blue of california foundation

connectedness and continuity: patient-provider relationships among low-income californians

June 2012

Langer Research Associates

introduction

The United States health care system is in the midst of rapid change. New laws and regulations brought on by the Patient Protection and Affordable Care Act (ACA) and changes in the health care marketplace bring both challenges and opportunities. Most visibly, the ACA is expected to expand health insurance coverage to millions of Californians. However, state budget issues and limited provider participation in Medi-Cal have many concerned that expanded health coverage may not translate into improved access to care for those who need it most – low-income Californians.

Following up on findings from last year's survey of low-income Californians, published in *On the Cusp of Change*, this report provides further insight into patients' perceptions of alternative models of care. *On the Cusp of Change* showed us that patients want to maintain a direct relationship with their primary care provider; however, alternative care models that re-shape the delivery of primary care have the potential to improve patients' experiences by delivering better care at a more affordable cost. Given the changes on the horizon, it is time for patients and providers to explore new models that expand the primary care team and employ new tools to engage patients.

In this report, we learn that connectedness and continuity, no matter what the model of primary care, are the most important elements for patients. Team-based care, text message reminders, and other new models can provide patients with the personal connections they desire. Too often we focus on how systems and procedures can be improved to benefit providers, forgetting that there are real people on the other end of every transaction. The information in this report will be invaluable for policymakers and health care providers as they redesign primary care to meet the needs and aspirations of low-income Californians.

The valuable insight offered in this report would not have been possible without the hard work of the team at Langer Research Associates – Gary Langer, Julie Phelan, Greg Holyk, and Damla Ergun – as well as our Health Care and Coverage program officer, Cecilia Echeverría. Their relentless dedication to high quality research has generated new knowledge that will inform the future of the health care safety net. We hope the conversations on patient experience and engagement will continue in communities across the state and nation. We welcome your comments and questions about the findings of this survey, and hope that you find it useful to your work.

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

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executive summary

Large numbers of low-income Californians seek a more personalized healthcare experience – a connection, when established, that offers compelling benefits for patients and their care facilities alike. And crucially, new routes to that connectedness are opening.

Most patients express their interest in a personal bond as a desire for a traditional doctor-patient relationship. However, majorities also are open to new approaches – team-based care, healthcare navigators, group care, and alternative communication methods – that offer the prospect of reinvigorated patient-provider relationships through a more viable and scalable model.

Majorities are open to new approaches that offer the prospect of reinvigorated patient-provider relationships.

The current shortfall in connectedness is clear in this statewide Blue Shield of California Foundation survey of poor and near-poor Californians: Eighty percent think it is important to have someone at their place of care "who knows you pretty well." But just 38 percent say there is such a person there now.

Yet the survey finds that those relationships can be built – and when they are present, the benefits can be profound. Patients who report a personal connection with someone at their healthcare facility are more likely than others to express satisfaction with the quality of their care, a prime driver of patient loyalty. They also are more likely to exhibit greater healthcare efficacy – the capacity and confidence to take an active role in their health and healthcare decisions, two key aims of patient-centered care.

Specifically, patients who say someone at their facility knows them well are far more apt than those without that kind of relationship to say the care they receive is excellent or very good, 65 vs. 38 percent. They're also much more likely to feel very informed about their health (64 vs. 37 percent), more apt to be highly comfortable asking questions about their care, and more likely to be very confident in their ability to make healthcare decisions.

In addition to familiarity, another element of personalized care is continuity with the same provider. Like those who feel someone at their facility knows them well, patients who regularly see the same provider – whether a doctor, nurse, or physician's assistant – rate their care more positively, feel more informed about their health, and take a more active role in care decisions.

But one-on-one care isn't the only route: This survey also finds that team-based care, a model that achieves continuity and personal connection via a team of medical professionals rather than one care provider, is enormously popular with those who have it – and also is independently associated with greater patient satisfaction and health efficacy.

Indeed, and perhaps surprisingly, having a regular personal doctor, in and of itself, does not independently predict the key outcomes of more satisfied and self-reliant patients – further strong evidence that a personalized healthcare experience can be established outside the confines of the traditional model.

Key predictors of patient satisfaction and efficacy

- Connectedness
- Continuity
- Team-based care

Having a regular personal doctor, in and of itself, does not independently predict the key outcomes of more satisfied and self-reliant patients.

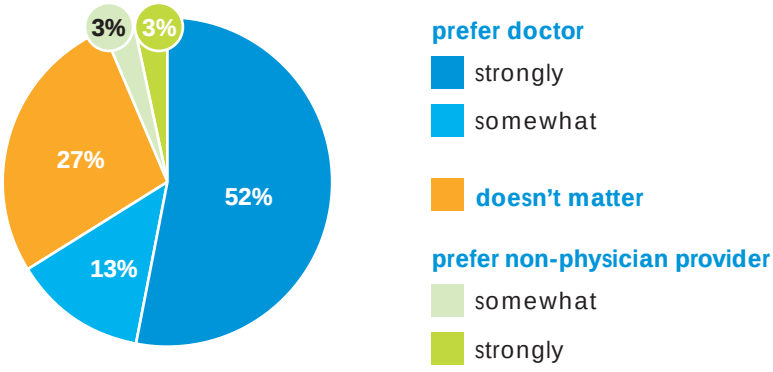
This survey explores the landscape of new approaches to patient-provider relationships for poor and near-poor Californians age 19 to 64, examining their desires for a personal doctor, current experiences of healthcare relationships, and openness to alternative models of care.

The study builds on *On the Cusp of Change: The Healthcare Preferences of Low-Income Californians*, the Blue Shield of California Foundation survey last year that focused on the healthcare experiences, expectations, and desires of low-income, non-senior residents of the state. The appeal of a personal doctor was one key finding: Lacking but wanting a regular personal doctor was one of the strongest predictors of interest in switching to a new healthcare facility, and having a well-liked doctor independently predicted overall patient satisfaction.

This report explores that sentiment in greater detail, with results suggesting that the expressed desire for a doctor is more figurative than literal for many patients, and may be better understood as seeking connectedness and continuity in their healthcare experience. Among the findings:

- Traditional care remains the norm today. Even for routine care, nearly seven in 10 low-income Californians say they usually see a doctor rather than another type of care provider, and two-thirds say seeing a doctor indeed is their preference.

initial preference for type of care provider



- Such is the pull of physician care that majorities of those who have an initial preference for a doctor over another care provider hold that position even if it means appointments are briefer (73 percent say that's worth the tradeoff), the doctor doesn't know them as well (60 percent), or it's harder to get an appointment (56 percent).

- While doctors are present, continuity is lacking. Two-thirds of patients say they don't see the same care provider every time they visit their facility. Nearly six in 10 of them would prefer more regular contact with the same caregiver – a desire that helps open the door to consideration of alternatives.

- For many, preference for a doctor falls short of a demand. One-third have no preference for a doctor over a nurse or physician's assistant, and more are open to non-doctor care under specific circumstances. Among those who initially prefer a doctor, nearly four in 10 shift their preference to a non-physician provider if it means it's easier to get an appointment. And just 23 percent of all low-income Californians prefer a doctor across every condition tested.

- Openness to non-doctor alternatives rises in some groups, for example among younger patients and those in better health. And among people who don't currently see the same care provider each time, a not-insubstantial four in 10 are content with that arrangement. Insight can be gained from closer examination of this and other more flexible patient populations, provided in the full report that follows.

The survey finds that safety-net providers, including California's community clinics and health centers (CCHCs), face challenges but also striking opportunities in developing patient connectedness. Private doctors' offices currently hold an advantage, over clinics and the Kaiser Permanente network alike, in having patients who say someone there knows them fairly well. But CCHCs are ahead of the curve in offering new models such as team-based care and health navigators. And connectedness among people enrolled in such programs is virtually as high as it is among patients in private doctors' practices.

Relatively few low-income Californians have used alternative models of care to date, although the numbers are not insubstantial. About one in four reports having team-based care, and about two in 10 say they have a healthcare navigator, or coach – that is, someone to help them get the appointments, information, and services they need. Participation peaks at CCHCs, where a third report currently having team-based care and a quarter have healthcare navigators.

CCHCs are ahead of the curve in offering new models such as team-based care and health navigators.

Safety-net facilities that adopt these approaches have advantages across a range of outcomes. Satisfaction with care is 14 points higher among clinic users who have team-based care than among those who do not, 55 percent vs. 41 percent – approaching the levels of satisfaction seen among Kaiser Permanente and private doctors' patients overall (61 percent).

Clinic patients who have team-based care, further, are equally likely as Kaiser Permanente and private doctors' office patients to feel very informed about their health and to say they always understand the instructions given by their care provider. Clinic patients who lack team-based care lag on these measures, as well as on satisfaction overall.

Moreover, even given preferences for a doctor's personal care, the survey results show substantial openness among poor and near-poor Californians to alternative approaches, especially among those who most desire continuity and connectedness. In summary:

- Among low-income Californians who don't have team-based care now, a broad 81 percent say they'd be willing to try it, peaking among CCHC patients. And the prospects for satisfaction are good: Among the one in four who currently have a care team, a nearly unanimous 94 percent like it.

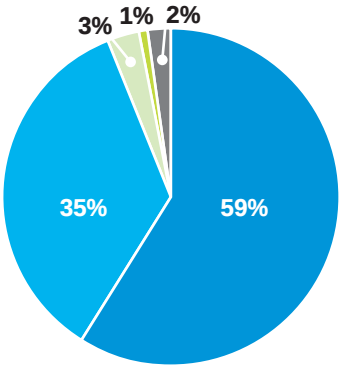
- Satisfaction also is exceedingly high, 91 percent, among the one in six low-income Californians who report having a healthcare navigator. Of those who don't have a navigator, more than half, 55 percent, are interested, and the high satisfaction rate implies the approach could hold broader appeal once tried.

- Group programs present opportunities as well: Just more than three-quarters say they'd be willing to join a group in which they'd receive information and share experiences with others about a common medical condition. Openness to group programs, and particularly strong willingness to participate, is highest among women, individuals with a chronic condition, and those who seek more input in decisions about their health care.

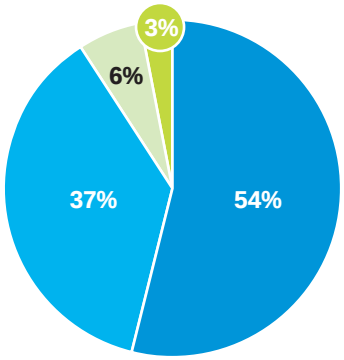
- For routine matters, six in 10 express willingness to substitute telephone consultations for personal visits. Fewer, but still 41 percent, say they're willing to use e-mail for this purpose (with a sharp difference by age). Openness to alternative communication methods is especially high among individuals with a full-time job, marking its appeal as a time-saver.

Technology is another potential avenue for establishing patient connectedness. Numbers ranging from 54 to 63 percent of poor and near-poor, non-senior Californians say they'd be interested in text messages reminding them about appointments or providing health information; and in the ability to see health records, schedule appointments, and renew prescriptions online. Yet currently fewer than 5 percent report using these tools – indicating a largely untapped opportunity.

team-based care: like it



healthcare coach: like it



Not surprisingly, younger adults in this population are especially interested in online and text-messaging options. Text messaging is particularly popular among non-whites compared with whites, and online options are more desired by better-educated and English-speaking patients than by those with less education or who mainly do not speak English at home, respectively – suggesting a targeted approach to the deployment and marketing of these tools.

In communication and care models alike, people who seek continuity with a provider seem willing to use unconventional means to obtain it. Holding other factors constant, statistical modeling finds that those who want to see the same care provider more often also are more willing than others to be interested in new modes of communication, as well as to try team-based care, and to express interest in a health coach.

In communication and care models alike, people who seek continuity with a provider seem willing to use unconventional means to obtain it.

In sum, this study offers actionable findings for safety-net healthcare providers and others serving low-income patients, with potential applicability to broader populations as well. It finds three key predictors of patient satisfaction and efficacy: connectedness, meaning having someone at the facility who knows you well; continuity, or seeing the same provider regularly; and the use of a team-based care model. Achieving these goals offers the prospect of better-served patients, higher patient loyalty, and a more efficient and sustainable model of care.

project overview

This Blue Shield of California Foundation survey extends a course of research initiated by BSCF with its 2011 study, *On the Cusp of Change: The Healthcare Preferences of Low-Income Californians*. Identical in sample design, this year's survey focuses on two key findings of the 2011 report: Expressed interest in a traditional doctor-patient relationship, and hesitancy in some patient groups to embrace the concept of shared decision making in healthcare matters.

The first of these findings raised a variety of questions for care facilities serving the poor and near-poor population, including:

- Were patients expressing an affirmed desire for physician care, or rather invoking the traditional model as a means of expressing their broader interest in a more personalized healthcare experience?

- What is the state of personal connectedness for these patients today, and how does it relate to satisfaction and efficacy?

- What is the extent of this population's openness to alternative care models, and can these alternatives help establish the personal relationships patients seek?

This report addresses those questions. A second report from this study, focused on the role of information in shared decision making and on patient receptiveness toward other core concepts of patient-centered care, will be released later this summer.

This study, like last year's, was produced and analyzed by Langer Research Associates after an extensive review of relevant literature, listed in Appendix D, and discussions on questionnaire development with a group of prominent researchers and practitioners in the field: Carol Beasley, director of strategic projects, Institute for Healthcare Improvement; Susan Dentzer, editor, *Health Affairs*; Rushika Fernandopulle, co-founder and CEO, Iora Health; Ed O'Neil, director, Center for the Health Professions at University of California, San Francisco; Lyn Paget, director of policy and outreach, Informed Medical Decisions Foundation; Julia Paradise, associate director, Kaiser Commission on Medicaid and the Uninsured; Jane Stafford, managing director, Community Clinics Initiative; and Isabelle Von Kohorn, program officer, Institute of Medicine. We are grateful for their insights.

Blue Shield of California Foundation, long a thought leader in safety-net healthcare services, 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.

BSCF in particular has a long history of support for the state's community clinic and health centers (CCHCs) through its Community Health Center Core Support Initiative and Clinic Leadership Institute offerings.

This survey was conducted among a representative, random sample of 1,024 Californians age 19 to 64 with household incomes less than 200 percent of the federal poverty level. Interviews, averaging 22.6 minutes in length, were conducted by both landline and cellular telephone, in English and Spanish, from March 12 to April 18, 2012; see details in the methodology section of this report. Results for the full sample have a margin of sampling error of plus or minus 3.5 percentage points.

Sampling, fieldwork and data tabulation were carried out by SSRS/Social Science Research Solutions of Media, Pa. SSRS has performed similar services in a range of prominent healthcare studies, including surveys for the Harvard School of Public Health under the sponsorship of the federal Centers for Disease Control and Prevention, the Massachusetts Division of Health Care Finance and Policy (via the Urban Institute), the Minnesota Department of Health (through the University of Minnesota and the State Health Access Data Assistance Center), the Oregon Department of Human Services, the Colorado Health Institute, The Commonwealth Fund, and the Henry J. Kaiser Family Foundation.

sections guide

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

part a: personal relationships and the traditional model

- section i: personal relationships. How many patients say someone at their healthcare facility "knows you pretty well," compared with how many prioritize such a relationship, and an evaluation of paths to achieving the connectedness many patients seek.

- section ii: a regular personal doctor. The number of patients who say they have "a regular personal doctor," overall and among groups, and demographic and attitudinal differences in having such a relationship.

- section iii: doctors and alternatives. The extent to which physician-based care predominates, and preferences for doctors vs. other care providers among groups and in a range of circumstances.

- section iv: continuity and consistency. Predictors of continuity in care and its impact on patients' satisfaction with their care and on their health efficacy, meaning their levels of information, confidence and self-reliance in healthcare matters.

part b: program-based alternatives

- section v: use, ratings, and impact of alternatives. Numbers of patients who currently have team-based care or a healthcare navigator. Ratings of these programs among participants and the impact of these alternatives on patients' satisfaction and efficacy.

- section vi: team-based care and healthcare navigators. Use of team-based care and health system navigators among facility types, and their uptake among groups.

- section vii: willingness to try team-based care. Evaluation of the groups most open to this care model, in which patients are assigned an ongoing healthcare team, customarily including a doctor, navigator, nurse or physician's assistant, and health educator.

- section viii: interest in a healthcare navigator. Openness among groups to having a health coach or navigator, that is, an individual assigned to helping patients get the appointments, information, and services they need, make sure their questions have been addressed and maintain contact between office visits.

- section ix: willingness to join group programs. A look at the types of individuals willing to participate in group care, in which patients with a common medical condition or concern meet to share their experiences as well as get healthcare information.

part c: technology alternatives

- section x: telephone and e-mail consultations. Willingness to substitute in-person visits with consultations via e-mail or telephone.

- section xi: interest in internet and text-messaging options. Openness to alternative means of communication, including the use of text messaging for reminders or information, and the internet to see medical records, schedule appointments, and renew prescriptions.

- section xii: communication interests among groups. A breakdown of the groups most interested in various alternative communication options, including predictive modeling.

methodology

A detailed description of the survey's sampling methodology, field work, data processing, weighting, response rate information, and procedures for healthcare facility identification.

The report concludes with appendices explaining the statistical modeling used in this study, and presenting the topline results for questions included in this report, the full questionnaire, and source references.

Questions on any aspect of this study, and requests for further data analysis, should be directed to Cecilia Echeverría, Blue Shield of California Foundation, 50 Beale Street, 14th Floor, San Francisco, Calif., 94105-1819, tel. (415) 229-6147, cecilia.echeverria@blueshieldcafoundation.org.

part a: personal relationships and the traditional model

overview

Broad majorities of low-income Californians desire a more personal connection with their healthcare facility than they have now. For many, this is expressed as a preference for a traditional, ongoing doctor-patient relationship. Yet many poor and near-poor patients also are open to new models of care – health navigators, team-based care, group programs, and technology-based communication methods – that can serve as alternative means of achieving greater connectedness.

That goal, this survey shows, clearly is worth pursuing. Individuals who report having a personal relationship with someone at their healthcare facility are more likely than others to express satisfaction with the quality of their care and non-care support services (such as referrals and transportation), as well as to exhibit greater personal health efficacy – having the information and confidence to take an active role in their own health and in their care decisions. By creating connectedness, successful patient-provider relationships are a crucial element in achieving the goals of patient-centered care – an involved, active, and informed patient population.

By creating connectedness, successful patient-provider relationships are crucial to achieving the goals of patient-centered care – an involved, active, and informed patient population.

Continuity with the same provider (whether it's a doctor, nurse, or physician's assistant) also is key to greater efficacy and patient satisfaction. Like those who report a personal connection with someone at their facility, people who see the same provider consistently rate their current care more positively, feel more informed about their health, and take a more active role in care decisions. While continuity and connectedness overlap, each independently predicts these important outcomes. A third factor, team-based care, similarly is associated with greater patient satisfaction and efficacy, and is almost unanimously popular among those now participating in such programs.

Notably, having a traditional doctor-patient relationship (i.e., someone the patient considers a regular personal doctor), while currently the primary route to continuity and connectedness, does not independently predict patient satisfaction and engagement.[1] This indicates that paths beyond the traditional route can lead to a satisfied and empowered patient population, provided they establish the personalized healthcare experience that these patients seek.[2]

section i: personal relationships

Currently there is a dramatic gap between patient desires for a personal connection and the delivery of that goal. Eighty percent of low-income, non-senior Californians say it's important to them to have someone at their healthcare facility "who knows you pretty well," but just 38 percent say there is such a person there now.

The existence of a personal relationship peaks in particular groups. It reaches 54 percent among those who have a regular personal doctor or who see the same provider every time they visit their care facility. These groups overlap, and a sense of personal connection climbs to 62 percent among those who report having a regular personal doctor whom they also see on every visit.

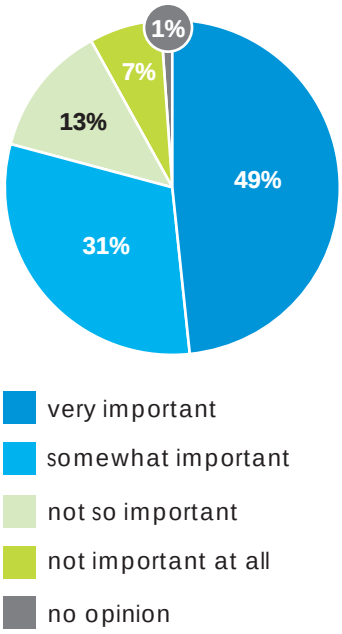
Patients at private doctors' offices are more likely than others to have a personal doctor whom they see consistently; partially because of this, they also are more apt to report having a personal connection with someone at their care facility. Fifty-one percent do, compared with 38 percent of clinic users (at CCHC and non-CCHC clinics alike)[3] and 36 percent of Kaiser Permanente clients. Just 16 percent of those who go to a hospital emergency room for their care report that someone there knows them well.[4]

Yet traditional paths are not a panacea in establishing personal connectedness. Remarkably, even among patients who say they have a regular personal doctor whom they see on each visit, 37 percent also say there's no one at the facility who knows them well. Similarly, even given the more traditional care model typically provided at private doctors' offices, nearly half of their patients, 47 percent, say they lack a personal connection.

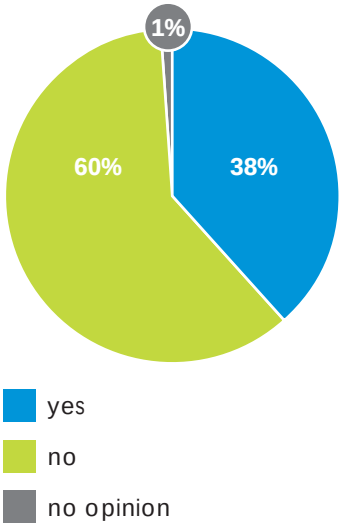
Nonetheless, as noted, having a regular personal doctor currently is the leading source of connectedness. The sense that someone there "knows you pretty well" is expressed by more than six in 10 of those who have a regular personal doctor whom they see on each visit. That declines to 46 percent of those who have a personal doctor, but one they don't always see; to 25 percent of those who don't have a personal doctor; and to a mere 11 percent of those who both lack a personal doctor and rarely or never see the same care provider.

Another result further marks the current dominance of the traditional model. Among patients who say there's someone at their care facility who knows them well, most – six in 10 – say that individual is a doctor. (Two in 10 say it's a nurse and one in 10 says it's someone at reception.) Patients at Kaiser Permanente or private doctors' offices who have someone they feel knows them well are most apt to say it's a doctor (66 percent). That slips to 53 percent among clinic patients.[5] There nurses play a greater role: Among clinic patients who say someone knows them well, 27 percent say it's a nurse, vs. 16 percent among private doctors' office and Kaiser Permanente patients.

importance of having someone who knows you well



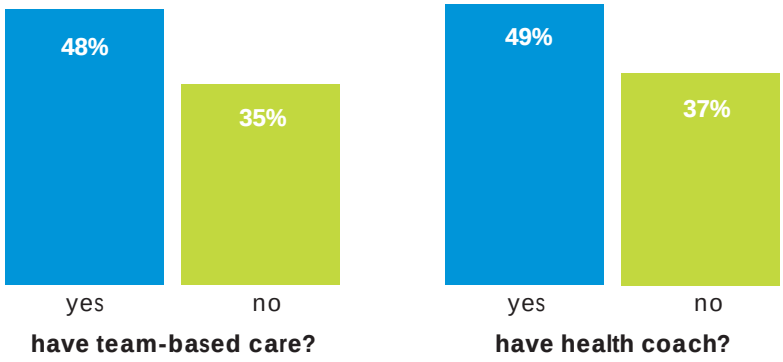
currently have someone who knows you well



Alternative care models nonetheless show promise in fostering connectedness outside the traditional patient-doctor relationship. Among patients who report currently having team-based care, 48 percent say there is someone at the facility who knows them well, compared with 35 percent of those who don't have team care. Similarly, reports of a personal connection are 12 points higher among those who report having a healthcare navigator or coach (that is, someone whose job it is to help them get the appointments, information, and services they need). And among low-income Californians who have both team-based care and a health coach, 53 percent report having a personal relationship – compared with 35 percent of those who have neither.

personal connection and alternative care models (among all low-income Californians)

% who report a personal connection



Indeed, while half of doctors' office patients say someone at their facility knows them well, the number is nearly as high among those who go to other facility types but report having team-based care or a health coach, 47 and 46 percent, respectively – strongly suggesting that personal connection can be fostered in a variety of care settings.

Specifically among clinic patients who have team-based care, 51 percent say someone at their facility knows them well – exactly matching the level of connectedness reported by patients at private doctors' offices. To the extent CCHC and other safety-net clinics continue to adopt these alternative care models (see Section 2 for more details), they may be able to close their current connectedness gap with private doctors' practices.

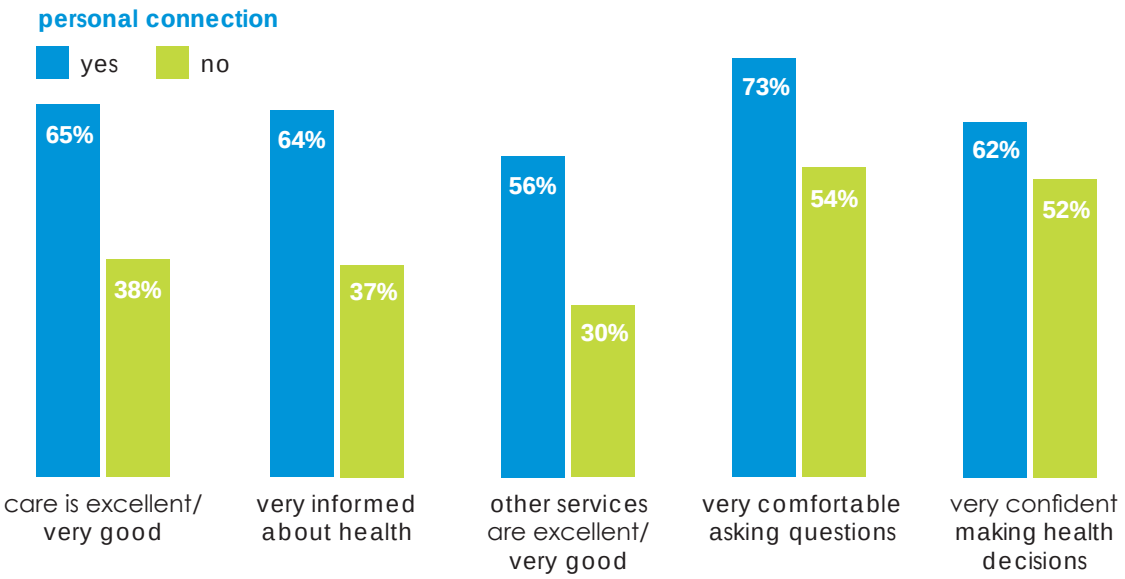
There also are important demographic differences in connectedness, which may help to shape overall healthcare experiences. Women are more likely than men to report having a personal connection with someone at their facility, 44 vs. 32 percent. While there are no racial or ethnic differences in connectedness, those who mainly speak English at home are 12 points more apt to report having a personal relationship at their place of care than are those who primarily speak some other language, again by 44 vs. 32 percent – indicating the importance of addressing language barriers.[6]

Those who mainly speak English at home are more apt to report having a personal connection, indicating the importance of addressing language barriers.

Among other groups, low-income Californians who lack insurance are particularly unlikely to have a personal relationship with someone at their facility; just a quarter do, compared with 43 percent of those with private or government-funded insurance. As the 2011 BSCF *On the Cusp of Change* report showed, uninsured low-income Californians are especially interested in finding a new facility for their care – and their lack of connectedness may be at least partially the reason. The extension of insurance coverage to currently uninsured adults via the Patient Protection and Affordable Care Act (ACA), then, raises the prospect – and the challenge – of establishing greater connectedness, and through it greater loyalty as well as healthcare efficacy, among this now more-disconnected population.

As noted, feeling personally connected with someone at their care facility is vitally important in satisfaction and efficacy alike. Patients who say someone at their facility knows them well are nearly twice as apt as those without that kind of close relationship to say the care they receive is excellent or very good, 65 vs. 38 percent. They're also much more likely to feel very informed about their health (64 vs. 37 percent), very comfortable asking questions about their care (73 vs. 54 percent), to rate their non-care support services positively (56 vs. 30 percent) and, albeit by a closer margin, to be very confident in their ability to make healthcare decisions (62 vs. 52 percent).

satisfaction and efficacy by presence of a personal connection



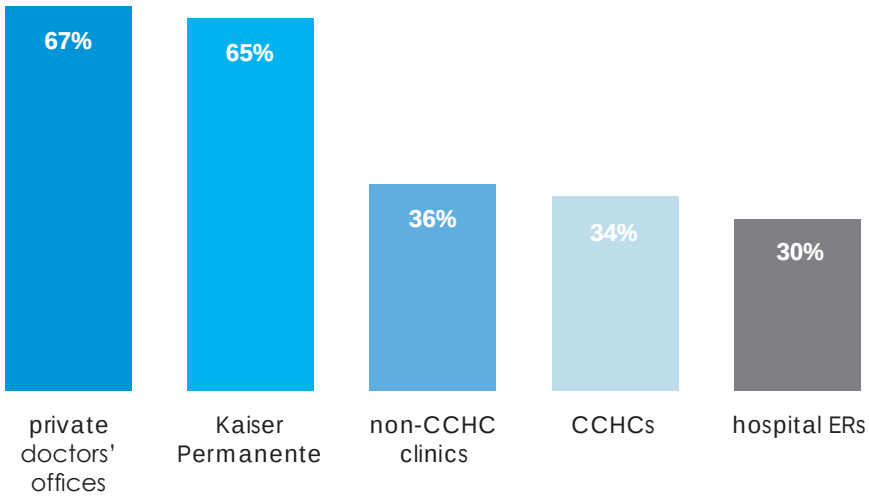
section ii: a regular personal doctor

The 2011 BSCF *On the Cusp of Change* report found that not having a regular personal doctor, but wanting one, was among the strongest independent predictors of interest in changing healthcare facilities. And an improved measurement in this year's study finds that the lack of such a caregiver is widespread: Fewer than half of poor and near-poor Californians, 47 percent, say they have a regular personal doctor.[7] Among those who do, 87 percent like having one, with just 13 percent saying it's not that important to them.

Having someone the patient considers a regular personal doctor peaks among patients of private doctors' offices (67 percent) and Kaiser Permanente (65 percent). That compares with just 34 percent of CCHC users, 36 percent of other clinic users, and 30 percent of those who use a hospital emergency room for their care. Those who have private insurance are also especially likely to report having a regular personal doctor – 65 percent do, compared with 54 percent of those on Medi-Cal and just 16 percent of those who report lacking insurance entirely.

have a regular personal doctor?

among patients of…



Individuals with greater needs for a personal doctor also are more likely to have one – low-income Californians with a disability or chronic condition, who are in poor health, or who have been to the doctor six times or more in the past year are more likely to report having a doctor than are their peers. And two-thirds of older respondents (age 50 to 64) have a personal doctor, compared with just 34 percent of low-income adult Californians age 19 to 29.

Among those who lack a regular personal doctor, 58 percent say they'd like to have one. But a not-insubstantial 41 percent say it's not that important to them. That means that slightly more than one in five low-income Californians overall don't have a personal doctor and don't mind it.

Some of the more flexible demographic groups include low-income Californians younger than 30, those who are employed full-time, are single or have Medi-Cal insurance. In each of these groups, half or fewer of those who currently lack a personal doctor want one.

On the other side of the coin, desire for a personal doctor is to some extent a function of health challenges. Among people who now lack a personal doctor, those who are disabled or have a chronic condition are 18 percentage points more likely than those without a chronic condition to want one, 72 vs. 54 percent. Wanting (while currently

lacking) a personal doctor also is 17 points higher among those who rate their health negatively, 69 vs. 52 percent; and 16 points higher, 71 vs. 55 percent, among those who are particularly concerned about health issues in general.

desire for a personal doctor (among those who don't have one)

	would like a personal doctor	not that important
age		
<30	50%	48%
30+	62	36
employment		
full-time	50	49
not full-time	61	37
marital status		
single	48	49
married/other	63	36
insurance		
private	52	48
medi-Cal	48	51
none	68	30
chronic-condition		
yes	72	28
no	54	44
health		
good or better	52	47
fair/poor	69	28

One of the sharpest differences in desire for a personal doctor corresponds with interest in connectedness. Among those who think it is important that someone at their facility knows them fairly well, 65 percent of those who lack a personal doctor want one. That declines to 37 percent among those who lack a personal doctor but think connectedness is not important.

At the same time, again among patients who lack a personal doctor, those who nonetheless are satisfied with their care are 16 points less apt to want a regular doctor than are those who rate their care less positively. In tandem, the results suggest that while the desire for connection often is expressed as interest in having a personal doctor, patient satisfaction can mitigate that preference.

section iii: doctors and alternatives

This survey uses a variety of measures of patient-provider relationships. Those include whether patients feel they have a regular personal doctor, what sort of care provider (doctor vs. nurse or physician's assistant) they typically see for routine visits, how often they see the same care provider, and what type of provider they prefer to see in general and in specific circumstances.

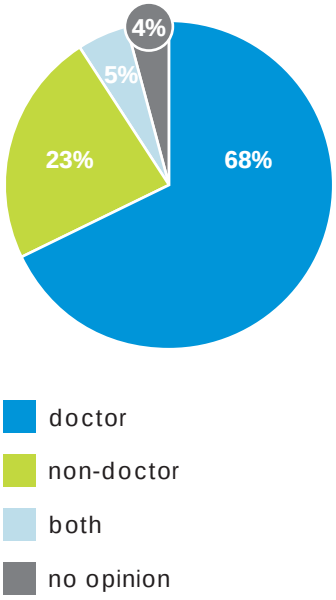
Regardless of whether low-income Californians feel they have a regular personal doctor, it's a doctor that they're accustomed to seeing. About seven in 10 say they usually see a doctor rather than another type of provider for routine care – albeit, for many, not the same doctor each time, nor necessarily someone they consider a regular personal doctor.

About as many, two-thirds, say that seeing a doctor is their preference, including 52 percent who feel that way strongly. The rest of low-income Californians are less resistant to non-physician-based care – 13 percent just "somewhat" prefer a doctor, and a third either say it doesn't matter to them what kind of care provider they see (27 percent), or prefer to see a nurse or physician's assistant (6 percent).

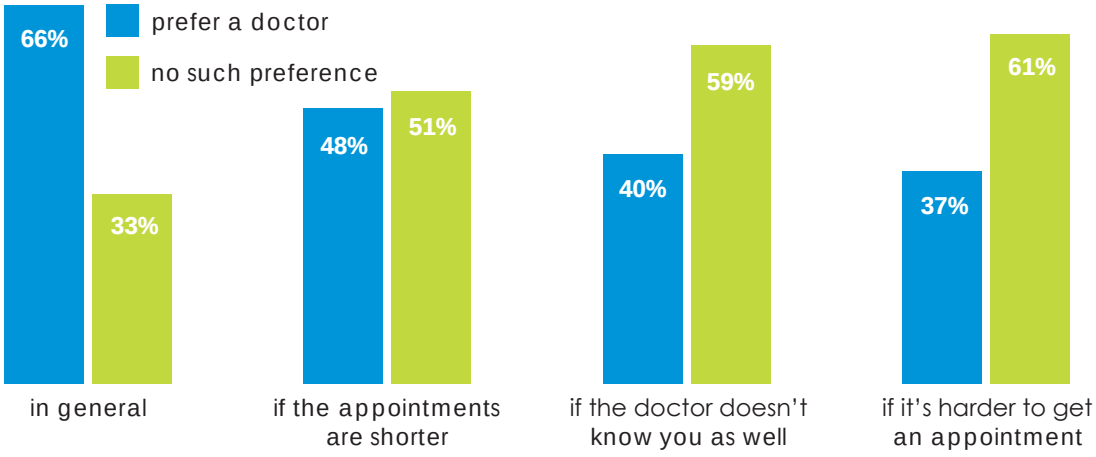
Follow-up questions asked those who prefer to see a doctor whether they would still feel that way given potentially negative consequences, such as greater difficulty getting an appointment. The appeal of physician-based care is such that majorities of those with an initial preference for a doctor continue to feel that way even if that means appointments are briefer (73 percent say that's worth the tradeoff), the doctor doesn't know them as well (60 percent), or it's harder to get an appointment (56 percent).

Alternatives nonetheless are possible. As noted, 47 percent of patients either don't prefer a doctor in the first place, or don't strongly prefer one. Furthermore, a combined total of 61 percent either don't prefer a doctor in the first place, or don't prefer one if it means it's harder to get an appointment. Just 23 percent of respondents always prefer to see a doctor, regardless of the conditions tested.

usual provider



preference for type of care provider among all low-income Californians



Younger adults (i.e., those younger than 30) are particularly open to a non-doctor alternative. They are less likely than those 30 or older to see a doctor for routine visits in the first place, don't care as much about seeing a doctor, and are less apt than older patients to continue to prefer a doctor if it's harder to get an appointment or if visits are briefer.

Younger patients' openness to a non-doctor alternative likely reflects their better health status. Preference to see a doctor for routine care ranges from 59 percent of those who rate their health as excellent or very good to 66 percent of those in "good" health, and 74 percent of those whose health is only "fair" or "poor."

Whites and non-Latino minorities (e.g., those who identify themselves as African-American, Asian, Native American, multiracial, or other)[8] are more likely to say it doesn't matter to them whether or not they see a doctor (37 percent and 35 percent, respectively) than are Latinos (20 percent). Whites and non-Latino minorities also are less likely to say they usually do see a doctor for care (61 percent, vs. 72 percent of Latinos).

Preference for type of care provider among groups

	prefer doctor	doesn't matter	prefer non-doctor
age			
<30	56%	39%	5%
30+	71	21	7
health status			
excellent/very good	59	32	8
good	66	26	8
fair/poor	74	23	2
race/ethnicity			
white	55	37	8
latino	74	20	6
other	58	35	7
normally see for care			
doctor/both	72	24	4
non-doctor provider	50	34	16
ratings of care			
excellent/very good	59	31	9
good/not so good/poor	73	23	4

More generally, individuals who are less likely to see a doctor for regular visits also are less likely to care so much about it. It may be that people who see non-physician health providers do so because they're less focused on seeing a doctor; that they're more flexible because they've grown accustomed to other alternatives; or some of both. Regardless, this result means that seeing non-physician providers does not in and of itself create demand to see a doctor instead.

In addition, respondents who are more satisfied with their care overall are more open to trying a non-doctor provider – four in 10 of those who rate their care as excellent or very good say they'd be willing (or even prefer) to see a non-doctor provider for care, compared with 27 percent of those who rate their care less positively.

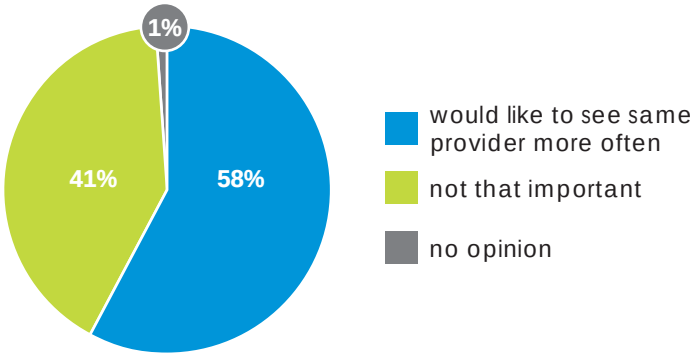
As noted, the three key predictors of patient satisfaction in this study are connectedness (having someone at the facility who knows you well), continuity (seeing the same provider regularly), and having team-based care.[9] The results of this survey suggest that facilities that work to improve connectedness and continuity, or that implement team care, may not only boost patient satisfaction, but also help to increase willingness to see non-physician care providers.

section iv: continuity and consistency

As noted, while nearly seven in 10 low-income Californians usually see a doctor even for routine visits, that's often not the same doctor: Overall, two-thirds say they don't see the same caregiver each time they go in for care. That includes six in 10 of those who say they usually see a doctor rather than a non-physician provider for care, and half of those who say they have a regular personal doctor.

This is not the preferred situation for most. Among those who don't see the same caregiver each time, nearly six in 10 would prefer more regular contact with an individual caregiver. Still, this leaves four in 10 of those without regular contact who are content seeing an assortment of caregivers.

desire for greater continuity (among those who don't always see the same provider)



Following some of the same patterns as connectedness, continuity is much higher among individuals who have a regular personal doctor, have private insurance or go to a private doctor's office for care. Among people in these groups, anywhere from 73 to 82 percent say they usually see the same caregiver. That drops to 41 percent of those without a regular personal doctor and 43 percent among those who lack insurance. It's 41 percent among users of hospital emergency rooms, rising to 56 percent of clinic users overall, including 60 percent of CCHC patients.

There are demographic differences in continuity. Women are more likely than men to report seeing the same provider at least most of the time (66 vs. 54 percent). And lower-income Californians under age 30 are far less likely to report continuity than those in the oldest age group, 53 vs. 73 percent, respectively. At 48 percent, young men are the least likely to see the same provider on a regular basis.

Whites are more likely than non-whites to have continuity in their care, 70 vs. 56 percent, as are citizens more so than noncitizens, 66 vs. 50 percent. Following the same pattern as results for having a regular personal doctor, respondents who go to the doctor more frequently, who are in poor health, or who have a chronic condition are all more likely to see the same provider most of the time when they go in for care.

always or usually see the same care provider

facility type	
private doctors' offices	76%
Kaiser Permanente	66
CCHCs	60
non-CCHC clinics	54
hospital E.Rs.	41
insurance	
private	73
Medi-Cal	63
none	43
gender	
women	66
men	54
age	
<30	53
30-49	59
50+	73
race/ethnicity	
white	70
latino	58
other	53

As described above, continuity is critical. As with connectedness, low-income Californians who usually see the same provider are more likely than others to rate their care highly and to have greater healthcare efficacy. Specifically, those who have continuity in their relationship with a provider feel more informed about their health, take a more active role in decisions about their care, and are more likely to feel their provider gives them information and instructions they can understand.

Connectedness and continuity overlap – among those who usually see the same provider, 51 percent report having someone at their facility who knows them well, compared with a quarter of those who only sometimes see the same provider, and just 13 percent of those who rarely or never see the same person when they go for care. Yet each is an independent predictor of satisfaction and efficacy, even when controlling for socioeconomic status (including education, race, citizenship, and income), health and insurance status, and related factors such as having a personal doctor and usually

seeing a doctor for care. This suggests that facilities that seek to engage and satisfy their clients are best served by focusing on both continuity and connectedness, not only one or the other.

Despite the positive outcomes associated with having a consistent relationship with a care provider, a considerable minority of low-income Californians are content with not seeing the same person every time – 41 percent of those who currently don't see the same provider on every visit (28 percent of poor and near-poor Californians overall).

Among those who currently don't see the same health professional each time, regression modeling shows that the desire for continuity is lower among those who say there is someone at the healthcare facility who knows them well. In other words, the desire for continuity in care may be eased by having a personal connection with someone at the care facility.

Additionally, those who are more open to trying a non-physician healthcare provider are more likely to be content with not seeing the same provider on each visit.[10]

On the other hand, desire for continuity is far greater among those who lack but seek connectedness in the form of a personal doctor. Among those who don't currently have a personal doctor but want one, 76 percent would like to see the same provider more often. That compares with 32 percent of those who lack a personal doctor but don't especially want one.

But there are other paths to continuity and connectedness. Compared with patients of private doctors' offices, CCHC patients in general are less apt to report having a personal connection, having a personal doctor, or seeing the same person on each visit – but, as described below, they're more likely to have other care options available, such as team-based care or a healthcare navigator. As noted, these care options show strong potential for establishing the relationships that low-income Californians seek.

Facilities that seek to engage and satisfy their clients are best served by focusing on both continuity and connectedness, not only one or the other.

part b: program-based alternatives

overview

When patients express a desire for a regular personal doctor whom they see on each visit, they are voicing interest in an inefficient and increasingly expensive model of care. The traditional doctor-patient model may be unsustainable for safety-net facilities on staffing and cost grounds; yet it also may not be in patients' own best interests, given the comprehensive array of services – medical and nonmedical alike – that alternative care models can provide.

Indeed, patients who say they want a regular doctor may in fact simply be describing the most familiar route to their real aim – the personal relationship that having a doctor implies. This section explores the extent to which other routes to this connectedness are acceptable to patients, and how such options are rated by those who have tried them.

The results are promising. While relatively few low-income Californians have used new models of care to date, the numbers are not negligible, and the experience is overwhelmingly positive. Among people who don't have these care models now, sizable numbers express openness to trying them. And the impact is measurable: As noted above, those who use team-based care or a health coach are more likely to report a personal connection with someone at their facility, and team-based care in particular is one of the strongest unique predictors of patient satisfaction and healthcare efficacy.

section v: use, ratings, and impact of alternatives

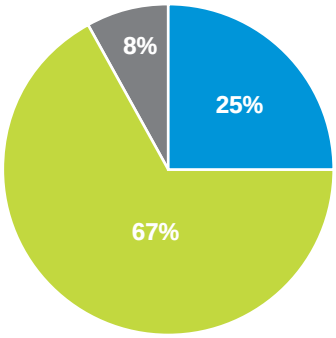
One in four low-income Californians reports having team-based care; a nearly unanimous 94 percent of them like it, with six in 10 liking it a "great deal." Fewer, 18 percent, have a healthcare navigator or health coach (that is, someone "whose job it is to help people get the appointments, information, and services they need"); among those who do, its popularity is similarly high, with 91 percent liking the service, including 54 percent who like it a great deal.

There's a strong relationship with satisfaction. Among those who currently have team-based care, 58 percent rate the quality of their care positively and 50 percent give positive ratings to the support services available at their facility, compared with 47 and 37 percent, respectively, of those who don't have team care.

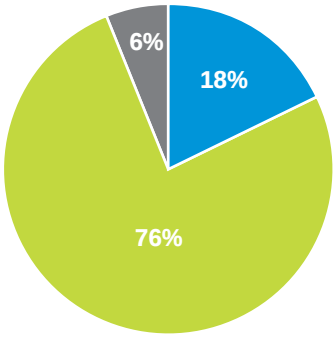
Those who have either team-based care or a health coach also are more likely to consider themselves very informed about their health. And team-care patients are more likely to feel very confident in making medical decisions, very comfortable asking questions, and to say they have a great deal of input in their medical care – all central goals of patient-centered care.

current use of alternative models of care

have team-based care?



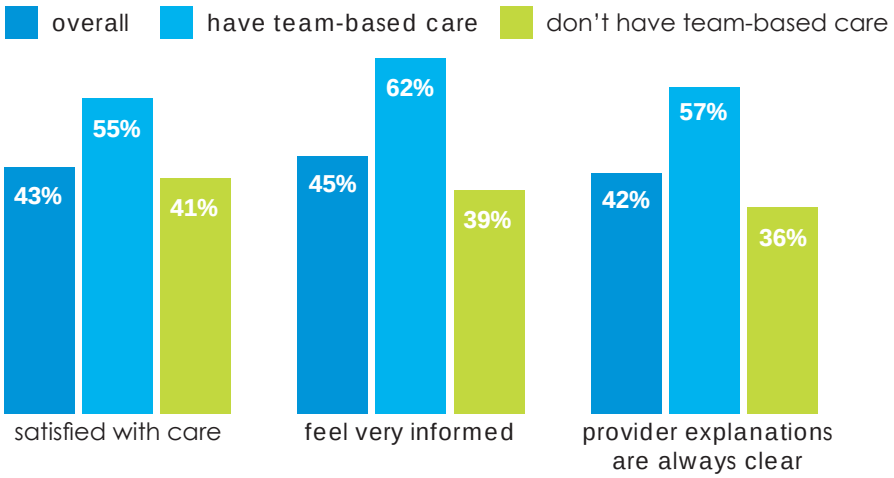
have healthcare navigator?



yes
no
no opinion

The impact is clear when specifically comparing clinic users (including patients of CCHCs and other clinics) who have team-based care with those who don't. Among clinic patients who have team-based care, 55 percent are satisfied with their care, vs. 41 percent among those who don't have team care. Indeed satisfaction among team-care users at clinics approaches its level among Kaiser Permanente and private doctors' office patients overall (61 percent).

key outcomes among clinic patients by use of team-based care



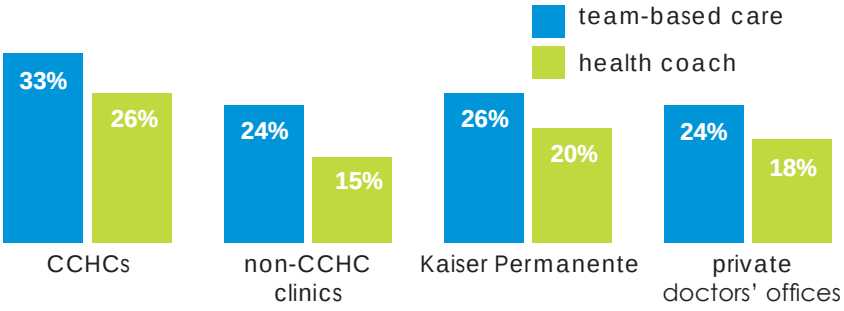
In addition, taken as a whole, clinic users (again, CCHC and other clinic patients, combined) are less likely to say they feel very informed about their health (45 percent) and that their healthcare provider explains things in a way that's always clear to them (42 percent) than are Kaiser Permanente or private doctors' office patients (56 percent and 52 percent, respectively). However, clinic users who have team-based care are just as likely as Kaiser Permanente and private doctors' office patients to feel very informed about their health (62 percent) and always to understand the instructions given by their care provider (57 percent). It's among clinic patients who lack team-based care that these lag.

section vi: team-based care and healthcare navigators

There is some overlap in the use of team-based care and a health navigator or coach; among those who have team care, four in 10 also have health coaches, suggesting that facilities that offer one are more apt to offer the other as well. While, as noted, liking for team-based care overall is quite high, it peaks, at a remarkable 98 percent, among those who have a health coach as part of their team.

CCHCs are ahead of the curve in offering these new care options. Their patients are more likely than those who go to Kaiser Permanente, private doctors' offices, or other clinics (combined) to report currently having team-based care (33 vs. 24 percent) or healthcare navigators (26 vs. 17 percent).

use of alternative care models by facility type



Results also indicate that these newer care models are reaching the more disadvantaged among California's poor and near-poor population. Use of team-based care rises to more than three in 10 of those with no more than a high school education, vs. 18 percent of better-educated low-income Californians. The less-educated also are more apt to have a health navigator, 23 percent vs. 12 percent of their more-educated counterparts.

In addition, alternative care models are more often used by Latinos than by members of other ethnic and racial groups. Thirty-two percent of Latinos have team care and 22 percent have a navigator, compared with 16 and 14 percent of whites, and 16 and 19 percent of other minorities.

Latino women are especially likely to have both types of alternative forms of care – more than a quarter have a health coach (including nearly three in 10 Latino women under 40) and four in 10 report currently having team-based care. On the flip side, just 8 percent of white women overall have a health coach and just 16 percent have team-based care.

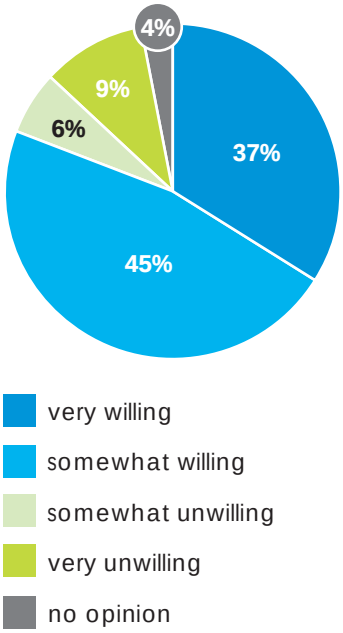
Those who hold some form of government insurance (including Medi-Cal) are more apt to have team-based care or a health coach (31 and 27 percent) compared with those who have private insurance (23 and 16 percent for each form of care) and those who are uninsured (20 and 12 percent).

section vii: willingness to try team-based care

A broad 81 percent of those who don't have team-based care say they'd be willing to try it, and nearly four in 10 say they'd be very willing to do so. Willingness peaks at 87 percent among CCHC users, compared with three-quarters of users of other clinics. Nearly eight in 10 users of Kaiser Permanente or private doctors' offices are likewise interested in trying team-based care, with a third very willing to give it a try.

Those who are open to one form of non-traditional care are largely open to trying others. Statistical modeling finds that among the best predictors of willingness to try team-based care are openness to using a healthcare navigator, willingness to try group health programs, and interest in using technology to communicate with care providers. Modeling also shows that those who want to see the same care provider more frequently are more open to team-based care, suggesting that those who seek continuity may be willing to try team care as a means of finding it.[11]

willingness to try team-based care (among those who don't have it now)



Among groups, women are more likely than men to be very willing to try team-based care (41 vs. 32 percent). Strong willingness peaks among women aged 30 to 49 (46 percent, vs. 31 percent of middle-aged men) and Latino women (45 percent, vs. 34 percent of Latino men). It's lowest among white men, with just 27 percent very willing to give it a try.

Desires for a personal connection and better communication with providers also are related to willingness to try alternatives. Nearly half (47 percent) of those who don't have a personal doctor but want one are very willing to try team care, compared with only a quarter of those who don't want a personal doctor and about a third of those who already have one.[12]

Strong willingness to try team care also is higher among those who feel their providers often don't explain things clearly (46 percent, vs. 34 percent who say their providers are clear) and among those who want more of a say in their health care (43 percent, compared with 34 percent of those who report having enough input now). These results underscore the potential for team-based care to satisfy the need for connectedness among those patients who seek stronger relationships with their healthcare providers.

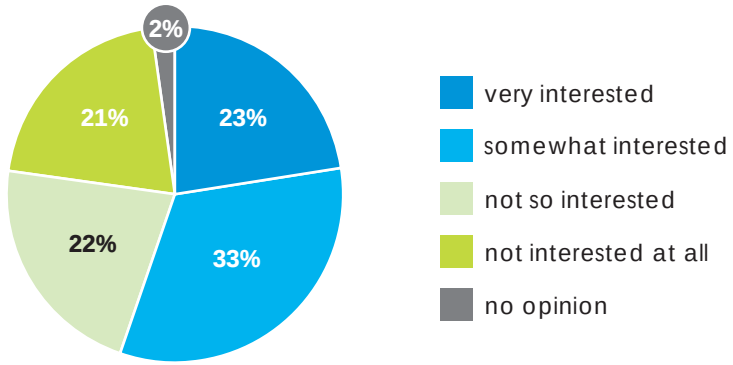
These results underscore the potential for team-based care to satisfy the need for connectedness among patients who seek stronger relationships with their healthcare providers.

Willingness to try team-based care also may be associated with need for services: Strong interest is 12 points higher among people in less than excellent health, compared with low-income Californians in the best health. And strong interest grows as ratings of overall care and support services decline. For example, while 31 percent of those who rate their support services as excellent or very good are very willing to try team-based care, that rises to 43 percent of those who rate their support services as not so good or poor.

section viii: interest in a healthcare navigator

While more are willing to try team-based care than are interested in having a healthcare coach, still most of those who don't currently have a coach are at least somewhat interested in having one, 55 percent.[13] And the high satisfaction rate noted above implies the approach could hold broad appeal once tried.

interest in having a healthcare navigator (among those who don't have one now)



Modeling again shows that those who are open to some of the other alternative care models also are more interested in having a care navigator. Perhaps more important, those who desire connectedness (either in the form of a personal doctor or someone in the facility who knows them well) and continuity (i.e., the ability to see the same provider more frequently) are more open to trying a health navigator, likely as a means of obtaining the personalized health care they seek.

On the flip side, modeling suggests that respondents who rate the support services at their facility especially positively are less interested in a healthcare navigator – perhaps because they feel they are already getting the assistance and information they need.[14]

Some group differences in interest in a health coach are similar to those in willingness to try team care, and reinforce the suggestion that seeking connectedness and a greater say in decisions may help to fuel interest in alternative care models. Specifically, desire for a navigator is 18 to 29 points higher among those who would like more say in their care, who want a personal doctor, who think it's important to have someone who knows them well and who think their doctors don't often explain things clearly, compared in each case with their opposites.

Unlike willingness to try group-based care, there are no differences in interest in a health coach by facility type. There is, however, a significant difference between racial and ethnic groups, with Latinos and African-Americans (combined) more interested in having a health coach than whites and other racial groups (combined), 61 vs. 49 percent.[15] Perhaps surprisingly, Latino and African-American men under age 40 are the group most broadly interested in having a healthcare navigator (67 percent express interest in it). In contrast, just 46 percent of white men say they'd be interested.

Latino and African-American men under age 40 are the group most broadly interested in having a healthcare navigator.

Interest in a health coach also is higher among less-empowered groups that may be seeking an advocate. For example, six in 10 Californians below 133 percent of the federal poverty limit are interested in a health navigator, compared with 48 percent of better-off low-income Californians. Those with no insurance or with government-funded insurance are more interested in a health coach than are privately insured respondents. And modeling shows that even when controlling for education and language spoken at home, noncitizens are more interested in a health coach than are citizens.

Those who are in poor health or have chronic conditions or disabilities also are more likely to express strong interest in having a healthcare navigator than are others, by 38 vs. 21 percent and 31 vs. 20 percent, respectively.

section ix: willingness to join group programs

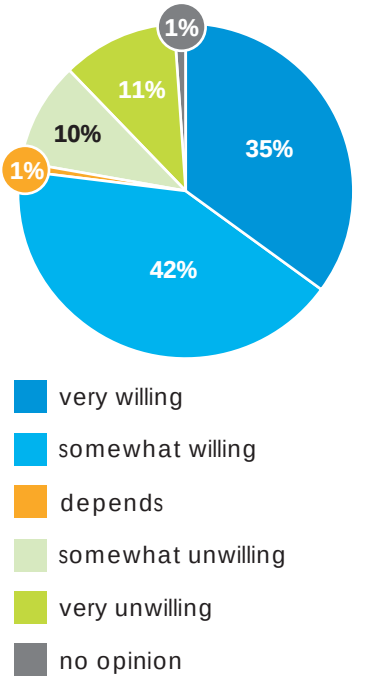
Group programs present another opportunity for extending health care beyond the traditional doctor-patient relationship. A substantial majority, slightly over three-quarters, say they'd be willing to join a group in which

they'd receive information and share experiences with others about a common medical condition, and just more than a third say they'd be very willing. Just one in 10 says they'd be very unwilling to give this group approach a try.

CCHC users are more disposed to trying group care than are non-CCHC clinic users (83 vs. 72 percent, respectively). And while CCHC patients' overall willingness to try group programs is similar to Kaiser Permanente and private doctors' office users (80 percent, combined), they're more likely to be very willing to give this care model a try (43 vs. 33 percent). This suggests a particular opportunity for CCHCs to establish connectedness and continuity through the use of group care.

Willingness to participate in group programs for shared medical issues varies among subpopulations. More than eight in 10 women are amenable to in participating in such groups, compared with a still-substantial seven in 10 men. Openness to group classes bottoms out at six in 10 younger men (age 18 to 29), and peaks among women under 40, among whom 85 percent are willing to try such classes. In addition, strong willingness to try group care is about 10 points higher among Latinos, noncitizens, and those who have not been to college, compared with whites, citizens, and those who have a college education.

willingness to try group programs



very willing to try group programs

facility type	
CCHCs	43%
hospital E.Rs.	38
private doctors' offices	35
non-CCHC clinics	35
Kaiser Permanente	27
gender	
women	42
men	27
race/ethnicity	
latino	40
other	32
white	30
citizenship	
no	41
yes	32
education	
no college degree	36
college graduate	25

As with interest in a healthcare navigator, strong willingness to participate in group programs also is higher (by 14 points) among people with chronic conditions or disabilities than among those who don't have such medical problems.

Willingness to participate in group programs is 16 points higher among those who don't currently have a personal doctor and want one, compared with those to whom having a personal doctor is unimportant. And strong willingness to try group programs is about 10 points higher among those who currently have someone who knows them well at their care facility.

Strong willingness to join group programs also is higher among people who feel they have a great deal of say in their care, or who want more say than they currently have, compared with those who feel they have little to no input, or seek no more than they have now, respectively.

As with other types of alternative care, cross-pollination is at work. Statistical modeling shows that openness to team-based care or to a non-physician provider independently predict inclination to try group programs. So does interest in using a variety of technological tools for communication.

The model also shows that when holding all other factors constant, older respondents, healthier respondents, and women are more willing to try group care are than their counterparts. And those who usually see a doctor for care similarly are more willing than those who normally see a non-physician provider, suggesting that this alternative care model may be palatable to those who are accustomed to the more traditional doctor-patient relationship, as well as to those open to alternative models of care.

Modeling also finds that openness to group care is predicted by thinking it's important that a provider is knowledgeable about the community and has cultural understanding; by interest in having more information on facilities, treatments and providers; and by having misunderstood a provider's instructions in the past (all variables which will be explored in greater detail in the second report from this survey). Each of these can be used in targeting communication about group care opportunities to prospective participants.[16]

part c: technology alternatives

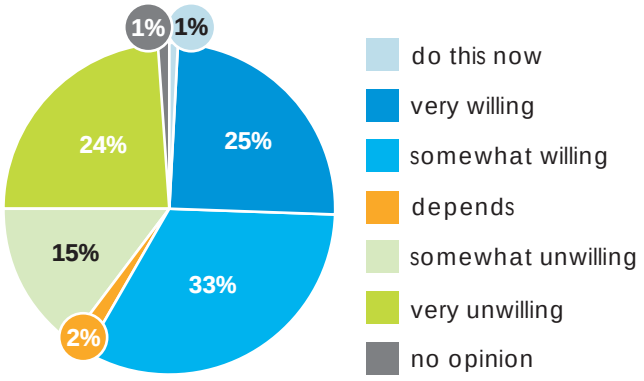
overview

For all their promise, new models of in-person care delivery are not the only ways of enhancing the connection between patients and their care facilities. This survey also finds considerable interest among poor and near-poor Californians in taking advantage of communication technologies, including the internet and text messaging, for a variety of care-related purposes.

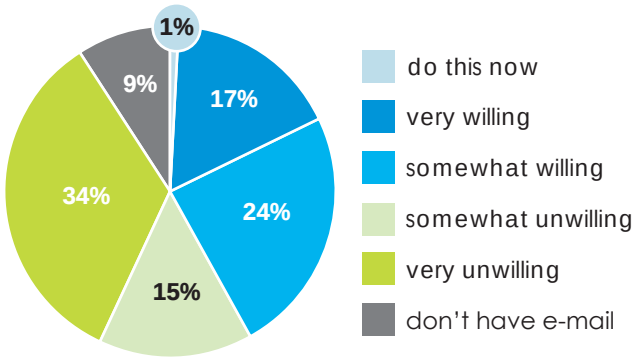
section x: telephone and e-mail consultations

In one striking result, six in 10 express willingness to substitute telephone consultations for personal visits to their care facility on routine healthcare matters. Fewer, but still 41 percent, say they're willing to use e-mail for this purpose.

willingness to try telephone consultations



willingness to try e-mail consultations



Just a quarter of low-income Californians strongly resist using a phone call in place of an in-person appointment. Strong resistance rises to 34 percent when it comes to substituting e-mail for an in-person visit; an additional 9 percent say they have no access to e-mail or the internet.

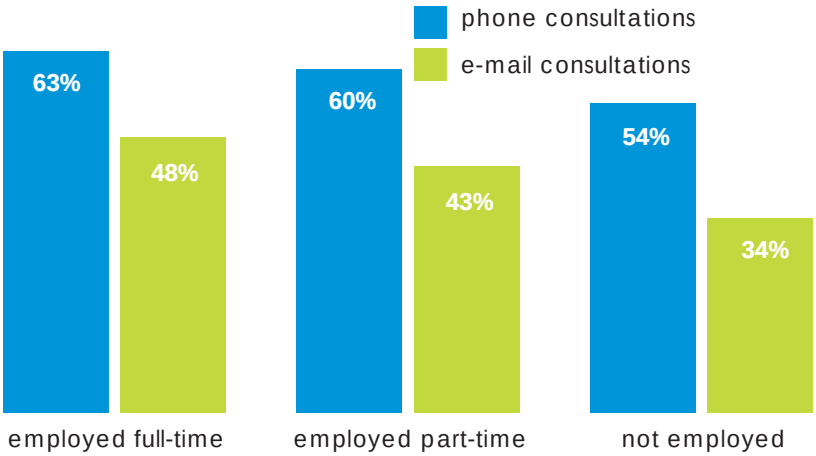
The two are related; willingness to substitute a phone conversation for an in-person appointment is among the best predictors of willingness to do so by e-mail, and vice versa, in models that hold demographic factors such as facility type, education, and insurance status constant. But there are differences that offer guidance in targeting these alternatives. Modeling shows that willingness to substitute a phone call for an in-person appointment increases with age, while willingness to use e-mail for these purposes decreases with age.[17] This means older respondents are more willing to try phone appointments, but less apt to want to use e-mail this way than are younger patients. Race also plays a role – two-thirds of whites are willing to call their healthcare provider instead of having an in-person visit, but just 56 percent of Latinos and other racial or ethnic minorities say the same.

Those seeking continuity in their care are more willing to substitute a phone call for an in-person appointment, perhaps as an alternative means of fulfilling their desire for personalized care. That doesn't apply to interest in e-mail communication.

In another instructive difference, those who are employed full time are more willing to have a phone-call appointment than are those who are not employed, 63 vs. 54 percent, and to be willing to e-mail their provider in place of an in-person appointment, 48 vs. 34 percent – suggesting that these alternative care models may be successfully marketed as a time-saving tool.

While there are no differences by facility type in willingness to substitute a phone call for an in-person appointment, there is for e-mail. Kaiser Permanente patients are especially inclined to use e-mail communication with their provider in place of an in-person appointment – 58 percent are willing, compared to 41 percent of private doctors' office patients and 37 percent of clinic users overall (with no significant difference between CCHC and other clinic patients). Kaiser Permanente patients are more likely to be employed full-time and to have used the internet for health reasons in the past, both of which help to explain this greater willingness to try e-mail consultations.

willingness to substitute phone calls or e-mail for in-person appointments



Respondents in better health also are more willing to try phone and e-mail-based appointments than are those in lesser health (62 vs. 51 percent for phone appointments; 49 vs. 33 percent for e-mail appointments). This makes sense – individuals in better health likely have less pressing medical concerns and therefore may be more willing to discuss them on a call or by e-mail.

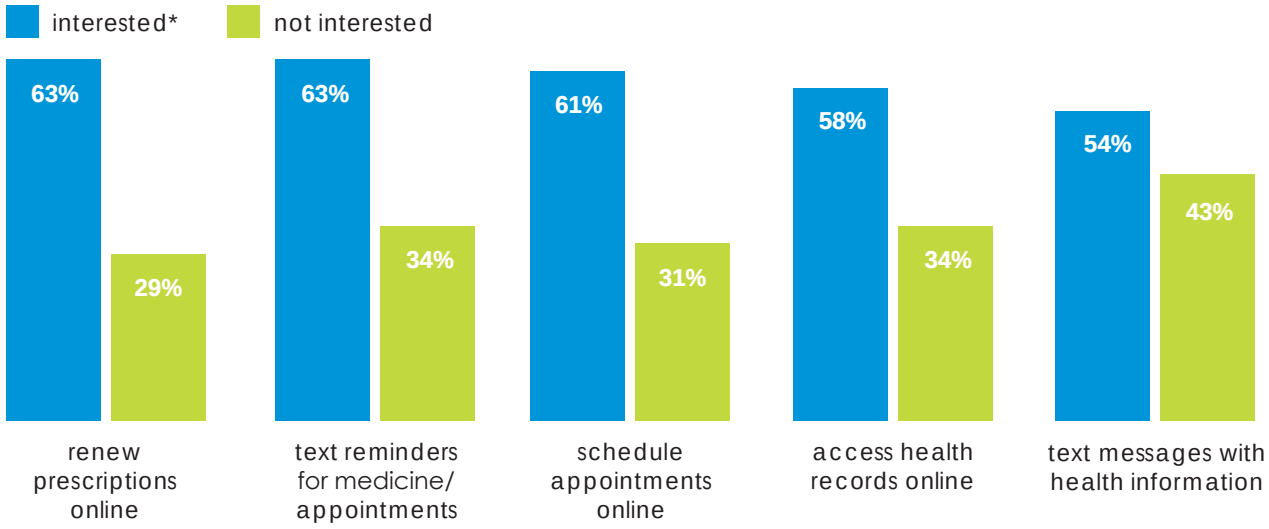
Those who feel there is someone at the facility who knows them well also are more willing to give phone appointments a try, 64 vs. 55 percent, and are more likely to be very willing to e-mail instead of having an in-person appointment, 22 vs. 15 percent – perhaps, at least in part, because their needs for personalized care are already being met.

Modeling shows that willingness to substitute a phone call for an in-person appointment increases with age, while willingness to use e-mail for these purposes decreases with age.

section xi: interest in internet and text-messaging options

Anywhere from 54 to 63 percent of poor and near-poor Californians say they'd be interested in receiving text messages reminding them about appointments (63 percent) or providing health information (54 percent); and in the ability to use the internet to see health records (58 percent), schedule appointments (61 percent), and renew prescriptions (63 percent). Yet currently fewer than 5 percent report using these tools – suggesting a largely untapped opportunity.

interest in text and internet options



*Includes "currently using," 2 to 4 percentage points per item

Majority interest in internet use holds even though 71 percent express concern about the privacy of their health information on the internet. Interest in internet options peaks among those who say they're "somewhat" or "not so" concerned about internet privacy, and is lowest among those at either extreme of the scale – those who are "very concerned" and those who are "not concerned at all." (The latter chiefly do not use the internet for health information.) Addressing privacy concerns and providing clear instructions on how to use online tools for those who are less internet savvy could encourage uptake of these services among those with internet access.

Regression modeling combining these five items in an index of interest in communication options again demonstrates that there's an element of general openness to alternatives to the traditional in-person, doctor-patient approach. Willingness to substitute e-mail for an in-person appointment, as well as openness to non-tech alternatives such as a health navigator and team- and group-based care, all strongly predict greater interest in text and online communication options.

section xii: communication interests among groups

As is the case with e-mail appointments, younger people are more interested in text messaging and online communication. Desire for a regular

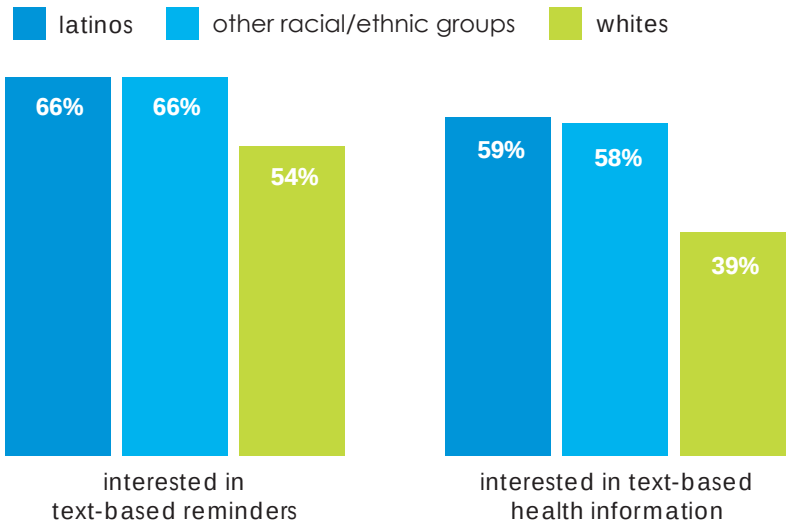
personal doctor also is positively related to greater interest in these options, providing further evidence that those who seek connectedness are willing to use alternative means of obtaining it.

Modeling reveals a positive effect of education on interest, especially in online communication tools. Eight in 10 college graduates in this population are interested in renewing prescriptions over the internet, three-quarters are interested in scheduling appointments online, and seven in 10 are interested in being able to look at their health records online. Interest falls to 54, 50, and 49 percent of low-income Californians who have a high school degree or less. Similarly, interest in online tools is lower among those who don't mainly speak English at home.[18]

As with e-mail and phone appointments, technology-based tools might be well-suited as options for those who don't have enough time to visit their facility for medical care.

For interest in text-based communication tools, modeling shows a difference by racial and ethnic groups, with whites less interested than non-whites in text-based reminders and health information, even after controlling for differences in education and income. Fifty-four percent of whites are interested in text-based reminders about appointments, compared with 66 percent of Latinos and other non-whites alike. And just 39 percent of whites would be interested in text-based information about a health issue that is relevant to them, compared with 59 percent of Latinos and 58 percent of other ethnic or racial minorities.

interest in text-based communication options by race/ethnicity



These results suggest that a targeted approach to marketing communication tools may be most effective. Both online and text-based tools are more likely to be used by younger patients and those most open to alternative care models in general. But beyond that, the support profiles differ. Text-based appeals would be best marketed to Latinos, African-Americans, and other racial or ethnic minorities rather than whites; while internet options may be most popular with English speakers and more-educated respondents, rather than their counterparts.

Moving beyond modeling, there are other group differences. Kaiser Permanente patients are more likely to be interested in scheduling medical appointments over the internet (75 percent) and being able to look at their health records online (72 percent), at least in part because they're more likely already to be doing this.

Employed low-income Californians (either full-time or part-time) are more interested in each of the online and text-based communication options than are those who aren't working (i.e., either unemployed, disabled, retired, a student or a homemaker). As with e-mail and phone appointments, this suggests that these technology-based tools might be well-suited as options for those who don't have enough time to visit their facility for medical care.

In addition, those who feel it is important that someone at their facility knows them well are more interested in nearly all communication options compared with those who don't place an emphasis on connectedness. This includes being more interested in text-based reminders (66 vs. 52 percent), being able to renew prescriptions online (65 vs. 55 percent), being able to access health records online (60 vs. 50 percent), and receiving text-based information (57 vs. 42 percent). That result reiterates one of the key findings of this study overall: that those who seek connectedness also seem more open to alternative means of obtaining it.

summary

In sum, this survey establishes broad interest among poor and near-poor Californians in obtaining a more personalized healthcare experience; demonstrates the value of the continuous, close relationships that many seek; and points to achievable means of creating them. Further studies could confirm whether these same conditions hold for the public more broadly.

Certainly for this population, patient satisfaction and efficacy – two key goals of patient-centered care – are independently predicted in this survey by patients' sense that someone at the facility knows them well, by a stable point of caregiver contact, and by the use of a team-based care model. When these are present, patients both feel better-served – a key predictor of loyalty – and express greater involvement in their own health and health care. Alternative care models, attractive for their efficiency and sustainability, carry broad promise as a new paradigm in healthcare delivery.

endnotes

1 Specifically, having a personal doctor by itself does predict efficacy and satisfaction. But when variables are added to the model that account for the greater continuity and connection that having a regular personal doctor typically provides, the effect of having a personal doctor itself no longer is significant. This mediation suggests that having a doctor is not a positive in and of itself, but because it's one path to continuity and connectedness.

2 See Appendix A, Models 1, 2 and 3 for full details of the models predicting overall satisfaction with care, ratings of non-care assistance and healthcare efficacy.

3 Here and in all cases, "clinic" refers to all clinic types. References to individual clinic types, e.g. CCHCs, are specified in the text.

4 The sample size for hospital emergency room patients is small, 94. This and all characterizations of differences in data in this report have been tested for statistical significance.

5 Sample sizes are inadequate to report this result by specific clinic type or among hospital emergency room users.

6 Regression modeling confirms that gender and language spoken at home are independent predictors of having a personal connection, in addition to having a personal doctor, having team-based care and having a health coach. For details, see Appendix A, Model 4.

7 A measurement improvement reduced this estimate from 57 percent in the 2011 BSCF survey to 47 percent this year, as detailed in the methodology section of this report.

8 The sample sizes for other (non-white and non-Latino) racial groups are inadaquate to report on their own.

9 The 2011 BSCF study also modeled satisfaction with care, using a different set of predictors. It found ratings of care best predicted by staff courtesy, patient involvement in medical decisions, facility cleanliness, the amount of time the provider spends with a patient and having a highly regarded personal doctor. These results are largely in accord with this study's findings on connectedness, continuity and team-based care.

10 See Appendix A, Model 5 for full details of the model predicting desire for continuity in a care provider.

11 See Appendix A, Model 6, for full details of the model predicting willingness to try team-based care.

12 Modeling and crosstabulated data are inconclusive on the role of having a personal doctor in predicting willingness to try team-based care.

13 "Willingness" was asked about a change in current care models, "interest" was asked about additional care options.

14 See Appendix A, Model 7, for full details of the model predicting interest in a healthcare navigator.

15 The sample size for African-Americans is inadaquate to report on its own, but results suggest that for interest in a health-coach, African-Americans respond similarly to Latinos, while other racial and ethnic minorities respond similarly to whites.

16 See Appendix A, Model 8, for full details of the model predicting willingness to try group care.

17 See Appendix A, Models 9 and 10, for full details of the model predicting willingness to substitute phone and e-mail for in-person appointments.

18 See Appendix A, Models 11, 12 and 13, for full details of the models predicting interest in online and text-based communication tools.

methodology

This Blue Shield of California Foundation survey was conducted March 12 to April 8, 2012, via telephone interviews with a representative statewide sample of 1,024 Californians between the ages of 19 to 64 with family incomes below 200 percent of the federal poverty level (FPL).[19] The sample was comprised of 618 landline and 406 cell phone interviews, with 719 interviews conducted all or mostly in English and 305 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/Social Science Research Solutions of Media, Pa.

sample design

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

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

Population figures for each of the 12 stratum-by-area sampling cells were estimated through MSG's GENESYS system, and a sampling design was implemented oversampling those cells with an estimated higher incidence of respondents matching the survey criteria for eligibility (that is, family income below 200 percent of the federal poverty level). An initial estimate

of the eligible population was created based on the percentage in each one of these cells who, according to the GENESYS data, had an annual household income of less than $35,000.[20] In estimating the size of the eligible population in each cell, two adjustments were made: (1) Correction for the proportion of non-working numbers in the listed sample. Because the size of the unlisted sample in each stratum was calculated as the total population minus the number of listed records, the size of the listed sample in each stratum was decreased by the percentage of non-working numbers found among the listed numbers; and (2) Correction for the cell phone only (CPO) population. The initial total estimated number of unlisted households in each stratum included any household that did not have a listed landline number. However, since about 40 percent of the qualifying population was estimated to be CPO, the estimated number of people in each of the unlisted cells was reduced by 40 percent.

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

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

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

		Low-Income Households			Interviews	
Stratum	**Area**	**Estimated #**	**Estimated %**	**Observed %**	**%**	**#**
Residual	Los Angeles	746,365	20%	22%	10%	62
Residual	SF/SAC/SD	777,174	20	21	10	60
Residual	Other	279,040	7	7	7	44
High Latino	Los Angeles	471,844	12	13	18	109
High Latino	SF/SAC/SD	41,028	1	1	4	24
High Latino	Other	76,052	2	2	3	21
High Low Income	Los Angeles	387,198	10	11	15	95
High Low Income	SF/SAC/SD	79,447	2	3	4	27
High Low Income	Other	260,109	7	8	8	50
Low Income Listed	Los Angeles	297,607	8	5	7	46
Low Income Listed	SF/SAC/SD	161,027	4	5	5	29
Low Income Listed	Other	217,477	6	3	8	51
Total		**3,794,367**	**100%**	**100%**	**100%**	**618**

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 (excluding the Listed-Low Income 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. (At present, there is no capability to scrub such a sample or to run it through listed databases.)

field preparations, fielding and data processing

Before the field period SSRS programmed the study into CfMC Computer Assisted Telephone Interviewing (CATI) 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 officially launched. Call-center supervisors and interviewers were walked through each question in the questionnaire. Interviewers were given instructions to help maximize response rates and ensure accurate data collection. Interviewers were monitored throughout the study and project staff provided feedback to interviewers throughout the survey period.

A live pretest of the survey instrument was conducted on March 5, 2012. In all, 18 pretest interviews were completed throughout the afternoon and evening. Pretest interviews were scheduled prior to the live pretest and respondents were offered a $20 incentive to participate. Langer Research Associates and BSCF representatives monitored the interviewing live, along with SSRS project managers, for approximately two hours. Additional interviews were digitally recorded and placed on a secure FTP site for review. Several questions were reworded or removed altogether based on the pretest results.

The questionnaire screened for eligible households by establishing the respondent's family size and annual family income[23], then selecting only respondents between the ages of 19 to 64 with family incomes lower than

200 percent of the FPL.[24] In households that were reached by landline, respondents were randomly selected from the age-qualifying household residents by asking for the male or female with the most recent birthday.

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

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

- Each non-responsive number not already set up with a callback (answering machines, no answers and busies) was called approximately 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 $5 for any cell phone respondent who mentioned concerns with the costs of cell phone usage.

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

procedures for identifying healthcare facility usage

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

Those who said they have no usual place of care (5 percent) were asked where they last went for care (using the same options listed above), and whether it was in California. Those who said they went for care to a non-professional location (e.g., a relative or friend) were asked where they go for professional care.

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 800 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 California community clinics and health centers 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. 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 coding 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."

This procedure produced the following breakdown of facility usage: Clinics, 43 percent; private doctors' offices, 27 percent; Kaiser Permanente, 13 percent; and hospital emergency rooms, 10 percent. Remaining categories were hospital, unspecified, 1 percent; someplace else, 4 percent; never have received health care, 1 percent; and no opinion, 1 percent.

Clinics were subcategorized as follows: CCHCs, 17 percent; public hospital clinics, 9 percent; clinic, other/unknown type, 7 percent; private clinics, 4 percent; private/religious hospital clinics, 4 percent; county or city clinics, 2 percent; and hospital clinic, other/unknown type, 1 percent.

CCHC estimates

The 2011 BSCF survey estimated that 11 percent of the population used CCHCs, vs. the 2012 estimate of 17 percent. Given this difference, SSRS and Langer Research undertook a highly detailed review of all procedures related to this measurement – sampling, questionnaire, field work, coding protocols and weighting – in comparison to the 2011 survey. SSRS took the additional step of re-contacting 49 clinic patients, all of whom confirmed their clinic type.

There was essentially no change in overall provider-type classifications. Clinic users overall were 43 percent of the sample in 2012, 44 percent in 2011; private doctors' office patients, 27 vs. 28 percent; Kaiser Permanente patients, 13 vs. 12 percent; hospital ER, 10 percent both times. The only change of any size was in the clinic subgroup of CCHC users, with slight numerical declines in use of other clinic types.

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

	4/08/12	4/25/11	Difference
Kaiser Permanente	13%	12%	+1
Doctor's office	27	28	-1
Clinic NET	**43**	**44**	-1
Community clinic/health center	*17*	*11*	*+6*
Public hospital clinic	*9*	*10*	-1
Private hospital clinic	*4*	*5*	-1
Hospital clinic – other/unknown type	*1*	*1*	=
County/city clinic	*2*	*5*	-3
Private/other clinic	*4*	*5*	-1
Clinic – other/unknown type	*7*	*8*	-1
Hospital emergency room	10	10	=
Hospital unspecified	1	2	-1
Someplace else	4	2	+2
Never have gone for health care	1	2	-1
No opinion	1	1	=

Numerical increases in CCHC use was found across almost all groups in 2012 vs. 2011; they were largest in three related populations: Spanish speakers, noncitizens and the lowest-income respondents.

Differences did appear in other estimates in 2012 vs. 2011, e.g., -7 points in non-employment, +5 in full-time employment, -6 in ratings of personal health as "good" and +5 in "strong" preference not to have an equal say. Other figures matched closely; net provider type, ratings of current care provider, overall interest in an equal say, prevalence of a disability or chronic condition, insurance type, marital status and education all were within 2 points year-to-year.

Nothing was identified in the survey design or execution that created the change in the CCHC estimate. Some of it may reflect an actual increase in CCHC usage, albeit presumably not at this level; the rest seems attributable to sampling variation.

personal doctor estimate

There was a deliberate change in approach to measurement of the prevalence of having a personal doctor, resulting in a 47 percent estimate in the 2012 survey vs. 57 percent in 2011.

In 2011, during field work pretests, some respondents who said they went to a private doctor's office were confused or annoyed when asked if they had a regular personal doctor. We elected to automatically code those who said they went to a private doctor as having a personal doctor.

Upon reconsideration in 2012, the autocode was dropped. There were no trouble reports from the field, indicating the 2011 adjustment had been unnecessary. Moreover, 32 percent of private doctors' office patients in 2012 said they did not have a regular personal doctor.

Had the autocode been retained, the 2012 estimate of individuals with a regular private doctor would have been 55 percent overall, essentially the same as 2011's 57 percent. We conclude, however, that 47 percent is the better estimate.

weighting procedures

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

1. Sample design correction. In order to correct for over- or undersampling of each of the 12 stratum-by-area landline cells, each landline case was assigned a weight equal to the estimated percentage of the cell among landline-qualifying households divided by the percentage of the cell among completed landline interviews. For example, cases in the *Residual-LA* cell received a weight equal to their estimated share among low-income households (22 percent) divided by their share among the landline interviews (10 percent). Using more exact values, the calculation for the weight for this cell ($W_{resid\text{-}LA}$), is:

$W_{resid\text{-}LA}$ =.21783/.10032=2.17131.

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

2. Within-household selection correction. This stage corrected for the unequal probabilities caused by some households having more qualified adults than others. Households with a single adult 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 baseweight.

3. Post-stratification weighting. With the baseweight applied, the sample was put through iterative proportional fitting (IPF, or 'raking'), in which the sample was balanced to reflect the known distribution of the target population along specific demographic parameters. These parameters were based on the 2011 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. 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);[5] and percent CPO.

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

The design effect is 1.4.

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

table 2. acs estimates and unweighted and weighted sample percentages

	ACS	Unweighted Sample	Weighted Sample
Race			
White non-Latino	28.0%	29.0%	27.3%
Black non-Latino	7.1	8.8	7.0
Latino	52.8	51.3	53.9
Other non-Latino	12.1	9.4	11.6
Sex/race			
Male, non-Latino	21.1	24.5	21.6
Female, non-Latino	25.3	23.1	24.8
Male, Latino	25.1	23.2	25.4
Female, Latino	27.3	29.3	28.1
Education			
Less than high school	33.3	33.0	33.1
High-school education	26.0	25.6	26.1
Some college	29.9	25.2	29.9
College graduate +	10.9	12.0	10.9
Age			
19-29	33.5	23.6	33.3
30-39	23.4	18.3	23.2
40-49	21.0	21.1	21.0
50-64	21.2	37.0	22.6
Region			
Sierra/Northern Counties	4.4	7.1	4.5
Greater Bay Area	14.4	10.6	13.7
Sacramento Area	5.4	5.9	5.4
San Joaquin Valley	12.9	13.4	12.4
Central Coast	5.6	6.2	5.5
LA County	30.4	27.9	29.2
Other Southern CA	27.0	27.1	25.7
Phone status			
Cell phone only	43.2	31.8	43.1
Some landline use	56.4	68.1	56.7

response rate

The response rate for this study was calculated at 27.6 percent for the landline sample and 22.1 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	704	301	**1005**
Eligible, non-interview (Category 2)			
Refusal (Eligible)	303	57	**360**
Answering machine household	32	20	**52**
Physically or mentally unable/incompetent	6	1	**7**
Language problem	13	86	**99**
No interviewer available for needed language	0	3	**3**
Unknown eligibility, non-interview (Category 3)			
Always busy	532	1632	**2164**
No answer	8696	3866	**12562**
Technical phone problems	144	20	**164**
Call blocking	8	0	**8**
No screener completed	2634	2126	**4760**
Housing unit, unknown if eligible	2623	4085	**6708**
Not eligible (Category 4)			
Fax/data line	1814	409	**2223**
Non-working number	28517	6865	**35382**
Business, government office, other organizations	947	609	**1556**
No eligible respondent	1930	1311	**3144**
Total phone numbers used	48903	21304	**70294**

endnotes

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

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

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

22 Families were defined in accordance with the definition applied by the U.S. Census bureau and FPL was based on the 2012 HHS Poverty Guidelines.

23 Regions were defined following the California Health Interview Survey (CHIS) operationalization of regions. Each California county was assigned to one of the seven regions. County was derived from respondents' self-reported ZIP code. When respondents refused to identify their ZIP codes, 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.

appendix a – statistical modeling

Several sections of this study refer to regression analyses used to measure the relationships among various attitudes, demographic variables and predicted outcomes, such as the desire to see the same healthcare provider more frequently, interest in team-based care, and overall satisfaction with care. This appendix provides details of those statistical analyses.

A regression is a form of statistical modeling that measures the independent strength of the relationship between each predictor with the posited outcome, known as the dependent or outcome variable. While it does not establish causality, a regression reveals the strength of the relationship between a predictor (e.g., having team-based care) and the dependent variable (e.g., satisfaction), with other predictors in the model held constant.

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

key variables

Overall health (W1): A continuous variable reflecting respondents' self-reported health status, with 1 = poor health and 5 = excellent health (*Mean* = 3.1, *Standard Deviation* = 1.2).

Prioritize health (Q1): A binary variable indicating whether the respondents say their top priority is taking care of their health or not (0 = not health, 1 = health).

Number of medical appointments in the past year (Q2): A continuous variable indicating the number of times respondents went to the doctor in the past year (*M* = 4.3, *SD* = 7.6).[24]

Facility type (Q3-4): The type of facility used by each respondent was coded using a series of binary variables indicating, separately, whether he or she received care at a community clinic and health center (CCHC), or not; a Kaiser Permanente facility, or not; a private doctor's office, or not; a public clinic, or not; some other type of clinic (not CCHC or public) or not; and a hospital emergency room (ER), or not. For each facility type, respondents were coded 1 if a patient, 0 if not.

Overall quality-of-care rating (Q5/Q5a): A continuous variable reflecting respondents' overall ratings of their health care, on a scale from 1 = poor to 5 = excellent (*M* = 3.6, *SD* = 1.0).

Non-care assistance rating (Q6): A continuous variable reflecting respondents' ratings of the assistance provided by their healthcare facility to get the support services they may need, on a scale from 1 = poor to 5 = excellent (*M* = 3.4, *SD* = 1.1).

Has a personal connection (Q7): A binary variable indicating whether or not respondents say there is someone at their healthcare facility who knows them well (0 = no, 1 = yes).

Importance of personal connection (Q9): A continuous variable reflecting how important respondents think it is to have someone who knows them well at their care facility, on a scale from 1 = not important at all to 4 = very important (*M* = 3.2, *SD* = .9).

Has a personal doctor (Q10): A binary variable indicating whether or not the respondents have a regular personal doctor (0 = no personal doctor, 1 = personal doctor).

Want a personal doctor (Q10-11): A binary variable indicating whether or not respondents desire a personal doctor (0 = have a personal doctor already or lacks one, but say having one is not important to them, 1 = does not have a personal doctor but wants one).

Like having a personal doctor (Q10, Q12): A binary variable indicating whether or not respondents like having a personal doctor "(0 = do not have a personal doctor or do, but say having that doctor is not important, 1 = have a personal doctor and like it).

Continuity in a care provider (Q13): A continuous variable reflecting how frequently respondents see the same healthcare provider when they have an appointment, on a scale from 1 = never to 5 = every time (*M* = 3.66, *SD* = 1.28).

Desire for continuity in a care provider (Q14): A binary variable indicating whether or not respondents would like to be able to see the same healthcare provider more often (0 = do not think seeing the same provider more often is important or already see the same provider every visit, 1 = would like to see the same provider more often).

Usually see a doctor for care (Q15): A binary variable indicating whether respondents normally see a doctor or usually see a non-physician provider (e.g., a nurse or physician's assistant) for routine care (0 = usually see a non-physician provider for routine care, 1 = usually see a doctor, or both a doctor and a non-physician provider for routine care).

Openness to a non-doctor provider (Q16-17): A continuous variable reflecting how open respondents are to seeing a non-physician care provider for routine care, where 1 = always prefer to see a doctor over a non-physician provider, 2 = initially prefer to see a doctor over a non-

physician provider, and continue to prefer a doctor in 2 of the 3 follow-up scenarios tested, 3 = initially prefer to see a doctor, and continue to prefer a doctor in 1 of the 3 follow-up scenarios tested, 4 = initially prefer to see a doctor, but prefer to see a non-physician provider in all three of the follow-up scenarios, 5 = initially prefer to see a non-physician provider or don't care either way (*M* = 3.10, *SD* = 1.61).

Willingness to try phone appointments (Q18): A continuous variable reflecting how willing respondents are to talk with a healthcare provider over the telephone for routine health questions instead of having an in-person appointment, on a scale from 1 = very unwilling to 4 = very willing/already do (*M* = 2.63, *SD* = 1.11).

Willingness to try e-mail appointments (Q19): A continuous variable reflecting how willing respondents are to e-mail a healthcare provider for routine health questions instead of having an in-person appointment, on a scale from 1 = very unwilling/don't use e-mail to 4 = very willing/already do (*M* = 2.16, *SD* = 1.17).

Has a health navigator (Q20): A binary variable indicating whether or not respondents currently have a health navigator or health coach (0 = do not have a health navigator, 1 = have a health navigator).

Interest in a health navigator (Q22): A continuous variable among only those respondents who do not currently have a health navigator that reflects how interested they would be in having a health navigator, on a scale from 1 = not at all interested to 4 = very interested (*M* = 2.58, *SD* = 1.07).

Openness to a health navigator (Q20-22): A continuous variable reflecting how open respondents are to having a healthcare navigator on a scale in which 1 = not interested in having a health navigator at all/don't like having a health navigator at all and 4 = very interested in having a health navigator/like having a health navigator a great deal (*M* = 2.73, *SD* = 1.07).

Has team care (Q23): A binary variable indicating whether or not respondents currently have team-based care (0 = do not have team-based care, 1 = have team-based care).

Willingness to try team care (Q25): A continuous variable among only those respondents who do not currently have team-based care that reflects how willing they would be to try team-based care, on a scale from 1 = very unwilling to 4 = very willing (*M* = 3.13, *SD* = .90).

Openness to team care (Q23-25): A continuous variable reflecting how open respondents are to having team care on a scale in which 1 = very unwilling to try team care/don't like having team care at all and 4 = very willing to try team care/like having team care a great deal (*M* = 3.23, *SD* = .86).

Index of interest in tech-based communication tools (Q27a-e): A composite measure of interest in text-messaged reminders, text-messaged health information, online appointment scheduling, online access to health records and online prescription renewal. Each of these items was recoded so that 1 = not interested at all/don't use text messaging or internet and 4 = very interested/already do this. They were then averaged to form an overall index (α = .82), which ranges from 1 (indicating no interest in any of the communication tools) to 4 (indicating strong interest in all five communication tools). The average index value is M = 2.64, SD = .95.

Subindex of interest in text-based communication tools (Q27a-b): A composite measure of interest in the two text-based communication tools – text-messaged reminders and text-messaged health information. These two items were recoded so that 1 = not interested at all/don't use text messaging and 4 = very interested/already do this. They were then averaged to form a sub-index (r = .61, p < .001), which ranges from 1 (indicating no interest in either text-based tool) to 4 (indicating strong interest in both text-based tools). The average index value is M = 2.59, SD = 1.10.

Subindex of interest in online communication tools (Q27c-e): A composite measure of interest in the three online communication tools – online appointment scheduling, online access to health records and online prescription renewal. These three items were recoded so that 1 = not interested at all/don't use the internet and 4 = very interested/already do this. They were then averaged to form a sub-index (α = .84), which ranges from 1 (indicating no interest in any online tool) to 4 (indicating strong interest in all three online tools). The average index value is M = 2.66, SD = 1.11.

Very concerned about internet privacy (Q28): A binary variable indicating if respondents are very concerned about internet privacy or not (0 = not very concerned about internet privacy, 1 = very concerned about internet privacy).

Importance of community knowledge (Q29a): A continuous variable reflecting how important respondents think it is that the healthcare provider and staff at their facility know what's going on in their community, where 1 = not important at all and 4 = very important (M = 3.05, SD = 1.00).

Importance of cultural understanding (Q29b): A continuous variable reflecting how important respondents think it is that the healthcare provider and staff at their facility understand their cultural and ethnic background, where 1 = not important at all and 4 = very important (M = 2.88, SD = 1.12).

Importance of speaking respondent's language (Q29c): A continuous variable asked of respondents who do not primarily speak English at home that reflects how important they think it is that the healthcare provider and staff at their facility be able to speak with them in the language they prefer, where 1 = not important at all and 4 = very important. Respondents who mainly speak English at home were coded as 1 (M = 2.17, SD = 1.41).

Willingness to try group care (Q30): A continuous variable reflecting how willing respondents are to try group programs on healthcare issues in which 1 = very unwilling and 4 = very willing (M = 3.02, SD = .95).

Index of healthcare efficacy (Q35, Q37, Q41, Q43, Q44): A composite index that includes items that assess how much say respondents feel they currently have in decisions about their health care (recoded so that 1 = none and 5 = a great deal), how informed respondents feel about their health (recoded so that 1 = not informed at all and 4 = very informed), how confident they are in their ability to make healthcare decisions (recoded so that 1 = not confident at all and 4 = very confident), how frequently they understand their provider (recoded so that 1 = never and 5 = every time) and how comfortable they feel asking their provider questions (recoded so that 1 = very uncomfortable and 4 = very comfortable). These five items were standardized using a z-score transformation and then averaged to form an index (α = .71), which ranges from -2.93 to .88. The average index value is M = .00, SD = .68.

Index of interest in more health information (Q40a-d): A composite measure of interest in having more information about the pros and cons of different tests or treatments, the training and experience of local health professionals, patient satisfaction ratings for local healthcare facilities, and quality ratings for local healthcare providers. These four items were recoded so that 1 = not interested at all and 4 = very interested and then averaged to form the index (α = .83), which ranges from 1 (indicating no interest in more information on any of the four topics) to 4 (indicating strong interest in more information on all four topics). The average index value is M = 3.28, SD = .74.

Has misunderstood care provider (Q45): A binary variable indicating whether or not there has been a time when the respondents didn't follow a healthcare provider's advice or treatment plan because they didn't understand what they were supposed to do (0 = have misunderstood care provider, have not misunderstood care provider).

Has a disability (Q48): A binary variable indicating whether or not respondents have a disability or chronic medical condition (0 = do not have a disability or chronic condition, 1 = have a disability or chronic condition).

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

modeling details and results

model 1: ratings of overall quality-of-care (patient satisfaction)

To determine what factors independently predict patient satisfaction, we performed a regression with overall quality-of-care ratings as the outcome variable and the following variables included as predictor variables (see above for definitions): overall health, number of medical appointments in the last year, facility type, has a personal connection, has a personal doctor, continuity in a care provider, usually see a doctor for care, has a health navigator and has team care. All demographic variables listed above were also included. Table 1 shows the results of this model (Model 1).

table 1. significant predictors of overall quality-of-care ratings

	Standardized coefficient (β)	Significance test (*t*)
has a personal connection	.21	5.95***
overall health	.18	5.10***
continuity in a care provider	.12	3.40**
citizen	-.12	2.87**
has team care	.11	3.14**
race/ethnicity: Latino	-.10	1.99*

Model R^2 = .22, $p < .001$

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

model 2: ratings of non-care assistance provided by facility

To determine what factors independently predict ratings of non-care assistance, we performed a regression with non-care assistance ratings as the outcome variable. Model 2 used the same predictors as were included in Model 1. Table 2 shows the results of this model.

table 2. significant predictors of non-care assistance ratings

	Standardized coefficient (β)	Significance test (*t*)
overall health	.20	5.60***
continuity in a care provider	.18	5.02***
has a personal connection	.17	4.98***
has team care	.10	3.07**
age	.09	2.12*

Model R^2 = .22, $p < .001$

model 3: healthcare efficacy

To determine what factors independently predict healthcare efficacy, we performed a regression with the healthcare efficacy index as the outcome variable. Model 3 used the same predictors as were included in Models 1 and 2. The significant predictors are shown in Table 3 below.

table 3. significant predictors of the index of healthcare efficacy

	Standardized coefficient (β)	Significance test (*t*)
overall health	.17	4.73***
has a personal connection	.15	4.41***
continuity in a care provider	.15	4.19***
has team care	.12	3.53***
employment status: unemployed	-.12	3.14**
race/ethnicity: white	.11	2.24*
income	.10	2.53*
household size	-.08	2.06*
race/ethnicity: black	.07	1.97*

Model R^2 = .22, p < .001

model 4: having a personal connection

To determine what factors predict whether or not respondents have someone at their healthcare facilities who knows them well, we performed a regression with having a personal connection as the outcome variable. Model 4 used the same predictors as Models 1-3 (though, of course, without having a personal connection as a predictor). The significant predictors are shown in Table 4 below.

table 4. significant predictors of having a personal connection

	Standardized coefficient (β)	Significance test (*t*)
continuity in a care provider	.18	4.93***
language spoken at home: english	.13	3.00**
has a personal doctor	.12	3.21**
facility: hospital ER	-.11	3.07**
gender: male	-.07	2.11*
has team care	.07	2.06*
age	.07	1.70+
number of medical appointments in the past year	.06	1.91+
has health navigator	.06	1.83+

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

model 5: desire for continuity in a care provider (among those who don't currently see the same provider on every visit)

To determine what predicts the desire for continuity in a care provider, we performed a regression among those who don't currently see the same care provider on every visit, with desire for continuity as the outcome variable. Model 5 included the following variables as predictors (see above for definitions): overall health, number of medical appointments in the last year, facility type, overall quality-of-care rating, non-care assistance rating, has a personal connection, importance of personal connection, has a personal doctor, want a personal doctor, like having a personal doctor, continuity in a care provider, usually see a doctor for care, openness to a non-doctor provider, willingness to try phone appointments, willingness to try e-mail appointments, openness to team care, openness to a health navigator, index of interest in tech-based communication tools and willingness to try group care.[25] All demographic variables were also included. Significant predictors are shown in Table 5 below.

table 5. significant predictors of desire for continuity in a care provider

	Standardized coefficient (β)	Significance test (*t*)
want a personal doctor	.28	5.40***
like having a personal doctor	.20	2.54*
openness to a non-doctor provider	-.17	4.32***
facility: Kaiser Permanente	-.16	2.69**
non-care assistance rating	.13	2.56*
has a personal connection	-.11	2.56*
has a disability	.09	2.02*

Model R^2 = .32, $p < .001$

model 6: willingness to try team care (among those who don't currently have it)

To determine what predicts willingness to try team care, we performed a regression among those who don't currently have team-based care, with willingness to try it as the outcome variable. The predictor variables for Model 6 were identical to those used in Model 5, with the exception that openness to team care was removed as a predictor and desire for continuity in a care provider was added. Results of the model are shown in Table 6 on the next page.

table 6. significant predictors of willingness to try team care

	Standardized coefficient (β)	Significance test (*t*)
openness to a health navigator	.30	7.59***
willingness to try group care	.21	5.62***
has a personal doctor	.18	2.26*
index of interest in tech-based communication tools	.16	3.52**
desire for continuity in a care provider	.13	2.99**
facility: public clinic	-.12	2.27*
insurance: Medi-Cal	-.12	2.09*
citizen	.10	2.34*

Model R^2 = .35, $p < .001$

model 7: interest in a health navigator or coach (among those who don't currently have one)

Interest in a health navigator was investigated in a regression model among those respondents who don't currently have a health coach. Model 7 included the same predictors as Model 6, with the exception that openness to a health navigator was removed as a predictor and openness to team care added as one. The results of the model are shown in Table 7 below.

table 7. significant predictors of interest in a health navigator

	Standardized coefficient (β)	Significance test (*t*)
openness to team care	.26	7.35***
index of interest in tech-based communication tools	.25	6.26***
race/ethnicity: Latino	.14	2.46*
want a personal doctor	.11	2.45*
race/ethnicity: white	.11	2.23*
desire for continuity in a care provider	.10	2.48*
non-care assistance rating	-.10	2.39*
importance of personal connection	.09	2.62*
willingness to try phone appointments	.09	2.50*
citizen	-.09	2.22*
age	.09	2.19*

Model R^2 = .39, $p < .001$

model 8: predicting willingness to try group care

To determine the best predictors of willingness to try group care, we performed a regression model using all of the variables included in Models 6 and 7, as well as a few additional variables. The variables new to Model 8 are: prioritize health, importance of community knowledge, importance of cultural understanding, importance of speaking the respondent's language, the index of healthcare efficacy, the index of interest in more health information and whether the respondent has misunderstood a care provider. Significant predictors of willingness to try group care are shown in Table 8 below.

table 8. significant predictors of willingness to try group care

	Standardized coefficient (β)	Significance test (*t*)
openness to team care	.19	5.59***
importance of community knowledge	.18	5.10***
index of interest in more health information	.16	4.37***
age	.15	3.74***
has misunderstood care provider	.10	3.31**
facility: hospital ER	.10	2.25*
facility: CCHC	.10	2.03*
usually see a doctor for care	.09	2.85**
gender: male	-.09	2.71**
overall health	.09	2.54*
importance of cultural understanding	.09	2.51*
index of interest in tech-based communication tools	.09	2.27*
number of medical appointments in the past year	.08	2.62**
openness to a non-doctor provider	.08	2.55*
importance of personal connection	-.07	2.08*

Model $R^2 = .34$, $p < .001$

models 9 and 10: willingness to substitute a phone call or e-mail for an in-person visit

To investigate the independent predictors of willingness to substitute a phone call or an e-mail for an in-person appointment, we performed two separate regression analyses, one with willingness to try phone appointments as the outcome variable (Model 9), and the other with willingness to try e-mail appointments as the outcome variable (Model 10). The models included the same predictors as Models 6 and 7. In addition, Model 10 included very concerned about internet privacy as a predictor. The results of these models are shown in Table 9 and Table 10 below.

table 9. significant predictors of willingness to try phone appointments

	Standardized coefficient (β)	Significance test (*t*)
willingness to try e-mail appointments	.37	10.17***
desire for continuity in a care provider	.10	2.70**
age	.10	2.33*
race/ethnicity: white	.10	2.02*
openness to a health navigator	.09	2.30*

Model R^2 = .24, p < .001

table 10. significant predictors of willingness to try e-mail appointments

	Standardized coefficient (β)	Significance test (*t*)
index of interest in tech-based communication tools	.34	10.12***
willingness to try phone appointments	.30	9.89***
age	-.10	2.74**
overall quality-of-care rating	.09	2.25*

Model R^2 = .38, p < .001

models 11-13: overall interest in tech-based communication tools

Three separate models were used to investigate the predictors of interest in tech-based communication tools. Model 11 used the full index of interest in tech-based communication tools as the outcome variable, Model 12 used the subindex assessing interest in text message-based communication tools as the outcome variable and Model 13 used the subindex assessing interest in online communication tools as the outcome variable. The predictors in each model were identical to those used in Model 9, except willingness to try e-mail appointments was added as a predictor. The results of these three models are shown in Tables 11, 12 and 13 on the following page.

table 11. significant predictors of the index of interest in tech-based communication tools

	Standardized coefficient (β)	Significance test (*t*)
willingness to try e-mail appointments	.32	10.12***
openness to a health navigator	.18	5.56***
age	-.18	4.95***
willingness to try group care	.12	3.81***
race/ethnicity: white	-.11	2.59*
openness to team care	.10	3.13**
education	.09	2.77**
want a personal doctor	.08	1.96*

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

model 12: interest in text message-based communication tools

table 12. significant predictors of the subindex of interest in text-based communication tools

	Standardized coefficient (β)	Significance test (*t*)
willingness to try e-mail appointments	.20	5.87***
openness to a health navigator	.20	5.53***
race/ethnicity: white	-.15	3.33**
openness to team care	.13	3.87***
willingness to try group care	.12	3.68***
age	-.11	2.72**
want a personal doctor	.08	1.91+

Model $R^2 = .31$, $p < .001$

model 13: interest in online communication tools

table 13. significant predictors of the subindex of interest in online communication tools

	Standardized coefficient (β)	Significance test (*t*)
willingness to try e-mail appointments	.33	10.54***
age	-.19	5.19***
education	.15	4.51***
openness to a health navigator	.13	4.08***
language spoken at home: English	.09	2.34*
willingness to try group care	.09	2.87**

Model $R^2 = .43$, $p < .001$

endnotes

24 The mean was skewed by one respondent who indicated he/she had been to the doctor more than 300 times in the past year. This response was removed.

25 We checked whether openness to any of the alternative care models (team care, healthcare navigator, phone appointments, e-mail appointments and group care) could be combined to form an index of general openness to alternative care. While openness to one form of alternative care often predicts openness to other care models, the variables were not so highly related that they appeared to be measuring the same construct ($\alpha = .52$). Indeed, the highest correlation among the items was between openness to team care and openness to a health navigator, $r = .41$, $p < .001$ – but even for these two variables, just 16 percent of the variance is shared. Therefore, we treated each of the variables as unique, albeit often related, constructs.

appendix b – topline data report

This appendix provides complete question wording and topline results for data included in this report on the 2012 Blue Shield of California Foundation survey of low-income Californians. Some material is on hold for an upcoming report on patient-centered care.

*= less than 0.5 percent

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

Excellent/very good		NET		Fair/poor		NET	
Excellent	Very good		Good	Fair	Poor		No opinion
16%	22	38	30	22	10	31	1

1. Of the items I name please tell me which one is the single biggest concern for you right now – is it (housing issues), (being able to pay for basics like food), (getting or holding a job), (immigration or legal issues) or (taking care of your health)?

not health

Health	NET	Housing	Food	Job	Legal	Other (vol.)	No Opinion
30%	67	13	15	29	6	4	3

2. 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
19%	20	41	20	1	4.34	2

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

Kaiser Permanente	13%
Doctor's office	27
Clinic NET	**43**
Community clinic or health center	*17*
Public hospital clinic	*9*
Private/religious hospital clinic	*4*
Hospital clinic other/unknown type	*1*
County/city clinic	*2*
Private clinic	*4*
Clinic other/unknown type	*7*
Hospital emergency room	10
Hospital unspecified	1
Someplace else	4
Never have gone for health care*	1
No opinion	1

*Asked W1, Q1-4a, Q10-14, Q16-19, Q27-42, Q46-47 and demographics

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

Excellent/very good		**NET**		**Not so good/poor**		**NET**	
Excellent	Very good		Good	Not so good	Poor		No opinion
25%	24	49	40	7	3	10	1

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

6. Apart from the health care they provide, what about the kind of assistance they offer to help you get the support services you may need, such as information, referrals, transportation and other assistance – would you rate this as excellent, very good, good, not so good or poor?

Excellent/very good		**NET**		**Not so good/poor**		**NET**	
Excellent	Very good		Good	Not so good	Poor		No opinion
20%	20	40	40	11	6	17	2

7. 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
38%	60	1

8. (IF SOMEONE THERE WHO KNOWS YOU WELL, Q7) Who is that person – I mean their job? Could be a doctor, nurse, healthcare navigator, someone at reception, or so forth?

doctor	60%
nurse	21
healthcare navigator	1
someone at reception	11
nurse's aide (vol.)	1
physician's assistant (vol.)	3
pharmacist (vol.)	*
case worker/social worker (vol.)	1
billing clerk (vol.)	*
entire staff/everyone (vol.)	1
other (vol.)	1
no opinion	1

9. How much does this matter to you – having someone there who knows you well? (Is that/Would that be) very important to you, somewhat important, not so important or not important at all?

Important		NET	Not important		NET	
Very	Somewhat		Not so	Not at all		No opinion
49	31	80	13	7	20	1

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

Yes	No	No opinion
47%	53	*

11. (IF NO PERSONAL DOCTOR, Q10) Would you like to have your own personal doctor, or is it not that important to you?

Would like doctor	Not important	No opinion
58%	41	1

10/11 NET:

	No Doctor		NET	
Has doctor	Would like	Not important		No opinion
47	31	22	53	*

12. (IF HAS PERSONAL DOCTOR, Q10) Do you like having your own personal doctor, or is it not that important to you?

Like it	Not important	No opinion
87%	13	*

10/12 NET:

Has doctor		NET		
Like	Not important		No doctor	No opinion
40	6	47	53	*

13. Regardless of whether or not you have a personal doctor, 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		NET		Rarely/never		NET	
Every time	Most of the time		Some of the time	Rarely	Never		No opinion
33	28	60	19	11	8	20	1

14. (IF NOT EVERY TIME, Q13) Would you like to be able to see the same healthcare provider more often than you do now, or is that not that important to you?

More often	Not important	No opinion
58%	41	1

15. Thinking about when you go in for routine care or a checkup, not for a special problem – (do you usually see a doctor), or (do you usually see a care provider who is not a doctor, like a nurse or a physician's assistant)?

Doctor	Other provider	Both (vol.)	No opinion
68%	23	5	4

16. For routine visits or checkups, would you prefer to see (a doctor), would you prefer to see (a nurse or physician's assistant) or does it not matter much to you either way? IF MATTERS: Do you feel that way strongly or somewhat?

Prefer doctor		NET		Prefer nurse/PA		NET	
Strongly	Somewhat		Does not matter	Somewhat	Strongly		No opinion
52	13	66	27	3	3	6	*

17. (IF PREFERS DOCTOR, Q16) What if [ITEM] – in that case would you (still prefer to see a doctor) for routine care, or would you (prefer to see a nurse or physician's assistant)? IF DOCTOR OR NURSE/PHYSICIAN'S ASSISTANT: Do you feel that way strongly or somewhat?

Full item wording:

a. It's harder to get an appointment with a doctor
b. The appointment with the doctor is shorter than it would be with a nurse or physician's assistant
c. The doctor doesn't know you as well as the nurse or physician's assistant

	Prefer doctor		NET		Prefer nurse/PA		NET	
	Strongly	Somewhat		Either (vol.)	Somewhat	Strongly		No opinion
a. Harder to get appt.	47	9	56	4	19	19	38	2
b. Appointment is shorter	59	13	73	5	9	13	21	1
c. Doctor less familiar	49	11	60	4	10	24	34	2

18. For routine health questions, how would you feel about talking with a healthcare provider over the telephone instead of having an in-person appointment – would you be very willing to do this, somewhat willing, somewhat unwilling or very unwilling?

Willing			NET		Unwilling		NET	
Do now (vol.)	Very	Somewhat		Depends (vol.)	Somewhat	Very		No opinion
1	25	33	59	2	15	24	39	1

19. How about using e-mail? For routine health questions, how would you feel about using e-mail instead of having an in-person appointment to communicate with a healthcare provider – would you be very willing to do this, somewhat willing, somewhat unwilling or very unwilling?

Willing			NET		Unwilling		NET		
Do now (vol.)	Very	Somewhat		Depends (vol.)	Somewhat	Very		No e-mail/ internet	No opinion
1	17	24	41	*	15	34	49	9	*

20. On another subject, 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 healthcare navigator or healthcare 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
18%	76	6

21. (IF HAS HEALTH NAVIGATOR, Q20) How do you like having this healthcare navigator – do you like it a great deal, somewhat, not so much or not at all?

Like having navigator		NET	Dislike having navigator		NET	
Great deal	Somewhat		Not so much	At all		No opinion
54	37	91	6	3	9	0

22. (IF DOES NOT HAVE HEALTH NAVIGATOR, Q20) How interested would you be in having a healthcare navigator providing these services – very interested, somewhat interested, not so interested or not interested at all?

Interested		NET	Not interested		NET	
Very	Somewhat		Not so	At all		No opinion
23	33	55	22	21	43	2

23. Some places have what's called team-based care. Each patient gets a healthcare team that includes a doctor, a healthcare 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 healthcare team at the place (you go/last went) for care, or not?

Yes	No	No opinion
25%	67	8

24. (IF HAS TEAM-BASED CARE, Q23) How do you like this team-based approach – do you like it a great deal, somewhat, not so much or not at all?

Great deal/somewhat		NET	Not so much/at all		NET	
Great deal	Somewhat		Not so much	At all		No opinion
59	35	94	3	1	4	2

25. (IF DOES NOT HAVE TEAM-BASED CARE, Q23) If it was available where you go for care, would you be very willing to have team-based care, somewhat willing, somewhat unwilling or very unwilling?

Willing		NET	Unwilling		NET	
Very	Somewhat		Somewhat	Very		No opinion
37	45	81	6	9	15	4

26. (IF DOES NOT HAVE TEAM-BASED CARE, Q23) The idea of team-based care is that while you may see a doctor less often, it's easier to see more types of healthcare providers who know you and can help in different ways. Knowing this, would you be very willing to participate in team-based care, somewhat willing, somewhat unwilling or very unwilling?

Willing		NET	Unwilling		NET	
Very	Somewhat		Somewhat	Very		No opinion
34	47	81	6	10	15	3

27. There can be different ways to communicate with a healthcare provider. For each item I name, please tell me how interested you are in doing that, if at all. If you're already doing this, please just say so. The first is [ITEM] – are you very interested in doing that, somewhat interested, not so interested or not interested at all? How about [NEXT ITEM]?

Full item wording:

a. Receiving text messages reminding you to take medicine or come in for a test
b. Receiving text messages with information about health issues you may be having
c. Being able to schedule a medical appointment over the internet
d. Being able to look at your health records over the internet
e. Being able to renew prescription medicines over the internet

	Interested			NET	Not interested		NET		
	Do now	Very	Somewhat		Not so	At all		Can't*(vol.)	No opinion
a. Text reminders	2%	35%	26%	63%	8%	26%	34%	3	*
b. Texts with health info.	2	25	27	54	11	31	43	3	*
c. Schedule appts. over internet	4	34	24	61	8	23	31	8	*
d. Access records over internet	4	32	22	58	7	27	34	7	1
e. Renew prescrip. over internet	4	35	24	63	7	22	29	8	1

*Includes respondents who indicated they don't have a cell phone, don't use text messaging or lack access to the internet or a computer.

28. How concerned are you, if at all, about the privacy of your health information on the internet and in e-mails – very concerned, somewhat concerned, not so concerned, or not concerned at all?

Concerned		NET	Not concerned		NET		
Very	Somewhat		Not so	At all		No Internet (vol.)	No opinion
45	26	71	13	12	25	4	*

29 held for release.

30. Some places offer group programs on healthcare issues. There may be a program for people with diabetes, or for pregnant women, or for people trying to quit smoking, for example. These are places for people to share their experiences as well as get healthcare information. If there was a group program where you go that addressed a health issue you have, how willing would you be to participate in that – very willing, somewhat willing somewhat unwilling or very unwilling?

Willing		NET		Unwilling		NET	
Very	Somewhat		Depends (vol.)	Somewhat	Very		No opinion
35	42	77	1	10	11	21	1

31-47 held for release.

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

Yes	No	No opinion
29%	71	*

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

Private health insurance through an employer	22%
Private health insurance that you buy on your own	11
Medi-Cal, also known as Medicaid	25
Any other state health insurance program	5
The V.A., Tri-Care, military, federal insurance	2
Indian Health Service	*
Medicare	2
Medicare and Medi-Cal	2
None, you are uninsured	29
No opinion	3

selected demographics:

Sex	
Male	47%
Female	53

Age	
19-29	33%
30-39	23
40-49	21
50-64	23

Relationship status	
Married	39%
Living with a partner	15
Widowed	3
Divorced	6
Separated	4
Single	33

Employment status	
Employed, full-time	36%
Employed, part-time	21
Not employed NET	**41**
Retired	4
Homemaker	8
Student	9
Unemployed	14
Disabled	6
Other	*
No opinion	2

Education	
Less than high school NET	**33%**
8th grade or less	12
Some high school	21
High school graduate	26
Some college/associates degree	30
College graduate NET	**11**
Graduated college	10
Post graduate	1

Race/Ethnicity	
White, non-Latino	27%
Black, non-Latino	7
Latino NET	**54**
White Latino	36
Black Latino	13
Latino unspecified	5
Asian	8
Multiracial	1
Other	2

Income	
< $16,000	30%
$16,000-$30,999	47
$31,000-$51,999	15
$52,000+	2
No opinion	6

appendix c – full questionnaire

This appendix reproduces the full, formatted questionnaire for Blue Shield of California Foundation's 2012 survey of low-income 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	THANK AND TERM.
R	(DO NOT READ) Refused	THANK AND TERM.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ASK EVERYONE; READ ITEM IN PARENS IF S1=2+)
S3. To ask the right questions, we need to know whether in 2011, 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 healthcare costs. We need to know that to ask the right questions.)

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

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

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

VALUES FOR Y*

IF S1=1	$23,000	IF S1=6	$62,000
IF S1=2	$29,000	IF S1=7	$70,000
IF S1=3	$36,000	IF S1=8	$78,000
IF S1=4	$46,000	IF S1=9+	$93,000
IF S1=5	$55,000		

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

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

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

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

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

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

VALUES FOR M*

IF S1=1	$2,000	IF S1=6	$5,100
IF S1=2	$2,400	IF S1=7	$5,800
IF S1=3	$3,000	IF S1=8	$6,500
IF S1=4	$3,800	IF S1=9+	$7,800
IF S1=5	$4,500		

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

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

(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 & GO TO Q.S5
3	Person is unavailable	GET NAME & SCHEDULE CALLBACK
4	No one in the HH of that gender	
R	(DO NOT READ) Refused	THANK & TERM.

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

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

S5. What language do you mainly speak at home? (DO NOT READ.)

1 English
2 Spanish
3 Chinese/Mandarin/Cantonese
4 Korean
5 Filipino/Tagalog
7 Other
R (DO NOT READ) Refused

S6. RECORD GENDER OF RESPONDENT

1 Male
2 Female

main questionnaire

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	THANK AND TERM.
R	(DO NOT READ) Refused	THANK AND TERM.

(SCRAMBLE LIST)
1. Of the items I name please tell me which one is the single biggest concern for you right now – is it …?
(READ LIST.)

1	Housing issues
2	Being able to pay for basics like food
3	Getting or holding a job
4	Immigration or legal issues
5	Or, taking care of your health
7	(DO NOT READ) Other
D	(DO NOT READ) Don't know
R	(DO NOT READ) Refused

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

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

(ROTATE VERBIAGE IN PARENS)
3. 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.3a IF Q.3 = 6, D, OR R)
3a. OK, where's the last place you went when you needed health care?
(ENTER ONE ONLY)

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

(IF Q.3a = 1, 2, 4, 5)
3b. Was this in California, or not?

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

(ASK Q.4 IF Q.3 = 3 OR Q.3a = 3)
4. What's the city or town where your clinic is located?
(ENTER 1ST LETTER OF CITY/TOWN FOR LIST OF AVAILABLE CITIES/TOWNS)

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

(ASK Q.4aa IF Q4 = 096, 158, 201, 213, 254, 255, 258, 259, 263, OR 330 OR 997)
4aa. 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.4a IF Q.3 = 3 OR Q.3a = 3)
4a. 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.4b IF Q.4a = 997, DDD, OR RRR)
4b. As far as you know, is that a clinic that's operated by a hospital, or not?
(ENTER ONE ONLY)

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

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.4d IF Q.4b = 2)
(ROTATE VERBIAGE IN PARENS)
4d. 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.4e IF Q.3 = 4 OR Q.3a = 4)
(ROTATE VERBIAGE IN PARENS)
4e. 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.4f IF Q.4e = 1)
(ROTATE VERBIAGE IN PARENS)
4f. 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.3 = 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.3a = 1-5, D OR R)
5a.Thinking about the last time you received health care – was the health care you received
excellent, very good, good, not so good or poor?

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

(ASK Q.6 IF Q.3 = 1-5 OR Q.3a = 1-5, D OR R)
6. Apart from the health care they provide, what about the kind of assistance they offer to help you get the support services you may need, such as information, referrals, transportation and other assistance – would you rate this as 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.7 IF Q.3 = 1-5 OR Q.3a = 1-5, D OR R)
INSERT 1ST VERBIAGE IN PARENS IF Q.3 = 1-5; INSERT 2ND VERBIAGE IN PARENS IF Q.3a = 1-5, D, OR R)
7. 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

(ASK Q.8 IF Q.7 = 1)
(SCRAMBLE 01-04)
8. Who is that person – I mean their job?
(IF NEEDED: Could be a (INSERT CODES 01-04), or so forth?)
(READ LIST.)

INTERVIEWER NOTE: healthcare navigator also can be "healthcare coach" or similar

01 Doctor
02 Nurse
03 Healthcare navigator (Spanish: Promotores de salud)
04 Someone at reception
05 (DO NOT READ) Nurse's aide
06 (DO NOT READ) Physician's assistant (PA)
07 (DO NOT READ) Pharmacist
08 (DO NOT READ) Nutritionist
09 (DO NOT READ) Case worker/social worker
10 (DO NOT READ) Billing clerk
97 (DO NOT READ) Other (SPECIFY) _____
DD (DO NOT READ) Don't know
RR (DO NOT READ) Refused

(ASK Q.9 IF Q.3 = 1-5 OR Q.3a = 1-5, D OR R)
INSERT "Is that" IF Q.7 = 1
INSERT "Would that be" IF Q.7 = 2, D, OR R
9. How much does this matter to you – having someone there who knows you well? (Is that/Would that be) very important to you, somewhat important, not so important or not important at all?

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

10. 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.11 IF Q.10 = 2)
11. Would you like to have your own personal doctor, or is it not that important to you?

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

(ASK Q.12 IF Q.10 = 1)
12. Do you like having your own personal doctor, or is it not that important to you?

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

13. Regardless of whether or not you have a personal doctor, 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?

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

(ASK Q.14 IF Q.13 = 2, 3, 4, 5, D, OR R)
14. Would you like to be able to see the same healthcare provider more often than you do now, or is that not that important to you?

1 Yes, would
2 Not that important
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.15 IF Q.3 = 1-5 OR Q.3a = 1-5, D OR R)
(ROTATE VERBIAGE IN PARENS)
15. Thinking about when you go in for routine care or a checkup, not for a special problem – (do you usually see a doctor), or (do you usually see a care provider who is not a doctor, like a nurse or a physician's assistant)?

1 Usually see a doctor
2 Usually see a care provider who is not a doctor, like a nurse or physician's assistant
3 (DO NOT READ) Usually see both
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ROTATE VERBIAGE IN PARENS)
16. For routine visits or checkups, would you prefer to see (a doctor), would you prefer to see (a nurse or physician's assistant) or does it not matter much to you either way?

(INTERVIEWER NOTE: If respondent says "both", say, "Well, if you had to choose…")

1 Prefer to see a doctor
2 Prefer to see a nurse or physician's assistant
3 Doesn't matter either way
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.16a IF Q.16 = 1 OR 2)
INSERT "doctor" IF Q.16 = 1
INSERT "nurse or physician's assistant" IF Q.16 = 2
16a. Do you feel that way strongly or somewhat?
(IF NECESSARY: That you prefer to see a (doctor/nurse or physician's assistant)

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

(ASK IF Q.16 = 1)
(ROTATE VERBIAGE IN PARENS)
(SCRAMBLE ITEMS)
17. What if (INSERT ITEM) – in that case would you (still prefer to see a doctor) for routine care, or would you (prefer to see a nurse or physician's assistant)?

1 Still prefer to see a doctor
2 Prefer to see a nurse or physician's assistant
3 (DO NOT READ) Either/Doesn't matter
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

a. It's harder to get an appointment with a doctor
b. The appointment with the doctor is shorter than it would be with a nurse or physician's assistant
c. The doctor doesn't know you as well as the nurse or physician's assistant

(ASK Q.17a IMMEDIATELY FOLLOWING Q.17 FOR EACH = 1 OR 2)
INSERT "still prefer to see a doctor" IF Q.17 = 1
INSERT "would prefer to see a nurse or physician's assistant" IF Q.17 = 2
17a. Do you feel that way strongly or somewhat?
(IF NECESSARY: That you (still prefer to see a doctor/would prefer to see a nurse or physician's assistant)

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

a. It's harder to get an appointment with a doctor
b. The appointment with the doctor is shorter than it would be with a nurse or physician's assistant
c. The doctor doesn't know you as well as the nurse or physician's assistant

18. For routine health questions, how would you feel about talking with a healthcare provider over the telephone instead of having an in-person appointment – would you be very willing to do this, somewhat willing, somewhat unwilling or very unwilling?

1 Very willing
2 Somewhat willing
3 Somewhat unwilling
4 Very unwilling
5 (DO NOT READ) Depends
6 (DO NOT READ) Already do this
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

19. How about using e-mail? For routine health questions, how would you feel about using e-mail instead of having an in-person appointment to communicate with a healthcare provider – would you be very willing to do this, somewhat willing, somewhat unwilling or very unwilling?

1 Very willing
2 Somewhat willing
3 Somewhat unwilling
4 Very unwilling
5 (DO NOT READ) Depends
6 (DO NOT READ) Already do this
7 (DO NOT READ) Do not use internet/e-mail and/or computer
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.20 IF Q.3 = 1-5 OR Q.3a = 1-5, D OR R)
INSERT "you go" IF Q.3 = 1-5
INSERT "last went" IF Q.3a = 1-5, D, OR R
20. On another subject, 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 healthcare navigator or healthcare 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.21 IF Q.20 = 1)
21. How do you like having this healthcare navigator – do you like it a great deal, somewhat, not so much or not at all?

1 A great deal
2 Somewhat
3 Not so much
4 Not at all
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.22 IF Q.20 = 2, D, OR R)
22. How interested would you be in having a healthcare navigator providing these services – 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.23 IF Q.3 = 1-5 OR Q.3a = 1-5, D OR R)
INSERT "you go" IF Q.3 = 1-5
INSERT "last went" IF Q.3a = 1-5, D, OR R
23. Some places have what's called team-based care. Each patient gets a healthcare team that includes a doctor, a healthcare 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 healthcare 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.24 IF Q.23 = 1)
24. How do you like this team-based approach – do you like it a great deal, somewhat, not so much or not at all?

1 A great deal
2 Somewhat
3 Not so much
4 Not at all
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.25 IF Q.23 = 2, D, OR R)
25. If it was available where you go for care, would you be very willing to have team-based care, somewhat willing, somewhat unwilling or very unwilling?

1 Very willing
2 Somewhat willing
3 Somewhat unwilling
4 Very unwilling
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.26 IF Q.23 = 2, D, OR R)
26. The idea of team-based care is that while you may see a doctor less often, it's easier to see more types of healthcare providers who know you and can help in different ways. Knowing this, would you be very willing to participate in team-based care somewhat willing, somewhat unwilling or very unwilling?

1 Very willing
2 Somewhat willing
3 Somewhat unwilling
4 Very unwilling
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(SCRAMBLE a-e)
(IF CODE 6, ENTERED AT ANY TIME, THEN ALL OTHER INTERNET-RELATED ITEMS SHOULD BE AUTO-GEN'D A CODE 6 [ITEMS c, d, e]. IF CODE 7 ENTERED AT ANY TIME, THEN ALL OTHER TEXTING-RELATED ITEMS SHOULD BE AUTO-GEN'D A CODE 7 [ITEMS a,b])
27. There can be different ways to communicate with a healthcare provider. For each item I name, please tell me how interested you are in doing that, if at all. If you're already doing this, please just say so. The first is (INSERT ITEM) – are you very interested in doing that, somewhat interested, not so interested or not interested at all? How about (INSERT NEXT ITEM)?

1 Very interested
2 Somewhat interested
3 Not so interested
4 Not interested at all
5 Already doing this
6 (DO NOT READ) No e-mail/internet/computer access
7 (DO NOT READ) No cell phone/don't text message
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

a. Receiving text messages reminding you to take medicine or come in for a test
b. Receiving text messages with information about health issues you may be having
c. Being able to schedule a medical appointment over the internet
d. Being able to look at your health records over the internet
e. Being able to renew prescription medicines over the internet

28. How concerned are you, if at all, about the privacy of your health information on the internet and in e-mails – very concerned, somewhat concerned, not so concerned or not concerned at all?

1 Very concerned
2 Somewhat concerned
3 Not so concerned
4 Not concerned at all
5 (DO NOT READ) Do not use internet/e-mail
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(SCRAMBLE ITEMS)
(ASK ITEM c IF Q.S5 = 2-7 OR R)
29. How much does it matter to you that the healthcare provider and staff at your healthcare facility (INSERT ITEM) – is that very important to you, somewhat important, not so important or not important at all?

(INTERVIEWER NOTE: IF R SAYS "NO FACILITY" SAY, "IF YOU HAD ONE…")

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

a. Know what's going on in your community
b. Understand your cultural or ethnic background
c. Are able to speak with you in the language you prefer

30. Some places offer group programs on healthcare issues. There may be a program for people with diabetes, or for pregnant women, or for people trying to quit smoking, for example. These are places for people to share their experiences as well as get healthcare information. If there was a group program where you go that addressed a health issue you have, how willing would you be to participate in that – very willing, somewhat willing, somewhat unwilling or very unwilling?

(INTERVIEWER NOTE: IF R SAYS "NO HEALTH ISSUES" SAY, "WELL, IF YOU DID HAVE ONE…")

1 Very willing
2 Somewhat willing
3 Somewhat unwilling
4 Very unwilling
5 (DO NOT READ) Depends
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ROTATE VERBIAGE IN PARENS)
31. If a healthcare facility in your area had a seal of approval from a national healthcare association would that make you (more likely) to go there, (less likely) to go there, or wouldn't it make a difference?

1 More likely
2 Less likely
3 Wouldn't make a difference
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

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

(INTERVIEWER NOTE: If respondent seems confused by the term "equal say" please say: "EQUAL SAY – LIKE AN EQUAL VOICE.")

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

(ASK Q.32a IF Q.32 = 1 OR 2)
32a. Do you feel that way strongly, or somewhat?

(IF NECESSARY: That you would [INSERT RESPONSE FROM Q.32])

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

(ASK Q.33 IF Q.32 = 1)
(ROTATE VERBIAGE IN PARENS)
33. Is that more because (you feel you don't have enough information to make the right decision) or more because (you feel that making care decisions is the doctor's responsibility, not yours)?

1 You feel you don't have enough information to make the right decision
2 You feel that making care decisions is the doctor's responsibility, not yours
3 (DO NOT READ) Both
4 (DO NOT READ) Neither/other
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.34 IF Q.32 = 1, D, OR R)
(ROTATE VERBIAGE IN PARENS)
34. Now imagine the doctor has selected treatment options for you – a choice of things you might do, any of which is medically appropriate – and you've been given information that you understand about these options. In this situation, would you prefer to (leave the decisions mostly up to the doctor or nurse) or would you prefer to (have an equal say with the doctor or nurse in the decisions)?

(INTERVIEWER NOTE: If respondent seems confused by the term "equal say" please say: "EQUAL SAY – LIKE AN EQUAL VOICE.")

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

35. 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?

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

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

36. Regardless of whether or not you want an equal say, would you like more of a say in decisions about your health care than you have now, less of a say, or is it about right?

(INTERVIEWER NOTE: If respondent seems confused by the term "equal say" please say: "EQUAL SAY – LIKE AN EQUAL VOICE.")

1 More say
2 Less say
3 It's about right

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

37. In general, how informed do you feel about your health and any health problems you may have – 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 Very informed
2 Somewhat informed
3 Not so informed
4 Not informed at all
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

38. Have you ever used the internet to access health information, or not?

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

(ASK Q.39 IF Q.38 = 1)
39. Do you do that very often, somewhat often, just occasionally or rarely? (IF NEEDED: Use the internet to access health information…)

1 Very often
2 Somewhat often
3 Just occasionally
4 Rarely
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(SCRAMBLE ITEMS)
40. How interested, if at all, would you be in having more information about (INSERT ITEM) – 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

a. The pros and cons of different tests or treatments you might need
b. The training and experience of the health professionals in your area
c. Patient satisfaction ratings for the healthcare facilities in your area
d. Quality ratings for providers in your area – like with more stars for the better ones

41. How confident are you in your ability to make decisions about your health care – very confident, somewhat confident, not so confident, or not confident at all?

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

(ROTATE VERBIAGE IN PARENS)
42. Overall, who do you feel is most responsible for managing your health – (you yourself) or (your healthcare provider)?

1 You yourself
2 Your healthcare provider
3 (DO NOT READ) Both equally
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.43 IF Q.3 = 1-5 OR Q.3a = 1-5, D OR R)
43. When you go for medical care, how often does the healthcare provider explain things in a way you can understand – 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

(ASK Q.44 IF Q.3 = 1-5 OR Q.3a = 1-5, D, OR R)
44. How comfortable or uncomfortable do you feel asking the healthcare provider questions about your health or treatment – very comfortable, somewhat comfortable, somewhat uncomfortable, or very uncomfortable?

1 Very comfortable
2 Somewhat comfortable
3 Somewhat uncomfortable
4 Very uncomfortable

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

(ASK Q.45 IF Q.3 = 1-5 OR Q.3a = 1-5, D, OR R)
45. Has there ever been a time when you didn't follow a healthcare provider's advice or treatment plan because you didn't understand what you were supposed to do, or has that nothappened?

1 Yes, there has been a time
2 No, this has not happened
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

46. Changing subjects, as you may know, a health reform bill was signed into law in 2010. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?
(GET ANSWER THEN ASK: Is that a very favorable/unfavorable or somewhat favorable/unfavorable opinion?)

1 Very favorable
2 Somewhat favorable
3 Somewhat unfavorable
4 Very unfavorable
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ROTATE VERBIAGE IN PARENS)
47. Do you think you and your family will be (better off) or (worse off) under the health reform law, or don't you think it will make much difference?

1 Better off
2 Worse off
3 Don't think it will make much difference
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

48. 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

49. What is your main source of health insurance coverage, if any?
(READ LIST IF RESPONDENT DOES NOT IMMEDIATELY VOLUNTEER AN ANSWER FROM THE LIST)

(INTERVIEWER NOTE: IF RESPONDENT SAYS "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, also known as Medicaid
04 Any other state health insurance program
05 The V.A., military insurance through Tri-Care or any other federal government program
06 Indian Health Service
07 Medicare, which would only be if you are disabled
08 (DO NOT READ) Both Medicare and MediCAl (Medi-Medi)
00 Or none, you are uninsured
DD (DO NOT READ) Don't know
RR (DO NOT READ) Refused

READ: Now for classification purposes only...

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

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

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

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

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

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

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

1	Full time	(SKIP TO Q.D4)
2	Part time	(SKIP TO Q.D4)
3	Not employed	(GO TO Q.D3a)
R	Refused	(SKIP TO Q.D4)

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

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

D4. May I please have your zip code?

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

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

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

D6. Are you of Hispanic origin or descent?

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

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

1 White
2 Black

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

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

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

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

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

01 Less than $16,000
02 At least $16,000 but less than $20,000
03 At least $20,000 but less than $24,000
04 At least $24,000 but less than $31,000
05 At least $31,000 but less than $36,000
06 At least $36,000 but less than $41,000
07 At least $41,000 but less than $47,000
08 At least $47,000 but less than $52,000
09 At least $52,000 but less than $62,000
10 Or $62,000 or more
DD (DO NOT READ) Don't know
RR (DO NOT READ) Refused

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

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

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

(READ IF INT0 =1)
The survey sponsor is the Blue Shield of California Foundation, a nonprofit group that works on healthcare 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

(READ IF SAMPLE = CELL AND INT1=1)
That's the end of the interview. We'd like to send you $5 for your time. Can I please have your full name and a mailing address where we can send you the money?
INTERVIEWER NOTE: If R does not want to give full name, explain we only need it so we can send the $5 to them personally.

1 [ENTER FULL NAME] – 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

appendix d – references

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In addition to these experts, the following references were consulted in preparation and analysis of Blue Shield of California Foundation's 2012 survey of low-income Californians.

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