In the Wake of the Affordable Care Act: Understanding Community Barriers and Facilitators to Health Care Access

Findings from a Community-Based Survey of South Sacramento

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Developed by Texas Health Institute

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ABOUT TEXAS HEALTH INSTITUTE

The Texas Health Institute (THI) is an independent, nonpartisan, nonprofit organization with the mission of improving the health of communities in Texas and nationally. As a respected leader in Texas, THI acts as a neutral convener, facilitates balanced health care dialogue, creates a vision of improved health care, addresses health disparities, and develops feasible solutions to health problems through collaboration. Nationally, THI's Health Equity Team has been monitoring the evolution of health care reform since 2008, with the release of a seminal report following the enactment of the law, *Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations*. Since then, THI has undertaken a singular national, multi-year, multi-funder initiative to monitor and report on the implementation progress of the Affordable Care Act from a health equity perspective, addressing topics of health insurance, the safety net, workforce diversity, quality improvement, and prevention. Together these efforts are intended to increase awareness and education among stakeholders and practitioners while also facilitating dialogue, advocacy, and policy. To find this report or our related reports online, visit www.texashealthinstitute.org/health-care-reform.html.

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Executive Summary

Background

A 2013 community health needs assessment called attention to South Sacramento as a "community of concern," revealing consistently worse health outcomes in this area compared to the county and state overall. South Sacramento's relatively poor population health highlighted the need for a closer examination of health care access in the region. While the Affordable Care Act (ACA) and California's Medicaid expansion have created opportunities to enroll many of South Sacramento's culturally and linguistically diverse residents in health coverage, health insurance alone is not sufficient to assure timely and appropriate access to care. Individuals and families newly insured under the ACA, as well as those remaining uninsured, may continue to encounter social, economic, environmental, and institutional barriers that limit health care access.

With support from Sierra Health Foundation and in partnership with community-based organizations, the Texas Health Institute (THI) created a new survey for uninsured and newly insured residents of South Sacramento to measure local perceptions and experiences of barriers to health care access in the region, and to assess what facilitators would better enable residents to obtain care they need. Locally, survey findings are intended to work in concert with other efforts to lay the foundation for evidence-informed dialogue around addressing barriers and cultivating community-clinical linkages to enhance health care access for South Sacramento's diverse residents. Regionally and statewide, the survey itself may offer opportunities for communities to assess progress and identify barriers in accessing care.

Methods

THI implemented a multi-pronged, capacity-building approach to develop and administer a health care access survey for South Sacramento residents. To contextualize the survey in community realities, THI assembled a Stakeholder Advisory Group of ten community-based organizations. Input from the Advisory Group was merged with a comprehensive review of the literature to guide development of the instrument. Working in partnership with La Familia Counseling Center, THI also sought to cultivate local capacity by training a cohort of surveyors from several community-based organizations who administered the survey to South Sacramento community members. THI staff conducted descriptive data analysis with particular attention to patterns emerging by insurance status, race/ethnicity, English proficiency, and geography.

Results

Community surveyors collected data from 313 culturally and linguistically diverse residents of a seven-ZIP code region of South Sacramento. Two-thirds of respondents had obtained health insurance in the last two years, while the remaining one-third was uninsured. Nearly three in ten respondents reported being in fair or poor health, and a high burden of chronic illness—particularly mental illness—was observed among the sample. Noticeable differences in disease prevalence by race and ethnicity were detected for asthma (highest among Whites and African Americans) and diabetes (highest among Hispanics).

Only about half of survey respondents had a personal doctor, usual source of care, or a routine checkup within the last year. Use of a hospital emergency department or emergency room (ER) as a usual source of care was highest among uninsured respondents, but one in five newly insured respondents said they

used the ER more frequently since obtaining coverage. A doctor's office was the most common source of care for all racial/ethnic groups except Hispanics, who were substantially more likely to seek care at a clinic or health center. Residency in particular ZIP codes was also associated with differential patterns of health care utilization.

Cost emerged as a chief reason that South Sacramento residents could not access a health care provider, regardless of whether or not they were insured—100% of uninsured respondents and 70% of insured respondents cited cost as an important access barrier. Additionally, one in two insured respondents said access was difficult due to providers not accepting their health insurance, and of these respondents, 92% were enrolled in Medi-Cal (California's Medicaid program). Issues of trust, cultural competence, care coordination, and health literacy emerged as key impediments, and were especially common among respondents with limited English proficiency (LEP). Among those who spoke a language other than English at home, nearly half indicated a need for interpreter services in health care settings, and 60% of all respondents said they had trouble understanding their provider's instructions at least some of the time.

Social determinant barriers also appeared to influence access to care. While most respondents felt their neighborhood had adequate sidewalks, public transit, and parks, they were less likely to say they felt safe in these places. Strong patterns of safety perception emerged by ZIP code. One in five respondents explicitly noted that crime and safety concerns prevented them from accessing care they need. Transportation and economic security concerns were among other salient social determinant barriers surveyed individuals faced.

Respondents' most trusted sources for health information varied by race/ethnicity. Asian respondents were most likely to rely on community-based organizations for health information, Whites tended to trust health care providers, and African Americans most often cited either consulting friends and family or having no source for information. Overall, respondents felt that education on obtaining and using health insurance would substantially improve their ability to access care.

Discussion

Despite historic increases in health coverage attributable to the ACA, our results lend credence to concerns that health care access in South Sacramento remains a challenge regardless of insurance status. In particular, seven key themes emerged from our work highlighting primary health care access concerns in the community:

- **Barriers to health insurance remain**, with surveyed Hispanics and LEP individuals facing some of the greatest challenges.
- **Health insurance alone does not guarantee access to care**. Newly insured respondents explicitly report that accessing care has become more challenging, not less so, since obtaining coverage. Unmet health needs and non-emergent ER utilization are still prevalent among this group.
- **Cost remains a major barrier to access even after coverage**, with concerns most pervasive among African American respondents.
- **Health system barriers**, especially narrow provider networks and related capacity concerns, continue to impede access to care even after coverage.
- **Broader social determinant factors**, such as economic security, transportation, and safety, are salient barriers. In addition, language, culture, and literacy also contribute to access, with concerns most prevalent among Asian, Hispanic, and LEP respondents.
- **Community-based organizations and health centers were identified among key assets and partners** in South Sacramento, especially among surveyed Asian and Hispanic members.

Moving Forward

Expanding coverage and transitioning residents from coverage to care to improve overall health in South Sacramento and beyond will require a set of concerted strategies that in tandem address the many individual, systems, and community levers of access to care (Figure A).

Figure A. Framework to Improve Community-Wide Access to Care and Health

Community Levers	• Addressing broader social, economic, environmental, and political drivers of health care access.
Health System Levers	• Addressing factors within health care systems to improve care capacity, accessibility, and quality.
Individual Levers	• Addressing knowledge, language, culture, behaviors, and other individual factors.
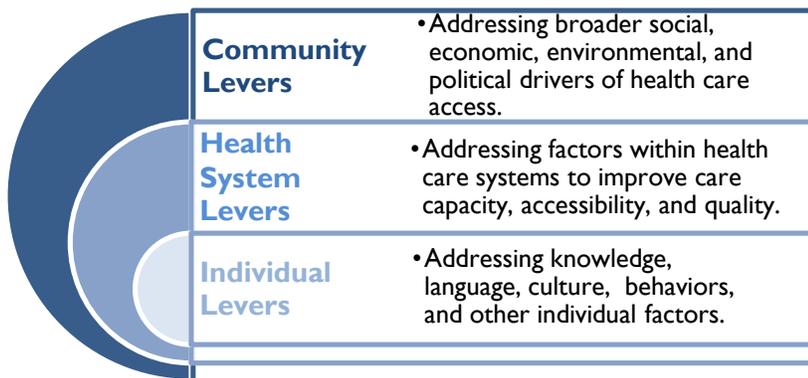
Building on this framework, our findings, and the literature, we identify a set of actions that cut across these three levers. For each set of actions we provide evidence, promising practices, and models from around the country to help inform and guide local advocates, organizations, policymakers, and philanthropies as they work to support and advance access in the Sacramento region and beyond.

- **INDIVIDUAL LEVERS:** *Advancing health insurance literacy* by engaging and supporting trusted partners and applying culturally and linguistically tailored approaches to help foster individual understanding of its importance, maintenance, and health care use.

- **HEALTH SYSTEM LEVERS:** *Enhancing primary care capacity and access* through a focus on patient-centeredness, team-based care, care coordination, and service integration as well as reinforcing the need for adequate payments for Medi-Cal.

- **COMMUNITY LEVERS:** *Moving toward Accountable Communities for Health* by building new or enhancing existing regional clinical-community partnerships to strategically plan, measure, and hold community-wide organizations accountable for the region's overall health.

Conclusion

The success of the ACA in expanding health care coverage has been unprecedented. At the same time, not all communities have benefited equally, with many still facing significant gaps in coverage. For those newly covered, health insurance alone does not guarantee access to affordable and quality services, especially in communities where a confluence of demographic, socioeconomic, and neighborhood factors inhibit ready access to care. Working to improve access will require health system providers and communities to work in concert through innovative, yet proven, delivery and payment reforms to holistically address the upstream and downstream barriers to care. Through such collaborative and integrated approaches, South Sacramento can advance health care access and population health in an ever-changing post-ACA environment.

Introduction

In the six years since its passage, the Patient Protection and Affordable Care Act (ACA) has made historic gains toward achieving its overall mission: improving access to quality and affordable health care for all populations. While expanding health insurance has been central to achieving this mission, the ACA included dozens of other provisions to create a more equitable health care system, including expanding the number of health care settings near where people live and work, increasing diversity among health professionals, and addressing language and culture in delivery of services through innovative clinical and community-based approaches.

Nearly 20 million individuals have gained health insurance since the ACA's enactment, lowering the national uninsured rate to its lowest in 15 years.[1] However, having health insurance does not guarantee access to affordable and quality services, as evidenced in many local communities where a confluence of demographic, socioeconomic, and neighborhood factors have inhibited ready access to care. This has become especially evident in many communities across California, including Sacramento, where pockets of extreme poverty and diversity coupled with lack of public infrastructure (such as transportation or health care systems) have greatly affected the ability to access affordable care.

The Sierra Health Foundation commissioned the Texas Health Institute to examine the underlying reasons why many newly insured and those remaining uninsured in the Sacramento region continue to face challenges to accessing health care, and to identify clinical-community strategies to facilitate access in a new, post-ACA environment. To this end, the primary objectives of this project were to:
- Design a replicable community-based survey to identify health care access barriers and facilitators for the newly insured and uninsured;
- Build a cadre of community surveyors by engaging members of community-based organizations through all aspects of survey design, implementation, and evaluation; and
- Inform future program and policy directions that build on clinical-community partnerships to improve access to care.

While a large body of work examines health care access for the insured and uninsured, this pilot study explicitly addresses the topic in three unique but integrated contexts with relevance not only for Sacramento but communities across the country. First, it identifies access-related perspectives and experiences directly from *newly* insured Medicaid and marketplace enrollees. Secondly, it considers access beyond the health system, in the context of the broader community and the social determinants of health. Third, it captures perspectives from specific racial/ethnic population groups. These design features offer a more strategic and focused post-ACA look at local health care access challenges and opportunities.

This study builds on the 2013 Sacramento County Community Health Needs Assessment, prepared by Valley Vision on behalf of the Healthy Sacramento Coalition and the Sierra Health Foundation, which identified 15 ZIP codes in Downtown, North, and South Sacramento termed "communities of concern" based on a set of socioeconomic, health, and health care indicators. As a pilot, the current study focuses on seven of the 15 ZIP codes identified by Valley Vision among communities of concern in South Sacramento. Home to almost 20% of Sacramento County's population, these ZIP codes consistently exceeded both county and state health measures of vulnerability, especially for chronic disease, mental illness, tobacco use, and violence/safety.

Background

South Sacramento: A Region Rich in Diversity, High in Need

Historical and Current Population Trends.
In the early 1900s, South Sacramento began to transition from sparsely populated farmland to subdivided neighborhoods due to new roadway construction and investments from wealthy developers who sought to transform the area into Sacramento's first suburb.[2] South Sacramento's farming and ranching economy—driven by workers of Asian, European, and Mexican descent—had become industrialized by World War II.[3,4] American internment policies following the Pearl Harbor attack permanently drove out most of the area's Japanese farmers amid a climate of racial and ethnic hostility.[5] A post-war boom occurred in the 1950s and 1960s, with new neighborhoods anchored around the area's public parks such as Oak Park, Land Park, and Tahoe Park.[6] While many Sacramento communities were racially restricted during this time, South Sacramento generally remained available to non-Whites, attracting an influx of African Americans and other minority groups.[7] Migration to suburbs further from the city's core eventually depressed the area's property values and reduced working class job opportunities, ushering in a period of economic decline.[8]

Figure 1. Sacramento ZIP Codes in Study Area

Valley Vision CHNA, 2013

Today, the seven-ZIP-code South Sacramento area is home to a racially, ethnically, and linguistically diverse population of 290,000 residents, many of whom belong to communities that have experienced persistent disenfranchisement.[9] On average, three out of four individuals are non-White[10] and nearly one-quarter have limited English proficiency (LEP), or speak English less than "very well."[11] South Sacramento neighborhoods are challenged with high rates of joblessness, poor housing conditions, and prevalent gang and drug activity, but community activism has helped drive attention and investment toward some of these issues, hinting at the potential for resurgence.

Population Health Needs. Rates of uninsured are higher in South Sacramento compared to the region as a whole, where in 2011 nearly 20% were uninsured.[12] Health and health status between residents of South Sacramento and those of the county or state as a whole also differ notably. For example, adults in South Sacramento are more likely to have asthma (25%) than adults in California (14%).[13] Safety is a major concern, with 77% of children feeling safe in nearby parks or playgrounds in South Sacramento as compared to 95% of children in Sacramento County and 90% in California.[14] Studies in the region also suggest that the prevalence of serious psychological distress is nearly twice as high in South Sacramento (19%) than Sacramento County (9%) and California (7%).[15] Following are other markers of health disparities faced in South Sacramento as identified through various local studies:
- Residents have the lowest life expectancy in Sacramento County.[16]
- South Sacramento has among the county's highest rates of accidents, homicides, and violence.[17]
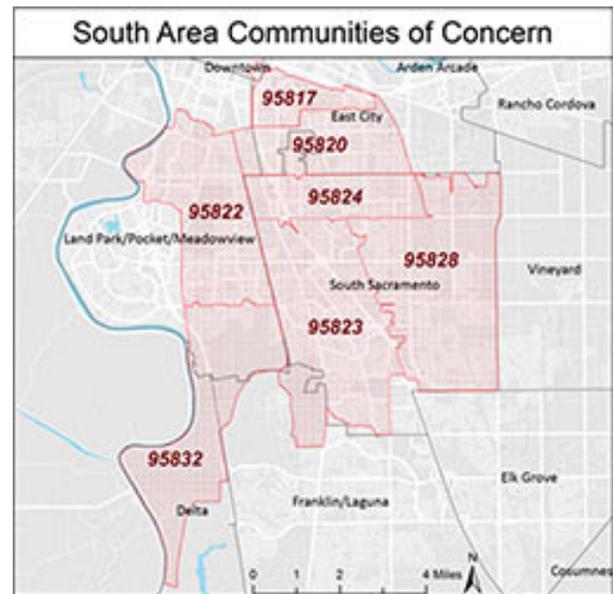
- Rates of emergency department or emergency room (ER) visitation are nearly double the state average.[18]
- All-cause mortality is above the county average in five of seven South Sacramento ZIP codes.[19]
- In 2011, 30% of people in South Sacramento were obese, compared with 25% in Sacramento County, and 21% in the state. [20]
- Four of seven ZIP codes are considered food deserts.[21]

In recent years, the region has also grappled with a host of social and economic challenges including food insecurity, crime and violence, and higher-than-average mortality rates. Specific areas such as The Avenues have been characterized as "food deserts," where physical barriers have isolated neighborhoods from grocery stores and other community resources such as banks, libraries, and clinics.[22] Approximately one in five South Sacramento residents is considered "food insecure"—or uncertain whether they will be able to get enough nutritious food during the month—nearly double the rate observed in some other areas of Sacramento County.[23] In addition, nearly 70% of very low-income households in Sacramento County pay more than 50% of their income in rent, a burden that may escalate in coming years.[24] After adjustment for inflation, Sacramento County's median household income declined 13% from 2000-2012, while median rent increased 12% over the same time period.[25]

Taken together, these indicators paint a portrait of communities where many face major challenges to health and quality of life. They also suggest that dynamics affecting access to health care are likely to extend far beyond the clinic or hospital door and well into the fabric of neighborhoods and homes. These social determinants and their effect on health care access are the focus of this project.

Community and Health Care Assets

Community Assets. While social, economic, and health disparities are widespread in South Sacramento, in recent years, the region has benefited from a strengthening network of community and health care resources. Core and central to this network are community-based organizations that have a history of serving diverse and low-income populations. La Familia Counseling Center, United Iu-Mien Community Services, Ubuntu Green, Asian Resources, Inc., and Hmong Women's Heritage Association serve as trusted community access points for health programs and services, including resources for active living, healthy eating, psychosocial wellness, and case management. Many faith communities in South Sacramento, including Saint Matthew Christian Church, Shiloh Baptist Church, and Antioch Progressive Church, play an active role in addressing food insecurity and promoting healthy lifestyles among congregants.

Investment in Neighborhoods. South Sacramento is one of 14 sites across California implementing the 10-year, $1 billion Building Healthy Communities (BHC) project funded by The California Endowment. The Sacramento BHC has engaged over 6,500 community stakeholders in creating a plan to improve neighborhood conditions, advance health and wellness in school settings, and ensure families have access to health care.[26] Since the project's launch in 2009, the Sacramento BHC has provided grants to 20 local organizations addressing critical health priority areas such as food access, health insurance enrollment, land use, and youth development. Asian Resources, Inc., serves as the host agency for the Sacramento BHC Hub, which convenes and supports stakeholders, grantees, and partner organizations to guide their collective efforts.[27]

Other recent initiatives have worked to target specific public health priorities. For example, Kaiser Permanente supported the South Sacramento Healthy Eating Active Living (HEAL) Zone initiative, a multi-sectoral effort to prevent chronic diseases such as diabetes and hypertension.[28] Through its

network of community partners, the South Sacramento HEAL Zone engages community residents in activities to increase physical fitness, promote fresh fruit and vegetable consumption, and improve the safety and walkability of the built environment.[29] In 2014, the Health Education Council launched the Sacramento Minority Youth Violence Prevention Initiative, supported by the U.S. Department of Health and Human Services' Office of Minority Health in partnership with the Department of Justice. This initiative was "aimed at addressing violence as a public health issue and integrating public health, education, and local community policing efforts in a coordinated violence prevention approach."[30]

The Sacramento Housing Alliance contributes to neighborhood health improvement through efforts to assure safe, accessible, and affordable housing for Sacramento area residents. The Alliance's Coalition for Regional Equity has engaged as a partner in the South Sacramento BHC project and has partnered with Ubuntu Green on an environmental justice initiative addressing the state of several vacant lots and brown fields in Oak Park.[31] In 2015, the Alliance convened the Sacramento Regional Affordable Housing Summit to advance dialogue around housing as a "prescription for healthy communities," with a focus on housing vulnerable populations including LGBT seniors and veterans.[32]

Health Care Assets. The South Sacramento area is home to 15 major community clinics, federally qualified health centers, and hospitals that deliver essential preventive services, primary and emergency care, and self-management resources for persons with chronic conditions. Several specifically target their services toward low-income and uninsured patients and are equipped to serve populations speaking languages other than English. Eight additional South Sacramento clinics serve people with mental health and substance use disorders, providing individual and family counseling, addiction treatment, and substance use prevention workshops.

Table 1. South Sacramento Community Assets

Community Clinics & FQHCs	Hospitals	Mental Health & Substance Use Treatment
• WellSpace Health* • Imani Clinic • Joan Viteri Memorial Clinic • Health For All* • Sacramento County Primary Health Services • Planned Parenthood Fruitridge Health Center • Health and Life Organization • Mercy Family Health Center • Golden Rule Services *multiple locations	• Shriners Hospital for Children – Northern CA • UC Davis Medical Center • Methodist Hospital • Kaiser Permanente	• Asian Pacific Community Counseling • La Familia Counseling Center • Southeast Asian Assistance Center • Sacramento Counseling and Family Services Center • Another Choice Another Chance • Visions Unlimited • Strategies For Change • Mexican American Addiction Program

Design and Methods

Throughout this project, the Texas Health Institute (THI) worked in partnership with community-based organizations to ensure the appropriate inclusion and framing of critical issues. Our collaborative, multi-pronged approach was imperative to achieving the project's primary objectives: (1) to develop and administer a community-based survey of health care access needs, barriers, and facilitators; (2) to build a cadre of trained community evaluators in South Sacramento by engaging members of community-based organizations in the development, training, administration, and evaluation of the survey; and (3) to inform future local program and policy directions.

Figure 2. Collaborative, Multi-Pronged Design
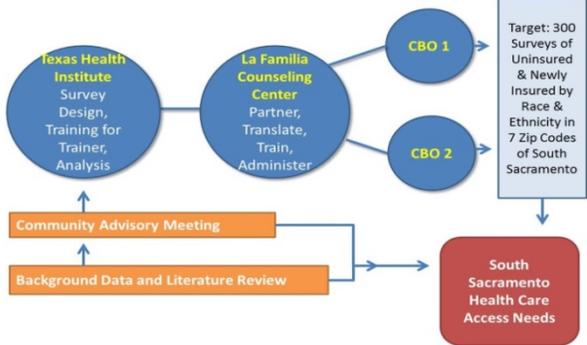
As a collaborative, community initiative, THI partnered at the onset with an established and well-connected lead organization in South Sacramento, La Familia Counseling Center (referred to as La Familia hereafter). La Familia served many roles through the life of the project including as liaison to other representative organizations and individuals, as hub entity for building a cadre of evaluators in the community, and as our "eyes" and "ears" to assure this work remained grounded in local priorities and circumstances.

In the following narrative we describe our methodology, focusing in particular on stakeholder engagement, literature review, survey and sampling design, training and administering surveys, and data analysis.

Stakeholder Engagement

Purpose and Structure

In Spring 2015, THI assembled a Stakeholder Advisory Group comprised of 10 community-based organizations representing diverse racial/ethnic populations and with knowledge of South Sacramento's neighborhoods and health care access landscape (see Table 2). The group's purpose was to guide survey development and add community context to the study. THI convened the stakeholders in a four-hour, in-person meeting on July 20, 2015.

Table 2. List of Stakeholder Organizations

Organization Name
Asian Resources, Inc.
Centers for Fathers and Families
Hmong Women's Heritage
La Familia Counseling Center
Sacramento ACT
Sacramento Building Healthy Communities
Sacramento Covered
Sac City USD
United Iu-Mien Community Services
Yes 2 Kollege

The primary objectives of the meeting were to:
- Engage stakeholders in a dialogue on the health care access landscape of South Sacramento;
- Identify leading access barriers from a broad social determinants of health perspective; and
- Identify community assets and opportunities to address modifiable access barriers.

At this meeting, THI provided an overview of the survey, including its purpose and proposed framework, and outlined the Committee's charge in guiding its design and development. In so doing, the project team asked participants to share their knowledge and perspectives on South Sacramento's

health care access landscape, reflecting in particular on the needs and concerns of diverse communities as well as those newly insured and uninsured in the seven-ZIP-code area; to consider what questions they would want asked in the survey to better understand the health care access landscape that might potentially inform community planning efforts to enhance access to care; and to consider existing community assets and facilitators that could be leveraged to improve health care access.

Stakeholder Input

Comments and responses from the stakeholder group generally converged around five broad themes, which emerged as priority topic areas for THI to build into the survey: health system challenges, health literacy, health behaviors, broader non-health barriers, and community assets.

Health system challenges. In discussing health system challenges, stakeholders identified a number of concerns including insufficient provider capacity, network adequacy, care coordination, and specialty access. In particular, stakeholders suggested that South Sacramento had an insufficient number of providers and sites to treat patients and that this challenge was especially acute for non-English-speaking populations. Further, there was a sense that geographic managed care was keeping people from seeing their preferred providers, as was reinforced by attendees who shared "there is no flexibility in providers you can see" and "how do we maintain flexibility in where insured can go?" Stakeholders also discussed the challenges of access to specialty care and care coordination, which seemed to be more pronounced in historically disenfranchised communities such as African Americans and the LEP. Finally, other topics of discussion included the need for additional interpreters at health care settings, the extent to which patients had to wait to receive care, and information on patients' interpersonal relationships and level of trust with providers.

Health literacy. Health literacy—compounded by language and cultural barriers—was discussed throughout the meeting, including in the context of limited literacy and knowledge of health systems navigation and health insurance utilization. Stakeholders felt that many individuals were unsure where and from whom to seek care, a challenge especially for the newly insured who also needed assistance understanding the basics about their coverage (e.g., premiums, deductibles, and co-pays) as well as how to use it.

Individual behaviors. Individual behaviors were also identified as a challenge, including a need to focus on prevention in high-risk communities. To better understand individual behaviors, stakeholders wanted to know more from the survey about how community members sought information about their health and health care and how certain neighborhood or community barriers may inhibit healthy behaviors.

Non-health system barriers. Additionally, there was discussion of broader community challenges faced by residents of South Sacramento in accessing health care. Prime among these concerns was transportation. Other identified topics included neighborhood safety, walkable surroundings, and access to healthy food outlets.

Community assets. A final point of discussion centered on community assets and how they might be leveraged to improve access for underserved populations in South Sacramento. The overarching response from stakeholders emphasized the need for programs and policymakers to improve their understanding of how individuals recognized and used assets, and how health care providers, insurers, and community-based organizations might better coordinate their efforts. The stakeholder groups identified a number of community assets, including those organizations present, public services like schools and libraries, and other organizations with different foci. Overall, there appeared to be a sense among the group that the strengths of each were not yet fully utilized across South Sacramento.

Following the initial meeting, THI engaged a subset of stakeholders to review and comment on drafts of the survey instrument, to assist with developing and vetting translations of surveys, and to participate in training and administering the survey. The Survey Methods section explains this process in further detail.

Literature Review

THI conducted a systematic review of the literature to augment advisory group guidance on leading health care access concerns in South Sacramento and to identify relevant survey-based research studies. The project team scanned peer-reviewed and other literature to evaluate the evidence for clinical and social determinants of health outcomes and access to care. Synthesis based on this review categorized content by financial, structural, or cognitive relevance, with attention targeted toward determinants that were measurable and modifiable. Key search terms included but were not limited to "health disparities," "barriers," "facilitators," "access to care," "health literacy," and "utilization." Within these search results, the THI team specifically focused on surveys conducted among diverse racial/ethnic groups, LEP populations, uninsured or Medicaid-enrolled populations, and immigrants.

Survey Methods

Survey Design

THI's survey design was intended from the beginning to reflect the experiences and feedback of community stakeholders as well as Sacramento-specific concerns identified in the literature. In order to collect high-quality data, THI initially collected relevant questions from existing surveys, such as Behavioral Risk Factor Surveillance System, Enroll America National Survey of Uninsured Adults, Ohio Medicaid Assessment Survey, and several others. From these sources THI formulated a draft survey to elicit information on demographics, individual health status, health care access and utilization, health care quality, external barriers and facilitators to care, and how individuals understand and navigate the health care system. After editing for content and to manage the length of the survey, a first draft was distributed to key stakeholder organizations who were asked to provide feedback on its applicability to the targeted community. This feedback was incorporated into a second draft that was presented at the surveyor training on September 30, 2015. Information gathered at this training, described in the next section, was incorporated into the final survey tool (see Appendix).

The final tool was translated into Spanish, Hmong, and Vietnamese, the three most common languages other than English spoken in South Sacramento. Overall, the survey contained 50 questions, including those aimed at verifying respondent eligibility for participation, and was designed to take approximately 15-20 minutes to administer. Respondent inclusion criteria included residing in one of the specified seven ZIP codes and being either uninsured or having obtained health insurance for the first time in the two years preceding the date of the survey.

Sample Construction

In constructing the study sample THI sought to represent the geographic and racial/ethnic diversity of South Sacramento as well as experiences of the uninsured and newly insured. To this end, THI collected recent data from the American Community Survey on the estimated number of uninsured individuals in the seven ZIP codes of interest by race/ethnicity. With an estimated 300 survey respondents, the sample was composed proportionally according to these numbers, with some reconfiguration to ensure adequate representation of Whites and African Americans.

Table 3. Target Sample by ZIP Code and Race/Ethnicity

	95817 Oak Park	95820 Elmhurst, Tahoe Park	95222 Land Park	95823 Parkway, Valley Hi	95824 City Farms	95828 Florin	95832 Meadow -view	**Total**
Hispanic	8	18	14	32	16	20	8	116
Asian	2	2	8	14	14	22	8	70
African American	4	4	8	16	4	6	4	46
White	8	6	4	6	6	10	4	44
Other	4	2	4	4	2	4	4	24
Total	26	32	38	72	42	62	28	300

Surveyor Training

Training objectives. THI developed and convened a half-day, in-person Training-for-the-Trainer on September 30, 2015, for two primary purposes: (1) to build community-based capacity and a cadre of community surveyors; and (2) to assure consistent and valid administration of the survey. Three primary organizations were identified and selected to receive training and administer the survey given their longstanding community relationships and experience with outreach to diverse populations:

- La Familia Counseling Center (focused in particular on reaching Hispanics);
- Asian Resources, Inc. (focused on reaching Asians, including sub-population groups such as Hmong, Vietnamese, Chinese, and others);
- Always Knocking (focused on African Americans).

Lead personnel from these three organizations received training on the importance and process of survey data collection, both generally as well as specifically for this project, and by the end of the training were equipped to train other members of their organizations to administer surveys. The training was intended to assure that surveyors were competent in four tasks: (1) identifying the purpose of the project; (2) describing how the survey should be administered, (3) defining the meaning of the questions and terms used in the survey; and (4) explaining these aspects to other surveyors and community members. Attendees were not expected to be topical or methodological experts after one training session, and ongoing technical support was available from THI throughout the survey period.

Training structure. Prior to the training, THI had engaged with community organizations to solicit input on survey design and sampling, but the training itself provided an opportunity for discussion around these themes. As the lead local organization, La Familia provided justification for the need for 300 completed surveys and identified target quotas for each of the community-based organizations. La Familia developed these targets based on organizational capacities and the geographic, racial/ethnic, and linguistic characteristics of those served by each organization. This portion of the training also covered survey logistics, including the need for surveys to be administered orally and in one-on-one settings to ensure consistency and to maximize the likelihood that respondents understood the questions. The group then discussed potential recruitment strategies, with each organization contributing ideas and offering to share resources to help each meet their targets.

The remainder of the training elaborated on survey content, introducing the instrument's individual questions, and providing an opportunity to practice its administration. In this first part, attendees were asked to share their opinions on the propriety of questions in terms of both experiences and social norms of their clientele. For example, there was wide consensus that the survey ought to exclude any questions on respondent income. Second, each attendee was paired with another from a different organization to practice administering the survey and evaluate it for content, flow, and other potential

problems. In this exercise, changes to the wording of multiple items were incorporated to clarify question meaning.

Survey Administration

Given their wide reach in the community and the size of the Hispanic population in South Sacramento, La Familia was chosen to coordinate local data collection efforts. Considering sample targets described above and the strengths and capacities of each partner organization, La Familia devised the means by which the three organizations would collect 300 completed surveys. Generally, La Familia targeted Hispanic respondents, Asian Resources, Inc. targeted Asian respondents, and Always Knocking targeted African American respondents. During the training described above, the three groups discussed potential recruitment strategies and exchanged offers to share resources, such as meeting spaces in different parts of the community and contacts with other community institutions.

Data collection occurred in October and November 2015. La Familia surveyed individuals at a variety of locations including local colleges, eateries, markets, coffee shops, laundromats, libraries, residences, and at La Familia's facilities. Always Knocking used similar locations, while the majority of Asian Resources, Inc. surveys were conducted at either their main office or their Alhambra office.

Having local community-based organizations to administer surveys was very important for the rapid, in-depth collection of data. These groups had existing knowledge of the communities and were able to utilize existing ties to maximize surveys from a defined sample population (i.e., newly and uninsured respondents representing the racial/ethnic and geographic spread of South Sacramento).

Data Analysis

Each week during the data collection period, completed surveys were bundled from the multiple surveying organizations and mailed to THI for data entry. Responses were entered into an Excel spreadsheet designed for the study, validated, and then exported to an SPSS .SAV file. THI conducted descriptive analyses, including frequencies and cross tabulations, in SPSS with consideration of survey skip patterns and geographic, racial/ethnic, and linguistic grouping variables.

Data Limitations

We worked with three South Sacramento community organizations to conduct convenience sampling, with purposeful selection based on geographic and racial/ethnic categories. One objective of this project was to build a cadre of community surveyors by engaging members of community-based organizations throughout the process. In doing so, the study sample may be biased towards including participants already familiar with and potentially utilizing the services of these organizations. However, respondent familiarity and comfort with these organizations may have enhanced data quality and assured otherwise reluctant participants of the importance and confidentiality of their involvement. Additionally, the reliance on convenience, non-representative sampling may have biased the sample by selecting those participants who were easiest to reach rather than a true cross-section of the South Sacramento community. As a pilot study in a large multiracial/multiethnic city, a random sample was not feasible and purposefully selecting participants by their ZIP code and racial/ethnic identification sought to guarantee a sample representative of the study area.

Results

Respondent Characteristics

Overall Demographics

In all, 313 residents of South Sacramento responded to the survey (see Table 4). Respondents were roughly apportioned based on the relative population of each ZIP code. The largest proportion of respondents was from City Farms/Fruitridge Manor (95824) and Parkway/Valley Hi/North Laguna (95823) neighborhoods, comprising 28% and 18% of the sample, respectively. Between 6-13% were from the remaining five ZIP codes in South Sacramento.

Reflecting the overall racial/ethnic composition of the region, the majority of the sample (over 92%) was non-White. Hispanics comprised the largest racial/ethnic group (39%), followed by Asians (30%) and African Americans (19%). Only 8% of respondents identified as non-Hispanic White. In terms of racial/ethnic distribution of respondents across neighborhoods, a majority of respondents from Land Park (95822), Elmhurst/Tahoe Park (95820), and City Farms/Fruitridge Manor (95824) were Hispanic, whereas a majority of Asian respondents were from Florin (95828), Parkway/Valley Hi/North Laguna (95823), and Meadowview (95832). African American respondents were generally dispersed across the neighborhoods; however, they comprised the largest share of Oak Park respondents (95817).

Just over two-fifths of the sample (44%) reported having LEP, defined as speaking a language other than English at home and speaking English less than "very well." Among this group, the majority (51%) spoke Spanish while the remainder spoke Asian languages.

Gender distribution of the sample was approximately two-thirds female and one-third male. Nearly two-thirds (63%) of respondents lived in a home with one or more children under the age of 18, most commonly with one or two children.

Table 4. Characteristics of Survey Respondents

	No.	Percent
Total Number of Respondents	313	100%
ZIP Code/Neighborhood		
95817/Oak Park	20	6.4%
95820/Elmhurst, Tahoe Park	32	10.2%
95822/Land Park	37	11.8%
95823/Parkway, Valley Hi, N. Laguna	57	18.2%
95824/City Farms, Fruitridge Manor	88	28.1%
95828/Florin	40	12.8%
95832/Meadowview	39	12.5%
Race and Ethnicity		
Hispanic	122	39.0%
White	24	7.7%
African American	59	18.8%
Asian	93	29.7%
Other	15	4.8%
Gender		
Female	201	64.2%
Male	112	35.8%
Language Spoken at Home		
Spanish	70	51.1%
Hmong	31	22.6%
Vietnamese	23	16.8%
Chinese	9	6.6%
Other (Filipino, Thai, Igbo)	4	2.9%
Insurance Status		
Newly Insured	215	68.7%
Medi-Cal	137	63.7%
Covered California	38	17.7%
Employer	26	12.1%
Other/Not specified	14	6.5%
Uninsured	98	31.3%

Figure 3. Survey Respondents by Race/Ethnicity and ZIP Code
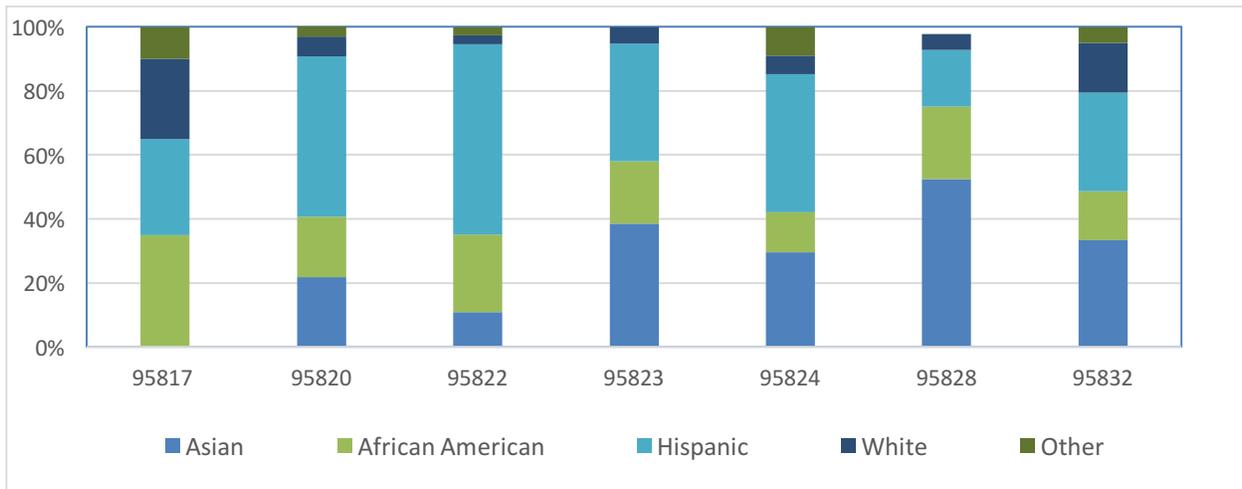
Insurance Status

Over two-thirds (69%) of the respondents were newly insured whereas nearly one-third identified as uninsured. Of those with health insurance, Medi-Cal (64%) was identified as the primary source of coverage, followed by Covered California (18%). When insurance status was considered by ZIP code, fairly minimal variation existed. However when insurance status was considered by race/ethnicity, Hispanics had notably higher uninsured rates (48.4%) than all other groups. Among LEP respondents, 42% were uninsured. Both in absolute and relative terms, uninsured rates were highest for Spanish-speaking individuals (47 respondents or 67%). About 29% of respondents speaking Hmong identified as uninsured.

Table 5. Uninsured Rates by ZIP Code

ZIP Code	% Uninsured
95817	35.0%
95820	25.0%
95822	37.8%
95823	35.1%
95824	29.6%
95828	30.0%
95832	28.2%

Figure 4. Uninsured Rates by Race/Ethnicity
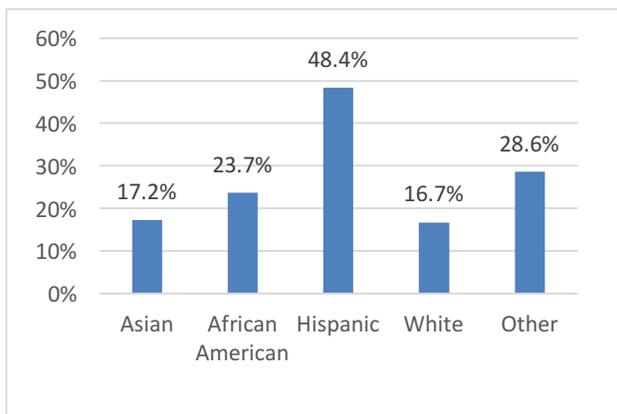
Figure 5. Uninsured Rates by Non-English Language
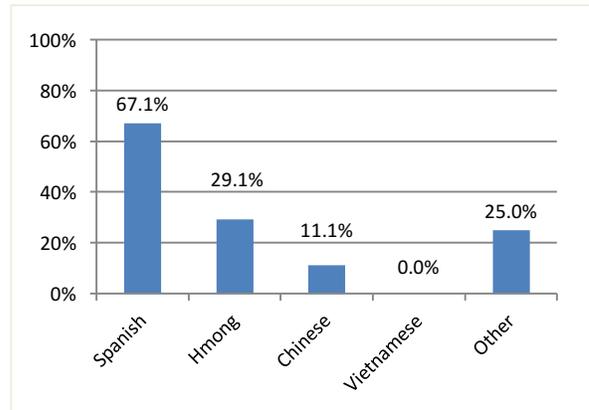
Health Status

Overall, 85 respondents (27%) indicated that they were in fair or poor health. Considered by insurance status, the data revealed that a larger proportion of uninsured (39%) reported being in fair or poor health as compared to newly insured (22%). Among ZIP codes, this percentage was highest in Oak Park (95817).

The percentage of respondents reporting fair or poor health was higher among Hispanics and Asians and lower among African Americans. Among LEP respondents, 45% reported being in fair or poor health, with rates highest among Spanish- and Vietnamese-speaking respondents.

Figure 6. Percentage of Respondents in Fair or Poor Health Status by Insurance Status
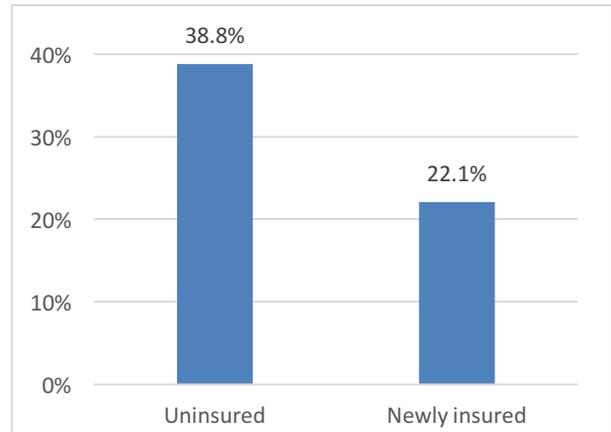
Figure 7. Percentage of Respondents in Fair or Poor Health Status by Non-English Language Spoken
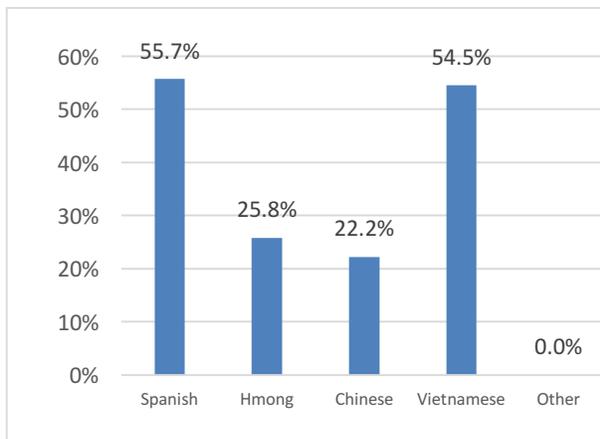
Figure 8. Percentage of Respondents in Fair or Poor Health Status by Race/Ethnicity
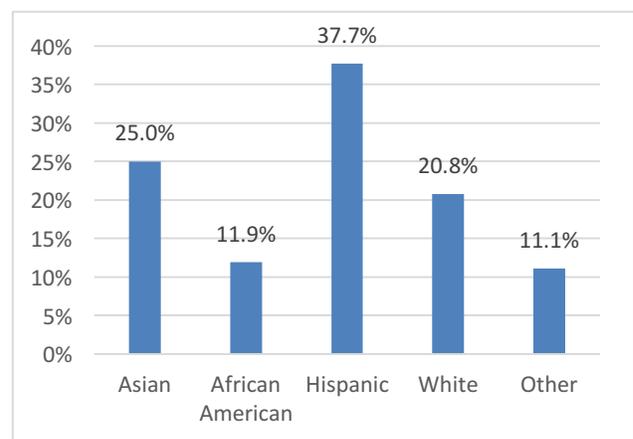
Chronic Morbidities

The survey found that nearly a quarter (23%) of respondents had been diagnosed with a mental health condition such as depression or anxiety, with asthma, arthritis, and diabetes diagnoses also reported as commonly. Prevalence of these illnesses varied by race/ethnicity and language. For example, Hispanics reported notably higher rates of diabetes than all other groups. Hispanics and Whites reported the greatest prevalence of mental health conditions. Rates of asthma were highest among White and African American respondents. In terms of prevalence of serious health conditions among LEP respondents, rates were highest for mental health conditions (25%), diabetes (21%), and arthritis (18%).

Figure 9. Survey Respondents and Diagnosis of Serious Health Conditions

Condition	Percent
Mental health condition	22.9%
Arthritis	15.4%
Asthma	15.3%
Diabetes	14.9%
Kidney problems	6.1%
Heart condition	3.4%
Cancer	3.3%
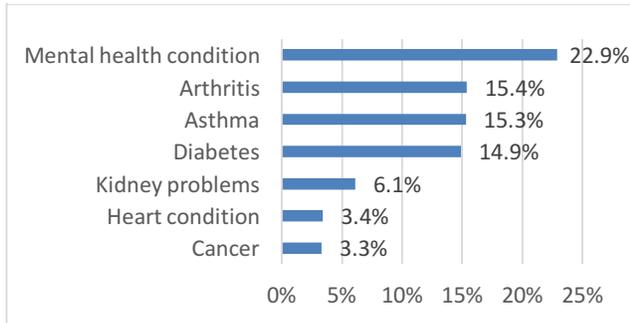
Table 6. Prevalence of Serious Health Conditions among LEP Population

	Percent Prevalence
Heart Condition	4.1%
Asthma	7.8%
Cancer	6.3%
Arthritis	18.0%
Mental Health Condition	25.4%
Kidney Problems	5.6%

Figure 10. Prevalence of Serious Health Conditions by Race/Ethnicity

Legend: ■ Asian ■ African American ■ Hispanic ■ White
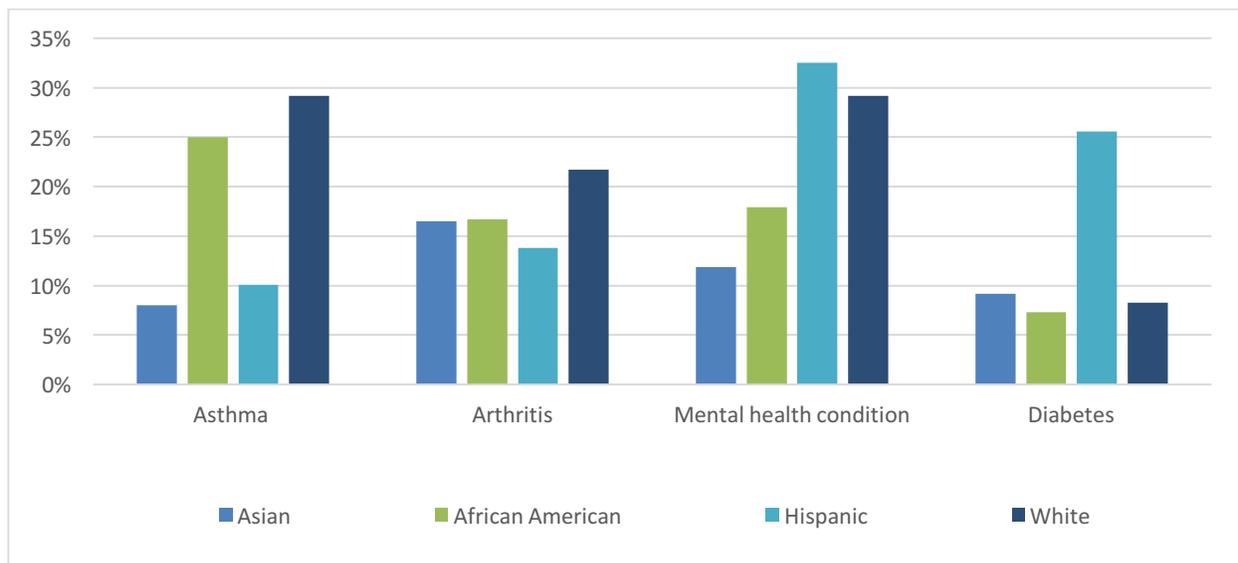
Health Care Utilization

Usual Source of Care

Overall, 146 or 54% of respondents said they had a personal doctor or usual source of care. Having a usual source of care was more prevalent among insured—where 72% of insured had a personal doctor versus only 12% of uninsured. Hispanics were least likely to report having a personal doctor. Whereas only 39% of Hispanics reported having one, more than half of Asians (62%), Whites (64%), and African Americans (64%) said they had a personal doctor. Having a usual source of care largely varied by ZIP code. Roughly half of the respondents in Parkway/Valley Hi/North Laguna (95823), City Farms/Fruitridge Manor (95824), and Land Park (95822) reported lacking a usual source.

Where people accessed care largely varied as well, from 39% of respondents frequenting the doctor's office as a usual site of care, 27% visiting clinics or health centers, and 18% going to ERs, among other locations. When insurance status was considered, some varying patterns emerged. For example, 13% of

insured respondents went to the ER as their usual source of care as compared to 29% of uninsured. While half of the insured (50%) reported using the doctor's office, only 15% of uninsured reported it as a usual source of care.

With respect to place, respondents living in Elmhurst/Tahoe Park (95820) and Land Park (95822) were more likely to use the ER as their usual source of care than respondents overall. Respondents in Oak Park (95817) most often sought care at the doctor's office, those in Parkway/Valley Hi/North Laguna (95823) a clinic or health center, and those in Meadowview (95832) cited other sources.

Usual source of care also largely varied by race/ethnicity. Whereas Whites (63%) were most likely to access care at a doctor's office, Hispanics (21%) were least likely to do so. Asians (51%) and African Americans (47%) also cited a doctor's office among their primary sources of care. African Americans (33%) had the highest rate of utilization of ERs as a usual source, followed by Whites (25%) and Hispanics (22%). Asians (7%) were least likely to use the ER as their usual source of care. Hispanics (36%) were most likely to access usual care at a clinic or health center. Over one in four Asians (27%) also accessed usual care at a clinic or health center, in comparison to very few African Americans (11%) and Whites (6%).

Figure 11. Usual Source of Care by Race/Ethnicity
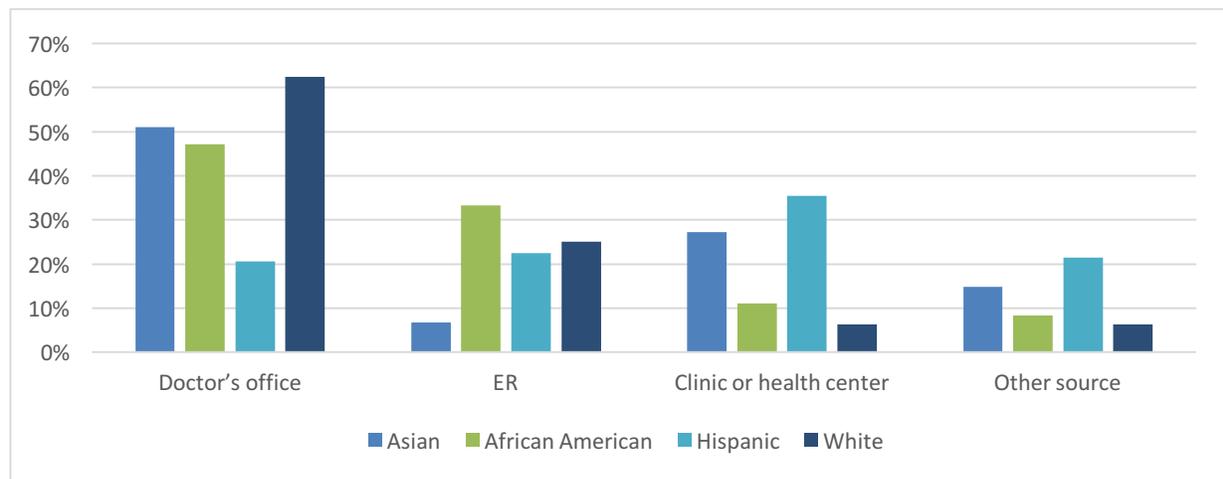
Primary and Preventive Care

As a measure of health care utilization and access to primary care services, respondents were asked how long it had been since their last routine checkup or general physical exam. Over half (53%) of the respondents indicated that they had done so within the past 12 months while an additional 19% reported having done so in the previous year (13 to 24 months). Sixteen percent of respondents reported either never having a routine exam or having one more than five years ago. Among insured respondents, the percentage having had a routine checkup within the past 12 months was almost twice (62%) the rate of uninsured respondents (35%). Additionally, the percentages of uninsured respondents who had checkups between two and five years ago, over five years ago, and never were all roughly double the percentages of insured respondents.

Routine checkups largely varied by ZIP code, with 71% of respondents from Elmhurst/Tahoe Park (95820) having had a checkup within the past 12 months as compared to 60% of respondents from Florin (95828) not having had one during this time period. Likelihood of having had a checkup in the past

12 months did not vary much by race, though Whites and African Americans were more likely to have done so in the past two years than were Asians or Hispanics.

Additionally, respondents were asked how many days they had to wait for their last doctor's appointment. Over a quarter of respondents (28%) indicated that they were able to see their doctor either the same day or the next day, while an equal percentage had to wait more than seven days. Uninsured respondents were more likely to wait 7 or more days as compared to insured (45% and 21%, respectively). The percentage waiting more than seven days also varied by race/ethnicity. In particular, a much larger proportion of Hispanics (43%) waited more than 7 days than all other population groups (20% African Americans, 20% Asians, and 5% Whites). While just 29% of insured Hispanics waited more than seven days, 58% of uninsured Hispanics did so.

Table 7. Percentage Waiting More than Seven Days for an Appointment by Race/Ethnicity

	Overall	Asian	African American	Hispanic	White
Percentage waiting more than 7 days for an appointment	27.7%	19.5%	20.0%	42.7%	5.3%

Specialty Care

Over one-third of respondents reported having sought specialty care in the preceding 12 months. These data did not vary substantially by insurance status, although there was some variation by ZIP code. For example, 41% of respondents in the Meadowview (95832) and 38% in Parkway/Valley Hi/North Laguna (95823) had seen a specialist within that time period. By comparison, each of the other ZIP codes had proportions of a third or less. When specialist utilization was considered by race/ethnicity, Whites (42%) and African Americans (41%) showed higher proportions than Hispanics (34%) and Asians (26%).

Of note, 38% of those who had seen a specialist described their attempt to access specialty care as a "big problem" while 19% viewed it as a "small problem." Among the uninsured, 74% portrayed the process as a "big problem," compared to 25% of insured. Half of Hispanics and a third of Asians and African Americans also classified it as a "big problem." Just 20% of Whites reported specialty access as a "big problem."

Figure 12. Percentage Describing Access to Specialty Care as a "Big Problem"
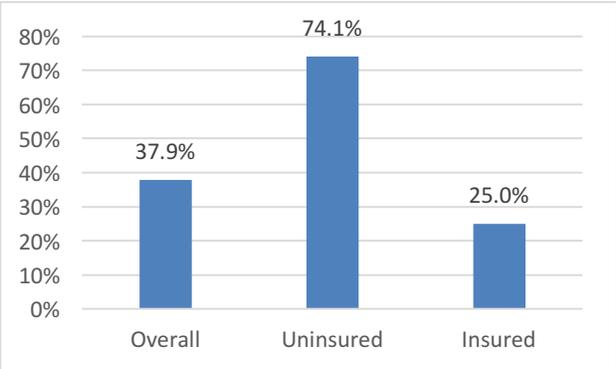

Figure 13. Percentage Describing Access to Specialty Care as a "Big Problem" by Race/Ethnicity
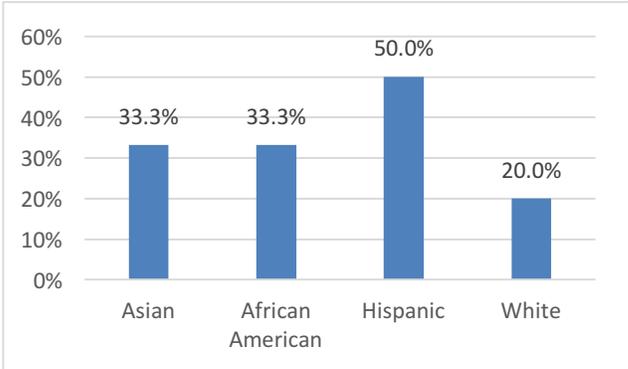
Emergency Care

Several survey questions sought to understand utilization patterns and choices of care in the ER. Nearly one in three (30%) respondents reported seeking care in the ER in the past 12 months. While ER utilization was generally comparable between uninsured and insured, utilization varied by race/ethnicity. African Americans had the highest rate of ER use (49%), followed by Hispanics (35%) and Whites (33%). Asians had by far the lowest utilization rate (9%). More than half reported no change in ER utilization since obtaining coverage whereas one-fifth (19%) said they used it more following coverage than before.

Figure 14. Percentage Using Emergency Room in the Past 12 Months by Race/Ethnicity
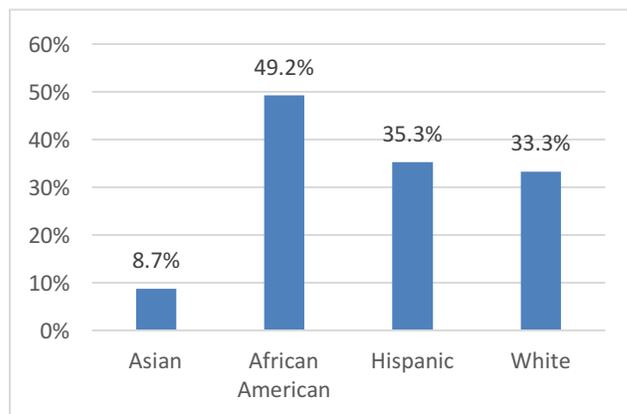
Respondents were asked to rank the importance of reasons for ER use aside from serious injury or illness. Two-thirds or more of respondents using the ER cited at least one of the following: the ER as the "best" place to get care, they don't turn anybody away, it is convenient, and it is affordable. Responses varied somewhat by insurance status, race/ethnicity, and ZIP code.

For the overwhelming majority of uninsured (94%), ER utilization mainly stemmed from not having coverage or a lack of financial resources to afford care elsewhere. In contrast, for many newly insured, the ER was a choice of convenience, with nearly two-thirds saying they used the ER as it did not require an appointment. A large majority of both the uninsured (90%) and insured (63%) felt that the ER was the best place to get care for their condition, with this perception held more strongly among the uninsured. Half or more of both uninsured and insured respondents also suggested they turned to the ER because they did not know where else to go and they felt ER staff was well-equipped to communicate in their primary spoken language. Finally, 43% of uninsured and 35% of newly insured said they relied on the ER to help connect them to social services, such as housing or food.

Table 8. "Very Important" Reasons why Respondents Use the Emergency Room by Insurance Status

Reasons to use the Emergency Room	Insured	Uninsured	Total
Can't afford to go elsewhere	41.5%	93.9%	61.6%
No doctor's office or clinic is nearby	32.6%	42.1%	35.4%
No doctor's office or clinic accepts my health insurance (insured respondents only)	30.4%	-	-
No doctor's office of clinic would accept me (uninsured respondents only)	-	80.0%	-
They don't turn anybody away	65.3%	73.9%	68.0%
Don't know where else to go	51.0%	62.5%	54.8%
Convenience/don't need an appointment	63.2%	62.5%	62.9%
Best place to get care for condition	62.7%	89.5%	70.6%
Prefer/like this as usual source of care	41.7%	36.8%	40.3%
Easy to communicate/they have staff who speak my language	50.0%	52.6%	50.7%
No regular doctor/nurse (Uninsured respondents only)	-	66.7%	-
They connect me to social services I need, such as housing or food	34.7%	42.9%	39.4%

Barriers to Care

Unmet Health Care Needs

Over a third of respondents (35%) said they were unable see a doctor or health care provider when needed within the past 12 months. More than half (58%) of uninsured respondents reported that they could not see a doctor when needed in the past 12 months, compared to 25% of insured respondents. Unmet health care needs varied by race and ethnicity—40% of Hispanics, 38% of Asians, 25% of African Americans, and 21% of Whites reported having unmet needs. Overall across the ZIP codes, about one-third of respondents reported not being able to see a doctor when needed. Elmhurst/Tahoe Park (95820) had the highest proportion of unmet needs identified among respondents (44%).

Figure 15 chart: Overall 35.3%, Uninsured 58.3%, Insured 25.1%

Figure 16. Percentage of Respondents Reporting an Inability to See a Doctor/Health Care Provider due to Cost by Race/Ethnicity

Figure 16 chart: Asian 37.6%, African American 25.4%, Hispanic 40.0%, White 20.8%
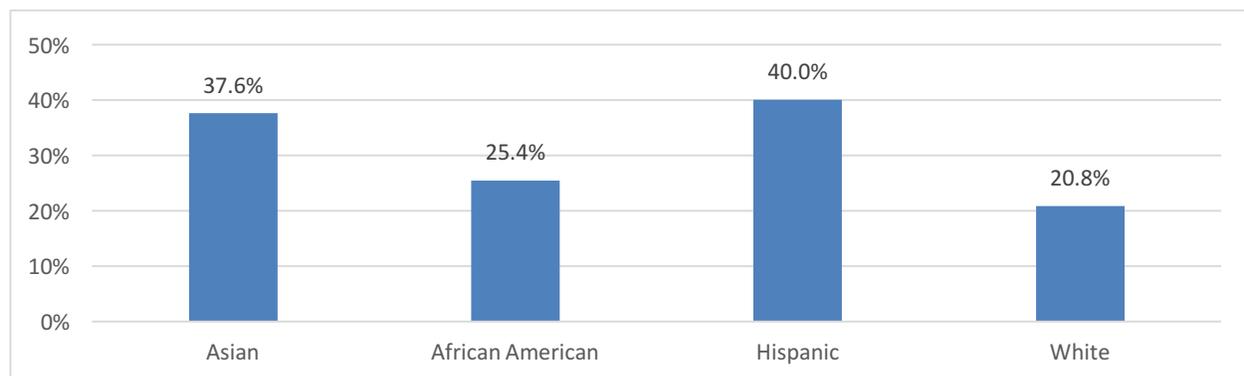
Overall Health Care Access Barriers

We found that having health insurance did not guarantee access to care. In fact, a large proportion of insured respondents continued to face a range of access barriers, with cost (such as co-pays, deductibles, and out-of-pocket expenses) emerging as a chief reason, followed by health system barriers including appointment wait times, providers not accepting patients, and lack of providers nearby. Overall, nearly 85% of all respondents facing challenges to accessing care cited cost as a primary reason, with 100% of uninsured and 70% of insured saying cost was an important access barrier.

In terms of health system barriers, more than half of both insured (54%) and uninsured (64%) respondents cited appointment delays as a major barrier and near equal proportions (43-44%) said lack of health care providers nearby inhibited access. Providers not accepting patients was also cited as a key access barrier for both uninsured and insured. Whereas 77% of uninsured said providers would not see

them without insurance, 50% of insured said providers would not accept their health insurance. Among the latter group, 92% (23 of 25 respondents) received insurance through Medi-Cal.

A larger proportion of insured respondents (35%) said that transportation was among key barriers to accessing care as compared to 19% of uninsured. Similar proportions of insured and uninsured cited child care (21% and 22%, respectively) and work-related barriers (28% and 29%, respectively). With respect to race/ethnicity, 43% of Asians cited a lack of time off work as a reason for not getting care. Language barriers were more prevalent among uninsured (51%) than insured (33%), though both groups cited this among top barriers. More than half (55%) of those with limited English proficiency indicated that language barriers were among the most important reasons for not being able to access a health provider.

Table 9. Proportion of Respondents Indicating Barriers to Care by Insurance Status

Barriers to Accessing Care	Insured		Uninsured		Total	
	#	%	#	%	#	%
Cost	37	69.8%	53	100%	90	84.9%
Appointment delay	28	53.8%	27	64.3%	55	58.5%
No provider nearby	22	43.1%	20	44.4%	42	43.8%
Language barrier	17	33.3%	21	51.2%	38	41.3%
No night/weekend hours	19	37.3%	18	41.9%	37	39.4%
No time off work	14	28.0%	12	28.6%	26	28.3%
Transportation barriers	18	35.3%	8	19.1%	26	28.0%
Past bad experience	13	26.0%	12	29.3%	25	27.5%
No child care	10	21.3%	8	22.2%	18	21.7%
Provider does not accept insurance or will not see without insurance	25	50.0%	36	76.6%	-	-

In addressing whether gaining access to health care had become easier or harder in the past year, 50% indicated that it was no different than a year ago, 28% indicated that it got harder, and 22% said that it had gotten easier.

Table 10. Change in Difficulty of Accessing Care by Insurance Status

	Easier	Same	Harder
Newly Insured	10.3%	51.9%	37.9%
Uninsured	48.9%	45.6%	5.6%

These numbers did not appear to vary by race/ethnicity, ZIP code, or English proficiency. However, these numbers varied substantially by insurance status. In particular, over three times as many newly insured (38%) reported that accessing care had gotten harder in the past year as compared to 10% saying it had gotten easier. Nearly half of uninsured reported access getting easier, with only 6% saying it got harder over the past year.

Specialty Care Access Barriers

As noted above, over one-third of respondents said that they needed to see a specialist for a health problem within the past 12 months. To recap, 38% of those who had seen a specialist described their attempt to access specialty care as a "big problem" while 19% viewed it as a "small problem." Among the uninsured, 74% portrayed the process as a "big problem," compared to 25% of the insured. Half of Hispanics and a third of Asians and African Americans also classified it as a "big problem." Just 20% of Whites did so.

Individuals identified a number of reasons for facing difficulties accessing specialty care. Among the uninsured, 95% of respondents cited cost as the biggest factor preventing them from accessing care. Among the insured, cost was also the most salient reason for having problems accessing specialty care,

with 42% citing this as a barrier. Other key barriers faced by one-third or more of the insured answering this question included delays/difficulty finding appointments, finding a provider nearby who accepts coverage, and plan restrictions related to specialty care.

Other Health System Barriers

Trust. Findings from the survey suggest that trust of providers is a challenge for many—and especially the uninsured. Over two-thirds (65%) of uninsured respondents and 43% of insured respondents shared that their trust was "somewhat, little, or not at all" among providers they had seen in the past 12 months (50% of all respondents). These sentiments were particularly prevalent among Asians (64%) and Hispanics (51%), while just 27% of African American respondents said so. Little to no trust was also very prevalent among LEP respondents, 61% of whom said they trusted their provider somewhat, little, or not at all (as compared to 42% of English proficient respondents).

Cultural competence. Nearly half of respondents (45%) said that their provider understood and respected their cultural beliefs somewhat, a little, or not at all. This sentiment was more prevalent among the uninsured (57%) as compared to the insured (40%). Nearly two-thirds (60%) of Asians reported that their health care provider did not understand or respect their cultural beliefs. This was the case for 41% of Whites, 39% of Hispanics, and 29% of African Americans.

Care coordination. Over half of all respondents (51%) indicated that care coordination served as a challenge. However, these numbers varied greatly by insurance status. Specifically, 72% of uninsured described care coordination as presenting difficulty, compared to 44% of insured respondents. Slightly more Hispanics (58%) reported this than Asians (50%), African Americans (40%), and Whites (47%). Respondents with LEP were slightly more likely to indicate some difficulty (58% to 47%) and more likely to describe care coordination as very difficult (32% to 13%) as compared to English proficient respondents.

Cost-Related Barriers

Over a third of respondents (34%) indicated that they were unable to see a doctor in the past 12 months because of cost. There was a substantial difference in responses between insured respondents (21%) and uninsured respondents (63%). When asked which costs prevented them from seeking care, co-pays and prescription drug costs were cited by the newly insured slightly more commonly than deductibles. Similarly, over a fifth of respondents (20%) indicated that they had been unable to pay their medical bills within the past 12 months. Thirty-seven percent of uninsured respondents faced these challenges compared to 13% of insured respondents, with proportions varying by race/ethnicity. In particular, African Americans had the highest rate of difficulty paying medical bills (32%), as compared to 24% of Hispanics, 17% of Whites, and 10% of Asians citing difficulty paying bills.

Moreover, 38% of respondents indicated a reluctance to seek health care services from providers to whom they owed money. Reluctance was higher for uninsured respondents (46%) as compared to insured (28%). One out of four (24%) respondents voiced a reluctance to use health care services from *any* provider because they owed money.

Table 11. Proportion of Respondents with Difficulty Paying Medical Bills by Race/Ethnicity

Asian	African American	Hispanic	White
9.7%	32.2%	24.1%	16.7%

Neighborhood Barriers

In an attempt to understand access barriers outside the health care system, we asked respondents to indicate their level of agreement with statements about their neighborhood infrastructure and community surroundings (e.g., safety, crime, walking paths, parks, and transit stops). While an overwhelming majority of respondents agreed that their neighborhood had many sidewalks (89%), only 69% said they feel safe walking in their neighborhoods. Perceptions of safety varied by place, with 87% in Land Park (95822) feeling safe walking in their neighborhood as compared to 55% in Parkway/Valley Hi/North Laguna (95823). Nearly two-thirds of respondents (62%) felt their neighborhood had a high crime rate. When asked if high crime rate prevented access to care, one of five respondents said it did.

Table 12. Proportion of Respondents Agreeing with Statements

	Total
My neighborhood has many sidewalks for me to walk regularly	89.2%
My neighborhood has at least one grocery store near me where I can buy fresh fruits/vegetables	79.3%
It's easy to walk to a transit stop from my home	78.3%
I feel safe walking in my neighborhood	68.5%
My neighborhood has parks and green areas where children can play	68.2%
My neighborhood has a high crime rate	62.2%

Literacy and Language Barriers

Health literacy. As a measure of health literacy, we asked respondents how often within the past 12 months they had difficulty understanding a health care provider's medical advice or instructions. Among insured, 57% indicated they had difficulties as compared to 72% of uninsured. Nearly half (48%) of White respondents indicated they had difficulties as compared to 67% of Asians, 64% of African Americans, and 57% of Hispanics. With respect to English-language proficiency, those who were not proficient were more likely to always have difficulties understanding medical advice than English-proficient individuals.

Table 13. Frequency of Respondents with Difficulties Understanding a Health Care Provider's Medical Advice or Instructions

Never	Sometimes	Usually	Always
38.4%	39.7%	13.1%	8.9%

Table 14. Frequency of Respondents with Difficulties Understanding a Health Care Provider's Medical Advice or Instructions by English Language Proficiency

	Never	Sometimes	Usually	Always
LEP	33.8%	39.1%	12.8%	14.3%
English proficient	41.9%	40.1%	13.4%	4.7%

Linguistic Barriers. In order to understand linguistic barriers, we asked three questions of those who said they spoke a language other than English at home. The first question asked whether there was a time in the last 12 months when the respondent needed an interpreter at a health care setting. Forty-six percent of respondents indicated that they had faced such a situation, and among the limited English proficient 54% had required the services of an interpreter. Asians (as a whole) were less likely to indicate a need than were Hispanics (36% and 57%, respectively). By language, however, 67% of Chinese speakers, 24% of Hmong speakers, 61% of Spanish speakers, and 40% of Vietnamese speakers indicated the need for an interpreter.

Of those who had indicated a need for an interpreter, we asked whether they had been informed at the health care setting that an interpreter was available free of charge. Overall, 28% indicated that they had not been told of free interpreter services. Among the insured, 21% had not been informed of free

interpreter services while 42% of uninsured respondents were not informed. Responses did not vary by race/ethnicity and there were insufficient data to analyze by language spoken at home.

Table 15. Frequency of Need for Interpreter Services by Insurance Status

	Never	Sometimes	Usually	Always
Newly insured	8.6%	40.0%	0.0%	51.4%
Uninsured	9.7%	38.7%	19.4%	32.3%
Total	9.1%	39.4%	9.1%	42.4%

Facilitators to Accessing Care

Overall Facilitators

Respondents identified several factors that would facilitate or help them access health care, chief among them being able to afford the expense of care as well as learning the knowledge and skills necessary to navigate the health care system. Facilitators varied somewhat by insurance status. For example, for the insured, being able to find a doctor nearby (69%) or a doctor in general (66%) were reported as the top priority, followed by understanding of how to use health insurance (65%) and being able to afford out-of-pocket expenses (62%). In contrast, for the uninsured, health insurance was identified as the top facilitator, as reported by nearly 9 out of 10 uninsured respondents. More than half of insured respondents and nearly three in four uninsured suggested enhancing clinic/health center capacity would also help access, especially the availability of more sites and night/weekend hours.

With respect to race/ethnicity, insured Asians were less likely to indicate being able to afford out of pocket expenses (28%) compared to other race/ethnic groups (9%). African Americans were more likely to cite transportation as a potential facilitator (76%) compared to other groups (46%). Finally, individuals with LEP were more likely (74%) than the English proficient (47%) to want a doctor who looked like them or spoke their language. Likewise, those with LEP cited the desire for written medical forms, instructions, and information in their language (73%) more often than did the English proficient (47%)

Table 16. Facilitators for Accessing Care by Insurance Status

Facilitators to Accessing Care	Insured		Uninsured		Total	
	#	%	#	%	#	%
Out-of-pocket expenses for insured/health insurance for uninsured	124	62.0%	79	88.8%	-	-
How to use for insured/How to get insurance for uninsured	129	64.8%	64	75.3%	-	-
Finding a doctor (insured only)	127	66.1%	-	-	-	-
Finding a doctor nearby (insured only)	123	68.7%	-	-	-	-
Transportation	94	48.7%	43	54.4%	137	50.4%
More clinics/health centers	116	59.2%	58	73.4%	174	63.3%
Night and weekend hours	108	56.0%	56	73.7%	164	61.0%
Child Care	74	41.3%	30	44.1%	104	42.1%
Language Providers	102	54.3%	57	74.0%	159	60.0%
Health Literacy	96	53.9%	55	74.3%	151	59.9%

In addition to determining what facilitators would improve access to care, the survey was also interested in identifying whether partnerships between health care providers and community-based organizations might improve access to care. The table below indicates the percentage of respondents who felt that

such partnerships would improve access by organization type. More than half of respondents cited that partnerships between health care providers and community organizations would improve access. In particular, 7 in 10 cited partnerships that address underlying socioeconomic determinants as most important (e.g., education, job training, food security, and housing support).

Table 17. Percentage of Respondents Indicating it Would be Easier to Access Care if Health Care Providers Partnered with Community Organizations, by Type of Organization

Type of Community Organization	Percent
Adult education/job training	77.6%
Schools (K-12)	73.8%
Food banks or pantries	71.8%
Housing support (subsidized, emergency, transitions)	69.4%
Child care/day care settings	67.4%
Legal aid/criminal justice	67.1%
Family planning	62.9%
Mental health counseling	62.2%
Behavioral health/substance abuse counseling	61.0%
Places of worship (e.g., churches, temples)	57.3%

Health System Navigation

Care coordination. Overall, 72% of uninsured and 44% of insured respondents had difficulties with care coordination. Respondents who indicated that they experienced difficulty coordinating care were asked to identify what would make the process easier. By race/ethnicity, Asians were most likely to express a need for each of the potential facilitators to coordinated care.

Health insurance and system navigation. To understand how community members perceived various sources of information on health care, respondents were asked to identify the source they trusted most. Of note, newly insured respondents more often cited their health care providers while the uninsured more often cited friends and family or did not have a most trusted source.

Thirty-seven percent of Asians indicated that their most trusted source was a community-based organization. By comparison, no African-American or White respondents cited community-based organizations. Additionally, English-proficient respondents were more than twice as likely to cite health care providers while the LEP were nearly three times as likely to indicate a community-based organization. African Americans cited either friends and family or none at all (21.7% each) as the most trusted source of information on health care. Respondents were also asked where they received the most helpful information on health insurance options through Medi-Cal and Covered California. Newly insured respondents were more likely to indicate community-based organizations while the uninsured cited friends and family most commonly. Of note, once again a large proportion of Asian respondents (51%) cited a community-based organization as their most helpful source. White respondents were most unlikely to indicate friends and family as their key source of information.

Table 18. Facilitators of Care Coordination by Insurance Status

	Insured	Uninsured	Total
Education about seeing multiple providers	52.7%	41.0%	48.7%
Help understanding, scheduling, and visiting providers	50.0%	41.0%	46.9%
Sharing medical histories between providers	52.7%	53.8%	53.1%
Someone to help manage and navigate providers	68.9%	59.0%	65.5%
Knowing my eligibility to get care	58.1%	79.5%	65.5%

Table 19. Most Trusted Sources of Health Care by Insurance

Sources on Health Care	Insured	Uninsured	Total
Friends and family	20.4%	33.3%	23.7%
Community-based organization	20.4%	20.5%	20.4%
Health care providers	18.6%	5.1%	15.1%
Online	12.4%	10.3%	11.8%
None	4.4%	18.0%	7.9%
News media	7.1%	5.1%	6.6%
My employer	4.4%	5.1%	4.6%
Covered California	5.3%	0.0%	4.0%
Other	3.5%	2.6%	3.3%
Faith-based organization	2.7%	0.0%	2.0%
Insurance agent or company	0.9%	0.0%	0.7%

Table 20. Most Helpful Information Sources on Medi-Cal and Covered California by Insurance Status

Sources on Medi-Cal and Covered California	Insured	Uninsured	Total
Friends and family	28.2%	42.6%	32.7%
Community-based organization	30.1%	10.7%	24.0%
None	6.8%	12.8%	8.7%
Other	5.8%	12.8%	8.0%
News media	3.9%	6.4%	4.7%
Health care providers	7.8%	2.1%	6.0%
Online	5.8%	4.3%	5.3%
Insurance agent or company	1.0%	2.1%	1.3%
My employer	4.9%	2.1%	4.0%
Covered California	4.9%	2.1%	4.0%
Faith-based organization	1.0%	2.1%	1.3%

In an open-ended question asking the newly insured about what they would like to learn that would help them most in using their health insurance, common responses included education about deductibles and how they met them, benefits and what services were covered, where to go to get covered medical care, how to gain easier access to care, and how to improve communications with their doctors.

Finally, both newly insured and uninsured respondents were asked how helpful educational/informational events on a variety of topics would be to understand health insurance options and use their health insurance, if applicable. Larger proportions of insured African Americans (76%) and Hispanics (69%) indicated that an event focused on understanding the basics of health insurance would be very helpful, compared with Asians (54%) and Whites (50%).

Table 21. Percentage of Respondents Indicating a Potential Event as "Very Helpful" By Insurance Status

Hypothetical Event Topic	Percent Describing Event as "Very Helpful"		
	Insured	Uninsured	Total
Understand the basics of health insurance (such as knowing what premiums, deductibles, and co-pays are)	63.5%	-	-
How to determine insurance eligibility	-	84.0%	-
How to buy health insurance	-	78.8%	-
How to find a provider of your choice	67.8%	82.1%	71.8%
How to use health insurance at health care settings	61.4%	83.1%	67.5%
How to communicate with providers	65.8%	84.0%	71.1%

Discussion

The Affordable Care Act has made historic gains in boosting health care coverage nationally and in the state of California. In the Sacramento area alone, 393,000 people were eligible for coverage through the marketplace and Medi-Cal expansion.[33] Since 2014, 95,000 have purchased health insurance through Covered California and an additional 155,000 enrolled through Medi-Cal, with many low-income, racially and ethnically diverse, and LEP communities gaining new coverage.[34,35,36] These new gains are important especially as studies on health insurance confirm that higher rates of coverage contribute to increased access and use of preventive services, improved disease management, and better overall health.[37,38,39] Within this pilot study's sample, having any kind of health insurance was associated with improved access to care, as represented by better health status and greater likelihood of having a usual source of care, and lower rates of forgone or delayed care. However, health insurance alone is not sufficient to assure access to care. Our findings point to a host of barriers within and beyond the health care system that prevent access even among those with coverage.

In this section, we identify and discuss major themes that emerged from our study highlighting the complex web of factors contributing to access barriers in South Sacramento. As discussed, these findings reinforce coverage and access challenges observed nationally in the aftermath of the ACA's implementation. While grounded in one community's local experiences and circumstances, our results offer lessons and points for consideration that may be of relevance to other states and localities facing similar concerns across the country.

Key Study Findings on Access to Care in South Sacramento

- *Barriers to health insurance remain*, with surveyed Hispanics and limited English proficient individuals facing some of the greatest challenges.

- *Health insurance alone does not guarantee access to care*. More than one-third of newly insured respondents felt that accessing care had become more challenging, not less, since obtaining coverage. Unmet health needs and non-emergent emergency room utilization are still prevalent among newly insured.

- *Cost remains a major barrier to access even after coverage*, with concerns most pervasive among African American respondents.

- *Health system barriers*, especially narrow provider networks, impede access to care even after coverage.

- *Broader social determinant factors*, such as economic security, transportation, and safety, are playing out as salient barriers. In addition, language, culture, and literacy also contribute to access, with concerns most prevalent among Asian, Hispanic, and limited English proficient respondents.

- *Community-based organizations and health centers were identified among key assets and partners* in South Sacramento, especially for reaching Asian and Hispanic populations.

Barriers to health insurance remain, especially among surveyed Hispanics and limited English proficient populations. Nearly one-third of those surveyed reported not having any kind of health insurance. Among respondents, Hispanics had the highest uninsured rates—nearly half of all Hispanics in our study did not have coverage, while of those in this group who were LEP, two-thirds were uninsured. While language was identified as a key barrier, immigration status was also cited anecdotally as an important contributor. Notwithstanding the study group size and sampling, however, our findings generally align with emerging national and state data following the ACA's insurance expansion that suggest that while all racial/ethnic groups have seen coverage gains, Hispanics continue to have the highest uninsured rates.[40]

In California, for example, a longitudinal panel survey by Kaiser Family Foundation found considerably higher rates of uninsured among Hispanics, of which almost half were not eligible for Covered California or Medi-Cal due to immigration status.[41] Many who were eligible reported their reluctance to enroll as they feared the process would bring attention to their family's immigration status. In addition, one national study found differences by nativity, reporting that 87% of US-born Hispanics were covered as compared to 78% of foreign-born Hispanics. This study suggested that language, ineffective outreach to Hispanic populations, concerns of affordability, and varying views of personal health care were all contributing reasons why many still did not have coverage.[42] Improvements may be on the horizon for undocumented immigrants in Sacramento, beginning in May 2016 when an estimated 240,000 undocumented children will become eligible for Medi-Cal under a new California law.[43] At least one California state lawmaker intends to introduce a bill to extend Medi-Cal coverage to undocumented adults in the upcoming legislative session.[44]

> *"I can't get an appointment because I don't have documents.*
> *This is also why I can't get insurance."*
> *--Uninsured Hispanic Respondent*
>
> *"No papers, no service!"*
> *--Uninsured Hispanic Respondent*

Health insurance is not sufficient to guarantee access to care, as evidenced by continued unmet health care needs, non-emergent emergency room utilization, and other factors. More than one-third of newly insured respondents felt that accessing care had become more challenging, not less, since obtaining coverage. Unmet health care needs also remained even after coverage as cited by one in four newly insured. The highest rates of unmet health care needs were observed among Hispanic and Asian respondents, and the most prevalent health concern identified by respondents was mental health. In addition, even after obtaining coverage, many newly insured cited the ER as a usual source of care or a source they had recently used for non-emergent medical concerns. ER utilization was highest for African Americans in our survey—where nearly half cited use of the ER in the past 12 months as compared to one-third of Hispanics and Whites. African Americans were also most likely to explicitly cite the ER as a usual source of care. When asked reasons for why individuals utilize the ER for non-medical emergencies, nearly two-thirds said it was a choice of convenience given that no appointment was required. Difficulty securing a primary care appointment within seven days was cited as a problem by more than half of the survey respondents.

Our findings generally mirror recent studies from California and the region. For example, in 2015, the California Health Care Foundation (CHCF) reported that one in six Medi-Cal enrollees did not have a usual source of care other than the ER, despite being insured.[45] And a January 2016 report from CHCF partially attributed overcrowding concerns in Sacramento safety-net ERs to populations newly insured under the ACA.[46] Sacramento-area hospital administrators observed that pent-up demand for care spilled over into ERs because the region's primary care capacity was strained due to difficulty securing appointments for primary or urgent care services. These local circumstances mirror national concerns that unmet demand for primary care may be contributing to use of ER services for non-emergent needs:

in a 2016 nationwide survey, 80% of respondents said they had resorted to ER care at least once in the past two years after being unable to see their regular doctor.[47]

Cost remains a major barrier to access, even after coverage, with cited concerns most pervasive among African American respondents. Even with the financial assurance of health coverage, our responses showed that low-income residents of South Sacramento continue to face difficult choices between health care and other essential expenses, which for some involves taking on costly medical debt. Our data suggest that surveyed African Americans in South Sacramento are facing some of the greatest difficulties paying medical bills, a trend that is generally playing

Hispanic survey respondents had the greatest difficulty accessing care they needed, while African Americans were most likely to have difficulty paying for care.

out nationally. Other research has suggested that while 1 in 5 Americans still face hardships due to medical costs, African Americans are the hardest hit.[48] For instance, a 2013 survey by NPR, the Robert Wood Johnson Foundation, and the Harvard School of Public Health found that 1 in 3 African Americans had serious problems paying bills from doctors or hospitals in the past year (comparable to the 32% we found through our work in South Sacramento). Additionally, nearly 1 in 4 African American families had problems paying for needed prescription drugs. These challenges are likely tied to general economic insecurity faced by many African Americans in the community. Median household income for African American families in the seven South Sacramento ZIP codes averages $31,642, with an unemployment rate over 20%.[49]

Costs associated with maintaining and utilizing coverage (e.g., monthly premiums, deductibles, and copayments) and purchasing prescription medications were among primary challenges cited by newly insured to accessing care. These data reaffirm many updates emerging from studies around the country. For example, a recent national survey administered by the Harvard School of Public Health similarly found that health care costs have created a serious financial problem for 26% of American families, with approximately 20% saying they have financed health care by taking on debt that may be difficult to pay off.[50] Similarly, Kaiser Family Foundation found that nearly half of newly insured adults in California said it was difficult to afford monthly premiums and more than a third delayed or went without care due to cost.[51] The nationally representative Health Reform Monitoring Survey conducted by the Urban Institute also showed that while affordability improved by 2.7 percentage points from before to two years following enrollment, nearly one-third of respondents still reported unmet need for care due to cost.[52]

Health systems barriers, especially narrow provider networks, continue to impede access even after coverage. Frustration with narrow provider networks was among the top concerns cited by newly insured in this study, closely following cost. Nearly half of them said that providers would not accept their health insurance. Of this group, an overwhelming majority (92%) were enrolled in Medi-Cal. Concerns with provider access under Medi-Cal has been an ongoing challenge in California, and many advocates point to low provider reimbursement rates as the primary reason. Medi-Cal pays approximately 40 cents for every dollar that Medicare reimburses for a traditional office visit for a returning patient — a rate lower than nearly all states in the country.[53] This lower rate discourages doctors from taking on new or more patients. In fact, a 2014 report found that the ratio of primary care doctors participating in Medi-Cal was 35 to 49 full-time-equivalent physicians per 100,000 enrollees, nearly half the federally estimated amount of need. Whereas 92% and 77% of responding primary care physicians stated that they accepted privately insured and Medicare patients, respectively, only 69% said they cared for any Medi-Cal patients.[54] Additionally, a 2015 CDC report ranked California 49th out of 50 states in Medicaid patient acceptance rates, with only 54.2% of physicians indicating new Medi-Cal patients were accepted in their practice.[55]

A state audit of managed care programs covering nearly 4 in 5 Medi-Cal beneficiaries released in June 2015 highlighted other reasons for continued access concerns.[56] Provider directories were reportedly inaccurate or not updated with current contact information, and the report identified regulatory concerns around proper certification of plan networks to include an adequate distribution of providers geographically. Three out of Sacramento County's four Medi-Cal managed care plans are troubled with ongoing quality and access problems that compound difficulties in delivering care to the Medi-Cal expansion population.[57] Only Kaiser, which covers 18% of Medi-Cal managed care enrollees in Sacramento County, performs acceptably on quality and satisfaction measures.

> *92% of newly insured survey respondents whose providers would not accept their insurance were covered by Medi-Cal.*

Beyond Medi-Cal, narrow networks in marketplace plans also can potentially limit health care access for newly insured. Many health plans in state health insurance marketplaces have reduced the number of covered hospitals and physicians in an attempt to hold premiums down and improve efficiency. The trade-off, however, has been access. Nearly 75% of Covered California customers have narrow physician networks, meaning fewer than 25% of physicians are included in a rating area. Only three other states (Georgia, Florida, and Oklahoma) have a higher percentage of small provider networks.[58]

Broader social determinant factors, such as economic security, health literacy, transportation, and safety, are also among key access barriers. Newly insured were more likely to identify social determinant-related challenges to access that extended beyond the hospital or clinic and into the communities where people live, work, and play (most uninsured respondents were almost exclusively concerned about cost and affordability challenges). Respondents' concerns focused on four community and individual priorities:

> *"I never let my children go [to the park]. It's very dangerous."*
> --Uninsured Hispanic Respondent
>
> *"Safety depends on the time. In the evening it is dangerous. I drive and prefer not to ride the bus."*
> --Uninsured Hispanic Respondent

- ***Transportation***. One in three newly insured and one in five uninsured cited transportation as a barrier to accessing care. Lack of transportation and longer geographic distances to providers are associated with decreased likelihood for a usual source of care.[59] Nationally, as many as 55% of low-income populations have reported missing appointments due to transportation barriers.[60] And following the ACA, anecdotal accounts from other states suggest that transportation is among primary barriers to care experienced by newly insured.[61]

- ***Crime and Safety***. Crime and safety were also identified as key community issues. Several respondents described intentionally avoiding public spaces like parks, sidewalks, and transit due to safety concerns, and one in five respondents explicitly stated that such concerns prevented them from accessing health care. Similar results from the South Sacramento

> *20% of South Sacramento residents surveyed did not seek needed health care due to crime and safety concerns.*

California Health Interview Survey indicate that adults in South Sacramento are less likely than the county and state population to feel safe in their neighborhoods. Just three in four children in

South Sacramento feel safe in local parks and playgrounds compared to over 90% of children county- and state-wide.[62]

- **Socioeconomic factors**. As previously discussed, economic security also seemed to be an important access barrier, especially among surveyed African Americans who reported the greatest difficulty paying medical bills and considerably higher ER utilization rates. In addition, we found that over one-third of all respondents reported that they used the ER to help them connect to social services such as housing or food. When asked whether social service and clinical partnerships were important, more than half of those surveyed reiterated their importance, with over 7 in 10 citing that community-clinical partnerships around education, employment, food security, and housing would facilitate access. Leading health care groups in California and the nation have also observed and reacted to this need by innovating strategies to reach out to medically vulnerable individuals where they live, work, shop, attend school, and pray.[63]

- **Language, literacy, and culture**. Health literacy, as measured in our survey by level of ease in understanding medical advice, was also cited among key barriers to accessing care. In particular, over two-thirds of surveyed Asians and Hispanics said that they had difficulty understanding medical advice. And rates of difficulty were higher among LEP individuals than those speaking English. In addition, trust and culture may be playing contributing roles in access to care decisions, especially among culturally and linguistically diverse populations. For example, we found that nearly two-thirds of Asian respondents had somewhat, little, or no trust in providers they saw in the past 12 months and similarly felt that providers did not understand or respect cultural beliefs. These findings reiterate the important and integrated role that language, culture, and literacy play in shaping access perceptions and opportunities for many diverse communities.

Community-based organizations and health centers identified among key assets and partners. Finally, our survey revealed that community-based organizations and health centers are playing important facilitating roles to ease access burdens and challenges in the community. When asked to identify their usual sources of care, community health centers were identified among primary sources for responding Hispanics, Asians, and LEP individuals. Similarly, when asked to report primary sources of information and resources on coverage and care, community-based organizations were identified as important sources, and the top source for Asians, the LEP, and the newly insured. In addition we found African Americans tended to rely most on information from social support networks, including family and friends. These findings reinforce a large body of work that suggests that community assets, trusted sources of information, and messengers largely vary by race/ethnicity, culture, and English language proficiency.[64] For example, other studies in California have found the promise of partnering with community organizations, including nonprofits, ethnic organizations, faith-based organizations, and schools, as important sites for health insurance education and enrollment among Asian and Pacific Islander populations.[65]

Moving Forward

Our survey and review of related findings from California and the nation identified and reaffirmed many of the challenges facing South Sacramento communities. Covered California estimates that 131,000 or more Sacramento area residents remain uninsured.[66] The marketplace has identified portions of South Sacramento, including Florin, as "hot spots" where a high proportion of subsidy-eligible residents have yet to enroll in coverage.[67] For many of those who are now insured, health care system and setting concerns are a continuing challenge in accessing care, with community and individual circumstances having the potential to also significantly impede access. Expanding coverage and transitioning residents from coverage to care to improve overall health in South Sacramento and beyond will require a set of concerted strategies that integrate and address individual, systems, and community drivers of access to care (Figure 17).

Figure 17. Framework to Improve Community-Wide Access to Care and Health

Community Levers	• Addressing broader social, economic, environmental, and political drivers of health.
Health System Levers	• Addressing factors within health care systems to improve care capacity, accessibility, and quality.
Individual Levers	• Addressing knowledge, language, culture, behaviors, and other individual factors.
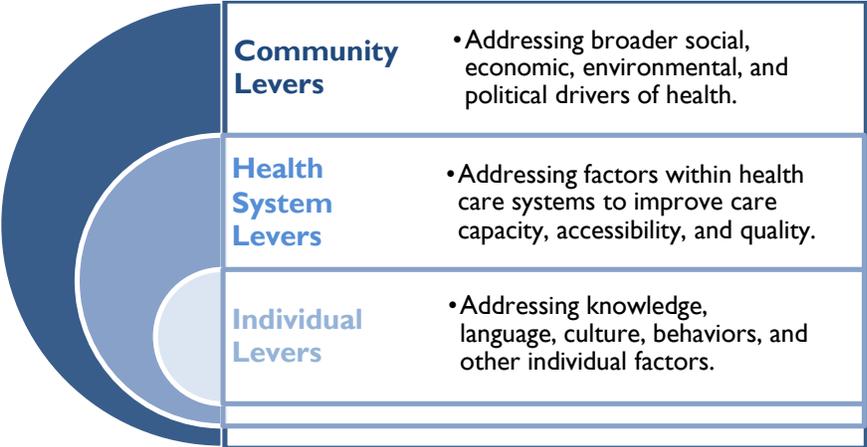
As described in the following narrative, we use the three dimensions of this framework to identify three potential areas of priority for policymakers, philanthropies, health care providers, and community advocates to consider as they work to advance and improve access and care at the individual, system, and community level in communities across Sacramento, California, and the nation:

- **INDIVIDUAL LEVERS:** *Advancing health insurance literacy* by engaging and supporting trusted partners and applying culturally and linguistically tailored approaches to help foster individual understanding of its importance, maintenance, and health care use.

- **HEALTH SYSTEM LEVERS:** *Enhancing primary care capacity and access* through a focus on patient-centered team-based care, care coordination, and service integration as well as reinforcing the need for adequate payment for Medi-Cal and other historically disenfranchised populations.

- **COMMUNITY LEVERS:** *Moving toward Accountable Communities for Health* by building new or enhancing existing regional clinical-community partnerships to strategically plan, measure, and hold community-wide organizations accountable for the region's overall health.

INDIVIDUAL LEVERS: Advancing Health Insurance Literacy

Health insurance literacy (HIL) is defined as "the capacity to find and evaluate information about health plans, select the best plan given financial and health circumstances, and use the plan once enrolled."[68] HIL is central to arm individuals with the information they need to understand coverage options, motivate enrollment, maintain coverage, and encourage proper utilization and access to care.[69,70] Several of our findings such as lack of a usual source of care, continued ER utilization, and concerns with narrow provider networks among newly insured, strongly affirm the value of improving HIL. Related initiatives can significantly improve the capacity of recently enrolled individuals to understand, navigate, and use health care services and choose the insurance options most appropriate for them.

> *Over two-thirds of newly insured surveyed in South Sacramento say that education on the following knowledge and skills would help them access care:*
>
> - *Basic health insurance terms*
> - *Finding providers*
> - *Using coverage*
> - *Communicating with providers*

When asked directly in our survey, more than half of all respondents said that education on health insurance would help improve their ability to understand and use care.

Reviewed research and our survey affirm that substantial gaps remain in knowledge about health insurance—with potentially significant consequences. These gaps, and sometimes myths or misconceptions, not only stand as barriers to gaining coverage, but for those newly insured is often tied to buyer's remorse, improper utilization of health care services, and/or loss of coverage.[71] In addition, when compounded by cultural or linguistic barriers, HIL gaps are far more pronounced among non-white and non-English speaking individuals than others.[72] Empowering individuals with HIL is associated with confidence in ability to pay and retain coverage.[73] Promising efforts from around the country suggest that working to improve HIL rests on four key strategies:

- ***Meeting consumers where they are:*** providing information on coverage options, how to enroll, and how to use health insurance in trusted, accessible venues (where they live, work, pray, and play) such as faith organizations, schools, libraries, and through ethnic or social media platforms.

- ***Educating through trusted voices:*** providing education and information through trusted messengers. For example, an Enroll America survey found that consumers want to learn about their coverage and how to use it from their health insurance company (54%), in-person assister (42%), and non-profit organizations (33%).[74] Trusted voices will likely vary by race/ethnic group. For example, through our study we found that in South Sacramento, Asians preferred education from community-based organizations, Whites tended to seek information from health care providers, and African Americans consulted their friends or family most often.

- ***Assuring culturally and linguistically appropriate and tailored education:*** What motivates consumers, the barriers they face, and a priori judgments are often driven by historical experiences, cultural norms and beliefs, and language. As such, education and orientation on coverage and utilization must be tailored for culturally and linguistically diverse consumers.

- *Recognizing that many individuals require "multiple touches"*: A resounding theme year after year following open enrollment is that many individuals, especially those unfamiliar with health insurance and with low literacy or numeracy require "multiple touches" or interactions before they can fully grasp the concept of health insurance and how to use it to access care.[75]

Models and evidence. Enroll America has led national efforts to test and understand ways to improve HIL, with early indications that suggest the need for more consumer-specific information and tools to help individuals understand components of coverage, compare different plans, and calculate costs. Still other work highlights the central role of in-person education, pointing to the "lifelong health liaison" role that navigators, in-person assisters, and brokers have adopted as "go to" sources of information about health insurance and accessing care.[76] Many marketplaces have also established programs to help advance HIL. For example, Access Health CT, Connecticut's state health insurance marketplace, collaborated with a TV station to create short videos on health. Washington's state marketplace explicitly undertook a health literacy project in 2014 to produce plain language materials in eight languages to help consumers buy and use coverage. The marketplace also developed a Health Literacy toolkit for assisters.[77,78] In addition, the Colorado Consumer Health Initiative created an interactive website called CoveredU with easy-to-understand information in English and Spanish on buying and using insurance. [79]

> **Health Insurance Literacy Tools**
>
> - Enroll America's Health Insurance Literacy Resource Hub
> - Centers for Medicare and Medicaid Services Health Insurance Literacy Resources
> - Office of Minority Health's Coverage to Care Initiative
> - Alliance for Health Reform's Health Insurance Literacy Resources
> - Kaiser Family Foundation's Cartoon Series on insurance concepts, accessing care, and filling prescriptions
> - Families USA materials targeting assisters

While concerted in-person education that is culturally and linguistically tailored and provided by trusted and knowledgeable messengers at accessible venues is critical to advance a better understanding of health insurance, its importance, and its utilization, these efforts require dedicated staffing and support to initiate and sustain—a potential role that local philanthropies or nonprofit organizations with related foci could fill.

HEALTH SYSTEM LEVERS: Enhancing Primary Care Capacity and Access

Expanding primary care capacity to meet surging demand has been a key challenge facing many health care providers, and especially those in the Sacramento region. A confluence of factors over the years have contributed to the region's strained health care capacity, stemming from a mix of economics, politics, and policies such as the ACA's coverage expansions and very low Med-Cal reimbursement rates, reductions in inpatient and outpatient mental health care in the wake of the 2009 budget crisis, and a fragmented, under-funded system of safety-net providers. While a recent California Health Care Foundation report[80] found an upswing in these circumstances (such as 2015 restoration of mental health funding) and a somewhat more progressive County Board of Supervisors, many providers continue to report strains on their capacity to meet rising demand. This contention was supported by our survey that suggested that even those with coverage are facing serious barriers to accessing care—including reportedly narrower networks, long delays for appointments, and preventable utilization of ERs. While shoring up capacity to meet existing shortages and demand could take years of investment, focusing on the patient and improving efforts to integrate and coordinate care and link services may offer more

short-term opportunities that are built around existing health care and community-based resources. In doing so, systems that have already established patient-centered medical homes (PCMHs), or may be transitioning to do so, may find opportunities to improve access as they work to achieve its five key attributes: patient-centeredness, comprehensive care, coordinated care, accessibility, and commitment to quality and safety. In particular, our findings point to three key PCMH features for consideration for hospital systems, health centers, clinics, and philanthropies in the region as they work to facilitate health care access:

- **Team-based care**: As difficulty finding providers, care coordination, and limited health/health insurance literacy were all identified as key barriers from our survey, providers in the region may benefit from strengthening existing or transitioning to establish new team-based, coordinated care initiatives. Team-based care is care provided by a small group of clinical and non-clinical staff who, together with a provider, are responsible for the health and well-being of a panel of patients. The approach was borne out of a need to address regional physician shortages as well as better coordinate and deliver quality, patient-centered care. As such, team-based care has expanded the role of advance practice clinicians (such as physician assistants and nurse practitioners) who provide acute, non-urgent, and routine care, sometimes working with supervising physicians and in other cases having their own designated patient panels. In addition, many have incorporated new roles for social workers, case managers, and community health workers, often termed Clinical Community Health Workers (CCHWs), who together with medical providers seek to address and manage both downstream health concerns as well as upstream, root causes.

    Models and evidence. CCHWs are playing important roles to provide case management, support individual care plans, patient health education, system navigation, home visits, social support, and referrals—all of which can provide an opportunity to improve and facilitate access by providing culturally, linguistically, and socioeconomically tailored education and interventions.

Five Key Attributes of Patient-Centered Medical Homes

o *Patient-centered,* meaning that health care is grounded in relationships with individuals and families, including respect for unique cultures, values, and preferences. Patients are viewed not as care recipients, but care participants.

o *Comprehensive,* wherein the medical home assumes accountability for the health of the population it serves. Teams of providers including physicians, nurses, physician assistants, pharmacists, nutritionists, social workers, and more combine their knowledge and skills to support patients in achieving whole-person wellness.

o *Coordinated,* facilitating seamless transitions between sites of care and other services in the broader health community. Clear and open communication between patients and providers is the foundation of this function.

o *Accessible,* characterized by reasonable waiting times, evening and weekend hours, on-call services, and alternative methods of connectivity to the care team including telephone, e-mail, and videoconference.

o *Committed to quality and safety,* guided by evidence-based practices and clinical decision support tools, performance monitoring, quality improvement, and data sharing.

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In California, spurred by a wave of transformation waivers, many models of successful team-based care have emerged. For example, San Francisco General Hospital's Pediatric Asthma Clinic has used the model for over 10 years to address whole child health, coordinating care between clinicians and social workers—including addressing the underlying environmental, home-based triggers of asthma in children. Recent studies suggest that team-based care can reduce health care costs by as much as 60%, in large part by reducing number of preventable ER visits.[81]

- **Integrated health services**: Our survey revealed considerable unmet health care needs, long appointment wait times, and problems accessing both primary and specialty care. Coupled with these findings, mental health concerns were cited as the top health priority across all racial/ethnic populations. Addressing mental health, as well as health concerns stemming from upstream, social determinant causes, will require "health in all policies" strategies that commit programs, agencies, and private sector organizations to work in concert to improve health care access and health. The current dynamics around the ACA and health care reform more broadly offer an important "point in time" opportunity for the Sacramento region to reinforce and expand efforts to integrate services, especially as it works to ramp up its capacity to address the large and growing demand in mental and behavioral health services (with the $14 million mental health funding restoration authorized in 2015). The Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration (HRSA) have developed a continuum of care integration that has helped systems assess their current position and progress toward achieving behavioral health integration. The SAMHSA-HRSA framework proposes integration at three levels, presented here from least to most fully integrated: [82]
    - *Coordinated*, which emphasizes communication and referral relationships between mental/behavioral health and other providers;
    - *Co-located*, characterized by availability and collaboration with mental/behavioral health services on-site or in close proximity;
    - *Integrated,* closely approaching a transformed/merged practice with frequent communication, interoperable information systems, and team-based approaches to care.

  Models and evidence. Movement toward integrated systems of care has been a central goal of California's 1115 Medicaid waivers, but progress in the state has been mixed, with considerable progress in some areas such as access to specialists and improving quality, but less success with others like coordinating care and aligning financial incentives.[83] A handful of safety-net systems in other parts of the nation have achieved sophisticated integration of mental and behavioral health with physical health care, and may serve as leading models for other systems. For example, the Cambridge Health Alliance in Cambridge, Massachusetts, has piloted a Mental Health Home that co-locates mental health and medical care in a single, familiar outpatient setting. The medical home delivers evidence-based clinical services and psychotherapy, and offers counseling groups to promote social-emotional functioning and physical wellness. Frequent social gatherings and accessible community support are core features of the Mental Health Home.[84]

- **Building clinical-community linkages to advance health care access**: Clinical-community linkages (CCLs) are defined as "creating sustainable, effective linkages between clinical and community settings to improve patients' access to preventive and chronic care services by developing partnerships between organizations that share a common goal of improving the health of people and the communities in which they live. These linkages connect clinical providers, community organizations, and public health agencies."[85] CCLs help to better coordinate health care delivery to promote healthy behavior; form partnerships to fill gaps in

needed services; and promote community involvement in strategic planning and improvement activities. Generally, CCLs fall under one of the following five types: [86]

- o Linkages that involve referral processes between providers—e.g., primary and specialty;
- o Linkages that connect academic and community providers for the purpose of training;
- o Clinical partner referrals to health resources in the community;
- o Clinical partner referrals to social service and other community organizations; and
- o Clinical volunteering in community programs.

CCLs differ from care coordination or case management, the latter of which focus on mobilizing resources and information toward individual patients' specific care needs. In contrast, CCLs enhance interagency relationships and in so doing work to overcome systemic barriers to caring for specific populations of concern. CCLs may vary in the formality of the relationships between partners, time commitments, and the extent of information and resource sharing between referral sources and destinations. [87]

Models and evidence. The AHRQ Innovations Exchange has compiled evidence on implementation experiences and outcomes from CCL initiatives across the nation, and has identified some promising efforts.[88] In Richmond, Virginia, for example, a group of medical practices mutually adopted electronic referral software allowing clinicians to easily connect patients to behavior counseling services for tobacco cessation, alcohol dependence, and weight loss. The referral software also allowed community-based counseling resources to report patients' progress back to clinicians. Frequency of community referrals increased and smoking quit rates improved among the population served.[89] In Seattle, Washington, the King County Steps to Health Project deployed community health workers as liaisons between patients, clinics/providers, and community resources. Efficiency of referrals improved, and better clinical outcomes were observed in patients with asthma and diabetes.[90]

While evidence mounts to suggest the promise of PCMHs, behavioral health integration, CCL initiatives, and team-based care, the optimization of service delivery in primary care remains contingent upon adequate system capacity and uptake of alternative reimbursement strategies. In South Sacramento, aligning payments will be critical to incentivizing providers to accept newly insured patients—especially those with Medi-Cal coverage. For patients, the value of enrolling in and maintaining health coverage diminishes if the system fails to demonstrate a capacity to meet their needs.

COMMUNITY LEVERS: Moving Toward Accountable Communities for Health

There is growing interest in building regional and collaborative systems of care that hold a broader set of organizations, including public health entities, health care providers, and social service organizations, accountable for the overall health and well-being of the community. This concept, also known as Accountable Communities for Health (ACH), has gained increasing momentum to shift the focus and accountability of improving population health from health care providers to community providers at large. This shift and context is especially important as communities work to address the root causes observed for health care access barriers, unmet health care needs, and preventable emergency and inpatient care. [91] For example, our survey pointed to many social determinants that may be playing an underlying role in hindering access, including transportation; financial concerns, especially among African Americans; language barriers among Hispanic, Asian, and other LEP populations; and neighborhood crime and safety that impeded as many as one-fifth of respondents from accessing care.

A growing body of work documents that clinical care accounts for a much smaller proportion (20%) of modifiable variation in health outcomes, whereas the majority (80%) is due to social and economic

determinants, health behaviors, and the physical environment.[92] Community services that address these health-related social and economic needs—such as transportation, unemployment, food insecurity, and unstable housing—have the potential to improve access to care, reduce preventable emergency visits and hospitalizations, and reduce unnecessary costs.[93,94,95,96,97]

ACHs represent an important emerging approach to health system transformation that seeks to link health care with community well-being. Sacramento, in the earlier years of health reform, was considered a "giant Petri dish" for new value-based delivery systems, especially as it implemented the state's most prominent Accountable Care Organization (ACO)—the CalPERS ACO. ACHs differ from ACOs in their view of health care as one of many intersecting systems that impact population health. ACHs address health from a community perspective by cultivating broader investment in health across all sectors, including public health, housing, transit, criminal justice, education, and more. Central to the ACO model are value-based payments and pay-for-performance initiatives that form the financial basis for supplying care, but ACHs aim to deliver added value through strong multi-sector coalition building and alignment that extends accountability to stakeholders both in health care and key social determinants of health.[98]

Models and evidence. Promising ACH models have recently emerged driven in large part by the ACA—some in efforts to widen the scope of existing ACOs and others conceived through State Innovation Model (SIM) grants. Hennepin Health,[99] a Medicaid demonstration project serving more than 10,500 enrollees in Minneapolis, Minnesota, emerged as a promising model of a social ACO. Hennepin Health enrollees are 70% non-White, and a large proportion has a mental health diagnosis.[100] Members receive coordinated care from interdisciplinary teams comprised of nurses, social workers, and community health workers who facilitate access to nonclinical and social services. Hennepin Health receives a per-member per-month capitation payment from the state to fund services to the Medicaid-enrolled population, and social services provided by the county are partially financed with dollars from these capitated payments. In the first year of implementation, ER visits declined by 9.1%, and 87% of patients were satisfied with their care; $2.4 million in cost savings has been achieved and reinvested in the ACO infrastructure and partners.[101,102]

State-supported regional partnerships also offer new opportunities. For example, King County ACH is among the regional ACHs formed as part of a statewide *Healthier Washington* initiative started in 2015.[103,104,105,106] Nine regions in Washington have been formally designated as ACHs after meeting requirements to establish formal operations and governance, multi-sector and community engagement, regional health improvement plans, and initial sustainability planning.[107] Central to these regional ACHs are "backbone" organizations or those providing operational support, including local public health, community-based organizations, and nonprofits. ACHs are focusing on a range of regional health priorities from access to care and community-based care coordination to specific chronic conditions such as obesity and diabetes to building community-clinical linkages to address underlying upstream drivers of health (e.g., housing, employment, and food security).

Minnesota is also among states advancing the ACH model. The state devoted 14% ($5.6 million) of its SIM funds to test and evaluate 15 community-led ACH grant projects coordinating care among 180 clinical and social providers for over 100,000 people.[108] Much like Washington's regional ACHs, those in Minnesota are built around regional health priorities, with an added emphasis to address and tailor efforts for historically disenfranchised and vulnerable populations—e.g., low income minorities, the homeless, individuals with disabilities, and those with behavioral health concerns.

Building on this promising momentum, ACHs have gained traction federally and in California. Federally, the Centers for Medicare and Medicaid Services (CMS) released a funding opportunity announcement in

early 2016 to further test and advance the ACH model through awarding 44 cooperative agreements ranging between $1 million to $4.5 million per recipient, totaling approximately $122 million over five years. This opportunity is intended to implement three AHC interventions of varying intensity that link community-dwelling beneficiaries who have unmet health-related social needs to appropriate community services—these interventions are as follows:[109]

1. *Awareness*: increase beneficiary awareness of available community services through information dissemination and referral;
2. *Assistance*: provide community service navigation services to assist high-risk beneficiaries with accessing services; and
3. *Alignment*: encourage partner alignment to ensure that community services are available and responsive to the needs of beneficiaries.

In California, a consortium of California foundations (The California Endowment, Blue Shield of California Foundation, and Kaiser Permanente) released a request for proposals to fund ACH projects throughout the state. Up to six awardees will receive up to $250,000 in the first year of funding and up to $300,000 per year for the next two years. Grantees will also receive technical assistance and participate in a learning community. California's deadline for ACH proposals is April 29, 2016, with an anticipated start date of July 1, 2016.

As communities across the state chart their paths forward through ACH or similar models, our findings strongly support the need for local perceptions and experiences of health care access barriers to drive planning and implementation of population health initiatives. The survey created as part of this study offers a tool that can be replicated or adapted to identify community-based health care access needs, barriers, and facilitators to inform strategic priorities for ACH formation. At the same time, this work provides a process by which to engage, involve, and build capacity for ongoing community-driven evaluation.

Conclusion

The success of the ACA in expanding health care coverage has been unprecedented—nearly 20 million have enrolled in marketplace and new Medicaid coverage, with the national uninsured rate at its lowest. At the same time, not all communities have benefited equally, with many still facing significant gaps in coverage. And for those newly covered, health insurance alone does not guarantee access to affordable and quality services, especially in communities where a confluence of demographic, socioeconomic, and neighborhood factors inhibit ready access to care. South Sacramento is a case in point, with resident respondents illuminating the community's health care access dynamics while also offering a reference for other communities regionally and across the country. Their collective experiences affirm that, for them, working to improve access will require health system providers and communities to work in concert through innovative, promising delivery and payment reforms to holistically address the upstream and downstream barriers they face. Only through such collaborative and integrated approaches can we work to advance health care access and population health in a post-ACA environment where health care demand and competition are quickly outpacing supply and capacity.

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