blue of california
foundation

delivering on a promise: advances and opportunities in health care for low-income Californians

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LANGER RESEARCH ASSOCIATES
SURVEY RESEARCH DESIGN • MANAGEMENT • ANALYSIS

introduction

As both the recipients and drivers of our evolving healthcare system, patients' voices matter. So, we started listening. Four years ago, we surveyed low-income Californians about their healthcare experiences in order to help guide the transformation of our safety net in the lead-up to reform. It was a challenging time for community health providers, and much of what we learned was difficult for the field to hear – including the fact that many patients would change their care facility if given the choice.

Thankfully, we also learned that many of the factors affecting that choice are were well-within the clinic's control; things like facility cleanliness and staff courtesy. The keys to patient loyalty are not complex, but they do take time and effort. Overall, clinics responded and took-on the challenge of improving for their patients - even in the face of multiple, competing priorities. Since then, significant progress has been made, and positive results can be seen through the very individuals they serve:

Today, low-income Californians report a thirteen percent improvement in staff courtesy and nine percent more continuity in their care since 2011. We've also seen an eleven percent improvement in wait times, which is remarkable given the recent influx of patients and the systems-changes it has required.

The effort was, and remains, a huge undertaking for clinics – including community health centers. Though there is still much to be done, safety net organizations should be proud of how far they've come in just four years. In a system so large and complex, "easy fixes" are not possible. Change takes time. Given all that has been achieved, we can - and should - pause to celebrate success, and then take deliberate steps in the right direction.

Now that we know where we're going and how to get there, safety net providers must be willing to continue to transform the way that they operate and deliver care– not only in response to a new era of competition, but for the communities, families, and individuals who remain at the heart of their work.

We hope this report will further illuminate the road ahead, and look forward to seeing what will be accomplished in the next four years.

Onward,

Peter Long, PhD
President and CEO
Blue Shield of California Foundation

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key terms

care experience: all aspects of patients' experience at their healthcare facility, from the courtesy of staff and facility cleanliness to their relationships and effective communication with care providers.

patient-provider relationships: the amount of time providers spend with patients and how well they communicate, give treatment options, encourage questions, and ask about stress or other health issues.

satisfaction: patients' positive ratings of their health care overall, their facility, and their relationships with their providers. Ratings of "excellent" or "very good" are desirable in achieving patient loyalty.

loyalty: patients' interest in finding a different healthcare facility if they had "more choices and insurance to cover it." Lower interest reflects greater loyalty.

connectedness: a sense among patients that, at the place they go for care, "there's a person there who knows you pretty well." The connection can be with a provider, nurse, or other staff member.

continuity: the extent to which patients see the same provider when they go in for care. Continuity exists when patients say they see the same provider all or most of the time.

empowerment: the extent to which patients feel they have the tools necessary to take an active role in their care. This includes how informed patients feel, their level of confidence that they can make healthcare decisions, and their comfort asking providers questions.

engagement: how much of a say patients report having in decisions about their care – a goal of the patient-centered care movement.

facility types

There are important differences among the types of facilities that offer care to low-income Californians, reflected in demographics and healthcare experiences alike.

The largest share, 41 percent, use a clinic for their care. That includes 15 percent who use CCHCs, 11 percent who go to a public clinic, and 15 percent who use a private or other type of clinic. Of the rest, 27 percent of low-income patients obtain their care from a private doctor's office, 15 percent use the Kaiser Permanente system, and 10 percent rely on hospital emergency rooms.

The breakdown is far different among higher-income Californians. In this population, clinic use drops to 19 percent, and use of Kaiser Permanente and private doctors' offices rises to 23 and 51 percent, respectively.

Low-income clinic patients in general, and CCHC users in particular, are more likely than private doctors' office or Kaiser Permanente patients to lack any insurance, and far less likely to have private insurance. Clinic patients have especially low incomes, and clinics serve more Latinos and non-citizens than other facility types. Many clinics' willingness to care for all patients regardless of their ability to pay has set them apart historically as safety net healthcare providers.

Kaiser Permanente is a closed system that provides coverage as well as care, and often offers a variety of services under one roof. Its low-income patients are on the higher-earning end of the low-income spectrum.

At private doctors' offices, patients' income and private insurance levels fall between those of Kaiser Permanente and clinics. These facilities are more likely than others to serve white patients, and less apt than clinics to provide care to non-citizens.

executive summary

Today's healthcare environment is very different from what it was four years ago, and it continues to transform. In order to help ensure that the ongoing changes are being built around the individuals they aim to serve, Blue Shield of California Foundation has sought to bring patient voices into the conversation. The Foundation has been listening to low-income patients – asking about their needs, experiences, and preferences in their care – in a series of surveys since 2011.

The Foundation began by focusing on satisfaction and loyalty, then in subsequent years dived deeper into the driving factors behind patient engagement and empowerment. The results of this research have helped California safety net providers better understand their patient population and prepare for the influx of newly insured patients in a newly competitive market.

The first survey, conducted by Langer Research Associates in 2011, showed that nearly six in 10 low-income patients would be interested in changing their healthcare facility if given the option. Where are we today? And now that patients have greater choice, what can safety net providers do to retain them? This report provides new answers and insights from low-income patients across California.

The Patient Protection and Affordable Care Act (ACA) sought not only to increase access to care for the uninsured, but also to improve the quality of the care that's being delivered. Early signs indicate that California's healthcare providers are making strides in delivering on that promise. In just four years there have been a number of improvements that help drive patient satisfaction and loyalty.

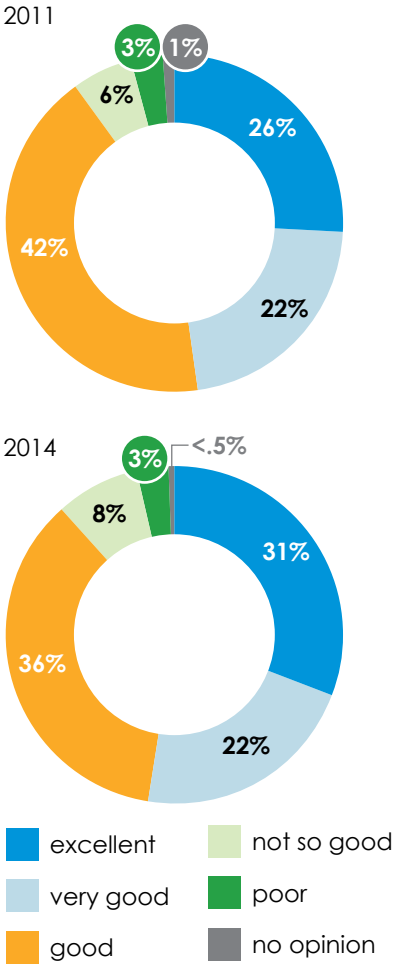
Among the advances:

- For the first time in the Foundation's research, more than half of low-income Californians (53 percent) rate the quality of their health care as excellent or very good. Compared with 2011 results, this is a 5 percentage point increase, or approximately 400,000 additional low-income patients who are highly satisfied with their care.

- More low-income Californians now report that they see the same provider on a consistent basis, which is important because continuity of care is one of the single strongest predictors of patient satisfaction and loyalty to their care facility.

For the first time in the Foundation's research, more than half of low-income Californians rate the quality of their health care as excellent or very good.

the quality of the health care you receive (among low-income Californians)



- The number of low-income patients with a "regular personal doctor" has increased, and more say that someone at their healthcare facility knows them well. These changes suggest a greater sense of connectedness, which is another essential building block of patient satisfaction and engagement.

- There has been a significant improvement in many of the individual patient experience ratings, including a 13-point increase in clinic patients' positively rating staff courtesy.

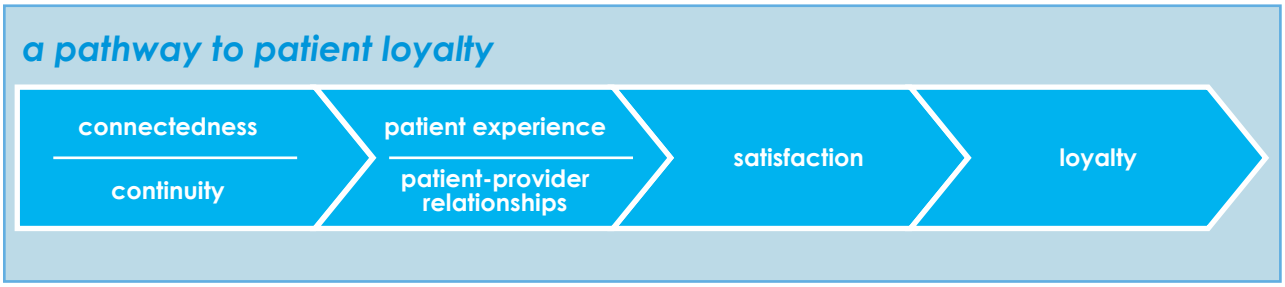
- Among the broader low-income population, Latinos and other nonwhites also are showing improvements in their patient experience ratings. This is important because Latinos are the state's main users of clinic-based care making up 54 percent of the low-income population, but 68 percent of clinic patients. Many gaps in satisfaction between whites and Latinos that existed in 2011 have been eliminated or dramatically narrowed by these improvements.

- Since 2011, patients at California community health centers (CCHCs) have become more satisfied with their care, and compared with last year are much more likely to say that someone at their facility knows them well. CCHCs also are performing comparatively well in areas such as cultural competence and social service referrals.

- Advances in low-income patients' experiences reflect significant gains for the newly insured. Compared with those who were uninsured in 2011, patients who now have insurance via Covered California report much higher overall satisfaction with their care. They also are much more likely to report that they have a regular personal doctor, that they usually see the same provider, and that someone at their facility knows them well.

As safety net facilities continue to make changes that deliver on the promise of healthcare reform, this research shows that the needle undoubtedly is moving in the right direction. However, change of this scale takes time and long-term commitment. While some gaps have been narrowed or even closed, others continue to exist and require focused efforts for improvement. Low-income Californians continue to trail their higher-income counterparts in terms of basic quality-of-care ratings and loyalty to their healthcare facility.

This study reinforces previous Foundation research establishing a data-driven model of patient engagement, satisfaction, and loyalty. Patients who exhibit connectedness and continuity are far more likely than others to give positive ratings to specific aspects of their health care and their care providers alike. Those ratings, in turn, are the strongest independent predictors of patients' overall satisfaction with their care. And patient satisfaction is the prime element of patients' loyalty to their healthcare facility.



While satisfaction is up, overall loyalty of low-income patients has not changed. What the research suggests is that if providers continue to improve on the drivers of patient satisfaction, improved loyalty is very likely to follow. It will be important to stay the course, particularly as patients are able to exercise the power of choice offered to them by the ACA.

changes in insurance status

Improvements in patient experiences have occurred within a time of profound changes resulting from implementation of the ACA. The number of low-income Californians who lack health insurance has fallen dramatically, from 30 percent in 2013 to 15 percent after the ACA's first enrollment period, this survey finds. Among other impacts, this means that the number of clinic patients[1] with Medi-Cal coverage has soared from three in 10 in 2013 to nearly half in 2014. And low-income patients who've signed up via the Covered California marketplace are heavy healthcare users, reporting many more medical visits, on average, than other patients.

The impact of the ACA is not confined to low-income Californians, who are defined in this survey as those with household incomes less than 200 percent of the federal poverty level, or $48,000 for a family of four. A separate sample of higher-earning residents shows that the uninsured rate has fallen in this group as well, from 10 to 5 percent in a single year. Further change is likely; the second round of signups that began in November 2014 is not included in these figures. (As in past years, the survey is limited to adults age 19 to 64, to exclude traditional Medicare recipients.)

advances in patient satisfaction

Clinic patients have shown some particularly positive gains in the past few years, including an increase of 11 points in overall satisfaction, and 12- and 8-point advances in their continuity of care and the extent to which they feel they have a say in decisions about their care.

Clinic users' ratings also have improved in nine out of 15 individual patient experience measures that were initially tested in 2011. Those include especially positive changes in staff courtesy ratings and time spent in the waiting room.

the role of personal experience

Critically, the survey also shows that patients' overall satisfaction is profoundly impacted by modes of care, extent of services, and clear patient-provider communication that helps patients feel informed, involved, and confident in their care decisions.

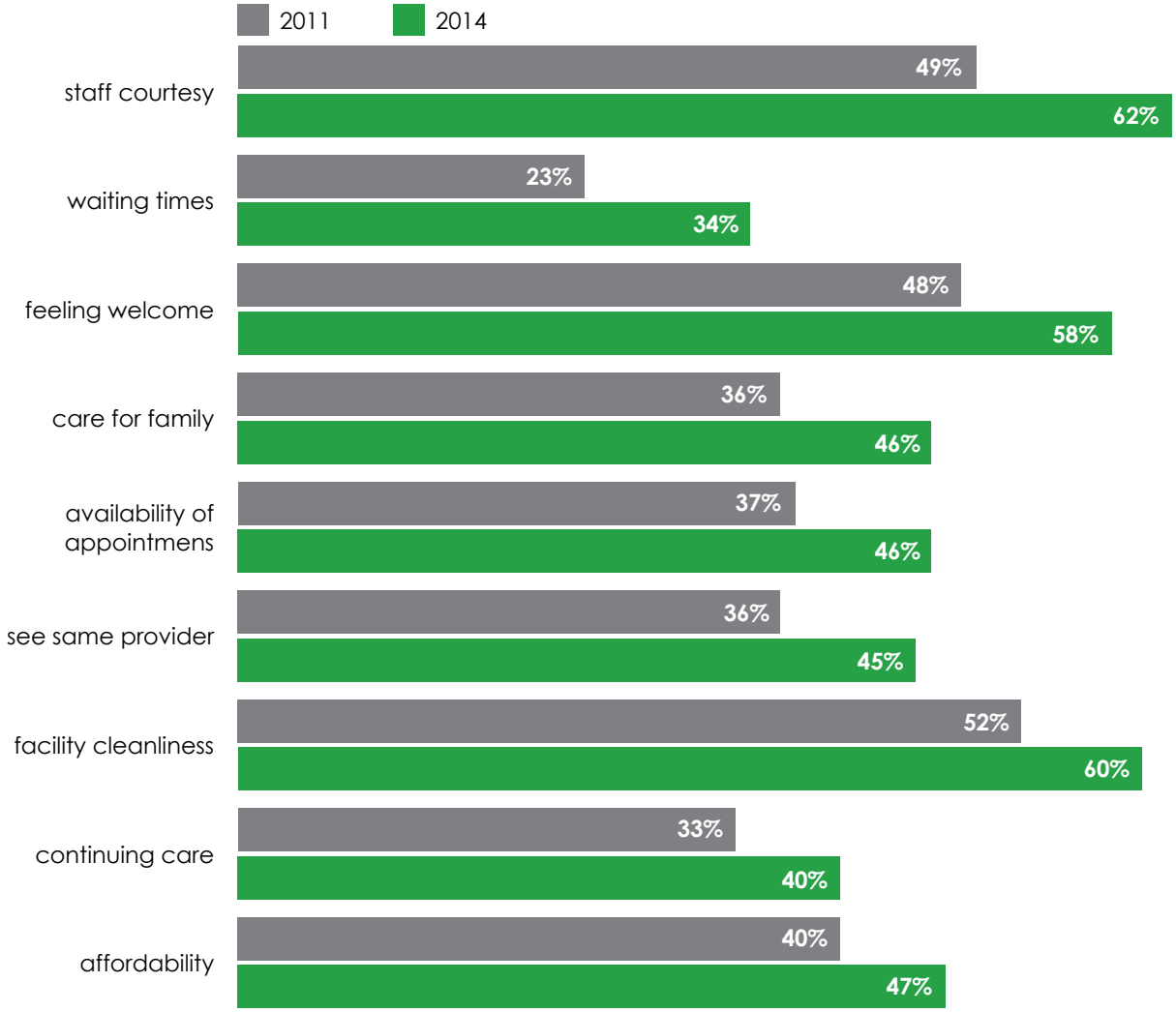
Patients' overall satisfaction is profoundly impacted by modes of care, extent of services, and clear patient-provider communication.

Some examples:

- Among patients who rate the courtesy of staff at their place of care as excellent or very good, 70 percent are highly satisfied with the quality of their care overall. Among those who rate courtesy less positively, satisfaction plummets to 24 percent.

- There are similar gaps in satisfaction on the basis of how patients rate their experiences on items ranging from the facility's cleanliness and the convenience of its location to the availability of timely appointments.

% rating their care as excellent or very good (among low-income Californians who are clinic patients)



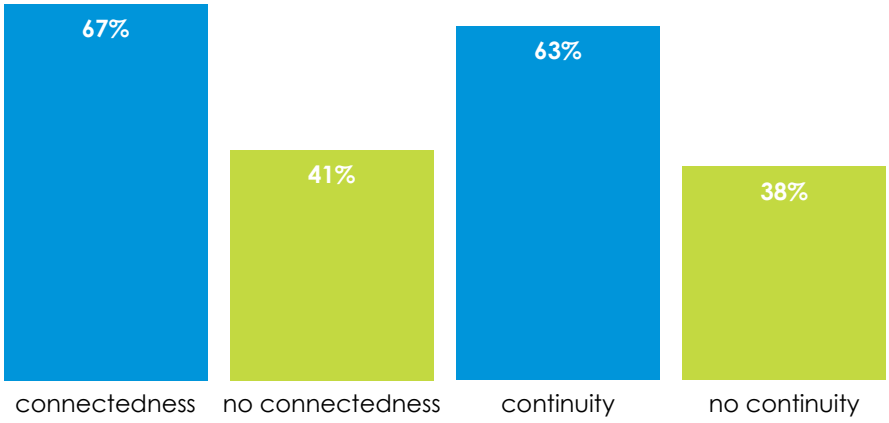
- Satisfaction with care also is much higher among patients who say staff members understand their cultural background.

- Those who can e-mail or text their providers also are more apt to rate their care positively.

- Provider performance matters as well, with vast differences in patient satisfaction on the basis of how much time the provider spends with them, how well the provider communicates with them, and how positively they rate the treatment options offered.

- Patients who feel a personal connection with their care facility are far more likely to rate their care positively than those without a sense of connectedness. Usually seeing the same provider has a very similar impact.

% rating their care as excellent or very good (among low-income Californians)



- Among those who feel they can have a substantial say in their care decisions, 64 percent rate their overall care positively. Among those with less of a say, satisfaction declines to 26 percent.

patient-provider relationships

While facility ratings are important, so is the quality of the relationship between patients and their care providers. As with other ratings, these are positive overall, albeit lower among low-income Californians compared with their higher-income counterparts.

Seven in 10 low-income patients rate their provider's ability to explain things well as excellent or very good, and six in 10 or more say the same for a variety of other patient-focused behaviors. Fewer, 55 percent, highly rate the amount of time the provider spends with them, although this has improved since 2011.

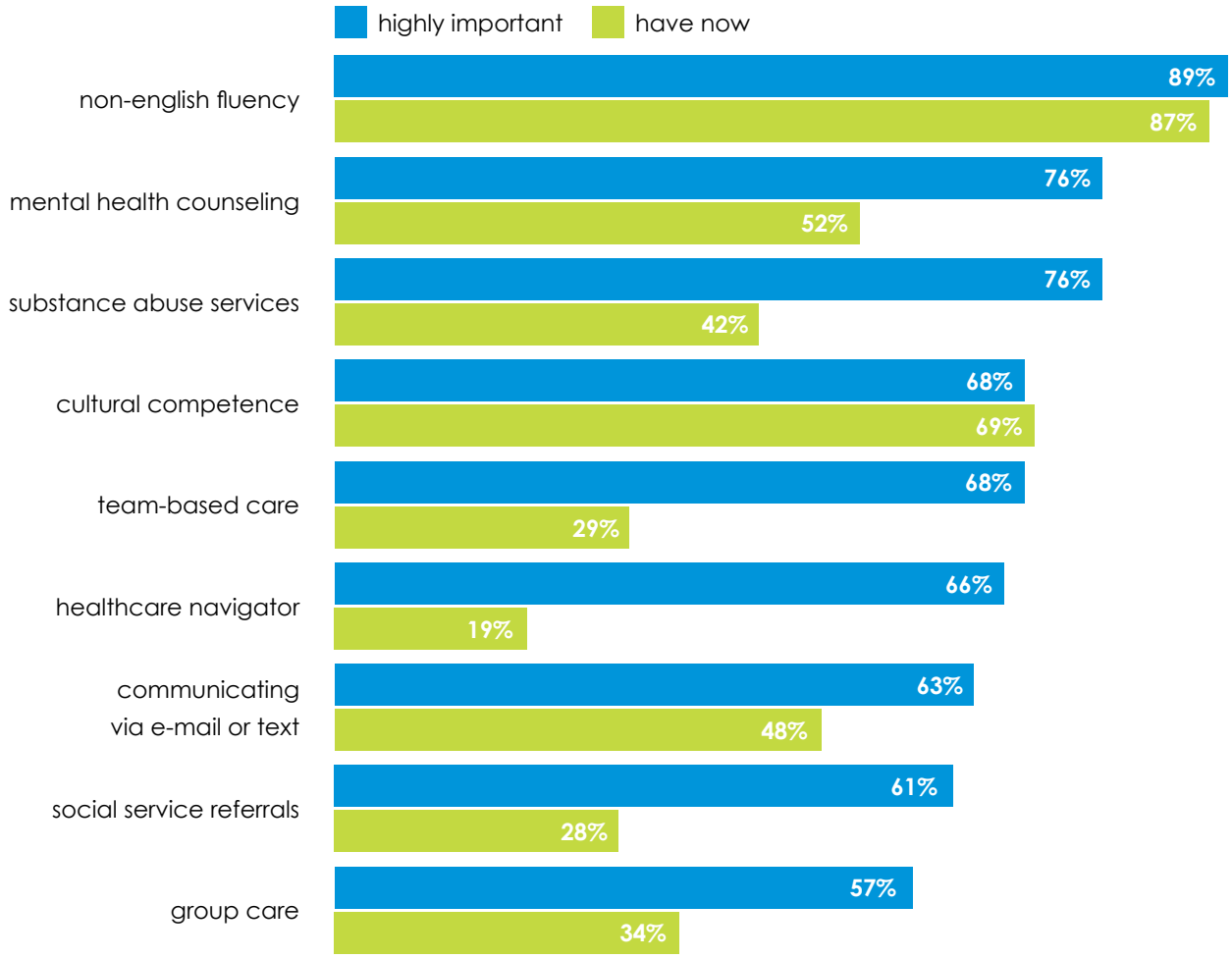
While these are clear majorities, substantial numbers of patients continue to lack strong provider relationships. Further development is warranted, given the powerful role of such relationships in engagement, satisfaction, and loyalty.

services, care models, and communication

An evaluation of facility offerings – those available and those in demand – provides additional insight. About half of low-income patients say mental health counselors are available where they go for care; fewer say they have access to substance abuse counselors, group care, or social service referrals. Just three in 10 have team care[2] and two in 10 have healthcare navigators[3].

Access to these modes of care and services falls far short of demand. Anywhere from nearly six in 10 to three-quarters call it extremely or very important that facilities provide access to each of these items. Interest is higher among low-income Californians compared with their higher-income counterparts, and, in several cases, higher among Latinos than others. Given the association of these options with overall satisfaction, taking steps to better meet patient interest could benefit care providers and their patients alike.

patient services, modes of care, and communication (among low-income Californians)



the impact of empowerment and engagement

Many of the same factors that relate to patient satisfaction also are linked to two other central concerns – empowerment, the extent to which patients feel they understand their health and are comfortable taking an active role in their care; and engagement, meaning how much they actually participate in their healthcare decisions.

Empowerment levels are substantial. Anywhere from two-thirds to nearly three-quarters of low-income Californians highly trust the information they get from their provider, feel extremely or very comfortable asking questions about their care, are highly confident in their decision making, and report feeling well informed about their health. At the same time, that means that a quarter to a third of low-income patients have lower-than-desirable empowerment levels. And empowerment is higher, by 13 to 16 points, among higher-income patients.

It matters: The survey finds very broad gaps in satisfaction, engagement, and patients' loyalty depending on their empowerment levels. And empowerment is the main predictor of patient engagement, an objective of patient-centered care.

cultivating loyalty

Loyalty is defined in this research as the extent to which patients are or are not interested in changing their place of care, assuming they had a choice and insurance coverage to pay for it. In all, 55 percent of low-income Californians express interest in changing facilities, essentially unchanged since 2011. Fewer higher-income patients desire a change of facility, 39 percent.

The type of healthcare facility that patients use is one factor that relates to these views. But the primary driver of loyalty, as noted, is patients' overall satisfaction with their quality of care: Lower satisfaction is by far the strongest independent predictor of patients' interest in changing facilities.

The fact that patient satisfaction has improved since 2011 but loyalty has not likely indicates that improvements in patients' care experiences either have not yet been large enough or have not been sustained long enough to have a significant impact on their desire to stay at their current healthcare facility. That said, if low-income Californian's quality of care continues to improve, greater loyalty likely will follow.

Other items also influence loyalty, including having a choice of care facilities, having a regular doctor, and participating in care decisions. Satisfied and engaged patients, in short, are far more apt to be loyal ones.

charting a course for the future

Beyond measuring changes in patient experiences and attitudes over time, this study helps chart future steps. Some solutions seem simple: About a third of low-income Californians give their healthcare facilities middling or lower ratings on two of the most basic items, cleanliness and staff courtesy. Both have improved from 2011, but could be better still.

About half give less-than-strong ratings to a range of other patient experiences, from being able to get an appointment when they want one to the availability of specialists and continued care for long-term health issues. Waiting times, though improved, remain the most widespread complaint.

Broad majorities still lack access to team-based care or healthcare navigators, two approaches that continue to show promise in efficiently achieving connectedness and continuity. There also are promising opportunities for advancement in developing patient-provider relationships, enhancing communication and offering a range of facility services.

The results, in total, include both encouraging trends and targets for the future. The Foundation's research illuminates the pathways available to safety net providers to cement their relationships with the patients who use their services – and the benefits of doing so. Progress in key measures has been realized. Building upon it is the task ahead.

endnotes

1 "Clinic patients" refers to all low-income Californians who use a clinic for their care. This includes CCHC, public, private, and other clinic types. Results for individual clinic types are specified.

2 Having team care was assessed with the following question: "Some places have what's called team-based care. Each patient gets a health care team that includes a doctor, a health care navigator, a nurse or physician's assistant, and a health educator. The same team always works with that patient. As far as you're aware do you personally have a health care team at the place you go for care, or not?"

3 Having a healthcare navigator was assessed with the following question: "Some places have a person whose job it is to help people get the appointments, information, and services they need, make sure their questions have been addressed, or may even call to check in on them between visits. There are different names for this kind of role, for example a health care navigator or health care coach. Do you personally have a health navigator or health coach at the place you go for care, or not?"

project overview

This Blue Shield of California Foundation survey extends research initiated by the Foundation in 2011 to help safety net providers in the state better understand and serve their low-income clients in the changing healthcare marketplace.

The project has produced four in-depth surveys focused on the healthcare experiences and preferences of low-income Californians, exploring motivators of patient satisfaction and engagement, evaluating patients' receptiveness to alternative care models, and identifying pathways to successful patient-provider relationships.

Two aims have motivated this work: To help California's community health centers and other safety net providers successfully navigate the changes brought about by the ACA; and, via a reliable, representative sample, to bring low-income patients' voices into the conversation on primary care redesign, through the prism of patient empowerment and engagement – principles at the heart of the movement toward more patient-centered care.

The research has produced six main reports:

- *On the Cusp of Change: The Healthcare Preferences of Low-Income Californians*
- *Connectedness and Continuity: Patient-Provider Relationships among Low-Income Californians*
- *Empowerment and Engagement among Low-Income Californians: Enhancing Patient-Centered Care*
- *Building Better Health Care for Low-Income Californians*
- *Health Care in California: Leveling the Playing Field,*
- *Engaging California Patients in Major Medical Decisions*.

Six issue briefs also have been produced, including, in 2013, a practitioner-focused summary of the research to date, entitled *Improving the Healthcare Experience for Safety Net Patients: 10 Things Health Centers Can Do.* The Foundation has hosted a series of seminars, webinars, and presentations on the research findings in Washington, D.C., and across California.

As previously, the 2014 survey is based on telephone interviews with a representative, random statewide sample of Californians age 19 to 64 with household incomes less than 200 percent of the federal poverty level, about $48,000 a year for a family of four. As in 2013, this year's survey includes a representative sample of higher-income Californians for comparison.

Sampling, survey field work, and data tabulation have been carried out each year by SSRS/Social Science Research Solutions of Media, Pa. The latest interviews were conducted in English and Spanish on landline and

cellular telephones from Aug. 14 to Oct. 5, 2014, among 1,033 low-come Californians and 513 with higher incomes. The margin of sampling error is plus or minus 4 percentage points for the low-income sample and 5 points for the higher-income sample, including design effects.[4]

This report builds on the Foundation's previous research in two ways, repeating basic patient experience, satisfaction, and loyalty questions from 2011, and adding measurement of patient-provider relations, empowerment, and engagement from the subsequent studies. Among the research questions it addresses:

- What changes, if any, have occurred in patient experience, satisfaction, and loyalty since publication of the *On the Cusp* report? What factors inform these ratings, and how do they differ among groups within the patient population?

- How has implementation of the ACA affected insurance status among low-income Californians, with what impacts on healthcare providers and on patient experience alike?

- What healthcare services, modes of care, and communication options are available to patients, compared with those they're interested in having available? How do these differ among groups, and how do they impact patient experiences?

- Has change occurred in the crucial items of connectedness, continuity, and having a regular personal doctor? What is the status of patient empowerment and engagement, key outcomes of patient-centered care?

- Finally, how can safety net providers leverage the results of this inquiry to improve their patients' healthcare experiences?

The study was produced and analyzed by Langer Research Associates of New York, N.Y., led by Julie E. Phelan, Ph.D., senior research analyst and lead writer; with Gary Langer, president; Damla Ergun, Ph.D.; Gregory Holyk, Ph.D.; Christopher C. Weiss, Ph.D.; and Ryan Struyk.

Langer Research is a charter member of the Transparency Initiative of the American Association for Public Opinion Research, and this report complies with AAPOR's Code of Professional Ethics and Practices and the Principles of Disclosure of the National Council on Public Polls. All comparisons of data have been tested for statistical significance.

Blue Shield of California Foundation, long a thought leader in safety net healthcare, has sponsored this research as part of its mission to improve the lives of Californians, particularly underserved populations, by making

health care accessible, effective, and affordable for all Californians. The Foundation in particular has a history of support for the state's community health centers through its Community Health Center Core Support Initiative and Clinic Leadership Institute offerings.

endnotes

4 See Appendix A for methodological details, Appendix B for the topline data report and Appendix D for the survey questionnaire.

sections guide

Key results of this survey are described in the executive summary. The full report provides details, presented as follows:

- **section i:** satisfaction and patient experience. Changes in patients' ratings of their healthcare experiences since 2011 overall and among groups. Ratings among those who have gained insurance through the ACA vs. those who had insurance previously. The relationship of these ratings with availability of care and communication services and the quality of patient-provider relationships.

- **section ii:** patient-provider relationships. Changes in patients' assessments of whether or not someone at their place of care knows them well, the frequency with which they see the same provider, and their providers' communication behaviors. Differences in these ratings by facility type, insurance status, and access to alternative care models.

- **section iii:** services, modes of care, and communication. Access to and perceived importance of service, care model, and communication options including team-based care, healthcare navigators, group care, social service referrals, e-mail or text-based communications, and cultural competence of places of care, overall and among groups.

- **section iv:** patients' loyalty to their care facility. Interest in changing facilities, perception of having a choice in place of care, and tenure at current facility, including changes since 2011. Differences in these views by facility type, insurance status, satisfaction with care, patient-provider relationships, and engagement.

- **section v:** empowerment and engagement in healthcare decisions. The extent to which patients are empowered to take an active role in their care, and whether or not they are doing so. Differences by patient-provider relationships, access to alternative care models, facility types, insurance status, and demographics.

- **section vi:** comparing low- and higher-income patients' healthcare experiences. Gaps in satisfaction, ratings of patient-provider relationships, access to alternative care models and services, loyalty, and patient engagement between low- and higher-income patients.

- **section vii:** insurance, care facilities, and health status. Changes in and overall levels of insurance coverage and types, facility types used, and perceived health status. Frequency of facility visits overall and among groups, including changes over time.

In addition to conclusions and recommendations, the report includes appendices with topline results; a detailed description of the survey's sampling methodology, including field work, data processing, weighting, response rate information, and procedures for healthcare facility identification; details of statistical modeling used in this report; and the full questionnaire.

Questions on any aspect of the this study, and requests for further data analysis, should be directed to Crispin Delgado, Program Officer, Health Care and Coverage, Blue Shield of California Foundation, 50 Beale Street, 14th Floor, San Francisco, Calif., 94105-1819, tel. 415-229-6080, e-mail bscf@blueshieldcafoundation.org.

section i: satisfaction and patient experience

The healthcare experiences of low-income Californians have improved significantly in recent years, reflecting positive changes in the safety net facilities that serve them as well as a dramatic rise in the number of patients covered by health insurance.

Satisfaction with care has improved for approximately 400,000 low-income patients.

Compared with surveys from 2011 to 2013, low-income patients express greater satisfaction with their care in general and across a range of basic items, including the cleanliness of their place of care, waiting times, the availability of timely appointments, and the courtesy of the staff.

More than half, 53 percent, now rate the quality of the overall health care they receive as excellent or very good – up by 5 percentage points[5] compared with 2011. Of the rest, very few rate their care negatively, 11 percent. The balance choose the midpoint, "good," 36 percent.

The 5-point improvement in care ratings, while slight, has positive implications. Given the size of the low-income population, more than 7.7 million individuals, it represents a change for the better among approximately 400,000 low-income patients in the state.

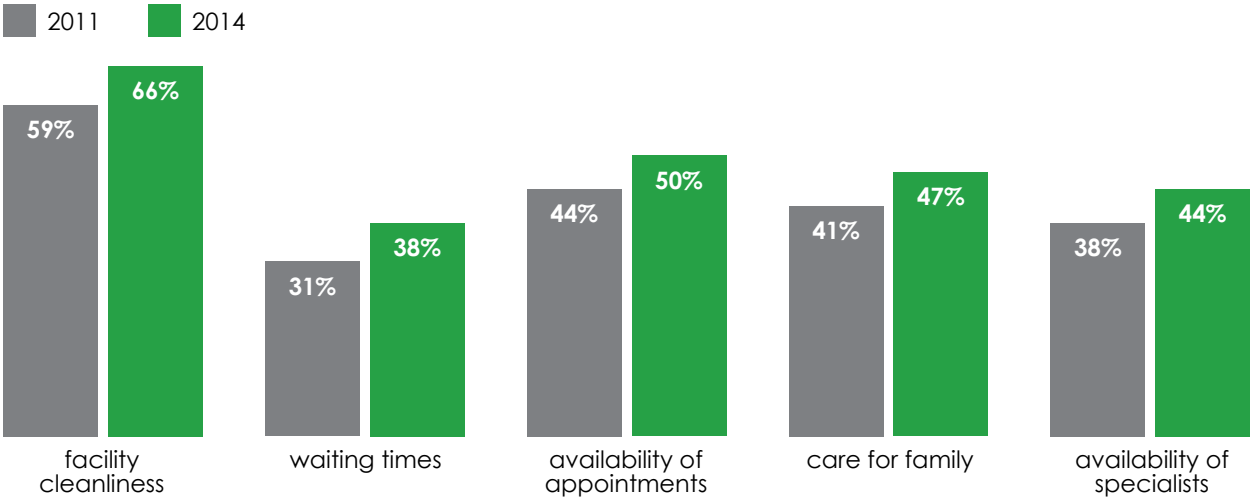
Notably, as well, the shift is concentrated at the high-end of the scale. Steadily from 2011-13, a quarter rated their care as excellent. Today it's 31 percent.

Patients' ratings of many specific aspects of their healthcare experiences also have improved, compared with identical questions asked in 2011. Among them:

- Two-thirds rate the cleanliness of their care facility positively, up by 7 points.
- Thirty-eight percent give a positive rating to the amount of time they have to spend in the waiting room, also up by 7 points, albeit with much room for further improvement.
- Half are well-satisfied with their ability to get an appointment when they need one. Nearly as many, 47 percent, positively rate the availability of care for family members, and 44 percent highly rate their ability to see a specialist. Each of these has gained 6 points since 2011.

- Other ratings are up a bit more modestly, by 5 points each: patients' ratings of the courtesy of the staff at their facility (63 percent positive), their ability get continued care for long-term health issues (50 percent), and the availability of care on nights and weekends (25 percent).

excellent/very good ratings of healthcare experiences (among low-income Californians)



Several other items are essentially unchanged from three years ago. Six in 10 patients are well-satisfied with the extent to which people like them are welcome at their facility, and about as many call its location especially convenient. Among those who don't primarily speak English at home, about half are satisfied with the staff's ability to speak with them in the language they prefer. Half overall give positive ratings to the staff's understanding of their medical history and to the amount of involvement they can have in their care, 45 percent rate the affordability of their care highly, and 42 percent highly rate their ability to get continuing care.

The improvements in healthcare ratings overall and across specific experiences are encouraging. There also is room for continued growth: Forty-seven percent of low-income Californians rate their overall care as only good, the midpoint, or worse; as discussed in Section IV, it takes better ratings – excellent or very good – to achieve higher levels of patient loyalty. More than half give middling or lower ratings to six of the 15 items tested: seeing a specialist, access to continuing care, availability of care for family members, affordability, waiting times, and night or weekend hours.

Additionally, as described in Section VI, low-income Californians continue to trail higher-earning patients in satisfaction with their care, often by wide margins. So while advances are evident, the quest to improve health care experiences for safety net patients is a continuing one.

change in overall satisfaction among groups

The growth in satisfaction with care overall, while broadly based, has been strongest among certain groups. One is low-income Californians who have gained insurance through Covered California, the state's insurance marketplace created through the Affordable Care Act.

Patient satisfaction is up among previously insured patients as well as among those newly covered under the ACA.

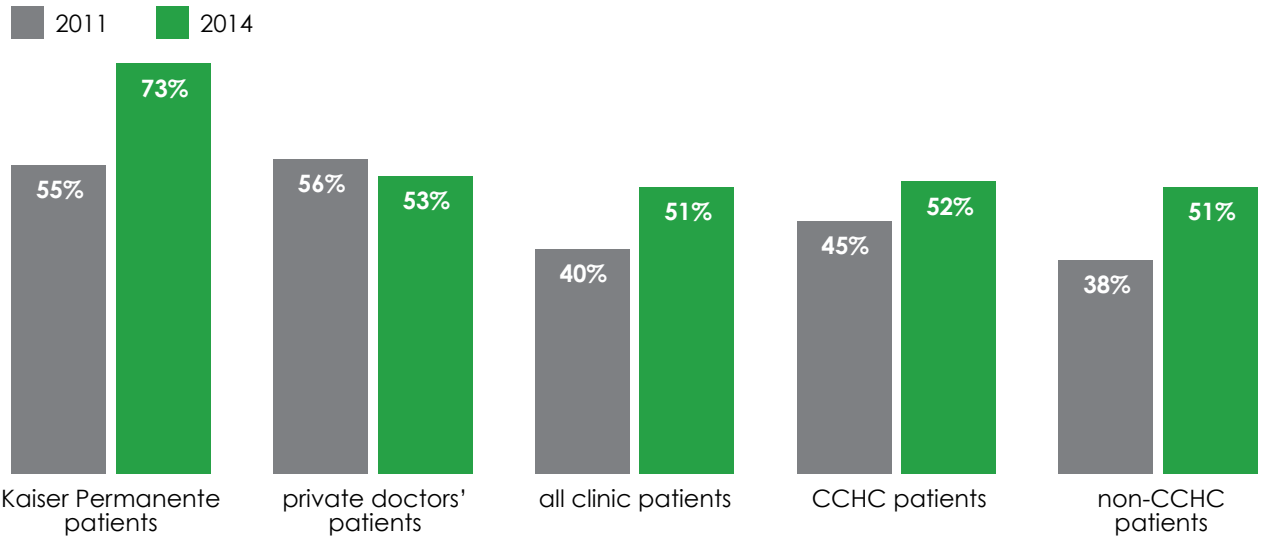
Fifty-four percent in this group are highly satisfied with their care – 14 points higher than satisfaction in 2011 among those without insurance. And the group is a large one, with the number of low-income Californians who lack insurance plummeting in the past year, from 30 percent to 15 percent. The increased coverage brought about by the ACA is thus one factor in the improved healthcare outlook among low-income patients.

However, even removing newly ACA-insured patients from the currently insured population, there is a significant increase in satisfaction. Fifty-eight percent of patients insured outside the ACA now rate their care positively, up from 50 percent among those with insurance in 2011. This suggests that above and beyond serving the newly ACA-insured population, facilities that serve low-income Californians are enhancing previously insured patients' experiences as well.

Looking by facility type, the largest improvement in overall satisfaction has occurred among Kaiser Permanente patients – 73 percent now rate their overall care positively, up from 55 percent in 2011. Clinic[6] patients, too, show significant gains – 51 percent now rate their overall care as excellent or very good, up from 40 percent three years ago. Satisfaction among clinic patients now essentially matches its level among patients at private doctors' offices.

The rise in satisfaction among clinic patients has occurred across all clinic types – a numerical 7-point increase among CCHC patients, and a 13-point rise among other clinic users.

% rating their care as excellent or very good (among low-income Californians)



There also are differences by race and ethnicity. These groups are worth examining because nonwhites in general, and Latinos in particular, are key safety net populations – they make up 82 and 68 percent of clinic users, respectively. Satisfaction with care among both groups has increased since 2011, by 8 points in each case, to 52 and 50 percent, respectively. Among whites, satisfaction has held essentially even, at 54 percent. The 11-point gap in satisfaction between whites and nonwhites in 2011, therefore, has all but disappeared.

other group differences in overall satisfaction

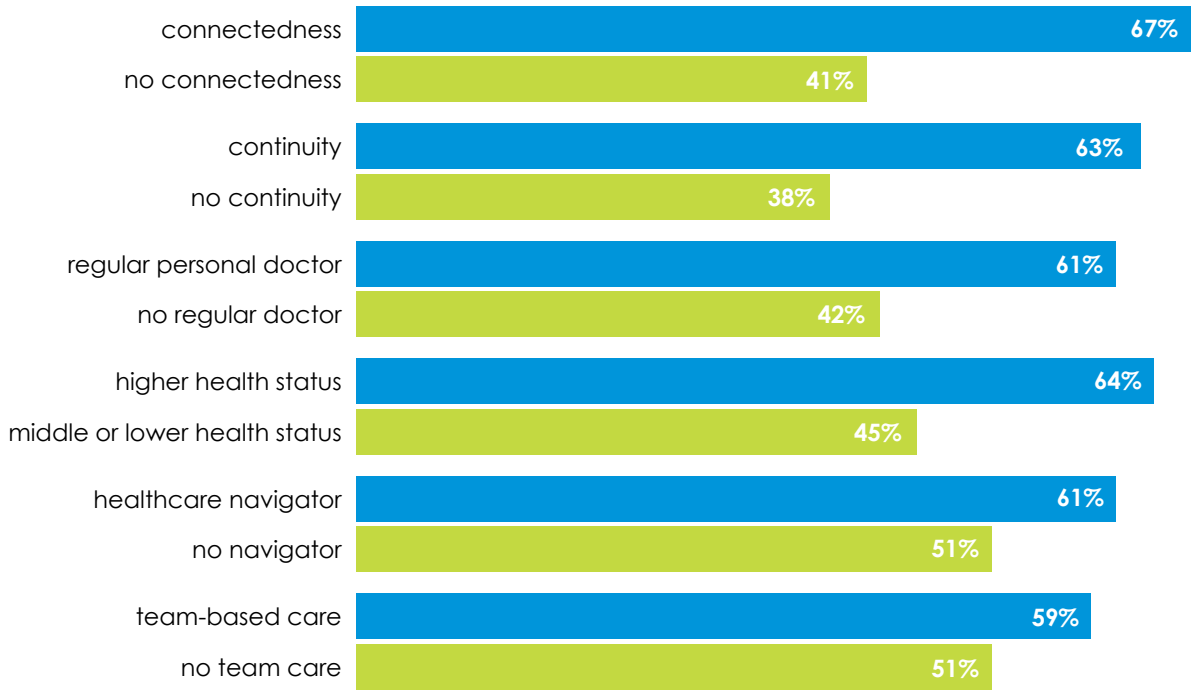
Among other factors that strongly influence patient satisfaction, two main elements are the sense by patients that someone at their healthcare facility knows them well, and that they'll usually see the same care provider when they have an appointment. These two measures, connectedness and continuity, were shown in the Foundation's surveys in 2012 and 2013 to be leading predictors of patients' involvement in their care.

In this survey, among low-income Californians who report a sense of connectedness, 67 percent rate their overall health care positively, as do 63 percent of those who report continuity in their care. Among those who lack a personal connection or a sense of continuity, positive ratings are dramatically lower, 41 and 38 percent, respectively.

Satisfaction ratings also are higher among patients who have a regular personal doctor and those who report being in excellent or very good health, compared with others. Those with a healthcare navigator to guide

% rating their care as excellent or very good (among low-income Californians)

patients who have…

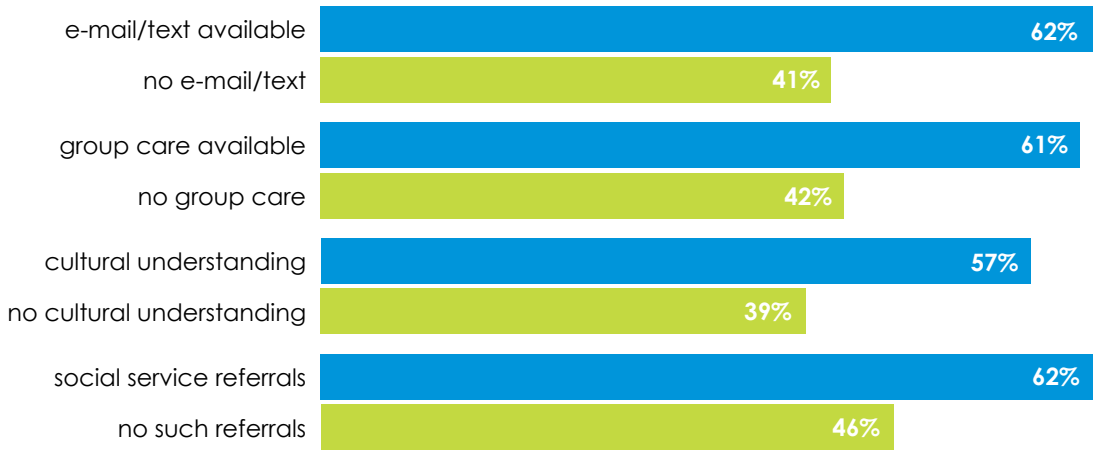


them through the system report greater satisfaction than those without one, and the same is true of those in team-based care programs vs. those without team care.

The extent to which patients feel empowered to take a role in their care, and indeed are actively engaged, also strongly relates to overall satisfaction. On the latter, for instance, low-income Californians who have a great deal or good amount of say in their care are 38 points more likely to be satisfied with their quality of care than are those who are less engaged. Modeling, described in detail below, confirms that engagement is an independent predictor of satisfaction.

Elements of empowerment – that is, feeling highly informed about one's health, confident that one can make healthcare decisions, comfortable asking questions, and trusting of information given by providers – also are closely associated with higher levels of satisfaction, with 20- to 36-point gaps between those more and less empowered.

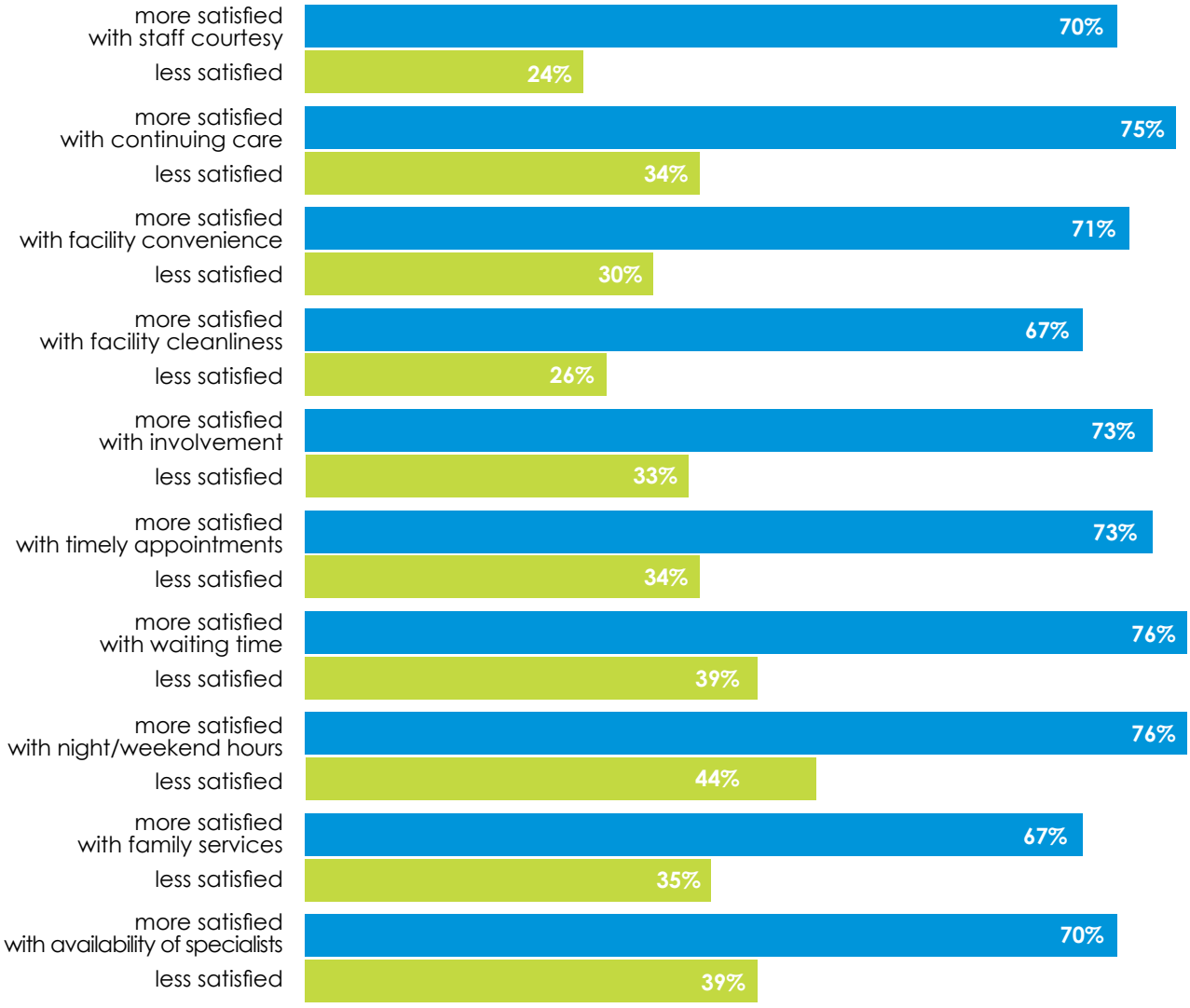
% rating their care as excellent or very good (among low-income Californians)



The provision of a variety of healthcare services, modes of care, and communication options (detailed in Section III) plays a role in patient satisfaction as well. Satisfaction is much higher, for example, among those who can communicate with their providers and staff by e-mail or text. It also is higher among those who say staff members at their facility understand their cultural or ethnic background and among those with access to group care and referrals for social services. Introducing or expanding such offerings hold the prospect of further improving satisfaction.

Overall satisfaction also is far higher among patients who rate specific aspects of their healthcare experience positively. For instance, those who are satisfied with the courtesy of the staff at their facility are vastly more likely than others also to be satisfied with their overall quality of care.

% rating their care as excellent or very good (among low-income Californians)



There are many other cases in which better patient experiences line up with satisfaction with overall care. In all, general satisfaction is 31 to 41 points higher among patients who are highly satisfied with 10 individual items tested, ranging from their ability to get continuing care for ongoing problems to the ability of family members to get care at the same facility.

Some of these differences are more challenging to address, but others less so. As was the case in 2011, the survey results indicate that even attending to such basics as courtesy and cleanliness can positively impact satisfaction, along with the provision of broader services and meaningful efforts to involve patients in their care.

Indeed, overall satisfaction similarly depends on the extent to which patients see their providers as engaging in a range of patient-centered behaviors – explaining things, providing treatment options, giving clear information, encouraging questions, and asking about other issues (detailed

in Section II). Patients who say their providers do these things well are 34 to 42 points more likely than others to be highly satisfied with their care. Satisfaction, further, is 46 points higher among those who give positive ratings to the amount of time their provider spends with them and how well he or she communicates with them.

Positive ratings of staff courtesy are up by 13 points among clinic patients.

ratings of care experiences among groups

As with overall quality-of-care satisfaction, patients' ratings of specific aspects of their care have improved more among certain low-income Californians than others. Not surprisingly, these shifts in experiences often mirror those found in satisfaction with care overall.

Insurance status is one factor. Among low-income patients insured through the ACA marketplace, positive ratings of waiting times, availability of continuing care, ability to get a timely appointment, staff courtesy, location convenience, and ability to see the same doctor all are higher than these were in 2011 among those without insurance. That's further evidence that patients who've gained insurance through the ACA are driving some of the positive changes in patient experiences.

However, as with quality-of-care ratings overall, satisfaction in specific areas has increased even among those who did not gain insurance through the ACA. Specifically, ratings of cleanliness, the availability of family care, the ability to see a specialist, and availability on nights and weekends all have risen significantly among those who were insured previously.

There also are differences within facility types. Among clinic patients, for example, ratings of nine of the 15 specific areas tested in this survey have improved since 2011:

- Positive ratings of staff courtesy have increased among clinic patients by 13 points, to 62 percent.
- While just 34 percent are satisfied with the amount of time they have to spend in the waiting room, that has increased by 11 points compared with three years ago.
- Feeling welcome, and positive assessments of the ability of family members to get care, both have risen by 10 points.
- Satisfaction with the ability to get a timely appointment and to see the same provider both are up by 9 points.
- Six in 10 now rate the cleanliness of their facility positively, up by 8 points since 2011.
- Satisfaction with the availability of continuing care for long-term health problems and the affordability of care also have risen slightly among clinic patients, by 7 points.

In most cases, ratings of healthcare experiences have improved among patients of CCHCs, public clinics, and other types of clinics alike. There are some exceptions.[7] For example, there's been a 12-point rise in non-CCHC patients' ratings of their ability to see a specialist (now 38 percent), but a numerical decline in these ratings among CCHC patients (now 32 percent), resulting in no change among clinic users overall when these groups are combined.

In most cases, ratings of healthcare experiences have improved among patients of CCHCs, public clinics, and other types of clinics alike.

In addition, there are three areas in which the positive change among clinics overall is driven by improved ratings among non-CCHC patients. Waiting times, feeling welcome, and affordability of care are up by 16, 12, and 9 points, respectively, among non-CCHC patients, with no change among CCHC users. In these cases, CCHCs were at least numerically ahead of other clinic types in 2011; the other clinic types now have caught up.

Gains in ratings of access to family care and being able to see the same provider over time are driven largely by 12- and 13- point improvements among private clinics and other clinic types, with little to no change among CCHC or public clinic patients.

At the same time, CCHCs outperform other types of facilities in other measures, including establishing greater connectedness with their patients, covered in Section II, and areas such as cultural competence and providing social service referrals, detailed in Section III.

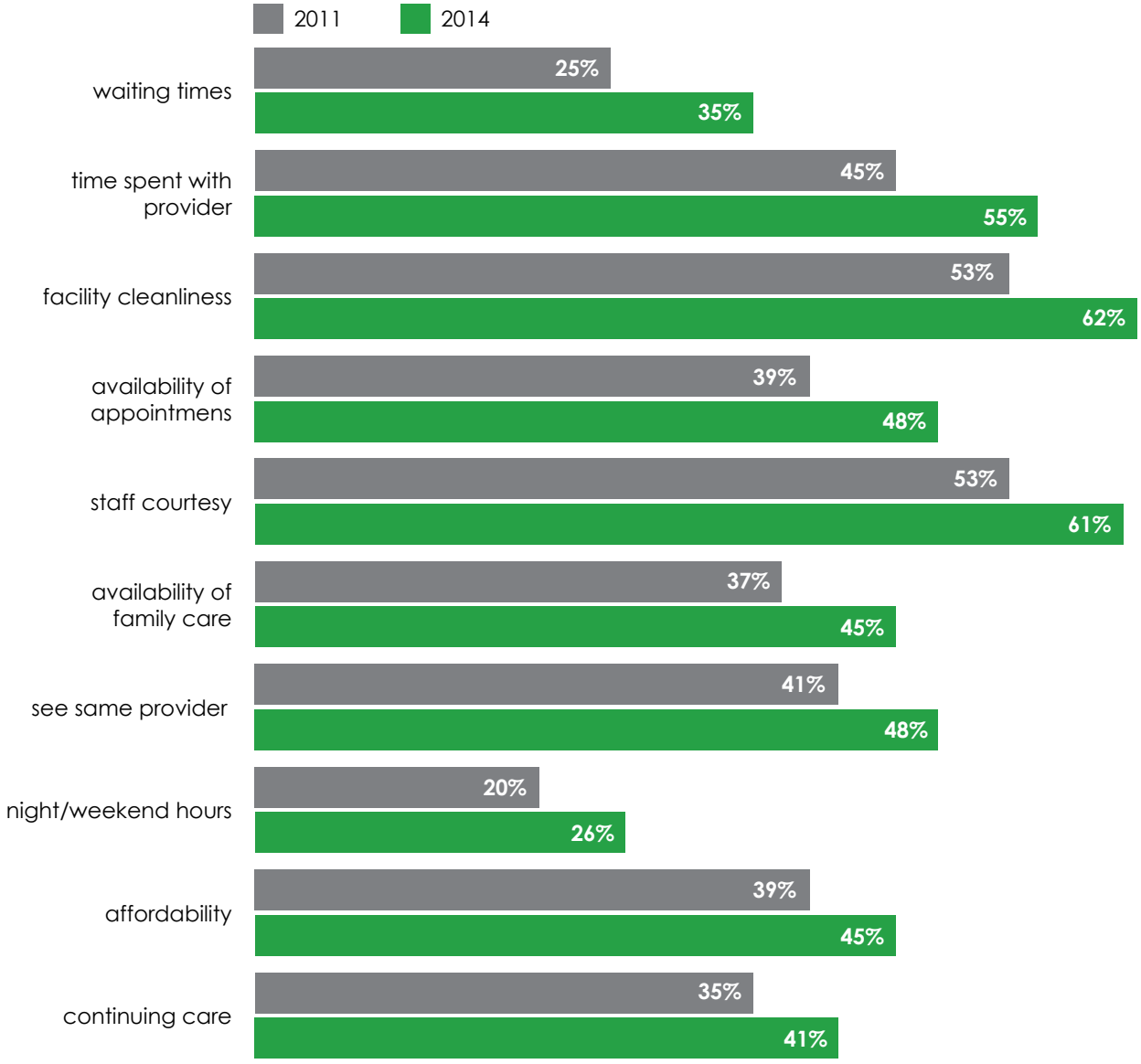
Beyond clinics, ratings of many of these care experiences by Kaiser Permanente patients also have improved in the past three years. This includes double-digit increases in positive ratings of the ability to see the same doctor, the affordability of care, the convenience of the location, time spent in the waiting room, and availability on nights and weekends.

Among patients who see private doctors for their care, by contrast, patients' ratings of their experiences have held steady since 2011. As a result, clinics have caught up with private doctors' offices in many areas. Satisfaction with the convenience of the location, the cleanliness of the facility, staff courtesy, waiting times, the availability of family care, and feeling welcome, which previously were higher among private doctors' patients than among clinic patients, now are essentially even. In addition, the gap in positive ratings of the ability to see the same doctor each time has been cut in half, from 33 points in 2011 to 16 points now.

The results also show that improvements in patient experience ratings have occurred almost exclusively among nonwhites in general and, in particular, Latinos (who make up the vast majority of the nonwhite population and clinic users alike). Evaluations by white patients have remained essentially steady since 2011, while among nonwhites there have been gains in satisfaction in 10 of the 15 areas tested.

As with overall satisfaction, improved ratings of care experiences among nonwhite patients have substantially narrowed the racial and ethnic gaps evident in 2011. What were double-digit differences between whites and

% rating each item as excellent or very good (among latino and other minority low-income Californians)



nonwhites in the 2011 survey in ratings of staff courtesy, ability to get timely appointments, availability of family care, ability to see the same doctor, and availability of continuing care have shrunk to non-significant single digits. Nineteen-point gaps in ratings of cleanliness and time spent waiting have narrowed to 12 and 9 points, respectively.

As with care overall, patient satisfaction with individual experience items is far higher among those who report connectedness, continuity, a regular doctor, and access to a variety of alternative modes of care, communication, and services, compared with their counterparts.

There are many such examples. Virtually across the board, patients with connectedness, continuity, or greater care options and services are significantly more satisfied with their care experiences, including on

items such as cleanliness, convenience, and affordability. Those who are highly engaged and empowered in their care also are far more positive about their experiences. This may mean that healthcare facilities that are improving are doing so across the board; it also may be that patient satisfaction in one area simply carries over into others.

Regardless, the takeaways are clear: Satisfaction among low-income patients with their health care has improved, both overall and in terms of individual patient experiences. And opportunities exist for even further improvements.

Virtually across the board, patients with connectedness, continuity, or greater care options and services are significantly more satisfied with their care experiences.

modeling patient satisfaction

Statistical modeling (detailed in Appendix C) supports many of the results reported above. Connectedness and continuity predict patients' satisfaction with specific aspects of their care (for example, the courtesy of the staff and their ability to get timely appointments) and their ratings of providers on a range of patient-centered behaviors (such as explaining things clearly and encouraging questions; see Section II). Those satisfaction and provider ratings, in turn, are the strongest independent predictors of patients' overall satisfaction with their care.

These stand out against many other potential factors, including demographic characteristics (such as age, sex, race/ethnicity, education, and income, among others), type of care facility, and insurance status. Two other predictors of satisfaction also emerge: better health status and, crucially, the extent to which patients feel they have a say in decisions about their care – a measure of patient engagement that's further explored in Section V.

These statistical analyses underscore the central finding that helping patients feel personally connected with their facility, providing them with continuity in their care relationships, and developing the quality of their caregiving interactions are the fundamental building blocks of patient satisfaction. As those are pursued, further progress in satisfaction should follow.

endnotes

5 The term "points" refers to a specific percentage-point difference between two results. The difference between 48 percent and 53 percent, for example, is 5 points.

6 Throughout the report "clinic" refers to all clinic types, including CCHCs, public, private and other types of clinics. When results among specific types of clinic patients are included, they are specified as such.

7 In some cases, the change within a clinic type is not statistically significant, but still numerically positive. These cases are not considered exceptions.

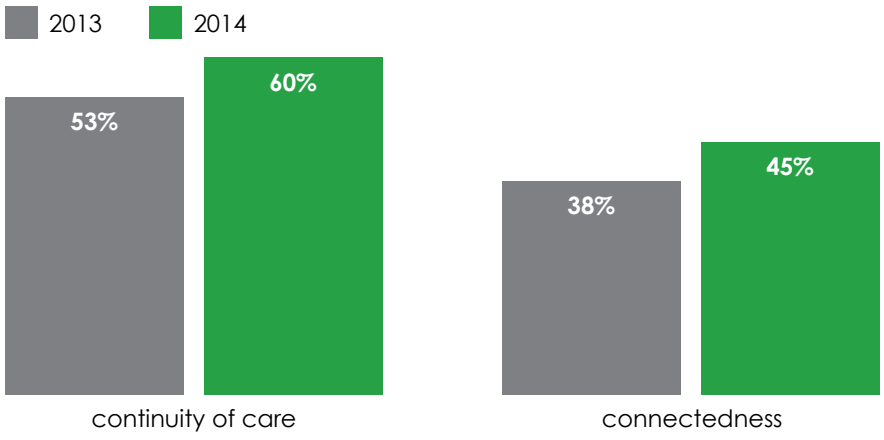
section ii: patient-provider relationships

The first section of this report focuses on low-income Californians' satisfaction with their health care overall and with individual elements of their care. Section II covers their relationships with their care providers, a key element of the healthcare experience and an essential predictor of satisfaction, empowerment, and engagement. Patient-provider relationships are another area that has seen meaningful improvements.

Compared with previous years, more patients now say that they usually see the same provider each time they have an appointment (i.e., continuity), that someone at their facility – a doctor, nurse, or staff member – knows them well (connectedness), and that they have someone they consider a regular personal doctor (one way to establish connectedness). Patients also are more satisfied with the amount of time their provider spends with them and how well he or she communicates. Given the importance of patient-provider relationships to the healthcare experience, these gains are especially encouraging.

Specifically, more than half of low-income Californians, 55 percent, report having a regular personal doctor, up by 8 points since 2012. Connectedness and continuity, previously established as major drivers of patient engagement and satisfaction, have risen by 7 points since 2013.

among low-income Californians



As with satisfaction and patient experience ratings, these gains indicate that positive change has occurred. That said, nearly half of low-income Californians continue to lack a regular care provider, more than half feel no one at their care facility knows them well, and four in 10 say they infrequently see the same provider when they have an appointment, indicating the opportunity for continued improvement.

provider ratings

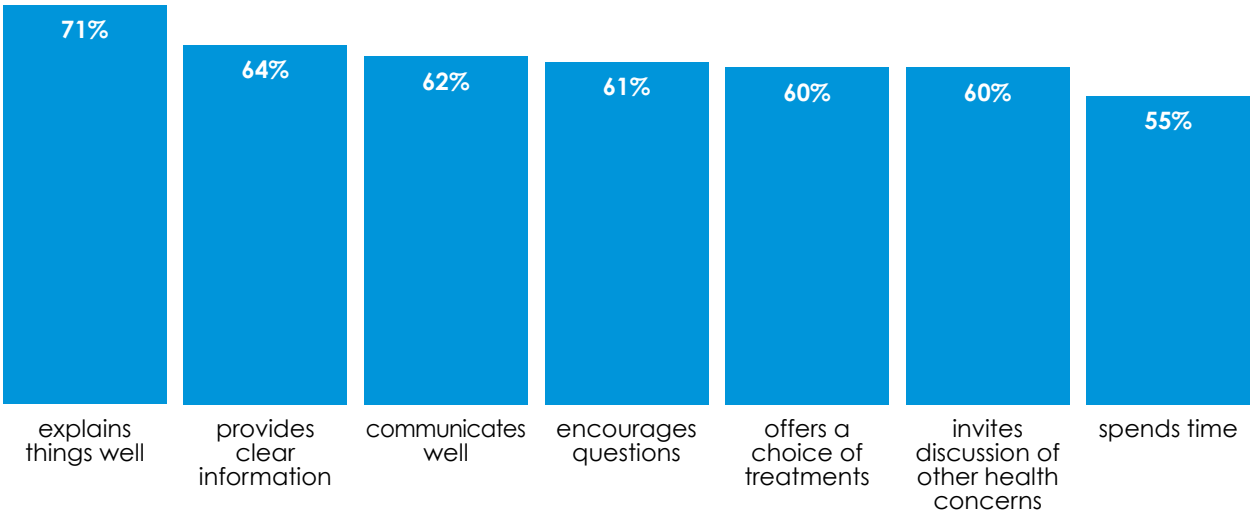
Previous Foundation research has found that patients' relationships with their care providers strongly influence how informed they feel, their comfort asking questions, and their confidence making healthcare decisions – all central elements of patient empowerment.

Most low-income patients rate their providers positively across a range of supportive behaviors. Anywhere from six in 10 to seven in 10 say their providers do an excellent or very good job explaining things understandably, giving clear information that helps with decision-making, encouraging patients to ask questions or express concerns, offering a choice of treatment options, and inviting discussion of other health-related issues.

Two other items, repeated from 2011, show improvement. Sixty-two percent of low-income patients are satisfied with how well their provider communicates with them overall, and 55 percent say the same about the amount of time the provider spends with them, both up by 7 points.

excellent/very good ratings (among low-income Californians)

healthcare provider…



connectedness among groups

Connectedness has increased especially among low-income Californians who get their care at clinics – 44 percent in this group report that someone at their facility knows them well, up from 31 percent in 2013. This includes a sharp increase in reports of connectedness among CCHC patients, from 30 to 47 percent, and a smaller rise among non-CCHC clinic users, from 32 to 42 percent.

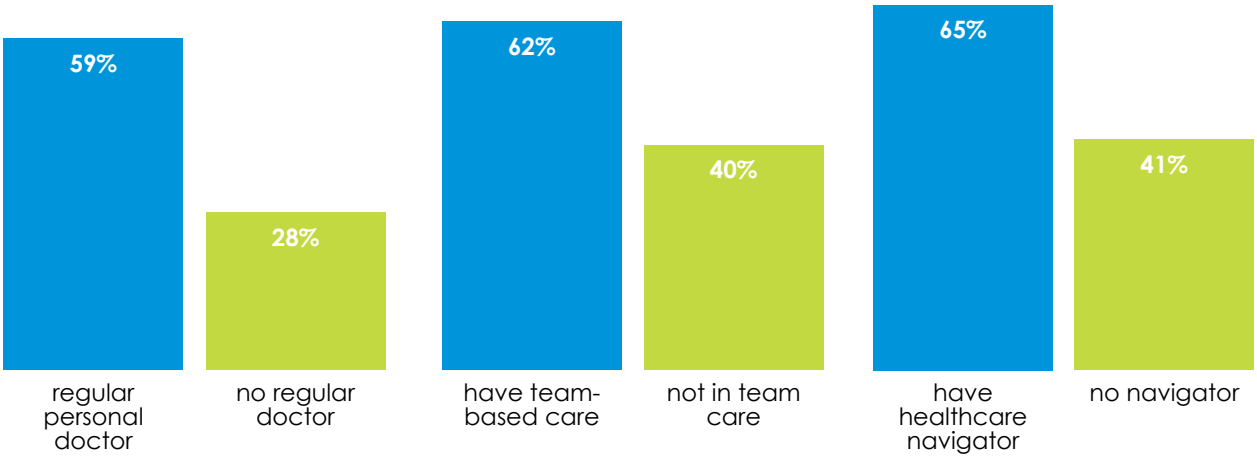
Private doctors' office patients, by contrast, are no more likely than in 2013 to report that someone at their place of care knows them well. This means that a 19-point gap between clinic and private doctors' office patients in connectedness has narrowed to a slim, 8-point difference. Clinic patients also are now as likely as Kaiser Permanente patients to say someone at their facility knows them well.

Connectedness is 17 points higher among people who have insurance through the ACA (41 percent) compared with those who lacked insurance in 2013 (24 percent). But connectedness also has increased among those who've had insurance all along, from 44 percent to 51 percent. Gaining insurance appears to help patients establish connectedness, but regardless, facilities have successfully fostered more personal connections with their patients in the past year.

Part of the reason clinic patients and the newly insured report greater connectedness may reflect increases in their likelihood of having a regular doctor, detailed below. In general, those who report having a regular personal doctor are 31 points more likely than those who do not to say that someone at their facility knows them well.

But connectedness is not confined to the traditional patient-doctor relationship. As previous Foundation research has shown, connectedness also can be achieved through new approaches such as team-based care and the use of healthcare navigators. Low-income patients who have a care navigator or who are enrolled in team-based care are 24 and 22 points more apt than others to report having a personal connection at their healthcare facility. This means that fostering connectedness, with its benefits in terms of patient empowerment and engagement, can be achieved in a more sustainable model.

connectedness with care facility (among low-income Californians)



There are demographic differences in connectedness. Nonwhites in general and Latinos specifically are less apt than whites to say someone at their facility knows them well, by 10-point margins (42 vs. 52 percent in both cases).

continuity among groups

In addition to connectedness, continuity – usually seeing the same care provider over time – has increased in particular among clinic patients. Six in 10 in this group now say they usually see the same provider when they have an appointment, up from 47 percent in 2013, with similar increases among CCHC and non-CCHC clinic patients alike.

Continuity among clinic patients still is lower than it is among private doctors' office and Kaiser Permanente patients (68 percent), but the gains among clinic patients have vastly narrowed the continuity gap by facility type.

Echoing the connectedness results, gaining insurance through the ACA is associated with an increase in continuity, but those who have been insured all along also show gains. Among those insured through the marketplace, 64 percent usually see the same care provider, up from 38 percent among the previously uninsured in 2013. Among those who have insurance that's not through the exchange, two-thirds report continuity, up much more modestly, from 60 percent.

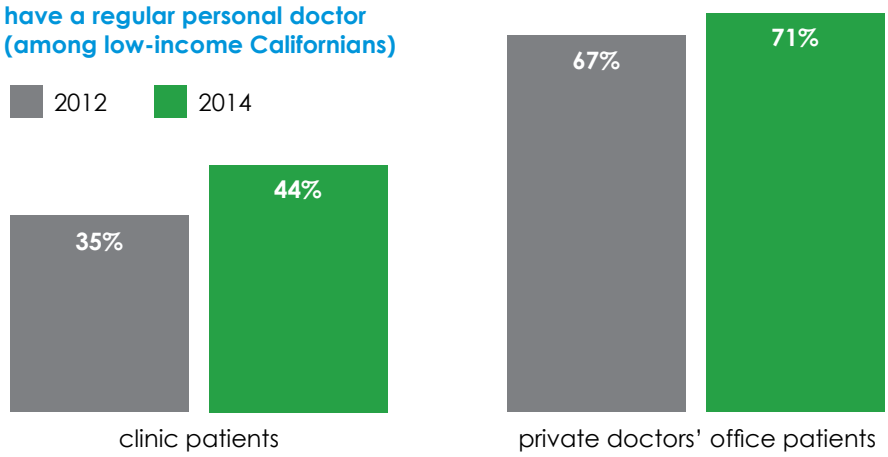
Not surprisingly, those with a regular personal doctor are 44 points more likely to report seeing the same provider each visit, compared with those who do not. Those who report having team care or a health coach also are more likely than others to have continuity, by 23- and 20-point margins, respectively.

Nonwhites, those who don't mainly speak English at home, and noncitizens all continue to be significantly less likely than their counterparts to say they usually see the same provider.

having a personal doctor among groups

The number of patients who report having a regular personal doctor has changed more among some groups than others. Most strikingly, people who have gained insurance through the ACA marketplace have seen a vast jump in rates of having a regular personal doctor – it's now 58 percent in this group, compared with just 16 percent among those who did not have insurance in 2012.

Forty-four percent of clinic patients now report having a personal doctor, up 9 points since 2012, with the increase occurring among CCHC and non-CCHC patients alike. That compares with a negligible 4-point change among private doctors' patients; they're still far more likely to have a personal doctor (71 percent do), but the gap has narrowed a bit.



provider ratings among groups

Changes in patients' satisfaction with the amount of time doctors give them, and how well their care providers communicate with them, mirror advances in continuity and connectedness. Perhaps most important, clinic patients are significantly more likely to rate their providers positively in both areas than they were when these were tested three years ago.

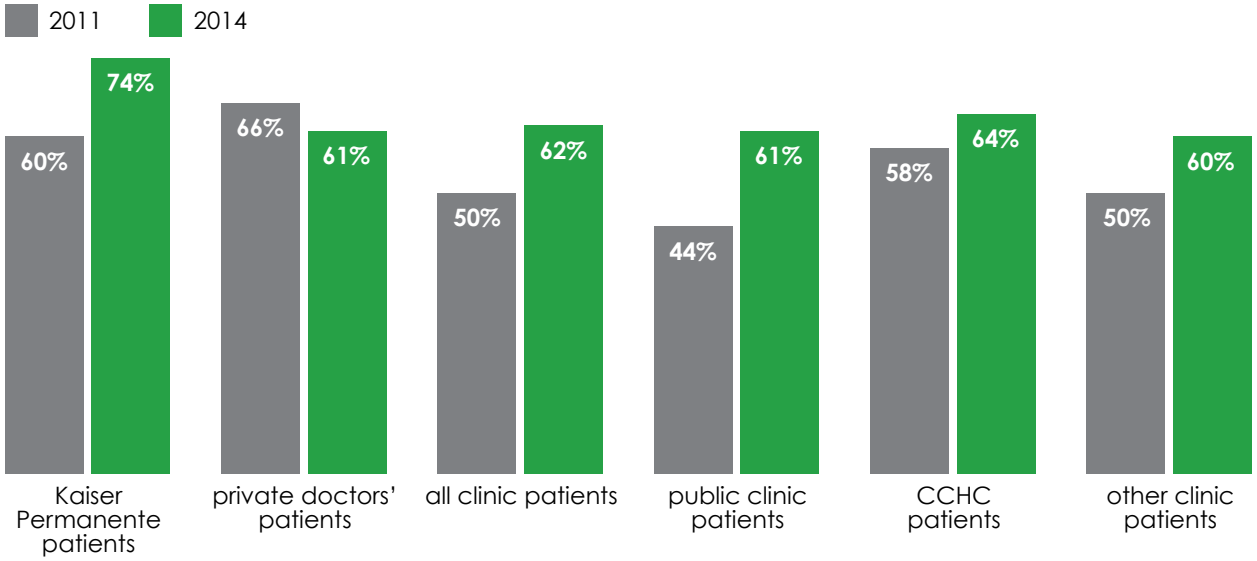
Just half of clinic patients rated their doctors' clarity of communication positively in 2011; that's now up to 62 percent. This includes a large boost in positive ratings among public clinic users, from 43 to 61 percent, and smaller changes among CCHC patients, from 58 to 64 percent, and other clinic patients, from 50 to 60 percent (neither of the latter two is statistically significant, given the sample sizes).

Patients' satisfaction with the amount of time their doctor spends with them likewise is up among clinic users overall, from 43 to 51 percent. This has occurred almost exclusively among private and other clinic users, rising from 38 to 53 percent. About half of CCHC and public clinic patients continue to be satisfied with their time spent with a provider.

Kaiser Permanente also has seen gains. Seventy-four percent of its patients rate their doctors' communication positively, and 71 percent say the same about the amount of time the doctor spends with them, up from 60 and 55 percent respectively, in 2011.

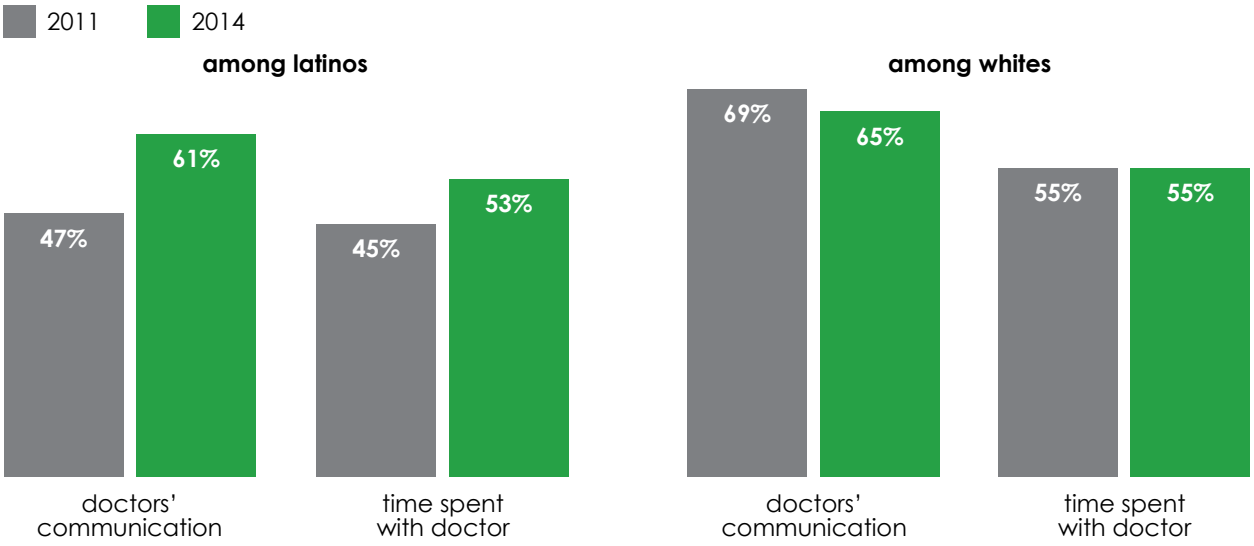
Ratings among private doctors' office patients have not changed on these measures. In this group 61 percent rate their doctors' communication positively and 63 percent are satisfied with the time the doctor spends with them. That means the previous 16-point gap between clinic and doctors' office patients in satisfaction with provider communication has closed entirely.

positive ratings of how well doctors communicate (among low-income Californians)



As with satisfaction with care facilities (see Section I), positive ratings of providers on these measures has increased among Latinos and nonwhites in general, while remaining unchanged among whites. Among Latinos, satisfaction with provider communication has jumped by 14 points, while satisfaction with time spent has increased by 8 points. These gains eliminate the previous racial and ethnic gaps in these measures.

positive ratings of each item (among low-income Californians)



Other provider attributes assessed in this year's survey show significant, and telling, differences by groups. Low-income Californians who have a connection with someone at their facility, who usually see the same provider, and who have a regular doctor all are more likely than others to rate their provider positively across all five attributes tested.

Some key differences include the following:

- Those who feel that someone at their care facility knows them well are 31 points more likely to be highly satisfied with the clarity of the information given by their provider to help them make decisions, compared with those who lack a personal connection.
- Positive ratings of how well providers give choices about treatment, encourage questions, ask about other issues, and explain things clearly are 23 to 29 points higher among those with a personal connection at their facility than those without.
- Eight in 10 low-income Californians who usually see the same provider are satisfied with how well their providers explain things. That falls to 56 percent of those who lack continuity.

- Seven in 10 or more patients with continuity give positive ratings to the clarity of the information providers give them, how well they encourage questions, whether they ask about other issues, and their offering of treatment options. Among those who lack continuity of care, fewer than half are satisfied with their provider on any of these items.

- Those who report having a regular personal doctor are 13 to 18 points more likely than others to be satisfied with their providers across all five items.

Notably, while having a regular doctor impacts satisfaction, connectedness and continuity have a larger influence – further evidence that a strong relationship with a single, regular provider is not the only route to patient satisfaction.

	among low-income patients with			
	connectedness		continuity	
care provider…	yes	no	yes	no
explains things well	84%	61%	81%	56%
offers choice of treatment	76%	47%	70%	43%
gives clear information	81%	50%	75%	48%
encourages questions	77%	49%	72%	44%
asks about other issues	75%	48%	72%	43%

Indeed, having a healthcare navigator or team-based care are related to big differences in patients' ratings of their providers. Navigators facilitate communication with patients, answer questions, and ensure that they understand providers' instructions. Perhaps not surprisingly, then, those with a navigator are 13 to 27 points more likely than those without one to rate their providers' communication positively across the five items tested. The differences by team care are similar.

	among low-income patients with			
	a navigator		team care	
care provider…	yes	no	yes	no
explains things well	82%	69%	83%	67%
offers choice of treatment	78%	56%	74%	54%
gives clear information	79%	61%	79%	58%
encourages questions	83%	56%	78%	53%
asks about other issues	74%	58%	72%	56%

Kaiser Permanente patients are more likely than clinic and private doctors' office patients to rate their providers positively on giving them treatment options, perhaps reflecting that system's usual practice of placing primary care physicians and specialists in the same location. There are few other differences in provider ratings by facility type.

	among low-income patients at		
	private doctors' offices	Kaiser Permanente	clinics
care provider…			
explains things well	74%	76%	72%
offers choice of treatment	61%	71%	59%
gives clear information	65%	70%	65%
encourages questions	59%	70%	64%
asks about other issues	61%	64%	63%

As with results on satisfaction, there is opportunity for further improvements. Regardless, these ratings of patient-provider relationships show significant progress in involving low-income patients in their care by providing them with continuity, connectedness and clear, effective communication.

section iii: services, modes of care, and communication

While factors such as connectedness, continuity, and patient-provider relations are critical, the options for care and communication offered at healthcare facilities also strongly impact patient experience. As detailed in Section I, satisfaction is higher among patients who have access to team-based care, a healthcare navigator, group care, social service referrals, and e-mail or text-based communication, and whose facilities exhibit cultural competence. This section evaluates how widespread such options and services are, as well as how desirable.

About three in 10 low-income Californians report having team-based care, and one in five has a healthcare navigator, both unchanged from previous years. As noted, both continue to be associated with more positive ratings of overall care and patient experiences.

Seven in 10 say staff members at their facility understand their cultural or ethnic background – an impressive level of cultural competence among facilities that serve low-income Californians. In a related result, among patients who mainly speak a language other than English, 87 percent say their facility has someone available to speak with them in the language they prefer. (However, as noted in Section I, fewer rate such language services highly positively – 51 percent.)

Many fewer say a mental health counselor is available, 52 percent, and fewer still say that, as far as they're aware, their facility provides help for substance abuse (42 percent), group care meetings (34 percent), or social service referrals (28 percent). Forty-eight percent say that their facility offers e-mail or text communication.

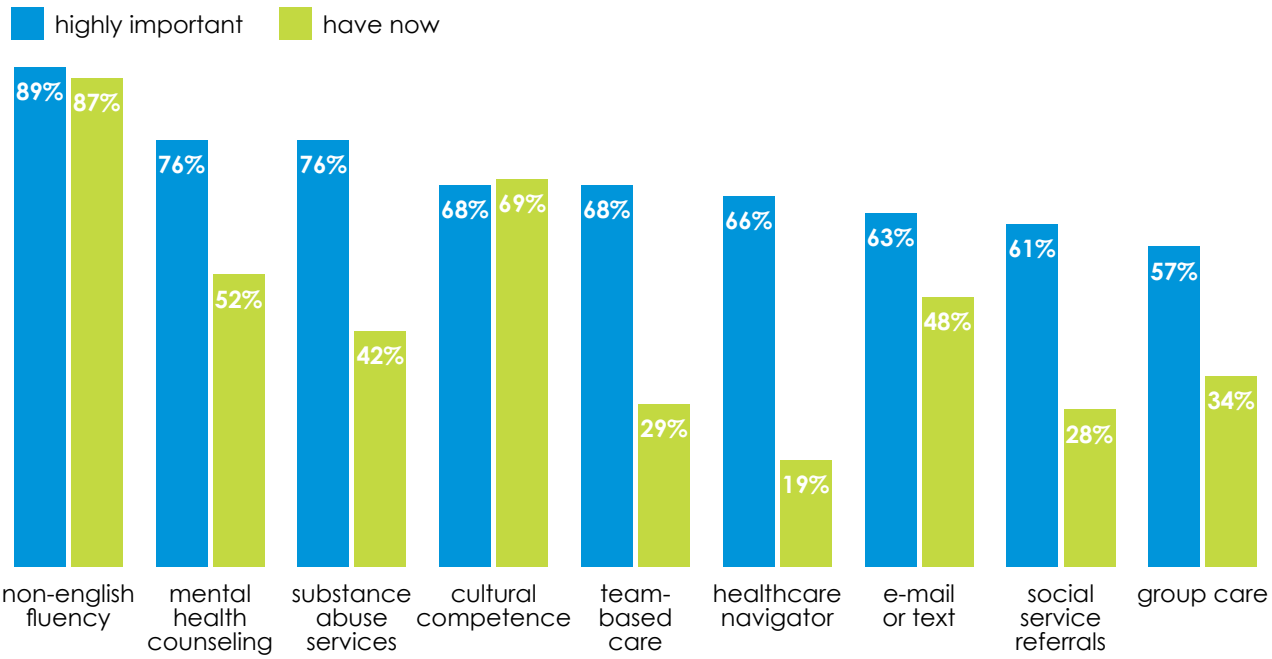
Access to such services, modes of care, and communication options is greatly desired. Among low-income Californians who don't speak English, a nearly unanimous nine in 10 think it's highly important that facilities have someone who is able to speak with them in the language they prefer. Nearly seven in 10, likewise, see cultural competence as highly important.

Large numbers also say it's important to have access to services or other amenities that currently are much less widely available. Anywhere from six in 10 to three-quarters call it extremely or very important to them that facilities provide access to mental health and substance abuse counselors,

team-based care, a healthcare navigator, the ability to e-mail or text with providers, and referrals to social services, such as housing, employment or legal issues.

Very few say such options are not important for facilities to provide, and in nearly all cases, interest far outstrips availability. Meeting demand for these options, then, is another potential path to achieving greater patient satisfaction.

views on services, modes of care, and communication options (among low-income Californians)



access to services, modes of care, and communication options among groups

Availability of these items differs by facility type. Clinic users are 10 points more likely than private doctors' office patients to report that staff members understand their cultural background, and to say they have access to social service referrals.

CCHCs are especially strong in providing staff who understand their patients' cultural background.

Kaiser Permanente patients are more likely than clinic or private doctors' office patients to report that they have access to help with mental health or substance use issues, to have group care options, and to be able to text or e-mail with their providers.

Within clinic types, the availability of care and communication services is similar, with two exceptions. CCHCs are especially strong in providing staff who understand their patients' cultural background – it's reported by 79 percent of CCHC patients, vs. 65 percent of public clinic users. While less prevalent across the board, the availability of social service referrals is significantly higher among CCHC and public clinic users than it is among patients at other clinic types, 38 vs. 17 percent.

Among other groups, as in 2013, Latinos – the primary users of California's safety net facilities – are significantly more likely than whites to report having a healthcare navigator, 26 vs. 11 percent, and to report having team care, 34 vs. 24 percent. Those gaps also are reflected among those who are primarily Spanish speakers compared with those who only or mainly speak English at home. (Translation can be part of a navigator's services.)

Access to other care and communication services is similar among whites and Latinos, with the exception of assistance for substance abuse, which is more commonly reported by whites (especially white men) than Latinos, 47 vs. 39 percent. Latinos report greater access to a mental health counselor than do other nonwhite racial and ethnic groups.

perceived importance of care and communication options among groups

Latinos are significantly more likely than members of other racial and ethnic groups to value some specific services and modes of care, including team-based care (highly important to 74 percent of Latinos, vs. 61 percent of others), health navigators (72 vs. 60 percent), and staff members who understand patients' cultural background (77 vs. 60 percent). Facilities that largely serve Latino populations could benefit by responding accordingly.

There also are differences depending on the type of healthcare facility patients use. Both clinic and Kaiser Permanente patients are significantly more likely than private doctors' office patients to see team-based care, a healthcare navigator, and cultural competence as highly important. This partially reflects the fact that private doctors' office patients are much more likely to be white and less likely to be Latino.

Kaiser Permanente patients also are significantly more likely than others to value having a mental health counselor, help with substance abuse, e-mail or text communication, and group care. These differences may reflect the fact that, as noted, Kaiser Permanente patients already report having greater access to these care and communication options, and therefore value them.

% seeing patient services and care options as highly important (among low-income Californians)

	clinic patients	private doctors' patients	Kaiser Permanente patients
team-based care	71%	58%	71%
healthcare navigator	68%	55%	74%
mental health counseling	75%	72%	86%
cultural competence	71%	58%	78%
non-english fluency	91%	91%	87%
substance abuse services	73%	73%	88%
e-mail or text	61%	55%	84%
group care	56%	52%	70%
social service referrals	63%	55%	61%

Finally, it's worth noting that those who currently have access to care and communication choices are more likely to view them as important, suggesting that providing such amenities will further drive demand. For example:

- Among patients who say their facility has staff members who understand their cultural or ethnic background, 74 percent call this highly important. Among those who don't see their facility as culturally competent, fewer – 52 percent – see it as especially important.

- Those who currently have a healthcare navigator or team-based care are 20 points more likely than those who don't have these alternative models to see them as highly important.

- Similarly, patients who can e-mail or text their providers are 20 points more likely to value this method of communication, compared with those who can't.

- Even among patients who do not have support for substance use issues available, seven in 10 see this resource as highly important. But seeing it as important rises to 83 percent of those who do have substance-abuse support available.

- Eighty-one percent of patients with a mental health counselor available call this extremely or very important, compared with seven in 10 of those who don't have a counselor available.

- While just a third overall report having access to group care, those who do are 32 points more apt than others to call such classes highly important. And the 28 percent who are able to get referrals to social services are 21 points more likely than those who cannot to call that assistance highly important.

The most striking of the results in this section is the extent to which patient interest in care and communication options far outstrips the current supply. Given that having these services and other amenities promote patient satisfaction, as covered in Section I, providers can benefit by making them available – and/or by ensuring that patients know about them.

The details reported here show the differences in how such options currently are provided across provider types – for example, demonstrating the advantage CCHCs have in cultural competence. And they suggest paths to tailor services to specific patient groups, maximizing the patient satisfaction benefits that should follow.

section iv: patients' loyalty to their healthcare facility

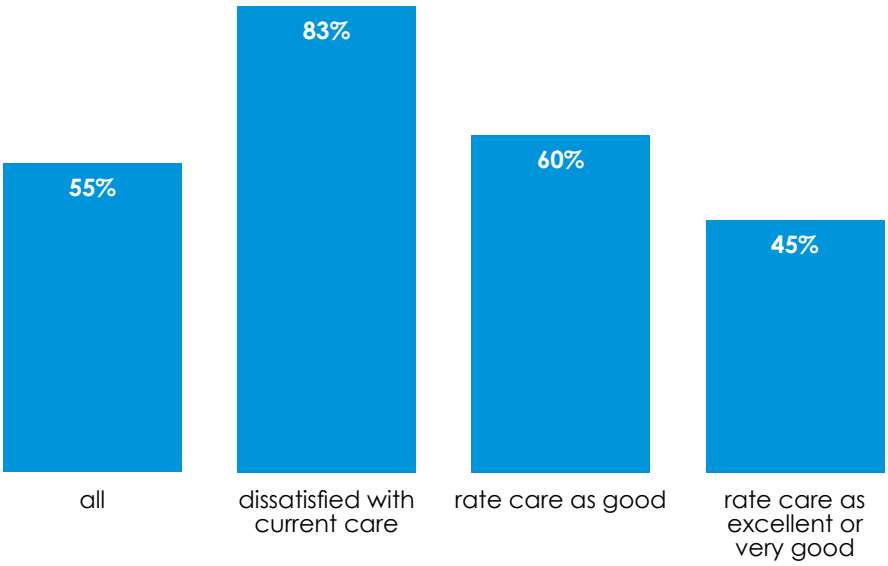
Gains in low-income Californians' satisfaction with their health care have not yet resulted in increased patient loyalty. But if the advances hold – or, better yet, improvement continues – that's the likely outcome.

This conclusion reflects the strong relationship between satisfaction and loyalty, established in the Foundation's 2011 survey of patient experiences and confirmed in this report: As patients express greater satisfaction with their care, their interest in looking elsewhere sharply declines.

As patients express greater satisfaction with their care, their interest in looking elsewhere sharply declines.

The impact is powerful. Among low-income Californians who rate their overall care negatively, 83 percent express interest in finding a new place for care. Among those who say their care is just "good," fewer but still a majority, 60 percent, are interested in change – suggesting that "good," in terms of loyalty, is not good enough. Only among those who rate their care as excellent or very good are fewer than half interested in changing their place of care, 45 percent.

% interested in changing place of care (among low-income Californians)



Combining these groups, 55 percent overall say they'd be interested in going to a different place for their health care if they had more choices and the insurance to cover it, including 28 percent who are very interested in a new facility. Forty-three percent are not so or not at all interested in switching.

Those numbers are essentially the same as in 2011, despite increases in patient satisfaction. It may be that perceived improvements in care, being recent, haven't had enough time to impact patient loyalty, or that they aren't yet sizable enough.

There's also been no movement in patients' tenure at their current place of care. Low-income Californians report having gone to their healthcare facility for an average of six and a half years, with a quarter there a year or less. Both are essentially the same as three years ago.

There's no change, as well, in the number who say they have no choice of where they go for care. Four in 10 report that they go to their facility because it is the only one available to them. Even with the ACA in place, affordability is the main reason given for this lack of choice, cited by 42 percent. Three in 10 say it's the only place close enough and 10 percent indicate it's the only one covered by their insurance.

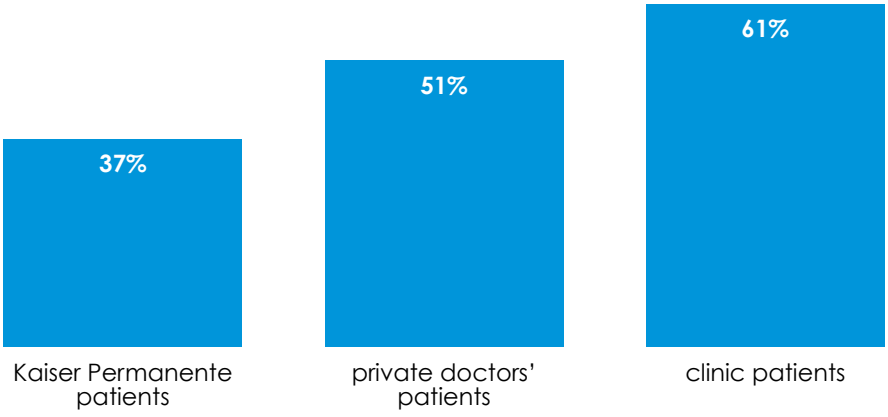
Among those who do have a choice, convenience is the most frequent reason for picking their current place of care, cited by 38 percent. A quarter say they followed a friend or relative there, and one in 10 says it's the least expensive option. Price, then, still is not the top driver of choice, even for this low-income population.

interest among groups in changing facilities

As with the results overall, interest in changing facilities has not significantly shifted among groups; it's about the same as it was in 2011 regardless of facility type, insurance status, health status, gender, race and ethnicity, age, or education.

While the levels of interest have held essentially steady, there continue to be big differences. Kaiser Permanente patients are the least interested in seeking out a new place of care (37 percent are), followed by private doctors' office patients (51 percent), and finally clinic patients (61 percent). Interest in changing facilities is similar across clinic types (it's 58 percent among CCHC users and 63 percent among non-CCHC patients).

% interested in changing place of care (among low-income Californians)



Patients who lack insurance continue to be the most interested in finding a new facility – seven in 10 are, compared with 57 percent of low-income Californians with government-funded insurance, and 48 percent of those with private insurance.

Patients who say they have a choice of where to go for care are less interested in finding a new one than those who feel they have no choice, 47 vs. 65 percent. Those who have been at their facility longer also are less apt to want to find a new place; 45 percent of those who've been there for six or more years express interest in changing, compared with 65 percent of those who've been there for a year or less.

The impact of satisfaction with overall care on patient loyalty is echoed in other results. Patients who give more positive ratings to their individual care experiences or to the quality of their providers' communication also are significantly less interested in switching facilities, compared with those less satisfied. For example:

- Patients who are satisfied with the amount of involvement they can have in their care, the availability of continuing care, and their ability to see the same doctor consistently are at least 20 points less likely to be interested in seeking out a new healthcare facility than those less satisfied.

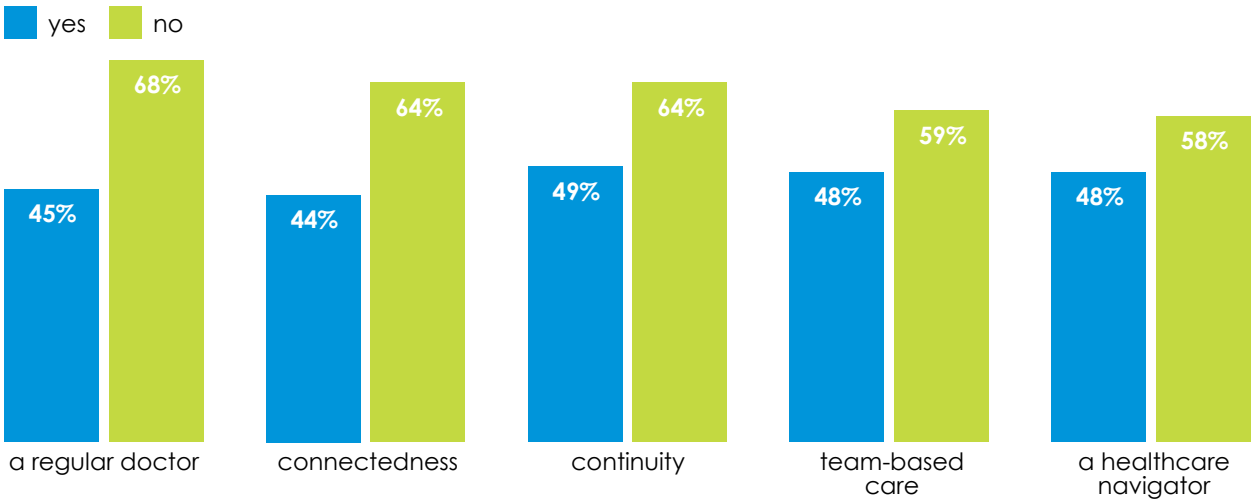
- Patients who are satisfied with how well their provider offers treatment options are 20 points less interested in finding a new facility than those who are less satisfied. Those who are satisfied with the clarity of providers' information likewise are 18 points less interested in changing their place of care.

- Similarly, patients who have continuity, connectedness, a regular doctor, team-based care, or a healthcare navigator – all strong predictors of satisfaction – are 10 to 23 points less likely than their counterparts to express interest in changing facilities.

Patients who are satisfied with the clarity of providers' information are 18 points less interested than others in changing their place of care.

% interested in switching their place of care (among low-income Californians)

patients who have…



Patient empowerment and engagement also strongly predict loyalty. Low-income Californians who report having a "great deal" or "good amount" of say in their care are 22 points less interested in switching facilities than others. Likewise, compared with others, empowered patients are 16 to 22 points less interested in finding a new place of care.

% interested in switching their place of care (among low-income Californians)

patients who…

group differences in lack of choice

As noted, 44 percent of clinic patients indicate that their current facility is the only one available to them. That's higher than the number of private doctors' office patients who say the same, 32 percent, but it's down from 52 percent in 2011. (Four in 10 Kaiser Permanente patients say they lack any other option, similar to three years ago.)

Among low-income Californians who lack insurance, half say they go to their current facility because it's the only choice they have, compared with 43 percent of those with government-funded insurance and just three in 10 patients with private insurance.

As was the case three years ago, low-income Latinos are significantly more likely to say they have no choice of facilities than whites or members of other racial and ethnic groups, 45 vs. 35 percent. Similarly, non-citizens and non-English speakers are 17 and 12 points less likely than citizens and English speakers, respectively, to say they have options.

There also is an income difference; nearly half of those with household incomes less than $16,000 annually report having no choice where they go for care, compared with 36 percent of those with higher incomes. There's a similar effect for education, which relates to income.

modeling patient loyalty

Statistical modeling (see Appendix C) parses out the main factors in predicting patients' interest in changing their place of care. The strongest independent predictor, by far, is patients' level of satisfaction with their current quality of care, including ratings of specific aspects of that care. Lower satisfaction, naturally, predicts interest in switching facilities.

There are other predictors as well. Holding other factors constant, patient loyalty is predicted by having a choice of care facilities, having a regular doctor, and having a say in care decisions (as well as by longer tenure at one's current place of care).

These results show the risk faced by facilities that fail to achieve patient satisfaction – and the opportunities for those that do. Facilities that are able to deliver connectedness, continuity, positive patient experiences, and successful patient-provider relationships sharply increase their chances of achieving a loyal customer base.

section v: empowerment and engagement in healthcare decisions

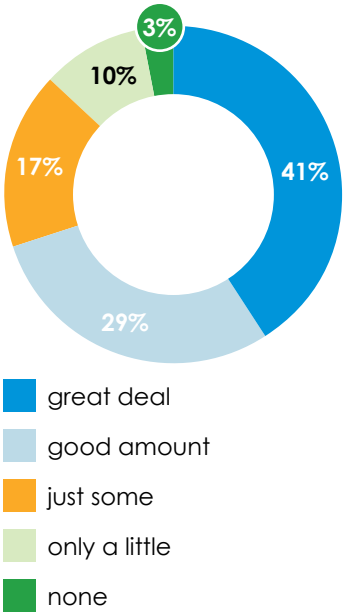
Empowerment and engagement are among the most important elements of patient-centered care. The former means the extent to which patients feel encouraged and informed enough to take an active role in their care; the latter, how much of a say in their care decisions they feel they actually have. Both are crucial in healthcare experiences and are strongly tied to overall satisfaction.

Engagement among low-income Californians is broad, but not especially deep. Seven in 10 say they have at least a good amount of say in decisions about their care, similar to 66 percent in 2013. That includes four in 10 who feel they have a great deal of say, leaving room for growth.

Empowerment, for its part, is measured in several gauges. Nearly three-quarters highly trust the information they get from their provider, 72 percent feel extremely or very comfortable asking questions about their care, seven in 10 are highly confident in their decision making, and 66 percent report feeling well informed about their health.

While substantial majorities, these trail empowerment levels among higher-income patients by 13 to 16 points apiece, as covered in Section VI. And they leave sizable minorities of low-income patients with lower-than-desirable empowerment levels.

level of say in decisions about your care (among low-income Californians)



engagement among groups

As detailed in a 2012 Foundation report, *Empowerment and Engagement among Low-Income Californians*, engagement is strongly predicted by the strength of patient-provider relationships, facility ratings, and empowerment levels. In this year's results, patients who feel that someone at their facility knows them well are 24 points more likely than others to report having at least a good amount of say in their care, 83 vs. 59 percent. And those who regularly see the same provider are 23 points more likely to be engaged than those without continuity, 79 vs. 56 percent.

Low-income Californians who have a healthcare navigator or team-based care also are more likely than those without these options to be engaged in their care, by 19- and 15-point margins, respectively. There's a 12-point boost in engagement among those who say they have a regular doctor. Access to other care services, such as staff with cultural understanding and the availability of mental health counselors, also correspond with greater engagement.

Critically, there are vast differences in engagement depending on empowerment levels. For example:

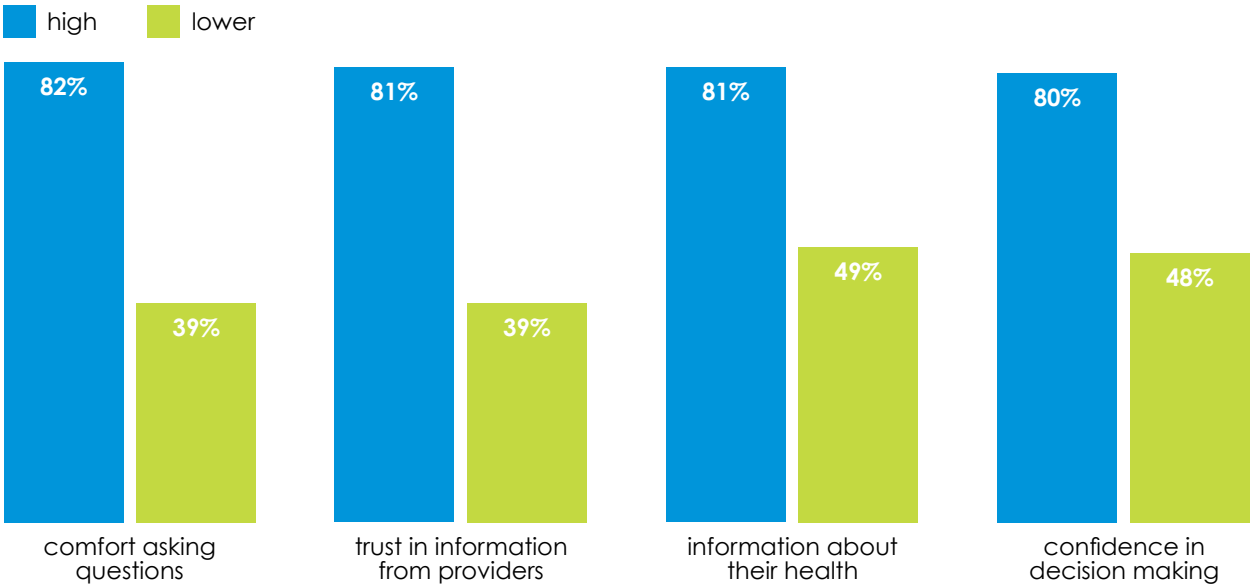
- Among patients who are most comfortable asking questions of their provider, 82 percent say they have at least a good amount of say in their care. Among those less comfortable asking questions, that plummets to 39 percent.

- There's a similarly sharp difference by trust; those who highly trust the information they receive from their provider are far more likely to be engaged in their care than those who are less trusting, 81 vs. 39 percent.

- Patients who feel well informed about their health, or who are confident in their ability to make healthcare decisions, also are far more likely to be engaged than those who feel less informed or have less confidence.

% engaged in their care (among low-income Californians)

patients' level of…



As noted in Section I, engagement and satisfaction are closely related. Patients who are more engaged in their care tend to be more satisfied with their care overall, with their facility, and with their provider relationships alike.

There have been some shifts among groups. Engagement has risen since 2013 among clinic patients; 71 percent now say they have at least a good amount of say in their care, up from 63 percent. That's been offset by small numerical declines in other patient groups, erasing what had been a 13-point gap.

The engagement gaps between whites and Latinos, as well as by citizenship status and preferred language, also have gone away. Seven in 10 whites and Latinos alike say they have a good amount or great deal of say in their care. That's essentially unchanged among whites, while up from 60 percent among Latinos in 2013.

Patients who say someone at their facility knows them well are 19 points more likely to feel confident in their ability to make decisions about their care.

empowerment among groups

As with engagement, low-income Californians' relationships with the providers and staff at their facility have a strong influence on empowerment. For example:

- Patients who say someone at their facility knows them well are 26 to 28 points more likely than those without a personal connection to feel highly informed, comfortable asking questions, and trusting of providers. They're also 19 points more likely to feel confident in their ability to make care decisions.

- The pattern is virtually identical by continuity of care, with those who usually see the same provider significantly more likely than those with less continuity to show empowerment across all four measures, ranging from a 16-point difference in confidence making decisions to a 29-point advantage in comfort asking questions.

- Patients with a healthcare navigator are more likely to be highly trusting of information from their provider, to be highly confident in their ability to make healthcare decisions, to feel well informed, and to be highly comfortable asking questions, by 14- to 19-point margins. And there are similar differences for those with team-based care compared with those without it.

- Those with a regular doctor are 11 to 21 points more likely than those who don't have one to feel highly comfortable asking questions, informed, trusting of their providers, and confident they can make decisions.

	among low-income patients	
	have connectedness	**no connectedness**
feel well-informed	82%	54%
comfortable asking questions	87%	60%
trust information from their provider	88%	62%
confident making decisions	80%	61%

Access to other items, such as staff with cultural understanding or a mental health counselor, relates to greater empowerment – echoing the results on engagement. And empowerment also is strongly linked to satisfaction.

Two elements of empowerment vary by place of care: Compared with other patients, those at Kaiser Permanente are more likely to report feeling highly informed about their health (82 percent) and to highly trust the information given to them by their providers (84 percent). Comparable numbers are 66 and 74 percent, respectively, among clinic and private doctors' office patients combined (it's similar among both).

Results given in this section cut to the core of patient-centered care – the effort to give patients the tools they need to take a more active role in their health care. Connectedness and continuity build empowerment, and empowerment builds patient engagement. Efforts by safety net providers to track these measures – and to improve them over time – should produce benefits in satisfaction and loyalty alike.

section vi: comparing low- and higher-income patients' healthcare experiences

Even with improvements in low-income Californians' healthcare experiences, large gaps remain in satisfaction, ratings of patient-provider relationships, and patient engagement between low and higher-income patients, underscoring the unique challenges facing safety net facilities.

Low-income Californians, defined in this study as those with household incomes less than 200 percent of the federal poverty level, give more negative ratings than those with higher incomes to the quality of their care, conditions at their healthcare facility, and their relationships with their healthcare providers. They're also less apt to report feeling engaged in their care, and they express greater willingness to find a new place to go for their healthcare needs.

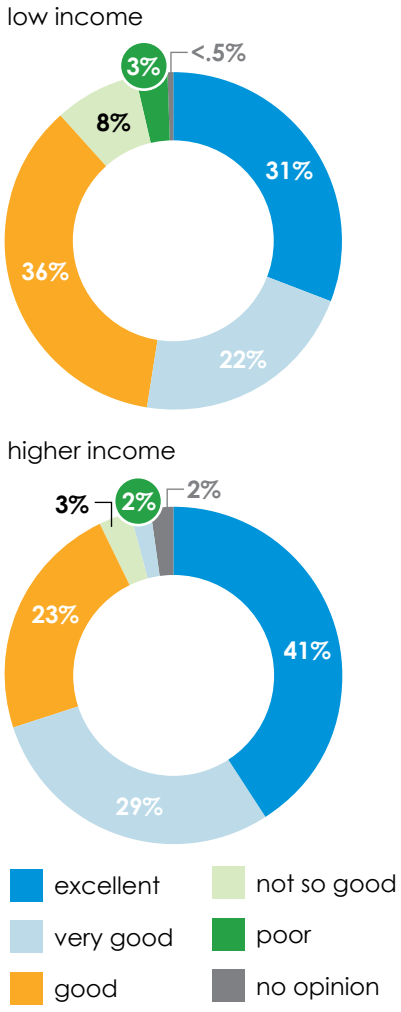
As detailed in the Foundation's 2013 report, *Health Care in California: Leveling the Playing Field*, income-based gaps in patient satisfaction and engagement stem largely from differences in the quality of patient-provider relationships and the essential metrics of connectedness and continuity – patients' feelings that someone at their facility knows them, and that they can see the same provider over time. Previous sections of this report describe gains in these items among low-income Californians. But they've not been nearly large enough to erase the income gap.

A summary of the key differences by income follows.

satisfaction and patient experience

Seven in 10 higher-income Californians rate their overall quality of care positively, compared with 53 percent of low-income patients; that difference is little changed from 2013. (Satisfaction levels include 41 percent of higher-income patients who call their care "excellent," compared with 31 percent of low-income patients.)

quality of care ratings



Higher-income patients also give higher ratings to almost all of the individual care experiences tested in this survey. Most strikingly, three-quarters are satisfied with their ability to be involved in decisions about their medical care, 24 points higher than satisfaction on this measure among their low-income counterparts.

Ratings of other elements of patient experiences are 10 to 17 points higher among better-off Californians. The only areas in which higher and low-income Californians are similarly satisfied are the availability of caregivers on nights and weekends and the affordability of their care.

positive ratings of healthcare facilities among low- and higher-income Californians

	low income	higher income	difference
involvement in care decisions	50%	74%	-24 pts.
feeling welcome	60%	77%	-17
ability to see the same provider	50%	67%	-17
services for family members	47%	64%	-17
waiting time	38%	55%	-17
cleanliness of facility	66%	82%	-16
understanding of your medical history	51%	67%	-16
convenience of facility	57%	72%	-15
timely appointments	50%	65%	-15
availability of specialists	44%	57%	-13
staff courtesy	63%	74%	-11
long-term care	42%	52%	-10
night/weekend hours	25%	29%	-4
affordability	45%	48%	-3

patient-provider relationships

Beyond differences with low-income Californians in rating their healthcare facilities, higher-income patients consistently report stronger and more positive relationships with their healthcare providers, as well.

Eight in 10 in the higher-income group say they usually see the same provider each visit, and that they have a regular personal doctor; fewer, but 55 percent, say someone there knows them pretty well. Continuity, having a personal doctor, and connectedness all are significantly lower among low-income patients.

patient-provider relationships among low- and higher-income Californians

	low income	higher income	difference
regular personal doctor	55%	79%	-24 pts.
continuity of care	60%	79%	-19
connectedness	45%	55%	-10

Ratings of communication with providers show similar gaps. Higher-income Californians express greater satisfaction with their provider on seven items tested, by 11- to 14-point margins.

ratings of provider communication among low- and higher-income Californians

	low income	higher income	difference
healthcare provider…			
explains things well	71%	85%	-14 pts.
offers a choice of treatments	60%	73%	-13
communicates overall	62%	75%	-13
provides clear information	64%	76%	-12
encourages questions	61%	73%	-12
spends time	55%	66%	-11
invites discussion of other health concerns	60%	71%	-11

These differences in the quality of patient-provider relationships underlie many of the income discrepancies in patient experiences and overall satisfaction. As *Leveling the Playing Field* illustrated, the quality of patients' relationships with their care providers is a major factor driving the income divide. Shrinking the gap continues to rely on the extent to which safety net facilities can further improve their patients' connectedness and continuity, and, in so doing, enhance communication and trust between low-income patients and their providers.

access and interest in services, modes of care, and communication

Team-based care and the use of healthcare navigators – important because they can enhance connectedness, continuity, and patient-provider relationships – are equally available to low- and higher-income patients. There's also little difference between income groups in terms of access to a variety of other services and modes of care.

Two items do show differences. Low-income patients are 8 points less apt than those with higher incomes to say they have access to substance abuse counselors. And, in the largest difference by far, they're 17 points less likely to say they can e-mail or text with their healthcare providers.

That last item likely reflects the digital divide between low- and higher-income groups in access to the internet. But it's also worth efforts to address, since, as found in the Foundation's 2013 survey, online communication is a predictor of stronger patient-provider relationships as well as an independent factor in the income gap in patient satisfaction.

ratings of access to services and modes of care among low- and higher-income Californians

	low income	higher income	difference
e-mail or text	48%	65%	-17 pts.
substance abuse services	42%	50%	-8
mental health counseling	52%	53%	-1
team-based care	29%	24%	5
social service referrals	28%	24%	4
healthcare navigator	19%	15%	4
cultural competence	69%	66%	3
group care	34%	31%	3

While the availability of most of these options is similar, there are consistent differences in the importance low- and higher-income Californians place on them. Low-income patients are more likely than those with higher incomes to think it is extremely or very important for their place of care to provide a variety of services and modes of care. The only exception is the ability to communicate with providers via e-mail or text – roughly equal numbers in both groups call this highly important, although, as noted, it's more available to the better-off.

% seeing patient services, modes of care, and communication as highly important

	low income	higher income	difference
social service referrals	61%	39%	22 pts.
healthcare navigator	66%	46%	20
team-based care	68%	49%	19
group care	57%	43%	14
mental health counselor	76%	66%	10
cultural competence	68%	58%	10
substance abuse help	76%	70%	6
e-mail or text	63%	64%	-1

The greater importance placed on these modes of care and communication options by low-income patients suggests an opportunity for safety net providers; providing them should boost engagement, satisfaction, and loyalty alike, helping to close the income gaps in these measures.

loyalty and choice

As noted, in line with their greater satisfaction, higher-income Californians express less interest than those with low incomes in finding a new place to go for their health care. Four in 10 in the higher-income group express interest in changing facilities, 16 points lower than it is among low-income patients. And while three in 10 in the low-income group express strong interest in changing facilities, only about half as many higher-income Californians say the same.

Reflecting their greater loyalty, higher-income Californians report longer tenure at their current place of care – close to 10 years on average, vs. 6.5 years among low-income patients.

In another gap, 80 percent of higher-income patients say they have a choice of where they go for care, compared with 57 percent of those with low incomes. That's another factor in care experiences, in that Californians who have a choice of facilities are much more likely than others to have positive care relationships and to express satisfaction with their health care overall.

Eighty percent of higher-income patients say they have a choice of where they go for care, compared with 57 percent of those with low incomes.

empowerment and engagement

As found in the 2013 *Health Care in California: Leveling the Playing Field* report, higher-income Californians again express greater patient empowerment and engagement. They're more likely than those in the low-income group to feel they have at least a good amount of say in their care, to feel highly informed about their health, to feel more trust in the information they receive from their providers, to be highly comfortable asking questions, and to express greater confidence about making healthcare decisions.

engagement and empowerment among low- and higher-income Californians

patients who…

	low income	higher income	difference
have say in their care	70%	86%	-16 pts.
feel well informed	66%	82%	-16
trust information from their provider	73%	88%	-15
are comfortable asking questions	72%	86%	-14
are confident making decisions	70%	83%	-13

Rather than being based on income, these differences appear to reflect differences in the quality of patients' relationships with their providers and their care facilities. Regardless of income, patients who have a personal connection are 24 points more apt than others to feel they have a say in their care, and 28 points more likely to feel informed about their health. There are broad impacts of continuity as well. And since connectedness and continuity are comparatively lacking among low-income patients, so are their healthcare experiences, engagement, and satisfaction.

section vii: insurance, care facilities, and health status

The ACA has produced a dramatic shift in the insurance status of low-income Californians: As of Fall 2014 just 15 percent reported having no insurance, half the level of noncoverage reported in 2013.

As addressed in previous sections of this report, this increase in coverage has positively impacted patients' satisfaction with their care overall, their care experiences, and their ratings of their providers, showing the important role of health insurance in enhancing patient care.

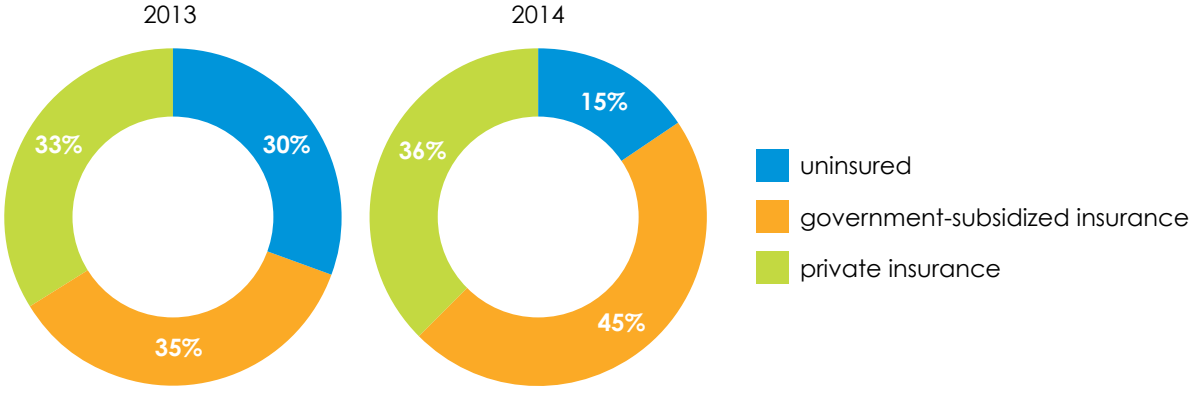
Low-income residents aren't the only Californians to have gained coverage via the ACA. The share of higher-income patients who lack health insurance also has declined, from 10 percent in 2013 to 5 percent in Fall 2014.

Further, as detailed below, low-income patients who've obtained insurance through the ACA are making particularly robust use of the healthcare system, with an average 7.6 visits the past year. That's higher than the average number of visits by non-ACA patients, and much higher than the level of visits by those who were uninsured before the ACA went into effect.

Thirty-four percent of low-income patients now report being insured through the Medi-Cal program,[8] a 10-point increase over its level in the 2013 Foundation survey. As a result, 45 percent now have government-backed insurance, with private coverage essentially unchanged, at 36 percent.

Just 15 percent of low-income Californians report having no insurance, half the level of noncoverage in 2013.

change in insurance status (among low-income Californians)



Among low-income patients with coverage, 35 percent say they obtained it through the Covered California marketplace. As suggested by the overall shifts in coverage, most of those insured through the marketplace – 61 percent – say they are covered by Medi-Cal. Twenty-eight percent report having private insurance, and 11 percent are in another government-backed program.

Noncoverage rates have been cut in half among clinic users, from 34 to 17 percent.

Noncoverage rates have been cut in half among clinic users (from 34 to 17 percent) and private doctors' office patients (from 22 to 11 percent). Lack of insurance has held essentially steady in another group, Kaiser Permanente patients, now at 8 percent.

Within the clinic population, CCHC and non-CCHC users are 15 and 19 points less likely to lack insurance than they were a year ago, respectively. Forty-eight percent of all clinic users now are covered by Medi-Cal, up sharply from three in 10 in 2013. That includes 59 percent of CCHC patients and four in 10 non-CCHC users, up by 16 and 17 points, respectively.

Higher-income Californians remain more likely to be insured than lower earners, 93 vs. 81 percent, but the rise of ACA coverage means that gap has narrowed, from 21 points in 2013 to 12 points now. Eight in 10 higher-income residents have private insurance coverage, 44 points more than its level among low-income Californians.

facility use

Forty-one percent of low-income Californians say they use a clinic for care, 27 percent a private doctor's office, 15 percent Kaiser Permanente, and 10 percent rely on hospital emergency rooms. These roughly match their averages the past three years.

Specific types of clinic use have held largely steady, with 15 percent of low-income Californians using CCHCs, 11 percent in public clinics (either a public hospital clinic, 9 percent, or a county or city clinic, 2 percent), and 15 percent using clinics of another type.

Higher-income Californians continue to be significantly more likely than lower earners to go to a private doctor's office (51 percent) or Kaiser Permanente (23 percent) for their care. Just two in 10 use a clinic; 2 percent rely on hospital emergency rooms. All have held steady since 2013.

health status

There continue to be dramatic differences in health status between low- and higher-income Californians. Four in 10 low-income residents rate their health as excellent or very good, compared with 64 percent of higher-income Californians, a 24-point gap. Low-earners are 19 points more apt that those with higher incomes to rate their health as fair or poor.

There are differences, as well, within low-income groups. Clinic users continue to report being in less positive health than other patients. Half of Kaiser Permanente patients and 44 percent of private doctors' office patients say they're in at least very good health; that declines to 36 percent of clinic patients. These numbers indicate the challenges faced by traditional safety net facilities as they seek to serve a less-well population.

Latinos are less likely to say they're in excellent or very good health compared with others, 36 vs. 45 percent. Noncitizens are 17 points less apt than citizens to rate their health positively, 28 vs. 45 percent. And socioeconomic levels matter: There's a 20-point gap in positive health status between those in the lowest-income households and those with incomes of at least $16,000 a year (26 vs. 46 percent), and an 18-point gap between those who have or have not gone beyond high school.

facility visits

Low-income Californians report an average 6.1 visits for care in the past year, up slightly from 4.8 the previous year, suggesting increased use of the facilities that serve them. This now exceeds the number of average visits by higher-income patients, 4.3.

The increase in medical visits has occurred exclusively among low-income Californians who have received coverage through the ACA. As noted above, those newly covered individuals have averaged 7.6 visits apiece in the past year, well up from the 2.4 visits uninsured patients averaged in 2013, and also above the average in this survey for non-ACA patients, 5.8. This suggests that gaining insurance may motivate patients to seek out care they need but previously delayed because they lacked coverage.

Reflecting their lower health status, healthcare visits rise among those with Medi-Cal coverage, to an average of 10.1, compared with an average of 3.5 visits by those with private insurance. However, despite being in similar health as those with Medi-Cal, the uninsured report far fewer trips to their facility (2.6 on average), underscoring the importance of insurance coverage for patients to get the medical attention they require.

endnotes

8 In this report, those covered by Medi-Cal include residents covered exclusively by Medi-Cal as well as those covered by both Medicare and Medi-Cal.

section viii: conclusions and recommendations

Healthcare facilities serving low-income Californians have made clear strides since 2011. Patients' ratings of the quality of their care overall, specific aspects of their facility's services, and their communication with their providers all have improved.

Critically, among those advances, low-income patients are more apt to report feeling a personal connection with their care facility and experiencing continuity of care – precursors of empowerment, engagement and satisfaction. These reflect both gains among previously insured patients as well as an ACA-driven rise in those who are newly insured.

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Differences by race and ethnicity also are instructive. After trailing in previous years, Latinos' care experiences in particular have moved ahead, helping to eliminate their shortfall in satisfaction – a positive result for a long underserved population. Latinos, though, still trail whites in connectedness and continuity of care, areas ripe for future efforts.

There's room for further growth more generally. Many advances are modest in size, and they have not occurred among all facility types and patient groups. Patients' loyalty to their care facility has yet to improve, and low-income Californians' healthcare experiences continue to lag those of higher-earners.

Results of this survey can encourage more progress by identifying where facilities and providers have improved in their patients' eyes, and what's in reach. While rolling out new services may be challenging, other steps are simpler, ranging from staff courtesy and facility cleanliness to a continued focus on fostering connectedness, continuity and patient-provider relationships.

Findings on the accessibility and importance of a variety of care and communication options also lend themselves to specific actions. Such options – including alternative care models such as team-based care, healthcare coaches, and group care, as well as services such as a mental health and substance abuse counseling – promote patient satisfaction. And interest in them far surpasses current access, suggesting that providers can benefit by making them available.

Levels of empowerment and engagement among low-income patients are broad, but could be deepened. This means encouraging patients to take a more active role in their health care, and providing them with the tools they need – information and confidence among them – to do so. The progress realized to date shows the benefits that such efforts can produce.

appendix a – topline data report

This appendix provides complete question wording and topline results for data included in this report on the 2014 Blue Shield of California Foundation survey.

* in data columns = less than 0.5 percent

1z. 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				Fair/poor			
		NET	Excellent	Very good	Good	**NET**	Fair	Poor	No opinion
10/5/14	All	56	24	32	27	17	13	4	*
	200%+ FPL	64	27	37	25	10	8	2	*
	<200% FPL	40	18	22	31	29	22	7	*
6/18/13	All	52	20	32	29	19	15	4	*
	200%+ FPL	61	24	37	26	13	11	2	*
	<200% FPL	35	12	22	34	31	25	7	*
4/8/12	<200% FPL	38	16	22	30	31	22	10	1
4/25/11	<200% FPL	33	13	19	36	31	22	8	1

1. About how many times in the past year have you seen a doctor, nurse or other healthcare provider?

		None	Once	2-5 times	6+ times	No opinion	Mean	Median
10/5/14	All	14	22	44	19	1	4.86	2
	200%+ FPL	12	22	48	17	*	4.26	2
	<200% FPL	16	21	37	23	2	6.13	2
6/18/13	All	16	23	42	17	1	4.55	2
	200%+ FPL	15	25	44	16	*	4.38	2
	<200% FPL	19	21	40	18	2	4.83	2
4/8/12	<200% FPL	19	20	41	20	1	4.34	2
4/25/11	<200% FPL	16	18	41	23	2	5.03	2

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)

OK, where's the last place you went when you needed health care?
[Follow-ups specified – see questionnaire.]

	10/5/14			6/18/13			4/8/12	4/25/11
	All	200%+ FPL	<200% FPL	All	200%+ FPL	<200% FPL	<200% FPL	<200% FPL
Kaiser Permanente	20	23	15	19	24	9	13	12
Doctor's office	43	51	27	41	50	25	27	28
Clinic NET	26	19	41	27	17	48	43	44
Community/health ctr.	8	4	15	8	5	16	17	11
Public hospital	5	3	9	5	2	11	9	10
Private/relig. hosp.	4	4	4	4	4	3	4	5
Hospital oth./unknown	*	*	1	*	-	1	1	1
County/city	1	*	2	1	1	3	2	5
Private	4	4	4	4	3	6	4	5
Other/unknown type	5	5	6	5	3	8	7	8
Hospital ER	5	2	10	5	3	9	10	10
Hospital unspecified	1	1	2	1	1	1	1	2
Someplace else	4	3	4	5	4	6	4	2
Never have gone*	*	*	1	1	*	1	1	2
No opinion	*	*	*	1	*	1	1	1

*Asked 13, 17, 19-24, 27-30, 32-34 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				Not so good/poor			
		NET	Excellent	Very good	Good	NET	Not so good	Poor	No op.
10/5/14	All	65	38	27	27	7	5	2	1
	200%+ FPL	70	41	29	23	5	3	2	2
	<200% FPL	53	31	22	36	11	8	3	*
6/18/13	All	63	36	27	30	6	5	2	*
	200%+ FPL	69	40	29	25	5	4	1	*
	<200% FPL	49	26	23	41	9	6	3	1
4/8/12	<200% FPL	49	25	24	40	10	7	3	1
4/25/11	<200% FPL	48	26	22	42	9	6	3	1

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

5x. (IF USUAL PLACE) About how long have you been going there for health care?

		1 year or less	2-5 years	6+ years	No opinion	Mean	Median
10/5/14	All	20	30	49	2	8.83	5
	200%+ FPL	17	28	54	2	9.88	7
	<200% FPL	26	34	38	2	6.50	4
4/25/11	<200% FPL	26	38	35	2	6.30	4

6. (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
10/5/14	All	72	26	2
	200%+ FPL	80	18	1
	<200% FPL	57	40	3
4/25/11	<200% FPL	53	44	3

7. (IF NO CHOICE) 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?

	10/5/14			4/25/11
	All	200%+ FPL*	<200% FPL	<200% FPL
Only place close enough	28	NA	31	29
Only place you can afford	39		42	45
Volunteered responses				
Both equally	4		4	4
Only one covered by my insurance	13		10	12
Only one with services I need	4		3	1
Only place available to me	-		-	2
Like my doctor	-		-	1
Recommendation/referral	-		-	1
Have no health insurance	*		1	1
It was assigned to me/was sent by my doctor	2		2	NA
Get it through employment	2		1	NA
Familiarity	2		1	NA
Something else	5		4	4
No opinion	1	"	1	1

*Insuffient sample size.

8. (IF CHOICE) 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?

	10/5/14			4/25/11
	All	200%+ FPL	<200% FPL	<200% FPL
Relative or friend uses it	23	23	24	23
Health care/social provider recommended	9	8	9	10
Saw it advertised	1	*	1	1
It's the most convenient	33	31	38	38
It's the least expensive	7	6	10	9

	10/5/14			4/25/11
	All	200%+ FPL	<200% FPL	<200% FPL
Volunteered responses				
Friend/relative works/worked there	*	*	1	NA
Meets healthcare needs/specializes in my disease	*	*	1	NA
Other quality service/care	1	1	1	NA
Trust	*	*	*	NA
Doctor	2	2	1	3
Covered by insurance/employer	6	7	2	3
Familiarity/going there for years	6	7	3	3
Personal preference	*	*	*	2
Good reputation	2	2	1	1
Other recommendation/referral	2	3	1	1
Needed emergency care	-	-	-	1
Provide a variety of services	-	-	-	*
Other convenience	1	1	1	1
Quality care/best care	3	3	3	1
Researched	1	1	*	1
Other	3	3	2	2
No reason	*	*	-	NA
No opinion	1	1	*	*

9. 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?

		More interested			Less interested			
		NET	Very	Somewhat	NET	Not so	Not at all	No opinion
10/5/14	All	44	19	25	54	19	35	2
	200%+ FPL	39	15	24	58	20	38	2
	<200% FPL	55	28	27	43	16	27	2
4/25/11	<200% FPL	58	28	30	41	16	25	2

10. 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]?

		Excellent/very good				Not good/poor					
		NET	Excellent	Very good	Good	NET	Not so good	Poor	No op.	Not offered (vol.)	Don't use (vol.)
a. Your ability to get an appointment as soon as you want one											
10/5/14	All	60	31	28	29	11	7	4	*	NA	NA
	200%+ FPL	65	34	31	26	9	6	3	*	NA	NA
	<200% FPL	50	27	22	34	15	8	6	1	NA	NA
4/25/11	<200% FPL	44	23	20	36	18	13	6	1	NA	NA

		Excellent/very good				Not good/poor					
		NET	Excellent	Very good	Good	NET	Not so good	Poor	No op.	Not offered (vol.)	Don't use (vol.)
b. The convenience of the location											
10/5/14	All	67	40	27	27	6	5	1	*	NA	NA
	200%+ FPL	72	44	28	24	4	3	1	*	NA	NA
	<200% FPL	57	32	25	33	10	8	2	*	NA	NA
4/25/11	<200% FPL	54	31	23	37	8	7	1	*	NA	NA
c. The cleanliness and appearance of the office											
10/5/14	All	77	50	27	20	3	2	1	*	NA	NA
	200%+ FPL	82	54	28	15	2	1	1	*	NA	NA
	<200% FPL	66	41	24	30	4	3	1	*	NA	NA
4/25/11	<200% FPL	59	37	22	35	5	4	1	1	NA	NA
d. The courtesy and helpfulness of the staff											
10/5/14	All	71	44	27	23	6	4	2	*	NA	NA
	200%+ FPL	74	47	27	21	5	3	2	-	NA	NA
	<200% FPL	63	36	26	29	8	6	2	*	NA	NA
4/25/11	<200% FPL	58	35	23	33	9	7	2	1	NA	NA
e. The amount of time you spend in the waiting room											
10/5/14	All	49	24	26	35	15	9	5	1	NA	NA
	200%+ FPL	55	26	29	34	10	6	3	1	NA	NA
	<200% FPL	38	19	20	36	25	15	10	1	NA	NA
4/25/11	<200% FPL	31	16	15	38	30	21	9	1	NA	NA
f. Their availability on nights or weekends											
10/5/14	All	28	14	14	24	26	15	11	7	4	12
	200%+ FPL	29	14	15	22	26	15	11	7	3	12
	<200% FPL	25	14	12	27	26	14	12	6	4	11
4/25/11	<200% FPL	20	11	10	26	28	17	11	4	7	14
g. Your ability to see the same doctor each time											
10/5/14	All	61	40	21	26	11	7	4	2	NA	NA
	200%+ FPL	67	44	22	24	8	5	3	2	NA	NA
	<200% FPL	50	32	18	29	17	11	6	3	NA	NA
4/25/11	<200% FPL	45	29	17	33	19	14	5	3	NA	NA
h. Your ability to see a specialist if you need one											
10/5/14	All	53	31	22	26	12	7	5	4	1	5
	200%+ FPL	57	34	23	24	10	6	4	4	1	4
	<200% FPL	44	25	19	29	18	10	7	3	*	6
4/25/11	<200% FPL	38	20	18	32	19	12	6	4	1	6

11. 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]?

		Excellent/very good				Not good/poor					
		NET	Excellent	Very good	Good	NET	Not so good	Poor	No op.	Not offered (vol.)	Don't use (vol.)
a. The amount of time the doctor spends with you											
10/5/14	All	62	34	29	29	8	5	3	*	NA	NA
	200%+ FPL	66	36	30	27	6	4	2	*	NA	NA
	<200% FPL	55	30	25	32	13	8	5	*	NA	NA
4/25/11	<200% FPL	48	28	20	38	13	10	3	1	NA	NA
b. How well your doctor communicates with you											
10/5/14	All	71	43	28	23	6	3	2	*	NA	NA
	200%+ FPL	75	46	29	21	4	2	2	-	NA	NA
	<200% FPL	62	36	25	29	9	6	3	*	NA	NA
4/25/11	<200% FPL	55	32	23	33	11	8	4	*	NA	NA
c. The amount of involvement you can have in making decisions about your health care											
10/5/14	All	66	38	28	26	6	4	2	1	NA	NA
	200%+ FPL	74	43	31	21	5	3	1	1	NA	NA
	<200% FPL	50	28	22	39	10	5	4	1	NA	NA
4/25/11	<200% FPL	49	26	23	39	10	7	3	2	NA	NA
d. The continuing care they offer for ongoing or long-term problems											
10/5/14	All	49	28	21	28	8	6	2	6	*	8
	200%+ FPL	52	30	22	25	6	4	1	7	-	10
	<200% FPL	42	23	19	36	13	9	4	4	*	5
4/25/11	<200% FPL	39	22	17	38	12	8	4	4	*	7
e. (IF FAMILY SIZE IS TWO OR GREATER) The ability of other family members in your household to get health care at the same place											
10/5/14	All	59	40	18	24	11	7	4	6	NA	NA
	200%+ FPL	64	46	18	21	9	6	3	7	NA	NA
	<200% FPL	47	28	19	32	15	8	7	6	NA	NA
4/25/11	<200% FPL	41	23	18	37	15	9	6	7	NA	NA

12. 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]?

		Excellent/very good				Not good/poor			
		NET	Excellent	Very good	Good	NET	Not so good	Poor	No op.
a. The understanding they have about your medical history									
10/5/14	All	61	36	25	30	8	5	3	1
	200%+ FPL	67	41	26	27	5	3	2	1
	<200% FPL	51	28	23	34	14	10	4	1
4/25/11	<200% FPL	50	27	23	36	12	9	3	2

		Excellent/very good			Good	Not good/poor			No op.
		NET	Excellent	Very good		NET	Not so good	Poor	
b. How much you feel that people like you are welcome there									
10/5/14	All	71	49	22	24	4	3	1	2
	200%+ FPL	77	54	22	20	2	2	1	2
	<200% FPL	60	37	23	32	7	5	2	1
4/25/11	<200% FPL	56	32	24	35	6	5	2	2
c. (IF NOT PRIMARILY AN ENGLISH SPEAKER) Their ability to speak with you in the language you prefer									
10/5/14	All	52	37	15	40	7	6	1	*
	200%+ FPL*	74	43	31	21	5	3	1	1
	<200% FPL	51	36	14	37	11	9	2	1
4/25/11	<200% FPL	49	33	16	40	11	8	2	1
d. The affordability of the health care you receive									
10/5/14	All	47	29	19	35	16	10	6	3
	200%+ FPL	48	29	19	33	16	10	6	3
	<200% FPL	45	27	18	38	16	11	5	1
4/25/11	<200% FPL	41	24	17	40	18	12	5	2

*Insufficient sample size

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

		Yes	No	No opinion
10/5/14	All	71	28	1
	200%+ FPL	79	19	2
	<200% FPL	55	44	1
4/8/12	<200% FPL	47	53	*
4/25/11	<200% FPL	57	43	*

14. Next I'd like to ask about some ways that health care services can be delivered. Some places have a person whose job it is to help people get the appointments, information and services they need, make sure their questions have been addressed, or may even call to check in on them between visits. There are different names for this kind of role, for example a health care navigator or health care coach. Do you personally have a health navigator or health coach at the place (you go/last went) for care, or not?

		Yes	No	No opinion
10/5/14	All	16	79	5
	200%+ FPL	15	80	5
	<200% FPL	19	75	5
6/18/13	All	17	79	4
	200%+ FPL	15	81	3
	<200% FPL	21	74	5
4/8/12	<200% FPL	18	76	6

15. Some places have what's called team-based care. Each patient gets a health care team that includes a doctor, a health care navigator, a nurse or physician's assistant and a health educator. The same team always works with that patient. As far as you're aware do you personally have a health care team at the place (you go/last went) for care, or not?

		Yes	No	No opinion
10/5/14	All	25	68	6
	200%+ FPL	24	71	5
	<200% FPL	29	63	7
6/18/13	All	27	66	7
	200%+ FPL	24	70	6
	<200% FPL	33	59	8
4/8/12	<200% FPL	25	67	8

16. I'm going to read some kinds of health care services. For each one, please tell me, as far as you know, whether it is or is not available at the place you (usually go/last went) for care. If you don't know whether or not it's available, just say so. First is [ITEM]? How about [NEXT ITEM]?

	Available			Not available			No opinion		
	All	200%+ FPL	<200% FPL	All	200%+ FPL	<200% FPL	All	200%+ FPL	<200% FPL
a. A counselor to talk to about any stress, anxiety or emotional issues	52	53	52	21	19	25	27	27	24
b. Staff members who understand your cultural or ethnic background	67	66	69	13	12	14	20	21	17
c. Someone who is able to speak with you in the language you prefer	81	73	87	14	21	8	5	6	5
d. Help for people with drug or alcohol issues	47	50	42	16	14	21	37	36	37
e. The ability to communicate with healthcare providers or staff by e-mail or text message	59	65	48	24	20	31	18	15	22
f. Group visits where people with the same health issues or interests meet to share their experiences and get information	32	31	34	26	24	32	42	45	35
g. Referrals to social services for things like housing, employment or legal issues	25	24	28	27	24	33	48	52	39

17. (Now, for each of those items/For each item I name), I'd like to ask how important you think it is for this service to be provided at the place where you go for healthcare. First is [ITEM]. How important do you think it is for this service to be provided at the place where you go for care – extremely important, very important, somewhat important, not so important or not important at all? How about [NEXT ITEM]?

		More important				Less important			
		NET	Excellent	Very good	Good	NET	Not so good	Poor	No opinion
a. Team-based care									
10/5/14	All	55	17	38	30	14	9	5	1
	200%+ FPL	49	17	32	34	16	10	6	1
	<200% FPL	68	19	49	22	8	6	3	2
b. A health care navigator									
10/5/14	All	53	15	38	29	17	10	7	2
	200%+ FPL	46	14	33	33	19	12	8	1
	<200% FPL	66	18	48	21	11	7	4	1
c. A counselor to talk to about any stress, anxiety or emotional issues									
10/5/14	All	70	27	43	19	10	6	5	1
	200%+ FPL	66	25	41	20	12	6	6	1
	<200% FPL	76	28	48	15	7	4	2	2
d. Staff members who understand your cultural or ethnic background									
10/5/14	All	61	22	40	22	15	9	6	2
	200%+ FPL	58	21	37	24	17	11	6	2
	<200% FPL	68	23	45	19	12	7	5	1
e. Someone who is able to speak with you in the language you prefer									
10/5/14	All	85	24	61	8	6	4	2	*
	200%+ FPL*								
	<200% FPL	89	26	64	8	3	2	1	*
f. Help for people with drug or alcohol issues									
10/5/14	All	72	27	45	15	11	5	6	2
	200%+ FPL	70	26	44	16	12	5	6	2
	<200% FPL	76	30	46	13	8	4	4	3
g. The ability to communicate with healthcare providers or staff by e-mail or text message									
10/5/14	All	63	24	40	26	10	6	4	1
	200%+ FPL	64	25	38	26	9	6	3	1
	<200% FPL	63	21	42	24	12	7	4	1
h. Group visits where people with the same health issues or interests meet to share their experiences and get information									
10/5/14	All	48	15	33	31	18	10	9	2
	200%+ FPL	43	15	28	34	21	11	11	2
	<200% FPL	57	15	42	26	14	9	5	2
i. Referrals to social services for things like housing, employment or legal issues									
10/5/14	All	46	16	30	25	26	14	12	3
	200%+ FPL	39	15	24	25	33	18	16	3
	<200% FPL	61	19	42	23	13	9	5	2

*Insufficient sample size

18. Thinking about the people working at the place where you (usually go/ last went) for care, do you feel there's a person there who knows you pretty well, or not really?

		Yes	No	No opinion
10/5/14	All	51	48	1
	200%+ FPL	55	44	1
	<200% FPL	45	54	1
6/18/13	All	47	52	1
	200%+ FPL	52	48	1
	<200% FPL	38	61	1
4/8/12	<200% FPL	38	60	1

19. How often do you see the same healthcare provider when you have a healthcare appointment – every time, most of the time, some of the time, rarely or never?

		Usually			Some of the time	Rarely/never			No opinion
		NET	Every time	Most of the time		NET	Rarely	Never	
10/5/14	All	73	43	30	13	13	8	5	1
	200%+ FPL	79	47	32	10	10	6	4	1
	<200% FPL	60	36	24	19	19	12	7	2
6/18/13	All	66	39	27	14	19	13	6	1
	200%+ FPL	72	44	28	11	16	11	5	*
	<200% FPL	53	29	24	21	25	16	9	1
4/8/12*	<200% FPL	60	33	28	19	20	11	8	1

*regardless of whether or not you have a personal doctor

20. I'd like you to rate the way your healthcare provider handles each thing I name. First is [ITEM]. How would you rate the way your healthcare provider handles that - excellent, very good, good, not so good or poor? How about [NEXT ITEM]?

		Excellent/very good			Good	Not good/poor			No opinion
		NET	Excellent	Very good		NET	Not so good	Poor	
a. Explaining things to you in a way that you can understand									
10/5/14	All	80	46	34	16	3	2	1	*
	200%+ FPL	85	47	38	14	1	1	*	*
	<200% FPL	71	43	29	21	7	5	2	1
b. Giving you choices about your treatment options									
10/5/14	All	69	37	32	23	8	5	3	1
	200%+ FPL	73	39	34	21	5	2	2	1
	<200% FPL	60	32	28	26	13	9	4	1
c. Giving you clear information to help you make decisions about your care									
10/5/14	All	72	41	31	22	6	4	2	*
	200%+ FPL	76	44	32	20	4	2	2	*
	<200% FPL	64	34	30	26	10	6	3	*

		Excellent/very good			Good	Not good/poor			No op.
		NET	Excellent	Very good		NET	Not so good	Poor	
d. Encouraging you to ask questions or express your concerns									
10/5/14	All	69	39	30	21	9	7	3	1
	200%+ FPL	73	41	33	19	7	6	2	1
	<200% FPL	61	35	26	25	13	8	5	1
e. Asking you about any stress, anxiety or emotional issues									
10/5/14	All	55	29	26	25	15	10	5	4
	200%+ FPL	57	29	28	26	13	8	4	4
	<200% FPL	52	27	25	25	19	12	7	3
f. Asking if there's anything else you wanted to discuss about your health									
10/5/14	All	68	38	29	22	10	7	3	1
	200%+ FPL	71	39	32	21	8	6	2	*
	<200% FPL	60	37	24	23	15	9	6	1

21a. How much of a say do you feel you currently have in decisions about your health care – a great deal of say, a good amount, just some, only a little, or none at all?

		Has more say			Some	Has less say			No opinion
		NET	Great deal	Good amount		NET	Only a little	None at all	
10/5/14	All	80	50	30	11	8	5	2	*
	200%+ FPL	86	54	31	9	5	3	2	*
	<200% FPL	70	41	29	17	13	10	3	1

Compare to: Changing topics, how much of a say do you feel you currently have in decisions about your health care – a great deal of say, a good amount, just some or only a little?

		Has more say			Some	Has less say			No opinion
		NET	Great deal	Good amount		NET	Only a little	None at all	
6/18/13	All	75	46	29	24	14	10	1	1
	200%+ FPL	79	50	29	20	12	7	1	2
	<200% FPL	66	37	29	33	18	15	1	1
4/8/12	<200% FPL	72	38	34	27	14	12	1	1

21b. How informed do you feel about your health and any health problems you may have – extremely informed, very informed, somewhat informed, not so informed or not informed at all?

		More informed			Somewhat	Less informed			No opinion
		NET	Extremely	Very		NET	Not so	Not at all	
10/5/14	All	77	35	42	18	4	3	1	1
	200%+ FPL	82	38	44	15	2	2	1	1
	<200% FPL	66	29	37	25	9	6	3	*

21c. How confident do you feel in your ability to make decisions about your health care – extremely confident, very confident, somewhat confident, not so confident, or not confident at all?

		More confident				Less confident			
		NET	Extremely	Very	Somewhat	NET	Not so	Not at all	No opinion
10/5/14	All	79	37	41	17	4	3	1	*
	200%+ FPL	83	40	42	14	3	2	*	*
	<200% FPL	70	29	40	23	6	5	2	*

21d. How comfortable do you feel asking your healthcare provider questions about your health or treatment – extremely comfortable, very comfortable, somewhat comfortable, not so comfortable or not comfortable at all?

		More comfortable				Less comfortable			
		NET	Extremely	Very	Somewhat	NET	Not so	Not at all	No opinion
10/5/14	All	82	44	38	14	4	2	2	*
	200%+ FPL	86	48	38	11	3	1	1	*
	<200% FPL	72	35	37	21	7	4	3	*

21e. How much do you feel you can trust the information you get from your healthcare provider – can you trust it completely, mostly, somewhat, not much or not at all?

		More trust				Less trust			
		NET	Completely	Mostly	Somewhat	NET	Not much	Not at all	No opinion
10/5/14	All	83	48	35	12	5	3	2	1
	200%+ FPL	88	52	36	8	3	2	1	*
	<200% FPL	73	42	31	18	8	5	3	1

Compare to: Thinking about different sources of health information, how much do you think you can trust health information you can get from [ITEM] – can you trust it completely, mostly, somewhat, not much or not at all?

6/18/13 - Summary Table

		More trust				Less trust			
		NET	Completely	Mostly	Somewhat	NET	Not much	Not at all	No opinion
a. Doctors you see	All	81	33	48	14	4	3	1	*
	200%+ FPL	87	35	51	12	1	1	0	*
	<200% FPL	70	29	42	19	10	6	4	1

21f. How comfortable would you feel talking with your healthcare provider about any stress, anxiety or emotional issues you might be having – extremely comfortable, very comfortable, somewhat comfortable, not so comfortable or not comfortable at all?

		More comfortable				Less comfortable			
		NET	Extremely	Very	Somewhat	NET	Not so	Not at all	No opinion
10/5/14	All	70	33	37	21	8	6	2	1
	200%+ FPL	74	35	39	18	7	5	1	1
	<200% FPL	61	27	34	28	9	6	3	1

Q22-31 held for release.

32. On another topic, do you have any disability or chronic medical condition that requires ongoing health care, or not?

		Yes	No	No opinion
10/5/14	All	25	75	*
	200%+ FPL	24	76	*
	<200% FPL	27	72	1
6/18/13	All	22	78	*
	200%+ FPL	21	79	*
	<200% FPL	23	76	*
4/8/12	<200% FPL	29	71	*

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

	10/5/14			6/18/13			4/8/12	4/25/11
	All	200%+ FPL	<200% FPL	All	200%+ FPL	<200% FPL	<200% FPL	<200% FPL
Private NET	65	80	36	65	81	33	33	33
Employer-purchased	55	69	25	55	71	25	22	24
Self-purchased	10	10	11	10	10	9	11	9
Government subsidized NET	24	14	45	16	9	35	35	36
MediCal, aka Medicaid	16	8	34	10	3	24	25	24
Other state program	2	1	4	3	2	5	5	4
V.A., Tri-Care, other fed	2	2	3	3	3	3	2	4
Indian Health Service	*	-	*	*	0	*	*	*
Medicare	2	1	3	1	1	1	2	2
Medicare and MediCal (vol.)	2	2	2	*	*	1	2	2
None, you are uninsured	9	5	15	17	10	30	29	29
No opinion	2	1	4	1	1	2	3	2

34. (IF SELF-PURCHASED PRIVATE, MEDI-CAL/MEDICAID, OTHER STATE PROGRAM, MEDICARE, OR MEDICARE AND MEDICAID) Did you get this health plan through the Covered California marketplace, also called the Affordable Care Act or Obamacare, or did you get it on your own without using the marketplace?

		Through marketplace	On your own	Other	No opinion
10/5/14	All	37	49	6	8
	200%+ FPL	40	47	7	7
	<200% FPL	35	50	6	8

appendix b – methodology

This Blue Shield of California Foundation survey was conducted Aug. 14 to Oct. 5, 2014, via telephone interviews with a representative statewide sample of 1,568 Californians between the ages of 19 to 64, including 1,033 with household family incomes below 200 percent of the federal poverty level (FPL) and 513 with household family incomes at 200 percent of the FPL or more.[1],[2] The sample was composed of 723 landline and 845 cell phone interviews, with 1,172 interviews conducted all or mostly in English and 396 in Spanish. The survey was produced, managed and analyzed by Langer Research Associates of New York, N.Y., with sampling, fieldwork and data tabulation by SSRS 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 simultaneously reach the lower-income population as efficiently as possible, while reaching a representative sample of the higher-income population. The design accounted for the high incidence of Latino families among the low-income California population and addressed the regional distribution of low-income households in the state.

Three main landline strata were identified: (1) a *High Low-Income* stratum, which consisted of all 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; (2) a *High Latino* stratum, comprised of remaining landline telephone exchanges associated with Census-block groups in which Latinos were at least 57.5 percent of the population; and (3) a *Residual* stratum, which included all exchanges other than those in the first two strata.

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; and (3) Other areas: all remaining California landline exchanges.

Population figures for each of the 9 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 low-income status (that is, family income below 200 percent of the FPL). 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.[3] 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.

Cell phone numbers were similarly stratified by the estimated income level of the population covered by local rate centers. The low-income cell phone stratum consisted of telephone numbers affiliated with rate centers located in areas where 34 percent or more of the population was estimated to have an annual income of $25,000 or less; the middle-income was defined as rate centers where 27 percent to less than 33 percent have incomes of $25,000 or less; and all other cell phone rate centers in California were consider higher-income.

In addition to the income-based stratification, each cell phone number was labeled based on the rate center's geographic affiliation with the three sampling areas used for the landline sample (LA; SF/SD/Sac; Other). CPO California residents with non-California phone numbers could not be included.

Landline 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 cell phone 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 percent of all non-working and business numbers. Cell phone numbers were designated as active, inactive, or unknown using MSG's Cell WINS procedure. Two-thirds of inactive numbers were removed to improve sample efficiency.[4]

field preparations, fielding, and data processing

Before the field period SSRS programmed the study into CfMC Computer Assisted Telephone Interviewing (CATI) software. 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 the languages according to their comfort level.

In advance of interviewing, CATI interviewers received both 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 both prior to 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 and project staff provided feedback to interviewers throughout the survey period.

A live pretest of the survey instrument was conducted Aug. 5-6, 2014. In all, 26 pretest interviews were completed during this time period (five in Spanish). Pretest interviews were scheduled prior to the live pretest and respondents were offered a $20 incentive to participate. Representatives of Langer Research Associates and Blue Shield of California Foundation accessed digital recordings via a secure FTP site and modified the questionnaire based on the pretest observations.

The questionnaire screened for eligible households by establishing the respondent's family size and annual family income,[5] then selecting only respondents between the ages of 19 and 64. Since the intent was to reach a larger sample of lower-income Californians, higher-income respondents were excluded from the study once their target number of completed interviews (by stratum) was reached.[6] In households that were reached by landline, respondents were randomly selected from the qualifying household residents by asking for the male or female 19 to 64 years old with the most recent birthday.

Interviews in the *High Latino* and *High Low-Income (cell phone)* 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 busy signals) was called approximately eight 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 $10 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 that the timing was bad or expressed disinterest in participating) were contacted at least once more.

weighting procedures

A multi-stage weighting design was applied to ensure an accurate representation of the target population(s). Weighting was done separately for each income group (less than 200 percent FPL and 200 percent-plus FPL) and involved the following stages:

1. *Sample design correction*. In order to correct for over- or undersampling of each of the nine stratum-by-area landline cells and the nine equivalent cell phone cells, each case was assigned a weight equal to the estimated percentage of the cell among landline/cell phone-qualifying cases divided by the percentage of the cell among completed interviews (within the phone type). For example, low-income cases in the *Landline-Residual-LA* cell received a weight equal to their estimated share among low-income households (27 percent of low-income households) divided by their share among the landline low-income interviews (13 percent). Using more exact values, the calculation for the weight for this cell ($W_{resid\text{-}LA}$), is:

$W_{resid\text{-}LA}$ = .26953/.13154 = 1.99453

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 age 19 to 64 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, within-household correction) was then calculated as the sampling weight, or base weight.

3. *Post-stratification weighting*. With the base weight applied, the low-income and higher-income samples were put, separately, 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 2012 American Community Survey (ACS) for the state of California,

based on residents age 19 to 64 and members of families with incomes less than 200 percent FPL and those with family incomes of 200 percent FPL or more, respectively. 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 (19-29, 30-39, 40-49 and 50-64); education (less than high school, high school, some college and college or more); race (white non-Latino, African-American non-Latino, other non-Latino and Latino); sex by Latino status (i.e., Latino-male, Latino-female, non-Latino-male, non-Latino-female); region (Northern and Sierra counties, Greater Bay Area, Sacramento area, San Joaquin Valley, Central Coast area, Los Angeles County and other Southern CA);[7] citizenship status 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 at the values of the top and bottom fifth percentile.

5. *Income-group proportionate adjustment*. The sample design called for a minimum of 1,000 interviews with respondents with household incomes less than 200 percent FPL and 500 with respondents with household incomes at or greater than 200 percent FPL. However, among 19- to 64-year-old Californians, only 33.6 percent are low-income. To create an accurate estimate of the state of California overall, the low-income sample weights were multiplied by approximately 0.5, while the higher income weights were multiplied by approximately 2.0. The sum of weights for the 22 cases who refused income remained 22.

ACS[8] 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 and rounding.)

table 1a. ACS estimates and unweighted and weighted sample percentages – less than 200 percent FPL

	ACS	Unweighted sample	Weighted sample
Race			
White non-Latino	27.7%	27.4%	27.2%
Black non-Latino	7.3	4.6	6.9
Latino	52.8	58.4	54.0
Other non-Latino	12.1	9.7	11.9
Sex/race			
Male, non-Latino	21.7	18.4	21.1
Female, non-Latino	25.4	23.4	25.5
Male, Latino	25.5	23.4	25.6
Female, Latino	27.4	34.8	27.8

	ACS	Unweighted sample	Weighted sample
Education			
Less than high school	31.5	30.5	31.3
High-school education	26.1	28.0	26.5
Some college	31.2	26.3	30.8
College graduate-plus	11.3	15.2	11.4
Age			
19-29	33.1	25.6	32.3
30-39	22.7	20.0	22.8
40-49	21.1	20.1	21.0
50-64	23.0	34.4	24.0
Region			
Sierra/Northern Counties	4.2	5.5	4.4
Greater Bay Area	14.2	15.4	14.9
Sacramento Area	5.8	4.2	5.8
San Joaquin Valley	13.4	11.6	13.3
Central Coast	5.3	11.2	5.6
LA County	29.5	27.1	28.4
Other Southern CA	27.7	24.4	27.6
Phone status			
Cell phone only	57.0	47.8	56.0
Some landline use	43.0	52.2	44.0

table 1b. ACS estimates and unweighted and weighted sample percentages – 200 percent or more FPL

	ACS	Unweighted sample	Weighted sample
Race			
White non-Latino	48.6%	60.6%	50.1%
Black non-Latino	5.5	4.9	5.8
Latino	28.5	22.9	28.1
Other non-Latino	17.3	11.6	15.9
Sex/race			
Male, non-Latino	36.0	40.5	36.7
Female, non-Latino	35.5	35.9	35.2
Male, Latino	15.0	11.9	14.8
Female, Latino	13.6	11.7	13.4
Education			
Less than high school	9.2	6.1	8.7
High-school education	18.3	14.2	17.7
Some college	34.5	25.0	34.4
College graduate-plus	38.1	54.6	39.1
Age			
19-29	22.1	15.8	22.1
30-39	22.0	15.4	21.5
40-49	23.2	21.6	22.9
50-64	32.8	47.2	33.5

	ACS	Unweighted sample	Weighted sample
Region			
Sierra/Northern Counties	3.2	3.8	3.2
Greater Bay Area	22.9	27.6	23.3
Sacramento Area	5.7	5.2	5.9
San Joaquin Valley	8.1	6.6	7.9
Central Coast	6.2	7.6	6.5
LA County	25.6	20.9	24.6
Other Southern CA	28.3	28.4	28.6
Phone status			
Cell phone only	43.0	33.0	42.1
Some landline use	57.0	67.0	57.9

table 1c. ACS estimates and unweighted and weighted sample percentages – California (19-64)

	ACS	Unweighted sample	Weighted sample
Race			
White non-Latino	41.6%	38.6	42.3%
Black non-Latino	6.1	4.6	6.1
Latino	36.7	46.9	36.9
Other non-Latino	15.6	10.6	14.6
Sex/race			
Male, non-Latino	31.2	25.6	31.4
Female, non-Latino	32.1	27.6	32.0
Male, Latino	18.5	19.6	18.5
Female, Latino	18.2	27.2	18.2
Education			
Less than high school	16.7	22.5	16.3
High-school education	20.9	23.4	20.6
Some college	33.4	25.8	33.1
College graduate-plus	29.1	28.2	30.0
Age			
19-29	25.8	20.7	25.6
30-39	22.2	18.9	21.9
40-49	22.5	21.1	22.2
50-64	29.5	39.3	30.2
Region			
Sierra/Northern Counties	3.6	4.8	3.6
Greater Bay Area	19.9	19.5	20.4
Sacramento Area	5.7	4.6	6.0
San Joaquin Valley	9.9	10.2	9.8
Central Coast	5.8	10.4	6.1
LA County	26.7	24.9	25.9
Other Southern CA	27.9	25.6	28.2

	ACS	Unweighted sample	Weighted sample
Phone status			
Cell phone only	47.7	43.0	46.3
Some landline use	52.3	57.0	53.7
Income status			
Less than 200% FPL	33.6	66.8	33.6
200% FPL or more	66.4	33.2	66.4

procedures for identifying healthcare facility usage

The survey included a highly detailed effort to identify usage of various types of healthcare facilities. Respondents were asked if they usually go for health care to a Kaiser 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 (2.5 percent) were asked where they last went for care (using the same options listed above), and whether it was in California or not. Those who said they went for care to a nonprofessional location (e.g., a relative or friend) were asked where they go for professional care.

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.

The CATI program included codes for more than 900 California community clinics and health centers (CCHCs) or hospital-based clinics. Those who said they use a clinic were asked the clinic's name and location. These were compared with a list of CCHCs compiled by the California Primary Care Association (CPCA) 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 or not. 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 CPCA 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 clinic codes by internet searches or by directly calling the clinics named.

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, other/unknown type," "hospital clinic, other/unknown type," "hospital, unspecified" or "someplace else."

For a breakdown of facility usage for the full sample, as well as those with family household income below 200 percent FPL and 200 percent FPL and above, see the table for Q2/2a/3/4 of the topline data report.

response rate

The response rate for this study was calculated at 25 percent for the landline sample and 20 percent for the cell phone sample using the "Response Rate 3" formula of the American Association for Public Opinion Research.

Following is a full disposition of the sample selected for this survey:

	Landline	Cell	Total
Eligible, Interview (Category 1)			
Complete	718	850	1,568
Eligible, non-interview (Category 2)			
Refusal (Eligible)	197	159	356
Answering machine household	44	57	101
Physically or mentally unable/incompetent	0	2	2
Language problem	2	6	8
Unknown eligibility, non-interview (Category 3)			
Always busy	1,526	1,057	2,583
No answer	10,708	12,502	23,210
Technical phone problems	377	67	444
Call blocking	914	43	957
No screener completed	5,584	8,199	13,783
Housing unit, unknown if eligible	4,107	5,518	9,625
Not eligible (Category 4)			
Fax/data line	3,877	409	4,286
Non-working number	68,033	8,372	76,405
Business, government office, other organizations	10,078	650	10,728
No eligible respondent	1,509	1,925	3,434
Total phone numbers used	107,675	39,815	147,490

design effect and margin of sampling error

The survey has a design effect due to weighting of 1.6 for respondents with household incomes less than 200 percent of the federal poverty level, 1.4 for respondents with incomes of 200 percent of the FPL or more and 2.1 for the entire California sample. The margin of sampling error is 3.5 percentage points for the full sample, 4 points for the low-income sample and 5 points for the higher-income sample. Error margins are higher for subgroups. All differences described in this report have been tested for statistical significance.

endnotes

1 Twenty-two respondents did not provide enough information to determine their household family income.

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

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

4 In total, 16 of 845 cell phone interviews were completed with numbers designated inactive.

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

6 Families were defined in accordance with the definition applied by the U.S. Census bureau and FPL was based on the 2014 HHS Poverty Guidelines.

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

8 Phone status is based on estimates from NHIS.

appendix c – statistical modeling

This appendix details the regression analysis and mediation modeling used in this study to help identify key motivators of patient attitudes and behaviors.

A regression measures the relationships between an outcome and variables that might predict it. Those variables may include behaviors, attitudes and demographic characteristics. The outcome also may be an attitude, such as rating one's health care positively (or a behavior, such as taking an active role in one's care). While a regression does not establish causality, it identifies the extent to which each predictor independently explains the outcome, holding all the other predictors in the model constant.

modeling overall satisfaction with care

We evaluated patients' satisfaction with their care using the following predictors: facility type; connectedness; continuity; having a personal doctor; extent of say in care decisions; an index based on facility ratings; an index based on provider ratings; an index based on the availability of services, models of care, and communication options; use of weekend hours; use of a specialist; use of continuing care; self-reported health, disability, insurance, employment, marital/relationship and citizenship status; gender; age; household size; urbanicity; education; race/ethnicity; language mainly spoken at home (English or not); and income.[1]

The table below shows the strongest predictors, establishing patients' ratings of their facilities and their providers, and the amount of say they have in their care decisions, as key factors in patient satisfaction, along with health status.

	Standardized coefficient (β)	Significance test (*t*)
Facility ratings index	.32	7.06***
Provider ratings index	.25	5.58***
Overall health	.11	3.39***
Amount of say in care decisions	.10	3.25**

Model R^2 = .42, $p < .001$

Here and below: ***$p < .001$, **$p < .01$, *$p < .05$, +$p < .10$

mediation models

The regression above identifies direct predictors of patient satisfaction. It also can be useful to evaluate indirect relationships, in which a third variable acts as a mediator between a predictor and the outcome.

Specifically, while the regression finds that connectedness and continuity are not directly related to overall satisfaction with care, we hypothesized that they might indirectly influence satisfaction through its key predictors, facility and provider ratings.

This was tested through a series of regressions called a mediation model. We followed Baron and Kenny's (1986) steps for mediation, as follows:

1. Confirming that connectedness predicts satisfaction (x → y) when no other variables are included (and the same for continuity).

2. Confirming that connectedness predicts positive ratings of facilities (x → m); that it predicts positive ratings of providers; and that continuity does the same.

3. Confirming that connectedness and positive ratings of facilities both predict satisfaction (x and m → y), and that connectedness does so less strongly than in Step 1. Again, this was repeated using provider ratings as a mediator, and using continuity as the predictor.

We then computed a Sobel z-test, which tests whether the indirect effect of the predictor on the outcome through the mediator is statistically significant. If so, it means that the predictor in fact influences the outcome through its effect on the mediator.

The table below shows results of each step of the mediation for each of the two predictors (continuity and connectedness) and mediators (facility ratings index and provider ratings index), a total of four mediation models. In each case, the indirect effect of connectedness and continuity through the mediator is statistically significant.

The final model, shown at the end of the table, combines each of the individual mediations to show the collective effect. It shows that connectedness and continuity predict satisfaction when they alone are included in the model, but that they cease to be significant predictors when facility ratings and provider ratings are added. This shows that connectedness and continuity significantly influence patient satisfaction largely because they improve patients' perceptions of how well their facilities and providers handle specific aspects of their care.

	Standardized coefficient (β)	**Significance test (*t*)**
Mediation model 1		
step 1: connectedness → satisfaction with care	.26	8.70***
step 2: connectedness → facility ratings index	.36	12.36***
step 3: connectedness + facility ratings index → satisfaction with care		
connectedness	.06	2.15*
facility ratings index	.57	20.89***
Sobel test		10.64***

	Standardized coefficient (β)	Significance test (*t*)
Mediation model 2		
step 1: connectedness → satisfaction with care	.26	8.70***
step 2: connectedness → provider ratings index	.38	13.00***
step 3: connectedness + provider ratings index → satisfaction with care		
connectedness	.06	2.10*
provider ratings index	.54	19.44***
Sobel test		10.77***
Mediation model 3		
step 1: continuity → satisfaction with care	.24	7.71***
step 2: continuity → facility ratings index	.35	11.67***
step 3: continuity + facility ratings index → satisfaction with care		
continuity	.04	1.40
facility ratings index	.58	21.10***
Sobel test		10.30***
Mediation model 4		
step 1: continuity → satisfaction with care	.24	7.71***
step 2: continuity → provider ratings index	.36	12.17***
step 3: continuity + provider ratings index → satisfaction with care		
continuity	.04	1.44
provider ratings index	.55	19.69***
Sobel test		10.17***
combined model: predicting satisfaction with care		
step 1: connectedness and continuity alone		
connectedness	.20	6.15***
continuity	.16	4.85***
step 2: income level + patient-provider index, trust in medical sources, current health info. technology use, connectedness, continuity, and feel informed → satisfaction with care		
connectedness	.03	.95
continuity	.00	.07
facility ratings index	.37	9.42***
provider ratings index	.27	6.73***

modeling interest in changing your place of care

We also produced a regression using patients' interest in changing their healthcare facility as the outcome. The same predictors used in the satisfaction model were included, along with two others – patients' perceptions that they have a choice of places to go for care, and their overall satisfaction with their care (as part of the facility ratings index).

The table below shows the results. The model finds that patients' ratings of their facilities, having a choice of facilities, having a personal doctor, their tenure at their facility and having more of a say in their care independently

predict loyalty to a facility; while using a hospital emergency room for care, using a public (non-CCHC) clinic, having a disability and not using a specialist predict interest in changing facilities.

	Standardized coefficient (β)	Significance test (*t*)
Facility ratings index	-.23	4.32***
Facility: Hospital ER	.12	3.28**
Having a choice of healthcare facilities	-.11	3.33***
Has a personal doctor	-.09	2.24*
Facility: Public clinic (non-CCHC)	.09	2.40*
Has a disability	.09	2.26*
Doesn't use specialist	.09	2.54*
Tenure at place of care	-.09	2.52*
Amount of say in care decisions	-.08	2.24*

Model $R^2 = .23$, $p < .001$

endnotes

1 The facility ratings index averages responses to questions 10a-h, 11c-e, and 12a-d. The provider ratings index averages responses to questions 11a-b and 20a-f. The availability of services index is based on the number of services, modes of care and forms of communication available, based on questions 14, 15 and 16a-i.

appendix d – full questionnaire

This appendix reproduces the full, formatted questionnaire for Blue Shield of California Foundation's 2014 survey of Californians.

[CONFIRM LANGUAGE AT THE BEGINNING OF THE INTERVIEW]

INTRO [ALL SAMPLE]: Hello. My name is _____. I'm calling from SSRS 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
R (DO NOT READ) Refused

(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 ten 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.

1z. 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
RR (DO NOT READ) Refused

(READ ITEM IN PARENS IF S1=2+)
S3. To ask the right questions, we need to know whether in 2013, 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 SAYS THEY ARE NOT SURE, PROBE: Can you estimate?]

1	More than (AMOUNT)	
2	Less than (AMOUNT)	
3	(DO NOT READ) Exactly (AMOUNT)	
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 $24,000
IF S1=2 $30,000
IF S1=3 $37,000
IF S1=4 $48,000

IF S1=5 $56,000
IF S1=6 $64,000
IF S1=7 $73,000
IF S1=8 $81,000
IF S1=9+ $96,000

(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 in 2013 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 SAYS THEY ARE NOT SURE, PROBE: Can you estimate?]

1 More than (AMOUNT)
2 Less than (AMOUNT)
3 (DO NOT READ) Exactly (AMOUNT)
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

VALUES FOR M*
IF S1=1 $2,000
IF S1=2 $2,500
IF S1=3 $3,100
IF S1=4 $4,000
IF S1=5 $4,700
IF S1=6 $5,300
IF S1=7 $6,000
IF S1=8 $6,700
IF S1=9+ $8,000

(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	
R	(DO NOT READ) Refused	

(IF CELL SAMPLE OR Q.S2a = 2 GO TO Q.S5)

(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 AND GO TO Q.S5
3	Person is unavailable	GET NAME SCHEDULE CB
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, respondent coming to the phone	REPEAT INTRO AND GO TO Q.S5
3	Person is unavailable	GET NAME SCHEDULE CB
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 Q.S7a IF Q.S7 = 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 Q.S7b IF Q.S7a = R)
S7b. Can you just confirm that you are older than 18 and younger than 65?

1 Yes
2 No
R (DO NOT READ) Refused

(IF Q.S7b = 2 OR R, THANK & TERM.)

main questionnaire

1. 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)

(INTERVIEWER NOTE: IF RESPONDENT SAYS 100+ TIMES, PLEASE CONFIRM BEFORE ENTERING RESPONSE)

_____ 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 Someplace else
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?
(RE-READ LIST IF NECESSARY)

(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 Or, someplace else
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, or not?

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
158 Los Angeles
201 Oakland
213 Oxnard
254 Sacramento
255 Salinas
258 San Diego
259 San Francisco

263 San Jose
330 Ventura
997 Other answer given (SPECIFY) _____
DDD (DO NOT READ) Don't know
RRR (DO NOT READ) Refused

(ASK Q.3aa IF Q.3 = 096, 158, 201, 213, 254, 255, 258, 259, 263, 330 OR 997)
3aa. 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.3a IF Q.2 = 3 OR Q.2a = 3)
3a. 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.3b IF Q.3a = 997, DDD, OR RRR)
3b. 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.3c IF Q.3b = 1)
(ROTATE VERBIAGE IN PARENS)
3c. Is this clinic run by a (county hospital) or a (private or religious hospital)?

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

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

(INTERVIEWER NOTE: IF "COLLEGE OR UNIVERSITY RUN STUDENT CLINIC" CODE AS 3 "OTHER")

1 County or city
2 Private company
3 (DO NOT READ) Other
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 (DO NOT READ) Other
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.5x IF Q.2 = 1-5)
5x. About how long have you been going there for health care?
(IF NECESSARY: The place you usually go for healthcare)

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.6 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
6. (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.7 IF Q.6 = 2)
ROTATE VERBIAGE IN PARENS
7. 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) Only one that takes my insurance
6 (DO NOT READ) Something else (SPECIFY) _____
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.8 IF Q.6 = 1)
(SCRAMBLE 1-5)
8. Which of these is the main reason you chose this place – is this because…?
(READ LIST.)

(INTERVIEWER NOTES:
- IF RESPONDENT SAYS "WIFE/HUSBAND, PARENT PICKED IT, CODE AS "1."
- RE-READ OPTIONS IF NEEDED.)

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.9 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
9. 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.10 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
(DO NOT SCRAMBLE ITEMS)
10. 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/I don't use weekend hours/don't need a specialist

7 (DO NOT READ) Not offered/ My clinic doesn't offer weekend hours / My clinic doesn't offer these services
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.11 IF Q.2 = 1-5 OR Q.2a = 1-5, D OR R)
(DO NOT SCRAMBLE ITEMS)
(ASK ITEM h ONLY IF Q.S1 = 2+)
INSERT "usually go" IF Q.2 = 1-5
INSERT "last went" IF Q.2a = 1-5, D, OR R
11. 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 AS NEEDED)

1 Excellent
2 Very good
3 Good
4 Not so good
5 Poor
6 (DO NOT READ) Not applicable/I don't need or use continuing care
7 (DO NOT READ) Not offered/my clinic does not offer continuing care
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 the 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.12 IF Q.2 = 1-5 OR Q.2a = 1-5, D OR R)
(DO NOT SCRAMBLE ITEMS)
(ASK ITEM c IF S5 = 2-7)
12. 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 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

13. 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.14 IF Q.2 = 1-5 OR Q.2a = 1-5, D OR R)
INSERT "go" IF Q.2 = 1-5
INSERT "last went" IF Q.2a = 1-5, D, OR R
14. Next I'd like to ask about some ways that health care services can be delivered: Some places have a person whose job it is to help people get the appointments, information and services they need, make sure their questions have been addressed, or may even call to check in on them between visits. There are different names for this kind of role, for example a health care navigator or health care coach [Spanish: promotores de salud]. Do you personally have a health navigator or health coach at the place you (go/last went) for care, or not?

1 Yes
2 No
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 "go" IF Q.2 = 1-5
INSERT "last went" IF Q.2a = 1-5, D, OR R
15. Some places have what's called team-based care. Each patient gets a health care team that can include a doctor, a health care navigator, a nurse or physician's assistant and a health educator. The same team always works with that patient. As far as you're aware do you personally have a health care team at the place you (go/last went) for care, or not?

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

(ASK Q.16 IF Q.2 = 1-5 OR Q.2a = 1-5, D OR R)
(SCRAMBLE ITEMS)
(ASK ITEM e IF Q.S5 = 2-7)
INSERT "usually go" IF Q.2 = 1-5
INSERT "last went" IF Q.2a = 1-5, D, OR R
16. I'm going to read some kinds of health care services. For each one, please tell me, as far as you know, whether it is or is not available at the place you (usually go/last went) for care. If you don't know whether or not it's available, just say so. First is [INSERT 1ST ITEM]? How about [NEXT ITEM]?

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

1 Is available
2 Is not available
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

a. A counselor to talk to about any stress, anxiety or emotional issues
b. Staff members who understand your cultural or ethnic background
c. Someone who is able to speak with you in the language you prefer
d. Help for people with drug or alcohol issues
e. The ability to communicate with healthcare providers or staff by e-mail or text message
f. Group visits where people with the same health issues or interests meet to share their experiences and get information
g. Referrals to social services for things like housing, employment or legal issues

(SCRAMBLE IN SAME ORDER AS Q.16 – ITEMS a & b SHOULD ALWAYS BE ASKED LAST)
INSERT "Now, for each of those items" IF Q.2 = 1-5 OR Q.2a = 1-5, D, OR R
INSERT "For each item I name" IF Q.2a = 6
(ASK ITEM e IF Q.S5 = 2-7)
17. (Now, for each of those items/For each item I name), I'd like to ask how important you think it is for this service to be provided at the place where you go for healthcare. First is [READ ITEM]. How important do you think it is for this service to be provided at the place where you go for care – extremely important, very important, somewhat important, not so important or not important at all? How about [NEXT ITEM]? [REPEAT LIST]

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

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

a. Team-based care (IF NEEDED: That's when each patient gets a health care team that can include a doctor, a health care navigator, a nurse or physician's assistant and a health educator.)
b. A health care navigator (IF NEEDED: That's a person whose job it is to help people get the information and services they need.)
c. A counselor to talk to about any stress, anxiety or emotional issues
d. Staff members who understand your cultural or ethnic background
e. Someone who is able to speak with you in the language you prefer
f. Help for people with drug or alcohol issues
g. The ability to communicate with healthcare providers or staff by e-mail or text message
h. Group visits where people with the same health issues or interests meet to share their experiences and get information
i. Referrals to social services for things like housing, employment or legal issues

patient engagement

(ASK Q.18 IF Q.2 = 1-5 OR Q.2a = 1-5, D OR R)
INSERT 1ST VERBIAGE IN PARENS IF Q.2 = 1-5; INSERT 2ND VERBIAGE IN PARENS IF Q.2a = 1-5, D, OR R)

18. Thinking about the people working at the place where you (usually go/ last went) for care, do you feel there's a person there who knows you pretty well, or not really?

(IF NEEDED: I mean someone who has a pretty good idea of what's going on in your life that may affect your health. This can be anyone you see there, not necessarily the doctor.)

1 Yes, there is someone that knows you pretty well
2 No, there is no one that knows you pretty well
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

19. How often do you see the same health care provider when you have a health care appointment – every time, most of the time, some of the time, rarely or never?

1 Every time
2 Most of the time
3 Some of the time
4 Rarely
5 Never
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(SCRAMBLE ITEMS; ALWAYS ASK ITEM f LAST)
20. I'd like you to rate the way your healthcare provider handles each thing I name. First is [READ 1ST ITEM]. How would you rate the way your healthcare provider handles that - excellent, very good, good, not so good or poor? How about [NEXT ITEM)?

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. Explaining things to you in a way that you can understand
b. Giving you choices about your treatment options
c. Giving you clear information to help you make decisions about your care
d. Encouraging you to ask questions or express your concerns
e. Asking you about any stress, anxiety or emotional issues
f. Asking if there's anything else you wanted to discuss about your health

(SCRAMBLE Q.21a-Q.21f)

21a. How much of a say do you feel you currently have in decisions about your health care – a great deal of say, a good amount, just some, only a little, or none at all?

(INTERVIEWER NOTE: If respondent seems confused by the term "say" please say: "SAY – AS IN VOICE OR INPUT.")

1 A great deal
2 A good amount
3 Just some
4 Only a little
5 None at all
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

21b. How informed do you feel about your health and any health problems you may have – extremely informed, very informed, somewhat informed, not so informed or not informed at all?

(INTERVIEWER NOTE: IF R SAYS "NO HEALTH PROBLEMS", SAY "HOW INFORMED DO YOU FEEL ABOUT YOUR HEALTH IN GENERAL?")

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

21c. How confident do you feel in your ability to make decisions about your health care – extremely confident, very confident, somewhat confident, not so confident, or not confident at all?

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

21d. How comfortable do you feel asking your healthcare provider questions about your health or treatment – extremely comfortable, very comfortable, somewhat comfortable, not so comfortable or not comfortable at all?

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

21e. How much do you feel you can trust the information you get from your healthcare provider – can you trust it completely, mostly, somewhat, not much or not at all?

1 Completely
2 Mostly
3 Somewhat
4 Not much
5 Not at all
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

21f. How comfortable would you feel talking with your healthcare provider about any stress, anxiety or emotional issues you might be having – extremely comfortable, very comfortable, somewhat comfortable, not so comfortable or not comfortable at all?

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

integrated behavioral health services

READ TO EVERYONE: I want to ask you about the subject of help with personal challenges that can arise in people's lives. This can be stress, emotional issues, drug or alcohol use, marital or family issues or just feeling down about things.

22. In the past 12 months, was there a time you felt like you might want to talk with a healthcare professional about any issues like these, or not?

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

(ASK Q.23 IF Q.22 = 1, D, OR R)
23. Did you talk about this with a healthcare professional, or not?

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

READ IF Q.23 = 1: Some people may talk about these issues with a healthcare provider who they usually see for routine health care. Others may talk with a counselor like a therapist, a social worker, a psychologist or a psychiatrist.

(ASK Q.24 IF Q.23= 1)
24. Did you talk about it with a healthcare provider, with a counselor, or both?

1 Healthcare provider
2 Counselor
3 Both
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.25 IF Q.24= 2 OR 3 AND [Q.2 = 1-5 OR Q.2a = 1-5, D, OR R])
INSERT 1ST VERBIAGE IN PARENS IF Q.2 = 1-5; INSERT 2ND VERBIAGE IN PARENS IF Q.2a = 1-5, D, OR R)

25. Was this counselor located at the place where you (usually go/last went) for care, or somewhere else?

1 Located at the place you (usually go/last went) for care
2 Located somewhere else
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.26 IF Q.25 = 2)
26. Did your healthcare provider refer you to this counselor, or did you find the counselor some other way?

1 Healthcare provider referred counselor
2 Found some other way
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.27 IF Q.24 = 2 OR 3)
27. In talking with you about this, was the counselor you saw extremely helpful, very helpful, somewhat helpful, not so helpful or not helpful at all?

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

(ASK Q.28 IF Q.24 = 1 OR 3)
28. In talking with you about this, was your healthcare provider extremely helpful, very helpful, somewhat helpful, not so helpful or not helpful at all?

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

(ASK Q.29 IF Q.23 = 2, D OR R)
(SCRAMBLE ITEMS)
INSERT "was or was not a reason; did" IF Q.23 = 2
INSERT "would or would not be a reason; might IF Q.23 = D OR R
29. For each item I mention, please tell me if it (was or was not a reason/ would or would not be a reason) that you (did/might) not talk about this with a healthcare professional. First, how about (INSERT 1ST ITEM)? Next, how about (INSERT NEXT ITEM)? (IF YES REASON, ASK: Was that a big reason, or not so big?)

1 Yes, big reason
2 Yes, not so big of a reason
3 No, not a reason
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

a. Because you did not know who to talk to
b. Because you were uncomfortable bringing it up
c. Because you did not think they could help
d. Because you did not want to talk about it
e. Because there was not enough time in the appointment

(READ IF Q.22 =2 or Q.23 = 2, D, R: Some people may talk about these issues with a healthcare provider who they usually see for routine health care. Others may talk with a counselor like a therapist, a social worker, a psychologist or a psychiatrist).

30. If you wanted to talk about these issues in the future, would you be more comfortable talking with a health care provider, or with a counselor?

1 Healthcare provider
2 Counselor
3 (DO NOT READ) Either/No preference
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.31 IF Q.2 = 1-5 OR Q.2a = 1-5, D, OR R)
INSERT 1ST VERBIAGE IN PARENS IF Q.2 = 1-5; INSERT 2ND VERBIAGE IN PARENS IF Q.2a = 1-5, D, OR R)
31. Imagine if you wanted to see a counselor in the future. Would you prefer to see someone where you (usually go/last went) for healthcare, or somewhere else?

1 Where you (usually go/last went)
2 Somewhere else
3 (DO NOT READ) Wouldn't want to see a counselor
4 (DO NOT READ) No preference
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

clinic rating

32. On another topic, 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

33. 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 NOTES:
- IF RESPONDENT SAYS "Kaiser 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 (PRONOUNCE: Meda-CAL), 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

(ASK Q.34 IF Q.33 = 02, 03, 04, 07, 08)
34. Did you get this health plan through the Covered California marketplace, also called the Affordable Care Act or Obamacare, or did you get it on your own without using the marketplace?

1 Through the Covered California marketplace
2 On your own without using the marketplace
7 Other (SPECIFY) _____
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

demographics

(ASK IF NOT ORIGINAL RESPONDENT – Q.S4 = 2 OR Q.S4a = 2)
1z2. 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

READ: Now for classification purposes only...

(ASK CELL SAMPLE ONLY)
35. 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

36. 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

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

1	Full time	(SKIP TO Q.40)
2	Part time	(SKIP TO Q.40)
3	Not employed	(GO TO Q.39a)
R	Refused	(SKIP TO Q.40)

(ASK IF NOT EMPLOYED IN Q.37)
37a. 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

38. May I please have your zip code?

[INTERVIEWER: IF THE PROGRAM DOES NOT ACCEPT THE ZIP CODE, RE-ASK. IF IT STILL WON'T TAKE IT ENTER 99997]

_____ ZIP CODE
99997 (DO NOT READ) Other (Specify)
DD (DO NOT READ) Don't know
RR (DO NOT READ) Refused

39. 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

40. Are you of Hispanic or Latino origin or descent?

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

(ASK Q.40a IF Q.40 = 1)
40a. 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.40b IF Q.40 = 2, D, OR R)
40b. Are you white, black, Asian or some other race?

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

(READ VERBIAGE IN PARENS IF Q.S1 = 2+
IF FPLscreen=1:
- 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.

IF FPLscreen=2.
- DO NOT DISPLAY CODE 01-02.
- DISPLAY CODE 03 IF S1<2.
- DISPLAY CODE 04 IF S1<3.
- DISPLAY CODE 05, 06, AND 07 IF S1 <4.
- DISPLAY CODE 08 IF S1<5.
- DISPLAY CODE 09 IF S1<6.
- DISPLAY CODE 10 IF S1<7.
- DISPLAY CODE 11 IF FPLScreen=2 AND Q.S1 = 6+.
- DISPLAY CODE 12 FOR EVERYONE.

IF FPLscreen=9.
- DISPLAY ALL CODES.

(IF FPLscreen2 AND Q.S1 = 6+, DISPLAY CODES 11 & 12 ONLY)

41. 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 $16,000
02 At least $16,000 but less than $20,000
03 At least $20,000 but less than $25,000
04 At least $25,000 but less than $32,000
05 At least $32,000 but less than $38,000
06 At least $38,000 but less than $42,000
07 At least $42,000 but less than $48,000
08 At least $48,000 but less than $54,000
09 At least $54,000 but less than $64,000
10 At least $64,000 but less than $100,000
11 Less than $100,000
12 Or $100,000 or more
DD (DO NOT READ) Don't know
RR (DO NOT READ) Refused

42. 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

FOR INTERVIEWER
INT0. 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 – GO TO INST. ABOVE INT1

(READ IF RESP ASKED SPONSOR AT INTRO)
The survey sponsor is the 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):
INT1. 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

(ASK CELL PHONE RESPONDENTS WHO REQUESTED FOR MONEY (INT1=1)):
INSERT "$10" IF CELL PHONE RESPONDENT
That's the end of the interview. We'd like to send you $10 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 $10 to them personally.

1 [ENTER FULL NAME] – INTERVIEWER: PLEASE VERIFY SPELLING
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.

end of questionnaire

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email: bscf@blueshieldcafoundation.org