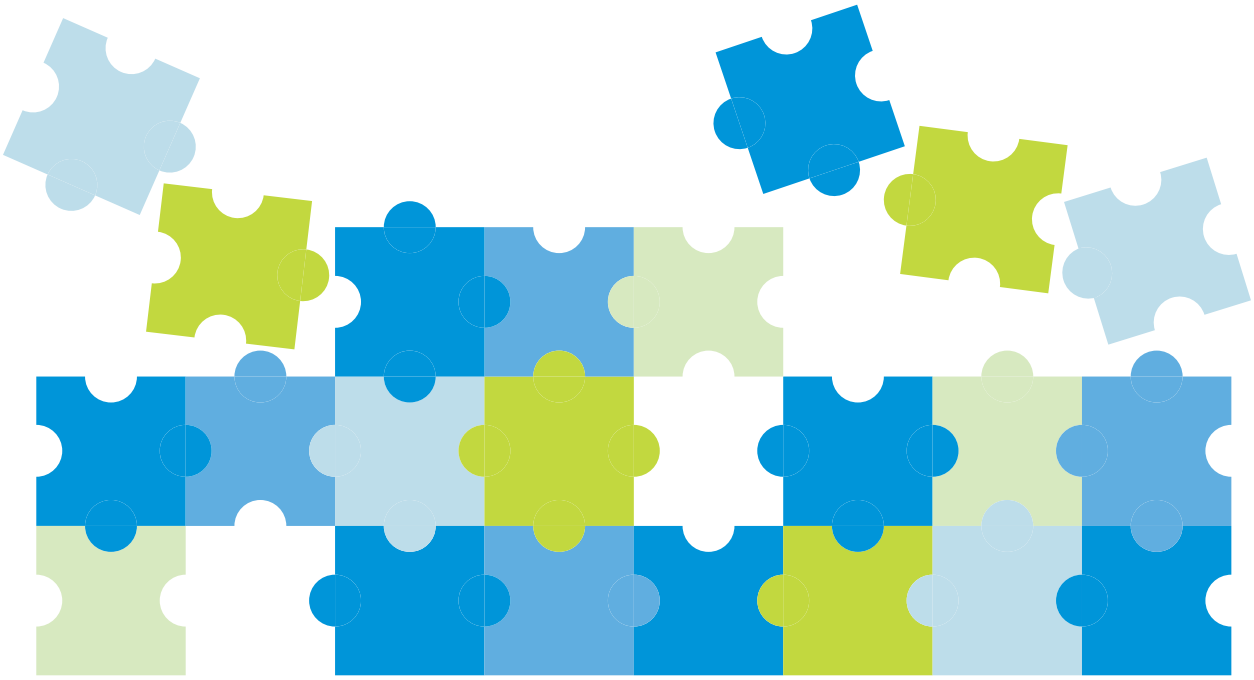
blue of california
foundation

exploring low-income Californians' needs and preferences for behavioral health care

March 2015



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introduction

Nearly 70 years ago, world health leaders from 61 nations recognized that "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." They understood then, and we – as human beings – have always been acutely aware, that the mind and body are inextricably connected. Unfortunately, the American healthcare system has only recently begun to acknowledge this reality.

Historically, behavioral and primary care systems operated and were funded independently. Support for mental health and substance use treatment was largely unavailable for low-income patients, creating a significant unmet need due to coverage limitations and high out-of-pocket costs. Thankfully, we are now experiencing a major expansion of behavioral health benefits, especially for those newly enrolled in Medi-Cal under the Affordable Care Act. Although affordability has improved and demand for services is on the rise, provider shortages and siloed systems remain.

In order to inform the continued transformation and integration of behavioral healthcare, we solicited the views of low-income Californians to understand their preferences, aspirations, and concerns. We know that these low-income residents not only experience a higher prevalence of mental health and substance use challenges, many face additional language and cultural barriers that prevent them from seeking needed support and services. Their voices are critical to guide the field forward.

The Foundation commissioned this research to help fuel the evolving conversation about behavioral health and its implications for California's safety net providers and patients. Building upon a series of surveys that began in 2011, this report reinforces the need to connect and simplify the systems that serve vulnerable patients. For example, its findings show us that patients prefer behavioral health services to be available in the same setting as their primary care, but many are not yet able to access services on-site. Throughout the report we see clear tensions that need to be addressed.

This research represents an important contribution to the broader dialogue taking place around health care generally, and behavioral health specifically. We look forward to continuing the discussion, and to our collective, ongoing work to improve the lives of all Californians.

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

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key terms

behavioral health issues: personal challenges that can arise in people's lives, these are defined in this survey as stress, emotional issues, drug or alcohol use, marital or family issues, or "just feeling down about things."

satisfaction: patients' positive ratings of their health care overall, their healthcare facility, and their relationships with their providers.

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

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

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

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

integrated care

For the purposes of this study, **integrated care** includes incorporating behavioral health services into the primary care setting to address mild to moderate behavioral health issues, or to refer more serious cases. Integration also can flow in the opposite direction, with behavioral care facilities incorporating primary care in their services.

executive summary

Dramatic changes are occurring in the provision of behavioral healthcare services to low-income Californians, driven both by increased insurance coverage and a new care paradigm, integrated behavioral health care. This Blue Shield of California Foundation report was produced to help safety net healthcare facilities in the state enhance their services by better understanding their patients' behavioral health needs, experiences, and preferences.

Behavioral health needs are defined in this survey as personal challenges that can arise in people's lives, including stress, emotional challenges, drug or alcohol use, marital or family issues, or "feeling down." Research has estimated that up to half of adults with such needs have not received services to help address them, largely because of cost, lack of coverage, reluctance to seek help because of stigma, or not knowing where to obtain services.

By expanding coverage, the Patient Protection and Affordable Care Act is expected to produce demand for services from an additional 300,000 Californians with behavioral health needs and 200,000 in need of substance abuse counseling. Many federally qualified health centers are expanding or initiating integrated behavioral health services to meet this anticipated demand.[1] Such services are based on the concept that behavioral and primary health care are best provided, to the extent possible, in a unified setting.

As the ACA increases coverage, integrated care can remove other barriers. Introducing behavioral health into the primary care environment reduces stigma and eases access for patients who may be reluctant to address their behavioral health needs. Behavioral health professionals, ideally within the same facility, coordinate with primary care providers to deliver appropriate counseling and substance abuse services, or referrals, as needed.[2,3]

Designed as a baseline assessment, this survey measures low-income Californians'[4] self-reported needs for behavioral health assistance, the service options available, their concerns or hesitations about using those services, and the factors that motivate them to seek help. Its findings reinforce previous research on the benefits of integrating mental health and substance abuse services into the primary care setting. Among the results:

- A broad gap exists between needs and treatment: Among low-income Californians who've felt a need to discuss behavioral health issues with a healthcare professional in the past year, only half have done so.

- Patients' interest in receiving behavioral health services at their primary care facility far exceeds the availability of such services. Many more say it's highly important that their facilities provide these services than say they currently have access to them. And six in 10 would rather discuss behavioral health issues with a professional at their primary care facility than with one located off-site.

- Comparatively few low-income Californians, 52 percent, rate their primary care providers highly for asking about stress, anxiety, or emotional issues they may have – indicating clear grounds for improvement.

- Behavioral health services are an element of a patient-centered approach. Patients who have such services available are much more apt than others to feel that someone at their care facility knows them well (known as connectedness), to see the same care providers over time (continuity), and to have strong patient-provider relationships overall. These, in turn, enhance patient satisfaction and loyalty and encourage patients to take an active role in their care.

the treatment gap in behavioral health care

Three in 10 low-income Californians say there's been a time in the past year when they've felt a need to talk with a healthcare professional about their behavioral health. Yet only half of those who felt such a need actually spoke with a professional about these issues, a non-treatment rate comparable to those found in other recent studies.

While the ACA expands coverage, this survey finds significant remaining impediments, including stigma, cultural and language barriers, and simply not knowing where to go for help. Each, however, is addressable, with clear benefits for patients and care facilities alike.

differences among groups

Some groups within the low-income population are more apt than others to have wanted to speak with a healthcare professional about behavioral health concerns in the past year. These include those with the lowest incomes; women; whites; U.S. citizens; English speakers; and those who have lower self-reported health status, a chronic condition, or who visit their primary care provider especially often. Most of these align with previous research on group differences in self-assessed need for such services.[5]

Some of these groups also are more likely to have gone ahead and spoken with a healthcare professional about behavioral health concerns – those with a chronic condition, those who visit providers comparatively often, U.S. citizens, English speakers, and the very poor.

It follows that non-citizens and non-English speakers, for their part, are among those who both are less apt to say they need help for a behavioral health issue, and to get help. Clinics, with their cultural and linguistic competence, are particularly well-positioned to help such patients recognize a need for such treatment should it arise, and to obtain that assistance.

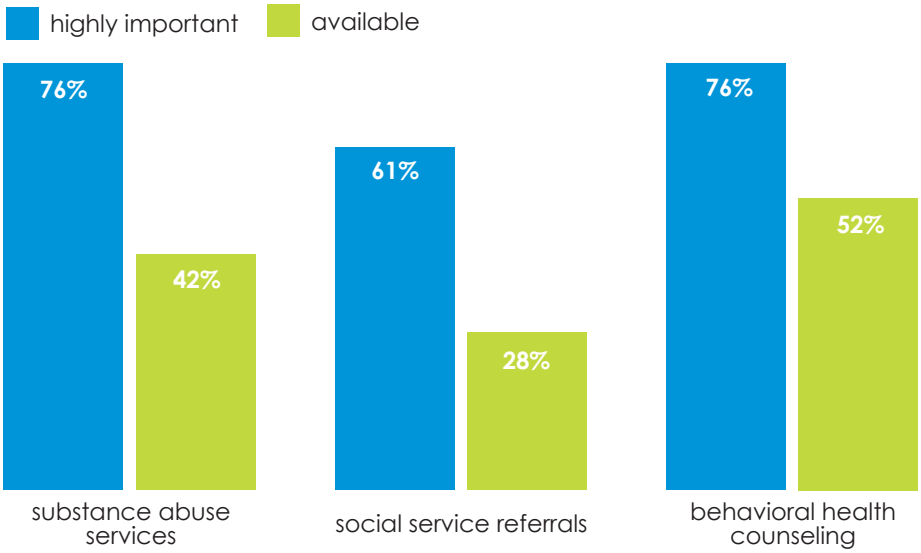
The survey also finds an income gap in treatment. While low and higher-income Californians are equally likely to have wanted to talk with a healthcare professional about their behavioral health in the past year, two-thirds of higher-income patients who needed help actually obtained it, compared with half of those with lower incomes. Among other factors, that reflects higher-income patients' greater comfort talking with a provider about these issues, as befits their level of connectedness and continuity and stronger patient-provider relationships. Improving these in the lower-income population would help to close the treatment gap.

importance of services vs. their availability

As noted, the survey finds a division between the perceived importance of behavioral health services and their availability. Three-quarters of patients say it's extremely or very important to them to have access to a counselor at their place of care. About half say one actually is available.

Three-quarters also see it as highly important to have drug or alcohol counseling at their facility, while only four in 10 say such services are available.[6] There are differences, as well, in perceived importance vs. availability of team-based care, a healthcare navigator,[7] and referrals to social services, all of which can support integrated behavioral health care models.

importance vs. availability (among low-income Californians)



Behavioral health services reflect patient-centeredness; healthcare facilities offering them are more likely to provide healthcare navigators and team-based care, and their patients are more apt than others to

exhibit connectedness and continuity, to be satisfied with their care, and to take an active role in it. Notably, preference for on-site counseling is much higher among patients who have strong personal connections at their care facilities.

talking with healthcare professionals about behavioral health issues

The survey also finds that a patient-centered approach is strongly related to patients' willingness to engage in behavioral health services.[8] Those who've needed help are about twice as likely to have spoken about it with a healthcare professional if they feel that someone at their facility knows them well, usually see the same primary care provider at each visit, say they have a regular doctor or rate their primary care provider's performance highly, compared, in each case, with their opposites.[9]

Similarly, talking with a professional is much more common among empowered patients, meaning those who are highly informed, confident, and comfortable being involved in their care. And it's far likelier among engaged patients, those who take an active role in their care decisions.

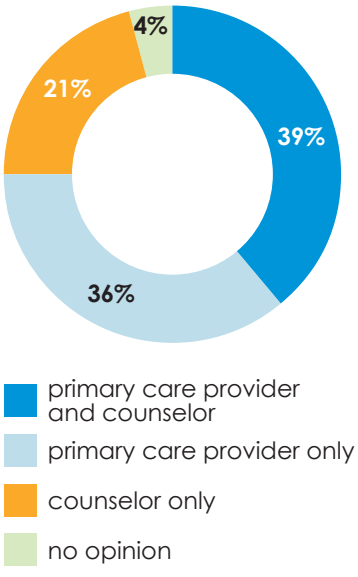
Together these findings suggest that delivering integrated behavioral health services is most effective in primary care settings where strong patient-provider relationships exist. But the opposite may also be true – that delivering behavioral health care improves such relationships.

Regardless, patients at facilities where counselors are available are nearly twice as apt as others to have spoken with a healthcare professional about their behavioral health when they felt the need to do so. Discussing these issues also is about twice as prevalent among patients who give positive ratings to their primary care providers. Those results indicate the dual importance of on-site counselors and the availability of primary care providers to address such needs.

Other findings also confirm the key role of primary care providers. Among low-income patients who've spoken with a healthcare professional about behavioral health issues in the past year, four in 10 say they talked with both their primary care provider and a counselor, and 36 percent spoke with their primary care provider only. The remainder, 21 percent, spoke only with a counselor.[10] Notably, patients are equally likely to say talking with a healthcare professional was extremely or very helpful, regardless of whether it was a primary care provider or a counselor.

That said, given a choice, low-income Californians say they'd prefer to talk about such issues with a counselor rather than their primary care provider, 57 vs. 35 percent. This could reflect a preference for specialists, a lack of familiarity in talking with primary care providers about such issues – and, as the results suggest, shortcomings among some providers in showing that they're open to discussing behavioral health issues.

if talked to a healthcare professional, who did you talk to? (among low-income Californians)

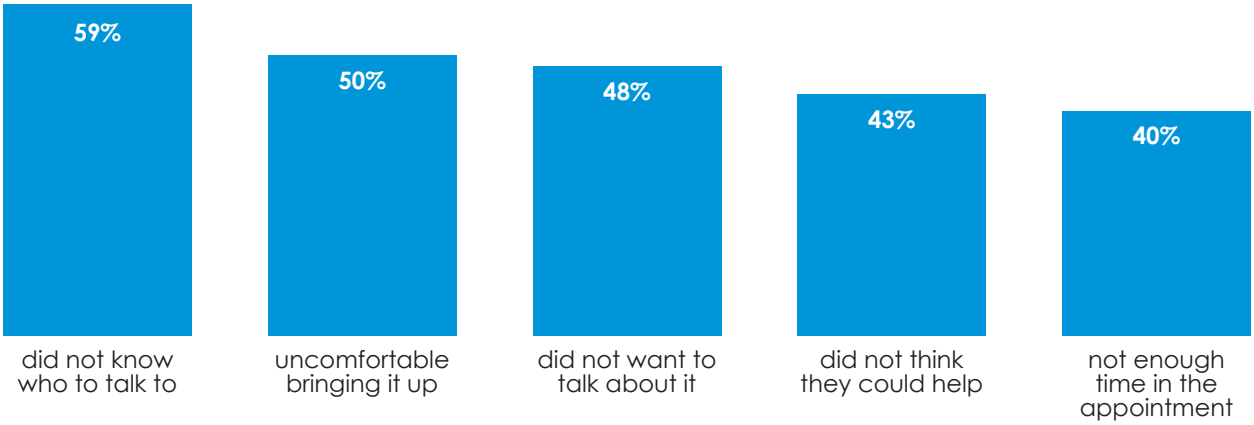


comfort communicating about behavioral health

Regardless of whether or not they've spoken with a healthcare professional about a behavioral health issue, six in 10 low-income Californians say they'd be extremely or very comfortable talking with their primary care provider about stress, anxiety, or emotional issues.

However, among patients who say there was a point in the last year when they needed help with a behavioral health issue but didn't talk about it with a healthcare professional, 59 percent say they didn't know whom to talk to. This suggests that facilities should ensure they're making their patients aware that help is available, and how to obtain it.

% saying each item is a reason for not speaking with a healthcare professional about behavioral health issues (among low-income Californians)



Indeed, many primary care providers often don't sufficiently assess how their patients are doing in terms of behavioral health. As mentioned, slightly more than half rate their primary care providers highly for asking about stress, anxiety, or emotional issues they may have, lowest among six behaviors on which primary care providers were tested.[11] That shows substantial room for improvement in creating an environment in which patients feel comfortable raising such issues.

The impact of such efforts is clear. Empowered and engaged patients are much more apt than others to express comfort discussing their behavioral health, and thus to tap into the resources being offered.

opportunities to improve behavioral health treatment

Integrated care is effective in expanding needed behavioral health treatment for low-income Californians. By including behavioral health in regular primary care visits and offering on-site counseling, facilities that integrate behavioral health and primary care are better positioned to de-stigmatize such care and address patients' lack of knowledge about where to get help.

Primary care providers who inquire about behavioral health and put their patients at ease talking about it vastly improve the chances their patients will seek assistance. Team-based care that incorporates behavioral health professionals into the primary care setting represents an especially encouraging avenue to integrated care. And the benefits of connectedness and continuity, strong patient-provider relationships, patient empowerment, and engagement apply directly to behavioral health. Each is strongly related to comfort talking about behavioral health needs and the likelihood of getting help.

The importance of patients' relationships with their primary care providers, combined with the majority's preference to talk with a trained counselor about behavioral health issues, suggest a two-pronged approach to integrated care. Taken together, the efforts of primary care providers and the availability of behavioral health counselors can provide coordinated paths to assessing and delivering the care patients need.

Taking these steps to integrate physical and behavioral health care has the potential to dramatically improve behavioral health treatment for low-income Californians. And such efforts can do still more – deepening the quality of patients' relationships with their care providers and healthcare facilities, and in doing so, enhancing patients' satisfaction, loyalty, and engagement in their physical and behavioral health care alike.

endnotes

1 See Appendix A for a review of relevant previous research, including the sources of these estimates.

2 The terms "behavioral health professional" and "counselor" are used interchangeably in this report to refer to providers who specialize in behavioral health treatment. The terms "primary care provider" and "provider" are used to refer to non-specialist primary care providers. The term "facility" refers to the primary care facility that patients use, e.g., a clinic, private doctor's office, or Kaiser Permanente location.

3 This study focuses on providing behavioral health services in primary care settings, given its wide applicability to most patients' experiences. Care also can be integrated in the other direction, with behavioral health facilities bringing primary care services into their models.

4 Low-income Californians are defined in this study as those with household incomes less than 200 percent of the federal poverty level.

5 See the literature review, Appendix A, for details.

6 The nature of these services – e.g., whether available by referral, from an in-house substance abuse specialist or from a primary care provider – was not specified.

7 Navigators, also known as healthcare coaches, help patients with appointments, information, and services.

8 This result echoes previous Foundation research. See, for example, *Connectedness and Continuity: Patient-Provider Relationships among Low-income Californians*, Blue Shield of California Foundation, June 2012.

9 Frequency of seeing the same provider is based on a question asking patients how often they see the same healthcare provider at their facility – every time, most of the time, some of the time, rarely, or never. A separate question asks patients, regardless of frequency, whether or not they feel they have a "regular personal doctor." As covered in previous reports, the former is the stronger independent predictor of patient engagement.

10 A counselor was defined as a therapist, social worker, psychologist, or psychiatrist.

11 The survey asked patients to rate their primary care providers on how well they explain things in an understandable way; provide treatment choices; provide clear information; encourage patients to ask questions; ask about stress, anxiety, or emotional issues; and, ask if there's anything else patients want to discuss.

project overview

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

In 2014, the Foundation conducted a follow-up survey that resulted in two reports. The first report based on that survey, ***Delivering on a Promise: Advances and Opportunities in Health Care for Low-income Californians***, built on the Foundation's previous research in two ways, repeating basic patient experience, satisfaction, and loyalty questions from 2011, and adding measurement of patient-provider relations, empowerment, and engagement from subsequent studies.

This, the second from the 2014 survey, focuses on behavioral health issues and integrating primary and behavioral healthcare. Among the research questions it addresses:

- How many low-income Californians felt they needed help with a behavioral health issue in the past year? How many actually sought such help, and from whom?

- What behavioral health-related services are available to patients at their primary care facilities? How important are these services to patients?

- What barriers prevent patients with behavioral health needs from seeking help? What factors are related to their likelihood of getting help? How can comfort talking with healthcare professionals about behavioral health issues be enhanced?

- What models of behavioral healthcare services do patients prefer, and what factors influence those preferences?

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

Sampling, survey field work, and data tabulation have been carried out each year by SSRS/Social Science Research Solutions of Media, PA. The latest interviews were conducted in English and Spanish on landline and cellular telephones from Aug. 14 to Oct. 5, 2014, among 1,033 low-income

Californians and 513 with higher incomes. The margin of sampling error is plus or minus 4 percentage points for the low-income sample and 5 points for the higher-income sample, including design effects.[12]

This report was produced and analyzed by Langer Research Associates of New York, N.Y., led by Gregory Holyk, Ph.D., research analyst and lead writer; with Gary Langer, president; Julie E. Phelan, Ph.D.; and Damla Ergun, Ph.D.

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

Blue Shield of California Foundation, long a thought leader in safety net healthcare, has sponsored this research as part of its mission to improve the lives of Californians, particularly underserved populations, by making health care accessible, effective, and affordable for all Californians. The Foundation in particular has a history of support for the state's community health centers through its Community Health Center Core Support Initiative and Clinic Leadership Institute offerings.

endnotes

12 See Appendix A of this year's first report, *Delivering on a Promise: Advances and Opportunities in Health Care for Low-income Californians*, for methodological details and Appendix D for the full survey questionnaire.

sections guide

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

- **section i:** the treatment gap in behavioral health care. Patients' needs to talk with a healthcare professional about behavioral health problems vs. their actually getting help. Group differences in such needs.

- **section ii:** importance of services vs. their availability. Perceived importance of integrated behavioral health services compared with access to them, including counseling, substance abuse services, and referrals to social services. Preference for on-site counselors.

- **section iii:** comfort talking with a healthcare professional. Patients' level of comfort talking with a healthcare professional about behavioral health issues, their reasons for not doing so, and opportunities for healthcare providers to increase comfort levels.

- **section iv:** getting help with behavioral health issues. Factors related to getting help for stress, anxiety, or emotional issues when needed. Preference to talk with a primary care provider or a behavioral health counselor, and the preferred location of such care.

- **section v:** conclusions and recommendations.

In addition to conclusions and recommendations, the report includes appendices with a review of the relevant literature on integrated care, topline results, and references.

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

section i: the treatment gap in behavioral health care

Three in 10 low-income Californians say there's been a time in the past year when they've felt a need to talk with a healthcare professional about stress, emotional issues, drug or alcohol use, or related concerns. Yet only half of them actually did so.

That sharp division, which aligns with findings from previous studies, is influenced by a variety of factors. As covered in the literature review (see Appendix A), these include cost concerns, lack of insurance, perceived stigma, cultural and linguistic barriers, and difficulties accessing counseling.

This study finds highly promising routes to addressing the shortfall in behavioral health care. These include efforts to help patients feel more personally connected with their care facility, to build greater continuity in their care, and to strengthen patient-provider relationships. Integrated behavioral health services, an effort to break down traditional barriers between physical and behavioral health care, are well positioned to help accomplish these goals.

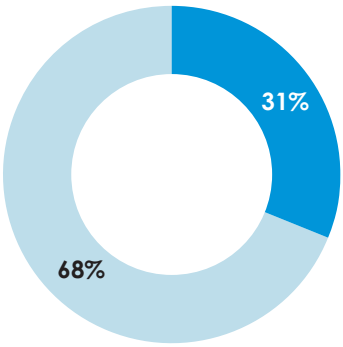
The need for expanded efforts is great, given the increased demand likely to follow the rise in insurance coverage under the ACA. As discussed in a previous report of data from this study, the number of low-income Californians without health insurance was sliced in half in the first year of the law's full implementation. One study has predicted that the ACA will produce 300,000 new patients for behavioral health services and 200,000 for substance abuse services in California alone.

As coverage expands, integrated care can address other barriers to behavioral health care. Previous Foundation research has established the vital importance of connectedness – feeling that someone at your place of care knows you well – and continuity, an ongoing relationship with the same primary care provider, in patient-provider relationships and patient satisfaction. These apply here as well, with connectedness and continuity related both to greater comfort talking about behavioral health concerns and greater likelihood of patients getting the counseling they need.

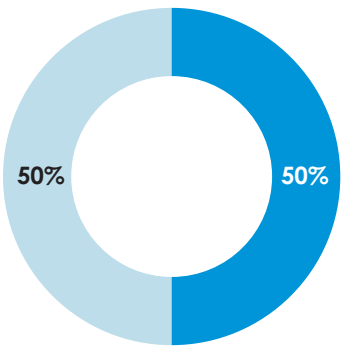
differences in need among groups

A look at these issues starts with who reports a need for help. Among other groups, women are more apt than men to say they've needed help with

needed to talk about a behavioral health issue (among low-income Californians)



if needed to talk, actually talked with a healthcare professional (among low-income Californians)



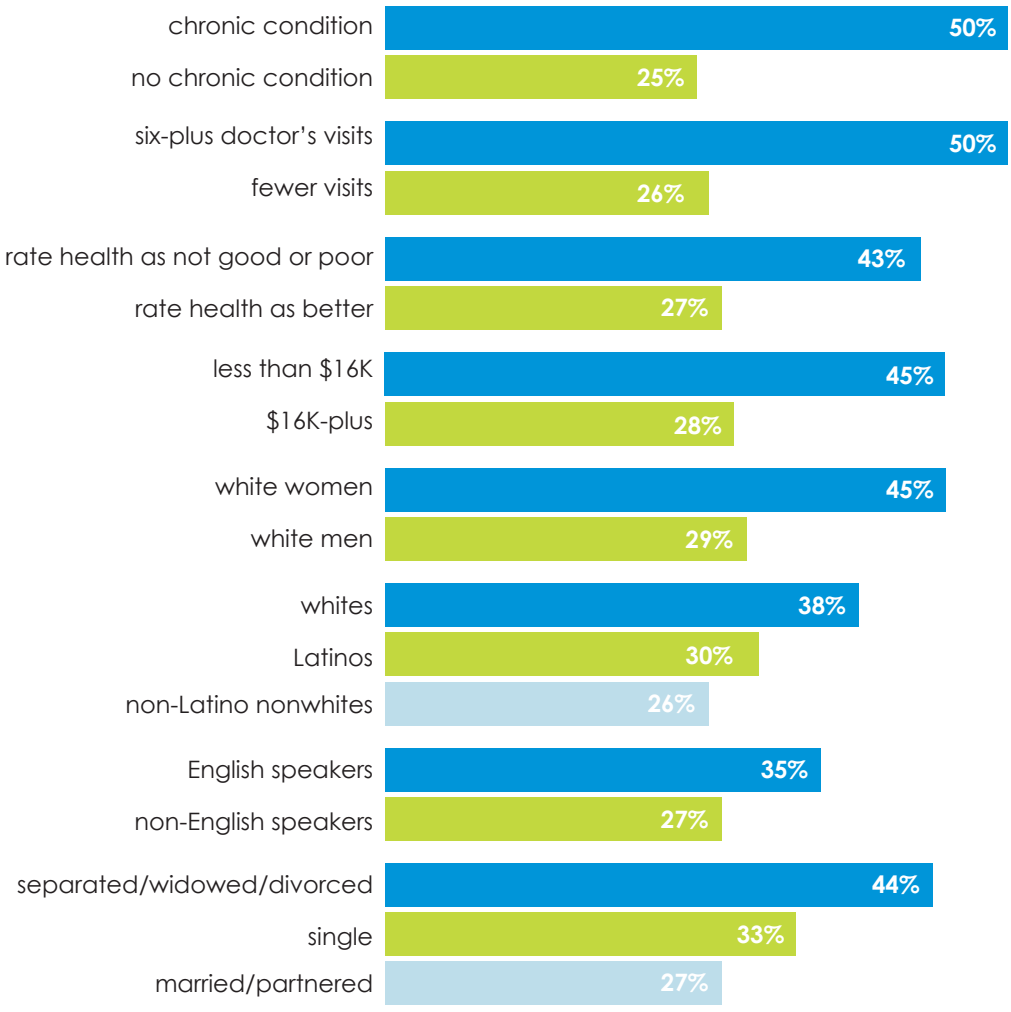
yes

no

a behavioral health issue in the past year – due almost entirely to greater self-reported need among white women compared with white men – and whites overall are more likely than nonwhites to report needing help. These findings dovetail with the literature, which suggests that women and whites are more willing to report a need for assistance with issues that may carry a social stigma. (Also, those who are separated, widowed, or divorced are more apt than people who are married or living with a partner to say they've needed help.)

Replicating the findings of several previous studies, including a 2011 report by the Center for Behavioral Health Statistics and Quality, people with greater physical health challenges are much more likely than others also to say they've needed help for behavioral health issues. Half of those with a chronic condition say they've had a behavioral health need in the last year, vs. a quarter of those without a chronic condition. The results are comparable among patients who rate their health negatively, and who visit their facility more often, compared with others.

% who wanted to talk with a healthcare professional about behavioral health concerns in the past year (among low-income Californians)



By income, reporting a behavioral health need peaks among especially poor Californians, those with family incomes less than $16,000 a year. Other studies have suggested that behavioral health issues are more prevalent among the less well-off; this finding indicates that increased need appears, in particular, among the very poor.

These results describe who currently feels a need for counseling. The next section details desires for such services more generally – regardless of personal need – as well as their availability. Sections III and IV then examine comfort talking with a healthcare professional about behavioral health issues, and actually doing so.

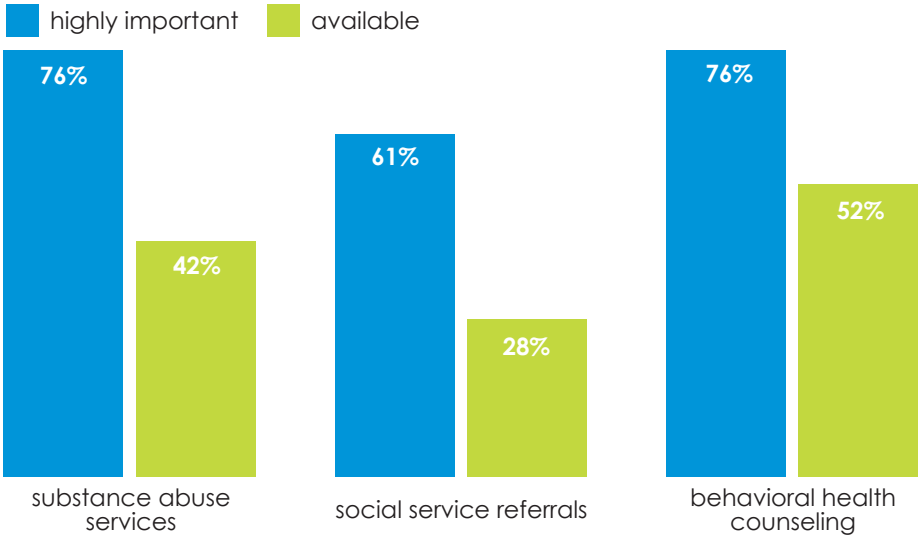
section ii: importance of services vs. their availability

Regardless of their own self-reported need for counseling, large majorities of low-income patients say it's highly important for their facility to offer behavioral health services. Far fewer, though, say such services currently are offered.

While 76 percent say it's extremely or very important to have access to a behavioral health counselor at their primary care facility, 52 percent say such counseling is available. Seventy-six percent also call substance abuse services highly important; again fewer, 42 percent, say they can get this kind of help at their place of care. And 61 percent see referrals to social services (such as help with housing and employment) as highly desirable, while just 28 percent say these are available.

There's also higher interest than availability in team-based care and healthcare navigators (individuals who help patients with appointments, information, and services), both of which can be a part of integrated care programs. While seven in 10 say it's highly important for their facility to offer team-based care (which can include behavioral health specialists), many fewer, three in 10, say it's offered at their place of care. And while two-thirds of low-income patients see access to a navigator as highly important, only two in 10 report having one available to them.

importance vs. availability (among low-income Californians)



A critical result demonstrates the importance of availability: Patients who have a counselor available at their place of care are twice as likely as others to have discussed behavioral health issues with a healthcare professional. This finding strongly supports suggestions in the literature that the availability of integrated care increases the likelihood that patients will get needed treatment. (In another positive finding, those who have a counselor at their facility also are more likely than others to think that this is highly important, 81 vs. 70 percent.)

There are differences in availability of services by facility type. Low-income patients at community clinics and health centers (CCHCs) are more likely than others to report having access to social service referrals. Those in the Kaiser Permanente system are much more likely than others to say they have access at their place of care to a counselor and to substance abuse services.

availability of behavioral health-related services (among low-income Californians)

	counselor	substance abuse services	referrals to social services
kaiser permanente	77%	57%	29%
all clinics	50%	42%	31%
CCHC	55%	43%	38%
non-CCHC	46%	41%	26%
private doctor	42%	34%	21%

Behavioral health and substance abuse services generally are more likely to be available at facilities that also have healthcare coaches, team-based care, and patients who have continuity and connectedness. The benefits can be profound: Patients at such facilities are more apt to be empowered to take a role in their care, and to give their facilities higher satisfaction ratings virtually across the board.

section iii: comfort talking with a healthcare professional

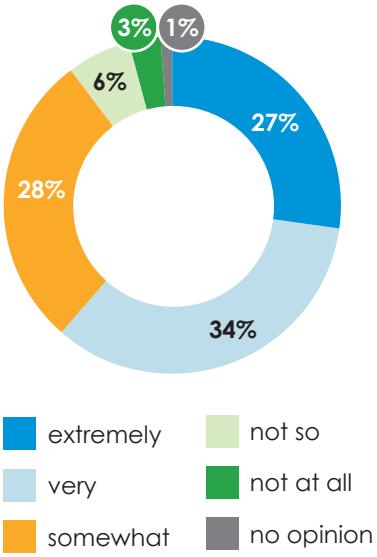
As the literature on behavioral health highlights, much of the opportunity for progress in identifying and treating behavioral health issues lies in creating an environment in which patients feel comfortable enough to talk about sensitive and often stigmatized issues.

Helpfully, six in 10 low-income Californians say they'd feel a great deal of comfort talking with a primary care provider about stress, anxiety, or emotional issues. But that leaves a substantial number who are less comfortable, and other results indicate the stigma that some feel. Among those who've felt a need to discuss such issues but haven't done so, half say they were uncomfortable bringing it up, and half also say they "didn't want to talk about it."

Integrated care can help with these concerns: Incorporating behavioral health care into the primary care setting signals to patients that it's as normal to talk about these issues as other health concerns, helping to reduce stigma and worries about discrimination.

Beyond stigma, previous findings point to cost or lack of insurance as prime reasons for not getting needed behavioral health treatment. This survey adds another key factor – lack of knowledge about where to go for help. Six in 10 of those who needed help but didn't get it say they simply didn't know who they'd talk to. Primary care facilities can address this shortcoming through integrated care, by involving primary care providers in behavioral health outreach – even simply by asking patients how they're doing emotionally – and by using healthcare navigators to steer patients in the right direction.

comfort level talking to primary care providers about behavioral health concerns (among low-income Californians)



factors in comfort discussing behavioral health issues

The nature of patient-provider relationships is directly related to patients' comfort in talking with a healthcare professional about behavioral health issues (as well as their actually doing so, covered in the next section). Patients who feel a personal connection with someone at their place of care, often see the same primary care provider, say they have a regular doctor, have a healthcare navigator or have team-based care all express more comfort in talking with their primary care provider about their behavioral health.

There are similar links between comfort talking about behavioral health, on one hand, and patients' satisfaction overall and ratings of primary care providers on a range of patient-focused behaviors. And patients who say their facility has a counselor available are much more apt than others to be highly comfortable with these conversations.

These results reflect not only what providers do, but how patients respond. Those with personal connections, continuity, and strong relationships exhibit empowerment – understanding their health problems and feeling confident and comfortable being involved in health decisions – and engagement, meaning they in fact take an active role in their care. Empowered and engaged patients are about twice as likely as those who lack these attributes to feel highly at ease talking with their primary care providers about behavioral health concerns.

It's important to note that asking about emotional health issues interacts with comfort discussing them. Among people who rate their primary care provider highly for raising the subject, 81 percent are highly comfortable discussing it. Among those who rate their provider lower for asking, comfort drops sharply, to 39 percent.

Beyond these powerful connections, one difference among groups stands out: CCHC patients are 11 points more apt than those who go to non-CCHC clinics to say they'd be at ease talking with their primary care providers about behavioral health issues. This may reflect CCHCs' cultural sensitivity, which aligns with comfort discussing behavioral health.

section iv: getting help with behavioral health issues

Patients who are highly comfortable talking about these issues, naturally, are far more likely than others to have discussed behavioral health concerns with a healthcare professional. As a result, the factors linked to comfort talking with a provider also are linked to actually doing so.

As mentioned, patients who say someone at their care facility knows them well, see the same primary care provider at least most of the time, have a regular doctor, and highly rate their provider across a range of patient-centered behaviors all are about twice as likely as others to have talked with a healthcare professional about behavioral health issues. Patient empowerment, overall satisfaction, and engagement show the same relationships.

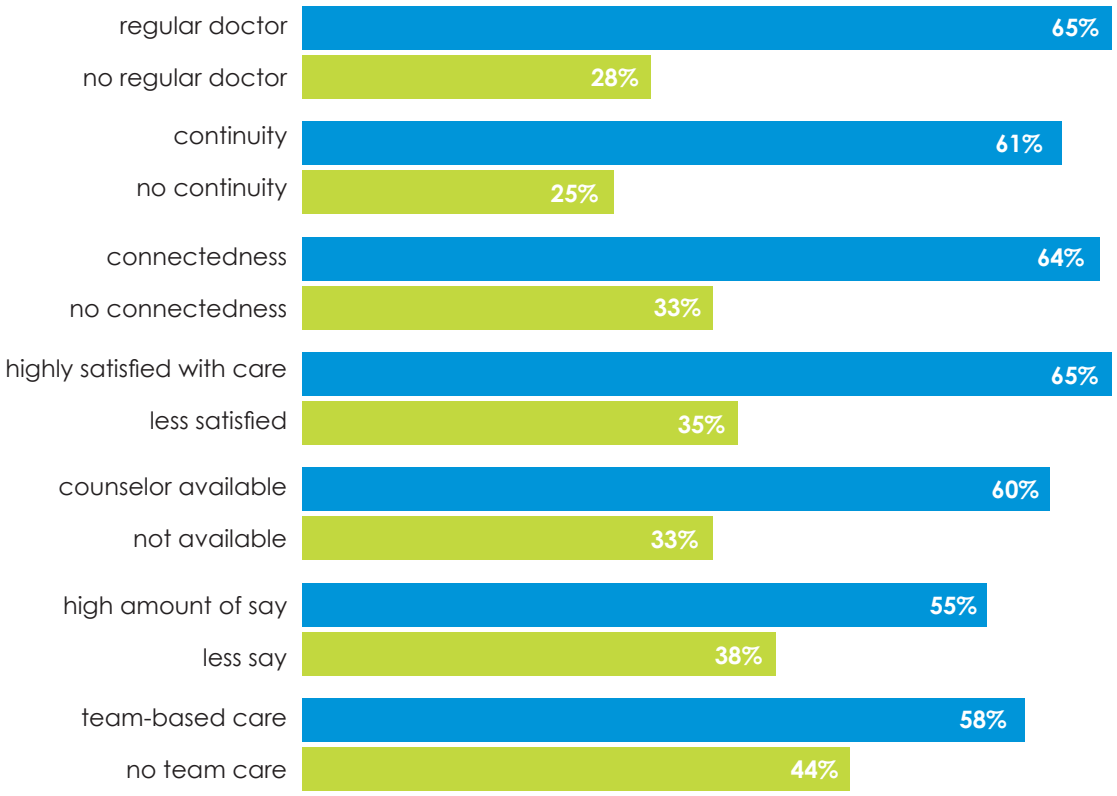
Notably, there are two additional items: The strong connection between seeking help and having a primary care provider who asks about behavioral health issues, and between seeking help and having a counselor available at one's facility. Consider:

- Among patients who felt a need to talk to someone about a behavioral health issue in the past year, and who rate their primary care provider highly for asking about their emotional health, seven in 10 actually did talk to a healthcare professional. Seeking treatment plummets to three in 10 of those who rate their primary care provider less positively in terms of behavioral health outreach.

- Again, among patients who felt a need to talk to someone, six in 10 actually did so if counseling was available at their place of care. Among those who lack on-site counseling, far fewer, just a third, obtained such services.

Connectedness, continuity, and overall satisfaction are closely associated with high ratings for primary care providers in terms of their asking about emotional issues. This indicates that providers who address behavioral health concerns also succeed at fostering strong patient-provider relationships more broadly. Patients who get this support are encouraged to obtain the services they need.

% of those who spoke with a healthcare professional about their behavioral health (among low-income Californians who felt a need to do so)



Among demographic groups, seeking help for behavioral health issues is lower among people who don't primarily speak English at home and non-citizens – groups for which self-reported need also is lower. Previous studies have found that immigrants are less willing to seek help for behavioral health issues, often because of cultural differences, and that only about a quarter of facilities have counselors who can speak Spanish. Both suggest reasons for lower treatment rates. These are areas in which cultural and linguistic competence, a strong suit for clinics, can come to the fore. (Seeking treatment also is lower among individuals with less formal education.)

talking with primary care providers and behavioral health counselors

Among those who've sought help from a healthcare professional, four in 10 spoke with both their primary care provider and a counselor, 36 percent with a primary care provider only, and 21 percent only with a counselor (such as a therapist, social worker, psychologist, or psychiatrist). This echoes previous research showing that primary care providers often are at the front line in dealing with behavioral health issues.

An integrated care team that includes both a primary care provider and a counselor can increase the likelihood that patients will talk with someone, depending on their needs, comfort, and preference. The goal is to have coordinated care that encourages patients to seek help when they need it, whether it's from their primary care provider, a counselor, or both.

Among all low-income Californians, 57 percent say they would like to talk to a counselor about behavioral health issues. Fewer, 35 percent would like to address these kinds of issues with their primary care provider. While further study could isolate the reason, possibilities include preference for counselors' specialized training, unfamiliarity with the idea of discussing these issues with a primary care provider, and/or a perceived reluctance on the part of primary care providers to take this role.

Barely more than half of low-income patients, 52 percent, give their primary care provider highly positive ratings in asking about stress, anxiety, or emotional issues they may have. That's last on the list of six behaviors that were tested. Patients who rate their providers highly on this gauge divide more closely on whether they'd prefer to see a counselor or primary care provider to discuss such issues. Among those who rate their providers less positively, two-thirds would rather see a counselor.

This is a critical point; it suggests that for primary care providers to gain acceptance as a point of entry for behavioral health services, they need to offer a supportive approach that communicates to patients their willingness to help. That effort positions primary care providers to ease patients into the conversation, with the opportunity, as needed, to refer them to a behavioral health counselor, ideally on-site, in a coordinated, integrated care effort.

Other relationship factors also influence patients' openness to talking with a primary care provider about behavioral health issues. It's higher among patients who report a personal connection with their place of care, have team-based care or a healthcare navigator (both of which increase connectedness), and feel more empowered to take an active role in their care.

% rating their care provider's performance on each item as excellent or very good (among low-income Californians)

explaining things to you in a way that you can understand	71%
giving you clear information to help you make decisions about your care	64%
encouraging you to ask questions or express your concerns	61%
asking if there's anything else you wanted to discuss about your health	60%
giving you choices about your treatment options	60%
asking you about any stress, anxiety, or emotional issues	52%

In another important result, the survey indicates that primary care providers do succeed in this role when they engage with their patients about their behavioral health needs. Seven in 10 patients who talked with their healthcare provider about behavioral health issues found it extremely or very helpful to have done so – similar to the number who found it highly helpful to talk with a counselor who specializes in such issues.

location of behavioral health care

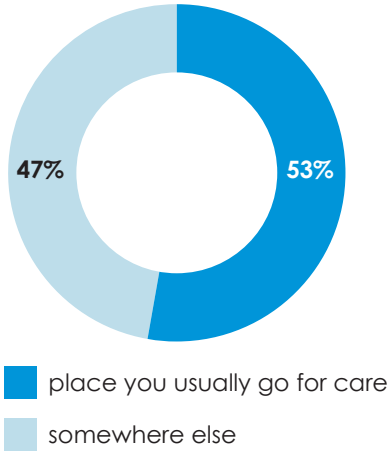
Among low-income Californians who've talked with a counselor, 53 percent say they did so at their usual place of care. It's much the same for future preference; among low-income patients in general, 54 percent say that if they were to see a counselor in the future, they'd prefer to do so at the place they usually go for care.

Strikingly, again, preference for obtaining counseling at one's regular place of care is strongest among patients who have better relationships with their primary care providers. Those with connectedness, continuity, or a regular doctor at their place of care all are more apt to prefer to see a counselor there than elsewhere. This sentiment also is higher among patients at facilities that offer a healthcare navigator, team care, and staff with cultural and linguistic competence. Preference to see someone in-house also is higher among patients who feel more informed, confident, and comfortable participating in their health care, and among patients who rate their primary care providers highly overall and on a variety of specific measures.

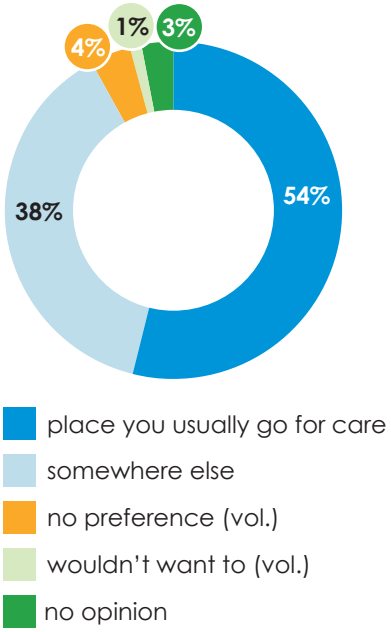
Combining these results shows a broad potential constituency for integrated behavioral health services: The sum total of patients who prefer to discuss these issues with a primary care provider, who prefer to discuss them with an on-site counselor, or who have no preference, adds up to 61 percent of low-income patients.

These results carry an important message: Healthcare providers that build strong ties with their patients can further cement those relationships by providing integrated behavioral health services. The findings on cultural and linguistic competence are instructive, as well, given non-citizens' and non-English speakers' comparative reluctance to seek treatment for behavioral health issues.

among those who saw a counselor, where was it? (among low-income Californians)



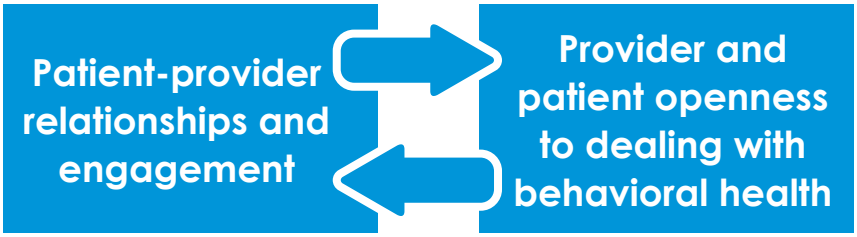
where would you like to see a counselor in the future? (among low-income Californians)



section v: conclusions and recommendations

Integrating behavioral health into the primary care setting is helping to reduce the gap between the number of low-income Californians who need treatment for behavioral health issues and those who in fact are receiving it. This study demonstrates its further potential.

The results also encourage a focus on the cornerstones of patient engagement as a route to providing needed behavioral health treatment. The general benefits of connectedness and continuity, stronger patient-provider relationships, and increased patient empowerment all apply directly to behavioral health. They're strongly related to greater comfort talking about behavioral health, higher likelihood of getting help when it's needed, and heightened willingness to talk about these issues with a primary care provider.



The ACA is addressing two key, related roadblocks to behavioral health care, cost and lack of insurance, as shown in the dramatic decrease in the number of uninsured and the increase in those receiving government-subsidized health care.[13] Results of this study indicate that healthcare facilities can do much to address others. Among the recommendations that emerge:

- Integrate behavioral health specialists into the primary care practice, ideally on site.
- Increase patient awareness of behavioral health resources.
- Inquire about patients' emotional well-being – a simple opening that, when effectively presented, encourages their engagement on behavioral health needs.

- Provide access to substance use treatment and referrals to social services.
- Implement team-based care and healthcare navigators as vehicles for behavioral health integration.
- Focus on empowering and engaging patients through connectedness, continuity, and strengthened patient-provider relationships.
- Provide culturally sensitive, linguistically capable staff.

By inviting patients to discuss their behavioral health needs within the primary care setting, primary care providers may vastly improve the chances that their patients will seek help. By strengthening and deepening their relationships with their patients, providers and healthcare facilities have the potential to dramatically enhance behavioral health treatment for low-income Californians.

endnotes

13 See *Delivering on a Promise: Advances and Opportunities in Health Care for Low-income Californians*, Blue Shield of California Foundation, January 2015.

appendix a: literature review

This report was designed after a review of nearly 30 studies on behavioral health services. The results of that literature review are described in this appendix.

The research makes clear that behavioral health problems are prevalent, yet that many who can benefit from treatment do not seek it. Reasons include perceived stigma, lack of knowledge about where to get help and the real or perceived absence of available services.

A 2013 report by the Center for Behavioral Health Statistics and Quality (2013c) estimated that 44 million American adults had a diagnosable behavioral health issue, but only about a quarter in this group had received behavioral health services. It also estimated that 10 million adults had a serious mental illness.

One innovative approach is integrated care, in which primary care providers offer help and referrals for behavioral health and substance abuse issues. The concept makes addressing behavioral health issues integral to treating the whole patient in a primary care setting.

Research finds positive outcomes of integrated care. Two Institute for Healthcare Improvement reports found that it led to better physical and behavioral health, reduced costs, and higher patient satisfaction (Institute for Healthcare Improvement, 2013; Laderman & Mate, 2013). A 2013 California Mental Health Services Authority report found the same outcomes, plus increased adherence to treatment regimens.

Bartels et al. (2004) noted marked improvement in getting treatment for behavioral health issues among elderly patients in integrated care settings, vs. those who received outside referrals (71 vs. 49 percent). And a study of Kaiser Permanente patients with serious physical ailments found that complementing primary care with psychological interventions produced substantial decreases in length and frequency of hospitalizations, number of prescriptions, and primary care and emergency room visits (Sobel, 2000).

In addition to general findings on integrating primary care and behavioral health, this review includes sections on patient preferences regarding behavioral health care, reasons for not seeking help, the role of stigma, group differences in behavioral health issues and seeking help, and the importance of insurance and the Affordable Care Act.

reasons for integrating primary care and behavioral health services

Integrated care proposes a person-centered approach intended to reduce stigma for those who might not seek behavioral health treatment outside the primary care setting. It suggests that primary care providers should consider all health conditions – physical illness, behavioral health problems, and substance abuse – in providing coordinated care. Team-based systems can provide integrated care by including a counselor as part of the team. Specialized behavioral health and addiction services are made available via primary care providers.

Primary care providers, by default, already are the chief source of help for those with behavioral health issues (California Mental Health Services Authority, 2013; Perez, Reidy & McNamara, 2012). Several studies estimate that most visits to primary care providers are directly or indirectly related to mental health issues (Fries et al., 1993; Perez, Reidy, & McNamara, 2012). Eisenberg (1992) estimated that up to a third of primary care provider visits involved patients with diagnosable psychiatric disorders. Jarvis and Freeman (2011) noted that most low to moderate behavioral health problems can be dealt with effectively in the primary care setting, though severe cases need referral to behavioral health professionals.

Community clinics and health centers (CCHCs) are primary contact points for many low-income Californians with behavioral health issues, making integrated care particularly important for these facilities to consider. According to the 2013 California Mental Health Services Authority report, "CCHCs are uniquely positioned as primary care providers to screen for and identify behavioral health conditions and substance use disorder, and to address these concerns through education, referral, brief treatment, and/or care coordination" (p.15).

Laderman and Mate (2013) list several principles of integrated behavioral and primary care, including:

- Self-care support
- Care management and care team
- Stepped care (with intensity increased as needed)
- Systematic caseload review
- Patient tracking and registry functions for outcomes measurement
- Adoption of evidence-based interventions
- Engagement of social service agencies (e.g., housing, employment, justice)

Other services, or referrals, can be included as part of integrated care, some of which are particular to the low-income population. These include:

- Case management
- Social skills development
- Assistance obtaining social services
- Self-help groups

- Mentoring/peer support
- Assistance locating housing
- Transportation to treatment
- Employment counseling and training
- Child care

Behavioral health issues often are associated with stressful life events and living conditions, which are more apt to be concentrated in the low-income population. These behavioral health issues may manifest themselves in physical symptoms for which the patient will seek primary care treatment (Kroenke & Price, 1993; Unutzer et al., 2006). For example, those with chronic conditions are more apt to have a behavioral health issue or substance abuse disorder (Perez, Reidy, & McNamara, 2012; U.S. Department of Health and Human Services, 2011a). Behavioral health and substance abuse issues often are comorbid as well (U.S. Department of Health and Human Services, 2013a).

All of these relate to socioeconomic status: Those with co-occurring behavioral health issues and a chronic condition are more apt to be poor, to work only part-time or not at all, and (pre-ACA) to be uninsured (U.S. Department of Health and Human Services, 2011a).

Integrated primary care can play a part in helping patients get the help they need for broader life issues that may contribute to behavioral health and substance abuse problems. Offering services such as employment support, transportation, and child care can increase treatment effectiveness and reduce costs of substance abuse treatment (U.S. Department of Health and Human Services, 2011c).

patient preferences for behavioral health assistance

Nearly four in 10 of those who've had a major depressive episode did not talk to a healthcare professional about it (U.S. Department of Health and Human Services, 2014c). Among those who did talk to a professional, primary care physicians were most frequently seen.

	Source of help (multiple response)
GP/family doctor	37%
psychiatrist/psychotherapist	20
psychologist	16
counselor	14
religious/spiritual advisor	11
other MD	7
social worker	7
other behavioral health professional	4
nurse/occupational therapist/other	4
herbalist/chiropractor/acupuncture/massage	4

A 2000 National Mental Health Association study found that a third of adults with undiagnosed behavioral health needs would turn to their primary care providers for help, vs. only 4 percent who would approach a behavioral health professional for help. (The rest would not seek help or would turn to a non-healthcare professional.)

Integrating behavioral health into primary care takes advantage of these preferences. Wulsin (2013) says, "Timing, trust and continuity of patient care may often be everything – reaching a patient or provider before serious harm occurs, reaching a provider when the moment of readiness for behavioral change is reached" (p.23). Just as they are integral to other aspects of care, connectedness, continuity, and accessibility are important to behavioral health care.

Integrated care in turn seeks to strengthen patient-provider relationships. According to Alexander Blount, Clinical Professor of Family Medicine and Psychiatry at the University of Massachusetts Medical School, "Combining this care allows patients to feel that, for almost any problem, they've come to the right place" (Perez, Reidy, & McNamara, 2012).

reasons for not seeking treatment

Even among those with insurance coverage, half do not get treatment for their behavioral health issues (CHIS 2012). Indeed a 2014 Center for Behavioral Health Statistics and Quality report (2014b) found that half of adults with serious thoughts of suicide did not receive any behavioral health services. Additionally, the majority of people who need substance abuse treatment do not receive it (U.S. Department of Health and Human Services, 2014a).

Why aren't people getting the help they need? In a 2013 Center for Behavioral and Health Statistics study (2013b), cost and insurance issues were the most frequently mentioned reasons; others included low perceived need, stigma, structural barriers, and thinking the services wouldn't help.

	reason for not getting needed behavioral health services		
	age group		
	18-25	26-49	50+
cost/insurance	48%	54%	46%
low perceived need	35	32	34
stigma	35	27	19
structural barriers	37	31	29
did not think would help	13	9	14

There were differences by age. Young adults were more apt than older ones to cite stigma and structural barriers. Those in the 26- to 49-year-old range were relatively more likely than others to cite cost and insurance concerns.

the role of stigma

As the data show, stigma is an important reason why those with behavioral health issues don't seek treatment, especially for low-income adults who often are reliant on Medi-Cal (Allen et al., 2014). This can include fear of disclosure, fear of rejection by friends, fear of discrimination, and incompatibility with cultural traditions.

Those findings suggest that primary care staff require training in how to handle behavioral health issues sensitively, with an eye toward reducing stigma in order to encourage those who need help to feel comfortable asking for it. The 2013 California Mental Health Services Authority report suggests that integrated care programs help reduce stigma and discrimination alike, by making it easier for patients to discuss their behavioral health issues with caregivers and to get help within their existing, familiar framework of care.

group differences in behavioral health needs and treatment

California Health Interview Survey data (Grant et al., 2011; Mental Health Services Oversight and Accountability Commission, 2012; Padilla-Frausto et al., 2012) show that self-reported behavioral health needs are higher in some groups. These include:

- Women
- Young adults
- Single heads of households (with or without children)
- U.S.-born Latinos (vs. immigrant Latinos)
- Both the uninsured and publicly insured
- Those living in poverty
- Those with chronic conditions
- Chronic smokers, binge drinkers, and substance abusers
- Native Americans
- Sexual minorities

Notably, the list includes Californians with government insurance, especially Medi-Cal recipients, and those with no insurance (in this pre-ACA study), as well as those with low incomes, chronic conditions, and substance abuse problems.

As mentioned, even among those with insurance coverage, half don't get treatment for their behavioral health issues. Those more apt than others to lack treatment include:

- Young adults
- Seniors
- Men
- The less-educated
- Asians, blacks, Latinos, and Asian immigrants
- Non-English speakers
- The uninsured and privately insured

Among the interesting patterns is that women are more apt than men to report behavioral health needs, while men are more likely than women to lack treatment.

Linguistic and cultural challenges also are notable. Latino and Asian immigrants are less apt than others to report behavioral health needs (U.S. Department of Health and Human Services, 2011b). Only a quarter of substance abuse treatment facilities have counselors who speak Spanish (Grant et al., 2011). Beyond language, cultural factors, among others, may play a role.

insurance coverage and the ACA

According to California Health Interview Survey data from 2009 (Padilla-Frausto, 2012), 1.6 million California adults age 18-64 needed help for behavioral health issues; a third of them had no insurance. The ACA, however, includes behavioral health as one of the 10 essential health benefits. It was expected to make behavioral health treatment available to four in five uninsured California adults in 2014 (Padilla-Frausto, 2012).

The provision of insurance under the ACA thus is likely to have a major impact on demand for behavioral health services, given that non-treatment rates drop from 69 percent among the uninsured to 46 and 40 percent, respectively, among those with private or public insurance. (Padilla-Frausto, 2012).

Jarvis and Freeman (2011) estimated that California will see about 300,000 new patients seeking expanded mental health services and roughly 200,000 new patients for substance abuse services under the ACA. The Commonwealth Fund (Abrams et al., 2014) found that 53 percent of federally qualified health centers were expanding or integrating behavioral health services to handle this anticipated increase in demand.

The challenge of dealing with increased demand for behavioral health services, and in particular its impact on healthcare facilities serving low-income Californians, animates the present study.

appendix b – topline data report

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

*= less than 0.5 percent

Previously released: 1-15, 16b-c, 16e-f, 17a-b, 17d-e, 17g-h, 18-20d, 20f, 21a-e, 32-34

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

a. A counselor to talk to about any stress, anxiety or emotional issues

		Available	Not available	No opinion
10/5/14	All	52	21	27
	200%+ FPL	53	19	27
	<200% FPL	52	25	24

d. Help for people with drug or alcohol issues

		Available	Not available	No opinion
10/5/14	All	47	16	37
	200%+ FPL	50	14	36
	<200% FPL	42	21	37

g. Referrals to social services for things like housing, employment or legal issues

		Available	Not available	No opinion
10/5/14	All	25	27	48
	200%+ FPL	24	24	52
	<200% FPL	28	33	39

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

c. A counselor to talk to about any stress, anxiety or emotional issues

		More important				Less important			
		NET	Extremely	Very	Somewhat	**NET**	Not so	Not at all	No opinion
10/5/14	All	70	27	43	19	10	6	5	1
	200%+ FPL	66	25	41	20	12	6	6	1
	<200% FPL	76	28	48	15	7	4	2	2

f. Help for people with drug or alcohol issues

		More important				Less important			
		NET	Extremely	Very	Somewhat	**NET**	Not so	Not at all	No opinion
10/5/14	All	72	27	45	15	11	5	6	2
	200%+ FPL	70	26	44	16	12	5	6	2
	<200% FPL	76	30	46	13	8	4	4	3

i. Referrals to social services for things like housing, employment or legal issues

		More important				Less important			
		NET	Extremely	Very	Somewhat	**NET**	Not so	Not at all	No opinion
10/5/14	All	46	16	30	25	26	14	12	3
	200%+ FPL	39	15	24	25	33	18	16	3
	<200% FPL	61	19	42	23	13	9	5	2

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

e. Asking you about any stress, anxiety or emotional issues

		Excellent/very good				Not so good/poor			
		NET	Excellent	Very good	Good	**NET**	Not so good	Poor	No op.
10/5/14	All	55	29	26	25	15	10	5	4
	200%+ FPL	57	29	28	26	13	8	4	4
	<200% FPL	52	27	25	25	19	12	7	3

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

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

22. I want to ask you about the subject of help with personal challenges that can arise in people's lives. This can be stress, emotional issues, drug or alcohol use, marital or family issues or just feeling down about things. In the past 12 months, was there a time you felt like you might want to talk with a healthcare professional about any issues like these, or not?

		Yes	No	No opinion
10/5/14	All	30	70	*
	200%+ FPL	29	71	*
	<200% FPL	31	68	*

23. (IF YES OR NO OPINION) Did you talk about this with a healthcare professional, or not?

		Yes, did	No, did not	No opinion
10/5/14	All	60	40	1
	200%+ FPL	66	33	1
	<200% FPL	50	50	*

24. (IF YES) Some people may talk about these issues with a healthcare provider who they usually see for routine health care. Others may talk with a counselor like a therapist, a social worker, a psychologist or a psychiatrist. Did you talk about it with a healthcare provider, with a counselor, or both?

		Healthcare provider	Counselor	Both	No opinion
10/5/14	All	39	22	38	1
	200%+ FPL	41	21	39	0
	<200% FPL	36	21	39	4

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

		Place usually go	Somewhere else	No opinion
10/5/14	All	30	69	1
	<200% FPL*	53	47	0

*Insufficient sample size for 200%+ FPL

26. (IF SOMEWHERE ELSE) Did your healthcare provider refer you to this counselor, or did you find the counselor some other way?

		Referred	Other way	No opinion
10/5/14	All*	27	73	0

*Insufficient sample sizes for 200+% FPL and <200% FPL

27. (IF TALKED WITH A COUNSELOR) In talking with you about this, was the counselor you saw extremely helpful, very helpful, somewhat helpful, not so helpful or not helpful at all?

		More helpful				Less helpful			
		NET	Extremely	Very	Somewhat	**NET**	Not so	Not at all	No opinion
10/5/14	All	81	38	43	13	6	4	3	0
	<200% FPL*	73	37	36	18	9	6	4	0

*Insufficient sample size for 200%+ FPL

28. (IF TALKED WITH A HEALTHCARE PROVIDER) In talking with you about this, was your healthcare provider extremely helpful, very helpful, somewhat helpful, not so helpful or not helpful at all?

		More helpful				Less helpful			
		NET	Extremely	Very	Somewhat	**NET**	Not so	Not at all	No opinion
10/5/14	All	74	38	36	16	10	6	5	*
	<200% FPL*	69	28	41	19	11	5	5	*

*Insufficient sample size for 200%+ FPL

27/28 NET:

		More helpful				Less helpful			
		NET	Extremely	Very	Somewhat	**NET**	Not so	Not at all	No opinion
10/5/14	All	80	41	42	18	9	5	5	*
	200%+ FPL	80	42	41	17	9	4	5	0
	<200% FPL	79	37	46	21	10	5	5	*

29. (IF DID NOT TALK WITH A HEALTHCARE PROVIDER OR NO ANSWER) For each item I mention, please tell me if it (was or was not a reason/would or would not be a reason) that you (did/might) not talk about this with a healthcare professional. First, how about [ITEM]? Next, how about [NEXT ITEM]? (IF REASON) Was that a big reason, or not so big?

a. Because you did not know who to talk to

		Reason				
		NET	Big	Not so big	Not a reason	No opinion
10/5/14	All	57	36	21	42	2
	<200% FPL*	59	37	22	38	3

*Insufficient sample size for 200%+ FPL

b. Because you were uncomfortable bringing it up

		Reason				
		NET	Big	Not so big	Not a reason	No opinion
10/5/14	All	48	30	18	51	1
	<200% FPL*	50	36	15	49	1

*Insufficient sample size for 200%+ FPL

c. Because you did not think they could help

		Reason				
		NET	Big	Not so big	Not a reason	No opinion
10/5/14	All	41	25	15	58	1
	<200% FPL*	43	28	15	55	2

*Insufficient sample size for 200%+ FPL

d. Because you did not want to talk about it

		Reason				
		NET	Big	Not so big	Not a reason	No opinion
10/5/14	All	49	30	19	50	1
	<200% FPL*	48	33	15	51	1

*Insufficient sample size for 200%+ FPL

e. Because there was not enough time in the appointment

		Reason				
		NET	Big	Not so big	Not a reason	No opinion
10/5/14	All	31	19	12	67	2
	<200% FPL*	40	24	16	58	2

*Insufficient sample size for 200%+ FPL

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

		Healthcare provider	**Counselor**	**Either/no pref. (vol.)**	**No opinion**
10/5/14	All	31	58	8	3
	200%+ FPL	30	59	9	3
	<200% FPL	35	57	6	3

31. Imagine if you wanted to see a counselor in the future. Would you prefer to see someone where you (usually go/last went) for health care, or somewhere else?

		Usually go/ last went	**Somewhere else**	**Wouldn't want to see one (vol.)**	**No preference (vol.)**	**No opinion**
10/5/14	All	49	39	1	7	3
	200%+ FPL	47	39	2	9	3
	<200% FPL	54	38	1	4	3

appendix c: references

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