



California
Health Care
Foundation

**LISTENING TO CALIFORNIANS WITH COMPLEX NEEDS
PHASE II – WESTSIDE COMMUNITY IMPROVEMENT ASSOCIATION
IN-DEPTH INTERVIEWS & FOCUS GROUPS
KEY FINDINGS PRESENTATION**

MAY 2024



THE CLEAR PATH

Public Opinion Research

OVERVIEW

I. Research Objectives and Methodology

II. Sample Characteristics

III. Partner-Specific Key Findings

IV. Overall Phase II Key Findings

A Key Findings

B Needs—In Their Own Words

V. Focus Groups



I. RESEARCH OBJECTIVES AND METHODOLOGY

RESEARCH METHODOLOGY

- From February 5–February 9, 2024, EVITARUS conducted 20 in-depth interviews (IDIs) among residents experiencing complex needs in Eureka, California.
- Each interview was conducted by a professional interviewer in person, in partnership with Westside Community Improvement Association (WCIA), facilitated by Cal Poly Humboldt (CPH).
- Interviews were approximately one (1) hour in length. Each was recorded and transcribed to facilitate data analysis.
- Each participant received a gift card honorarium in the amount of \$150.00 in appreciation of their time and opinions.
- EVITARUS managed research planning, implementation, data collection and processing, analysis, and reporting.

RESEARCH OBJECTIVES

- The **primary objectives of the research** were to, at an individual level:
 1. **Gain insight into the experiences of Californians with complex needs:**
 - Experiencing being unhoused (homelessness) or housing insecurity;
 - Coping with mental health challenges and/or substance use disorder;
 - Challenges living independently as they age; and
 - Impacts of incarceration.
 2. **Identify the types of resources, social services, and health care supports** that individuals with complex needs would find helpful to promote health, wellbeing, and good quality of life.

RESEARCH AREAS OF FOCUS

- The interviews explored the following topics:
 - Aspirations and goals for better health;
 - Perceptions of needs and access to resources;
 - Experiences with case management;
 - Gaps in resources and services;
 - Trusted sources of care; and
 - Positives and negative experiences surrounding care, and care transitions.

II. SAMPLE CHARACTERISTICS

PARTICIPANT DEMOGRAPHICS

A total of
20 Eureka residents
participated in the study.

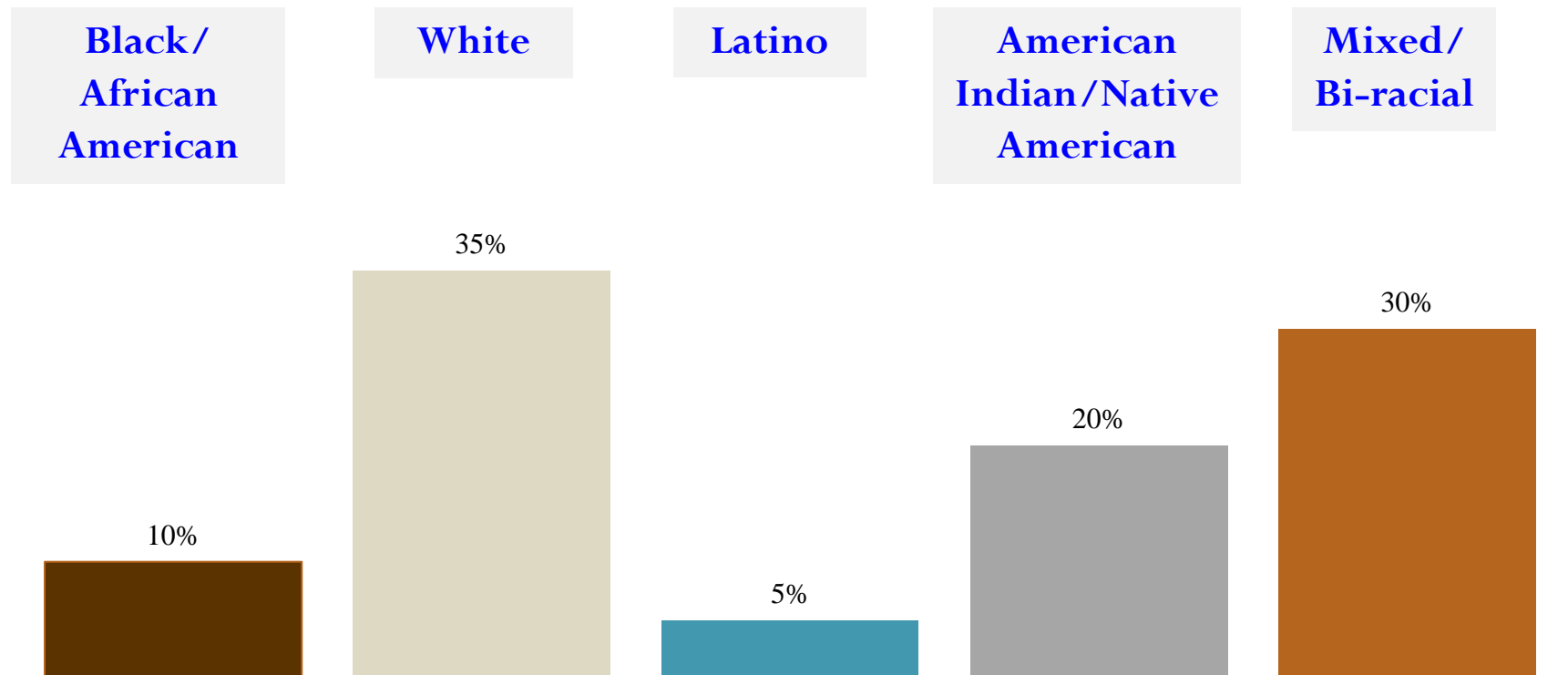


9 Women 10 Men

1
Non-Binary/
Prefer to Self-Describe

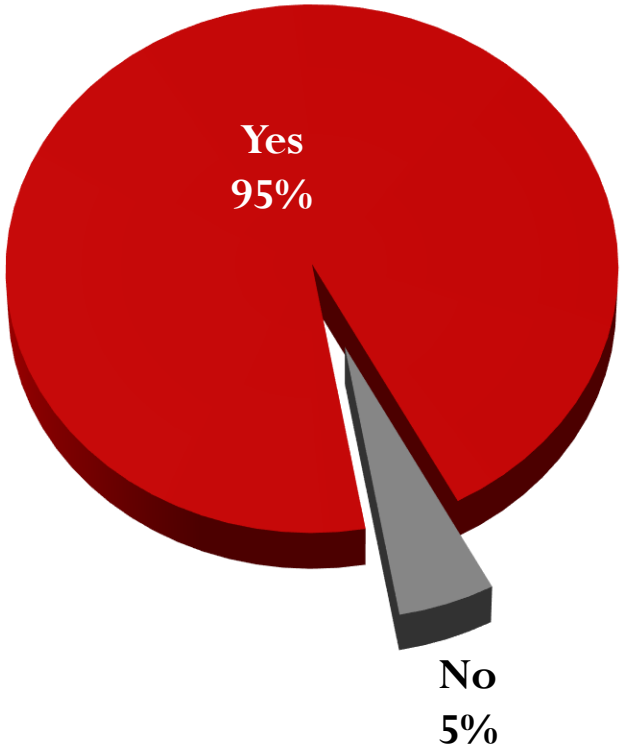
Age Range
18 – 60

Participants reflected the racial/ethnic composition of the Rural Far North, including Black/African American, White, Latino, American Indian/Native American, and Mixed/Bi-Racial.

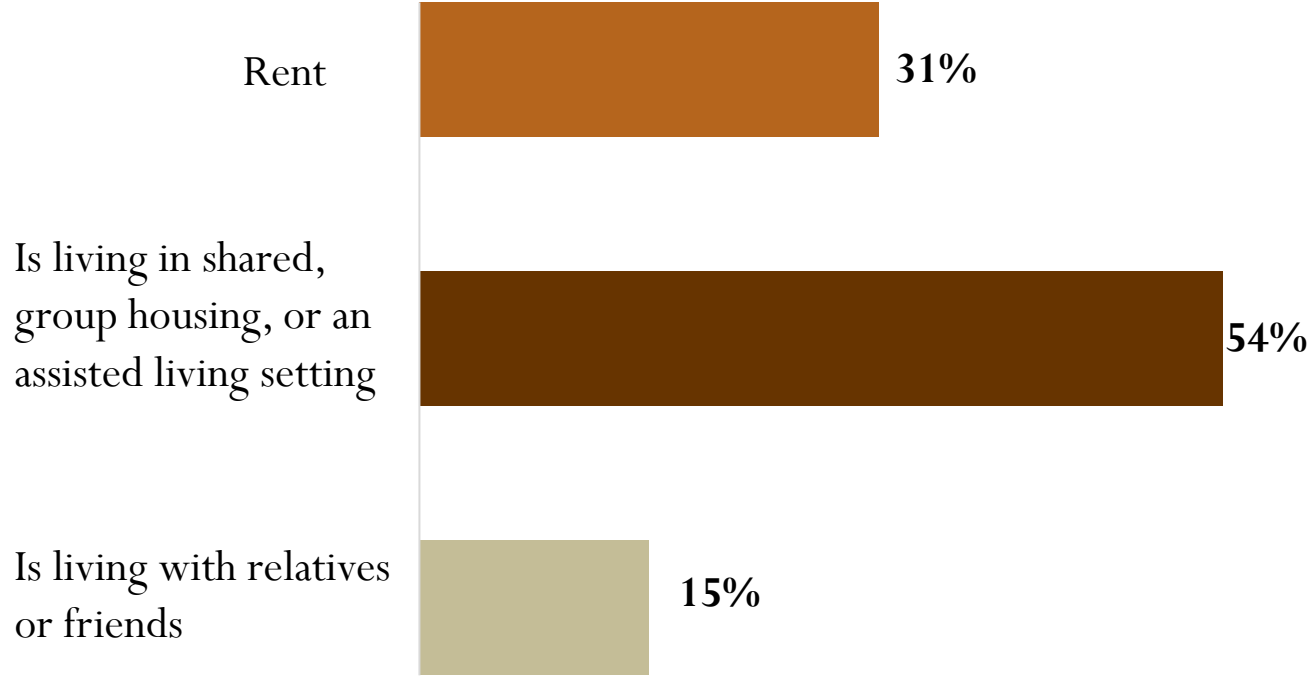


NEARLY ALL PARTICIPANTS HAVE EXPERIENCED HOMELESSNESS

Q: Have you ever been homeless or without a stable place to live?

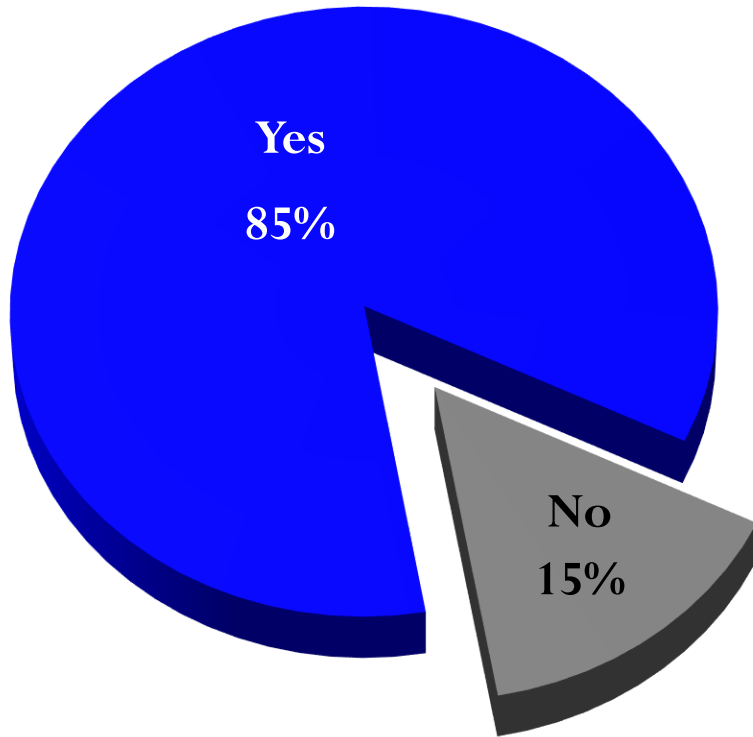


Q: Do you **currently** own the home or apartment where you live, do you rent, do you live with family, or do you not have stable housing?

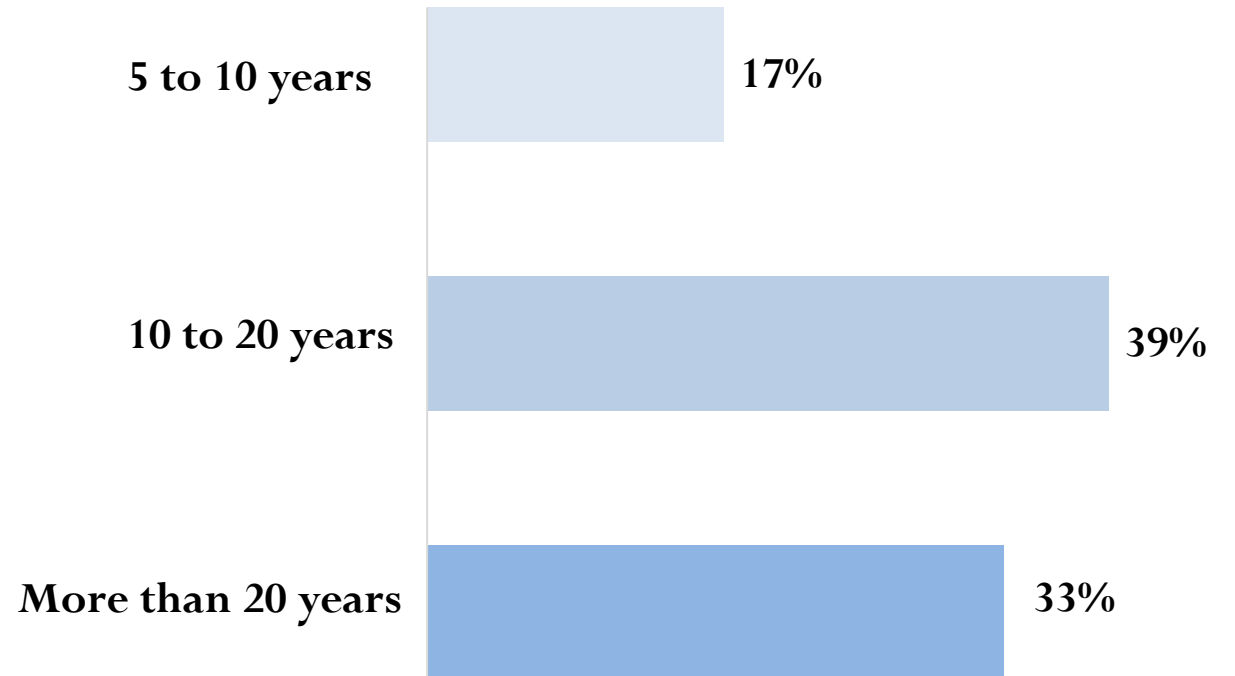


MOST ARE LONG-TERM SUBSTANCE USERS

Q. Does the participant have any experience (past or present) with substance use addiction/disorder?



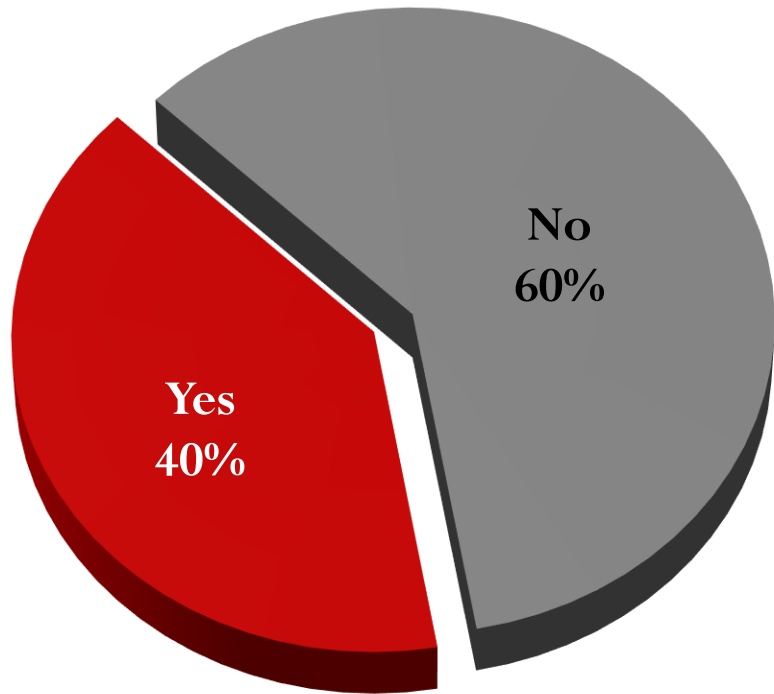
Q. How long has the participant been dealing with substance use disorder?*



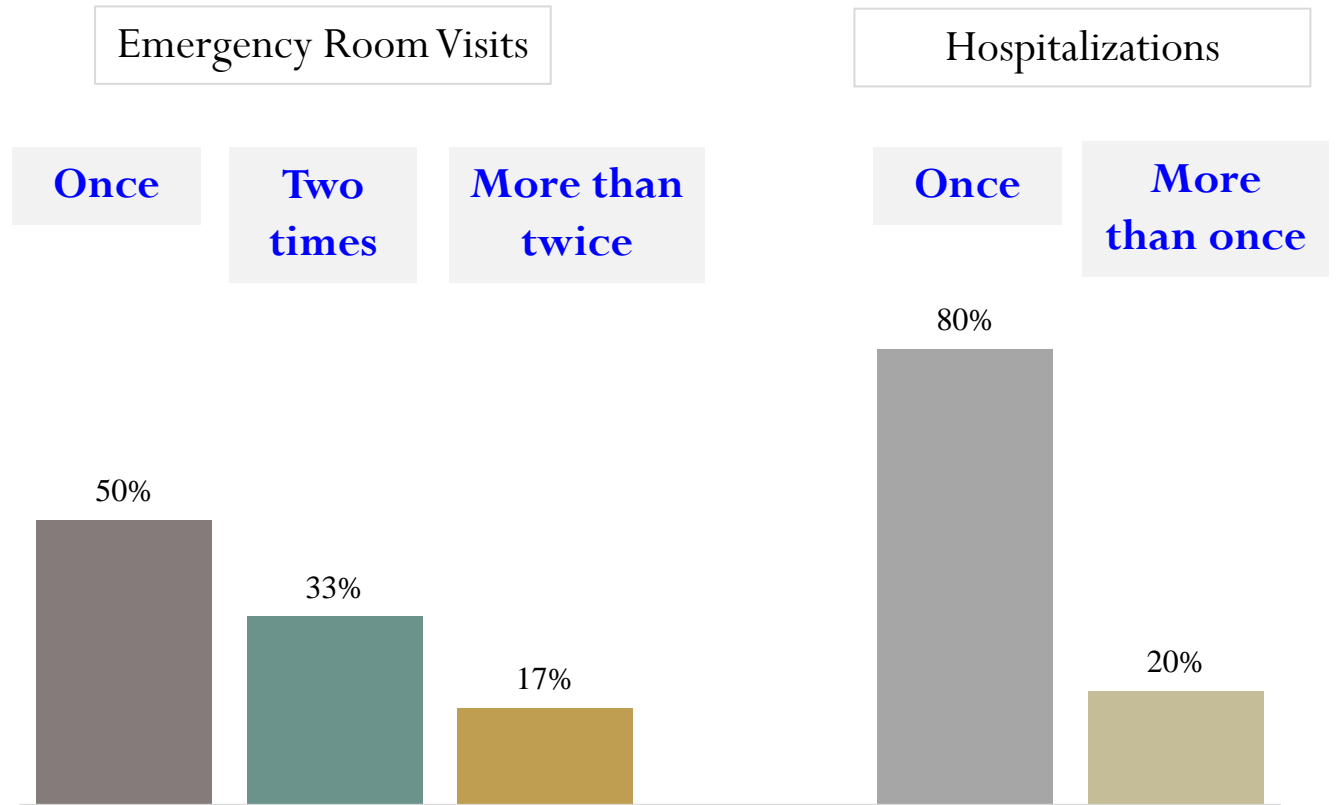
**One participant did not disclose the length of their substance use.*

2 IN 5 ARE INTENSIVE USERS OF THE EMERGENCY CARE SYSTEM

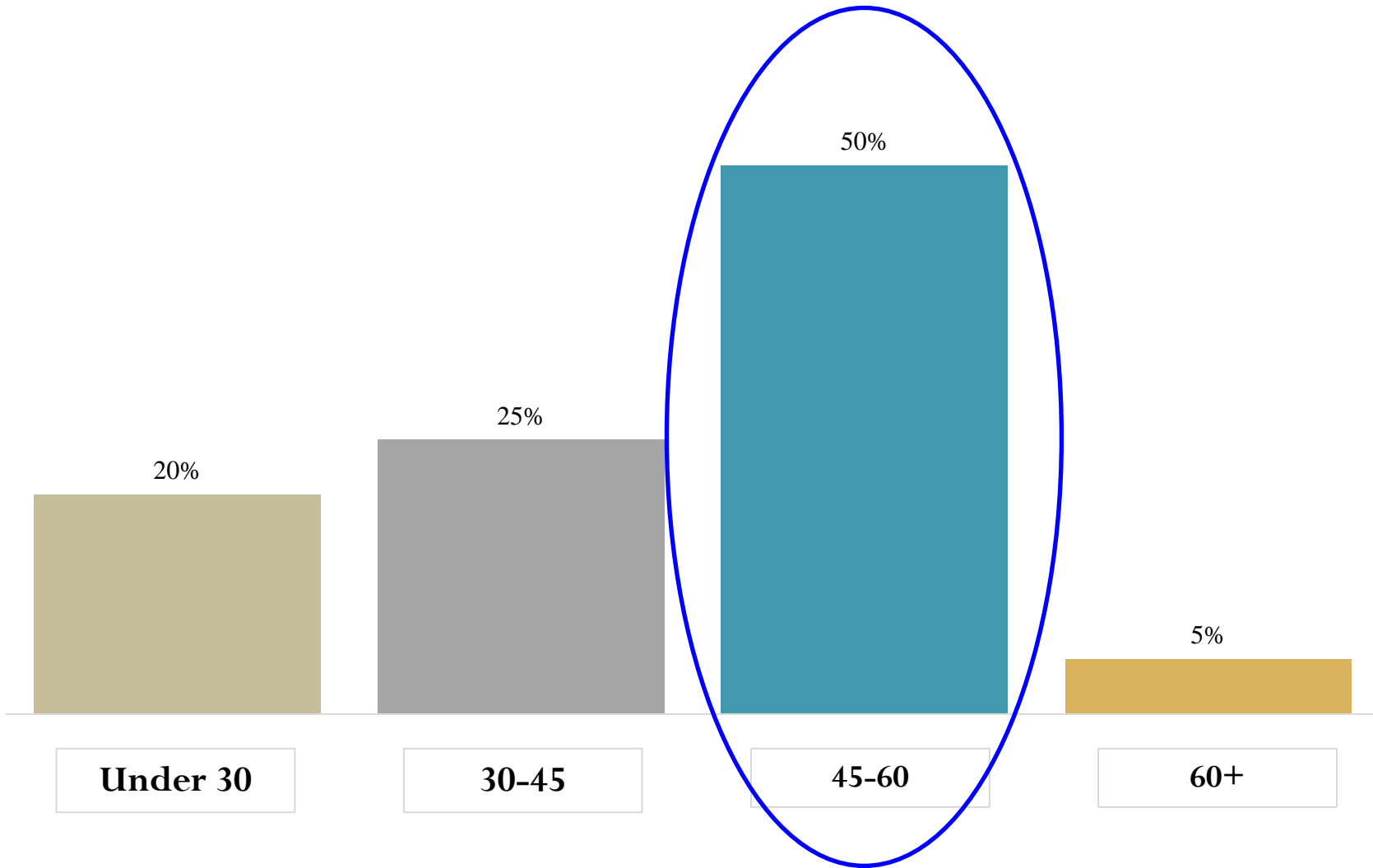
Q. In the last six months, has the participant gone to the emergency room or hospital for a physical or behavioral health problem?*



Q. In the last six months, how many times has the participant gone to the emergency room or hospital?*



OVER HALF WERE MIDDLE-AGED RESIDENTS FACING COMPLEX HEALTH NEEDS



PARTICIPANTS EXHIBITED COMPLEX ISSUES & NEEDS

	WCIA
Experience with Homelessness	19
▪ Currently Unhoused	7
▪ Previously Unhoused	12
Foster Care (Former)	5
Substance Use	17
▪ Active Substance Use	4
▪ Prior Substance Use	13

PARTICIPANTS EXHIBITED COMPLEX ISSUES & NEEDS

	WCIA
Incarceration	17
Mental Health Conditions	18
Complex Health Challenges	14

PARTICIPANTS DISCLOSED A RANGE OF SUBSTANCES USED

	WCIA
Marijuana/Cannabis/Pot/Weed	6
Cocaine	2
Fentanyl	3
Methamphetamines/Ecstasy/Adderall	8
Opioids/Opiate/Heroin/Vicodin/Percocet	9
Alcohol	7
Ketamine	1

PARTICIPANTS DISCLOSED A RANGE OF MENTAL HEALTH CONDITIONS

	WCIA
Depression	14
Post-Traumatic Stress Disorder	11
Bipolar Disorder	4
Schizophrenia	2
Dementia	1
Anxiety	9
Borderline Personality Disorder	1
Other	3

Alzheimer's and Schizoaffective Disorder were also asked during recruitment, but no participants were affected by the condition.

OTHER HEALTH CONDITIONS SHARED BY PARTICIPANTS

	WCIA
Cancer	2
Diabetes	3
Hypertension or High Blood Pressure	6
Kidney Disease	1
High Cholesterol	2
Asthma	4
Parkinson's Disease	-
Other	7

Heart Disease was also asked during recruitment, but no participants were affected by the condition.

III. PARTNER-SPECIFIC FINDINGS

**WESTSIDE COMMUNITY
IMPROVEMENT ASSOCIATION**

KEY FINDINGS—WCIA

1

Networks of services, resources, and health care were overburdened, difficult to navigate, or unavailable to access in rural and remote settings.

- ❑ Participants pointed out a lack of specialized care nearby, such as dental care, pain management, or substance use treatment, which forced them to travel up to two hours to larger cities for urgent or longer-term treatment.
- ❑ They noted that there were not enough facilities and health care and social service providers to meet the needs of current residents in smaller areas such as Eureka, Ferndale, or Hoopa Valley, resulting in long wait times.

“What is really difficult is you are constantly waiting for services, and **oftentimes that is all you’re doing—is just waiting.** Then you keep calling back and they are like, “I’m sorry, we still don’t have a provider,” since **everyone is either aging out up here, and no one is moving up here, because it is very rural and isolated, and they don’t get paid well.”**

—Multi-Racial Woman, Age 33, WCIA, Eureka, CA

KEY FINDINGS—WCIA

2

Participants have identified a concern with drug culture in the Rural Far North, and substance use impacted their ability to stay housed and connected to services and social networks.

- ❑ With a lack of mental health facilities and employment opportunities, many described their substance use as a source of self-medication that was easier to access than services.
- ❑ Participants had experiences using methamphetamines, fentanyl, heroin, and cocaine, with multiple experiences with rehabilitation centers and sober living homes. Those who were in recovery were receiving regular suboxone or methadone treatment for withdrawal.
- ❑ They felt that there was inadequate training for health care and social service providers in treating patients with substance use disorders, often leading to feelings of being stigmatized.
- ❑ However, American Indian/Native American participants described positive experiences with substance use treatment centers that were culturally specific, integrating traditions such as basket-weaving and beading into traditional group therapy methods.

IN THEIR OWN WORDS: SUBSTANCE USE CHALLENGES

“Right now, the drug culture is the only reason why this city exists and that is something I can’t overemphasize. When you make drugs the culture, and it is the way of life, it is funny that they get mad with you when you do drugs here.”

—Black/African American Man, Age 56, WCIA, Eureka, CA

“Fentanyl is a very addicting drug, and once it has you in its grasp, it’s like nothing else matters. Your kid doesn’t matter, your family doesn’t matter, life doesn’t even matter. And it’s really not worth it because one day either you’re going to die or someone around you will that is using with you. And it literally takes your life away if it really doesn’t take your life away.”

—American Indian/Native American; Latina; and White Woman, Age 21, WCIA, Eureka, CA

“If you say you’re an addict and you’re seeking treatment or something for, say meth or heroine, people look at you very differently than if you are an alcoholic. I have very much seen that in real life, and it’s kind of disheartening because you are part of the healthcare system.”

—Multi-Racial Woman, Age 33, WCIA, Eureka, CA

IN THEIR OWN WORDS:

COGNITIVE IMPACTS OF SUBSTANCE USE

“It takes a while to get your head straight after coming out of addiction, especially as many years as I have. Just getting clean for a month and detoxing and getting drugs out of your system is one thing **but actually letting your brain heal and the neuroplasticity grow back and being able to get your memories back and be able to get your cognition back, it is a growth process, and it can take some time.**

– *American Indian / Native American Man, Age 48, WCIA, Eureka, CA*

“I’ve only been off of drugs for about 18 months now. **So my brain is still not functioning properly because it takes some learning. I’m learning that it takes a long time for your brain to heal, at least five years, when you’ve been on drugs.**”

– *Latina, Age 51, WCIA, Eureka, CA*

IN THEIR OWN WORDS:

CULTURALLY-SPECIFIC TREATMENT

“It helps having a Native American provider if you’re Native American, because they know a lot about culture and everything as well. When I was going to Two Feathers [substance use recovery], it helped me reconnect with my heritage, because while you’re talking to them, you guys would bead necklaces together or go to like workshops for bear grass weaving and basket weaving.”

—American Indian / Native American Woman, Age 18, WCIA, Eureka, CA

“The great thing about Friendship House was you got to stay really connected to your culture and it was a 12-step NA/AA program and then there’s a Red Road for Natives, which is more spiritual, which I think it’s great. It was cool being more into your culture.”

—American Indian / Native American Woman, Age 26, WCIA, Eureka, CA

KEY FINDINGS—WCIA

3

There was cyclical to participants’ interactions with health care, carceral settings, and substance use treatment programs. Across interviews, participants described a cycle of relapse, homelessness, incarceration, and release.

- ❑ A few participants described the positive effect incarceration had on their trajectories, as their probation officers connected them to housing and substance use treatment programs. Others, however, shared negative experiences with incarceration and required legal services.
- ❑ Support post-release was unanimously considered inadequate. Participants were often released at night with missing belongings, soiled clothing, uncharged phones, and nowhere to go. Without the awareness of long-term support services, they stated that they were often incarcerated again.
- ❑ To break this cycle, participants suggested that probation officers or guards offer a ready-at-hand list of services and resources for housing, social services, and substance use treatment.

“They do release you at midnight. ... I also didn’t have any chance to get a phone call while I was in there for three days. They didn’t give me a phone call for those 72 hours, so **nobody knew where I was or what had happened.”**

—White Woman, Age 49, WCIA, Eureka, CA

IN THEIR OWN WORDS:

DIFFERENT EXPERIENCES WITH INCARCERATION

“I’ve always been the type of person; this is the first time I ever got clean and actually done probation. Before I was always getting in trouble absconding. I never really did probation. Now I’m about to be getting a new probation officer, because I’m completing my year, because I have her for a year. But she has been a good support with me. **She’s a really good probation officer. I always thought they were against you, but she’s helped me out with different programs.”**

—*White Man, Age 38, WCIA, Eureka, CA*

“They release people when they want to, and it’s according to who you are. **Or sometimes they make you wait until 12:00 A.M., and somebody has got to come push a button from the outside and let you out. ...** The clothes that I came in, they were freshly washed, **and when I got my stuff again, it was all molded. It was wet, it was molded.”**

—*Black / African American Man, Age 51, WCIA, Eureka, CA*

KEY FINDINGS—WCIA

4

Transportation was a critical gap to care in the Rural Far North, as a majority did not own a personal vehicle and relied on friends, family, or public transportation to access services.

- ❑ Public transportation was not consistent enough to rely upon, and many participants were forced to turn to friends or family for transport. However, as a result, they avoided going to appointments unless they were for urgent needs.
- ❑ One participant from Ferndale, a rural town 25 miles from Eureka, described her unique difficulties with transportation. With only one path in and out through a bridge and no personal vehicle, she relied on Partnership transportation to medical appointments, which needed to be booked in advance.

“But it’s just one way in and out, ... there’s no public transportation. However, if I have a medical appointment, I do have services if I book one week in advance.”

—White Woman, Age 49, WCIA, Eureka, CA

IN THEIR OWN WORDS: TRANSPORTATION

“I live on the whole other side of Eureka, and most of my appointments are in Arcata, which is like a 30-to-40-minute drive. So I always have to get a ride there and back. I have probation that I have to get a ride to. Then I have baby, and I can’t leave baby in the car, so I’m going back and forth all over town. But it’s ridiculous, because I give them \$20 to give me a ride two blocks down. ... I don’t have money like that. But buses, I don’t feel comfortable bringing baby on the bus yet.”

— American Indian / Native American; Latina; and White Woman, Age 21, WCIA, Eureka, CA

“The nearest area outside of this is 150 miles and it’s Redding, or 200 miles to Santa Rosa, which oftentimes people have to drive to go to Santa Rosa for dental care.”

— Multi-Racial Woman, Age 33, WCIA, Eureka, CA

KEY FINDINGS—WCIA

5

Dental care remained a top priority for Rural Far North residents.

- Participants who had substance use disorders mentioned that dental care was an urgent need, as many had lost their teeth or were wearing ill-fitting dentures.
- However, nearly all participants flagged that dental care was severely lacking in Eureka, with only one or two clinics accepting new Medi-Cal patients. For those who were able to get care, they described the inefficient systems of scheduling and only receiving one treatment per appointment, which resulted in repeated appointments over many months.

6

Access to reliable internet was a barrier to care for participants, who thus preferred in-person services despite a lack of transportation.

- Without internet access or personal devices such as laptops, participants faced difficulties accessing or searching for services online and trusted in-person services more.
- Those who were able to access care virtually or held a degree of interest in telehealth expressed doubt about fostering a personal connection to providers and sobriety groups online.

IN THEIR OWN WORDS: DENTAL CARE

“First of all, there’s not very many and especially dental, **nobody takes new patients, and the Medi-Cal or the Partnership dental situation is a total disaster, like the continuity of care is just not there.**”

—*White Woman, Age 49, WCIA, Eureka, CA*

“Every resident here in Humboldt will say the same thing. ... **If you need dental or vision and you want to make an appointment, you have to go to Santa Rosa. That’s what is now. You have to go two hours.** You can’t go here because they’re full. So, it’s like there’s been many times I wanted to go the dentist. I’ll be in pain for days, and I want to go to the dentist, and then when I go to the dentist and I tell them what’s going on, they’re like, ‘We’re full. If you want to get it fixed, you have to go to Santa Rosa or somewhere else.’”

—*American Indian / Native American and Latino Man, Age 50, WCIA, Eureka, CA*

IN THEIR OWN WORDS: INTERNET ACCESS

“I don’t really trust the process. I rather just go in person to the office and take an hour or two to sit there and wait and do it in person than to do it on the Internet... I had a bad experience because I had to renew my Medi-Cal and I had submitted all the paperwork in advance and then I got a letter saying that I didn’t submit paperwork or that I didn’t get it turned in on time when I did, and I had copies, and so they cut my Medi-Cal off and so I had to recertify again. And that’s when I had to stress out about my insulin and all my medications because it’s all connected to my Medi-Cal and I knew that I had done it in advance, at least a month in advance, and then they said they never got any paperwork.”

–Latina Woman, Age 51, WCIA, Eureka, CA

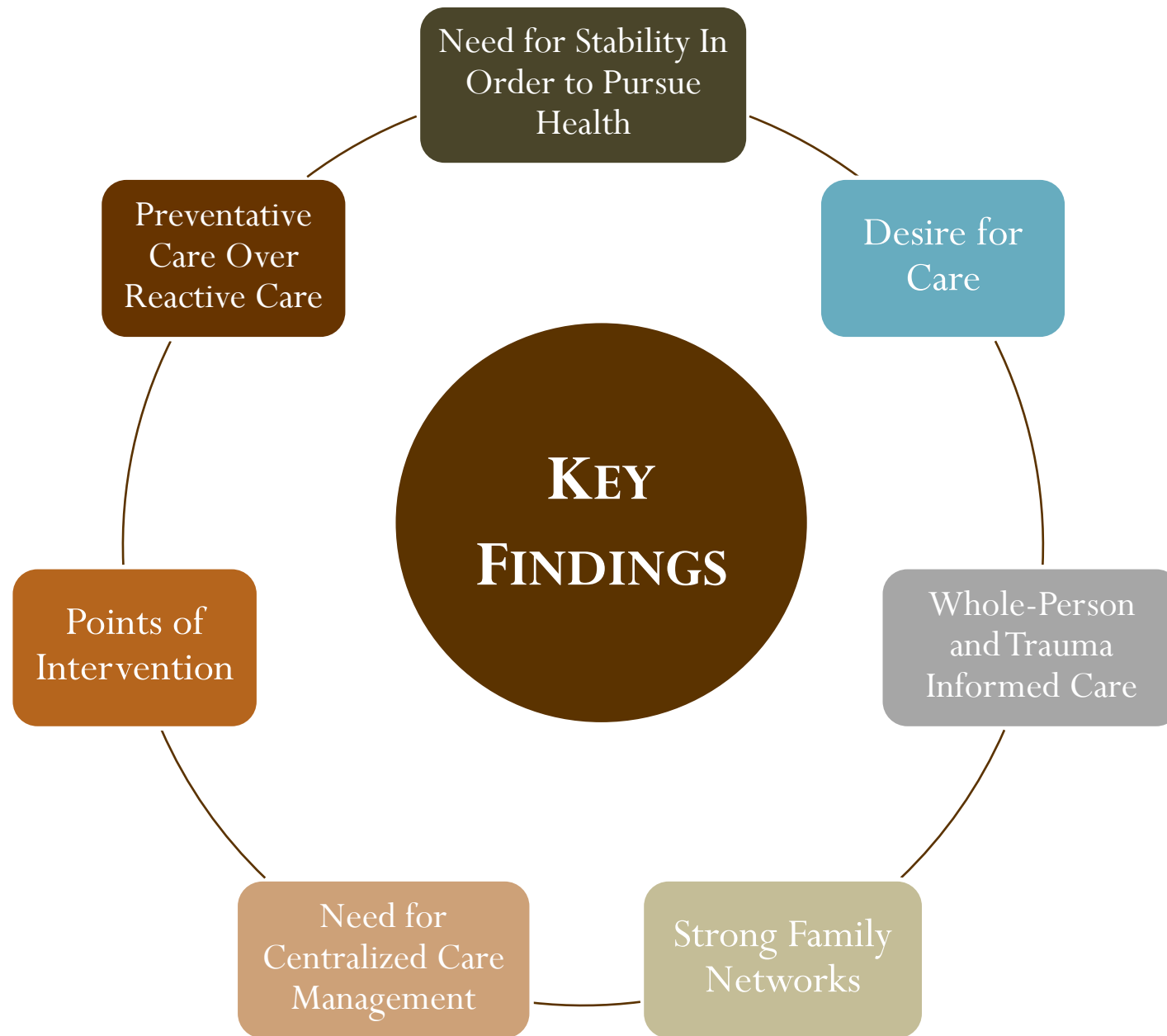
“I don’t really know about the whole online stuff, because I’m not that bright with technology, and technology is getting a lot harder these days. I struggle with dyslexia, so I am not fully capable of comprehending each and every word that they put on the paper, which makes it more difficult. I feel like they should take more time with you to actually go over your paper with you and explain it and give you more details.

–American Indian / Native American Woman, Age 18, WCIA, Eureka, CA

IV. PHASE II OVERALL KEY FINDINGS

COMPLEX NEEDS—AS EMPHASIZED BY PARTICIPANTS

Homelessness/ Housing Insecurity	Mental Illness	Substance Use	Incarceration	Challenges Living Independently—Age
<i>Service/Resource Need</i>	<i>Service/Resource Need</i>	<i>Service/Resource Need</i>	<i>Service/Resource Need</i>	<i>Service/Resource Need</i>
Long-Term and Low- Income Housing	Mental Health Care Coordinators	Accessible Treatment Programs	Immediate Housing Options Available Upon Release	In-Home Care Services (Personal, Cleaning, Cooking)
Places to Shower and Wash Clothes	Affordable Care Therapy, Counseling	Dental Care	Lists of Services Provided Upon Release	Reliable Transportation
Case Manager and/or Services Navigator	Increased Number of Providers	Increased Number of Sober Living Homes	Job/Financial Assistance	Case Manager and/or Services Navigator
Mental Health Support	Family Counseling	Mental Health Support	Empathetic Health Care Providers	Support With Technology
Empathetic Health Care Providers	Peer Engagement and Support Groups	Empathetic Health Care Providers	Mental Health Support	Spaces To Socialize With Peers



KEY FINDINGS

1

Participants’ primary goals were to acquire the stability to pursue better health—through continued housing and employment—after dealing with barriers due to previous substance use or incarceration.

- Housing was a critical concern among participants. Programs such as Section 8 were valuable but often came with long waiting lists or eligibility issues.
- Some participants detailed how welfare systems—while providing essential support—often did not cover all living expenses, leading to difficult trade-offs between employment, healthcare access, and basic needs. Welfare programs also imposed income limits that deterred participants from seeking employment or better-paying jobs.
- Participants who had previously been incarcerated or faced substance use disorders experienced barriers and discrimination while trying to seek employment and housing, which was what they needed to gain stability and avoid relapse.

KEY FINDINGS

2

The desire for more “caring” care was a consistent and recurring theme across regions. Participants used the term “going through the motions” when describing the mannerisms of services and health care providers, and **sought genuine compassion, empathy, shared their lived experiences, and willingness to listen and ask about their goals for better health.**

- Several participants reported experiencing racism within the health care system, which negatively impacted their willingness to seek out services. As a result, many expressed a preference for health care providers from the same racial/ethnic background but had no choice in selecting their providers—especially in the Rural Far North, where there weren’t enough providers of color.
- Some participants, particularly those who were overweight, faced body shaming from healthcare providers.
- Others perceived the attitudes of the staff in hospitals and emergency rooms as judgmental, rude, and demeaning to those who are experiencing homelessness and/or substance use disorders, causing them to either avoid these settings altogether or leave before being treated.

KEY FINDINGS

3

Participants stated that **more robust preventative services could help prevent them from falling into crisis** (especially when they might be on the brink), rather than requiring reactive care after a full-blown crisis had developed.

Many participants felt that they were **unable to obtain needed social supports because they were not yet actively or visibly experiencing a crisis**—their conditions weren't severe enough to qualify for immediate housing, and they had to **exaggerate symptoms of mental health conditions or substance use to be prioritized for services.**

- ❑ Some participants stated that they were often ignored in favor of those with more urgent needs. They attributed this to the housing, health care, and social service systems being overburdened. This in turn, ended up sending more people into crisis due to lack of support, thereby further overwhelming the system.
- ❑ Participants of color described a hierarchy in receiving services—as white unhoused individuals usually receive resources ahead of them. Others stated that finding housing (without religious affiliation) as a single person, or without substance use addiction and diagnosed mental health conditions, was nearly impossible.

KEY FINDINGS

4

When asked where they would turn to for information about services and support, **participants shared that they do not know where to go or what to ask for as resources.**

Participant stated that they prefer **being sought out and provided information**, underscoring the **need for community outreach**, better case management, and **one-stop-shop facilities.**

- ❑ Many **participants** shared experiences with trauma or substance use, and some **were in immediate crisis**—which **impacted their cognition** and **ability to manage** their **complex needs**. They struggled with finding resources or handling the paperwork and applications that came with managing their complex needs.
- ❑ They reacted positively to the suggestion of having a dedicated case manager and a one-stop shop facility, which would eliminate confusion about who to turn to for support.

KEY FINDINGS

5

Participants noted that **more information, available services, and support could be provided at critical places/points in time, such as interactions and exits from emergency rooms and hospitals, mental health facilities, and carceral settings (jails and prisons).**

- Some participants emphasized that—if they had received a list of services before being released or upon release or immediately after release from these potential intervention points, they would have been able to access needed social supports and continued care.
- Doing so, they stated, could have prevented them from needing more intensive services at a later point in time, and thereby mitigate a more resource-intensive engagement with the health care system.

KEY FINDINGS

6

Participants stated that comprehensive training in providing **trauma-informed** care and services would better equip providers to **understand the complex needs** and backgrounds of those whom they serve. This, in turn, would help them **respond** in ways that are **better suited to their needs**.

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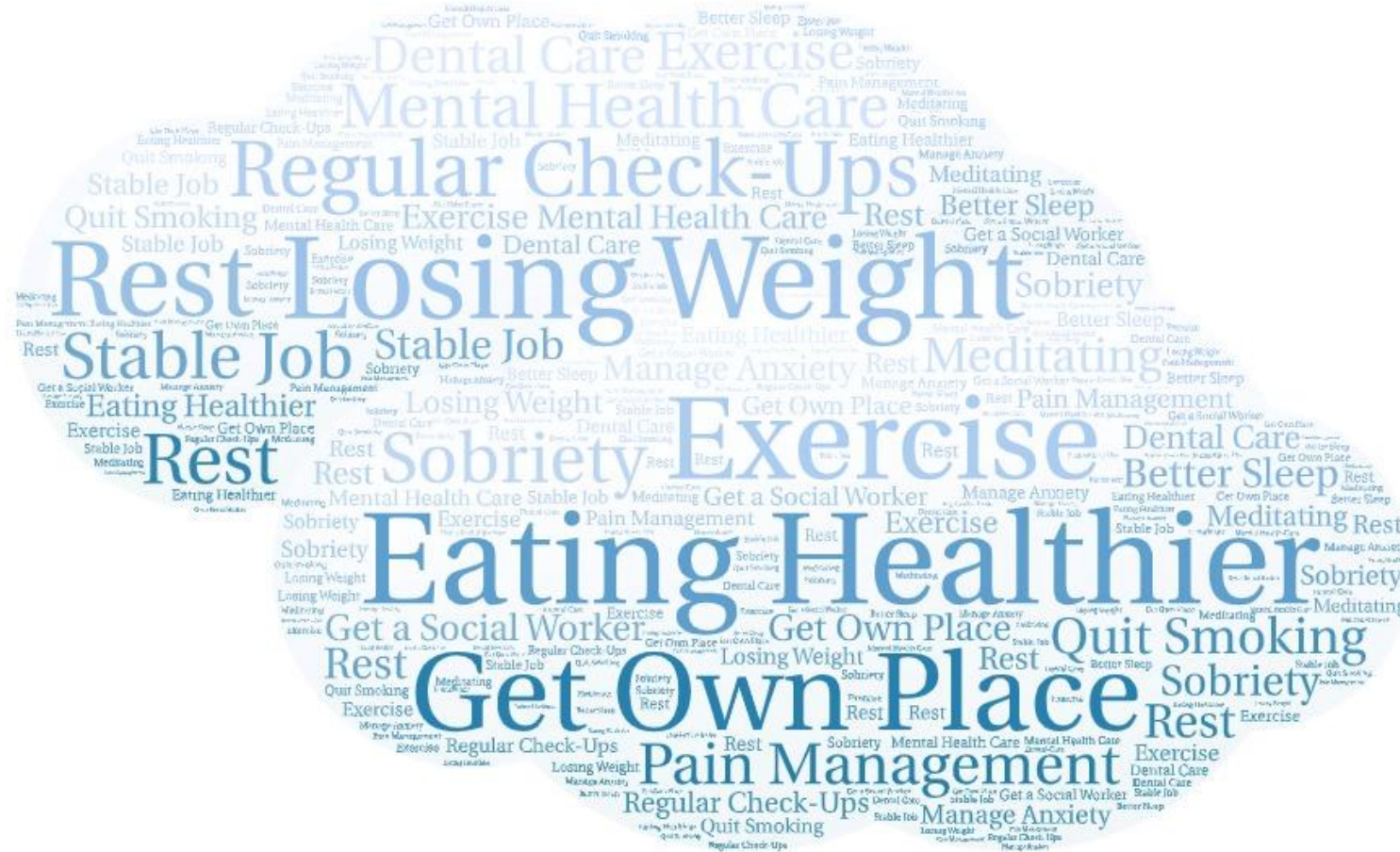
There was an evident value in having a strong support system, whether it was through family, friends, or community services.

- Family and social networks were often the first point of contact that participants turned to during crisis, and their support was a critical turning point for many in getting the help they needed.
- This suggested that integrating families and friends into a whole-person care model—by supporting them as caregivers, offering more group counseling, and equipping them with more information and resources—could be an avenue for improving the quality of care.

NEEDS—IN THEIR OWN WORDS

PARTICIPANTS STATED A RANGE OF HEALTH GOALS

Q: Are there any goals that you are working toward for better health, well-being, or more stability in your life?



IN THEIR OWN WORDS: ACQUIRING STABILITY

“There’s a lot of problems with housing here in Humboldt County, or everywhere. The waiting list for housing is years and years long, it can be. If I wasn’t in these programs, I probably would be screwed. If I wasn’t in these programs, I wouldn’t have gotten the help. ... If I was in somebody else’s shoes, that’s how a lot of people become homeless. There’s a lot of people with mental health issues out there, and they’re not able to get these services.”

– White Man, Age 38, WCIA, Eureka, CA

“If you don’t have kids, you don’t get [general relief], so then what? If you don’t have the proper clothing or the proper hygiene, then you can’t do CalWORKs because you don’t have nowhere to shower or to get ready for work, so it makes it difficult.

– Latina Woman, Age 51, WCIA, Eureka, CA

SUBSTANCE USE TREATMENT, HOUSING & TRANSPORTATION RANK AS TOP RESOURCES NEEDED

Question:
Are there any specific
resources that would be
helpful?

Substance Use Treatment

75%

Housing Insecurity/
Homelessness Service Providers

70%

Transportation

70%

Counseling/Therapy

70%

Benefits Assistance

65%

Dental Care

60%

Percent of Respondents

IN THEIR OWN WORDS: QUALITY CARE

“Quality would be like actually listening again, actively listening, participating and really wanting to help you rather than going through the motions. Then a higher quality would be those heightened things. The idea of having a provider regardless of the services is sort of hoping that they understand you interpersonally and really want to help you.”

– Multi-Racial Woman, Age 33, WCIA, Eureka, CA

IN THEIR OWN WORDS: CONTINUED CARE

“A good quality of life for me is to have a system to where either a mobile team or you can go to a facility, get time to spend in there, **have counselors, mental health specialists, doctors, nurses who are trained to know how to help you, work with you, diagnose you and then when you leave, you not only feel better, but you also want to give back.”**

– Black / African American Man, Age 56, WCIA, Eureka, CA

“Getting my doctor’s appointments, every time I go to the doctor, it’s a different doctor. **They never have the same one. They don’t know what’s going on. I throw my hands up. I just give up. I just been living with this pain and no income, no nothing. I just don’t know what to do there.”**

– White Man, Age 56, WCIA, Eureka, CA

IN THEIR OWN WORDS:

DISCRIMINATION & STIGMA WHILE SEEKING CARE

“I remember one time in the past I went, and I had a fever of 102.7, and I could barely move. She was like, ‘Okay, I am just going to get you some antibiotic pills to give you, and you can go get them from the pharmacy tomorrow.’ It was like midnight or something, and she was like, ‘Okay, I’m going to get you signed out here.’ ...**The doctor came in and took my temperature and looked at the nurse and was like, ‘What are you doing? If you sent this guy out of here, he would have been dead tomorrow.’ That’s just an example of how homeless people and drug addicts get treated sometimes in the healthcare industry.**”

— *White and American Indian / Native American Man, Age 32, WCIA, Eureka, CA*

IN THEIR OWN WORDS: TRAUMA-INFORMED CARE

“The moment you say Bipolar 1, even in the medical profession, people switch. I think that there is no compassion. Very rarely if you have extreme or, let’s say, worse conditions than other conditions, people lose compassion. I can see that with severe mental health to severe substance use disorder. I don’t know, I think that the school systems need to do better in order to teach these people who are working in communities. It’s just like, why isn’t cultural competency taught?”

—Multi-Racial Woman, Age 33, WCIA, Eureka, CA

BENEFITS ASSISTANCE & DENTAL CARE RANK AS SECOND PRIORITIES

Question:
Are there any specific
resources that would be
helpful?

Substance Use Treatment



Housing Insecurity/
Homelessness Service Providers



Transportation



Counseling/Therapy



Benefits Assistance



Dental Care



Percent of Respondents

IN THEIR OWN WORDS: BARRIERS TO SERVICES

“You’re waiting longer than, say, someone that was white and came from an educated background, how their stuff would move a little quicker ... Even when you’re homeless and on the streets, like they would help some white people better than they would ask, say, a Hispanic.”

– Latina Woman, Age 51, WCIA, Eureka, CA

“Sometimes you aren’t homeless enough, and sometimes they want you to literally be on the street. I had a situation where I wouldn’t have been able to get into the homeless shelter, because even though I was impending homelessness, I technically wasn’t homeless.”

– White Non-Binary Person, Age 24, WCIA, Eureka, CA

IN THEIR OWN WORDS:

CENTRALIZED CARE MANAGEMENT

“If I had the help of a person who was up to bat for me, wanted the best for me and was willing to help me in ways that I was willing to help myself, to be able to get into the system and go to the places that need to be gone to and use the phone when they need and call the right numbers and stuff like all that. That seems like the most useful thing, because that can help in many areas of life, not just one.”

—White and American Indian / Native American Man, Age 32, WCIA, Eureka, CA

IN THEIR OWN WORDS: POINTS OF INTERVENTION

“There was a lot of people that come directly from the hospital to Waterfront, and I wish that they would have given me that opportunity ... because **maybe I would have been a little further along than I am today. I didn’t know that there was caseworkers or case managers at the hospital that can do that for you.**”

— *Latina Woman, Age 51, WCIA, Eureka, CA*

“Almost all of my arrests and time spent in jail were drug-related. At no point was I ever given an option or even saying, “If you need help, maybe you can go see Waterfront or HRC, Humboldt Recovery Center. **If you need help or you want to get help with your addiction or quit repeating the cycle, rinse and repeat of ending up here, then maybe you can try this other option,**” or point me in the direction of NA [Narcotics Anonymous] meetings. **Having a list of where to go to for a meeting or something like that.**”

— *American Indian / Native American Man, Age 48, WCIA, Eureka, CA*

V. FOCUS GROUPS

RESEARCH METHODOLOGY

- From February 8 – 9, 2023, EVITARUS conducted two (2) focus groups among caregivers of residents experiencing complex needs in Eureka, California.
- Each focus group was conducted by a professional moderator in person, in partnership with Westside Community Improvement Association (WCIA), facilitated by Cal Poly Humboldt (CPH).
- Focus groups were up to two (2) hours in length. Each was recorded and transcribed to facilitate data analysis.
- Each participant received an honorarium in the amount of \$150⁰⁰ in appreciation of their time and opinions.
- EVITARUS managed research planning, implementation, data collection and processing, analysis, and reporting.

RESEARCH OBJECTIVES

- The **primary objectives of the focus group research** were to:
 - Gain insight into the experiences of caregivers of individuals with complex needs in helping the person they support get the care and resources they need to be healthy and have a good quality of life.
 - Identify the current needs and resources available as well as challenges connecting person of focus to care and services, including:
 - Quality of care offered;
 - Trusted sources of care delivery and;
 - Gaps in care transitions.

THE FOCUS GROUP RESEARCH METHOD

- Focus groups delve deeply into the mindsets, perceptions, beliefs, and actions of research participants as they “focus” their attention on an issue.
 - Guided, in a semi-structured way, by a professional moderator;
 - Utilizes a series of open-ended questions and projective exercises; and
 - Focus group research provides insight into how research participants think and reason together.
- Focus group research may be considered *suggestive* of perceptions and attitudes that underlie the opinions of the demographic subgroups from which participants were drawn.
- Focus group research provides insight. It is reflective of the perceptions and attitudes present among the population of interest—but these insights are not necessarily generalizable more broadly—particularly given the small sample sizes.

PARTICIPANT DEMOGRAPHICS

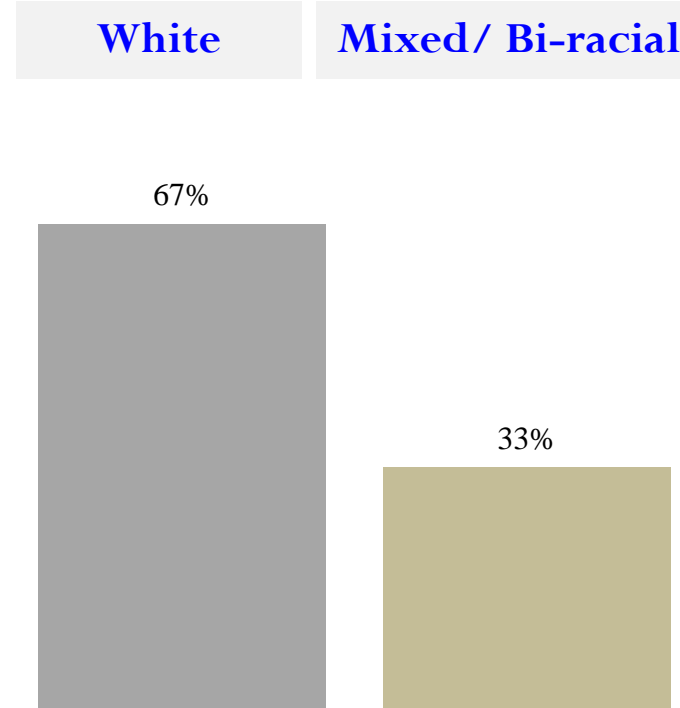
A total of
9 Rural Far North residents
participated in the study.



7
Women 2
Men

Age Range
30 – 68

Participants belonged to variety of racial/ethnic backgrounds, including
Mixed/Bi-Racial and White



FOCUS GROUP KEY FINDINGS

KEY FINDINGS

1

Caregivers were tasked with a wide array of responsibilities, not only in health care, house duties, and transportation **but also in coordinating resources and scheduling appointments**—all of which placed a burden on their mental health.

- ❑ The stressful process of managing these logistics and the mental challenges of residents often resulted in challenges in the relationship between caregivers and residents.

“There was a few times there where **we had no food, we had no gas money, we were trying to figure out how to get to his appointments.** It was really a struggle. And if you miss appointments, then you get kicked off your Workman’s Comp. So, it has been really hard getting everything arranged with that. ... That is my duty being the wife, but like **having to stop and do everything and email the doctor and email the attorney, do all this stuff, check in. It’s hard sometimes to be able to do everything else and be his coordinator. But that’s my job.**”

—Female Caregiver, WCIA, Eureka, CA

KEY FINDINGS

2

Caregivers stated that they typically have to **drive long distances to connect residents to health care services.** This is attributed to:

- Limited health care provider options;
- Resident distrust in medical professionals due to past experiences with misdiagnosis and/or mistreatment;
- Lengthy wait times for appointment to receive care from the limited number of providers that accept their insurance; and
- A lack of available resources and specialized services, such as wound care and physical therapy in their vicinity.

“There’s not a lot of choices in the doctors around here. ... And a lot of it has to do with like your insurance and all of that, and whether you can even get in and get seen. Like you were saying, nine times out of ten when you’re trying to go to the doctor, it’s going to be the clinic. **And it’s going to be somebody that’s never seen you, and it’s going to be somebody that doesn’t know you and doesn’t have any care other than getting you in and out and doing it as quick as they can.”**

—Male Caregiver, WCIA, Eureka, CA

IN THEIR OWN WORDS: LIMITED ACCESS TO QUALITY HEALTH CARE

“I don’t trust the doctors around here. I don’t. My kid has been wrong diagnosed. If I can’t get an appointment with the primary care that they have which normally you can’t get anything unless you do a walk-in clinic, which then you’re not even seeing your primary, you’re seeing somebody else. And he’s wrong diagnosed so many times.”

—Female Caregiver, WCIA, Eureka, CA

“We do physical therapy here in Eureka that we have to drive to two times a week here. So we were homeless. We got approved for the Rapid Rehousing Program through Salvation Army. They were going to pay for first month’s rent and our rent for a full year. We got approved to that. We went down to Redway where we got our place, and then the injury happened, and now everything is in Eureka, all the care doctors and all that kind of stuff. We are making it work, but it’s a lot of driving on our vehicles, it’s a lot of transportation stuff.”

—Female Caregiver, WCIA, Eureka, CA

KEY FINDINGS

3

Caregivers expressed challenges faced in accessing training, information, and health care resources. For many, even though they were equipped with some prior knowledge, the complexity of navigating the health care system proved overwhelming. In their view, this **reinforces the need for those having complex needs to obtain assistance of a navigator.**

Caregivers **sought a case manager or navigator with smaller caseloads.** Having fewer cases, they noted, would provide sufficient time for in-depth follow up on residents' needs, **and manage all aspects of care.**

- The lack of professional training in health care, such as wound care, compounded the difficulty of providing in-home healthcare when local healthcare services were unavailable.
- Ineffective communication and coordination among social services and health care providers were primary factors leading to inappropriate treatments and inconsistent services.
- Caregivers reported that they had to go through a process of referrals to finally get care, which was complicated even with the help of the case manager.

IN THEIR OWN WORDS:

CHALLENGES IN NAVIGATING THE HEALTH CARE SYSTEM

“We live in Redway, so there is no wound care. So, I had to change the wound bandages and stuff like that, and that stopped because it's like he doesn't want to be mean to me, but he wants to punch me in the face. It was just really hard. It was really challenging... No [training]. I seen it a little bit in the doctor's office. The doctor was just like, ‘Put water on it and get it moist and peel it off.’”

—Female Caregiver, WCIA, Eureka, CA

“I was born and raised here, and it's still hard. It's still hard to find any openings ... I was searching for like a year for somebody to help me. I was working with North Coast Rape Crisis. I've been going to school for social work, and all this stuff was just getting heavier and heavier. I called around multiple people for a long period of time and trying to find somebody that was taking clients that took Medi-Cal.”

—Female Caregiver, WCIA, Eureka, CA

IN THEIR OWN WORDS: NEED FOR NAVIGATORS

“But it would be helpful to have a case manager designated for everything, not just for mental health or not just for physical health or anything like that. If you had like a main guy who just did it all and made the referrals to everything, because it does come hand in hand. You can’t just do one without the other... That’s who you see first. Then every other appointment or every appointment you go and meet with them for ten minutes and talk about everything and then go to your regular care provider where you coordinate those appointments to make sure everything is set up and good and in order. So if you could have a coordinator like that, that would be really cool. I think that would be really helpful, and it wouldn’t take much more because you already have the doctor in the office anyway. **Just keep it at the same place...that would be helpful.”**

—Female Caregiver, WCIA, Eureka, CA

KEY FINDINGS

4

Although caregivers received support from IHSS, they expressed the desire for more allocated hours, and compensation at a level that is sufficient to cover residents' needs.

- Caregivers emphasized that the combination of low wages, and the resulting high turnover rate among caregivers, makes it challenging to provide continuous, personalized care to residents.
- Caregivers shared that they receive limited mileage reimbursement of the travel they undertake on behalf of residents' care. This hinders their ability to transport residents to/from appointments, grocery shopping, other important tasks, or leisure activities.

5

Caregivers mentioned the need for more engaging and interesting adult day services, offering a variety of options for people to participate in and enjoy, which would facilitate social interactions for residents.

IN THEIR OWN WORDS: INSUFFICIENT COMPENSATION

“One of them is in Eureka. Just getting to the doctors and everything, because I put miles on my car that I don’t want ... **They don’t pay you to take them anywhere or go to the store for them. They just pay you to go to and from their house...** Then they don’t want to pay a caregiver to go with her down south because she had an appointment down south. It was crazy. **They don’t pay at all enough for what people do. It’s so frustrating.**”

—Female Caregiver, WCIA, Eureka, CA

“I would say for the facility that I work for, **we have a very high turnover rate because they don’t pay all that great. So you get really good people on there and they stay for a while and then they leave, and then you start over again.** So you’re constantly trying to build your group back up ... I make \$17.50 an hour and I’ve worked for the facility eight hours a day, and I’m on call 24 hours a day, and I get calls all the time ... \$25 an hour for somebody that’s literally taking care of people and trying to help change their lives is not a lot of money.”

—Male Caregiver, WCIA, Eureka, CA

KEY FINDINGS

6

Caregivers expressed hope that **their opinions will be taken more seriously**, especially since they **shared experiences of being frequently met with dismissive attitudes by health care providers**, despite possessing detailed information and an informed understanding of residents' cases.

Some caregivers reported that **residents have experienced misdiagnosis**—after transitioning to another hospital or doctor due to **poor communication** between **medical providers and caregivers**.

“Sometimes it puts you in a really awkward situation, because you kind of feel like you’re intruding, but you also want to make sure he’s getting the care that he needs. And then when you try to speak up, you kind of feel like you’re being dismissed. ... He doesn’t understand how to explain what he needs to communicate to them. He’s thinking in terms of, ‘How I feel today, not overall how I’ve been feeling for the last six months.’ So there’s a lot of problems with that when the person can’t communicate for themselves, how it needs to be presented to the doctors or specialists and things. ‘You’re not the person, so we’re not listening to you,’ type of thing.” – *Female Caregiver, WCIA, Eureka, CA*

IN THEIR OWN WORDS: DISMISSAL

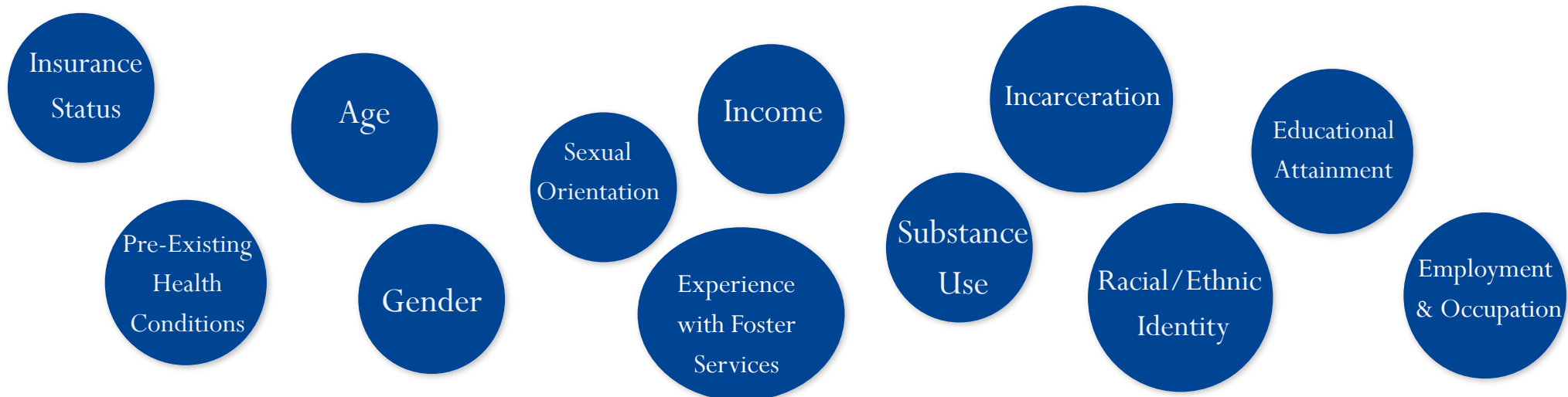
“There was a consumer that I helped, who passed away because the doctors had medication errors, and he had transitioned between two different doctors... He had a new doctor coming in, because they experienced a high rate of turnover in the medical field as well. The doctor came in and thought they had the right idea with the medicine. Gave the medicine, however he had a bad countereffect, and the person ended up having a stroke, passed away. ... **But just communication and consistency across the board, medical providers and then the care providers.** Because a lot of times it is one person thinks they know more than the other, but the doctor who’s met this client for all of ten minutes, when you’re somebody who’s been with them for ten+ hours a day over the last couple years. ... So I just think people just need to realize that both of you could be right and it’s not one person has got to be right, and the other is wrong. **Like both opinions are going to count and should be taken into consideration.**”

—Male Caregiver, WCIA, Eureka, CA

APPENDIX

COMMUNITY PARTNER RECRUITMENT

- A **recruitment questionnaire** was developed and shared with community partners who identified, screened, and recruited community members who expressed interest in potentially participating in an interview.
- Community partner **WCIA** selected the final set of participants which included residents exhibiting a diverse range of demographic characteristics and complex needs.



SCREENING CONSIDERATIONS

- Based upon responses to the recruitment questionnaire, **community partner staff screened participants by the following:**
 - Age cohort;
 - Racial/ethnic background;
 - Gender balance;
 - Complex life challenges;
 - Mental and physical health conditions; and
 - Insurance status.
- Only a limited number of recruitment survey respondents were invited for an interview.

PARTICIPANT SELECTION

- If selected for an interview, respondents:
 - Received follow-up phone calls and emails to confirm that they were selected for an interview, and that they were still willing and available to attend and participate in the interview;
 - Worked with Community Partner to schedule the interview at a suitable, available date/time;
 - Completed an IDI Participant Consent Form.
- Upon completing the interview, participants received the \$150⁰⁰ gift card.
- Selected participants were also asked to do a video interview, for which they received an additional \$25⁰⁰ gift card.



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