronic condition, 1 = has a disability or chronic condition).

FPL 100 to 133%: A binary variable indicating whether the respondent is between 100-133% of the federal poverty limit (0 = not between 100-133% of FPL, 1 = between 100-133% of FPL), with FPL calculated using family size and income, based on U.S. Census Bureau guidelines. Respondents in this income range will be able to receive Medi-Cal starting in 2014 as a result of the new federal health care law.

Demographic variables: In addition to the variables listed above, the following demographic variables were included in all models: insurance status, gender, age, relationship status, employment status, education, ethnicity (Latino or not), race (white or not), language mainly spoken at home (English vs. not English), income, citizenship status, metro status (urban area or not), and household size. All were coded as binary variables by category except for age and income, which were coded as continuous variables.

regression predicting number of doctor visits in the past year (section i)

To determine what factors independently predict frequency of doctor visits in the past year, we performed a regression with number of doctor visits as the outcome variable and the following variables included as predictor variables (see above for definitions): health rating, facility type, care worse, choice of facility, index of health care quality, interest in changing facility, lacking a personal doctor, ratings of personal doctor, pediatrician at same facility and disability. We entered all demographic variables listed above as controls. The outcome variable was log transformed to correct for a significant positive skew caused by the few respondents who indicated a high number of doctor visits in the past year.

As shown in Table 1, having a disability or chronic condition is positively related to number of doctor visits (i.e., those with chronic conditions go to the doctor more frequently), while overall health ratings and lacking a personal doctor are both negatively related to number of doctor visits (i.e., those who rate their overall health more positively go to the doctor's office less frequently and those who have a personal doctor go to the doctor's office more frequently). In addition, as reported in Section I, the overall quality-of-care rating index is significantly positively related to number of doctor visits, indicating that those who rate their healthcare facility more positively report more trips to the doctor's office than those who rate their health facility less positively.

table 1 – significant predictors of number of doctor visits in the past year

	Standardized coefficient (β)	**Significance test (*t*)**
Disability	.32	9.37***
Health rating	-.16	4.96***
Index of health care quality	.15	4.03***
Lacking a personal doctor	-.14	3.59***

Model $R^2 = .36$, $p < .001$

Note. ***p < .001, **p < .01, *p < .05.

regression predicting overall quality-of-care ratings (section ii)

To determine what aspects of care are the most important predictors of overall quality of care, we performed a linear regression with overall quality-of-care ratings as the outcome variable and ratings of 18 specific areas of care entered as predictors (ability to get an appointment, convenience, cleanliness, courtesy, time spent in the waiting room, availability on nights/weekends, ability to see the same doctor each time, ability to see a specialist, time spent with the doctor, communication with the doctor, involvement in decisions, availability of continuing care, availability of

family care, understanding of medical history, welcoming to people like you, language accommodation, affordability and ratings of variety of services). Lacking a personal doctor, wanting a personal doctor, ratings of personal doctor and pediatrician at the same facility also were included as predictors. We entered all of the demographic variables described above as controls, as well as overall health rating, disability and facility type.

In addition, to determine whether there were differences between facility types in what aspects of care are the most important determinants of overall quality of care, we ran regressions separately for each of the following facility types: Kaiser Permanente, private doctor's office, community clinics and health centers and all other clinic types combined. These regressions were identical to the regression described above, with the exception that facility type was not entered as a control variable.

As shown in Table 2, in the full sample, controlling for type of facility, the strongest factors influencing overall quality-of-care ratings are the courtesy of the staff, the cleanliness of the facility, how involved patients feel they can be in medical decisions, the amount of time patients can spend with the doctor and how the doctors at the facility are rated. More positive ratings on each of these factors is related to more positive overall quality-of-care ratings.

Table 2 also shows that the best predictors of overall quality-of-care ratings differ by facility type. For Kaiser Permanente patients, involvement in care decisions is the most significant factor influencing overall care ratings. For private doctor's office patients, ratings of their personal doctor, ratings of the cleanliness of the doctor's office and how well the doctor communicates are significant predictors of overall care ratings. For CCHC clinics, the important factors are the staffs' understanding of the patient's medical history and the ease with which patients are able to see a specialist. For all other clinic types combined, the amount of time the doctors spend with patients, the courtesy of the staff, the cleanliness of the facility and how much time patients spend in the waiting room emerged as the most significant factors influencing overall ratings of care.

It should be noted that all of the 18 domain ratings significantly correlate with the overall quality-of-care rating when tested individually. These regressions allow us to determine what particular domains are most influential in predicting overall quality of care, when holding these other correlations constant.

table 2 – significant predictors of overall quality-of-care ratings

	Standardized coefficient (β)	Significance test (*t*)
Full sample, R^2 = .42, p < .001		
Courtesy	.13	2.81**
Involvement in decisions	.12	2.41*
Cleanliness	.11	2.59*
Time spent with the doctor	.10	2.08*
Ratings of personal doctor	.07	1.98*
Kaiser patients, R^2 = .78, p < .001		
Involvement in decisions	.51	2.47*
Wanting a personal doctor	-.40	2.37*
Private doctor's office patients, R^2 = .51, p < .001		
Ratings of personal doctor	.28	2.86**
Cleanliness	.21	2.12*
Communication with the doctor	.22	1.96*
Community clinic and health center patients, R^2 = .81, p < .001		
Understand medical history	.48	2.30*
Ability to see specialist	.36	1.99*
Patients of all other clinic types, R^2 = .56, p < .001		
Time spent with doctor	.26	3.02***
Courtesy	.23	3.17**
Cleanliness	.20	2.84**
Time spent in waiting room	.17	2.38*

Note. ***p < .001, **p < .01, *p < .05.

regressions predicting interest in changing and willingness to recommend facilities (section iv)

To determine what factors best predict desire to change healthcare facilities as well as what best predicts willingness to recommend facilities, we performed two separate regressions, one with interest in changing as the outcome variable, the other with willingness to recommend as the outcome variable. The following variables were included as predictor variables in each model: overall health, facility type, care gotten worse, choice of facility, index of health care quality, lacking a personal doctor, wanting a personal doctor, ratings of personal doctor, pediatrician at same facility, disability and all demographic variables listed above.

As shown in Table 3, the strongest predictor of interest in changing facilities is the index of health care quality, a negative predictor indicating that as ratings of a healthcare facility go up, interest in seeking out an alternative facility declines. Insurance status is a positive predictor, such that those with no insurance or Medi-Cal are more interested in switching facilities than are those who have private insurance. Age and choice of healthcare facility are negative predictors – indicating that those who are older or have a choice about where they go to receive care are less likely to be interested in switching facilities than their counterparts. Employment status,

lacking a personal doctor and feeling that a facility's care has deteriorated are all positive predictors; those who have a full time job, those who lack a personal doctor and feel their care has worsened over time all more interested in seeking out an alternative facility.

table 3 – significant predictors of interest in changing facilities

	Standardized coefficient (β)	**Significance test (*t*)**
Wanting a personal doctor	.28	6.54***
Index of health care quality	-.24	6.15***
Insurance status: None	.14	3.72***
Insurance status: Medi-Cal	.09	2.50**
Age	-.09	2.35**
Employment status: Full-time	.09	2.21*
Choice of healthcare facility	-.09	2.60*
Care worse	.07	2.23*

Model $R^2 = .26$, $p < .001$

Note. ***p < .001, **p < .01, *p < .05.

As shown in Table 4, the strongest predictor of willingness to recommend one's facility is the index of health care quality, indicating that as ratings of a healthcare facility go up, willingness to recommend one's facility also rises. Citizenship status is a negative predictor, such that citizens are less likely to recommend their facility than non-citizens. Feeling that a facility's care has deteriorated and having a college education are also both negative predictors; those who feel their care has worsened over time and those with a college degree are less likely to recommend their facility to others.

table 4 – significant predictors of willingness to recommend facility

	Standardized coefficient (β)	**Significance test (*t*)**
Index of health care quality	.55	15.36***
Citizenship	-.14	3.70***
Care worse	-.08	2.84**
Education: College graduate	-.06	2.06*

Model $R^2 = .36$, $p < .001$

Note. ***p < .001, **p < .01, *p < .05.

appendix c – topline data report

This appendix provides complete question wording and topline results of Blue Shield of California Foundation's survey of low-income Californians.

*= less than 0.5 percent

W1. I'd like to ask you about your overall health. In general, would you say your health is excellent, very good, good, fair, or poor?

Excellent/very good		NET		Fair/poor		NET	
Excellent	Very good		Good	Fair	Poor		No opinion
13%	19	33	36	22	8	31	1

1. About how many times in the past year have you seen a doctor, nurse or other health care provider? (IF NONE) About how many times have you seen a doctor in the past two years?

None	Once	2-5 times	6+times	No opinion	Mean	Median
16%	18	41	23	2	5.03	2

1a. (IF NONE) About how many times have you seen a doctor in the past two years?

None	Once	2-5 times	6+times	No opinion	Mean	Median
57%	22	13	3	6	.83	0

2/2a/3/4. Where do you usually go when you are sick or need health care for any reason – (Kaiser), (a private doctor's office), (a community clinic or health center), (a hospital) or someplace else? (IF NO USUAL PLACE) Where's the last place you went? [Follow-ups specified – see questionnaire.]

Kaiser	12%
Doctor's office	28
Clinic NET	**44**
Community clinic	*11*
Public hospital clinic	*10*
Private hospital clinic	*5*
Hospital clinic unknown type	*1*
County/city clinic	*5*
Private/other clinic	*5*
Clinic unknown type	*8*
Hospital emergency room	10
Hospital unspecified	2
Some place else	2
Never have gone for health care*	2
No opinion	1

*Only asked W1, Q1, Q19-39 and demographics

5/5a. Thinking about the place where you usually go for health care*, how would you rate the health care you receive – excellent, very good, good, not so good, or poor?

Excellent/very good		**NET**		**Not so good/poor**		**NET**	
Excellent	Very good		Good	Not so good	Poor		No opinion
26%	22	48	42	6	3	9	1

*if no usual place: "the last time you received health care"

6. (IF USUAL PLACE, Q2) About how long have you been going there for health care?

1 year or less	**2-5 years**	**6+ years**	**No opinion**	**Mean**	**Median**
26%	38	35	2	6.30	4

7. (IF USUAL PLACE, Q2) In the time you've been a patient there, has the health care they provide you gotten (better), gotten (worse) or remained about the same?

Better	Same	Worse	No opinion
24%	63	11	2

8. (Do you have a choice of places where you can go for health care), or ([do/did] you use this place because it's the only one available to you)?

Have a choice	Only one available	No opinion
53%	44	3

9. (IF NO CHOICE, Q8) Is that mainly because it's (the only place close enough), mainly because it's (the only place you can afford), or is there some other reason?

Only place close enough	29%
Affordability/coverage NET	**57**
Only place you can afford	45
Only one covered by insurance/employer (vol.)	12
Volunteered responses:	
Both equally	4
Only one with services I need	1
Only place available to me	2
Like my doctor	1
Recommendation/referral	1
Have no health insurance	1
Something else	4
No opinion	1

10. (IF CHOICE, Q8) Which of these is the main reason you chose this place – is this because (you have a relative or friend who uses it), (a health care or social services provider recommended it to you), (you saw it advertised), (it's the most convenient), (it's the least expensive) or some other reason?

Relative or friend uses it	23%
Health care/social provider recommended	10
Saw it advertised	1
Convenience NET	**39**
It's the most convenient	38
Other convenience (vol.)	1
Affordability/coverage NET	**12**
It's the least expensive	9
Covered by insurance/employer (vol.)	3
Volunteered responses:	
Doctor	3
Familiarity/going there for years	3
Personal preference	2
Good reputation	1
Other recommendation/referral	1
Needed emergency care	1
Provide a variety of services	*
Quality care	1
Researched on the Internet	1
Other	2
No opinion	*

11. If you had more choices for health care and insurance to cover it, how interested would you be in going to a different place for your health care than the place you [go now/last went] – very interested, somewhat interested, not so interested, or not interested at all?

Interested		NET	Not Interested		NET	
Very	Somewhat		Somewhat	Very		No opinion
28%	30	58	16	25	41	2

12. (IF REGULAR CLINIC PATIENT AND INTERESTED IN CHANGING, Q11) Do you think you'd (go to a different community clinic), or (look for a place that's not a community clinic)?

Different clinic	Not a clinic	No opinion
38%	56	6

13. (IF CLINIC PATIENT, Q2; AND INTERESTED IN CHANGING, Q11) Why would you look for a different place – what's the main reason?*

Verbatim responses:

I would look for convenience.
I would look for place that would have things done.
Because next year I get Medicare.
If I need some specialized tests or something.
The community clinic is not very good, would prefer to go to a doctor of your choice.
The doctors.
Because when you have insurance they treat you wherever you want.
They have a better a system, better consult.
More specialists.
To know the difference.
To find another doctor.

*Asked of every 5th respondent meeting these criteria.

14. (IF CLINIC PATIENT, Q2; AND NOT INTERESTED IN CHANGING, Q11) Why would you stay with the clinic you use now – what's the main reason?*

Verbatim responses:

It's a network through my employer.
I get the medicines I need and I give a donation.
I just like it, it's cool.
It has all the services I need.
I haven't given them a chance yet.
I feel good there.
It's the top hospital in the country.

*Asked of every 5th respondent meeting these criteria.

15. Thinking about the place where you [usually go/last went] for health care, I'd like you to rate some of your experiences. The first are about how the place is run. How would you rate [ITEM] – excellent, very good, good, not so good, or poor? How about [NEXT ITEM]?

Full item wording:

a. Your ability to get an appointment as soon as you want one
b. The convenience of the location
c. The cleanliness and appearance of the office
d. The courtesy and helpfulness of the staff
e. The amount of time you spend in the waiting room
f. Their availability on nights or weekends
g. Your ability to see the same doctor each time
h. Your ability to see a specialist if you need one

	Excellent/very good		NET		Not good/poor		NET		(Vol.)	
	Excellent	Very good		Good	Not so good	Poor		No opinion	Not offered	Don't use
a. Appointment	23%	20%	44%	36%	13%	6%	18%	1%	NA	NA
b. Convenience	31	23	54	37	7	1	8	*	NA	NA
c. Cleanliness	37	22	59	35	4	1	5	1	NA	NA
d. Courtesy	35	23	58	33	7	2	9	1	NA	NA
e. Wait time	16	15	31	38	21	9	30	1	NA	NA
f. Night/wknd	11	10	20	26	17	11	28	4	7	14
g. Same doctor	29	17	45	33	14	5	19	3	NA	NA
h. Specialist	20	18	38	32	12	6	19	4	1	6

16. These next items are about the care you receive there. Again, thinking about the place where you [usually go/last went] for health care, how would you rate [ITEM] – excellent, very good, good, not so good, or poor? How about [NEXT ITEM]?

Full item wording:

a. The amount of time the doctor spends with you
b. How well your doctor communicates with you
c. The amount of involvement you can have in making decisions about your health care
d. The continuing care they offer for ongoing or long-term problems
e. (IF FAMILY SIZE IS GREATER THAN TWO) The ability of other family members in your household to get health care at the same place

	Excellent/very good		NET		Not good/poor		NET		(Vol.)	
	Excellent	Very good		Good	Not so good	Poor		No opinion	Not offered	Don't use
a. Time w/doctor	28%	20%	48%	38%	10%	3%	13%	1%	NA	NA
b. Communication w/doctor	32	23	55	33	8	4	11	*	NA	NA
c. Involvement in decisions	26	23	49	39	7	3	10	2	NA	NA
d. Cont. care	22	17	39	38	8	4	12	4	*	7
e. Family access	23	18	41	37	9	6	15	7	NA	NA

17. Thinking more about how the place is run, how would you rate [ITEM] – excellent, very good, good, not so good, or poor? How about [NEXT ITEM]?

Full item wording:

a. The understanding they have about your medical history
b. How much you feel that people like you are welcome there
c. (IF NOT PRIMARILY AN ENGLISH SPEAKER) Their ability to speak with you in the language you prefer
d. The affordability of the health care you receive

	Excellent/very good		NET		Not good/poor		NET	
	Excellent	Very good		Good	Not so good	Poor		No opinion
a. Understand medical history	27%	23%	50%	36%	9%	3%	12%	2%
b. People like you welcome	32	24	56	35	5	2	6	2
c. Language	33	16	49	40	8	2	11	1
d. Affordable	24	17	41	40	12	5	18	2

18. How likely are you to recommend the place you [usually go/last went] for health care to your friends – very likely, somewhat likely, not so likely, or not likely at all?

Likely		NET	Not likely		NET	
Very	Somewhat		Not so	Not at all		No opinion
56%	27	82	8	9	17	1

19. Do you have a regular personal doctor, or not?

Yes	No	No opinion
57%	43	*

20. (IF PERSONAL DOCTOR, Q19) How would you rate your personal doctor – excellent, very good, good, not so good, or poor?

Excellent/very good		NET		Not so good/poor		NET	
Excellent	Very good		Good	Not so good	Poor		No opinion
51%	21	72	24	2	*	3	1

21. (IF NO PERSONAL DOCTOR, Q19) Would you like to have your own personal doctor, or is it not that important to you?

Yes	No	No opinion
55%	45	*

22. Do you have any children under age 18 living with you?

Yes	No	No opinion
45%	55	-

23. (IF CHILDREN, Q22) Does your child or do any of your children have a personal doctor or pediatrician that they regularly see for most of their care, or not?

Yes	No	No opinion
79%	20	1

24. (IF PEDIATRICIAN, Q23) Is that pediatrician located at the same place you go for care, or somewhere else? [IF MORE THAN ONE PEDIATRICIAN: Are any of them located at the same place you go, or not?]

Same place	Somewhere else	No opinion
38%	62	*

22/23/24 NET

Have a child			NET		
No Doctor	Doctor, different place	Doctor, same place		No child	No opinion
9%	22	14	45	55	-

25-27. The health care system is changing in a way that will give more people access to health insurance and may give you more choices of places to go for health care. Imagine you were deciding between your current place of care and a NEW place. Which of the following would be the SINGLE MOST important factor in your choice: Would it be (how much money it costs to go there) or (the ability to see the same doctor each time) or (short waiting times) or (the convenience of the location)? [IF WOULDN'T CHANGE: Say your current place closed.] What would be the NEXT most important factor? [REPEAT WITH REMAINING THREE ITEMS. REPEAT WITH LAST TWO ITEMS]

4/25/11 – Summary Table

	Cost	Same doctor	Convenience	Short wait	No opinion
Most important	35%	33%	19%	11%	2%
Second	25	29	26	19	1
Third	18	21	26	35	1
Fourth	21	15	28	35	1

28. Thinking about your relationship with (a/your) doctor – which of these is most important to you: (the amount of time the doctor spends with you), how well the doctor explains things to you), or (how much the doctor takes your opinions and concerns into account)?

Amount of time spent	Quality of explanations	Listening to your concerns	No opinion
19%	47	32	2

29. How interested would you be in being able to communicate with your doctor by e-mail or text message – very interested, somewhat interested, not so interested or not interested at all?

Interested			NET	Not interested		NET	
Very	Somewhat	Do now (vol.)		Not so	Not at all		No opinion
32%	24	1	57	14	28	42	*

30. In choosing where you go for health care, which of these would be most important to you: (the availability of wellness programs with advice on healthy living), (the availability of continuing care for ongoing or long-term problems), or (whether other family members can get their care there too)?

Wellness programs	Continuing care	Family can go too	No opinion
27%	40	30	3

31. In terms of access, which of these would be most important to you in choosing where you go for health care: (your ability to get an appointment when you want one), (the availability of night and weekend hours), or (the availability of walk-in services without an appointment)?

Get appointment when you want	Night and weekend hours	Walk-in service	No opinion
44%	18	37	1

32. Would you rather go to a health care place that has a focus on serving people of similar backgrounds as your own, or would you say this doesn't matter much to you? (IF SAME BACKGROUND) Do you feel that way strongly, or somewhat?

Similar backgrounds		NET		
Strongly	Somewhat		Doesn't matter	No opinion
8%	11	20	79	1

33. Some places that provide health care offer a variety of services in addition to regular medical care – such as wellness programs, care for pregnant moms and children, a dentist, a nutritionist and elder care. Does the place you [usually go/last went] for health care offer services like these in addition to regular medical care, or not?

Yes	No	No opinion
52%	38	10

33a. (IF VARIETY OF SERVICES, Q33) Overall, how would you rate the variety of these additional services that are available - would you say the number of additional services offered is excellent, very good, not so good, or poor?

Excellent/very good		NET		Not so good/poor		NET	
Excellent	Very good		Good	Not so good	Poor		No opinion
25%	27	52	41	5	*	6	2

34. If you were choosing a NEW place to go for health care, how important would it be to you that they offer a variety of additional services beyond regular medical care – extremely important, very important, somewhat important, not so important or not important at all?

Important		NET		Not important		NET	
Extremely	Very		Somewhat important	Not so	Not at all		No opinion
21%	42	63	25	8	3	11	1

35. Community health clinics are the non-profit clinics around the state that provide health care for anyone who needs it, whether or not they're insured or can pay. Based on what you have heard, would you say the reputation of community health clinics is excellent, very good, good, not so good, or poor?

Excellent/very good		NET		Not so good/Poor		NET	
Excellent	Very good		Good	Not so good	Poor		No opinion
14%	17	31	37	20	6	25	6

36. Thinking about health care decisions, is it your preference to (leave decisions about your health care mostly up to the doctor or nurse), or would you prefer to (have an equal say with the doctor or nurse in decisions about your health care)? Do you feel that way strongly, or somewhat?

Leave to the doctor		NET	Have an equal say		NET	
Strongly	Somewhat		Strongly	Somewhat		No opinion
24%	15	39	48	10	59	2

37. As you may know, the Congress recently passed and President Obama signed into law a health reform bill that changes the nation's health care system. As a result of the new health care law do you think that your own health insurance coverage, or ability to get coverage, will get better, get worse, or not change?

Get better	Not change	Get worse	No opinion
40%	29	20	11

38. Do you have any disability or chronic medical condition that requires ongoing health care, or not?

Yes	No	No opinion
31%	68	1

39. What is your main source of health insurance coverage, if any?

Private health insurance through an employer	24%
Private health insurance that you buy on your own	9
Medi-Cal, also known as Medicaid	24
Any other state health insurance program	4
The V.A., Tri-Care, military insurance	4
Indian Health Service	*
Medicare	2
Medicare and Medi-Cal	2
None, you are uninsured	29
No opinion	2

selected demographics

Sex	
Male	48%
Female	52

Age	
19-29	33%
30-39	23
40-49	22
50-64	22

Relationship status	
Married	37%
Living with a partner	16
Widowed	3
Divorced	8
Separated	4
Single	33

Employment status	
Employed, full-time	31%
Employed, part-time	21
Not employed	
Retired	5
Homemaker	10
Student	10
Unemployed	14
Disabled	8
Other	1
NET	**48**
No opinion	–

Education	
Less than high school	
8th grade or less	13%
Some high school	21
NET	**34**
High school graduate	25
Some college/associates degree	30
College graduate	
Graduated college	8
Post graduate	3
NET	**11**

Race/Ethnicity	
White, non-Hispanic	29%
Black, non-Hispanic	7
Hispanic	
White Hispanic	33
Black Hispanic	13
Hispanic unspecified	7
NET	**53**
Asian	6
Multiracial	2
Other	3

Income	
< $15,000	30%
$15,000-$29,999	45
$30,000-$49,999	18
$50,000+	3
No opinion	4

appendix d – full questionnaire

This appendix reproduces the full, formatted questionnaire for Blue Shield of California Foundation's survey of low-income Californians.

[CONFIRM LANGUAGE AT THE BEGINNING OF THE INTERVIEW]

INTRO [ALL SAMPLE]: Hello. My name is _____ and we're conducting research on important issues concerning healthcare in California. We're not selling anything – just getting opinions on how to make health care better for more people. Our questions are for research only and your answers are strictly confidential.

(IF CELL SAMPLE)
CELL1. May I please ask if I've reached you on a cell phone, or on a regular landline phone?

(INTERVIEWER NOTE: IF RESPONDENT ASKS, WHY DO YOU NEED TO KNOW CELL VS. LANDLINE PHONE? SAY, "So we can make sure all people are included whatever phone they use.")

1	Cell phone	
2	Landline phone	THANK & TERM.
R	(DO NOT READ) Refused	THANK & TERM.

(IF CELL SAMPLE)
CELL2. Before we continue, are you driving or doing anything that requires your full attention right now?

1	Yes, respondent is driving/doing something	SET UP CALLBACK
2	No, respondent is not driving/doing something	CONTINUE TO CELL3
R	(DO NOT READ) Refused	THANK & TERM.

(IF CELL SAMPLE AND IF RESPONDENT ASKS ABOUT OR OBJECTS TO COST OF CALL OR LOSS OF MINUTES DURING ANY PART OF THE INTERVIEW, TYPE "CELL" AT PROMPT TO REACH THE FOLLOWING SCEEEN): We are able to offer you five dollars as reimbursement for the use of your cell phone minutes for this call. If you complete the full survey, I will ask for your mailing address at the end of the survey so we can send you a check. Is this OK? (CONTINUE TO CELL3 OR TO NEXT QUESTION)

(IF CELL SAMPLE)
CELL3. So we can ask you the right questions, could you please tell me if you are 18 or younger, older than 18 but younger than 65 or are you 65 or older?

1	18 or younger	THANK & TERM.
2	19 to 64	
3	65 or older	THANK & TERM.
R	(DO NOT READ) Refused	THANK & TERM.

(IF Q.CELL3 =2)
CELL4. In what state do you currently live?

1	California	
2	Not California	THANK & TERM.
R	(DO NOT READ) Refused	THANK & TERM.

W1. I'd like to ask about your overall health. In general, would you say your health is excellent, very good, good, fair, or poor?

1 Excellent
2 Very good
3 Good
4 Fair
5 Poor
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

INSERT "this household" IF LL SAMPLE
INSERT "the same house as you" IF CELL SAMPLE
S1. To ask the right questions we need to know how many people in your family usually live in (this household/the same house as you). By family we mean any blood relatives or people related to you by birth, marriage or adoption. Including yourself, how many people in your family live there?

(INTERVIEWER NOTES:
– THIS INCLUDES ANY FAMILY MEMBER THAT LIVES IN THE SAME HOME. FAMILY MEMBERS WHO NORMALLY LIVE IN THE HOUSEHOLD BUT ARE TEMPORARILY LIVING SOMEPLACE ELSE (e.g. hospital or school) SHOULD BE COUNTED)

– UNMARRIED COUPLES DO NOT COUNT AS FAMILY MEMBERS. IF THERE ARE ANY CHILDREN FROM THIS RELATIONSHIP, THEY DO COUNT AS FAMILY MEMBERS)

– IF HH SIZE MORE THAN 15, PLEASE CONFIRM BEFORE ENTERING RESPONSE.)

_____ (valid: 1-100)
RRR (DO NOT READ) Refused THANK & TERM.

(ASK Q.S2a IF Q.S1=1 AND LL SAMPLE)
S2a. And are you 18 or younger, older than 18 but younger than 65 or are you 65 or older?

1	18 or younger	THANK & TERM.
2	19 to 64	
3	65 or older	THANK & TERM.
R	(DO NOT READ) Refused	THANK & TERM.

(ASK Q.S2 IF Q.S1=2+ AND LL SAMPLE)
S2. And how many of these family members, including you are older than 18 but younger than 65?

_____ (RANGE = 1- RESPONSE IN Q.S1)

NN	None	THANK & TERM.
RR	(DO NOT READ) Refused	THANK & TERM.

(ASK EVERYONE; READ ITEM IN PARENS IF S1=2+)
S3. To ask the right questions, we need to know whether in 2010, your (family's) total annual income from all sources, before taxes, was more or less than (INSERT Y*)?

(IF NEEDED: Family income includes income from you and any family members living with you. Income can be pay for work or any other money coming in).

(IF NEEDED: Your income makes it easy or hard to take care of health care costs. We need to know that to ask the right questions.)

[INTERVIEWER: IF RESPONDENT REFUSES: Your responses are strictly confidential and are not attached to any identifying information. It is important for us to know this information to ask you about your healthcare.]

[INTERVIEWER: IF RESPONDENT IS UNSURE, PROBE: Can you estimate?]

1	More than (AMOUNT)	THANK & TERM.
2	Less than (AMOUNT)	
3	(DO NOT READ) Exactly (AMOUNT)	THANK & TERM
D	(DO NOT READ) Don't know	GO TO Q.S3b
R	(DO NOT READ) Refused	GO TO Q.S3b

VALUES FOR Y*

IF S1=1	$23,000	IF S1=6	$60,000
IF S1=2	$28,000	IF S1=7	$68,000
IF S1=3	$35,000	IF S1=8	$76,000
IF S1=4	$45,000	IF S1=9+	$90,000
IF S1=5	$53,000		

(ASK Q.S3b IF Q.S3 = D OR R)
(READ ITEM IN PARENS IF S1=2+)
S3b. How about average monthly income? Can you estimate whether your (family's) average monthly income from all sources was more or less than (INSERT M*)?

(IF NEEDED: Family income includes income from you and any family members living with you. Income can be pay for work or any other money coming in).

(IF NEEDED: Your income makes it easy or hard to take care of health care costs. We need to know that to ask the right questions.)

[INTERVIEWER: IF RESPONDENT REFUSES: Your responses are strictly confidential and are not attached to any identifying information. It is important for us to know this information to ask you about your healthcare.]

[INTERVIEWER: IF RESPONDENT IS UNSURE, PROBE: Can you estimate?]

1	More than (AMOUNT)	THANK & TERM.
2	Less than (AMOUNT)	
3	(DO NOT READ) Exactly (AMOUNT)	THANK & TERM.
D	(DO NOT READ) Don't know IF CELL SAMPLE,	THANK & TERM
R	(DO NOT READ) Refused IF CELL SAMPLE,	THANK & TERM

VALUES FOR M*

IF S1=1	$1,900	IF S1=6	$5,000
IF S1=2	$2,400	IF S1=7	$5,700
IF S1=3	$2,900	IF S1=8	$6,300
IF S1=4	$3,700	IF S1=9+	$7,500
IF S1=5	$4,400		

(ASK Q.S3c IF LL SAMPLE AND Q.S3b = D OR R AND Q.S1>1)
S3c. Is there someone else there you can ask?

1	Yes, coming to phone	RE-READ INTRO & GO TO Q.S3
2	Yes, but presently unavailable	GET NAME & SCHEDULE CALLBACK
3	No	THANK & TERM.
R	(DO NOT READ) Refused	THANK & TERM.

(ASK Q.S4 IF LL SAMPLE AND Q.S1 = 2+)
(IF Q.S2 = 1, DO NOT INSERT ANY OF THE VERBIAGE IN PARENS)
S4. To complete our survey we need to speak with the (male/female) family member living in your household, who is between the ages of 19 and 64 and had the last birthday. Is that person at home right now?
(INTERVIEWER NOTE: IF RESPONDENT ASKS WHY DO YOU NEED TO TALK TO THE MALE/FEMALE WHO HAD THE LAST BIRTHDAY? SAY, "Our research experts set it up that way so that all types of people will be represented."

1 Yes, respondent on the phone
2 Yes, respondent coming to the phone REPEAT INTRO/GO TO Q.S5
3 Person is unavailable GET NAME/SCHEDULE CALLBACK
4 No one in the HH of that gender
R (DO NOT READ) Refused THANK & TERM.

(ASK Q.S4a IF Q.S4 = 4)
S4a. Then may I please speak with the (female/male) (INSERT OPPOSITE GENDER FROM Q.S4) family member living in your household, who is between the ages of 19 and 64 and had the last birthday?

1 Yes, respondent on the phone
2 Yes, resp. coming to the phone REPEAT INTRO/GO TO Q.S5
3 Person is unavailable GET NAME/SCHEDULE CALLBACK
R (DO NOT READ) Refused THANK & TERM.

S5. What language do you mainly speak at home? (DO NOT READ.)
1 English
2 Spanish
3 Chinese/Mandarin/Cantonese
4 Korean
5 Filipino/Tagalog
7 Other
R (DO NOT READ) Refused

S6 RECORD GENDER OF RESPONDENT
1 Male
2 Female

S7. And just to confirm, what is your age?
_____ (19-64)
LL 18 or less THANK AND TERM.
65 65 OR MORE THANK AND TERM.
RR (DO NOT READ) Refused

(ASK S.7a IF S.7 = RR)
S7a. Could you please tell me if you are…? (READ LIST.)

(INTERVIEWER NOTE: IF RESPONDENT SAYS "YOUNGER THAN 19" OR "OLDER THAN 65" – PLEASE CONFIRM BEFORE ENTERING RESPONSE)

1 Younger than 19 THANK AND TERM.
2 19 to 29
3 30 to 39
4 40 to 49
5 50 to 64, or
6 65 OR OLDER THANK AND TERM.
R (DO NOT READ) Refused

(ASK S.7b IF S.7a = R)
S7b. Can you just confirm that you are older than 18 and younger than 65?

1	Yes	
2	No	THANK AND TERM
R	Refused	THANK AND TERM

main questionnaire

About how many times in the past year have you seen a doctor, nurse or other health care provider? (IF NEEDED: Just your best guess)

_____ NUMBER OF TIMES
NN None
DD (DO NOT READ) Don't know
RR (DO NOT READ) Refused

(ASK Q.1a IF Q.1 = NN)
1a. About how many times have you seen a doctor in the past two years?

_____ NUMBER OF TIMES
NN None
DD (DO NOT READ) Don't know
RR (DO NOT READ) Refused

(ROTATE VERBIAGE IN PARENS)
2. Where do you usually go when you are sick or need health care for any reason – (Kaiser), (a private doctor's office), (a community clinic or health center), (a hospital) or someplace else?

(INTERVIEWER NOTES:
– IF MULTIPLE PLACES, ASK "Which one usually?"

– IF RESPONDENT SAYS "DOCTOR" ASK: IS THAT A PRIVATE DOCTOR'S OFFICE OR A DOCTOR AT [REPEAT OTHER CHOICES]?

– IF RESPONDENT SAYS NON-PROFESSIONAL, I.E., "PARENT, FAMILY, HOME", SAY "I mean for professional healthcare." AND RE-ASK QUESTION.)

1 Kaiser
2 A private doctor's office
3 A community clinic or health center
4 A hospital
5 Some place else (SPECIFY) _____
6 (DO NOT READ) No place I usually go
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.2a IF Q.2 = 6, D, OR R)

2a. OK, where's the last place you went when you needed health care?

(INTERVIEWER NOTES:
– IF RESPONDENT SAYS "DOCTOR" ASK: IS THAT A PRIVATE DOCTOR'S OFFICE OR A DOCTOR AT [REPEAT OTHER CHOICES]?

– IF RESPONDENT SAYS NON-PROFESSIONAL, I.E., "PARENT, FAMILY, HOME", SAY "I mean for professional healthcare." AND RE-ASK QUESTION.)

1 Kaiser
2 A private doctor's office
3 A community clinic or health center
4 A hospital
5 Some place else (SPECIFY) _____
6 (DO NOT READ) Never have gone to doctor/nurse/health care provider
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(IF Q.2a = 1, 2, 4, 5)
2b. Was this in California?

1 Yes
2 No
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.3 IF Q.2 = 3 OR Q.2a = 3)
3. What's the city or town where your clinic is located?
(ENTER 1ST LETTER OF CITY/TOWN FOR LIST OF AVAILABLE CITIES/TOWNS)

096	Fresno	259	San Francisco
158	Los Angeles	263	San Jose
201	Oakland	330	Ventura
213	Oxnard	997	Other answer given (SPECIFY) _____
254	Sacramento	DDD	(DO NOT READ) Don't know
255	Salinas	RRR	(DO NOT READ) Refused
258	San Diego		

(ASK Q.3a IF Q.3 = 096, 158, 201, 213, 254, 255, 258, 259, 263, OR 330 OR 997)
3a. What's the name of the street where your clinic is located?
(ENTER 1ST LETTER OF STREET FOR LIST OF AVAILABLE CLINICS)

001 Answer given (SPECIFY) _____
DDD (DO NOT READ) Don't know
RRR (DO NOT READ) Refused

(ASK Q.3b IF Q.2 = 3 OR Q.2a = 3)

3b. What's the name of that clinic?
(ENTER 1ST LETTER OF CLINIC FOR LIST OF AVAILABLE CLINICS)
(INTERVIEWER NOTE: IF 2+ CLINICS WITH SAME NAME, VERIFY STREET NAME IF AVAILABLE)

997 Answer given (SPECIFY) _____
DDD (DO NOT READ) Don't know
RRR (DO NOT READ) Refused

(ASK Q.3c IF Q.3b = 997, DDD, OR RRR)
3c. As far as you know, is that a clinic that's operated by a hospital, or not?

1 Yes, operated by a hospital
2 No, not operated by a hospital
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.3d IF Q.3c = 1; ROTATE VERBIAGE IN PARENS)
3d. Is this clinic run by a (county hospital) or a (private or religious hospital)?

1 County hospital
2 Private or religious hospital
3 Other (SPECIFY) _____
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.3e IF Q.3c = 2; ROTATE VERBIAGE IN PARENS)
3d. Is this clinic run by a (county or city), or by a (private company)?

1 County or city
2 Private company
3 Other (SPECIFY) _____
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.4 IF Q.2 = 4 OR Q.2a = 4; ROTATE VERBIAGE IN PARENS)
4. Is that a (hospital clinic), or is it a (hospital emergency room)?

1 Hospital clinic
2 Hospital emergency room
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.4a IF Q.4 = 1; ROTATE VERBIAGE IN PARENS)
4a. Is this clinic run by a (county hospital) or a (private or religious hospital)?

1 County hospital
2 Private or religious hospital
3 Other (SPECIFY) _____

D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.5 IF Q.2 = 1-5)
5. Thinking about the place where you usually go for health care, how would you rate the health care you receive – excellent, very good, good, not so good or poor?

1 Excellent
2 Very good
3 Good
4 Not so good
5 Poor
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.5a IF Q.2a = 1-5, D OR R)
5a. Thinking about the last time you received health care – was the health care you received excellent, very good, good, not so good or poor?

1 Excellent
2 Very good
3 Good
4 Not so good
5 Poor
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.6 IF Q.2 = 1-5)
6. About how long have you been going there for health care? (IF NECESSARY: The place you usually go for health care)

01 _____ YEARS GIVEN
02 _____ MONTHS GIVEN
LL Less than 1 month
DD (DO NOT READ) Don't know
RR (DO NOT READ) Refused

(ASK Q.7 IF Q.2 = 1-5; (ROTATE VERBIAGE IN PARENS)
7.In the time you've been a patient there, has the health care they provide you gotten (better), gotten (worse) or remained about the same?

1 Better
2 Worse
3 Remained about the same
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.8 IF Q.2 = 1-5 OR Q.2a = 1-5, D,R; ROTATE VERBIAGE IN PARENS

(INSERT "Do" IF Q.2 = 1-5; INSERT "Did" IF Q.2a = 1-5, D,R)
8. (Do you have a choice of places where you can go for health care), or ([Do/Did] you use this place because it's the only one that's available to you)?

1 Have a choice of places
2 Only one that's available
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.9 IF Q.8 = 2; ROTATE VERBIAGE IN PARENS)
9. Is that mainly because it's (the only place close enough), mainly because it's (the only place you can afford), or is there some other reason?

1 Only place close enough
2 Only place you can afford
3 (DO NOT READ) Both equally
4 (DO NOT READ) Only one with services I need
5 (DO NOT READ) Something else (SPECIFY) _____
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.10 IF Q.8 = 1; SCRAMBLE 1-5)
10. Which of these is the main reason you chose this place – is this because…? (READ LIST.)
(INTERVIEWER NOTE: IF RESPONDENT SAYS "WIFE/HUSBAND, PARENT PICKED IT, CODE AS "1")

1 You have a relative or friend who uses it
2 A health care or social services provider recommended it to you
3 You saw it advertised
4 It's the most convenient
5 It's the least expensive
6 Or, some other reason (SPECIFY) _____
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.11 IF Q.2 = 1-5 OR Q.2a = 1-5, D,R)
(INSERT "go now" IF Q.2 = 1-5; INSERT "last went" IF Q.2a = 1-5. D, R)
11. If you had more choices for health care and insurance to cover it, how interested would you be in going to a different place for your health care than the place you (go now/last went) – very interested, somewhat interested, not so interested or not interested at all?

1 Very interested
2 Somewhat interested
3 Not so interested
4 Not interested at all
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.12 IF Q.2 = 3 AND Q.11 = 1 OR 2; ROTATE VERBIAGE IN PARENS)
12. Do you think you'd (go to a different community clinic), or (look for a place that's not a community clinic)?

1 Go to a different community clinic
2 Look for a place that's not a community clinic
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.13 OF RANDOM EVERY 5TH RESPONDENT WHO IS Q.2 = 3 AND Q.11 = 1/2)
13. Why would you look for a different place – what's the main reason?

1 Answer given (SPECIFY) _____
2 No reason
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.14 OF RANDOM EVERY 5TH RESPONDENT WHO IS Q.2 = 3 AND Q.11 = 3/4)
14. Why would you stay with the clinic you use now – what's the main reason?

1 Answer given (SPECIFY) _____
2 No reason
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.15 IF Q.2 = 1-5 OR Q.2a = 1-5, D OR R)
(INSERT "usually go" IF Q.2 = 1-5; INSERT "last went" IF Q.2a = 1-5, D, OR R)
(DISPLAY CODE 6 AND 7 FOR ITEM F and H ONLY)
15. Thinking about the place where you (usually go/last went) for health care, I'd like you to rate some of your experiences. The first are about how the place is run. How would you rate (INSERT 1ST ITEM) – excellent, very good, good, not so good, or poor? How about (INSERT NEXT ITEM)?

(INTERVIEWER: READ RESPONSE OPTIONS FOR FIRST 2 ITEMS. REPEAT ALL RESPONSE OPTIONS EVERY THIRD ITEM AFTER THAT OR MORE AS NEEDED)

1 Excellent
2 Very good
3 Good
4 Not so good
5 Poor
6 (DO NOT READ) Not applicable/Don't use /don't need a specialist
7 (DO NOT READ) Not offered
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

a. Your ability to get an appointment as soon as you want one
b. The convenience of the location
c. The cleanliness and appearance of the office

d. The courtesy and helpfulness of the staff
e. The amount of time you spend in the waiting room
f. Their availability on nights or weekends
g. Your ability to see the same doctor each time
h. Your ability to see a specialist if you need one (IF NEEDED: That's a doctor who specializes in treating a certain kind of health condition)

(ASK Q.16 IF Q.2 = 1-5 OR Q.2a = 1-5, D OR R)
(DISPLAY CODES 6 AND 7 FOR ITEMS D ONLY)
(ASK ITEM E ONLY IF Q.S1 = 2+)
(INSERT "usually go" IF Q.2 = 1-5; INSERT "last went" IF Q.2a = 1-5, D, OR R)
16. These next items are about the care you receive there. Again thinking about the place where you (usually go/last went) for health care, how would you rate (INSERT 1ST ITEM) – excellent, very good, good, not so good, or poor? How about (NEXT ITEM)? (RE-READ LIST AS NECESSARY)

(INTERVIEWER: READ RESPONSE OPTIONS FOR FIRST 2 ITEMS (REPEAT ALL RESPONSE OPTIONS EVERY THIRD ITEM AFTER THAT OR MORE AS NEEDED)

1 Excellent
2 Very good
3 Good
4 Not so good
5 Poor
6 (DO NOT READ) Not applicable/Don't need or use continuing care
7 (DO NOT READ) Not offered
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

a. The amount of time the doctor spends with you (IF NEEDED: The last time you saw one)
b. How well your doctor communicates with you
c. The amount of involvement you can have in making decisions about your health care
d. The continuing care they offer for ongoing or long-term problems
e. The ability of other family members in your household to get health care at the same place

(ASK Q.17 IF Q.2 = 1-5 OR Q.2a = 1-5, D OR R)
(ASK ITEM C IF S5 = 2-7)
17. Thinking more about how the place is run, how would you rate (INSERT 1ST ITEM) – excellent, very good, good, not so good, or poor? How about (NEXT ITEM)?

(INTERVIEWER: READ RESPONSE OPTIONS FOR FIRST 2 ITEMS. REPEAT ALL RESPONSE OPTIONS EVERY THIRD ITEM AFTER THAT OR MORE AS NEEDED)

1 Excellent
2 Very good
3 Good
4 Not so good
5 Poor
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

a. The understanding they have about your medical history
b. How much you feel that people like you are welcome there (IF NEEDED: People of your cultural or economic background)
c. Their ability to speak with you in the language you prefer
d. The affordability of the health care you receive

(ASK Q.18 IF Q.2 = 1-5 OR Q.2a = 1-5, D OR R)
(INSERT "usually go" IF Q.2 = 1-5; INSERT "last went" IF Q.2a = 1-5, D, OR R)
18. How likely are you to recommend the place you (usually go/last went) for health care to your friends – very likely, somewhat likely, not so likely or not likely at all?

1 Very likely
2 Somewhat likely
3 Not so likely
4 Not likely at all
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK IF Q2=1,3,4,5,6,D,R)
[IF Q2=2, AUTO-GEN "1']
19. Do you have a regular personal doctor, or not? [IF NEEDED: I mean one you would regularly see if you need a checkup, want advice about a health problem, or get sick or hurt.]

1 Yes, do
2 No, do not
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.20 IF Q.19 = 1)
20. How would you rate your personal doctor - excellent, very good, good, not so good, or poor?

1 Excellent
2 Very good
3 Good
4 Not so good
5 Poor
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.21 IF Q.19 = 2)
21. Would you like to have your own personal doctor, or is it not that important to you?

1 Yes, would like to
2 No, not that important
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK IF Q.S1>1 AND Q.S1 NE Q.S2)
22. Do you have any children under age 18 living with you?

1 Yes
2 No
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.23 IF Q.22 = 1)
23. Does your child or do any of your children have a personal doctor or pediatrician that they regularly see for most of their care, or not?

1 Yes, does
2 No, does not
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.24 IF Q.23 = 1)
24. Is that pediatrician located at the same place you go for care, or somewhere else? (IF RESPONDENT SAYS MORE THAN ONE PEDIATRICIAN: Are any of them located at the same place you go, or not?)

1 Same place
2 Somewhere else
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(SCRAMBLE ITEMS IN PARENS)
25. The health care system is changing in a way that will give more people access to health insurance and may give you more choices of places to go for health care. Imagine you were deciding between your current place of care and a NEW place. Which of the following would be the SINGLE MOST important factor in your choice: Would it be (how much money it costs to go there) or (the ability to see the same doctor each time) or (short waiting times) or (the convenience of the location)?

1 How much money it costs to go there
2 The ability to see the same doctor each time
3 Short waiting times

4 The convenience of the location
7 (DO NOT READ) I would not leave my current place
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.25a IF Q.25=7)
(SCRAMBLE ITEMS IN PARENS)
25a. Say your current place closed and you HAD to pick a new place for health care. If that happened, what would be the SINGLE MOST important factor in your choice of a new place to go for health care: Would it be (how much money it costs to go there) or (the ability to see the same doctor each time) or (short waiting times) or (the convenience of the location)?

1 How much money it costs to go there
2 The ability to see the same doctor each time
3 Short waiting times
4 The convenience of the location
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.26 IF Q.25=1,2,3,4 OR q.25a=1,2,3,4)
(DO NOT SHOW THE RESPONSE SELECTED AT Q.25 OR Q.25a)
(SCRAMBLE ITEMS IN PARENS)
26. What would be the NEXT most important factor in choosing a new place to go for health care - Would it be (how much money it costs to go there) or (the ability to see the same doctor each time) or (short waiting times) or (the convenience of the location)?

1 How much money it costs to go there
2 The ability to see the same doctor each time
3 Short waiting times
4 The convenience of the location
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.27 IF Q.26=1,2,3,4)
(DO NOT SHOW THE RESPONSE SELECTED AT Q.25 OR Q.25a OR Q.26)
(SCRAMBLE ITEMS IN PARENS)
27. And what would be the NEXT most important factor in choosing a new place to go for health care - Would it be (how much money it costs to go there) or (the ability to see the same doctor each time) or (short waiting times) or (the convenience of the location)?

1 How much money it costs to go there
2 The ability to see the same doctor each time
3 Short waiting times
4 The convenience of the location
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ROTATE VERBIAGE IN PARENS)
INSERT "a" IF Q.19 = 2, D, OR R; INSERT "your" IF Q.19 = 1
28. Thinking about your relationship with (a/your) doctor – which of these is most important to you: (the amount of time the doctor spends with you), (how well the doctor explains things to you), or (how much the doctor takes your opinions and concerns into account)? [IF NEEDED, REPEAT: Thinking about your relationship with (a/your) doctor – which of these is most important to you]

1 The amount of time the doctor spends with you
2 How well the doctor explains things to you
3 How much the doctor takes your opinions and concerns into account
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

29. How interested would you be in being able to communicate with your doctor by e-mail or text message - very interested, somewhat interested, not so interested or not interested at all?
1 Very interested
2 Somewhat interested
3 Not so interested
4 Not interested at all
7 (DO NOT READ) Already doing this
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

30. In choosing where you go for health care, which of these would be most important to you: (the availability of wellness programs with advice on healthy living), (the availability of continuing care for ongoing or long-term problems), or (whether other family members can get their care there too)?

1 The availability of wellness programs with advice on healthy living
2 The availability of continuing care for ongoing or long-term problems
3 Whether other family members can get their care there too
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ROTATE VERBIAGE IN PARENS)
31. In terms of access, which of these would be most important to you in choosing where you go for health care: (your ability to get an appointment when you want one), (the availability of night and weekend hours), or (the availability of walk-in services without an appointment)?

1 Your ability to get an appointment when you want one
2 The availability of night and weekend hours
3 The availability of walk-in services without an appointment
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

32. Would you rather go to a health care place that has a focus on serving people of similar backgrounds as your own, or would you say this doesn't matter so much to you?

1 Rather go to a health care place that has a focus on serving people of similar backgrounds
2 Doesn't matter so much
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q32a IF Q32 = 1)
32a. Do you feel that way strongly, or somewhat?

1 Strongly
2 Somewhat
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK If Q2=1-5 or Q2a=1-5, D,R)
(INSERT "usually go" IF Q2=1-5; INSERT "last went" IF Q2a=1-5, D,R)
33. Some places that provide health care offer a variety of services in addition to regular medical care - such as wellness programs, care for pregnant moms and children, a dentist, a nutritionist and elder care. Does the place you (usually go/last went) for health care offer services like these in addition to regular medical care, or not?

1 Yes
2 No
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK IF Q.33=1)
33a. Overall, how would you rate the variety of these additional services that are available would you say the number of additional services offered is excellent, very good, good, not so good, or poor?

1 Excellent
2 Very good
3 Good
4 Not so good
5 Poor
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

34. If you were choosing a NEW place to go for health care, how important would it be to you that they offer a variety of additional services beyond regular medical care - extremely important, very important, somewhat important, not so important or not important at all?

1 Extremely important
2 Very important
3 Somewhat important
4 No so important
5 Not important at all
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

35. Community health clinics are the non-profit clinics around the state that provide health care for anyone who needs it, whether or not they're insured or can pay. Based on what you have heard, would you say the reputation of community health clinics is excellent, very good, good, not so good or poor?

1 Excellent
2 Very good
3 Good
4 Not so good
5 Poor
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ROTATE VERBIAGE IN PARENS)
36. Thinking about health care decisions, is it your preference to (leave decisions about your health care mostly up to the doctor or nurse), or would you prefer to (have an equal say with the doctor or nurse in decisions about your health care)?

1 Prefer to leave decisions mostly up to the doctor or nurse
2 Prefer to have an equal say with your doctor or nurse in decisions
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.36a IF Q.36=1,2)
36a. Do you feel that way strongly, or somewhat?

1 Strongly
2 Somewhat
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

37. As you may know, the Congress recently passed and President Obama signed into law a health reform bill that changes the nation's health care system. As a result of the new health care law do you think that your own health insurance coverage, or ability to get coverage, will get better, get worse, or not change?

1 Get better
2 Get worse
3 Not change
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

38. Do you have any disability or chronic medical condition that requires ongoing health care, or not?

1 Yes, do
2 No, do not
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(DISPLAY CODE 07 IF Q.38 = 1)
39. What is your main source of health insurance coverage, if any? (READ LIST IF RESPONDENT DOES NOT IMMEDIATELY VOLUNTEER AN ANSWER FROM THE LIST)

(INTERVIEWER NOTE: IF RESPONDENT SAYS "Kasier Permanente", "Anthem/ Blue Cross or other insurance company" PROBE FOR WHETHER IT'S CODE "01" OR "02." IF RESPONDENT SAYS "COBRA", CODE AS "02"; IF RESPONDENT SAYS "SCHIP", CODE AS "04.")

01 Private health insurance through an employer
02 Private health insurance that you buy on your own
03 MediCal, also known as Medicaid
04 Any other state health insurance program
05 The V.A., military insurance through Tri-Care or any other federal government program
06 Indian Health Service
07 Medicare, which would only be if you are disabled
08 (DO NOT READ) Both Medicare and MediCAl (Medi-Medi)
00 Or none, you are uninsured
DD (DO NOT READ) Don't know
RR (DO NOT READ) Refused

READ: Now for classification purposes only...

(ASK CELL SAMPLE ONLY)
D1a. For personal calls do you only use a cell phone, or do you also have regular landline telephone service in your home on which I could have reached you?

1 Only use a cell phone
2 Have regular landline
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK LL SAMPLE ONLY)
D1b. For personal calls, do you only use a landline phone like this one, or do you also have a cell phone on which I could have reached you?

1 Landline phone only
2 Cell phone also
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

D2. Are you currently married, living with a partner, widowed, divorced, separated, or single, meaning never married and not living with a partner?

1 Married
2 Living with a partner
3 Widowed
4 Divorced
5 Separated
6 Single, meaning never married and not living with a partner
R (DO NOT READ) Refused

D3. Currently, are you yourself employed full time, part time, or not at all?

1 Full time
2 Part time
3 Not employed
R Refused

(ASK IF Q.D3=3)
D3a. Are you: (READ LIST)?

1 Retired
2 A homemaker
3 A student, or
4 Temporarily unemployed
5 (DO NOT READ) Disabled/handicapped
7 (DO NOT READ) Other
D (DO NOT READ) Don't Know
R (DO NOT READ) Refused

D4. May I please have your zip code?

_____ ZIP CODE
DD (DO NOT READ) Don't know
RR (DO NOT READ) Refused

D5. What is the last grade of school you've completed? (DO NOT READ LIST.)

1 8th grade or less
2 Some high school
3 Graduated high school
4 Some college/associates degree
5 Graduated college
6 Post graduate
R (DO NOT READ) Refused

D6. Are you of Hispanic origin or descent?

1 Yes
2 No
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.D6a IF Q.D6 = 1)
D6a. Are you white Hispanic or black Hispanic?

1 White
2 Black
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.D6b IF Q.D6 = 2, D, OR R)
D6b. Are you white, black, Asian or some other race?

1 White
2 Black
3 Asian
4 Multiracial
7 Other (SPECIFY) _____
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(DISPLAY CODES 01-03 FOR EVERYONE; DISPLAY CODE 04 IF S1>1; DISPLAY CODE 05 IF S1>2; DISPLAY CODES 06 AND 07 IF S1>3; DISPLAY CODES 08 AND 09 IF S1>4; DISPLAY CODE 10 IF S1>6; READ ITEM IN PARENS IF S1=2+)

D7. To help us describe the people who took part in our study, it would help to know which category describes your (family's) total annual income last year before taxes. That's income from all family members living in your household. Is it…? PROBE: Your best estimate is fine. (READ LIST.)

01 Less than $15,000
02 $15,000 but less than $19,000
03 $19,000 but less than $23,000
04 $23,000 but less than $30,000
05 $30,000 but less than $35,000
06 $35,000 but less than $40,000
07 $40,000 but less than $45,000
08 $45,000 but less than $50,000
09 $50,000 but less than $60,000
10 Or $60,000 or more
DD (DO NOT READ) Don't know
RR (DO NOT READ) Refused

D8. Confidentially and for statistical purposes only, are you a citizen of the United States, or not?

1 Yes, citizen
2 No, not a citizen
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

CB. Some organizations may be interested in talking with you a little more about some of these issues. Would it be OK if a representative of Blue Shield of California Foundation, the California Primary Care Association or Health Affairs magazine called you back at some time? Again this would just be to learn some more about your ideas and experiences.

1 Yes
2 No/hesitant
R (DO NOT READ) Refused

(ASK Q.CBa IF Q.CB = 1)
CBa. May I please have your first name, so the caller knows who to ask for? (VERIFY SPELLING)

1 Answer given (SPECIFY) _____
R (DO NOT READ) Refused

FOR INTERVIEWER
SP. DO NOT READ. Did respondent ask for sponsor information at intro?

1 Yes, asked for sponsor information
2 No, did not ask for sponsor information

(READ IF Q.SP=1)
The survey sponsor is Blue Shield of California Foundation, a nonprofit group that works on health care issues in the state. The Foundation is a separate non-profit organization from the Blue Shield of California health plan. It has an independent Board of Trustees, which oversees its grant-making program. The Foundation is funded entirely by a contribution from the health plan.

FOR INTERVIEWER (CELL PHONE SAMPLE ONLY):
R. DO NOT READ. Did respondent request money for using their cell phone minutes?

1 Yes, requested money
2 No, did not request money – GO TO END OF INTERVIEW

(READ IF SAMPLE = CELL AND R=1)
That's the end of the interview. We'd like to send you $5 for your time. Can I please have your full name and a mailing address where we can send you the money?

INTERVIEWER NOTE: If R does not want to give full name, explain we only need it so we can send the $5 to them personally.

1 [ENTER FULL NAME]
2 [ENTER MAILING ADDRESS]
3 [City]
4 [State]
5 CONFIRM ZIP from above
R (VOL.) Respondent does not want the money

CLOSING: That completes our interview. Thank you very much for your time.

48. INTERVIEWER: Would you describe this respondent as very well-spoken, somewhat well-spoken, not so well-spoken or not well-spoken at all?

1 Very well-spoken
2 Somewhat well-spoken
3 Not so well-spoken
4 Not well-spoken at all

end of questionnaire

appendix e – references

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