sampling low-income Californians to assess their healthcare preferences

survey sponsor:
Blue Shield of California Foundation

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project overview: purpose

New health care paradigm for low-income Californians

- currently many patients lack choice
- ACA expands their options
- safety-net facilities will need to respond

A first step: assess healthcare experiences/preferences

- where poor and near-poor Californians go for care now
- health status and satisfaction with care
- interest in change and levers of choice

project overview: challenges

Target sample: Californians age 19-64 at <200% of the federal poverty level (about $45,000 for a family of four).

Problems:

- Low incidence (30% of CA HHs) means low efficiency, high expense; worsened by difficulties reaching lower SES, minorities, and younger respondents
- Screening: will asking income at the beginning of a survey produce unacceptable levels of non-response?

Problem 1: expense and efficiency

Solution: employ 12 mutually exclusive LL strata

- *High Latino*: landline exchanges associated with Census-block groups in which Latinos = min. 57.5% of population
- *High Low-Income: remaining* landline exchanges associated with Census blocks in which more than 40% have annual HH incomes <$35,000
- *Residual:* all remaining exchanges
- *Listed Low-Income:* all phone numbers associated with households whose infoUSA records indicate at least one resident aged 19-64 with annual HH income <$23,000

Each stratum further divided geographically: Los Angeles, San Francisco/San Diego/Sacramento and Other

Problem 1: expense and efficiency

Oversample higher-incidence strata:

- High Latino, high low-income and low-income listed strata are called disproportionately, but not exclusively
- Full coverage is maintained by also calling residual LL strata.
- No SES strata for cell-phones. Randomly sample all CA cell-phone exchanges (oversampling LA County exchanges)

Full coverage is maintained: all low-income Californians have a known probability of selection, but efficiency is also achieved.

- Stratified design results in a *deff* of 1.6

Problem 2: screening

Concern that asking annual income at the start of a survey will encourage non-response

Solution: ask income threshold rather than income level

- Initial questions: Rating of overall health, household size, number of family members between the age of 19 and 64, then…

- **To ask the right questions, we need to know whether in 2010, your (family's) total annual income from all sources, before taxes, was more or less than [X AMOUNT]**

  - **X AMOUNT determined using the 2010 weighted average poverty thresholds:**

    - **If family size = 1, threshold = $23,000**
    - **if family size = 2, threshold = $28,000**
    - **etc.**

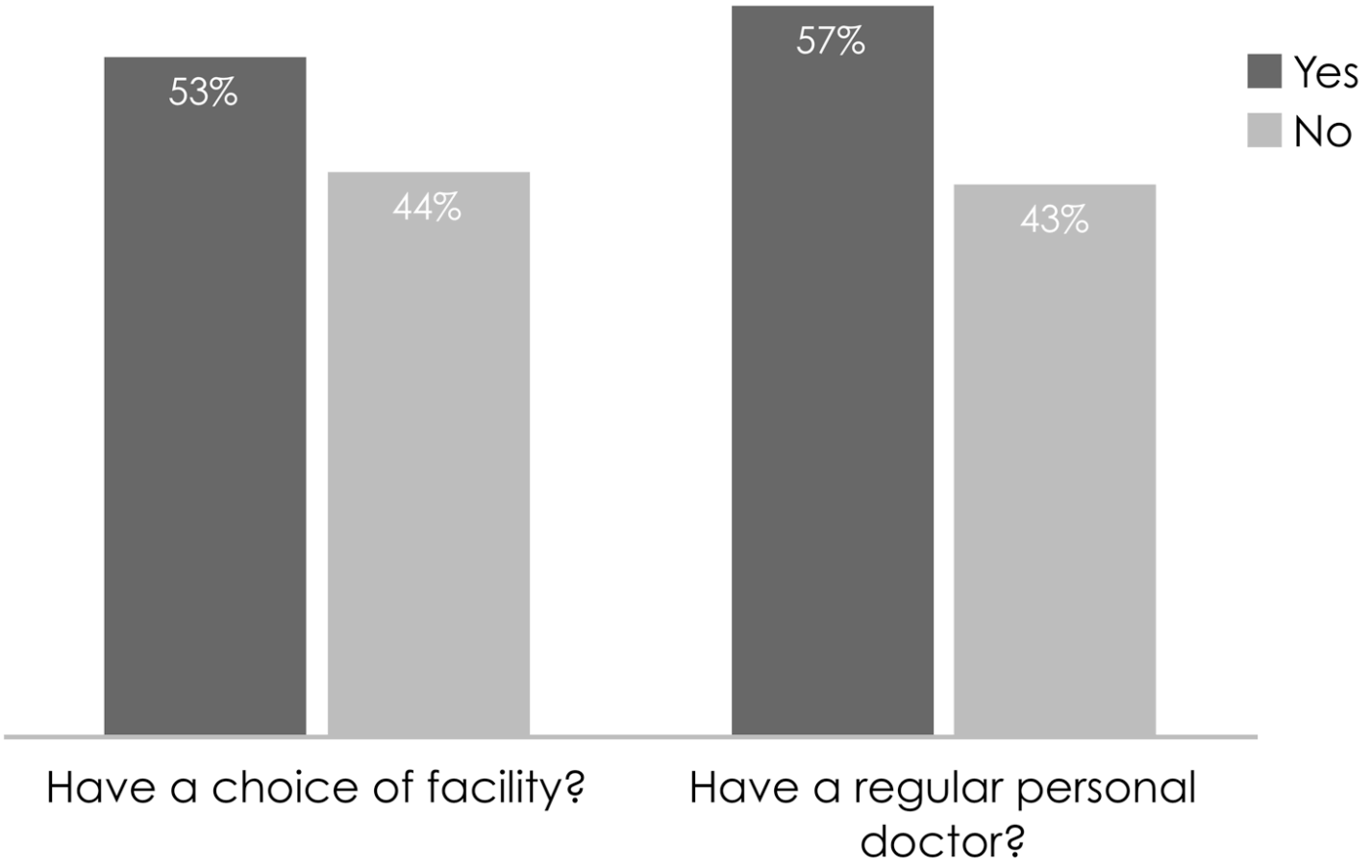
Results

- Use of targeted strata increased incidence, among age qualifying respondents, **from 32% to 46%**
- Using an income threshold: **96.5% of respondents answered** (compare with typical non-response for income question)
- 28-day field period, 10-call rule produced AAPOR 3 response rates of 29.3% LL, 19.8% CP (with 21 min QQ.)

Substantive Findings

choice and current care

low-income Californians



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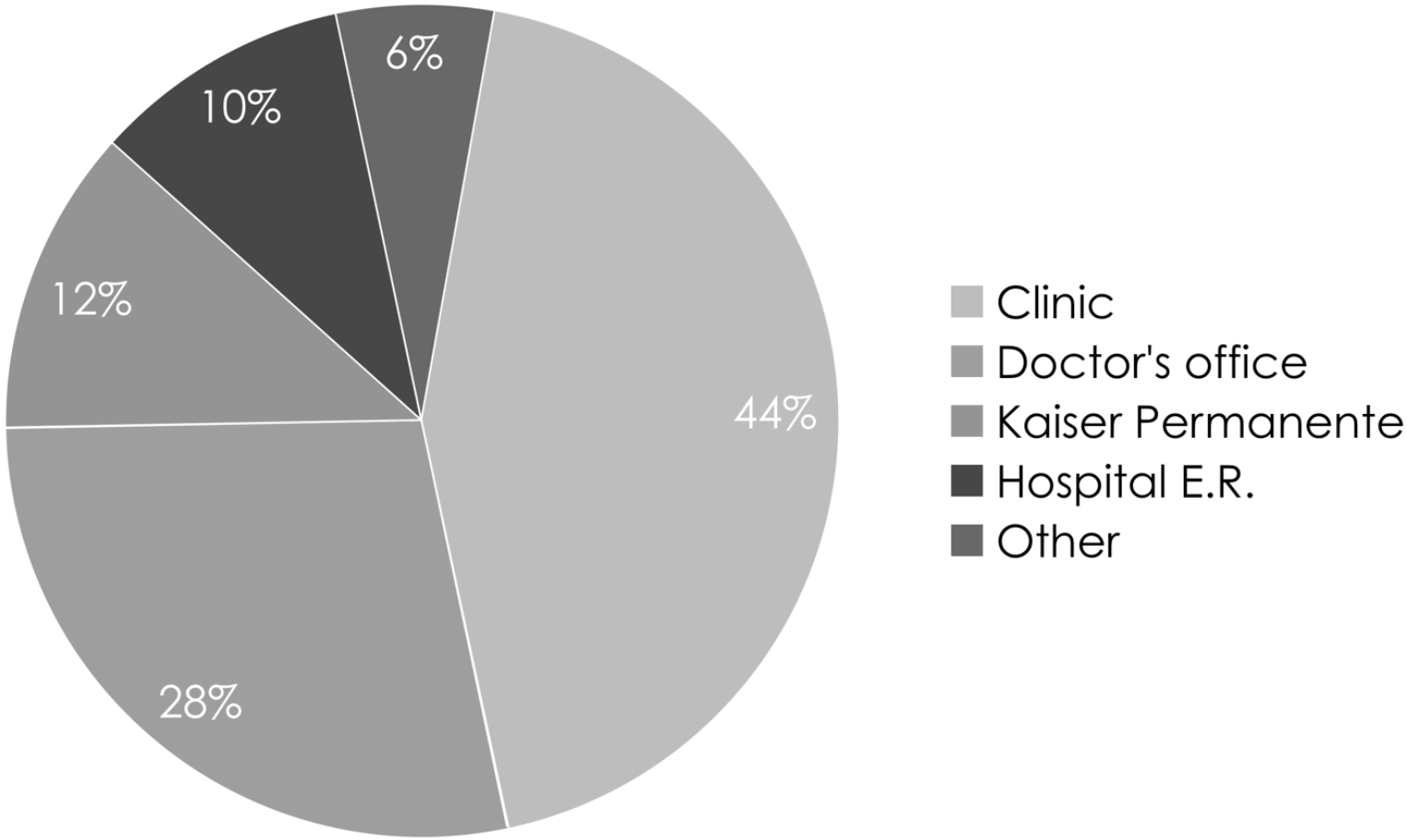
current use of facilities

low-income Californians



"Clinic" includes community clinics and health centers, public hospital, county or city, private, other clinics

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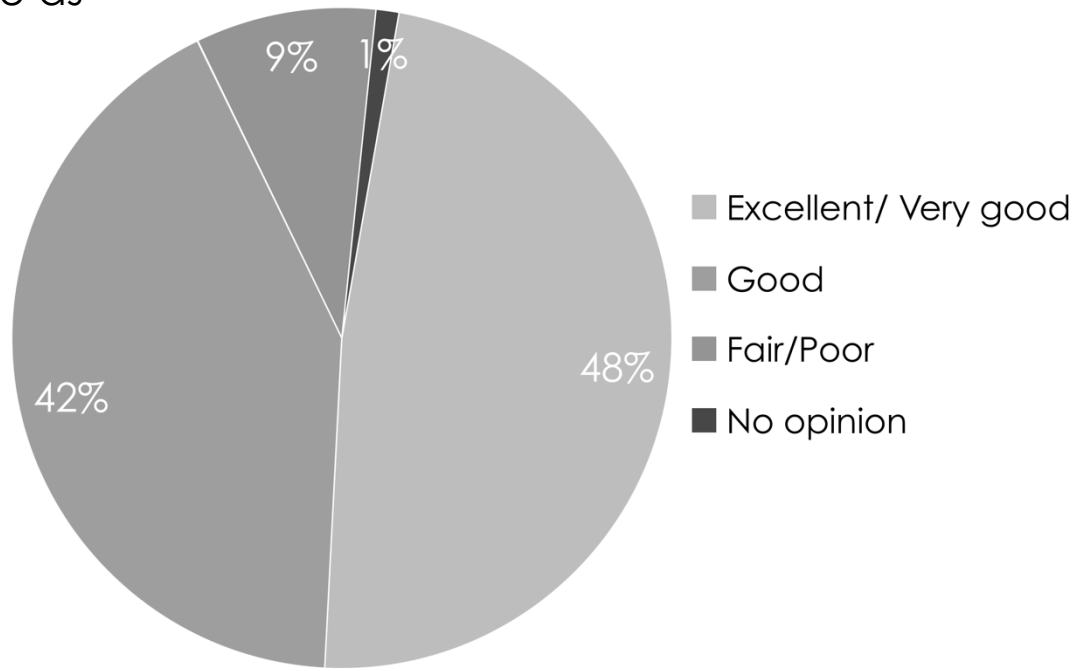
satisfaction with care

low-income Californians

fewer than half (48%) rate their care as excellent or very good

42% say their care is good

9%, not so good or poor



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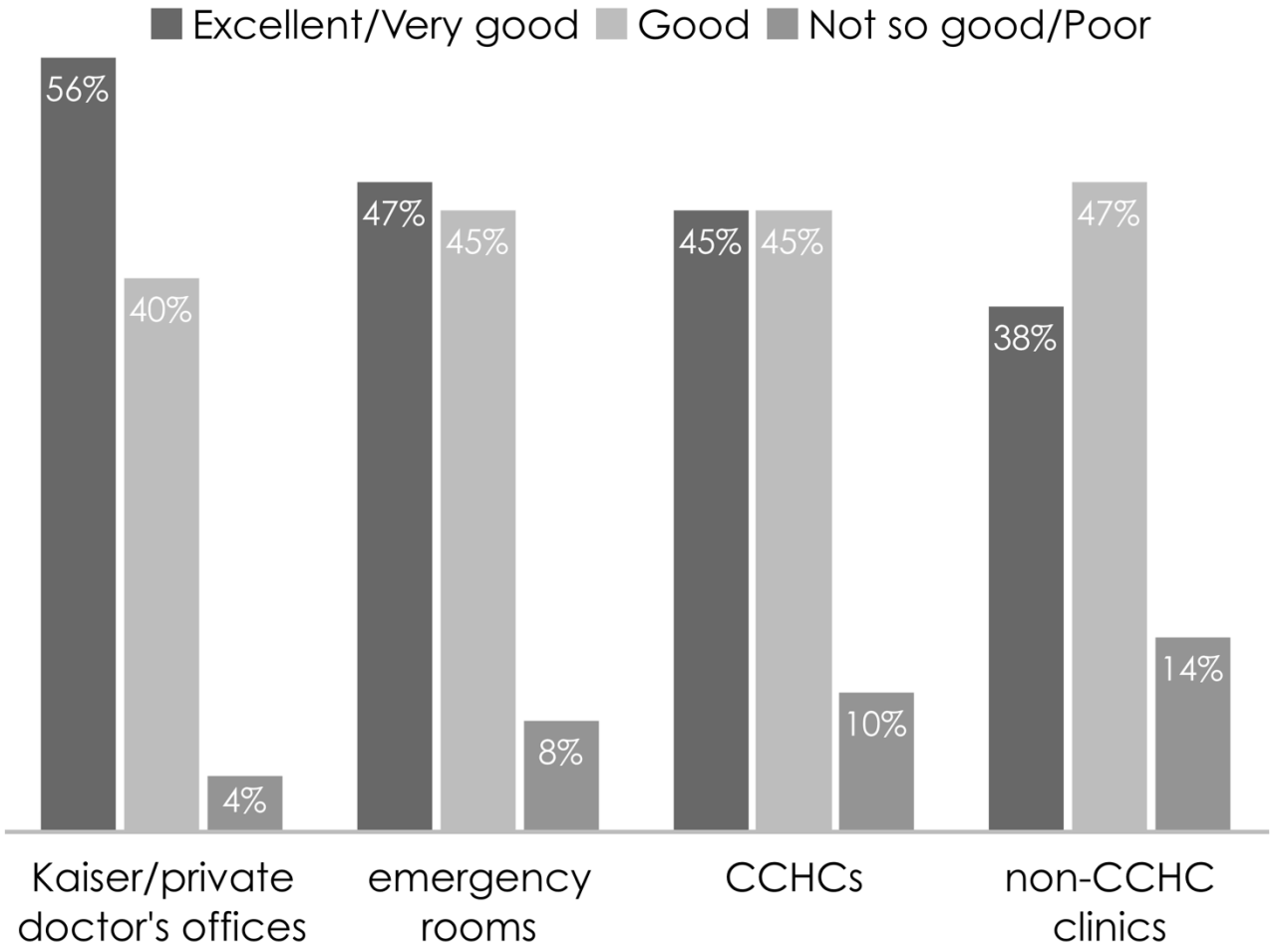
satisfaction with care

low-income Californians by facility type



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rating aspects of care

Excellent/very good ratings on specific aspects of care	
Cleanliness of facility	59%
Courtesy of staff	58%
Communication with doctor	55%
People 'like you' welcome there	56%
Convenience	54%
Understanding of your medical history	50%
Amount of involvement you can have in decisions	49%
Amount of time doctor spends with you	48%
Ability to see the same doctor each time	45%
Timely appointments	44%
Affordability	41%
Ability for family to get care at the same place	41%
Availability of continuing care	39%
Ability to see a specialist	38%
Time spent in the waiting room	31%
Availability on nights/weekends	20%

top predictors of satisfaction

low-income Californians

Statistical modeling reveals the prime determinants of overall satisfaction:

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

Controlled for demographics, facility type and overall health status

health needs vs. utilization

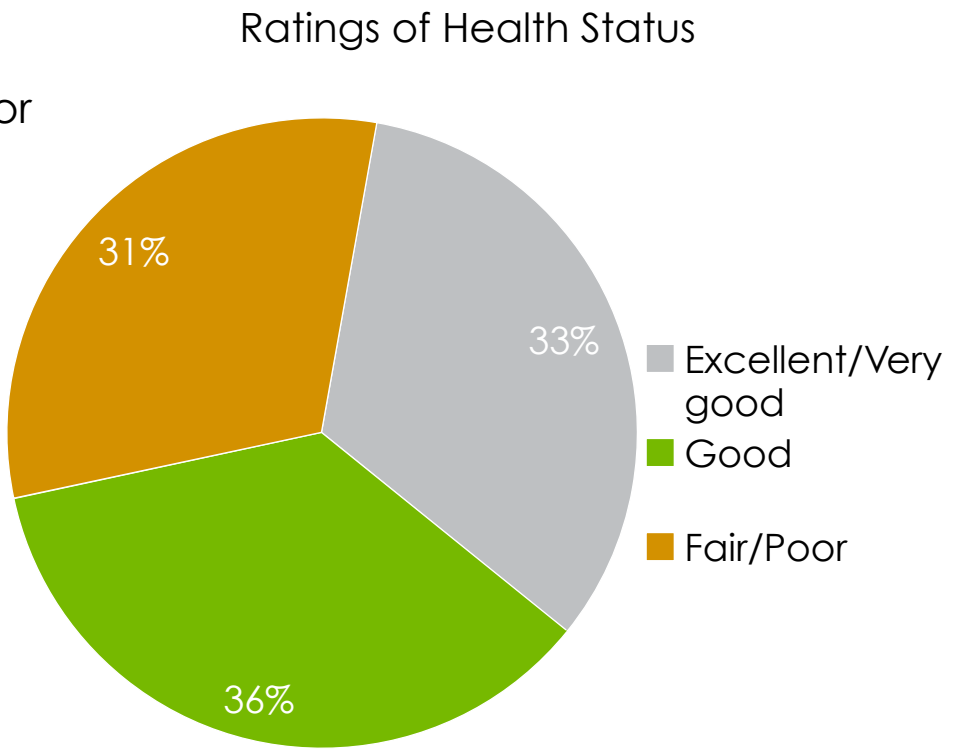
low-income Californians

A health-stressed population:

- Just a third say their health is excellent or very good
- Compares to 57% of all Californians (CHIS), 52% of all Americans (KFF)
- Three in 10 report a disability or chronic condition

But they're no more likely to get care

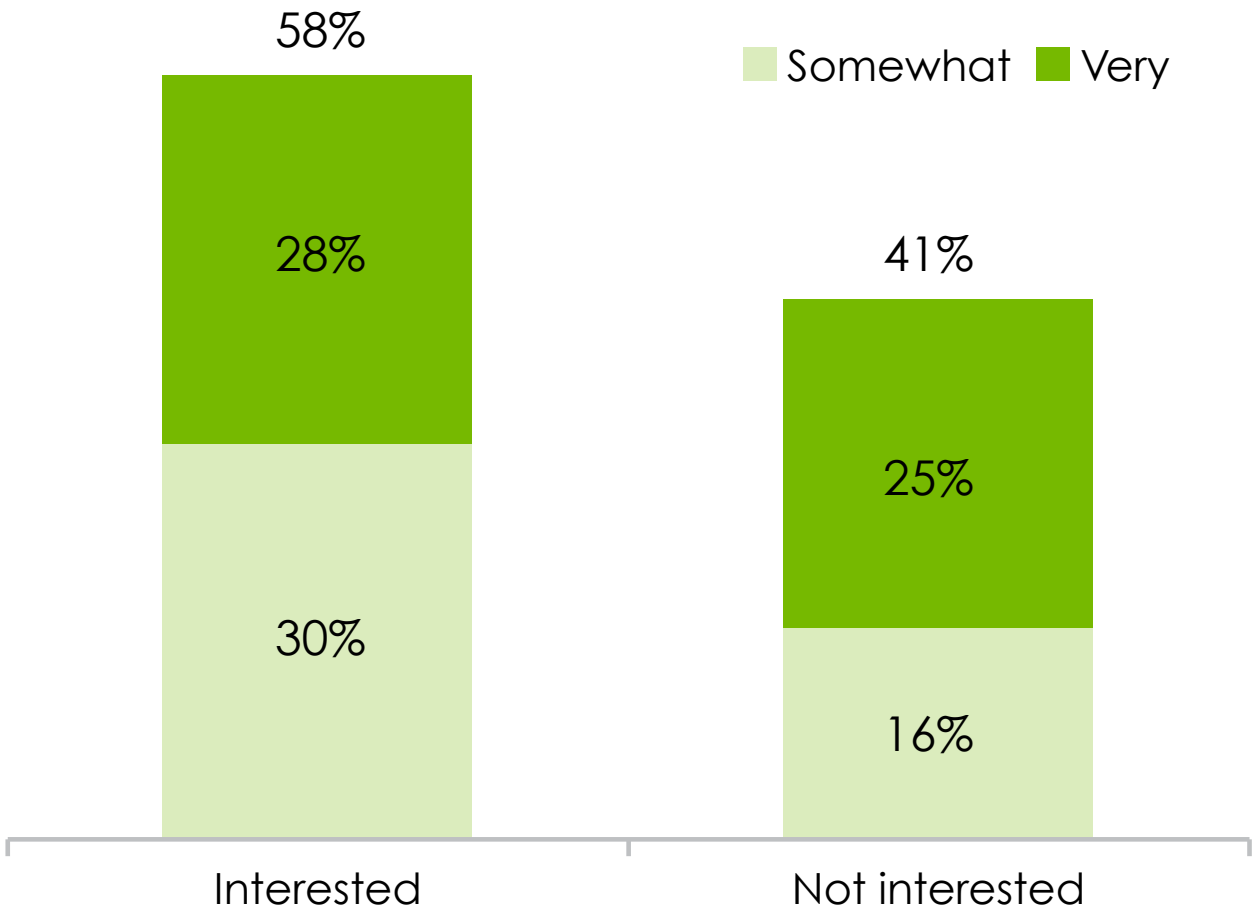
- 34% have seen a doctor once or less in the past year, compared to 31% of all Americans, 37% of all Californians



the future (ACA-shaped?)

broad interest in changing facility

low-income Californians



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groups most interested in change

- 86% of those who lack a personal doctor and want one are interested in changing healthcare facilities, as are…
- 73% of those who lack insurance
- 72% of those who say the care has deteriorated at their current facility
- 69% of those who rate their current care less than very good
- 69% of parents whose child's pediatrician is not at the same place they go to for care
- 67% of those who currently lack a choice of facility
- 66% of emergency room patients
- 63% of clinic patients
- 62% of those who are in less than very good health
- 62% of those under age 40

top predictors of interest in change

low-income residents of California

Statistical modeling reveals the prime determinants of interest in change:

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

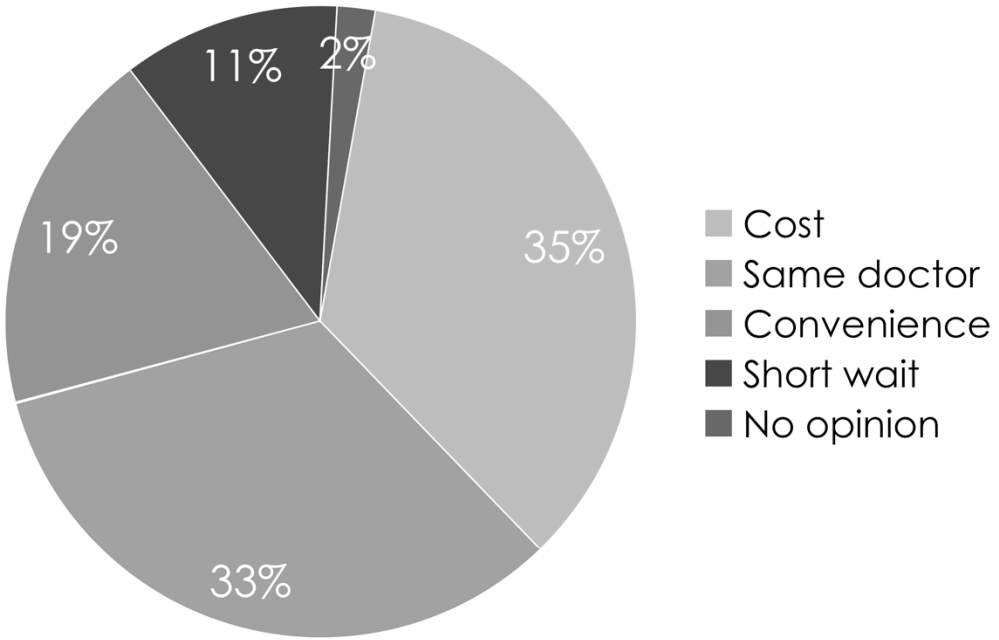
Controlled for facility type and overall health status

preferences in a facility

low-income Californians

Most important factor in the choice of a new health care provider

- As many prioritize being able to see the same doctor each time as cost
- Convenience and a short wait are viewed as most important by fewer, but about 1/3 combined



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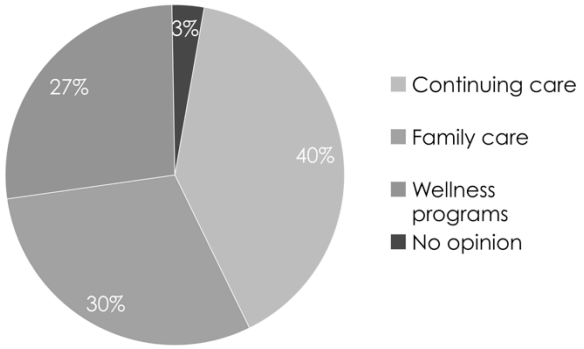
other priorities for change

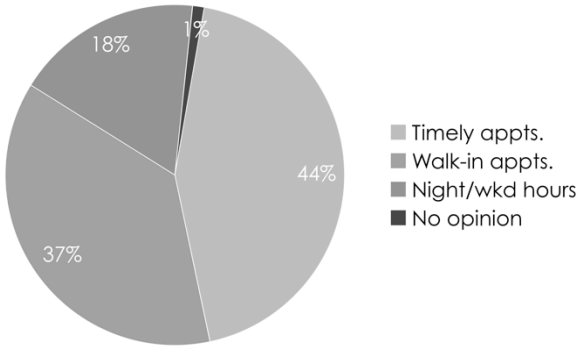
In terms of services

- continuing care for long-term problems, 40%
- services for other family members, 30%
- wellness programs, 27%



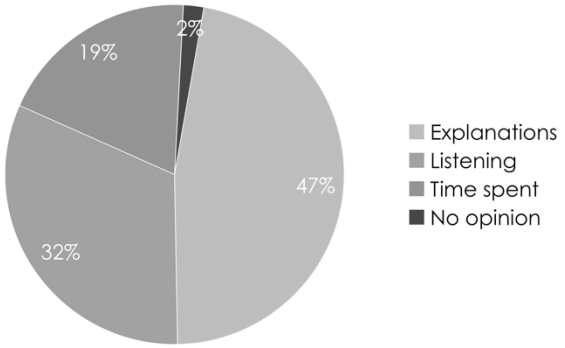
In terms of convenience

- appointment when you want one, 44%
- walk-in services, 37%
- night/weekend hours, 18%



In a doctor

- explains things well, 47%
- takes your opinions/concerns into account, 32%
- spends time with you, 18%



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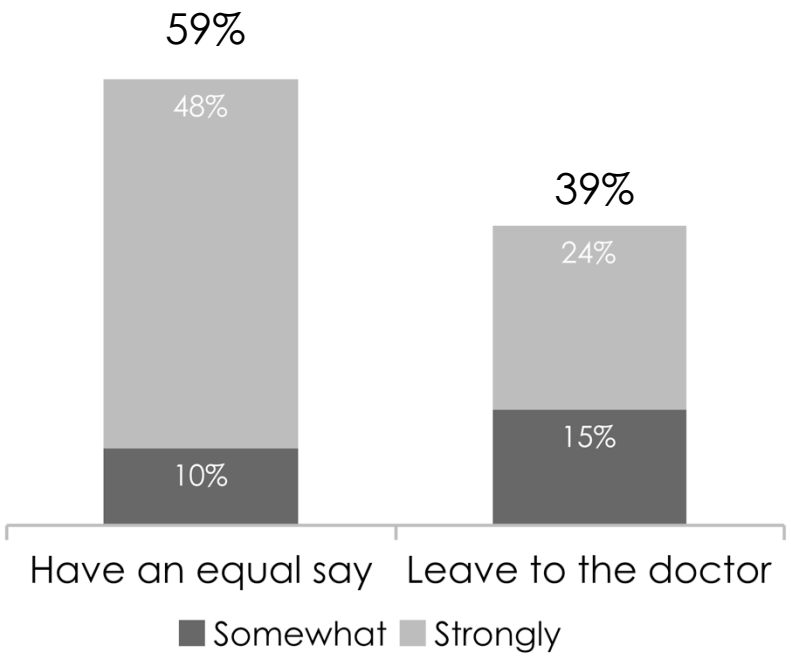
patient-centered care: views on shared decision-making

low-income Californians

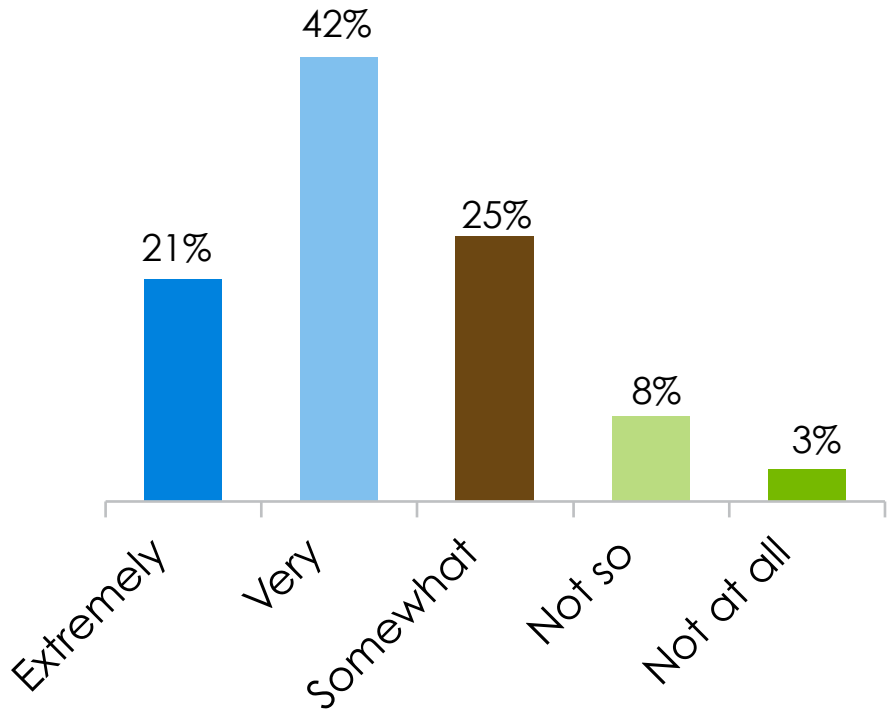


Prefer to have an equal say in health care decisions or leave decisions up to the doctor or nurse?

- Six in 10 say they want an equal say
- But still 39% prefer the more traditional model, with sizable differences among groups

views on a health care home

low-income Californians

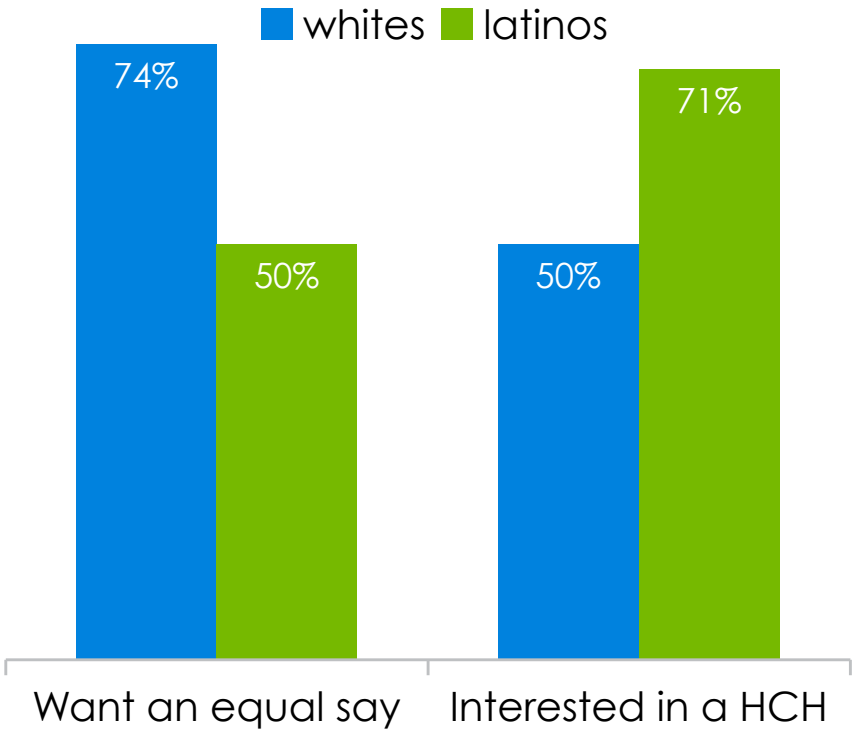


If you were choosing a new place to go for health care, how important would it be to you that they offer a variety of additional services beyond regular medical care?

- More than six in 10 say it's extremely or very important
- 36% say it's less important than that

one-size does *not* fit all

low-income Californians



Distinctly different groups are interested in having an equal say with their doctor than are interested in a health care home:

- Whites, citizens and high school graduates are all more interested in having an equal say with their doctor
- But those with less education, non-citizens, Latinos, and the uninsured are all more interested in a health care home

summary

Sampling challenges overcome:

- stratified sampling to increase efficiency and decrease expense
- income-threshold rather than income-level screening to protect against high non-response

Predictors of satisfaction:

- courtesy of staff
- involvement in medical decisions
- cleanliness/appearance of facility
- time spent with the doctor
- having a highly regarded personal doctor

Predictors of interest in change:

- wanting a personal doctor, quality of current care, insurance, age, lack of choice

Factors in choice:

- top priorities divide among cost, same doctor, convenience/wait-time
- many are interested in PCC - but about four in 10 are not

Rx for safety-net providers

- evaluate facilities and mix of services through the prism of patient preferences
- tailor focus to community characteristics
- watch for easy fixes – cleanliness, appearance and courtesy count
- understand and seek to meet the high value of a regular personal doctor and clear communication
- prepare for increased demand from a currently underserved population

Thank you

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